HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Ms L Linard MP (Chair)
Mr MF McArdle MP (Deputy Chair)
Mr SE Cramp MP
Ms LE Donaldson MP
Mr AD Harper MP
Dr MA Robinson MP

Staff present:

Mr K Holden (Research Director)
Mr J Gilchrist (Principal Research Officer)

PUBLIC BRIEFING—OVERSIGHT OF HEALTH SERVICES COMPLAINTS MANAGEMENT SYSTEM

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 22 MARCH 2017

Brisbane

WEDNESDAY, 22 MARCH 2017

Committee met at 9.32 am

CHAIR: Good morning. Before we start I request that mobile phones be turned off or switched to silent. I now declare open this public briefing of the Health, Community, Disability Services and Domestic and Family Violence Prevention Committee. I would like to welcome you this morning. Thank you for coming back before the committee. I would like to acknowledge the traditional owners of the land on which we meet and pay my respect to elders past, present and emerging. Today we will be hearing from the Health Ombudsman and representatives from AHPRA and the national boards as part of the committee's ongoing oversight of the Queensland Health service complaints management system. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. The other members of the committee are: Mr Mark McArdle, deputy chair, member for Caloundra; Ms Leanne Donaldson, member for Bundaberg; Mr Sid Cramp, member for Gaven; Mr Aaron Harper, member for Thuringowa; and Mr Mark Robinson, member for Cleveland.

There are a few procedural matters before we start. This committee is a statutory committee of the Queensland parliament and, as such, represents the parliament. It is an all-party committee which takes a non-partisan approach to inquiries. This briefing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. Witnesses have been provided with a copy of the instructions for witnesses and we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript. This briefing will also be broadcast live on the parliament's website.

ATKINSON-MacEWEN, Mr Leon, Health Ombudsman, Office of the Health Ombudsman

AYSCOUGH, Ms Kym, Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency

KENT, Ms Rose, State Manager, Queensland, Australian Health Practitioner Regulation Agency

O'DWYER, Dr Susan, Chair, Queensland Board of the Medical Board of Australia

CHAIR: I would now like to welcome you again Mr Atkinson-MacEwen, Health Ombudsman. I invite you to make an opening statement to the committee and perhaps leave questions til the end.

Mr Atkinson-MacEwen: If you would like to leave questions til then end, that is fine. I will go straight through. Thank you very much. You have asked me to update the committee on a number of points. I will go through those as quickly as I can to give my colleagues an opportunity to speak as well.

I am noting that the government's response to the committee's report was published last Thursday. In relation to recommendation 1, joint consideration, while there is not yet a clear understanding of the options that might be put forward for joint consideration, in the interim my staff have been talking to the staff of the HCCC in New South Wales—the Health Care Complaints Commission—particularly looking at the model they have adopted in relation to joint consideration with the councils of New South Wales. We have a good understanding to date of that, but we will keep doing work with them and also with the ACT, which has a slightly different model to the other national law jurisdictions as well. Whilst we wait for options to be developed, we continue to look at the practical matters that might be involved in implementing any option that is put forward.

In relation to recommendation 2, again because there is no clear understanding of what options might be put forward in relation to not splitting serious matters, we are just looking at how other jurisdictions have dealt with those sorts of things, particularly in New South Wales obviously, again, to provide what practical advice we might be able to provide in relation to how it might be implemented and what the legislation might look like.

In relation to the Health Ombudsman Act, the national law amendments, in the seven or eight months since I wrote to the minister with some possible amendments, I have provided him with an updated list. A few more matters have come through where we think some fairly minor amendments to the Health Ombudsman Act in particular will smooth things. I have also flagged with the minister that we have a legislative issue in relation to the apportionment of costs in matters going before the tribunal as well as some issues that have arisen with information sharing between ourselves and police and the DPP in matters of conduct where there is criminality alleged. Hopefully, some amendments might be forthcoming to smooth those processes over.

In relation to recommendation 3 and the datasets—and we can both talk about this obviously—over the last three months both agencies have been working on the issue of both OHO access to AHPRA data but also the issue of providing datasets to AHPRA for their use. As recently as yesterday my staff and AHPRA staff were involved in a lengthy series of conversations around identifying issues with datasets and what the way forward might be on those.

In addition, because obviously we looked at the submissions that went into the inquiry as well as the inquiry report itself, we have particularly looked at submissions by stakeholders where we have tried to identify pathways to make things smoother for them. For example, we have had consultations on referral of matters to the hospital and health services looking at ways to make it easier for them and easier for us to refer matters back and forth. That new process has been put in place recently. We will continue to look at those submissions and continue to work through a program of work and try where we can where it does not require legislative change in particular to make thing as easy as possible for our stakeholders as much as for ourselves.

