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

Members present:
Mr AD Harper MP (Chair)
Mr MA Hunt MP
Mr MF McArdle MP
Mr BL O'Rourke MP
Ms JE Pease MP

Staff present:
Ms S Galbraith (Acting Committee Secretary)
Ms A Groth (Assistant Committee Secretary)

PUBLIC BRIEFING—INQUIRY INTO THE HEALTH TRANSPARENCY BILL 2019

TRANSCRIPT OF PROCEEDINGS

MONDAY, 16 SEPTEMBER 2019

Brisbane

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The committee met at 9.34 am.

CHAIR: Good morning. I now declare this public briefing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I want to start by acknowledging the traditional owners of the land on which we are meeting today. I am Aaron Harper, chair of the committee and member for Thuringowa. Other committee members are Mark McArdle, member for Caloundra and deputy chair; Marty Hunt, member for Nicklin; Barry O'Rourke, member for Rockhampton; and Joan Pease, member for Lytton. We have apologies from Michael Berkman, member for Maiwar.

This morning's briefing is a part of the committee's inquiry into the Health Transparency Bill 2019. The bill was introduced and referred to the committee on 4 September 2019 and the reporting date is 18 October 2019. This public briefing of the committee is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind all witnesses that misleading the committee is a serious offence. I remind members of the public that, under the standing orders, the public may be admitted to or excluded from the hearing at the discretion of the committee. The proceedings are being recorded by Hansard and broadcast live on the parliament's website. The program for today has been published on the committee's web page and there are hard copies available from committee staff.

FORRESTER, Ms Kathleen, Deputy Director-General, Strategy, Policy and Planning Division, Queensland Health

LIDDY, Mr James, Manager, Legislative Policy Unit, Queensland Health

MATTHIAS, Ms Tricia, Acting Director, Legislative Policy Unit, Queensland Health

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

SKETCHER-BAKER, Ms Kirstine, Executive Director, Patient Safety and Quality Improvement Service, Queensland Health

WAKEFIELD, Dr John, Acting Director-General, Queensland Health

CHAIR: I welcome witnesses from Queensland Health. Thank you all for your attendance today. I invite you to make an opening statement before we move to questions.

Dr Wakefield: Thank you, Chair, and may I also acknowledge the traditional owners of the land on which we meet today. Thank you for the opportunity to brief the committee today about the Health Transparency Bill 2019. I will not introduce the panel, for brevity's sake, but I welcome my colleagues. The main purpose of the Health Transparency Bill is to improve transparency in public and private health facilities, to improve transparency in residential aged-care facilities and to amend the Health Ombudsman Act 2013 to implement the recommendations of this committee and the Health Ombudsman. I will deal with each of these in turn, starting with the new transparency website being developed by Queensland Health.

International research indicates that transparency of health service information leads to better quality care and outcomes. Queenslanders presently do not have easy access to information about public and private health services or aged-care facilities. This bill will enable consumers to make informed choices through being able to easily access and compare different providers. It will encourage providers to improve and will ultimately lead to a better health system for Queenslanders.

A new Queensland Health website will be developed to improve the transparency of the health and aged-care sectors in Queensland. The website, co-designed with consumers, will be an easy way to access information about health and residential aged-care facilities that is up to date, informative and Queensland focused. This website will provide a single point of reference for consumers to view and compare information about public and private hospitals, health facilities and residential aged-care facilities. The website will help consumers make informed decisions about their health care and it will also contribute to improved health literacy.

Public health facilities, including all public hospitals, and private health facilities, including day hospitals and private hospitals, will be required to provide general information and quality and safety information. Quality and safety information includes information about a facility's accreditation status, information about activity performed by that service, access to care information and, importantly, information on patient outcomes. It will also include information about waiting times for surgeries and outpatients as well as things like infection management and hygiene practices. The types of quality and safety information able to be requested from health facilities can and will be expanded by regulation. This will provide flexibility to expand the available information over time.

The bill also allows Queensland Health to request and publish information from both public and private aged-care facilities about staffing levels. Contextual information will also be provided to help consumers understand how staffing ratios impact and relate to quality of care. Private aged-care facilities will be able to opt out of providing information for this website. If an aged-care facility chooses not to provide information, it must indicate in writing to the department its decision to opt out and this will be published on the new transparency website.

Queensland Health currently operates 16 residential aged-care facilities across seven of our hospital and health services. These facilities are generally located in areas poorly served by private or non-government providers or provide very specialised care to those with particularly high needs that are not generally catered for in the private and non-government sector. The bill will require residential aged-care facilities operated by Queensland Health to maintain a minimum nurse and support worker skill percentage and also to provide a minimum average of care hours to residents on a daily basis. As outlined in the Draft Hospital and Health Boards (State Aged Care Facilities) Amendment Regulation 2019, residential aged-care facilities operated by Queensland Health will be required to maintain a minimum nurse workforce—that is, enrolled nurses and registered nurses of 50 per cent of that workforce, with 30 per cent of the total care staff required to be registered nurses—and the number of support workers must not exceed 50 per cent of the total care staff. I am happy to talk in more detail to answer any questions about these reforms for the committee.

As I mentioned, the bill also amends the Health Ombudsman Act to implement recommendations of this committee and the Health Ombudsman to improve the operation and the efficiency in the health complaints system. In 2016 the predecessor to this committee tabled its report, *Inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013*. The committee made four recommendations aimed at improving the performance of Queensland's health complaints system and the government's response supported those recommendations. Recommendations 1, 2 and 4 required changes to the legislation, and this bill will give effect to those recommendations. I understand that the Health Ombudsman is also briefing the committee today, so I might leave the detail of these amendments for that session. In conclusion, thank you for the opportunity to address the committee about the legislative changes contained in the bill. I am now happy to take questions from the committee and may refer particular questions to colleagues with particular expertise. Thank you.

CHAIR: Thank you very much, Dr Wakefield. Given the recent committee's work in Earle Haven and the incidents there—this might lead into answering the question—what do you think the benefit of providing transparent information about health care in Queensland public hospitals is to Queenslanders? What is the estimated cost to government?

Dr Wakefield: In respect of the first question, international evidence very strongly supports the finding that, when you shine a light on data and indicators around clinical care in the hospital setting, that leads to improved quality and improved outcomes. In making that statement I am referencing numerous studies, some of which I have with me today should the committee wish to see those.

CHAIR: I was going to ask whether we could table that international evidence for the benefit of the committee and report.

Dr Wakefield: Would the committee like those to be tabled now?

CHAIR: Is leave granted? There being no objection, leave is granted.

Dr Wakefield: In tabling papers today I am seeking to table four papers: a 2010 report by Chen; a 2013 report by Peter Hibbert and colleagues; a 2016 report from the Health Quality and Safety Commission from New Zealand; and 2016 research article by Campanella et al. In summary, these studies, including a summary study of all the literature in relation to transparent reporting of hospital indicators, falls down significantly towards the transparency of health information in the public domain, particularly around clinical care—both what we call process indicators of care, such as accreditation status, hand hygiene rates and so on, and outcomes in terms of how well people do after care in our hospital facilities such as mortality and survival rates, as well as other types of

outcome indicators such as infection rates et cetera, are improved as a consequence of putting this information in the public domain. The reason for that is hypothesised to be down to clinicians, particularly, and services not wanting to be bottom of the performance list and in that way that motivates clinicians and service providers to address issues of variation in their performance and outcomes. That is deemed to be the likely reason why putting information in the public domain leads to better outcomes.

