



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
Mr MC Berkman MP

Staff present:

Ms S Galbraith (Committee Secretary)
Ms A Groth (Assistant Committee Secretary)

PUBLIC HEARING—INQUIRY INTO THE HEALTH TRANSPARENCY BILL 2019

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 9 OCTOBER 2019

Brisbane

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The committee met at 9.00 am.

CHAIR: Good morning, everyone. Before we start, I request that mobile phones be switched off or to silent. I declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I would like to start by acknowledging the traditional owners of the land on which we are meeting today. I am Aaron Harper, the chair of the committee and member for Thuringowa. The other members here today are Mark McArdle, the member for Caloundra and deputy chair; Marty Hunt, the member for Nicklin; and Linus Power, the member for Logan, who is substituting for Barry O'Rourke, the member for Rockhampton. Joan Pease is an apology and Michael Berkman, the member for Maiwar, may join us later on today.

This morning's hearing is part of the committee's inquiry into the Health Transparency Bill. The bill was introduced and referred to the committee on 4 September 2019. The reporting date for the bill is 18 October 2019. This public hearing 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 intentionally 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.

MOHLE, Ms Elizabeth, Secretary, Queensland Nurses and Midwives' Union

PRENTICE, Mr Daniel, Professional Research Officer, Queensland Nurses and Midwives' Union

PYRA, Ms Kalina, Hall Payne Lawyers

TODHUNTER, Dr Elizabeth, Research and Policy Officer, Queensland Nurses and Midwives' Union

CHAIR: Thank you very much for joining us. Thank you for your submission. It was quite detailed. Would you like to make an opening statement before we move to questions on the bill?

Ms Mohle: Thank you. We will make a short submission. Thank you for inviting us to appear today at the hearing. We also thank the Queensland government for introducing this bill, which will enable transparency in the reporting of health data and improved quality of care in state provided aged-care facilities.

The QNMU has a longstanding commitment to public reporting. The benefits of public reporting improvements and clinical outcomes. The proposed website and the legislative framework that aims to improve the transparency of the quality and safety of health services and aged-care services provided in Queensland is the first step in building a transparent health and aged-care sector.

The undoubted benefit to stakeholders in creating a website for public reporting is transparency. We see this website evolving to include other measures and topics that provide consumers with information to make informed decisions about where to go for their health care and aged care. Our submission provides a number of other indicators that we believe should be published, such as bed numbers; licence to operate; costings on the average prices for common hospital procedures, out-of-pocket expenses and the type of arrangement the hospital will have with each health fund; the top 10 Australian refined diagnosis related groups—AR-DRGs—for each facility; the average length of stay; readmission rates; post-surgical mortality rates; presentations to emergency departments; nurse or midwife-sensitive outcomes; and patient experience surveys for all facilities.

For many years the QNMU has been lobbying to improve quality and safety in aged care. We therefore strongly support the introduction of nurse-to-resident ratios in state aged-care facilities. We believe that ratios will lead to better care for residents and more manageable workloads for our members and that they should be introduced in all aged-care facilities.

Among other recommendations, we have suggested that the average minimum 3.65 hours per resident per 24 hours be clearly identified as the minimum, with actual hours of care calculated by the business planning framework and documented in the facility, ward or unit service profiles. Our submission puts forward several other areas of public reporting for the aged-care sector. In particular, we seek public reporting of adverse incidents such as assault, abuse, poor care, mistreatment or neglect in all Queensland and Australian aged-care facilities. We suggest that the process for complaint should be evaluated to ensure the reporting pathway is accessible, visible and easily understood. These reported incidents should be made available on the website.

The QNMU has some concerns around proposed amendments to the Health Ombudsman Act. As these are technical legal matters affecting our members, Kalina from Hall Payne Lawyers has come with us to assist the committee with any queries about these amendments. Thank you for the opportunity to present today.

CHAIR: Thank you very much. Dan and Liz would remember the Earle Haven inquiry just a couple of weeks ago on the Gold Coast. Some discussion ensued about the federal oversight body. In that particular instance there were some sanctions imposed on that facility over a period of years. On page 8 of your submission you state—

The QNMU also asks the Committee to consider the establishment of a Health Performance Commission.

That was something that was apparent to me. Obviously, the intent of the bill is to advertise the facility's nurse-to-patient ratios and a number of other things. Can you go a little deeper into a health performance commission and the benefit it might have in terms of this bill?

Ms Mohle: I will open with some introductory comments and then hand over to Liz and Dan. We have argued for this for some time. There is a need for much greater data to be out in the public domain and for that to be auspiced, if you like, by an independent body. At the national level we have an organisation such as the IHPA—the Independent Hospital Pricing Authority—and other related bodies under national health reform. We believe that there is a necessity for something like that in Queensland. We believe that the more information that is publicly available and able to be interrogated by the general community and by researchers the better. It is a plank that we have had for some time in terms of openness and transparency.

Dr Todhunter: There are some shortfalls in the way in which data is currently managed and collected. I think there have been a couple of Queensland Audit Office reports that have highlighted that there are some serious gaps in the way HHSs record information and the way they make that available publicly. It is very difficult to compare like with like across a whole range of indicators. This is about data management, and we certainly feel that, in the health sector, some of the main resources are obviously human resources. Then you have your facilities and your high-end equipment. The other major resource is data, and that is not handled particularly well. We have been calling for this independent authority to be able to manage data better in that sector.

Ms Mohle: And for a consistent approach. We have had difficulties in getting even basic information for the hospital and health services, because they are all entities in their own right. Even basic information like staffing information is incredibly difficult. They all report on it in a different way. If you have a look at the annual reports on the website, there is not a standardised dataset.

We recently had a meeting with the chairs of the hospital and health services in Queensland Health raising that point and there was agreement from everybody in the room that we need to do better in terms of establishing a standardised dataset. We believe that it is better for that to be auspiced under an independent authority so that there is more confidence in the integrity of the data.

CHAIR: Will that also concentrate on the private sector?

Ms Mohle: We believe that it should, very much. The more we can get information out there to allow—and I hate the word 'consumers'—people who consume health services to have the information so that they can make informed the decisions the better. We believe that governments have a key role to play in making that information available not only from private hospitals but also from aged care.

Dr Todhunter: And I just add private aged care.

CHAIR: Yes. One of the intents of the bill is to have the option to opt out of reporting but to provide confidence to consumers where their loved ones will be placed and the level of care. I keep asking the question: is the current regulatory framework in the national space good enough in Queensland?

Ms Mohle: No, the current framework is not good enough. We did an audit of aged-care facilities in May last year just to look at the variability in terms of the hours of care provided per resident per day. That ranged from 1.69 hours in the federal electorate of Moncrieff—we did a number of Brisbane

facilities in each of the 30 federal electorates—to 3.11 hours in Groom. There was such significant variability in residential aged-care facilities, even on one indicator such as the number of hours of care provided per resident per day. To us, that is just staggering. It is totally unacceptable that there could be such variability across Queensland. That is why we think that shining a light on the issue of data will have the effect of bringing about a decrease in variability—if people know and are asked to explain why this variability exists. The experience in the USA, where public reporting in a number of states is much more widespread, has been that that has effected change in terms of private providers there changing their staffing numbers and skill mix as a result.

CHAIR: On page 10 of your submission under the heading 'General information' you suggest that the following information be included as general information on the website: bed numbers (capacity) and, interestingly, licence to operate. I will raise again the Earle Haven example of a subcontractor. Is there a view from the QNMU that subcontractors should have some level of regulatory control in the licensing? After all, they are providing a level of care.

Ms Mohle: There is a view, firstly, that it is a threshold issue—that subcontracting should not be allowed in aged care and in health because of the fact that it is just so opaque. I will throw to Dan in terms of providing any further comments about that. If they are allowed, certainly they should be subject to the same level of scrutiny as everybody else.

Mr Prentice: Yes. That is exactly right. If you are providing a service within the aged-care sector on behalf of a provider, the requirements for you to operate in that environment should be exactly the same as for the provider itself.

CHAIR: In the current circumstances, the provider has a licence and they can appoint anyone to care.

Mr Prentice: That would seem to be the case.

CHAIR: We need to have some stronger regulatory control around that?

Mr Prentice: Yes. I think that has been highlighted through the royal commission's investigation of Earle Haven and certainly at the state level as well. There seems to be a bit of a disconnect between the requirements to be a provider under the act and who can provide those services on a subcontracted or some kind of contractual basis, yes.

Ms Mohle: If we do not have that, we will have the situation of what happened at Earle Haven, where 70 residents were effectively abandoned. To me, that that could happen is criminal. Thank goodness Queensland Health was able to intervene and provide appropriate accommodation for those people. That was just a totally unacceptable set of circumstances. I think everybody, not only in Queensland but also in Australia, was left shaking their head about how that could be allowed to happen. The regulatory system is fundamentally failing elderly Australians.

Mr HUNT: Thank you for coming out today and thank you for your submissions. Beth, you mentioned the variation of between 1.69 hours and 3.11 hours. Is that across all facilities?

Ms Mohle: We did a random sample of two or three residential aged-care facilities in each of the 30 federal electorates. That was the average of those facilities per electorate. It varied, as I said, from 1.69 hours per resident per day in Moncrieff to 3.11 hours in Groom—a significant variability.

Mr HUNT: Do you have any stats just related to Queensland Health run facilities?

Ms Mohle: We do, and Dan would be able to talk to that.

Mr HUNT: Would you have the variation for that?

Mr Prentice: Yes. In the work that was done with the QNMU and OCNMO, for example, in the preparatory work that we did for the public sector aged-care ratios—part of the exercise that was done by Queensland Health was to analyse both the staffing and the skill mix of each of the 16 facilities that would be subject to that legislation. That work was done in detail. That certainly would be available to the committee.

Mr HUNT: Would you be able to table that for us at some stage?

Mr Prentice: I cannot table it. OCNMO would probably be the most appropriate body to provide that information. We were simply on that working group and that was provided by Queensland Health.

Ms Mohle: There certainly was variability. What we have agreement to do, implementing ratios in state government nursing homes, is go to 3.65 hours per resident per day. If you have more than that in terms of staffing numbers, you are not going to come down. No-one is going to come down to the average; people will maintain their current hours.

Importantly, what we are also doing as part of that process is an evaluation in Queensland about what is actually needed—similar to what we did with the rollout of ratios in medical and surgical units in Queensland Health. We had a research evaluation with the University of Pennsylvania. Similarly, before we introduced ratios in medical and surgical wards there was considerable variability across those units. In Queensland it ranged from one nurse to two patients to one to 12 in medical and surgical units. Now that variability has been decreased to one to four on days and lates and one to seven on night duty across the state as a result of the rolling out of ratios. We are trying to achieve a similar policy objective with the rollout of ratios in state government nursing homes and also acute mental health facilities.

Mr Prentice: The other thing to remember is that the 3.65 hours in this particular legislation and regulations reflects the average of the hours per resident per day in those 16 aged-care facilities.

Mr HUNT: That was going to be my next question.

Mr Prentice: That is significantly higher than the average that we demonstrated during our audit in May.

Ms Mohle: The best we got in that audit last year was 3.11 hours.

Mr Prentice: When you look at the state aged-care facilities in terms of their skill mix, the mix of registered and enrolled nurses and assistants in nursing is significantly more aligned with our 30-20-50 per cent aged-care campaign ask and the research that that is based on. In terms of the hours per resident, certainly some of those 16 facilities have significantly higher hours per resident per day, simply based on the services they provide and the fact that it is underpinned by the business planning framework and the service profile development that those facilities undertake.

Mr HUNT: Just to be clear, on page 15 your recommendation is 3.65 hours of care. Beth, you have said that you had come to an agreement on that obviously with the government. That figure is an average across the 16 services of the highest and the lowest? Is that how that average figure was reached?

Ms Mohle: Yes.

Mr HUNT: Is there any other research to suggest that is the best figure to land on?

Ms Mohle: We have national research that was undertaken by our national body, the Australian Nursing and Midwifery Federation, but undertaken by independent researchers, that indicates that on average across the country 4.3 hours per resident per day is required with a skill mix, as Dan has said, of 30 per cent registered nurse, 20 per cent ENs and 50 per cent AINs/PCAs. Because that research has not been done specifically in Queensland, that is the reason we have, as part of this process, an evaluation process that we have agreed to implement. We are very evidence driven, as evidenced by our support for the research that the University of Pennsylvania has done, so we really welcome that because we think state government nursing homes, for example, in Queensland are a bit different because they tend to have a higher acuity of residents. They have a lot of psychogeriatric patients, for example—a lot of residents who may not be accepted by private nursing homes because of the complexity of care. We need to do that research to unpack that.

Mr HUNT: Do you recall what the lowest ratio was in the Queensland service?

Mr Prentice: No, not offhand.

Mr HUNT: Below two?

Mr Prentice: When we are looking at staffing and skill mix in aged care it is a little different from the acute sector, where we might see, for example, one RN to four residents. In terms of ratios in aged care, there are two parts to that: one is the amount of care a resident receives over a 24-hour period, expressed as hours per resident per day, and the other is the staffing mix to deliver that care. That is where the 30-20-50 split comes in. That is delivered over a 24-hour period, acknowledging that often in aged care that arbitrary distinction between a morning shift, an afternoon shift and a night shift is a little bit more flexible than it is, for example, in a hospital.

Mr HUNT: In your opinion, are there Queenslanders currently in any of our 16 aged-care facilities who are receiving inadequate care?

CHAIR: I think that shies away from the intent of the bill.

Mr HUNT: I do not know about that.

Mr McARDLE: Point of order.

Mr HUNT: Then why are we bringing in a bill? The whole intent of the bill is to give people adequate care.

CHAIR: You are asking a question that shies away from—

Mr HUNT: It is the whole reason we are here, with respect.

CHAIR: Can I make a ruling?

Mr McARDLE: Why don't we hear the point of order that has been raised?

CHAIR: There are 459 privately-run facilities.

Mr HUNT: Point of order, Mr Chair. The question relates to the whole purpose of the bill. The purpose of the bill is to provide Queenslanders in state-run facilities, that we are responsible for, with adequate care. I am asking the nurses union if they feel as though there are any Queenslanders, as of today, in our aged-care services receiving inadequate care. It goes to the whole purpose of the bill.

CHAIR: I might ask the same thing of the private facilities. I will allow the question.

Mr McARDLE: They are not here, Mr Chair, and this is a bill related to the public health facilities. They can say yes or no.

Ms Mohle: We believe that variability across the board is a problem, which is why we have a longstanding campaign for ratios everywhere—public, private and aged care—and we will continue with that campaign until we achieve that objective.

Mr POWER: I see the bill through the eyes of someone who has an ageing mother, like many of us have, and having to make decisions as an outsider to the system rather than someone who is a participant. My father experienced post-surgical problems. That information about post-surgical mortality rates is very important, but I imagine in terms of data and decision-making on the outside, when you have a relatively low sample of the number of residents or patients or, as you talked about, variability in the cohort that goes into a particular type of nursing home, you might have very different results which would distort decision-making. There might be higher rates of post-surgical mortality in places with greater age and greater complications and a different cohort and the nature of the surgery they were involved in. For people on the outside making those decisions, how would you make that information make sense? You would need to, with sample size, roll it over time. If someone goes into heart surgery as opposed to ingrown toenails, the nature and danger of those surgeries is very different and post-surgical mortality may not be a reflection of the care they receive in a residential home. How would that information be provided in a way that was not distorting for those like myself making those decisions?

Ms Mohle: That is a really important point. You do not want to have the data scare people inappropriately. You do want to make sure that the sample size is sufficient and that you are not actually identifying people if it is a small set. I think we have to view this, though, in the context of it being a broader education and engagement strategy for people to actually know about their health care and you have to have the experts working with consumer groups like Health Consumers Queensland about establishing what those datasets will be so that they are meaningful and they are comparable. I might throw it to Dan and to Liz for comments on that as well.

Mr Prentice: I think, again, that is the argument for having an independent body at the state level that manages this data resource. I think that is a very good argument so that data is consistent, it is treated in the same way, it is weighted, categorised, stratified—all those sorts of things that all good benchmarking organisations can do with data to provide a picture that provides a realistic view of how a particular organisation operates in relation to its peers.