You asked about the recent quarterly and six-monthly performance reports. Complaint numbers are up again this year. They are up at least 10 per cent on last year. During the first six months of this financial year they were 29 per cent higher than the first six months of the previous financial year. We are rather hoping that the second half of this financial year will be more or less the same as the first half, in a sense seeing a bit of a plateau. We do not know yet, but we would like to think there will be a plateau because we are looking at more than 6,000 complaints this financial year. If it stays more or less the same or it increases, it will be certainly more than 6,000 complaints to be dealt with. Decisions made within seven days to accept a complaint—they have continued to improve quarter on quarter. We have been working very hard with stakeholders and internally to improve processes. In the last three months, on average, 85 per cent of matters have been dealt with within seven days. Similarly, assessment decision time frames continue to improve quarter on quarter. Again, we have provided the committee with updates over the last 12 to 18 months on what we have been trying to do. Fundamentally, more than 50 per cent of assessment decisions are made within 30 days. On average, only about a quarter, or 25 per cent, of assessments take more than 60 days. Because we have to deal with all the complex serious matters, that average may drop but it is not fundamentally going to drop terribly far. Certainly, 75 per cent of matters at the moment are assessed and dealt with within 60 days.

Local resolution time frames continue to be met; 78 per cent of matters are resolved within 30 days and the rest within 60 days. That small team does an excellent job. It is the same with conciliations. Whilst there are no legislative time frames around conciliations, 70 to 80 per cent of matters are finalised within six months, which is a remarkable achievement for a very small team.

In relation to investigations, over the last six months there has been a concerted effort to finalise investigations over 12 months while managing the new investigations that come in, roughly 15 to 20 investigations per month. The trend in investigations is that fewer and fewer investigations are lasting longer than 12 months. At the end of the last month, only 37 per cent of investigations were more than 12 months old. The notable exception of course in investigations are those matters which go to criminal conduct or allegations of criminal conduct where either the police are investigating or the matters are going through the courts. We have no control over the time frames there and they can take some time for matters to be finally heard and a decision to come out of a court.

In relation to trends or issues arising with AHPRA and the boards, there are a couple of things that I think are important, and I have certainly been discussing one of them very recently. That is, there is some work that has been done and is being done by Dr Matthew Spittal at the University of Melbourne in relation to the consistency of board decisions across the country. That work is around whether board decisions are consistent within boards and across boards. That is, is a doctor in New South Wales or in Victoria being treated exactly the same way as a doctor in WA for the same matter? Is there internal consistency in a sense across the boards, but also is the same sort of conduct, for example, with a nurse or a psychologist or a doctor, being treated the same by the Nursing and

Midwifery Board, the Medical Board or the psych board? That work is important because it is very much around alerting us to whether or not there are inconsistencies. I am trying to get Dr Spittal up to Queensland so we can have a round table with ourselves and the boards to work through what his research is saying to us to date, which would be great. The one thing that we want to do is to be as consistent as possible in Queensland with obviously courts and tribunals but with decisions made across the country for equity's sake if nothing else.

Another thing that has come up is looking at the investigations that we conduct into serious matters particularly into conduct. We have looked at where matters have transferred to us from AHPRA and the boards and looking in particular at the work that was done, particularly using things like coercive powers to obtain information from witnesses to obtain physical evidence. It is apparent that it would be really good for the two organisations to sit down and have a chat. We have a number of investigations that we would like to be able to debrief with AHPRA and the boards on and in particular talk about the use of investigative powers to ensure that when we all do our work, whether it is AHPRA or ourselves, we are capturing all the relevant information at the earliest instance, so we are getting comprehensive witness statements with whatever physical evidence needs to be obtained—text messages, things on computers et cetera. I think it would be really good to have a couple of sessions where we can roundtable and talk around these things. It would be useful generally, but I think it would also be very useful for building up the collaboration between those two agencies. That is it from me. I will throw to my colleagues.

CHAIR: Thank you very much. We appreciate that update. If the committee is happy, we will leave questions til the end. Thank you very much for the update. I invite Ms Kym Ayscough, Executive Director, Regulatory Operations; Ms Rose Kent, State Manager Queensland AHPRA; and Dr Susan O'Dwyer, Chair of the Queensland Board of the Medical Board of Australia. Will you be giving an opening statement, Ms Ayscough?

