

***Health Consumers
Queensland ... your voice in health***

**Health Consumers Queensland submission to
Queensland Health:**

Health and Hospitals Network Bill 2011

31 July 2011

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1. Health Consumers Queensland

Health Consumer Queensland's (HCQ) Terms of Reference and Mission are to support the voices of Queensland consumers to achieve better health outcomes. HCQ does this by contributing to the continued development and reform of health systems and services in Queensland, by providing the Minister for Health with information and advice from a consumer perspective, and by supporting and promoting consumer engagement and advocacy. HCQ's aim is to strengthen the consumer (patient) perspective in health policy development and system reform and improvement.

HCQ comprises a 12-member Ministerial Consumer Advisory Committee (Committee) and a Secretariat. The Committee is comprised of a mix of health consumers from a broad range of health populations and social groupings.

In line with HCQ's priority areas and as part of its role in contributing to state and national health reform, HCQ has provided ongoing consumer feedback to Queensland Health and the Commonwealth in relation to proposed legislation, policies, service and systems delivery and accountability mechanisms to ensure robust and meaningful consumer engagement in all components of health reform. HCQ's previous submissions relevant to these issues can be accessed at <http://www.health.qld.gov.au/hcq>.

2. Scope of this submission

In line with its three priority areas - quality and safety; equitable access and targeted responses; and participation and engagement - HCQ has developed this submission in response to the Health and Hospitals Network Bill 2011 (Qld) ('the Bill') and welcomes the opportunity to provide comment.

HCQ's response has been informed by feedback from:

- HCQ's 12-member Ministerial Consumer Advisory Committee
- HCQ's statewide Consumer Network of 235 individual and organisational members
- Two focus groups with consumers, consumer representatives and representatives from community organisations across Queensland on 14 July 2011.

This submission provides both general and specific comments about the provisions proposed in the Bill. It will not address all aspects of the Bill; rather it will focus on those issues upon which HCQ has received feedback.

Some proposed clauses have been extracted from the Bill and reproduced in this submission in order to provide specific comments on the wording, content and/or interpretation of the clause. Those clauses are shaded in green and noted in italics.

The feedback in this submission is based on the information currently available to HCQ with respect to Local Health and Hospital Networks, and in particular the current content of the Bill. HCQ notes that the Regulations to accompany the Bill are still being developed. Accordingly, HCQ may provide further feedback and/or to reconsider its positions contained in this submission upon consideration of proposed Regulations.

3. General Comments

HCQ commends Queensland Health for initiating this consultation and engaging with consumers and key stakeholders around the Bill. HCQ supports and advocates for the right of health consumers to receive safe, quality, timely, effective, affordable and accessible healthcare. HCQ welcomes the Bill's focus on consumer and community engagement and participation, and the inclusion of specific provisions around consumer and community engagement strategies, underpinned by regulations.

HCQ considers that further clarification and provision needs to be made in relation to key aspects of the Bill, in particular:

- The Object, Purpose and Guiding Principles
- Equity and access for vulnerable and marginalised groups
- The functions of Local Hospital Networks (LHHNs) and the membership of Governing Councils
- Integration and coordination between LHHNs and primary health care organisations (Medicare Locals)
- Consumer and community engagement mechanisms
- Quality and safety, in particular performance reporting, Quality Assurance Committees and Root Cause Analysis
- Confidentiality of information.

Consumer feedback and key recommendations in relation to these areas are detailed below.

4. Specific Comments

SCHEDULE 3: Dictionary

Consumer and community

Definitions of 'consumer' and 'community' are not included in the Schedule 3 Dictionary, or elsewhere in the Bill, resulting in a lack of clarity around the meaning of those terms. ***HCQ recommends that definitions of these terms be included in Schedule 3, given the strong focus on consumer and community engagement throughout the Bill.*** HCQ emphasises that 'consumer' and 'community' are distinct concepts, and require separate definitions, rather than interchangeable use, in order to accurately convey their meaning.

It is suggested that the definitions of ‘consumer’ and ‘community’ contained in HCQ’s *Consumer Engagement Framework* be adopted and included in Schedule 3 of the Bill. HCQ’s definitions reflect contemporary definitions, including those used by Queensland Health. They are:

‘Consumer’: a person who uses, or potentially uses, health services, including their family and carers. Consumers may participate as individuals, groups, organisations of consumers, consumer representatives or communities.

‘Community’: refers to groups of people or organisations with a common interest. While some communities may connect through a local or regional interest in health, others may share a cultural background, religion or language. Some communities may be geographically dispersed but linked through an interest in a specific health issue by the internet, or some other means.¹

It is further suggested that the definition of ‘carer’ from *The Carers (Recognition) Act 2008* (Qld) be included, in particular to clarify that a carer includes a paid or unpaid carer.²

Throughout the Bill the word ‘patient’ and ‘user’ are used when referring to health consumers. As noted above, a consumer is broader than a patient as it includes a person, family or carer who potentially uses the health system. As such, ***it is also recommended that the words ‘patient’ and ‘user’ be changed to ‘consumer’ and that ‘consumer’ be used consistently throughout the Bill.***

PART ONE: Preliminary

Object, Purpose and Guiding Principles (Divisions 2, 3 and 4)

5 Object

(1) *The object of this Act is to establish a public sector health system that delivers high quality hospital and other health services to persons in Queensland having regard to the principles and objectives of the national health system.*

(2) *The object is mainly achieved by—*

(a) *strengthening local decision-making and accountability, and local consumer and community engagement; and*

(b) *providing for State-wide health system management including health system planning, coordination and standard setting; and*

(c) *balancing the benefits of the local and system-wide approaches.*

13 Guiding principles

(1) *The following principles are intended to guide the achievement of this Act’s object—*

¹ This definition is from Queensland Health, *Consumer and community participation toolkit: For Queensland Health staff* (2002), Brisbane.

² *The Carers (Recognition) Act 2008* (Qld) s 6.

(a) the best interests of users of public sector health services should be the main consideration in all decisions and actions under this Act;

(b) there should be a commitment to ensuring quality and safety in the delivery of public sector health services;

(c) there should be responsiveness to the needs of users of public sector health services about the delivery of public sector health services;

(d) information about the delivery of public sector health services should be provided to the community in an open and transparent way;

(e) there should be a commitment to ensuring that places at which public sector health services are delivered are places at which—

(i) employees are free from bullying, harassment and discrimination; and

(ii) employees are respected and diversity is embraced;

(f) there should be openness to complaints from users of public sector health services and a focus on dealing with the complaints quickly and transparently;

(g) there should be engagement with clinicians in planning, developing and delivering public sector health services;

(h) opportunities for research and development relevant to the delivery of public sector health services should be promoted;

(i) opportunities for training and education relevant to the delivery of public sector health services should be promoted.

(2) A person must have regard to the guiding principles when performing a function or exercising a power under this Act.

HCQ has received strong feedback from consumers that the object and guiding principles of the Bill are incongruent and that the guiding principles do not sufficiently reflect the object, or the overall intent of state and national health and hospital reforms.

It is understood clause 13 has been replicated from the *Health Services Act 1991* (Qld) and provides guiding principles to which persons performing a function or exercising a power under the Bill must have regard. This is therefore a significant provision which needs to comprehensively embody the intention of health and hospital reforms as well as providing a strong commitment to achieving better health outcomes for consumers and communities.

