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

Members present:
Mr AD Harper MP (Chair)
Mr MF McArdle MP
Mr MA Hunt MP
Mr LP Power MP

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

PUBLIC BRIEFING—INQUIRY INTO THE HEALTH TRANSPARENCY BILL 2019

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 9 OCTOBER 2019

Brisbane

WEDNESDAY, 9 OCTOBER 2019

_____

The committee met at 1.08 pm.

HARMER, Mr David, Senior Director, Strategic Policy and Legislation Branch, 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, Director-General, Queensland Health

CHAIR: I welcome representatives from Queensland Health and the director-general, Dr John Wakefield. We appreciate the department's response to issues raised by submitters. Do you want to talk to any of those before we move to questions?

Dr Wakefield: I do have a brief opening statement, if I may. Thank you for the opportunity to further brief the committee about the Health Transparency Bill 2019 and respond to issues raised in the submissions. With the committee's permission, I would like to address some of those stakeholder issues before taking questions.

The majority of submissions to the committee supported the transparent reporting of health facilities provided for in the bill, including public and private hospitals and residential aged-care facilities. Some stakeholders, however, suggested that health facilities and residential aged-care facilities should report on a wider range of information, such as cardiac services, patient bed numbers et cetera, and some submitters provided feedback that the website should not be limited to surgical procedures and maternity information. In developing the bill, stakeholders and particularly consumers were extensively consulted about the types of information about health services that would be of most benefit to them. The health service information that will be published has been selected on that basis and refined further.

I think it is important to note, though—certainly it is our intention—that this information should be seen as a starting point. The aim is to collect and publish more information in the future, and the bill includes the ability to do this by regulation. It is a start, and we would really like to progress that in a measured manner after really settling down the initial approach.

We do envisage establishing an advisory committee consisting of consumers and various industry stakeholders to guide the development of future information for publication. Clearly, there is a lot of interest in what information is provided and I think it would be critical for us to make sure that that governance is in place going forward. Similarly, the reporting metric for the aged-care sector is intended to be a starting point. Residential aged-care facilities may be requested to provide more information in the future to increase transparency and provide consumers with a broader view of the industry.

Again, I would like to make the point that this is nested in a transparency bill which is focused around providing information that consumers want and that helps them make healthcare decisions. Any expansion of this reporting for aged care, for example, would be informed by further consultation with consumers and industry stakeholders. Indeed, some stakeholders have raised that Queensland Health should risk-adjust information about hospital acquired complications before publishing it on the website. Queensland Health will risk-adjust information published about maternity indicators and hospital acquired complications. We do acknowledge the importance of this, particularly when comparing outcomes data across facilities.

Some stakeholders expressed reservations about patient and clinician privacy for the publication of health service information. The framework is aimed at creating transparency at a facility level. Stakeholders can be assured that there is no intention to report on individual clinicians or to publish information that would identify individual patients. We will have appropriate strategies in place to protect the privacy and confidentiality of individuals, particularly as it pertains to very small services.

Two submissions raised concerns that asking private residential aged-care facilities to report residential care information would pre-empt findings of the Royal Commission into Aged Care Quality and Safety and this committee's inquiry into aged care. There is currently a significant amount of activity occurring in the aged-care sector with a focus on making improvements to the way elderly are cared for. The reporting measures in this bill will provide consumers with additional information to assist in selecting an aged-care provider whilst improving the visibility of care provided in the aged-care sector. We will continue to engage with the reviews that are happening and respond to any changes as they arise, including any outcomes from the royal commission and this committee's inquiry.

Referring specifically now to the Queensland Health residential aged-care facilities, most submissions supported the implementation of minimum standards of care in residential aged-care facilities operated by the state of Queensland. I would like to reiterate that these minimum levels of care only apply to aged-care facilities operated by Queensland Health; they do not apply to private providers. Queensland Health facilities will continue to rely on existing processes to calculate the care needs of an individual. The level of care provided to residents will be adjusted according to that individual's needs and to what we call acuity. The requirement to provide 3.65 hours of care daily to a resident actually ensures a minimum benchmark. It is a floor; it is not a ceiling. In appropriate cases, a higher level of care will be provided and the hours will be greater.

