Speech By

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HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE: REPORT, MOTION TO TAKE NOTE

Mr JANETZKI (Toowoomba South—LNP) (12.34 pm): It has been a couple of weeks since I have been on the committee myself, but I thought it was appropriate that I make a few comments because there were some alarming things that came out of this particular inquiry. As the chair has noted, this was the committee's first report as part of its monitoring and oversight responsibilities in relation to the health service complaints management system. There does appear to be serious teething problems with the Health Ombudsman's operation and their interaction with other key stakeholders in the industry. The health services complaints framework was amended significantly in 2014 with the establishment of the Health Ombudsman under the Health Ombudsman Act 2013. The amendments transferred investigation of serious professional conduct complaints about health practitioners to the ombudsman rather than AHPRA and the national boards, which deal with such matters in most other Australian jurisdictions.

While the Office of the Health Ombudsman ought to be granted more time to bed down their operation, it is time, frankly, to start cracking the whip. The office is well staffed but continually fails to meet its statutory time frames. In 2015-16 the Health Ombudsman only met its statutory time frame of seven days to reach an initial decision in 49 per cent of complaints, and the statutory time frame to complete an investigation in one year in 53 per cent of complaints. This must improve. The Health Ombudsman has acknowledged the challenges in starting the new office and took over 300 existing matters from AHPRA and HQCC. To quote the Health Ombudsman, 'These staffing and other issues had an impact over the first 12 months of operation and beyond.'

As mentioned, the Office of the Health Ombudsman is well staffed but arguably not with the right people. There were many complaints regarding the time to consider and finalise complaints, with concerns raised about a lack of reliance on clinical directions and insights. A number of stakeholders considered the clinical input into decision-making about complaints was essential, noting that it was possible for a serious complaint to be resolved, including immediate action to suspend or place conditions on a health practitioner's registration, with no clinical input whatsoever. Close examination must be undertaken to ensure that relevant clinical input is available and utilised. We need to have clinicians forming opinions on these matters and fewer case managers. We need more technical ability and fewer paper pushers moving complaints from one pile to the next. Queensland consumers deserve better and I believe that there is an argument for establishing permanent health professional councils or advisory committees within the structure of the OHO.

OHO, AHPRA and the national boards seem in many instances to be working completely independently of each other. In many cases, OHO, AHPRA and the national boards seem to prosecute the same issues relating to the same practitioner. This builds stress on practitioners, and there are a number of practitioners who have made submissions to the committee and to me privately and repeatedly. There is double handling—where complaints are assessed and on occasion investigated

by OHO and then subsequently referred to AHPRA and the national boards, where they are assessed and potentially investigated again. Stakeholders believed that greater collaboration and more direct referrals from OHO to AHPRA at the earlier stage of the complaints process would reduce duplication of work and delays. It is for this reason that I request that consideration be given to a joint consideration process which would streamline time frames for initial decisions and assessment and evaluate whether the current statutory time frames are appropriate.

What is staggering in the 21st century is the inability of the Health Ombudsman to share and slice and dice like-for-like data. They fail to share valuable information, and there is a compelling need to identify the information needs of all parties and remove barriers to the sharing of relevant information. In particular, AHPRA and the national boards raised concerns that there is no statutory obligation to share information about complaints received by the OHO that are not referred to AHPRA and the national boards. There was evidence tendered which only highlights the urgency to agree on an approach for resolving data issues that are currently preventing the production of nationally consistent data about health service complaints.

One minor example of the practical problems—which in my opinion is symptomatic of the challenging relationship between OHO, AHPRA and the national bodies—is software licensing. AHPRA operates a database to store practitioner information, but OHO staff cannot use one of the licences to access the data. It is unfathomable in the 21st century and in such an important field that there are so many shortcomings.