Consumers oppose use of a 'best interests' approach in clause 13(1)(a) as it may be perceived as paternalistic. Consumers strongly support a consumer-centred approach which provides for person-centred, timely, affordable, safe, quality, effective and responsive healthcare and treatment. **HCQ recommends 'best interests' be removed and that the main consideration in decisions and actions under the Bill be 'public sector health services which are consumer-centred, affordable, safe, quality, effective and responsive'. Conversely, 'best interests' could be omitted and replaced with 'rights and needs of health consumers'.**

Additionally, consumer feedback supports the following amendments and improvements of the guiding principles to ensure consistency with the Bill's object and the overall intention of health and hospital reforms:

- ***That clause 13(1)(g) be amended to state ‘there should be engagement with clinicians, consumers and community members in planning, developing and delivering public sector health services’.*** The principles fail to mention local and consumer and community engagement, despite the Bill’s strong commitment to the development of a consumer and community engagement strategy, and the object of the Bill, which is to be achieved by ‘strengthening local decision-making and accountability, and local consumer and community engagement’. Rather, the principles refer only to *clinician engagement in planning, developing and delivering public health services* (clause 13(1)(g)). It is further noted that consumer and community engagement is a key aspect of the health and hospital reform agenda, and should therefore be emphasised as a key consideration to which persons should have regard when performing a function or exercising a power under the Act.

- ***That the guiding principles include wording around coordinated, integrated services across public and private health sectors.*** The principles should reflect the need for health services to be seamless across services and sectors as well as the close working relationship LHHNs will need to have with Medicare Locals, private health services and community services to ensure coordination and integration of healthcare and service delivery.

- ***That the guiding principles include an express statement around adherence to the principles and objectives of a national health system.*** While the Bill recognises and gives effect to the principles and objectives of the national health system (clause 4), there is no linking between clause 4 and the guiding principles, and consequently consideration of the national health system principles is not a guiding principle. Consumers consider these principles should be a key consideration for persons performing a function or exercising a power under the Bill.

- ***A statement be included in the guiding principles that encompasses wording around the right of individuals to healthcare, and the right to choose care and services.***

- ***The guiding principles expressly provide for access and equity in healthcare and service delivery.*** Although the principles and objectives of the national health system in clause 4 include an access and equity provision (clause 4(1)(a)(ii)) the guiding principles in the draft state legislation make no provision for this. Inclusion of wording around access and equity would embody one of the fundamental intentions and goals for the national reforms, namely the tackling of access and equity issues.³ HCQ advocates for the provision of healthcare in an environment where consumers have the access and support they require to actively engage. This is essential for consumers from vulnerable, disadvantaged and marginalised groups to ensure they have **equitable access to healthcare. Such groups may include**

³ National Health and Hospitals Reform Commission, *A Healthier Future for all Australians: Final Report June 2009* (June 2009) 3.

amongst others, consumers who may be less visible and ‘hard to reach’, such as Indigenous consumers, consumers from culturally and linguistically diverse backgrounds, consumers with disability and their carers and/or formal/informal decision-makers, consumers who are homeless, and consumers in regional and rural areas.

- ***The guiding principles contain a commitment to the protection of the confidential information of consumers of public hospital services.*** This would overcome the current absence of linking between the guiding principles and the confidentiality provisions in Part 7 of the Bill.

It is further noted that the Bill does not make reference to the *Australian Charter of Healthcare Rights*. The Charter was formally launched by the Deputy Premier in Queensland in 2010, and is currently being implemented across public and private health services in Queensland. The Charter strongly reinforces the right of health consumers to be heard and included in decisions and choices about their individual healthcare and in local, regional, state and national health initiatives.

Accordingly, ***it is recommended the Bill include a reference to the Australian Charter of Healthcare Rights in either the object of the Bill, or the guiding principles.*** This would be consistent with the overall purpose and intent of the Act and its focus on strengthening consumer and community engagement.

PART TWO: Establishment of Local Health and Hospital Networks

Functions of Networks (Division 1)

19 Functions of networks

(1) A network’s main function is to deliver the hospital services, other health services, teaching, research and other services stated in the service agreement for the network.

(2) A network also has the following functions—

(a) to ensure the operations of the network are carried out efficiently, effectively and economically;

(b) to enter into a service agreement with the chief executive;

(c) to comply with the health service directives that apply to the network;

(d) to contribute to, and implement, State-wide service plans that apply to the network and undertake further service planning that aligns with the State-wide plans;

(e) to monitor and improve the quality of health services delivered by the network, including, for example, by implementing national clinical standards for the network;

(f) to develop local clinical governance arrangements for the network;

(g) to undertake minor capital works, and major capital works approved by the chief executive, in the network area;

(h) to maintain assets owned by the network or the State in the network area;

(i) to cooperate with other providers of health services, including other networks, the department and providers of primary healthcare, in planning for, and delivering, health services;

(j) to cooperate with local primary healthcare organisations;
(k) to arrange for the provision of health services to public patients in private health facilities;
(l) to manage the performance of the network against the performance measures stated in the service agreement;
(m) to provide performance data and other data to the chief executive;
(n) to consult with health professionals working in the network, health consumers and members of the community about the provision of health services;
(o) other functions approved by the Minister;
(p) other functions necessary or incidental to the above functions.

One of the key intentions of health and hospital reforms is to ensure local planning and flexibility to provide responsive services which meet the needs of local health consumers and communities. Consumer and community feedback to HCQ indicates the LHHN functions contained in clause 19 need to be amended and strengthened to better reflect these key intentions. As such, HCQ provides the following comments in relation to this clause, and recommendations for amendments:

- ***The wording in clause 19(2)(d) be changed from ‘to contribute to’ to ‘to develop’ to better reflect the significant role LHHNs will have in state-wide service planning.*** LHHNs should be at the forefront of State-wide service planning and should have an integral role in driving the development of such plans, to ensure plans reflect the needs of consumers and communities within their boundary.
- HCQ supports the Draft National Safety and Quality Health Service Standards being developed by the Australian Commission on Safety and Quality in Healthcare. HCQ considers the implementation of such national clinical standards should be mandatory under clause 19(2)(e) in order to improve monitoring of performance and accountability, and the quality of health services delivered by the network.
- ***Clause 19(2)(i) and (j) provide for networks to cooperate with other providers of health services, and with local primary healthcare organisations (Medicare Locals).*** Consumers are concerned by the limited information detailed in the legislation in relation to how such cooperation will be carried out (particularly in relation to Medicare Locals and private hospital services) and enforced.

Consumers consider use of the word ‘cooperation’ is not strong enough to compel LHHNs to engage with Medicare Locals and other health services. HCQ believes that engagement between LHHNs, Medicare Locals and other health services within LHHN boundaries should be mandatory to ensure the delivery of integrated, coordinated, consistent services responsive to local need. (Further comments in relation to the need for strong working relationships between LHHNs and Medicare Locals are detailed below in relation to ‘Protocols’).

- Consumers consider that ***health services delivered to public patients in private health facilities as per clause 19(2)(k) should be linked to key performance measures or some other measurable indicator*** to ensure appropriate

monitoring and reporting of performance and services delivered in private facilities. This is discussed further in Part Four below.

