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

Members present:

Ms L Linard MP (Chair)
Mr MF McArdle MP (Deputy Chair) (via teleconference)
Mr SE Cramp MP (via teleconference)
Mr AD Harper MP
Mr SR King MP
Dr MA Robinson MP

Staff present:

Mr K Holden (Committee Secretary)
Mr J Gilchrist (Assistant Committee Secretary)

PUBLIC BRIEFING—INQUIRY INTO THE PUBLIC HEALTH (INFECTION CONTROL) AMENDMENT BILL

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 6 APRIL 2017

Brisbane

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Committee met at 1.03 pm

HARMER, Mr David, Director, Legislative Policy Unit, Strategic Policy and Legislation Branch, Department of Health

YOUNG, Dr Jeannette, Chief Health Officer and Deputy Director-General, Prevention Division, Department of Health

CHAIR: Good afternoon, ladies and gentlemen. I now declare this public briefing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I want to acknowledge the traditional owners of the land on which we meet and pay my respects to elders past, present and emerging. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. Other members of the committee are Mr Mark McArdle, the deputy chair and member for Caloundra, who is joining us via teleconference; Mr Aaron Harper, the member for Thuringowa; Mr Sid Cramp, the member for Gaven, who is also joining us via teleconference; Mr Shane King, the member for Kallangur, who today is kindly replacing Ms Leanne Donaldson, the member for Bundaberg; and Dr Mark Robinson, the member for Cleveland.

Today's briefing is part of the committee's examination of the Public Health (Infection Control) Amendment Bill 2017. The bill was introduced by the Hon. Cameron Dick, Minister for Health and Minister for Ambulance Services, on 21 March 2017. The committee is required to report on the bill by 15 May 2017. 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 nonpartisan approach to inquiries. Witnesses have been provided with a copy of the instructions for witnesses, so 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. I welcome Dr Jeannette Young, Chief Health Officer and Deputy Director-General at the Prevention Division at the Department of Health, and Mr David Harmer, Director of the Legislative Policy Unit at the Department of Health. Thank you both for joining us today and assisting the committee with its inquiry. I invite you to make an opening statement and we will then open it up for questions.

Dr Young: Thank you for the opportunity to brief the committee on the Public Health (Infection Control) Amendment Bill 2017. Madam Chair, with your permission, I will briefly outline the key features of the bill and then Mr Harmer and I will answer any questions committee members might have. The bill amends the Public Health Act 2005 to strengthen the statutory infection control framework for healthcare facilities. A healthcare facility is defined in the act to mean any place where a declared health service is performed which involves an invasive procedure or a procedure which might expose a person to blood or another bodily fluid. Some examples of these facilities are public hospitals, dental and acupuncture clinics, blood banks and any place where vaccinations or midwifery services are provided. The procedures performed at healthcare facilities involve the risk of patients and staff coming into contact with infectious blood-borne diseases. These might include hepatitis, HIV or other infections.

Because of this risk, the act requires people involved in performing declared health services to take reasonable precautions and care to minimise infection risks. The act also requires the operator of a healthcare facility to develop, implement and review an infection control management plan showing how infection risks will be minimised. However, the act does not currently empower Queensland Health to properly monitor infection control practices at healthcare facilities, investigate complaints of poor practices, enforce compliance with the statutory framework, or require noncompliant practices to be rectified. This shortcoming in the existing statutory framework was identified following an investigation into a Brisbane dental clinic. In that case, there was a pattern of substandard infection control practices in breach of the act, including inadequate staff training and sterilisation procedures. It was only with the cooperation of Brisbane City Council that Queensland Health was able to adequately respond to the situation. Queensland Health issued a public health order temporarily closing the clinic until appropriate remedial measures had been implemented. While

Queensland Health was able to establish an agreement with Brisbane City Council regarding the issuing of the public health order, the requirement to negotiate with a second regulator creates undue administrative complexity and potentially delays the taking of appropriate action.