One stakeholder sought changes to the definitions of certain terms in the bill. The definitions were drafted to ensure consistency with existing legislation across Queensland and the Commonwealth statute books. It is thought that using definitions that already apply to the aged-care sector will reduce confusion and misinterpretation. The definitions were drafted with care and should be read in the context of the bill.

Turning finally to the Health Ombudsman amendments, only a minority of submissions related to amendments to the Health Ombudsman Act. The issue that attracted most comment was allowing the Health Ombudsman rather than QCAT to make final prohibition orders for unregistered practitioners. It is important to note that safeguards will be in place for the use of this power. For example, a prohibition order can only be issued after an investigation has been conducted and the Health Ombudsman can only make an order if satisfied that the practitioner poses a serious risk to persons. There are also natural justice provisions that ensure a practitioner will have the right to make submissions before a decision is made. I think it is really important to note that this reform aligns Queensland with the other jurisdictions including Victoria, New South Wales and South Australia. In these jurisdictions, the relevant health complaints bodies are empowered to issue these types of orders for unregistered practitioners, rather than the tribunal.

In conclusion, I thank you for the opportunity to address the committee on some of these key issues raised during this inquiry into the bill. I am very happy to take questions now from the committee.

CHAIR: Thank you, Dr Wakefield. I am sure the Royal Australasian College of Surgeons and the Queensland Surgical Advisory Committee would welcome the comment you made on the risk adjustment of data. They did raise that this morning and I think that goes some way to providing some certainty around their concern.

There have been observations in the fallout of Earle Haven in terms of getting better public reporting of levels of care. We have heard some commentary from those to my left this morning on the risk of duplication from having two websites. The Commonwealth currently do not publicly report under the Aged Care Quality and Safety Commission, compared to this bill, and this has sought quite a bit of support from people who have submitted in welcoming that public reporting. I will try to phrase this correctly, if I can. Is there a need to go a little further? There are two parts to my question. Some submitters this morning talked about levels of care being placed on the future website. That might mean around dementia, high acuity and low acuity. Can you comment on that?

Dr Wakefield: My initial comment would be that this is a starting point, as I said. Consumers have spoken to us very clearly about the need and want for transparency. From a private and non-government residential aged-care sector perspective, this will ensure there is visibility as well as matching the requirements we place on public residential aged care. We are well aware that context

is always important with numbers. It is intended that contextual information can be provided by those organisations submitting data to give some explanation around the context. I might ask my colleague in the first instance to comment on what that might look like and see if that answers your question.

Ms Sketcher-Baker: Facilities will be able to submit that information to the website. Information will then go back to that facility to validate that is the correct information submitted. They will also have the opportunity to provide contextual information around certain figures. That contextual information will then show as kind of like a pop-up on the website where that information will be presented from the facility providing that contextual information.

CHAIR: My second question is probably more around an observation the committee made, and I will use Earle Haven just because of the recent investigation. There were 10 years of sanctions under the former quality and safety commission, which has now been reformed. Going forward, would you consider moving towards an ageing and disability commissioner, like New South Wales has? I say that to contextualise that. We had a decade of sanctions and nothing changed. In fact, the facility got worse to the point where your own department and the Queensland Ambulance Service had to intervene. From a Queensland perspective, do we need to have a closer look at the regulatory framework?

Dr Wakefield: Clearly, any decision about the establishment of any sort of statutory body at a state level is a policy matter for government and it is not one that I should comment on. We recognise that there are calls for a lot more information to be provided to consumers. The Commonwealth has the prime responsibility in a regulatory sense, so we are not aiming to duplicate that. We will be making sure that the information on this website about residential aged care, which is limited to that staffing, provides relevant links to the broader Commonwealth My Aged Care website et cetera so that consumers and others can access the other types of information available. I will ask my colleague David Harmer to comment on anything else in relation to that question.