- ***'Provision of health services' in clause 19(2)(n) should be amended to state 'to consult with health professionals working in the network, health consumers and members of the community about the development, planning and delivery of health policies and services'.*** Feedback supports that consultation with health professionals, consumers and the community should not be restricted to 'the provision of health services' but should occur in relation to health policy, service and system planning, development, implementation and delivery. Such consultation and engagement should occur from the most initial phase and be part of a continuum of engagement and consultation.

Clause 19(2)(n) should also make reference to the engagement strategies detailed in clause 40 as one of the mechanisms which may be used to undertake such engagement.

- ***A provision should be included in clause 19 specifically referring to the obligation of LHHN's to uphold the rights of consumers embodied in Australian Charter of Healthcare Rights (the Charter).*** Currently the functions make no reference to the rights of consumers and communities to access safe, affordable, quality, efficient healthcare, or their right to access healthcare in a timely manner in the area where they live. These rights are enshrined in the Charter.

General comments in relation to the functioning of LHHNs

HCQ supports health and hospital reforms, and considers the reforms will potentially deliver better health and hospital systems by, among other things, providing localised control, and healthcare and services which are more responsive to local needs. It is hoped the national reforms will ultimately provide greater local consumer and community input into decision-making around health services and systems, and healthcare delivery.

HCQ's feedback in relation to Medicare Locals and their interface with LHHNs and private hospital services is contained in feedback around protocols below. ***HCQ reiterates the need for strong mechanisms to be inserted in the Bill to ensure the delivery of integrated and coordinated services across LHHNs and Medicare Locals within LHHNs.***

Further, the Bill does not contain provisions around pathways for communication between the LHHNs themselves. ***HCQ recommends such pathways be legislated in order to provide appropriate avenues for communication and to facilitate cooperation and collaboration where appropriate.***

Governing Councils for Networks (Division 2)

23 Membership of governing councils

(1) A governing council consists of 5 or more members appointed by the Governor in Council, by gazette notice, on the recommendation of the Minister.

(2) The Minister is to recommend persons the Minister considers have the skills, knowledge and experience required for a network to perform its functions effectively and efficiently, including—

(a) persons with expertise in health management, business management, financial management and human resource management; and

(b) persons with clinical expertise; and

(c) persons with legal expertise; and

(d) persons with skills, knowledge and experience in primary healthcare; and

(e) persons with knowledge of health consumer and community issues relevant to the operations of the network; and

(f) where relevant, persons from universities, clinical schools or research centres with expertise relevant to the operations of the network; and

(g) persons with other areas of expertise the Minister considers relevant to a network performing its functions.

Clause 23(2)(d): Persons with knowledge of health consumer and community issues

HCQ strongly supports the inclusion of consumer and community members in the membership of Governing Councils consumer and community members. However, HCQ has received consistent feedback that the current wording of clause 23(2)(d) is not sufficient as it does not ensure that people with appropriate experience in health consumer and community issues will be granted membership. As the provision currently reads, arguably any person 'with knowledge of health consumer and community issues relevant to the operations of the network' may seek membership, regardless of whether they have a strong, demonstrated background and experience in representing health consumers and communities. For example, under the current provision, a bank manager or mechanic with no experience in health advocacy or engagement could arguably meet the 'having knowledge' test. Indeed, a health professional could also meet this test.

Consumer feedback to HCQ indicates that consumers and community representatives consider actual experience with health consumer and community issues, engagement and advocacy necessary for persons to be eligible to represent health consumers and communities on Governing Councils. They do not consider persons who merely have *knowledge* of health and community issues appropriate to represent the needs of consumers and communities.

It is noted that in early July 2011 expressions of interest for chairpersons and members of Governing Councils were sought by Queensland Health. The Information Kit for applicants states in relation to skills and experience that Governing Council Chairs and Members are expected to meet criteria including having '**technical expertise**' or '**significant expertise or qualifications** within one or more of the following areas':

- health management, business / financial management or human resource management

- clinical expertise
- legal expertise
- primary health care
- expertise in health research or academia relevant to the operations of the network
- *patients and community issues relevant to the operations of the network*
- other areas of expertise the Minister considers relevant to a network performing its functions.

The use of the language ‘technical expertise’ and ‘significant expertise or qualifications’ in relation to ‘patients and community issues’ is in itself considerably stronger than ‘having knowledge of health and community issues’, and should be reflected in the Bill.

HCQ recommends that clause 23(2)(d) be reworded to ensure persons with appropriate knowledge as well as technical and/or significant experience and qualifications around consumer and community issues are included as members of Governing Councils. This will also enable an appropriate balance of persons with particular expertise on the Governing Councils.

A further option is for ‘knowledge of consumer and community issues’ to be specifically defined in Schedule 3, or for an example of a person who may meet this test to be included in clause 23(2)(d).

Such a definition, or a specific example, could include:

- A person who is an active member of a health advocacy group.
- A person who has been a member of a health services advisory body, such as a Health Community Council.
- A person who has, or is engaging in teaching or research relating to health consumer issues.
- A person who has appropriate qualifications in relation to health consumer and community issues.
- A person who has acted, or is a community representative for the purpose of advising health services or agencies about consumer and community health issues.
- A representative of a non-government organisation which undertakes work in relation to health consumer issues.

Such a definition would better ensure the Bill’s object in strengthening local consumer and community engagement is realised in practice, and that consumer and community issues are represented robustly in Governing Councils.

In the recruitment process for a Governing Council member with 'knowledge of health consumer and community issues' it is also suggested that assessment of candidates include consideration of factors such as the extent of their prior experience within and commitment to community needs within their region; which local organisations they belong, or have belonged to; what professional membership they have; what committees or associations they have been or are a part of and the capacity in which they acted.

Other comments

HCQ provides the following additional comments and suggested amendments in relation to Clause 23:

- ***There should be a requirement that regardless of the size of the LHHN, at least two (2) members of LHHNs must be persons with knowledge and actual experience in consumer and community issues.*** This will ensure both consumer and community issues and perspectives are represented on Governing Councils. It is also consistent with the provision of consumer-centred health services and systems which meet the needs of local communities.
- ***An additional provision should be included to ensure that the number of members in each LHHN is reflective of the size of the population within each LHHN*** (i.e. the larger LHHNs should have more members than smaller LHHNs to ensure more representative membership and decision-making).

HCQ received diverse feedback as to whether it should be a requirement that members of each Governing Council must be persons who live in a region within the LHHN boundary. Some feedback indicated this should be a requirement to ensure governing council members have relevant knowledge about local health consumer and community issues and needs. Other feedback indicated that given the size and location of some LHHNs it may be appropriate for a council member to reside outside that LHHN boundary provided they were able to demonstrate a detailed understanding of consumer and community perspectives and issues and established networks with a range of consumer and community bodies within the LHHN.

- HCQ received diverse feedback in relation to whether members of Governing Councils can also be members of the governing bodies of Medicare Locals. Some consumers consider it would be beneficial to have cross-membership to ensure collaboration and consistency, while others were concerned that cross-membership may compromise independence and result in conflicts of interest.

Governing Council Delegations

30 Delegation by governing councils

(1) The governing council for a network may delegate the network's functions under this Act and the Financial

Accountability Act 2009—

(a) to a committee of the governing council if all of the members of the committee are governing council members; or

(b) to the network chief executive.