Ms Ayscough: I will. Thank you for the invitation to appear before you today. I attended the hearing in November last year and, to assist with continuity for the committee, I am pleased to be with you again today, this time in my regular role as the executive director of regulatory operations for AHPRA. With me are Rose Kent, our Queensland state manager, and Dr Susan O'Dwyer, who was recently appointed as the chair of the Queensland board of the Medical Board of Australia and a member of the national Medical Board. We are pleased also to have the opportunity to talk to you about the progress that has been made particularly on the committee's recommendations and to provide you with some information on our recent performance. I will try to keep the statement brief and I will try not to duplicate the things that you have heard already.

AHPRA and the national boards welcomed the committee's recommendations and the government's response to them. We have been doing some work, as you have heard, on the three recommendations of particular relevance to AHPRA and the national boards. If I look first to recommendation No. 3 which you assigned to OHO and AHPRA to progress in relation to information sharing, the government has made clear its expectation that we implement this recommendation with the OHO to ensure that nationally consistent data about health service complaints can be produced and that both agencies have the information that we require. As you have heard, I am pleased to be able to confirm that we have two projects currently underway—one that will enable Queensland data to be included in the national data set for reporting purposes and the other that will provide the OHO with the practitioner information they need in a format that is easily accessed and used. Both projects have benefited from the willingness of our two organisations to find a solution to these information issues and they are progressing well. We expect to have made significant gains in both of these projects by the end of this financial year.

Since the committee tabled its report we have also had a number of discussions around the joint consideration recommendation. We have suggested that we establish a joint working party to look at how the model would work best for both agencies and we have also canvassed the idea of undertaking a trial of joint consideration to assist in the development of the model. As you have heard this morning, the Health Ombudsman has been open to these discussions and has advised that as his first step his office is undertaking some initial research with the New South Wales commission in particular to understand the practicalities of the model as its operates in that state.

You have also heard a little this morning already about the recommendation relating to the splitting of matters. As you know, splitting of matters at the moment is a consequence of legislation that requires the Health Ombudsman to retain the serious conduct matters and AHPRA and the boards to deal with health and performance matters. Currently, there are matters in relation to about 40 practitioners that are split between the OHO and AHPRA and the national boards. We support the

government considering ways that will enable these matters to be dealt with as a whole and avoid unnecessary duplication as recommended by the committee. We are, however, aware that legislative amendment will be needed to achieve this. In the meantime though, AHPRA and the Office of the Health Ombudsman have discussed how we might better manage those split matters and a protocol is under development to ensure better communication about them so that both agencies are fully aware of the progress in each aspect of a practitioner's case and the impacts of any proposed action by one agency on the work of the other.

In terms of performance, I will just give some highlights which really are reinforcing some of the issues around volume in particular. As you are aware, last financial year we had a significant increase in the number of complaints that were being referred from the OHO to AHPRA and the national board. In 2015-16, 1,919 notifications were referred and that is more than double the number of notifications that were referred in the previous year. So far this year we have seen a further increase but not to the same extent. In the first six months of 2016-17, 1,119 notifications have been referred to us. Since the establishment of the OHO we have actually seen more complaints referred in the second half of a financial year, so we are expecting an overall increase of about 20 per cent in the number of referrals this year compared to last.

Last year about 55 per cent of complaints received were about medical practitioners, and that percentage is about the same in 2016-17. However, there has been an increase in complaints overall. For medical practitioners, for example, we received an average of 105 complaints a month in the first half of this financial year compared to an average of 88 referrals a month in the previous year. This kind of increase in the number of complaints referred means an additional challenge for us to ensure that we deal with those complaints in an appropriate and timely way. In response, we have introduced some changes both to our resources and our processes. Firstly, we have run ongoing recruitment campaigns to increase the size of our workforce dealing with notifications. Of course, once recruited, these officers need to be trained in the investigation process and closely supervised as their skills develop. Secondly, we have changed the way we assess medical complaints to improve timeliness and ensure that risk is identified early and appropriately managed. This has enabled us to meet the expected time frames for assessment despite the significant increase in the referrals. Thirdly, a fast-track investigation process has been introduced for medical notifications so we can deal more quickly with those matters that require less investigation so that both practitioners and notifiers can be advised of the outcome of a notification as soon as possible. This process is currently in a trial stage and, if successful, we would expect to expand it to include notifications about practitioners in all professions.

I would close these opening remarks, if that makes sense, by saying that we have been working closely with the OHO since the committee tabled its report, particularly to progress recommendation 3 but also to consider ways that we could be proactive in exploring the options for joint consideration and better management of the split matters. We continue to build effective working relationships with the Office of the Health Ombudsman so that Queensland's co-regulatory arrangements keep the public safe, treat practitioners in a fair and consistent way and meet community expectations. We welcome any questions that the committee has for us.