The bill will assist owners and operators of healthcare facilities to meet their infection control obligations by enabling the Public Health Regulation 2005 to prescribe appropriate training qualifications and competency standards. The bill also empowers Queensland Health inspectors to conduct a timely and thorough investigation where there is a suspected breach of infection control obligations. Inspectors will be able to immediately enter a healthcare facility if necessary to minimise or prevent an imminent infection risk. The owner or operator of a healthcare facility will be required to provide a copy of their infection control management plan on request or to amend a substandard plan. New penalties will apply for noncompliance. In more serious situations where practices at a healthcare facility are putting staff or patients at actual risk of harm, the chief executive of Queensland Health will be empowered to issue a directions notice. This notice temporarily stops the facility providing declared health services until necessary remedial action is taken. There is a significant penalty for continuing to provide a declared health service in defiance of a directions notice.

The bill also creates offences for breaches of existing obligations under that framework. The most serious of these offences will be failure by a person involved in providing a declared health service to take reasonable precautions and care to minimise an infection risk. Other offences include failure by the owner or operator of a healthcare facility to have an infection control management plan or to update the plan as needed. The amendments in the bill are required urgently. In the past few weeks another complaint alleging substandard infection controls at a dental clinic has been received. Queensland Health is responding to the situation, but again the shortcoming in the statutory framework may create problems for investigating and rectifying breaches of the act and taking appropriate enforcement action. Prior to today's briefing, the committee requested clarification on a range of matters. This additional information has been included in the written briefing material provided to the committee. I and my colleague would now be happy to answer any questions you may have.

CHAIR: Thank you, Dr Young. Thank you for the written briefing that was provided and thank you also for those opening comments. I just want to better understand first what has been happening to date, because the explanatory notes and the opening statements you made then are that this particular recent incident gave rise to perhaps Queensland Health becoming more aware of some of the shortcomings in the legislation. Is it that something like that has not occurred to date? How have compliance and risk minimisation been working to date in these facilities?

Dr Young: In the past this was seen as a professional issue for the professional boards to manage, so for dentists it was expected that the dental board would manage those sorts of issues as a professional standard and it has become clear that that has not occurred. That is why we think this now needs to happen and be clearer in terms of the process and the responsibilities.

CHAIR: To pick up that example of the dental board, is it with regard to both the practitioners within those facilities and also the facility itself?

Dr Young: It has always been thought that it was a professional standard that the people working in a facility—whether they be general practitioners, dental practitioners, midwives—were the accountable and responsible person for making sure that infection control standards were met in anything they did. Now as these facilities tend to become corporatised, you can end up with a facility that has substandard processes in place and the OHO, the Office of the Health Ombudsman, can take on and manage the professional obligations and can stand a dentist down immediately through immediate action but they cannot close the facility down. What could happen—this is what concerns me with these two cases—is that the dentist could be removed but then the facility remain open because it is owned by someone else who can then bring someone else in, but then they are working in an environment where the standards are not met. It is just the changed way that things have evolved over the last few decades that I think has really led to this issue coming to the fore now.

CHAIR: Are these infection control management plans something that they currently are required to do?

Dr Young: They are, but there is no penalty if they do not do it.

CHAIR: They are not required to submit it to anyone currently?

Dr Young: No, they are not.

CHAIR: They are just required to hold it, so would it be the Brisbane City Council doing a compliance check where they would then look at it? What is that relationship like?

Dr Young: No. Brisbane City Council nor any local government council really sees this as their area. We have had those discussions with them because at the moment the way the act is read it is their responsibility, but they do not see that as their responsibility and so there has not been any process that they have audited this in the past. Since we have become aware of this as being an issue, we have started doing some audits and we are seeing that there are a number of practices that do not have the plans as required.

CHAIR: So really the onus has been put on the registered health professionals to be doing the right thing. I am interested in the suggested amendments under clause 5 that propose to impose a penalty on 'a person involved in the provision of a declared health service'. I am just interested in how that proposed provision compares to other jurisdictions, because in the main would it not be that the potential implications of not doing so would be a report to the OHO and strict issues and penalties to them in terms of their registration? I am just trying to understand: is that something that sits in other legislation that fines them as a person rather than the facility or the owner of the organisation they work in? How does that compare?

Dr Young: These are new penalties. They have been aligned with similar types of penalties in other acts where we have public health risks—for instance, in terms of safe food or the legionella issue that parliament discussed not long ago. There have been penalties put in place. These are to align with those. It would depend who owns the practice and who is responsible and accountable. I might see if my colleague can be clearer than me.

