

QUEENSLAND HEALTH SYSTEMS REVIEW

Final Report

September 2005

An independent review of Queensland Health's systems (the Review) was announced by the Premier on 26 April 2005.

The Review, headed by Peter Forster of The Consultancy Bureau, is supported by a team comprising people from the Department of the Premier and Cabinet, Queensland Treasury, Queensland Police Service, Department of Public Works and Queensland Health.

The *Queensland Health Systems Review Interim Report, July 2005* was prepared following visits to 18 of 37 Queensland Health Service Districts. It included preliminary findings and principles for consideration.

This report includes the findings of the review of Queensland Health's systems, principles and recommendations for improving health outcomes for Queenslanders.

Foreword

This Review of Queensland Health's systems has come at a time of heightened community concern about the events at Bundaberg Hospital, and other health service problems such as waiting lists, clinical workforce shortages, quality of clinical services and the integrity of public reporting.

The Review has been very mindful of its obligation to properly understand the nature and cause of all of these issues or failures before suggesting remedies.

Conclusions have been derived from direct observation, assessment and discussion with several thousand staff about the performance of systems within Queensland Health and from consultation with the broader community, former patients, consumers of community health services, and some 1,300 formal submissions.

The future that has emerged can be summarised in the following broad terms.

Australia has one of the best health services in the world, if not the best. Queensland's health services and in particular the public health service, is a good service. Overall, based on all available information, it is performing as well as any other health service in Australia. The service which is supported by a large workforce of very dedicated personnel is experiencing unprecedented demand pressures. It is showing increasing signs of strain and in some cases is failing. Service demand is fuelled by population growth, advances in medicine and new technology, critical staff shortages across all professions including doctors, nurses and allied health professions, shortages in critical infrastructure such as emergency theatres and intensive care beds and limited service capability in areas such as mental health and Indigenous health.

The issues surrounding Queensland Health this year which include this Review, the initial and subsequent Commissions of Inquiry and the full glare of modern media, need also to be considered in the future planning of health services. Services will remain available only if people choose to join and continue to work in the public health system. This not only requires fair conditions of employment but maintaining a general feeling of pride in the organisation. It will be important that Queensland Health can demonstrate quickly to the community that it serves them well so that the adverse effect on its reputation can begin to be repaired. Queensland Health must restore its reputation with the community and with its staff or this may have dire consequences for its ability to continue to recruit staff and therefore provide services. Significant reform and improvement is now necessary.

The Review considered the health status of Queenslanders and access to a range of primary health care services, which if working more effectively could prevent and minimise the incidence of many serious chronic illnesses. This is important because for issues such as obesity, smoking and suicide Queensland is comparatively worse than the rest of Australia. Comprehensive primary care can not only lessen these risks but as well, limit the number of admissions to acute hospitals.

Our acute hospital health services run quite efficiently compared to the rest of Australia, but they are relatively under funded. Additional funding is required now, but it must be wisely targeted at the areas of greatest need, so Queensland Health does not lose efficiency gains that have been hard fought and won by a dedicated workforce over many

years. The Review foreshadows where funding might be best allocated, but cautions that this allocation must be backed by a greater focus on patient needs, and advice from the clinical workforce about the best ways to deliver more patient centric health services.

The Review shows that if demand for health and hospital services keeps trending the way that it has been in recent years, then greater and greater percentages of Gross Domestic Product will be required to support health care. This trend, based on current assumptions about population ageing, cost of services and statewide service demand, could not be supported indefinitely by any community, as infrastructure and supply shortages would fall progressively further and further behind demand. Clearly, long term strategies best developed by the Commonwealth and States working together, would try and fundamentally change society's approach to health care and in turn the demand for health services. However, in the next five years there is much that can be done to alleviate the very real problems that exist now.

The first important set of initiatives would be for the State and Commonwealth Government to achieve more complementary and streamlined health funding arrangements. This would ideally reduce current dysfunctions at the interface between the public and private health sectors, enabling better access across the health service spectrum to all consumers and a more coordinated focus on health status and health care generally.

Even if current funding issues are resolved and health services are performing to their best, higher percentages of Gross Domestic Product will be required to support the public health service in the coming years. The options to deal with this issue for any government include:

- increasing taxes and general community contributions and/or redistributing existing taxes (this may mean re-allocating money from other public purposes)
- introduce means tested co-payments for public health services, with private health insurance or self-insurance for individuals with the capacity to make a contribution to their health care (this includes for elective procedures)
- manage demand through encouraging greater personal effort to stay healthy and enhancing community care services to support healthier living outside of acute hospitals
- rationing or withdrawing from the delivery of certain health services altogether where these services can be provided through the non-government sectors.

The Review acknowledges that none of these options are palatable, but they are best addressed and resolved in an atmosphere of openness about the extent of the problems, likely options and consequences, and informed and meaningful public debate to guide governments and policy makers in choosing the best course of action. The Review recommends a more open and transparent public health system and a stronger community consultation role for Queensland Health in planning future health services.

For Queensland Health now the Review has identified some immediate and very practical patient centred and community centred systemic improvements that should be made, and these include:

- address the most dysfunctional aspect of the organisation's culture through the appointment and development of leaders who can by example inspire staff and develop the attitudes, culture and beliefs desired
- address immediate workforce shortages to the greatest practical extent

- improve strategic and health service planning to ensure services are targeted towards the areas of greatest need
- strengthen partnerships between the public, non-government health service sectors to gain the best possible value from combined community resources
- ensure that the organisational arrangements that deliver health services are efficient and streamlined, and allocate as many resources as practical to frontline services, where clinicians work in teams and networks across Queensland to use scarce resources to best effect
- make better use of existing capacity to meet additional needs and provide additional capacity for areas of greatest need
- implement systems and procedures to ensure the recruitment and retention of a well qualified and experienced clinical workforce, to reduce adverse clinical events and to support clinicians in their efforts to continually improve clinical practices
- implement a range of systemic improvements relating to the way clinicians are supported, the manner in which assets are planned and managed, the manner in which IT and communications services are conceived and managed, and the way in which the performance of the health service will be monitored and reported
- improve avenues for members of the community and staff of the public health service to raise concerns about aspects of the service and have these concerns responsibly and appropriately addressed and resolved.

The range of reforms recommended will require significant additional funding and a focused program of intense reform over the next three years. Continuing improvement will be required into the future, but if reforms over the first three years are successful Queensland Health will have developed the renewal capacity to ensure continuous improvement becomes a part of its normal operations.

The contribution made by many people to this Review is gratefully acknowledged, including community members, health service personnel and stakeholders including elected representatives from all political persuasions who attended forum sessions and made specific submissions.

Two Advisory Panels of eminent clinicians and other professionals have provided insightful advice to the Review, along with very generous support and contributions from neighbouring State health services in New South Wales and Victoria and from the Commonwealth Government. They added significant value to Review findings and conclusions.

The Review has comprehensively endeavoured to deal with a broad range of very complex issues in this very large organisation.

Reform recommendations offered are supported by a significant body of evidence and information and through assessment. Suggestions have also been made about the timing and staging of necessary reforms.

It would be imprudent to think that the solutions offered are the only solutions. Reform leaders should be guided by, but not constrained by what is offered.

This Review and Report would not have been possible without the tireless and willing support of a dedicated team of professional public servants assigned to assist the Review from Queensland Health, Queensland Treasury, the Department of the Premier and Cabinet, the Queensland Police Service and the Department of Public Works. It has been my privilege to work with them.

Review recommendations are commended to Government as a sound basis to reform Queensland Health's systems and services for the benefit of all Queenslanders.

Peter Forster
September 2005

Contents

| | |
|--|------------|
| Foreword | iii |
| Contents | vii |
| Executive Summary | x |
| Summary of recommendations | xxv |
| 1. Introduction | 1 |
| 1.1 The purpose of the Review | 1 |
| 1.2 Context for the Review | 2 |
| 1.3 Scope of the Review | 3 |
| 1.4 The Review process | 3 |
| 1.5 The Interim Report | 5 |
| 1.6 Final report structure..... | 5 |
| 2. The state of Queensland Health’s systems | 7 |
| 2.1 The current state based on performance reporting | 7 |
| 2.2 The current state based on the consultation processes | 19 |
| 3. Queensland’s future health care issues | 32 |
| 3.1 Future Queensland Health service demands | 33 |
| 3.2 Implications for the future of health care delivery..... | 44 |
| 3.3 Summary..... | 55 |
| 4. Culture | 56 |
| 4.1 Queensland Health culture..... | 56 |
| 4.2 Queensland Health culture: what have been the influences? | 60 |
| 4.3 The mandate for cultural change..... | 61 |
| 4.4 Directions for change..... | 61 |
| 5. Queensland Health’s structure | 68 |
| 5.1 Overview of the current structure | 68 |
| 5.2 Problems with the current structure | 68 |
| 5.3 Governance structures in Queensland Health | 69 |
| 5.4 Main features of an improved structure | 70 |
| 5.5 Review of Central Office | 76 |
| 5.6 Roles of the different levels | 77 |
| 5.7 Minister..... | 89 |
| 5.8 Involving the community..... | 89 |
| 6. Corporate planning and budgeting | 92 |
| 6.1 Health service planning | 93 |
| 6.2 Queensland Health budget systems | 101 |
| 7. Improving patient care and health services | 114 |
| 7.1 Improving patient centred care and patient flows | 114 |
| 7.2 Partnerships to improve health services for Queenslanders..... | 118 |
| 7.3 Surgical access..... | 122 |
| 7.4 Rural and remote health services | 130 |
| 7.5 Indigenous health..... | 139 |
| 7.6 Mental health | 145 |
| 7.7 Community health services..... | 151 |
| 7.8 Health services for Queenslanders in correctional institutions | 154 |
| 7.9 Oral health services..... | 154 |
| 7.10 Child and youth..... | 156 |

| | |
|---|------------|
| 8. Clinical support services..... | 158 |
| 8.1 Provision of pathology services..... | 158 |
| 8.2 Provision of radiology services..... | 160 |
| 8.3 Provision of pharmacy services..... | 162 |
| 8.4 Operational support services..... | 164 |
| 8.5 Administrative support for clinical services..... | 165 |
| 9. Risk management and clinical governance..... | 167 |
| 9.1 Risk management..... | 167 |
| 9.2 Clinical Governance..... | 169 |
| 9.3 The right person doing the right job..... | 173 |
| 9.4 The right skills..... | 179 |
| 9.5 Effective organisational systems..... | 180 |
| 9.6 The patient experience..... | 188 |
| 9.7 Clinical Governance – external oversight..... | 198 |
| 9.8 Public reporting..... | 201 |
| 9.9 Proposed roles and responsibilities for clinical governance in Queensland..... | 202 |
| 10. A workforce for the future..... | 205 |
| 10.1 Key findings..... | 205 |
| 10.2 Profile of Queensland Health’s clinical workforce..... | 207 |
| 10.3 Queensland Health’s workforce management systems..... | 218 |
| 10.4 Initiatives for doctors..... | 222 |
| 10.5 Initiatives for nurses..... | 237 |
| 10.6 Initiatives for allied health professionals..... | 252 |
| 10.7 Addressing organisational and cross-disciplinary education and training issues..... | 262 |
| 10.8 Planning for the future..... | 265 |
| 10.9 The way forward - relationships between Queensland Health and educational organisations..... | 266 |
| 11. Asset management and capital works planning to support service delivery..... | 269 |
| 11.1 Overview..... | 269 |
| 11.2 The focus of the Capital Works and Asset Management Branch (CWAMB)..... | 270 |
| 11.3 Capital works and asset management governance structures..... | 274 |
| 11.4 Health service plans as vital inputs to asset strategic plans..... | 276 |
| 11.5 Locating facilities to meet health service needs..... | 278 |
| 11.6 Capital works program funding arrangements..... | 280 |
| 11.7 Information on the performance of existing assets to support planning..... | 285 |
| 11.8 Asset management systems..... | 288 |
| 12. Information management to support service delivery..... | 290 |
| 12.1 Overview..... | 290 |
| 12.2 Current project initiatives..... | 293 |
| 12.3 Key systems..... | 293 |
| 12.4 Governance of ICT..... | 294 |
| 12.5 Organisational structures..... | 298 |
| 12.6 Information Management..... | 306 |
| 12.7 Delivering ICT projects..... | 310 |
| 12.8 Technology gaps..... | 317 |
| 12.9 Supporting the IT environment..... | 321 |
| 13. Performance monitoring of health system outcomes..... | 324 |
| 13.1 Improvements to health system performance monitoring arising from this Review..... | 325 |
| 13.2 Current performance monitoring and reporting arrangements in Queensland Health..... | 326 |
| 13.3 Performance monitoring and reporting arrangements in other jurisdictions..... | 329 |
| 13.4 Directions for change..... | 330 |

| | |
|---|------------|
| 14. Queensland Health reform..... | 340 |
| 14.1 Overview | 340 |
| 14.2 Reform success | 341 |
| 14.3 Guiding principles | 344 |
| 14.4 Reform strategy | 345 |
| 14.5 Programs of reform..... | 346 |
| 14.6 Funding..... | 347 |
| 14.7 Reform process | 347 |
| 14.8 Monitoring reform | 350 |
| 14.9 Reform programs, sequencing and timelines..... | 350 |
| | |
| Appendix 1.1 Bundaberg Hospital Commission of Inquiry Terms of Reference..... | 375 |
| Appendix 1.2 Membership of Queensland Health Systems Review Reference Panels | 378 |
| Appendix 1.3 List of Queensland Health Service Districts visited during consultation..... | 379 |
| Appendix 1.4 List of community forums held..... | 380 |
| Appendix 1.5 Excerpt from the Queensland Health Systems Review Interim Report, July 2005 | 381 |
| Appendix 6.1 Leadership and clinically managed networks | 391 |
| Appendix 9.1 RPTS summary..... | 400 |
| Appendix 12.1 Information management project initiatives..... | 405 |
| Appendix 12.2 Approved enterprise wide Information systems | 409 |
| Appendix 13.1 International Indicator Sets..... | 412 |
| Appendix 13.2 Detailed description of performance monitoring and reporting arrangements in other jurisdictions | 413 |
| Appendix 14.1 Detailed scheduling of reform programs..... | 418 |
| Abbreviations and acronyms | 423 |
| Glossary..... | 425 |

Executive Summary

Chapter 1. Introduction

- An independent review of Queensland Health's administrative, workforce and performance management systems was announced by the Queensland Government on 26 April 2005. The review was established in the context of public disquiet about the quality and safety of public hospital services, particularly arising from the circumstances surrounding the appointment and practice of Dr Jayant Patel at Bundaberg Hospital.
- The Queensland Branch of the Australian Medical Association was also instrumental in influencing the State Government to undertake a far reaching review of Queensland Health's systems. Specific concerns raised at that time by a range of professional groups related to Queensland Health's culture, excessive structural layers of decision making, the excessive numbers of administrative staff, bureaucratisation of clinical practice and care, and secrecy in dealing with information. These issues have also been examined in the context of reviewing Queensland Health's systems.
- The review is focused on Queensland Health's systems, based on direct assessment, observation, consultation, research and cooperation from Queensland Health staff, a broad range of stakeholders and public consultation to inform its views.
- The review of Queensland Health's structure and systems provides a unique opportunity to consider how well the significant systems which have been developed to support the delivery of frontline services are working, and whether these systems are effective in providing the best possible health and health care for Queenslanders.
- This report builds on the findings and principles in the *Queensland Health Systems Review Interim Report, July 2005* (Interim Report). It also includes findings from consultation with Corporate Office staff, some 1,300 submissions and relevant systemic issues passed on by the Commission of Inquiry. The recommendations for systems change and an organisation reform strategy outline how Queensland Health can implement far reaching reforms to achieve improved health outcomes for consumers, patients and the community generally.

Chapter 2. The state of Queensland Health's systems

- From an international perspective Queenslanders currently enjoy good health. However Aboriginal and Torres Strait Islander peoples, those from socio-economically disadvantaged groups and some communities from non-English speaking backgrounds experience a disproportionate share of the burden of disease.
- Chronic diseases (such as heart disease, stroke, cancer and diabetes) and mental health have the biggest impact on the quality and length of life of Queenslanders. It is estimated that through the better use of a range of health services the following deaths (largely due to chronic disease) could be avoided.
 - 3,486 deaths through better health promotion and prevention of disease
 - 1,496 deaths avoided through improved detection and management of disease in the community
 - 1,380 deaths avoided through better inpatient care in hospitals.

- Some structures and initiatives to improve the quality and safety of health services are in place but the infrastructure and an organisational culture that foster commitment to service improvement and patient safety are only in formative stages.
- In an environment of global competition for workforce, Queensland Health has the challenge of major shortage of all clinical staff. This is exacerbated by imperfect workforce management systems and a failure to invest sufficiently in the training and development of staff.
- Medium term planning of the scope and delivery of health services to achieve the greatest health benefit for Queenslanders has been limited. This has restricted the effectiveness of recent large investments in capital works (\$2.8 billion hospital rebuilding program) and information technology in meeting health service delivery needs. Priorities for performance monitoring have focused on budget integrity, inpatient activity and waiting lists at the expense of giving attention to patient outcomes, population health and quality and safety.
- While the centralised and hierarchical organisational structure (with many layers of decision making and loss of appropriate accountability and authority throughout) may in fact be partly a response to some of these challenges, it has also contributed to the frustration experienced by many staff and patients on a day to day basis. In this environment, organisational culture has taken on quite negative characteristics as evidenced by reports of bullying and intimidatory behaviour when seeking to deliver patient care in a resource constrained environment.

Chapter 3. Queensland's future health care issues

- Queensland Health has a range of challenges which will impact on the way it delivers future health services including workforce shortages, an increasing prevalence of chronic disease, changing models of health service delivery, managing increasing consumer expectations about access to services and quality of care and the ongoing need to provide services to a growing and ageing population.
- The ageing population will have an increasing impact on the health care workforce. Over the coming two decades, growth in working age population in Australia is projected to slow from an average growth of around 170,000 extra employees each year, to an annual growth of just 12,000 extra employees per year in the 2020s.
- In 2003-04, Queensland government expenditure on health services including public hospitals, mental health, public and community health and oral health was 14 percent lower than the national average, \$1,245 per person compared to \$1,444 per person. However, it would be wrong to conclude that an additional \$200 per person is justified for public health services. For many services Queensland Health provides a similar level of activity but with a lower level of expenditure.
- Increasing health expenditure without considering the priority areas of health need or the capacity of the system to delivery additional services (eg. available workforce), could risk loss of efficiency gains which Queensland Health staff have achieved over a number of years. This strength of efficiencies in the Queensland Health system should be taken into account in consideration of future funding arrangements.
- It has been estimated that Queensland Health would require an additional 170 beds per annum over the next two decades (a size equivalent to Mackay Hospital or Bundaberg Hospital per year) to meet future demand. In 2005-06, the recurrent cost of a Mackay sized hospital is approximately \$45 to \$50 million per year.

- However, workforce trends indicate that this scale of acute bed demand in Queensland would not be able to be adequately staffed in future years even if it could be financed. Longer term innovative ways of delivering health services are needed to provide health care sustainability. Simply providing more doctors, more nurses, more beds and more money is unlikely to be sustainable.
- The Report recommends a range of health system reforms to improve the way services are provided and achieve the greatest value from expenditure on health care. However, given funding limitations and workforce shortages in the public sector rationing of certain health services is inevitable and may get worse. If significant enhancements are sought to the public health system, the Queensland Government and community may need to give consideration to:
 - the need to raise additional revenue to support health services, whether it be through State taxes or means-tested co-payments for public health services
 - potential means testing for eligibility of services to public health services, with services targeted to more urgent procedures and those who can least afford to pay for healthcare
 - reviewing the current set of public health services which should continue to be provided through the public health system.
- Our current health care arrangements are fragmented and complex because of both Commonwealth and State funding roles. The Queensland Government should commence dialogue with the Commonwealth Government to review their respective roles and responsibilities and achieve better integrated, simpler health service arrangements for the community.
- A number of joint initiatives have been suggested where the Queensland and Commonwealth governments could address immediate priorities including
 - a single funding arrangement
 - Commonwealth payments for all medical practitioners whether in the public or private sector;
 - pooled funding arrangements with simpler reporting requirements
 - re-weighting Medical Benefit Schedule in favour of rural and remote practice
 - greater Commonwealth funding of clinical student placements in public hospitals, registrar and protected teaching time
 - working with other States and the Commonwealth to promptly achieve the implementation of a national system of registration for medical practitioners.
- Everyone has a role to play in ensuring the future sustainability of the health system. It is estimated that one-third to one-half of the burden of disease is preventable or can be delayed. The western lifestyle including diet, inactivity, excess consumption of alcohol and smoking is contributing to pressure on the health system. Changing lifestyle is challenging, but essential to improving personal health and reducing future reliance on healthcare.

Chapter 4. Culture

- Queensland Health personnel generally are a dedicated, professional and committed workforce, with a strong ethos to do the best for patients and consumers. However, district visits, district surveys and submissions to the Review confirmed that there are negative features of the organisations culture which are severely impeding its ability to delivery the best possible standard of service to patients and consumers.
- Dysfunctional behaviours including bullying, intimidation and a reluctance to share information were frequently reported and confirmed at least to some extent by the staff survey which was undertaken.
- Other features of culture in keeping with health care systems generally are the professional ‘silos’ which reflect traditional occupational groupings. The Review confirmed that budgetary and workload pressures have worsened these ‘tribal’ behaviours and contributed to a less than satisfactory workplace environment.
- The Report advocates a culture where:
 - patient centric services and community engagement are pre-eminent values
 - individuals are well informed about the scope and access to services and options to enhance their own care
 - leaders are empowered and demonstrate positive behaviours which support and value the contribution of the staff
 - staff are confident in their leaders and their employer and have pride in the services they deliver
 - all people in the organisation treat each other with respect.
- The Review emphasises that new and reformed leadership, setting the right example and engendering the commitment, support and trust of the staff will be essential in achieving the culture desired. A significant focus on teamwork and reform activity will be necessary to achieve the desired changes.
- Fundamental to this change is a shift from centralised decision making to clinician lead decision making. The Report recommends the establishment of empowered Area Health Services and clinical networks to facilitate this change.
- This culture change depends on additional funding support to relieve work pressures and enable the degree of training and team development necessary.

Chapter 5. Queensland Health’s structure

- Queensland Health’s services are currently provided though a network of 37 Health Service Districts, the Mater public hospitals and statewide services supported by three Zones and a large corporate office.
- Queensland Health has a bureaucratic mechanistic structure characterised by highly centralised formal authority and hierarchical layers of decision making and separate directorates which do not support a responsive, integrated and efficient health system. A key problem with the structure relates to bottlenecks in decision making particularly as the position of Senior Executive Director of Health Services is responsible for more than 80 percent of the department’s resources. This slowed

down the flow of information and the capacity of the organisation to implement new policy or respond to service delivery pressures.

- The proposed structure has been designed to support the provision of health services having regard to community need and internal service capabilities. Such a structure would be flatter with accountability and decision making devolved to a lower level. In particular, clinical decisions should be made as close to the point of patient care as possible and in a timely and responsive manner conducive to good quality care.
- The proposed structure features three Areas Health Services largely based on the boundaries of the existing Zones which align with population aggregates of around one to two million each and maintains 37 health service districts. The Area Health Services will have increased leadership, management, policy, planning and performance monitoring capacity coinciding with greater budget responsibility, accountability and decision making authority.
- Central Office functions will be reduced commensurately and will focus on policy, planning, resourcing, performance, statewide population health and support services for Area Health Services and Districts.
- Of the estimated 4,590 positions that directly report to or are within Central Office 679 positions be transferred to Area Health Services of which around 365 positions relate to public health networks that are already located within Districts and will now report to the Areas. 162 positions from the existing Corporate Office are recommended to be abolished with any savings to be redirected to health service priorities.

Chapter 6. Corporate planning and budgeting

- *Smart State: Health 2020* set a strategic direction to commence addressing the issues outlined above. Queensland Health faces the challenge of undertaking a longer term change process while at the same time needing to deal with the immediate imperatives of improving public health care services, particularly acute care and mental health services.
- There are a myriad of plans in Queensland Health, although these plans are developed individually with no clear link to a broader health service plan reflecting population health needs and integrating clinical, workforce, infrastructure and financial planning. There has been limited coordinated service planning since the substantial work undertaken at the time of the Statewide Hospital Rebuilding Program.
- A key priority must be to develop a health services plan to integrate the burden of disease and changing demographics, the identified need to change models of care, community values and priorities for health and health care service, a scope of services - recognising quality and safety requirements and setting achievable targets. Clinical networks will be developed over time to provide strong clinical input into the development of these plans.
- The Review identified significant opportunities to better coordinate and rationalise health services across metropolitan Brisbane. The General Managers of Southern and Central Health Service together with the clinical networks will address these issues.
- Queensland Health's budget in 2005-06 is \$5.4 billion. The health budget has grown at an average 7 percent per annum over the last ten years. Over the last ten years, Queensland Health has moved from a department which routinely recorded deficits to one which now operates within its budget.

- Queensland Health's budgets are allocated internally on the basis of historic funding. While the budget growth has sought to match population growth areas, hospitals in areas such as the Gold Coast and Sunshine Coast are struggling to meet demand. A more responsive and transparent approach to budget allocation is required, including one which supports new funding being directed promptly to service delivery entities.
- The Review is recommending the implementation of a regional distribution formula for the allocation of funding to Area Health Services and over time to districts, and the implementation of casemix funding for acute hospital services. Altering historical patterns will be very difficult as all major hospitals are struggling to cope with current demand pressures. Any change to district budgets would need to occur through the distribution of growth funding over five years. The allocation decisions should be strongly influenced by clinical networks.

Chapter 7. Improving patient care and health services

- There are many opportunities to improve health outcomes, improve patient care and design more effective and efficient service models.
- Examples from Queensland and other states show that redesigning business processes can improve the responsiveness of services, including reduced waiting times for patients and reduced pressure for clinical staff. Redesign is recommended at the local level, with regular input from clinicians and support from reform facilitators in districts.
- It is suggested that Queensland Health invest in a broader range of partnerships to maximise available resources and provide more effective services. This will require cultural change and recognition within Queensland Health that other service providers may be better able to meet patient and community needs. Models such as fund pooling, service devolution, service coordination and outsourcing should be considered across the continuum of health care and with other sectors such as non-government and private sector health providers, local government, community services and universities.
- The vagaries of elective surgery waiting times and waiting lists have caused great anxiety for patients. There is much concern about the inordinate waiting times to see a surgical specialist which is then followed by a wait for surgery, in some instances longer than a year. Excessive waiting periods have resulted from budget and workforce constraints, resulting in less than optimal patient outcomes.
- It is estimated that 108,571 people (based on July 2004 data) are waiting to see a public surgical or medical specialist in outpatients. Of these it is estimated that 25,000 would be assessed as requiring surgery and be placed on the surgical waiting list. This is in addition to the 33,656 people already on the waiting list at July 2005 of which 22 percent have been waiting longer than clinically appropriate.
- The Review estimates an additional \$100.8 million in funding for surgical services (\$61.6 million ongoing) would be required to ensure that patients received treatment within clinically appropriate timeframes and to address unmet demand from access blocks in specialist outpatients. Improving access to specialist outpatient services should be a priority with private models, similar to those used in other States, pursued in collaboration with the Commonwealth Government.

- Surgical services are currently funded and managed in a way that does not support the prioritisation of care based on clinical need. There are financial incentives for districts to meet elective surgery targets which have in some instances been to the detriment of other hospital services.
- Recommendations reforming the funding and management of surgical services as well as principles to guide the further development and enhancement of surgery have been offered through a set of principles. It is envisaged that as clinical networks become established that they take responsibility for shaping the future direction of surgery in Queensland public hospitals.
- Given the interrelationship between the public and private health sectors, Government should explore measures that will improve access to priority surgical services and eliminate long waits for emergency and urgent surgery. Such measures could include a means tested co-payment to access to non-urgent surgical services in the public system.
- Rural and remote communities are entitled to expect safe and timely health care. However, different models of care, more “generalist” workforce roles and improved transport assistance are required to provide sustainable services in these communities. Queensland Health should work with local communities, other service providers and the education and training sector to meet these challenges. Competitive remuneration and incentive packages and ongoing professional support are also needed to recruit and retain a skilled clinical workforce.
- Indigenous people continue to be amongst the most disadvantaged people in Queensland and their health continues to lag behind that of other Queenslanders: on average, Indigenous Queenslanders die 20 years earlier than their non-Indigenous counterparts and experience a much higher burden of disease, including chronic diseases, injury and many infectious diseases. Concerted efforts should be continued across sectors to improve the socio-economic status of Indigenous Queenslanders, promote healthy living, deliver existing and new models of health service within the principle of self-determination and community control, and increase the representation of Indigenous people in health professions.
- Consumers and advocates raised significant concerns with the quality of, and access to, mental health services in Queensland. The Review heard numerous tragic accounts of systemic failure within the community and acute settings despite real funding increases to mental health (74 percent between 1997-98 and 2003-04, rising from \$240 million to \$419 million). Despite this significant increase, Queensland’s expenditure was 11 percent below the national average in 2002-03 and more must be done to increase mental health services, particularly in community settings.
- Increased funding could be directed to improved staff and facilities, hospital discharge support, increased partnership with the non-government sector and improved linkages with other community services such as housing and disability services. Improved services and models of care are required for specific population groups include people with mental illnesses who are Indigenous, homeless, in prison, have dual diagnosis, living in rural and remote communities and children and young people.
- With respect to community health services more generally, service models need to be clearly defined in collaboration with the acute sector, general practice, non government organisations and community groups. A particular focus is required on providing post-acute care and preventing unnecessary hospital admissions. Improved

information systems are needed to monitor activity and performance at the local and State-wide levels.

- Queenslanders have the lowest standard of oral health in Australia. Public oral health services are unable to meet demand, particularly adult services where treatment is directed to health care card holders and for emergencies. School dental services should be continued whilst service models for adults should be reviewed including informed public debate about the benefits of water fluoridation, targeting eligibility criteria, increasing involvement of private oral health practitioners through flexible local arrangements and developing alternative workforce roles.
- Children and young people aged 0 to 14 years comprise 20 percent of the population and have distinctive health needs and priorities. While Queensland Health provides many services and programs for children, young people and their families, there is not a comprehensive plan across the continuum of health. A child and youth clinical network is suggested to undertake dedicated planning for children and young people's health. More broadly, continued efforts with other agencies on priority issues such as education and child safety are suggested, including concerted efforts to identify and assist "at risk" families to reduce the risk of child abuse and neglect.

Chapter 8. Organisation and delivery of clinical support services

- Queensland Health is experiencing workforce shortages for radiology and pharmacy, and is also experiencing real competition with the private sector for pathologists.
- The Review recommends the implementation of a Clinical Support Services Group within Queensland Health to provide statewide services to provide radiology and pharmacy, similar to the arrangements currently applied to the Queensland Health Pathology Services.
- The Clinical Support Services Group will provide a more commercial focus to the delivery of clinical support services, including contracting with private providers for the provision of services where Queensland Health is unable to provide adequate services internally. The Clinical Support Services Group will need to help to ensure its delivery of services is cost effective from a statewide perspective compared to private alternatives.
- Many clinicians in Queensland Health indicated that increasing amounts of their time is being taken up by administrative tasks. Clinicians in particular highlighted the reality of a 24/7 service, but that much of the organisation (including administrative support) functions nine to five, Monday to Friday.
- Clinicians should focus their time on clinical services, not administrative and operational support tasks. Business process reviews are required within Queensland Health to simplify the current administrative load. The Review is recommending the increased use of administrative support staff in clinical areas including extended hours of administrative support in hospitals.

Chapter 9. Clinical governance and risk management

- The quality and safety of health care is an increasing concern for the community. These community concerns have been recently highlighted by events surrounding clinical care at the Bundaberg Base Hospital.

- The quality and safety of health services can be improved by having the right people - doctors, nurses and allied health - doing the right job, with the right skills, working in well functioning teams and supported by effective systems. These are the essential elements of a good clinical governance system.
- Comprehensive reforms are recommended which will result in Queensland Health having a vastly improved clinical governance system in which the community can have confidence. It will include improved:
 - recruitment and selection processes,
 - credentialing and privileging,
 - incident monitoring and reporting
 - involvement of clinicians in enhancing practice and comprehensive, multi-disciplinary clinical audits.
- The cornerstone of the external governance framework is a Health Commission proposed to be established under new enabling legislation. It would assume the role of the current Health Rights Commission as well as oversee the development and implementation of quality, safety and clinical practice standards throughout the state's public and private health facilities. It is further proposed that a Parliamentary Committee established under the *Parliament of Queensland Act 2001*, would oversee the operation of the Health Commission.
- A stringent accountability framework has been proposed for complaints handling in which local resolution is coupled with open disclosure with patients and overseen by external bodies. Complaints coordinators should be authorised to resolve complaints. Area Complaints Managers and locally based Health Commission staff are proposed to ensure that patients have their concerns appropriately and effectively addressed. Independent Patient Support Officers will further assist patients resolve their concerns.
- Recommended changes to the *Whistleblowers Protection Act 1994* (the Act) will increase the categories of persons who can claim protection under the Act. These changes also provide for Whistleblowers to lodge public interest disclosures with Members of Parliament and have protection under the Act.
- Given recent events in Queensland, the public must have access to accurate information about the quality and safety of health services. Proposed sources of public reporting by external bodies will be the Minister for Health, the Health Commission and District and Area Health Councils.

Chapter 10. A workforce for the future

- The ability to provide quality health services to the community depends on the availability of a workforce of highly skilled and trained health professionals. Queensland Health is the largest employer of health professionals in the State with over 53,300 people employed across the organisation which equates to 43,790 full time equivalent staff.
- The Review was particularly impressed by the dedication and commitment of the doctors, nurses, allied health professionals and other staff who work in Queensland's public health system. Staff are working in increasingly complex and stressful environments having to cope with rising workloads, sicker patients, and growing expectations from consumers about what health services can deliver.

- The Review found extreme levels of dissatisfaction amongst Queensland Health staff with many staff feeling angry, frustrated and resentful especially towards senior management in Queensland Health. Morale is concerningly low amongst some clinical staff who feel undervalued and marginalised from the system. A culture of bullying, coercion and cover-up has served to further alienate staff and is contributing to significant levels of dysfunction in the workplace.
- Workforce management systems such as rostering and payroll systems impose unnecessary administrative burdens on staff, reducing the time available for patient care and adding to the frustrations of clinical staff. Recruitment processes are drawn out, administratively cumbersome and do not always support the attraction of the most suitable candidate for a position. Strategies to attract and retain staff are piecemeal and vary across the different professional groups and across Districts. Staff experience difficulties in accessing basic training and professional development opportunities and increasing service delivery demands are impacting on the important role of the public health system in teaching and training the health workforce of the future.
- Queensland Health has managed to grow its workforce in numbers in all categories of staff, however, particularly clinical staff in acute hospitals are experiencing unsustainable workload levels. Queensland continues to have the lowest number of health professionals per capita of any State or Territory except for Tasmania and now requires additional clinical staff for all health service placements, particularly hospital roles.
- In summary, the organisation is failing its employees in many fundamental ways. An enormous improvement effort is now required, with leaders and HR/IR support personnel having critical roles to fulfil. Queensland Health must become a very good and contemporary employer especially as it is facing such critical supply constraints for its future professional workforce.

Doctors

- The number of medical practitioners employed by Queensland Health has increased by 69 percent since 1996 from 2,027 full time equivalent salaried medical staff to 3,434 full time equivalent staff in 2005. The number of Visiting Medical Officers (VMOs) who are private specialists performing sessional work in the public hospital system fell from 407 full time equivalent staff in 1996 to 240 full time equivalent staff in 2005. This reflects reducing hours rather than numbers of staff as the headcount for VMOs decreased from 883 to 851 staff over the same period.
- A significant proportion of the growth in salaried doctors has been accomplished with the use of overseas trained doctors with special purpose registration who now comprise approximately 27 percent of Queensland Health's medical workforce.
- Immediate steps are necessary to relieve the pressure on the medical workforce and increase staffing numbers. The Review estimates Queensland Health requires a growth of 160 to 180 doctors each year.
- It is less than appropriate that Queensland Health should rely on doctors trained in developing countries where their skills are most needed. Every effort should be made to employ Australian trained doctors. Shortfalls will inevitably remain. Recruiting should target doctors from countries with similar educational standards in the first instance. An active recruitment campaign needs to commence straight away to attract more doctors including private specialists who may be willing to provide sessions in the public hospitals, interstate doctors and overseas doctors from countries with

comparable training standards. A greater use of general practitioners also needs to be explored. Recruitment of doctors from developing countries should be an option of last resort.

- Recruitment efforts must be supported by measures to clearly demonstrate that Queensland Health values its clinical staff including changing the organisational culture, ensuring fair remuneration and more flexible working conditions, and providing access to appropriate training and skills development. Basic amenities for staff need to be upgraded including personal space, meeting and staff common rooms and increased administrative support should be provided to deal with a large volume of basic administrative material to free up doctors time for patient care.
- Our senior clinical staff should have protected time to undertake teaching and provide adequate support and supervision to junior staff. The number of specialist training positions must be expanded to address skills gaps and avoid further exacerbation of specialist shortages in the future.

Nurses

- Nurses constitute the largest proportion of the health workforce (16,943 full time equivalent staff or 21,750 staff on a headcount basis). However, nursing numbers have not kept pace with growth in demand, growing by only 12.1 percent from 1996 to 2005 which is less than population growth over the same period.
- It is estimated that more than 50 percent of nursing staff are working part-time and the average age of a nurse is now in the mid-forties. Many nurses leave the nursing profession altogether with wastage rates reported to be as high as 30 percent. Queensland Health needs to urgently implement strategies to encourage nurses back into the workforce including scholarships for re-entry and refresher courses. A staff incentive program to re-attract nurses in particular experience categories is suggested. A strategy to support registered nurses with assistants-in-nursing and enrolled nurses is necessary. Much more must be done to support students and new employees through the provision of preceptors and supervisors with dedicated time.
- A target of recruiting an additional 1500 nurses over three years (including registered and enrolled nurses and assistants in nursing) is suggested to provide immediate relief to the nursing workforce. In addition, the Review estimates Queensland Health will need to recruit a further 500 registered nurses per year to manage future demand for services.
- Nurses should have access to flexible and family friendly working arrangements and amenities such as safe car parking. Remuneration for Queensland Health nurses should be fair and comparable to other States, taking into consideration differences such as cost of living.
- Queensland Health needs to make better use of its existing workforce including a greater role for nurse practitioners, enrolled nurses, assistants in nursing and other health workers as well as encouraging and supporting nurses to take on advanced practice roles. Adequate funding needs to be provided to Districts to increase nursing numbers in line with increasing demand for services. In-house nursing relief pools should be established so as to reduce reliance on agency staff and support reforms recommended in the Report. Queensland Health needs to review nurse education numbers and provide adequate resourcing for backfilling of positions to allow staff to access training and professional development opportunities.

Allied health

- While the number of professional staff employed by Queensland Health which includes allied health professionals has grown by almost 60 percent since 1996, staffing levels in Queensland are significantly below those in other States. The lack of sufficient allied health staff working in the public hospital system is a major problem and active efforts are required to recruit additional allied health staff, in particular allied health therapy staff, as a matter of priority.
- Given the overall smaller numbers of allied health professionals, it is important that there is strong leadership representation at the highest level. The Review is recommending that an allied health leadership position be created in the new Areas Health Services to raise the profile of the profession and drive recruitment activities.
- Allied health staff need high levels of support particularly those practising in rural and remote areas. Districts should be encouraged to establish peer support networks for staff in rural and remote areas and establish a register for staff willing to undertake country rotations. This would include allied health professionals as well as doctors and nurses.
- An improved career structure for allied health staff is required and improved clinical career paths for advanced and extended practice roles and clinical leadership positions should be introduced. To encourage ongoing education, allied health staff should be made aware of their entitlements and adequate resourcing be made available to support them attending professional development courses.
- A target of recruiting 2,000 additional allied health staff over three years has been set with university partnerships a big part of the long term strategy.

Chapter 11. Asset management and capital works planning to support service delivery

- Chapter 11 highlights that although there has been considerable investment in Queensland Health assets over the last decade, the investment levels have not matched the increase in demand for new and replacement health service assets, particularly the growth in inpatient demand and the need for step-up and step-down facilities.
- Many past capital investment decisions have been questionable, leading to health service facilities that are not fit-for-purpose or support efficiency in infrastructure and health service delivery.
- The Report calls for more comprehensive health service planning to better inform asset strategic planning and investment decisions.
- Development and use of standard infrastructure design guidelines are recommended to ensure development of health service facilities that integrate best practice design features leading to efficient service delivery to patients.
- A greater focus on the alignment of investment in capital infrastructure and assets with health service delivery is recommended through increased health service staff input and representation on the Capital Works and Asset Management Committee and in development of Queensland Health's Asset Strategic Plan and Capital Works Program. Bringing asset decisions closer to the people delivering health services should facilitate better outcomes for patients and the health service overall.

- Future decisions regarding the location of health facilities need to have a more transparent and patient-focused processes involving stakeholders and with greater accountability for decision makers, through independent review by the Auditor-General.
- Queensland Health faces many challenges in funding the capital works program. Preliminary estimates, that will need to be confirmed, indicate a shortfall of some \$500 million in funding required to meet projected demand for new and replacement assets over the next four years, and an unfunded maintenance backlog (once off cost) estimated at between \$200 million and \$300 million. To maintain the department's asset stock adequately and the capacity to deliver high quality health services, Queensland Health and Queensland Treasury need to establish a long term sustainable funding model that is responsive to growth in demand for new and replacement health service assets and health technology equipment. Patient care priorities should be targeted in the first instance.
- The Chapter also highlights several management and organisational characteristics and issues impacting on the operational efficiency and effectiveness of the Capital Works and Asset Management Branch and identifies the need for Queensland Health to implement effective management information and reporting systems to monitor performance of assets in meeting health service needs and whether value for money was achieved from its asset investments including establishment of a rigorous post-occupancy evaluation process for all major capital work projects.

Chapter 12. Information management to support service delivery

- Information is a key enabler in the delivery of health outcomes in Queensland. Information and Communication Technologies (ICT) management services within Queensland Health are currently governed and delivered at the corporate level. Other states have indicated a view that the centralised nature of ICT provision in Queensland Health has provided significant information management benefits.
- Queensland Health has many information systems providing a wealth of data. These systems are met with varying levels of acceptance by system users. Districts expressed overall dissatisfaction with the systems and support for ICT.
- While investments in administrative systems have generally met basic requirements, there has been a higher level of dissatisfaction expressed because of the relatively low level of ICT investments in clinical systems. Small, local solutions have flourished in this environment.
- The current information systems are not well integrated and not designed around work processing needs of clinicians. Rather, individual systems are designed for individual lines of business resulting in access to a multitude of systems with sometimes duplicate data input required to conduct duties. This problem is not unique to Queensland Health and is characteristic of the maturity of ICT systems in the health sector.
- The information management function (in this context, the manipulation, re-organization, analysis, graphing, charting, and presentation of data for specific management and decision-making purposes) is not well understood or resourced across Queensland Health. The Information Management Strategic Plan recognises this and has flagged a strategic initiative aimed at improving information management competencies.

- There is a lack of focus on strategic information management and use of data to guide decision making in the organisation. Queensland Health would benefit from a more coordinated approach to analysis and interpretation of data, with a specific goal of supporting service planning, quality and safety and monitoring performance.
- It is critical to develop and maintain skills and corporate knowledge in data management, statistical and epidemiological services across the organisation. A data management and epidemiology analysis network would address this issue.
- The Information Directorate, that is currently responsible for provision of enterprise wide ICT, is in the process of implementing a major change program aimed at improving the level of ICT governance and ICT service delivery in Queensland Health. This reform agenda has been detailed and thorough, although at the time of this Review, results were not expected to be evident. The recommendations of this Review in regard to ICT are supplementary to the reform already underway, which needs to continue and be carefully monitored if benefits are to be realised.
- The basic needs of clinical staff for access to and training on computers are not being met. Until these basic tools are in place, Queensland Health will find it difficult to leverage the potential benefits of new investments in ICT.
- The information management recommendations are broadly focused at:
 - Improving the customer focus and performance management environment around Information Directorate.
 - Reshaping the accountability, resourcing and change management environments for new project initiatives to ensure they meet clinical and patient needs.
 - Meeting the basic needs of clinicians for access to and training in ICT, which have been overlooked in recent times.
 - Delivering small pilot systems to support essential elements of clinical care and practice to demonstrate the value of such approaches to the clinical workforce before delivering system wide solutions where risks are high and acceptance uncertain.
- The recommended organisation of the information management function is designed to gain the maximum advantage of a coordinated and systemic approach to information systems across Queensland Health, yet keep the operational delivery and design of systems as close to the front line as possible.

Chapter 13. Performance monitoring of health system outcomes

- Queensland Health has a range of frameworks for monitoring and reporting its performance, a number of strategic indicators of performance and hundreds of operational indicators that are required to be reported against under various funding arrangements. The focus on performance has clearly been on hospitals and in particular financial and activity measures. The Department recently attempted to introduce a more balanced approach to monitoring its performance on strategic priorities but this approach was limited to internal monitoring and has not resulted in significant performance reporting to date. Major performance gaps exist in monitoring patient outcomes and the quality and safety of clinical services.
- The recommendations made in relation to other terms of reference will significantly improve Queensland Health's capacity to monitor health system outcomes, particularly the development of a statewide health service plan which integrates

clinical service planning, workforce planning, capital planning and information technology planning. This plan, together with plans developed by clinical networks for high priority issues, will identify targets to be measured including patient outcomes and the quality and safety of services.

- The health system outcomes that should be monitored are: health status and health determinants; patient outcomes; health service activity, expenditure and efficiency; workforce, the quality and safety of services, service responsiveness, and health service sustainability.
- The performance monitoring and reporting system should:
 - be based on the above performance outcomes
 - be influenced by performance agreements with service managers and senior executives
 - comprise monthly reporting and six monthly interactive performance reviews that are focused on the collaborative identification of performance improvements and innovations
 - include external review of monthly and six monthly performance by District and Area Health Councils and regular review of the systems to support clinical governance and the quality and safety of clinical services through an independent Health Commission which reports to the Minister for Health and a parliamentary committee.
- The public should have access to the health system outcomes achieved by Queensland Health through annual reports by the District Health Councils and Area Health Councils, six monthly area health service reports, hospital performance reports, annual reports on sentinel events, annual reporting to government and biennial reports on the health of the population. The Health Commission should publish an annual report on the implementation of clinical governance systems and the quality and safety of clinical services. The Auditor General should conduct performance audits of non-clinical health systems.

Chapter 14. Queensland Health service renewal

- A set of reform principles, reform strategy and program has been suggested, which would see significant progress and improvement over an initial intense three year period. Reform should be ongoing after this as an integral part of the way Queensland Health operates.