I think having data that relates to specific peered organisations is really important so that you actually get that comparison of like with like within the broader set of data, so that if you wanted to compare a couple of similar regional health facilities or regional aged-care facilities it is done in a way that is sensitive to the issues, that makes that information meaningful and so that you are not comparing it, for example, to a tertiary referral hospital where the casemix and all those other variables are really quite different.

I think that argues to have an independent view of the data. The consideration that the data is actually a state resource and not a resource that is at the HHS level—by all means let them collect it and do the all the right things about providing it, for example, but I think we really need to see this data in particular as a state resource. It is essential for assessing the performance of all of the health services and aged-care services in this state but, most importantly, it is a resource that both public and private sector providers can use—as well as the state government—to plan the services that they deliver into the future in a coordinated and meaningful way.

Mr POWER: In terms of the quality and safety information at that level—some of those more complex things where you have to roll averages from small numbers of patients and you have complexities around the initial presentation and condition and a whole range of things—it would seem

to me, as an outsider of the medical system making decisions about where my mum should go, to be too complex for me to process at a level that would be fair to the institution involved and it is more of an internal management issue for Queensland Health.

Dr Todhunter: Data is used for many purposes. It is obviously consumer driven in this case, but it is also used to represent patterns and to look for things across the board in a statewide comparison. Post-surgical mortality rates may be subject to a number of variabilities, but those sorts of things are still necessary to report on to be able to get a good understanding of the whole of the health system and the health outcomes.

Ms Mohle: I think patient satisfaction surveys are an example of something people would be interested in, and they would be able to understand that information and compare across facilities. It depends on the nature of that. It would be a broad range of data that would be available. Some would be of more interest to technical people, some to clinicians, but a dataset like patient satisfaction—I am sure people would want to know staffing numbers and skill mix and things like that which are quite easily interpreted and comparable across information. You are quite right: some information would probably overwhelm consumers, but some would be of great benefit.

Mr Prentice: It is about providing views of the data that are relevant to particular groups so that they can use that information. As Beth indicated, for example, if it is consumer-facing information it is essential that consumers be involved in that process of identifying what is meaningful for them as consumers. That will be really quite different, for example, if I am working as a hospital or a facility manager in terms of what is happening on my particular patch and what I have to respond to in that context.

Mr McARDLE: Thank you for being here today and, as usual, for a fulsome submission that is always good to read. What is the average age of RNs in Queensland at the moment?

Ms Mohle: Of our members it is about 45, I think. Interestingly, it is coming down a little, because we have done such good work in terms of recruiting more new graduates to the system.

Mr McARDLE: At the moment, the business planning framework is the document used by Queensland Health to fix the staffing numbers in their aged-care facilities. Ms Miller and Dr Wakefield commented about that in September before this committee. Dr Wakefield said—

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.

It looks at acuity, the number of patients et cetera. I think the QNMU actually helps in the revision of that document on a yearly basis. Would you say to the committee that that document is not sufficient moving forward? If that is the case, in what way is it deficient?

Ms Mohle: Again, it gets back to the issue of variability in terms of implementation. That is why ratios are not implemented on their own. When we implement minimum ratios in Queensland Health, the BPF is there to underpin it. If you like, the ratios are one to four on day and evening shifts, and one to seven on night shifts in the medical and surgical wards. That is underpinned by the BPF. That is the floor that you cannot go underneath. That is what you are guaranteed: the care guarantee.

If you have a much higher acuity in that particular unit, the BPF would be applied and it might demonstrate that you need one to two on a morning shift. They are in tandem. That is the way the legislation has been created, very thoughtfully, to make sure we are getting the best of both. The BPF is a tool that is very sophisticated, but the difficulty we have had, again, has been with variability. The whole objective of our ratios campaign is to decrease variability so that we can lock it down, so that there is decreased variability not only in the implementation of ratios but also in the implementation of the BPF.

Mr McARDLE: Dr Wakefield also referred to the BPF. He said—

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 ...

If we have a tool that actually looks at the acuity of a patient, it may well be that the staffing ratio, in the broad sense of that term, will be less than 3.65 hours per day. Would that not be an argument?

Ms Mohle: The reason we are doing the evaluation of the rollout in state government nursing homes is to unpack the issue of acuity and complexity.

Mr McARDLE: That is my next question. From what I have read and heard, it seems to me that when we look at the 3.65 hours the rigour of setting that figure is not based upon best evidence. It seems to be a platform that has been arbitrarily put in place based upon the BPF data used by Queensland Health, the Pennsylvania study and other ancillary documents, but we are going to undertake more research to find out what it really should be; is that right?

Ms Mohle: The Pennsylvania data is not relevant to the state government—

Mr McARDLE: No, but the rigour of the study is.

Ms Mohle: The national aged-care research was an input. It was considered when we looked at the ratios for state government nursing homes. We really need to remember that the BPF would still be being applied.

Mr McARDLE: How is it applied if we have a 3.65-hour ratio across the board? Where does the BPF fit into the regulation that says that in the 16 aged-care facilities there must be 3.65 hours? How is the BPF applied if it drops lower?

Ms Mohle: That is actually the minimum, if you like. You cannot fall beneath that. The BPF might demonstrate that you need 4.3 hours per resident per day, so you should actually apply, according to the BPF, the 4.3 hours.

Mr McARDLE: If it drops down to 2.3 hours, which supersedes?

Ms Mohle: Service profiles for the business planning framework are done regularly. They are reviewed at least on an annual basis. If the acuity is changed, there are changes in staffing numbers and skill mix accordingly. It is a live tool. It is not just a set-and-forget tool. It is reviewed very regularly.

Mr McARDLE: I accept that.

Ms Mohle: In our experience, we have not seen acuity decreasing in that way. If anything, the complexity in acuity of patients, not only coming into aged-care facilities but also coming into our hospitals, is increasing significantly. That is why we are focusing, particularly through our collaborative enterprise bargaining process, on the issues of acuity and complexity of care. It is getting harder and harder to actually apply tools like that because of the nature of the patients and residents who are literally coming through the door. We do not sit on our hands and say, 'Set and forget.' We are forever looking at ways that we can improve the data and make assessments based on the best available evidence.

Mr McARDLE: Can I summarise the connection between the current BPF and the new 3.65-hour ratio moving forward? The BPF will still apply. It will apply for those scenarios where it should be over 3.65. Therefore, each day the BPF will be undertaken by the relevant aged-care facility—or whatever time line they use—but it will not apply if it comes up with three hours?

Ms Mohle: If there is a change in acuity as a result of someone passing away or something like that—there is a significant event; it would have to be a significant number of people doing that—there is a mechanism by which the BPF is adjusted. There is an ability to make those adjustments.

Mr McARDLE: Would the 3.65 be adjusted to three hours?

Ms Mohle: It could be, but I would find that highly unusual, in my experience. Dan might want to comment on that—

Mr McARDLE: But you could envisage that that could happen?

Ms Mohle:—because he was involved in the detailed unpacking of what currently exists in state government nursing homes.

Mr McARDLE: We spoke about surgical and medical wards in relation to nurse-patient ratios. Certainly I accept that if you have a patient in a surgical ward there are two RNs—or two nurses anyway. How do you record the 3.65 hours per day per patient in a state aged-care facility? What is the mechanism to record that data, that you get the 50 per cent RN et cetera?

Mr Prentice: The 3.65 is an averaged amount at the facility level. A number of the current 16 public sector aged-care facilities already operate on hours per resident day that are certainly higher than that. As you can imagine, being an average, there are a number that would fall above that. In terms of the staffing level, that 30-20-50 split is over a 24-hour period, acknowledging that each of those 16 facilities is slightly different, has a slightly different resident mix and is located everywhere from metropolitan areas to regional and rural areas. That is applied over a 24-hour period on the basis of their rostering needs. That might mean that some of the staff, for example, maybe work a four-hour shift if that is required of them and that is part of their contracted hours, right through to some staff who may simply work an eight-hour shift. Certainly, the kind of variability that we see in terms of rostered hours probably is less in the public sector than it is by some private providers. To calculate the amount of hours on average that each resident is getting is really a factor of the total rostered hours registered nurses, enrolled nurses and—

Mr McARDLE: An average of the total provision of hours—

Mr Prentice: That is right—applied to the total number of residents in whatever business unit or facility that we are looking at.

Ms Mohle: For us, the most important thing is the fact that the clinical judgement of the registered nurse should not be overridden. No matter what it says on paper or whatever the BPF or whatever tool says, if their judgement is that it is unsafe to have that staffing level that should be respected. What underpins all of it for us is that we have to have respect for the expert professional clinical judgement of registered nurses who are on shift at the time. We have processes for escalating that if there are concerns in terms of changes of acuity or patient mix and the like. The predominant thing for us is that you have to respect our members' professional judgement.

CHAIR: That sounds like good, common sense. Thank you very much, Deputy Chair. We are over time, but that is okay. We will work into the break. It seems to me there is some concentration on the 16 state-run facilities by those to my left.

Mr HUNT: And by the bill, too. That is why we are here.

CHAIR: Allow me to finish, member for Nicklin. It was the opposition that heavily opposed nurse-patient ratios in 2016 in the surgical and—

Mr HUNT: Speaking of irrelevant.

CHAIR: However, given that, I started with some commentary around the need for more oversight nationally. A letter from the federal Minister for Health is in the public arena. It has been tabled in this place. It heavily opposes reporting, particularly from those 459 private facilities, saying that it is going to be too burdensome. Do you have any comments on that?

Ms Mohle: I was gobsmacked by that correspondence and incredibly disappointed. In our experience in Queensland you only have to look at Earle Haven, and we have seen other examples where elderly Australians are currently at risk. The more that we can shine a light on issues of quality, staffing and skill mix, the better it will be. I think the royal commission has a significant interest in this issue. We believe that the situation in aged care is important enough to warrant a royal commission—very much so. The concern that we have is the fact that we cannot wait until the royal commission reports in October next year for action to be taken. We will continue our campaign, not only in Queensland but also through our national body, the ANMF, to make sure that the federal government takes action to address the current deplorable situation in aged care.

Mr McARDLE: Mr Chair, I think you have opened up a new line of questioning. I would like to ask Ms Mohle a question. The chair has raised the issue of the federal government. I am not going to go into that arena, because this bill is about the state government. What other factors do we need to take into account in providing a better care environment in Queensland public facilities for aged-care residents? Outside of ratios, what do you think needs to be considered? You raised some points in your opening comment. What else needs to be looked at?

Ms Mohle: Apart from staffing numbers and skill mix?

Mr McARDLE: Yes.

Ms Mohle: As I said before, there is a whole lot of work we need to do around acuity and complexity of care. It disproportionately falls to state-run aged-care facilities to care for the most complex residents. I remember when there were plans to shut some units at Eventide under the previous Newman government. The residents in those facilities were longstanding psychogeriatric patients who had no family members to speak up on their behalf. We and other members of the community did stand up to say, 'No, we need to keep these facilities open, because the private sector will not actually care for those complex types of residents.' We need to be unpacking a whole lot of issues about the complexity of care and the needs of residents. It is not as simple as just a numbers game. It is also about the culture of workplaces and having a safe environment in which you can speak up. It is multifactorial.

Mr McARDLE: With those who are coming through colleges and universities obtaining nursing degrees—and I do not mean this to be disparaging—there seems to be a concept that working in the aged-care sector is not seen in the same light as working in, say, the RBWH or Cairns Hospital. You used the word 'culture'. How do we change that culture? To get people to work in aged care, we need to get aged care into a position where it is seen as equivalent to working elsewhere.

Ms Mohle: In our experience, we do not have anywhere near the problem in attracting people to work in state government nursing homes compared to the private sector. For example, a registered nurse in the private sector on average earns around \$300 per week less than their counterpart in the public sector, and indeed in private hospitals as well. There are a whole range of issues that you need to consider about the attractiveness of working in a sector.

As I said, our experience with state government nursing homes is that we do not have the same degree of difficulty of attracting people to that sector because it does have better pay, better conditions and better opportunities to advance and to actually undertake professional development leave. That is another entitlement we have in the public sector that we do not have in private and in aged care. There are a lot of factors that go into making a workplace an attractive place to work.

Mr McARDLE: I agree with that.

Mr POWER: Chair, as a point of order, the last two questions deliberately and explicitly went outside what we are actually dealing with in the bill. Your question was specifically about an issue. Can we keep to the bill, seeing as we are over time?

CHAIR: Yes, we are going to. I thank QNMU for your time today.

Mr POWER: The answer was very illuminating. I do not mean to be disparaging about that.

KIDD, Dr Richard, Chair, Council of General Practice, Australian Medical Association Queensland

CHAIR: Good morning. Thank you very much for being here today. I apologise that we have run over time. I will ask you to go straight to an opening statement before we move to questions.

Dr Kidd: Thank you very much for the opportunity to speak to this inquiry. I probably should mention a couple of other things that might be of relevance. I am the chair of the federal as well as the Queensland AMA Council of General Practice. I sit on the ministerial aged care advisory group and the My Aged Care Carer Gateway Advisory Group and some of the Australian Commission on Safety and Quality in Health Care committees, including its primary care committee. I am a GP with a specific interest in aged care. I have been working here in Brisbane in the northern suburbs with a predominantly aged-care practice for 30 years now.

AMA Queensland wishes to state from the outset that we are extremely supportive of the amendments contained within the Health Transparency Bill 2019. We congratulate the government for these changes—in particular, the move to publish the level of care, safety and health outcomes in hospitals and aged-care facilities and the introduction of minimum nurse and support worker skill mix ratios in public residential aged-care facilities. These changes are needed because of the appalling state of affairs regarding the quality of care being provided in aged-care facilities in Queensland and the rest of Australia. Recent examples of poor care being provided in aged-care facilities presented to the aged-care royal commission and, closer to home, the abrupt closure of the Earle Haven Retirement Village at the Gold Coast tell us we are failing those who need our help the most. This situation has come about due to a number of factors.

The first factor is that the business model for aged care in Australia has some major limitations due to serious workforce issues, systemic funding issues and structural difficulties which need to be addressed to meet the demands of an ageing society. The reality is that the regulations in funding in aged-care facilities are forcing providers to deliver a reduced quality of care and a mix of staff that does not meet the care needs of residents. The result is reduced nursing care, reduced medical care and reduced support, such as food services.

The second factor is the reluctance of aged care to embrace evolving technology and medical practices. Substantial differences in patient care could be achieved through an increased use of technology based consultations. Technology based consults provide consultation between the patient, the nursing staff and the general practitioner. They facilitate prescriptions being filled and assessments made and improve hospital avoidance. There are other wraparound things like case conferencing, which is I think very important.

The third factor is the poor cooperation between aged-care providers, the health system and service providers. If there is time, I will touch on this later—things like clinical handover between the acute sector and the aged-care sector. There are massive deficiencies there that lead to bad outcomes.

The fourth factor is the lack of home care packages being delivered to the elderly. Home care packages keep the elderly out of aged-care facilities, which is something that a lot of Australians would wish, but the reality is that there are around 120,000 Australians waiting for various levels of home care packages. In the last year, 16,000 Australians died waiting for a home care package. That is something that has to change.

AMA Queensland will now address each of the objectives of the bill. How much time do I have to do this?

CHAIR: We will shorten our break considerably, considering we extended the earlier session. Please continue.

Dr Kidd: The first objective is to establish a legislative framework for collecting and publishing information about public and private hospitals and residential aged-care facilities. The AMA Queensland supports the collection and publishing of patient data and elective surgery data, including activity information and patient outcome information, from public and private hospitals and residential aged-care facilities. The Queensland health system provides a level of care and safety in hospitals and other care facilities that is among the best in Australia, despite recent pressures at accident and emergency departments as witnessed recently at Logan, Cairns and Townsville hospitals, where AMA Queensland's interventions and representations were warranted.

Queensland's communities rightfully expect to receive a high quality of care in all publicly owned health facilities irrespective of their geographical location and, on the whole, place enormous trust and understanding in the doctors, nurses and other staff who deliver quality care every day.

However, recent adverse media coverage of Queensland's hospitals—including ramping at Logan Hospital, the code yellow at the Princess Alexandra and the abrupt closure of the Earle Haven Retirement Village—have the public questioning the perceived variation in quality of care between public and private facilities. I note that variability is something you have just been discussing in some detail.