CHAIR: In terms of safe food handling, it is different if you have an individual who is handling food compared to a registered nurse who is already operating under strict requirements of their licence. I am trying to understand if this is something that could sit elsewhere.

Dr Young: You could end up being penalised by both. As happened recently, the dentist has been stood down by the Health Ombudsman in terms of professional standard but then the practice has also been closed to then prevent other people coming into an unsafe practice and continuing to work.

CHAIR: Under this legislation, could that particular individual be stood down by the OHO in regard to their professional practice but also be issued a fine?

Dr Young: Yes.

Mr Harmer: Yes.

CHAIR: Do we have any comparison of that particular situation? Does that sit anywhere else?

Mr Harmer: I cannot speak to the situation in other jurisdictions. As Dr Young said, we have identified a gap in our framework and we have created new penalties as a way of ensuring compliance, but we have looked to align the penalties with other like provisions in our own legislation for consistency. We typically would not look to other jurisdictions when we are trying to have a consistent framework within Queensland. If you did want a comparison with other jurisdictions, I am afraid that is something that I would have to take on notice.

CHAIR: Can we do that? I am quite interested in this from the point of view that they are already operating under strict requirements of their licence. I just wondered if it really sits in any other legislation at all where they would also be open to personal fines. If that is the case, I would love to know that.

Dr Young: It is possible. I licence the private facilities in the state and some of those are very small. They might just be an endoscopy clinic. It is similar there. They can have professional registration requirements. If you had a gastroenterologist who was doing colonoscopies in an unsafe way, they could be professionally disciplined or deregistered but under my licence, because I am not involved in the professional registration, I could also prosecute the clinic—and I have done so in the past—for being unsafe in terms of the services they have provided. If the gastroenterologist was the owner of that clinic then they could end up being caught up under two separate pieces of legislation.

CHAIR: If they were the owner.

Dr Young: If they were the owner. They might not be the owner, so then it might be someone different who would be prosecuted in terms of providing an unsafe environment for that service. The issue here is that we have not had anything similar for dental surgeries, for midwifery practices that are happening outside of facility or for a whole range of other areas where there are genuine infection control risks but they are not captured under the Private Health Facilities Act.

CHAIR: That was my final question before I allow the members a chance. I was trying to work out how the private facilities fit within this. Public hospitals, dental clinics, private medical clinics but not private hospitals sit under that.

Dr Young: No. They would sit under this as well. There are many situations where private facilities have to meet obligations under several acts.

Mr McARDLE: Dr Young, you mentioned in regard to this clinic that there was a pattern of behaviour. Does that pattern go back a long way? Did they come to the attention of Queensland Health or BCC in earlier years?

Dr Young: No, they had not come to our attention earlier. The pattern went back to when the practice was first opened. We could not see any reason that the practises that had been utilised in that particular facility would be any different today to when they opened the facility. We took our investigation and notification of people who had attended that practice back to when the practice first opened.

Mr McARDLE: What pattern are you referring to in relation to the matters that were brought to your attention?

Dr Young: The practice was re-using single-use items that should only be used once and then disposed of. They were re-using them. Some of those single-use items were not being sterilised between uses. They were not adequately sterilising some surgical instruments that were being used. We found that they had been thought to have been sterilised. Then we tested them for sterility and found bacteria on them. There were a number of issues that we picked up when we went in. Their staff were not adequately trained. They did not have an adequate infection control plan in place. There were a range of issues.

Mr McARDLE: Dr Young, how many HCFs are there in Queensland? Do you have any idea?

Dr Young: There are around 179 healthcare facilities under the Private Health Facilities Act. Then there is a similar number of public facilities. Then there is around, I think, 600 dental practices in place. Then there is a whole range of other practices—pathology practices that take blood, for instance. They would be in the thousands.

Mr McARDLE: What is the current regime for reporting incidents of this nature to an authority, whether to Queensland Health or BCC or anybody else? Is there an obligation on an HCF to report a matter?