Summary of recommendations

The following is a summary of the recommendations contained in this report. The principles and rationale for the recommendations can be found in their respective chapters and for this reason, it is advisable that the recommendations are read in the context of their respective chapters.

| Chapter 3. Queensland's future health care issues | |
|--|---|
| 3.1 | The Queensland Government implement a three to five year funding plan to increase provision of public health services to a level more comparable with other States. |
| 3.2 | To address future health care challenges, alternative models of health care must be developed to reduce future pressure on acute hospital services consistent with the directions outlined in the recommendations of this report. |
| 3.3 | The Queensland Government to seek a specific national review of the future health care system in Australia, to resolve the respective roles and responsibilities of Commonwealth and State Governments in the provision of integrated health care for the Australian community. |
| 3.4 | <p>Within the current Commonwealth-State responsibilities, the Queensland Government should work closely with the Commonwealth Government to address immediate health care priorities including:</p> <ul style="list-style-type: none"> • implementation of the national system of registration for medical practitioners in conjunction with the other States • urgently examine the feasibility of the Commonwealth becoming the sole funder of doctors to reduce the current Commonwealth financial incentives for doctors to leave the public sector • urgently develop, in conjunction with professional colleges, a timetable for the establishment of all additional specialist medical training positions recommended by the Australian Medical Workforce Advisory Committee, with the Commonwealth Government to provide funding for the training positions • review the Medical Benefits Schedule to improve the alignment of Commonwealth funded services and the public health system including providing incentives to address particular areas of need such as rural health and Indigenous health • develop pilot sites in Queensland to trial arrangements such as pooled funding and general practitioners working in public hospitals.. |
| 3.5 | The Queensland Government should engage with the Queensland community to clarify what the community expects from its health system, what it is prepared to pay and how it is prepared to pay for it. This needs to occur in the context of Queensland Health developing comprehensive health service planning and development of options with the community. |
| 3.6 | Queensland Health in conjunction with local government engage the community on the feasibility of introducing fluoridation to the drinking water, the consequences and cost. |

| Chapter 4. Culture | |
|---------------------------|--|
| 4.1 | <p>Appoint a senior executive leadership team able to demonstrate positive leadership behaviours.</p> <p>Existing senior managers should demonstrate required leadership behaviours and be genuinely committed to processes to eradicate bullying and other inappropriate aggressive or coercive behaviours. They should be supported in this through leadership development programs.</p> <p>Leadership style and behaviours should be monitored to ensure only those leaders with the capacity to influence culture in the manner desired remain in critical leadership positions.</p> <p>Clinical leadership should be fostered and encouraged and progressively relied upon to be responsible and accountable for many of the functions currently performed by executives in Corporate Office and district hierarchies and executives.</p> <p>Written correspondence, especially the Code of Conduct, formal policy and guidelines should be written in an enabling rather than constraining manner.</p> <p>Staff should be encouraged to form allegiances to a new set of organisation values that are patient and consumer centric whilst maintaining a performance and efficiency orientation.</p> <p>Surveys of workplace culture and staff satisfaction be undertaken regularly across the organisation so that all districts can monitor their progress with cultural change through time.</p> |
| 4.2 | <p>New approaches are developed to deal with staff conflict and grievances to be supported by</p> <ul style="list-style-type: none"> • access to training for managers where required to ensure that they have the skills to manage and develop staff and undertake performance assessments • formalised performance assessment processes for senior executive staff and more flexible approaches for other staff which involve regular discussions with managers and supervisors, monitoring access to agreed training and development opportunities, clarifying expectations and reviewing performance • local access to industrial and human resource expertise to assist managers in effectively dealing with difficult and complex human resource issues • a system to monitor the effective and timely resolution of grievances • a review of the effectiveness of the current internal process of investigation with a view to utilising private sector Human Resource expertise in this area. |

| Chapter 5. Queensland Health's structure | |
|---|---|
| 5.1 | <p>The current 37 Health Service Districts are retained.</p> <p>Three Area Health Services be established: Southern, Central and Northern.</p> <p>Each Area Health Service to be led by a General Manager who reports to the Director-General. District Managers within each Area will report to the General Manager of the Area Health Service.</p> <p>Areas would have greater management and budget authority and accountability to plan, manage and deliver health services in their Areas.</p> <p>It is important that the General Manager positions be recruited promptly so that the reforms driven from the Areas can commence.</p> |
| 5.2 | <p>The functions to be retained within Central Office are:</p> <ul style="list-style-type: none"> • strategic direction setting • statewide health service plans and policies • statewide workforce planning and reform initiatives • acquisition and allocation of funding to the Area Health Services • performance monitoring • regulation • population health policy and monitoring • capital and asset planning. <p>The Chief Operations Officer with responsibility for statewide clinical services and business services will report to the Director-General but be located outside of the Central Office.</p> <p>Central Office functions will be managed by the following positions that report to the Director-General. These positions should be recruited promptly:</p> <ul style="list-style-type: none"> • Executive Director Policy, Planning and Resourcing • Executive Director Performance • Chief Health Officer • Chief Operations Officer • Executive Director Corporate Services |
| 5.3 | <p>Plan and establish a Health Commission, the membership of which consists of eminent health professionals, experts in the field of quality and safety systems, consumers and those with an interest in improving health in Queensland.</p> <p>Establish a Reform Advisory Panel with membership of eminent health professionals to provide advice to the Minister and Director-General on the implementation of reforms.</p> <p>Establish a Business Services Board to oversee activity and advise the Chief Operations Officer and Director-General on commercial issues relating to statewide business and clinical support services to enable contestability for these services.</p> |

| | |
|------------|--|
| <p>5.4</p> | <p>Central Office to be reduced to 644 positions. Central Office to include the Office of the Director-General, Policy, Planning and Resourcing, Performance, Corporate Services, and the Chief Health Officer.</p> <p>679 positions transferred to Area Health Services. The majority of these positions are physically located outside of Central Office but have reported through Central Office as part of a statewide public health service. Other positions will be transferred to Areas to fulfil the broader role that Areas have under the proposed structure.</p> <p>162 positions within Central Office have been identified as surplus under the new arrangements.</p> <p>Under the proposed structure the following staffing profile is recommended:</p> <ul style="list-style-type: none"> • Office of the Director-General: 91 FTE positions • Policy, Planning and Resourcing: 124 FTE positions • Performance: 79 FTE positions • Chief Health Officer: 209 FTE positions • Corporate Services: 141 FTE positions <p>All positions within Central Office should be established under the Public Service award. All other positions should be established under the Public Sector award.</p> <p>Central Office staffing establishments be allocated and monitored so that accurate data is available.</p> |
| <p>5.5</p> | <p>The following measures should be undertaken to provide the Rural and Regional Districts with a greater degree of support:</p> <ul style="list-style-type: none"> • The 19 Rural and Regional Districts with a population less than 60,000 be known as Rural and Regional Districts. These districts are shown in Table 5.2 of the report. • Each Area Health Service will have a Director of Rural and Regional Services who will be responsible for ensuring effective support to these districts. The District Managers for these Rural and Regional Districts will report to the Area General Manager. • The Director of Rural and Regional Services will provide assistance to the Rural and Regional Districts for the implementation of statewide policies. |
| <p>5.6</p> | <p>Area Health Services review Health Service District boundaries and align district boundaries to Local Government Area and Statistical Local Area boundaries.</p> |
| <p>5.7</p> | <p>Area Health Service General Managers rationalise district executive structures to compliment clinical leadership and governance changes recommended to minimise overheads and ensure members of the district executive share equivalent tenure.</p> <p>A suggestion for consideration is that the Director of Medical Services at a tertiary facility may have appropriate skills for the Area Director of Clinical Governance and a Director of Nursing in such an institution may have skills relevant to an Area Director of Nursing.</p> |

| | |
|------|--|
| 5.8 | <p>The District Managers will report to the General Manager of the Area Health Service and be accountable for:</p> <ul style="list-style-type: none"> • implementation of the Area Service Delivery Plan in their district • the provision, funding and coordination of health services for the population of the district within the budget allocated, compliance with Clinical Services Capability Framework and as detailed in the Performance Agreement with the Area Health Service • the safety and quality of health services provided • consulting and liaising with the District Health Council to assist the Council to meet their functions. This would include ensuring the Council has the support required to carry out their role. • working collaboratively with other health service providers, government and non-government services that interact with the health service • taking on portfolio area responsibilities as delegated by General Manager Area Health Service. |
| 5.9 | <p>South Burnett Health Service District be transferred from Central to Southern Area Health Service.</p> |
| 5.10 | <p>By 2010 the need for a fourth Area Health Service should be considered.</p> |
| 5.11 | <p>The General Manager Area Health Services positions are to be recruited promptly.</p> <p>The General Manager Area Health Services will be responsible for:</p> <ul style="list-style-type: none"> • planning public sector health services and capital works • public sector health services delivered through Health Service Districts • population health • Indigenous health strategies working with Indigenous communities • workforce management, reform and training • Area resource allocation, utilisation and monitoring • clinical governance including medical credentialing and privileging • performance management • risk management • consulting with the community regarding planning and provision of health services • consulting with and supporting the Area Health Council • partnering with other service providers and government agencies • commenting on health service and operational issues to the media. |
| 5.12 | <p>Clinical Networks be established within twelve months and be recognised as a legitimate and authorised part of the formal structure.</p> |
| 5.13 | <p>District Health Councils be maintained as per the Health Services Act 1991 with appropriate remuneration for their involvement.</p> <p>District Health Council members be recruited and nominated to the Minister by the Health Commission.</p> |

| | |
|------|---|
| | <p>Council members be provided with a suite of regular reports to monitor the performance of the District as described in Chapter 13.</p> <p>District Health Councils be allocated a recurrent budget for Council activities.</p> <p>District Health Councils meet monthly.</p> <p>District Health Councils to publish an annual report.</p> |
| 5.14 | <p>Area Health Councils be established in each Area Health Service.</p> <p>The role of the Area Health Council is to advise the General Manager Area Health Services on the performance of the Health Service Districts, services planning and service improvement opportunities.</p> <p>Membership of the Area Health Councils to be drawn from the District Health Councils.</p> <p>Area Health Council members be provided with a suite of regular reports to monitor the performance of the Area as described in Chapter 13.</p> <p>Area Health Councils to publish an annual report.</p> |

Chapter 6. Corporate planning and budgeting

| | |
|-----|--|
| 6.1 | Queensland Health to develop a comprehensive Health Services Plan for Queensland to inform clinical service planning, workforce planning, capital planning and information technology planning by the end of 2006. |
| 6.2 | Area Health Services to develop an Area Health Services Plan to inform State health service planning, local clinical service planning, workforce planning, capital planning and information technology planning. |
| 6.3 | Queensland Health in conjunction with the Commonwealth Government develop the concept of a universal service obligation for small rural communities with a population of less than 5,000 people to outline the minimum level of health service access. |
| 6.4 | Clinical networks to play an active role in service planning and in the distribution of available funding to support improving clinical practice. |
| 6.5 | Queensland and Area Health Service planning must take account of the minimum requirements necessary to provide quality and safe services, consistent with the Clinical Services Capability Framework. |
| 6.6 | Southern and Central Area Health Services to work closely to develop a health services blueprint for South East Queensland by the end of June 2007. |
| 6.7 | Queensland Health should sell its residential aged care places and where appropriate associated facilities. |
| 6.8 | Queensland Health review its continued provision, or scope of provision, of some health services where there are alternative providers who may be able to provide the service more effectively or provide services to areas of highest need (eg. provision of home and community care services). |

| | |
|------|--|
| 6.9 | Queensland Health develop a resource distribution formula which takes account of factors including population, geographic location and health need for the basis of the allocation of funding to Area Health Services from 1 July 2006. Area Health Services to use the resource distribution formula as a guide to the allocation of growth funding to districts, to improve the equitability of resource allocation within five years. |
| 6.10 | Responsibility for budget allocation and management for health service delivery to be devolved to Area Health Services. |
| 6.11 | Area Health Services to move to a casemix funding model as a tool to set targets for acute hospital services and to measure performance with casemix funding phased in over several years. |
| 6.12 | Area Health Services to provide funding certainty to districts, consistent with the phasing-in of the regional distribution formula and casemix. |
| 6.13 | Budget management and team development within districts is to provide improved incentives for clinicians and administrators to work more closely together in the delivery of patient care. |
| 6.14 | Queensland Health to review and increase patient fees and charges where possible, in the context of the Queensland Government's commitments under the Australian Health Care Agreement. |
| 6.15 | A Queensland Health Innovation Fund be established with a \$15 million recurrent budget. |

| | |
|--|---|
| Chapter 7. Improving patient care and health services | |
| 7.1 | That support be provided to clinicians in local areas to redesign patient flows for acute hospital services. Priority areas are to include emergency departments, elective and emergency surgery and outpatient services and links to respective hospital wards. District change facilitators will establish and assist local implementation of reforms and liaise with a Patient Flow Collaborative to guide system redesign. |
| 7.2 | Partnerships should focus on the health, university, community services and local government sectors to improve health promotion and service delivery, drawing on examples of good practice such as funds pooling, service devolution and service delivery service coordination. Area Health Services should use the Innovation Fund to encourage and assist health service districts to develop appropriate partnerships which could be established to improve health promotion or service delivery. Building partnerships will be an expectation of key roles in the organisation including Area Health Service general managers and district managers and will be included in performance agreements for these positions. Primary care practitioners within Queensland Health, general practice and allied health services should be included in clinical collaboratives to improve |

| | |
|------|---|
| | <p>coordination between sectors in provision of primary health care.</p> <p>The recommendations from the Queensland Health review of multicultural health policies, in collaboration with community representatives, should be implemented.</p> |
| 7.3 | Specialist outpatient and surgical waiting times should be made available publicly in such a way that it help patients and their health care providers make informed choices about their individual care options. |
| 7.4 | As part of the performance framework, report and monitor activity (weighted for complexity) and waiting times for elective, emergency and other surgery. |
| 7.5 | Consistent with the national approach to reporting elective surgery waiting times, the 5 percent long wait performance benchmark should be abolished consistent with the objective of prioritising patients according to clinical need. |
| 7.6 | Increase access to specialist outpatients by examining opportunities, including those detailed in the report, for specialist outpatient services (surgical and medical) to be provided privately as is done in other States and Territories. |
| 7.7 | Integrate the management and funding of all surgical activity including emergency, elective and other surgery with a view to prioritise patients on the basis of clinical need. This is consistent with recommendations in Chapter 6 where all acute services are proposed to be funded using a casemix funding model. |
| 7.8 | <p>That the following principles be adopted to guide implementation of recommendations to improve timely access to public surgical services:</p> <ul style="list-style-type: none"> • Access to both specialist outpatient and surgery services are prioritised based on clinical need. • All patients requiring trauma surgery receive treatment within 24 hours if clinically appropriate. • Encourage all patients with private health insurance to use it as private patients in public hospitals or in the private hospital system. • Any planned increases in surgical activity needs to be considered in the context of bed capacity and the likely impact on medical patients. • Additional non-emergency surgery should not adversely affect the provision of care for emergency (surgical and medical) cases. • Patients and their primary health care providers (GPs) should be empowered to make informed decisions about their care which would include access to accurate and timely information about waiting times and costs. <p>Further development of these principles needs to be considered by the relevant clinical networks to guide a Government position on public surgical services in Queensland.</p> |
| 7.9 | Explore the introduction of means tested measures for non-urgent surgical services to improve the safety and timeliness of public surgical services for those least able to afford care. |
| 7.10 | Increase surgical throughput by 31,195 surgical separations weighted for complexity at an estimated cost of \$100.8 million (\$61.6 million of which is ongoing). |

| | |
|------|--|
| 7.11 | <p>Expansion of surgical activity, with a view to reducing excess demand, over and above existing targets should involve offering the opportunity to provide extra surgical services to the following (in order of priority):</p> <ol style="list-style-type: none"> 1. existing staff specialists at overtime rates 2. Visiting Medical Officers currently operating in the public system (at sessional rates) 3. other specialists to operate as Visiting Medical Specialists (at sessional rates) 4. where services are unable to be provided in the public system, activity at an appropriate type and volume should be offered to syndicated private specialists, private hospitals and other interested parties who operate outside the public system (contracted arrangements based on a specific performance agreement). |
| 7.12 | <p>Investigate and pursue the following clinical quality and improvement practices with a view to improve surgical capacity and patient outcomes:</p> <ul style="list-style-type: none"> • Pre-admission clinics • Day of surgery admission procedures • Discharge planning processes • Outpatient and surgical waiting list booking processes • Peri-operative management guidelines and procedures • Theatre management and utilisation strategies • Integrated bed management procedures • Flexible rostering of staff (including 10 hour shifts) • Post-acute and transitional care services • Hospital in the home services • After hours theatre utilisation • Dedicated trauma / emergency surgery sessions • Dedicated hospitals for elective surgery • Expand the ‘Fit for Surgery’ scheme • Regular administrative and clinical audits of the surgical access waiting list. |
| 7.13 | <p>That as clinical networks become established, they be given responsibility for the implementation of strategies to improve surgical access in Queensland public hospitals. This would involve providing advice and recommendations to the sponsoring Area Health Service General Manager on surgical access issues for implementation.</p> |
| 7.14 | <p>The Queensland Government to encourage the Commonwealth Government to explore alternative funding or service models that would increase access to Commonwealth funded health services in rural and remote communities.</p> <p>Safe, sustainable service models should be developed in partnership with rural and remote communities, the Commonwealth Government and other service providers. Suggestions should be drawn from innovative service models already in practice.</p> <p>The report “Access to Services (Transport is the Key)”, should be used as the basis for reforms to patient transport, particularly in rural, remote and regional</p> |

| | |
|-------------|---|
| | <p>areas.</p> <p>Education and training providers will be engaged to assist with increasing workforce supply in rural and remote areas and better develop “generalist” roles including rural generalist doctors, advanced rural and remote nurses, nurse practitioners and paramedic primary care providers.</p> <p>The Queensland Government to engage with the Australian Medical Council and the Commonwealth Government to advocate for recognition of rural general medicine as a new specialty.</p> <p>Queensland Health will partner with the Australian College of Rural and Remote Medicine to facilitate procedural training for rural generalist doctors.</p> <p>Remuneration and incentive packages, including better access to professional development should be improved, to attract clinicians to rural and remote areas.</p> <p>Peer support networks should be established at Area Health Service level, for isolated workers, based around professional groups or streams of care.</p> <p>All rural and remote services will need to be networked with larger centres, including a tertiary metropolitan hospital. The purpose will be to provide outreach services and some staffing relief.</p> <p>Area Health Services will establish a register of clinicians willing to perform short or long term country service.</p> |
| <p>7.15</p> | <p>Better ways will be trialled, to work closely with Indigenous communities, government departments and the non-government sectors to contribute to efforts to reduce Indigenous disadvantage in both urban and remote settings. In particular, Queensland Health will urgently lead the development of alcohol demand management strategies in the nineteen Indigenous communities where Meeting Challenges Making Choices is implemented.</p> <p>There should be a stronger emphasis on health promotion so that Indigenous people have the skills, knowledge and resources to make healthy choices.</p> <p>A more flexible approach to Indigenous health services should be established to support existing and new service models including fund pooling and service coordination models, with an overriding commitment to the principle of self-determination and community control.</p> <p>Partnerships with universities and other providers should be developed to increase Indigenous entry and retention into health professional education and training.</p> <p>The role of Indigenous Health Workers should be further developed, through access to funded training and skills enhancement programs and will aim to recruit local workers to local positions to improve staff retention.</p> |
| <p>7.16</p> | <p>A review of the current funding arrangements for mental health should occur, and Area Health Services will undertake an immediate mapping exercise to inform further mental health reforms with a view to:</p> <ul style="list-style-type: none"> • Continuing to increase investment in the community health sector • Increasing provision of supported accommodation including “step up” and “step down” facilities • Developing new models of care with the private and non-government sectors and continuing to increase investment in non-government mental health |

| | |
|------|---|
| | <p>services</p> <ul style="list-style-type: none"> • Increasing participation of consumers and carers in decision making • Improving linkages and partnerships with other sectors to improve post-discharge support, improve services for population groups with multiple and complex needs and increase efforts around mental health promotion and prevention • Improving mental health services for people in correctional facilities and custodial settings • Increasing integration of mental health and alcohol, tobacco and other drugs services • Strengthening organisational leadership around mental health including stabilising turnover in key central leadership positions • Addressing workforce pressures as recommended in Chapter 10. |
| 7.17 | <p>Within 12 months a clear, strategic approach to community health service provision in line with the directions for change outlined in section 7.7.1 will be adopted.</p> |
| 7.18 | <p>Health care in correctional institutions be resourced adequately and Queensland Health and Department of Corrective Services seek agreement on the best future delivery options.</p> |
| 7.19 | <p>Options to improve provision of oral health services be explored including continuation of school dental services, review of eligibility criteria for adult services, alternative workforce roles and mixed models of public/private practice. There should be an informed public debate about widespread fluoridation of Queensland’s water supply.</p> <p>The involvement of private sector oral health practitioners in delivering public services be encouraged through local fees and arrangements that flexibly address the merits of each case.</p> |
| 7.20 | <p>A state wide network should be developed for child and youth health across the health continuum involving other major providers and partners. Further expansion of telehealth services should occur where appropriate to maximise availability of paediatric services and clinical education. The development of tertiary paediatric sub-specialty services should be reviewed.</p> |

| | |
|--|---|
| <p>Chapter 8. Clinical Support Services</p> | |
| 8.1 | <p>Queensland Health Pathology Service to be included in the Clinical Support Services Group.</p> |
| 8.2 | <p>The Queensland Health Pathology Service to develop a benchmarking system to allow for comparison with private sector providers to demonstrate ongoing cost competitiveness with the external providers at a statewide level.</p> |
| 8.3 | <p>Queensland Health to review the number of training positions required for pathologists to meet future needs.</p> |

| | |
|-----|--|
| 8.4 | Establish a statewide radiology service network, to provide radiology coverage across Queensland Health under the Clinical Support Services Group. Districts to have the option of using the statewide service for radiology services or purchasing services from external provider. |
| 8.5 | Queensland Health to consider the requirement for additional radiologists in line with the Australian Medical Workforce Advisory Committee recommendations. |
| 8.6 | Queensland Health to develop an education and training system for radiographer and medical imaging nurse practitioners and the possible development of radiographer practitioners along the proposed nurse practitioner model. |
| 8.7 | The responsibility for pharmacy services to be integrated into the Clinical Support Services Group. Districts to have the option of acquiring pharmacy services from the Clinical Support Services Group or from private pharmacy arrangements. |
| 8.8 | District Health Services develop initiatives to improve support for operational staff. |
| 8.9 | Additional administrative resources should be provided at the clinical level to free up clinician time to deal with patient issues. This should include extension of administrative support hours in hospitals to reflect the hospital operating environment. |

| | |
|---|---|
| Chapter 9. Clinical governance and risk management | |
| 9.1 | Queensland Health should establish risk registers at all levels in the organisation (District, Area and Central Office) and identify the individuals who are accountable for the management of those risks. |
| 9.2 | The importance of the risk management function needs to be recognised by providing recurrent funding for this activity. |
| 9.3 | The Medical Board of Queensland be encouraged to: <ul style="list-style-type: none"> • ensure that registration processes (current and future) provide a high quality assessment and are implemented in a timely and efficient manner • conduct clinical assessments of non-specialist grade overseas trained doctor with special purpose registration and • continue to conduct the assessment of overseas trained doctors (OTDs) for practice at specialist level via the established Australian Medical College/College pathway. • That Queensland Health implements the Recruitment, Assessment, Placement Training and Support (RAPTS) program for OTDs. |
| 9.4 | Credentialing of medical practitioners should occur at Area Health Service level facilitated by the Clinical Governance Unit using National Guidelines. Clinical privileging (the specific services that are suitable for the local health service) should also be performed by the Clinical Governance Unit and should include on the committee a representative of the District Manager of the specific |

| | |
|------|---|
| | employing health service. Privileging decisions should be based on the Service Capability Framework. |
| 9.5 | <p>Policy, guidelines and training should be developed to support a consistent statewide approach to:</p> <ul style="list-style-type: none"> • conduct individual clinician performance assessment and development • manage concerns about an individual clinician's performance. <p>Where there are concerns about an individual clinician's performance:</p> <ul style="list-style-type: none"> • the Area Clinical Governance Units should take responsibility for the assessment of the clinician and recommendations regarding remediation • the District Manager will be responsible for decisions regarding the management of an individual clinician. <p>The Medical Board of Queensland be encouraged to:</p> <ul style="list-style-type: none"> • develop a performance evaluation program that is non-punitive and provides a framework for ongoing demonstration of professional competence. This will require new legislation. • develop guidelines regarding its expectations of medical practitioners to participate in continuing professional development. |
| 9.6 | Queensland Health through the Patient Safety and Clinical Improvement Service should proceed to implement the national Open Disclosure Standard for communication with patients and relatives following an adverse clinical incident or event. |
| 9.7 | Appropriate training in the use of specific service improvement techniques such as incident investigation, clinical audit, benchmarking and clinical pathway variance analysis should be developed and implemented with the support of the Patient Safety and Clinical Improvement Service and involvement of clinical leaders. |
| 9.8 | Evidence based clinical pathways targeting high volume services (where standardisation will improve safety and quality) should be developed (or purchased) and implemented by clinical networks with the support of the Patient Safety and Clinical Improvement Service. |
| 9.9 | <p>Effective quality and safety benchmarking processes should be developed by Clinical Networks facilitated by the Patient Safety and Clinical Performance Service.</p> <p>Clinicians participating in clinical networks should involve local clinical teams in the discussion and interpretation of benchmarking data.</p> |
| 9.10 | Clinical audit (including routine death review) should be a routine activity for all clinicians, clinical networks and services. The necessary tools, resources, information systems and support should be developed and made available to facilitate this activity. |
| 9.11 | <p>Review and implement the incident management policy.</p> <p>Address the current issues with PRIME before continuing implementation across the state including improved training for staff. Develop a strategy for future</p> |

| | |
|------|--|
| | <p>system enhancement (including a review of national progress on the development of incident monitoring systems and potential benefits of national standardisation).</p> <p>Queensland Health in conjunction with the State Coroner should develop a policy and process to enable reporting to the State Coroner of all deaths that are not reasonably expected to be an outcome of a health care procedure.</p> <p>Analyse serious and sentinel events at an area health service and state level (and contribute to national reporting) with a focus on preventing and minimising harm.</p> <p>Based on incident analysis develop and implement state-wide safety initiatives using clinician led networks.</p> <p>Measure and report on safety culture within health services to promote attitudes and behaviours associated with safe practice.</p> <p>Provide an annual public report on sentinel events.</p> |
| 9.12 | <p>Endorsed priority programs in medication safety, infection prevention and control, falls, correct site surgery and pressure ulcers should continue to be developed and implemented.</p> |
| 9.13 | <p>Development of legislation encouraging and protecting good quality and safety assurance analysis should proceed and be submitted to the Health Minister to progress.</p> <p>Review of the recent confidentiality provisions of the <i>Health Services Act 1991</i> should be conducted during 2006 to determine the impact on the effective sharing of information by clinicians for quality assurance purposes.</p> |
| 9.14 | <p>Queensland Health should work with health service accreditation agencies to establish more meaningful quality and safety measures for accreditation assessments.</p> |
| 9.15 | <p>Revise the Patient Charter to incorporate changes resulting from this Review and communicate patients' rights and responsibilities to patients and their carers.</p> <p>Establish District Health Council and Area Health Council processes for consumer and community input into service planning and evaluation.</p> <p>Establish a strategy for consumer feedback (including but not limited to patient satisfaction surveys) at the District and Area Health Service levels. This should be developed in the context of a statewide framework for consumer and community engagement and supported through the development of appropriate tools and methodologies and appropriate resourcing.</p> |
| 9.16 | <p>A complaints model be adopted that provides for local resolution first whilst requiring escalation to an independent complaints body, a Health Commission, if the complaint is not resolved in 30 days.</p> <p>District Complaints Coordinators with the skills and the delegation required be employed to take primary responsibility for complaint resolution and be supported through appropriate training and networks.</p> <p>A Complaints Manager position be created for each of the Area Health Services to support District Complaints Coordinators and ensure all complaints about health care in the Area Health Service are resolved or escalated to a Health Commission</p> |

| | |
|------|--|
| | and that actions taken in response to such complaints are appropriate. |
| 9.17 | District Managers will table regularly at District Health Council meetings de-identified district complaints and compliments data and any Health Service District and Area Health Service trends and learnings to keep community representatives informed. |
| 9.18 | Consideration should be given to developing one statewide complaints database with a number of security access levels which would record all complaints and compliments about Queensland Health's services. |
| 9.19 | <p>A Health Commission should have access to Queensland Health complaints data about patient care and the complaints database, and should be able to take over the management of a complaint at any time.</p> <p>An independent patient support officer service be arranged with the non-government sector and managed through the Health Commission.</p> <p>Some Health Commission staff be located around the state to assist healthcare consumers in resolving complaints.</p> |
| 9.20 | All current and prospective employees should undergo criminal history checks in the interests of patients and staff. Staff working with the most vulnerable patients/consumers should be targeted first. |
| 9.21 | <p>Changes considered to the <i>Whistleblowers Protection Act 1994</i></p> <p>Whistleblowers should be able to lodge Public Interest Disclosures with Members of Parliament and have protection under the Act.</p> <p>The media should not be approved as one of the bodies to whom Whistleblowers can lodge Public Interest Disclosures and have protection under the Act.</p> <p>Any person not just a public officer should be afforded protection for disclosing danger to public health and safety.</p> |
| 9.22 | A separate and short review needs to be undertaken of the legislation and working arrangements between existing external complaint bodies nominated in the report. |
| 9.23 | <p>The Health Commission recommended in this report, with functions that include the coordination of health care complaints, be established.</p> <p>A Parliamentary Committee with the role and functions described in this report, be established to provide external oversight.</p> |
| 9.24 | There needs to be public reporting on the performance of health services, as described in Chapter 13. This would include an enhanced role for Area and District Health Councils. |
| 9.25 | <p>A clinical governance structure be established that is clinician and patient focused with functions as outlined and the following components:</p> <ul style="list-style-type: none"> • Safety and quality committees in all districts, chaired by senior clinicians (who are involved in clinical networks) • Area Clinical Governance Units in each Area Health Service led by a senior medical officer with experience in systems improvement |

| | |
|--|--|
| | <ul style="list-style-type: none"> • A statewide Patient Safety and Clinical Improvement Service • An independent Health Commission with responsibility to monitor the implementation of clinical governance and the safety and quality of health services and report publicly. • A Parliamentary Committee to provide external oversight. <p>Professional bodies must be involved in implementing the clinical governance processes and enablers.</p> <p>The District Manager is accountable for the local implementation of clinical governance.</p> <p>District Health Councils and Area Health Councils will be provided with performance reports on quality and safety in their monthly performance information and a six monthly performance review report and will be provided with annual public reports on performance for the District and Area respectively (as detailed in Chapter 13).</p> |
|--|--|

| | |
|---|--|
| Chapter 10. A workforce for the future | |
| 10.1 | <p>Provide immediate relief for doctors</p> <p>Queensland Health should:</p> <ul style="list-style-type: none"> • implement a local, interstate and overseas campaign to rebuild Queensland Health’s reputation as an employer, including focused campaigns in the United Kingdom and other countries with equivalent doctor training (with the aim of recruiting 280 additional doctors to meet the shortfall in local supply and increasing demands for services) • undertake routine exit surveys of staff to determine factors driving loss of staff so as to better inform and target recruitment activities • increase flexibility in recruitment processes including advertising and selection processes • clarify with line managers the range of flexible recruitment processes that can be used under the Recruitment and Selection Directive to recruit doctors • maintain the capacity of local districts to undertake recruitment activities but introduce a centralised process for the recruitment of doctors with special purpose registration • seek to expedite national efforts to establish uniform medical registration arrangements through the Australian Health Ministers Advisory Committee including automatic recognition of graduates from countries with similar educational standards such as the United Kingdom, Ireland, and Canada • develop recommended student intakes in Queensland to inform negotiation with the Commonwealth to increase student places in all Queensland medical schools. <p>Area Health Services should:</p> <ul style="list-style-type: none"> • through their workforce planning areas, facilitate and support districts to undertake career and succession planning with the existing medical workforce and resource districts to maximise recruitment and retention of younger doctors upon completion of their training or return from training overseas. |

| | |
|-------------|---|
| | <p>The Queensland Government should:</p> <ul style="list-style-type: none"> • seek from the Commonwealth an immediate increase in medical student places and/or consider funding additional bonded places in Queensland medical schools. |
| <p>10.2</p> | <p>Improve retention of the medical workforce</p> <p>The Queensland Government should:</p> <ul style="list-style-type: none"> • encourage enterprise bargaining approaches that are interest based rather than adversarial, which address the lack of flexibility and complexity of the current arrangements and occur as close as possible to clinicians and service delivery • negotiate with Visiting Medical Officers (VMOs) to achieve a move from award based to contractual arrangements • pending the outcome of the enterprise bargaining process, adjust the level of clinical loading paid to clinical academics working in public hospitals. <p>Queensland Health should:</p> <ul style="list-style-type: none"> • plan and develop a hospital generalist career structure and work with the university consortium to develop a training program to support this new role • offer HECS payment in return for a period of bonded service to retain junior doctors and registrars upon completion of their training • urgently implement strategies to improve organisational culture and foster strong leadership and change management capacity within the department, discussed in Chapter 4 • ensure doctors are provided with timely, quality travel and accommodation services. <p>Area Health Services should:</p> <ul style="list-style-type: none"> • ensure doctors have access to revised and better targeted and resourced training in managing patient and carer aggression • create peer support networks along professional groupings or streams of care to improve support for isolated workers. <p>Districts should:</p> <ul style="list-style-type: none"> • discuss and agree with VMOs the best way to establish and improve communication • provide amenities such as meeting and training rooms, tea rooms and personal space (eg lockers) where feasible and in consultation with doctors • ensure all medical staff are made aware of their entitlements through a clear induction process, that these entitlements are included explicitly in individual performance and development plans and that medical staff are supported to access their entitlements. |

| | |
|------|--|
| 10.3 | <p>Maximise the value of the medical workforce</p> <p>Queensland Health should:</p> <ul style="list-style-type: none"> • offer increased sessional work to the existing VMO workforce and increase numbers of VMOs in the public system • offer incentives for existing medical staff and VMOs to perform additional sessions especially surgery • outsource services in areas of acute service and workforce pressure, subject to work first being offered to existing medical staff and VMOs • monitor evaluation of new technologies used in other jurisdictions and undertake cost benefit analysis to determine suitability for local implementation. <p>Area Health Services should:</p> <ul style="list-style-type: none"> • facilitate trials of consultant led services in a small sample of metropolitan and regional hospitals • facilitate and resource districts to devolve non-clinical tasks to non-clinical categories of staff including provision of adequate secretarial support to doctors • establish a register of clinicians – including doctors – willing to undertake country service rotations and design a country service incentive package • incorporate use of technology such as telehealth within service and workforce planning to maximise opportunities for medical outreach to smaller districts. <p>Districts should:</p> <ul style="list-style-type: none"> • explore new practice and partnership arrangements with general practitioners, in association with the medical College and the Rural Doctors Association of Queensland, particularly in the management of outpatients clinics and provision of medical services in rural and remote communities by procedural general practitioners on a sessional or outsourced basis • negotiate opportunities to introduce flexible hours of work to increase productivity subject to staff availability and interest. <p>Clinical networks should:</p> <ul style="list-style-type: none"> • lead implementation of outcome based clinical pathways to improve care and streamline work practices. |
|------|--|

| | |
|------|--|
| 10.4 | <p>Improve medical education and training</p> <p>Under the new structure, Queensland Health should establish a dedicated medical workforce planning group to undertake the following specific tasks:</p> <ul style="list-style-type: none"> • assess the adequacy of current and planned undergraduate medical student places to meet future workforce needs • review the number, mix and distribution of current medical training places across the public health system • develop a strategic plan for the placement of trainees and detail priority areas and locations to be addressed • explore options with the universities, professional colleges and other relevant agencies to improve education and support of the medical workforce • progressively increase registrar training numbers in line with AMWAC recommendations • develop clinical training networks which link teaching hospitals in metropolitan and provincial centres with non-teaching hospitals in both metropolitan and rural areas • review the suitability of the current apprenticeship based training model to cope with increasing medical graduate numbers and opportunities to fast track training programs • examine avenues for greater private sector involvement in medical training. <p>Queensland Health should:</p> <ul style="list-style-type: none"> • review the membership and operation of the Queensland Medical Education Council to strengthen its role in providing strategic direction and advice on medical education issues • seek support from the Commonwealth and the State to increase the level of funding available to support the teaching and training of students on clinical placements within Queensland’s public health system given this is an area of shared responsibility • explore with the Colleges opportunities to further consolidate teaching and development time under specialist training programs linked to competencies • introduce mechanisms to provide protected time for senior clinicians and trainee specialists involved in teaching and training junior staff and ensure that sufficient resources are available to support this role • work with the Commonwealth to examine strategies for seeking contributions from the private sector and medical practitioners who choose to leave the public sector, towards the costs of clinical training • expedite the implementation of the new training model for overseas trained doctors with special purpose registration so they can achieve full registration within four years. |
|------|--|

| | |
|------|--|
| 10.5 | <p>Provide immediate relief for nurses</p> <p>The Queensland Government should:</p> <ul style="list-style-type: none"> • increase the number of graduate nurses employed annually • provide infrastructure support to enable Queensland Health facilities to accommodate the clinical placement of larger numbers of student nurses • increase places in the vocational education and training sector for enrolled nurses and assistants in nursing <p>Queensland Health should:</p> <ul style="list-style-type: none"> • implement a local and interstate campaign to encourage former nurses back into the workforce and promote available support with a target of an additional 1,500 nurses (phased in over three years in addition to the need to continue growing the workforce by an average of 500 to 600 nurses per annum) • undertake routine exit surveys of staff to identify the factors driving loss of nursing staff and to inform recruitment activities • support the existing nursing workforce to attract and recruit senior nursing staff back into the workforce in targeted specialties including critical care, mental health, theatre and midwifery • continue and evaluate the nursing re-entry scholarship scheme as a strategy to attract nurses who are no longer registered or enrolled • increase flexibility in recruitment processes including advertising and selection processes and devolve recruitment responsibility to the facility level • develop recommended nursing student intakes in Queensland to inform negotiation with the Commonwealth to increase student places. <p>Area Health Services should:</p> <ul style="list-style-type: none"> • be resourced to support districts provide paid nursing refresher courses for registered or enrolled nurses wishing to resume practice • receive funding to support annual growth in the nursing workforce to maximise recruitment of graduate nurses and provide training to support their transition into clinical practice recognising the needs of nurses transitioning into specialty areas such as theatre, intensive care and emergency departments. <p>Districts should:</p> <ul style="list-style-type: none"> • establish in-house relief nursing pools and implement other strategies to better manage the existing nursing workforce as noted above (where this is not already occurring). |
| 10.6 | <p>Improve retention of nursing staff</p> <p>The Queensland Government should:</p> <ul style="list-style-type: none"> • review the process for enterprise bargaining to address the lack of flexibility and complexity of current arrangements and seek to provide fair remuneration and conditions • use nursing awards to create clinical career pathways to encourage advanced and extended practice roles and clinical leadership positions • consider extending paid maternity leave to support female clinicians, in |

| | |
|-------------|--|
| | <p>particular the predominantly female nursing workforce</p> <ul style="list-style-type: none"> • use enterprise bargaining to remove impediments to workforce reform including extending scope of nursing practice, negotiating flexible employment arrangements and creating temporary positions for training purposes. <p>Queensland Health should:</p> <ul style="list-style-type: none"> • undertake a feasibility study to determine the level of subsidy that may be required to support viable child care services located on health campuses • enhance clinical career pathways for nurses through creation of advanced and extended positions – including nurse practitioners - under a new award or additional paypoint in the existing award structure • urgently implement strategies to improve organisational culture and foster strong leadership and change management capacity within the department, discussed in Chapter 4 • ensure nurses are provided with timely, quality travel and accommodation services. <p>Area Health Services should:</p> <ul style="list-style-type: none"> • create peer support networks along professional groupings or streams of care to improve support for isolated nurses • ensure nurses have access to revised and better targeted and resourced aggression management training. <p>Districts should:</p> <ul style="list-style-type: none"> • make every effort to accommodate flexible working hours and part-time work • explore with private child care providers opportunities to collocate child care centres on large health campuses • take a Statewide view of recruitment and retention and facilitate mobility at level between districts for existing nursing staff • provide amenities such as meeting and training rooms and safe car parking where feasible and in consultation with nurses • provide all new nursing staff with an induction which includes information about entitlements, with access to entitlements supported and monitored through individual performance and development plans. |
| <p>10.7</p> | <p>Maximise the value of the nursing workforce</p> <p>The Queensland Government should seek from the Commonwealth:</p> <ul style="list-style-type: none"> • access to the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme for community based nurse practitioners, in recognition that these roles are taking on functions traditionally performed by doctors. <p>Queensland Health should:</p> <ul style="list-style-type: none"> • undertake urgent assessment with clinical networks and area health services of the size and nature of the potential nurse practitioner workforce • begin immediate negotiations with universities to ensure relevant course content for nurse practitioner master degrees • work with the Queensland Nursing Council to ensure appropriate registration and endorsement systems are established. |

| | |
|-------------|---|
| | <p>Area health services should:</p> <ul style="list-style-type: none"> • be resourced to facilitate local, team based development and implementation of advanced nursing and nurse practitioner roles in areas of workforce or service pressures and managed through clinical networks where feasible • facilitate and resource districts to devolve non-clinical tasks to non-clinical categories of staff including provision of roster clerks, and support for advanced nurses with less time for non-clinical work • establish a register of clinicians – including nurses– willing to undertake country service rotations and design a country service incentive package. <p>Districts should:</p> <ul style="list-style-type: none"> • negotiate opportunities to introduce flexible hours of work to increase productivity subject to staff availability and interest. <p>Clinical networks should:</p> <ul style="list-style-type: none"> • lead implementation of outcome based clinical pathways to improve care and streamline work practices. |
| <p>10.8</p> | <p>Improve nursing education and training</p> <p>Queensland Health should:</p> <ul style="list-style-type: none"> • adopt a strategic and proactive approach to influencing the direction of undergraduate nursing education to ensure it continues to meet service delivery needs and to adequately prepare graduates for entry to the workplace • strengthen relationships with universities through adjunct or conjoint appointments and review the role of clinical facilitators at ward level to support nursing education • negotiate with the Department of Employment and Training and the Commonwealth Government to increase funding for enrolled nurses, assistants in nursing and other certificate based health workers with a focus on also attracting these workers to rural and remote communities • seek support from the Commonwealth and State governments to increase the level of funding available to support the clinical teaching and training of nursing students within the Queensland public health system given this is a shared area of responsibility • support nurses undertaking post-graduate study through scholarships and/or paid study leave • expand its transition to work programs so that new graduate nurses receive appropriate supervision and support • establish an ongoing education and training program for nursing staff which is linked to service delivery needs, addresses identified skills gaps and supports advanced clinical practice roles • review the number of nurse educators working in the system and provide adequate resourcing and support for them to undertake their roles • ensure adequate backfilling of positions to allow clinicians to attend training and education programs. |

| | |
|-------|---|
| 10.9 | <p>Provide immediate relief for allied health professionals</p> <p>The Queensland Government should:</p> <ul style="list-style-type: none"> • seek from the Commonwealth an immediate increase in allied health student places and/or consider funding additional bonded places in Queensland tertiary institutions • seek support for the State to immediately increase the employment of allied health personnel in Queensland’s health system with an emphasis on a willingness to teach allied health students. <p>Queensland Health should:</p> <ul style="list-style-type: none"> • implement a local and interstate campaign to position itself as an employer of choice for allied health staff with the aim of increasing staffing numbers by around 2,000 over the next three years • increase flexibility in recruitment processes including advertising and selection processes and devolve recruitment responsibility to the facility level except where staff are being recruited across a number of facilities • develop recommended student intakes in Queensland to inform negotiation with the Commonwealth • create leadership positions in the Areas Health Services which focus on workforce planning and recruitment activities. |
| 10.10 | <p>Improve retention of the allied health workforce</p> <p>The Queensland Government should:</p> <ul style="list-style-type: none"> • review the process for enterprise bargaining to address the lack of flexibility and complexity of current arrangements and remuneration levels • use enterprise bargaining to remove impediments to workforce reform including extending scope of practice, outsourcing work, negotiating flexible employment arrangements and creating temporary positions for training purposes. <p>Queensland Health should:</p> <ul style="list-style-type: none"> • enhance clinical career pathways for allied health professionals through creation of advanced and extended positions under a new award or additional paypoint in the existing award structure • increase the scale and flexibility of the Clinical Advancement Scheme as suggested in 10.6.2 • implement strategies to improve organisational culture and foster strong leadership and change management capacity within the department, discussed in Chapter 4 • provide allied health staff with timely, quality travel and accommodation services. <p>Area Health Services should:</p> <ul style="list-style-type: none"> • create peer support networks along professional groupings or streams of care to improve support for isolated allied health workers • ensure allied health staff have access to revised and better targeted and resourced aggression management training. |

| | |
|--------------|---|
| | <p>Districts should:</p> <ul style="list-style-type: none"> • provide amenities such as meeting and training rooms where feasible and in consultation with allied health workers • provide all new allied health staff with an induction which includes information about entitlements, with access to entitlements supported and monitored through individual performance and development plans. |
| <p>10.11</p> | <p>Maximise the value of the allied health workforce</p> <p>Area Health Services should:</p> <ul style="list-style-type: none"> • be resourced to facilitate local, team based development and implementation of advanced and extended allied health roles in areas of workforce or service pressures and managed through clinical networks where feasible • be resourced immediately to implement alternative models of care using allied health professionals to reduce pressure in outpatient clinics and accident and emergency departments, as discussed in 10.6.3 • facilitate and resource districts to devolve non-clinical tasks to non-clinical categories of staff including support for advanced allied health professionals with less time for non-clinical work • establish a register of clinicians – including allied health workers– willing to undertake country service rotations and design a country service incentive package. <p>Districts should:</p> <ul style="list-style-type: none"> • negotiate opportunities to introduce flexible hours of work to increase productivity subject to staff availability and interest eg community health services running clinics out of business hours. <p>Clinical networks should:</p> <ul style="list-style-type: none"> • lead implementation of outcome based clinical pathways to improve care and streamline work practices. |
| <p>10.12</p> | <p>Improve education and training for allied health workers</p> <p>Queensland Health should</p> <ul style="list-style-type: none"> • facilitate better linkages with external agencies including the tertiary sector and professional associations to develop a long term education, training and professional development program for allied health staff • ensure the provision of clinical placements for allied health students is coordinated and able to cope with continued increases in student numbers • negotiate with the State and Commonwealth to address the issue of an adequate teaching and support environment during clinical placements, and funding models that reflect student retention and clinical placement costs • consider expanded peer support programs for young allied health professionals working in rural and remote areas and ensure they have access to professional development opportunities • identify areas of skills shortages amongst its allied health professional staff and consider providing financial subsidies in targeted areas of post-graduate study. |

| | |
|-------|---|
| 10.13 | <p>Address organisational and multi-disciplinary education and training issues</p> <p>Queensland Health should establish a central coordination point for training and education in the organisation to facilitate better linkages with external agencies. The central coordinating area would be responsible for training and education across all health professional groups and would be charged with:</p> <ul style="list-style-type: none"> • establishing the overall strategic direction for training and skills development across the State based on future service needs • providing input into curriculum development to ensure sufficient levels of practical experience are incorporated in under-graduate health education programs • examining the feasibility of fast-tracking health professional education to meet workforce shortages • exploring opportunities to train multi-skilled health workers in the Vocational Education and Training (VET) sector with a range of competencies to provide a more flexible and adaptable workforce • expanding transition to work programs so that health professional graduates receive sufficient supervision when first entering the workplace. <p>Queensland Health should refocus the operation of the Skills Development Centre and staff and resource the Centre to enable it to operate on an expanded basis to promote skills enhancement and training for clinical staff across the State. A clinical director should be appointed and increased resourcing provided so the Centre can operate as the training hub for staff across the State at least six days a week.</p> <p>Queensland Health should foster a learning culture across the organisation by:</p> <ul style="list-style-type: none"> • designing in-hospital training programs which are linked to service needs and provided equitably across professional groups • providing standard entitlements to ongoing training and professional development • expanding assistance under the Study and Research Assistance Scheme to include subsidisation of HECS costs • streamlining approval processes for study leave and professional development attendance. <p>Queensland should review the level of funding available for education and training across the organisation and seek increased support for teaching clinical students from the Commonwealth Government.</p> <p>Districts should receive dedicated budgets to support education and training and these should be linked to student and staffing numbers.</p> |
| 10.14 | <p>Improve workforce planning</p> <p>Queensland Health should ensure the Central Office workforce planning unit undertakes the specific roles outlined in section 10.8, to be overseen by a governance structure comprising Central Office, Area Health Services, district representatives and representatives of external stakeholders such as universities, the Commonwealth Government, professional and regulatory bodies.</p> |

| | |
|-------|--|
| 10.15 | <p>Way Forward – Relationships with Educational Organisations</p> <p>Queensland Health needs to explore the following range of jointly funded initiatives or initiatives funded in innovative ways:</p> <ul style="list-style-type: none"> • In recognition of the national importance of medical workforce training , the Commonwealth Government be approached to accept responsibility for funding all training posts for doctors (registrars within the public hospital system) and for the funding of dedicated teaching time and/or new positions for specialists, teaching VMOs, as well as trainees (registrars, senior health officers and interns). • The support infrastructure, medical equipment, practical sessions etc. must be properly planned and funded across the continuum of nursing, allied health and medical training with adequate human resources to support training and service continuity. The investment is significant. International experience suggests that these costs may be approximately 20 percent of total recurrent costs. • Networking of teaching and training across hospital and sector boundaries to ensure consistency and access to comprehensive training. For example, trainee specialists accessing learning opportunities in the private sector and private hospital based specialists providing teaching support for specialist trainees in the public sector. • Unilateral recognition for trained health professional graduates (including medical graduates) with qualifications from countries with similar training requirements and standards, e.g. the United Kingdom, Ireland, Canada and New Zealand. • Supernumerary preceptor positions and a network of facilities throughout the State to cope with student nursing places and undergraduate allied health workforce placements. • Pilot programs for new types of health practitioners and new models of care including clinical associates’ positions such as physician’s assistants and nurse practitioners etc. • Use simulation, telehealth and tele-education linkages to enhance integration of clinical placement and academic teaching models with service provision, in a strong Area Health teaching network. • Integrated models of vocational and university education and training to deliver mainstream health professional qualifications in the more remote parts of the State. • To ensure Area Health Services are resourced to provide a decentralised Skills Centre network which provides for the clinical needs of health professionals and trainee health professionals in that Area Health Service. Each Area Health Service Skills Centre network would be resourced to provide equitable access to basic clinical skills training and team based training. |
|-------|--|

| Chapter 11. Asset management and capital works planning to support service delivery | |
|--|---|
| 11.1 | <p>The direct management of construction projects presently undertaken within the Project Coordination Unit should be outsourced to the Department of Public Works who in turn will outsource where appropriate to private sector firms.</p> <p>Consolidate Capital Works and Asset Management Branch staffing levels and position relativity in light of expected reduction in workload as Areas and Health Service Districts assume more responsibility for asset management functions.</p> <p>Establish a Design Standards Unit within Capital Works and Asset Management Branch with responsibility for developing and maintaining standard design guidelines and planning practices for building health service assets.</p> |
| 11.2 | <p>The Capital Works and Asset Management Branch form part of Business Services reporting directly to the Chief Operations Officer.</p> <p>The Capital Works and Asset Management Committee be reconstituted as a decision making body (rather than as the current advisory body) with powers to determine project priorities and to allocate funding within the approved limits of the Capital Works Program and Asset Strategic Plan.</p> <p>The governance role and functions of the Capital Works and Asset Management Committee be broadened to include responsibility for monitoring performance of the Capital Works and Asset Management Branch for delivering physical infrastructure and assets that support health service outcomes.</p> <p>Membership of the Capital Works and Asset Management Committee be revised to strengthen health service delivery representation with inclusion of: the Chief Operations Officer, an Area Health Service General Manager, three Health Service District Managers, a senior officer from the Department of Public Works and an expert from the building and construction industry to provide specialist advice on industry's capability and to guide development of capital works design and delivery solutions that the contracting sector can most competently deliver.</p> |
| 11.3 | <p>The Capital Works and Asset Management Branch develop and implement an improved Asset Strategic Planning process for 2006-07 which recognises the restructure of the department and enhanced capability within Areas and revised roles and responsibilities of stakeholders.</p> <p>Capital Works and Asset Management Branch conduct an immediate review of the justification and priority assigned to all projects on the current Asset Strategic Plan in the context of Queensland Health's patient service needs and seek re-approval from the revised Capital Works and Asset Management Committee of all Asset Strategic Plan projects.</p> <p>Capital Works and Asset Management Branch evaluate the current Northern Zone's Clinical Service Planning Framework as a model for strengthening alignment and linkages between current health service planning and asset planning within Queensland Health.</p> |