CHAIR: Thank you both for your opening statements. It is excellent to hear the constructive approach that is being taken between the agencies and we appreciate that with regard to our recommendations and with regard to the ongoing relationship. That is excellent and thank you for the work that has been done over these past few months in that regard. I have a question about the increase in complaints, and I will just direct it generally because I am interested in both of your views. You mentioned a 10 per cent increase in complaints in terms of what you are seeing and, Ms Ayscough, you mentioned a 20 per cent increase in referrals. In terms of the substantial increase in the number of complaints that are being referred to AHPRA, I am interested in your views about why that is occurring. You are getting a larger increase than you are seeing overall, so can you talk a little about that trend and what your views are about why that is occurring from the different agency's points of view?

Mr Atkinson-MacEwen: It is interesting because Kym mentioned the proportion of medical practitioners in the overall number, and it appears that the proportions are remaining more or less the same in terms of the different practitioners that are being referred. We are seeing a 10 per cent increase obviously off a high base. It is interesting in that Kym mentioned the second half of the year, but we seem to be seeing, if you like, a bit of a steep rise in the first six months of the year and then a bit of a plateauing across the next six months. Overall for us it is not necessarily something that we can predict, nor is it something where we can say with any degree of certainty why we are seeing

more complaints about registered practitioners in any particular quarter or six months or 12-month period. In a sense, they are what they are. They come through the front door. For the most part the proportion of registered to unregistered practitioners in complaints as opposed to health service providers more broadly is still about 95 per cent registered practitioners to five per cent unregistered. It is difficult for both agencies and I can appreciate the resource implications for AHPRA because we have exactly the same resource implications ourselves and we are looking at the same pool of people in many cases to draw on to bring on to deal with these matters. Fundamentally, we have no control about what comes in through the door. We consult on every matter that goes across. It just is for some reason at the moment a bit of a bubble with registered practitioners which may or may not remain a bubble.

Ms Ayscough: Yes, I would have to echo largely that. I would be very relieved if the 10 per cent prediction turns out to be more accurate than our 20 per cent with the second half of the year.

Mr Atkinson-MacEwen: So would I.

Ms Ayscough: It is, as Leon says, incredibly difficult to forecast what is going to come through the door. We are seeing across the country again an increase generally in the number of notifications coming in and in some parts of the country really quite a significant surge in the first two quarters of this financial year and much as you are expressing, Leon, a similar kind of flattening in most places in the first couple of months of this calendar year. It is extraordinarily difficult to understand what it is that creates the surge and the decline, but each of us really just have to respond to what comes through the front door. In our case we look at that in the three domains of resources, structure and process as you would in trying to find ways of managing such fluctuating demand for our services.

CHAIR: Mr Atkinson-MacEwen, without forecasting, are there any observations that you feel that you would make that would be of assistance to the committee in that of the increased complaints are they across-the-board or are you seeing any trend or increases in particular areas?

Mr Atkinson-MacEwen: As I mentioned, it is still proportionally around, of individual practitioners who come by way of complaints, 95 per cent registered to five per cent unregistered. There is work going on across the country in relation to implementing codes of conduct for unregistered. We have a code of conduct for Queensland. Work is going on across the rest of the country to implement codes of conduct in the remaining states and territories. Without a doubt that increased profile and visibility of mechanisms to complain about the unregistered is likely to lead to increases in complaints more broadly about the unregistered. Given though the number of, if you like, health service interactions people have, it is still predominantly going to be with registered practitioners, so we might see it flatten out to sort of 90 per cent to 10 per cent rather than 95 per cent to five per cent over time.

That has a range of difficulties associated with it because there are fewer levers to pull in relation to the unregistered, but nevertheless that is potentially going to be a trend. We still see the same proportionality more or less in relation to doctors versus nurses versus phycologists and dentists and then it tails away, and that does not appear to be changing much either. Certainly we are seeing—and we have seen it the last 18 months of course—concerns raised about maternity which do not necessarily link directly to the practitioners involved but more to the services in which the maternity services are being delivered of which practitioners are a part. In terms of the overall trends with registrants, for example, one or two high-profile cases in the media might see a flurry of complaints of a similar nature but, generally speaking, the trend appears to be relatively stable.

CHAIR: Thank you. The other question I had before opening up to other committee members is with particular regard to investigations exceeding two years. I think that you have made the comment that completing investigations in some respects has been delayed because of departure of investigators. I note from your annual report that your office has a 24 per cent separation rate for staff. I am just interested to know what is being done to alleviate that issue.