Mr Harmer: I would just reiterate what the director-general said. The Commonwealth is responsible for regulating aged care under its legislative framework. There is an existing Aged Care Quality and Safety Commission. It has a number of areas of focus it is actively pursuing in terms of quality of care, built environment and models of nursing care. If the government were to consider a regulatory body here, it would need to be cognisant of the fact that any legislation would need to act together with Commonwealth legislation in such a way that it was not in conflict. I think the reality for a Queensland regulator would be that, even if they had the ability to go into facilities here, it would ultimately be for the Commonwealth regulators to take action if they identified a problem.

CHAIR: That is a good point.

Mr HUNT: I am glad you mentioned the My Aged Care website and the reporting on that, because I think I have heard it said that there is no federal portal and there obviously is. Whether or not it provides sufficient information is another debate. This bill goes toward one specific piece of information that is not there in terms of staff ratios. We talked about data and how it can mean very little out of context. In relation to the potential duplication of Commonwealth reporting requirements, your submission states—

> The chief executive's power to request information from RACFs is discretionary. If the Commonwealth Government legislates to require providers to publish staffing information or information about hours of care, the chief executive ... can elect not to request information under the Bill.

Would it be ideal for Queensland Health to not be in this space if the federal government provided that information on that portal?

Mr POWER: Absolutely.

Mr HUNT: Can I get him to answer instead of you?

Dr Wakefield: I think the decision to be in this space, if you like, is a policy matter that is not my decision. It is a decision for government, so I need to be clear that it is not something I should comment on. I think I can and should go back to: what is the evidence behind what is being done here? Obviously, this is a broad transparency bill. It is not specifically about residential aged care. Its goal is to find out from consumers what helps them make decisions about their health care. From a policy perspective, it has been determined by government that, at least at this stage, there is no information of use in the Commonwealth space that provides any specific information about staffing in the context of residential aged care. At this stage, particularly in line with the government's decision to regulate minimum care hours in public residential aged care, it is perhaps reasonable to think that merely shining a light on the private sector is a reasonable thing to do to help consumers make choices and at the same time potentially encourage providers to take a closer look at how they staff their residential aged-care facilities in the context of clinical care.

Mr HUNT: We have discussed how that figure came about in terms of averages et cetera, so it is not necessarily based on evidence that the best quality of care comes from that ratio. With that in mind, there is regulation under the federal quality framework to ensure adequate staffing and an adequate mix, and that is overseen by that federal body. It is also reported on in that portal if there are breaches, so there is in fact reporting on that website if people are not up to that quality of staff; is there not?

Dr Wakefield: Breaches are reported on, as you say. Again, I think the relationship between staffing and quality outcomes—there is some evidence in that space, but it is scant. There is certainly not cast iron evidence that links a particular number of hours to a particular outcome, albeit there is some face value validity to the man in the street that would suggest there is a relationship between staffing and outcomes. Again, I cannot comment on the policy position the government has taken, but I can comment on the fact that that information is not currently available in terms of the specifics of staffing, and in our consultation consumers have said that they want it.

Mr HUNT: We have heard a lot of submissions today about other data that people would like which is not available. I was interested in why the government cherrypicked this particularly, but that is a policy decision as you said. I will leave it at that.

Mr POWER: With regard to other data, obviously the federal government has failed to give this information to people who want it. They have explicitly written to you to say that they are not interested in ratios or providing this data; is that correct?

Dr Wakefield: They have written to us. I would need to check the specifics of what they said.

Mr POWER: It was tabled in parliament.

Mr Harmer: I am not sure that is an appropriate characterisation of what they said. I do not have access to the letter myself. I think the Commonwealth was acknowledging the fact that there is a royal commission underway and that they would await the outcome of that process.

Mr POWER: They did say they had no interest in ratios.

Mr HUNT: Why don't you quote it, member, instead of paraphrasing?

Mr POWER: The minister says they were not supporting the mandatory staff ratios in aged care: 'While not supporting the staff ratios in aged care'. This document was tabled in parliament on 21 August 2019. It was addressed to Dr John Wakefield. It is quite clear that their policy position is not to support the mandating of staff levels.