The proposed interactive website associated with this bill which will display patient data and elective surgery data, including activity information and patient outcome information, from all public and private hospitals and residential aged-care facilities will not only provide some reassurance about quality of care but also allow the public to choose a facility that best meets their expectations. For health providers, this proposed website increases accountability to health consumers, governments and stakeholders and places the hospitals and aged care facilities who are not performing as highly as other facilities on notice.

AMA Queensland fully supports the collection and publishing of relevant patient data and elective surgery data, including activity information and patient outcome information from public and private hospitals and residential aged-care facilities, on the understanding that the provisions within the Hospital and Health Boards Act and the Private Health Facilities Act to protect the confidentiality of information acquired by individuals in performing their duties are upheld, and for private facilities that information must not be disclosed if the disclosure of the information would be likely to damage the commercial activities of the facility.

The second objective is to amend the Hospital and Health Boards Act 2011 to introduce a minimum nurse and support worker skill mix ratio and minimum average daily resident care hours in public residential aged-care facilities. AMA Queensland congratulates the minister for establishing a minimum nurse and support skill mix ratio and minimum average daily resident care hours in public aged-care facilities. AMA Queensland has been advocating for some time for the establishment of minimum registered nurse and support worker skill mix ratios to match the care needs of patients. As I said, I am a GP who has been working in this area for 30 years and it was no surprise to me when the aged-care royal commission was shown the latest data which showed that the number of registered nurses as a proportion of total staff involved in aged-care facilities had dropped by about a third.

The Department of Health used a study by Mavromaras et al in 2016 in its *The Aged Care Workforce* report which showed that nursing staff as a proportion of the aged-care workforce had dropped from 22 per cent to 14 per cent from 2003 to 2013—that is, only 13 years. Similarly, access to allied health staff was affected, with a halving of their proportion of the aged-care workforce—from about eight per cent to four per cent. This decrease, which also was confirmed by LASA during the aged-care royal commission, corresponded with an increase in the number of personal care workers, who have significantly less training and less clinical background than trained nurses. This of course leads to a lesser standard of care being provided to older Australians in these facilities. I would be very happy to give some clear personal examples of that later.

Registered nurses should be involved in all stages of care for patients, including clinical handover, ensuring prescriptions are actioned, managing emergency situations and the provision of palliative care. Nurses are crucial when it comes to clinical handover between the general practitioner, nurses and other staff in the facility. This exchange of information is critical and vital to the continuity of care of the patient. Without an appropriate trained nurse, tests may not be followed up—and often are not—and clinical handover may not occur as this forms the foundation of good clinical care. When a GP prescribes medication, having access to a nurse is really important. The GP needs the facility to action the script as soon as possible. In the situation that a nurse is not present, the pharmacist should pick up the script at the next available opportunity or the GP would fax it to the pharmacist for action. Without a nurse present, there is the possibility of a delay in the script being acted upon. I have seen that.

In relation to managing an emergency event, having trained nurses is very important in the event of an emergency event for two reasons. One is where an ambulance may have to be called. If the nursing supervisor is not available and a personal care attendant is required to call an ambulance, then the patient would typically be transferred to any emergency department. It may not be the ideal place if you do not have the nurse actually saying, 'This person should go to this emergency department.' The other thing is that, if you have a nurse involved at that stage, the patient perhaps will not be transferred. One of the things that really bothers me is the number of transfers to hospital that should not have been done, that were inappropriate.

CHAIR: We had data from that last year. We might stop there and go to questions because the rest of it is in your submission. That last point was interesting. The QAS reported, from memory, around 34,000 transfers from Queensland residential aged-care facilities to emergency departments. We have always said that if you can get a better level of care you might actually reduce those number of transfers. At the bottom of page 3 you say—

AMA Queensland is concerned with the opt-out provisions for private RACF in Queensland (as contained within the Bill) associated with a minimum nurse and support worker skill mix—

Is there any particular reason? Can you go a little bit further with that statement?

Dr Kidd: We would prefer not to see participants opting out. The data is so important. If they opt out, if you are not measuring and reporting, it may well not be happening and you just do not know. Data-driven quality improvement is really the main game in town now. General practice is doing it. Hospitals are doing it. It is about time aged-care facilities were doing it.

CHAIR: Schools are doing it.

Dr Kidd: Schools are doing it, yes.

CHAIR: The other thing you mentioned in your opening statement was that 16,000 people died last year waiting for a home care package. We have heard that firsthand in some harrowing stories throughout Queensland through the broader aged-care and palliative care inquiry. Do you have any data on that that you can table in relation to those numbers that you quoted?

Dr Kidd: I may be able to. I will get the secretariat to dig it up.

CHAIR: Can you take that on notice?

Dr Kidd: I will take it on notice, yes.

Mr McARDLE: Dr Kidd, thank you for being here today. You said that there are other issues we need to consider in relation to providing adequate and better care for patients in aged care. It does not matter where it is—private or public facilities. You mentioned technology and case conferencing. I am keen on the technology aspect. Can you elaborate with only a few words on what we need to consider in relation to providing better care in addition to the provision of a staff ratio?

Dr Kidd: A lot of that technology would be around clinical information systems. The systems that I see in aged-care facilities—and there are a number of them in practice at the moment—have been designed primarily as administrative tools rather than as clinical tools. In most cases, they are not fit for purpose and they are very, very difficult to search to try to find important information. I have sometimes spent half an hour searching through clunky systems trying to find something that I was pretty sure was there that was going to be very important for the patient. Usually the search has been worth it, but half an hour of my time is ridiculous. It should be something I should be able to find almost immediately if it is a good system.

Mr McARDLE: My point is that holistically we need to look well beyond a one-bullet solution. We need to go wider. I think that is what Ms Mohle from the union was referring to. This may be a starting point, but to think this is going to solve the problem, given the royal commission is running for two years, is simply not the only answer.

Dr Kidd: Agreed.

Mr POWER: Is there a question, Mark?

Dr Kidd: I am happy to take a question out of that. Yes, it is a multifactorial issue. You know the saying, 'How do you eat an elephant? One bite at a time.' It is very clear that we can start making some bites right now, and one of them is around the nurse-to-personal-care ratio. From my personal experience, that dropped way below a critical level years ago. This is a bit harrowing, and I apologise to anyone who may not like a bit of a gory story. In about 1990 I amputated the foot of a 96-year-old lady. There was no way she was going to be able to undergo general anaesthetic, major surgery. She had a gangrenous foot and I amputated it bit by bit in one sitting. I had two very experienced nurses who had been doing a lot of aged care for a long time assisting me. That lady recovered and had a very good quality of life for another nine years. She died when she was about 105 or 106, and I think it was only in the last year that things did not go so well for her. That was a good outcome.

If I come forward to last year, there was a woman who was discharged from hospital with an above-knee amputation and a very clear note that they did not want to take her back to hospital because she had a number of issues that really precluded trying to do another operation. The back of the stump was rotten. I arranged to come in the next day and take away a lot of that rotting flesh to try and give her some quality of life. On that occasion, despite giving a time I would be there—I was half an hour late because of another emergency—when I got there the nurse was walking out

the door. She was a young nurse, inexperienced. She said that she had to go to something else, and she got one personal carer to assist me with this big lady by holding up her stump. This girl must have been about 18 years old. She had started working in the aged-care facility about two weeks earlier. She had not seen anything like this before. Halfway through the procedure she was shaking, she was crying, she was on the point of vomiting. It was an incredibly traumatic experience for her and for the patient. We got through the procedure and I got rid of a lot of that rotten tissue, but I then spent another hour debriefing this poor young person, who had no training and no experience to prepare her for this. As I said, the patient also needed some debriefing. She was quite traumatised too. It was a very different experience to 30 years ago. You would like to think there would progress, an improvement in quality. Without enough qualified, experienced nurses, things like this just fall apart.

CHAIR: Thank you very much for your contribution here today representing the AMAQ.

ROWE, Mr Geoff, Chief Executive Officer, Aged and Disability Advocacy Australia

STALKER, Mr John, Policy Coordinator, Council on the Ageing

WYNNE, Dr Michael, Policy Analyst, Aged Care Crisis

CHAIR: Welcome back, gentlemen. It seems like a few weeks ago we were all sitting on the Gold Coast for the Earle Haven hearing. We do thank you for being here today. It is timely, given that the intent of the bill is to implement more rigour around staff-to-resident ratios. Mr Rowe, would you like to begin with an opening statement?

Mr Rowe: Thank you for the opportunity to present here today. I will take our submission as read. ADA Australia is supportive of the proposed changes and any strategy that promotes the human rights of older people, particularly within the aged-care system. I am supportive of the changes because, as I read it, it is leading to greater transparency in information about aged care in Queensland, whether it is public or private. As an advocacy provider, we speak to thousands of Queenslanders each year who access or use aged-care services. Time and time again we hear that access to information has been very difficult for them.

Most older people enter residential aged care at a time of crisis. They find that they are confronted with contracts with aged-care providers that are large and complex. You may have heard me in this forum or other forums call for some sensibility regarding aged-care contracts. I know that is outside the ambit of this committee, but I will say it again. For residential tenancy agreements we can get standardised contracts so that, whether I am here in Brisbane or on Thursday Island, I get the same contract agreement with one page that spells out the variations. In aged care I can go to 17 different facilities in Brisbane and get 17 different contracts, all of extremely long length. Inevitably, we find that because people have signed up and entered aged care during a time of crisis they have agreed to things they had no idea they were agreeing to. One of those outlined in my submission was the use of their own general practitioner.

While you are considering the development of a website, I would like to touch on a discussion I had. I have recently returned from undertaking a Churchill Fellowship that looked at the abuse of older people in aged care and the community across the world. When I was in the UK I spoke to the Care Quality Commission, which has quite an extensive website with lots of information about care facilities. The person I spoke to was very concerned that the information they had available, while large in volume, was not in real time. People were looking it up and getting advice and a picture of an organisation or a facility that was now six or 12 months old. I think one of the challenges in setting it up is that it needs to be available in real time. It needs to be simple and user-friendly, with easy links to other websites that are relevant, be it My Aged Care or the Aged Care Quality and Safety Commission, so that people can see if there are any sanctions or conditions imposed on the facilities they are looking at.

The proposal to mandate staff-client ratios in public facilities is absolutely important. We have heard from other presenters this morning so I will not labour on it, but I did a presentation recently that looked at the changing demographic of users of residential aged care over the past 10 years. Ten years ago, 20 per cent of people entering residential aged care had high or complex health needs; effectively 80 per cent did not. In 2018, 80 per cent of people entering residential aged care had complex health conditions.

Mr POWER: What was the first date?

Mr Rowe: In the period 2008 to 2018 effectively the stats have flipped. ADA would be very happy to work with Queensland Health in the development of the website, identifying the information that consumers tell us is really important they have access to at the time of entry or while in residential aged care.

CHAIR: Thank you very much, Mr Rowe. Mr Stalker, do you have any comments?

Mr Stalker: I thank the committee for inviting us to appear today. COTA Queensland believes there is a need for better comparative information to be made available to both consumers and their families with respect to aged-care facilities; in particular, with regard to the overall model of care used. This information would include information on how the aged-care facility is staffed.

COTA Queensland supports the concept behind the Health Transparency Bill as it relates to consumers gaining better access to information on provider operations. COTA commends the Queensland government on commencing action to improve the level of information available to consumers and not simply passing it off as a Commonwealth issue. However, the range of information
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needs to allow a consumer to gain an understanding of the full model of care offered by a provider and not just one particular area. The reporting of average daily resident care hours in isolation from information on other elements of the model of care will not allow for a valid comparison across providers. Consumers face the risk of being misled without understanding the full context of the operations of the providers they are considering.

Dr Wynne: Thank you for asking us to attend again. Aged Care Crisis has been pressing for structural changes to the aged-care system for the last 10 years, and we are delighted to see Queensland leading the way in this important reform in the face of federal government criticism and inaction. We welcome and strongly support the submissions made by ADA Australia and the Public Advocate, including the additional transparencies they advocate for aged care. To be useful, we do need information about skills as well as acuity of residents, as is reflected in the funding. As with staffing ratios, transparency like this is a necessary condition for improving standards but is not really a sufficient condition. It is the beginning and much more is needed. I think others have mentioned that.

Potential issues we can readily identify are that, as ADA have indicated, there is a risk that unwilling aged-care providers will not report accurately, particularly on sensitive issues. This has been a major problem in the USA and some verification is required. The other difficulty is that some complexity is needed for the data to have a value when choosing. The majority of citizens either do not engage with the data or are confused by it. Studies into aged care and health care in Europe and the USA reveal that public data is very effective in improving standards, but the number of consumers who engage with the data is often disappointing. The impact when making choices is not high, and most use the community networks instead. Citizens need some assistance in order to engage with the data.

The third point is that sometimes transparency in health, and possibly in aged care, can change the behaviour of providers in ways that adversely affect the system and outcomes that must be prevented. We think that these problems are best addressed at the source by acknowledging that it is the communities that are responsible to their fellows and maintaining standards. They should work with their agents—and I think the providers really should be agents of the community, as they are working on their behalf—to see that they do what is required. We are pressing for community structures that work closely with empowered visitors, advocates and providers. This would be based on principles of co-design, co-evaluation, co-regulation and participatory research that would engage with the data, support and help families, and so spread insight into community networks. This approach would also address the other three potential problems, and that would build social capital. Queensland Health is already setting an example by adopting a co-design approach to the proposed website, and obviously we support that.

While some of these matters are outside the scope of the legislation, we believe that any legislation should be based on clear objectives and the sort of road map that leads towards somewhere we want to be. At the moment we have a road map that is not leading in the right direction.

CHAIR: I thank all three of you for your broad support of the bill and its intent. Dr Wynne, you talked about unwilling providers and issues you observed in the USA. How did they overcome that?

Dr Wynne: First of all, they have far more regular visits from state regulators. I think they go in and do a thorough, full assessment every year, and I think they are in every quarter or something like that. In addition, they check a lot of things—staffing, for instance—through payroll tax and things like that. Fewer and fewer of the quality indicators that they use are totally self-reported.

CHAIR: Mr Rowe, you mentioned the Care Quality Commission in the UK. What learnings might we be able to take from them in relation to this bill?

Mr Rowe: I think the standout for me during the conversation that I had was about the frustration that the reporting was not in real time. Picking up on Dr Wynne's comment, it was also about self-reporting being problematic. I will go off on a slight tangent and say that if you look at the promotion of aged care more broadly nowadays, it has moved very much to a marketing exercise: 'How do we get you into the business?' I have a friend who recently supported his father-in-law moving into aged care, and he described that the initial approach was like a first date. The doors were open and there were flowers and chocolates, but the minute they entered it was a very different perception. With self-reporting by itself, on the broader picture, you get the image that people want to present rather than the experience they actually get. We need to link whatever is developed by Queensland Health into the Aged Care Quality and Safety Commission's information regarding recent audits of facilities and what it found so that people are able to access real information.

Also, there is the issue about people gathering information from others in their local community. Potentially, the website could also be a bit of a guidebook. Some resources have been developed interstate by a collaborative group—that is, 10 questions to ask when going into aged care. They suggest that people talk to others who have used the service and get local feedback. Some of that information is out there. It is not only reporting on what it is; it is also giving people some information about what questions they should ask, what they should look for or what they should look at rather than being taken by the five-star image. Certainly advocates who work at ADA report that sometimes there is an inverse correlation between how beautiful a place looks and the quality of care. Often it is those that are very daggy looking where the quality of care is really great. If you took it on that first impression, you would not go there. I think that is one of the challenges for this to be really useful.

CHAIR: Perhaps you were on the Gold Coast when the example came up of crockery and cutlery being hired in to pass an audit at one of the facilities.

Mr Rowe: Yes, that was my comment.

CHAIR: That is deeply disturbing. At the risk of duplicating the Aged Care Quality and Safety Commission—obviously it has some, I believe, flaws; Earle Haven had sanctions from 2007 to the current day—do we consider a Queensland based commission?