(2) The network chief executive, with the approval of the governing council, may subdelegate the functions mentioned in subsection (1) to an appropriately qualified network health executive or network employee.

(3) In this section—

appropriately qualified *includes having the qualifications, experience or standing appropriate to the exercise of the power.*

Example of standing— the person's classification level or how senior the person is in the network

HCQ recognises it will be necessary, from an operational perspective, for the LHHNs' functions to be delegated. However, HCQ emphasises the need for LHHN Governing Councils to continue to have strong oversight of delegated functions, particularly those which relate to quality assurance, safety of health services, complaints management, clinical governance and financial management.

Consumers oppose the delegation of the appointment of auditors and consider that the Governing Council is best placed to appoint auditors, except where the matter being audited relates to the Governing Council itself (the appointment of auditors is discussed further in Part 6 below).

Further comments in relation to Governing Councils

Feedback to HCQ indicated that consumers consider there should be a requirement for members of Governing Councils, including the Chair, to undertake training in relation to consumer and community engagement, to ensure they have the skills, knowledge and capacity to effectively develop consumer and community engagement strategies, and engage with local consumers and communities.

Consumers also consider the Bill should provide for the Chair's performance to be appropriately monitored, and that there should be linking of performance indicators for Governing Councils with the consumer engagement principles and mechanisms outlined in the Draft National Safety and Quality Health Service Standards.

Service Agreements (Division 4)

16 Meaning of service agreement

(1) A service agreement, for a network, means an agreement between the chief executive and the network that states—

(a) the hospital services, other health services, teaching, research and other services to be provided by the network; and

(b) the funding to be provided to the network for the provision of services, including the way in which the funding is to be provided; and

Example of a way of funding a health service— activity-based funding

(c) the performance measures for the provision of services by the network; and

(d) the performance data and other data to be provided by a network to the chief executive, including how, and how often, the data is to be provided; and

(e) any other matter the chief executive considers relevant to the provision of services by the network.

(2) Without limiting subsection (1), a service agreement may—

(a) deal with the matters stated in subsection (1) relating to funding provided by the Commonwealth, without the Commonwealth being a party to the agreement; and

(b) state the circumstances in which a network (the first network) may agree with another network to deliver services for the first network.

Access and equity

Consumers gave feedback to HCQ that service agreements should require mandatory consideration of and planning, as part of service agreement negotiations between the State and LHHNs, to cater for the access and equity needs of vulnerable and marginalised consumers within LHHNs. This should include planning around marginalised groups' hospital and health service needs; funding to sufficiently address those needs; and inclusion of performance measures to ensure accountability. Populations which may require specific consideration to address equity and access issues include Indigenous consumers, consumers from culturally and linguistically diverse backgrounds, consumers with disability and their carers and/or formal/informal decision-makers, and consumers in regional and rural areas. An example of such consideration/planning is ensuring provision within the service agreements for funding for patient transport arrangements under the Patient Travel Assistance Scheme.

HCQ recommends the Bill be amended to require mandatory consideration of and planning around access and equity issues during service agreement negotiations to better ensure appropriate allocation of funding for each LHHN, and improved responses to local need.

Interface between funding bodies and service agreement negotiation

The COAG agreements relating to health and hospital reforms establish funding arrangements for public hospital services, and provide that an independent National Funding Authority will be responsible for distributing funds to the LHHNs.

The Bill does not provide information about the interface between the State, LHHNs and the funding body during negotiations of service agreements, and the process for allocation of funds under the service agreement. Further clarification around these issues is needed.

Protocols (Division 4)

42 Protocol with primary healthcare organisations

(1) A network must use its best endeavours to agree on a protocol with local primary healthcare organisations to promote cooperation between the network and the organisations in the planning and delivery of health services.

(2) A protocol must—

(a) satisfy any requirements prescribed by regulation for the protocol; and

(b) be published in a way that allows the protocol to be accessed by members of the public, including, for example, on the internet.

Consistent feedback was received by HCQ that clause 42 does not provide for mandatory interaction, engagement, collaboration and cooperation between LHHNs and Medicare Locals. Consumers oppose use of the terminology ‘best endeavours’ and ‘protocol’ and ‘promote cooperation’, and consider this terminology and approach lacking in strength and enforceability. Consumers consider this approach fails to ensure that LHHNs and Medicare Locals will practically engage and plan with each other around the delivery of integrated, coordinated, seamless health services.

HCQ notes that a key impetus for health reform is the improvement of health and hospital services by, among other things, delivering seamless care across sectors of the health system, in order to enhance the quality of care consumers receive and improve health outcomes. The COAG National Health and Hospitals Agreement commits LHHNs and Medicare Locals to working together to achieve integrated, coordinated service delivery and care, and in particular to ensure smoother transitions between service providers.⁴

As such, **HCQ recommends clause 42 be reconsidered and amended to strengthen the interface between LHHNs and Medicare Locals and provide for formal agreements which facilitate and ensure seamless, integrated and coordinated care.** Inclusion of stronger provisions in the Bill governing discussion, cooperation, collaboration and planning between LHHNs and Medicare Locals is consistent with the intention of the national health reforms, and would ultimately facilitate improved health service delivery and health outcomes for consumers and communities.

HCQ supports robust engagement, discussion, cooperation, collaboration and planning between LHHNs and Medicare Locals underpinned by strong, formalised agreements in order to:

- Facilitate coordination across sectors and the different levels of the health system;
- Support population health planning, health needs assessments and service development activities with other health service partners at the local community level;

⁴ COAG, *National Health and Hospitals Agreement* (February 2011) 19, 21.

- Enable seamless, coordinated transitions between acute and community-based services;
- Improve quality and safety of healthcare; and
- Enable appropriate management of:
 - patient flows;
 - pathways between services;
 - smooth transitioning to subacute care;
 - equity of access, and
 - service gaps.⁵

The Bill should also contain provisions to address circumstances where agreements between LHHNs and Medicare Locals are unable to be reached, in order to provide mechanisms decision-making and resolution of issues.

Engagement Strategies (Division 4)

40 Engagement strategies

(1) A network must develop and publish the following strategies—

*(a) a strategy (a **clinician engagement strategy**) to promote consultation with health professionals working in the network; and*

*(b) a strategy (a **consumer and community engagement strategy**) to promote consultation with health consumers and members of the community about the provision of health services by the network.*

(2) The network must consult with the following persons in developing the strategies—

(a) for the clinician engagement strategy—health professionals working in the network;

(b) for the consumer and community engagement strategy—health consumers and members of the community.

(3) Each of the strategies must—

(a) satisfy any requirements prescribed by regulation for that strategy; and

(b) be published in a way that allows the strategy to be accessed by members of the public, including, for example, on the internet.

HCQ welcomes the establishment of consumer and community and clinician engagement strategies in the Bill as a key mechanism to facilitate consumer, community and clinician engagement and participation in the development, planning and provision of LHHN health policies and services.

