Health Transparency Bill 2019

Explanatory Notes

Short title

The short title of the Bill is the Health Transparency Bill 2019.

Policy objectives and the reasons for them

The Bill:

- establishes a legislative framework for collecting and publishing information about public and private hospitals and residential aged cared facilities (RACFs);
- amends 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 RACFs; and
- amends the *Health Ombudsman Act 2013* to implement recommendations of the Health, Communities, Disability Services and Domestic and Family Violence Committee's *Inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013*.

Transparent reporting framework

- ***Transparent reporting by Queensland public and private health facilities***

Evidence from both Australia and international jurisdictions indicates that health facilities with the highest quality of care have a dedicated focus on establishing and promoting a strong safety culture. Academic and research evidence suggests that transparency of data stimulates efforts to improve clinical healthcare performance that internal reporting of the same information fails to produce.

Queensland health consumers do not currently have access to comprehensive comparative outcomes information for public and private health facilities. Public reporting of health facility information is intended to provide a meaningful picture for patients, support quality improvements for health service providers and drive better outcomes at a systems level.

Public reporting of health facilities' outcome information can:

- improve healthcare outcomes and reduce unwanted variation in care due to the competitive nature of providers;
- inform system learning and improvement through better understanding of variation;
- increase accountability of providers to health consumers, governments and stakeholders;
- help foster a spirit of openness and trust with the public;
- increase health literacy of the public;
- reassure the public about the quality of care received at health facilities; and
- improve efficiency, reduce waste and drive better value care.

For public reporting to achieve these outcomes and drive quality improvement in clinical practice, the data must be timely, accurate and accessible to health consumers.

All States and Territories report on healthcare quality and patient safety, although reporting is primarily focused on public health facilities. There is also variance in the level of reporting and the approach adopted. The majority have either a legislative or administrative framework for regular reporting.

In Queensland, private and public health facilities are already required to provide a range of information to Queensland Health under the *Hospital and Health Boards Act 2011*, *Public Health Act 2005* and *Private Health Facilities Act 1999*.

- ***Reporting residential care information for Queensland residential aged care facilities***

The *Aged Care Act 1997* (Cwlth) and subordinate legislation provide the regulatory framework for federally funded aged care services within Australia. The Aged Care Act sets out the responsibilities of approved providers for aged care quality and compliance. Section 54.1 of the Aged Care Act provides that approved providers must "maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met".

Approved providers of aged care are required to publish information on the Commonwealth Government's 'MyAgedCare' website about the types of services provided at a facility, accreditation status, availability of places and information related to fees and charges. Approved providers report updates as the relevant information changes.

From 1 July 2019, all Commonwealth subsidised RACFs were required to participate in the National Aged Care Quality Indicator Program. RACFs are required to collect and report quality indicator data quarterly about pressure injuries, use of physical restraint and unplanned weight loss to the Commonwealth Department of Health. The data will be consolidated and published on the Australian Institute of Health and Welfare website, allowing aged care providers to compare their results with a national data set.

Australian jurisdictions including the Commonwealth Government do not require aged care providers to report staffing information about nursing care and personal care providing at facilities. Revelations at the current Royal Commission into Aged Care Quality and Safety have illustrated the need to ensure more transparency in Queensland RACFs.

The Queensland Government is committed to ensuring that elderly Queenslanders and their families have access to comparative information to make informed decisions when selecting a residential aged care provider. The public reporting of staffing information in public and private RACFs is expected to facilitate improved transparency about residential care and staffing in RACFs.

The reporting of staffing information in public and private RACFs may also contribute to improvements similar to those associated with the reporting of hospital outcome information. Reporting of RACFs' staffing information will improve RACFs accountability to consumers, foster a culture of transparency, and provide information to consumers to enable informed choices. This may result in changes to the practices of the private aged care sector and drive providers to respond to what consumers want.

Amendments to the *Hospital and Health Boards Act 2011* – legislating minimum standards in public residential aged care facilities

In 2016, the Hospital and Health Boards Act and *Hospital and Health Boards Regulation 2012* were amended to provide a legislative framework for mandated nurse and midwife-to-patient ratios in prescribed public-sector health service facilities.

Minimum nurse and midwife-to-patient ratios are mandated for in-scope acute adult medical and surgical wards in prescribed public hospitals. Minimum nurse and midwife-to-patient ratios are also prescribed for the acute adult mental health wards in the Princess Alexandra Hospital and the Royal Brisbane and Women's Hospital.

International research indicates that the number of nurses to the number of patients and the work environment for nurses has a clear impact on patient outcomes. A higher proportion of nurses to patients can lower patient mortality and benefit persons receiving care and treatment with improved patient safety and quality of care. In turn, this provides greater patient satisfaction and improved patient outcomes, such as reduced patient falls and reduced facility-related pressure injuries. Higher nurse-to-patient ratios can also potentially provide safer workloads for the front-line public sector nursing workforce, improving recruitment and retention and staff satisfaction, and may lead to greater workforce sustainability. The effects of legislated nurse-to-patient ratios on nursing, patient and organisational outcomes in Queensland is currently being assessed through an independent research and evaluation process led by the University of Pennsylvania in collaboration with the Queensland University of Technology.

In 2016, a joint study by the Australian Nursing and Midwifery Federation, Flinders University and the University of South Australia identified that the absence of an effective staffing methodology had resulted in decreasing staffing levels and skill mix in residential aged care services across Australia. The National Aged Care Staffing and Skills Mix Project Report 2016 recommended a minimum care requirement for residents in aged care facilities including a skill mix requirement.

Minimum nurse-to-resident ratios are not legislated for public RACFs in Queensland. Currently, staffing and average daily resident care hours in public RACFs are determined using the *Queensland Health Business Planning Framework: A tool for nursing and midwifery workload management, 5th edition* (Business Planning Framework). The Business Planning Framework is an industrially mandated tool designed to support business planning for managing nursing and midwifery resources and workload management in public sector health facilities.

During the 2017 State Election, the Queensland Government committed to introduce safe staff-to-resident ratios, including nurse-to- resident ratios, in public aged care settings and introduce public reporting on safe staff-to-resident ratios in aged care settings. Aged care ratios will set a minimum standard of care for residents in Queensland's public RACFs.

Workforce skill mix differences are dependent on the types of patients and their nursing care needs in each sector. The current minimum nurse and midwife-to-patient ratios in the Hospitals and Health Boards Act are expressed as a numerical ratio, as care in the acute adult wards outlined above is predominantly provided by a nursing workforce.

In contrast, nursing care for residents in public RACFs is provided by a skill mix of registered nurses, enrolled nurses and support workers such as personal care workers or assistants in nursing. For this reason, a minimum nurse and support worker skill mix ratio, as opposed to a minimum nurse-to-resident ratio, is appropriate for public RACFs.

Amendments to the *Health Ombudsman Act 2013*

The Health Ombudsman Act established the Office of the Health Ombudsman (OHO), which commenced full operations on 1 July 2014. The Health Practitioner Regulation National Law (National Law), which is a schedule to the *Health Practitioner Regulation National Law Act 2009*, established the Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards responsible for specific health professions. AHPRA is referred to in the Health Ombudsman Act and the National Law as the 'National Agency'.

Although OHO is the single point of entry for all health service complaints, the responsibility for dealing with health complaints in Queensland is currently shared between OHO, AHPRA and the National Boards.

Under the Health Ombudsman Act, the Health Ombudsman's functions include:

- receiving health service complaints and taking relevant action to deal with them, including referring matters to AHPRA;
- identifying and dealing with health service issues by undertaking investigations, inquiries and other relevant action; and
- identifying and reporting on systemic issues in the way health services are provided, including issues affecting the quality of health services.

On 16 December 2016, the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee of the Queensland Parliament (Committee) tabled its report titled *Inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013*.

The Committee made four initial recommendations aimed at improving the performance of the health complaints system:

- **Recommendation 1:** That the Queensland Government investigate the merits of amending the *Health Ombudsman Act 2013* to introduce a joint consideration process for health service complaints between the OHO and AHPRA and its National Boards.
- **Recommendation 2:** That the Queensland Government consider options for ensuring potentially serious professional misconduct matters are able to be dealt with as a whole, rather than being split between the OHO and AHPRA and the National Boards.
- **Recommendation 3:** That the OHO, AHPRA and the National Boards produce a joint plan which identifies the information needs of all parties and any barriers to the sharing of information, and an approach to resolving data issues that prevent nationally-consistent data about health service complaints.
- **Recommendation 4:** That the Queensland Government considers introducing legislative amendments suggested by the Health Ombudsman.

The Government response to the report accepted all four recommendations. The amendments to the Health Ombudsman Act and Queensland-specific provisions of the National Law in this Bill implement recommendations 1, 2 and 4. The Health Ombudsman and AHPRA have implemented an ongoing, collaborative approach to administrative and operational

improvements to data sharing and no legislative amendments are needed to address recommendation 3.

- ***Joint consideration of matters between OHO and AHPRA (Recommendation 1)***

The Committee's recommendation to introduce a joint consideration process was based on feedback from stakeholders that joint consideration could help to reduce duplication of work between OHO, AHPRA and the National Boards, reduce delays in dealing with complaints and contribute to more informed and consistent decision-making.

The Health Ombudsman Act gives the Health Ombudsman relatively broad discretion to consult and exchange information with AHPRA and the National Boards in the performance of the Health Ombudsman's functions. However, it does not specifically authorise a joint consideration process.

Although the Health Ombudsman may consider input from AHPRA and the National Boards, the Health Ombudsman (or their delegate) must come to an independent decision about how to proceed in each case and cannot be bound by, or give determinative weight to, the views of AHPRA or the National Boards. The Health Ombudsman Act requires the Health Ombudsman to act independently, impartially and in the public interest, and the Health Ombudsman must not be subject to direction. Therefore, OHO, AHPRA and the National Boards cannot engage in a shared decision-making process. Instead, AHPRA and the National Boards' views must be regarded as advisory and the Health Ombudsman must disregard these views if the Health Ombudsman forms a different view of the matter or how it should be resolved.

- ***Reducing the splitting of matters between OHO and AHPRA (Recommendation 2)***

Section 91 of the Health Ombudsman Act provides that the Health Ombudsman may refer a health service complaint or other matter about a registered health practitioner to AHPRA, unless the matter indicates that:

- the practitioner may have behaved in a way that constitutes professional misconduct; or
- another ground may exist for the suspension or cancellation of the practitioner's registration.

Section 91 reflects the policy intent that the Health Ombudsman should be responsible for handling the most serious complaints about health practitioners in Queensland.

Complaints about a health practitioner can involve one or more of three elements:

- conduct – such as inappropriate behaviour;
- performance – such as repeated poor surgical outcomes for a surgeon; or
- health – such as an impairment that impacts the practitioner's ability to practise.

Some matters are multifaceted and involve more than one of these elements. A matter may involve both the health practitioner's conduct and an underlying impairment that may or may not be related to the conduct. For example, a complaint may be made that a health practitioner is dishonestly obtaining prescription drugs. This is a conduct matter and depending on the level of seriousness it may be considered professional misconduct. It may also be related to an underlying health issue that could impact on the practitioner's ability to practise their profession, such as a substance abuse issue.

The Health Ombudsman is not empowered to undertake health assessments of practitioners. However, National Boards have the power to conduct health assessments under the National Law (see part 8, division 9).

The result is that serious matters that involve a health issue are generally split, with the Health Ombudsman retaining the overall matter as required by section 91 while referring the health issue to AHPRA and the National Boards as a separate matter.

In its report, the Committee noted that the splitting of matters prevents a holistic approach to reviewing and resolving complaints and introduces inefficiencies, such as the need for the complainant and the practitioner to deal with multiple regulatory bodies.

- ***Amendments recommended by the Health Ombudsman (Recommendation 4)***

The amendments outlined below were developed in conjunction with the Health Ombudsman to improve the operational, administrative and legislative processes for dealing with health service complaints, including matters about how the Queensland Civil and Administrative Tribunal (QCAT) deals with matters about health practitioners. The amendments related to QCAT were also developed in conjunction with the Department of Justice and Attorney-General.

- ***Deciding how to proceed with a complaint***

The Office of the Health Ombudsman has dealt with a significant increase in health service complaints each year since it commenced operations. Between 2014-15 and 2015-16, complaints increased by 28 per cent, with increases of 12 per cent and 19 per cent in the following years. As demands on the Health Ombudsman increase, it is necessary to consider ways in which complaints can be more effectively managed to ensure that the Health Ombudsman is operating efficiently and making the best use of its resources.