Mr Rowe: That is an issue I raised at the hearing. I think there is a frustration: when you do not get joy from the established mechanisms, where can you go? Across Australia we also have the added complexity that more older people are living in retirement villages and accessing aged care via the home care that comes in or their loved one, as in the case of Earle Haven, moves to a nursing home on site. The jurisdictional responsibility for nursing homes rests with the Commonwealth and for retirement villages with the states. It becomes quite complex. Somewhere people can go when they have been unable to get joy—that final stop—is an issue the royal commission asked about when I appeared as a witness. They asked whether there should be an aged-care ombudsman. Certainly New South Wales and Victoria recently established an aged-care commissioner or an aged-care and disability commissioner as that last port of call for people to get joy.

We hear time and time again from people—this is going back six months; I need to give the new Aged Care Quality and Safety Commissioner a chance to get the car back on the road—that we support that they have been through the formal Commonwealth aged-care complaints system and have been fobbed off. Indeed, a family we are supporting at the moment—they were involved in Earle Haven—were told when they FOI'd their file that their complaint was low level and should be able to be closed almost immediately. They were horrified. There were serious allegations of neglect. It does need to be taken seriously.

Dr Wynne: I do not think the new quality commission is really a big change from what we had before. They have brought it all together but it is the same people, the same attitudes and the same approach. I think it is still captured. The industry is so powerful. At the moment we are getting a lot of failures of standards but, in time, an equilibrium develops where the pressure between the two evens out and you go back to what was happening before. I do not think it is a permanent solution.

Mr HUNT: You have all acknowledged that staff ratios are not the silver bullet and that quality care is a greater scope. Mr Rowe, I think you said that integrating the data on staff ratios with the quality standards is best. I refer to the new federal Aged Care Quality Standards. Standard 7 relates to human resources. The organisation statement reads —

The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

Are staff ratios best overseen by the federal quality standards?

Mr Rowe: I think that is where ultimately the responsibility lands. I think the frustration is that—

Mr HUNT: Considering these are brand-new standards.

Mr Rowe: They are brand-new standards and they are the standards that agencies will be assessed by. If I think back over the last five years, my thinking on staff ratios has changed. If you had asked me the question three years ago I would have said that I do not think we should be mandating staff ratios because the needs of our consumers within aged-care facilities vary so greatly. Now I am of the view that a minimum staff ratio is required. I still think it is very tricky to mandate. The previous speaker talked about high-care wards and low-care wards within a hospital. There is the same difference within aged care. I go back to my earlier comment. It is a terrible term to use, but people do not go to residential aged care to live; they go there to die. That has been one of the changes. My grandmothers, who both went into residential aged care, were there for three, four or five years. The average stay is considerably less. The complexity of the health needs is considerably higher. We have seen the staff demographic change and—

Mr HUNT: My question is primarily about responsibility. Under the new regulatory requirements, organisations are clearly responsible to the federal government to have a workforce that is sufficient, skilled and qualified to provide safe, respectful and quality care and services. If this bill is brought in, they will have a responsibility to report to both.

Mr Rowe: It is a reporting. You cannot close them if they decide their number. All you are doing is making that number transparent. At this stage, I do not see that number transparent anywhere else.

Mr HUNT: Is it not transparent through that quality framework?

Mr Rowe: It is a tick in a box that the public has access to. In terms of making informed choice about where you want to go—you will have heard me previously say that older people are required to check in their rights when they check into aged care. That is one of my huge frustrations—that they cease to be a person who is capable of making decisions or is engaged in the process. To me, anything that allows an older person or their families to make informed choices is a positive thing.

Mr HUNT: Transparency is the key?

Mr Rowe: Transparency is absolutely the key.

Mr HUNT: What about complaints history?

Mr Rowe: Complaints history sounds good by itself, but we know—Earle Haven is a classic example—that if people threaten to make a complaint they are threatened with eviction. On paper they had a relatively low complaints history so you would think that is great, but it was because of the culture there that people were not encouraged. It also goes to where places are. Maybe it is about the non-identifying details—the nature of the complaints. It was said earlier that staff ratios by themselves are not a silver bullet. It is one component of the bullet. There is a whole range of things that are really important to allow people to make an informed choice, but it is also an informed choice at a time of crisis. I work in aged care. When my father had a fall earlier this year and broke his arm—he was the primary carer for my mum—I was scrambling, with a whole heap of staff who were able to inform me to understand where to go and who to look at. For the average person in the street, accessing aged care and making an informed decision is extraordinarily complex. If this bill can bring together Queensland based information that makes it easier for Queenslanders, fabulous. If it is taking the lead and showing the rest of the country where to go, fabulous.

Mr Stalker: I support all of the comments Geoff has just made. Currently there is a discrepancy in terms of access to information and service which is largely based on income and your ability to buy your way into appropriate aged care. That also then relates to the level of information available to allow you to make a sensible decision about what provider best suits. If you have the finance to go out and employ an aged-care broker—if you are lucky enough, that broker is not tied to particular providers—that broker hopefully can navigate an appropriate solution for you. A lot of people cannot afford access to that sort of information support. Whatever can be done at the state level to improve the quality and understandability of information on aged-care providers is only going to help.

Dr Wynne: Pennsylvania has divided aged care into five groups. The lowest group is 'dangerously low'. If you look at the staffing figures that we have available in Australia, over half of them would fall into the 'dangerously low' situation. That is why aged-care ratios are so absolutely essential. It may be that when we eventually get sufficient data—at the moment we do not have data; no research has been done—these things can be modified. At this time, it is absolutely essential and very urgent. It is not something you can wait for the royal commission to come up with.

Mr POWER: Mr Rowe gave us information about how aged-care nursing homes are changing. In 2008, 21 per cent of people were high acuity; in 2018, it was 80 per cent. We have seen a profound change in the nature of the patient mix. What is shocking is that, at the same time, the AMA has told us that the ratio of nurses to staff has gone from 21 per cent in 2003 to 14.9 per cent now. That percentage should have gone the opposite way with the increases in high needs. Given that the federal government has failed to keep pace in terms of nursing ratios with the increase in high acuity, isn't it essential that we have this information? I think Queenslanders would be shocked if they knew that needs had gone up but the ratio of nursing staff had gone down. Isn't it essential that we get this information so that people can make that basic decision on this most central information?

Mr Rowe: The old statement 'knowledge is power' continues, whether you are in aged care, business or wherever. More information is good. I will repeat myself, but people enter aged care at a time of crisis. People do not plan for their aged care. We all want to live a long life, but none of us want to get old. The amount of research that people do is really minimal.

When we are talking about Queensland and we are talking about choice, a lot of Queenslanders, particularly outside the south-east corner, do not have a lot of choice in terms of residential aged care. There is one provider in town, so it is that or it is no-one. In some towns there
Brisbane

are no aged-care providers. There is the move within aged care, more and more, for people to be supported to live in their own home. We have heard the figures; we know that there is a long waiting list for that. That often means that either people go without or they end up inappropriately in residential aged care. I think there also should be consideration about how people are educated around the home-care options within that. Often when people think about aged care they think about nursing homes. They do not think, 'How can I be supported in my own home?' Again it comes back to information and transparency.

Dr Wynne: To repeat what I said at the last meeting we had, the competition is basically to keep costs down and it is that competitive pressure that has put us in this situation. To counter that it requires power. It requires community power. This is why I feel it is so important that we get the community engaged in some way with the knowledge, use it and then put social pressure. The most effective regulation is the regulation that we have as we are sitting here and arguing with one another. We want members of the community sitting down and arguing with the providers about what they are doing. If people have the knowledge and are learning about it, they are then going to look after their fellows because we all worry about one another and that builds social capital and it builds community. It has a far wider positive than just in aged care.

Mr POWER: But to build that social pressure, given that we have seen this almost collapse in nursing, we need that information?

Dr Wynne: Yes, the first step is the information. The next thing is to get people to use it to give them power to change the system. The difficulty is that we have a community that is very disengaged. It has basically been pushed aside by the current belief system. To bring them back is not going to happen overnight, but we need to have that as a direction to go if we are going to change the system. We have to think of that in the long term.

Mr POWER: There seems to be a catchphrase that 'it's not a silver bullet'. There is complexity and it is multifactorial, but this is going to be used as an excuse to not do this in other states and to not do this federally. They will quote the opposition members when they say, 'It's not a silver bullet.' The educated providers will say, 'We heard in parliament that it wasn't a silver bullet,' so they will not do the voluntary reporting. Isn't it essential that we have this information to build that community pressure to get people to understand that nursing ratios have collapsed while care needs and acuity have gone up? We need to get this information out there, don't we?

Dr Wynne: Look at Q & A on Monday night. How do you get that sort of information out when the discussion does not go into it in that depth?

CHAIR: I think it was the QNMU that said in their submission that this bill will help with health literacy. It will help inform and educate people about the facilities and standards of care that are there.

Dr Wynne: It is setting a pathway for the future. That is what is more important. The worry, of course, is that the private operators will all opt out and that will be very disappointing.

Mr POWER: They will be quoting someone saying, 'Oh, it's not a silver bullet so we do not have to report.' This is vital to—

Mr HUNT: They will still be subject to quality assurance. They will still be subject to the federal law.

Mr POWER: Which is a tick box. We have heard that.

Mr Rowe: Community awareness and understanding are vitally important. When the NDIS was first proposed, the organisation I worked for pulled together service providers, peak bodies and advocates—all of the players—to talk about what the issues were and to agree to work together. Disability had a long history of us fighting each other. We did some market research and at that stage, whether it was in Canberra, Sydney or Brisbane, eight out of 10 people interviewed said, 'We do not have a problem in disability. We are the lucky country and we look after our own.' I really suspect that this is the same with aged care. People think that, as a fabulous country that Australia is, those services are there, that people care and that they do a good job. It has only been recently with the royal commission that that is coming more into public light.

It should not be solely reliant on government to make change to put pressure on aged-care providers; it also needs to be on the general public. As part of the baby boomer population I know that when I go to aged care they will be asking me to pay. If I am using my own money, I want to have more say about what it looks like and I will need to be an informed consumer. I am doing a really clumsy job of trying to agree with Michael's comments, but it is not just about government; it is about the broader community having an insight into and an understanding about aged care and being able to make an informed choice. Regulation by itself will never work. People will always find their way to move around legislation.

Knowledge is power. I will say it again. In Queensland we have a human rights bill coming into effect in 2020. I think we need to look at how that interfaces with what is being proposed here so that we can make sure people can make informed choices.

Mr McARDLE: Thank you again for being here. We meet on a regular basis, it would appear, on various matters. I want to look at the issue of a website. I do not know how many websites are hosted by Queensland Health, the education department, the police or the federal government. To navigate a website you virtually need a degree to understand (1) how to get there, (2) what the information means and (3) how to relate it to your own circumstances. Although we talk about a website as being a good tool to gather information to become informed, that cannot be the only method. I could walk out into Alice Street, pull somebody aside and show them the Queensland Health website in relation to elective surgery and emergency departments, but they would not have a clue as to what it means. If you are going to have a website, doesn't it have to be a lot more than that? Mustn't there be a full program of education looking at this bill alone—forget about the federal government; they will come down the track—to inform the public? It is not just in relation to the one-off scenario but it has to be on a continual basis, a bit like the antismoking campaign, to be successful. Would you agree with that?

Mr Rowe: A website by itself will get those who are motivated to go and look. Education is incredibly important—that is, broader education of the community. There are a range of strategies to do that. Ultimately, if the key people—the health practitioners, the hospital system, social workers et cetera—are aware of where to go, when people are faced with a crisis they can at least point them in a direction.

Mr McARDLE: I accept that point, but as a starting point that is all it is.

Mr Rowe: Yes.

Mr Stalker: We would support that comment. From our perspective, there has been a lot of work done in recent times in terms of providing consumer education on retirement villages and manufactured home parks. In some respects, when you move into an aged-care facility it is your next housing step. Apart from any health issues or implications, it is your next stage of housing and you need better information on your choices and your rights as a consumer. You need a lot of supporting information to understand, particularly in a website context, what you are looking at.

Dr Wynne: If you look at community movements—we have a lot of community activity at the moment—they have an agenda and they have an objective and they go flat out for it and they achieve it. Once they have achieved that objective—they were motivated—it drops off because there is nothing else and then it all goes back to what it was before. That happened with chemical restraint in the USA. Somehow you have to get the community involved and give them a role. Get a reasonable proportion of them involved in aged care, in participating. We are all existential beings: we all build our lives by doing things. Get them building their lives by being involved. We are retiring earlier now and then we have another 20 years—of effective life. There is an opportunity to get into community activities like this and be really involved and maintain that so that you have a continuous interest that keeps the whole thing going.

Mr McARDLE: I think, Dr Wynne, your comment on the Gold Coast was that there should be some form of community collective that oversees the operation and continuing operation of an aged-care service, which is an extrapolation of what you just said.

Dr Wynne: We are suggesting a community built around community visitors who have some investigative powers and advocacy so that those services are delivered through community groups, supervised and helped by government, if you like, or by the ADA, working with them, so there is somebody they can call on for help and assistance. They are regularly on site, it brings the community into the nursing home, it makes the nursing home part of the community and they are also supporting and doing things with the residents. It is some way of bringing the system together in a community situation. Kendig and Duckett in 2001 suggested that the funding would be much better done locally because you can see what is happening and you can adapt and change. One of the problems with CDC is that it is so fixed that you cannot ration and adapt things flexibly.

Mr McARDLE: So you would advocate a public advocate role to be part of any rollout to ensure standards are being met? It might well be through the Public Advocate here in Queensland or it might be somebody else.

Dr Wynne: Fair enough—somebody like that, but it would be through building community groups so that each community group has people who go into the nursing homes on a fairly regular basis to have a look and see what is happening. They would liaise with the advocacy group. They could probably do a lot of that themselves, particularly if you have an empowered visitor drawn from

that group. Rodney Lewis is a lawyer who is advocating for an arbitration system. If there are disputes, it would go into a cheaper and simpler arbitration system rather than become a complex legal dispute. All sorts of things like that are possible if it moves more into a community type of service and the market has to fit in and comply with the community, rather than the community having to be trapped behind.

Mr McARDLE: Just touching on the 3.65 hours, I raised a concern with the QMNU about the rigidity of how that figure was derived. I quoted some information in relation to the business planning framework, which I think you may all be aware of, which is used in Queensland to set the number of staff required daily or weekly, as the case may be, in the aged-care services. It is a framework that looks at acuity and patient numbers and then works out staffing levels and staffing type or qualifications. If that system was working well, to my mind that should give the answer per facility required daily to provide the level of care. Am I wrong in that?

Mr Rowe: On paper, it makes sense.

Mr McARDLE: I agree with that. I accept that comment.

Mr Rowe: I think there are issues about culture within a facility. The feedback we get from people we support is often about them being treated as a nonperson. There is no engagement or there is a frequent turnover of staffing so that every day they are having to deal with a different person who requires personal care. The relationships that people used to form are not being formed anymore.

I think we need a minimum staff ratio that we know provides a reasonable quality of care. Aged care is largely dependent on the public purse. It is not a bottomless pit, although I did hear on Q&A on Monday night where I think it was Joseph Ibrahim who was talking about the current aged-care spend of OECD countries being 1.5 per cent of GDP and Australia's expenditure on aged care is one per cent of GDP. People use statistics like a drunk uses a lamppost: for support rather than illumination.

Mr McARDLE: I will not quote that back to you, but I will take your personal observation.

Mr Rowe: You can use statistics in every way you want to, but to me it begs the question: we need to look at why other OECD countries are spending so much more than we are. Perhaps the better question is: why are we having the crisis that we are currently having within aged care? This is not a conversation we were having 10 years ago.

Mr McARDLE: Let me quote Dr Wakefield to you.

Mr POWER: Can I just clarify your question? Were you suggesting that a business planning framework be applied to the 700-odd private providers to set their—

Mr McARDLE: I cannot apply that because the bill raises a state government authority.

Mr POWER: I thought you might have been suggesting to your federal friends some kind of business planning framework.

Mr McARDLE: In relation to the business planning framework, on 16 September Dr Wakefield, who is now the director-general, said—

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.'

My question is: if those words translate and it is used efficiently and effectively, leaving aside the issue of culture, which is a different question to a certain extent, if that business planning framework is used properly should that not provide the relevant number of healthcare providers to residents?

Mr POWER: It is a private provision.

Mr McARDLE: If you cannot answer that, that it is fine. I accept that.