The second question that you have asked is how much will it cost. I would split that into two parts. The first is that there is a specific component about minimum ratios in public residential aged-care facilities which is a very specific component of this bill. It is estimated that to achieve those minimum ratios Queensland Health will have to invest around $10 million in additional recurrent funding. That will ensure that those public residential aged-care providers that are currently below the minimum level of hours per resident day will be able to achieve that over the next two years.

CHAIR: The bill initially asks both public and private aged-care facilities to report quarterly on the average hours of daily care provided to each resident by nurses and support workers. Do public aged-care facilities currently collect this data and, if not, will they be ready to report?

Dr Wakefield: I might pass to my nursing colleague, Deborah Miller, to answer that.

Ms Miller: Currently aged-care facilities are using the business planning framework so would be collecting some of this information to inform that process in relation to the appropriate staffing for the number of residents and the total hours of care that are provided.

Dr Wakefield: Can I add there that the current staffing in public residential aged-care facilities is managed and developed using the business planning framework tool. That basically uses acuity and the types of staff and their skills to determine essentially what staff are deployed. That is appropriate. What this new bill will do is it will put a mandated floor into all of our public residential aged-care facilities such that none of them will have below the 3.65 hours per resident day. That does not mean that they will all stick to that. Several of them will actually have higher hours per resident day by virtue of the complexity of the residents that they are looking after—but, yes, they do all collect this data now.

CHAIR: What about the private facilities; do they collect data?

Dr Wakefield: Let me start by saying that we do not have visibility of what, indeed, private sector and non-government sector residential aged-care facility providers actually collect by way of data, but it is a fact that, if one is running a business and staffing that business, it is a very simple calculation for any employer to determine what staff they have for a 24-hour period and it is a simple arithmetic calculation as to the number of hours of direct care provision. It does not count, for example, people who come in from outside; it is simply about nursing and healthcare workers on the ground. It is simple arithmetic. We would argue that it would be a very simple thing for any employer to provide that data.

CHAIR: The committee has, in its work currently under the aged-care, palliative care, end-of-life care inquiry, visited a couple of public residential aged-care facility—one in my electorate of Thuringowa in Parklands, where Frank Della, won nurse of the year. I must note that and give him a tick. We were very impressed with that facility and the one at Redlands, which we visited before we went to the Gold Coast last week. I have noted that there are 459 private facilities. There seems to be, on balance, a stark difference already. I hope that this bill goes some way to alleviate some of that and better inform the public about choice. Before I open to other questions, do you think improving our aged-care system will relieve pressure on our public hospitals?

Dr Wakefield: I think the primary objective in relation to this policy is to ensure that there is sufficient both numbers of staff and clinical skills of staff to make sure that the care provided to elderly people in residential aged-care facilities is of a high standard. We do know that, when care of a high quality and a high standard is delivered, it can certainly diminish the deterioration and acute demand on hospitals but not alone. We have a range of other things that we do in terms of outreach from our public hospital system—for example, bringing the hospital to the care home, for want of a better way of putting it—that also contribute to that, but there is no doubt that our elderly residents in our residential aged-care facilities do need to have basic standards of care met. That is the right thing to do, but it will also contribute to appropriate demand on our public hospital system.

CHAIR: I should have underpinned that by noting the increased workload. In our broader inquiry we heard from the Queensland Ambulance Service of some 34,000 transports from residential aged-care facilities—which is 459 privately run facilities.

Mr HUNT: Thank you for your briefing. My first question was around how many private services there are in Queensland. I think the chairman just outlined that—it is 459. I want to explore how this reporting system will work from those services in terms of how they are to report. Is it an online

reporting system? Is that reported on a website? I think someone mentioned quarterly. Is it a form they fill out? Is the department prepared for that administrative burden each quarter to receive some 459 reports to be entered into a system?

Dr Wakefield: Before I ask my colleague to answer that, Chair, are you specifically referring to residential aged care or the broader bill and private and public hospitals as well?

Mr HUNT: I am referring specifically to aged-care services in this case.

Dr Wakefield: I might ask my colleague Kirstine Sketcher-Baker to provide some information on that.

Ms Sketcher-Baker: The residential aged-care facilities will provide the data to Queensland Health and we will be publishing that on the website. There will be a formal process where essentially there will be a notification that is sent through to the provider. They will be required to provide that information within 15 days and then that information will be published on the website.

Mr HUNT: Has that format already been established? Is there a form? Is there an online entry porthole?

Ms Sketcher-Baker: There is a website that is currently underway in terms of the development. That will be set up for the providers who actually enter that information onto the website itself.

Mr HUNT: Did you have something to add, Dr Wakefield?

Dr Wakefield: I was just going to ask my colleague Kathleen Forrester to give some more specifics about the legislative detail of that.

Ms Forrester: You suggested that there were 459 aged-care facilities. We have 461.

CHAIR: I was going to say do not quote me on that. That was the data I read last year when we started this journey.

Ms Forrester: That is actual facilities and we believe that is 157 providers, or businesses. In relation to the reporting, I also wanted to mention that we are commencing in a staged way. Queensland Health aged-care facilities will commence reporting earlier than the private sector facilities. The intention is that by the end of the year, assuming that parliament does pass the bill, we will commence with the Queensland Health facilities first. Then there will be a period of time, possibly into early next year, when we ask the private facilities to start to report. We are going to stage that reporting. That will give plenty of time for people to get to understand the look and the feel of the system and to understand the detail of the reporting requirements. That will be a quarterly reporting requirement.

Mr HUNT: Also, the ability to opt out was mentioned and that that would be reported. Dr Wakefield, I note that you said that if they want to opt out there is a requirement that they write in to opt out. Is there any penalty for not complying with the requirement to write in and just being completely ignorant of the process?

Ms Forrester: If a service does not respond—so does not either provide us with information or does not advise that they are opting out—there is a penalty of up to 100 penalty units. There is a penalty that can be applied.

Mr HUNT: If a service or a number of services opt out, how will that be reported on the website? Is it going to be a list or a report? How is that going to be reported?

Ms Forrester: I will ask Kirstine to respond to that.

Ms Sketcher-Baker: Each facility will have their name and it will be reported against their name that they have not provided the information or opted out.

Mr HUNT: If they provide a written response as required as to opting out and their reasons why, will that be published along with their name on the website as to their reasons why?

Ms Sketcher-Baker: At this stage it is just going to be noted that they will be opting out, but that is something that can be considered.

Mr HUNT: Dr Wakefield, I note your comments about transparency in improving health outcomes. I quote the explanatory notes—

Public reporting of health facility information is intended to provide a meaningful picture for patients, support quality improvements for health service providers and drive better outcomes at a systems level.