| | |
|------|--|
| 11.4 | <p>Queensland Health base all future decisions regarding the location of health facilities on a transparent, patient focused process that ensures wide community and stakeholder involvement together with relevant advice from technical experts. All decisions should be supported by full documentation, to enable independent review and ensure accountability and probity of decisions.</p> <p>It would be appropriate that the Queensland Auditor-General have regard to asset planning and infrastructure decisions in undertaking the annual audit of Queensland Health.</p> |
| 11.5 | <p>Health Service Districts and Area Health Services take a greater role in developing the department's capital works program and associated funding allocations.</p> <p>Queensland Health implement a process that enables capital works initiatives and their associated cost estimates to be progressively refined before the final project budget is formally adopted.</p> |
| 11.6 | <p>Queensland Health and Queensland Treasury establish a sustainable funding model designed to maintain the service capacity of existing assets, the replacement and purchase of minor and major assets, the recurrent costs associated with capital works projects and to ensure adequate levels of funding are available for the Asset Strategic Plan.</p> <p>Revised funding arrangements for the Asset Strategic Plan be established and implemented for the 2006/07 financial year.</p> <p>Queensland Health confirm and further refine cost and funding estimates furnished in the report on the Capital Investment Review (November 2004) in respect of future capital investment need, maintenance of the asset base and backlogs of asset maintenance with a view to submission of a consolidated funding request for consideration and discussion with Queensland Treasury by December 2005.</p> |
| 11.7 | <p>For planned future capital works projects announced by Government, Queensland Treasury and Queensland Health establish and implement funding approaches that will resolve the present under funding of capital works projects which arises when the initial publicly announced cost of a project is significantly less than the cost required to actually deliver the project.</p> |
| 11.8 | <p>Queensland Health, with assistance from the Department of Public Works, immediately trial the implementation of the asset reporting framework developed under the Facilities Management Improvement Initiative in one health district to test the methodology and assess its potential for statewide implementation.</p> <p>Capital Works and Asset Management Branch continue development of standard design guidelines and post occupancy evaluation frameworks and implement both approaches as a matter of priority.</p> |
| 11.9 | <p>Capital Works and Asset Management Branch should continue to develop a program for implementing the approved Asset Management Systems Review recommendations throughout Queensland Health, with a finalisation date no later than December 2006.</p> <p>Capital Works and Asset Management Branch report quarterly to the Capital Works and Asset Management Committee on progress of implementation of the approved recommendations.</p> |

| Chapter 12. Information management to support service delivery | |
|---|--|
| 12.1 | The current membership of the Information Strategy and Investment Board is immediately revised to include the Chief Operations Officer and to ensure a dominant representation from Area Health Services and District Managers. |
| 12.2 | An Operations Board, chaired by a district or Area Health Service representative and with strong district representation is to be immediately formed as an independent advisor to the Information Strategy and Investment Board on the performance of the Information Directorate. |
| 12.3 | The Information Management Strategic Plan initiatives focus on priority areas that will improve clinical practice and health outcomes which is built from detailed gathering and analysis of needs in districts. This must include CHIME and PRIME. |
| 12.4 | <p>Queensland Health continue to centrally manage and coordinate information and communication technology (ICT) resources with specific ICT functions delivered within the following parameters:</p> <ul style="list-style-type: none"> • ICT strategies and priorities are to be driven by clinical and patient needs, which are gathered and reported to Information Strategy and Investment Board by Information Directorate • new ICT systems are developed by systems sponsors, with all project staff reporting to the system sponsor for the duration of the project. The sponsor is accountable to Information Strategy and Investment Board for the performance of the project. Information Directorate will source the ICT skills and provide the methods, architectures and standards to be met in the ICT development. • Information Technology Units will continue to be located in districts to meet the on the ground needs for ICT support. |
| 12.5 | That the Information Directorate structurally report to the Chief Operations Officer, but is directly accountable to the Information Strategy and Investment Board for ICT strategies, priorities and performance. |
| 12.6 | The InfoSolutions Branch establish pre-qualified panels to provide applications development services for the Department. |
| 12.7 | <p>Information Directorate pursue productivity dividends from the InfoOperations area by:</p> <ul style="list-style-type: none"> • immediately implementing a project to improve work practices and implement technology tools, including remote diagnostics and resolution of problems • undertaking an assessment of the resource levels required in each functional area and identifying surplus positions • abolishing surplus positions, with incremental increases of staff occurring in other areas, with different skill sets, in line with any demonstrable requirements arising from the desktop expansion. |

| | |
|-------|--|
| 12.8 | New enterprise wide ICT projects need to identify the impact on end users in terms of data entry, data analysis and reporting. Resources for any additional workload must be built into the business case and agreed before systems development commences. |
| 12.9 | Information management, including extracting, analysing and interpreting data for use in decision making across the organisation must be appropriately resourced and skilled. |
| 12.10 | Health Information Branch focus its role to service central policy, planning, performance and evaluation, and leadership in information management standards. The function is to be structurally incorporated into the Performance Directorate. |
| 12.11 | A data management and epidemiology analysis network should be established to develop and maintain critical skills across the organisation in data management, statistical and epidemiological services. |
| 12.12 | The definition and agreement to a standard way of identifying patients across ICT systems needs to be progressed as a high priority initiative, as this forms the basic building block from which IT systems integration can begin to occur. |
| 12.13 | Systems need to be designed with connectivity to external providers, such as general practitioners, private hospitals and non-government organisations, as a key consideration. |
| 12.14 | New enterprise wide ICT projects should not be progressed until a system owner (sponsor) is identified with the control or influencing power to drive the associated business change across the organisation. Provision of adequate funding and resources for sponsors must be identified and funded through initiative budgets prior to commencement. |
| 12.15 | Enterprise wide development of ICT systems should continue where there is a common need across Queensland Health. Investment in the design and implementation of standardised processes and practices must occur as a precursor to initiating ICT developments. |
| 12.16 | When implementing new ICT systems, a more robust decision making process is required to balance the costs and benefits of tailoring solutions, with a strong bias towards implementing core functionality only in the initial implementation. |
| 12.17 | \$5 million is provided to improve the basic ICT proficiency of clinical staff through the state. Areas are to determine the method of training delivery. The delivery of this training is to coincide with the planned program for computer expansion recommended in section 12.8.2. |
| 12.18 | Training users on the job in new systems needs to coincide with the implementation of the system and be backed up with on the ground support, particularly over the initial months of running a new system. Full training costs need to be included in the project business case. |

| | |
|-------|--|
| 12.19 | <p>Information Directorate should:</p> <ul style="list-style-type: none"> • seek commercial partners with proven expertise in project management and contract management in preference to employing temporary or contract staff as an alternate model for project management. • undertake an immediate review of the contract term of current contractor and consultancy services and confirm the ongoing need for each service. |
| 12.20 | Reprioritisation of ICT initiatives in line with the recommendations and priorities outlined in this Review is to be agreed through the reformed Information Strategy and Investment Board within 3 months. |
| 12.21 | A pilot upgrade for desktop expansion is undertaken in 4 representative hospitals and 2 community health centres within 6 months and rolled out to all districts over the following 12 months. The results to be used to project total needs across the state. This is indicatively estimated at around \$25 million in once off funding and \$7 million per annum in recurrent expenditure. |
| 12.22 | All staff with computer access need to be given access to the Internet, with appropriate policies and training being established to manage the associated risks. Any associated infrastructure costs (e.g. network bandwidth) need to be managed as a corporate cost. |
| 12.23 | Head agreements for individual applications should be negotiated with the system sponsor for inclusion into an overall Service Level Agreement with each district specifying all services delivered in that district. Management and reporting on service levels needs to occur directly with both districts and sponsors and will also be monitored by the proposed Operations Board. |

Chapter 13. Performance monitoring of health system outcomes

| | |
|------|--|
| 13.1 | <p>The health system outcomes that should be monitored are: health status and health determinants, patient outcomes, health service activity, expenditure and efficiency, workforce, the quality and safety of services, service responsiveness, and health service sustainability.</p> <p>Health system outcomes should be monitored using a standard set of strategic indicators. The example set of indicators detailed in this report should be used as a guide in determining the appropriate set of indicators. The standard set of indicators include targets and should be reported on at all levels eg Districts to Area Health Services, Area Health Services to Department, Department to Government.</p> <p>A review of the operational indicators which Queensland Health is required to report against under various funding arrangements should be conducted within 12 months with the aim of negotiating with funding bodies to reduce the number of indicators and report more strategically.</p> <p>The administrative burden associated with performance monitoring and reporting against all performance indicators (ie strategic and operational) should be minimised by automating systems where possible.</p> |
|------|--|

| | |
|------|--|
| 13.2 | <p>The performance monitoring and reporting system should comprise:</p> <ul style="list-style-type: none"> • the use of performance agreements with District Managers and Area Health Service General Managers and Central Office senior executives • monthly reports and participation in a six monthly interactive performance review process for Health Service Districts and Area Health Services • quarterly reports to Director-General for Central Office for the first year then participation in six monthly interactive performance reviews • community review through District and Area Health Councils' comment on monthly and six monthly performance reports • independent regular review and reporting by the Health Commission on the implementation of clinical governance systems and the quality and safety of clinical services, and the Auditor General on the performance of the health system • external oversight of the Health Commission by a parliamentary committee. |
| 13.3 | <p>A six monthly statewide health service performance report should be published including elective surgery waiting lists, annual reports on outputs, aspects of service quality (sentinel events, infection control) and biennial reports by the Chief Health Officer on health status and burden of disease.</p> <p>The public should have access to external reviews of the performance of the health system including annual reports by District Health Councils and Area Health Councils. The independent Health Commission should publish reports on the implementation of clinical governance systems and the quality and safety of clinical services and the Auditor General should report on the performance of the Queensland public health system.</p> |

1. Introduction

1.1 The purpose of the Review

On 26 April 2005 the Queensland Government announced an independent review (the Review) of Queensland Health's systems. The objective is to review **administrative, workforce and performance management** systems to recommend how Queensland Health can provide better health services and health outcomes for Queenslanders.

The **terms of reference** for the Review are:

Objective:

To undertake a review of the performance of Queensland Health's administrative and workforce management systems with a focus on improving health outcomes for Queenslanders.

To specifically review:

1. Existing administrative systems and recommend improvements to support health service delivery, focusing on:
 - District and corporate organisational structures and layers of decision making
 - Corporate planning and budgeting systems
 - Cost effectiveness of services compared to relevant jurisdictions
 - Effectiveness of performance reporting and monitoring systems
 - Organisation and delivery of clinical support services
 - Risk management systems
 - Quality and safety systems and
 - Clinical audit and governance systems.
2. Clinical workforce management systems to deliver high quality health services, with a particular focus on:
 - Recruitment
 - Retention
 - Training
 - Clinical leadership and
 - Measures to assist in improving the availability of clinicians.
3. Performance management systems including as they relate to:
 - Asset management and capital works planning and delivery
 - Information management
 - Monitoring health system outcomes.

The terms of reference for the Review have been interpreted and analysed from the perspective of patients and the community. The Review has sought to:

- describe the public health system in lay terms
- identify Queensland's health outcomes and services as compared to other places
- ensure a patient focused approach to the review of health services
- identify the performance of the health system overall
- examine the performance of specific systems
- make recommendations to improve the whole system as well as individual systems.

1.2 Context for the Review

The Review was announced by the Queensland Government in the context of public disquiet about the quality and safety of public hospital services, particularly arising from the circumstances surrounding the appointment and practice of Dr Jayant Patel at Bundaberg Hospital.

The Queensland Branch of the Australian Medical Association was also instrumental in influencing the State Government to undertake a far reaching review of Queensland Health's systems and was consulted in development of the Review's terms of reference. Specific concerns raised at that time by a range of professional groups related to Queensland Health's culture, excessive structural layers of decision making, the excessive numbers of administrative staff, bureaucratisation of clinical practice and care, and secrecy in dealing with information. These issues have also been examined in the context of reviewing Queensland Health's systems.

The Bundaberg Hospital Commission of Inquiry (the Morris Inquiry) was established at the same time to investigate specific issues arising from the appointment of Dr Jayant Patel to Bundaberg Hospital and other matters. The full terms of reference for this inquiry are attached at Appendix 1.1. The Commissioner was restrained by the Supreme Court from proceeding with the Inquiry and consequently systemic evidence was then referred to this Review for consideration and forming recommended actions.

A Commission of Inquiry (the Davies Inquiry) was established on 6 September 2005 to continue the work of the Morris Inquiry. The terms of reference for the Davies Inquiry are based on those of the Morris Inquiry. They exclude examination of systemic issues, which are considered in this Review, and include inquiry into whether any reprisals have been taken against persons on account of their making disclosures about matters relevant to the other terms of reference.

This Review has relied on direct assessment, observation, consultation and cooperation from Queensland Health staff and a very broad range of stakeholders, and public consultation to inform its views. The Review is focused on Queensland Health's systems and its terms of reference do not extend to the investigation of individual complaints or grievances.

Queensland Health reviewed health services at Bundaberg Hospital as part of its response to the Morris Inquiry. It offered consultation with patients, staff and the community to determine what occurred, give assistance where it could and identify areas for improvement. This report was also considered by the Review and informed this report's

assessment of Queensland Health's quality and safety, risk management, clinical governance and performance monitoring systems.

1.3 Scope of the Review

The review of Queensland Health's structure and systems provides a unique opportunity to consider how well the significant systems, which have been developed to support the delivery of frontline services are working, and whether these systems are effective in providing the best possible health and health care for Queenslanders.

The Review's terms of reference do not address global funding. Systems are therefore reviewed in the context of the current funding arrangements for Queensland Health. That is, the Review considered how effectively current funding provided by the State and Commonwealth governments is allocated to provide a quality health service. This includes consideration of whether Queensland Health is achieving an appropriate balance of resources between clinical and administration functions, across the health continuum and across geographical areas.

However, because the Review identified such significant systemic deficiency and failure throughout the public health service, some observations have been made.

The total amount of funding allocated to Queensland Health is the subject of annual budget deliberations by the Queensland Government for State funding, and agreements negotiated with the Commonwealth Government. These issues must be finally resolved there.

However, this Review does address approaches a government might consider in delivering a free public health service in a future of ever escalating service cost.

The Review was not tasked to address the specific concerns of individuals regarding their treatment in the health system, whether as patients or employees. However, specific issues raised with the Review have been considered and addressed to the extent that they indicate how well Queensland Health's systems are working both as a whole and individually.

Individuals were advised and in some cases supported in directing their specific concern or case to those in the health system best placed to assist.

1.4 The Review process

The Review team is headed by an independent consultant Mr Peter Forster, and includes experienced senior personnel with systems review and content expertise from the Department of the Premier and Cabinet, Queensland Treasury, Queensland Police Service, Department of Public Works and Queensland Health.

To achieve the Review's objective, the Review:

- considered the needs and expectations of Queensland Health's clients/patients in assessing the effectiveness of health service systems

- defined Queensland Health's services within the broader Queensland and Australian context
- assessed the strengths and weaknesses of Queensland Health's current systems
- identified organisational 'culture' issues impacting on system performance
- reviewed systems with a focus on delivering high quality health services, and health outcomes for Queenslanders with a consumer focus
- reviewed administrative, workforce management and performance management systems collectively as well as individually, to ensure sound performance of the overall health service
- adopted an evidence based approach involving direct and critical assessment of systems as well as undertaking a broad range of consultations with the community.

The review process included:

- research and direct contact to identify national and international trends in respect of the health systems under review
- consultation and analysis of systems and practices currently operating in other states, including visits to New South Wales and Victoria
- opinions from consumers, clinicians, health educators and peak bodies
- input by two reference panels, drawn from metropolitan, regional and rural Queensland, of highly experienced professionals, one which considered broader systemic issues, the other which focussed on health service issues in regional, rural and remote areas of Queensland (the composition of the panels is included at Appendix 1.2)
- over 1,300 submissions from Queensland Health staff, patients, peak bodies, other organisations and the community
- site visits in 18 of the 37 Queensland Health districts, covering all geographic regions within Queensland, plus the Mater Public Hospitals. The visits included detailed assessment of systems, discussions with all categories of Queensland Health staff especially front line clinicians. The list of Health Service Districts visited can be found at Appendix 1.3
- 14 community forums held throughout Queensland to discuss issues with local communities. The list of community forums can be found at Appendix 1.4
- assessment of systems within Queensland Health's Corporate Office and other statewide services
- consideration of issues raised in papers released by the Morris Inquiry
- consideration of issues raised in papers released by Queensland Health
- consideration of material referred from the Morris Inquiry relating to systemic issues.

This report builds on the findings and principles in the *Queensland Health Systems Review Interim Report, July 2005* (Interim Report). It also includes findings from consultation with Corporate Office staff, submissions and systemic issues identified by the Commission of Inquiry. The recommendations for systems change and an organisation reform strategy outline how Queensland Health can implement far reaching reforms to achieve improved health outcomes for Queensland Health service consumers, patients and the community generally.

1.5 The Interim Report

The Interim Report provided an overview of the current Australian and Queensland health system, the range of Queensland Health's services and its systems. It described Queensland Health's role in the broader health system and identified areas that impact on the effectiveness in fulfilling this role.

It analysed Queensland Health's service delivery quality and outcome performance. This included comparison with other jurisdictions, the cost effectiveness of services, and the nature of Queensland's workforce management systems.

The Interim Report highlighted preliminary views based on district visits and submissions received in relation to: rural, regional and remote issues; Indigenous communities, community and patient advocates; the terms of reference – administrative systems, clinical workforce management and performance management systems; and culture.

The Executive Summary from the Interim Report is included as Appendix 1.5.

Following release of the Interim Report the Queensland Government announced funding for initiatives totalling \$20 million including: 20 extra specialist doctors; \$2 million for emergency, renal medicine and operating theatres in Bundaberg; 11 extra hospital beds; \$2.1 million for acute beds to help hospitals manage winter demand; 19 additional clinical staff to focus on preventing chronic disease; funding for 6 multi-disciplinary teams to help patients with chronic respiratory diseases and heart failure; and training for rural doctors and nursing home staff.

1.6 Final report structure

This report comprises summary information from the Interim Report as well as findings from submissions, the review of Corporate Office, and consultation with numerous stakeholders including unions, other government and non-government organisations and community representative groups. The advisory panels and interstate research visits made a significant contribution. The findings regarding the current systems and research conducted on the elements of good administrative, workforce and performance monitoring systems inform the recommendations to improve health outcomes for Queenslanders. A program of reform to renew Queensland Health's capacity to address its problems includes a reform plan to guide how the Queensland Government and Queensland Health can implement change to achieve improved health outcomes.

This report is structured as follows:

Chapter 2 provides an overview of the current state of Queensland Health's systems including a summary of information contained in the Interim Report and the key findings from consultation and research.

Chapter 3 describes Queensland's future health system, the community's expectations of the health system and the challenges Queensland faces in meeting these expectations. Future demands for health services are detailed together with an analysis of fundamental changes which may need to be considered to ensure the sustainability of safe and quality public health services.

Chapters 4 to 13 outline Queensland Health's culture and current systems for each of the terms of reference. Each chapter details the findings from consultation and, based on analysis of possible options, identifies the directions for change and specific recommendations.

Chapter 14 outlines the organisation reform strategy and an indicative plan of stages and timing for programs of change and improvement to guide the Government's reform intentions.

A summary of the recommendations is included following the Executive Summary.

2. The state of Queensland Health's systems

Queensland Health has a very broad role in improving the health of Queenslanders which includes its health promotion and illness prevention activities, primary health care through its network of community health centres, public hospitals, aged and palliative care services. At each stage in the service continuum there is interaction and overlap with the Commonwealth and local governments, other state government departments, and the non-government sector. Overall, Queensland Health is the principal provider of health services in Queensland and in some rural and remote areas the only health service provider.

Health services are delivered through 37 health service districts, 3 public health networks, the Mater Public Hospitals and around 1,100 non-government health care providers. Queensland Health has a network of 178 public hospitals and 277 primary and community health centres and a workforce equating to 43,785 full time equivalents (FTEs).

2.1 The current state based on performance reporting

The Interim Report highlighted significant health system issues and trends which must now be addressed. These issues are briefly summarised in this chapter and the Executive Summary of the Interim Report which is found in Appendix 1.5.

2.1.1 How healthy are Queenslanders?

There has been an unprecedented improvement in health and life expectancy in Australia through the 20th century. In the early part of the century these improvements were due to improved sanitation and living conditions, a reduction of maternal and infant mortality and the discovery of antibiotics. General improvements in socio-economic status, education levels, healthy lifestyles and continuous improvements in health care were responsible for health improvements in the later part of the century.

From an international perspective, Queenslanders currently enjoy good health as demonstrated in high life expectancy and low levels of infant mortality. However these outcomes are not enjoyed by all groups in the community and Aboriginal and Torres Strait Islander peoples in particular, experience worse health outcomes in almost all indicators measured. Those from socio-economically disadvantaged groups and some communities from non-English speaking backgrounds also have a disproportionate share of the burden of disease.

In 2005 chronic disease is the greatest cause of ill health in Queensland. This includes heart disease, stroke, cancer, mental illness, chronic respiratory diseases and diabetes. Many of these conditions are preventable or able to be better managed through healthy lifestyles and early detection and management.

Comparisons nationally and internationally identify suicide, ischaemic heart disease, transport accidents, some cancers and tobacco related conditions as the areas where there is the greatest potential for health gain for Queenslanders.

Queenslanders are more likely to smoke, consume alcohol at risky levels and be overweight or obese, all of which contribute to increased prevalence of chronic disease. It is estimated that 3,486¹ deaths could be avoided each year in Queensland through healthier lifestyles and improved prevention of disease. Prevention initiatives require partnership across a range of health providers as well as many government and non-government agencies, industry and community groups to address the broad spectrum of determinants of health (including public infrastructure, socio-economic status, education levels and the behaviour of individuals).

There is also significant potential for gain through improved detection and management of chronic conditions by non-hospital services (avoiding an estimated 1,496 deaths per year) and in hospital treatment (avoiding an estimated 1,380 deaths).

If governments comprehensively promote and support the community's obligations to healthier lifestyles, and more individuals accept their personal health responsibilities, pressure on the acute hospital system will ease and make hospital care more accessible for those with acute or emergent conditions.

It is for these reasons that Queensland Health must continue to direct investment to health promotion and prevention and primary health care activities as well as hospital activity. There is no reason why Queensland should not be able to at least achieve the performance of the other states by addressing these issues.

2.1.2 Health service activity in Queensland

Admitted patient services

Admitted patient services (721,013 admissions and 2.5 million patient days in 2003-04) account for over 50 percent of Queensland Health's budget².

Over the period 2000-01 and 2003-04 hospital admissions in Queensland have grown by 3.8 percent while population growth has been 4.7 percent.

Queensland treats a higher proportion of public patients (93.5 percent) in its public hospitals compared to the Australian average (91.6 percent)³ but the public patient admission rate is 4 percent lower than Australia as a whole.

Despite lower levels of private health insurance, Queenslanders are higher end users of private hospitals for inpatient services (29 percent above the national average per capita). However, the rate of self funding or Department of Veterans' Affairs funded private hospital admissions is considerably higher and may explain some of this trend.

Queensland has a well developed private hospital network (in coastal areas) that reduces the duplication in services evident in other states. Even though a high proportion of public hospital services in Queensland are directed to public patients, fewer services per capita are being provided by public hospitals.

¹ Unpublished data Health Information Branch, Queensland Health

² Ministerial Portfolio Statement Minister for Health, State Budget 2005-06

³ Department of Health & Aging, The state of our public hospitals, June 2005 report

Non-admitted hospital services

Queensland Health provides a range of hospital-based services on an outpatient basis.

Emergency department presentations

In 2003-04, there were 1.25 million emergency department presentations in Queensland public hospitals at a rate per capita that was 3.5 percent higher than the national average⁴. The Royal Brisbane Hospital and Gold Coast Hospital emergency departments are two of the three busiest emergency departments in Australia.

Over the period 1999 to 2005 presentations in the top 20 public hospital emergency departments increased by 14 percent compared to 12.9 percent population growth⁵. General practitioners services are an alternative for many of the less urgent cases seen in emergency departments. However, according to 2002-03 reporting, Queenslanders' use of Medicare services is 4 percent lower per capita compared to national average⁶.

There has been increasing pressure on emergency departments as presentation rates have increased rapidly in recent years. A geographically dispersed population and fewer general practitioners, particularly in rural and remote areas, are contributing factors.

Outpatient services provided in public hospitals

In 2003-04, Queensland Health provided 7,553,000 individual occasions of outpatient services.

To a greater extent than other states and territories, Queensland Health provides specialist outpatient clinics services to the public free of charge through the public hospital system. In recognition of this, the Commonwealth government has recently allowed Queensland specialists working in public hospitals to treat patients privately within certain guidelines and thereby access Medicare.

There have been disproportionate lower levels of utilisation of Medicare for public patients compared to other states which has disadvantaged Queenslanders and placed high levels of demand on outpatient services in Queensland's public hospitals.

Community health services

Despite the importance placed on health services delivered in the community for the management of chronic diseases, Queensland has a less developed community health sector than in other states.

Queensland also has slightly higher rates of preventable hospitalisations than the Australian average which suggests primary health care activities (general practice and community health) could be improved.

Currently there is limited data available to enable performance monitoring of community health services provided by Queensland Health at the local and aggregate level.

⁴ Australian Hospital Statistics 2003-04

⁵ Queensland Health, Emergency Department Information System

⁶ The State of Health of the Queensland Population, Queensland Health, 2005

Queensland Health also coordinates the delivery of a range of health related services from 1,100 government and non-government (community and private sector) providers. These include a range of Home and Community Care (HACC) services for frail older people and younger people with moderate to severe disabilities.

Given the importance of non-inpatient services in improving the health of people with chronic diseases, Queensland Health must invest in a coordinated approach to providing a range of community health services through both government and non-government providers and must establish mechanisms for monitoring the delivery of these services.

Aged care services

Queensland Health provides aged care services through community health services, as detailed above, and through 22 Residential Aged Care Facilities (which represents only 5.7 percent of the total residential care places in the state).

The Queensland Health model of care for the provision of residential aged care is more expensive than other models primarily due to salary arrangements. The appropriateness of Queensland Health as a provider of aged care facilities is questioned. Opportunities to sell these facilities to private sector providers with appropriate safeguards for residents and staff should be assessed and if favourable sold.

Jointly with the Commonwealth government, Queensland Health also provides 13 Multi Purpose Health Service centres in small rural communities. These services amalgamate acute hospital services, residential aged care services, and community health services including home and community care services.

Multi Purpose Health Centres are the preferred model of care for communities with small populations (ie less than 10,000).

Population health services

Population health is distinguished from other roles of the health system by its focus on protecting the health and wellbeing of populations, rather than individuals. Population health is not solely a public sector responsibility, nor is it exclusive to the health sector (public, private or non-government) therefore a strong partnership approach is essential to achieving public health outcomes.

We rely on Queensland Health to regulate and ensure health of populations especially in times of natural disaster or communicable disease outbreaks or pandemics. Where Public Health has been adequately resourced it has achieved national targets in the implementation of population health programs. Breast screening and immunisation programs (childhood and adult) are good examples of such programs where Queensland Health is performing as well if not better than the national average. However in other areas such as overweight and obesity we lag behind other states.

Population health activities must be strengthened to adequately address a range of health determinants such as overweight and obesity and we must ensure we are geared up to manage large scale threats to population health.

2.1.3 Queensland Health service expenditure and efficiency

The Queensland Health budget for 2005-06 is \$5.4 billion and as at April 2005, Queensland Health's asset base was worth \$6.3 billion (gross) and \$3.5 billion (net).

The budget has grown by approximately \$2.2 billion since 1997-98 (average annual growth rate of approximately 7 percent per annum). Over the same period Queensland's population has grown by an average of 1.9 percent per year⁷. In addition, health costs are estimated to have grown by an average of 3.5 percent⁸ and 5.3 percent⁹ per year. This suggests that the average annual budget increase for health of 7 percent has kept pace with growth in health care costs and population. However there are other indicators which suggest higher increases for non salary costs of 6 to 7 percent.

While expenditure has grown Queensland Health's (including some Commonwealth special purpose payments) relative recurrent expenditure in 2003-04¹⁰ was \$1,245 per person, \$199 (or 14 percent) less per person lower than the national average of \$1,444.

Compared to averages of Australian States and Territories, Queensland Health spends less per person on each of the categories listed in the following table:

| | \$ per capita | | Difference | |
|------------------------------------|---------------|-----------|---------------|----------|
| | Queensland | Australia | \$ per capita | % |
| Inpatient services | \$604 | \$767 | -\$163 | 27% less |
| Non-inpatient & community services | \$351 | \$375 | -\$24 | 7% less |
| Population and preventative health | \$66 | \$68 | -\$2 | 4% less |

Source: Commonwealth Grants Commission 2003-04

These figures represent an update on those that were available for the Interim Report.

Queensland also spends less per person on some key areas of health need such as mental health and Indigenous health as shown in the following table.

| | \$ per capita | | Difference | |
|--------------------------------------|---------------|-----------|---------------|----------|
| | Queensland | Australia | \$ per capita | % |
| Mental health services ¹¹ | \$89 | \$100.50 | -\$11.50 | 11% less |
| Indigenous health ¹² | \$2,400 | \$2,749 | -\$349.00 | 13% less |

⁷ Population by Age and Sex, Australian States & Territories (time series spreadsheets), Australian Bureau of Statistics catalogue no. 3201.0 (released Dec 2004)

⁸ 6401.0 Consumer Price Index, Australia TABLE 7F. CPI: Health, Weighted Average of Eight Capital Cities.

⁹ Average Private Health Insurance Premium increase (1990-00 to 2004-05)

¹⁰ Australian Bureau of Statistics data

¹¹ Productivity Commission, 2005

¹² Australian Institute of Health & Welfare, Expenditures on Health for Aboriginal and Torres Strait Islander Peoples 2001-02, 2005)

Compared to averages of Australian States and Territories, Queensland spends more per person on each of the categories listed in the following table:

| | Percentage difference | \$ per capita | |
|--|-----------------------|---------------|-----------|
| | | Queensland | Australia |
| High level residential aged care ¹³ | 44% more | \$31.50 | \$22.00 |
| Dental health ¹⁴ | 78% more | \$30.00 | \$16.70 |

By expenditure category, employee expenses account for approximately 60 percent of Queensland Health's total expenditure with supplies and services representing 22 percent. By service type, hospital expenditure (inpatient & outpatient) is the largest expenditure component and accounts for around 64 percent of the total Queensland Health budget.

The expenditure data also indicates that Queensland Health spends \$9.40 (82 percent) more per person overall on health administration than other states¹⁵. However hospital administration costs per weighted separation are approximately 15.6 percent (or \$66) lower than the national average¹⁶. The higher administration costs most likely reflect Queensland Health's more centralised structure with costs being recorded corporately rather than locally and some inconsistencies in how administrative staff are defined in different states.

This data is consistent with what has been observed in district visits and in Queensland Health Corporate Office. There are insufficient numbers of basic administrative support staff in hospitals resulting in clinicians being diverted inappropriately to administrative tasks. Corporate Office on the other hand has taken on a range of functions supported by administrative staff and projects officers that should not be performed by a central office and would be better performed closer to health service delivery.

Queensland hospitals operate very efficiently compared to averages of Australian States and Territories. Queensland¹⁷:

- has a similar number of public hospital beds per 1000 people (2.6 beds compared to 2.7 nationally)
- spent 11 percent less per casemix adjusted separation (\$2929 compared to \$3293) (an indication of the efficiency of Queensland hospitals which takes into account the complexity of the admission)
- has lower relative lengths of stay in hospital (0.94 compared to 0.99) (also having taken into consideration the average complexity of cases) and
- is achieving a similar rate of same day admissions (49 percent).

The key drivers for the lower cost include lower expenditure on nursing, allied health and medical services (staff numbers and average salaries) and lower relative stays than other States.

Queensland Health, unlike other states, also provides a statewide pathology service that supports clinical care in its hospitals. This centralised approach has been reported to provide a high quality and cost effective service across the state.

¹³ Australian Institute of Health & Welfare, Health Expenditure Australia 2002-03 (2004)

¹⁴ Australian Institute of Health & Welfare, Health Expenditure Australia 2002-03 (2004)

¹⁵ Australian Institute of Health & Welfare, Health Expenditure Australia 2002-03 (2004)

¹⁶ Australian Institute of Health & Welfare, Australian Hospital Statistics 200-04 (2005)

¹⁷ Australian Institute of Health & Welfare, Australian Hospital Statistics 2004

Queensland Health should strive to maintain efficiency, but not at the expense of quality outcomes for patients and impacts on staff. Other priority aspects of service delivery performance should also be carefully monitored such as quality, safety, effectiveness and responsiveness.

Interstate comparisons suggest that expenditure needs to be boosted across the entire health system including population health, community health, mental health, Indigenous health and hospitals. However, the decisions a government should make about how and for what purposes finite health resources are allocated would ideally be informed by robust community debate.

2.1.4 Workforce planning and management

Queensland Health spends 60 percent of its budget on staffing and employs staff equating 43,785 (FTE)¹⁸ positions. In an environment of workforce shortage and increasing focus on quality and safety, workforce management (attracting, retaining and effectively using staff) and workforce planning (preparing an appropriate workforce to meet future organisational requirements) is critical¹⁹.

Clinical staff (doctors, nurses and professional staff) represent 60 percent of Queensland Health's full time equivalent employees. The current profile of Queensland Health staff and workforce growth rates for the last 10 years are shown in the table below.

| Staff category | FTEs | Percent of total FTEs | FTE growth since 1996-97 |
|---|---------------|-----------------------|--------------------------|
| Doctors (including visiting medical officers) | 3,674 | 8% | 51% |
| Nurses | 16,943 | 39% | 12% |
| Professional staff (including allied health) | 4,961 | 11% | 59% |
| Operational staff (wards persons, food, linen and cleaning) | 8,414 | 19% | 8% |
| Managerial and administrative | 8,433 | 19% | 84% |
| Technical, trade and artisan | 1,360 | 3% | 0% |
| Total Queensland Health | 43,785 | 100% | 27% |

Source: Queensland Health Human Resource Management Information System

Note these figures are based on FTEs not headcounts as in some data in Chapter 10

Queensland has a lower than average proportion of doctors in the population; 333 per 100,000 persons compared with 381 nationally²⁰. However, Australia as a whole has maintained higher numbers of doctors and nurses than the United States, Canada, the United Kingdom and New Zealand²¹.

One in five of the 3,433 full time equivalent doctors (excluding visiting medical officers) employed by Queensland Health have provisional registration²² under the area of need provisions in the *Medical Practitioners Registration Act 2001*. Queensland Health is heavily reliant on these doctors who are generally overseas trained and recruited. Any changes to these arrangements would have a significant impact on service delivery

¹⁸ Queensland Health March 2005 estimate

¹⁹ Australian Health Ministers' Advisory Council (AHMAC)(2005), Submission to the Productivity Commission Health Workforce Study

²⁰ based on registration of medical practitioners

²¹ OECD, 2005

²² Queensland Health unpublished data (2005)

particularly in non-metropolitan areas where higher proportions of doctors with provisional registration are practicing.

Contrary to popular myth, this Review can confirm that managerial and administrative staff make up 17 percent of all staff. Compared to other states Queensland Health has fewer administrative staff in public hospitals and more in Corporate Office due to its more centralised service delivery system. This Review addresses this imbalance.

Queensland also has the lowest number of nurses per capita of any state in Australia (except Tasmania) and has a critical shortage of nurses. With both the nursing and medical workforce there has been a trend to reduce working hours and do part-time work to achieve a work/life balance.

In the public hospital setting, approximately 70 percent of the total costs (excluding capital costs) are related to staffing. Compared to the Australian averages, Queensland:

- employs 11 percent fewer public hospital staff per 1000 people²³ and
- pays 5.6 percent less in average salaries for public hospital staff (Queensland's general average weekly earnings are the lowest in Australia at between 6 and 7 percent below the national average)²⁴.

Compared to the Queensland public sector, Queensland Health employees have higher rates of absenteeism particularly due to sick leave and a higher percentage of employees taking work cover leave²⁵. These are often indicators of workplaces where staff are experiencing work stress and pressure. It should also be appreciated that health staff are exposed to potentially higher levels of communicable disease than the rest of the community.

In an environment of global health workforce shortage and an increasing requirement to focus on quality and safety, Queensland Health needs to monitor and analyse workforce dynamics, and take effective action to deal with immediate and longer term problems of workforce shortage.

2.1.5 Quality and safety of health services

Health services that adhere to established standards for clinical care and have processes in place to minimise harm, are more likely to deliver quality health services for patients and communities.

Queensland Health services (inpatient and non-inpatient) have embraced health service accreditation by an external third party aimed at ensuring that processes and standards are in place to deliver quality health services²⁶. The proportion of public hospitals accredited in Queensland (89 percent) is higher than the national average (84 percent)²⁷. While accreditation is a necessary starting point, it is not sufficient on its own to ensure the quality of services provided by facilities. This has been demonstrated in Australia and overseas where major inquiries into adverse events (including Bundaberg Hospital) have occurred in quality accredited facilities.

²³ Productivity Commission 2005

²⁴ Australian Institute of Health & Welfare

²⁵ Department of Industrial Relations March 2005 data

²⁶ Australian Institute of Health & Welfare, Australian Hospital Statistics 2003-04, 2005

²⁷ Australian Institute of Health and Welfare, Australian Hospital Statistics 2003-04, 2005

Using indirect measures of quality, Queensland public hospitals on average appear to perform as well as other public hospitals elsewhere in Australia for most measures. However there is considerable variation between hospitals within Queensland.

For selected conditions small groups of clinicians in some Queensland public hospitals (known as collaboratives) have been collecting data to establish how closely evidence based guidelines for treatment are being followed. Such measurement and feedback has been shown to be an effective strategy in improving the quality of health service delivery. Queensland Health is beginning to expand this type of monitoring for a range of high volume conditions but this process is not yet systematic across all procedures and services or state-wide.

It is estimated that one in ten patients that are admitted to Australian hospitals are harmed as a result of the health care that they receive and that approximately half of this harm is potentially preventable²⁸. Much of the avoidable harm can be accounted for by falls, pressure ulcers, poor medication management, surgical complications and hospital acquired infections. Local systems are being developed and implemented to monitor these events but they are not yet able to report meaningfully on incidence on a statewide level.

Queensland Health as a high priority must continue to develop statewide clinician supported systems that support improved quality and safety and enable quality improvement activities to be monitored and evaluated.

2.1.6 Queensland Health responsiveness to the needs of patients and communities

Queenslanders need to be able to access treatment in a timely manner. Currently this is monitored and reported only for selected services described below. Such a focus potentially gives priority to these services over other equally important services (for example cancer treatment services or community health services).

Emergency department admissions

Waiting times for emergency departments in Queensland public hospitals met national targets for resuscitation cases but not for emergency, urgent, semi-urgent and non-urgent presentations²⁹. In Queensland only 60 percent of emergency department presentations over all categories are seen on time.

Outpatient appointment waiting times

All states, in both the public and private sector have waiting times between referral from a general practitioner and the date for an appointment with a specialist. These waiting times are not systematically measured but have been the subject of much reported criticism recently in Queensland as well as in some other states which have problems of the same scale as Queensland.

²⁸ Wilson RM, Runciman WB et al, The Quality in Australian Health Care Study, Med J Aust 1995;163:458

²⁹ Australian Hospital Statistics 2003-04, AIHW

Elective surgery waiting lists

Queensland has the second highest rates (30 patients per 1,000 population) of elective surgery in Australia (national average 26 patients per 1,000 population). The proportion of elective surgery cases seen on time has declined since 1998-99 but Queensland is reported as second highest (90 percent of patients seen on time) compared to the other states (84 percent)³⁰.

The number of elective surgery cases increased from 87,050 in 2000-01 to 92,491 in 2004-05.

Oral health

Queensland provides the largest and most comprehensive oral health service in Australia in both proportionate and absolute terms but continues to face heavy demand (resulting in long waiting times) for dental services particularly for aged, chronically ill and disadvantaged adults. Free oral health services are restricted to school children up to year 10 and holders of Commonwealth Health Care cards. The demand for public dental services in Queensland is much higher than some other jurisdictions due to a lack of widespread fluoridation in local communities in comparison with the rest of Australia.

Public and private hospital funding

Waiting lists for public health services in comparison to private health services are impacted by some major differences in the way public and private hospitals are funded. The private sector is motivated to increase patient throughput because revenue is attached to the number of patients seen and the type of care provided. In contrast, the public sector receives a fixed grant to provide a range of medical and surgical services. Therefore if the level of activity increases beyond the level planned, it can only be managed by:

- Increasing the cost efficiency per patient to increase throughput (ie reduce length of stay and bed numbers or reduce staffing)
- Prioritise access via a waiting list with priority given to urgent cases or diverting resources for other services to acute services.

Queensland's public health services use all of these demand management measures.

Potential opportunities for reducing waiting times:

- improved primary care and linkages between general practitioners and hospitals
- redesign of work practices and workforce reforms that improve patient flow through health services
- stronger partnerships with community health services and non-government organisations to deliver step down facilities for patient care.

Patient satisfaction

Overall most patients (89 percent) have indicated satisfaction with their hospital stay³¹. The areas requiring improvement all related to systems in hospitals associated with admissions and discharges, provision of information, and management of patient

³⁰ State of our Hospitals Report, 2005, Australian Government

³¹ Queensland Health, Queensland Hospitals in the Twenty-first Century, 2003

complaints. Patients however were not asked in these surveys to what extent their health problem was resolved as a result of their hospital treatment.

Inequities in responsiveness

Mental health patients and patients from non-English speaking backgrounds had lower levels of satisfaction with Queensland hospitals. On a number of indicators Indigenous peoples' access to health services is less than non-Indigenous peoples' despite their experiencing a significantly larger burden of disease.

Consumer and carer input into services

For mental health services, it is desirable to have a person appointed to represent the interests of consumers and carers to advise on all aspects of service delivery. Half of the health service districts in Queensland met this goal in 2003³². Consumer or carer input into the delivery of other health services is not well developed.

Where resources are the barrier to timely service delivery, this should be clearly communicated not only to affected patients but to the leaders of Queensland Health and the government.

The provision of culturally safe and accessible health services for Indigenous Queenslanders (including urban communities) and people from non-English speaking backgrounds must be a high priority for Queensland Health.

2.1.7 Queensland Health effectiveness in achieving the desired results for patients and the community

Health services at a state level should result in the prevention of illness and improved health for communities and improved functioning and survival for individuals with specific conditions. These results are achieved through the full range of services including population health, primary care and hospital services.

Currently for the vast majority of Queensland Health services (and health services in other jurisdictions) there is limited monitoring in a systematic way to inform whether patients and communities are benefiting. A notable exception is survival for Queenslanders diagnosed with cancer (an outcome that is impacted by a range of services) which is equivalent to that achieved overseas and in other Australian states³³.

Assessment of health status before and after undergoing procedures in hospital provides a very direct measure of the effective performance of a health service. This approach is not routinely used by Queensland Health but has been piloted at The Prince Charles Hospital among patients admitted for selected surgical procedures. Significant improvements in physical and mental functioning, comparable to some of the best results achieved internationally were demonstrated. This model of assessment of the effectiveness of services delivered by Queensland Health should be incorporated in routine evaluation.

Measurement of the effectiveness of Queensland Health's delivery of programs and services should be part of a culture of evaluation, learning and improvement across the whole range of service types. Such monitoring is a strong motivator for seeking to achieve the optimal performance of health services.

³² Productivity Commission, Report on Government Services, 2005

³³ Queensland Health & The Queensland Cancer Fund, Cancer survival in Queensland 2002, 2005

2.1.8 Are services delivered in a sustainable way?

Continuity and sustainability are critical issues for any health system and key themes to consider are as follows:

Coordination of health programs and services with other providers

The average health consumer in Australia faces a complex array of health providers in a system that has been largely shaped by funding mechanisms rather than a focus on consumer and community needs. In fact these funding mechanisms have often created conflicting priorities. For example the Commonwealth government funds general practitioner and private specialist services and the state government (with contributions from the Commonwealth) funds public hospitals.

A broad range of stakeholders have a legitimate interest in and contribute directly or indirectly to attaining health outcomes for Queenslanders. Partnerships with these stakeholders are essential to optimise the collective effectiveness in improving health services for all Queenslanders.

The most significant opportunity in the medium term for achieving a more consumer and community focused and cost effective health system would be to simplify and reorganise the health funding, policy and regulatory roles of the different levels of government.

Creating a culture of learning and excellence

In health service delivery settings, health and medical research contributes to a culture of excellence and learning and is important for attracting and retaining good clinicians. In turn, the community in Queensland derives a direct benefit from improved quality of care particularly from research with a focus on delivery of health services and quality and safety. On a per capita basis Queensland invests significantly less on health and medical research than most other states. This is quite concerning in an environment of workforce shortage and global competition for clinicians.

Efforts to re-establish a research culture within Queensland Health could contribute to attracting and retaining clinicians and fostering an environment where evaluation and learning is highly valued.

Capacity to deal with emerging issues

There are a number of conditions which are likely to increase in incidence and prevalence in Queensland Health in the twenty first century (including chronic disease, mental illness, dementia and hepatitis C). Based on projected numbers of cases of these conditions the current health model, with a focus mainly on treatment rather than prevention, will be unable to meet these challenges in the medium to long term.

At a population level, emerging threats such as bio-terrorism and infectious disease outbreaks need to be addressed. Should one or both of these threats eventuate, there would be significant demand on workforce with the knowledge and skills required to effectively respond to the threat, and on health infrastructures.

Maintaining a watching brief on emerging issues and innovative approaches to dealing with these issues are critical to the sustainability of the health system in Queensland.

2.2 The current state based on the consultation processes

The Interim Report (based on consultation with health service districts and preliminary research) provided an overview of the current Queensland Health systems and culture including an analysis of how well these systems are performing to deliver health services and improved health outcomes for Queenslanders. A summary of the key findings of the Interim Report is provided below.

2.2.1 Overview

- Queensland Health has a dedicated and professional workforce. District visits confirmed through wide ranging discussion and observation of elements of work practice across the occupations, that staff are committed to delivering high standards of services for those in their care.
- The public health system in Queensland depends not only upon permanent public sector employees, but a broad range of staff from the private and non-government sectors as well, who also contribute significantly to the delivery of public health services throughout the State.
- Clinical outcomes being achieved in Queensland's public hospitals are comparable to the outcomes in other Australian states. However, there is variability in clinical outcomes within Queensland Health, particularly between the larger tertiary hospitals and the regional centres, with regional and smaller centres not achieving the results of the large hospitals.
- Staff, infrastructure and financial resources in Queensland Health are stretched very thinly, and are not keeping pace with demand. This is an urgent and significant problem particularly in high population growth areas.
- From a patient perspective, patients and the community are expressing concern and anger about the excessive delays for accessing specialists in outpatient clinics at public hospitals after receiving a referral from a general practitioner, and for elective surgery.
- Patients who considered they had not received adequate care or suffered due to procedural failures were resentful and angry that the avenues of complaint through the local health service, Crime and Misconduct Commission, Ombudsman, and Health Rights Commission, had failed them.
- Patients have also expressed a strong need for improved communication with health professionals, including being advised of expected waiting times for receiving a service, whether it be in an emergency department or on an elective surgery waiting list. In some cases, patients advised they had received little acknowledgement, explanation or information about their medical or surgical procedures or when medical care had gone wrong.
- Improving the patient experience with the health system, including strengthening the continuum of care between Queensland Health's services and other health providers is an ongoing issue. Within Queensland Health, patients have expressed the need to

build a consistent relationship with individual health professionals, with concern about high levels of turnover within the system and lack of coordination of their care.

- Insufficient mental health services, both in acute settings and in community settings has been one of the most consistent themes raised with the Review, from both patients and Queensland Health staff. The accounts of systemic failure leading often to untimely death of young adults are particularly distressing.
- In rural and remote areas, patients expressed the need for improved planning of services, including the need to have access to appropriate transport and accommodation arrangements where services could not be provided locally.
- Aboriginal and Torres Strait Islander people have significantly poorer health outcomes and experience social and lifestyle factors which contribute to a high burden of disease. Significant added resources across the government and Indigenous community support spectrum will be required for programs from prevention, community education, support and services, through to acute services over a number of years.

These issues have been noted by the Review to ensure recommended system improvements within Queensland Health will help to achieve improved patient outcomes for all Queenslanders.

2.2.2 District and corporate organisational structures and layers of decision making

- Compared to health departments in other states, Queensland Health is highly centralised, and has operated as a single department for a number of years, with a brief period of regionalisation in the 1990s.
- The centralised delivery of health services has provided a number of benefits for Queensland, including districts operating with a level of collaboration across a large geographic area at a time when health service resource shortages are so critical. Queensland Health has also used its centralised structure to support consistent information technology arrangements, drive bulk purchasing and coordinate approaches to new initiatives.
- The centralised structure has however diluted levels of authority at the local service delivery levels. Queensland Health is perceived as having become a cumbersome bureaucracy with too many layers to make decisions quickly. Corporate Office has become sizeable and heavily involved in operational activities and service rather than providing the strategic direction, resource support and performance overview. At the district level Corporate Office is seen as being detached from the day-to-day service delivery functions it is intended to support.
- Queensland Health's three zones were established in 1999. The zonal staffing structures are relatively small in size compared to similar arrangements in New South Wales which has recently established area health services of approximately one million population. From a decision making perspective, it is Corporate Office rather than the zones making decisions about planning, budget allocations and policy direction which need to be made closer to service delivery.
- District Managers have wide delegations to allow timely decisions. However, the department's centralised structure, combined with tight budgetary conditions and

growing demand for health care services have strongly influenced where decisions are being made in the organisation and impact on the capacity of districts to make decisions locally.