Mr Atkinson-MacEwen: Sure, and that is fundamentally down to budget—that is, the processes by which our budget is provided are such that it is difficult to provide certainty year on year. Because we are there to respond to demand, we have had to maintain somewhere in the order of 85 per cent permanent appointments to roughly 15 per cent fixed term appointments in many cases simply because of the need to be able to manage budgets should they shrink. So that budget uncertainty—and I talk to my staff regularly about these issues—is one where, clearly, if I cannot say with any certainty that I am going to have 35 full-time permanent employees in the investigation space but need to have, say, 28 or 29 with five to six fixed terms to meet budgetary considerations, that is always going to be a driver of separations, particularly in investigations.

CHAIR: Are there other drivers?

Mr Atkinson-MacEwen: I do not think so. We do exit surveys of our staff and for the most part staff say, 'Look, we would really like to stay, but there is a permanent role being offered at the same level' or, quite frankly, at higher levels. That is great for staff when they go to something better. When you have a fixed-term arrangement in place, we know that staff will be looking four months out from when that contract ends to see whether or not the contract is to be extended, is a permanent role going to be offered in the organisation, or do they need to look elsewhere and I do not blame staff for doing so.

CHAIR: Also, you appreciate that working in the area of complaints is not always an easy job.

Mr Atkinson-MacEwen: That is the other thing. Of course, as much as we try to support staff in relation to things like resilience, yes, you can get burnt out, particularly if you have been doing it for a very long time in other agencies.

CHAIR: Thank you.

Mr McARDLE: Can I start by congratulating you on the camaraderie and collaboration that has occurred since the report came down. Mr Atkinson-MacEwen, you mentioned the apportionment of costs as an issue that you had. Could you elaborate upon that? I know what it means, but the detail about it.

Mr Atkinson-MacEwen: When the Health Ombudsman Act was introduced, prior to that and in the national and other jurisdictions there was a mechanism by which costs could be recovered. That has been taken out of the national law and laws introduced into the Health Ombudsman Act. In a sense, we fall back on what is in the Queensland Civil and Administrative Tribunal legislation. There have been a couple of recent decisions in the tribunal around costs that are a bit concerning in the sense that we might not recover the costs in the work that both agencies do in relation to matters being taken to the tribunal. The other part of that is, in practical terms, if the legal representatives of a practitioner understand that they may be liable for our costs in a matter, that helps to turn their minds to settlement at an early stage. If they know, for example, that they may not need to worry about the costs, they can delay it and stretch things out by reducing the amount of cooperation they give us on the basis that the costs will be worn by us. Simple matters cost $35,000, $40,000. If you do a couple of $100,000 matters where you do not get your costs back, they might see that as a strong incentive for us to perhaps not pursue matters as fully as we might. So cost is a really important issue.

Mr McARDLE: Just remind me again, with QCAT, what is the jurisdictional issue in regard to costs? Do they have discretion?

Mr Atkinson-MacEwen: They have a discretion and recent decisions have exercised that discretion towards the practitioner, not towards the regulator.

Mr McARDLE: Does that follow the event?

Mr Atkinson-MacEwen: Yes, generally speaking. We normally would argue for our costs in a matter, but there have been a couple of recent decisions, including a decision in a matter where the decision was very much around, 'No, you don't get your costs.'

Mr McARDLE: Did you succeed in the matter?

Mr Atkinson-MacEwen: We succeeded in the matter with the practitioner, but we did not get our costs.

Mr McARDLE: What was the rationale behind that? It did not follow the event in those cases?

Mr Atkinson-MacEwen: Mainly because I think the tribunal took the view—and I do not necessarily want to be paraphrasing His Honour—that they had a discretion. Particularly given that the issue of costs had been removed from the regulatory framework, they believed that parliament's intention is clearly not to award costs in every case.

Mr McARDLE: That has now gone back to the health minister?

Mr Atkinson-MacEwen: Yes, I have written to the minister in that matter.

Mr McARDLE: Turning to your 2015-16 report at page 46, you talk about an action plan to maintain and make improvements to staff morale. Is staff morale a particular concern?

Mr Atkinson-MacEwen: It is actually the issue that the chair raises. It is the issue of resilience, because, as AHPRA staff deal with, we can deal with both conduct and performance matters that are quite confronting. We have a project that we are trying to help get some assistance from the University of Queensland on in relation to building the resilience of staff.

We can do things—and we do things—like put warnings on the material that comes in, for example, photographs of particular confronting surgeries and the like. Our staff have a warning that there is confronting material, or confronting conduct—sexual conduct, conduct with children et cetera. We can do that for staff but, fundamentally, they are being confronted day by day with complaints about people's health issues. We are trying to ensure that every mechanism is available to assist them to deal with the confronting issues that they see—debrief with their colleagues, debrief with their supervisors, use the employee assistance program; all of those things—to ensure that we are not making matters worse for staff, adding to the confronting material by not helping them earlier.

Mr McARDLE: Are you able to provide to the committee a breakdown of the staff survey assessment forms?