Are complaints about state-run aged-care service providers published in any form?

Dr Wakefield: On this website and as part of this bill, there is no plan to publish specific complaints. In respect of residential aged care, the Commonwealth is the regulator. In respect of what the Commonwealth chooses to publish around complaints, that is a matter for the Commonwealth. For residential aged care particularly, the initial focus of this website will be on comparative information around staffing. I might check with my colleague, Kathleen Forrester, whether there is anything else to add to that answer.

Ms Forrester: I think that the committee will be aware of the Commonwealth's regulatory functions around aged care and that the Aged Care Quality and Safety Commission provides a complaints service for the public.

Mr HUNT: I am aware of that, but in terms of your comments around transparency in the state-run facilities, would you agree that providing data, at least on numbers of complaints at a particular facility, would increase that transparency and information for the public?

Dr Wakefield: In terms of numbers of complaints per se, I understand that is not included as a metric at this stage. Again, I point to the fact that the regulation that is proposed, which prescribes the initial indicators, is certainly subject to change over time to include other indicators that are deemed to be useful. I think it is also worth pointing out at this stage that a significant amount of consultation was done over the past 18 months in a couple of tranches, but particularly with consumers, around what consumers want to know and what is important to them to be able to help them make healthcare decisions. At this stage I think we plan to run with the information that we have now, based on that consultation.

Mr HUNT: The explanatory notes also state that during the 2017 state election the Queensland government committed to introducing safe staff-to-resident ratios, which I guess is what we are talking about here. You mentioned before that there are some state facilities currently below the rates that are intended. Are there residents currently living in state owned facilities who are at risk?

Dr Wakefield: Perhaps I can answer that question in the following way: in the first instance, staffing is one component of considerations around quality, but it is a very important one. As part of the preparation for this policy position of government, we undertook to understand the current nurse-to-resident and staff-to-resident ratios, expressed as hours per resident day, across all of our public residential aged-care facilities. Obviously we had no sight of the privates and not-for-profits. What we found was that the range—and correct me, Deb—was roughly between 2.5 and 4.8 hours[1] per resident day. That includes the nursing and the non-nursing component. It is the nurses and the assistants in nursing or support workers.

Why was there variation? Simply because, across the 16 residential aged-care facilities that we run, there is a significant diversity in the acuity of residents. For example, at Redlands, where they have a closed dementia unit and very high acuity patients or residents who generally would not be accepted by the private sector, those rates were something like 4.5 or 4.8 hours per resident day. At some of the smaller rural residential aged-care facilities, the acuity of patients generally was a lot less. That is the reason for the differences across different facilities.

It is true to say that not all facilities are the same and not all facilities require the same level of health worker hours per resident day. The position of 3.65 hours per resident day was arrived at as a consequence of some research that was undertaken as a collaborative between the Australian Nursing and Midwifery Federation and the university, and we used that as a guide. The 3.65 hours was an average of all of the public residential aged-care facilities. We chose to take that average and make that the floor.

Ms PEASE: Dr Wakefield, you made some comments around the hypothesis that practitioners and organisations would not want to be on the bottom of the list. You also talked about consumers and their willingness or desire to be able to access relevant information. Can you tell me what sort of feedback you have had around that, where consumers might want to be able to compare centres and how you obtained that?

Dr Wakefield: I might ask Kirstine Sketcher-Baker to summarise the consumer consultation feedback, particularly from consumers.

Ms Sketcher-Baker: We undertook quite a rigorous consultation process. The first part was, in late 2017, to go out to consumers and clinicians to understand whether or not they wanted public reporting in the first instance. The second part was really about then establishing from consumers and clinicians what information they actually wanted to see on a website.

[1] In correspondence dated 26 September 2019 Queensland Health clarified that the range of care hours provided daily was between 2.8 and 5.2 hours. See: **link to correspondence**.

In terms of the feedback that we received from consumers, they were interested in basic hospital information. Furthermore, they were really interested in comparisons between hospitals around a range of measures. When looking at length of stay, they were interested in knowing particularly how long they would be expecting to go into hospital for. In terms of knowing how long they had to wait, they were very interested to compare hospital against hospital. In terms of maternity patients or women who were pregnant, they were also really interested to know comparisons around caesarean section rates, inductions of labour, perineal tears. They were probably more informed in their decision-making than some of the other consumer cohorts we talked to.

Ms PEASE: You say that you actually consulted with the community to see whether they wanted to have this information. Obviously, they overwhelmingly indicated that, yes, they did?

Ms Sketcher-Baker: Yes, 99 per cent of people had indicated that they wanted reporting around public and private hospital information, because there is a general lack of information that is comparable between public and private information.

Ms PEASE: Would the same apply with the aged-care sector?

Ms Sketcher-Baker: I would think so, yes. At the time when we went out, we were not specifically consulting on aged care. That was just for the initial phase of the consultation.

Ms PEASE: My colleague the member for Nicklin asked about facilities opting out and being named or stating that they have opted out. Will it be by facility or by provider?

Ms Sketcher-Baker: It will be by facility.

Mr O'ROURKE: In the public hospital system, do we currently collect the data that is proposed in this bill?

Ms Sketcher-Baker: We collect the majority of the data that is proposed in the bill. Currently, we collect what is called the hospital admitted patient data collection and the perinatal data collection. Both of those data collections are basically reflective of every single patient's admission to hospital. We are able to generate a range of indicators from those data collections, to look at patient outcomes.

Mr O'ROURKE: Would I be right in saying that they will be ready to report when it comes in? They will have the data and be right to go?

Ms Sketcher-Baker: There are two parts to it. There is the information that we collect from public and private hospitals. There is also some information that we will require from public and private hospitals that we will have to collate. That will be a very similar process to the aged-care facilities, where essentially we collect that information through a website portal. The initial phase will be to collect information such as name, address, phone number, hospital website and some of the services that are being offered at the particular facility. That will be initial information that will be provided through to the website. Hospitals will then be able to modify that over time as things change within the hospital. That is essentially it.

Mr O'ROURKE: Do you know whether the private hospitals are collecting the data at the moment?

Ms Sketcher-Baker: Within the Private Health Facilities Act there is a requirement for private hospitals to provide that information for the admitted patient data collection and the perinatal data collection through to Queensland Health at the moment. We have a lot of that information already.

Mr McARDLE: Thank you for being here again today. It is like meeting an old friend on the road to Damascus. I want to start with the international research that you referred to. The explanatory notes refer to the ANMF paper with Flinders University. They also talk about the *National aged care staffing and skills mix project report 2016*. Are those part of the four papers that you gave us? I have not seen them yet.

Dr Wakefield: No, they are not. Again, I would like to create a distinction between the broad evidence base for transparency—

Mr McARDLE: I will come to that, too.

Dr Wakefield:—and the reference to specific evidence around carer hours per resident day, which is a very specific component. We have not tabled that. That is a public document. I think we have a copy here and I am very happy to table that for the committee's reference.