- Local communities and district staff have strong attachments and identification with their local districts including their particular hospital. However, it is evident that some rural and regional districts do not have adequate infrastructure or capacity to fully support their expected roles including clinical governance, training and support services.
- District Health Councils were created in 1996 to provide local community input into health services. The current model is ineffective in enabling meaningful community input into health service delivery and must be strengthened.
- In December 2003, a Shared Service Provider was established to consolidate the corporate services functions (including finance, procurement and human resource management) within Queensland Health. This structure is intended to produce longer term administrative savings. However, there has been considerable concern expressed about the performance of the Shared Service Provider to date especially human resource services.

2.2.3 Corporate planning and budgeting systems

- Queensland Health faces significant challenges in future years to address a range of issues in the health sector, including meeting growing demand for services due to an ageing and growing population, an increasing prevalence of chronic disease and medical advances increasing health options. Queensland Health faces workforce shortages, a need to change the way health services are delivered to address the future challenges and overcome integration issues caused by the fragmented Commonwealth/State health care systems.
- Service planning (including clinical, infrastructure and workforce) within Queensland Health has been limited. Current planning efforts are not sufficient to provide information necessary to inform longer term service capacity needs. This is now a grave concern for both workforce and infrastructure planning particularly in South East Queensland.
- Clinicians and the community have expressed a strong need to be more heavily involved in health and clinical planning in Queensland as well as provide input into how resources are allocated.
- Internally, budgets are allocated based on historical budgets and are adjusted annually for enterprise bargaining costs and non-labour escalation. Funding for new initiatives at the local level is determined by Corporate Office, either through the allocation of growth funding or direction through new initiatives considered as part of the overall State Government budget process and regional demands.
- District budgets are not automatically adjusted to reflect changing demand or community expectations. A review of funding allocations based on a regional allocation formula shows an inequitable allocation of resources across the districts, particularly in high growth areas. The historical funding arrangements are no longer considered to meet the needs of the department in delivery of services.

2.2.4 Cost effectiveness of services compared to relevant jurisdictions

- Queensland is more cost efficient in the delivery of acute care services than other states. Queensland's cost per casemix weighted separation is approximately 11 percent lower than the national average, with at least part of this due to Queensland's lower wages structure. There is a concern from staff, patients and the community that efficiency should not compromise quality and safety for patients or be at the expense of not providing adequately for Queensland health staff.
- Staff generally reported the health system as being under significant pressure, with insufficient resources to meet increasing demand.
- The Review has identified opportunities for service improvement including improving patient flows in the acute care settings and strengthening service integration between acute and community services.
- A number of clinicians identified the need to improve the interface between general practitioners and outpatients. In a number of hospitals, clinicians identified opportunities to redesign: the process for admission; improved access and planning for theatres and intensive care unit beds; discharge arrangements (including patient transport post discharge); and step down care facilities and services.
- A number of the barriers to improving patient care and the improved function of the system involve the interface between the State and Commonwealth funded services.
- External providers including non-government organisations and the private sector indicated that they may be able to provide some services more cost effectively than Queensland Health. However, they indicated Queensland Health would need to more clearly define its role in service provision and how it operated with external partners.

2.2.5 Organisation and delivery of clinical support services

- Pathology, radiology and pharmacy services are all indicating significant difficulties recruiting and retaining qualified staff. In January 2005, pharmacy was reporting 16 percent vacancies. All services are indicating staff shortages which are impacting on service delivery capacity and the workloads of the remaining staff.
- The lack of specialist staff is impacting on service quality, particularly in radiology. Some doctors indicated concern that inadequate access to radiology services was impacting on diagnostic capabilities particularly after-hours and on weekends. Some districts are also reporting that waiting times for radiology are increasing.
- The public sector is seen to pay less than the private sector for all three disciplines, with continual competition for quality staff. On the other hand, the public sector is seen as offering wider experience and more interesting work than the private sector.
- Insufficient administrative support for clinicians has been raised as a consistent theme. Clinicians in all sectors expressed concern about the increasing levels of administration work required in their day to day work, impacting on clinical time.

2.2.6 Clinical audit and governance systems

- Queensland Health has a range of clinical governance systems that should theoretically have detected the events in Bundaberg Hospital. Their failure to do this reinforces that systems and committees alone will not of themselves ensure that a chain of adverse events is quickly identified and addressed. Clinical governance and quality and safety programs have been in place for many years including:
 - all districts have arrangements in place for the credentialing and privileging of doctors, although their capacity to undertake this assessment rigorously varies from district to district, being dependent largely on size
 - in some districts, committees exist which routinely look at morbidity and mortality. However, there are no formal requirements for these reviews to take place or requirement to share the findings with other staff.
 - there have been few clinical audits conducted by the Office of the Chief Health Officer and no statewide training for clinicians on clinical audit processes.
- Queensland Health does not have the systems to adequately support or encourage clinicians (ranging across the professions) to report concerns about the competence and decisions of another clinician. Identification of declining or questionable clinical competence is hampered by inadequate clinical data collections and insufficient involvement of clinical leaders.

Quality and safety

- Quality and safety systems are being implemented but are still immature. Most districts have some form of quality committee. There is a wide range of variation in the level of consideration given to quality committee reports and feedback provided.
- Quality and safety systems have focused on issues such as falls prevention, medication errors, incident reporting and workplace health and safety issues to date.
- In many districts, the quality system has become synonymous with the accreditation process. The quality process is not seen by staff to be a part of normal practice. Accreditation alone is not an adequate measure of the quality and safety of services.

Risk management

- Risk management development is still in its infancy in Queensland Health and to some extent is still being seen as a legislative compliance issue rather than a tool for managing and ensuring good patient outcomes.
- All districts have risk registers, but they do not roll up to a corporate risk register. The quality of the risk registers vary markedly between districts as does the link between the risks identified and evidence of strategies to manage the risks.
- In the main, risk management in the districts is reactive, rather than proactive. There is a belief by some staff that the informal system of risk management works well and lack of time due to patient load does not permit them to value or use the formal systems.

Complaints management

- Public forums and many submissions received by the Review raised consistent concerns with Queensland Health's ability to adequately deal with complaints, whether from patients or staff.
- There is an inconsistent approach across the State for dealing with the various complaint categories. Complaints management within Queensland Health is not sufficiently coordinated and in many cases ineffectual. In some districts local resolution of patient complaints appears to be working well, although in a number of districts patient complaints are being escalated directly to the Minister for resolution or external legal avenues are being pursued because of the difficulty in gaining local resolution.
- The public does not have satisfactory complaints systems upon which to rely, nor are there sufficient patient support mechanisms or checks and balances. There was some concern by rural communities that people were not lodging complaints in the fear that services would be closed. Some staff advised that little regard has been paid to workplace, health and safety systems and views of district staff are that the grievance system, as a means of resolving workplace issues, is an abject failure.
- A great deal of dissatisfaction was expressed about the delays and lack of effective complaint resolution by bodies such as the Ombudsman and the Health Rights Commission.

2.2.7 Workforce management systems

- Queensland Health is the largest employer of health professionals in Queensland. Its role includes recruitment, placement, supervising, training and mentoring the health workforce of the future.
- Queensland Health is competing in a global market for the health workforce where there are growing shortages across the medical, nursing and allied health professions.
- In the context of critical health workforce shortages, it is important that Queensland Health's workforce management systems support clinicians to deliver services and assist in attracting and retaining the best and most highly skilled practitioners in the State's public health system.
- An effective workforce management system would be expected to include long term workforce planning, effective recruitment and retention processes, appropriate remuneration and employment conditions, a fair and transparent staff complaints system, quality controls including credentialing and periodic reassessment of skills, access to training and professional development, mechanisms for allocating staff, and up to date workplace health and safety management systems.
- Most importantly, the workforce management system as a whole should support, value and nurture staff. Health professionals are working in increasingly complex and stressful environments characterised by rising workloads, sicker patients, more demanding and at times physically violent patients, rapid technological advances and growing community expectations about what health services can deliver.

A range of workforce management systems are used within Queensland Health. Broadly, the major systems include:

- Human Resource information management systems such as LATTICE, which provide data about the Queensland Health workforce including trends over time
- workforce planning in some districts or zones and a corporately developed Queensland Health Workforce Strategic Plan 2005-10
- representation on national workforce planning forums [the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Officials Committee (AHWOC)]
- recruitment processes based on whole of government merit selection and vacancy advertising requirements as well as use of recruiting agencies
- a range of systems to cover temporary vacancies including: use of private agency staff for nurses; deployment of junior doctors to cover leave taken by medical staff in rural and remote areas; internal relief arrangements in some districts
- credentialing and clinical privileging policies and procedures, with final responsibility resting with District Managers
- a fragmented and complex award based system of remuneration and conditions for professional groups, determined through whole of government enterprise bargaining processes
- a range of retention strategies including: study leave, motor vehicle entitlements and private practice arrangements for medical staff, rural and remote allowances and rental assistance for some staff; limited qualification allowances for nursing staff; and a Clinical Advancement Scheme for allied health professionals
- a hospital based postgraduate and vocational training system for doctors which operates in partnership with universities, the Medical Board and Australian medical colleges
- clinical placements for nursing and allied health students in partnership with universities, to support education of future clinicians
- training and professional development arrangements including mandatory corporate training for all staff (eg fire safety, aggression management, cross-cultural training) and varied arrangements for clinical skills development for doctors, nurses and allied health professionals
- rostering systems for nurses including ESP and the Business Planning Framework
- grievance processes to manage staff complaints and disputes.

Queensland Health's workforce systems are working imperfectly overall despite its ability to sustain steady increases in its clinical workforce over the past decade. However, there is room for improvement, with key findings outlined below.

Monitoring of key workforce trends

- The Review appreciated the significant efforts undertaken by Queensland Health to provide data on the workforce in terms of numbers, trends over time, vacancy rates,

areas of key workforce pressure and turnover and wastage rates. However, the difficulties in providing this data highlight a failure within the organisation to systematically monitor and analyse workforce data, including identification of key trends and areas of concern.

- In terms of monitoring staff morale, the Review accessed surveys occurring on an ad hoc, district by district basis, but could not identify any statewide staff satisfaction survey activity.
- More comprehensive monitoring and analysis of workforce trends would be useful to inform statewide workforce planning.

Workforce planning

- Plans were available in some districts and zones. There was no comprehensive plan which modelled future workforce needs and scenarios, options to meet future demand which included specific targets, strategies and timeframes.
- Queensland Health contributes to national workforce planning activities which are most developed in the area of medical and nursing workforce but underdeveloped in respect of allied health. Additionally, national workforce planning activities are based on current models of care and workforce trends.
- National work to examine alternative workforce scenarios or models would be desirable, given the widespread agreement that the existing workforce model cannot be sustained in the context of a shrinking and ageing workforce. The advantage of national planning is the opportunity to engage the Commonwealth government given its critical roles in funding student university places, private medical activity, primary health care and aged care.

Recruitment systems

- The Interim Report identified the need for more flexibility in recruiting clinicians and the limits of whole of government merit selection processes in identifying the best clinicians to fill a vacancy, especially the nursing workforce. There is a need for more flexibility in advertising positions, timely placement of requested advertisements, and the need for improved recruitment systems in selecting OTDs with special purpose registration.
- A degree of casualisation was observed in the nursing workforce, with a high reliance on agency staff to regularly cover nursing vacancies at short notice.
- The Review was told that many clinicians are awaiting the outcome of the Bundaberg Commission of Inquiry and the Queensland Health Systems Review before determining whether they will remain in the public sector. This, combined with damage to Queensland Health's reputation as an employer following events at Bundaberg Hospital, suggests that intensive efforts are needed immediately to improve recruitment and conditions resulting in greater retention of employment of Queensland Health's current and future clinical workforce.
- These issues may be partly addressed by the Queensland Government's announcement on 2 August 2005 to give Queensland Health more flexibility than other departments in its recruitment techniques.

Credentialing and clinical privileging

- Queensland Health has in place credentialing and clinical privileging policies and procedures. However, events in Bundaberg Hospital have clearly raised questions about the adequacy of implementation of these systems.

Remuneration and entitlements

- Clinical staff identified a range of issues impacting on retention. This included a perception that Queensland clinical staff earn less than their interstate counterparts. However, non-salary issues were clearly presented as being more significant in determining whether to remain in the public sector. The Interim Report highlighted these issues in detail. Broadly, clinicians reported feeling undervalued and marginalised from a system with unmanageable workloads, lack of management support, lack of clinical input into decision making including budget allocations, insufficient time for teaching, research and professional development, budget constraints impacting on quality of clinical care, limited opportunities to develop collegiate networks within and across professional groups and poor organisational culture.
- Remuneration and entitlements are determined through whole of government enterprise bargaining processes. Often enterprise negotiations are escalated to the highest levels in government, thus diminishing the worth of the enterprise concept. Such arrangements leave very limited discretion within Queensland Health and at the district level to negotiate individual employment arrangements. To some extent, standardised entitlements are helpful in that they contain uncontrolled escalation of salary costs through competition between districts.
- It is important for remuneration and entitlements to be fair and just and competitive with other states to position Queensland Health as an attractive employer. This is not presently the case.

Retention strategies

- District staff identified a range of issues impacting on retention. However, many other system improvements, particularly in the areas of workload, budgeting, service planning and information systems, will also be critical in improving work conditions and ensuring clinical staff feel valued and supported.

Education and training

- Queensland Health is unable to provide essential teaching, education and training as it struggles to cope with increasing demands for services. Across all professional groups, the Review heard from senior clinicians who were concerned that they did not have time to adequately support, supervise and mentor junior clinicians due to high clinical workloads. In turn, many junior clinicians felt exposed due to insufficient supervision and support.
- Senior medical staff – including full time and visiting medical officers – have an entitlement as part of their conditions of employment, to study or take professional development leave. However, doctors consistently reported major frustrations with the convoluted and mean spirited approval processes required for them to attend overseas conferences and to take study leave.

- Junior doctors and registrars are employed in public hospitals in both a service delivery role and to meet training requirements under what could best be characterised as the medical apprenticeship training model. Junior doctors and registrars reported not receiving adequate support or supervision due to high clinical workloads of senior doctors.
- The supply of medical graduates into the system is expected to double by 2010 with the expansion of medical courses across the State's universities. This will pose major challenges to Queensland's public hospital system in terms of the need for additional training positions and the extra demands for supervision which will be placed on already stretched senior specialist staff.
- This has led to questions around the continued suitability of the current traditional time-based medical training system which is based on an apprentice type model and undertaken predominantly in metropolitan and regional public teaching hospitals. If increasing graduate numbers are accompanied by worsening senior medical staff shortages then this model may be difficult to sustain.
- There are numerous players involved in medical training including the Commonwealth and State Governments, universities, colleges, registration boards, professional associations, and the private sector. The multiplicity of players and their differing objectives makes long term coordinated planning critical in addressing future medical training needs.
- Queensland Health has implemented a number of strategies to improve training and education for the nursing profession including the development of a Statewide Nursing Staff Development Framework to provide a coordinated direction for training across the State. Nurse educators are employed in most of the medium and larger sized facilities and there has been a major emphasis on developing transition programs for new graduate nurses and nurses re-entering the workforce. Special programs for nurses working in rural and remote areas have also been developed.
- Notwithstanding these efforts, there is considerable variation in the delivery and quality of training undertaken across the districts. Generally, access to training is restricted in rural and remote areas and there can be disparities in availability between community and acute settings. Some districts have put in place a range of training programs including specific skills development programs for emergency department and intensive care nurses while in other facilities, there are limited specific training or education programs available.
- Often the workload has prohibited staff from attending training due to the lack of backfill available.
- Clinical practice differences can be attributed to infrastructure, availability of nurse educators, and the level of staff and organisational commitment to training and professional development. The increasing casualisation of the nursing workforce also presents challenges for training as resources are usually allocated on the basis of the number of full time equivalent staff employed.
- Nurses were also concerned at the focus on administrative mandatory training, frequently emanating from Corporate Office, which is not risk based or appropriately targeted, is seen as of little value by staff and is not related to higher priority clinical requirements.
- Allied health comprises a diverse range of professionals with different training needs and requirements. While Queensland Health has recognised the need for improved

training for allied health professionals, as with nurses, the application of training strategies can be variable across the State. The relatively smaller numbers of each professional group within the allied health profession makes mentoring support difficult particularly in the smaller health service districts where there may be only one or two practitioners.

- Concerns commonly raised by allied health staff included increasing patient demands which limits time available to support junior staff, inability to backfill positions and attend training, and difficulties associated with meeting specific registration board requirements regarding supervised practice. The Review also noted the industrial action which occurred in 2004 where allied health staff withdrew supervision for clinical placements due to concerns about lack of resourcing to support supervision.
- Allied health staff also report dissatisfaction with their preparation for the work environment and a lack of support and preparation for working in rural and remote areas. The majority of professional development undertaken by allied health employees is self-funded which also acts as a major disincentive for professionals to keep their skills up to date.

In summary, the dearth of teaching and training is one of the most serious, if not the most serious, problem identified.

Grievance processes to manage staff complaints and disputes

The Review heard from many Queensland Health staff that existing grievance systems are not resolving concerns for aggrieved staff or resolving workplace conflict. Whilst grievance procedures are a key workforce management strategy, the process:

- Removes responsibility for workplace harmony from management/supervisors
- Takes an inordinate amount of time
- Resolves little and often escalates conflict and resentment.

Workforce information systems

- District visits highlighted the administrative burden imposed on clinicians in managing workforce information and rostering systems. There was a consistent view expressed by clinicians in districts that these systems could be far more efficient and that management of some of these systems might be more appropriately performed by administrative support officers to increase availability of clinicians to perform clinical work.

2.2.8 Asset management and capital works

- There has been considerable modernisation of Queensland Health's asset base over the last 10 years, particularly following the completion of the \$2.8 billion Statewide Health Rebuilding Program. However health planning input was deficient and all major facilities rebuilt have insufficient beds for today's demand and future growth. There has been a tendency over many years for government to impose their view on where health services should be located. This should be addressed.
- Improving the link between health service planning and capital works planning has been identified as an ongoing issue for Queensland Health. There has been limited

routine service planning in Queensland Health for a number of years, with no effective link between health service planning and capital works or asset strategic planning.

- A number of districts have indicated a gap in sub-acute capacity, for both acute and mental health conditions. Many considered that investment in these areas would ease pressure on acute facilities and improve continuity of care.
- Budget setting for new capital works projects has been an ongoing challenge for Queensland Health, partly due to insufficient planning prior to project announcement, inadequate scope definition and insufficient total funding.
- Districts have indicated a gap between their asset needs and the annual capital works plan, with limited involvement of the districts in the overall capital planning and prioritisation arrangements. Funding for asset replacement, refurbishment, maintenance and building operations continues to be an issue for the department.

2.2.9 Information management

- Information is a key enabler in the delivery of health outcomes within Queensland. Information technology and management services Queensland Health is governed and delivered at the corporately. This centralised approach is viewed by other states as providing significant information management benefits.
- Queensland Health has many information systems providing a wealth of data yet information has tended to concentrate on financial performance, hospital activity and, far less perfectly, human resource systems. Queensland Health does not have information systems for all of its major service delivery functions eg. community health or allied health services. Information management to support clinical processes and outcome monitoring have not been a focus of the organisation to date.
- At the operational level, issues raised by staff regarding information technology and information management include inadequate access to information technology infrastructure, the need for information systems to be considered in their totality, including the impact on clinical staff of a number of systems and improving system integration to minimise time spent entering data into different systems.
- From a corporate perspective, there is a strong need for a systematic review of the administrative processes across the department commencing with human resource systems to minimise the overall administrative burden which has become cumbersome and time consuming.

2.2.10 Performance monitoring and reporting of health system outcomes

- Queensland Health provides a range of performance measurement data publicly to meet the requirements of the both the State and Commonwealth Governments, and participates in a range of benchmarking activities with national bodies including the Australian Institute of Health and Welfare and the Productivity Commission.
- External health outcome reporting by Queensland Health has been a combination of annual input into the Queensland Government's Priorities in Progress report and through the *State of Health of the Queensland Population series*. The latter reports in

identify the burden of disease for Queensland and highlight areas of potential health improvement.

- Public performance measurement and reporting of the health system has focused heavily on hospital based services, particularly activity, access and expenditure. Queensland Health reports publicly on waiting times for elective surgery on a quarterly basis. However routine public reporting of quality, safety and clinical outcomes does not occur.
- Internal reporting within Queensland Health is based traditionally around activity levels and financial monitoring. The Measured Quality Program was the first corporate attempt to measure quality and safety across the hospital system.
- Compared to New South Wales and Victoria, Queensland Health provides less routine public information about a range of health services including access and quality of health services.

2.2.11 Culture

- Queensland Health has a positive culture of dedication towards patient care and wellbeing which was also very strongly evident during district visits. The general commitment of Queensland Health staff to providing quality care in some times difficult circumstances is commendable. Queensland Health has also had a culture of clinical innovation in a number of specialities, considered a world leader in a number of areas.
- However it has also been widely reported in the media, to the Review through its district visits and submissions, that an entrenched and negative feature of the Queensland Health culture is one of bullying, threat, intimidation, coercion and retribution on the one hand, and of secrecy, blaming and avoiding responsibility on the other. These values, attitudes and behaviours are not conducive to a cohesive staff environment or good patient care.
- There is a strong culture of budget containment which has developed within Queensland Health. There has been a clear message from the highest levels of all Governments over the last decade that failure to perform to budget will not be tolerated. Staff concede budget management is important, but feel that the manner in which cost consciousness and budget efficiency have been driven, has been responsible for exacerbating the incidence of bullying and intimidation.
- There is also a culture of secrecy and cover-up where it is argued protection of patient rights is used to avoid release of information in the public interest.
- There is a need to improve the commitment and skills of leaders, managers and supervisors to deal with difficult and complex problems, engaging effectively with staff and encouraging staff contribution to the resolution of problems.
- All too frequently staff report that problems are addressed through processes where verbal instruction evoked antagonism and formal processes involving lengthy written correspondence with no response or follow up. The lodgement of formal grievances and lengthy investigations with inconclusive outcomes was a commonly reported feature.

3. Queensland's future health care issues

Good health for ourselves and our families is one of the most valuable things we have as individuals. Being able to access safe, high quality health services in an emergency, or during illness or injury is fundamentally important to all Australians. Australia in recent decades has developed a universal health system, based on the principle of being able to provide all Australians with access to free health services when needed. The public health system is a highly valued part of the Australian community.

It is clear from statewide consultation the public has an expectation that the public health system should be able to meet all the health needs of Queenslanders. An effective public health system which meets community needs and expectations would:

- ensure the environment is safe eg. safe water, food production and air quality
- deal effectively with public health issues such as prevention of communicable disease and management of epidemics
- inform and educate the community about how they can improve their own health and the health of their family
- provide access to primary health care, including early detection of disease
- assist individuals in the management of their chronic conditions
- provide for all emergency situations, including emergency surgery
- provide access to general medical services and elective surgery within a reasonable time period, depending on clinical urgency and at an appropriate facility
- provide safe birthing services locally
- ensure delivery of the best possible treatment or procedures safely
- provide a meaningful and prompt response when individuals engage with the health system, including management of complaints.

All governments would like to provide a health system which delivers such services at a cost that is acceptable to the community. Health care providers, governments and international agencies including the World Health Organisation are grappling with how to meet ever increasing demand fuelled by population growth and ageing, the increasing prevalence of chronic disease, new technology, workforce shortages and looming infrastructure shortages. It is obvious however, that regardless of the extent and manner in which services are provided, the people and the funds required to deliver these services are limited.

The Queensland health system is not unique. The challenges facing Queensland Health are shared by other States and Territories to varying degrees and by health systems across the western world. The Interim Report showed Queensland Health's services and systems are already strained and that future community needs and demands of the health service are escalating. This Review therefore must consider the type of health system that might best serve the needs of the community now and in the future.

This chapter provides estimated demand for Queensland Health’s hospital services over the next twenty years. These projections are based on a continuation of the current model of health care delivery. However, without longer term significant change Queensland Health’s ability to deliver sustainable additional services using present care arrangements is uncertain.

The later part of the chapter discusses more fundamental changes which may need to be considered in the provision of health services from a broader State and Commonwealth perspective. The issues identified are challenges being considered by all State Governments and are not within the direct control of Queensland Health or the Queensland Government. However, these issues are of national significance and have a fundamental bearing on the future provision of health care services in Queensland.

Fundamental changes in the way health services are organised and delivered in Queensland and throughout Australia are now urgently required to try and avoid major gaps developing in the system’s capacity to meet future health needs. These emerging problems, clearly evident are not easily solved. The Commonwealth-State issues discussed are not new and have been the topic of discussion in numerous reviews of State and Commonwealth health service provision for a number of years. These issues are raised again to reinforce the need for community debate about the longer term organisation of health service delivery in Australia.

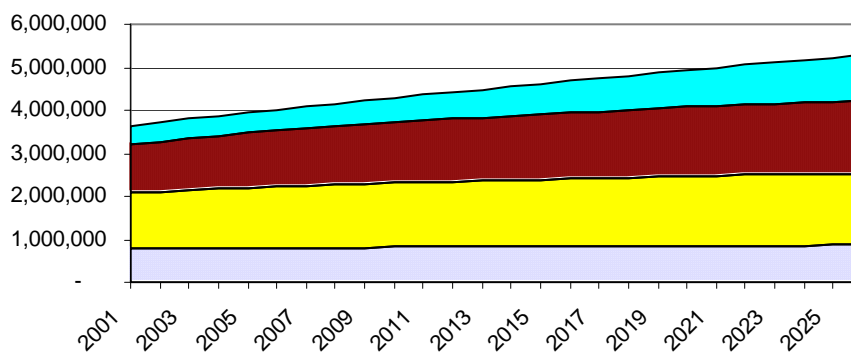
3.1 Future Queensland Health service demands

3.1.1 Impact of a growing and ageing population

Queensland is expected to continue to experience the fastest population growth of any State or Territory. The State’s population is projected to increase by nearly a third over the next twenty years, from around 4 million people in 2005 to 5.3 million in 2026. Queensland has a relatively younger age profile compared to other States, but population ageing is accelerating. By 2026 people aged 65 years and over will account for 20 percent of Queensland’s population compared to 12 percent in 2005.

Queensland Population Projections

□ Persons: Age 0-14 □ Persons: Age 15-39 ■ Persons: Age 40-64 ■ Persons: Age 65+



Source: Office of Economic and Statistical Research, Medium Series Population Projections 2005

The incidence of illness and disability rises with age and it is expected that diseases such as cancer and cardiovascular disease will increase in line with the ageing population. For health services as a whole, expenditure on people aged over 65 is roughly four times more per person than those under 65 years of age and increases to between six and nine times for the older groups.³⁴

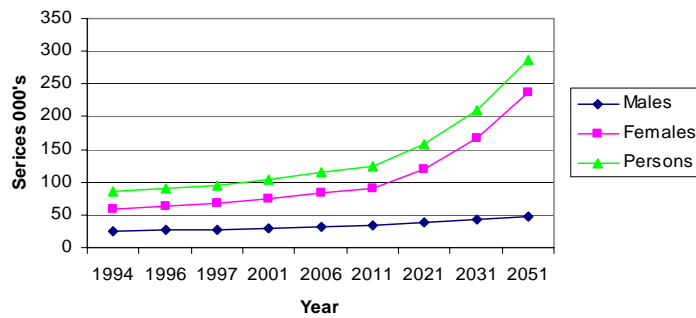
Based on a simple extrapolation of current known trends by 2026, Queensland would use around 75 percent of hospital capacity for people aged 65 years and over compared to the current 40 percent.

With an ageing population:

- the ageing population is expected to account for a 31 percent increase in cancer cases between 2002 and 2011³⁵.
- the prevalence of mental health problems, particularly disorders such as anxiety and mood disorders are known to be increasing with predictions that depression is likely to rank second in the burden of disease by 2020. Access Economics has projected the number of people with dementia will grow from 1 percent of the population in 2005 to 2.8 percent of the population by 2050³⁶
- growth in the need for renal dialysis is a particular issue for Queensland, with the number of patients growing by 7.6 per cent per annum. Renal disease is more prevalent for Indigenous Queenslanders.

Impact of ageing and falls

The incidence and severity of falls is expected to increase rapidly in the older population. A recent Queensland Health study examined the resource implications of injuries to elderly people from falls and highlights the increasing cost pressures associated with an ageing population.



Age related falls are projected to lead to large increases in the number of acute services required increasing from an estimated 85,000 hospital bed days in 1994 to 287,000 bed days in 2050. Associated with the extra bed days is an increase in health expenditure on falls related injuries which is projected to increase from \$86.2 million in 1994 to \$266.7 million in 2051.³⁷

Source: Health Information Centre, Queensland Health

³⁴ Productivity Commission, Economic Implications of An Ageing Australia, 24 March 2005.

³⁵ Source: Cancer incidence projections Australia 2002 to 2011, AIHW 2005

³⁶ Source: Dementia estimates and Projections: Australian States and Territories. Reported by Access Economics for Alzheimer’s Australia, 2005

³⁷ Queensland Health, Changing Resource Demands Related to Fall Injury in an Ageing Population, a Modified version of the report prepared for the NSW Health Policy Unit by J. Moller, 2002.

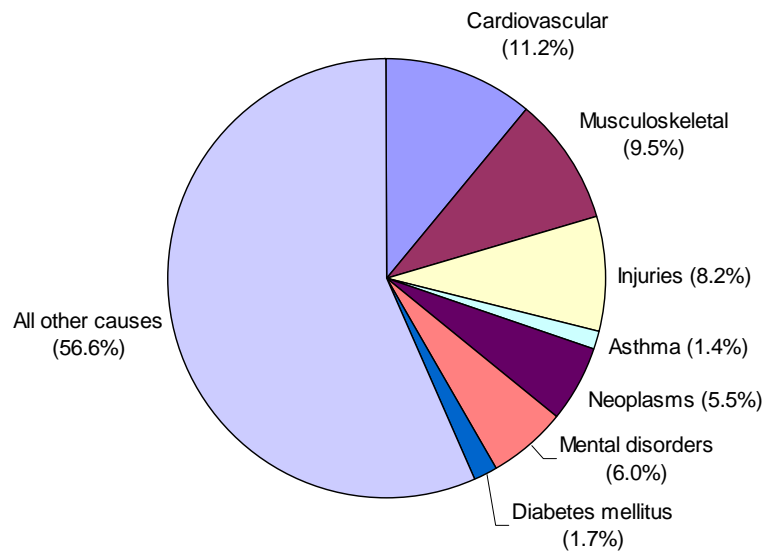
3.1.2 Future health pressures and the changing model of health for Queensland

Forecasting the future demand for public health services based on Queensland’s projected burden of disease is a difficult task. The relationship between lifestyle factors and chronic disease makes the task more complex given the estimates that a significant proportion of the burden of disease could be prevented or delayed with changes in diet, exercise, smoking and alcohol consumption.

Changing medical practices and health technologies can also significantly change treatment patterns and life expectancies. It is estimated that changing medical technologies, rather than ageing itself, is probably one of the most significant drivers of future health demand³⁸. For example, the average person today would at some stage in their life expect to have a hip replacement, knee replacement, cataract surgery or potentially all of these surgeries performed. Medical technology has made these surgeries more accessible today than they were twenty years ago, widening the number of people who might be considered for procedures.

Australia has nine national health priority areas which account for around 44 percent of all health expenditure in Australia including cardiovascular disease, musculoskeletal diseases, injuries, cancers and mental illness.

Health system expenditure by National Health Priority Area, Australia 2000-01



Source: Health System Expenditure on Disease and Injury in Australia 2000-01, AIHW 2004

The *Smart State: Health 2020 Directions Statement 2002* (Health 2020) highlighted that increasing chronic disease and changing treatment models would change the traditional hospital based model of care.

³⁸ Ham C, *The Global Challenge of Health Care Rationing* cited in the Senate Community Affairs Reference Committee, *Healing our Hospitals – A Report on Public Hospital Funding*, 2002

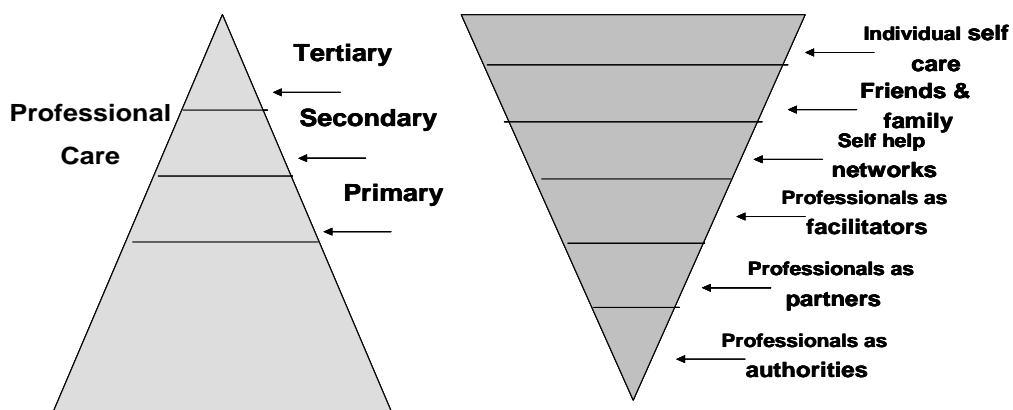
Over the last decades, changing medical technology and disease patterns have changed the role of acute hospitals, with hospitals increasingly having the capacity to treat and manage acute illness and injuries on day-only and short stay arrangements. However, this model of delivery is dependent on strong relationships between general practitioners, rehabilitation and community care providers to ensure patients receive the care they need.

The World Health Organisation is indicating chronic conditions require an evolution of health care from an acute “find it and fix it” model towards a coordinated, comprehensive system of care. It is increasingly considered that increasing numbers of chronic conditions can be better managed by individuals and carers with assistance from general practitioners, community and allied health workers.

This model of care also requires a major change in the way patients and the health system interact. The following diagram shows the changing nature of health care from a system of professional-centred care, to a system where the individual is empowered as a partner in achieving optimal outcomes of care.

New patterns of service delivery

Industrial age medicine is transforming into information age healthcare



Source: Jennings, Miller and Matema - *Charging Healthcare*, Santa Monica: Knowledge Exchange, 1997

Information management would play a key part in the transformation from a model reliant on health professional advice for all decisions to a model which places an emphasis on supported self-care and the transfer of knowledge and decision making to the patient.

The ageing population will have an increasing impact on the health care workforce. Over the coming two decades, growth in working age population in Australia is projected to slow from an average growth of around 170,000 additional employees each year, to an annual growth of just 12,000 additional employees per year in the 2020s.

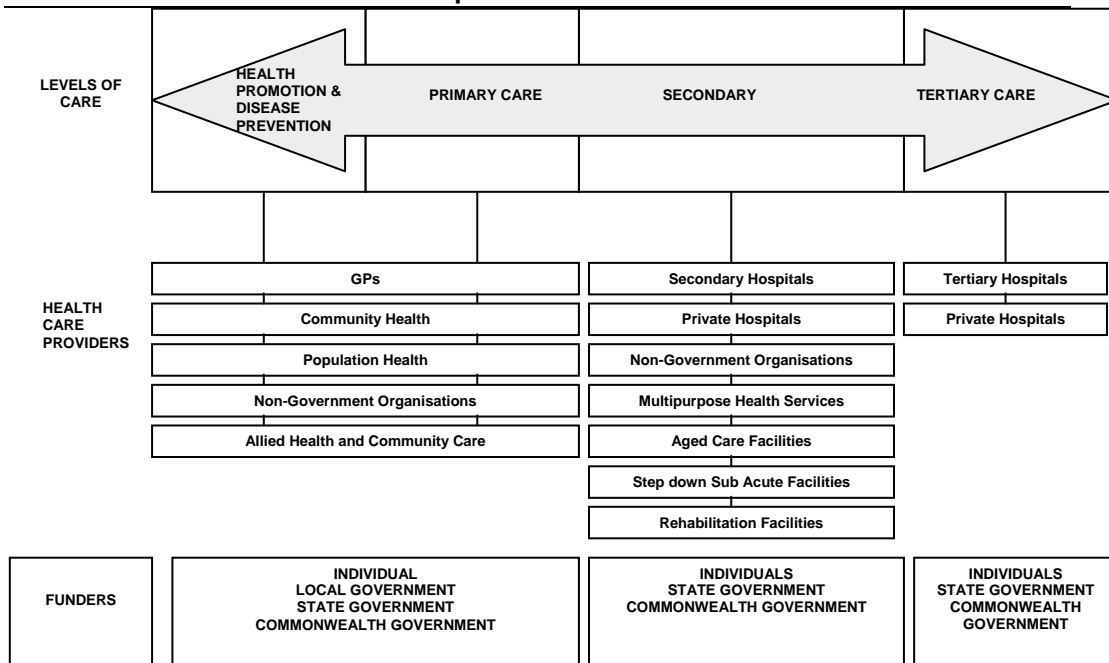
For the health care sector and other human services which are heavily reliant on the workforce for service delivery, the need to change the traditional professional roles is clearly apparent. Across the western world, health care providers, educational bodies and governments are considering options to reshape the health workforce, improving the integration of professions and encouraging the support of patients and their families to manage chronic conditions.

3.1.3 Queensland Health and other providers

Australia’s health system is a complex mixture of public and private sector health service providers and a range of funding and regulatory mechanisms. In comparison to health systems in other countries a unique characteristic of the Australian system is that both the public and private sectors are substantially funded/subsidised by government. In many respects, the high level of government involvement has led to care of patients being organised around funding arrangements rather than the funding arrangements supporting a planned/consumer centred approach to health.

Queensland Health is just one of a number of health care providers in Queensland, having primary responsibility for public hospital services, mental health, population health and some community health. Queensland Health also provides oral health and some aged care services.

Continuum of care and health care providers in Queensland



With a myriad of health care providers and funders, the service delivery functions of Queensland Health are strongly influenced by the effective functioning of both its own services, other health care providers and effective integration between all parts of the health service. Where there are gaps in other services, Queensland Health will be impacted, for example:

- where access to general practitioner (GP) services is inadequate (Commonwealth responsibility), there is arguably an impact on public hospital emergency departments (a state/territory responsibility).
- public hospital services, can be impacted by a lack of suitable aged care services (Commonwealth responsibility) which leaves frail non-hospital type patients unable to leave costly acute care beds.

A challenge is to improve integration between the services Queensland Health provides and other health services to ensure that patients receive the best possible care. Chapter 7 outlines the need to improve partnerships with other health care providers.

In the longer term, more fundamental change to Commonwealth-State health policy and funding responsibilities will need to be considered to ensure future sustainability of services. These issues are discussed in section 3.2.

3.1.4 The private hospital system and Queensland Health

The future demand for public hospital services will be influenced by the level of demand for private hospital services. In recent years, there has been an increasing level of service provided in the private sector associated with more and more people taking out private health insurance in Queensland.

As shown in the table below, the number of services provided in Queensland's private hospitals has been growing at a faster rate than the level of public hospital activity. This has resulted in the public hospital share of overall hospital activity falling from 61 percent of all hospital activity in Queensland in 1999-00 to 52 percent in 2003-04. This trend has occurred across Australia in response to Commonwealth Government policy initiatives designed to encourage private health insurance.

While some pressure has been taken off public hospitals, the public sector is losing increasing numbers of doctors to private practice. Doctors entering the private sector in this climate of heightened private demand can quickly become financially secure with a minimum of risk compared to earlier eras.

Episodes of Care in Queensland Public and Private Hospitals

| Year | Public Hospitals All patients | % Share | Private Hospitals All patients | % Share | Total |
|--------------------|----------------------------------|---------|-----------------------------------|---------|-----------|
| 1999/00 | 706,530 | 61% | 452,506 | 39% | 1,159,036 |
| 2000/01 | 687,952 | 57% | 526,313 | 43% | 1,214,265 |
| 2001/02 | 694,264 | 54% | 593,116 | 46% | 1,287,380 |
| 2002/03 | 701,753 | 54% | 602,166 | 46% | 1,303,919 |
| 2003/04 | 720,673 | 53% | 640,048 | 47% | 1,360,721 |
| July 2004 to March | 547,167 | 52% | 503,175 | 48% | 1,050,342 |

Source: Queensland Hospital Admitted Patient Data Collection

It is difficult to predict the level of private provision into the future as it is sensitive to government policy initiatives. For instance, if changes were contemplated to reduce the Commonwealth Government's 30 percent private health insurance rebate or remove the financial penalties on high income earners who do not hold private health insurance, this would be expected to be associated with a reduction in the overall number of privately insured people and usage of private hospital services generally.

On the other hand, Queenslanders like the rest of Australia, are generally becoming wealthier and significant numbers may therefore be in a position to support increasing levels of private health insurance into the future.

Private Health Insurance

Currently 40 percent of Queenslanders are privately insured. Compared to elsewhere in Australia, fewer people per capita in Queensland have taken up private insurance. Private hospitals are limited to South East Queensland and coastal areas. Queenslanders, however, use 24 percent more private hospital services per person than the national average, the highest level of private hospital usage in Australia.

3.1.5 Estimating future resource needs for Queensland Health

With a growing and ageing population Queensland Health will have an ongoing need to continue its investment in expanded health services in future years. Public consultation and the intense interest in the provision of services by Queensland Health over recent months have indicated a desire for expanded access to public health services, particularly for improved access to hospital services including elective surgery and outpatient services, enhanced mental health services including community based mental health and improvements to Indigenous health generally.

Using national average expenditure as the basis

In 2003-04, Queensland General Government expenditure on health services including public hospitals (approximately 64 percent of total expenditure), mental health, public and community health and oral health was 14 percent lower than the national average. (\$1,245 per person compared to \$1,444 per person³⁹, ie. around \$200 per person).

Per capita General Government Expenditure, State and Local Government 2003-04

| NSW | Vic | Qld | SA | WA | Tas | NT | ACT | Average ⁴⁰ |
|---------|---------|---------|---------|---------|---------|---------|---------|-----------------------|
| \$1,445 | \$1,460 | \$1,245 | \$1,657 | \$1,515 | \$1,308 | \$2,528 | \$1,622 | \$1,444 |

Source: Australian Bureau of Statistics 5512.0

When extrapolating expenditure trends at the national level and for Queensland it is apparent that a \$1.2 billion difference in 2005-06 would rise to approximately \$1.9 billion by 2009-10. The rising gap reflects Queensland's population growth being faster than the national average. This illustrates the particular problem Queensland faces in maintaining health services to a growing community even though a 7-8 percent escalation in the Queensland Health budget is now the norm.

Despite lower per capita health expenditure, Queensland provides similar levels of health service activity to other states, (as shown in the table below) with the major exception being public hospital activity which is approximately 4 percent below the national average (Chapter 2).

³⁹ Note the data set includes a small amount of expenditure by local governments as well as Commonwealth expenditure under the Australian Health Care Agreement and other specific purpose payments

⁴⁰ Averaged weighted by population

| | Queensland activity compared to the national average |
|---|--|
| Public hospital services (public & private) | Lower (8%) |
| <i>Public patients</i> | Lower (4%) |
| <i>Private patients in public hospitals</i> | Lower (23%) |
| <i>Elective surgery</i> | Higher (15%) ⁴¹ |
| Outpatients/Emergency Department | Higher |
| Home and Community Care | Similar |
| Mental health | |
| <i>Hospital services</i> | Higher |
| <i>Community services</i> | Lower |
| Community health | Insufficient data* |
| Public health | Similar |
| Oral health | Higher |
| Residential aged care | Higher |

Sources: Commonwealth Department of Health and Ageing, AIHW,

*There is insufficient data collected at the State/national level to compare activity

Differing levels of expenditure and activity across the States reflect a variety of factors including:

- the health status and age profile of the respective populations - Queensland has a younger age profile than most other states
- relative wage differences - Queensland’s average weekly earnings in all sectors are on average 6 to 7 percent below the national average
- comparative efficiency levels - Queensland’s public hospitals are 11 percent more efficient than the national average measured on a weighted separation basis (lower wage levels are included in the efficiency measures)
- numbers of private patients in public hospitals. For example, 11.8 percent of patients in New South Wales public hospitals are private patients compared to 6.5 percent in Queensland and 8.4 percent nationally⁴².

For these reasons, it would be wrong to conclude that an additional \$200 per person is justified for public health services. For many services Queensland Health provides a similar level of activity but with a lower level of expenditure.

Increasing health expenditure without considering the priority areas of health need or the capacity of the system to deliver additional services (eg. available workforce), could risk loss of efficiency gains which Queensland Health staff have achieved over a number of years. This strength of efficiencies in the Queensland Health system should be taken into account in consideration of future funding arrangements.

Increasing public hospital activity to the national average

Public hospital expenditure accounts for 64 percent of Queensland Health’s total budget and is the area of greatest pressure within the public health system currently.

In 2003-04, to increase public patient hospital separations to the national average, taking into account Queensland’s relatively younger age profile, Queensland Health would need to provide an extra 37,500 additional weighted separations in public hospitals. (Weighted separations are the accepted methodology to compare the costs of public hospital services per patient across Australia). 37,500 separations represent additional public patients only and do not include private patients treated in public hospitals.

⁴¹ Australian Department of Health and Ageing, State of our public hospitals report (June 2005)

⁴² Australian Department of Health and Ageing, State of our public hospitals report (June 2005)

At a cost of \$2929 per weighted separation in 2003-04, Queensland would have needed to spend an extra \$110 million on public hospital services. Escalating the number of services and the cost of providing services, Queensland would need to provide an additional 61,000 weighted separations in 2005-06, at an estimated cost of \$3230 per separation, costing an additional \$197 million on acute inpatient services to align with projected national average public patient service levels.

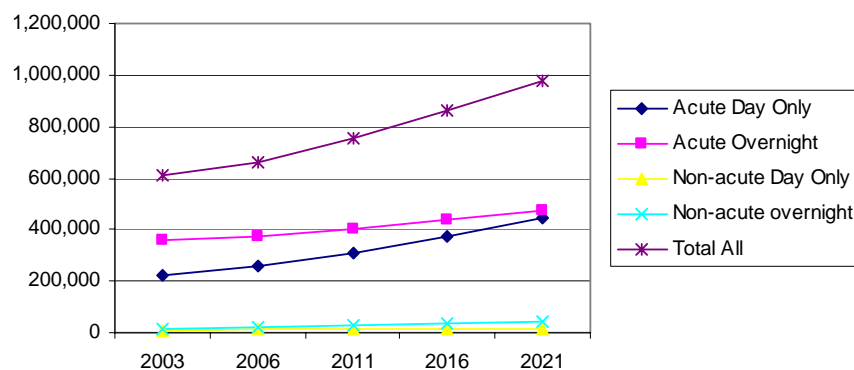
These estimates are based on the current workload per casemix. Increasing nursing numbers and allied health numbers to meet average workload per employee per casemix would require an additional 1,000 nurses and 1,780 allied health staff and would cost an additional \$209 million.

Projected future demand for public inpatient services

Queensland Health commissioned the consulting firm Hardes and Associates to estimate the demand for public hospital services over the next twenty years. The consultants' report forecasts hospital separations will increase by 60 percent from 613,000 in 2003 to 980,000 in 2021. This takes into account the impacts of Queensland's growing and ageing population, historical patterns of hospital usage, the level of private hospital provision and advances in technology⁴³.

The most significant increases will be experienced in acute day only separations which are projected to increase from around 226,000 to 442,000 separations. Although smaller in overall terms, there is also a significant increase in non-acute overnight separations (178 percent) associated with an older population with chronic illnesses which increase from 16,000 to roughly 45,000 over the same period.

Projected Separations Queensland Public Hospitals 2003 to 2021



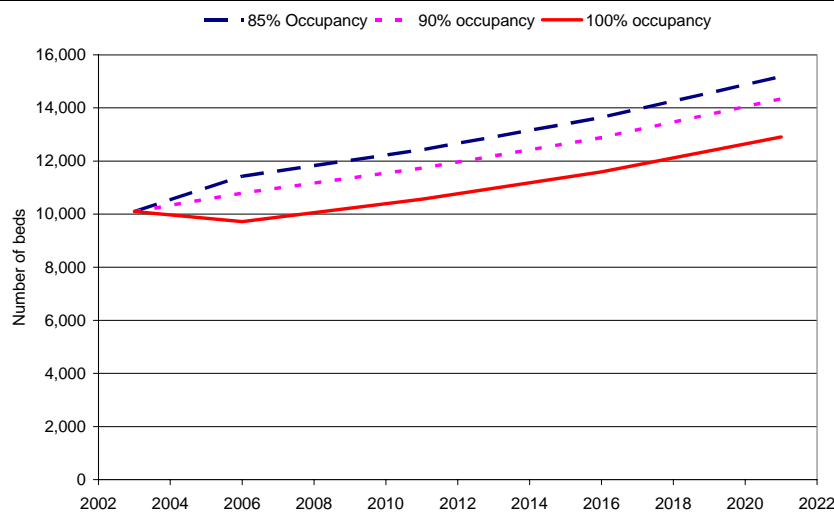
Source: Hardes and Associates, 2005

Increasing rates of day-only procedures will mean not all of the increased activity will translate into increased hospital bed days. There will be a need to accommodate an additional 12,500 same day admissions per year. This will impact on accident and emergency, diagnostic facilities, theatres and other support services. Increases in long stay non-acute separations associated with older patients with chronic illnesses highlight the need for additional step down rehabilitation type facilities to provide more appropriate accommodation and support.

⁴³ Hardes and Associates, Trends in Acute Hospital Demand Overview of Implications for Queensland. Estimates exclude chemotherapy, radiotherapy, renal dialysis and newborn babies.