Dr Wakefield: In relation to that question, again I think there are two pieces to this. Mandating minimum staff ratios is the position that government is taking with this bill with respect to public residential aged-care facilities. The position with respect to the private and non-government sector is not to mandate minimum ratios at all—full stop.

Mr POWER: It is only about reporting.

Dr Wakefield: It is about shining a light on the staffing they have in that context. I think that is an important distinction. Going to the letter you quoted—yes, I acknowledge that letter was sent. I do not have it in front of me right now. I think they have made a commentary there that they have no intention to mandate minimum staff ratios. There is very much two arguments here. The position being taken by government is really, I believe, based on the notion and the evidence that transparency is a very important vehicle to drive accountability and quality. Whilst there may be debate about the number, whatever that number is—3.65 or 4.3, and I am sure you have heard lots of debate about that—the government has not taken the decision to mandate that number in the private sector. Neither does it have, I believe, the head of power to do so. It is simply to shine a light into that so that consumers can vote with their feet but also I guess to apply pressure to the sector to be accountable for it.

Mr POWER: We heard from the AMA that the percentage of nurses in residential aged-care facilities, as a proportion of their staff, has gone from 21 per cent to 14.9 per cent from 2003 to now. You are saying that it is important to shine a light for consumers to understand that that percentage has gone down in that way. At the same time, we have seen the percentage of patients with really high needs go up. It is important that consumers then get some information about the facility that they are putting themselves or a loved one into in terms of the level of nursing care that exists in that facility.

Dr Wakefield: It is one piece of information. I think it is a very important piece of information as a proxy for quality but there are many other pieces of information. Obviously I am across the submission from the AMAQ. It is fair to say—we have given evidence before—that this is part of the

challenge. We have no visibility of those data in the private sector. I would ask my colleague David about that, to see if that is correct. I do not know where that number came from, but I think that is part of our issue. We have no visibility of staffing levels and ratios in private residential aged care. David?

Mr POWER: The AMA refers to the College of Nursing quoting data from Flinders University of 13 February 2019.

Mr Harmer: The department really has visibility for the 16 facilities it has responsibility for, bearing in mind that there 451 facilities in Queensland. To reiterate the director-general's point, we do not necessarily have the same insight to how private facilities are staffed.

CHAIR: Before I move to the deputy chair, I will quote some of this letter because I was very interested to hear from submitters today and from those written submitters who support the publication and intent of the bill to better inform Queenslanders of existing facilities' staff-to-patient ratios should they take it up. Of course, they have an opt-out option. Mr Hunt says—

A robust framework exists to detect any failures with the standards including unannounced reaccreditation audits and regular assessment contact visits.

It would be my observation after doing the Earle Haven investigation of a decade of failures that that does not exist at all. The further—

Mr HUNT: Is this a question or commentary?

CHAIR: I will make a comment. Thank you. I will move to the deputy chair in a minute. He goes on further to say —

It will create a reporting burden on providers.

My observation after hearing from submitters is that they want to hear it. Health Consumers Queensland wants consumers to be able to access those particular points. Thank you, member for Nicklin. It is a comment. I am not asking for a response.

Mr HUNT: The member for Logan did not like us making comments earlier.

CHAIR: Thank you. Deputy Chair?

Mr McARDLE: Can we get back to the Queensland bill in relation to the position that will occur if the bill is passed by the House? First, congratulations on your appointment to director-general. I sincerely hope that your term is long. I hope that you benefit—and that we do as well—from being director-general. It is a very important position—perhaps in some ways more important than a minister. I did not really say that!

Dr Wakefield: Thank you, Mr McArdle.

Mr McARDLE: I want to start with the advisory committee that you referred to. The chair and the member for Logan made comment in relation to a submitter endorsing that principle. Will that be enshrined in the bill by way of an amendment or will it be simply a committee established in-house, shall we say?