Section 35 of the Health Ombudsman Act provides two options for how the Health Ombudsman must deal with a complaint:

- accept a complaint and take relevant action, as defined in section 38; or
- take no further action in relation to the complaint.

There is no option for the Health Ombudsman to not accept a complaint in the first instance. If the Health Ombudsman decides to take no further action, the Health Ombudsman must notify the complainant of the decision within seven days. This means that, if the Health Ombudsman believes a complaint should not be accepted, the Health Ombudsman must notify the complainant, including giving reasons for their decision. This diverts resources that would be better spent dealing with other complaints.

It is considered the Health Ombudsman should have the ability to refuse to accept a complaint if the matter is more appropriately dealt with by another entity, or if the complainant has not first attempted to resolve the matter directly with the health service provider.

Under section 44 of the Health Ombudsman Act, one of the grounds for taking no further action is that the Health Ombudsman reasonably considers a complaint is being adequately dealt with by another appropriate entity. However, this provision requires the Health Ombudsman to be satisfied that the other entity is already dealing with the matter. It does not allow the Health

Ombudsman Act to take no further action or to not deal with a complaint if the matter *could be* more appropriately dealt with by another entity.

Under section 30 of the Health Ombudsman Act, the Health Ombudsman must consult and cooperate with a wide range of regulators and public entities with related functions. There are many situations where it may be more appropriate for a complaint to be dealt with by another regulator or entity. For example, some complaints may be better dealt with by the Queensland Police Service, Australian Federal Police, State Coroner, Hospital and Health Services or Medicare. Complaints involving workplace grievances may be better dealt with by the Queensland Industrial Relations Commission. Complaints that allege a breach of privacy under the *Privacy Act 1988* (Cwlth) are best dealt with by the Australian Privacy Commissioner. Complaints relating to alleged discrimination are more appropriately dealt with by the Queensland Human Rights Commission or Australian Human Rights Commission. Complaints about practitioners appointed by a court to provide a report for family law proceedings may be best dealt with in the court proceedings.

The Health Ombudsman is empowered to facilitate local resolution of a complaint between the complainant and health service provider under part 6 of the Health Ombudsman Act. The purpose of local resolution is to facilitate an agreed outcome between the complainant and health service provider as quickly as possible with minimal intervention by the Health Ombudsman. However, local resolution is a formal process that often consumes significant resources for OHO, as it may involve facilitating meetings between the parties, considering submissions and assisting the parties to reach agreement on a course of action.

Many complaints about health services result from situations involving miscommunication, misunderstanding or unintentional behaviour. In some cases, it may be appropriate for a complainant to seek to resolve the complaint directly with the health service provider in the first instance, before making a complaint to the Health Ombudsman. This will help to ensure that the Health Ombudsman's resources are being used effectively. A number of other state and territory complaint entities, including the Queensland Ombudsman, have similar powers.

- ***Practitioner monitoring***

Part 15 of the Health Ombudsman Act deals with authorised persons. Section 186 provides that the functions of an authorised person are to carry out activities for the purpose of an investigation by the Health Ombudsman under part 8 and to investigate, monitor and enforce compliance with the Health Ombudsman Act.

Some of the specific powers provided for authorised persons include entering places, searching and examining places and documents and seizing evidence. Section 228 of the Health Ombudsman Act also provides that an authorised person can require a person to provide stated information or to meet with the authorised person to answer questions or produce documents.

However, there is no specific power in the Health Ombudsman Act for monitoring compliance with conditions, prohibitions and other action that may be taken by the Health Ombudsman under part 7 of the Act. For example, authorised persons are only able to compel information or attendance from a person if they reasonably believe an offence against the Act has been committed.

It is proposed to clarify the role of authorised persons relating to practitioner monitoring. This will assist to ensure there is a clear and effective basis for monitoring activities to be undertaken by the Health Ombudsman.

- ***Final prohibition orders for unregistered practitioners***

The Health Ombudsman Act provides for interim and final prohibition orders to be made for unregistered health practitioners. Prohibition orders can impose restrictions on a person's practice or prohibit the unregistered health practitioner from providing any health service or a stated health service. Under section 113 of the Act, a final prohibition order can only be made if the practitioner poses a serious risk to persons. This can include, for example, instances of the unregistered health practitioner practising unsafely, financially exploiting a person, or engaging in an improper personal relationship with a person.

Under part 7, division 2 of the Health Ombudsman Act, the Health Ombudsman can only make interim prohibition orders, while final prohibition orders can only be made by QCAT under section 113 on referral from the Director of Proceedings.

It is proposed to enable the Health Ombudsman to make final prohibition orders for unregistered health practitioners, with QCAT becoming responsible for reviewing these decisions upon application. The Health Ombudsman will also continue to be able to make interim prohibition orders. The reform will align Queensland with other jurisdictions including Victoria, New South Wales and South Australia. In these jurisdictions the relevant health complaints bodies are empowered to issue these types of orders for unregistered practitioners, rather than the tribunal.

- ***Constitution of QCAT for certain matters***

Under the *Queensland Civil and Administrative Tribunal Act 2009*, the president of QCAT has discretion to choose how to constitute the tribunal, including whether a judicial member should be chosen to preside over a matter. However, if an Act that confers jurisdiction on QCAT provides that the tribunal is to be constituted for a particular matter in a particular way, the president must ensure the tribunal is constituted that way.

The Health Ombudsman Act and National Law confer jurisdiction on QCAT to review certain decisions. The Health Ombudsman Act requires that, for a disciplinary proceeding, QCAT must be constituted by one judicial member. A 'disciplinary proceeding' is defined in schedule 1 of the Health Ombudsman Act and includes a wide range of QCAT proceedings, including proceedings to review a decision by the Health Ombudsman to take immediate registration action or issue an interim prohibition order, and to hear matters referred to QCAT by the Director of Proceedings and by a National Board.

Constituting the tribunal with a judicial member has the potential to lead to delays given the limited number of judicial members available. Queensland is currently the only State that requires a judicial officer to hear disciplinary proceedings involving unregistered health practitioners.

It is proposed to amend the Health Ombudsman Act and the Queensland-specific provisions of the National Law to give greater discretion to the president of QCAT to decide which members should constitute QCAT for certain matters.

- ***Obtaining additional information after referral to the Director of Proceedings***

The Director of Proceedings is established by section 12 of the Health Ombudsman Act. The Director is a staff member of OHO and is responsible for taking proceedings about health practitioners to QCAT.

Section 103 of the Health Ombudsman Act provides that if a matter has been referred to the Director of Proceedings, they must either refer the matter to QCAT on behalf of the Health Ombudsman or refer it back to the Health Ombudsman. When referring a matter back to the Health Ombudsman, the Director of Proceedings may recommend that further action be taken by the Health Ombudsman, such as recommending that the matter be further investigated under part 8.

In dealing with a referral from the Health Ombudsman, the Director of Proceedings may decide that a complaint would be suitable to refer to QCAT, but that further information or evidence is required. As an independent position, the Director of Proceedings has no power to require the provision of information. In order to obtain further information, the complaint must be referred back to the Health Ombudsman under section 103 of the Health Ombudsman Act with a recommendation that the matter be further investigated to obtain additional information.

The referrals to the Health Ombudsman for further investigation often relate to technical legal issues about obtaining further evidence or information for the matter, rather than requiring the Health Ombudsman to further investigate it. It is proposed to amend the Health Ombudsman Act to clarify that, rather than referring the matter back to the Health Ombudsman for further investigation, the Director may refer a matter to the Health Ombudsman to obtain additional information.

- ***Calendar days and business days***

Schedule 1 of the *Acts Interpretation Act 1954* defines commonly used words and expressions in Queensland legislation, including 'business day', which is defined as a day that is not a weekend, public holiday, special holiday or bank holiday. The majority of references to timeframes in the Health Ombudsman Act refer to 'days', and therefore include days that fall on weekends, public and special holidays.

At particular times of the year, such as the Christmas/New Year period, Easter holidays and the public holidays of Anzac Day and May Day, a number of public holidays occur in close proximity, which impacts on the Health Ombudsman's ability to comply with the timeframes included in the Act. At these times, references to a particular number of days provides an inconsistent number of business days for which to undertake an action.

To ensure consistent timeframes, where appropriate, it is proposed that timeframes in the Health Ombudsman Act will be changed from 'days' to 'business days' for actions under the Act.

Achievement of policy objectives

Transparent reporting framework

The Bill provides an enabling legislative framework to compel public and private health facilities and RACFs to provide information, and to enable that information to be published. The intention is for the information to be published on a new interactive website.

The legislative framework will apply to public and private health facilities, including licensed private hospitals and licensed day hospitals, as well as public and private RACFs.

The chief executive will be empowered to collect and publish:

- general information about public and private health facilities and RACFs;
- quality and safety information for public and private health facilities; and
- residential care information about public and private RACFs.

General information is administrative in nature such as contact details, types of health services provided and information to assist visitors, including information about carparking, public transport and interpreter services.

Quality and safety information encompasses a broad range of clinical information and patient data, including performance against the National Safety and Quality Health Service Standards, percentage of patients treated within clinically recommended timeframes, numbers of admitted patients, information about patient outcomes and information about infection management.

Residential care information for public and private RACFs is information about the nursing care and personal care provided to residents of RACFs, including staffing provided for the care.

- ***Reporting by public and private health facilities***

The Bill will empower the chief executive to request general information and safety and quality information from public and private health facilities. The chief executive may also request quality and safety information prescribed in a regulation. This will allow future flexibility to expand reporting requirements of health facilities and enables the chief executive to request information outside of existing data collections.

The Bill will enable the chief executive to publish information provided under the Bill as well as information provided for another purpose under other legislation. This will include information such as the Queensland Perinatal Data Collection, Queensland Hospital Admitted Patient Data Collection and Queensland Elective Surgery Data Collection. The information or data published must not contain personal information about an individual. The information may be published on mechanisms other than the website.

When requesting the information prescribed in a regulation from a public or private health facility, the chief executive is required to provide a notice that specifies the reasonable period within which the information must be given, the purpose for which the information will be used and that it is an offence not to comply with the notice.

The Bill will provide for a maximum penalty of 100 penalty units if a health facility fails to provide the information or data requested under a notice without a reasonable excuse.

The Hospital and Health Boards Act and the Private Health Facilities Act contain provisions to protect the confidentiality of information acquired by individuals in performing their duties. The Private Health Facilities Act also provides that information must not be disclosed if the disclosure of information would be likely to damage the commercial activities of a facility.

While the website will not publish confidential information, the Bill provides a mechanism for information obtained under other health legislation to be used for the website. This will ensure that the relevant confidentiality provisions are not breached when information obtained under those Acts is used for publication.

- ***Reporting by public and private residential aged care facilities***

The Bill will empower the chief executive to collect and publish general information and residential care information about a State aged care facility or private RACF. The chief executive may also request information that explains and helps understand this information.

The specific type of residential care information to be provided will be prescribed by regulation. This will provide future flexibility to expand reporting requirements of public and private RACFs. Public and private RACFs will initially be requested to report quarterly on the average hours of daily care provided by nurses and support workers to each resident at a RACF. This will be referred to as 'average daily resident care hours'.

The chief executive must request the information from an approved provider by way of a notice. Approved providers of public RACFs must provide the requested residential care information.

In contrast, the Bill will provide approved providers of private RACFs with the option to opt-out of reporting this information and for this opt-out to be publicly reported. Approved providers of private RACFs will have 15 business days to respond to a notice for information. The Bill will enable approved providers of private RACFs to respond by opting to provide all or some of the requested information or none of the requested information. The Bill provides for a maximum penalty of 100 penalty units if the approved provider of a private RACF fails to respond to the notice altogether.

Amendments to the *Hospital and Health Boards Act 2011*

The Bill will amend the Hospital and Health Boards Act to create a legislative framework for aged care ratios in public RACFs. The Bill will enable a minimum nurse and support worker skill mix ratio and minimum average daily resident care hour requirement to be prescribed by regulation. This will ensure the legislative framework is consistent with the current framework for nurse-to-patient ratios.

The Bill provides a head of power to prescribe the minimum nurse and support worker skill mix ratio in terms of the minimum ratio of registered nurses, enrolled nurses and support workers that must provide residential care in a public RACF.

The amendments will not impose a sanction on a public RACF for non-compliance with the minimum nurse and support worker skill mix ratios and minimum average daily resident care hours. Instead, the Bill will enable the chief executive to publish information about compliance of public RACFs with the minimum standards.