Mr McARDLE: I suggest that the four papers that you have tabled are predominantly nurse-patient ratios that would have been referred to and used in the 2016 debate in relation to HHSs and the acute, surgical and—

Dr Wakefield: No, that is not correct. Again, I think there is the potential to confuse and conflate aspects of this bill. The broad transparency agenda does not specifically relate to workforce and staffing. It pertains to the broad ability of consumers, clinicians and others to be able to access a wealth of information about hospital and health services, either at an individual facility level or to compare up to three facilities, public and private, to assist them in making decisions. That can be about all aspects from car parking to the availability of public transport right through to outcomes, and in this case the early work will be in maternity indicators.

Dr Wakefield: Correct. That is very general. The ratio element as it pertains to residential aged care is a specific additional component of this bill. It is the transparency bill that actually includes those data in the broad information available to the general public. The evidence base that suggests there is a relationship between staffing and outcomes in residential aged care is that there is very little research underpinning that at this stage. The ANMF evidence report, which we have here, is one of the only pieces of literature that we could find in relation to that specific piece—that is, what is the relationship between nursing hours and staff hours per resident day and outcomes? That does not mean to say there is not one; it just means that the evidence base is pretty scant. That piece of work provided a level of evidence upon which we were able to draw some conclusions.

Mr McARDLE: Your search would have been global, I take it, in relation to that question.

Dr Wakefield: We did a traditional literature search looking at literature that may be international. Given that there is little research, one of the commitments under this policy is that that research occur. On this implementation of minimum hours per resident day in the public sector, we would seek to research and evaluate that so we understood what the impact would be of putting a floor into the hours per patient or resident day.

Mr McARDLE: How does the Queensland Health *Business planning framework: a tool for nursing and midwifery workload management*, fifth edition et cetera, operate in aged-care facilities in Queensland operated by Queensland Health? How is that ratio, if that is the correct word, determined?

Dr Wakefield: I might ask my colleague to answer that question in a very practical way. How is that done?

Ms Miller: The *Business planning framework: a tool for nursing and midwifery workload management* is usually referred to as the BPF. It is an industrially mandated tool and it is designed to support business planning for the management of nursing and midwifery resources and workload management in the public sector. The BPF, as you mentioned earlier, was first established in 2001 and has had periodic reviews since that time, and we are about to review it again. The current edition was reviewed with the Queensland Nurses and Midwives' Union. It provides a framework for HHSs to collate their nursing human resource requirements; determine the appropriate nursing and skill mix levels required to meet service requirements; and develop and implement strategies to manage nursing resources, supply and demand. It evaluates the performance of its nursing resources and focuses on achieving a balance between supply and demand.

Dr Wakefield: At a practical level, it is effectively an objective and transparent instrument which allows the management on the ground, based on the acuity of the patient, or patients, and the staffing profile—rather than pull it out of thin air—to use that data to say, 'For this facility with this mix of residents we would need X number of nurses and healthcare workers on the morning shift and the afternoon shift,' and so on. Out of that data, you can easily compute the number of hours per resident day. If you like, it provides an objective way of creating that staffing, rather than something which is opaque and invisible. That tool—which is different for every ward in every aged-care facility because it depends on the resident type—essentially computes a staffing plan which they then staff to during each year. I think it is revised on a 12-monthly basis.

Ms Miller: We can table an example of how that calculation is done.

Mr McARDLE: If that would help the committee, by all means.

CHAIR: Procedurally, there was also a document that you earlier sought to table as well as the information you have just referred to. Is leave is granted? There being no objection, leave is granted.

Dr Wakefield: I will summarise this for the record. This is the *National aged care staffing and skills mix project report 2016* and an example of how the BPF relates in a practical sense to how staffing may be calculated for a residential aged-care facility.

CHAIR: I am pretty that sure we may have already received from Queensland Health rostering from those 16 facilities. That may help.

Mr McARDLE: Both the study of the ANMF and the university are here, plus the documentation. You would be acutely aware that the royal commission is now well and truly underway. They have an interim report due by the end of next month, if I recall correctly. The royal commission contacted every provider of aged care across the nation asking for questions to be answered. That is public knowledge. You are such a provider. I suggest that you did respond and you did provide that information to the royal commission. Are you able to provide that information publicly to this committee?

Dr Wakefield: I might ask my colleague Kathleen to answer that.

Ms Forrester: Deputy Chair, you may recall that as part of our work with the parliamentary committee into your investigation into aged care, palliative care and voluntary assisted dying we have an agreement with you that we will provide to the committee all of the information that we have provided to the royal commission, so all of the information that we have provided to the royal commission has been provided to the parliamentary committee. I do not believe that it has been provided publicly, but the committee should have all of the information that has been received by the royal commission.

CHAIR: Just to clarify, I think that was dealt with in private session with the committee. It has not yet been made public. I should clarify my last statement: we had sought to receive both public and private information, and that will be dealt with by the committee in private.

Mr McARDLE: Can I just make this very clear: the conversation we just had was a private conversation.

Ms Forrester: I apologise. Can you repeat your question for me, please?

Mr McARDLE: Given that you have provided to the royal commission the documentation they sought way back in relation to aged-care facilities operated by Queensland Health to the committee—you have said that—are you able to provide that publicly?

Ms Forrester: At this point we would not provide that publicly out of respect to the royal commission and their processes. You have pointed to the process that the commission itself worked through, which I believe is a matter of public record, where they contacted the 100 largest providers of aged-care services across the nation and sought information from them. I have not seen the commission report on that publicly. My expectation would be that we would see their analysis and the conclusions they draw in their upcoming draft report. The position that we are adopting out of respect to the royal commission is that, having provided them with the information, we will allow them to undertake their role and produce their draft report.

Mr McARDLE: Queensland operates 16 aged-care facilities, but there are a number of other facilities that do provide aged-care services of varying degrees. How many in total, including the 16 we are speaking about, provide that form of service in one form or another across the state?

Ms Forrester: Just to clarify, Queensland Health has 16 residential aged-care facilities that you are familiar with. In addition, we have 34 multipurpose health services.

Mr McARDLE: That is right. There are some more as well, I think, after that.

Ms Forrester: We have multipurpose health services. We also have a number of transitional care places that people receive which are funded by the Commonwealth, and we have three facilities or services that provide home care services.

Mr McARDLE: The bill before the House will only cover the 16 aged-care facilities. It will not cover any other facility under the auspices of Queensland Health that provides, in one form or another, an aged-care service; is that correct?

Ms Forrester: Yes, that would be correct. We might check this. The multipurpose health services are run from small hospitals in our regional centres, so I am not sure how much of a distinction we would be making in relation to the reporting out of that facility.

Dr Wakefield: I can respond to that. The decision was made to not have the multipurpose health services in scope because they were not specifically providing only residential aged-care services. In that mix of services that they provide, including some acute care—because they are an amalgam of the federal and state services on the ground it is too difficult to get the fidelity of a residential aged-care model because it is a hybrid. The staffing minimum, if you like, pertaining to residential aged-care was not deemed to be able to apply to that.