To meet the projected increase in demand, the consultants estimated Queensland Health will require an additional 960,000 overnight bed days over the next eighteen years (57 percent acute, 43 percent non-acute). Assuming an 85 percent occupancy rate, this equates to an additional 170 beds per annum over the next two decades (a size equivalent to Mackay Hospital or Bundaberg Hospital per year). In 2005-06, the recurrent cost of a Mackay sized hospital is approximately \$45 million to \$50 million per year. Queensland Health receives population growth funding from the State and Commonwealth Government which is intended to provide additional capacity to meet this need. Workforce trends indicate that this scale of acute bed demand in Queensland will not be able to be adequately staffed in future years even if it could be financed.

Required number of beds (Total acute and non-acute day only and overnight use)



Source: Hardes and Associates, 2005

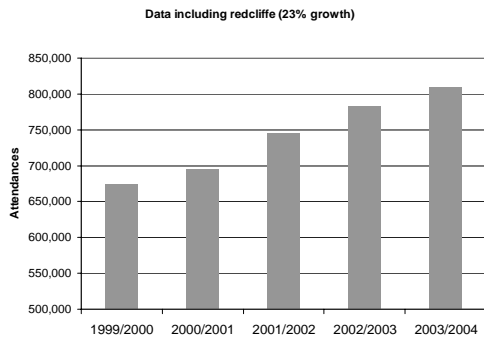
Demand for non-inpatient services

Queensland Health will experience continued pressure on its public outpatient and emergency departments into the future, due to population growth and ageing. Compared to other States Queensland has relatively lower numbers of general practitioners and the reduction in bulk billing rates impacts on emergency departments.

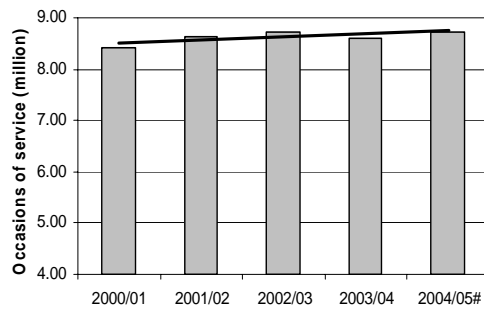
Over the period 1999 to 2005 activity in public hospital emergency departments has increased by 23.5 percent compared to 12.9 percent population growth. The graph below shows the increasing trend in emergency department activity over this period. Attendances in the 20 largest public hospital emergency departments have increased from around 689,000 in 1999-00 to 809,000 in 2003-04.

Non-admitted patient occasions of service (outpatients plus pathology) have also increased steadily from around 8.4 million occasions of services in 2000-01 to 8.7 million in 2004-05, growing at around 2.3 percent over this period. Queensland Health has reported approximately 109,000 people waiting on lists for an outpatient appointment.

**Emergency department attendances
Queensland public hospitals**



**Non-admitted occasions of service
Queensland public hospitals**



Source: Queensland Health Hospital Monthly Activity Collection (# Preliminary data only)

Continuation of these trends, particularly in emergency departments will contribute to further pressures on the system. Access block in emergency departments and long outpatient waiting times are already being experienced in busy public hospitals, and are likely to worsen over the coming years under current service delivery arrangements.

Demand for other health services

There are no reliable forecasts of the services which might be required for mental health, community health (including home and community care) and other public health services. However, these areas have been significant areas of expenditure growth over recent years. Over the period 2001-2004 there has been considerable expenditure growth in Queensland Health’s non-hospital health services including:

- community health which has grown by an average of 12.9 percent per year
- mental health which has grown by around 9.6 percent per year
- public health which has grown by an average of 6 percent per year
- residential aged care has grown at a slower rate of 2.6 percent per year.

Future demand for services will need to be considered as part of an integrated approach to improving the overall delivery of health services. Improving health outcomes in these areas most particularly needs to be coordinated with other Government departments and non-government organisations. For example, improved services for mental health will be a combination of Queensland Health services, but also housing and non-government organisation support.

Recommendation 3.1

The Queensland Government implement a three to five year funding plan to increase provision of public health services to a level more comparable with other States.

Recommendation 3.2

To address future health care challenges, alternative models of health care must be developed to reduce future pressure on acute hospital services consistent with the directions outlined in the recommendations of this report.

3.2 Implications for the future of health care delivery

3.2.1 How much is a community prepared to pay for health care?

Expenditure on health as a percentage of Gross Domestic Product (GDP) has grown steadily from approximately 7.4 percent in 1974-75 to 9.3 percent in 2001-02. Over the last decade, total health expenditure has outstripped growth in GDP growing at 7.5 percent per annum, compared to GDP growth of 5.9 percent per annum.

It is widely recognised expenditure on health services will consume an increasing proportion of GDP due to the effects of population ageing and advances in health technology and treatments. The Productivity Commission projects total government health expenditure (excluding aged care) will increase from 5.7 percent of GDP in 2002-03 to 10.3 percent in 2044-45⁴⁴.

As the population ages and technology and medical advances increase, the potential access to health care and spending on health care will continue to grow as a percentage of GDP. The issue for Australia generally is to decide the appropriate level of health expenditure relative to other areas including education, transport and other essential infrastructure. Spending more on health will not necessarily provide better health. For example, in 2001 the United States spent 13.9 percent of GDP on health care, but Japan spent 7.6 percent of GDP and has the highest life expectancy in the world.

In all health systems where there are limited resources and unlimited demand for services; rationing and waiting lists are inevitable. This is a challenge recognised by all public health systems nationally and internationally. Waiting lists are the most visible measure of access to health services. As waiting lists grow, so too does community frustration about access to the public health system.

Queensland's capacity to meet increasing expenditure requirements for hospital and other health services is directly linked to its ability to raise taxation and other revenue sources. Queensland has always been a lower taxing State and while the State's revenue base has been increasing in line with GST revenue growth, it also faces the prospect of a shrinking tax base as the Commonwealth rolls back State taxes such as stamp duty.

The Queensland Context: State Government Revenue and Expenditure

In 2005-06, Queensland's estimated state taxes per capita are 25 percent below the average per capita tax of the other States and Territories⁴⁵. Queensland has been a lower taxing state for many years, with a comparatively lower revenue raising capacity than States such as New South Wales and Victoria.⁴⁶ State taxes currently account for 26 percent of the State budget. State tax revenue will reduce over the coming years in line with the State and Territories agreement with the Commonwealth Government to phase out a series of taxes following the implementation of the *Goods and Services Tax* (GST).

48 percent of the State budget comes from Commonwealth grants (including GST and the Australian Health Care Agreement). In 2005-06, Queensland will receive 19.8 percent of the total GST revenue pool compared to a 19.6 percent population share. The remainder of the State budget is comprised of other sources such as sale of goods and services, interest income and revenue from Government Owned Corporations.

⁴⁴ Economic implications of an Ageing Australia, Productivity Commission 2005

⁴⁵ Queensland Budget 2005-06, Queensland Treasury

⁴⁶ Update Report 2004, Commonwealth Grants Commission

With a comparatively lower taxation base, Queensland Government expenditure has also been lower on a range of Government services including health, education, disability services and police. Queensland spends more on primary industries, main roads and child protection. Queensland's capacity to deliver services from a lower expenditure level is assisted by a generally lower wage structure. (Queensland's average weekly earnings and costs of living are generally lower than in other States).

The Queensland Government is estimating an operating surplus in 2004-05 of over \$3 billion, with a substantial part of the surplus due to high investment earnings on superannuation. Investment earnings on superannuation funds must be reinvested and are not available for general expenditure.

The budgeted operating surplus for 2005-06 is \$934 million, with lower forecast operating surpluses in future years reflecting a combination of lower long term investment return expectations, tax reductions consistent with the Queensland Government's GST implementation commitments, service enhancements and growing operating expenses associated with increased expenditure on infrastructure.

From this perspective, the Queensland Government and community will need to give consideration to what the public health system should provide, what the community is willing to pay for its public health services and who should have priority access to public health services.

The options which may need to be considered are:

- *Increase State taxes to Expand the capacity of the existing public health system*

If significant enhancements are sought to the capacity of the public health system, the Queensland Government and the community may need to give consideration to additional State tax arrangements. Additional State taxation options are comparatively limited with the abolition of a number of State taxes occurring following the introduction of the GST. State tax options also impact on the competitiveness of the economy, particularly where taxes are related to business input. Queensland is the one state in Australia which provides a fuel subsidy, estimated to cost \$532 million in 2005-06.⁴⁷ The Review notes the impact high world oil prices are having on industry and the community currently.

- *Review the current range of services provided through the State public health system*

Queensland Health provides some health services which could be delivered through the private system including outpatient services and oral health services. For example, some outpatient services could be provided in the specialist's rooms rather than in the hospital setting, with outpatient costs covered through the MBS. New South Wales uses this approach for the provision of some outpatient services, rather than providing services in a hospital outpatient environment.

The arrangements for Queensland under the Australian Health Care Agreement 2003-08 require that Queensland continue its level of public hospital service provision at the levels at least equivalent to 1998. Expanding outpatient services to non-hospital settings would require a review of the AHCA agreement for Queensland.

Queensland is also one of the few States to provide free access to dental health services for adults (means tested) and children. Victoria provides a subsidised dental health services for individuals on low incomes.

⁴⁷ 2005-06 Queensland Budget, Queensland Treasury 2005

- *Review eligibility for free access to public health services*

Under the current Australian Health Care Agreement 2003-08, the Queensland Government has committed to “ensure that eligible persons are able to access public hospital services, free of charge, as public patients”. All Queenslanders have the right to elect to be treated as public patients, including those who have private health insurance.

Any review of the eligibility to access to free public hospital services is an issue which would need to be addressed in close consultation with the Commonwealth Government and the Queensland community in the context of Commonwealth funding arrangements and the Commonwealth’s continued commitment to support of the private health sector through its Private Health Insurance Rebate.

In the longer term, consideration may need to be given to whether eligibility for free public hospital services is continued for all Queenslanders, regardless of income. For example, those on higher incomes who are eligible to pay the Medicare Levy Surcharge⁴⁸, could be charged as private patients in public hospitals. These fees could be covered by private health insurance or self-insurance.

Queensland Health estimates that around 6 percent of patients in public hospitals currently have private health insurance but do not elect to use it when being treated. The Review is conscious that issue of “gap” payments not covered by private health and front end deductibles is an issue for some individuals who hold private health insurance.

The issue of any introduction of means-tested co-payments for public hospital services is a difficult issue and needs to be considered in the context of ensuring that low income earners who can least afford to pay for services are able to access health care, with individuals who have a greater capacity to pay making a contribution.

Co-payments and private health insurance arrangements in selected countries are shown in the tables below. Australia’s private health insurance system, which provides a duplicate funding arrangement for services also covered through the public health system, differs to countries such as the Canada and the United Kingdom where the emphasis of private health is to cover the costs of services not provided through the public system.

User charges for health care services in selected countries, 2001 unless specified

| | Specialists | Inpatient | Comments |
|---------|--|--|--|
| France | Co-insurance rate of 30% balance billing by specialists in Sector 2 (38% of specialists) | Co-insurance rate of 20% (up to 31 days in acute care and a maximum of EUR 200) plus a per day charge of EUR 10.67 | Most individuals have voluntary health insurance to cover co-payments. Since 2000, low income earners can receive state subsidy for complementary insurance. |
| Germany | EUR 10 per quarter for doctor visits (2004) | EUR 9 per day up to a maximum of 14 days per year | In 2004, Germany introduced a co-payment of EUR 10 for emergency department visits. |
| Sweden | Co-payment of EUR 16-27 for outpatient visits to hospital specialists | EUR 8.6 per day for inpatient services | There is a 12 month ceiling of EUR 99 on direct patient fees for medical services not including inpatient care. |

European Observatory on Health Care Systems (2002). *Health care systems in eight countries: trends and challenges*.

⁴⁸ The Medicare Levy Surcharge is an additional 1 per cent surcharge of taxable income imposed on high-income earners who are eligible for Medicare but who do not have an appropriate level of hospital insurance with a registered health fund.

Co-payments for inpatient care are used in France deliberately to leave some part of the costs of care to be paid directly by the patients⁴⁹.

Population covered by public and private health insurance 2000

| | Public/social insurance (percent of population) | Private insurance (percent of population) |
|----------------|--|--|
| Australia | 100% (Medicare) | 45% Duplicate, complementary, supplementary |
| Denmark | 100% | 28% Complementary, supplementary |
| France | 100% | 92% Complementary, supplementary |
| Germany | 88% | 9% Primary 9% Supplementary, Complementary |
| Netherlands | 100% (Exceptional medical expenses) | 28% Primary 64% Supplementary |
| New Zealand | 100% (hospital care) | 35% Duplicate, complementary, supplementary |
| Sweden | 100% | 1-1.5% (supplementary) |
| United Kingdom | 100% | 11.5% (complementary and supplementary) |
| United States | 100% (Exceptional medical expenses) | 71.9% Primary (principle), supplementary and complementary |

Primary: private health insurance that represents the only available access to basic health cover because: i) there is no public cover or individuals are not eligible to cover under public programme (principal); ii) individuals are entitled to public coverage but have chosen to opt out of such coverage (substitute).

Duplicate: private health insurance that offers cover for health services already included under public health insurance, while also offering access to different providers or levels of service. It does not exempt individuals from contributing to public health coverage programmes.

Complementary: private health insurance that complements coverage of publicly insured services by covering all or part of the residual costs not otherwise reimbursed (e.g., co-payments).

Supplementary: private health insurance that provides cover for additional health services not covered by the public scheme.

European Observatory on Health Care Systems (2002). *Health care systems in eight countries: trends and challenges*.

OECD (2004). *Private Health Insurance in OECD countries*.

These issues are not simple, and are being debated in countries across the world. It is essential that the Queensland community be actively engaged in discussions about the public health services it expects and is prepared to pay for. Most importantly, the community needs to be provided with sufficient information to make informed choices about the allocation of health resources.

3.2.2 The national health care debate – future options

Fiscal projections of future health expenditure requirements serve to reinforce the need to fundamentally change the way the Australian health system is structured in the future. Rationing of health services is the inevitable result of funding limitations and workforce shortages. Without significant changes to the way services are delivered and funded at both the State and Commonwealth level, rationing of public health services in the future is likely to get worse.

⁴⁹ European Observatory on Health Care Systems (2002). *Health care systems in eight countries: trends and challenges*. (p 35)

Both Commonwealth and State Governments place priority on delivering health services. The different arrangements on the ground however cause confusion. The complexity of Commonwealth and State funding arrangements might not be such a significant problem if both entities worked well together in an integrated, patient centred manner.

Unfortunately this is not the community's perception nor the reality based on public forum feedback and review of recent Commonwealth/State performance and funding issues. This Report will attempt to highlight areas where the two levels of Government could work together in an improved spirit of cooperation to address patient and community need. If this could occur, then better overall value for money for health service expenditure would be the likely outcome.

From a community and patient perspective, the priority is to ensure best possible access to health services within the limitations of public funds, regardless of whether the services are provided by the Commonwealth or the State.

The current system of mixed roles and responsibilities for funding and delivering health services between the Commonwealth and the States is a major barrier to health service improvements, especially in achieving more effective utilisation of the total public/private workforce in a time of critical workforce shortages, and better health outcomes for the community. Problems of poor coordination and integration of health services (for example, between general practitioners and hospitals), overlap and duplication, the drain of doctors from the public to the private system and a culture of blame and cost shifting are a direct consequence of Australia's mixed system.

There are a range of national reviews and inquiries currently occurring currently including:

- A House of Representatives Standing Committee on Health and Ageing Inquiry into Health Funding. The Inquiry is amongst other things examining the roles and responsibilities of the different levels of government (including local government) for health and related services and examining options for simplifying funding arrangements with a particular emphasis on hospitals
- The Council of Australian Governments (COAG) review of the Australian Health System, agreed 3 June 2005. COAG agreed Senior Officials would consider ways to improve Australia's health system and report back to it in December 2005 on a plan of action to progress these reforms. It was also agreed that where responsibilities between levels of government need to change, funding arrangements would be adjusted so that funds would follow function.
- Productivity Commission Inquiry into the Health Workforce, with an anticipated completion date of December 2005.

While these reviews are considering options to improve the integration of the health system generally, they do not have the role to look at more fundamental change to the current separation of roles and responsibilities in the Australian health system. A fundamental overhaul of the roles and responsibilities in Australia's health system presents significant challenges which would require new levels of Commonwealth and State cooperation.

There is no clear or perfect option for resolution of these complex issues. Potential scenarios to improve the integration between Commonwealth and State provided health services are outlined in the box below:

Potential scenarios for the future delivery of health services nationally

Scenario 1: Commonwealth Government assumes funding responsibility for all health services

Ideally a single level of Government would be responsible for funding the provision of a basic set of health services and associated policy setting. A single funder model lends itself best to the Commonwealth Government given that it funds almost 50 percent of all health expenditure (compared to 20 percent for the States) and has:

- the ability to ensure all Australians regardless of where they live have access to similar levels of health care,
- primary taxation responsibility
- current responsibility for the Medical Benefits Scheme/Pharmaceutical Benefits Scheme
- responsibility for higher education including tertiary training of medical and nursing students

Operation of health services could continue to be the responsibility of the State Governments as a health care provider. A single funder and policy maker has the incentive to direct funds to areas of greatest need and benefit, with reduced incentive for cost shifting.

Scenario 2: State Governments to assume funding responsibility for all health services

State Government responsibility for health funding would also achieve the single funder objective. However, the States would carry significant workforce and fiscal risks, but remain reliant on the Commonwealth Government for taxation revenue and workforce policies.

Scenario 3: Pooled funding arrangements

A pooled funding arrangement would involve amalgamation of existing publicly funded health programs (Commonwealth and State) into a single program which would be either run by the Commonwealth or State. Funding would be distributed to regional health authorities on a per capita basis (adjusted for health status) to purchase the care needed, whether from general practitioners, hospital services or community care providers

Scenario 4: Commonwealth Government to employ all doctors regardless of whether they work in the public or private sectors

There is significant competition for doctors between the public sector, private sector and general practice. The Commonwealth fee for service arrangements which apply for privately provided services (through MBS) are generally more rewarding for doctors than the public system and standard salary arrangements. In an environment of relative workforce shortages, the dual system has the potential to move doctors to areas of highest pay rather than greatest patient need, with negative outcomes particularly for publicly provided health care where there is a lower ability to pay. The Commonwealth assuming sole government responsibility for paying doctors, would reduce disparity in payment of doctors and reduce the incentives for doctors in the public system to be enticed into private practice.

Scenario 5: State to purchase private health insurance on behalf of Queensland population

State government to fund the health insurance premiums for those Queenslanders who cannot afford private health insurance. Essentially Queensland Health and clinicians would access funds in similar ways to private hospitals and clinicians. Existing Queensland Health hospitals and health services would contract with health insurance funds as do private providers currently. The advantage of this initiative would be to remove the current "two tiered" system of access. (A similar scheme currently exists for Veteran's through the Department of Veteran's Affairs)

The Review recommends the Queensland Government seek a national review of the future health care system in Australia, to specifically consider the respective roles and responsibilities of Commonwealth and State Governments in the provision of integrated healthcare for the Australian community.

National reviews of the future of health care have been undertaken in Canada⁵⁰ and England⁵¹ including discussion of the respective roles and responsibilities of the Commonwealth and provinces in Canada and future commitments of GDP expenditure on health care in England.

Queensland is certainly in a position to contribute actively to reform at the national level. Queensland needs to engage the support of the other States and Territories, which are all experiencing similar pressures and problems, to work constructively with the Commonwealth to look at better ways of funding and organizing health services which are focused on the interests of patients and funded in the most effective manner rather than continuing to manage a system primarily driven by the interests of providers and institutions.

In the interim, there are a range of options the Queensland Government could pursue with the Commonwealth Government on a bilateral basis to improve the integration and quality of health care services in Queensland. These include:

- implementing the already agreed national system of registration for medical practitioners (discussed in more detail in Chapter 10)
- urgently examining the feasibility of the Commonwealth becoming the sole funder of doctors to reduce the current Commonwealth financial incentives for doctors to leave the public sector
- immediately develop in conjunction with the Commonwealth Government and professional colleges a timetable for the establishment of all additional specialist medical training positions recommended by the Australian Medical Workforce Advisory Committee, with the Commonwealth Government to provide funding for the training positions.
- reviewing the Medical Benefits Schedule to improve the alignment of the Commonwealth funded health sector and the public health system including providing incentives to address particular areas of need such as rural health and Indigenous health
- developing pilot sites in Queensland to trial arrangements such as pooled funding and general practitioners working in public hospitals.

Recommendation 3.3

The Queensland Government to seek a specific national review of the future health care system in Australia, to resolve the respective roles and responsibilities of Commonwealth and State Governments in the provision of integrated health care for the Australian community.

⁵⁰ *Building on Values: The Future of Health Care in Canada, Final Report.* Commission on the Future of Health Care in Canada 2002.

⁵¹ *Securing our Future Health: Taking a Long-Term View.* Final Report by Derek Wanless, April 2002.

Recommendation 3.4

Within the current Commonwealth-State responsibilities, the Queensland Government should work closely with the Commonwealth Government to address immediate health care priorities including:

- implementation of the national system of registration for medical practitioners in conjunction with the other States
- urgently examine the feasibility of the Commonwealth becoming the sole funder of doctors to reduce the current Commonwealth financial incentives for doctors to leave the public sector
- urgently develop, in conjunction with professional colleges, a timetable for the establishment of all additional specialist medical training positions recommended by the Australian Medical Workforce Advisory Committee, with the Commonwealth Government to provide funding for the training positions
- review the Medical Benefits Schedule to improve the alignment of Commonwealth funded services and the public health system including providing incentives to address particular areas of need such as rural health and Indigenous health
- develop pilot sites in Queensland to trial arrangements such as pooled funding and general practitioners working in public hospitals.

3.2.3 Community participation in health system reforms

Over the past few months, the Queensland community has expressed deep concern about the operation of its public health system. Consultations held during the course of this Review confirm that Queenslanders want and expect high quality clinical care, speed of access to services and the capacity to effectively raise and resolve concerns.

The question for governments everywhere is how best to involve the community in informed deliberation about these complex issues.

Canadian model for community participation in health reforms

In 2002, the Commission on the Future of Health Care in Canada wanted to learn how Canadians reconcile the difficult trade-offs inherent in sustaining the health care system in the twenty first century. The Commission was searching for reliable information on citizen's values and their preferred choices when they are asked to make difficult trade-offs.

Public opinion polls showed Canadians were deeply attached to their health care system and, wanted quick access, high quality, and universal coverage. The polls also suggested Canadians had not yet come to terms with how best to pay for the rising costs of services.

The Commission undertook a consultative process using a specific methodology that asked citizens to reflect upon four scenarios for reforming the health care system. Each scenario had at its core a reform perspective which was under active discussion at the time including public investment, sharing costs and responsibilities, increasing private choice and reorganising service delivery.

The outcomes of the Canadian work were that citizens in trying to create a better, financially sustainable health care system were able to develop and apply their own values to the fundamental questions of health care reform. They used their core values and principles to give government a mandate to make significant reform (which they agreed would involve increased taxes) and set some very challenging conditions for this consent.

Queensland Health has been relatively closed in its approach to community involvement. The traditional approach has been to provide information to people about services and health risk factors. Some consultation with stakeholder groups occurs on policy development; however, there is currently limited and inconsistent consultation processes for service planning.

Queensland Health has publicly articulated a clear commitment to community engagement which has raised expectations of community members, staff, partners and

other stakeholders. This commitment is however, not consistent with the degree, consistency and quality of community engagement activity occurring across Queensland Health. Queensland Health, its employees and the broader community will benefit from implementing community engagement with a skilled and informed workforce operating within clearly defined frameworks, expectations and parameters.

A key finding from the Canadian experience was that ‘engagement is needed when public policy is at a key turning point. This usually occurs when a society is reassessing its options, setting priorities, mapping the boundaries of where major change is possible. Engagement helps to clarify how deeply held values are evolving with changing circumstances. The legitimacy and sustainability of important public policies depend on how well they reflect those underlying (and evolving) values. Engagement only works when policy makers are ready to invest in learning and listening, when they are ready to open up a discussion on the big conflicted choices and trade-offs, and when they place a high value on the process of public learning’⁵². Meaningful engagement requires well researched information to inform debate and inspire confidence in the choices offered.

Recommendation 3.5

The Queensland Government should engage with the Queensland community to clarify what the community expects from its health system, what it is prepared to pay and how it is prepared to pay for it. This needs to occur in the context of Queensland Health developing comprehensive health service planning and development of options with the community.

Water fluoridation – engaging in a public debate

Oral health is provided as an example of a public health debate Queenslanders have not managed to have in a meaningful way. All too frequently, the threat of controversy and a failure to understand the consequences of alternative choices subordinates the need for informed decision making and action.

Queensland Health provides the most comprehensive free public dental service in Australia. Queensland residents suffer more tooth decay than residents of the States and Territories where water fluoridation is available. Less than 5 percent of Queenslanders have fluoridated water. Comparisons of children between the ages of 5 and 12 living in Townsville (fluoridated) show 45 percent less rate of tooth decay than children living in Brisbane (non-fluoridated)⁵³.

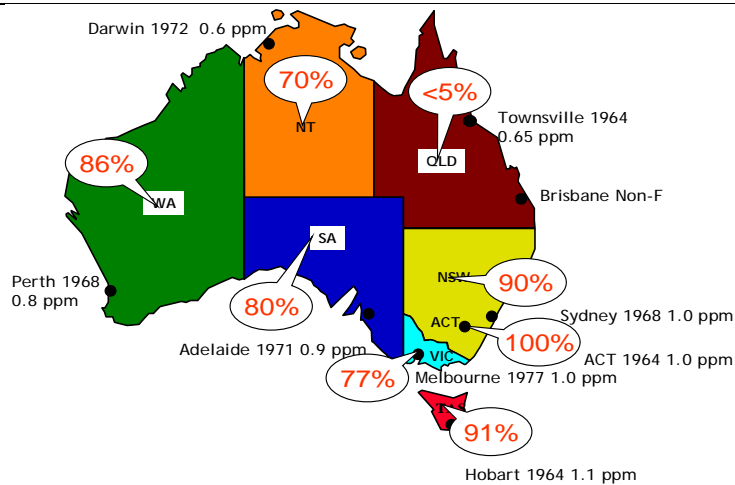
Responsibility for fluoridation of Queensland drinking water rests with local governments. In every other state and territory the responsibility for decisions related to water fluoridation resides with the state or territory governments. Capital costs are funded by the state or territory governments and the recurrent costs are generally borne by local governments. The Tasmanian Royal Commission on Fluoridation concluded that while local authorities have an essential role in the provision of water supplies, fluoridation is a public health issue and should be the responsibility of the State Government.

⁵² Report on Citizen’s Dialogue on Future of Health Care in Canada June 2002

⁵³ Queensland Health, Water Fluoridation question and answer sheet – June 2005

Dates of introduction of water fluoridation to Australian capital cities

The percentage of the population who have access to fluoridated water is also indicated.



Source: Spencer AJ (2003); State/Territory Health Departments, 2003

- In terms of cost effectiveness, fluoridation in the water returns \$6 in improved dental care of every \$1 spent. It is the most effective way to give everybody access to the benefits of fluoride regardless of age, income or education level.
- Studies of children in Victoria show that six year old children living in fluoridated areas experience 45 percent less decay in their baby teeth than those in non-fluoridated areas. Twelve year old children living in fluoridated areas experience 38 percent less decay in their adult teeth than those in non-fluoridated areas.
- Over 25 years, water fluoridation saved the Victorian community about \$1 billion, through avoided dental costs and lost productivity, and saved leisure time. The projected saving to Queenslanders would be similar.
- Water fluoridation is supported by many organisations worldwide including the World Health Organization, the Australian Dental Association and the Australian Medical Association.
- There are many studies about water fluoridation. The National Health Service Centre for Reviews and Dissemination, 2000 looked at 214 of the highest quality studies to assess the benefits and possible side effects of water fluoridation. It found that water fluoridation protects against tooth decay without causing any unwanted effects apart from isolated minor cases of dental fluorosis (nil in Australia, 5 in USA).
- Water fluoridation has been endorsed by the United States Centres for Disease Control and Prevention as one of the ten greatest public health achievements of the 20th century. While it is acknowledged that there will always be some people who do not agree with water fluoridation, it is a safe and effective way to help protect teeth throughout life.⁵⁴
- New Zealand, Hong Kong, Singapore, the United Kingdom, Ireland, Canada and the United States fluoridate water. On the other hand, some European countries including France, Sweden and Norway do not. Finland and the Netherlands have removed fluoride from previously fluoridated water.

Trends indicate Queensland Health is unlikely to remain in the situation where it can continue to fund free public dental health services to Queenslanders without increasing waiting times to the point where dental care is so neglected that lifetime damage is the consequence. The only option for a dental service under such pressure is to curtail access further or spend more on every increasing demand. (Adults without a pension or health care card status are already excluded.)

The interesting issue is that informed choice requires a full appreciation of the consequences of such a choice, ie. if a local community rejects this health measure is it willing to pay for the significant additional cost of oral health services for the young and the aged. Currently everybody pays, even those in Townsville who have taken up the fluoridation option.

⁵⁴ Queensland Health 2005, Helps protect teeth throughout life.

The Review recognises this issue has caused considerable concern regarding the perceived benefits and possible side effects. However, if the community is unwilling to have informed debate about issues such as this, how likely are we to have the tougher debates about rationing of other health services in coming years especially for our ageing population.

It is not the responsibility of this Review to resolve issues such as water fluoridation but uses this to suggest a process or model for governments to ensure resolution along the following lines:

- Encourage informed education and public debate
- Provide local communities with options and consequences of their choices

Endeavour to provide health services recognising the choices and ensuring the benefits and costs are apportioned accordingly.

Recommendation 3.6

Queensland Health in conjunction with local government engage the community on the feasibility of introducing fluoridation to the drinking water, the consequences and cost.

3.2.4 The role of individuals in health care

In the context of how Queensland Health is performing against the expectations of consumers, it is necessary to consider the individual's contribution to their own health status. It is estimated that one-third to one-half of the burden of disease is preventable or can be delayed.

The Interim Report outlined that the major contributing factors to the burden of disease for Queenslanders are cardiovascular disease, cancer and mental illness. Cardiovascular disease and cancer contribute to the highest levels of premature death.

Tobacco smoking is the single biggest risk factor responsible for the greatest burden of disease and injury in Australia. Other risk factors which make a major contribution to the burden of disease are physical inactivity, high blood pressure, excess alcohol consumption in males and overweight and obesity. Queensland men and women have somewhat higher rates of smoking, alcohol risk (both short term and long term), and overweight and obesity and are therefore more at risk of chronic disease.

The burden of disease experienced by Queenslanders could be significantly reduced if levels of tobacco smoking, physical inactivity, high blood pressure, risky alcohol consumption, overweight and obesity and poor nutrition were reduced.

It would be highly desirable for individuals to accept a greater share of responsibility for their health with health service providers. Providers would monitor the health of individuals, advise on lifestyle and social behaviour and treat and manage disease. Individuals would accept that risk taking behaviour such as inactivity, poor diet or drug abuse lead to adverse health outcomes and modify their behaviour accordingly.

All people have a role to play in ensuring the future sustainability of the health system. Changing lifestyle is challenging, but essential to improving health and reducing future reliance on healthcare.

3.3 Summary

Chapter 3 highlights the challenges facing the public health system in the future associated with a growing and ageing population, increasing demands for services, reducing workforce numbers, and the increasing prevalence of chronic diseases in the context of finite resources.

Queensland Health would desirably be in a position to respond to future challenges as well as cope with the health issues currently confronting the population. It can no longer simply continue doing what it is currently doing. New and innovative ways of thinking about and organising health services are now required and these have to be planned, resourced and implemented in a strategic and coordinated way making the best use of all health resources, public, private and non-government organisations.

Simply spending more and more on health services every year without evaluating the effectiveness of treatments and focusing on specific service gaps such as Indigenous health, mental health and rural and remote health, will only lead to unsustainable pressures on public resources and less than optimal health outcomes for the community.

Even with the best possible results it may still be necessary for governments to seriously contemplate the withdrawal of certain service types from free access lists or seek a consumer co-payment for services. The community needs to engage in a wide public debate about what it should spend on health services and where that expenditure should be targeted to best meet patient needs.

The national debate regarding Commonwealth and State responsibilities for health care need to be resolved, although debate about these issues over a number of decades has demonstrated this does not happen quickly.

While many health system challenges are outside the direct control of Queensland Health and the Queensland Government, many issues are within its capacity to control and influence. The terms of reference for the Queensland Health systems review are intended to make short to medium term improvements to the way in which Queensland Health operates. The remainder of the report addresses these issues in greater detail.

4. Culture

Organisational culture (defined as the organisation's prevailing pattern of beliefs, attitudes, values and behaviours) has a profound impact on staff and systems performance. The influence of the predominant culture in Queensland Health on all aspects of operation has been very evident to the Review and one of the major findings, if not the most important, is that if the changes recommended in this Review are to have any lasting value the underlying culture of the organisation must be addressed.

4.1 Queensland Health culture

4.1.1 The current culture: feedback from district visits and submissions

It was reported during district visits, that bullying, and intimidation on the one hand, and blaming and avoiding responsibility on the other typify part of Queensland Health's culture. Descriptions such as "tribalism", "tokenistic consultation", "no culture of teamwork" and a "culture of power and control" were repeated themes throughout the consultation.

This should not distract from other very positive aspects such as a culture of dedication towards patient care and wellbeing which was also very strongly evident during district visits. Staff were described as being "helpful and supportive", "committed to a standard of care for patients" and "having pride" in the services they provide.

The Review received reports and saw evidence of disempowered clinical teams and clinicians frustrated with slow formal decision-making processes and constrained by overly prescriptive and at times conflicting policies and procedures. In many cases, these policies and procedures were written in a manner designed to hinder rather than encourage or enable. The traditional bureaucratic style of leading and managing which relies upon such formal authority and regulation has permeated the organisation and inadvertently suppressed initiative.

In this environment it is understandable that relationships between health service managers and clinicians become strained. Doctors and nurses believe the balance of power within acute hospitals has moved too far to the side of formal authority and administration, driven largely by financial imperatives around budgets, measurement of throughput and economising in the use of staff resources and materials.

At the same time administrators and managers feel the clinical workforce with a primary focus on the health care requirements for each individual, has little concern about cost and less inclination to accept responsibility for broader service delivery considerations (such as allocation of scarce resources to deliver care for large populations of individuals).

4.1.2 Cultural surveys

As part of the Review process, the results of an independent culture survey were examined. This report confirms the finding of the Interim Report which found that staff are experiencing very significant work pressures, and in this environment are experiencing a higher than usual rate of dysfunctional interpersonal relationships. The survey confirms direct reports received about bullying and intimidation but suggests that this may not be as prevalent as anecdotally reported and reveals that it is much more prevalent in districts than in Corporate Office.

The results provide a wide range of views and experiences of work within Queensland Health. A number of people have indicated that they enjoy their work and have included positive responses and comments. Levels of workplace morale, professional interaction, and professional growth are not significantly below the benchmark. However, there are also a number of very negative reactions and comments, with some hope expressed that these issues may be dealt with as a result of the current enquiries. Staff recorded unfavourable scores on many of the organisational climate variables, particularly low participative decision making and high workloads.

Staff perceive a difference between their own work values, which they define as professionalism, teamwork, service quality and a patient-centred focus, and those of the management and bureaucrats within the Department, which they see as primarily focused on meeting budget performance standards. Overall attitudes and behaviours in the Health Service Districts are less positive than those reported in the central units.

Staff safety was raised as an important issue for many because of the risk of violence from patients and the public.

Reasons most frequently nominated for bullying behaviours were the hierarchical structure of the Department, the stress imposed on the system due to budgetary and workload pressures and the focus on financial rather than patient outcomes. Senior leaders were rated at or near 50 percent on aspects such as vision and inspiration, but were rated slightly lower on innovation and role modelling.

4.1.3 Specific examples of dysfunctional behaviours

A number of specific examples of dysfunctional behaviours resulting from the impact of culture on the organisation were reported repeatedly to the Review. Some of these are explored in more detail in this section.

Relationships between staff and managers

While there were reports of effective managers who engaged successfully with their staff and consulted about problems, there were many instances of varying degrees of dysfunction.

It was frequently reported that leaders, managers and supervisors have limited skill in dealing with difficult and often complex problems, in encouraging staff contribution to the resolution of problems, in engaging effectively with staff, and in dealing with particular staffing problems including staff who are troubled, disaffected or not performing.

All too frequently informal discussions to solve problems become antagonistic and subsequently lead to formal processes involving lengthy written correspondence, the lodgement of formal grievances and lengthy investigations with inconclusive outcomes. Of particular concern to staff is the use of internal officers for investigation of grievances resulting in possible bias and contributing to delays in dealing with the matter. Both parties emerge from such conflict with escalated feelings of anger, frustration and remembered resentment. The Interim Report also identified a contributing factor to the lengthy investigations and inconclusive outcomes being the variable skill level of staff appointed to investigate grievances.

Many staff reported examples of inaction or lack of appropriate and timely action by management in regard to staff who were not performing or who were exhibiting unacceptable behaviours such as bullying. There was also a perception reported that non-performance was managed by transferring or promoting staff. The impact of this failure to manage staff appropriately included an “unhappy workplace”, low staff morale, high absenteeism and people on long term stress leave. In the current environment of workforce shortages, this situation must be redressed.

Key factors in this appear to be:

- the length of time that it takes to manage non-performance (eg 12 to 18 month process)
- lack of expertise among managers in managing non-performance
- limited access to training for these managers
- lack of expert and timely advice from Human Resource personnel and
- attempts at managing non-performance leading to accusations of bullying and workplace health and safety claims.

Individual Performance Appraisal and Development (PAD) is a process for all staff to have the opportunity to engage with their supervisor for feedback (both positive and negative), career planning and professional and personal development. However, consultation undertaken for this Review indicates that the number of staff who had PAD plans in place varied across and within districts. Furthermore where PADs were routinely used, most staff did not view them as useful. This appears to be mainly due to the training and development goals identified in the PADs not being achieved and staff perceiving managers as failing to manage staff who are not performing up to standard.

Perverse use of the Code of Conduct

Codes of conduct are required for all Government Departments under s15 of the *Public Sector Ethics Act 1994* (Act). The purpose of a code of conduct is to provide standards of conduct for public officials consistent with the ethics obligations under the Act. The ethics obligations under Division 2 of the Act are respect for the law and system of government, respect for persons, integrity, diligence, economy and efficiency.

There has been much negative comment made by staff during consultations about misuse of the Code of Conduct within Queensland Health. It is considered by the Review that on occasions the Queensland Health Code of Conduct has been used as a tool to bully or intimidate Queensland Health staff. It is written in a style typically reflective of the formal prescriptive and bureaucratic aspects of culture, rather than an inspiring patient or consumer centred approach.

Openness and transparency

Another set of dysfunctional behaviours are those that inhibit the open sharing of information, particularly adverse performance related information about community access to health services and the quality of those health services. Numerous accounts were reported of individuals within the organisation preparing reports highlighting factual deficiencies, only to have these reports modified or suppressed at higher levels in the hierarchy.

The Review was told of examples of this occurring over more than two decades. Accounts of Cabinet, Ministers, Minister's advisors and support staff, senior public servants in Corporate Office and senior executive members of hospitals all reinforcing in various ways the need to suppress adverse information and highlight the more positive features of information. Sometimes patient confidentiality or public interest has been used as the rationale. While these are legitimate concerns they may not have been an issue in many instances reported.

Over many years this behaviour has become self perpetuating, with two very dysfunctional consequences. The first is the preparation of reports which fail to highlight problems. This inevitably reduces the emphasis on problem resolution and improvement to the detriment of health service quality and safety. The second is a tendency simply not to report, based on a previous expectation of having reports suppressed or receiving little feedback or negative feedback.

Patient versus clinician needs

While individual patient care is taken very seriously, consideration of the patients' needs from a non-clinical perspective is often lacking. Patient needs such as certainty in admission and discharge times, and coordination of various aspects of their care may be neglected to meet the convenience of the clinical workforce particularly in public hospitals which have a large focus on post graduate teaching of doctors.

An example of this issue is the scheduling of surgical procedures. This has evolved around the availability of procedural specialists and clinical support teams and operating theatre time. There are inevitable conflicts at times between emergency surgical procedures requiring theatre time and scheduled elective procedures resulting in cancellations. However there were numerous reports of theatres not being fully utilised during normal week day hours and a recognition that there is also capacity available, if staff were available, to work during evenings and/or on weekends.

Patients may prefer to have more certainty in the timing of elective procedures even if this meant attending theatre at different times such as evening sessions or on weekends. The availability and preparedness of clinicians to work at such times would of course need to be tested.

4.2 Queensland Health culture: what have been the influences?

Achieving a more supportive culture is a difficult undertaking, because culture exists in the present form for good reason. That is, the prevailing patterns of attitudes, values, beliefs and behaviours reflect the manner in which staff have learned over the years to contend and deal with their working life and experience within Queensland Health be this in Corporate Office, a zone, an acute hospital or a community health service in a district.

The Interim Report explored the origins of various aspects of the current culture in Queensland Health. These are:

- Contemporary hospitals have their origins in earlier models of military hospitals and historically have exhibited a highly mechanised authoritarian model of control and management.
- Between and within these traditional hierarchies, different professional streams were accorded different levels of rank, authority, status and standing with quite traditional roles, responsibilities, authorities and accountabilities. Conflicts have always been present but traditionally were subjugated by the rule of authority.
- Clear and concise lines of responsibility and decision accountability have been an essential feature of the running of acute hospitals where life and death decisions, clear instructions and immediate responses are an essential part of efficient operation.
- As hospitals can be turbulent places individuals seek to create their own small area of predictability or stability. Threats to these domains are repelled decisively and at times aggressively. Hence the term “tribal” being commonly reported to the Review to explain inter-group conflict.
- Queensland Health is a large centrally controlled government bureaucracy, which has depended in part upon traditional formal governance arrangements, structures, systems and procedures.
- On a more positive note, clinicians have been committed both individually and collectively to undertake their work in the best interests of patients and to develop their professional discipline through teaching of junior staff and research.

A further contributing factor to the current organisational culture and climate has been the focus during the last ten years on budget integrity. Over this period Queensland Health has changed from an organisation that always exceeded its budget by significant amounts, to one that meets allocated budgets. There has been an expectation driven by very firm and at times threatening and bullying behaviour by leaders, managers and supervisors at every level to achieve budget imperatives and to do better with less. The clear message has been that failure to perform to budget will not be tolerated. Staff recount that a number of District Managers’ contracts have not been renewed (up to a dozen) over recent years because they failed to address budget imperatives.

Staff willingly concede that budgets are important, but feel that the manner in which cost consciousness and budget efficiency have been driven, has been responsible for a high degree of bullying, intimidation, threats and retribution, and has induced behaviour in the organisation that is certainly not in the best interests of patients, nor in the interests of workforce harmony.

A final factor which significantly influences the culture prevalent throughout Queensland Health are the conflicting interests inherent in such a large multidisciplinary organisation. Examples are:

- the conflict between the optimal care for an individual patient and the overall benefits derived for the population and
- the current model of service delivery which relies on extensive use of doctors in training for various specialties. The primary motivation for doctors during this training program (particularly those who plan to pursue careers outside of the public system) is acquiring experience and knowledge they need to meet the requirements of the respective colleges.

4.3 The mandate for cultural change

There are many good reasons for seeking change to the prevailing culture in Queensland Health but two developments in recent years make change an imperative.

Firstly, undergraduate training and education of the hospital workforce now occurs in educational settings quite removed from service delivery. Today's health professionals are older (and more confident) at the time of graduation and are taught to enquire, challenge, question, to reason and to debate. Hence when they enter the service delivery environment they do not automatically accept the authoritarian models of operation. The professions are also changing and traditional rank and status structures are being and have been seriously challenged.

Secondly, in recent decades the range of health related technologies has grown exponentially. While these developments have brought enormous benefits for patients and communities they have also generated further specialisation and increased the fragmentation and complexity of health services. Modern medicine requires a multi-disciplinary team approach to effectively deliver this broad range of quite complex services. Conventional bureaucratic organisational structures and traditional health professional boundaries and approaches are no longer sufficient to ensure the delivery of effective, efficient and safe health care. This challenges the tribal boundaries within and between the various clinical streams. In particular the response of individuals working within such a complex and at times perplexing environment can be to restrict their activities and interest to the immediate setting that they can understand and control.

A paradigm shift in the pattern of behaviours, attitudes, values and beliefs is required if Queensland Health is to be able to address these issues.

4.4 Directions for change

The culture Queensland Health should aspire to is one which creates an environment where:

- services are oriented around the needs of patients, their families and the community
- the community is well informed about the services provided including:
 - how long they will need to wait for services

- how well the services meet best practice
- what risk there is of adverse events occurring and
- how to address concerns they have about the services
- individuals are provided with quality information about options and supported to make choices and provided with honest feedback on outcomes of their treatment
- staff are:
 - supported and valued for the contributions that they make to service delivery
 - provided with clear expectations of their duties and accept responsibility for them and
 - treated fairly and with respect
- information is shared in an open and transparent way to enable problem solving and service improvement
- conflicting priorities are resolved in a way that respects the rights and opinions of others and
- the interests of all staff can be aligned around a set of shared values.

The most important issues that need to be addressed are outlined in the following sections.

4.4.1 Leadership

The most critical ingredient in achieving the cultural change required is the changed style and behaviour of leaders within Queensland Health and its health services. It is the leaders who set direction, align different constituencies and motivate and inspire staff. Shared leadership should be increasingly relied upon to deliver the services necessary. Leaders will come from all sectors of health services, especially clinicians.

In a generic sense, it will be leaders at all levels in the organisation who must be:

- empowered
- share the same vision about reforms and the importance of re-establishing health and patient/consumer care priorities for the organisation
- set the desired example in respect to values and behaviour and
- assume influencing styles more in keeping with mentoring, guiding and supporting than are currently demonstrated in the organisation.

The difficult situation facing Queensland Health is to retain some of the gains made in efficiency and accountability over the past ten years but remove the unwanted “side effects” in terms of a lack of responsiveness and flexibility as well as the existing workplace conflict. There will be no perfect solution to this dilemma. However, the way forward must involve the building of trust, clinical leadership and decision making firmly linked to accountability by these clinical leaders. This will include accountability for patient outcomes and financial outcomes. It will be difficult for many clinicians and will require support and training. Some may simply not be willing to be accountable as it is personally difficult.

This will require a willingness of clinicians to expand their traditional professional leadership role from one that depends on their broadly respected and recognised expert knowledge, competence and experience, to new models of leadership focusing on system and service improvement and performance reporting, which will require a new set of organisation skills. They will also require a focus on priorities involving the needs of the population, in the context of restrained funding, as well as the needs of individual patients, which are sometimes conflicting. Clinical leaders need to drive reforms that are required in the redesign of models of health service delivery and new roles in the health professional workforce.

Chapters 5 and 6 explain the proposed approach to clinical leadership and the establishment of clinical networks which this Review supports as the best way to ensure meaningful input and decision making by clinicians to achieve health service enhancements.

Efforts to encourage clinical leadership require complementary changes in the traditional Central Office, hospital executive leadership style, to one of less command and control, to one more in keeping with strategic direction setting policy guidelines and reporting. The style of leadership required will depend more on enabling and supporting clinical networks and teams and providing information to ensure clinical objectives, outcomes and targets are achieved in a resource constrained environment.

The changes required are significant and profound and will require extensive leadership capacity building. Furthermore, members of the organisation will keenly observe the reform process, to see if it is based on fair and just principles supported by appropriate leadership.

The following principles will be important:

- That all existing managers and leaders have the opportunity to understand reform intentions and be supported to develop new leadership approaches before their suitability for providing ongoing leadership is judged.
- That once leadership development has been offered, leaders would be supported in their endeavours to lead and manage in more appropriate ways using more appropriate behaviours.
- The organisation takes steps to effectively assess whether leaders are setting the right example, and if leaders are unwilling or unable to do this, ensure that they are not in leadership roles. For example excellent clinicians who are not necessarily leaders should be able to pursue a career path which develops and maintains clinical excellence without leadership responsibility.
- The reforms are implemented in a way that encourages leadership to be shared at all levels in the organisation but particularly at levels closest to the point of health service delivery.

An example of how would this leadership development would work:

District Manager Leadership Competency Assessment

When the District Manager (DM) undertakes the leadership development program the chair of the District Health Council would be encouraged to also be involved.

Following the program a fair and balanced review process should be undertaken by the District Health Council. This could comprise:

- preliminary informal feedback on how the DM is tracking 3 months after commencing the program. This enables the DM to address identified issues and
- formal review 6 months and 12 months into the program which would involve broadly based feedback from peers, subordinates and supervisors.

The criteria for assessing leadership performance will be based on the leadership behaviours promoted in the leadership program.

External support would be provided to District Health Councils to undertake this review process.

Similar processes to that described in the box above would be used to assess all senior leaders in the organisation. For example the Area Health Council could be responsible for review of the Area Health Service General Manager and Director-General.

It is proposed that the Auditor General will monitor the entire process to ensure assessment of all leaders is being carried out appropriately.

4.4.2 Team building

Another essential feature of culture change (perhaps the most important) will involve multi-disciplinary teams working together to establish an atmosphere of trust. Leadership at all levels will be encouraged and culture changed in Queensland Health when staff experience a new working environment which encourages, supports and depends upon multi-disciplinary teams discussing and sharing common values and objectives, developing new ways of addressing old problems, implementing change and experiencing success. Participation in team problem solving, workplace redesign, systems improvement and patient-centric care are essential to the development of an improved culture.

4.4.3 Promoting healthy relationships between staff and managers

The culture of Queensland Health will depend ultimately upon the behaviour of staff at all levels in the organisation. If staff understand the values of the organisation, how their role contributes to achieving health outcomes, are adequately supported and developed, and treated with fairness and mutual respect they will be more motivated to embrace cultural change and the reform agenda.