Dr Young: People are obligated to report any incidents that involve a healthcare registered practitioner if the person is a health practitioner themselves. There is mandatory reporting and that reporting goes to the Health Ombudsman.

Mr McARDLE: The OHO is the first port of call for a complaint of this nature to date.

Dr Young: They all end up there. Some people might report incidents to me, for instance, or to the health department but they would then go to the OHO or they might report them to AHPRA, the Australian Health Practitioner Regulation Authority. There might be a number of mechanisms, but ultimately it is up to the Office of the Health Ombudsman to manage those complaints.

Mr McARDLE: In relation to this bill, there are powers within the bill to enter and undertake an examination et cetera and to compel the production of certain documentation. Is there also going to be a power for the HCFs to report directly to you or some other officer in Queensland Health a breach of the regulations under which they operate that cause an infection or will they still all go through the OHO?

Dr Young: People can always report to the health department. We get a lot of complaints reported through to us, but I would see that most people would report to the Office of the Health Ombudsman and then he or she would pass that on to the department.

Mr McARDLE: When you undertake the examinations of equipment and premises, will there be a report prepared on an annual basis to be tabled in the parliament or become available in some manner to the public as to what work is being undertaken, what has been detected and what work is required to rectify a situation?

Dr Young: We do yearly reports to the director-general, as he is the statutory officer responsible for the acts as per all departments, so we do compliance reports each year through to our director-general.

Mr McARDLE: They are not public though, are they?

Dr Young: No, not unless they are specifically allowed for in an act.

Mr McARDLE: I think to date you made the comment that there had not been a great deal of spot inspections and regular inspections because no power existed. Is that right?

Dr Young: There was a power that with 24 hours notice and reasonable concern we can go into a facility, and that is what happened with the initial dental complaint. The Health Ombudsman forwarded that complaint to the department. There was enough information in that to raise a concern, so we then gave the dentist 24 hours notice and went in and inspected. Our concern is that we would like the ability to go in without giving notice if there is a concern raised and also that we have the ability to go into healthcare facilities and areas that practise procedures that are potentially at risk at any time to audit that they are meeting the requirements.

Mr McARDLE: In the last five years how many complaints or referrals from the OHO has your office or Queensland Health received in relation to similar situations?

Dr Young: Only a handful. I would have to go and check the number, but certainly in the last 10 years we have had very few.

Mr McARDLE: Will you take that on notice, please?

Dr Young: Yes, we could do that.

Mr McARDLE: In the last 10 years how many of these HCFs have been prosecuted or in some manner penalised for poor performance or for lack of minimisation of risk?

Dr Young: That would possibly be an issue for the Health Ombudsman to answer because we have not had that power to do so other than, of course, with the private facilities which have had legislation in place. I would assume—if I could clarify the question, Mr McArdle—that you are asking about areas that were not captured under the [Private Health Facilities Act because they have always had an act?

Mr McARDLE: Yes. That is correct.

Dr Young: That would be an issue for the Health Ombudsman because he would have taken up those prosecutions.

Mr McARDLE: You paint a picture whereby this is a radical change from what we have in place now. I think you raise the concern that in years gone by it has been assumed that it is the practitioner and the relevant body that governs the practitioner or the practitioner who looks after control et cetera. This incident has now changed our thinking dramatically. Can you indicate to me the level of seriousness in relation to what you found or what Queensland Health found in this dental clinic?

Dr Young: Yes. The dental clinic that we inspected that led to this change being put forward was re-using single-use items. It was not adequately sterilising those items before re-use on a new person. There is a process that certain dental equipment can be re-used on the same person but never on a different person. With some of the equipment that they believed in the practice was sterile—they had put it through and said, ‘This is sterile’—when we organised sterility testing to be done it grew bacteria on that equipment. They were the major issues. There were a number of other issues in that the staff had not gone through adequate training and there was not an adequate plan in place for how to manage risks due to potential infection in that practice.

Mr McARDLE: You would definitely say that they were not minor but major breaches.