Mr Rowe: I am struggling with that. Again, I go back to my initial statement. On paper, if a facility is appropriately responding to the needs of their cohort, there should not be a need for ratios. I think the issue is that they are not. I have not been involved in the development of the number from the QMNU—I am not quite sure how they have got to that figure—but certainly we know that the peak time is of a morning when people are getting up and want to have a shower and get ready for the day and also at the end of the day, and there are periods during the day when you do not need the same level of staffing. There is also the issue that older people want some sort of engagement and stimulation. You cannot say, 'Because we have to have five people on then, we will have only one person on during this time.' Again, that is not meeting their needs. It is complex.

Mr McARDLE: I agree entirely. It is very complex. The bill before the House deals with the state government; it does not deal with the wider issue.

Mr Rowe: Yes, I am aware of that.

Mr POWER: On issues it does.

Mr McARDLE: That is for the royal commission in relation to the ratio. I take your point.

Dr Wynne: Can I comment on that? I think it comes back to common sense on the ground and not being subjected to very strong management and commercial pressures. Again, if you have a community group involved, they are talking to the staff and they get to know them. There is real social pressure. If care is being missed or if there are things being missed, they are going to see it and the staff are going to tell them about it. You need all of these regulations. At the end of the day, it is what happens in that nursing home that is going to matter. Changing the culture from one of a primary business to one of primary care changes the way it operates.

Mr McARDLE: Thank you.

CHAIR: Thank you very much, gentlemen. You form a very strong alliance. You have appeared before us before. We thank you for your advocacy and time today.

Proceedings suspended from 10.50 am to 11.10 am.

CURTIS, Ms Anne, Engagement Consultant, Special Projects, Health Consumers Queensland

FOX, Ms Melissa, Chief Executive Officer, Health Consumers Queensland

CHAIR: Welcome, ladies. Thank you for being here. I invite you to make an opening statement before we move to any questions.

Ms Fox: Firstly I would like to start by acknowledging the traditional owners of the land on which we are gathered and pay my respects to elders past, present and emerging. I acknowledge the role we all have to play together to work to improve the health outcomes of Aboriginal and Torres Strait Islander people.

We know that information and transparency drives improvement in the health system and that making informed decisions is a crucial cornerstone of a consumer centred health system. Health Consumers Queensland has long advocated for improved public reporting of safety and quality data. We did a submission to the Queensland Health discussion paper in 2017. In 2018 we surveyed our consumer network and asked them how important a number of issues were to them. Out of a list of 20 they ranked No. 1 consumer and carer engagement, which would be of no surprise, but No. 2 was the public reporting of safety and quality data.

We are thrilled to be at this juncture in Queensland of increasing our transparency and accessibility to meaningful information to help us make decisions about our care. This is about what consumers want. We are very grateful to have had the opportunity to be able to listen to what many Queenslanders want on this topic and we have supported an increased in-depth range of consumer engagement activities to be able to listen to them. I am going to hand over to Anne Curtis so that she can give you a summary of that.

Ms Curtis: In September 2018 we were asked by Clinical Excellence Queensland and the Patient Safety and Quality Improvement Service to come up with a way that we could consult with people whose voices are not normally heard around what is important in relation to safety and quality measures in hospitals and health services. That is where we came up with starting the process of doing kitchen-table discussions. We had nine consumer hosts who went out and consulted with their communities. They consulted with 69 people and came back with what was important to them.

I then joined with Patient Safety and Quality Improvement Service staff and we went around the state and actually spoke to more informed consumers within the health services. All up, there were 149 consumers in that first round. This year we were invited to bring the kitchen-table hosts in to meet with the Patient Safety and Quality Improvement Service and actually do a co-design around what a consumer friendly website might actually look like for comparing. Once the hosts had had their say on that, they actually went out and consulted again. This time they consulted with another 66 members of the community and fed that information back into the Patient Safety and Quality Improvement Service. We have been so thrilled to actually have been such an important part of this and to have that consumer voice leading the consultation around this.

The last time I was here we were talking about what matters to people in relation to ageing, end-of-life care and dying. We had consulted with over 400 people around the state. Among the key things that came from that, especially through the focus groups that we held, was the need for better patient-staff ratios within aged care and also that it is known how many staff are where and what is the quality of the staff or their qualifications. I have been doing some other consultation with consumers around the state right now and I can tell you there is one key thing that comes out for them and it is transparency around health.

CHAIR: That is a consistent message we have heard today. I thank you very much for the work that Health Consumers Queensland does in this important space. We deeply value your commentary and your submission. I like those kitchen-table scenarios and talking with people about their concerns. I am not surprised that many think that residential aged-care facilities are understaffed. Some say they are severely understaffed and that was repeated in urban, rural and remote areas—some of the more challenging areas. I come from regional Queensland and I am also interested in what we can do to improve residential aged-care facilities in rural and remote Indigenous communities, as we tend to sometimes focus on the greater south-east. Is there any commentary around that? Did you go far and wide in your consulting?

Ms Curtis: With the 'what matters' we went far and wide, and even with consultation around the public reporting. The process around kitchen tables is to go as far and wide as we possibly can and we did travel with the focus groups. With the kitchen tables we have a criteria, which is to meet

as many of the groups that we possibly can in the number of hosts that we have. We talk to them about the 10 people they each invite to the kitchen table being as diverse as possible. We cover an enormous amount of people whose voices are not heard.

CHAIR: I was interested in the discussion around developing the website and assisting in that. In our last session the deputy chair asked was it more than a website. How do we improve health literacy and informing people of what is available in a residential aged-care facility, no matter where it is in Queensland? Can you go into a little bit more detail about what that website would look like to navigate and what you were hoping people would be able to find, from the Health Consumers Queensland point of view?

Ms Curtis: It is interesting, because people do want to know what clinical services are offered. They want to know what are the models of care, what are the guidelines and the protocols, they want to know about accreditation—they want true information about accreditation status and what does it really mean. With complications from clinical care, it is very important to learn more about that. Even in hospital and health services, staff to patient ratios are important. But they also want some of that general information as well, which is car parking, cost of car parking, where to find food. There is some of that as well. They were very much the key things that came out of that. The importance of quality and safety information about hospital services is key for them.

Ms Fox: I think also it is about that information, they very clearly said, being meaningful. At the moment there is information online that is about particular areas of health, say cardiology, but people want to know about the safety and quality of a particular procedure in their particular geographic area, and that is whether or not they are rural or remote or live in an urban setting. A lot of the websites, like MyHospitals, at the moment are very dry and they are very statistically based, but listening to consumers has really brought home the message that it is about that breadth of information that Anne talked about and the context of where that sits.

CHAIR: I know that in the previous health committee you also assisted with the Health Ombudsman work. You have made five recommendations around the OHO powers. Number five is to make final prohibition orders for unregistered health practitioners subject to reviews by QCAT. I have read in some other submissions some people are asking for a stay or a review of QCAT. It might have been the Queensland Law Society, but do not quote me on that. One of them goes a little further: whether the OHO should have that degree of authority or power in that area. Do you have any commentary around that?

Ms Fox: As I understand it, we are unique in having a health regulator that does have powers over that particular group of professionals, the unregistered health practitioners. For us it makes sense that there is that level of scrutiny with QCAT being involved. That is behind our reason for supporting that.

CHAIR: If you have been following, you would know that between APRHA and the OHO there is a significant body of work in reducing the splitting of matters in recommendation No. 2. We have been very happy with the work the OHO has been doing in our recent public hearing. He reported some significant advances in assessment and actually getting through the complaints process. Thank you very much for your contribution today.

Mr HUNT: You mentioned quite clearly that transparency is the key and that information is power for people, and we talked about websites. You would be aware that enhanced information on quality of service is part of the new quality framework in the federal sphere. The My Aged Care website now includes several things. During the last session I was navigating that website and comparing aged-care homes in my area. It has information on current or past notices of noncompliance et cetera. It has quite a bit of information there. If we have a separate website for Queensland Health, is there a danger that that creates confusion for people as to what information to trust or what information to go to? Would it be better to try to improve the websites of those responsible for providing quality aged care?

Ms Fox: I have heard that argument in health as well. I think we need to grab this opportunity. We cannot wait for that to occur. Whilst there is a groundswell of support, I think, from all quarters for this to happen in Queensland, let us do it.

Mr HUNT: Are you talking about Queensland Health reporting or the fact that other services are required to report just their staffing ratios or opt out?

Ms Fox: In terms of all of the opportunities that we can grasp now with the ratios for aged care—being able to publish those, for the public and private data, and the advances that can be made possible by Queensland legislative change—we would encourage that to occur now, and consider how to make the websites as seamlessly linked to each other as possible to avoid what you are talking about.

Mr McARDLE: Ladies, it is good to see you both again and thank you for your submission. You made the comment that your surveys indicated what the public wanted to hear in relation to the content of the website. I go beyond that. I think the content of a website should not just cover, with all due respect to the public, what they want to hear but also what they need to hear. What does your body think should be included in the website, aside from what the public have informed you of?

Ms Fox: That does make me think about the reporting of individual clinician-led data. It is something that may have already come up in submissions and in the evidence that you have heard. We would say that, at the moment, we know that when clinicians can see each other's data that drives improvement. What is not so clear is how it drives individual consumers making decisions around the health care that they need. We see that as perhaps being something to come later. At the moment, really everything that has been flagged by the consumers in the consultation is everything that we would want: all of the information that Queensland Health currently collect, as much of that as possible being provided online in an easy-to-read portal. The key that will ensure the success of this initiative is how accessible it will be to consumers to read and access.

Mr McARDLE: I think New South Wales has a system whereby surgeons are reported upon in some form of public domain. I do not know how that functions. I am also led to believe that there is some doubt about the voracity of that actually informing consumers. If my mother is ready to go into a nursing home, I may have an advantage because I have been in this role and been in this place. However, generally speaking, I do not have that advantage. When you try to read websites, including the Queensland Health website, with all due respect, you still need a level of sophistication to understand, for example, what category 1 actually means; what is category 2 and category 3; what ENT stands for; what VAS stands for; and what is the meaning of the other terms that they use in relation to surgery. You would need to really make it very simple, because it goes to the very core of a person dealing with the most important people in their life, generally—that is, their parent or parents. To crowd the website actually makes it more difficult to navigate. The interrelationship of the information you are putting on the website needs to be very carefully considered, because that can confuse people very quickly. Would you agree with that? Simplicity is important, but a public education program is also.

Ms Fox: Absolutely, and the information on that website needs to suit whatever information someone is seeking. If they require it to be simple, easy to access and basic information, that should be there. If a consumer would like the number of procedures done by a particular health practitioner and the number of complications, they can easily access that. I will let Anne speak to that, because I know this was spoken about in the consultation.

Ms Curtis: The reason for having the consumer voice there was to look at how you actually simplify a website that carries the information that you want in it. What the kitchen-table hosts took out that second time was what it could possibly look like and to say to the people they consulted with, 'Could you actually work out how to use this very easily?' That was the information that came back. The work is already there around carrying the information that they would like to see, but is it in a way that you would understand how to access?

Mr McARDLE: Correct.

Ms Curtis: With some other work that I am doing right now, people are asking constantly to have all of their information in the one place. I think having a website that would carry that information on the hospital and health services or the aged-care homes, which may not be there right now or may be on their own individual websites, or to link into that information yet still carry the important information that they want to know, is of a real value to Queenslanders. The comment that I constantly hear as I travel around and do this work is, 'We want a hub where everything is available, where we just go to the one place. We don't have to go to the My Aged Care website or another website. We want to go where there is one place for that information.'

Mr McARDLE: One portal, shall we say.

Ms Curtis: Yes.

Mr McARDLE: That is a jurisdictional issue between the state and federal governments, which brings into account funding as well. That may be a bit outside our jurisdictional base today, but it is certainly worth pursuing down the track.

Ms Curtis: For a Queensland based website.

Mr McARDLE: Exactly. The only other point I would make is that one of the things that would attract me to a nursing home is the use of technology. If you go back only a few years, the old paper recording of data and information on patients was subject to the capacity of the person to write neatly and to record accurately in relation to time, what was provided to the patient et cetera. I think a

coordinated technology approach is also critical, because it allows the relevant practitioner or healthcare provider of all sorts to readily access information and get a very clear and quick update as to where the patient is at. Leaving aside the issue of the nurse-patient ratio, if we are focusing on the issue of what needs to be done to assist, would you agree that the website is an important one, with all the caveats we have attached to it, but also understanding that the use of technology and understanding the facilities that are available at the hospital—for example, rehabilitation units, OTs and all those sorts of personnel—are also very critical to inform the public?

Ms Curtis: We would agree.

CHAIR: If there are no further questions for Health Consumers Queensland, I thank you very much for your contribution today.

BAILEY, Prof. Deborah, Chair, Queensland State Committee, Royal Australasian College of Surgeons; Australasian Orthopaedic Association

CAMPBELL, Mr Chris, Queensland President, Pharmaceutical Society of Australia

FRANZ, Dr Robert, Chair, Queensland Surgical Advisory Committee

LOCK, Mr Mark, State Manager, Queensland, Pharmaceutical Society of Australia

CHAIR: Professor Bailey, would you like to make an opening statement?

Prof. Bailey: Thank you, Chair and honourable members. I represent the Royal Australasian College of Surgeons which is charged with advocacy for surgical standards, professionalism and surgical education in Australia and New Zealand. Our submission refers to only one part of the Health Transparency Bill. To be quite clear, our submission is not about the powers of the Health Ombudsman, our submission is not about the residential aged-care facilities, nor is our submission about the public website provision of information about parking, services and staff levels at public hospitals. Our submission is about the far-reaching powers given within the Health Transparency Bill to change at any time in the future the patient outcome information able to be requested and published by health executives. The process so far has failed to reassure the royal college that this information would not result in harmful effects on surgeons, surgical departments and patient expectations and other expensive and unintended consequences.

The stakes are high. Performance measurement done well is broadly productive for those concerned. Done badly, it is very costly and not merely ineffective but harmful and indeed destructive. The college is gravely concerned that undifferentiated future outcome data will be released that will affect patient confidence in public health surgical care and their surgeons.

Research from the US on veterans health found that cardiac surgical patient mortality rates did not follow a particular surgeon when they moved between institutions. This hospital specificity clearly showed that patient outcomes are not tied to an individual surgeon; they are dependent on other factors, such as the team, the facility, patient factors and the organisation. The college and the evidence does not support the release of reports of an individual surgeon's performance.

Instead of confusing everybody with science and literature, I am going to give you a Queensland example. The Cairns Base Hospital treats our most remote communities with many known social issues and people who are reluctant to engage in traditional health services. Therefore, the patients arriving for blood vessel diseases at Cairns are more advanced with multiple uncontrolled conditions, such as diabetes and kidney failure. Because of that, the incidence of amputations, ulcers and infections in these patients is very high compared with hospitals such as the Princess Alexandra or the Gold Coast Hospital. There is one surgeon in Cairns doing public vascular work. If in the future the infection rate for vascular surgery is published for Cairns and, say, Princess Alexandra, it would not only identify that Cairns surgeon; it would decrease the confidence of the local patients in their hospital care and may lead to an unrealistic expectation that patients can pick at which institution they may have their care.

The process so far has failed to reassure the college that this information will not result in harmful effects. The department or the director-general responded to the public submissions by reassuring that Queensland Health would risk-adjust the data so that patients with predisposing factors to complications could be fairly compared with other facilities and that health facilities—our hospitals—will have the option of adding explanatory information to help consumers interpret the information. In response to our question about a hospital with a sole surgeon, the department responded that they will publish the data anyway as it is recognised that the outcome for patients is a reflection of the care of the whole facility and the factors such as resourcing in the community. I would put this to you: who recognises these facts? The average patient? The media? Or the local member of parliament?

The same health division claimed to have done consultation on this part of the Health Transparency Bill that concerns us by presenting to the Queensland Surgical Advisory Committee on 3 December. At that presentation, the members were told there would be no surgical outcome data released on the website but it might be in the future. On 7 August 2019, a presentation was made to the Queensland state committee about the website, which now included surgical data, in which all the concerns raised in our college submission were submitted to the presenter but not addressed. The college is thus not reassured that these far-reaching powers to select outcome data and publish in the future will not be mitigated as these reassurances or mitigating controls are actually not in the legislation.