Communication with staff should be enabling and inspiring rather than punitive or constraining. This should encompass all written information including the Code of Conduct, policies, plans, instructions and guidelines. Most importantly relevant information will be shared.

The Review supports the recent decision by the Minister for Health to develop a new Code of Conduct for Queensland Health to set a high standard of behaviour for both managers and employees. However, it should be recognised that a commitment must be given to ensure that staff receive appropriate education on its purpose and application within Queensland Health along with a clear indication of their responsibilities as individuals towards acceptance of the code.

The new Code of Conduct must clearly be framed in a context of understanding the complex nature of healthcare. Whilst it is important that staff are cognisant of the government framework within which they work, their primary allegiance is to health and patient care. Values, professional ethics and allegiance to patient care should receive prominence in any revised code of conduct.

Managers and supervisors need to have the appropriate skills to manage and develop staff, undertake effective performance assessment and to deal with performance issues before they result in grievances. To undertake this they will also need to access support and training in the leadership and management behaviours that the organisation requires.

A process must be in place to monitor the performance of staff which relates to their primary duties. For staff in senior positions, a formal process in which roles and deliverables are agreed upon, recorded and regularly reviewed is required. The existing Queensland Health Performance Appraisal and Development (PAD) process appears to be a suitable tool to support this formalised process.

For other staff, more flexible approaches should be used, combining a mixture of formal and informal processes. There appear to be two key issues in implementing an effective performance appraisal process at more operational levels:

- that managers and supervisors take time to meet with staff on a regular basis to discuss and agree upon:
 - the expected contribution of that staff member (outputs)
 - the expected contribution of the staff member to the organisation's goals
 - the staff members training and development needs
- that staff see the process as a developmental (rather than punitive) process by being able to access their identified training and development needs.

There is no perfect system for performance appraisal and development. However, by taking a more flexible approach, it is likely that staff will increasingly view the process as relevant and use it to improve their performance.

Where there are concerns with staff performance or behaviour, managers and supervisors need to have the skills to deal with these issues in a manner that encourages learning and development. This is a difficult area and in recognition of this Queensland Health should provide access to training and skills development for managers and supervisors who need assistance. This could be through leadership programs as outlined in Chapter 14. Queensland Health should also establish a dedicated unit to provide human resource expertise and "coach" managers and supervisors when they are dealing with diminished performance or issues of inappropriate behaviour.

4.4.4 A fair and effective grievance process

While an effective grievance process is endorsed, Queensland Health needs to provide managers and supervisors with training and development in communication and management strategies to reduce the potential for grievances. The number of grievances should be monitored as an indicator of workforce climate.

The management of grievances should also be monitored with a view to more timely resolution. All grievances should be logged in the complaints database (discussed in Chapter 9). A dedicated team should monitor adherence to these timeframes and escalate variations for resolution. Managers responsible for resolving these grievances should be provided with additional “coaching” support through a dedicated team of human resource staff with the expertise in this area.

Given the variable skill level of staff appointed to investigate grievances, Queensland Health should review current arrangements and consider contracting the private human resource sector to conduct investigations. This may result in more timely investigations with staff who have the up-to-date procedures with reduced potential for bias.

4.4.5 Ongoing monitoring of organisational culture

Some areas within Queensland Health, including some districts, have previously used staff surveys (similar to one discussed in 4.1.2) to gauge the attitudes of their staff. The information gained from this most recent survey can now be added to the database and should form the basis of ongoing conduct of workplace culture and staff satisfaction surveys to enable Queensland Health to monitor and understand trends in organisational culture over time.

Results of these surveys should be discussed with staff locally with necessary facilitation and support. This will give staff greater confidence that they will be involved in developing appropriate local responses to issues raised. It will also be incumbent upon management to ensure that an appropriate organisational response occurs at all levels.

Surveys would optimally be carried out at two yearly intervals to enable this monitoring to occur.

4.4.6 Accountability

The challenges which lie ahead in regard to positive culture change in Queensland Health should not be underestimated. It will require insight about the totality of the organisation’s culture, so that reform and renewal activity can build upon the strengths of Queensland Health’s culture and devise strategies, leadership arrangements, systems and structures that will systematically extinguish the negative aspects and replace these with more positive behaviours as a basis of building improved relationships which will lead eventually to the improved culture desired.

Chapters 5 and 13 propose new external checks and balances that will assist in keeping Queensland Health accountable in pursuing the quantum of change that is necessary. This includes a Health Commission reporting to a Parliamentary Committee and an increased role for the Auditor General in monitoring Queensland Health's progress in achieving the recommendations of the reform agenda.

Recommendation 4.1

Appoint a senior executive leadership team able to demonstrate positive leadership behaviours.

Existing senior managers should demonstrate required leadership behaviours and be genuinely committed to processes to eradicate bullying and other inappropriate aggressive or coercive behaviours. They should be supported in this through leadership development programs.

Leadership style and behaviours should be monitored to ensure only those leaders with the capacity to influence culture in the manner desired remain in critical leadership positions.

Clinical leadership should be fostered and encouraged and progressively relied upon to be responsible and accountable for many of the functions currently performed by executives in Corporate Office and district hierarchies and executives.

Written correspondence, especially the Code of Conduct, formal policy and guidelines should be written in an enabling rather than constraining manner.

Staff should be encouraged to form allegiances to a new set of organisation values that are patient and consumer centric whilst maintaining a performance and efficiency orientation.

Surveys of workplace culture and staff satisfaction be undertaken regularly across the organisation so that all districts can monitor their progress with cultural change through time.

Recommendation 4.2

New approaches are developed to deal with staff conflict and grievances to be supported by

- access to training for managers where required to ensure that they have the skills to manage and develop staff and undertake performance assessments
- formalised performance assessment processes for senior executive staff and more flexible approaches for other staff which involve regular discussions with managers and supervisors, monitoring access to agreed training and development opportunities, clarifying expectations and reviewing performance
- local access to industrial and human resource expertise to assist managers in effectively dealing with difficult and complex human resource issues
- a system to monitor the effective and timely resolution of grievances and
- a review of the effectiveness of the current internal process of investigation with a view to utilising private sector Human Resource expertise in this area.

5. Queensland Health's structure

5.1 Overview of the current structure

Queensland Health has a bureaucratic, mechanistic structure characterised by highly centralised formal authority and hierarchical layers of decision making. The high level of centralised control reflects an earlier history when the organisation was much smaller and when generalist managers controlled central office and hospitals.

On 26 July 2005 an interim structure was implemented comprising two Deputy Director-General positions reporting to a new Director-General.

The characteristics of the structure for 18 months prior to this included:

- Five Directorates:
 - Strategic Policy and Government Liaison
 - Information
 - Resource Management
 - Innovation and Workforce Reform
 - Health Services
- Health and hospital services delivered through the network of 37 Health Service Districts plus the Mater public hospitals, which are split between the Southern, Central and Northern Zones. The Zonal Managers report through the Senior Executive Director, Health Services Directorate.
- The majority of Queensland Health staff report through the Health Services Directorate. This has affected the responsiveness of the organisation to meeting the health needs of Queenslanders.

Despite some shortcomings of the current organisational structure, it has supported the focus on containing expenditure and driving efficiency. However these objectives have tended to dominate health service responsiveness and quality objectives which require greater focus.

5.2 Problems with the current structure

Queensland Health's mechanistic structure does not support a responsive, integrated and efficient health system. Key problems with the organisational structure include:

- The responsiveness of the organisation and the relevance and capacity of its services have been constrained as a result of the centralised decision making.
- Bottlenecks in decision making, particularly as the position of Senior Executive Director of Health Services is responsible for more than 85 percent of the department's resources. This model of decision making slows down the flow of information and the capacity of the organisation to implement new policy or respond to service delivery pressures.
- There are some functions (e.g. budgeting, media) that are currently controlled centrally that should be managed closer to where services are delivered.

- The number of levels in the organisation promotes fragmentation between policy development, governance, service delivery and performance management.
- The mechanistic structure has not supported collaboration between directorates which has caused dysfunction in the way policy is developed and implemented. A disconnection between districts and Corporate Office was observed as a major issue.
- There is little evidence of accountability and authority being devolved beyond the senior executive level. Resourcing decisions in particular are centrally determined while districts lack discretionary budgets.
- Staff are concerned by the lack of forward health service planning which results in both urgent “reactive” decisions and decisions heavily influenced by short term political imperatives.
- Performance monitoring and performance management functions within Queensland Health have largely focused on compliance with Commonwealth and State government reporting requirements rather than measuring the organisation’s performance in terms of improved patient and service outcomes.
- The capacity of the Zones to support districts in the delivery of services is inadequate. While there is some good work at the zonal level, their ability to add further value to service delivery is largely limited due to resourcing and decision making authority being controlled centrally.
- The 37 Health Services Districts are not sufficiently integrated to provide a comprehensive statewide health service.
- There has been very limited engagement with local communities in health decision making. District Health Council members are significantly frustrated by this.
- There has not been a consistent approach to community and stakeholder engagement throughout the organisation.

5.3 Governance structures in Queensland Health

If any restructuring is contemplated, it should take place for the right reasons and strive to achieve a demonstrated enhancement to health service delivery, the services received by consumers and patients, and ultimately improved health outcomes.

A small number of submissions to the Review recommended the re-introduction of hospital boards, with authority and accountability for the running of individual hospitals. Hospital Boards and separate trust authorities operated in Queensland until 1992 and in later years were found wanting as the scale, size, complexity and need for integration of our health services became more pressing. Some of the deficiencies of the hospital boards revealed by those who either chaired them or were the general managers of hospitals who participated in them were as follows:

- The general manager of the hospital was not an employee of the board or the trust but was a public servant who reported directly to the Director-General. This often led to conflict between general managers and board members. The Department’s will generally prevailed.
- Hospital trusts in earlier years raised loan funds and hospital bonds for the purpose of undertaking capital projects. Once the borrowing requirements of hospitals were centralised (Queensland Treasury Corporation) there was a less compelling reason to have hospital boards exist in their own right.

- There were numerous reports of the inability of boards to properly understand or influence the growing complexities of health service delivery requirements and the difficulties of maintaining separate influence over wage and salary structures which were also increasingly becoming centralised and subject to whole of government approaches.
- Budgets were never a creation of boards, but rather an allocation by the Director-General to each particular hospital authority.
- Boards focused on the running of hospitals and not on the range of community and population health services that are now provided by Health Service Districts.
- There are numerous reports of the parochialism of these boards in that certain hospital appointments were made for reasons other than merit.
- The fact that members were appointed politically, rather than apolitically also caused some dissatisfaction and it led to a lack of trust in the board structure.

All of these matters aside, the most pressing argument against the creation of separate hospital authorities and associated boards today is the unprecedented need to properly integrate public health services across Queensland. There are now also many whole of government legislative, financial and human resource imperatives which are more appropriately managed at a statewide level.

The environment in which public health services are delivered today is also more complex than when Hospital Boards existed. The range, type and modes of health services delivered are far more specialised and increasingly provided outside of acute hospitals. Local Hospital or Health Boards are no longer relevant or appropriate for the management of health services.

A corporate authority or board exists to set strategic direction, focus organisation objectives, oversee capable governance, empower executives and manage corporate risks. These descriptions are not applicable to boards in a large health service where strategic directions are set federally and at a State government level through budget initiatives.

5.4 Main features of an improved structure

The proposed structure will be designed to support the provision of health services having regard to community need and internal service capabilities. Such a structure will be flatter with accountability and decision making devolved to a lower level. This will be a significant cultural shift for the organisation which has been characterised by central control for decades except for a five year period of regionalisation in the early nineties.

While arguments could be made for major changes to both district and zonal boundaries, it is considered that a major restructuring of the districts would result in minimal savings and would divert attention away from patient-centred improvement and the effort required for the implementation of the major reform agenda to change the direction of Queensland Health. While some amendments have been recommended to zonal and district boundaries (discussed later in this chapter) to align with other boundaries, they are minor and will enable more consistent management and data collection for improved planning and reporting purposes.

Many reports were noted during the review about duplication of existing services and competition for new and enhanced services across metropolitan Brisbane. It is generally

understood that services are built around clinical relationships with a particular tertiary centre such as Princess Alexandra Hospital in the Southern Area Health Service and the Royal Brisbane Hospital in the Central Area Health Service. While this is accepted, there is a requirement to rationalise existing services and develop new tertiary services in a greater spirit of consultation across Area Health Services boundaries.

In the revised structure, clinical network leaders would assist the Area Health Service General Managers to monitor activity levels across the metropolitan districts. Greater use of bed management systems and other monitoring processes would then ensure a more equitable distribution of common workloads across the metropolitan area.

The empowering of Area Health Services and the inclusion of clinical networks in the formal decision making process will result in more timely and clinically focused results.

It is recommended Queensland Health's organisational structure is revised to incorporate the following principles:

Principles of the proposed organisational structure

- Increased community engagement and influence over policy development, local services planning and local decisions affecting the availability and standard of health services.
- Decision making regarding patient services and care is made by or strongly influenced by clinicians. Clinical decisions occur as close to the point of patient care as possible and in a timely and responsive manner conducive to good quality care.
- Decisions made at the most appropriate level (close to patients) with devolved budgets.
- Greater openness and transparency in key decision making throughout the organisation.
- Improved responsiveness to better meet the health needs of Queenslanders.
- Greater service integration of public health services.
- Greater coordination and collaboration between Queensland Health, other government departments and non-government providers of health services.
- Significantly increased focus on performance monitoring and performance management to ensure that the right services are provided at the right place, at the right time and at the right cost.

Features of the structure

- Establish three Area Health Services largely based on the boundaries of the existing Zones which align with population aggregates of around one to two million.
- A General Manager will lead and manage each of the Area Health Services and report directly to the Director-General.
- Ensure the leadership, management, policy, planning and performance monitoring capacity of Area Health Services is such that it coincides with greater budget responsibility, accountability and decision making authority.
- Districts to have greater operational responsibility, authority, and budget discretion within the context of a performance agreement with their Area Health Service.

- Central Office functions will be reduced commensurately and will focus on supporting Area Health Services and Health Service Districts through the following functions:
 - setting strategic directions
 - developing statewide health service policies and plans
 - leading statewide workforce planning and reform initiatives
 - acquiring and allocating funding to Area Health Services
 - performance monitoring
 - regulation
 - population health
 - capital and asset planning
 - providing business support and statewide clinical services.
- These functions will be split between the following positions who will report to the Director-General:
 - Executive Director Policy, Planning and Resourcing
 - Executive Director Performance
 - Chief Health Officer
 - Executive Director Corporate Services
 - Chief Operations Officer, responsible for statewide clinical and business services, will report directly to the Director-General and be located outside of the Central Office structure.
- Central Office should operate in an integrated way across its various functions to ensure that it supports service delivery.
- Move to a commercial model to manage statewide clinical and business services to focus on improving cost and service outcomes.
- Structure should clarify roles with authority and accountability for decisions being clearly articulated for each position.
- Establish a development unit by consolidating certain existing innovation and reform functions with the skills centre.
- A small reform implementation team to support the Minister, Director-General, Area Health Service General Managers and District Managers in leading reform.

Independent Bodies

- Establish an independent Health Commission to oversee the development and implementation of quality, safety and clinical practice standards throughout the State's public and private services and monitor best practice clinical governance and patient safety. The Commission will report to a Parliamentary Committee and will submit an annual report on quality and safety to be tabled in Parliament. Three Directors be appointed, with one responsible for the existing Health Rights Commission functions including complaints, one responsible for the oversight of quality and safety, and one responsible for arranging the recruitment of District Health Council members and for community consultation. This is discussed in detail in Chapter 9.

- Establish an advisory panel of eminent health care professionals to guide the implementation of the government's response to the Health Systems Review by monitoring the progress of reform and providing advice to the Director-General, Minister and reform implementation team.
- Establish a Business Services Board to provide advice and direction to the Chief Operations Officer on the delivery of statewide clinical services including Pathology, Radiology and Pharmacy, and statewide business services, all to operate with commercial rigor.

Recommendation 5.1

The current 37 Health Service Districts are retained.

Three Area Health Services be established: Southern, Central and Northern.

Each Area Health Service to be led by a General Manager who reports to the Director-General. District Managers within each Area will report to the General Manager of the Area Health Service.

Areas would have greater management and budget authority and accountability to plan, manage and deliver health services in their Areas.

It is important that the General Manager positions be recruited promptly so that the reforms driven from the Areas can commence.

Recommendation 5.2

The functions to be retained within Central Office are:

- strategic direction setting
- statewide health service plans and policies
- statewide workforce planning and reform initiatives
- acquisition and allocation of funding to the Area Health Services
- performance monitoring
- regulation
- population health policy and monitoring
- capital and asset planning.

The Chief Operations Officer with responsibility for statewide clinical services and business services will report to the Director-General but be located outside of the Central Office.

Central Office functions will be managed by the following positions that report to the Director-General. These positions should be recruited promptly:

- Executive Director Policy, Planning and Resourcing
- Executive Director Performance
- Chief Health Officer
- Chief Operations Officer
- Executive Director Corporate Services

Recommendation 5.3

Plan and establish a Health Commission, the membership of which consists of eminent health professionals, experts in the field of quality and safety systems, consumers and those with an interest in improving health in Queensland.

Establish a Reform Advisory Panel with membership of eminent health professionals to provide advice to the Minister and Director-General on the implementation of reforms.

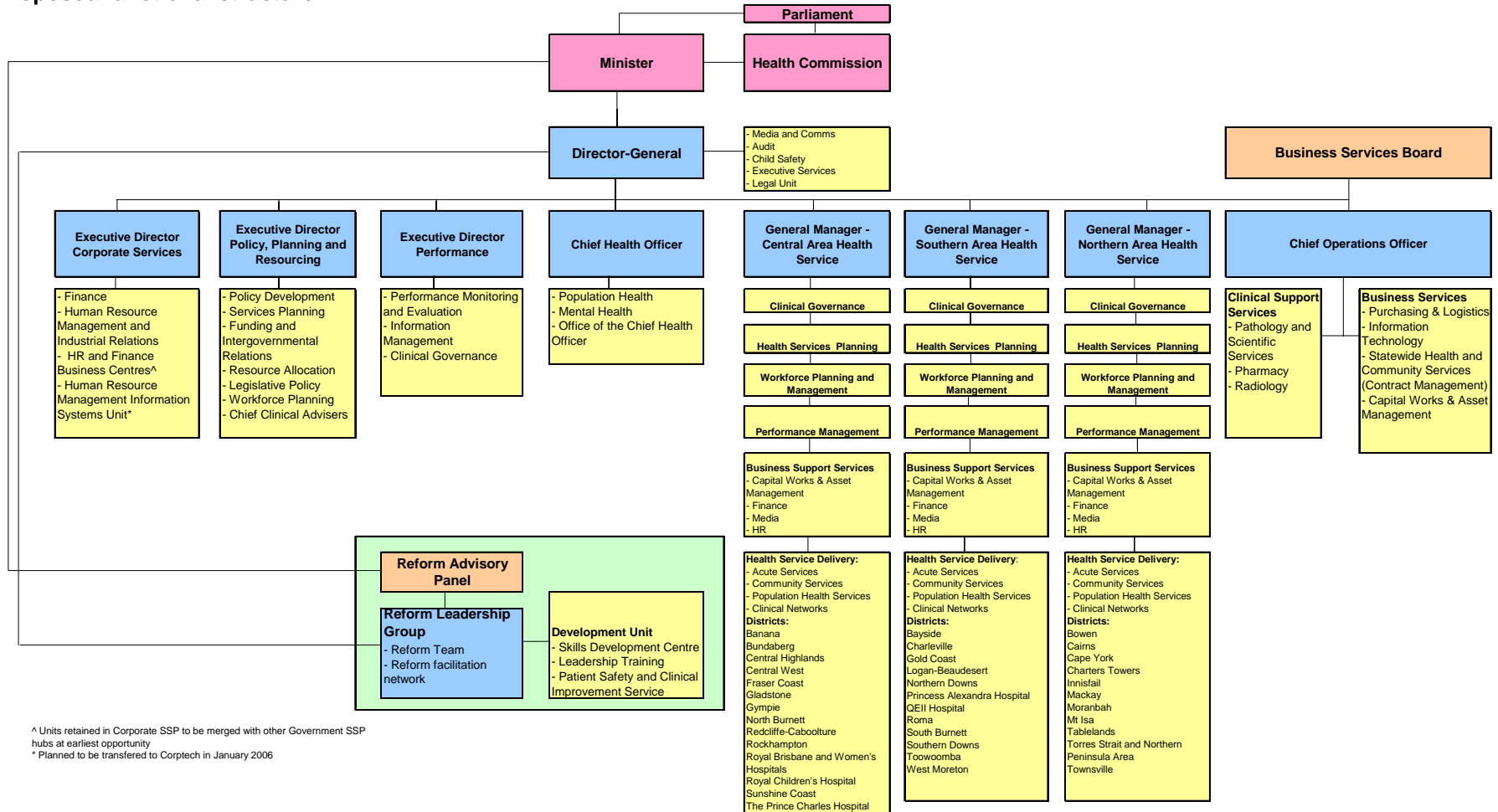
Establish a Business Services Board to oversee activity and advise the Chief Operations Officer and Director-General on commercial issues relating to statewide business and clinical support services to enable contestability for these services.

Culture

Structure review and realignment may offer some answers to problems but they are only part of the answer. A range of strategies need to be employed to promote leadership throughout the organisation that encourages a learning culture that can resolve problems, learn from mistakes and is better able to respond to changing situations and requirements in a sustainable way. Further discussion on culture is provided at Chapter 4.

The proposed functional structure is shown on the following page.

Proposed functional structure



5.5 Review of Central Office

The role of Central Office (previously known as Corporate Office) was evaluated in the context of the systemic organisational problems that were identified including a lack of responsiveness, level of central control and lack of collaboration between directorates, and with other providers of health services.

Members of the Review visited Corporate Office and interviewed numerous staff regarding the roles and functions within directorates. As a consequence of those interviews the functions of Central Office have been developed to focus on setting strategic directions, development of statewide health service plans and policies, workforce planning and reform initiatives, funding, performance monitoring, regulation and population health. In order to streamline Central Office and strengthen Area Health Services, 679 positions are to be transferred to Area Health Services and 162 positions have been identified as surplus.

Detailed work is now required to develop an organisational structure and to allocate the positions to best achieve the desired outcomes.

The following principles are suggested for the Central Office restructure:

- no AO2, AO3, AO4 staff are to lose their job. Where these positions are identified as being surplus within the revised Central Office structure, negotiations to occur with staff to arrange transfer at level to Area Health Services, Business Services, Health Service Districts or other Government Departments
- unions are to be consulted and involved in the restructure
- restructure to occur within the recommended number of positions for Central Office
- staff transferred to Area Health Services and Health Service Districts will access PBI status
- recruiting to the new structure to be completed within nine months
- clinical staff who wish to return to clinical positions to be given every assistance to do so
- surplus staff with the appropriate skills be given first option to fill vacant positions
- every effort is to be made to find positions for staff whose position is to be abolished
- Voluntary Early Retirement to be offered after all options have been fully explored.

Of concern to the Review is the inconsistency in how the number of positions within Central Office are managed and tracked. While every effort was made to ensure that the information presented in the report is accurate, consistent information on positional data was difficult to obtain. The general principle applied to the information presented here was to use approved and funded Full Time Equivalent positions.

A number of Central Office positions are under the Public Sector Award which is for Health Service District employees. Of the estimated 2,100 full time equivalent positions in Central Office, excluding Pathology and Scientific Services and the Public Health

Networks but including the entire Information Directorate, 1,328 are Public Sector (District) positions. It should be noted that these positions are paid out of Central Office cost centres but were established under Health Services Districts for a range of reasons. For example, a number of functions directly support Health Services Districts but report corporately. Where staff work in Central Office it is not appropriate for these to be Public Sector positions. In the future, Central Office will be comprised of public servants with public sector positions located in Areas and Districts.

Recommendation 5.4

Central Office to be reduced to 644 positions. Central Office to include the Office of the Director-General; Policy, Planning and Resourcing; Performance; Corporate Services; and the Chief Health Officer.

679 positions transferred to Area Health Services. The majority of these positions are physically located outside of Central Office but have reported through Central Office as part of a statewide public health service. Other positions will be transferred to Areas to fulfil the broader role that Areas have under the proposed structure.

162 positions within Central Office have been identified as surplus under the new arrangements.

Under the proposed structure the following staffing profile is recommended:

- Office of the Director-General: 91 FTE positions
- Policy, Planning and Resourcing: 124 FTE positions
- Performance: 79 FTE positions
- Chief Health Officer: 209 FTE positions
- Corporate Services: 141 FTE positions

All positions within Central Office should be established under the Public Service award. All other positions should be established under the Public Sector award.

Central Office staffing establishments be allocated and monitored so that accurate data is available.

An implementation plan for the organisation restructure is outlined in Chapter 14.

5.6 Roles of the different levels

5.6.1 Health Service Districts

It is proposed that service provision within Area Health Services will be provided through Health Service Districts.

The existing district boundaries have been reviewed and a range of options considered. It is recommended that district boundaries remain unchanged. This is not to say that there may be some value in combining some smaller districts with larger districts at some future time. The Review has taken the stance that this is not the most important task at this stage. However, Area Health Services may review this in consultation with the communities when and where appropriate.

Within the existing structure there is considerable variation in the size of the districts and scope of the services provided within these districts. Nine of the Queensland Health districts in regional Queensland have a population less than 20,000 and are projected to still have a population below that number by 2011. In contrast, there are five districts within South East Queensland that already have a population catchment in excess of 250,000 and are projected to expand considerably over the next six years (see Table 5.1).

There is much to be gained from strengthening or further developing the obvious connection that occurs between the existing districts and their community. However, there is a view that 37 districts are too many because many are small and disparate and place pressure on the available leadership capacity within Queensland Health. However, the Review noted that existing districts do represent real communities of interest.

Rural and remote districts with small populations distributed over a very large geographical area face particular challenges. However, the Review also noted that the additional overhead in maintaining a District Manager position was more than offset by the capacity to engage with the local community.

This Review will recommend nothing that would be perceived or would actually reduce service access or service provision in rural and remote areas of the State. The intention to the greatest extent possible is to strengthen and support such services

For this reason it is suggested that the 19 districts with a population less than 60,000 should be known as Rural and Regional Districts as shown in Table 5.2 and be given support from the Area Health Services. A Director of Rural and Regional Services be established in each Area Health Service, who will be responsible for ensuring effective support to these districts, which will include developing supportive strategies to help with implementation of statewide policies, etc.

Table 5.1 Health District Population and Area, June 2004

| Health District | Estimated Resident Population | Area (km ²) | Health District | Estimated Resident Population | Area (km ²) |
|--|-------------------------------|-------------------------|-----------------------------|-------------------------------|-------------------------|
| Banana | 14,266 | 15,750 | Mt Isa | 30,772 | 223,447 |
| Bayside | 193,823 | 851 | North Burnett | 10,280 | 17,350 |
| Bowen | 31,202 | 26,230 | Northern Downs | 30,857 | 50,860 |
| Bundaberg | 87,933 | 12,590 | Princess Alexandra Hospital | * | - |
| Cairns | 144,309 | 35,747 | QEII Hospital & District | 443,629 | 319 |
| Cape York | 8,252 | 115,161 | Redcliffe-Caboolture | 182,499 | 2,708 |
| Central Highlands | 24,038 | 58,570 | Rockhampton | 102,251 | 20,060 |
| Central West | 13,340 | 396,600 | Roma | 18,216 | 89,970 |
| Charleville | 8,736 | 229,900 | Royal Brisbane & Women's | ** | |
| Charters Towers | 15,495 | 136,500 | Royal Children's | ** | |
| Fraser Coast | 83,070 | 7,783 | South Burnett | 33,596 | 11,690 |
| Gladstone | 44,713 | 6,709 | Southern Downs | 59,080 | 33,520 |
| Gold Coast | 403,703 | 887 | Sunshine Coast | 275,143 | 3,125 |
| Gympie | 35,624 | 2,967 | Tablelands | 37,802 | 132,200 |
| Innisfail | 34,513 | 5,621.5 | The Prince Charles Hospital | 581,465 | 1425 |
| Logan-Beaudesert | 298,235 | 3,625 | Toowoomba | 144,835 | 7,435 |
| Mackay | 113,175 | 13,620 | Torres | 10,419 | 1,857 |
| Mater | n/a | n/a | Townsville | 169,956 | 6,618 |
| Moranbah | 19,505 | 55,550 | West Moreton | 177,801 | 7,779 |
| | | | Queensland (a) | 3,882,037 | 1,734,949 |
| (a) The area for Queensland is not equivalent to the sum of the component Health Service Districts due to rounding at the SLA level. * The population and areas for the Princess Alexandra District overlaps with the QEII District. ** The population and areas for the Royal Brisbane District overlaps with the Prince Charles District. Source: Office of Economics and Statistical Research, Queensland Treasury ABS, Regional Population Growth, Cat no 3218.0, (unpublished data) | | | | | |

Recommendation 5.5

The following measures should be undertaken to provide the Rural and Regional Districts with a greater degree of support:

- The 19 Rural and Regional Districts with a population less than 60,000 be known as Rural and Regional Districts. These districts are shown in Table 5.2 of the report.
- Each Area Health Service will have a Director of Rural and Regional Services who will be responsible for ensuring effective support to these districts. The District Managers for these Rural and Regional Districts will report to the Area General Manager.
- The Director of Rural and Regional Services will provide assistance to the Rural and Regional Districts for the implementation of statewide policies.

Table 5.2 Rural and Regional Health Service Districts

| Northern Area Health Service | Central Area Health Service | Southern Area Health Service |
|--|---|--|
| <ul style="list-style-type: none"> • Bowen • Cape York • Charters Towers • Innisfail • Moranbah • Mt Isa • Tablelands • Torres Strait & Northern Peninsula | <ul style="list-style-type: none"> • Banana • Central Highlands • Central West • Gladstone • Gympie • North Burnett | <ul style="list-style-type: none"> • Charleville • Northern Downs • Roma • Southern Downs • South Burnett |

Some district boundaries do not align with current Local Government Area (LGA) and Statistical Local Area (SLA) boundaries. Where possible district boundaries should not bisect LGA or SLA boundaries. This should improve the capacity for districts to work cooperatively with local governments and to improve the ability to use broadly available statistical information when planning services.

Recommendation 5.6

Area Health Services review Health Service District boundaries and align district boundaries to Local Government Area and Statistical Local Area boundaries.

District Organisational Structure

The Review observed differences in how the management of Health Service Districts were organised.

Smaller districts function with a District Manager, a Director of Nursing and a clinically involved Director of Medical Services. This arrangement seems both efficient and satisfactory.

Medium sized (provincial/regional) districts often have a District Manager, a Director of Nursing, a Director of Medical Services who is not involved clinically and a Director of Corporate Services with variable levels of budget delegation and management. This arrangement may evolve further with the implementation of clinical networks. It seems generally efficient and satisfactory.

Large districts (Princess Alexander Hospitals Health Service District, Royal Brisbane and Women’s Hospitals Health Service District, The Prince Charles Hospital, Townsville Health Service District and Gold Coast Health Service District) have evolved to a position where much of the budget and decision making is rightly devolved to clinically led divisions or institutes. The position of Director of Nursing and Director of Medical

Services are not “line management” but have “professional standards” responsibilities. These responsibilities are ill defined and accountabilities unclear. The development of Clinical Networks and Area Clinical Governance Units will further erode the functions of these “professional standards” roles.

The position of Director of Nursing in the tertiary hospitals may be better utilised in an Area Director of Nursing position where they could provide nursing leadership and influence nursing standards for all nurses in the Area Health Service.

A senior medical appointment is suggested to the position of Director Clinical Governance within each Area Health Service (see Chapter 9). This will take certain aspects of credentialing and privileging roles from existing Directors of Medical Services roles and it could be suggested that the existing Director of Medical Services at a tertiary facility may have appropriate skills for this role.

This Review supports the delegation of budgets and accountabilities to divisions or institutes in large Health Service Districts as described. It recommends that these divisions or institutes have a single point of accountability.

The salary of many Directors of Medical Services is higher than most senior positions in Queensland Health. The implications of this are that there would be no financial incentive for them to apply for senior leadership positions within Queensland Health.

The role of Director of Nursing and Director of Medical Services in the large districts where they have little or no line management responsibilities requires re-examination.

There are several options at least for these larger districts:

- Abolish the positions and redirect surplus funds to clinical services after creating an Area Director of Nursing and an Area Director of Medical Services/Area Director of Clinical Governance (preferred option).
- Abolish the District Manager positions in these large facilities and have a CEO/Director of Medical Services or CEO/Director of Nursing Services.
- Have a medical loading for all senior leadership positions including District Manager, General Manager Area Health Service and other Central Office senior positions acknowledging the differential earning capability so that doctors could apply for senior positions. This means that, should the Director of Nursing and Director of Medical Services positions be abolished, the potential for a Medical District Manager remains a financially viable option.

In these large districts, normally the District Manager and Director of Nursing are employed on contracts yet the Director of Medical Services has tenure. This is inconsistent with others in the executive management team where the team is expected to accept significant responsibilities and commensurate accountability.

The Review suggests as a minimum, that Directors of Medical Services in a non-clinically involved role be employed on a contractual basis to align the incentives for the entire executive management team.

The requirements in districts will differ. General Managers of Area Health Services who are to be the empowered leaders of their allocated Health Service Districts should

rationalise district senior structures in consultation with current district executives and clinical leaders of divisions.

Recommendation 5.7

Area Health Service General Managers rationalise district executive structures to complement clinical leadership and governance changes recommended to minimise overheads and ensure members of the district executive share equivalent tenure.

A suggestion for consideration is that the Director of Medical Services at a tertiary facility may have appropriate skills for the Area Director of Clinical Governance and a Director of Nursing in such an institution may have skills relevant to an Area Director of Nursing.

District Managers

There has been in recent times a number of comments made about the effectiveness of the role of the District Manager. It has been suggested that their role could be taken over by a Medical Superintendent or possibly a Director of Nursing. This view is not supported by the findings of the Review for the following reasons. With the pressing workforce issues that face the health sector it is imperative that the Directors of Medical Services and Directors of Nursing focus their energies on the changes to roles that will be required to meet patient needs and deal with the workforce challenges and address clinical governance imperatives. Management of Health Service Districts does not relate just to the management of acute hospital services. If Queensland Health is to achieve a more integrated approach to health service delivery and improve the health of our communities it will be important that the District Manager provides overall direction and leadership of acute hospitals, community health, mental health services, rural health services, support services and initiates and participates in collaboration with other government and non-government services.

One of the criticisms that has been raised is that many District Managers do not fully understand the clinical imperatives. However, it was noted that in many districts, District Managers come from a clinical background.

Health Service Districts through the District Manager would have responsibility and accountability for contributing to Area Health Service planning and provision of safe public sector health service delivery to the population of the district within the budget allocated. The type and level of service provided will depend on the service capacity of the district as described in Queensland Health's Service Capability Framework. In all districts this will include a base level of hospital services, a range of community health services, mental health services, rural health services in some and a range of support services. Since the introduction of the Shared Service Provider many of the corporate service functions like finance, payroll and human resource management services that were the responsibility of districts are now provided through a Service Level Agreement with the Shared Service Provider District. Health Service Districts will also work with District Health Councils, other service providers and other government departments to better integrate services. Existing District Manager delegations enable this role to be fulfilled.

The use of District Managers' delegations has on many occasions been hampered by a lack of discretionary funding to address identified local service or improvement initiatives. For example, the Royal Brisbane and Women's Hospital Health Service District reported that of some \$457 million recurrent expenditure including growth of \$38.9 million, only \$1.8 million, less than 1 percent, was discretionary i.e. there were no prior demands on that money at the start of the financial year. Given this reality it is little

wonder that any decisions requiring resources (and most significant decisions do have resource implications) would be escalated from the clinical levels to district executive, to Zones and then Corporate Office.

Recommendation 5.8

The District Managers will report to the General Manager of the Area Health Service and be accountable for:

- implementation of the Area Service Delivery Plan in their district
- the provision, funding and coordination of health services for the population of the district within the budget allocated, compliance with Clinical Services Capability Framework and as detailed in the Performance Agreement with the Area Health Service
- the safety and quality of health services provided
- consulting and liaising with the District Health Council to assist the Council to meet their functions. This would include ensuring the Council has the support required to carry out their role.
- working collaboratively with other health service providers, government and non-government services that interact with the health service
- taking on portfolio area responsibilities as delegated by General Manager Area Health Service.

5.6.2 Area Health Services

Effective aggregation of hospitals and health services is required to achieve well planned, integrated, cost effective health services across the State. Aggregations of approximately one to two million people justify sufficient critical clinical capability to provide a full range of services to that population. They would have the budget to either provide all services or purchase services from other providers and would have tertiary institutions including medical schools, nursing and allied health university courses, and teaching hospitals to support their geographic networks. These aggregates will be called Area Health Services. This aligns with the approach that has been undertaken in New South Wales and Western Australia. Health Service Districts will provide a majority of health services for this population.

The existing zonal boundaries have been reviewed. Based on the present populations there is no basis to make any major changes to these boundaries. Some consideration was given to create four Areas but it is not possible to create areas that had both geographic logic, populations of one million or more and reflect normal patient flows. Therefore it is proposed that the Areas will be based on similar boundaries to the existing Zones with one change to better reflect the referral patterns from this district (South Burnett Health Service District to transfer to Southern Area Health Service). Northern Area Health Service has a population of approximately 700,000 (no change), Central Area Health Service has a population of 1.5 million (South Burnett go to Southern Area Health Service) and Southern Area Health Service a population of 1.8 million (including South Burnett) as per Table 5.3.

At this stage of the State's growth a full range of clinical capability including fully productive medical, nursing and allied health schools are only available in Brisbane and Townsville. However, it is envisaged that in the next five to ten years there will be the population, clinical and educational capability in the Logan, Beenleigh, Gold Coast region to create a fourth Area Health Service.

There will be increasing cooperation and networking both within and between Area Health Services, particularly in an environment of critical shortage in all of the inputs to health service delivery (i.e. funding, workforce, capital infrastructure and equipment.) A key element of this will be enhanced opportunities for involvement by clinicians including support for new statewide clinical networks.

Opportunities exist for greater coordination and establishment of statewide services with clearly defined responsibilities to drive the provision of some tertiary hospital services for people living in regional Queensland. This should include support for and better provision of services to people living in Aboriginal and Torres Strait Islander communities. Greater support also needs to be provided for small population and large area rural and remote districts.

Recommendation 5.9

South Burnett Health Service District be transferred from Central to Southern Area Health Service.

Recommendation 5.10

By 2010 the need for a fourth Area Health Service should be considered.

Table 5.3 Districts in proposed Area Health Services

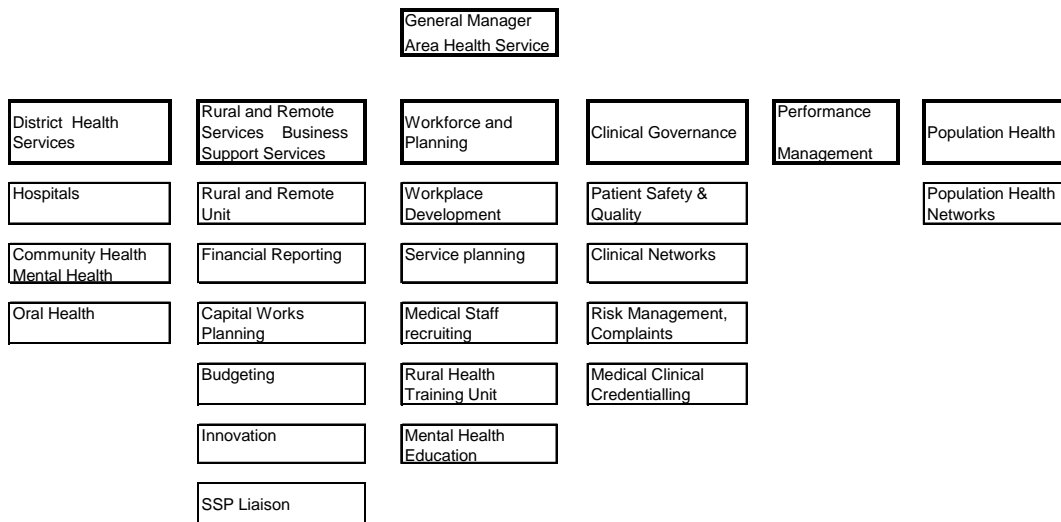
| Northern AHS | Central AHS | Southern AHS |
|---|-------------------------------------|-----------------------------|
| Bowen | Banana | Bayside |
| Cairns | Bundaberg | Charleville |
| Cape York | Central Highlands | Gold Coast |
| Charters Towers | Central West | Logan-Beaudesert |
| Innisfail | Fraser Coast | Northern Downs |
| Mackay | Gladstone | Princess Alexandra Hospital |
| Moranbah | Gympie | QEI Hospital |
| Mt Isa | North Burnett | Roma |
| Tablelands | Redcliffe-Caboolture | South Burnett |
| Torres Strait and Northern Peninsula Area | Rockhampton | Southern Downs |
| Townsville | Royal Brisbane and Women's Hospital | Toowoomba |
| | Royal Children's Hospital | West Moreton |
| | Sunshine Coast | |
| | The Prince Charles Hospital | |

Key functions of Area Health Services

- Major responsibility within Queensland Health for the planning and provision of health services within their Area
- Statewide support for selected tertiary services
- Implementation of high level policies that have been approved by the Minister
- Responsibility for the provision of services such as public hospitals, community health facilities, population health, mental health, aged support and child health
- Providing statewide leadership for certain clinical networks and statewide services as part of an agreement reviewed annually with Queensland Health
- Area Health Services are to be provided with their own budgets (and outputs within the Queensland Health budget) as the key drivers of service delivery across Queensland.
- Clinical governance.

The following proposed functional chart is provided to give some assistance with how Area Health Services should be set up. It is acknowledged that some of these functions are already functioning within Zones and further detailed planning is required.

Proposed Functional Chart for Area Health Services



General Manager Area Health Service

The General Manager of an Area Health Service will be directly accountable to the Director-General to ensure that health service delivery arrangements in the Area are working as intended by the government in the Area and that health service delivery needs are properly specified, planned, budgeted and staffed for the Area and the State as a whole. General Managers will be members of the Executive Management Group. It is important that recruitment commence promptly for these positions so that the reform driven from Area Health Services can commence.

Recommendation 5.11

The General Manager Area Health Services positions are to be recruited promptly.

The General Manager Area Health Services will be responsible for:

- planning public sector health services and capital works
- public sector health services delivered through Health Service Districts
- population health
- Indigenous health strategies working with Indigenous communities
- workforce management, reform and training
- Area resource allocation, utilisation and monitoring
- clinical governance including medical credentialing and privileging
- performance management
- risk management
- consulting with the community regarding planning and provision of health services
- consulting with and supporting the Area Health Council
- partnering with other service providers and government agencies
- commenting on health service and operational issues to the media.

The General Manager Area Health Services will have portfolio responsibilities for some statewide networks and other statewide responsibilities as delegated by the Director-General.

This Review has identified key roles and positions; however the specifics of Area Health Service staffing requires detailed planning.

5.6.3 Clinical Networks

Clinical networks will be a cornerstone of the new decision making and leadership structure of Queensland Health. It is important to note that while there is good evidence from Scotland, New Zealand and New South Wales that clinical networks do improve decision making and patient outcomes, this structure will evolve with time and may well be uniquely “Queensland”. Clinical networks do bring with them complexities around how the network interacts with the bureaucracy. A patient centric focus will assist in resolving any bureaucratic complexity.

The role of clinical networks will be to provide statewide clinical leadership in a speciality area. The primary purpose of these networks should be to:

- plan statewide service development and equitable access
- allocate growth funding for services
- set and monitor clinical standards
- learning and skills development in service improvement
- empower clinicians.

Networks should be clinician led, multi-disciplinary, involve and integrate primary, secondary and tertiary services across the continuum, involve health care consumers and explore innovative models of service delivery, education and staffing. Clinical networks would not be involved in the day to day management of clinical services or be the employer of clinical staff. The day to day management and support of the networks would be the responsibility of Area Health Services. The plans and funding allocations that come from the networks would then be given to Health Service Districts to implement the plans and to incorporate the service growth into new or existing service provision.

Implementation would include the following:

- provision of designated growth funds for pre-defined clinical outcomes
- statistically robust outcome measurement and analysis systems
- Chairs of clinical networks for a three year term with paid sessions
- adequate managerial support
- drawing on the skills and capacities of the Patient Safety and Clinical Improvement Service regarding service improvement and outcome measurement
- report to General Managers Area Health Services.

The networks are further described in Chapters 6 and 9.

In Southern Zone there are a number of clinical networks that have been functioning for a number of years and have made considerable gains in setting service standards and

service planning across the Zone. There are also a number of collaboratives that have been working for some time and making service improvements. It would be advisable to develop the first set of networks by combining the service improvement and operational components of existing and successful collaboratives and zonal networks.

Queensland is a national leader in the methodologies around clinical collaboration and practice change. It is strongly suggested that experienced experts from the previous Clinical Practice Improvement Centre (now in the Development Unit) play a lead role in establishing the networks.

Recommendation 5.12

Clinical Networks be established within twelve months and be recognised as a legitimate and authorised part of the formal structure.

5.6.4 Central Office

Over the coming years the focus for Queensland Health's Central Office will be setting strategic directions for clinical governance, resourcing, policy, planning, performance and centralised business support services. There will need to be a number of changes made at the Central Office level to better support this goal.

The Directorates based centrally under the proposed structure are described below.

Director-General

Key functions of the Director-General are:

- supporting and advising the Minister for Health
- providing leadership to Queensland Health and the Executive Management Group
- managing health services in accordance with strategic and financial plans approved by Parliament, Government and Minister.
- delivering health services in a manner described in health service plans with community and clinician input
- entering into performance agreements with Area Health Service General Managers
- reporting on performance to the Minister and recommending requirements for changes in services
- improving the quality and safety of health care delivery through Area Health Services and promote a culture of open disclosure
- being the accountable office under the *Financial Administration and Audit Act 1977*
- exercising powers and authorities of the *Public Service Act* and other legislation administered by the Department.

Policy, Planning and Resourcing Directorate

The following functions are proposed for the Policy, Planning and Resourcing Directorate:

- policy development
- health services planning

- funding and intergovernmental relations
- resource allocation
- legislative policy
- workforce planning and reform
- industrial relations and human resource strategy
- chief clinical advisers.

Many of these functions are currently based centrally but are fragmented across Directorates. The Policy, Planning and Resourcing Directorate will consolidate policy development functions across a range of areas. While the Directorate will provide specific policy and planning expertise, the expectation is that health policy and service delivery plans will be developed in close collaboration with Area Health Services and relevant stakeholders. Legislative policy is also proposed to be located within the Policy, Planning and Resourcing Directorate to better reflect the policy development cycle and the important role the development of legislation has in that process.

Another significant change recommended as part of the new structure will be to move the workforce planning and reform functions to the Policy, Planning and Resourcing Directorate. This dedicated workforce policy area will be responsible for workforce planning, and develop innovative workforce models to meet health service needs and workforce shortages. To support this, the chief medical, nursing, allied health and dental advisers will be located in the Policy, Planning and Resourcing Directorate.

The acquisition of funding for Queensland Health is a complex task involving negotiations with different levels of Government and in some instances the non-government sector. The Policy, Planning and Resourcing Directorate would have full carriage of the acquisition of funds. Queensland Health's compliance with funding conditions will also be managed within this Directorate. Consistent with the recommendations offered in Chapter 6, this Directorate will be responsible for the allocation of funding through resource allocation tools to the Area Health Service level. Part of this process will involve close liaison with all areas within the Department in particular the Performance Directorate and the Area Health Services.

Performance Directorate

The following functions are proposed for the Performance Directorate:

- performance monitoring and reporting
- information management
- clinical governance.

Queensland Health's performance monitoring and evaluation function is underdeveloped with the current focus being on compliance with Government funding requirements. The Performance Directorate will consolidate and align external and internal performance monitoring and reporting and facilitate better decision making at all levels of the organisation through use of information.

The Performance Directorate will be responsible for collation of all performance data. This includes data management, analysis and reporting. A critical role will be reporting to the Executive Management Group as well as Area Health Services, supporting their role as performance managers. This will primarily occur through development and monitoring of Area performance agreements.

Performance analysis at the system and facility level will be undertaken with a view to improve health outcomes for Queenslanders. The Performance Directorate will work collaboratively across the organisation to inform policy, planning, and resourcing decisions and assist in improved service delivery including clinical decision making.

Clinical governance and safety systems will also be a focus of the Performance Directorate as discussed in Chapter 9.

Chief Health Officer

The *Health Act 1937* provides for the appointment of a Chief Health Officer (s7) and a Manager of Public Health Services for the State (s 8A). The Chief Health Officer has a range of responsibilities including providing advice to the Minister in emergencies (s 17) such as epidemics, or major natural or man made disasters, the issuing and cancellation of licenses for private hospitals (s 76C) or being a member of the Radiation Advisory Council [1].[1] S 163, *Radiation Safety Act 1999*. It is proposed that the Chief Health Officer take responsibility for these legislated roles.

Under the new structure the Chief Health Officer will assume responsibility for:

- Emergency Health Services and the Private Health Unit which licenses private hospitals)
- Population Health (some of the population health capacity at the centre will be devolved to Area Health Services including the public health networks)
- Mental Health Unit (which has significant statewide legislative obligations).

At present clinical quality and patient safety functions are the responsibility of the Chief Health Officer. Under the proposed structure these responsibilities have been moved to the Performance Directorate. This will enable the Chief Health Officer to give greater focus to regulatory and legislative responsibilities.