This is similar to the current approach where prescribed public hospitals self-report their compliance with minimum nurse-to-patient ratios for in-scope surgical, medical and mental health wards quarterly. The compliance rate is currently published as a percentage on the Queensland Hospitals Performance website.

The Bill will allow the Minister to grant a temporary exemption from compliance with a State aged care facility regulation, that is a regulation made for the purposes of prescribing minimum nurse and support worker ratios or minimum average daily resident care hours for a period of not more than 3 months.

Amendments to the *Health Ombudsman Act 2013*

- ***Joint consideration of matters between OHO and AHPRA (Recommendation 1)***

The Bill amends the Health Ombudsman Act to introduce a joint consideration process between OHO and AHPRA for complaints about registered practitioners (proposed new sections 35B to 35L). The joint consideration process will commence after the Health Ombudsman accepts a complaint about a registered practitioner. The Health Ombudsman will be required to notify AHPRA of the complaint, including full details to allow AHPRA to consider the complaint. AHPRA will have five business days to provide its initial view to the Health Ombudsman about how the complaint should be dealt with, such as whether it believes the matter should be referred to AHPRA or retained by the Health Ombudsman.

If the Health Ombudsman and AHPRA agree about the action to be taken, the Health Ombudsman will take the agreed approach. If the Health Ombudsman and AHPRA do not agree after the initial five business day period, the Bill requires the two agencies to further consider the matter and attempt to reach agreement about how it should be dealt with. If they cannot reach agreement, the matter will be determined according to the following requirements:

- If the Health Ombudsman considers the matter is a serious matter (as set out in new section 91C), the Health Ombudsman must retain the matter.
- If the Health Ombudsman believes the matter should be assessed, investigated or referred to the Director of Proceedings under the Health Ombudsman Act, the Health Ombudsman must take that action.
- If neither of the above scenarios apply and either the Health Ombudsman or AHPRA believes the matter should be referred to AHPRA, the Health Ombudsman must refer the matter to AHPRA.
- Otherwise, the Health Ombudsman must deal with the matter under the Health Ombudsman Act.

Generally, if there is disagreement about how a complaint should be handled, the Health Ombudsman's approach will be preferred. However, if the Health Ombudsman proposes to take no further action in relation to a matter (for example, after the Health Ombudsman investigates the matter under part 8), AHPRA will have the ability to take on the matter if it believes further action may be required.

- ***Reducing the splitting of matters between OHO and AHPRA (Recommendation 2)***

The Bill amends the Health Ombudsman Act so that the Health Ombudsman will be required to refer matters that involve health or impairment issues about registered practitioners to AHPRA, along with any associated conduct or performance issues, unless the Health Ombudsman forms the view that the conduct or performance issues should be retained based on these factors:

- the serious nature of the alleged conduct, such as conduct involving a potential ground for suspension or cancellation of the practitioner's registration or professional misconduct; and
- the Health Ombudsman considers the matter should be dealt with by the Health Ombudsman, such as whether the practitioner's behaviour is of such a serious nature that it may only be appropriately dealt with by the Health Ombudsman or whether the matter involves a significant issue for the health and safety issue of the public (see new sections 91 to 91D).

This will preserve the Health Ombudsman's independence and primary role in protecting public health and safety, while allowing flexibility for most matters with a health or impairment component to be dealt with as a whole by AHPRA. The new provisions in the Bill are expected to significantly reduce the number of matters that will be split between OHO and AHPRA.

- ***Deciding how to proceed with a complaint***

The Bill empowers the Health Ombudsman to not accept a complaint if the complainant has not first attempted to resolve the complaint with the health service provider or if the complaint is better handled by another entity (see new section 35A). The Health Ombudsman's power is discretionary, which means the Health Ombudsman may accept complaints where direct resolution may not be appropriate, such as if the complaint involves an allegation of physical or sexual misconduct and the complainant may be uncomfortable in contacting the health service provider directly. The amendments do not authorise legitimate complaints to be refused. However, these changes will ensure that the appropriate entity is dealing with a complaint and that a complainant has first attempted a direct resolution with the practitioner or service, where possible and appropriate.

Enabling the Health Ombudsman to not accept a complaint where the complainant has not first attempted to resolve the matter with the health service provider will:

- assist in ensuring resources are allocated efficiently and directed to more complex and serious complaints;
- ensure resources are only directed to low-risk matters if attempts by the complainant to resolve the matter are unsuccessful or if it is unsuitable for the parties to resolve the matter without OHO's involvement.

OHO plans to develop resources for complainants and practitioners about making and resolving complaints under new section 35A. Additionally, guidance material for delegates within OHO will ensure that the following matters are considered when deciding whether to accept a complaint under new section 35A:

- the nature of the complaint;
- the attributes of the complainant (for example, whether the complainant is vulnerable or has an impairment); and
- any reasons given by the complainant as to why they do not feel able to progress the complaint themselves.

- ***Practitioner monitoring***

The Bill clarifies that authorised persons' powers include monitoring compliance with conditions, orders and other requirements imposed by the Health Ombudsman under part 7 of the Health Ombudsman Act (see amendments to sections 186, 203 and 228). This will enable effective monitoring to be undertaken to ensure practitioners are complying with administrative action taken by the Health Ombudsman.

- ***Final prohibition orders for unregistered practitioners***

The Bill empowers the Health Ombudsman to make final prohibition orders for unregistered health practitioners, with QCAT becoming responsible for reviewing these decisions (see new part 8A, sections 90A to 90Q and amendments to section 94). The Health Ombudsman will be

required to personally make the decision to issue a final prohibition order about an unregistered health practitioner, as the Bill includes an amendment that the Health Ombudsman may not delegate this power (see the amendments to section 285).

This reform is expected to provide several benefits. It will provide unregistered health practitioners with certainty regarding the limitations imposed on their practice or provision of health services at an earlier stage. It can take time for a matter filed in QCAT to proceed to final hearing and decision, which leaves practitioners in an uncertain position in the interim. The Health Ombudsman is expected to be able to make decisions about final prohibition orders more quickly than QCAT. The reform is also expected to reduce costs for practitioners and OHO. Unregistered health practitioners will still be able to apply to QCAT to seek a review of a decision by the Health Ombudsman to issue a final prohibition order, so QCAT will continue to have oversight of decisions about unregistered practitioners.

The reform will also align Queensland with other jurisdictions including Victoria, New South Wales and South Australia. In these jurisdictions the relevant health complaints bodies are empowered to issue these types of orders for unregistered practitioners, rather than the tribunal.

- ***Constitution of QCAT for certain matters***

The Bill amends the Health Ombudsman Act to give discretion to the president of QCAT about how QCAT should be constituted for the following matters:

- **for registered health practitioners** – when reviewing decisions covered by section 199 of the National Law (such as decisions by National Boards regarding registering a person, renewing registration, and imposing conditions on a person's registration). This will be limited to circumstances where the decision being reviewed was made under part 7 of the National Law, which deals with registration of health practitioners. Review of decisions about health, conduct and performance matters under part 8 of the National Law will continue to be required to be heard by a judicial member; and
- **for unregistered health practitioners** – when reviewing decisions by the Health Ombudsman about interim prohibition orders and final prohibition orders (see the amendments to section 97).

These changes align with the usual arrangements that the president of QCAT has the discretion to decide which members should constitute QCAT for a particular matter. The president is best placed to decide how QCAT should be constituted based on the complexity of a matter and to ensure QCAT is operating efficiently. The president may still decide to allocate a matter to a judicial member, if appropriate. These changes are expected to improve the timeliness of matters heard by QCAT.

- ***Obtaining additional information after referral to the Director of Proceedings***

The Bill empowers the Director of Proceedings to refer a matter to the Health Ombudsman to obtain additional information, rather than referring the matter for further investigation (see amendments to sections 103 and 105). This will improve OHO's efficiency in dealing with matters being referred to QCAT.

As this relates to internal processes between the Health Ombudsman and the Director of Proceedings about a matter and does not substantively affect how the matter is being dealt with, the complainant and health practitioner will not be required to be notified about these referrals.

The complainant and health practitioner will continue to be notified if the Director of Proceedings recommends further investigation and this is carried out by the Health Ombudsman.

- ***Calendar days and business days***

To ensure consistent timeframes, where appropriate, the Bill changes timeframes from 'days' to 'business days' for actions under the Health Ombudsman Act. The majority of these amendments are in schedule 1 to the Bill. These changes are not intended to provide materially shorter or longer timeframes for actions, but to ensure that timeframes are consistent and are not affected by weekends and public holidays.

Alternative ways of achieving policy objectives

There are no alternative ways of achieving the policy objectives of the Bill.

Estimated cost for government implementation

Implementation of the nurse and support worker skill mix ratios and minimum average daily resident care hours in public RACFs will require a majority of public RACFs to redistribute staff or potentially increase the number of enrolled and registered nurses. This will be managed locally by Hospital and Health Services (HHSs). These staffing impacts are expected to cost approximately $10 million annually.

The implementation of the amendments to the Health Ombudsman Act and the National Law will not incur significant costs for government and are expected to be achieved within existing budget allocations. The amendments have been developed to improve processes and create efficiencies, so are expected to contribute to improvements in performance by OHO and AHPRA.

Consistency with fundamental legislative principles

The amendments have been drafted with regard to the fundamental legislative principles (FLPs) in section 4 of the *Legislative Standards Act 1992*. However, a number of clauses in the Bill may potentially impact on particular FLPs. These are discussed below.

- ***Health Transparency and Hospital and Health Boards Act amendments***

The Bill includes new offence provisions which potentially breach the principle that legislation must have sufficient regard to individual's rights and liberties (Legislative Standards Act section 4(3)(a)).

For RACFs, clause 15 provides that a maximum penalty of 100 penalty units is applicable if a person fails to respond to a notice given by the chief executive requesting information. For public and private health facilities, clause 20 provides a maximum penalty of 100 penalty units if a person fails to respond to a notice given by the chief executive under sections 17 or 18.

Clause 21 provides that maximum penalty of 100 penalty units applies if, in relation to the administration of the Act, a person gives the chief executive information the person knows is false or misleading in a material particular.

The potential breach of FLPs by the inclusion of a penalty provision is necessary to ensure compliance with the provisions regarding the collection of information. The information provided is expected to be used by Queenslanders in making informed decisions about their health care. It is paramount that this information be provided in a timely and accurate way by health facilities and RACFs.

The quantum of the penalty is consistent with several similar sections of the Public Health Act that deal with persons providing information. For example, section 424 of the Public Health Act provides a maximum penalty of 100 penalty units for giving an authorised person a false or misleading document. Section 363 provides a maximum penalty of 100 penalty units for providing false or misleading documents to an emergency officer.

Clause 22 provides a maximum penalty of 50 penalty units if a person involved in the administration of the Act uses or discloses personal information. This is consistent with other health portfolio provisions that protect against the disclosure of personal information, such as sections 55,77, 105, 175 and 220 of the Public Health Act.

Section 4(4) of the Legislative Standards Act concerns whether legislation has sufficient regard to the institution of Parliament, including whether the legislation allows delegation of legislative power only in appropriate cases and to appropriate persons. Several provisions in the Bill may be seen to breach this principle.

Clause 9(1)(a) defines *quality and safety information* in part by reference to an external standard. Quality and safety information includes information about a facility's accreditation and performance against the National Safety and Quality Health Service Standards. These standards provide a nationally consistent statement of the level of care consumers can expect from health service organisations. They are developed by the Australian Commission on Safety and Quality in Health Care. All facilities must be accredited against these standards. The impact upon FLPs is considered minimal, as the amendments in the Bill do not impose any additional obligation in relation to compliance with the standards. Rather, the Bill requires health facilities to report on their accreditation status under the standards.

Section 4(4)(c) of the Legislative Standards Act states that whether legislation has sufficient regard to the institution of Parliament depends on whether the legislation authorises the amendment of an Act only by another Act.

Clause 24 of the Bill provides a general regulation-making power. Clause 9 allows a regulation to prescribe 'quality and safety information' that is access to care information, activity information, patient outcome information, process of care information and other information relating to the quality and safety of health services provided at a facility. The terms 'access to care information', 'activity information', 'patient outcome information' and 'process of care information' are all defined in the Bill, so any information to be prescribed by regulation must be consistent with the definition in the Bill and fall within the head of power. The types of information that may be prescribed under these provisions are technical and detailed in nature, and are subject to change over time, so are more appropriately prescribed by regulation than being included in the Bill.