CHAIR: Thank you for your opening statement. We might come back to you after we hear from Dr Franz.

Dr Franz: I am chair of the Queensland Surgical Advisory Committee. It represents about 12 to 15 senior clinicians of multiple specialties, from eyes, ENT, orthopaedics, general surgery, advising on various aspects. They are all fellows of the college. I will talk in a similar way to some of the themes from Professor Bailey.

In principle, we have no great problems with public reporting. What we do have concern with is data. Queensland Health, as any health service, collects a huge amount of data and unfortunately it is not always accurate and once published it is hard to retract even though it is false. Experiences overseas with cardiac surgery in New York and in the NHS have shown huge troubles when data was published erroneously. There was a vascular surgeon in London who was published in the media as having a 20 per cent death rate from aortic aneurysm repair, until he phoned and told the paper that he actually did not do that operation. That almost ruined his career. There needs to be a very close balance and checks before things become in the public domain.

With regard to an individual surgeon's performance and complication rates, again the data has to be very, very clean and risk adjusted. Having surgery unfortunately is an invasive procedure, whichever specialty we do, and there are complications. The ultimate decision is between the patient, the family and the surgeon, obviously with anaesthetic support et cetera. It depends how you risk adjust it. What I mean by risk adjusting is that if you are 20 and you have a bowel resection, your rate of complication is low; if you are 88 and you have a bad aortic valve, you have renal failure and you have cardiac disease elsewhere, the outcome is not going to be as good, yet you will publish the same results. There has to be very close risk adjustment otherwise you can disadvantage local hospitals, individuals and patients. I think that is the main concern. Putting out data that says, 'It has an infection rate of 20 per cent,' may well be acceptable in the right cohort of patients and it might be completely unacceptable in another cohort of patients. That is what the public needs to realise.

We are currently investing quite heavily in new systems to improve that, and these are words you may not be familiar with—for example, Getting It Right First Time from the NHS in orthopaedics and the North American quality improvement program where you can compare yourself to 700 other hospitals both nationally and internationally to look at complication rates, risk adjustment and so forth. That is a major new undertaking over the last couple of years and we are just in the process. The whole theme of that is to do good quality outcomes so we can tell our patients, 'Yes, our infection rate is 10 per cent and we are as good as Massachusetts General,' or wherever. They are our main concerns. It is easy to publish things, but once it is out there it is gospel and really hard to claw back. It has to be very heavily verified as being correct.

CHAIR: Thank you very much for that. We will move to the PSA.

Mr Lock: We would like to thank the committee for inviting the Pharmaceutical Society of Australia, the peak professional body for pharmacists, to be here today at this public hearing. The PSA commends the Queensland government's commitment to better health outcomes, improved safety and consistent and higher quality care in hospitals, health facilities and aged care. PSA supports the objectives of this bill: to establish a transparent reporting framework for public and private hospitals and residential aged-care facilities; to introduce minimum skill mix ratios and minimum daily resident care hours in residential aged-care facilities; and to amend the Health Ombudsman Act to reduce duplication of work, reduce delays in dealing with complaints and contribute to more informed and consistent decision-making.

In particular, we would like to highlight the importance of minimum skill mix ratios in residential aged-care facilities. We wish to reiterate and highlight PSA's position on the need to better utilise pharmacists as part of the healthcare team in aged-care facilities. As detailed in our submission and as previously presented to this committee during other public hearings, PSA's *Medicine safety: take care* report revealed alarming statistics associated with medication related problems in aged-care facilities. With medication administration and management issues being the most common complaint raised about residential aged care in the Aged Care Complaints Commissioner's annual report in 2017-18, it is PSA's opinion that the public view this as a high priority issue that needs to be addressed urgently.

The need to drastically improve the safe and effective use of medicines has also been a strong theme at the hearings for the Royal Commission into Aged Care Quality and Safety. Every day, 116 aged-care residents are hospitalised in Australia due to medication errors which could be prevented. Pharmacists spending more time on the ground in aged-care facilities, bringing them closer to the point of care, has become an urgent priority. Pharmacists must be recognised as a core

member of the healthcare team in all settings where medicine is being used or considered and as a component of a patient's healthcare management plan. In addition, pharmacists are able to support the aged-care workforce, which is predominantly nurses and personal care assistants, with regards to safer medicine use within the facility and improved quality use of medicines and outcomes for residents.

There are good examples, albeit very few, of some proactive, innovative and forward-thinking facilities which have invested to include a pharmacist in their facility, but this ad hoc approach is no longer acceptable based on the alarming medicine safety statistics. It is PSA's view that this is an opportune time to consider a funded model of embedding pharmacists in aged-care facilities in Queensland with minimum pharmacist-to-patient ratios which should be reported on and made publicly available. This will ensure improved medication safety and provide residents with greater access to timely, equitable, efficient and effective medication management services. This will also provide elderly Queenslanders and their families with more assurance about the quality of care provided by a facility when they are selecting an aged-care provider. The PSA encourages the committee to consider this recommendation in this regard for the benefit of Queensland residents in aged-care facilities and their families. We are happy to take questions.

CHAIR: Thank you, Mr Lock. We might come back to you in a couple of minutes. I recall you were part of the previous hearing on real-time prescription monitoring and a number of other benefits that might assist in the residential aged-care space.

I want to go back to Professor Bailey and Dr Franz, who had very similar commentary and I understand the concerns. Using Cairns was a good example, with it being rural and remote and with a higher proportion of Indigenous and Torres Strait Islander people who are more at risk of diabetes and a number of other things. I understand your concerns about risk adjusted and clean data, which I think were the words you used. I have the Queensland Health response here that has been published and it has the consultation that occurred. I have it highlighted here that consultation with the Queensland Surgical Advisory Committee started in October 2018 and was then in November and December and then in July and August 2019. That is from the Queensland Health response. Is that response suitable for you?

Dr Franz: The consultation, as I think Professor Bailey mentioned, was superficial and this was on the agenda. There was no in-depth discussion as to what could be reported on, what was the plan for the future, to my best recollection.

CHAIR: In those six months were you able to articulate your concerns?

Dr Franz: No.

CHAIR: It further says that Queensland Health will establish an advisory committee in 2020 and that it will invite stakeholders. Would you consider providing feedback to ensure the data is clean and risk adjusted?

Dr Franz: We are very keen to be involved in that. The experience we have taken is from overseas. For example, in cardiac surgery in New York they did exactly that. They did not risk-adjust and they published results of individual surgeons. The outcome was not patient improvement; it was that all of the surgeons said, 'We're not going to do high-risk cases,' because it was not worth their while. It disadvantaged patients more than advantaged them. It is a complicated area. There is a lot of discussion. If you do high-risk cases, it does not matter if you are the world's best surgeon you are still going to get less outcomes than if you do 20-year-olds. That was shown also in the NHS. We were quite taken aback by some of those results and what happened in those places almost 10 years ago. The data does need to be really very clear and verified. From the patients' point of view, we would be very happy to share data if it is accurate.

Prof. Bailey: Of course we would leap at the chance to be involved with the advisory committee. I represent the nine different specialities of the college of surgeons in Queensland. We are very invested in publishing good risk-adjusted outcome data. In fact, we believe that, going forward, sustainability in health will occur because we will look at patient outcome data rather than procedural data as such, meaning that the right procedure happened for the right patient at the right time—or no procedure happened, if that was the right thing for that patient. We are very invested in that. We want to know that we will be listened to and that we will be involved in deciding the appropriate outcome data to be published. Because of the process so far, we feel that may not occur. You can say that you are going to have a committee, but, unless it is legislated or put into print somewhere that it is going to happen, it may not actually happen. Our concerns are more that the legislation says they can publish any data they like and they can pick whatever data they like. Most

of the data currently available is already printed, but is it important data and is it risk-adjusted data? I believe that Queensland's Surgical Advisory Committee and the RACS both have similar concerns about what that means. People may change, but at the moment the system allows them to do whatever they like.

Dr Franz: In surgical circles we probably do more high-risk groups now than we have ever done before. When I was an intern—which was probably just last year—we did not dialyse people at 65. Now we dialyse people at 90. In my specialty I routinely resect bowel cancers at 90 because they are good 90s. That was not even thought of 15 or 20 years ago. Again, that is a decision between the family, the doctor and everyone else. If everything goes right, they have just as good outcomes. There is an increased risk and it does not take much to get not as good an outcome, but some patients accept the risk.

CHAIR: Mr Lock, in your opening statement you commented on the number of people admitted to emergency departments in Australia due to medication errors. Can you clarify that number, and do you have any data for Queensland?

Mr Lock: I do not have Queensland specifically, but across Australia 116 aged-care residents every day are hospitalised due to a medication related issue.

CHAIR: As we said at the last hearing, there are some benefits to be considered going forward in terms of not waiting for real-time prescription monitoring in the same context as perhaps reducing unnecessary transports to hospital if you can get a high level of care. That would include medications. Can you address that?

Mr Campbell: If we look specifically at residential aged-care facilities, it is looking at electronic medication charts and having that legislated as a prescription so the level of transcription error and administrative burden—so the focus can be on medication safety. Is this the right medication for the right patient? You brought up having that available on a website to say, 'This residential aged-care facility has implemented the best technology safety-wise.' We would encourage that sort of behaviour from a residential aged-care facility. We have pilots currently underway that demonstrate the value of having a pharmacist embedded in aged-care facilities to reduce the 116 hospital presentations every day for medication misadventures. It really raises our focus on delivering that quality use of medication, so it is the two coupled together: quality systems, electronic charts and providing electronic prescriptions.

If you talk about real-time prescription monitoring, we are lucky in residential aged-care facilities, per se, in that usually the same drugs are prescribed. There is a level of consistency there. We will see a massive benefit to the community with real-time prescription monitoring. More mobile patients could see multiple GPs or multiple pharmacies. We see that it will deliver a lot of benefits for medication safety-wise for those high-risk medications.

CHAIR: Where are those pilots being conducted? Are there any in Queensland?

Mr Lock: No.

Mr Campbell: We are lucky in Queensland to have section 18, so there is always an opportunity under a pilot or research framework to implement that. That could be turned on quite quickly. We have a precedent in Adelaide as well as Canberra of residential aged-care facilities putting in a half full-time equivalent per 100 patients and demonstrating a benefit in the quality of medication.

Mr HUNT: Professor Bailey and Dr Franz, we have heard a lot today about transparency and information. You have articulated very well the dangers of relying on numbers alone as indicators of quality et cetera. There is one particular comment I wanted you to clarify, Dr Franz. I am paraphrasing, but you said that Queensland Health produces a lot of data and a lot of it is false. Would it be more misleading without explanation, or is it false data?

Dr Franz: A lot of data is collected at various levels, and it is only as good as the people who input it. For example, in my own facility five or six years ago we got a report from our data collectors that 25 per cent of our patients postoperatively had renal failure. We could not remember one, and we had to pull up 300 charts manually. It was all the AV fistulas the vascular surgeon was putting in for established renal failure. The data entry person could not identify chronic renal failure and an operation for dialysis to renal failure. One of the programs I mentioned, NSQIP, has a data entry person specifically trained to do that for clean data at the coalface rather than someone further afield who is trawling through a chart. That is where we want to focus. We are running a collaboration with New South Wales Health, and it has taken them eight years to get to where they are now. We have done it in about six months, which is nice. They found the same issues, and they found improvements

almost immediately. We have three trial sites in Queensland at the moment. They have only been running for about three or four months, and we have already found quality improvement activities in at least one of the facilities.

CHAIR: I want to clarify that. You used the words ‘false data’, but by the sound of it it is inaccurate data.

Dr Franz: Yes, inaccurate data or data that looks good but is not appropriate, as with the renal failure example. Most clinical care is complex, so you need very qualified people at the coalface who understand what they are entering. Otherwise, you are barking up the wrong tree.

CHAIR: Where are those three sites you spoke of?

Dr Franz: Redcliffe, Logan and the Children’s Hospital.

Mr POWER: This is pretty personal for me. My dad died from postsurgical complications. It is one of those things that you go over again and again in your mind. What would we have done differently? Did the surgeon make the correct decision? How could we have been informed about what happened? This really matters a lot to me. We talked about getting good risk-adjusted data and having a high quality of data entry and an understanding of that data. As we do this we learn new things about surgical procedures, complications and especially decisions not to have surgery. By its nature that changes as evidence changes and as we learn more about procedures. I know there is a lot of evidence emerging now about the pros and cons of back surgery, so as a parliament—which cannot return regularly—it is very difficult for us to legislate at a fixed point in time. By its nature, it has to have a risk adjustment in the regulation. I do not think anyone on the community would want it any other way. I want to make sure you understand the process and that we would not be legislating for these particular risk adjustments, which are by their nature fluid as information comes to light. Do you understand that that would have to be by regulation?

Prof. Bailey: I think it was more that, if the legislation reflected appropriate expert clinicians were involved in decision-making around what outcome data would be appropriately gathered and published, that would mitigate the concerns we have if undifferentiated outcome data came out, understanding that you cannot legislate for a particular set of data because the set of data that is meaningful may change. At the moment you only publish activity data really, but in the future you may want to take the NSQIP data, which will be hopefully in the future rolled out to all hospitals, and publish that. If it has that data, then the surgical group would say that is good data. That is risk adjusted. It was clinically input. It has been checked before it was input to make sure it is accurate. That sort of transparency would be good to have across the board so that patients are able to see that their hospitals are performing well on a risk stratification basis. At the moment it just says that any data can be picked and put out there. We would like to see the legislation adjusted a little bit to make sure it is clinically relevant, clinically specific and verified, as opposed to just being picked by the Health executive, which is I think how it reads at the moment.

Dr Franz: I am sorry to hear about your father. You are absolutely right: medicine is a changing field. It has probably changed more rapidly in the last 15 to 20 years than ever before with technology, different procedures and less invasive procedures. They all need to be assessed very carefully. Just because someone has a hammer, everyone wants to try a nail. That is why we are pushing this quality activity, to make sure it is as safe as it can possibly be. I cannot think of an operation that does not have a risk factor, but we want to ensure the outcomes are as good as they can possibly be.

Mr POWER: They do not have hammers; they have scalpels. You spoke about the perverse outcome where New York surgeons do not want to take on high-risk cases. The other thing about risk-adjusted data is that a surgeon’s performance may be very good with high-risk patients compared to other surgeons, but they both might be killing high-risk patients and perhaps the procedure should not have taken place at all.

Dr Franz: That is a very good point. There has been quite a long discussion in the last two or three years about risk and futile surgery. There are some patients whom we do not operate on, and that is what I was referring to. That is a matter for discussion between family, relatives and advice from anaesthetists and surgeons. Sometimes people accept the risk: ‘Rather than dying from an obstruction, bowel cancer, I would rather risk having my resection.’ What are the alternatives? The discussions are quite difficult, and most senior clinicians would engage in those before going on. There is a death rate from every operation, depending on comorbidities. It is very much a personal decision. All we can try and do is make it as safe as possible and do the best job on the day as we can, realising that some people will have good results and some people will not.

Prof. Bailey: Taking up your point, though, this is the emerging dataset that has not come yet, which looks at how we measure the fact that the patient has been the centre of the decision and that their health literacy is high, so that when presented with the data they can make the decision—and their family—that they are willing to take the risk of the procedure if they are a high-risk patient. We all accept that legislation cannot be too restrictive, otherwise we will not be able to publish the data that we do not actually collect yet which is meaningful.

Mr POWER: With respect—and this is a bit personal for me—when we go into a process where a surgeon is leading us through the options for surgery, the information is something we deal with once in our life. The guidance we get from the surgeon is not something where we make an informed consumer choice. It is very much guided by the surgeon who guides us about the right choices to make. This is something where I think having some oversight over statistics of surgeons, especially in high-risk cases, is very much in the public interest.

Dr Franz: Absolutely. As I said, that has been a focus for the last two or three years at many meetings. Most surgeons, or at least the ones I know, would have at least one, two or three interviews before going ahead in a high-risk case. They usually get an opinion from an anaesthetist. There are already risk adjusted tables—although they are probably not quite as sophisticated as we would like—to say, ‘Well, you have a 10 per cent chance of dying’ or ‘You a 5 per cent chance of this.’ At least in my own practice that is what I give to the patients and family, and then say, ‘You decide and come back next week or next month. Take as long as you like.’ That is very much a personal family decision. Sometimes the alternatives may not be palatable either. It is a very personal and difficult decision.