A key objective of the Bill and health and hospital reforms is to strengthen local decision-making and accountability, and local consumer and community engagement.⁶ Appropriate and considered development and implementation of effective consumer, community and clinician engagement strategies, and a strong

⁵ Health System Integration in Queensland: a joint consultation paper, Queensland Health, General Practice Queensland, Royal Flying Doctor Service, Aged Care Queensland, Queensland Aboriginal and Islander Health Council, Health Consumers Queensland, 2010

⁶ Explanatory Notes Health and Hospitals Network Bill 2011, 3.

ongoing commitment by LHHNs to the implementation of those strategies is critical to ensuring:

- consumers and communities have opportunities to participate, be consulted and contribute to the development and implementation of health policy, planning and service delivery.
- health services are responsive to and support consumer and community needs and decision making around their healthcare.
- a viable, responsive, safe and effective health system which is able to change and evolve to meet the needs and improve the health of consumers and communities.
- supporting consumers and communities to better engage with their healthcare and the health system to achieve better health outcomes at the individual, service and broader agency levels.
- appropriate mobilisation of resources.

HCQ's *Consumer Engagement Framework* provides useful structures around meaningful and responsive communication and engagement between consumers, their representatives, health-related community organisations, health practitioners, health agencies and health services. Use of HCQ's consumer engagement framework in developing LHHNs' consumer, community and clinician engagement strategies is discussed further below.

With respect to clause 40, HCQ provides the following feedback and recommendations:

- ***Clause 40 provide enforcement mechanisms with respect to both the consumer and community and clinician engagement strategies, to ensure mandatory adherence and compliance by LHHNs.*** Currently the provision requires LHHNs to develop and publish strategies, but places no obligation on LHHNs to implement and abide by those strategies. There is therefore no enforcement mechanism to ensure that LHHNs, following development and publishing of the strategies, actually engage with consumers, the community and clinicians. There are also no relevant timeframes around implementation of the strategies, which are necessary to ensure regular engagement with consumers and clinicians. A provision in clause 40 providing for enforcement mechanisms would address these issues.
- ***Clause 40(2)(a) and (b) be amended to ensure clinicians, consumers and communities are engaged and involved in the development of each others strategies, using a collaborative approach, to enhance collaboration and consistency, and to address overlap.*** Feedback to HCQ strongly supports an integrated approach in developing the consumer and community and

clinician engagement strategies, as there will be overlap between these. As clause 40 currently reads, it appears that the strategies will be developed separately, and that clinicians and consumers and communities will not be consulted in the development of the other group's strategy. Rather, under clause 40(2) (a) and (b), health professionals will not be engaged in developing the consumer and community strategy; and health consumers and members of the community will not be consulted in the development of the clinician strategy. Clinicians, consumers and communities will have a strong interest in the strategy of the other, and the strategies must be complimentary to ensure they can be implemented and operate effectively.

- ***'Provision of health services' in clause 40(1)(b) be amended to: 'promote consultation with consumers and members of the community about the development, planning and delivery of health policies and services'.*** Clause 40(1)(b) provides the strategy will promote consultation with consumers and community members about 'provision of health services by the network'. As noted above in relation to the functions of networks (clause 19) consultation with consumers and the community should occur not only around provision of services, but more broadly in relation to health policy, service and system planning, development, implementation and delivery. Such consultation and engagement should occur from the most initial phase and be part of a continuum of engagement and consultation.
- ***Consumers indicated consumer engagement strategies should be consistent across LHHNs. They consider there needs to be, within each of the 17 LHHNs' strategies consistent minimum requirements, as well as provisions tailored to local communities, to ensure consistency in engagement approaches between the LHHNs, while catering specifically for local needs.*** For example, HCQ considers the principles, model and process for consumer engagement detailed in its *Consumer Engagement Framework* could inform the minimal strategies for engagement across all LHHNs, and would be flexible enough to also enable tailored approaches to meet local need.

Engagement strategy regulations

Consumer feedback supports the ***use of HCQ's August 2010 Consumer Engagement Framework (the Framework) to inform the development of LHHN's consumer, community and clinician engagement strategies.*** HCQ's attaches a copy of the Framework for your reference.

HCQ also urges consideration be given to the Framework when developing the regulations pertaining to the consumer and community and clinician engagement strategies.

HCQ has also received feedback from consumers that the Regulations for the engagement strategies should include, at minimum, the following:

- **Reference to the Australian Charter of Health Care Rights** (see discussion in relation to this in the comments above around objects and guiding principles).
- **The object and guiding principles of the Bill (and ultimately Act) should also be reflected at the start of the Regulations.**
- **Details as to who will be engaged; how they will be engaged; when engagement will occur; where it will occur and in what circumstances it will occur.** Mechanisms should be implemented to engage consumers and their representatives at every stage of the planning, development, implementation, delivery and evaluation of services, programs, policies and activities.
- **Provisions around how information and feedback obtained through the strategy will translate into practice and influence change.** There should be clarification around how the information will be taken into consideration by LHHNs when determining policy and planning matters.
- **Mechanisms which enable engagement with other health services, such as Medicare Locals, private health services, aged care services and community and mental health services.**
- **Mechanisms which ensure access and equity, and promote engagement with vulnerable groups and populations who experience isolation, disadvantage or marginalisation, as well as community based services which support them.** Such consumers may be 'voiceless' or 'hard to reach' and require flexible arrangements to better facilitate their engagement and to address inequities in health and access to health, social and welfare services.

Consumers and communities which may require more targeted engagement mechanisms include people from culturally and linguistically diverse backgrounds, Indigenous people, persons with disability and mental illness, the elderly, persons who are homeless, LGBT populations, carers and regional and rural consumers. It is critical that the strategy address the needs of these groups and provide a strong commitment to working with them in order to ensure access and equity in healthcare and service delivery, and to assist in addressing the social determinants of health which impact on consumers within those groups.

- **Mechanisms which ensure meaningful engagement with consumers and communities.** Engagement strategies should be delivered in a manner which respect consumers' beliefs, values and culture and in a way which is meaningful to consumers and enables them to effectively engage and participate. Appropriate supports should be provided where necessary (for example, offering support workers where required, assistance with travel,

reimbursement and remuneration of expenses commensurate with outer stakeholders; reading material in advance of engagement activity).

- ***How consumers, their representatives and community groups can undertake individual and systemic advocacy with LHHNs around issues relating to healthcare and health services and systems.*** HCQ's *Health Advocacy Framework* provides a number of options around this, including the development of formal health advocacy policies, underpinned by HCQ's *Health Advocacy Framework*. These options could be considered when developing provisions around advocacy in the consumer and community engagement strategy.
- ***Provisions for the establishment of a consumer and community engagement subcommittee across each LHHN and Medicare Local*** as a formal advisory mechanism in relation to their consumer engagement initiatives.
- ***Compulsory training for members of LHHN Governing Councils in relation to consumer and community engagement*** (this is also discussed in HCQ's comments relating to Governing Council membership). Such training should be linked to evaluation, monitoring, and performance management and KPIs to ensure accountability.

Once a draft consumer and community strategy and a draft clinical engagement strategy have been developed, they should be made publicly available for comment and feedback to ensure necessary amendments are made prior to finalisation. HCQ would also welcome the opportunity for consultation in relation to the development of draft Regulations around engagement strategies, to provide further feedback and comment where appropriate.