It is intended that the specific indicators to be reported and published will adapt to the needs of health consumers and the capacity of health providers to collate this information over time. Prescribing all the required information prescribed in primary legislation would be impractical. Allowing the specific indicators to be prescribed by regulation means that the specific reporting requirements can be readily adjusted.

Similarly, clause 10 of the Bill defines 'residential care information' as information prescribed by regulation about the personal care or nursing care provided to residents at a facility or the staffing for the personal care and nursing care provided to residents at a facility. This definition in the Bill allows specific types of information to be prescribed by regulation, which are technical and detailed in nature and may change over time.

The intention is that the information to be reported and published will adapt to the needs of health consumers and the capacity of health providers to provide new information over time. Allowing information to be prescribed by regulation means that the reporting requirements can be adjusted to meet consumers needs and changing clinical practices.

Providing for the minimum ratios and minimum average daily residential care hours in State aged care facilities is also to be provided in regulation. This is justified as it will allow these requirements to be updated in line with changes in clinical practice.

Clause 69 (new section 138L) also enables the chief executive to make a standard about State aged care facility workload management. A standard made under this provision will not be subordinate legislation and may potentially breach the FLP that legislation must have sufficient regard to the institution of Parliament.

To address this potential breach to fundamental legislative principles, the Bill provides that the Minister must notify the making of a standard and that the Minister's notice is subordinate legislation. As the notice is subordinate legislation, it is subject to the requirements under section 49 of the *Statutory Instruments Act 1992* and must be tabled in the Legislative Assembly within 14 sitting days after it is notified as required under section 47 of the Statutory Instruments Act. Section 50 of the Statutory Instruments Act enables a notice to be disallowed once it is tabled. The relevant standard will cease to have effect if the notice is disallowed.

- ***Health Ombudsman Act and Health Practitioner Regulation National Law Act amendments***

Final prohibition orders for unregistered practitioners

New division 8A will empower the Health Ombudsman to make final prohibition orders for unregistered practitioners. A prohibition order can:

- prohibit a practitioner, either permanently or for a stated period from providing any health service or a stated health service; or
- impose stated restrictions on the provision of any health service, or a stated health service, by the practitioner.

Section 4(3)(a) of the Legislative Standards Act requires legislation to have regard to whether rights, liberties and obligations are dependent upon administrative power only if the power is sufficiently defined and subject to appropriate review. Prohibition orders can significantly limit a practitioner's scope of practice or prevent a practitioner from practising. This can significantly impact on the practitioner's ability to earn an income.

The provisions of the Bill empowering the Health Ombudsman to make final prohibition orders for unregistered practitioners are well defined and subject to appropriate review. The Health Ombudsman will only be able to issue a prohibition order in specific circumstances provided for in new section 90C. Section 90C requires an investigation to be completed under part 8 of

the Act, and the Health Ombudsman must be satisfied that the practitioner poses a serious risk to persons because of the practitioner's health, conduct or performance.

The new power is also subject to appropriate review provisions. New section 90N provides the ability for practitioners who are subject to a prohibition order to apply to QCAT for a review of the decision.

Section 4(3)(c) of the Legislative Standards Act states that whether legislation has sufficient regard to FLPs depends on whether the it allows the delegation of administrative power only in appropriate cases and to appropriate persons. The Bill amends section 285 of the Health Ombudsman Act to ensure that the Health Ombudsman is not able to delegate the decision to issue a prohibition order. The Health Ombudsman is a very senior public official holding a statutory office under the Health Ombudsman Act and he cannot delegate this decision-making power to staff members of OHO. The Health Ombudsman is personally required to make the decision to issue a final prohibition order about an unregistered health practitioner, which is considered appropriate due to the significant impacts that a prohibition order can have for a practitioner.

Section 4(3)(b) of the Legislative Standards Act states that whether legislation has sufficient regard to FLPs depends on whether it is consistent with principles of natural justice. The new provisions enabling the Health Ombudsman to make a prohibition order include several processes designed to ensure that natural justice is afforded to the practitioner. This includes:

- A show cause process in new section 90D that requires the Health Ombudsman to give notice to the practitioner stating the proposed order and requiring the Health Ombudsman to have regard to any written submissions made by the practitioner in deciding whether to issue the order. The practitioner will be given at least 20 business days to make a written submission.
- Provisions for the Health Ombudsman to vary a prohibition order, either on the Health Ombudsman's own initiative (new section 90I) or upon application by the practitioner (new section 90J), if there is a material change in relation to the matter giving rise to the issue of the order. A show cause process also applies to the variation of orders.

The Bill also amends the Health Ombudsman Act to require the Health Ombudsman to publish information about prohibition orders, including the name of the health practitioner to whom the order was issued. This requirement is equivalent to the existing requirement in section 116 of the Health Ombudsman Act, which will be repealed by the Bill. The new requirement is subject to any non-publication order made by QCAT or a court, and the health ombudsman is also required to not publish any information the health ombudsman considers it would be inappropriate to publish. For example, this may apply if the health ombudsman considers that the publication of information may identify a victim or complainant.

Practitioner monitoring

Part 15 of the Health Ombudsman Act deals with authorised persons. Section 186 provides that the functions of an authorised person are to carry out activities for the purpose of an investigation by the Health Ombudsman under part 8 and to investigate, monitor and enforce compliance with the Health Ombudsman Act.

The Bill will clarify the role of authorised persons in the Act to ensure that it provides a clear and effective basis for monitoring compliance with conditions, orders and other requirements imposed by the Health Ombudsman under part 7 of the Act. This includes requirements

imposed as part of an interim prohibition order for unregistered practitioners or immediate registration action for registered practitioners. The Bill does not expand the actions that authorised persons can take but clarifies the circumstances under which existing powers can be used.

Constitution of QCAT for certain matters

The Bill will remove the requirement that QCAT be constituted by a judicial member when reviewing certain decisions by the Health Ombudsman or a National Board. This may be considered as potentially infringing the FLP that legislation be consistent with principles of natural justice. However, these changes align with the usual arrangements that the president of QCAT has the discretion to decide which members should constitute QCAT for a particular matter. The president is best placed to decide how QCAT should be constituted based on the complexity of a matter and to ensure QCAT is operating efficiently. The president may still decide to allocate a matter to a judicial member, if appropriate.

New offences

The Bill includes new section 90P which creates an offence. However, the offence replaces an existing offence provision in the Act that will be omitted as part of removing QCAT's original jurisdiction regarding unregistered practitioners. New section 90P makes it an offence to contravene a prohibition order or a corresponding interstate order. The maximum penalty for the offence is 200 penalty units. New section 90P is identical to section 115, which is omitted by the Bill. A significant penalty is considered necessary to deter a person subject to a prohibition order or corresponding interstate order from breaching the order and continuing to practice where they may be a serious risk to persons. The penalty is considered justified because it is consistent with the penalties for similar offences under sections 78 and 115 of the Health Ombudsman Act about contravention of prohibition orders.

Consultation

Health Transparency reporting framework

External stakeholders including operators of private RACFs, private health facilities, Private Hospitals Association, Leading Aged Services Australia (Queensland), Aged and Community Services Australia, Council on the Ageing, Carers Queensland, Health Consumers Queensland, Queensland Nurses and Midwives' Union (QNMU), Australian Medical Association Queensland (AMAQ), Aged Care Quality and Safety Commission, Heart Foundation, and Primary Health Networks were consulted on the proposed reporting framework.

Transparent reporting by Queensland public and private health facilities

Many stakeholders were supportive of improving transparency of health care quality and safety through public reporting:

- A few stakeholders suggested further consultation is required on the information that will be reported on the new website while others considered that the reporting requirements may impose an additional burden on clinicians and hospitals.
- Several stakeholders noted that reporting of certain information may lead to the identification of clinicians or patients while others stated that information must be risk adjusted before it is published.

- Some private hospital stakeholders were concerned that the publication of certain information such as the number of procedures performed by a hospital is commercially sensitive and may impact on the business of facilities.
- Certain stakeholders requested clarification on the implementation of the reporting framework and how information would be reported on the website.

Information from existing data collections will be published where possible to limit any potential burden on health facilities. All information will be reported at a facility level rather than a clinician level. Appropriate measures will be implemented to ensure confidential or potentially identifying information is not published. The new website will contain contextual information to support consumer understanding of the published information.

Queensland Health will continue to work with stakeholders to refine the indicators that will be reported on the website and minimise any potential impacts of the proposed reporting framework. Queensland Health will also develop policies and guidelines to guide health facilities through the processes for reporting, verifying and publishing information.

Reporting residential care information for Queensland residential aged care facilities

While some stakeholders including Health Consumers Queensland and Queensland Nurses and Midwives Union (QNMU) were supportive of improving transparency of health care quality and safety through public reporting, RACFs and aged care stakeholders were generally not supportive of reporting residential care information:

- Stakeholders noted that aged care was a Commonwealth responsibility and the reporting requirements would impose an additional burden on RACFs.
- Other stakeholders stated that the reporting requirements would duplicate existing Commonwealth requirements or overlap with potential recommendations from the Royal Commission into Aged Care Quality and Safety.
- Some stakeholders also suggested that multiple factors including patient acuity and models of care influence the delivery of care in RACF and the reporting of 'average daily resident care hours' would not provide consumers with a clear understanding of a RACF's service delivery.
- Some stakeholders suggested that the Act should require RACFs to report more information to provide consumers a comprehensive view of residential aged care services in Queensland.

The Bill does not compel private RACFs to report information and private RACFs may opt out of reporting the requested information. The Bill also allows private RACFs to provide contextual information to explain and support consumer understanding of a RACF's 'average daily resident care hours'. Queensland Health will work with stakeholders to minimise any potential impacts of reporting residential care information under the Bill.

The Bill was assessed by the Queensland Productivity Commission, in accordance with *The Queensland Government Guide to Better Regulation*. The Queensland Productivity Commission advised that further analysis under the Queensland Government Guide to Better Regulation is not required.

Amendments to the Hospital and Health Boards Act – Aged Care Ratios

HHSs and QNMU were consulted on the amendments to the Hospital and Health Boards Act. QNMU supported the legislative framework for aged care ratios generally and provided general comments about the definitions in the legislation.

The amendments were assessed by Queensland Health in accordance with *The Queensland Government Guide to Better Regulation* as being excluded from further regulatory impact assessment. The proposed amendments relate to the internal management of public sector services and will ensure minimum standards of care for residents in public RACFs.

Amendments to the Health Ombudsman Act and Health Practitioner Regulation National Law

Broad public consultation was undertaken as part of the Parliamentary Committee's report *Inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013*. The Committee received 55 submissions from a range of individuals, peak bodies, unions and government organisations. The Committee also heard evidence from several of these entities at its public hearings.

AHPRA and OHO were consulted during the development of the reforms relating to joint consideration of matters and reducing the splitting of matters. Queensland Health worked closely with the Health Ombudsman to develop the other reforms in the Bill.

A consultation draft of the amendments was circulated to a wide range of stakeholders in June 2019. In addition to AHPRA and the Office of the Health Ombudsman, this included peak bodies representing health practitioners, indemnity insurance providers, QCAT, Health Consumers Queensland, and relevant unions.

There was general support for the proposed reforms, particularly the reforms to introduce a joint consideration process and to reduce the splitting of matters between OHO and AHPRA. Feedback from stakeholders on several reforms has been incorporated in the Bill, including on the splitting of matters and empowering the health ombudsman to make final prohibition orders.

Some stakeholders noted that the reform to empower the Health Ombudsman to not accept certain complaints will need to be supported by appropriate guidance material to ensure that, for example, complainants with a valid reason for not first attempting to resolve a complaint with the health service provider are not turned away. OHO is expected to provide guidance material for both complainants, practitioners, and delegates within OHO about how the new provisions are expected to apply.

Several stakeholders considered that notice should be provided to a practitioner under the new arrangements provided for in the Bill, including if:

- the OHO declines to accept a complaint under new section 35A; and
- the Director of Proceedings refers a matter back to the Health Ombudsman to obtain further information under amended section 103.

While it is important to ensure that practitioners are kept informed while OHO is dealing with a complaint, additional notification requirements have not been included. The intention of these reforms is to reduce the administrative burden on OHO. If the OHO was required to provide

notice to each practitioner of complaints not accepted or referrals back to the Health Ombudsman for the purpose of obtaining further information, this would undermine the effectiveness of the reforms.