Mr Atkinson-MacEwen: Sure, absolutely.

Mr McARDLE: That would be fine, if you could. They are conducted over what time line? Over six months? Or 12 months? How do you do them?

Mr Atkinson-MacEwen: There is an annual survey done across the state service, which we plug into every year. In fact, I think the next one is due in May. We can give you the feedback. We conducted a baseline survey in about October 2014 so that we could have a starting point for the April-May 2015 survey. There was a survey conducted around the same time in 2016 and there is another one coming out.

Mr McARDLE: So you have two done?

Mr Atkinson-MacEwen: We have three surveys done.

Mr McARDLE: Could you table that documentation within the relevant period of time to the committee?

Mr Atkinson-MacEwen: Yes.

Mr McARDLE: Thank you very much. You mentioned that there had been meetings with the New South Wales counterpart. Did that range of meetings crystallise to you a process for the consultation process? Can I also ask Ms Ayscough to comment upon that as well, because there were meetings involving AHPRA on that as well?

Mr Atkinson-MacEwen: It is interesting, because our discussions with the HCCC indicate that, while they meet en masse, as we understand it, about three times a week with the medical council, they have far fewer frequent meetings with the other councils in New South Wales. They are currently using a paper based system to do their joint consideration. Obviously, we have time line considerations currently in the Health Ombudsman Act in terms of assessing matters in a very short period of time. That is going to be an issue in terms of the timeliness of any joint consideration.

Secondly, of course, we currently have an electronic portal whereby matters for consultation currently with AHPRA go across daily and electronically. In one sense we are technologically well advanced. We are looking at more the practical implications—not of the process necessarily but of the discussions themselves.

Ms Ayscough: We similarly are looking to what is in other parts of the country. New South Wales is a particular model of another co-regulator jurisdiction, but in other jurisdictions around the country there are varying processes for joint consideration. We—AHPRA and the national boards—have done quite a lot of work with the health complaint entities across the country over the past 18 months or so in looking at this early assessment of matters and joint consideration.

We have developed an agreed matrix that both organisations will apply, because there are a range of matters that almost automatically fall to one entity or the other because of the nature of the matter, or the likely resolution of it. We have captured those in a jointly developed matrix, which we apply now in all other jurisdictions other than the co-regulatory jurisdictions. We would feed that into the consideration of a future model.

For us, the critical element is that the development of the model is done on a collaborative basis. As we have indicated, we have started those discussions. We have been working together to look at what is going to be the most effective model in Queensland.

Mr McARDLE: At this point in time, how many meetings are taking place between OHO, AHPRA and the board? What is the regularity of those meetings to discuss these and other issues?

Ms Kent: Just on the recommendations?

Mr McARDLE: And the data itself.

Ms Kent: And the data? Leon and I meet on a monthly basis. Our executive teams meet on a monthly basis. At those meetings these discussions occur. We have also had the chair of the Medical Board as well meet with Leon and we have also had the chair of the Nursing and Midwifery Board meet with Leon. We have had discussions around the possibilities of a joint consideration model. It is very much at the top of our list in terms of how we might move forward with this. Of course, we are having to wait as well. Being mindful that it was a government consideration to be had, we did not want to overstep the mark, but we have certainly had very preliminary discussions about what it might look like going forward.

Just as recently as yesterday we have also had discussions with the AMAQ on what they would like to see in a joint consideration model. Taking all of those matters into consideration as well, and being clear about who needs to be at the table and whether practitioners need to be involved in all health performance and conduct matters, all of that will feed into those further discussions.

Mr McARDLE: Just assume that we get the tick-off and the act is amended. What time line would it take to put in place a joint consideration process? What time line would you need to assess its viability?

Mr Atkinson-MacEwen: With legislative changes, there can be consultation and, obviously, you would see draft legislation. From that point of view, we would know what we were expected to do. If the legislation were to commence on 1 September, or whatever, we would be ready to roll on 1 September. It then becomes an issue of what is an appropriate time frame to look at the success or otherwise. Is it six months or 12 months? Fundamentally, given the amount of consultation and involvement that we would all have in the drafting, or our views on the drafting of the legislation and identifying some of the practical issues that need to be included or thought about, we would be ready to roll whenever the legislation requires us to.

Mr McARDLE: When the bell goes, you are right to run?

Mr Atkinson-MacEwen: That would be our approach.

Ms Kent: I think that we would be tweaking as we went along and making sure that we got it right as we progressed and met on a regular basis.

Ms Ayscough: I think we mentioned the last time we appeared before the committee and referenced today that, in our view, it is open to us to test some of this even ahead of legislative amendments.