Dr Wakefield: At present that would be an administrative arrangement in terms of the governance of that going forward. I think it is, again, a matter for the committee in terms of its advice—

CHAIR: The committee can make recommendations.

Dr Wakefield:—and government to determine whether that needs a reference in the bill or the regulation.

Mr McARDLE: We may well recommend that. It would seem to give some succour and support to some issues that have arisen in relation to the information type, the depth et cetera that may be asked for by way of the department's request. I take it that the committee will also look at the concept of risk adjustment of the data. It was raised today that the term 'risk adjustment' can have numerous meanings based upon who you are and where you sit in the food chain. The royal college of physicians or GPs were quite concerned that how they see risk adjustment may well be distinct from how Queensland Health sees that. Do you see that as an issue in regard to terminology but more so definition?

Dr Wakefield: We could probably consume many days of your time—

Mr McARDLE: Enjoyable time, too!

Dr Wakefield:—with technical arguments about what should be in or out of risk adjustment. As a matter of principle, risk adjustment is important. We absolutely agree with that in the sense that, if there is some comparison between outcomes—be they about clinical outcomes, for example in maternity care or surgery or whatever the area, or indeed about hospital acquired complications,

which is another area that is already well established in the national system and framework—it does matter on the population that you are treating. If you are treating a particularly unwell population, an older population or a population with certain conditions, there are statistical methodologies for adjusting that to make sure that there is a kind of level playing field. As you have pointed out, there are many debates that have gone on for years about what should be in and what should be out. Should there be 10 items that you risk-adjust—age, sex, weight or whatever—or should there be 100 items? The person to my right is an expert in this area. Kirstine, please be brief but can you give the expert answer rather than the amateur answer?

Ms Sketcher-Baker: For all our outcome indicators, we will certainly be looking to risk-adjust. For the hospital acquired complications of surgery, there already exists a risk adjustment methodology and approach that has been nationally defined with clinicians and statisticians. We will be adopting that process. The reason for adopting that process is that, where possible, stakeholders have said, 'We need to adopt national indicators so that we avoid any confusion between yet again producing a different definition to something that already exists nationally.' That is what we intend to do for the hospital acquired complications. For our maternity indicators, we will be seeking some expert opinion around the maternity risk adjustment comorbidities and sex, age and things like that as well.

Mr McARDLE: The committee can be assured by those two answers that there is a national standard—if that is the right term—that will be adopted and placed over the information provided to give a risk adjusted outcome?

Ms Sketcher-Baker: Yes. Where there is something in existence already in terms of risk adjustment nationally defined, we will be adopting that. If there is nothing in existence in a national or a state approach we will be seeking advice, usually through our clinical networks.

Mr McARDLE: I want to ask a question, but the preamble is important to put to you before I pose the question. The bill imposes upon public owned facilities an obligation to use 'ratio data'. It does not on private because the jurisdiction is not there, as I understand it, to do that. It does say that the private facilities can be contacted by letter to provide information contained in the bill. If they do not reply or they determine that they are not going to opt out permanently and fail to make the response, they can be then fined. As I understand, they can be fined each quarter if they do not opt out on a permanent basis. Has the department satisfied itself that there is no inconsistency between the state and Commonwealth jurisdictions in relation to the capacity to ask private providers to provide information and then to impose the penalty? I think Mr Harmer touched upon this very slightly when he made an opening comment. I want clarification of that point for the committee because, with all due respect, I do not want there to be an issue down the track about jurisdictional argument that could in effect eliminate part of the bill in a court challenge.

Dr Wakefield: That is a technical question. I might ask David, who is the expert, to answer.

Mr Harmer: Broadly in answer to the question, the position is that the Queensland parliament can regulate to the extent that its laws are not inconsistent with those of the Commonwealth. In developing this legislation, the department satisfied itself that the requirements in the bill do not replicate or are not inconsistent with those of any currently existing Commonwealth laws. For that reason, if this bill is enacted Queensland could successfully require private facilities to provide information to the department.