The Bill allows the OHO to provide notice of the decision not to accept a complaint at the time the complaint is made, if the complaint is made over the telephone. To then provide notice to a practitioner of the OHO's decision not to accept a complaint would represent a significant administrative burden that is not consistent with the reform.

A referral from the Director of Proceedings back to the Health Ombudsman for further information is an internal process within the Health Ombudsman's office and not an operative decision. It is not considered that notice to the practitioner should be provided. The process does not preclude informal communication between the Director of Proceedings' office and the practitioner or their legal representative about the progress of the practitioner's matter. This is typically what occurs in practice.

QNMU did not support the amendments that empower the Health Ombudsman to make prohibition orders for unregistered practitioners. QNMU considered that given prohibition orders can be very broad in scope and can have significant impacts for a practitioner, they should only be made by an independent body such as QCAT.

There are several safeguards in the legislation to ensure that this power is exercised appropriately. For example,

- the Health Ombudsman cannot delegate the decision to make a prohibition order;
- there are only specific circumstances and grounds upon which a prohibition order can be made;
- practitioners are able to apply to QCAT for a review of the decision;
- several steps in the process for making a prohibition order are intended to ensure natural justice is afforded to the practitioner.

These safeguards are further discussed in the context of consistency with fundamental legislative principles above.

QNMU also did not support the reform to remove the requirement that QCAT be constituted by a judicial member for certain matters.

Consistency with legislation of other jurisdictions

Generally, the amendments are specific to the State of Queensland.

- ***Health Transparency***

All States and Territories report on healthcare quality and patient safety, although reporting is primarily focused on public health facilities. There is also variance in the level of reporting and the approach adopted. The majority have either a legislative or administrative framework for regular reporting.

In October 2017, the Victorian Government passed the *Health Legislation Amendment (Quality and Safety) Act 2017*. The Victorian Act contains a range of new reporting requirements to address risks to patient safety and extends reporting requirements to private health facilities. In January 2019, Victoria was the first State to release perinatal service performance indicators information for all public and private health facilities.

- ***Amendments to the Hospital and Health Boards Act 2011***

The Australian Government is the primary funder and regulator of the aged care system in Australia. The *Aged Care Act 1997* (Cwlth) sets out the responsibilities of approved providers in relation to aged care quality and compliance. The Australian Government's legislative framework does not incorporate nurse-to-resident ratios for aged care.

Victoria is currently the only jurisdiction in Australia that has legislated nurse-to-resident ratios in state-run RACFs. The *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* (Vic) provides for a numeric ratio allocation of nurses to patients, but only in residential high care places in residential aged care wards operated by the Victorian Government. The ratios do not apply to places not classified as high care or to aged care services operated by private or not-for-profit organisations.

- ***Amendments to the Health Ombudsman Act 2013 and the Health Practitioner Regulation National Law Act 2009***

Queensland and New South Wales are the only jurisdictions to have implemented 'co-regulatory arrangements' for registered health practitioners. In all other jurisdictions, registered health practitioners' health, conduct and performance issues are dealt with exclusively by the relevant National Board, supported by AHPRA.

Several of the proposed reforms, including empowering the Health Ombudsman to issue final prohibition orders for unregistered health practitioners and enabling the Health Ombudsman to not accept certain complaints will align Queensland's legislation more closely with other jurisdictions.

Notes on provisions

Part 1 Preliminary

Short Title

Clause 1 provides that, when enacted, the short title of the Act will be the *Health Transparency Act 2019*.

Commencement

Clause 2 provides for the commencement of the Act.

Purposes of Act

Clause 3 provides that the purposes of this Act are to improve the transparency of the quality and safety of health services provided in Queensland and to help people make better-informed decisions about their health care.

How purposes are achieved

Clause 4 provides that the purposes of this Act are achieved by enabling the publication and collection of particular types of information about public sector health service facilities, private health facilities, State aged care facilities and private residential aged care facilities.

Act binds all persons

Clause 5 provides that this Act binds all persons, including the State. However, the State can not be prosecuted for an offence against this Act.

Definitions

Clause 6 provides that the dictionary in schedule 1 defines particular words used in this Act.

Part 2 Information to which Act applies

Information to which Act applies

Clause 7 provides that this Act applies to:

- general information about public sector health service facilities, private health facilities, State aged care facilities and private residential aged care facilities;
- quality and safety information about public sector health service facilities and private health facilities; and
- residential care information about State aged care facilities and private residential aged care facilities.

This Act applies to information mentioned in subsection (1) that is publicly available or given to the chief executive under or in relation to the administration of this Act. The Act also applies to information mentioned in subsection (1) that is held by the chief executive as a result of

obtaining or having access to the information, or information from which the information was derived:

- under a service agreement entered under section 35 of the *Hospital and Health Boards Act 2011*;
- under sections 138F or 138M of the Hospital and Health Boards Act that collect compliance information of prescribed public hospitals with legislated nurse-to-patient ratios and of State aged care facilities with aged care ratios;
- because of a report given under section 144 of the *Private Health Facilities Act 1999*; and
- under sections 217 and 218 of the *Public Health Act 2005* that collect information about perinatal data in Queensland.

Subsection (2)(c) applies to information held by the chief executive on or after the commencement. This allows historical data obtained under the data collections outlined above to be published to report data trends over time.

What is *general information*

Clause 8 defines *general information*, about a public sector health service facility, private health facility, State aged care facility or private residential aged care facility to be:

- information that identifies the facility including, for example, the name, address, phone number and website of the facility and the type of facility; and
- details of the health services provided at or by the facility including, for example, the types of clinical specialities or maternity models of care a facility provides; and
- information about other services available at or near the facility that may help people who are admitted at the facility, attending an appointment at the facility or visiting the facility including, for example, carparking and public transport information or the availability of interpreter services at the facility.

What is *quality and safety information*

Clause 9 defines *quality and safety information*, about a public sector health service facility or private health facility, as information about the facility's accreditation and performance against the National Safety and Quality Health Service Standards. *Quality and safety information* can also be any of the following information prescribed by regulation:

- access to care information;
- activity information;
- patient outcome information;
- process of care information; and
- other information relating to the quality and safety of health services provided at the facility.

Clause 9 also provides definitions for *access to care information*, *activity information, patient outcome information* and *process of care information.*

What is *residential care information*

Clause 10 defines *residential care information*, about a State aged care facility or private residential aged care facility as information about the personal care or nursing care provided to residents at the facility or the staffing for the personal care and nursing care provided to residents at the facility as prescribed by regulation. *Residential care information* also includes information that explains and helps consumers understand the information mentioned in subsection (1)(a).

Resident is defined as a person who is provided residential care at a State aged care facility or private residential aged care facility. A *State aged care facility* is defined in schedule 1 to mean a residential aged care facility at which the State provides residential care. A *private residential aged care facility* is defined in schedule 1 to be a residential aged care facility other than a State aged care facility and only includes private aged care facilities that are approved to provide residential care under the *Aged Care Act 1997* (Cwlth). Aged care facilities that are not approved under the Aged Care Act, for example, fully privately funded facilities or retirement villages are not captured within the scope of the definition. However, if a facility provides both residential care and retirement village services, only the residential care function of the facility will be captured.

Part 3 Publishing information

Chief executive may publish information

Clause 11 provides that the chief executive may publish information to which this Act applies. The chief executive may not publish personal information under this part.

However, the chief executive may publish personal information about an individual who takes part in the management of a public sector health service facility, private health facility, State aged care facility or private residential aged care facility. This information must also be made publicly available by the facility. This will allow a list of board members or chief executives of a facility to be published.

How information may be published

Clause 12 states that the chief executive may publish information under this part in any way that allows the information to be publicly accessed. For example, information may be published on a website or in a report.

Part 4 Collecting information

Division 1 Private residential aged care facilities

Chief executive may request information from approved provider

Clause 13 states that the chief executive may ask the approved provider of a private residential aged care facility to provide general information and residential care information about the facility. The chief executive may only request information from a provider who is approved to provide residential care under the Aged Care Act.

Form of notice

Clause 14 provides that a notice given under clause 13 must state the purpose for which any information provided will be used. The notice must also state that it is an offence for the person who is given the notice to fail to respond to the notice as outlined in clause 15.

Failure to respond to notice

Clause 15 states that a person who is given a notice under clause 13 must respond to the notice by providing:

- all the information requested; or
- some of the information requested and a notice informing the chief executive that the remaining information will not be given; or
- a notice informing the chief executive that no information will be given.

A person will have 15 business days to response to a notice given by the chief executive and must provide a response as outlined above unless the person has a reasonable excuse. A maximum penalty of 100 penalty units applies for the contravention of this provision.

Essentially, private residential aged care facilities may opt whether to provide the general information or residential care information requested by notice. While a private residential aged care facility may opt not to provide the requested information, it must give notice of this in writing otherwise the offence will apply.

Chief executive may publish information about response to notice

Clause 16 applies if an approved provider informs the chief executive under clause 15(b) or (c), that information requested in a notice about a private residential aged care facility under clause 13 will not be given. The chief executive may publish the name of the private residential aged care facility and the fact that the requested information was not given.

Clauses 11(2) and 12 apply to the publication of the information.

Division 2 Other facilities

Chief executive may require information about public sector health service facilities and State aged care facilities

Clause 17 provides that the chief executive may, by notice, require the health service chief executive of a Hospital and Health Service to give any of the following information:

- general information about a public sector health service facility or State aged care facility that is, or is part of, the Service's health service area;
- quality and safety information about a public sector health service facility that is, or is part of, the Service's health service area;
- residential care information about a State aged care facility that is, or is part of, the Service's health service area.

In this section, *health service area* of a Hospital and Health Service means a health service area declared for the Service under section 17 of the Hospital and Health Boards Act.

Health service chief executive, of a Hospital and Health Service, means the health service chief executive appointed for the Service under section 33 of the Hospital and Health Boards Act.

Chief executive may require information about private health facilities

Clause 18 states that the chief executive may require the licensee of a private health facility to provide general information and quality and safety information about the private health facility by notice.

In this section, *licensee*, of a private health facility, means the holder of the licence for the facility, under part 6 of the Private Health Facilities Act.

Form of notice

Clause 19 provides that a notice given under clause 17 or 18 must state:

- the reasonable period within which the information must be given;
- the purpose for which the information provided will be used; and
- that it is an offence to fail to comply with the notice.

Failure to provide information

Clause 20 provides that a person who is given a notice by the chief executive under clause 17 or 18 must comply with the notice unless the person has reasonable excuse. A maximum penalty of 100 penalty units applies for the contravention of this provision.

Part 5 Other provisions

False or misleading information

Clause 21 states that it is an offence for a person, in relation to the administration of this Act, to give the chief executive information the person knows is false or misleading in a material particular. A maximum penalty of 100 penalty units applies for the contravention of this provision.

Subsection 1 does not apply to a person if the person, when giving information in a document, tells the chief executive, to the best of the person's ability, how the information is false or misleading and gives the correct information, if the person has, or can reasonably obtain it.

Confidentiality

Clause 22 applies to a person who is, or has been, the chief executive, an employee of the department or a contractor of the department and has obtained or has access to, or custody of, personal information in administering, or performing a function, under the Act. The person must not use or disclose the personal information unless the disclosure is:

- to the extent necessary to administer, or perform functions or exercise powers under, this Act;
- to, or with the consent of, the individual to whom the information relates;
- in compliance with lawful process requiring production of documents or giving of evidence before a court or tribunal; or

- as otherwise required or permitted under another law.

A maximum penalty of 100 penalty units applies for the contravention of this provision.

Delegation

Clause 23 provides that the chief executive may delegate their functions or powers under this Act to an appropriately qualified employee of the department.

Regulation making power

Clause 24 provides that the Governor in Council may make regulations under this Act.

Part 6 Amendment of Acts

Division 1 – Amendment of this Act

Act amended

Clause 25 provides that division 1 amends the *Health Transparency Act 2019*.

Amendment of long title

Clause 26 amends the long title of the Act to remove references to the other Acts that it amends. This is a technical amendment to ensure that if the Act is passed, the amendments of other Acts will be removed from the Health Transparency Act, which will be a new standalone Act.

Division 2 – Amendment of Health Ombudsman Act 2013

Act amended

Clause 27 provides that division 2 and schedule 2 amend the *Health Ombudsman Act 2013.*

Amendment of s 14 (Dealing with health service complaints and other matters)

Clause 28 amends section 14 to reflect the amendments in the Bill to give the Health Ombudsman the ability to issue prohibition orders to unregistered health practitioners and to reduce the splitting of matters between OHO and AHPRA.