PART FOUR: Performance reporting and auditing

Performance Reporting (Division 1)

Performance reporting

The Bill provides insufficient detail and information in relation to performance reporting for LHHNs and hospitals. Given that each LHHN will be individually accountable for its performance, ***further clarification is required around:***

- ***what performance measures will address.*** HCQ notes the February 2011 National Health and Hospitals Agreement states performance measures should address access to services, quality of service delivery, financial responsibility, patient outcomes and/or patient experience.⁷
- ***the type of data to be collected.***

⁷ COAG, *National Health and Hospitals Agreement* (February 2011) 34-35.

- ***how data will be collected.***
- ***who will be responsible within the LHHN for overseeing data collection and performance reporting.***
- ***how often such data must be reported on.***

HCQ considers the inclusion of provisions in the Bill in relation to these matters essential, and recommends they Bill be amended to included these.

It is noted that clause 16(1)(c) provides that the service agreement between the State and LHHN must state the performance data and other data to be provided, including how and how often the data is to be provided. Consumer feedback to HCQ raised issues around consistency of data collection and performance reporting across LHHNs and how this will be achieved in circumstances where each LHHN will negotiate separate service agreements with the departmental chief executive. Feedback indicated that as clause 16 currently reads, it may allow each LHHN to negotiate different data collection methods, type of data and time frames for collection.

The Explanatory Notes to the Bill state that the service agreements will have the effect of facilitating benchmarking across like services. Consumers report it is difficult to envisage how this will be achieved where the Bill does not specify how the performance of each LHHN will be measured against other LHHNs, and appears to provide for negotiation of inconsistent terms around data collection and performance under each agreement. This could result in difficulties in comparing the performance of LHHNs against other LHHNs.

It is recommended that provisions be inserted in the Bill which provide for LHHNs to collect the same data, using the same methods of collection, and report in similar time frames to ensure the highest degree of consistency in measuring LHHNs performance against other LHHNs. Training for LHHNs and Network chief executives around data collection and how it is to be interpreted is also necessary to ensure consistency of reporting.

In terms of data collection about performance of LHHNs and individual hospitals, HCQ suggests that one mechanism which could also be used is the distribution of surveys to consumers, patients and communities. Further, HCQ considers that data collection and reporting should specifically report on vulnerable and marginalised groups within LHHN's regions, and whether health services are responding effectively to their needs. Often such groups are isolated and not accessed when collecting performance and other data – to be effective data collection and performance reporting should include a broad cross-section of the demographic of hospital regions. In this way data about vulnerable groups and access to health services can be linked to accountability mechanisms, and issues can be better responded to.

HCQ recommends that data collection and performance reporting also occur in relation to LHHNs engagement with Medicare Locals, private hospital services and

other health services in their region to ensure accountability, particularly around the provision of integrated, coordinated health services. As noted above in relation to clause 19(2)(k) consumers consider that health services delivered to public patients in private health facilities should be linked to key performance measures or some other measurable indicator to ensure appropriate monitoring of performance and services delivered in private facilities.

Performance standards

The Bill does not specify which performance standards are to be used for assessing the performance of LHHNs. Consumers consider the establishment of a base or minimal set of performance standards to be met essential, and that the extent to which the LHHNs have complied with the terms of their services agreements with the State should also be measured. Consumers have also provided feedback that there could be benefit in LHHNs having to provide reporting around complaints received from patients.

HCQ has consistently advocated for performance reporting in Queensland hospitals to be measured against the Draft National Safety and Quality Health Service Standards, and perceives that implementation of the standards is one way of ensuring accountability, transparency and consistency in relation to performance monitoring and reporting. Further, the National Health and Hospitals Agreement provides that LHHNs will have a performance and accountability framework which will include:

- the national clinical quality and safety standards developed by the Australian Commission on Safety and Quality in Healthcare,
- national performance indicators agreed by COAG under the 2002 National Healthcare Agreement, and
- new Hospital Performance Reports and Healthy Communities Reports providing clear and transparent reporting on the performance of every LHHN, the hospitals within it, every private hospital and every Medicare Local.⁸

It is therefore recommended the Bill include a provision which reflects the performance and accountability framework specified in the National Health and Hospitals Agreement.

Improvement of services

In order to improve quality and safety in healthcare, ***consumers are also keen to see the inclusion of mechanisms in the Bill which provide for how performance reports and data will be used to ensure ongoing improvement of health services to address the issues indicated by the data.*** This is considered crucial to ensure that any issues

⁸ COAG, *National Health and Hospitals Agreement* (February 2011) 7.

are acted upon and redressed by LHHNs, particularly issues concerning patient quality and safety, and the effectiveness, timeliness and responsiveness of health care and services.

Provision of data to the Commonwealth

54 Chief executive may provide data to Commonwealth

(1) Subsection (2) applies to performance data and other data provided by a network to the chief executive—

- (a) under the service agreement between the chief executive and the network; or*
- (b) under a health service directive.*

(2) The chief executive may validate the data and provide relevant data to—

- (a) the Commonwealth; or*
- (b) an entity established under an Act of the Commonwealth.*

(3) In this section—

relevant data means data the State and Commonwealth have agreed is to be provided to—

- (a) the Commonwealth; or*
- (b) an entity established under an Act of the Commonwealth.*

Consumers have expressed concerns in relation to clause 54, including:

- It enables chief executives to ‘validate’ data, and
- The wording used appears to provide an ‘option’ for relevant data to be provided to the Commonwealth government, or a Commonwealth entity.

The national health and hospital reforms aim to introduce clear and transparent performance reporting. The COAG National Health and Hospitals Agreement provides that while States will take responsibility for data integrity within their systems, they must *establish appropriate independent oversight mechanisms for data integrity, to provide certainty to the Australian public about the actual performance of hospitals.*⁹

The Bill appears to establish health service audits as the independent oversight mechanism for data integrity in Queensland. However, to ensure accuracy, accountability and integrity of data provided to the Commonwealth, **HCQ recommends the Bill establish an independent oversight mechanism for data validated by the chief executive prior to provision of validated data to the Commonwealth.**

HCQ also recommends that clause 54 be reworded by inserting a ‘must’ before ‘provide relevant data’ in clause 54(2) to ensure mandatory provision of data to the Commonwealth.

⁹ Ibid.

Public reporting

Consumers are concerned about the absence of specific provisions relating to the public reporting of performance data about LHHNs. The Explanatory Notes state that a major benefit for Queensland from the national health reforms and enactment of the Bill is improved transparency, and that community members will have access, among other things, to information about 'how their network's or hospital's performance compares with like networks or facilities'. The Bill provides that LHHNs are to provide performance reports to the departmental chief executive, who may in turn provide it to the Commonwealth, but does not provide for public reporting of such data and reports.

To ensure integrity, transparency and ongoing consumer and community confidence in the Queensland public health system, performance data and reports must be made publicly available. HCQ recommends the inclusion of provisions in the Bill which allow for this.

Health Service Audits (Division 2)

Functions of health service auditors

A health service audit includes examination of performance data, investigation of failure to meet performance measures, and investigation of other matters to promote effective and efficient use of available resources in delivering public sector health services (clause 55).

HCQ considers 'investigation of other matters' in clause 55(2)(c) should include audits which monitor the frequency of consumer engagement, and in particular engagement with marginalised or vulnerable groups to ensure they are receiving equitable access to services and services responsive to their needs.

Appointment of auditors

Clause 56 provides that the departmental chief executive or the network chief executive can appoint a person as a health service auditor to undertake a health service audit in the Network.