Mr McARDLE: You would have, I would envisage, a similar level of acuity in an aged-care facility as you would in a multipurpose facility. The fact of the type of facility does not impact upon the acuity of the individual because that is relative to the person, not the location.

Dr Wakefield: Again, the information that I have is that those multipurpose health services are not specifically residential aged-care facility providers. They have other types of patient services, inpatient and outpatient. Therefore, it is very difficult to ascribe a staffing ratio, if you like, to a particular component of that because they are small and the staffing is worked out across the board. They still use the BPF, which is mandated, to derive their staffing, but it was deemed that they would not meet the criteria for a specific residential aged-care facility.

Mr McARDLE: The chair asked a question about the cost to government, and you said there were two limbs to that: one was $10 million in recurrent funding for two years for wages. I do not think we got to the second part.

Dr Wakefield: Yes. Given that for public residential aged-care facilities this is a mandatory minimum ratio, for want of a better word, it is not difficult to calculate the gap between what is currently being provided in the range that I spoke to you about before and the minimum that was determined, which was 3.65 hours per resident day. That equates to the $10 million. The other thing that I was referring to was the cost of production of the establishment of the website. We produce lots of websites and web pages. That is going to be undertaken and developed within existing resources. We will prioritise some of the work within the patient safety service around the establishment and then the subsequent maintenance of that website.

Mr McARDLE: Ms Forrester, I think the chair or the member for Nicklin asked a question in relation to penalties, and you said it was 100 penalty units. I think the reporting is once per quarter, isn't it?

Ms Forrester: It is once a quarter.

Mr McARDLE: So that penalty could apply every quarter. It is not just a one-off penalty. Every breach would constitute a penalty unit perhaps being imposed.

Ms Forrester: The approach that we have put into place is that it is possible for an aged-care service to permanently opt out. An aged-care service would only need to tell us once that they had elected not to put information forward as part of the website. I think that the intent is that people have the opportunity to be proactive to respond to us once and not to be subject to repeat requests, quarter upon quarter, and therefore subject to repeat potential penalties being applied.

Mr McARDLE: If you receive one penalty that is it, in essence?

Ms Forrester: Assuming we can work through with you to clarify that that is your position and report that on the website, yes.

Mr McARDLE: If I operate Mark McArdle Aged Care and I just say, 'No, forget it,' I am not going to get an ongoing penalty. That is right, isn't it?

Ms Forrester: That is the intent.

Mr McARDLE: That is the intent. Have you asked Treasury yet? I want to talk to you about the definition in the regulation. In the state aged-care facilities amendment regulation it talks about in clause 3 that 50 per cent of the care staff must be nurses. To clarify in my mind, nurses are RNs and ENs. Are they AINs as well?

Dr Wakefield: No. Where is says that 50 per cent of staff must be nurses, that includes registered nurses and enrolled nurses. The other 50 per cent is what we call assistants in nursing or support workers—staff with very basic support work training.

Mr McARDLE: I am not overly familiar with the structure or staffing in these facilities. In regards to a surgical ward, they will have a NUM in charge. In the bill that went before the House a couple of years ago, NUMs could not be calculated as part of the workforce mix. Is that the same case here? For example, are the clinical staff outside of staff on the ground calculated as part of the mix?

Ms Miller: The calculation includes direct care nursing staff.

Mr McARDLE: The range that you advise that the current aged-care services provide in hours is between 2.5 and 4.8 hours per patient per day. You spoke about the distinction between high acute and low acute, for want of a better phrase. I took from that that there are facilities at 2.5 hours and that is, on your assessment, what is required for that patient on that particular day. You then move to 3.65 hours and you said that you 'settled on' that. If 2.5 hours is what is required to provide the level of care, why would you go to 3.65 hours when that exceeds the level of care to particular patients?

What is the rationale between that figure and the higher figure? Why would you drop from 4.8 hours to 3.65 hours if that is the arrangement you put in place?

Dr Wakefield: The study that we tabled from the ANMF which was used as the basis for considering evidence based hours per resident day, I think had the figure of 4.3 hours as the optimum staffing hours per resident day. In advising government about this, we looked at our current range. The evidence base was 4.3 hours. That was the average of our current range that was deemed to be the best way, the most pragmatic way, of determining what that floor would be.

Mr McARDLE: I have to admit that I have some difficulty with that rationalisation because it seems that what you have done is picked two figures, added them together, divided by two and determined, 'Well, this is the way we are going to go.' That does not take into account, as a minimum figure, the level of acuity. It seems to me to take into account a rationalisation of hours, which is quite distinct based upon documentation tabled—I cannot quote this lady's name here—where they do look at the acuity. It might be a rhetorical comment. I just have difficulty understanding the acuity angle or question being paramount but it seems to be sidelined in the calculation.

Dr Wakefield: I think the best way I can explain the advice that was given was that there is little evidence to be able to define with some accuracy what a minimum level of hours should be. In terms of what inputs we had to consider and advise on that, there were really three things. There was the ANMF study which deemed 4.3 hours to be what I would regard as an optimum. There was the existing range, which is what we knew to be the case across our services, noting that the various services had different levels of acuity. Those data inputs were used to determine what we would recommend.

I think it is fair to say that, because we were focusing on a minimum rather than an optimum, we felt that it was appropriate—at some level there was an arbitrariness to determining what that was. We used both of those data inputs to make that decision, noting that more research was needed to make a determination about the link and the relationship between staffing and resident outcomes and that there was a commitment by government to put a minimum in place. Essentially that is how the figure was arrived at.

Mr McARDLE: Let me read to you in part from a submission from the QNMU, not in relation to this inquiry but relevant in regard to its contents. It refers to a study by Phillips in 2017 and it says, 'The proportion of those aged-care residents requiring high levels of care has dramatically increased from 13 per cent in 2009 to 61 per cent in 2016.' I cannot dispute those facts. The important point reads as follows: 'During the same period, the portion of qualified nurses fell dramatically, with the registered nurses cohort reducing by 33 per cent and the non-nursing qualified staff increased proportionally.' When I asked the QNMU reps on that day, my recollection was that they were talking about RNs, not RNs and ENs. That might be wrong, but either way they are a small proportion of the workforce generally speaking across nursing homes.

The concern I have is this: we have, as I understand, a shortage of nurses in Queensland in proportion to the need or the need of community. What thought has been taken into account in setting these ratios, given the acuity levels and, more importantly, given the potential shortfall in qualified nursing staff if, what I believe, is in fact the case? It may well be that, although you set ratios, it may be some time before the nursing cohort could reach a level of either number or experience to be of benefit to the patient.

Dr Wakefield: I will start and then I will ask Deborah to follow on in terms of answering: is there a shortage of nurses in Queensland? The first point is—

Mr McARDLE: It is in direct proportion to the need of nurses.

Dr Wakefield: With reference to the issue of will it take time for this to adjust and to work through these changes in the public system, the answer to that is yes. That is why the bill provides for a two-year introduction period whereby they work towards the changes both in terms of the uplift in hours and the recruitment that goes along with that and also the skill mix changes in accord with government policy around job security and so on. I might ask Deborah to deal with your question about a shortage of nurses.