Subclause (1) inserts a new subsection (4A) that provides the health ombudsman may make an order prohibiting an unregistered health practitioner from practising, or imposing restrictions on the practitioner's practice. Subclause (2) replaces the existing section 14(5) to provide that only matters about registered health practitioners can be referred to the Director of Proceedings for decision about whether proceedings should be taken against the practitioner before QCAT.

Subclause (3) amends section 14(6) to reflect the changes in new part 9, division 1 that will allow the Health Ombudsman to refer certain professional misconduct matters to AHPRA. Section 14(6) currently provides that the Health Ombudsman may refer a complaint to AHPRA except for professional misconduct and certain other serious matters. Subclause (3) removes the reference to professional misconduct from section 14(6).

Amendment of s 16 (Disciplinary orders)

Clause 29 amends the heading of section 16 to read "Disciplinary orders of QCAT and other jurisdictions". Clause 29 also replaces subsection (2) so that it only deals with orders of other jurisdictions about unregistered practitioners. These changes are required because the Bill will remove QCAT's ability to make prohibition orders for unregistered practitioners in the first instance.

Amendment of s 33 (How to make a complaint)

Clause 30 amends section 33 to reflect new section 35A which gives the Health Ombudsman the ability to not accept a complaint. It replaces subsection 33(2), which currently provides that the Health Ombudsman must make a record of the complaint if the complaint is made orally. The new subsection provides that in addition to making a record of the complaint, if the Health Ombudsman decides to not accept the complaint, this decision must also be recorded.

Amendment of s 35 (Deciding how to proceed)

Clause 31 makes several amendments to section 35. Subclause (1) amends the heading of section 35. Subclause (2) amends the statutory timeframe for the Health Ombudsman to make a decision under section 35 to 7 business days, instead of 7 days. Subclause (3) provides the Health Ombudsman with the ability to not accept a complaint. Subclause (4) amends section 35 to ensure that consideration of a matter under the joint consideration process in division 2A does not count toward the 7 business day timeframe in subsection (1). The joint consideration process in division 2A includes its own timeframes.

Insertion of new s 35A and pt 3, divs 2A and 2B

Clause 32 inserts a new section 35A and new divisions 2A and 2B into the Health Ombudsman Act.

New section 35A sets out the circumstances under which the Health Ombudsman may decide not to accept a complaint, which are:

- the Health Ombudsman must be satisfied that the complaint would be more appropriately dealt with by an entity other than the Health Ombudsman or an entity to whom the Health Ombudsman may refer the complaint; or
- the complainant has not sought a resolution of the complaint with the relevant health service provider and it is reasonable in the circumstances for the complainant to first seek to resolve the complaint directly.

New part 3, division 2A provides for the initial joint consideration of matters with the Australian Health Practitioner Regulation Agency (AHPRA), which is referred to as the 'National Agency' in the Health Ombudsman Act.

New section 35B provides that new division 2A applies if the Health Ombudsman accepts a complaint about the health, conduct or performance of a registered health practitioner. It also clarifies that the division does not restrict the Health Ombudsman from taking immediate action under part 7 for the complaint.

New section 35C requires the Health Ombudsman to inform AHPRA of a complaint as soon as practicable after it is accepted. The Health Ombudsman must provide AHPRA with a copy of the complaint (or if the complaint is not in writing, the Health Ombudsman's record of the

complaint) and any other relevant information. Subsection (2) provides that AHPRA may give its preliminary view on how the complaint should be dealt with within 5 business days of receiving notification from the Health Ombudsman.

New section 35D provides how the Health Ombudsman may deal with a complaint if AHPRA does not provide its preliminary view as provided for in new section 35C. In this case, the Health Ombudsman may deal with the complaint under the Health Ombudsman Act without further consulting AHPRA, other than to the extent required under division 2B.

New section 35E provides that if AHPRA provides a preliminary view within the 5 business day period stated in section 35C(2), and the Health Ombudsman agrees with that view, then the Health Ombudsman must ensure the complaint is dealt with under the Health Ombudsman Act in accordance with the agreed view.

New section 35F provides how a complaint is dealt with if the Health Ombudsman does not agree with the preliminary view given by AHPRA within the 5 business days. In this case, the Health Ombudsman and AHPRA have a further 15 business days to attempt to reach agreement about how the complaint should be dealt with.

New section 35G provides how a complaint is dealt with if the Health Ombudsman and AHPRA cannot agree during the further 15 business days provided for in section 35F. Section 35G provides a decision-making hierarchy of actions that must be taken in relation to the complaint, depending on the view the Health Ombudsman and AHPRA each have about how the complaint should be handled. It provides that the Health Ombudsman must deal with the complaint as follows:

(a) if the Health Ombudsman believes the complaint indicates a serious matter within the meaning of section 91C, the Health Ombudsman must retain the serious matter and deal with it under the Health Ombudsman Act, and must deal with any other aspect of the complaint as if the matter were the subject of a separate complaint;

(b) if the Health Ombudsman believes the complaint should be the subject of assessment under part 5, investigation under part 8 or a referral to the Director of Proceedings under part 10, division 2, the Health Ombudsman must retain the matter;

(c) if neither (a) nor (b) apply and the Health Ombudsman or AHPRA believe the complaint should be referred to AHPRA, the Health Ombudsman must refer the complaint to AHPRA;

(d) otherwise, the Health Ombudsman must deal with the complaint under the Health Ombudsman Act, whether or not in further consultation with AHPRA.

New section 35H provides that if the Health Ombudsman and AHPRA reach agreement about how a complaint is to be dealt with under new section 35F, the Health Ombudsman must deal with the complaint under the Health Ombudsman Act consistent with that agreement.

New division 2B contains provisions that deal with situations where the Health Ombudsman has retained a matter regarding a registered health practitioner and proposes to take no further action.

New section 35I provides for when division 2B applies. It will apply if the Health Ombudsman has accepted a complaint about a registered health practitioner and proposes to take no further action, and the complaint has not been referred to AHPRA. The division does not apply if the

proposal to take no further action is consistent with the preliminary view provided by AHPRA under division 2A.

New section 35J requires the Health Ombudsman to notify AHPRA as soon as practicable after forming a proposal to take no further action in relation to a complaint to which division 2B applies. The Health Ombudsman must also give AHPRA a copy of the complaint or record of the complaint if it was not in writing and any other relevant information the Health Ombudsman has.

New section 35K provides that, within seven business days of receiving a notification under section 35J, AHPRA may request the Health Ombudsman refer the complaint to AHPRA to be dealt with under the National Law. If AHPRA makes such a request, the Health Ombudsman must refer the matter and notify the complainant and the practitioner of the referral. Section 278 of the Health Ombudsman Act, as amended by schedule 1, requires this notice to be given within five business days.

New section 35L provides that if AHPRA does not make a request under new section 35K, the Health Ombudsman may deal with the complaint under the Health Ombudsman Act without further consulting AHPRA.

Amendment of s 38 (Meaning of *relevant action*)

Clause 33 amends section 38 to account for the changes in new part 8A that will empower the Health Ombudsman to make prohibition orders for unregistered practitioners. Subclause (1) inserts new subparagraph in section 38(1) that will include issuing a prohibition order under part 8A as a relevant action for dealing with a health service complaint. Subclause (2) limits the referral of complaints to the Director of Proceedings in section 38(1)(f) to matters concerning registered health practitioners. Subclause (4) inserts a new subparagraph in section 38(3) that will include issuing a prohibition order under part 8A as a relevant action for dealing with a matter relating to a health service other than as part of a health service complaint. Subclause (5) amends section 38(3)(d) to limit it to matters relating to registered health practitioners. Subclauses (3) and (6) renumber the subparagraphs in section 38 to account for the new provisions.

Amendment of s 49 (Period for completing assessment)

Clause 34 amends the 30-day period for completing an assessment to instead refer to 22 business days. It also provides that any days on which the Health Ombudsman is awaiting the outcome of a notification given under section 35J in relation to the complaint are not counted. This ensures that any time AHPRA is considering whether to request referral of a matter is not counted toward the period for completing an assessment, as these timeframes are not within the Health Ombudsman's control.

Amendment of s 55 (Period for attempting resolution)

Clause 35 amends the 30-day period for the Health Ombudsman to resolve a complaint under the local resolution provisions to instead refer to 22 business days. Clause 35 also provides that any days on which the Health Ombudsman is awaiting the outcome of a notification given under section 35J in relation to the complaint are not counted. This ensures that any time that AHPRA is considering whether to request referral of a matter is not counted toward the period for attempting local resolution, as these timeframes are not within the Health Ombudsman's control.

Amendment of s 58B (Varying immediate registration action on application by registered health practitioner)

Clause 36 makes minor amendments to clarify section 58B, which sets out the process for varying immediate registration action on application by a registered health practitioner. It amends sections 58B(5)(a) and (7) to omit the word 'written' because 'notice' is defined in the schedule to the Health Ombudsman Act as meaning 'written notice'. Clause 36 also clarifies that the Health Ombudsman is required to notify the complainant if the Health Ombudsman decides to vary an immediate registration action in the way requested in a practitioner's application. The clause also amends section 58B(7)(b) to refer to 5 business days instead of 7 days.

Replacement of s 64 (Health ombudsman must immediately take further relevant action)

Clause 37 replaces the existing section 64 with a provision that accounts for the joint consideration of matters provided in new divisions 2A and 2B. Subsection 64(1) provides for the actions the Health Ombudsman can take after taking immediate registration action in relation to a registered health practitioner. The Health Ombudsman may investigate the matter under part 8, refer the matter to AHPRA or another entity of the State, another State or the Commonwealth under part 9 or refer the matter to the Director of Proceedings under part 10, division 2.

The new subsection 64(2) ensures that the Health Ombudsman must take this relevant action after the joint consideration process in part 3, division 2A is completed if it is a matter to which that division applies, or otherwise immediately after the immediate registration action is taken.

Amendment of s 73 (Period of interim prohibition order)

Clause 38 replaces subsection 73(2) to account for the Health Ombudsman's ability to issue prohibition orders under new part 8A. The new section removes references to QCAT setting aside a decision to issue an interim prohibition order on referral by the director of proceedings, as QCAT will no longer have this jurisdiction. The new section also provides that an interim prohibition order continues to have effect until it ends under section 90H. New section 90H provides that if the Health Ombudsman issues a prohibition order, any interim prohibition order in relation to the complaint or matter ends when the prohibition order takes effect.

Amendment of s 90 (Notice of decision after investigating matter)

Clause 39 is a minor amendment to improve the clarity and drafting of the provision.

Insertion of new pt 8A

Clause 40 inserts a new part 8A into the Health Ombudsman Act, dealing with prohibition orders issued by the Health Ombudsman for unregistered health practitioners. To the extent practicable, these provisions are consistent with the existing provisions that empower QCAT to make prohibition orders under part 10, division 4 and the provisions that empower the Health Ombudsman to make interim prohibition orders under part 7, division 2.

New section 90A provides that part 8A does not apply to persons in their capacity as registered health practitioners.

New section 90B defines a *prohibition order*. This definition is consistent with the definition in section 113 which empowers QCAT to issue prohibition orders. Section 113 is repealed by the Bill.

New section 90C empowers the Health Ombudsman to issue a prohibition order to an unregistered health practitioner in certain circumstances. The Health Ombudsman can only issue an order if the matter has been investigated under part 8 of the Health Ombudsman Act, and the Health Ombudsman is satisfied that because of the practitioner's health, conduct or performance the practitioner poses a serious risk to persons.

Subsection (2) provides a non-exhaustive list of what may constitute a serious risk posed by a practitioner, including:

- practising unsafely, incompetently or while intoxicated by alcohol or drugs;
- financially exploiting a person;
- engaging in a sexual or improper personal relationship with a person;
- discouraging a person from seeking clinically accepted care or treatment;
- making false or misleading claims about the health benefits of a particular health service; or
- making false or misleading claims about the practitioner's qualifications, training, competence or professional affiliations.

Subsection (3) provides that the Health Ombudsman may have regard to a prescribed conduct document under section 288 in making a decision under section 90C(1)(b).