HCQ considers that the appointment of auditors should be a transparent and open process, providing for the greatest degree of independence. In this regard, ***HCQ considers it would be more appropriate for the Governing Council to appoint auditors, except where there is a conflict of interest, or where the audit relates to a significant issue concerning the administration of LHHNs or the activities/performance of the Governing Council itself. Where this occurs, the most appropriate party to appoint an auditor would be the departmental chief executive.***

Where possible public appointments should be made, particularly where the audit relates to financial matters. HCQ also recommends that where possible a consumer or community representative be included as part of the auditing team to ensure appropriate representation of consumer views and interests in the auditing of the health service.

Reports by health service auditors

In order to ensure transparency and accountability of health services, the Bill should include a provision that a copy of the auditor's report be provided not only to the person who appointed the auditor (the appointer), but also to the Governing Council and, where the appointer was not the network chief executive, to the network chief executive. This would ensure the findings are appropriately communicated, and allow scrutiny of reports so that errors and issues can be understood, learnt from and addressed within the LHHN the report relates to, better enabling continuous improvement across the LHHN.

Where the auditor's report has systemic implications across all LHHNs there should also be provision for the report to be provided to the Governing Councils and network chief executives of other LHHNs. Where the audit report has systemic implications applicable to an LHHN other than the LHHN audited, or to all LHHNs the departmental chief executive should also have the power to issue the same direction to another or all LHHNs. This would ensure consistency and continuous improvement across LHHNs, and redress of systemic issues.

Agreed standards

In undertaking audits and reporting, the performance of the health service, or any other issue being investigated should be considered and measured against relevant standards. HCQ considers a provision to this effect should be included in the Bill.

PART SIX: Safety and Quality

Quality Assurance Committees (Division 1) and Root Cause Analysis (Division 2)

Establishment of Committees

82 Establishment of quality assurance committees

(1) Any of the following may establish a quality assurance committee—

(a) for a matter relating to its functions—

(i) a network; or

(ii) a professional association, society, college or other entity whose functions relate to the provision of health services or to the providers of health services;

(b) the chief executive for a matter relating to a network or the department;

(c) the licensee of a private health facility for a matter relating to health services provided in its facility.

.....

Consumer feedback received by HCQ indicates that ***LHHNs should establish quality assurance mechanisms which allow independent scrutiny of quality and safety of healthcare and service delivery, whether through the establishment of Quality Assurance Committees (QAC) or some other mechanism, such as through external bodies i.e. the Australian Commission on Safety and Quality in Healthcare; the Health Quality and Complaints Commission.***

Further, clause 82(3)(c) specifies that an entity may not establish a QAC unless satisfied the QAC comprises individuals with training and experience appropriate to the services to be assessed and evaluated by the QAC. ***It is recommended that this clause 82(3)(c) specify that such individuals may include consumer and community representatives.***

Protections for documents and information

Consumers have raised concerns about the protection for documents and information relating to QAC and Root Cause Analysis (RAC) teams under clauses 87 and 119. Feedback to HCQ indicates that consumers consider that the absolute protection afforded by clauses 87 and 119 compromises transparency of process, and the right of individuals, groups or the public to access documents and/or information where they have a legitimate and genuine need and/or interest. Consumers have expressed particular concern in relation to clauses 87(2)(a) and 119(2)(a) which prevent documents and information from being accessed under any order, whether of a judicial or administrative nature, and the inadmissibility of documents or information in proceedings (clauses 87(2)(a) and 119(2)(a)).

Consumers have expressed strong concerns that these provisions:

- fail to safeguard the public's interest in access to information and are contrary to natural justice;
- may result in abuses of process enabling information which is genuinely in the public interest to be concealed, perpetuating a culture of secrecy;
- restrict the access of courts and tribunals to documents and information in circumstances where they should have legitimate access to such documents/information; and
- may prevent significant information which could be used to improve health services and quality and safety in healthcare across Queensland hospitals and health services from being used.

The Guiding Principles of the Bill in clause 13, which are intended to guide the achievement of the Act's object, provide that information about the delivery of public sector health services should be provided to the community in an open and transparent way, and that there should be openness around complaints (clause

13(1)(d) and (f)). The Explanatory Notes to the Bill reiterate this commitment to transparency and accountability in health service delivery, and state that a major benefit of the national health reforms for Queensland is improved accountability and transparency around clinical and financial performances, and network and hospital performance, through reporting and access to information.¹⁰ Improved accountability and transparency may not occur where information concerning QAC matters and RCA, which is genuinely in the public interest, is able to be concealed under the current protections contained in both clauses 87 and 119 of the Bill.

HCQ urges that an appropriate balance be struck in the Bill between protection of QAC and RCA teams and people who provide the QAC and RCA teams with information for the purpose of their functions, and the public interest in having access to and transparency around documents and information which concern public safety and quality of health services. HCQ recommends clauses 87 and 119 be reconsidered, and in particular clause 87(2)(a) and 119(2)(a) prohibiting access to information under any order, including judicial or administrative orders, be removed.

Protection of information provided to QACs and RCA teams

Clauses 89 protects from liability persons who honestly and on reasonable grounds give information to a QAC, or a relevant person for a QAC, for the QAC's functions. Clause 117 contains similar provisions with respect to information given to RCA teams for their conduct of a RCA of a reportable event.

Clause 90 states that a person cannot be compelled to divulge or communicate in a proceeding, or in compliance with a requirement under an Act or legal process:

- (a) whether or not the person gave information to a committee or a relevant person for a committee;
- (b) what information the person gave to a committee or a relevant person for a committee;
- (c) a document given by the person to a committee or a relevant person for a committee that was created by the person or another person for the committee;
- (d) information the person was given, or questions the person was asked, by a committee or a relevant person for a committee.

Clause 118 contains similar provisions with respect to RCA.

It is unclear whether the intention of clauses 90 and 118 is to afford protection to persons who give information to a QAC or RCA team, to protect the QAC or RCA team itself, or to do both. If the primary intention of this provision is to protect individuals, such as whistleblowers who provide information to the QAC, HCQ is supportive of this in principle (but notes that protection from liability is sufficiently

¹⁰ Explanatory Notes Health and Hospitals Network Bill 2011, 2.

provided for in clauses 89 and 117, and that additional protection under clauses 90 and 118 may not be warranted).

However, if the primary intention of clauses 90 and 118 is to prevent scrutiny of the Committee's or RCA team's activities by protecting an individual from disclosing, as part of a court, tribunal or legal proceeding or legal process information which may ultimately lead to such scrutiny, then HCQ opposes this provision.

HCQ has received strong feedback from consumers around the need for greater openness and transparency in QAC and RCA processes, and the need for checks and balances through legislation to ensure this. An individual should not be prevented from divulging in proceedings, or in compliance with other legislation or legal processes, information which may result in appropriate, legitimate and necessary scrutiny of QACs or RCA teams by external bodies concerned with the quality and safety of healthcare and health services. Such protections are too broad and potentially compromise consumers' rights to quality and safety in healthcare, and public confidence in the health system. It also potentially restricts the legitimate interests of courts, tribunals and other bodies to access information relevant to the QACs' and RCA teams' activities.