Mr McARDLE: That is fine. That is all I need to know: yes or no. You have dealt with the issue and have come to a conclusion. If the Commonwealth enacted similar information gathering—it may not be exactly the same—that question may be enlivened again down the track?

Mr Harmer: Yes, that is correct.

Mr McARDLE: What is the current Queensland Health budget in relation to aged care? Can you provide me with that data—a global figure? We will place it on notice if we need to.

Mr Harmer: I will be able to provide the answer during the course of the hearing. I have it with me. I just need to find it.

Mr McARDLE: Director-General, on the last occasion we spoke we slightly discussed the question of how the bill applies to residential aged-care facilities but there are a number of other aged-care facilities that Queensland Health does operate and it will not apply to them. One of those is multipurpose health services. There are about 33 of those operated by Queensland Health. In Barcaldine there are 14 residential places and eight home care packages; in Clermont there are 43 places and 18 home care places. Can you explain why they would not be captured by providing better information to the residents and also their family and by that not putting them under the spotlight, shall we say? What is the rationale, because in a number of places they are quite significant in number?

Dr Wakefield: In a moment I might ask my colleague, the acting chief nursing and midwifery officer, to address anything that I do not cover. We received advice early on in respect of this matter that for the multipurpose health services, by virtue of the fact that they are not specifically residential aged-care facilities—they are a mix; they are a pool of Commonwealth and state funded healthcare services and they are small—it was not possible to ring-fence the staffing related to the provision of residential aged care versus the provision of other types of services at the MPHSs such as walk-ins, outpatients and other things. In other words, because they are small and because the staffing there is very generalist in its nature—it has to deal with acute care, chronic care as well as residential aged care—it was not possible to sequester that and provide a ratio of what was happening or the care hours per resident per day. That was the information we got from the expert team that was providing information to the department. Deborah, is there anything that we need to add?

Ms Miller: I think you have covered it, Director-General. It is the variability of the mix of patients in MPHSs and it does differ depending on the numbers of urgent care patients coming in or some acute care patients that they may be caring for.

Mr McARDLE: The reason I pose that question is: when the parliament passed the ratio of 1:4 in relation to surgical and medical, we could define very clearly where the patients were because they were in the ward—that is, surgical and medical. Therefore you could impose the 1:4 ratio quite simply. Are the patients in Barcaldine not in the same situation as patients in facilities operated by an aged-care service? Are they not suffering the same dementia? Are they not suffering the same comorbidities? Are they not suffering the same concerns? That is where I have a problem. I accept surgical and medical because they are quite distinct patient types, generally speaking.

Dr Wakefield: It is true to say that a residential aged-care patient with needs has needs whether they are in Brisbane or they are in Barcaldine. What we are talking about here is a functional unit which you staff to provide care. To go to the surgical ward example, in the smaller regional hospitals we excluded mixed wards because, yes, they might have had some surgical patients in there but they had other types of patients as well. It is the same for the multipurpose health centres. If I am running a residential aged-care business or facility, that is what I am running. My staff are totally dedicated to providing care to those patients and therefore it is not difficult to provide that ratio and the number of hours. If I am running a multipurpose health service, the same little core group of staff are providing daily care to the residential aged-care clients, seeing the outpatients as they walk in from Barcaldine and doing some of the community work out in the community. It is the same staff, so you cannot—

CHAIR: It is hard to drill down to that detail?

Dr Wakefield:—segment that because the staff are multitasking. For that reason we deemed that it was too complex to include those services in this arrangement. That was based on advice from providers in the sector who strongly advised us exactly that reason—that you are running essentially in one little space several businesses all together with the same group of staff.

CHAIR: Something the committee observed in its travels is that in small communities people do not want to transfer out to a major centre—they want to stay in their community—and those levels of care are welcomed. That is an observation we have made in our travels to date.

Mr McARDLE: You mentioned when you first came before us in September 2016 that there would be ongoing research in relation to what will be potentially the final outcome of the ratio, and that was because there was scant evidence at that point in time. I accept that that is the case. That research will be done by whom—not the person but the facility?