New section 90D(1) provides for a show cause process if the Health Ombudsman proposes to issue a prohibition order to an unregistered health practitioner. The Health Ombudsman is required to give the practitioner a notice stating the proposed order and inviting the practitioner to make a written submission about the proposed order. The practitioner will have a minimum of 20 business days to respond. Subsection (2) provides that the Health Ombudsman must have regard to any written submissions made by the practitioner in deciding whether to issue the prohibition order.

New section 90E sets out the requirements for the content of a prohibition order. A prohibition order must state the details of the order that apply to the health practitioner. It must also state, or be accompanied by, a notice that states the reasons for the decision to issue the order, the practitioner's ability to apply to QCAT for review of the decision and how, and the period in which, the practitioner may apply for the review.

New section 90F requires the Health Ombudsman to give notice to the complainant of the details of the prohibition order, if the order was issued in response to a complaint.

New section 90G provides that a prohibition order takes effect on the day it is given to the health practitioner, or a later day if it is specified in the order.

New section 90H provides that a prohibition order ends any interim prohibition order that has been issued to the practitioner in relation to the complaint or matter, when the prohibition order takes effect.

New division 3 sets out processes for the variation or revocation of a prohibition order.

New section 90I empowers the Health Ombudsman to vary a prohibition order on their own initiative and provides the circumstances under which this may occur. For a variation, there must be a material change in the matter giving rise to the order, the Health Ombudsman reasonably believes the change justifies varying the order and the variation is on the grounds mentioned in section 90C.

New section 90J empowers the Health Ombudsman to vary a prohibition order on application from the practitioner who is subject to the order. Subsections (2) and (3) provide the process by which this can occur. The practitioner must apply to the Health Ombudsman in the approved form and provide any information reasonably required by the Health Ombudsman. On receiving an application, the Health Ombudsman must consider it and decide either to vary the prohibition order, whether or not in the way requested by the practitioner, or to not vary the order. Subsection (4) provides the grounds on which the Health Ombudsman may vary a prohibition order on a practitioner's request. This is the same criteria as varying an order on the Health Ombudsman's own initiative under new section 90I.

New section 90K provides that the show cause process in new section 90D applies to decisions to vary a prohibition order under new sections 90I or 90J, as well as a decision not to vary a prohibition order under new section 90J. These are defined as *show cause decisions*.

New section 90L provides for the effect of a decision to vary an order and the notice requirements associated with a decision to vary or not vary an order. Subsection (1) provides that if the Health Ombudsman varies a prohibition order, the Health Ombudsman must give the practitioner a replacement prohibition order that reflects the variation. If a prohibition order is issued in response to a complaint, the Health Ombudsman must also provide details to the complainant. The variation takes effect when the replacement order is given to the practitioner, or on another date stated in the order. Subsection (1)(c) provides that the existing prohibition order ends when the variation takes effect.

Subsection (2) requires the Health Ombudsman to give the health practitioner a notice about any decision to vary an order under new section 90I, vary an order under new section 90J in a way different to that requested, or not to vary a prohibition order under new section 90J. The notice must contain the decision, reasons for the decision, and details of the practitioner's ability to apply to QCAT for a review of the decision.

New section 90M requires the Health Ombudsman to revoke a prohibition order if the Health Ombudsman is satisfied the order is no longer necessary on the grounds mentioned in section 90C. If the Health Ombudsman revokes an order they must also give notice to the practitioner and, if the order was issued in response to a complaint, the complainant.

New division 4 provides for several other matters relating to prohibition orders, including the right to have a decision reviewed at QCAT, offence provisions and publication of orders.

New section 90N enables unregistered health practitioners who are subject to certain orders the ability to apply to QCAT for a review of the decision. This applies to the Health Ombudsman's decision to:

- issue a prohibition order;
- vary a prohibition order under section 90I;
- vary a prohibition order in a way different to that requested by a health practitioner under section 90J; and

- not to vary a prohibition order under section 90J in response to an application under that section.

New section 90O provides that a regulation may prescribe an order to be a corresponding interstate order, if the order is issued under a law of another State and corresponds, or substantially corresponds, to a prohibition order under part 8A.

New section 90P provides that it is an offence to contravene a prohibition order or a corresponding interstate order. It includes a maximum penalty of 200 penalty units. This is consistent with section 115 of the Health Ombudsman Act, which provides an offence for contravening a prohibition order made by QCAT. Section 115 is repealed by the Bill.

New section 90Q requires the Health Ombudsman to publish information about each current prohibition order on a publicly accessible website of the Health Ombudsman. Subsection (1) requires the following information to be published:

- the name of the health practitioner to whom the order was issued;
- the day the order took effect;
- the details of the order mentioned in section 90B(a) or (b) that apply to the practitioner; and
- the details of any variation of the order under division 3.

Subsection (2) requires the Health Ombudsman to publish information about corresponding interstate orders in a similar manner to subsection (1).

Subsection (3) empowers the Health Ombudsman to publish the information, in addition to publication on a website, in another way the Health Ombudsman considers appropriate.

Subsections (4) and (5) limit the requirements in subsections (1) and (2) for the Health Ombudsman to publish information. Subsection (4) provides that the section applies subject to any non-publication order under the *Queensland Civil and Administrative Tribunal Act 2009* or court order about publication of information.

Subsection (5) requires the Health Ombudsman to not publish information that the Health Ombudsman considers it would be inappropriate to publish. This provision may apply, for example, if publication would identify another party inappropriately (for example, a victim in a related criminal proceeding).

Replacement of s 91 (Referral to National Agency)

Clause 41 replaces section 91 of the Health Ombudsman Act with new part 9, division 1 to provide for the matters concerning registered health practitioners that can be referred to AHPRA.

New section 91 provides that the division applies to a health service complaint or other matter about a registered health practitioner.

New section 91A provides a general power for the Health Ombudsman to refer a health service complaint or other matter to AHPRA.

New section 91B compels the Health Ombudsman to refer matters that indicate the practitioner has or may have an impairment to AHPRA.

New section 91C provides an exception to the referral requirement for serious matters. Subsection (1) provides that the Health Ombudsman must not refer a health service complaint or other matter to AHPRA if it indicates that the registered health practitioner may have behaved in a way that constitutes professional misconduct, and/or that another ground may exist for the suspension or cancellation of the registered health practitioner's registration. In addition, the Health Ombudsman must be satisfied the matter should be dealt with by the Health Ombudsman.

Subsection 91C(2) provides the factors that the Health Ombudsman must consider in deciding under subsection (1)(b) whether to be satisfied that the matter should be dealt with by the Health Ombudsman. These are whether the registered health practitioner's behaviour is of such a serious nature that it may only be appropriately dealt with by the Health Ombudsman, and whether the matter involves a significant issue for the health and safety of the public.

New section 91D provides the course of action that must be taken where a complaint indicates both an impairment matter under section 91B and a serious matter under section 91C. In this case, the Health Ombudsman must deal separately with the impairment matter and serious matter. The Health Ombudsman must refer the impairment matter to AHPRA and must retain the serious matter.

New section 91E prescribes the form that a referral to AHPRA must take. The referral must include all relevant information the Health Ombudsman has about the complaint or other matter, including (for a health service complaint) details of the complaint, the complainant and the health service provider and notice of the Health Ombudsman's intention to start or continue conciliating the complaint while AHPRA or a National Board deals with it.

Amendment of s 94 (QCAT's jurisdiction)

Clause 42 amends QCAT's jurisdiction under the Health Ombudsman Act to account for the Health Ombudsman's new power to issue prohibition orders. Section 94(1)(a) is amended to include the ability for QCAT to review a decision by the Health Ombudsman to:

- issue a prohibition order to a health practitioner;
- vary a prohibition order issued to a health practitioner on the Health Ombudsman's own initiative;
- vary a prohibition order issued to a health practitioner in a way different to the way requested in an application by the practitioner; or
- not to vary a prohibition order issued to a health practitioner in response to an application by the practitioner.

QCAT's jurisdiction to hear a matter referred to QCAT by the Director of Proceedings on the Health Ombudsman's behalf under section 103 is limited by subclause 42(3) to matters concerning registered health practitioners. This reflects the fact that QCAT will no longer have the power to issue prohibition orders to unregistered practitioners.

Amendment of s 96 (Orders that QCAT may make)

Clause 43 amends the provision concerning orders that QCAT may make to account for QCAT no longer having the power to issue prohibition orders to unregistered practitioners. It removes section 96(2), which makes reference to division 4. Division 4 is repealed by clause 52.

Amendment of s 97 (Constitution of QCAT)

Clause 44 inserts a new subsection 97(2) that provides that QCAT does not need to be constituted by a judicial member when considering proceedings:

- for unregistered practitioners - a review of a decision by the Health Ombudsman mentioned in section 94 (1)(a) relating to an interim prohibition order or prohibition order; or
- for registered practitioners - the review of an appellable decision under the National Law, section 199 relating to a decision made under the National Law, part 7. These decisions deal with the registration of health practitioners, not decisions about health conduct and performance matters.

Amendment of s 100 (No stay of decision to take immediate action)

Clause 45 amends section 100 to ensure that in instances where the Health Ombudsman issues a prohibition order under part 8A, QCAT is not able to grant a stay of the decision if the health practitioner applies for a review of the decision.

Amendment of s 101 (Application of div 2)

Clause 46 amends section 101 to clarify that the division only applies to matters concerning registered health practitioners. This reflects the fact that the Health Ombudsman will only refer matters concerning registered health practitioners to the Director of Proceedings.

Amendment of s 103 (How director must deal with referral)

Clause 47 replaces subsection 103(2). The new subsection provides that when referring a matter back to the Health Ombudsman, the Director of Proceedings may request that the Health Ombudsman obtain stated information or information of a stated kind under this Act. This is in addition to referring the matter back to the Health Ombudsman recommending that particular further action be taken by the Health Ombudsman.

Amendment of s 105 (Referral back to health ombudsman)

Clause 48 inserts a new subsection (2) into section 105. It provides that if the Director of Proceedings refers a matter back to the Health Ombudsman requesting the Health Ombudsman obtain stated information or information of a stated kind (as provided in amended section 103), the Health Ombudsman must obtain the information and refer the matter back to the Director of Proceedings to deal with under section 103 on the basis of the information.

Replacement of pt 10, div 3, hdg (Matters relating to registered health practitioners)

Clause 49 amends the title of part 10, division three to instead read "Action QCAT may take". This reflects the changes to QCAT's jurisdiction that will mean this division covers all actions that QCAT may take.

Amendment of s 107 (Decision about registered health practitioner other than student)

Clause 50 updates section 107 to make consequential amendments and to reflect current drafting practice. It does not make any policy change.

Amendment of s 108 (Decision about student)

Clause 51 updates section 108 to make consequential amendments and reflect current drafting practice. It does not make any policy change.

Omission of pt 10, div 4 (Matters relating to practitioners other than registered health practitioners)

Clause 52 repeals part 10, division 4 of the Health Ombudsman Act. This division deals with QCAT's jurisdiction to hear matters regarding and issue prohibition orders to practitioners other than registered health practitioners. As this function will rest with the Health Ombudsman under new part 8A, it is necessary to repeal this division.

Amendment of s 140 (When conciliation may happen if other relevant action is taken)

Clause 53 is a consequential amendment.

Amendment of s 186 (Functions of authorised persons)

Clause 54 inserts an additional subsection (c) into section 186. It clarifies that a function of authorised persons is to investigate or monitor the activities of a person the subject of immediate registration action taken, or an interim prohibition order issued, by the Health Ombudsman under part 7, while the action or order is in effect.

Amendment of s 203 (Issue of warrant)

Clause 55 inserts an additional subsection (c) into section 203. It reflects the clarification to the functions of authorised persons in section 186 by ensuring that a magistrate can issue a warrant for an authorised person to enter a place if there may be evidence of a person acting in contravention of immediate registration action or an interim prohibition order issued by the Health Ombudsman under part 7.

Amendment of s 228 (Power to require information or attendance)

Clause 56 amends section 228 to ensure it remains consistent with the amendments to section 186 and 103.

It replaces part of subsection (2) to provide that, in addition to if an authorised person reasonably believes a person may be able to give information about a matter being investigated by the Health Ombudsman, section 228 also applies if an authorised person reasonably believes a person may be able to give information about:

- a health practitioner's compliance with immediate action taken against the practitioner under part 7; or
- that is information, or information of a kind, requested by the Director of Proceedings in a referral under section 103(2)(b).

Amendment of s 259 (Functions)

Clause 57 amends section 259 to be consistent with new part 8A, which empowers the Health Ombudsman to issue prohibition orders to unregistered practitioners. The amendment limits the matters that the director of proceedings can refer to QCAT to those concerning registered health practitioners.