Mr McARDLE: Professor Bailey and Dr Franz, you mentioned that you would be happy to be involved in a committee structure to work through the issues that you have raised here today. I think you said that for that to be of ‘any value’ it would need to be enshrined in legislation. The best way to go about that would be to put it in the bill and work it through like that. Committees formed by parliament, as passed in law, report to the minister directly. The minister does not form part of the committee and neither should he or she, as the case may be, and rightly so as you are answerable to the health minister. How do you ensure the outcome you are seeking will be the end result, because a report either to the parliament or to a health minister is not binding upon either the parliament or the health minister? How do you envisage that can be overcome given the apparent concern you have in relation to staff figures and staff information being put up?

Prof. Bailey: When you are part of an advisory group—and all in this room have been part of various expert advisory groups—you give your expert advice based on the evidence, literature and experience that you have. It will always be a risk that no-one listens to your advice, but at least you were able to give that advice and allow the people who make the decision to have all the evidence in front of them. The fact that you have enshrined in legislation that the appropriate decision-makers will consult with the relevant expert clinical advice in making the decisions does not obviously enshrine the fact that that information will be taken on board and enacted. I think we can only ask that we are included in that conversation.

Mr McARDLE: You would be satisfied with a provision that allowed the committee to be established and to provide a relevant report to the minister and that person then takes action or not as the case may be?

Prof. Bailey: Exactly.

Mr McARDLE: You talk about risk adjusted methodology. I have a very vague idea of what you are talking about. Can you give me a concrete example of how that would apply, in your circumstances, being placed on to a website?

Dr Franz: There are a couple of ways you could do it. Risks are often the comorbidities of what the patient has when they come to you: diabetes, peripheral vascular disease, ischemic heart disease, chronic renal failure and, my speciality, bowel cancer. We know that already there are set tables, as I said, not as quite refined as the newer programs coming up but they will tell you that you have a five per cent chance of dying under anaesthesia, you have a 20 per cent chance of infection. Of course, obesity is one of our big issues as well. It increases the risk of clots in your legs, clots going to your heart and pulmonary embolus infection rates—just about everything. Basically, if you have those factors, we would list, for example, that it is well known that if you stop smoking before a procedure you have a 30 per cent less complication rate. They are the things we give our patients. We have just started a program that mirrors the one in Washington. It is a patient improvement program that says get your diabetes under control, stop your smoking, get a regular check-up by your

GP. Those are patient factors that hopefully will improve the outcome, which then leads the surgeon to do the best job they can on the day. We can put up all those risk factors, which are fairly international now—they are well recognised—and then you go to the specific operation and you can expand on that.

Mr McARDLE: Health Consumers Queensland seemed to indicate that they were keen to put up adverse outcomes as well. You mentioned that in America and the UK that has led to some very iffy outcomes. It has not really determined or come to a better solution, but it might be too early to make that call. Has New South Wales started that? I thought I heard somebody mention that New South Wales was looking at that as well?

Dr Franz: We have a collaboration with New South Wales. We had our first meeting with them in May. They are using the NSQIP stuff. They started eight years ago and have some good data. They had two hospitals that were performing poorly and they really lifted using this program. Every surgeon who is worth his salt worries about adverse outcomes. The older you get, the more grey you get because of adverse outcomes. Some of them are patient-factor driven. With some of them you look at what we should have done. There is often a lot of soul searching and so forth. There is also peer review. Any good surgical department has a monthly peer review where we put up all complications, and they can be quite fiery meetings. You are always under the microscope. Again, every surgeon who is worth his salt is very attune to adverse outcomes.

Prof. Bailey: I can give a bit more information about NSQIP. I think that is the program you are talking about. It is a big data program. It involves hundreds of thousands of patients across North America. All New South Wales public hospitals are now in NSQIP.

Dr Franz: They have eight and they are just expanding to 16, but it has taken them a fair while.

Prof. Bailey: Eight years. We are going on to that as well. They also have isolated hospitals in South Australia and Victoria. You put the age and all the conditions for that particular patient into the big data computer. It spits out for a particular operation what the actual risk for every complication is of that operation for that patient, based on comparing them with thousands and thousands of similar patients. If you were going to put that on a website and make it simple for a consumer to look at, it will look at the surgical department across the whole range of operations they do and see basically if they fall in the green zone. If they fall in the green zone that means that for the entire range of operations they do, after taking into account all the different patients that they operate on and for all the different complications, they are benchmarking with most of the United States. Therefore, that is a good thing and that is all you need to do.

If your hospital is in the green zone, you do not need to know the nitty-gritty of how the big data works. As a department—and this is where the quality comes in—you look at it and say, ‘How can we do better than the benchmark?’ or, ‘We’re not as good as we thought we were. We’re a little bit below the benchmark. What are we doing and what can we do to improve it?’ That is where we are getting those really robust conversations with the surgeons, because up to now the surgeon can always say, ‘My patient is more complicated than yours, which is why my complications are higher.’ However, once you put it through the big data computer you can say, ‘You are absolutely right. Your patients are more complicated than mine; therefore, you are getting more complications’ or you can say, ‘In fact, I’ve just compared all your complicated patients with thousands of other complicated patients and you are still having too many complications. What can we do differently?’ That is how it works.

Dr Franz: I can give one quick example of what they found. It is not always the surgeon—although most of the time it is—but they found how the IDC, the indwelling catheter, was managed post operatively mattered. They changed their practice to reduce the infection rate by 10 per cent just by the way the nurses managed the catheter—which we did not even think of—in terms of, ‘Don’t drag it on the floor, don’t let it contact.’ That made a huge difference to urinary tract infection post operatively.

Mr POWER: Very much data-driven?

Dr Franz: Yes.

Mr POWER: That factor, though, does not take into account that some surgeries should not happen at all, given the clinical outcomes against surgical versus non-surgical. For someone with high-risk factors, as they get higher risk factors the non-surgical options become more attractive. Someone might be very good at doing high-risk operations, but those might be operations that should never have taken place because the non-surgical outcomes are better.

Dr Franz: Absolutely. You cannot argue with that.

Mr POWER: That green zone does not necessarily reflect those options, either.

Dr Franz: No, because those who have not had the operation will not be on that database. You are absolutely right, but that is probably a different conversation. There may be other alternatives and, again, that is where you seek opinions as to what are the alternatives.

Mr POWER: You made the analogy about holding a hammer. Overall, do surgeons not take into account non-surgical intervention being better in many cases?

Dr Franz: That at is probably a little bit unfair. In my career, many operations have come and gone when the evidence suggested that the outcome was not so good. In fact, the hot thing at the moment from New South Wales is knee arthroscopies. They are almost becoming a thing of the past because the data shows they are of no value.

Mr POWER: No value when balanced against risk?

Dr Franz: Or no outcome. It is the same. It is not even doing an arthroscopy in certain age groups. If you look at their figures, their rate of arthroscopy has gone down about 80 per cent. Medicine is a moving feast and there are many operations that become historical after a while, are replaced by others or by non-intervention.

CHAIR: Thank you very much. We all get replaced by others at some point. Thank you for your contribution today. I call the Public Advocate and the Queensland Law Society to the table. I acknowledge and welcome the member for Maiwar, Michael Berkman.

ANDERSON, Ms Rebecca, Chair, Elder Law Committee, Queensland Law Society

BURGESS, Ms Mary, Public Advocate, Office of the Public Advocate

FORBES, Mr Andrew, Deputy Chair, Occupational Discipline Law Committee, Queensland Law Society

POTTS, Mr Bill, President, Queensland Law Society

Mr Potts: Thank you very much for inviting the Queensland Law Society to appear at the public hearing on the Health Transparency Bill 2019. As many of you will be aware, the Law Society is the peak professional body for the state's legal practitioners, over 13,000 of whom we represent, educate and support. In carrying out our central ethos of advocating for good law and good lawyers and the good of the society and our community, the society proffers views which are truly representative of its membership practitioners. The society is independent. It is apolitical. It is a representative body upon which government and parliament can rely to provide advice which we hope promotes good, evidence based law and policy.

With respect to the bill under consideration, we raise the following key issues. The first is potential difficulties with the way in which the various types of information related to health facilities are described for the purposes of the bill and the lack of appropriate limits on the breadth of information that may be requested. The second is the limited utility of the information that will be published as a result of the bill and draft regulation in relation to residential aged-care services. The third is concerns about changes to the way in which serious decisions about the careers of health practitioners will be made as a result of the proposed changes to the Health Ombudsman Act 2013.

The Law Society supports efforts to improve safety and quality in aged care and health care and recognises that the availability of high-quality, meaningful data can both aid consumers to make choices and—we presume, hope and support—lead to improved outcomes. However, it is important that all stakeholders have a proper understanding of what data needs to be collected so that entities can meet their legal obligations without being disproportionately burdened by data collection and so that any published data is truly comparable from one facility to the next—oranges to oranges and apples to apples, effectively.

QLS recognises that the types of information to be requested and published are intended to be expanded via regulation and that this is intended to allow flexibility in the health transparency regime. However, the Queensland Law Society is of the view that the bill as currently drafted contains definitions that are ambiguous and it is therefore unclear what types of data may end up being prescribed in subordinate legislation. In particular, as pointed out in our submission, the definition of 'patient outcome information' is problematic. Similarly, the bill does not provide clear limits about the time frames to which requested information can relate, and the Law Society is concerned that the regulations could allow for overly burdensome requests.

In QLS's submission, the current drafting potentially breaches the fundamental legislative principles that legislation have clear meaning and sufficient regard for the institution of parliament. I would ask my colleague Rebecca to address issues surrounding residential aged-care information and then I would ask Andrew to address issues in our opening statement with the Health Ombudsman changes.

Ms Anderson: Thank you. The Law Society finds that the bill as drafted, taken with the draft regulations, only contemplates the collection and publication of average daily resident care hours in relation to residential care facilities; however, the introductory speech and explanatory notes provided that the bill would be looking for a skill mix of staff and workers in aged-care facilities. The Law Society does not consider that average daily resident care hours alone is sufficient information to allow consumers and their families to make meaningful comparisons between residential care facilities.

Average daily resident care hours does not address the skills and qualifications of staff. It does not advise consumers whether there are registered nurses, enrolled nurses or support workers around those hours. We also find that the information would be more useful if it contained model-of-care information around what type of work the facility is doing and what sorts of consumer needs they are meeting—low care, high care, dementia care and that sort of thing. It needs to be more plainly gathered and provided to consumers.

We also find that other information would be really useful to consumers, such as the history of a facility in restrictive practices. Is there a sanction history for a facility? Do they have lockdown histories? Have there been reportable deaths at a facility? All of that information would be very useful

for families and adults as their own decision-makers on deciding to where they might choose to move. The Law Society is concerned that the bill and regulations as currently drafted provide a missed opportunity in this regard.

Mr Forbes: With respect to the Health Ombudsman Act, there is one aspect of the society's submission we would like to qualify a fraction. Speaking about the powers of the Health Ombudsman with respect to unregistered practitioners, proposed part A contemplates that the Health Ombudsman be essentially the final arbiter after investigation with respect to unregistered practitioners. Having reflected upon it a little further and seeing what the Health Ombudsman said before the committee a couple of weeks ago, we would like to emphasise the second aspect of our submission—that is, what is proposed in section 100, not allowing an unregistered practitioner who faces a prohibition order to obtain a stay of that decision should they go across the road to QCAT.

What is currently there—those aspects for which a registered practitioner cannot obtain a stay order—are the immediate things: immediate action and those emergency powers. What is contemplated by a decision in 8A is after an investigation process. It is something that takes time. Allowing the avenue for an unregistered practitioner to go to QCAT and then not allowing them to stay the proceeding would be unfair. We suggest that that provision be removed. That is the part that we would like to emphasise as part of our submission.

One aspect which is not touched upon in the Law Society's submission is to do with division 2B. The mechanism contemplated by the amendments of the liaison between the Health Ombudsman and AHPRA and the discussions that have to take place and the mechanisms there is commendable; it is a very good process. Just to clarify, I have been speaking about division 2A and in particular section 35G, which talks about the mechanics between AHPRA and OHO. Part 2B effectively gives AHPRA a second bite of the cherry, and we question whether that is necessary in the circumstances.

The process in part 2A, as we understand it, allows both regulators to speak and decide what is going to happen with a complaint. If at the end of that investigation process the ombudsman decides to take no further action, AHPRA is given another seven days, I think it is, under the division, to take it over themselves and do with it what they like—continue the matter. The main concern there is probably from the practitioner's perspective. To have survived an investigation process before the Health Ombudsman and to have another regulator take it off and go through that angst again may be a little unfair. Really, in essence, the conversation should take place in the first process—in other words, during the provisions outlined in section 35G. If the ombudsman is going to decide not to take further action because it is not a serious matter, it could be decided to take action by referring to AHPRA at that point in time. We do not envisage that 2B would occur regularly—it is not something common—but it just has a risk of putting a practitioner through a two-phase investigation process that could have been cured in the first breath.

Mr Potts: That completes our opening statement.

CHAIR: Thank you very much, Mr Potts, Mr Forbes and Ms Anderson. Mr Forbes, as you know, this committee has oversight of the OHO and regularly engages with AHPRA and OHO in their performance. One of the issues that is constantly raised is the issue of going through QCAT. If there is a serious breach of care from an unregistered or registered health practitioner, the OHO can make an order to stop under that prohibition order. You are saying that it should go to QCAT before a decision is made. If there is an immediate risk to public safety, surely the OHO should be able to make a call there and then, whether registered or unregistered, without the need to—I know it gets to be a little bit of a fine line here, but just in terms of efficiency and delays going through QCAT, should the OHO have the power to make a prohibition order—and that is what the bill intends to do—in relation to serious risk?

Mr Forbes: There are two processes, and I think we might be at cross-purposes at this point. The society is not for a moment suggesting that in the context of an interim prohibition order—in other words, something has to happen urgently—the Health Ombudsman is either prevented from doing that or prevented from going to QCAT or, for that matter, in that context, a stay order should be allowed. The process I spoke about in the bill is the next process. In other words, immediate action has not been taken but an investigation process has taken place and the final outcome is a determination that that unregistered practitioner should not be allowed to remain working in the health space.

That decision is contemplated under the bill, with the final arbiter to be the Health Ombudsman rather than QCAT. The rights of review remain going to QCAT. In the society's submission, the concern was expressed that maybe that process should ultimately remain with QCAT rather than the Health Ombudsman. We do not wish to emphasise that at the moment. What we wish to emphasise

is the next step. In other words, should the decision remain with the Health Ombudsman and the unregistered practitioner brings a review to QCAT, they must be permitted to stay that decision. In that context, having gone through an investigation process, it is not an urgent action. It is not the case that the Health Ombudsman moves within a matter of days to stop them there and then; it has gone through a very considered process. As contemplated by the bill, there is a show cause process and so on. I think that is slightly different to what you—

CHAIR: I wanted clarification on that and I think you have articulated that well. They still have the ability to be reviewed through QCAT?

Mr Forbes: Absolutely.

CHAIR: Ms Burgess?

Ms Burgess: Thank you again to the committee for inviting me to speak on the bill today. As the Public Advocate, my primary role is to promote and protect the rights and interests of adults with impaired decision-making capacity and to encourage their participation in all aspects of community life. My comments today will focus on residential aged care.

Many users of residential aged-care services have developed or will potentially develop impaired decision-making capacity as a result of a range of conditions. Current data estimates that 52 per cent of aged-care residents have a diagnosis of dementia, making residential aged-care settings particularly important to my role and advocacy activities.

The first comment I would like to make about the bill is that I want to congratulate the government on introducing the bill and taking this initiative, which I think represents a strong commitment to improving the transparency and accountability of health services provided in Queensland, and supporting consumers to make better informed decisions in relation to their health and aged care. Legislation like this has the potential to significantly impact people's lives by providing access to the information necessary to make what often can be really difficult decisions, particularly when selecting a residential aged-care facility for themselves or for a family member.