Dr Wakefield: My understanding is that we are currently in a request for quote situation, which is where we have defined the research questions and scope of the research and we put that out to the market to say, 'Well, who wants to bid with the right expertise to be able to do that work?' Deb, that is on the way?

Ms Miller: That is correct. That process is underway to seek a request for quote.

Dr Wakefield: Once that is completed that announcement will be made.

Mr McARDLE: Is it theoretically possible that the 3.65 hours will not be the ratio figure at the end of the research?

Dr Wakefield: There are a number of inputs to the current 3.65 which I think we have been through. The outcome from the research I think, without pre-empting what that might look like, hopefully will provide us with an additional source of input to that decision. It will not be definitive, because I think there is a lot more research needed, but it might take us further on the journey to

understand what is the relationship between staffing and skill mix and outcomes for residents in residential aged care of different acuities and to what extent, based on the outcomes of that research, that informs us about that number: is that the right number to set as a minimum, as a floor? I do not want to pre-empt the outcome of that work, but I think once we have the outcome of that research there is always an opportunity to consider a policy position.

Mr McARDLE: Can I quote your comment to me? You make the initial comment about the literature not being readily available—

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.

You are going to evaluate the 3.65, as I understand that word to mean in your quote. Can you eliminate that the 3.65 may not vary or will not vary?

Dr Wakefield: Again, I cannot eliminate anything that would be a policy matter. If there is a mandate as a statutory minimum, that is a decision of government. We may be asked to advise on that. If significant information comes to light which varies from that, we of course would provide that information. Again, why did we get to where we are? Basically, what we know is that there is some research—we have tabled, as I know the QNMU would have tabled—the ANMF research, that led to the 4.3 hours. In addition to that, we run residential aged-care facilities so we know what our range is, and you have had that information. It was not a nil starting point. That is where we are at the moment. If new information came to light we would provide further information to government.

Mr McARDLE: I do not know that we have the report that shows 3.65 hours as the required figure at this point in time, but the QNMU did make the comment that they sat on a task force with OCNMO. They referred to a body that they sat on that actually delivered the 3.65 hours.

Dr Wakefield: What do we call that?

Ms Miller: It is the government election committee implementation advisory group.

Mr McARDLE: It is not a Queensland Health committee?

Dr Wakefield: Yes, it is a Queensland Health committee.

Mr McARDLE: You sat on the ALP—

Mr POWER: No.

Mr McARDLE: The director can talk for himself. He is a big man.

CHAIR: Thank you, Deputy Chair.

Dr Wakefield: I was forgetting the acronym. It is called the General Election Commitment Implementation Advisory Group, GECIAG. That group had five members to advise on the implementation of election commitments of government.

Mr McARDLE: And Queensland Health sat on that committee?

Dr Wakefield: That group, with its associated subgroups, had sought advice, input, research and so on. The membership of that group was Barbara Phillips as chair, who is the deputy director-general; myself as a member; the deputy director-general of CQ; Beth Mohle as the QNMU president; the chief nurse and midwifery officer; and a health service chief executive representative. That group provided advice—not decisions but advice to the director-general.

Mr McARDLE: Who was the director-general at that time?

Dr Wakefield: Michael Walsh.

Mr McARDLE: Do you have any idea what became of that advice or the documentation? What became of that documentation?

Dr Wakefield: In reference to?

Mr McARDLE: A report was prepared and went to the director-general, a written document. What became of that document?

Dr Wakefield: The outputs from that committee were provided to the director-general in the form of briefing notes, as per procedure.

Mr McARDLE: There was not a report prepared by the committee to the director-general on the outcome of the consultation process?

Dr Wakefield: It was a briefing note that was prepared after that consultation.

CHAIR: Just to clarify, the QNMU referenced OCNMO. What does that stand for?

Ms Miller: Office of the Chief Nursing and Midwifery Officer.

Mr McARDLE: I beg your pardon: did the chief nurse sit on that committee?

Ms Miller: Yes.

Mr McARDLE: Is that report readily available to be tabled to the committee?