Dr Young: Yes, we thought they were very significant breaches to the point where we then, the to the best of our ability, contacted every single patient that had been in that practice since it was first opened in 2014 to alert them to the risk that they potentially had acquired a bloodborne virus, as we thought that that was the biggest risk. Hepatitis C was my major concern, although hepatitis B and HIV were also of concern, but I thought they were far less likely as they are more fragile viruses and are more easily managed. We then contacted as many of those people as we could by phone. We made up to eight attempts to contact them by phone; those that we could not, we sent out registered letters to and asked all of them to go and see their treating GP. We also set up some clinics for people to access if they preferred to do it that way and tested them. We have managed to contact the majority of the over 5,000 patients involved, so it has been an enormous exercise. That is how concerned we were at what had been going on in that practice.

Mr HARPER: Dr Young and Mr Harmer, I commend you and the Health department on your response to date, because as we know infection control is very important, particularly in those healthcare facilities. Just touching on dental, you mentioned that another one had popped up just recently. I am sure it will get the attention of many in that particular profession. You talked about some audits that were to be done. I think you mentioned around 600 dental facilities along with the other, and there must be close to 1,000 based on the figures you said. I almost see it like you are dealing with food handling, as you touched on, with licensing and control. Do you foresee that each of these facilities will receive an audit if the bill is passed and in what time line? Is there going to be a focus particularly around the dental profession?

Dr Young: Yes, we will be working with the dental profession in particular to work through with them the requirements that they will need to meet. Every dental practice will need to have a plan in place that meets certain minimum requirements, so we will work through and then we will audit to make sure that, as a starting point, each practice does have a plan, and then we will go through and make sure that those plans are adequate. That is a starting point. We have already started auditing a selection of those practices to see where they are up to. The majority do have good plans in place, but there is a reasonable number who we are concerned do not. Initially about five out of 30 practices we have been concerned about have not had adequate plans. Just because they do not have adequate plans does not necessarily mean that they have poor practices; they just may not have worked through how to document and how to put it in place. We will have to work that one through with the dental profession.

Mr HARPER: The explanatory notes describe the amendments as urgent. If passed by parliament when is it envisaged that that legislation will commence from your point of view?

Dr Young: I would hope it does commence before the end of the year.

Mr HARPER: I did want to talk about time lines. You were talking about entry into some of these sites before this bill is done. It almost reminds me of workplace health preliminary safety infringement notices, and I guess that is what will come out of this to a degree. You were talking about delays in entering a site of up to 24 hours; is that correct?

Dr Young: At the moment we have to give 24 hours notice before we can go into a site.

Mr HARPER: Will this heads of power change that so you can do random checks if required?

Dr Young: We can, and we can go in immediately. If the Office of the Health Ombudsman was to alert us to a practice they were concerned about, we could go in immediately.

Mr CRAMP: Looking at some of the documentation—and, Dr Young, I am happy for you to say that my question has no relevance—I have been reading about some of the influenza strains that are increasingly occurring and becoming common throughout the world. I know that we do have some legislation and policies and procedures in place if a pandemic situation occurred in Queensland. Does this amendment bill assist with ensuring that, if we have any form of pandemic or any need to have stricter health controls and regimes on our borders and in our health facilities, these facilities adhere to any instructions if there were to be a pandemic?

Dr Young: I do not know that it would help in terms of managing a pandemic, but it would certainly help in terms of practices thinking about what they need to do to stop the transmission of an airborne virus between patients. So if you had someone with the flu in the waiting room, there is a process in place that that is recognised and that person puts a mask on. That would be one of the things that I would expect a well-thought-through documented infection control plan would consider. There are other diseases. If you had someone in the waiting room with measles, people would work that out and not expose the other people in that waiting room. That might be particularly relevant for a general practice. Yes, I think it is a very sensible question in terms of how to manage infections in a practice, no matter what they are or from what source.

Mr CRAMP: Effectively, this is just going to put more importance in the back of the mind of the management of each facility to make sure that they do follow through for their control procedures at all times.

Dr Young: Yes.

Mr CRAMP: I do not have any further questions. The deputy chair asked a couple of questions that I was interested in.

Mr KING: Of particular interest to me are the changes to clause 12, probably because the committee that I am usually on relates to water service providers rather than healthcare facilities. Can you explain why that provision is deemed to be necessary and why it has been included?