Mr McARDLE: Yes, that is my intention.

Ms Ayscough: That is what we are working towards. We will have probably quite a good idea of what we want to feed into the legislative process through that preliminary work that we are doing now.

Mr McARDLE: Congratulations to you all. Well done.

Ms DONALDSON: I have one question for AHPRA. In the 2015-16 period, the number of health assessments that remained open continued to increase. Firstly, I am interested to know how you are managing that, or what steps you are taking to manage that. Secondly, what are the measures that you are putting in place to ensure patient safety, the protection of the community and people's health while those processes are put in place?

Ms Ayscough: Sure. Thank you for that. Yes, I have mentioned the fact that we are continuing to see an increase in the number of matters referred from the Health Ombudsman. Our rate of completion of matters is also increasing, which is pleasing to us. Unfortunately at the moment, it is still not able to increase at the same rate as the incoming. So whilst we closed 874 matters in the first six months of this financial year, we received 1,119 new matters. As a consequence, we had 245 more notifications open at the end of that period than we had at the beginning, but we are confident that the risk is being well managed.

In the same period, boards took 26 immediate actions where it was considered essential to protect the public in that six-month period. We also referred three practitioners to the tribunal in the course of the six months for the most serious matters. At the end of December, we were monitoring 565 practitioners who had restrictions on their practice to ensure their compliance.

I mentioned that, in terms of dealing with the increasing numbers, we have an ongoing recruitment campaign. We have continued to bolster the number of notifications officers in our Queensland office. Most of our notifications officers are either lawyers or health practitioners, so they come with that sort of background and undergo our investigation training to understand the context in which they are working, and they are supervised while they come up to speed.

In terms of public protection at the assessment phase, we have particularly focused on bringing together members of the board and our staff at the earliest possible stage to look at the actual notification to do that early assessment of risk and to make that decision about what needs to happen next. We are trying to strip out any unnecessary administrative effort that goes into that. We are testing an approach where we minimise the amount of report writing, if you like, that goes into that decision-making and bringing the source material to the decision-makers early, having them articulate what they believe is necessary to make a safe decision and really focusing our investigations to obtain precisely what is required to make the decision as quickly as possible and to bring it back to be resolved. I think the combination of those things—early assessment, early involvement of the decision-maker, tailored approaches to investigation, applying the resources, taking immediate action where it is necessary—satisfies us that we are managing the risk to the public.

Ms DONALDSON: Do you feel that that is sustainable in light of increasing numbers?

Ms Ayscough: Increasing numbers will always pose a challenge to all of us. We are cognisant of the fact that our efforts—both AHPRA and the boards and the Health Ombudsman—are funded by the fees of registered practitioners. We are conscious of the need to maintain those fees as far as we can. Increasing numbers will always place pressure on resources, but the link to the fees is part of what drives us to continually refine our processes to look to be as efficient as we can possibly be without needing to try to expand our budgets.

Mr CRAMP: Mr Atkinson-MacEwen, you mentioned a Dr Matthew Spittal. This gentleman's name has come up before. He is studying consistency across boards. I take it that is medical boards?

Mr Atkinson-MacEwen: No, all boards. The research is interesting. It is part of a larger research area that has been undergoing for some time. There is a researcher called Dr Marie Bismark who has been oversighting a lot of research into the data coming out of notifications and complaints around practitioners. It is our understanding that Dr Spittal is now looking at these issues of consistency. We think it is really valuable to get that advice at the earliest possible moment about where the research is going, what it is seeing, what we can do to feed into that research and what we can learn from it.

Mr CRAMP: One of our main themes here is about that consistency across these two organisations. Who is funding his work presently and how does that allow our involvement from a state perspective?

Mr Atkinson-MacEwen: As I understand it, it is research being conducted by the University of Melbourne. He may well have an ARC grant or the like. Fundamentally, researchers are always approaching organisations like AHPRA and health complaints centres across the country for de-identified data. The work that Marie Bismark has done has been on the basis of de-identified data provided over a number of years. From a research perspective, we obviously have to look at what data is able to be provided to researchers like Dr Spittal and others and then look at the costs and benefits we might have in collaboration with a researcher of that nature. Given that that is what he is looking at, it would obviously be a good area for us to be engaged with that.

Mr CRAMP: Ms Ayscough, what is AHPRA's thoughts on that with regard to this gentleman's research? Do you think it has benefit for what we are talking about here today?

Ms Ayscough: AHPRA is partnering with a number of researchers working in this area. We have also partnered with Dr Marie Bismark, with Dr Spittal and with researchers from other universities. There have been some research programs that have been underway since the commencement of the national scheme, recognising that these questions around consistency and the impact for both practitioners and notifiers was something that would be worth tracking from the commencement of the national scheme.