Dr Wakefield: In terms of the recommendation to government going forward, we sought advice from the committee and that formed part of the cabinet processes in terms of advising on legislation, so that would be cabinet-in-confidence.

Mr POWER: One of the things that we heard about was the number of transfers from nursing homes to hospitals and the possibility that there is a lack of nurses either intervening early or being able to diagnose and make decisions about whether a transfer to hospital emergency was necessary. Is there any part of the research that looks at the fact that low nursing numbers—they changed, as I talked about, from 21 to 14.9—pushes costs from private nursing homes onto the public health system through ambulances, emergency and that process of triaging and also, when there is not enough intervention, ultimately ending up as an admission?

Dr Wakefield: I think in terms of the specifications for the research, obviously there are many questions. I am not sure that that is one of them in terms of the relationship specifically that will be sourcing those data. I would need to check with my colleague, the chief nursing and midwifery officer, around the specs for that research. I cannot actually answer that specifically.

Mr POWER: I phrased it as a question, but it was a point that I wanted to raise more generally. I think there is a cost to the Queensland taxpayer.

CHAIR: Certainly, there is. We have discussed previously the impact of residents taking up beds in acute hospitals whilst they are waiting for placement or whatever. There is no doubt a correlation between the two.

Dr Wakefield: In relation to that, before we move on, certainly with framing the research questions around the relationship between staffing and quality, including what is reasonable to maintain in a residential aged-care facility versus what needs to be moved to a hospital for example, there are many aspects to that and many contexts, and certainly that will be scoped down. You could spend many millions of dollars in a research centre on this. I think our scoping will be pretty much honed down to try to at least move us forward a little bit. In our knowledge about that, I think we need to be careful to manage expectations around that. I make that comment.

Mr POWER: Expectations managed!

Mr McARDLE: Director-General, I want to look at the current arrangement in public aged-care facilities operated by Queensland Health. They record the number of hours provided by way of care on a daily basis, as I understand it. Is it recorded in any way as to how many nursing hours, how many RNs, how many ENs, how many AINs currently?

Dr Wakefield: In respect of current public residential aged care?

Mr McARDLE: Yes.

Dr Wakefield: It is a fairly simple equation. They know what staff they have on what shifts and it is a simple equation of those hours. If I am a nurse and I am on for an eight-hour shift, those hours contribute to the numerator and the denominator is how many residents over a 24-hour period. Yes is the answer to the question, but it is not calculated based on how many minutes I do per patient.

Mr McARDLE: Not on patient A, patient B, patient C; I understand. That will also be the same under the new reporting regime, will it not? It will be an average number of RNs, number of ENs, number of AINs and that will then be divided by the number of patients?

Dr Wakefield: Correct. Again, we really took that on advice. Different to the ratios in the acute sector where we have morning, afternoon and night shifts and we measure by shift, the advice in the residential aged-care sector was that that is not how they run that business, because a lot of the needs are cohorted around particular times of day. Their staffing is not in three shifts. It was the least burden in terms of a data collection and the most accurate to put all of that together over a 24-hour period. That is the advice that we took.

Mr McARDLE: When you talk about the regulation, at least one half of care staff must be nurses and 30 per cent of care staff must be RNs. There will not be a calculation as to how much time RNs actually spent with a patient. It will be an average based upon the number of patients, the number of RNs, ENs and AINs. There will be no drilling down, as I understand your comment; is that right?

Dr Wakefield: Correct.

CHAIR: There are no further questions.

Mr Harmer: I can answer the question on notice. In the 2017-18 financial year, the Queensland government contributed approximately $61.5 million to residential aged-care services in Queensland. For context, the Commonwealth contributed approximately $54.4 million to residential aged care in Queensland, focusing just on the public residential aged-care facilities. Residents contributed approximately $20.6 million in fees.

Mr McARDLE: That is $140-odd million, as a very quick tabulation.

Mr Harmer: Yes.

Dr Wakefield: Thank you Chair, Deputy Chair and committee.

CHAIR: Thank you.

The committee adjourned at 2.03 pm.