HCQ seeks further clarification around the intention and effect of clauses 90 and 118, and again urges that an appropriate balance be struck between protection of QACs and RCA teams, and the public interest in quality and safety in healthcare.

Performance measures

Feedback to HCQ has indicated that agreed standards of practice and common practices around matters investigated by QAC and RCA teams are necessary in order to ensure accountability and appropriate measuring of performance. HCQ recommends provisions to this effect be inserted in Part 6, Division 1 with respect to QACs and RCA teams.

Provision for public reporting of information about QAC activities and performance, and information compiled by the Committee when exercising its functions

HCQ recognises that appropriate protections should be afforded to QACs and persons who provide information to QACs, and that this is necessary to ensure the effective functioning of QACs, and clinician participation.

Equally, HCQ recognises that in some cases consumers have a genuine interest in and right to access information which concerns the quality, safety and effectiveness of health care services in Queensland. Further, in circumstances where the issues considered relate to clinical practice, health practitioners may have a legitimate interest in findings arising from the QAC's evaluation and assessment in order to learn from events and prevent mistakes from reoccurring.

At present there is no opportunity for the consumers or practitioners to scrutinise the activities or performance of QACs, particularly as QACs are not subject to the provisions of the *Right to Information Act 2009* (Qld)

Overall, consumers have indicated that the Bill does not strike an appropriate balance between protection of QACs and the public interest in transparency around QAC activities and performance. Indeed, the Queensland Health website notes:

- that not all QACs will benefit from statutory protection;
- QACs must justify how the functions of the committee will be facilitated by the protection afforded by legislation the *Health Services Act 1991* (Qld)); and
- QAC's must justify how the public interest would be serviced by restriction of the information compiled by the committee in the course of exercising its functions.¹¹

Accordingly, consideration should be given to inclusion in the Bill or the Regulations of public reporting mechanisms in relation to:

1. QAC activities and performance; and

2. Reporting of information compiled by a QAC in the course of exercising its functions, particularly where it relates to quality, safety and effectiveness of health services, and recommendations for reform

where the public interest in access to such information overrides the benefit in protecting the QAC.

Further, HCQ recommends that an appropriate external statutory body independent of Queensland Health, such as the Health Quality and Complaints Commission have powers to scrutinise the activities and performance of QACs and report publicly where appropriate.

PART 7: Confidentiality

HCQ emphasises the necessity for robust confidentiality around the personal information of persons who are receiving or have received health services. In particular, HCQ notes the provisions of the *Information Privacy Act 2009* (Qld) which require Queensland Health to comply with the National Privacy Principles and to refrain from doing anything which is contrary to or inconsistent with those principles when collecting, storing, handling, accessing, amending, managing, transferring, using or disclosing personal information.¹²

Exceptions to confidentiality

¹¹ See http://www.health.qld.gov.au/cpic/quality_strategy/quality_assur_com.asp .

¹² *Information Privacy Act 2009* (Qld) s 31.

146 Disclosure to person who has sufficient interest in health and welfare of person

(1) A designated person may disclose confidential information if the confidential information—

(a) is about the condition of the person to whom the information relates and is communicated in general terms; or

Example of communicated in general terms—

A switchboard operator or other staff member at a hospital discloses that a person's condition is 'satisfactory'.

(b) is communicated by a health professional, under the recognised standards of the relevant health profession, to a person who, in the health professional's reasonable opinion, has a sufficient personal or professional interest in the health and welfare of the person to whom the information relates.

Example of persons to whom a health professional may communicate confidential information—

- a spouse, parent or child of the person*
- another relative of the person*
- a friend of the person who has a close personal relationship with the person and a personal interest in the person's welfare*
- an adult who is providing home care to the person who has a chronic condition or a disability*
- a general practitioner who has had responsibility for the care and treatment of the person*

(2) For subsection (1)(b), if the person to whom the confidential information relates is deceased, another person has a sufficient personal interest in the health and welfare of the deceased person if, in the health professional's reasonable opinion, the other person would have had a sufficient interest while the deceased person was alive.

(3) Subsection (1) does not apply to the disclosure of confidential information to a person if the person to whom the confidential information relates asks that the confidential information not be disclosed generally or to that person.

Consumers have raised concerns with HCQ that the above provision does not afford adequate protection to health consumers in relation to their confidential information, whether it relates to their condition or other matters.

Significantly, clause 146 imposes no obligation on designated persons to seek the consent of the individual to whom the information relates before disclosing such information, compromising consumers' autonomy. Similarly, section 146(3) does not impose a positive obligation on health professionals or other designated persons to seek the consent of a consumer where s/he has capacity, or the individual's substitute decision-maker where the person does not have capacity, prior to disclosing information about the consumer. Rather, it assumes that consumers will always advise designated persons and health professionals not to disclose information generally. For consumers who are vulnerable or not capable of making such a request, this provision is especially problematic.

Further, clause 146(1)(a) does not restrict to whom information about the person's condition may be provided. As this provision currently reads, it appears that any person or organisation may be able to access information under this provision, albeit 'general information about a condition', and that a designated person can disclose

such information to any person or organisation, regardless of whether the consumer would have consented to such disclosure.

Under clause 146(b), the test for determining whether confidential information is disclosed to a person who has an interest in the health and welfare of the person is the 'health professional's reasonable opinion'. There is no explanation of what would constitute a 'reasonable opinion'. Further, what a health professional may consider reasonable may not be considered reasonable by the consumer to whom the information relates.

Consumers also expressed concerns in relation to the persons whom confidential information may be provided to – in particular, the provision of information to 'a friend of the person who has a close personal relationship with the person and a personal interest in the person's welfare'. Consumers consider this provision to be unnecessarily broad and are concerned it may result in the improper release of information contrary to the consumer's wishes. Further, there is no explanation of what would constitute a 'close personal relationship' or 'personal interest in the person's welfare' and how a health professional would establish this.

In order to afford stronger protections to consumers in relation to disclosure of their personal information, ***HCQ recommends that clause 146 in its current form be removed and a provision inserted to replace it which provides:***

- ***Prior to disclosing confidential information, even in general terms, to any person, the consent of the consumer must be obtained by the designated person or health professional. Where a consumer lacks capacity to provide such consent, consent should be obtained from the consumer's formal or informal decision-maker, including statutory health attorney.***
- ***Where consent to disclose confidential information is unable to be obtained from the consumer, or, where the consumer has impaired capacity, their formal or informal decision-maker or statutory health attorney, designated persons are restricted from divulging any confidential information about the consumer, even in general terms (except to the consumer's formal or informal decision-maker or statutory health attorney in circumstances where the consumer has impaired capacity).***

5. Conclusion

HCQ welcomes the opportunity to provide consumer perspectives around the Health and Hospital Network Bill 2011 (Qld).

HCQ considers the amendments suggested throughout this submission will contribute to the development of robust and comprehensive legislation to underpin Queensland's LHHNs and public hospital system, as well as the delivery of healthcare and treatment which is consumer-centred, timely, affordable, safe, quality, effective

and responsive, to deliver better health outcomes for Queensland consumers and communities.

HCQ supports ongoing engagement and consultation of health consumers and stakeholders around the development of Health and Hospitals Network Regulations, and other proposed reforms to ensure the needs and perspectives of consumers and communities are considered.

Health Consumers Queensland
31 July 2011