The model proposed in the legislation will publish only one figure for the average number of care hours provided to residents of an aged-care facility during a 24-hour period, which represents the total sum of hours provided by registered nurses, enrolled nurses and support workers in a facility divided by the residents.

Like many other speakers appearing today, I feel that the legislation could be expanded to include additional information that is important to making decisions about levels and quality of care and allowing people to make meaningful comparisons between facilities. The additional information that I am suggesting includes the skill mix of staff and the level and models of care provided by residential aged-care facilities. Looking at the skill mix of staff available at a facility first, we have seen various reports and reviews over the past decade prepared by the Australian Productivity Commission and other Commonwealth government initiated reviews which highlight the importance of an appropriate skill mix being available in residential aged-care facilities. This has also been highlighted in the aged care royal commission with witnesses giving evidence about poor levels of care in facilities that are associated with high levels of inexperienced or untrained staff without the supervision of appropriately skilled and experienced nursing or other staff.

A requirement to publish a breakdown of the skill mix of staff available at a facility—and we would like to see it on weekdays, nights and weekends, because those levels vary quite significantly—and divided between registered nurses, enrolled nurses and support staff, would provide much more detailed information for people to really make a properly informed decision about what services are available and the quality and level of care that is actually being provided at the facility. It allows people to make choices about the service levels that they think best suit their needs or the needs of their family member. This approach is also consistent with the private member's bill that was introduced earlier this year in the Australian parliament by Rebekha Sharkie MP.

The mix of residents at any one residential aged-care facility and their care needs also have a significant impact on the staffing levels and the skill mix of staff required. For example, with facilities where residents primarily require lower levels of care, they would require a staffing structure that is quite different from one including a high number of residents with challenging behaviours associated with dementia and also perhaps with complex health conditions. It is a horses for courses kind of thing. If you just look at numbers of people and numbers of staff, you are getting a very raw figure that is not meaningful in terms of people drawing conclusions or making assessments about quality. A requirement to include information about the model and levels of care will also provide people with important contextual information about the staff mix and ratios.

Overall, we think the legislation is very necessary and it is a welcome first step. The decision to move a person into residential aged care has very significant impacts for people in their lives and it is really important that if we are going to do this that we do it as well as we can. I would encourage members of the committee to take the view that any reasonable changes that can be made to the bill to make the information provided more useful for members of the community to make these decisions should be made. These changes can only enhance the potential of the bill to achieve its objectives and I think that is why we are all here. Thank you.

CHAIR: Thank you very much. That is on point. The committee has travelled widely and extensively and seen many different models of care, both public and private. The issue of dementia is significant in our ageing population. It will be the leading cause of illness, if you like. I think your point is good in terms of articulating what levels there are. We have seen so many different models. Clearly when you have wandering behaviours and other types of behaviours you need more eyes on that patient to reduce falls and a number of other things. It is certainly something we have picked up in our travels. We thank you for your submission today and your statement. I will open up to questions. The member for Maiwar has not asked any questions today, so I will ask him to start.

Mr BERKMAN: Obviously having missed the beginning of the hearing, I am inclined to leave it to other members. I may in fact have to excuse myself again at some point to go and deal with this government's trashing of the committee process in respect of another bill before the parliament. If I do have to leave sometime soon, please excuse my non-attendance for the remainder of the hearing.

CHAIR: I do not know what you are talking about, but anyway. Member for Nicklin?

Mr HUNT: I acknowledge your comments around the intent of the legislation and congratulating the government on taking a step, but obviously good intention does not make good legislation. I acknowledge your comments—all of you—around the deficiencies in this bill and the deficiencies in the regulation. I draw your attention particularly to page 3 of the submission where it says—

While QLS can see the value in being able to compare facilities, it does not appear that the comparison will be meaningful where there is no contextual information around the model of care...

We are talking about ratios. A ratio is a number and we have heard a lot of evidence today about how data can give a false picture. I acknowledge your comments around the other data that should be collected and included. I would submit that that is in the sphere of the feds, but whether or not they do that well is a different argument. Mr Potts, in your opening statement you said the intention of the Queensland Law Society is to ensure good, evidence based law and policy.

Mr POWER: Is there a question here?

Mr HUNT: If you would let me finish.

Mr McARDLE: I think if you keep your mouth shut we will get to the question, so please do so.

CHAIR: Okay, members. We are nearly at lunch. Let's go.

Mr HUNT: In your opinion, is this bill good, evidence based law and policy as it stands now?

Mr Potts: To borrow Ms Burgess's comment, it is a good start but there is a lot more that can be done. There are two reasons behind this. One is that it has the effect of informing consumers, which is an important thing when, particularly as has been indicated by the chair, we have an ageing population and us baby boomers have to make real decisions around quality of care and the manner in which the dignity of our loved ones will be respected. Secondly, it will have effectively the push-me-pull-you effect by publishing these figures, provided they are meaningful and provided they are detailed. That is what I was talking about when I was saying comparing apples to apples and the like. Because there are going to be a significant number of variations—

Mr HUNT: Exactly.

Mr Potts:—it also has the effect of ensuring that the organisations about which this information is published also know the standard to which they must aspire. It is important that in doing these things we balance the cost of it because the cost is significant, but what we want is quality care for those people who are at a very vulnerable stage in their lives.

Mr HUNT: I do not think there is anyone in this room who does not want high-quality aged care. I guess the debate is around how we get to that. In terms of data collection, considering the oversight of the federal quality assurance scheme and the information that they collect, do you see this as a duplication by the states if we start to expand the requirements of what is required to be provided to make this data meaningful and the reporting requirements on the services themselves to both bodies?

Mr Potts: I will ask Ms Anderson to address the answer to that question.

Ms Burgess: I have a view on that, too.

Ms Anderson: I would say that the point of difference is that the federal government might be collecting the data, but it is not openly public to consumers. That is where the point of difference would be with this legislation: it is about making it public. It would be a really good idea for the committee to look at what the legislation is from the federal government, as far as what type of data they do collect. If there was a marrying up of what you are looking for from this bill to that bill, then I do not see that that would be adding to the workload of the aged-care providers.

Mr HUNT: Under the new federal regime, enhanced information on quality of service is a part of that. Would it be better to pursue it down that line, rather than duplicating it at a state level? I had some experience of this running childcare facilities when there were federal and state regulations that you had to comply with. Eventually that was seen to be too onerous so it was put together again in the end. I can see this coming full circle if the state goes down this road.

Ms Burgess: I can see that, but at this point there is no requirement for aged-care facilities to be providing that data at the federal level. As an agency that monitors what happens in these kinds of facilities and the treatment and care of people in these facilities, my view is that it has been woefully under-accountable and non-transparent. We do not really know what has been going on in there. We are finding out now and it is all a bit frightening really.

Mr HUNT: Acknowledging there is now a new framework.

Ms Burgess: I have very carefully gone over that new framework and I have made representations to the Commonwealth Parliamentary Joint Committee on Human Rights about the new principles and that they really focus on the use of restraint and restrictive practices—so chemical restraint and physical restraint. There is very little more detail in those changes than that. Certainly they have beefed up the power of the oversight agency, and we have yet to see where that all lands. Until very recently that agency was not even looking at things like restrictive practices or the use or misuse of chemical restraint and thus we are seeing the sorts of things that were reported by the pharmaceutical society this morning in terms of these adverse outcomes for people. I do think there is a problem, that there is an overlap here potentially, but at this point I do not think there is anything that has happened in the Commonwealth space that specifically and appropriately addresses this.

I would make one point about the ratio issue. I know that people keep walking out one statement in the Productivity Commission report that staff-to-patient ratios was a very blunt instrument for assessing quality and levels of care, and on the face of it it is. However, there is a tipping point beyond which the staff-to-patient ratio is just too low to be acceptable and there probably should be some absolute minimums. I actually reviewed evidence that was given to the Productivity Commission's review into the workforce in aged care and I heard stories from staff where some nurses were on at night—the lone nurse—with 150-plus patients.

CHAIR: We have heard worse.

Ms Burgess: At a staff ratio of one to five or one to 10 you are not going to see much in that space, but once we are getting to one to 30, one to 50, 1 to 70 there has to be a tipping point where quality is actually impacted. We would like to see the Commonwealth legislating in that space, but at least if we could get some movement here where some of this is reported we think it would actually benefit and it would start a movement across the board.

Mr HUNT: Can I summarise it, because of time constraints: the federal government has a new regime. You have looked at that extensively. You do not believe it goes far enough, so there is a place for the states to come in and regulate more heavily on information that should be provided, but this bill does not go anywhere near that.

Ms Burgess: The bill does not actually help people to tease out some of the contextual details that would allow them to make really good decisions about quality and levels of care.

Mr Potts: I would make two points subsequent to that. Firstly, there is nothing wrong with Queensland being both a thought leader and an action leader in this nation.

CHAIR: Hear, hear!

Mr Potts: The second thing is this, taking up the Public Advocate's very well made point: by making realistic changes here, by ensuring that quality, evidence based material is placed before consumers, we will have the effect, hopefully, of dragging the rest of the nation to ensuring that our elderly are better cared for.

Mr HUNT: But this bill does not do that, in your submission?

Mr Potts: Not in its present form, but with the submissions we have made, if taken up by this committee and this parliament, we believe it will have the substantial effect of bettering the lives of our elderly.

Mr POWER: The position of the QLS is not that there should be nothing done about reporting on the ratio of staff members and nurses, but that there should be even more information required to show the levels; not that nothing be done, but that more be done.

Ms Anderson: We absolutely support the movement of the bill, but what we would say is that it should be gathering more useful data, so a breakdown of the type of data they are talking about.

Mr POWER: We have heard this morning that the proportion of nursing staff as a whole in the period from 2003 to now has gone down from 21 per cent to 14.9 per cent and at the same time the level of people in high needs in nursing homes has gone from 21 per cent to 80 per cent. Needs have gone up, staffing ratios have gone down. As a baby boomer—I am not one myself, but I have faced some of the same concerns—you would want to know this fact, even if it is the minimum fact, so that you could ask that nursing home, ‘Why do you have such a low ratio? Is there a reason? Do you have low acuity patients? What care would you get from nurses on this ratio?’ You would want this information, wouldn’t not?

Mr Potts: Isn’t it about two things? It is about the right to know, most importantly. Secondly—and hopefully I am not going to overuse the hammer-and-nail analogy you talked about—

Mr POWER: I like it, though.

Mr Potts: One of the nails in here is better results. That can be achieved by that broader, more detailed and evidence based material to be placed before consumers. More importantly, for the consumers who eventually, even like yourself, might face being placed in a home, you want to know that the people who are making the decisions for you if you have dementia are making those decisions on an evidence base, so that there can be proper information and proper decisions made.

Mr McARDLE: Thank you for being here. Ms Burgess, with earlier witnesses today there has been a bit of banter about an advocate looking after the needs and care requirements of aged-care residents. Do you see your department as fulfilling a role along those lines? With all due respect, the population is ageing. We are getting grey hair and there are more of us.

Ms Burgess: I keep reminding people that we are all going to get there. We will all be old unless we die sooner.

Mr McARDLE: The question then becomes: is there a need for a public advocate? Dr Wynne, who is sitting behind you, advocated for that in a more broad sense.

Ms Burgess: I like to think that I do fulfil some of that role in aged care. Certainly I have been very active in the residential aged-care space for more than two years, specifically on this issue of restrictive practices. I appeared on that issue before your committee in your other inquiry. With the use of restrictive practices, the issue is that that is increasing as quality of care and staffing levels are decreasing. It is easier to manage people who are heavily sedated or who are tied to their chairs than it is to engage them with activities, programs and other things that help the day pass in a more pleasant way. It is hard for staff when they are understaffed. When I talk about these issues, I need to always acknowledge that I do not think people go to work in aged care to treat people badly. I think what happens is that they have to work with what they have and the number of resources around them. It is a pretty difficult job.

I do think that to a large degree we have been fulfilling that role in terms of advocating for people in aged care. I know that New South Wales has their own new commissioner. In fact, I will get to meet him next week at a national meeting of guardians and advocates. That is a very interesting and powerful role. They have a very impressive person appointed to it. I think that is a positive and we should be watching that.

Mr McARDLE: Do you see your role expanding? I am asking you as the Public Advocate: is this generating in your mind—

Ms Burgess: That is a possibility, but it completely depends on a legislative change. At the moment, my role is targeted for people with impaired decision-making capacity. In that aged-care space, I am really advocating for those people who may need someone to speak on their behalf or advocating for their rights and interests in that space and not everyone in aged care generally. However, that is open to the government to do at any time.

Mr Potts: It is a matter of resources. Obviously, as the point has been made and each of you has touched upon it, we have an ageing population. We know that the problem is going to get bigger. We know that, with all the care in the world that we have, they need a strong and well-resourced

advocate to keep the problems in the public view and to tackle the issues that this inquiry is dealing with. I suspect Ms Burgess is being somewhat coy, but resources and an expanded public advocate is, in my view, an inevitability in this state, once our parliament comes to grips with the fact that this is something that it really needs a significant look at and significant resources placed in it.

Ms Burgess: I also make the point, and this is moving into the territory of your other inquiry and we did make submissions to your committee around the complaint system and the availability of advocacy services for older people to support them to raise issues and concerns, and also for a community visitor scheme in aged care so that you have independent people coming in. The Commonwealth has a community visitors scheme, but it is sort of a friendship scheme where someone comes and says, 'Hi, how are you going?' and they have a talk. The community visitor scheme run by the Public Guardian in Queensland in disability and mental health facilities is a much more professional arrangement. People are paid to come in and they check certain things about what is happening in the institution. They also take complaints from people. We have been advocating quite strongly with the federal government to introduce that kind of program so that you have some independent people coming and going in these places who can get a sense of what is going on with the culture and the way that people are being treated.

Mr McARDLE: This is an observation only. Ms Anderson, you were talking about two regimes of reporting, and it might be a state one and a federal one. The bill also allows significant data and information to be gathered upon the state website. If the commission makes recommendations—we suspect that they will but we cannot be certain of that—my concern is that it is the public who will be confused, because two websites will be running in parallel, providing similar but different data. Say I have an elderly woman living next door to me and her children are trying to navigate their way through, I am really concerned about two things. One is the complicated nature of data on the website and the other is having two portals trying to get information that may look similar but is quite distinct in terms of the outcome for the son or daughter. You indicated that you could see two working in parallel. I have concerns about that down the track.

Mr POWER: Is this a hypothetical?

Mr McARDLE: It is a response to a comment made by Ms Anderson. I think she is qualified to make a statement.

Ms Anderson: Maybe I was confusing in what I was saying earlier. I was meaning that, when we are talking about the regulations in this bill for asking for information from facilities, we are saying that when you are scripting the regulations you look at the language used in the federal arena and see if it can be married together, so that you are not asking for the same information in two different ways; you are already providing data X to the federal government and that data X is useful for the state as well. At present, the federal government is not publishing anything. They may be collecting, but we do not know what they gather. It is about trying to marry it up.

Mr McARDLE: Would you agree to one portal?

Ms Anderson: At this stage I think this is the only portal on offer, so I would definitely propose that this is—

Mr McARDLE: I am not arguing that, but should there be the one portal?

Ms Burgess: In an ideal world, yes.

Mr POWER: Given that the federal minister has written a letter saying that he opposes the collection and publishing of this data, hypothetically would it seem likely they would turn around and do that?

Mr HUNT: Hypothetically? Isn't that what you objected to before? There is a portal, by the way. I am on it now. It is called the My Aged Care website.

CHAIR: Thank you, members.

Ms Burgess: I would make one additional point here. A significant positive of this bill is that it is requiring state operated aged-care facilities to report their own data. I think that is an incredibly positive thing. There will be problems, there will be complaints and there will be criticisms, but it is transparency. From our point of view and certainly from the consumer point of view, that is a really positive thing. It is clearly going to be at the discretion of other private facilities whether they report this data. I think it is a great thing that the state is making this commitment and I think we should be supporting and encouraging it. It is the only thing available at the moment and is a step forward, from our point of view.

CHAIR: Thank you very much. I think that summarises it nicely. I think it was Dr Wynne, who is sitting behind you and has remained here, who said earlier, and taking up the comments of Mr Potts, that it is Queensland leading the way. I thank the Queensland Law Society and the Public Advocate.

The committee adjourned at 12.55 pm.