Chief Operations Officer

The Chief Operations Officer will lead and manage business and clinical support services. The position will be responsible for:

Clinical Support Services

- Pathology and Scientific Services
- Pharmacy
- Radiology

Business Services

- Purchasing and Logistics
- Information Technology
- Statewide Health and Community Services (contract management)
- Capital Works and Asset Management

The position will be responsible for leading the physical infrastructure development (capital works) to support service delivery across the State.

Corporate Services

Corporate services will be led by an Executive Director and be responsible for:

- finance
- human resources and industrial relations
- Workplace Health and Safety
- Central Office support services such as records, facilities and fleet management

Corporate Services will be the principal source of advice to the Department on human resource management and development and monitoring of Queensland Health's financial management framework. This would include implementing appropriate taxation, accounting, financial policy and financial systems.

HR and Finance Business Centres will be retained temporarily as a Central Office SSP reporting to the Executive Director Corporate Services, until they are able to be merged with another Government SSP cluster. The Human Resource Management Information System Unit will also temporarily report the Executive Director Corporate Services until they are transferred to CorpTech in January 2006.

5.7 Minister

The Minister is accountable and reports to the Parliament regarding legislative obligations, the overall performance of Queensland Health and a range of statutory authorities, which are under the Minister's control. This includes professional registration boards and the independent health complaints body.

The Minister represents the interests of the community on health matters in Cabinet and approves the strategic direction and scope of activities of Queensland Health.

The Minister approves statewide policies for health services and is responsible for securing resources sufficient to fulfil legislative obligations and satisfy government specified service delivery expectations.

5.8 Involving the community

Queensland Health has been closed in its approach to community involvement, with low to medium level community participation activities implemented. Initiatives such as District Health Councils, established in all districts as a mechanism for community consultation, have lacked the necessary resources to make a real difference. A discussion on a recommended enhanced role for District Health Councils and establishment of Area Health Councils is provided below.

5.8.1 District Health Councils

The Review in its visits to districts talked to a number of District Health Council members and came to the conclusion that there was considerable commitment by members to make a meaningful contribution to their local health services. Across the State, Councils operated at varying levels of effectiveness. There are numerous reasons

for this variation including role clarity, quality of performance reports received and the extent to which members are engaged with their own local communities and health service. Much can be addressed by improving the resources and support that each Council receives to fulfil its role and by developing the capacity of Councils to meet this important role.

District Health Council functions are detailed in the *Health Services Act 1991 Part 2*. In summary, their function is to advise and make recommendations to the District Manager on the public sector health service needs for the district, planning for services and minor capital works. They also have a role in monitoring compliance against these plans, budget, quality of services, and performance of District Managers. What is required are consistent processes to enable District Health Councils to meet these functions. One section of the *Health Services Act 1991* that requires change is the present remuneration that members received. Some members who actively participated in community meetings, on behalf of the Health Service District received no remuneration or reimbursement for out of pocket expenses.

Within districts there are discrete towns and communities which have their own local health services. It is important that the membership of District Health Councils has the capacity to reflect the viewpoints of these towns and communities. Members should therefore be supported to establish mechanisms to engage the local community. Community Reference Groups were noted to be a good example of one way this might be achieved. Membership for such groups could be nominated from groups that represent the interests of that town with the District Health Council member as the chair.

With the introduction of Area Health Services, a member of each District Health Council will sit on the Area Health Council to provide advice to the General Manager on their community's feedback and expectations for health services and the performance of the district and District Manager.

At present District Health Councils are appointed by the Minister. The Review was informed about difficulties in getting timely appointments to Councils and the perception that some appointments were politically motivated. The role of advertising, recruiting and nominating District Health Council members to the Minister for appointment be assumed by the Health Commission.

Resources that District Health Councils require to meet their role include:

- a designated suite of regular reports that allow them to monitor the performance of the district as described in Chapter 13
- input to key committees within the district including patient safety committee and workplace health and safety
- appropriate remuneration for their time on all occasions that they are involved with District Health Council business.

Recommendation 5.13

District Health Councils be maintained as per the *Health Services Act 1991* with appropriate remuneration for their involvement.

District Health Council members be recruited and nominated to the Minister by the Health Commission.

Council members be provided with a suite of regular reports to monitor the performance of the District as described in Chapter 13

District Health Councils be allocated a recurrent budget for Council activities.

District Health Councils meet monthly.

District Health Councils to publish an annual report.

5.8.2 Area Health Councils

The present zonal structure does not have a requirement to engage stakeholders and the community. There are some arrangements for meetings to be held with Chairs of District Health Councils and zonal management but there is no requirement to do so.

It is proposed to set up Area Health Councils to provide the opportunity for communities to contribute to decisions about service planning at the Area Health Service level and to report on the functioning of the Health Service Districts.

Membership of Area Health Councils should be drawn from District Health Councils. Each District Health Council will appoint a member for a one year term but if unable to attend should send another nominee from the District Health Council.

Recommendation 5.14

Area Health Councils be established in each Area Health Service.

The role of the Area Health Council is to advise the General Manager Area Health Services on the performance of the Health Service Districts, services planning and service improvement opportunities.

Membership of the Area Health Councils to be drawn from the District Health Councils.

Area Health Council members be provided with a suite of regular reports to monitor the performance of the Area as described in Chapter 13.

Area Health Councils to publish an annual report.

6. Corporate planning and budgeting

Queensland Health is facing a range of complex challenges which are impacting on the way it satisfies regulatory obligations and delivers services. These challenges include:

- providing quality services while facing increasing workforce shortages
- improving the quality and safety of health services
- redesigning services to improve patient focused care and improve integration with other health service providers
- managing increasing health care options, including new technologies, treatments and drugs and consumer expectations about access and quality of services
- providing services to deal with the increasing prevalence of chronic disease, including changing the way health services are delivered
- managing services to deal with an ageing and growing population. This is a particular challenge for Queensland which has the highest levels of population growth in Australia and where per capita health expenditure has traditionally always been below the national average
- recognising that the health of individuals is determined by a range of genetic, societal, and economic factors, some of which can be influenced by Queensland Health, but many which cannot
- being only one of a number of health policy makers and providers, with the Commonwealth Government responsible for a range of policies including Medicare policy, private health insurance and higher education arrangements
- having limited resources to improve health outcomes compared to the options available.

Health 2020 set a strategic direction to commence addressing the issues outlined above. Queensland Health faces the challenge of undertaking a longer term change process while at the same time needing to deal with the immediate imperatives of improving public health care services, particularly acute care and mental health services. In 2003, Queensland Health commenced the Integrating Strategies and Performance project to form a basis for strategic planning and as a tool to monitor progress on achieving change initiatives.

The range of functions and services provided by Queensland Health today are more a product of history and incremental change than a planned approach to health and health care improvement. The Queensland Government, through Queensland Health has attempted to continue to provide the full range of historic services as well as meet emerging demands, rather than provide a defined range of quality services. The range of health services provided today show significant variables in access to services across the State and the quality of services.

It is the role of elected governments, reflecting the preferences of the community, to determine the allocation of total budget resources to be dedicated to meeting health service needs balanced against other competing priorities.

Queensland Health has historically provided a cost efficient health service, particularly in its acute hospitals. A proportion of the difference is due to comparatively lower wages. Queensland Health and all public health systems are under constant pressure to meet increasing patient and community expectations of the services which should be made available using allocated resources.

Clearly defining the range of services to be provided, including reasonable expectations of what Queensland Health should be able to provide within its available resources, will always be a problem for the Queensland Government and the community. Queensland Health ideally would clarify what it is able to provide and not provide within its available funding, including identifying where services cannot be provided safely if resources are stretched too thinly.

Effective corporate planning and budgeting systems are essential to ensure available health care resources are prioritised to meet the highest levels of need, service planning capabilities are coordinated and include all State resources at the district, area health service and statewide levels. It is also important to integrate with general practice, private health care providers, non-government organisations and the community. Budget management needs to be balanced with ensuring quality and safe health service delivery.

6.1 Health service planning

6.1.1 Improving health service planning

One of the consistent issues raised at both the district and Central Office level has been the absence of a service plan for the State. Queensland Health has created a small Statewide Planning Unit to strengthen its planning capabilities. However, the capabilities of this unit are not sufficient to meet departmental needs.

It seems there has been limited coordinated service planning since the substantial work undertaken at the time of the Statewide Hospital Rebuilding Program. Districts in particular are concerned that they are potentially planning new services with no coordinated framework within which they can undertake their own service planning.

Many people have suggested that the original planning estimates used to support the hospital rebuilding program overestimated the potential benefits which would be realised from the increasing trend to same day surgery and reduced lengths of stay, at the same time as the population continued to increase. Further, the original estimates were based on increased investment in step-up/step-down and rehabilitation services but this part of the strategy was not followed through.

Queensland Health has over recent years produced a range of strategies and plans, including Child and Youth Health, Cancer, Mental Health, Aged Care and Indigenous Health. In the 2005-06 Budget, Queensland Health announced funding for a range of future programs including chronic disease management, cardiac services, Indigenous health and renal disease. These plans are developed individually, but without a broader planning framework to integrate the clinical, workforce and infrastructure needs.

Current plans are not sufficient to provide information necessary to inform longer term service capacity needs. This is now causing concerns particularly in South East Queensland which is experiencing high levels of population growth.

Service planning priorities include addressing service capacity within acute settings, developing alternative options to acute care (eg. rehabilitation and step-up/step-down places and defining the role and scope of community health) and addressing the need for additional mental health services in the acute and community settings.

A priority for Queensland Health should be the development of a Health Services Plan to integrate:

- Queensland's health need based on the burden of disease and changing demographics
- changing models of care, including identifying minimum targets for investment in population and community health models
- community values and priorities for health and health care services
- a scope of services - recognising quality and safety requirements
- set achievable targets over the short, medium and longer term.

It is envisaged that a significant proportion of new funding would be allocated according to the priorities identified in the Queensland Health Services Plan. These earmarked funds would then be allocated to area health services and clinical networks to decide (within the agreed model of care) on service priorities at the clinical level.

Responsibility for the Queensland Health Services Plan would be informed by the Area Health Services but rest with Central Office, with general responsibility for overall planning and for setting of the broad strategic direction of the department, and negotiating funding arrangements with the State and Commonwealth Governments.

Recommendation 6.1

Queensland Health to develop a comprehensive Health Services Plan for Queensland to inform clinical service planning, workforce planning, capital planning and information technology planning by the end of 2006.

6.1.2 Developing Area Health Service planning

The Review is recommending that the current zones be reconfigured to become Area Health Services responsible for amongst other things, service planning, workforce planning and the distribution of funding to health service districts within their areas.

To inform the Queensland Health Services Plan, the Review recommends that the three Area Health Services prepare Area Health Services plans. These plans would consider the following issues:

- current demographic profiles including size and distribution, socio-economic status, the burden of disease profile and age profile
- the likely demand for services including demand for acute inpatient services (by clinical service), day-only services and outpatient services, community health, mental health, population health, Indigenous health and rehabilitation services

- consider how current and future services would be connected across Area Health Services and the State, and include interaction between Queensland Health services, general practice and other health services providers
- identify the workforce needs to meet the identified needs of the plan
- identify the funding priorities for the Area Health Services, within the regional distribution formula (Section 6.2.3).

All Area Health Services will have a combination of metropolitan, regional, rural and remote services. There are particular health services planning issues for rural and remote areas which will need to be reflected in Area Health Service Plans. These include:

- maintaining the capability to provide quality and safe services
- having access to larger support centres to provide services and outreach, including matching patient flows to public transport routes
- attracting and retaining a skilled workforce, with sufficient support from the larger metropolitan areas
- planning the capital needs for rural and remote communities, eg. changing models of care when refurbishing/replacing health infrastructure and options for telehealth which would support service provision
- facilitating improved integration between Queensland Health, general practitioners, non-government providers and aged care to support good local networks
- supporting patients with transport and accommodation to access health services.

It is proposed that Queensland Health with the Commonwealth Government (with responsibility for the Medical Benefits Schedule and aged care) develop the concept of a universal service obligation for small rural communities with a population of less than 5,000 people to outline the minimum level of health service access. The universal service obligation would be reflected in Area Health Service Plans as the basis for service coordination.

Involving the community in the development of Area Health Service Plans is essential to ensure that plans meet the needs of patients but also to ensure the community is included in discussion of what it is practical and feasible to provide using the available workforce and financial resources. Area Health Councils and local District Councils will also play a significant role in providing input into the Area Health Service Plans. Area Health Service plans should be made publicly available.

Recommendation 6.2

Area Health Services to develop an Area Health Services Plan to inform State health service planning, local clinical service planning, workforce planning, capital planning and information technology planning.

Recommendation 6.3

Queensland Health in conjunction with the Commonwealth Government develop the concept of a universal service obligation for small rural communities with a population of less than 5,000 people to outline the minimum level of health service access.

6.1.3 Involving clinicians in service planning and budgets – the role of clinical networks

Clinicians across the State have strongly expressed their desire to become more involved in the decision making regarding the allocation and prioritisation of resources across the State, including using new funding to influence changes to clinical practice. Clinicians have expressed concerns that service delivery priorities which had been established did not match where they considered there to be the greatest need, and were unsure of the decision making processes.

Queensland Health has been developing voluntary clinical collaborative or networks over several years to focus on quality and safety, improve service planning and standards of practice. These include the cardiac collaborative, renal collaborative and stroke collaborative. The Southern and Northern Zones have used collaborative models to some degree to better coordinate the placement of new services.

New South Wales and to a lesser extent Victoria have been developing the clinical network concept to strengthen the planning and funding allocation roles of clinicians and to improve the interface between clinical decision making and administrators.

“The Greater Metropolitan Transition Taskforce process has created a fundamental change in health service planning in New South Wales. This is being achieved by providing meaningful clinician engagement in planning and decision making by broadening the base of this engagement. There has been real diversification of the involvement which previously didn't exist. The process has diluted the influence of traditional networks and vested interests.

This broad based engagement, which includes all health professional groups, is fostering a high level of cooperation and consideration of all aspects of care delivery. One discipline's priority is now more likely to be seen in the context of the whole rather than the discipline specific component. In other words, the process has exposed a greater number of clinicians to the 'bigger picture' of health”.

Embracing Change: Report of the Greater Metropolitan Transition Taskforce 2004

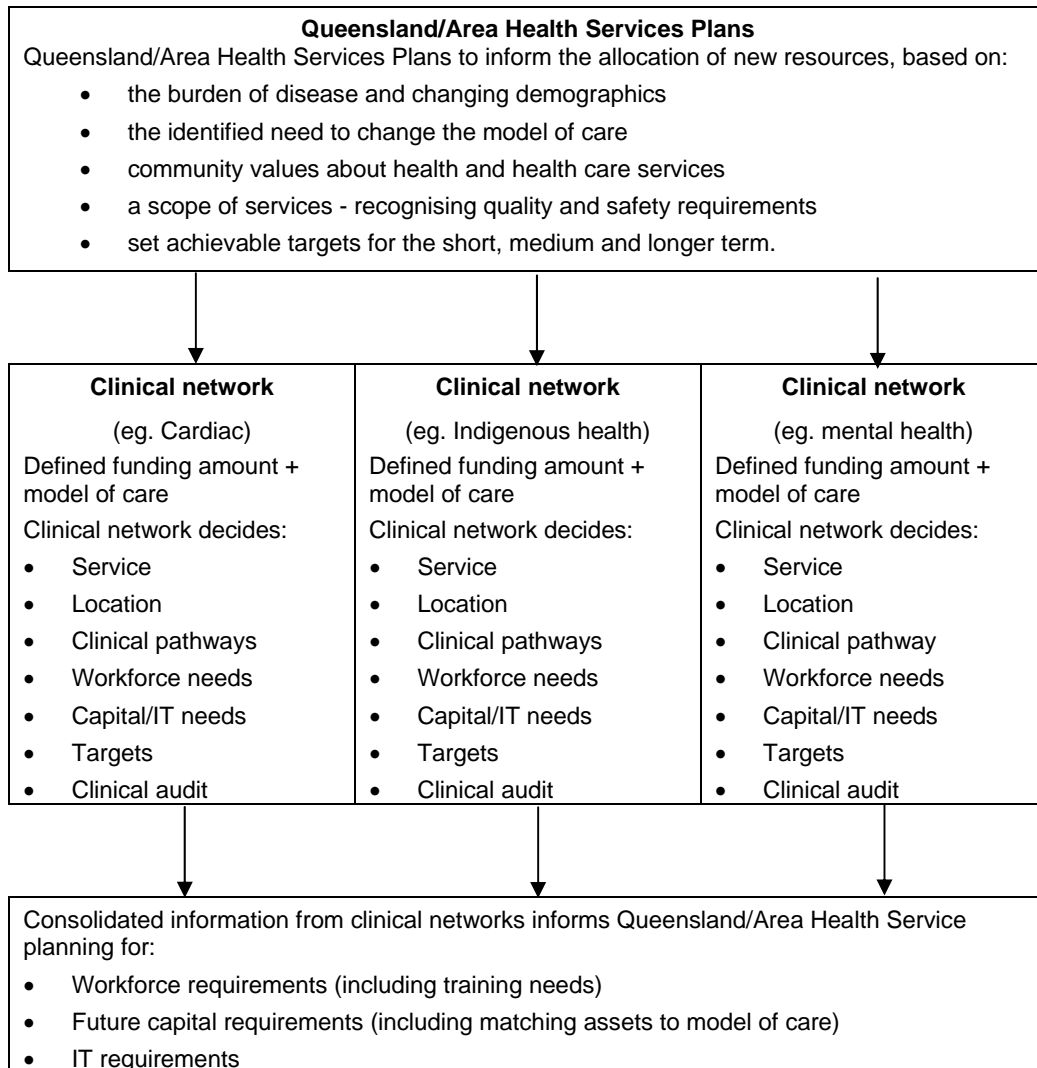
Building on the experience in Queensland to date and the evidence coming from New South Wales, it is proposed that a wider range of clinical networks be established over time, some at the statewide level, some at the Area Health Service level, to take a leadership role in improving the quality and safety of services, developing models of service delivery and clinical pathways to support the allocation for new funds. These models would be used to inform the Queensland and Area Health Service plans.

Clinical networks would play an increasing role over time to:

- develop clinical service plans and targets for their specific areas within their funding allocation
- develop models of care to improve service delivery, consistent with the Queensland Health Services Plan eg. minimum amounts of funds to be allocated based on the model of care - prevention, primary/community care
- allocate targeted funding to areas of highest need or potential health gain at the district level. The clinical networks may link the allocation of growth funding to quality and safety and practice improvements including implementation of clinical pathways
- monitor the outcomes being achieved through the new resources, including reporting on the achievement of clinical performance targets.

To be effective, the clinical networks would need to have a level of funding certainty to allow for some longer term planning. The clinical services plans would be used to inform broader planning by Queensland Health for workforce, capital and information technology requirements. Plans and funding allocation advice from the Networks would be provided to Area Health Services and implemented by District Health Services.

The relationship between health service planning and clinical networks is outlined in the diagram below.



Subjects for networks should be selected from a combination of strategic and operational priorities that would be broadly determined by:

- a high impact disease burden eg high incidence, mortality, or morbidity
- the presence of significant inter-district variances in clinical outcomes or access inequities, rapidly increasing demand for services, or other substantial gaps between evidence based best practice and current practice
- the ability to recruit clinician leaders with the ability to generate solutions for these problems.

Appendix 6.1 – Leadership and clinically managed networks – prepared for the Review by Professor Michael Ward, provides detail about the operation of clinical networks in other jurisdictions.

Recommendation 6.4

Clinical networks to play an active role in service planning and in the distribution of available funding to support improving clinical practice.

6.1.4 Application of the Clinical Services Capability Framework to provide safe services

In July 2004, the Clinical Services Capability Framework for public and licensed private health facilities was approved for staged application across Queensland Health. The Clinical Services Capability Framework defines the minimum support services, staffing, safety standards and other requirements to ensure safe and appropriately supported clinical services standards. The framework serves to:

- provide a standard set of requirements for most acute and sub-acute services provided by public and private facilities. The framework is currently being expanded to include non-acute services.
- provide a consistent language for health care providers and planners to use when describing health services and planning service developments.

Had the Clinical Services Capability Framework been in place, it would have been more apparent that some of the procedures being performed at the Bundaberg Hospital by Dr Jayant Patel were outside the hospital's capabilities eg. Bundaberg Hospital would not meet the clinical requirements to perform head and neck surgery eg. oesophagectomy.

Districts in conjunction with Area Health Services should perform a detailed review of their services against the framework, identify gaps in support and core service provision, and develop and implement risk management strategies. In some instances this may mean that Queensland Health will need to withdraw services from certain locations in the State, or provide enhanced support to improve quality.

As far as possible, Queensland Health should seek to provide health services to support local needs in local areas and support through hub and spoke arrangements to larger, more specialist health services. Situations will inevitably arise where the community and a district will disagree about the continued provision of a service eg. maternity services. Anecdotally, the Review has been told of instances where Government has made commitments to continue a service based on community pressure despite advice the service is unsafe to continue. This causes increased risk of adverse events and considerable stress for clinicians who continue to provide services in these circumstances.

Queensland and Area Health Service planning must support districts to provide safe services consistent with the Clinical Services Capability Framework. Where services cannot be provided locally, planning and providing adequate transport and accommodation is essential to allow patients to access health services away from their local communities.

Area Health Services and districts will need to work closely with Area/District Health Councils and the community where changes to service configuration are required to ensure the safety and quality of services.

Recommendation 6.5

Queensland and Area Health Service planning must take account of the minimum requirements necessary to provide quality and safe services, consistent with the Clinical Services Capability Framework.

6.1.5 Service planning for South East Queensland

The provision of public health services in South East Queensland will be the responsibility of both the Southern and Central Area Health Services and eleven districts. South East Queensland is the area of highest population growth in Australia, presenting significant planning and service delivery challenges for Queensland Health.

Under the current model of health service delivery, acute hospital infrastructure in South East Queensland seems to have reached a capacity constraint with high occupancy levels reported across the region. The Review is recommending that support be provided for hospitals to engage in some patient flow redesign to improve the functioning of current facilities in the short to medium term (Chapter 7).

Health service planning and infrastructure development in South East Queensland has often been influenced strongly by historical patterns of hospital provision, rather than a fully coordinated approach to service delivery. Clinicians and the community have formed strong bonds with individual hospitals making changed delivery complex. For example, Queensland has traditionally had two children's hospitals, the Royal Children's Hospital and the Mater Children's Hospital with very strong community links. However from a long term sustainability perspective, it may have been more effective to review the respective scope of services for these two hospitals prior to redevelopment. Similarly, there has been continued discussion about the consolidation of some tertiary health services of the Royal Brisbane Hospital and The Prince Charles Hospital over many years. These issues are still unresolved, despite the current redevelopment of The Prince Charles Hospital.

Service planning for South East Queensland will need to include planning in greater detail. The new services are to be provided through new health facilities identified through the *South East Queensland Infrastructure Plan 2005* and supporting services such as sub-acute care, rehabilitation services and community mental health options.

The development of Area Health Service Plans for the Southern and Central Area Health Services will need to address the wide service network arrangements across South East Queensland, including:

- identifying where super-specialities services are to be provided over the longer term to avoid duplication of services eg. tertiary paediatric services (Queensland's population is not large enough to support two specialist children's hospitals), transplant services, burns, gynaecological oncology.
- expanded elective surgery services at the QEII Health Service District and the Bayside Health Service District.

- improving integration between health service districts eg. community health services for the Princess Alexandra Health Service District are provided from the QEII Health Service District, the Royal Brisbane and Women's Health Service District's community health services are provided by The Prince Charles Health Service District.

Clinical networks will play an important role in coordinating the clinical services required across the region.

Recommendation 6.6

Southern and Central Area Health Services to work closely to develop a health services blueprint for South East Queensland by the end of June 2007.

6.1.6 Review of current health services

Within the context of limited resources compared to community demand for services, it is important that Queensland Health focus primarily on providing publicly funded health services where:

- it is to meet a specific government policy objective and/or
- there is highest community health need and/or
- where there are no alternative providers of the service and/or
- Queensland Health is the most cost effective provider of the services.

There is a need for Queensland Health to review the continued delivery of some current services to ensure it is best able to deliver services such as acute public hospital services. Residential aged care services and direct provision of home and community care services are areas where non-government organisations may be able to provide the service more effectively.

Residential aged care services

Queensland Health currently owns and operates 20 residential aged care facilities, representing seven percent of residential aged care placements in Queensland, with a heavy concentration on high care needs. The Commonwealth Government has responsibility for regulation, planning and funding of aged care services. Queensland has the second highest level of State Government provision within Australia, after Victoria.

Commonwealth Government funding, provided for the provision of the current number of residential aged care services, does not meet Queensland Health's cost of providing residential care services. It is estimated that Queensland Health provides an additional \$25 million per annum to support its residential aged care services.

There are a range of non-government and private providers in Queensland who have expressed an interest in acquiring Queensland Health's residential aged care facilities and would assume management responsibility for the existing beds, as well as progressing the development of residential care places which have been approved for Queensland Health but are yet to be developed.

The Review is very aware that contemplating changed ownership arrangements may be distressing to patients and their families, as well as the staff currently employed by Queensland Health in these residential care facilities and the need to ensure the ongoing

provision of quality care. Any changes would need to be managed to minimise the disruption to patients and staff, including offering current staff continued employment in the public sector where possible.

Recommendation 6.7

Queensland Health should sell its residential aged care places and where appropriate associated facilities.

Recommendation 6.8

Queensland Health review its continued provision, or scope of provision, of some health services where there are alternative providers who may be able to provide the service more effectively or provide services to areas of highest need (eg. provision of home and community care services).

6.2 Queensland Health budget systems

6.2.1 The budget systems context for Queensland Health

Queensland Health's budget for 2005-06 is \$5.4 billion. Queensland Health's budget has grown at approximately 7 percent per annum over the last ten years. The major cost drivers for Queensland Health have included:

- increasing labour costs, due to enterprise bargaining commitments
- increasing costs of non-labour items including pharmaceuticals and other medical supplies
- increasing demand for services across the community and acute sectors due to population growth and ageing, but also due to changes in medical techniques and technology which make a wider range of health services accessible for the community.

Queensland Health receives funding from the Queensland Government (57 percent), Commonwealth Government (38 percent) and from its own sources (5 percent), including revenue from the Department of Veterans' Affairs and private patients treated in public hospitals. Funding from the Queensland and Commonwealth Governments is indexed annually for population growth, cost escalation and service enhancement.

Since 2003-04, Queensland Health has had a level of funding certainty, with the implementation of an enhanced Queensland Government growth funding model and growth funding provided under the Australian Health Care Agreement with the Commonwealth Government.

Queensland Health receives numerous Specific Purpose Payments (SPPs) from the Commonwealth for health services. SPPs are tied grants which the State must spend on a particular area. The largest SPP is the funding provided by the Australian Health Care Agreement for public hospital services. Other SPPs cover areas such as high cost drugs, blood services, public health services and home and community care services. Some of these payments come with specific conditions including requirements that the State match Commonwealth funding which limits Queensland Health's flexibility to direct its own discretion.

Most SPPs involve extensive reporting and monitoring requirements which can impose significant administrative burdens on staff both in Central Office and the districts. Renegotiation of SPP agreements can also cause delays in the flow of funding and adversely impact on the continuity of service delivery. Further, Commonwealth funding is often adjusted close to the end of the financial year resulting in substantial rollover of funds to future years.

Work has been occurring between the States and the Commonwealth to streamline SPP reporting arrangements and consolidate the number of different payment streams. This includes developing performance reporting at a strategic level to reduce the overall administrative burden and ensure maximum flexibility in responding to changing service delivery needs.

Internally, Queensland Health uses a historical funding model to allocate budgets which are indexed annually for wage and non-wage cost escalation. New initiative funding provided through the State government budget process is managed corporately, through the Board of Management which consists of the senior executive directors of Queensland Health.

Queensland Health's budget strategy in recent years has been driven by:

- delivering Queensland Government election commitments
- implementation of other Government priorities eg. child safety reforms
- meeting unfunded components of the additional costs arising from EB5 (the State's share of nurses and VMO wages were fully funded and partially funded for non-nurses). Further, Commonwealth government wage-cost indexation (approximately 2.1 percent) falls well below the average cost escalations each year including meeting the costs of enterprise bargaining rounds 3.5 percent).
- meeting the escalating costs of services, with health inflation running at approximately 1.6 percent above CPI in 2002-03.
- providing funding to meet the recurrent costs associated with new capital projects and to meet some recurrent costs of capital replacement.
- meeting savings targets through the implementation of initiatives such as shared service provider arrangements which will flow back to Government. The savings have been relatively small to date but will grow to \$12.7 million by 2009-2010.

These factors have limited the ability of Queensland Health to use growth funding to meet increasing service delivery demands the primary purpose for which it is intended.

To meet its budget pressures, Queensland Health has managed its budget centrally. District budgets are allocated based on historical budgets. With the exception of new initiative funding, non-labour escalation and enterprise bargaining funds are provided through the annual budget process. Districts have been left to manage within historical budgets with small increments for additional costs.

Allocation of funding for new initiatives is based on internal budget submissions for pressures identified by the districts/zones. The time taken to develop and determine funding allocations for new policy and priority areas has meant delays in providing

advice to districts about their annual budget increases and Queensland Health underspending its annual budget and delaying expenditure to future years.

The historical budget arrangements have a number of issues including:

- district budgets have not been significantly reviewed to account for changes in demographics or patient flows. Queensland Health has attempted to match budget growth funds to areas of highest population growth but there is still significant inequity in base budget allocations in the State. Districts such as the Gold Coast, Logan, Redcliffe-Caboolture and Sunshine Coast are comparatively under funded when compared to more established areas such as Brisbane North and Brisbane South.
- the historical funding model combined with a relatively tight fiscal position has provided districts with limited flexibility to significantly change service levels and models of care
- there is a significant gap between operational and capital investment decision making. The limited approach to health services planning does not link capital and recurrent expenditure
- the historical budgets have provided a weak performance management function – the main performance criteria has been budget integrity with limited attention to whether meeting these targets were achievable given the service demands in the district and the lack of defined service scope. District deficits have been present in Queensland Health for a number of years.

6.2.2 Reforming budget allocation arrangements

The Review considers that the current historical budget arrangements should be reviewed over time and transitioned to a budget allocation model which:

- devolves accountability for budget, service output and health outcomes closer to the patient
- facilitates improved integration of strategic planning, services planning, investment planning and performance management
- responds to the variability in the demand for health services both within years and across years (seasonal fluctuations and population growth)
- balances the investment between acute care and community/public health based on an evidence based approach
- is clearly understood by providers and the community (transparent).

There are three main budget allocation arrangements being used in health services across Australia.

- Regional distribution formula – based on population distribution and weighted for issues such as health need, geography and local socio-economic conditions. This model is used in New South Wales.
- Casemix - funding is provided for the amount and type of work that is performed by each health service. A profile of cases and service volume provided in

previous years is used as a guide to estimate the cost for providing future services. Casemix is used predominantly for acute services, with alternative funding arrangements required to deal with community health, mental health and more specialised acute services.

Casemix has been used extensively by Victoria, and to a lesser extent by South Australia, the Northern Territory and Tasmania. New South Wales uses casemix as a management tool sitting under the regional distribution formula. Queensland Health has used casemix to manage its elective surgery funding arrangements.

- Historical funding arrangements adjusted annually to meet set policy objectives.
- Combination of the above arrangements.

It is proposed that a new approach to budget allocation be adopted for Queensland Health, which devolves more operational budgeting decisions to Area Health Services, and more clearly links budgets to a population and casemix based method of funding distribution.

6.2.3 Implementing a regional distribution formula

The Review recommends that Queensland Health commence moving to a regional distribution formula for allocation of funding between the Area Health Services. The regional distribution formula should be based on:

- population characteristics, including socioeconomic status, age/sex, indigenous population, cross-border flows
- health needs and other demand factors
- remoteness
- other relevant factors.

The Review has been provided with a study undertaken by Queensland Health in 2004, based on the regional distribution formula used in New South Wales and adapted for Queensland conditions. The Review also notes that the study undertaken was preliminary only and that any model implemented for Queensland would require further work and consultation before it could be used as a decision making tool.

The preliminary results provided to the Review show that at the Area Health Service level, there is a relatively even distribution of funding (plus or minus one percent of the overall distribution arrangements).

Within Area Health Services, there is significant variability of resources. The Review does not propose that the current base budgets of individual districts be adjusted to reflect the regional distribution formula. The Review recommends that the Area Health Services use the regional distribution formula to consider the distribution of growth funding over time, with the objective of moving to a more equitable allocation of the budget arrangements.

This is likely to take a number of years and would need to be sufficiently flexible to take account of the need for tertiary and quaternary services where high levels of funding are required.

Recommendation 6.9

Queensland Health develop a resource distribution formula which takes account of factors including population, geographic location and health need for the basis of the allocation of funding to Area Health Services from 1 July 2006. Area Health Services to use the resource distribution formula as a guide to the allocation of growth funding to districts, to improve the equitability of resource allocation within five years.

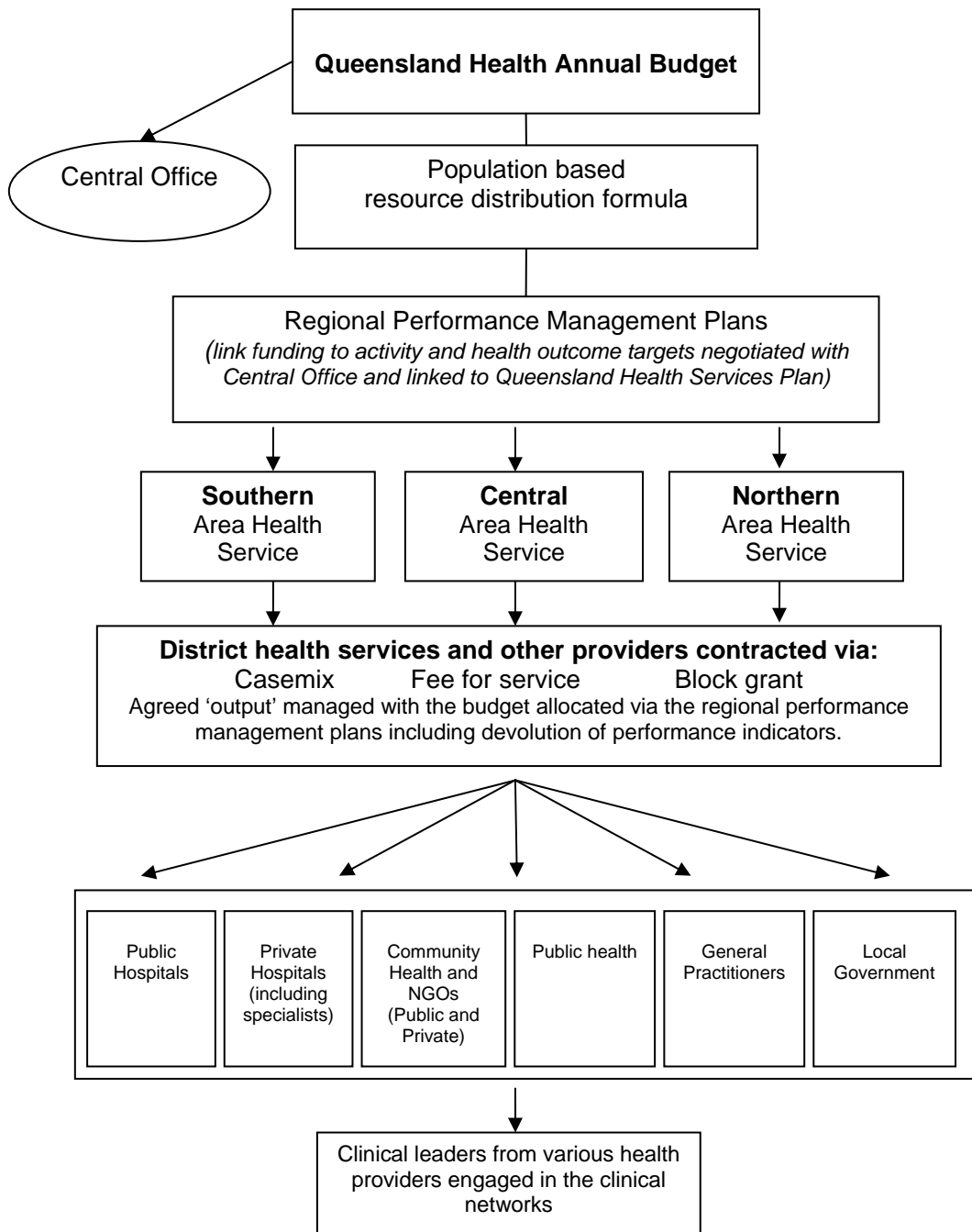
6.2.4 Role of Central Office in budget allocation and management

As outlined in Chapter 5, Central Office will be responsible for, amongst other things:

- the negotiation and acquisition of funding from State and Commonwealth government, including:
 - negotiation of funding arrangements to meet enterprise bargaining costs
 - government election commitments
 - advancing departmental and whole-of-Government new initiatives through the annual Budget process
 - negotiation of SPPs
- development of the resource distribution formula and casemix models to be used as a guide for allocation of funding to Area and District Health Services
- negotiation of Area Performance Management Plans to link funding to activity and health outcome targets and the Queensland Health Services Plan
- identification and management of corporate financial risk, including expenditure monitoring by Area Health Services and
- providing advice on a range of technical financial issues including GST, compliance with SPP requirements and other financial regulatory policy
- public financial reporting, including compilation of budget papers and Annual Reports.

The proposed approach to allocation of funding within Queensland Health to Area Health Services and districts is shown in the following diagram.

Proposed budget allocation approach for Queensland Health



6.2.5 Devolve budget distribution responsibilities and accountability to Area Health Services

Under the new governance and accountability framework for Queensland Health it is proposed that the Area Health Services will play a more significant role in determining the budget distributions for their health service districts. Central Office would allocate recurrent funding allocations to Area Health Services based on the regional distribution formula and any other specific funds provided by the Government with the budget process.

The departmental capital budget will continue to be managed centrally, however, districts and health service areas will have a greater role in the prioritisation of capital works projects and associated funding allocations. More details are provided in Chapter 11.

The Area Health Services would be guided in its budget distribution by:

- imperatives to meet Australian Health Care Agreement commitments to provide matching funding for hospital services and Home and Community Care Services, as well as any other specific arrangements negotiated with the Commonwealth Government
- allocating resources to meet the costs of enterprise bargaining at the district level
- meeting specific government priorities, potentially defined through the annual budget process or through the statewide services plan. In these instances, funding decisions would be advised by clinical networks, if possible
- taking account of the specific local needs of individual districts eg. increasing demand for emergency department and other local services.

It is proposed that Area Health Services will develop performance agreements with the districts for the delivery of health services. Performance agreements would include specific targets for areas such as activity, waiting times, implementation of clinical practice improvements (identified by the clinical networks). Area Health Services may also choose to contract with private hospitals, the non-government sector or general practitioners for the provision of some health services. The proposed funding allocation framework is outlined on the following page.

While Queensland Health in recent years has tended to focus heavily on budget containment at the expense of other areas of its service, good budget management is still an essential feature of operating within the public sector. One of the perceived failures of regionalisation in the early 1990s was insufficient budget management, with regions recording significant deficits.

In recent years Central Office has taken responsibility for global budget management including management contingencies to ensure the department can balance its annual budget. This has included managing over and under expenditure across districts, including offsetting district deficits against under expenditure in statewide services and deferrals in Commonwealth Government revenue. Devolution of greater budget flexibility and responsibility to Area Health Services will need to include consideration of strategies which concentrate on health service delivery but still maintain budget controls within the overall funding arrangement.

Area Health Services should also give consideration to those budget issues which are best managed at an area level compared to a district level. Conversely, Area Health Services together with districts might consider the establishment of some Area Health Service funding arrangements to be accessed by districts as required to deal with special cases which are unpredictable at the local district level but more manageable across a larger area.

Recommendation 6.10

Responsibility for budget allocation and management for health service delivery to be devolved to Area Health Services.

6.2.6 Using casemix funding for hospital services

It is proposed the Area Health Services use casemix as a management and funding tool to measure the performance of district acute hospital services, and set activity targets for districts in the delivery of acute hospital services. A casemix approach has the benefits of:

- relating funding to actual services provided, including identifying the full cost of service delivery including on-costs such as consumables, pharmaceuticals and a reasonable administrative component. This should overcome the issue of funding being provided to a district for more doctors, but no funding provided to provide the nursing and other support.
- providing a method for estimating a reasonable level of service which should be able to be provided by individual districts from within the funding provided.

In Victoria and New South Wales medical, surgical (elective and emergency) and other hospital services are funded based on the casemix approach. Casemix is not suitable for all services provided in the hospital environment including training and development, certain specialist services or reform initiatives. In Victoria in 2004-05, casemix funding accounted for approximately 60 percent of hospital services and 95 percent of all patient separations⁵⁵.

Casemix does not provide a model suitable for mental health, super specialities or community health or for smaller hospitals. Funding for these services would need to be provided through block funding arrangements.

Casemix has been used in Queensland Health to distribute the funding available for elective surgery only. Within the current budget framework, arrangements such as quarantined funding for the elective surgery waiting lists are seen to weight the importance of some areas of the health service more highly than others. This is seen to have causing unintended consequences eg. elective surgery emphasised to the detriment of medical or other services when the priority should be based on clinical need rather than meet budget imperatives.

⁵⁵ Victoria – Public Hospitals and mental health services: Policy and funding guidelines 2005-06, Department of Human Services

While Government will always set priorities and targets for achievement of certain objectives eg. reduction in elective surgery waiting lists, funding arrangements should as far as possible provide districts with the maximum flexibility and incentive to achieve these objectives. Victoria has recently implemented an incentive pool for hospitals which meet certain targets (eg. waiting list bonuses).

Casemix has caused some concerns when implemented in other states, notably Victoria when it was implemented in the context of significant budget cuts in the early 1990s. However, casemix is now generally accepted to be working well and provide appropriate incentives to hospitals for the level of services it provides.

Compared to the historical funding base a casemix model should be more reflective of the number and acuity of patients being treated. While casemix is more reflective of activity it will still function in the context of an annual budget constraint.

As with the regional distribution formula, there is currently significant variability between hospitals in terms of the allocation of funding based on casemix. It is not proposed that historical base budget be revised, but new growth funding and performance targets be used to move to a casemix model over several years.

Recommendation 6.11

Area Health Services to move to a casemix funding model as a tool to set targets for acute hospital services and to measure performance with casemix funding phased in over several years.

6.2.7 Providing increased budget certainty to districts

One of the challenges indicated by districts has been the need for increased budget certainty at the local level to support future planning, including the appointment of staff on a permanent rather than temporary basis. While historic budgets provide some guaranteed certainty about the level of funding and funding to cover additional enterprise bargaining costs, supplementation has been managed centrally while adjustments for cost escalation and other budget pressures have occurred in a less routine manner.

The increased funding certainty provided through the State funding formula and the Australian Health Care Agreement has provided Queensland Health with the capacity to improve longer term budget planning at the Central level.

To the extent possible, Area Health Services should seek to provide increased funding certainty to districts, consistent with the phasing-in of the regional distribution formula and casemix funding. Consideration will need to be given to the level of financial risk which will be managed corporately or at the Area Health Service level.

Recommendation 6.12

Area Health Services to provide funding certainty to districts, consistent with the phasing-in of the regional distribution formula and casemix.

6.2.8 Budget systems to support clinical service delivery

Budget management within districts is developed to clinical, operational and business unit levels, with budget management and financial monitoring taking a high priority throughout the department. At the clinical and operational unit levels, staff have indicated budgets are very tightly allocated and they have limited discretion to invest in improving local areas.

An ongoing tension exists across districts in particular between clinicians and administrators regarding patient care and the number or level of services to be provided and the need to balance the budget. Clinicians have expressed significant frustration considering that their clinical judgement is being overridden by administrators. There is a general perception that aside from punitive measures there is little incentive to improve budget management. In some instances business cases while of themselves a sensible management tool, seem to have become a means of administrators delaying or avoiding budgetary decisions rather than meaningfully engage with the clinical and operational streams about the availability of funds or alternative options to address problems or achieve change.

The distribution of the budget across functional streams (eg. nursing, medical, operational services rather than clinical lines (eg. surgery, medical, maternity) has also created tensions between professional streams and little incentive for multi-disciplinary teams to solve financial issues or clinical issues arising from the budget constraint. In some cases, the division of budgets across a variety of cost centres makes it difficult to clearly identify where increased investment in some areas may reduce costs in others.

At the business unit level, the organisational and culture change process must provide the incentives for team based problem solving to make best use of available resources. Organisational change will also focus on devolving decision making closer to the patient, with managers to have increased authority to funding allocation decisions with their financial delegations.

Recommendation 6.13

Budget management and team development within districts is to provide improved incentives for clinicians and administrators to work more closely together in the delivery of patient care.

6.2.9 Linking funding and performance

Budget monitoring has been one of the key monitoring systems within Queensland Health over the last number of years. While districts and Central Office have closely monitored over and under expenditure, the link between funding, activity and health outcomes being achieved is not as well developed.

The role of performance management needs to be significantly strengthened and refocused to ensure that resources are being best utilised to improve health outcomes. This will include evaluation of service initiatives that will inform future investment decision making.

Chapter 13 outlines a new system of performance monitoring and reporting for Queensland Health, including performance agreements between the:

- Government and Director-General
- Department and Area Health Service General Managers
- Department and senior executives within Central Office
- Area Health Service General Managers and District Health Service managers.

The performance monitoring system is designed to build a stronger link between the funding provided within Queensland Health and the health care outcomes being achieved by the department. Chapter 13 discusses the proposed changes in detail.

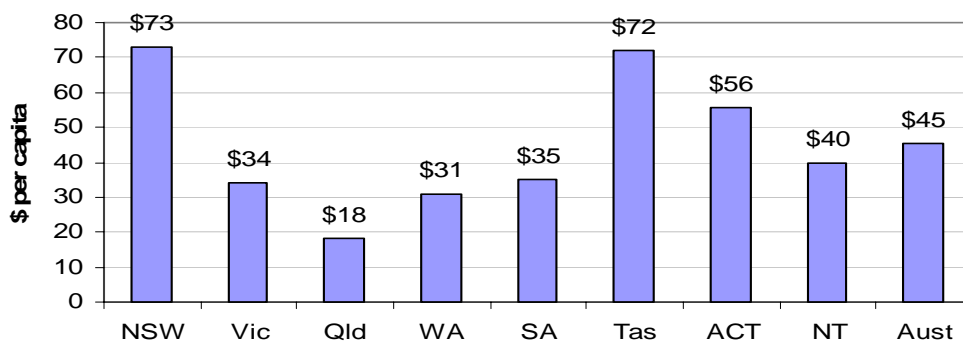
6.2.10 Patient contributions to health care

The issue of introducing co-payments or some form of charging arrangement in the public health system has been identified as an option for assisting in managing future health care costs in Queensland.

Queensland has had a long history of free provision of public hospital services. The Queensland Government is also a signatory to the Australian Health Care Agreement 2003-08 which commits to the policy of providing a free public hospital services to all Queenslanders.

Compared to other states, Queensland collects 60 percent less than the national average from patient revenue, the lowest level of revenue per capita raised from patient revenue (including private patients in public hospitals). This is due partly to fewer private patients treated in public hospitals than in New South Wales, Tasmania and the Australian Capital Territory, due to Queensland’s well developed private sector. Other variations include the wider availability of free outpatient clinics compared to New South Wales and Victoria.

Patient revenue per capita, public hospitals, 2003-04



Source: AIHW Australian Hospital Statistics 2003-04

If Queensland Health were to collect patient revenue at the same rate as the average of other states and territories, this would equate to an additional \$115 million per annum in funding for public hospital services.

A number of reviews have been undertaken within Queensland Health to identify the potential to increase patient revenue. It is recommended Queensland Health consider whether the areas where a patient contribution to care may be appropriate (within the principles of the Australian Health Care Agreement). It is essential that patient contributions do not become an impediment to patients receiving the care they need.

Potential options for patient co-payments could include:

- outpatient services. Under the Australian Health Care Agreement, Queensland Health is committed to providing free outpatient services at the same level as was provided in 1998. Outpatient services above this level may be the subject of fee for service arrangements with a level of reimbursement from the Medical Benefits Scheme.
- review of charging arrangements for private patients (current private patient fees do not cover the full cost of private services)
- increasing the cost of pharmaceutical services to the same level as those charged by community pharmacy under the Pharmaceutical Benefits Scheme
- co-payments for Home and Community Care services provided by Queensland Health (non-government sector already co-payments charges).

Recommendation 6.14

Queensland Health to review and increase patient fees and charges where possible, in the context of commitments under the Australian Health Care Agreement.

6.2.11 Queensland Health Innovation and Collaboration Fund

The centralised operations of Queensland Health have, over time, stifled the development of individuals to behave in flexible innovative empowered ways to resolve problems and implement solutions.

In the revised organisation structure there are opportunities for clinicians to influence health service outcomes through clinical networks, Area Health Services and District Health Services. It would also be of value to support projects that promote partnerships with organisations external to Queensland Health and which promote innovation in the workplace or new workplace reform. Projects which promote or practice new ways of delivering services to groups with special requirements should be encouraged.

It is proposed that a Queensland Health Innovation Fund be established with an annual budget of \$15 million. At this stage the dollar amount to drive innovation is indicative only and will require future review. The fund should be directed to best practice and new methods of service delivery and foster innovative solutions.

The fund will be open to initiatives proposed by individual employees of any category or by teams or groups of clinicians, and will be used to promote partnership arrangements across traditional boundaries. Funds will be directed towards projects and pilots that make a significant contribution to enhanced health service outcomes in areas such as:

- a new patient-centred approaches to health care
- improving quality and safety of patient care

- innovative workplace practices, including those directed to limiting red tape and overheads
- new models of health care and service delivery
- new approaches to the delivery of health care in rural and remote Queensland.