Ms Miller: Currently the supply in nurses is early career—that is, graduates and early career nurses. There is a significant supply there. The department is looking to build the image of nursing in the aged-care sector to encourage more nurses into that area. We also have some transitional support programs for nurses wanting to move into the aged-care setting. We are also currently working on some strength with immersion programs as well to rapidly build early career nurses up so that they are competent to work in those aged-care settings.

Mr McARDLE: What is the average age of an RN in Queensland at this point in time? I know it was well over 55 at one point and, with all due respect, they are reaching retirement age and they want to move on—which is their right to do so. What is the average age now of an RN in Queensland?

Ms Miller: I believe it is over 45.

Mr McARDLE: In terms of the younger cohort coming through, do you have any concept of how many of those would move into aged care if you are working with a range of organisations and people to try to divert them from what an RN may traditionally call nursing—that is, the RBWH et cetera—into aged care? That is a very taxing and trying exercise as well.

Ms Miller: We have not surveyed the early career nurses at this point to establish interest.

Mr McARDLE: With a two-year lead-in, do you have any idea how many additional RNs and ENs will be required in the public aged-care service in Queensland, if the bill becomes law?

Dr Wakefield: That was very easy to work out. That is where the $10 million recurrent figure comes from because it was worked out on the gap. In terms of the specific answer to that question, I will certainly be able to provide that, but I do not have that specifically with me at the moment. Chair, can I take that on notice, please?

CHAIR: You can take that on notice, yes.

Mr McARDLE: Thank you all.

CHAIR: As an interesting observation to date, given that the royal commission is looking at quality and safety of aged care, there is no doubt from hearing from Queenslanders during our inquiry they want their loved ones placed in a residential aged-care facility, be it public or private, where a high standard and level of care is provided. The irony is that in this very place two years ago—I remember, there were over 100 nurses in the public gallery until about 2 am—there was vehement opposition to bringing in ratios to the acute wards. We are now moving into the aged-care sector.

There seems to have been a line of questioning around our 16 state-run facilities today by non-government members of the committee. There are 461 privately run facilities, and our committee has been to some of those facilities. We have heard some shocking stories from people who have written to us about levels and standards of care where there is one nurse to 120 people or no registered nurse on site with an on-call arrangement.

I think there needs to be a focus broadly on bringing this bill forward for the safety and wellbeing of all elderly residents, no matter where they live in Queensland. Listening to that line of questioning earlier, pre-empted my statement. We will move to supplementary questions if there are any. In the explanatory notes, some stakeholders called for further consultation on information that will be reported on the website. Are there any plans to undertake further consultation on that matter?

Dr Wakefield: We plan to establish an advisory committee or an advisory board going forward to consider both the outcomes of the transparency bill and particularly the website going forward, both its impact and utility for consumers but also for clinicians and others. As a consequence of that, we will consider expanding to other areas. Our focus on clinical outcomes initially commences with maternity services. There are many calls, I think, to broaden that out to other areas such as stroke, heart attacks, cancer et cetera. I think we will be keen to explore that with stakeholders going forward and make sure we do that in a consultative way.

CHAIR: How will the reporting framework be evaluated going forward to ensure that the intended benefits are achieved?

Dr Wakefield: This is a similar answer to the last question. We are very keen to make sure that the No. 1 priority is that this helps consumers make decisions and provides them with the information that they want and need in a format that helps them and their families make decisions about health care. We will be working very closely with them to evaluate that and make changes as needed going forward. As I said, that will be overseen by an advisory committee going forward.

Mr HUNT: I want to go back to ratios again. You acknowledge that there is very little evidence around mandated ratios and improvements apart from this report that has been tabled today. This report, which was tabled today—the 2016 report—suggests 4.3 hours as a minimum. Why was that rejected by Queensland Health?

Dr Wakefield: In answer to the first question about whether there is a relationship between staffing, particularly clinical and non-clinical staffing, and outcomes for residential aged-care providers, at face value it seems pretty clear that, if you have insufficient people to do the work and people without the right skills to do the work, that will have a negative consequence. We have heard many stories about that. There is very little doubt in most fair and reasonable people's minds that

there is clearly a relationship. There is a lot of evidence for that relationship in the acute sector, as we have said—surgical wards, medical wards and so on—hence the ratios that have come from that. In the residential aged-care sector there is very little. Whilst we were very keen to examine in detail the ANMF-Flinders study, we felt that that was insufficient on its own to make assertive decisions to go with 4.3 hours.

In addition, we were really clear that we already have a BPF. We already had a mechanism for working out staffing. The question about the BPF is: is that right? As we have said, patients are getting more complex and, as the population ages, does that tool adequately recognise the staffing that is required and that it produces? Obviously, we considered a number of options, including 4.3 hours. The decision of the minister and cabinet was to go for a middle ground in terms of an average of what our current staffing was because that was real for us. We knew that that was the staffing that we had. It was not a research paper. The decision was made by cabinet to make a start and to choose the average, 3.65 hours, as the minimum in full knowledge that further work was required to determine whether that was well pitched or whether it needed to be expanded or increased, also in full knowledge that the royal commission and the considerations of this committee are in play. I think the decision was to make a start and make it very clear that staffing mattered.

Mr HUNT: Having been in possession of that report since 2016 and having the minimum across the Queensland Health service at 2.5 hours, do you consider that patients now with a staff ratio of 2.5 hours per patient are receiving adequate care?

Dr Wakefield: It is almost impossible to answer that question in an evidence based way by saying yes or no. I can only answer it in a qualified way. What we do know is that in our public residential aged-care facilities our staffing inputs, our costs—thus our staff that we provide—most likely significantly exceed that which occurs in the private and non-government sector. We know that not because we know their figures, but we know by proxy. We know because we provide significant additional funding over and above the traditional Commonwealth funding model. We stand by our staffing models and our staffing of our public residential aged-care facilities now. We can only seek to improve. This is more a case of how can we improve staffing and give greater hours to residents so that they can have the additional benefits of that.

CHAIR: Thank you very much, Dr Wakefield. There being no further supplementary questions, I ask that any questions taken on notice be provided to the committee by Wednesday, 25 September. We thank all representatives here today. We look forward to the follow-up briefing in late October.

Proceedings suspended from 10.52 am to 11.01 am.

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

McLEAN, Mr Scott, Director of Proceedings, Office of the Health Ombudsman

CHAIR: I welcome from the Office of the Health Ombudsman Mr Andrew Brown and Mr Scott McLean. Thank you for your attendance today. I invite you to make an opening statement with regard to the Health Transparency Bill which talks to the four recommendations from the 2016 report.

Mr Brown: My opening statement will be very brief. The provisions in the bill that relate to amendments to the Health Ombudsman Act fall into two different categories. The first are the amendments necessary to give effect to the recommendations of this committee to introduce a joint consideration process for decision-making and to improve the handling of what we call split matters, where there is a health impairment matter associated with a misconduct matter. That is one class of amendments. The other relates to some amendments that have been recommended by both me and my predecessor in relation to what might make the Office of the Health Ombudsman operate more efficiently, particularly in the face of increasing complaint numbers.