Mr Harmer: I am sure we can answer that question in the time available to us, but it is a technical amendment so it may take me a moment to track it down. If we can provide that information towards the end of the briefing, that would be good.

Dr ROBINSON: In terms of some of the private healthcare facilities that are covered and the scope of that, you have talked about breaches or issues arising within dental facilities. Have there been any issues arising concerns or breaches in the Marie Stopes clinics?

Dr Young: I am not aware of any. I can take that on notice and ask the Ombudsman if he is aware of any, but I am certainly not aware of any.

Dr ROBINSON: If you could take that on notice that would be good.

Mr HARPER: I have a supplementary question. You mentioned earlier, Dr Young, that the dental boards were primarily responsible prior to that. It seems to me there has been a failure by them to monitor and implement these measures that the department is putting in. I am just trying to find out where the gap started and why, but it might be difficult to answer that question.

Dr Young: The dental board is not responsible for the actual facility: they are responsible for the practitioners who work in that facility and they have standards and continuing professional development requirements. They do not actually go out and accredit or audit facilities. Unless the work was a complaint to them, they would not have any reason to go and inspect what a dentist was actually doing day to day.

Mr HARPER: How do they credentialise their members?

Dr Young: They register health practitioners. AHPRA, the Australian Health Practitioners Registration Agency, registers all health practitioners, and there is a defined group of those ranging from doctors to dentists to physios, pharmacists et cetera, and they do that based on their qualifications and their continuing professional development. They do not actually have ongoing exams, although that is being looked at at the moment. At the moment it is based on original qualifications and exams and the original registration. Then, as long as there are no complaints about that health practitioner and they continue maintaining their practice so that they have recency of practice—if they are out of practice for more than a certain period they have to do various things—they would then continue to renew that health practitioner's registration.

CHAIR: I have one supplementary question with regard to clause 13 with reference to an authorised person entering a facility to monitor compliance. The explanatory notes state that they must be reasonably satisfied that that facility is breaching its infection control obligations and that that breach is causing an immediate infection risk. I am totally supportive of not needing to give 24 hours notice—you would want people to come in and make sure that public health is protected—but could you just clarify for me what would it require to meet the threshold of 'reasonably satisfied' to your mind?

Dr Young: If the practice did not have an infection control plan, then I think that would be a reasonable reason to go in and look at what they are doing if they do not have a plan. There is a requirement under this act as proposed that they must have a plan and that it is an adequate plan. If they were not able to produce one, I think that would be reasonable reason enough to go in. They might then be absolutely fine and they have just not documented a plan, but I think that would raise concerns. If there was a complaint that raised concerns, then even if they had a plan that would be a reasonable reason to go in and inspect.

CHAIR: The other question that I had—and I am sorry I have not flagged it in my explanatory notes—is that you can issue an improvement notice, but could you please clarify in what situation you may potentially issue an improvement notice as opposed to a breach?

Dr Young: If their plan was inadequate but they were minor things, we would work with that practice—whether it is a dental practice or any other sort of practice—to say that you do need to consider these things and how you would address them.

CHAIR: I will check whether the deputy chair or the member for Gaven have any supplementary questions.

Mr McARDLE: I am fine, Madam Chair, thank you.

Mr CRAMP: I am fine as well, thanks, Madam Chair.

CHAIR: Thank you both very much. I think we were coming back to you, Mr Harmer.

Mr Harmer: The answer to the question ends up being quite straightforward. It really just gives us the ability to issue an improvement notice to a water supplier.

Mr KING: I imagine in a dental surgery, where you are providing a lot of water and that sort of thing, you would want some sort of hygiene control around that as well. It just seemed strange.

Mr Harmer: Water suppliers do have specific obligations in relation to the supply of safe drinking water, so the improvement notice would go to deficiencies in their plan.

CHAIR: There being no further questions, we will now conclude this public briefing. If members require any further information we will contact you seeking clarification. A number of questions and matters have been taken on notice, and I would confirm that, if we can receive responses to those by the close of business on Tuesday the 11th, that would be appreciated. Our secretariat will be in contact with you. Thank you again for coming and briefing the committee. We appreciate your assistance with the bill. I now declare this briefing closed.

Committee adjourned at 1.43 pm