Amendment of s 260 (Director not subject to direction)

Clause 58 amends section 260 to be consistent with new part 8A, which empowers the Health Ombudsman to issue prohibition orders to unregistered practitioners.

Amendment of s 273 (Publication of information about immediate action and QCAT decisions)

Clause 59 inserts a new subsection (1)(b) into section 273, which will empower the Health Ombudsman to publish information about a prohibition order issued under part 8A.

Amendment of s 278 (Notice of decision relating to complaint)

Clause 60 amends section 278 to account for the Health Ombudsman's ability to not accept a health service complaint (as provided for in new section 35A). If the Health Ombudsman does not accept a complaint made orally, notice of this decision may be given orally at the time when the complaint is made, and no notice is required to be given to the health service provider.

Amendment of s 279 (Notice to employers about particular serious matters)

Clause 61 amends section 279 to be consistent with new part 8A, which empowers the Health Ombudsman to issue prohibition orders to unregistered practitioners. It will require the Health Ombudsman to give notice of the prohibition order, or the variation of a prohibition order, to each person who the Health Ombudsman believes is an employer of the practitioner. It also requires the Health Ombudsman to give notice to the person if the Health Ombudsman decides to revoke the prohibition order.

Amendment of s 285 (Delegations)

Clause 62 amends section 285 to ensure that the Health Ombudsman must not delegate the function to issue a prohibition order under new part 8A.

Insertion of new pt 21, div 3

Clause 63 provides for transitional arrangements by inserting a new Division 3 into the Health Ombudsman Act.

New section 320C provides for existing complaints or other matters that the Health Ombudsman has commenced, but not finished dealing with under the act before the commencement or that the Director of Proceedings refers to the Health Ombudsman under new section 320F.

Generally, the Health Ombudsman is obliged to deal with the complaint or matter under the Health Ombudsman Act as in force after the commencement to the greatest practicable extent.

Section 320C(3)(a) applies the Health Ombudsman's ability to not accept a complaint under new section 35A to any complaint made before the commencement if the Health Ombudsman has not yet given notice of a decision under section 35 in relation to the complaint.

Section 320C(3)(b) applies the Health Ombudsman's ability to issue a prohibition order under part 8A to matters the subject of an investigation under part 8 completed before the commencement or started before the commencement and completed after the commencement.

Subsection 320C(3)(c) provides that part 9 division 1, which sets out when the Health Ombudsman may refer a matter to AHPRA, applies if, on commencement, the Health Ombudsman has not referred the complaint or matter to AHPRA.

New section 320D provides for immediate action that has been taken under part 7 prior to the commencement. New section 90H, which ensures that a final prohibition order issued by the Health Ombudsman under part 8A ends an interim prohibition order, applies to existing interim prohibition orders. The updated provisions regarding authorised persons' monitoring of compliance with immediate action under part 7 (sections 186, 203 and 228) apply if the immediate action is in effect on commencement.

New section 320E provides for complaints about registered health practitioners made before the commencement. If the Health Ombudsman has not given notice of a decision under section 35 on the commencement, the joint consideration process in part 3, divisions 2A and 2B will apply in relation to the complaint.

New section 320F provides for matters concerning unregistered practitioners that the Health Ombudsman had referred to the Director of Proceedings prior to the commencement. If the matter has not been dealt with, the Director of Proceedings is required to refer the complaint or matter to the Health Ombudsman to deal with under the act as in force after the commencement.

New section 320G provides for matters concerning unregistered practitioners that have been referred to QCAT by the Director of Proceedings where QCAT has not finally dealt with the matter on commencement. QCAT will be able to deal, or continue to deal with the matter under the Health Ombudsman Act as in force before the commencement. If QCAT does make a prohibition order, subsections (3) and (4) provide for the provisions that apply to these prohibition orders.

New section 320H provides that prohibition orders that were in force before the commencement continue to be in effect, and that the Health Ombudsman Act as in force before the commencement continues to apply to any appeal or other proceeding relating to the making of the order. New sections 90P and 90Q, which deal with the offence of contravening a prohibition order and the publication of prohibition orders, apply to these prohibition orders.

Amendment of sch 1 (Dictionary)

Clause 64 updates the definitions of *corresponding interstate order* and *prohibition order* and removes the definition of *appropriately qualified,* as this term is now defined in Schedule 1 of the *Acts Interpretation Act 1954*.

Division 3 Amendment of Health Practitioner Regulation National Law Act 2009

Act amended

Clause 65 provides that this part amends the *Health Practitioner Regulation National Law Act 2009* (Qld).

Part 4 of the Health Practitioner Regulation National Law Act (Qld) modifies the operation of the National Law in Queensland. The modifications take account of Queensland's co-regulatory arrangements, including the Health Ombudsman and the Health Ombudsman Act.

Amendment of s 34 (Replacement of pt 8, div 5 (Preliminary assessment))

Clause 66 amends section 34, which modifies the operation of section 148 of the National Law in Queensland. It updates the reference in section 148 to refer to part 9, division 1. This is consistent with the changes in the Bill concerning the referral of matters to AHPRA.

Amendment of s 50 (Replacement of pt 8, div 12 hdg and ss 193-195)

Clause 67 amends section 50, which modifies the operation of part 8, division 12 and sections 193 to 195 of the National Law in Queensland. It amends inserted section 193 to account for referrals and notifications to AHPRA under new part 3, division 2A or part 9, division 1 of the Health Ombudsman Act. The National Board will not be required to notify the Health Ombudsman if it is satisfied the Health Ombudsman is already aware of a matter.

Division 4 Amendment of Hospital and Health Boards Act 2011

Subdivision 1 Preliminary

Act Amended

Clause 68 provides that this division amends the *Hospital and Health Boards Act 2011*.

Subdivision 2 Amendments commencing on assent

Insertion of new pt 6, div 5

Clause 69 inserts new division 5 into part 6 of the Hospital and Health Boards Act comprising of new sections 138G to 138M to provide a legislative framework for aged care ratios in State aged care facilities.

New section 138G defines key terms for this division including *enrolled nurse*, *nurse*, *registered nurse*, *resident*, *residential care*, *State aged care facility*, *State aged care facility regulation*, *State aged care facility workload management information* and *support worker*.

The term *nurse* is used to refer to both registered nurses and enrolled nurses. The term *support worker* is defined to mean a person who is not a nurse and provides residential care under the supervision of a registered nurse. This may include an assistant in nursing, personal care assistant or an undergraduate student in nursing. *Support worker* does not include other staff such as allied health professionals and cleaners.

New section 138H provides a head of power to prescribe a requirement about the minimum percentage of nurses and registered nurses that must be directly involved in providing residential care to residents during a 24-hour period. The percentage will be prescribed by regulation and applies to the total number of nurses and support workers that provide residential care at the facility during the period. The regulation may prescribe the percentage by stated Hospital and Health Services; at stated facilities or parts of facilities; at stated times; and in stated circumstances. The regulation may also include a requirement about the skills and qualifications of the nurses and support workers. New section 138B defines a 24-hour period to mean the period starting at midnight on a day and ending immediately before midnight on the following day.

New section 138I provides a head of power to prescribe a requirement about the minimum average daily resident care hours in a State aged care facility by regulation. Daily resident care hours refer to the hours of care that registered nurses, enrolled nurses or support workers provide to each resident of a residential aged care facility daily. The regulation may prescribe the minimum average daily resident care hours by stated Hospital and Health Services; at stated facilities or parts of facilities; at stated times; and in stated circumstances. New section 138I provides that a State aged care facility must calculate the daily average by dividing the total hours of care provided by nurses and support workers to all residents in a day by the number of residents in the facility on the day. A registered nurse, enrolled nurse or support worker must be directly involved in providing residential care to a resident at the facility to be included in the calculation of the minimum average daily resident care hours.

New section 138J provides that the Minister can temporarily exempt a Hospital and Health Service from compliance with a State aged care facility regulation. The notice of exemption must be made in writing and published on the department's website. A temporary exemption may exempt a Hospital and Health Service from compliance with all or part of a State aged care facility regulation, or vary the application of a State aged care facility regulation so that it imposes a lesser requirement. This will provide flexibility to respond to any extenuating circumstances that may temporarily prevent a Hospital and Health Service from complying with the requirements under sections 138H and 138I. The Minister may grant a temporary exemption for a stated period of not more than three months and may impose conditions on the exemption. The exemption may also be extended for a further stated period of not more than three months. However, the total continuous period of a temporary exemption must not exceed six months.

New section 138K applies if the Minister proposes to prescribe a requirement under sections 138H or 138I or grant a temporary exemption from compliance with a State aged care facility regulation. The Minister must consider the Hospital and Health Service's capability to comply with the regulation and the likely effects of compliance. This is similar to the approach taken in section 138D of the Hospital and Health Boards Act for prescribing minimum nurse-to-patient ratios. The section includes example of the matters the Minister may consider:

- the likely financial costs of compliance;
- any matter that may affect the ability of the Hospital and Health Service to recruit and train staff;
- the infrastructure that the Hospital and Health Service has, or can acquire, to support staff; and

- the potential effects, on residential care delivered by the Hospital and Health Service, of actions the Hospital and Health Service may reasonably need to take to comply with the regulation.

New section 138L provides a head of power for the chief executive of the department to make a standard about State aged care facility workload management by Hospital and Health Services. A standard may include requirements about how a Hospital and Health Service:

- calculates its requirements for nurses and support workers;
- develops and implements strategies to manage supply and demand for nurses and support workers; or
- evaluates the performance of its nurses and support workers.

A standard may also include requirements about reporting State aged care facility workload management information to the chief executive. A standard will be binding on a Hospital and Health Service but will only apply to the delivery of residential care to the extent the residential care is subject to a State aged care facility regulation made under sections 138H or 138I. The Minister must notify the making of the standard and the Minister's notice is subordinate legislation. This means the standard is subject to Parliamentary scrutiny and potential disallowance under the disallowance provisions in the *Statutory Instruments Act 1992*. The chief executive must publish the standard on the department's website. New section 138L also clarifies that if it is not possible for a Service to comply with both the standard and the regulation in relation to a particular matter, the regulation prevails to the extent of the inconsistency.

New section 138M provides for the collection and publication of State aged care facility workload management information from a Hospital and Health Service. It is intended that Hospital and Health Services will provide the chief executive of the department with information about their compliance with the requirements under sections 138H and 138I and the standards. The chief executive may publish this information in a way that is publicly accessible.

Amendment of sch 2 (Dictionary)

Clause 70 amends the definition of *nurse* and adds definitions for *enrolled nurse*, *registered nurse*, *resident*, *residential care*, *State aged care facility*, *State aged care facility regulation*, *State aged care facility workload management information* and *support worker*.

Subdivision 3 Amendments commencing on proclamation

Insertion of new s160A

Clause 71 inserts new section 160A in the Hospitals and Health Boards Act which allows a designated person to disclose confidential information for performing a function under, or administering, the Health Transparency Act.

Division 5 Amendment of Private Health Facilities Act 1999

Act amended

Clause 72 provides that this division amends the Private Health Facilities Act.

Insertion of new s 147D

Clause 73 inserts new section 147D which provides that section 147 does not apply to the disclosure information to particular persons for performing a function under, or administering, the *Health Transparency Act 2019*.

Division 6 Amendment of Public Health Act 2005

Act Amended

Clause 74 provides that this division amends the Public Health Act.

Insertion of new s 228BA

Clause 75 inserts new section 228BA which provides that section 220(1) does not apply to the disclosure of confidential information to relevant persons for performing a function under, or administering, the Health Transparency Act.

Schedule 1 Dictionary

Schedule 1 defines particular terms used in the Act.

Schedule 2 Other amendments of Health Ombudsman Act 2013

Particular references to days-

Item 1 amends a range of sections in the Health Ombudsman Act to replace references to days with comparable references to business days.

Section 43A(a), 'section 91'-

Item 2 is a consequential amendment to ensure section 43A refers to the new part 9, division 1.

Section 68B(5)(a) and (7), 'written' -

Item 3 amends section 68B(5)(a) and (7) to remove the word 'written' before 'notice'. This amendment is made because 'notice' is defined in the schedule to the Health Ombudsman Act as meaning 'written notice' so the word 'written is unnecessary.

Section 280(1), before 'health practitioner' -

Item 4 is a consequential amendment to section 280, so that it only refers to QCAT deciding matters concerning registered health practitioners.

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