CHAIR: We know from the work that we have done with your office that there is significant improvement in the handling of complaints. I think it is probably important to outline why it is important to require joint consideration of matters about registered health practitioners by the Office of the Health Ombudsman and the Australian Health Practitioner Regulation Agency. Why is it important to have clarification of this joint consideration?

Mr Brown: Essentially I think it goes to both consistency and efficiency of decision-making and to avoid duplication of effort. As you are aware, in relation to registered practitioners, the management of complaints and notifications is shared between the two organisations, with the OHO dealing with the most serious complaints and notifications against registered practitioners. Also, our key role is to be the single point of contact for all complaints and notifications.

What happens at the moment and what has been happening since the office started in July 2014 is that the OHO on their own would make a decision when a complaint or notification came in, in relation to what to do with it. For a lot of those matters the decision is to refer them to AHPRA to manage because they do not meet the seriousness threshold for us to deal with it. That matter then goes to AHPRA. With a lot of those matters, no further action will ultimately be taken on them, quite appropriately. This process, from a complainant perspective, will ensure that some of those 'no further action' decisions that might ultimately be made by AHPRA on matters we refer to them will be made at the front door so that a complainant will not see their complaint be sent from one organisation to another just for it to be closed. Also, for practitioners, it is a better outcome because, if no further action is going to be taken, again it is better to do that early at the front door than send them through that process.

CHAIR: Thank you very much, Mr Brown. I perhaps should have underpinned that with the four recommendations in the report. For the benefit of members, to bring them up to date, in the 2016 report we made four recommendations aimed at improving the performance of the health complaint system.

Recommendation 1 is that the Queensland government investigate the merits of amending the Health Ombudsman Act 2013 to introduce a joint consideration process for health service complaints between the OHO, AHPRA and the national boards. I think you have covered off on that nicely.

Recommendation 2 is that the Queensland government consider options for ensuring potentially serious misconduct matters are able to be dealt with as a whole rather than being split between OHO and AHPRA and the national boards.

Recommendation 3 is that the OHO, AHPRA and national boards produce a joint plan—which I think you possibly talked briefly to—which identifies the information needs of all parties and any barriers to the sharing of information and sets out an agreed approach for resolving any data issues—we have started discussing that and I will ask you to talk to that in a moment—that prevent the production of nationally consistent data about health service complaints.

Recommendation 4 is that the Queensland government consider whether to introduce legislative amendments suggested by the Health Ombudsman. That is why we are here today. Did you want to talk to that third point about the data issues just briefly?

Mr Brown: Yes, certainly. That is not an issue that requires amendment to any act, so it is not covered in the bill. That is really to ensure that AHPRA can report, as much as possible, information relating to practitioners in Queensland in a consistent way across the country, in the same way they report in other states where they handle all of the registered practitioner matters.

As simple as that sounds as a concept, it is very complicated and involves the agreements in relation to a whole raft of different definitions and the way things are counted. It involves making changes to our fairly complex case management system. There was a road map designed for that a few years ago. We have been slowly but steadily moving down the path of making those changes. Each year, at least in the last couple of years, we have provided more and more data so that AHPRA are able to provide more and more data sets. We are not there yet. I think we provided eight or nine new data sets just recently for last year's annual report. I believe that by the end of next financial year we will be in a position to provide every piece of data that we can to AHPRA so they can provide a much more comprehensive reporting nationally. That will not necessarily be everything, but it will be fairly comprehensive.

CHAIR: My final question before moving to other members is: the bill makes changes to the constitution of QCAT for certain matters. Can you explain to the committee the reason for the proposed changes?

Mr Brown: Yes, the changes in relation to QCAT relate to the ability for QCAT to deal with matters without having a judicial member present. That relates specifically to any consideration of unregistered practitioner matters. I believe that is not only in relation to any dealing with any disciplinary matters against unregistered practitioners but also hearing any reviews of immediate action decisions that I may have made or interim prohibition orders I may have made against unregistered practitioners. Non-judicial members in QCAT will then be able to hear those. I believe also that there are other AHPRA registration matters that non-judicial members will be able to hear. The important thing in relation to that is that there is a lot of work sitting with QCAT at the moment and any ability for them to be able to more efficiently deal with those matters is a positive step. That means that it will not be quite as involved for QCAT hearing some of those matters after the amendments come into operation.

Mr HUNT: In the explanatory notes, the committee's recommendation to introduce joint consideration process was based on feedback from stakeholders that joint consideration could help to reduce the duplication of work between OHO, AHPRA and the national boards. What is an example of the duplication of work that has been going on at the moment?

Mr Brown: I think that relates to what I mentioned before. When a matter comes in it will come to us. At the moment our process is to decide what action to take. If it is a complaint about a registered practitioner, the test that we apply is, firstly, we make sure that it is particularised enough so that the complaint can be understood; secondly, we make sure that we can identify the parties or the registered practitioner that is the subject of the complaint; and, thirdly, we look at the seriousness of the allegations. We do not necessarily look to decide whether it can be substantiated or not, but we say, 'Well, taken at their highest, these allegations will not amount to professional misconduct or there will not be a ground to suspend or cancel their registration.' That is the trigger for us to then send the matter to AHPRA. AHPRA then assesses the matter and they might form more of a view about the merits of the particular case. If they decide that it is not ultimately a matter for them and it does not require any action then there will be no further action taken. We think that when this is up and running there will be a greater opportunity to make those 'no further action' decisions right at the front door and they will not be sending it through

Mr HUNT: Without referring to AHPRA?

Mr Brown: Yes. The other potential is that there are times when—we do this much less often than potentially the office used to—we will take a complaint in and we will form the view that we think it could be professional misconduct. It will go to our investigations area and it will be investigated by us. It may go to Mr McLean, the Director of Proceedings, for him to potentially say, 'I have looked at all of this and I do not think this is actually professional misconduct.' If so, we then send it to AHPRA to deal with. There will be a greater opportunity for AHPRA to have input at the front door to say, 'We do not think this is pm; we think this is something that we can manage.' It might result in those matters going to AHPRA at an earlier stage before we have done all of that work. It will not avoid it in every case because sometimes you need to investigate a matter to decide whether it meets the threshold of seriousness.

Mr HUNT: If it is referred to AHPRA, do they receive the full investigative file with interview notes—the whole works?

Mr Brown: They do, yes, and they do not have to re-invent the wheel necessarily. They will often rely on the work that we have done.

Mr HUNT: It is not a duplicate investigation as such; it is an assessment of what you have produced.

Mr Brown: That is right. To a degree there will be some duplication of effort but not a complete new investigation.