As I said, we are involved in this. We work similarly to assess when it is appropriate for us to provide data from the national scheme to support the research. In some cases we are more closely involved with it. Some national boards have commissioned specific pieces of research as well. About two years ago now AHPRA established within our own organisation a research capability. We have what we call a risk based regulation unit. We have specifically engaged staff who have the skills to interrogate our own data and develop and answer some research questions about regulation more widely. We certainly agree that the data that we collect, particularly now as a national scheme, around the entire body of registered practitioners really equips us well to research and understand the regulatory landscape.

Mr CRAMP: Should the committee be interested in seeing the outcome of this form of research? It would need to be in lay terms if it is going to be quantitative data, or at least succinct terms.

Mr Atkinson-MacEwen: Certainly. The Marie Bismark research has been published in a variety of ways looking at various research areas for some years now. Yes, I would certainly recommend the committee looking at some of the issues they have raised.

Mr McARDLE: Your organisations are heavily involved in collating data regarding practitioners across a range of initiatives to better develop the health system to provide better care for patients. Have you been approached in relation to the collation of data to substantiate the base for the revalidation scheme?

Ms Ayscough: I am going to look to Dr O'Dwyer, because the revalidation project is one for the Medical Board of Australia.

Mr McARDLE: I am really only curious about not the scheme per se but the base of the scheme data being collated.

Dr O'Dwyer: The evidence for it.

Mr McARDLE: Correct, evidence based data.

Dr O'Dwyer: The evidence exists in other jurisdictions around the world. Other jurisdictions already have revalidation schemes in place. The Medical Board charged an expert advisory group to look at all of the evidence and the schemes that were in existence around the world and put together a consultation paper, which I think I mentioned last time we were here, that went out for consultation. There was a consultation event occurring in Brisbane to look at that revalidation as well. The evidence base is strong for a scheme of strengthened continuing professional development and strong around identifying practitioners who may be at greater risk of not being up to date or confident of working in higher risk environments and investing in looking at their performance over time.

What the revalidation consultation is trying to do is understand how the medical profession in Australia would like to approach that from a medical professional point of view. Revalidation and continuing development of practitioners does not necessarily sit within a regulatory scheme because of specialist entities such as the specialist medical colleges or the universities or the professional organisations or even hospital and health services. Certainly there is a lot of work that is done in hospital and health services about looking at performance of surgeons and doctors, readmission rates, complications rates and all of that sort of thing. That is where we are at with revalidation. The consultation period has finished. The consultation and the input that has been given from around the country has been put together and will be presented back to the board to find a way forward from there.

Mr McARDLE: I know the UK did this some years ago now which I think is the basis of the procedure that you have adopted.

Dr O'Dwyer: The US has done it as well. Canada has something similar as well. The basis is that there are schemes in place around the world, but we do not necessarily want to pick up a scheme that is in place anywhere else in the world. We want to look at what the situation is in Australia and what would be best suited to Australia with an eye on continuing to have competent and professional practitioners throughout their life of practice.

Mr McARDLE: Therefore, my question really is: what Australian based data is being used or are you relying upon the schemes overseas to trigger revalidation? It is all about getting practitioners up to scratch, shall we say, in maintaining a high level of integrity in practice. What is the Australian data?

Dr O'Dwyer: At the moment the best data we would have would be around continuing professional development. It is a mandatory requirement of registration that you satisfy your CPD requirements on an annual basis and people have to certify that on renewal of registration. Currently, they do that through whichever specialist college they are affiliated through. The specialist colleges presently would hold the data around who is continuing with their continuing professional development—who is up to speed and who is not from that point of view.

Mr McARDLE: You do not access Medicare data for billing practices and those sorts of things.

Dr O'Dwyer: We access Medicare data only in terms of complaints. Billing practices and Medicare data would not really drive an improvement scheme unless you were particularly looking at billing practices around a particular procedure.

Mr McARDLE: Looking for throughput—the throughput issue of patients.

Dr O'Dwyer: Throughput—an efficiency issue?

Mr McARDLE: Exactly—which I thought would be a trigger at least, not a flag but a trigger, to look at whether that doctor or practitioner is performing to a level that satisfies the client's needs as well.

Dr O'Dwyer: That is an interesting prospect. There are issues with accessing data from Medicare. Certainly there is a significant time lag presently in terms of accessing the data that would not make it an efficient way to do it.

CHAIR: There being no further questions, we will conclude the public briefing. Again, on behalf of the committee, I thank you for your attendance today and for the constructive approach that you have taken to the recommendations of the committee. We very much appreciate it. I declare the briefing closed.

Committee adjourned at 10.26 am