Mr McARDLE: Thank you for being here today. It seems like eons ago that the report was written, but we are finally here. In relation to the issue of constitution of QCAT for certain matters—and I understand what it states—does the new power that will vest in the president by definition mean a quicker outcome? The reason I say that is this: QCAT has been criticised by the president, not in itself, but for the funding required to bring it up to what he believes is an acceptable level. Does changing this, given the resourcing of QCAT, actually alleviate a concern that existed in 2016 or is it words on paper?

Mr Brown: That is really a question that I cannot answer because I do not know the inner workings of QCAT and how they resource their matters. Through this process and through advice that the Department of Health would have had through working with the Attorney-General's department on that particular amendment, my understanding is that that will make the process work more efficiently, but I just do not have enough understanding of how it works.

Mr McARDLE: Until some time passes?

Mr Brown: There is really only one judicial member that hears our health practitioner matters. One would assume that there are more non-judicial members that might be available, but that is an assumption on my part.

Mr McARDLE: My question goes to any potential backlog in QCAT and again how it operates in turn within that body itself. Maybe time will tell. In two or three years time we can make an assessment as to whether or not that did result in a quicker and more efficient outcome.

Mr Brown: Can I just add to that? There is another amendment which will probably have more of an impact on the QCAT numbers than the make-up of the tribunal, and that is the ability of the Health Ombudsman to make final prohibition orders against unregistered practitioners, as is the case in New South Wales, Victoria and South Australia. That will mean that those matters will not have to go to QCAT in the first instance. They will not have to go to Mr McLean, the Director of Proceedings. They will still be investigated and there will still be a natural justice process, but I will be the decision-maker in relation to those matters. They could go on review to QCAT and that would still mean that QCAT would have to deal with them. My feeling is that that will probably be the exception to the rule.

There are a lot of unregistered practitioner matters where the practitioners have moved on; they really do not practise any more. Some of them have not necessarily invested a lot in their training and their career. There might be a massage therapist, for example, who might have done an online massage course—they have done something wrong; they have moved on. We still proceed against them to get a final order because they might have committed a criminal offence, but they are probably unlikely to seek a review in QCAT. Around 10 to 12 per cent of our workload, both in investigations and in Director of Proceedings matters, are unregistered practitioner matters, so it is probably about the same that goes to QCAT. That will take 10 to 12 per cent of the work out of QCAT. It is not massive, but everything helps.

Mr McARDLE: For you it could well be.

Mr Brown: Yes.

Mr McARDLE: The next topic is obtaining information after referral to the Director of Proceedings. The explanatory notes state—

> It is proposed to amend the Health Ombudsman Act to clarify that, rather than referring the matter back to the Health Ombudsman for further investigation, the Director may refer a matter to the Health Ombudsman to obtain additional information.

What is the distinction between the two terms?

Mr Brown: I brought the Director of Proceedings, Mr McLean, with me, so I will have him answer that one.

Mr McLean: It is a very good question. It is probably more in terms of how much is involved. It is probably best to give it by way of example.

Mr McARDLE: Please.

Mr McLean: I had one matter where the sole piece of information that I required before being able to make a decision was medical records. In order to do that, the matter had to go back to the Health Ombudsman. The Health Ombudsman had to make a decision to refer it to investigations. Investigations then were required to send out notices saying that there is an investigation undertaken.

It took a week. They then had to send out a notice again to say that the matter had been referred back to the Health Ombudsman, and then the Health Ombudsman had to refer it back to the DOP. Really, the only thing practically was that the DOP required some medical records. Practically the only distinction is the amount of work involved. With an investigation, one would assume that quite a substantial amount of work is required, in which case the notice provisions kick in. In relation to studying information, it will just be a small information that the DOP will be requiring.

Mr McARDLE: It really eradicates those matters that need not go back for investigation. It simplifies and quickens the procedure going forward.

Mr McLean: Correct.

Mr McARDLE: My final question to you is this: I remember in the inquiry some years ago—I was the chair as well—we spoke about the practical way that you would undertake a joint determination. In fact, flowing from that your predecessor held some meetings. How would that take place on the ground? How do you have a joint determination? Is it a meeting? Is it via electronic documentation? What do you do?

Mr Brown: There will be, we think, around about 3,500 decisions a year that have to be made as part of this joint consideration process. The processes that are being implemented at the moment are to try to automate that process as much as possible. We only have a very short period of time to undertake it—seven business days now as opposed to seven calendar days—so there really is not time to have meetings and have discussions. That will happen as an exception where agreement cannot be reached.

We are working towards having both information systems basically talking to each other. A complaint will come in. We will log it as we normally do. We will tick a box in our information system which will automatically share all the information we have to AHPRA. They will then receive a notification that a joint consideration matter has come in. They will have five business days to undertake their assessment. They will put their decision onto the system. We will put our decision onto the system. If there is a match, it will automatically produce a workflow outcome for us to say, 'Decision to be finalised'. Where it does not match, there will be actual communication where there is a 14-day period then for the two agencies to negotiate an outcome.

I have spoken to the committee before about the dentistry trial that we ran. I think there was about four or five per cent of the 120 matters where we disagreed in the first instance, and then we resolved them all going backwards and forwards. We think it will be a small proportion of cases on which we will disagree. The vast majority will result in matches in the system. Behind that we will also ensure that we can pick the phone up at any stage and communicate through that process if we need to. It is to be a little bit flexible and agile as well, but the system will do most of the heavy lifting.

Mr McARDLE: At the end of the day if you cannot decide—I cannot recall—who is superior?

Mr Brown: There is a hierarchy of decision-making. Essentially, if the Health Ombudsman office thinks the matter requires management by the Health Ombudsman then that decision will be made. If AHPRA believe that the matter should be referred to them and we do not think it should, that will trump our decision. The most serious action will prevail. If we think they should deal with it but they think we should deal with it, I think it will still go to them initially. I think that is the way it will work. It is a formula that will automatically apply to get an outcome.

Mr McARDLE: Is the guiding principle that action is to be taken or the consequences that will flow from a finding against a practitioner?

Mr Brown: I am not sure I understood the question.

Mr McARDLE: Is it the type of action that will flow that will dictate who will take on the matter or is the more prevalent matter the consequences that could flow by way of a finding against a practitioner?

Mr Brown: The most serious consequence will prevail.

Mr McARDLE: Will trump?

Mr Brown: Yes, will trump. That is from a risk management perspective.

CHAIR: As a segue from the comment you made regarding the dental trial, are you currently undertaking the pharmacy trial?

Mr Brown: That is right.

CHAIR: How is that proceeding?

Mr Brown: There is a smaller number of matters that have come in. I either have not been briefed or I just cannot recall. It is in its early days. I am not aware that there are any results in in relation to agreement or disagreement. I understand the numbers are a bit smaller than the dentistry trial. I can certainly provide you with that information.

CHAIR: That is fine. Thank you very much for that. We look forward to our continued good working relationship with the Office of the Health Ombudsman. It is good to see these reports finally come up. As the deputy chair pointed out, we are survivors of that previous report, literally. It took a couple of years, so it is good to see it before us. We look forward to further work with the Office of the Health Ombudsman. Thank you very much for your contributions today. I declare this public hearing closed.

The committee adjourned at 11.23 am.