Allocating the funding should be the responsibility of the Area Health Services. The selection of projects could be made by a committee that includes a member of the Area Health Council, representative of the Development Centre, District Manager, Clinical Network representatives and the General Manager Area Health Service. There needs to be a commitment up front that if a pilot is successful recurrent funding will be available to implement and to sustain changes.

Queensland Health has had two programs that have attempted to promote innovation. The major learning from these programs was that seed funding on its own is not enough to drive innovative. It is important to have funding for effective implementation and sustainability.

Innov8 and Activate 8 were introduced in 2005 to drive innovation. This concept was well accepted by Queensland Health staff with over 600 ideas submitted for assessment. The innovation fund would build on these concepts. It is proposed each Area Health Service be responsible for the progression of innovation arrangements, including Innov8 and Activate8.

Recommendation 6.15

A Queensland Health Innovation Fund be established with a \$15 million recurrent budget.

7. Improving patient care and health services

Improving patient care and access to health services is the key challenge facing Queensland Health today. Common concerns expressed to the Review from patients and the community related to:

- access to acute health services including waiting times for outpatient services and elective surgery, and in emergency departments
- the need for improved coordination between Queensland Health and other providers including general practitioners and non-government organisations
- accessing services in rural and remote areas
- health inequities between Indigenous and non-Indigenous Queenslanders
- access and care options for those with mental health conditions including community based mental health services
- access to oral health services.

A range of strategies are recommended below to improve the systematic approach to addressing these issues.

7.1 Improving patient centred care and patient flows

Patients treated in Queensland public hospitals generally indicate they are satisfied with the treatment they receive and are complementary of the professionalism and dedication of staff (89 percent based on patient satisfaction surveys). However, there are also a number of issues which cause frustration and distress to patients and staff, limit hospital efficiency and pose risks to patient safety including:

- patients being placed on a long referral list to see a specialist, especially when there is no clarity of waiting time and when treatment other than surgery may be required
- cancellation of scheduled elective surgery times – often at the last minute, sometimes twice (reportedly due to emergency surgery, decision of specialist to address another more urgent priority, theatre nursing staff being unavailable to extend theatre times, etc)
- all patients in some clinics being given the one appointment time on a specific day, leading to frustration because of length of time patients are kept waiting. This is worsened when doctors arrive late for clinics because of other priorities
- receiving care from multiple doctors and nurses while in hospital – patients indicated a desire to explain symptoms and problems to one doctor once and expressed concern that they often do not see the same nurse twice
- being moved from one ward to another, sometimes more than once in some cases, due to overall congestion and limited bed numbers
- discharge uncertainty - either too early, delayed or sudden and difficulty arranging transportation home
- long lapse times before letters from specialists are forwarded to general practitioners about follow up care
- lack of home or community support following discharge from an acute hospital.

Staff working in these environments also feel pressured and concerned they are not providing the best possible care. Some of these issues are due to capacity constraints within the public hospital system. Providing more doctors, more nurses and more beds is an obvious and important part of the solution. However, in a time of workforce shortage, it may not be feasible to increase clinician numbers significantly in the short term.

The Review gathered clear evidence from Queensland and other jurisdictions that there is significant potential, particularly within acute hospitals, for business process redesign to improve the responsiveness of services. This includes better models of referral from the general practitioner to the specialist, pre and post acute care in local settings, and facilitating teams involving patients and clinicians working at the local level to improve service from a patient perspective. Examples of work practice review and better integration of technology were observed in some of the districts visited including hospital wards and emergency departments. However, the approach was not as well developed or universally applied as one would have expected, based on experience with other industries.

While patient flow redesign is often achieved through simple arrangements, it is not always easy to change in busy workplaces where clinicians are under continued pressure to meet patient needs. Throughout the district visits, clinicians identified potential changes which could improve patient flows and care, but felt they were too busy or insufficiently resourced to design and implement these changes properly.

The Review had the opportunity to visit hospitals in New South Wales and Victoria which have been actively supporting patient flow improvement programs with their clinicians. Examples are provided below.

The Maggie's Journey: An approach to patient centred care in the New South Wales Hunter New England Area Health Service

The Maggie program has been a major reform with the objective of walking "Maggie" (a hypothetical patient) through standard entry points to healthcare and investigating the patient experience.

John Hunter Emergency Department

The Emergency Department (ED) Project began in May 2002 with a 14 week diagnostic and solution design process. During this time, a range of analysis activities were undertaken to understand the issues affecting emergency department patients and staff. These activities included interviews with staff and patients, process mapping sessions, patient tag-alongs, data analysis, and review of external reports and internal reports and surveys.

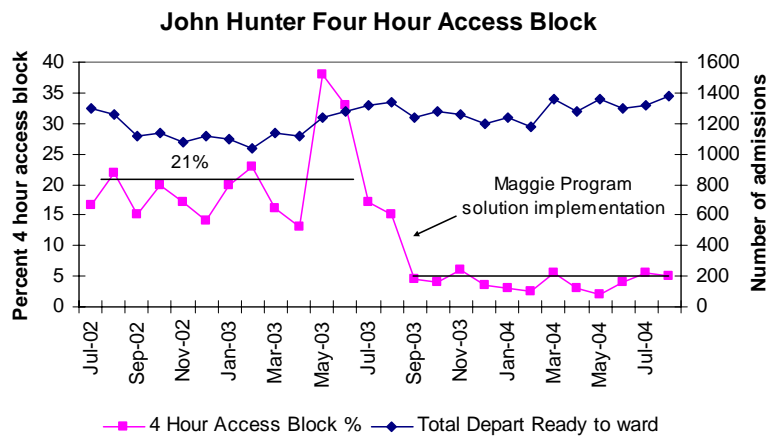
The problems:

- "Time to treatment" varied throughout the day. 6 percent to 10 percent left the ED in frustration. A number of attendances at the ED could have been treated elsewhere.
- Staff were under pressure and clearly frustrated with current working conditions. Staff rostering and staffing levels were not always aligned with peak patient demand. Acts of aggression toward staff seemed to occur during the 'waiting' phase of a patients stay.
- Delays in the availability of imaging and pathology services impeded patient diagnoses.
- Separate and complex work processes inhibited staff coordination and teamwork.
- IT and communications systems were often ineffective or inefficient.
- Access block and slow processing added to workloads and adversely affected patient care.
- Limited availability of transport led to delays in patient departure.

The solutions:

- Triage as the first point of contact and improved communication within the waiting environment reduced patient confusion and anxiety.
- A Rapid Emergency Assessment Team was formed to assess and stream patients quickly with a “Fast track Zone” to treat ambulatory patients, with treatment and testing commenced earlier.
- Patient care teams and zones were developed to improve medical-nursing-allied health teamwork within the ED and reduce fragmentation of care. Nursing roles were expanded to include nurse initiated tests and treatment.
- Telephone call handling/communication was handled by a designated communications clerk and bedside clerical and associated technology was introduced.
- A Nurse Unit Manager assumed responsibility for managing patient flow through the department and patient referrals - traditionally the responsibility of the staff specialist.
- ED samples sent to the pathology laboratory were clearly identified to improve test turn around times. Education was provided regarding pathology testing to reduce the volume of inappropriate tests.
- The admission process from ED was streamlined to ensure patients were admitted to the appropriate inpatient team in a timely manner.

The results:



With the implementation of the Maggie Program, triage performance improved in all categories, particularly categories 3 and 4 where there was a 42 percent to 48 percent improvement in meeting treatment times. There was an 80 percent reduction in four hour access block, despite a 10 percent increase in admissions and eight hour access block reduced from 41 percent to 31 percent.

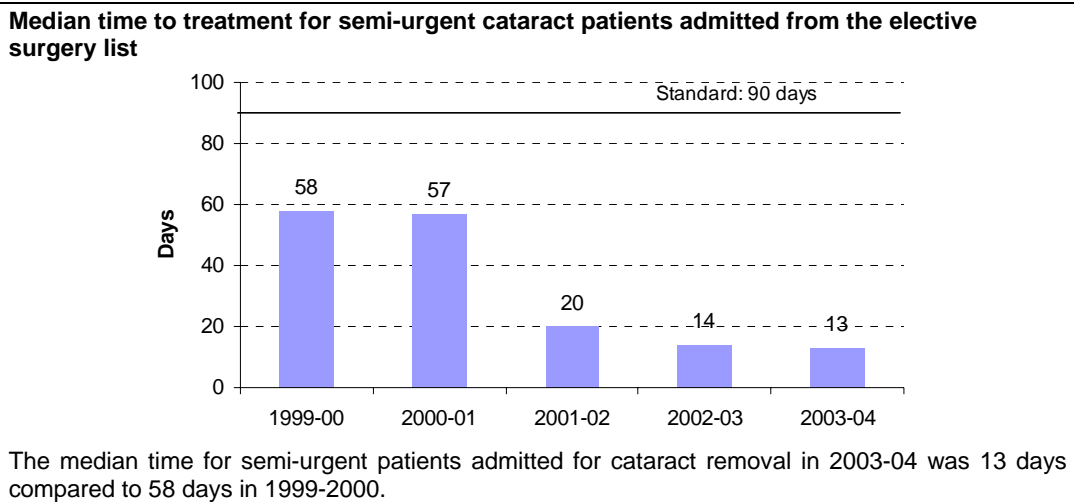
Source: Printed with the permission of Hunter New England Area Health Service NSW

Cataract surgery – Cranbourne Eye Service Victoria

In 2002, Victoria began focusing on the need to reduce the time to treat patients needing cataract surgery in metropolitan and rural Victoria, drawing on international research to devise the best model of care. This has comprised several different components including:

- Treating long-wait cataract patients in rural areas and on the Royal Victorian Eye and Ear Hospital’s waiting list
- Focusing on improving the day surgery rate for cataract surgery statewide
- Funding a regional eye service – Cranbourne Eye Service

Victoria’s Elective Surgery Access Service worked with the Cranbourne Eye Service to streamline the model of care for cataract patients. This included reducing the number of visits for cataract patients by combining the initial consultation and pre-admission visit and referring patients to their own optometrists at an earlier stage. The service operates in the local community but provides access to regional areas, with a “Cranbourne Eye Bus” provided to transport more remote patients to and from surgery



Source: *Your Hospitals, Department of Human Services, Victoria June 2005*

Improving flow process design will require investment and support including:

- a period of some months for most projects which will require regular clinical input sessions
- sufficient resources locally to allow clinicians as multi-disciplinary teams to step back from their clinical load, including funding to backfill shifts
- leadership support at senior levels to support the review and subsequent change process
- business process redesign expertise including the capacity to map patient journeys and facilitate clinicians in designing local solutions
- identifying patients willing to be involved in the redesign process and work with a team to ensure services are patient focused and to bring new perspectives to the design process
- an ongoing review process.

Victoria and New South Wales have formed Patient Flow Collaboratives to support clinicians and hospitals to redesign their patient flow functions. The collaboratives have focused on access to emergency departments, access to elective surgery, discharge planning and prevention of adverse events. The collaboratives have provided support for multi-disciplinary teams to assist local clinicians identify and implement best practice across multiple sites. This includes providing support to access international best practice models which can be adopted locally.

Recommendation 7.1

That support be provided to clinicians in local areas to redesign patient flows for acute hospital services. Priority areas are to include emergency departments, elective and emergency surgery and outpatient services and links to respective hospital wards. District change facilitators will establish and assist local implementation of reforms and liaise with a Patient Flow Collaborative to guide system redesign.

7.2 Partnerships to improve health services for Queenslanders

7.2.1 Issues and challenges

Effective partnerships require a willingness to negotiate and compromise in order to forge shared interests and a common purpose.⁵⁶ The Review heard that Queensland Health has not demonstrated a strong commitment to the concept of partnering, despite a willingness by other providers to deliver care through innovative partnership models. Queensland Health is perceived in some cases to be in competition with other providers rather than working cooperatively.

There is all this rhetoric about integration and partnerships but it is not clear what this means in practice and limited progress has been made.

Source: Submission to Queensland Health Systems Review, July 2005

Queensland Health only wants partnerships where they are in control.

Source: Submission to Queensland Health Systems Review, July 2005

In an environment of constrained public resources and workforce shortages, there is a tendency to be “risk averse” and avoid partnerships requiring resource pooling. However, these very resource and workforce constraints make it essential that Queensland Health works more effectively with other organisations to maximise available health resources. This is in line with public expectations that different health sectors and levels of government should work together to provide the very best of patient care and share information between services.

Building genuine partnerships may be challenging for Queensland Health as some partnerships may be most effective if funds are pooled or devolved to another sector altogether. Whilst it remains important that potential partnerships be subject to risk assessment and management, they should be primarily assessed on the potential to add value to service delivery and patient care rather than concern about who holds the dollars.

7.2.2 Partnership opportunities

Health sector partnerships

The most obvious partnership opportunities for Queensland Health involve improved coordination and cooperation between the public, private and non-government health sectors and across the continuum of care. In particular, it is important that Queensland Health focus on improving coordination within the primary care sector, particularly with general practitioners.

Queensland Health provides primary health care services in community health settings. In areas where it is not viable for general practitioners to operate a practice, such as rural and remote settings, Queensland Health is the sole primary care provider. Additionally, Queensland Health delivers primary care from inappropriate settings such as emergency

⁵⁶ Borys and Jemison in Keast 2003,p.46

departments in large hospitals, due to non-urgent patients being unable to access after hours general practitioners or being unsure of the urgency of their condition.

Further opportunities could be identified to ensure the right service is provided in the most appropriate setting. This may include Queensland Health outsourcing some of its primary care services to the non-government sector or general practice or re-orienting the roles of some community based workers to be “service coordinators.”

This will require significant cultural change within Queensland Health and improved relationships at all levels within the organisation. There are examples across the State where Queensland Health and general practice work together, including:

- Aboriginal and Torres Strait Islander controlled health services
- use of GPs to assess non-urgent patients in emergency departments
- outsourcing hospital services to a local general practice in a rural community
- colocated Queensland Health and general practice clinics.

A vehicle for improving collaboration between sectors is inclusion of primary care practitioners – including general practitioners and allied health professionals - in Queensland Health’s clinical collaboratives, which have been established for clinicians to come together for the purposes of improving patient care through data sharing and evaluation.

The case study below led to improved patient outcomes and continuity of care through successful partnership, service coordination and funds pooling. It also demonstrates that Commonwealth/State funding arrangements should not be seen as a barrier to working across health sectors.

Team Care model

The Team Care Health II research study aimed to improve the care of people with chronic disease by focussing on collaboration among health care providers including general practitioners, Queensland Health hospital and community based clinical staff and non-government organisations. The initiative is sponsored by the Brisbane North Division of General Practice and is stage two of the Coordinated Care Trials funded by the Commonwealth and Queensland Governments.

Over 2500 patients participated in the study. Patients found that the health care provided through the collaborative approach exceeded their expectations. While formal evaluation is currently underway, patients, GPs, and community nurses have all praised the model in its ability to improve efficiency in the health system, improve patient access to services and improve patient health outcomes. However, it will be important to assess the formal evaluation findings, including assessment of the model’s sustainability, before the model is considered for wider implementation.

Improved service coordination was achieved through community nurses working as ‘service coordinators’. Service coordinators worked closely with general practice and brought their knowledge of community resources and services to the practice. They assisted GPs in care planning and arranged services for patients. Workforce shortages and time constraints limit GPs’ ability to routinely implement prevention strategies with patients. The Team Care model overcame this issue and positively impacted on patient’s health and reduced unnecessary hospital admissions. The Service Coordinator also liaised with hospital staff to prevent readmission by arranging community services once patients were discharged.

The availability of brokerage funds appears to have been a successful strategy. GPs and service coordinators had access to funds made available from Queensland Health and Home and Community Care Services (HACC) to purchase services from the private sector for patients to address risk factors or prevent hospital admission. This brokerage model improved the timeliness of patient access to allied health and HACC services particularly where there were long waits in the public system and also minimised patient’s admission to hospital.

Universities

The university sector is a critical partner both as an educator of the clinical workforce and in maintaining a quality health system able to adapt to the rapidly changing health environment. Key academic clinicians such as professors of medicine, surgery, obstetrics, psychiatry and paediatrics as well as academics in nursing and allied health areas should assume key roles, along with Queensland Health clinical and administrative leaders, in quality, safety and innovation within health institutions and across health districts. Clinical academics have a significant role in designing, sustaining and monitoring local systems of clinical audit, innovation planning, near-miss incident reporting and analysis of routine health outcome data.

Through their research capability, universities can also make a major contribution in researching models of care, alternative workforce roles and better use of technology in health care. The Centre for On-line Health is an example of a successful collaboration between a university and Queensland Health.

Local government and community services sectors

There should not only be a focus on partnerships within the health and education sectors, but the department should also look to opportunities with local government and the community services sector to improve public health and outcomes for patients with complex or special needs. Regional Managers' Coordination Networks provide one vehicle for Queensland Health to work cooperatively at the local level with other Queensland Government agencies and local government, businesses and communities. Availability of discretionary funding to progress joint initiatives would assist in this regard (see discussion under Implementation which discusses this further).

Currently, Queensland Health has effective partnerships with a range of community services providers. In some cases, this relationship is cemented by a formal working agreement, including:

- Joint Work Plan with Education Queensland, which has a focus on the priority areas of healthy weight in children, skin cancer, alcohol, tobacco and other drugs, sexual and reproductive health, mental health promotion and partnership development.
- A Public Health Partnership Protocol between Public Health Services – Queensland Health, Local Governments of Queensland and the Local Government Association of Queensland Inc. (2000). The Protocol includes details of the working relationship between Queensland Health and Local Governments and action plans for: public health planning, communication and consultation, marketing, mosquito control, fluoridation and sharps disposal. It will be reviewed in the context of the broader relationship with local government, and mechanisms developed to improve these relationships at a state, regional and local level.
- Partnership agreements between the Departments of Housing and Health, which aim to support people with a diagnosed mental illness to sustain public housing tenancies and provide a stable, long-term accommodation option.

- In Logan, transitional supported accommodation is provided for people with mental illnesses through a partnership between a community housing provider, non-government disability support provider and mental health services. The integrated service provides short-term stable accommodation for people discharged from hospital with no housing or those who would be hospitalised without the supported housing option. This type of “step-down” model helps stabilise mental illness and assists people to transition into longer term, independent housing.

Responding to the needs of a multicultural community

Another area for focus is the growing cultural diversity within the community. Approximately one in five Queenslanders were born overseas (17.2 percent) and over one in twenty speak a language other than English at home⁵⁷ (7.1 percent). Despite the relatively high number of Queenslanders born overseas, there is little information available on the health of overseas-born people in Queensland. Of the little available information, it is clear that people born overseas have been shown to be less likely to rate their health as excellent or very good, compared with other Australians and, for those not proficient in English, more likely to report a disability or long term health condition. It is well recognised that refugees are a highly vulnerable group, with many having experienced torture or trauma. Recent refugee arrivals have been from refugee camps in Africa and have arrived with significant communicable and chronic conditions requiring urgent treatment.

Following community concern about ethnic communities’ access to services and their experience of health services, Queensland Health recently conducted a review of the implementation of its multicultural health policies. The review identified a number of areas of concern including the limited use of interpreting services and limitations in routine data collection on the health of ethnic communities and their use and experience of health services. This lack of information is a significant barrier to effective health service planning for these communities.

Queensland Health recently launched an initiative in response to the review findings, the key elements of which include the establishment of a statewide interpreter service to assist clients with language difficulties to talk to their doctors and specialists, and to better understand the medical process. Better data will be collected and a statewide cross cultural training program will also be conducted. Implementation and evaluation of this initiative must involve culturally and linguistically diverse communities to ensure that the health concerns of these communities are effectively addressed, particularly vulnerable sub-groups such as newly arrived refugees.

Implementation

As outlined in Chapter 5, an Innovation Fund is proposed to enable Area Health Services to provide seed funding for innovative projects or pilots. A major priority of the Innovation Fund will be development of partnerships to improve service delivery and health outcomes. Allocation of funding would be contingent upon development of a partnership plan and evidence that all parties have agreed on a partnership model, including roles and responsibilities.

⁵⁷ Queensland Health 2003 Culturally and Linguistically Diverse Population Profile 2001 Public Health Services.

There should be an expectation that Queensland Health will actively seek to enter into partnerships. To build this into core business and service planning, building effective partnerships should be monitored in performance agreements for key positions such as Area Health Service general managers and district managers.

Recommendation 7.2

Partnerships should focus on the health, university, community services and local government sectors to improve health promotion and service delivery, drawing on examples of good practice such as funds pooling, service devolution and service delivery service coordination.

Area Health Services should use the Innovation Fund to encourage and assist health service districts to develop appropriate partnerships which could be established to improve health promotion or service delivery.

Building partnerships will be an expectation of key roles in the organisation including Area Health Service general managers and district managers and will be included in performance agreements for these positions.

Primary care practitioners within Queensland Health, general practice and allied health services should be included in clinical collaboratives to improve coordination between sectors in provision of primary health care.

The recommendations from the Queensland Health review of multicultural health policies, in collaboration with community representatives, should be implemented.

7.3 Surgical access

Elective surgery waiting times and waiting lists have caused much anxiety for patients. There is much concern about the inordinate waiting times to see a surgical specialist which is then followed by a wait for surgery.

The current community and media focus on elective surgery waiting lists whilst understandable at one level, is not the best overall indicator of health service performance nor is it necessarily in the best interests of all patients. Waiting lists are an imprecise indicator of the level of access to public hospital services and place undue focus on certain kinds of surgical activity sometimes to the detriment of medical services. Due to budget and workforce constraints the community's need is not being met which is resulting in less than optimal patient outcomes.

Surgical waiting lists reflect Queensland Health's attempts to manage finite resources where demand for services exceed supply. Waiting lists are not limited to the public sector as there are quite lengthy waiting times in the private sector reported for some specialties. This indicates the impact that workforce shortages in some specialties is having on both the public and private sector.

There are many limitations of the surgical system that need to be addressed, including:

- people waiting longer than clinically appropriate
- inconsistent processes between public hospitals particularly for emergency surgery
- surgical cancellations
- lack of access to specialist outpatient services
- capacity to provide surgical services in regional and remote areas
- lack of transparency in the management of the waiting lists.

7.3.1 Specialist outpatient services

Specialist outpatient services are a key element in the process of accessing public surgical services. There is significant variation between Queensland public hospitals in the way that specialist outpatient referral information is managed and collected with scant information relating to specialist outpatient services reported publicly. Therefore, it is difficult for patients and health care providers to make informed clinical decisions.

Based on the most recent survey of Queensland's public hospitals undertaken by Queensland Health in July 2004, it was estimated that 108,571 people were waiting to see a public surgical or medical specialist. Of these, 65 percent had not yet received an outpatient appointment with the remaining 35 percent booked for a consultation. Data was not collected on the length of time these patients had waited to receive an appointment or the length of time between getting an appointment and being seen. This indicates there is a significant access block to specialist outpatient services in public hospitals.

Up to 30 percent of surgical specialist outpatient appointments result in the patient being assessed as having a need for surgery. Of the 108,571 people waiting to see a public specialist in outpatients as at July 2004 (both surgical and medical specialist services), 83,240 (76 percent) were for surgical specialists. Based on the estimated conversion rate above, up to 25,000 would likely require surgery and would be placed on the public surgical waiting list.

Anecdotally, a large proportion of the 70 percent assessed by a surgical specialist as not requiring surgery are referred back to a GP for ongoing management of their condition.

As part of any reasonable health care system, patients and health care providers should have access to information on the availability of services at their local hospital, the expected waiting time for assessment in outpatients and the expected waiting time for treatment. Currently patients and health care providers do not have any access to information on the availability and waiting times for specialist outpatient services nor waiting times for surgery at the individual hospital and specialty level, both of which are imperative to patients and health care providers being empowered to make informed health care decisions.

In many cases patients are waiting excessive periods until being able to access specialist services, during which time they are not getting the required treatment. An important benefit of providing improved information at the District level on the availability and waiting times for specialist services would be for primary health care providers being able to consider interim treatments while the patient waits for access to specialist services.

Currently, Queensland is the only State or Territory in Australia that uses a 5 percent target for the proportion of elective surgery patients not treated within a clinically appropriate time. This benchmark was arbitrarily set and creates a disincentive to treat patients in order of clinical urgency.

Recommendation 7.3

Specialist outpatient and surgical waiting times should be made available publicly in such a way that it help patients and their health care providers make informed choices about their individual care options.

Recommendation 7.4

As part of the performance framework, report and monitor activity (weighted for complexity) and waiting times for elective, emergency and other surgery.

Recommendation 7.5

Consistent with the national approach to reporting elective surgery waiting times, the 5 percent long wait performance benchmark should be abolished consistent with the objective of prioritising patients according to clinical need.

7.3.2 Strategies to improve access to outpatient services

Queensland has a history of providing free outpatient services which began with the free hospital system. Twenty years ago, medical outpatient services were provided across the spectrum from general practice to specialist services. These services were free at all interfaces including the doctor, the prescription medicine and any other service. The major changes over time to this arrangement have been around the cost of prescription drugs which have been aligned to the Commonwealth's Pharmaceutical Benefit Scheme and the range of outpatient services provided.

Under the current Australian Health Care Agreement, states and territories are required to provide at least the same range and volume of outpatient services as they did on 1 July 1998. This requirement was in response to some states reducing the range of outpatient services available publicly thereby shifting the cost of these services to the Medicare funded private sector. States (Queensland in particular) that did not reduce access to outpatient services prior to 1 July 1998 are therefore unfairly impacted by this provision. It also suggests that Queensland should not expand such services as it is not required to do so under the Australian Health Care Agreement.

A practical strategy would include:

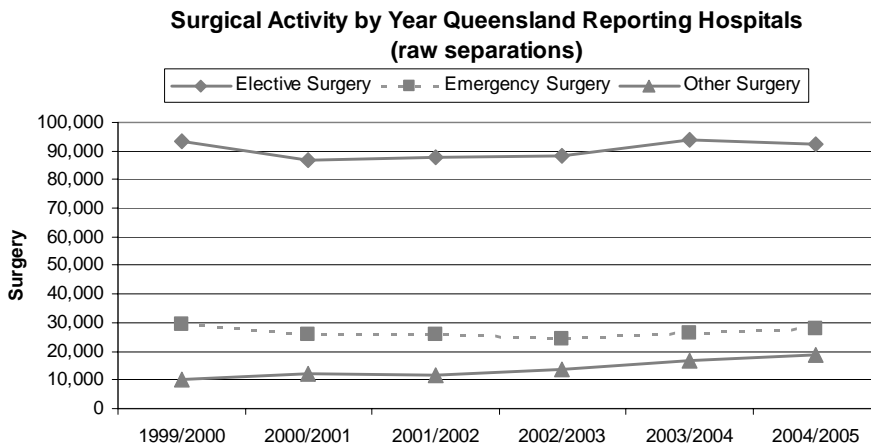
1. Maintain the current level and range of outpatient services.
2. Implement and support processes to improve productivity, eg.
 - new patient versus review patient ratios be piloted and benchmarked between specialty groups
 - appropriate clerical support for timely written communication with GPs
 - good discharge processes from outpatients to GPs
 - funding for GPs to continue to manage complex cases.
 - good support for GPs to manage complex cases with telephone and urgent consultation support for GPs who are managing complex patients
 - ensuring clinic time is appropriately booked and organised (eg. ringing patients the day before to remind them of appointments, ensuring medical records and test results are available).
3. Subsequent to these processes being implemented, the Queensland should advise the Commonwealth that outpatient services will not be expanded.
4. At a patient level, all patients who will wait greater than three months for an appointment should be advised so that they, with their doctor, can discuss other options, including accessing a private specialist.
5. For public patients who, after seeing a private specialist, require public inpatient care (eg. surgery) should follow a process that allows direct access to hospital care without an intermediate step of reprocessing through public outpatients.

Recommendation 7.6
 Increase access to specialist outpatients by examining opportunities, including those detailed in the report, for specialist outpatient services (surgical and medical) to be provided privately as is done in other States and Territories.

7.3.3 Surgical activity

In 2004-05, 139,009 surgical separations were provided in Queensland public hospitals representing around 20 percent of total hospital inpatient activity. It is estimated that surgery accounts for around \$1.1 billion of Queensland Health’s \$5.3 billion budget. Of the 139,009 surgical separations in 2004-05, 70 percent were elective procedures, 20 percent were emergency procedures and 10 percent were categorised as other procedures which includes diagnostic scopes such as endoscopies.

The level of surgical activity is largely driven by the demand for surgery and the availability of resources, specifically the availability of the clinical workforce and funding. Since 1999-00, surgical activity (raw) has remained relatively stable despite spikes in activity in 1999-00 and 2003-04 which can be explained by increases in resources allocated to elective surgery in those years. While elective surgery and emergency type surgery has remained relatively stable, there has been considerable growth of (82 percent between 1999-00 and 2004-05) in what is categorised as ‘other surgery’. The graph below shows the number of surgical separations provided between 1999-00 and 2004-05 split between the three categories of surgery which are emergency, elective and other surgery.



Source: Queensland Health Admitted Patient Data Collection (2005)

While the number of surgical patients treated has increased by an average annual rate of 1 percent since 1999-00, the complexity of cases has grown considerably. The number of weighted surgical separations, which is adjusted for complexity, grew by 8 percent in 2003-04 and 5 percent in 2004-05.

7.3.4 Surgical waiting times and performance

As noted in Chapter 2 of the report, national data indicates Queensland has the second highest rate of elective surgery in Australia and has the second highest rate of elective cases treated on time⁵⁸. Despite this, Queensland patients still wait longer than is clinically appropriate for many procedures, particularly for less urgent surgery and there is a significant access block issue for specialist outpatient services.

Based on preliminary 2004-05 data, 90.4 percent or 100,890 elective surgery patients were treated within clinically appropriate timeframes with around 10 percent or 10,691 patients waiting longer than clinically appropriate. Waiting time performance is reported across three categories of elective surgery which include Category 1, Category 2 and Category 3 and are shown in the table below.

2004-05 Elective surgery activity and 1 July 2005 waiting times

| | Activity in time | | Activity long waits | | TOTAL activity Number | Waiting List | |
|--|------------------|--------------|---------------------|-------------|--------------------------|---------------|--------------|
| | Number | % | Number | % | | In time | Long waits |
| Category 1 (< 30 days) | 35,155 | 89.6 | 4,102 | 10.4 | 39,257 | 2,255 | 128 |
| Category 2 (<90 days) | 44,895 | 90.6 | 4,644 | 9.4 | 49,539 | 10,114 | 1,290 |
| Category 3 (< 365 days) | 20,840 | 91.5 | 1,945 | 8.5 | 22,785 | 13,806 | 6,063 |
| Total | 100,890 | 90.4% | 10,691 | 9.6% | 111,581 | 26,175 | 7,481 |
| <p>Category 1: Admission within 30 days desirable for a condition that has the potential to deteriorate quickly, to the point where it may become an emergency</p> <p>Category 2: Admission within 90 days acceptable for a condition causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency.</p> <p>Category 3: Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.</p> <p>Long waits: Patients waiting longer than clinically appropriate</p> | | | | | | | |

Based on data at 1 July 2005, there were 33,656 people waiting for surgery with 7,481 or 22 percent waiting longer than clinically appropriate. This figure reflects only the number of patients that have been assessed as requiring surgery through specialist outpatients. As noted in Section 7.3.1, it is estimated there are an additional 25,000 people waiting to get on the surgical waiting list. Recommendations to meet this excess demand are provided as part of the Section 7.3.7.

The total number of patients waiting for surgery declined from the peak of around 40,000 in 2000 to the lowest level of 31,478 in 2004 from which time the number waiting has since increased to the current level.

Little focus is given to the performance and waiting times for emergency and other surgery. The review has observed a lack of consistent processes in place for patients who require emergency surgery resulting in sub optimal outcomes. There is also significant variation between public hospitals in the way emergency surgery cases are managed and prioritised. Strategies targeted at improving the management of emergency surgery in particular are provided at Recommendation 7.8.

⁵⁸ State of Hospitals Report, 2005, Australian Government.

7.3.5 Funding surgical services

An issue brought to the attention of the Review is the different way that the categories of surgical services are funded. Elective surgery is funded on an activity basis with the level of funding allocated to a district dependent on the quantity and complexity of surgical activity within agreed targets. In contrast, emergency and other types of surgery are funded from the existing district base budget.

This inconsistency in funding arrangements has created incentives for health service districts to place a greater emphasis on elective procedures which may provide disincentives to treat patients in terms of general clinical priority. The funding arrangements for surgery must support good clinical practice and not differentiate between the provision of elective, emergency and other surgery or medical services.

The recurrent base elective surgery funding is \$83.7 million which has specific activity targets. Hospital activity targets associated with this recurrent funding have been maintained each year despite increasing costs of surgery. This means that the same amount of activity has been expected from the same pool of funds. This situation has resulted in cross subsidisation of elective surgery from other clinical areas within hospitals. This has meant that some districts have made decisions that have compromised clinical services to ensure that elective surgery targets are met. The Government has committed extra funding to elective surgery as part of election commitments and other initiatives.

Recommendation 7.7

Integrate the management and funding of all surgical activity including emergency, elective and other surgery with a view to prioritise patients on the basis of clinical need. This is consistent with recommendations in Chapter 6 where all acute services are proposed to be funded using a casemix funding model.

7.3.6 Principles of an optimal surgical access system

The Review has observed much dysfunction in the way surgical services are managed and provided by Queensland Health. Much of this could be attributed to the absence of an explicit goal for public surgical services. A reasonable goal would be to ensure that no person waits longer than is clinically appropriate for public surgical services including emergency cases. However, due to the high demand for public surgical services and the capped budget environment, articulation of a clear goal is challenging.

Given the interrelationship between the public and private health sector, it may be necessary to explore measures to ensure those least able to afford care are provided timely access to safe hospital services. Those with the capacity to pay should be encouraged to use the private sector with a view to restore a responsive public system for those least able to afford care.

A goal and a number of principles for improving access to safe and timely surgical services form the basis of the following recommendations.

Recommendation 7.8

That the following principles be adopted to guide implementation of recommendations to improve timely access to public surgical services:

- Access to both specialist outpatient and surgery services are prioritised based on clinical need.
- All patients requiring trauma surgery receive treatment within 24 hours if clinically appropriate.
- Encourage all patients with private health insurance to use it as private patients in public hospitals or in the private hospital system.
- Any planned increases in surgical activity needs to be considered in the context of bed capacity and the likely impact on medical patients.
- Additional non-emergency surgery should not adversely affect the provision of care for emergency (surgical and medical) cases.
- Patients and their primary health care providers (GPs) should be empowered to make informed decisions about their care which would include access to accurate and timely information about waiting times and costs.

Further development of these principles needs to be considered by the relevant clinical networks to guide a Government position on public surgical services in Queensland.

Potential measures to reduce the reliance on the public hospital system to provide non-urgent surgical services by those able to afford private care include:

- actively encourage the community to retain and use their private health insurance
- means test access to non-urgent public surgical services
- introducing a means tested co-payment for non urgent public surgical services to stop a shift from the private to the public sector.

As outlined in Chapter 3, there are some significant barriers to implementing these options including financial penalties based on current Commonwealth policy.

Recommendation 7.9

Explore the introduction of means tested measures for non-urgent surgical services to improve the safety and timeliness of public surgical services for those least able to afford care.

7.3.7 Strategies to increase surgical activity

An estimate of the level of additional surgical activity on top of that provided in 2004-05 is provided below based on the following elements:

- *Long Waits* - 7,481 elective surgery patients were waiting longer than clinically appropriate at 1 July 2005 which broadly equates to 12,122 cases weighted for complexity.
- *Unmet demand* - It is estimated there are an additional 25,000 patients waiting to get on the surgical waiting list. Given that the rate of growth in the number of people waiting for access to specialist outpatients is unknown due to no periodic data collected on these services, it is difficult to estimate what additional surgical activity needs to be provided to meet this demand. However, should the recommendations to increase access to outpatient services be successful, it may be necessary to increase surgical activity by 5,000 weighted separations per year until the excess demand has been met.

- *Natural Growth* - Emergency surgery has grown by an average of 5 percent per year since 2002-03. Applying this rate of growth to the 2004-05 level it is estimated that an additional 4,347 weighted surgical separations will present in 2005-06. Other surgery has grown by an average of 20 percent per year since 2002-03. Applying this rate of growth to the 2004-05 level, it is estimated that an additional 7,653 weighted surgical separations will present in 2005-06.

The following table shows an additional 31,195 weighted surgical separations would need to be provided to meet forecast growth across the three categories of surgery, estimated unmet demand and eliminate the number of people waiting longer than clinically appropriate. Based on the average cost per weighted separation of \$3,230, the estimated cost of this surgical activity on top of that provided in 2004-05 would be \$100.8 million.

| | Elective Surgery | Emergency Surgery | Other Surgery | Total Surgery |
|-------------------------|-----------------------------|------------------------------|--------------------------|--------------------------|
| 2004-05 | 149,873 | 90,388 | 36,303 | 276,564 |
| 2005-06 Estimate | | | | |
| - Long Waits | 12,122 | | | 12,122 |
| - Natural Growth | 2,073 | 4,347 | 7,653 | 14,073 |
| - Unmet demand | 5,000 | | | 5,000 |
| 2005-06 TOTAL | 169,068 | 94,734 | 43,957 | 307,759 |
| Growth | 19,195 | 4,347 | 7,653 | 31,195 |

Further modelling would need to be done to determine how this additional activity will focus on long wait specialities, continue to prioritise patients based on clinical need and meet the needs of communities outside of metropolitan areas.

The level of surgical services provided publicly is dependent on many factors including funding, infrastructure and workforce constraints and capacity in the private sector. Recommendations targeting an increase to public surgical services are provided below. While many of these strategies require additional funding, others relate to redesigning the workflow around surgery and creating more flexible working arrangements.

Recommendation 7.10

Increase surgical throughput by 31,195 surgical separations weighted for complexity at an estimated cost of \$100.8 million (\$61.6 million of which is ongoing).

Recommendation 7.11

Expansion of surgical activity, with a view to reducing excess demand, over and above existing targets should involve offering the opportunity to provide extra surgical services to the following (in order of priority):

1. existing staff specialists at overtime rates
2. Visiting Medical Officers currently operating in the public system (at sessional rates)
3. other specialists to operate as Visiting Medical Specialists (at sessional rates)
4. Where services are unable to be provided in the public system, activity at an appropriate type and volume should be offered to syndicated private specialists, private hospitals and other interested parties who operate outside the public system (contracted arrangements based on a specific performance agreement).

Recommendation 7.12

Investigate and pursue the following clinical quality and improvement practices with a view to improve surgical capacity and patient outcomes:

- Pre-admission clinics
- Day of surgery admission procedures
- Discharge planning processes
- Outpatient and surgical waiting list booking processes
- Peri-operative management guidelines and procedures
- Theatre management and utilisation strategies
- Integrated bed management procedures
- Flexible rostering of staff (including 10 hour shifts)
- Post-acute and transitional care services
- Hospital in the home services
- After hours theatre utilisation
- Dedicated trauma / emergency surgery sessions
- Dedicated hospitals for elective surgery
- Expand the 'Fit for Surgery' scheme
- Regular administrative and clinical audits of the surgical access waiting list.

Recommendation 7.13

That as clinical networks become established, they be given responsibility for the implementation of strategies to improve surgical access in Queensland public hospitals. This would involve providing advice and recommendations to the sponsoring Area Health Service General Manager on surgical access issues for implementation.

7.4 Rural and remote health services

Rural communities have a right to expect safe and timely access to health services. Approaches that look at preventing avoidable illnesses, promoting good health, managing chronic disease and coordinating care across the lifespan are critical to the longer term well being and health of rural communities.

However, geographic isolation and smaller populations necessitate different models of care from metropolitan areas. Workforce requirements are also different in rural and remote areas with a greater need for a flexible workforce of “generalists.” Workforce availability is a key issue, with some services reported to be at risk of closure due to staff shortages. The isolation of remote workers who often work without peer support or supervision can also lead to “burn out” and the loss of valuable skills for communities.

7.4.1 Service models

Working with the Commonwealth Government

The Commonwealth Government is a key partner in this regard and has played a significant role in funding and coordinating rural and remote health services and funding structures such as the Divisions of General Practice and Health Workforce Queensland. Additionally, the Commonwealth Government has worked in partnership with Queensland Health and local communities to improve services in rural and remote areas. Examples include:

- combining Commonwealth funded aged care facilities and Queensland Health acute services into Multi-Purpose Health Centres in some rural and remote communities
- supporting telehealth services through the Commonwealth Medical Specialist Outreach Assistance program (see boxed text below)
- development of integrated outreach services through the North West Queensland Allied Health Service (see boxed text below).

Notwithstanding these efforts, major Commonwealth programs such as Medicare are currently failing to provide universal access to health care in rural and remote communities where general or specialist medical practices are not viable. In these instances, Queensland Health is often the sole provider and carries a disproportionate burden in providing health care.

The Commonwealth Government has previously responded to a similar market failure in respect of access to medical services by Indigenous people. In this instance, the Commonwealth recognised Indigenous people were not accessing their per capita share of Medicare funded services and “cashed out” what would have been spent. This funding was used to establish alternative medical services provided by Aboriginal and Torres Strait Islander controlled health services (see separate section on Indigenous health for further discussion of these services).

A similar approach could be taken in the area of rural and remote health services. That is, the Commonwealth Government could “cash out” the per capita share of Medicare services to which rural and remote communities are entitled. In partnership with Queensland Health, alternative service models could then be explored, including fund pooling between the Commonwealth and State Governments and/or devolving health services in rural and remote communities to another provider.

Alternatively, the Commonwealth Government could adjust Medicare rebates to create additional incentives for doctors to work in areas of need, including rural and remote communities. This could be done within existing global Medicare funding by reducing Medicare rebates across the board and redirecting the savings to create bonus schemes that reward doctors with a commitment to working in areas of need. Current Medicare rebates could remain unchanged and additional funds could be used to create bonus schemes. This approach would be in line with previous initiatives by the Commonwealth to influence private medical practice through incentive schemes.

The Queensland Government should explore these options with the Commonwealth to improve access to Medicare funded health services in rural and remote areas and explore new service models that could be jointly funded by both levels of government.

Improving access to services through technology: Telehealth

Telehealth enables the medical workforce to provide "outreach" support to regional or remote facilities experiencing workforce shortages or with insufficient service volume to warrant a local specialist. To date, Queensland Health has developed telehealth initiatives to facilitate consultations via videoconferencing (eg a Brisbane based psychiatrist providing consultations to patients in a regional or remote centre) and transmission and reading of medical images (eg a radiologist in Brisbane reading images from a remote centre).

The Commonwealth has provided funds via the Medical Specialist Outreach Assistance program for the establishment of e-Health initiatives in TeleDermatology and, in 2005, for Teleradiology. These services are provided via the Australian College of Rural and Remote Medicine's web platform Rural and Remote Medical Education Online

The Telederm service has operated since 2003 and was again funded in 2005. This service is available to all doctors in Queensland - both private and public. Over 600 doctors access this service to improve access to specialist advice to over 150 patients in areas where specialist services are not available. The service will extend to teleradiology from October 2005.

Queensland Health has invested significantly in telehealth, with 300 sites currently operating. Telehealth should be more widely integrated into service delivery to enable patients to be treated as close as possible to where they live.

Based on experience to date, telehealth programs should be developed in consultation with the providers expected to use them and a suitable clinical champion should be identified to encourage clinicians to participate in telehealth initiatives

One of the barriers to wider use of telehealth is the absence of Medicare Benefits Scheme recognition of private telehealth consultations in disciplines other than Psychiatry. This is a matter which should be pursued with the Commonwealth to recognise the legitimate role of telehealth/e-health in medical service delivery.

**Providing integrated outreach services to rural and remote communities:
North West Queensland Allied Health Service**

This integrated service model was developed to improve access to allied health services in north west Queensland. Before the service was developed, allied health services in this area were provided by a range of agencies with little coordination, short visits to communities, high staff turnover and service gaps in some disciplines.

Services are delivered using a hub and spoke model, with allied health professionals based in Mt Isa. Features of the service include:

- Allied health professionals travelling in teams
- Therapy assistants in each community to support follow up care and develop skills of local people
- Development of a six month calendar of service delivery to avoid clashes with other visiting services
- Each community is visited on a six-weekly basis
- A centralised booking number for referrals
- Use of videoconferencing to support therapy assistants, clients and carers
- Case conferencing with local health professionals at each visit
- Maximising clinical time and enabling service provision during the wet season by using charter aircraft to the Gulf and Highway precincts

The North West Queensland Allied Health Service is auspiced and managed by North and West Queensland Primary Health Care (formerly the Northern Queensland Rural Division of General Practice) and funded under the Commonwealth Government's Regional Health Strategy.

Directions for Queensland Health

Queensland Health's role in improving the health and well being of rural communities may involve directly providing services, coordinating provision in partnership with other providers or funders or completely integrating services.

All rural and remote districts should explore opportunities to replicate successful models such as these and develop innovative arrangements that maximise local services and resources. Sustainable service models must be:

- developed in direct consultation with communities, other providers and, where appropriate, the Commonwealth Government
- informed by the needs of the community based on its demography and service use patterns
- considered in the context of the changing nature of rural communities
- able to span the continuum of primary, secondary and tertiary care.

Consultation is required with rural and remote communities about the types of services which can and cannot be provided locally. It is easy to criticise Queensland Health for trying to scale down services in the bush when in some instances, this may be in the interests of patient safety.

For example, irrespective of workforce availability, it may not be safe to provide a service locally if there is insufficient volume of patients to maintain a practitioner's skills and credentials. Alternative models of care such as visiting specialists, assisted transport to larger centres, high quality aero-medical retrieval services and/or employment of an appropriately skilled generalist practitioner may need to be considered. These are difficult issues that should be considered and addressed locally.

Health service planning in rural and remote communities must take account of transport issues. On average, Queensland Health commits \$64 million annually to patient transport. This scheme is largely uncoordinated, resulting in a fragmented model of supply throughout Queensland⁵⁹.

The Review heard the travel subsidy scheme is not user friendly, does not reflect the true costs of living away from home for patients and/or their families and does not always take account of public transport routes which enable family and carers to join patients. Additionally, the Review heard that Queensland Health focused on the least expensive travel options without adequately considering the personal and health costs of some travel options. Bus travel, for example, can be uncomfortable over long distances at the best of times let alone when a person is injured or ill.⁶⁰

Queensland Health has commissioned a report "Access to Health Services (Transport is the Key)". This report should form the basis of decision making around changes and improvements to patient transport, particularly in rural, remote and regional Queensland.

Health services in rural and remote areas must be built on open and transparent communication and effective partnerships between local governments, Queensland Health and other government agencies. There is no place for intra-agency silos where

⁵⁹ Eustace G, Access to Health Care 2005

⁶⁰ RAPAD. Review of Health and Human Services p73. 2005

agencies see their activities as distinct from other government agencies.⁶¹ Local government has an important role to play as the representative voice of the community and should be involved in Queensland Health planning and decision-making, especially at local levels. Improved communication and the development of feedback channels and regular dialogue would support this increased involvement.⁶²

7.4.2 Building the rural and remote workforce

Service planning in rural and remote communities must be accompanied by analysis of existing and potential staff resources and the development of a workforce strategy. There are several dimensions to effective workforce management in rural and remote areas, including education, training and the development of incentives and professional support. This section outlines specific initiatives for the rural and remote workforce. Broader clinical workforce strategies are canvassed in Chapter 10 and apply equally to the rural and remote workforce.

Education and Training

In the 1990s, the Commonwealth and State Governments established Rural Health Training Units. In Queensland, three units were established (one in each zone) to increase the recruitment and retention of clinical staff in rural Queensland. The units have undertaken a range of initiatives including cultural awareness programs, programs for allied health skills enhancement and facilitation of recruitment to some allied health positions in rural and remote areas. However, each training unit has evolved differently.

Several reviews have identified that the roles and responsibilities of the Southern and Central Zone training units are unclear. Northern Zone has successfully adapted the training unit to play a workforce planning and development role which is well regarded within the organisation. The Southern and Central Zone training units should similarly be realigned and all three units should play a lead role in workforce planning for the three Area Health Services.

It will be important for these units to work closely with the university and training sectors at the regional level to ensure the health workforce is well trained and prepared for rural practice. Additionally, there is an opportunity to build on the benefits of recruiting rural students into health professional courses and teaching in rural, remote and Indigenous communities. Evidence suggests that students are more likely to choose rural clinical practice as a career if:

- they or their partner has a rural background
- they attended rural high schools
- they have repeated undergraduate rural clinical exposures and
- they have opportunities to work rurally during the early post-graduate period.

Intensive efforts must therefore be made to attract and assist students from rural and remote communities to study health professional courses and to provide rural and remote clinical placements for students.

⁶¹ RAPAD. Review of Health and Human Services p60. 2005

⁶² RAPAD. Review of Health and Human Services p 59. 2005

Additionally, Queensland Health should work with education and training providers to ensure availability of workforce roles that best meet the needs of rural and remote communities. As specialist services are generally unsustainable in rural and remote Queensland, there is a range of “generalist” roles which could be better used in these communities. These include the medical generalist, advanced rural and remote nurses, nurse practitioners and paramedic primary care practitioners. These roles need to be developed in very close consultation with communities and other partners. Given the immediate and long-term medical workforce shortages, the policy priority for government should be investment in generalist training (in primary care and specialist areas).

Building the Medical Generalist role

There is evidence that medical generalists produce comparable outcomes in a number of areas of specialist and sub-specialist medical practice (eg: birthing outcomes in small rural hospitals⁶³). The Review therefore supports the proposal put forward by the Queensland Government to create Rural General Medicine as a specialty with a broad scope of independent practice (in procedural areas as well as internal medicine and paediatrics). This should create a career path and increase the attractiveness of medical practice in rural and remote communities, at a time when numbers of rural generalists are decreasing. This role is distinct from a general practitioner or traditional specialist as it requires a broad understanding of diagnosis, treatment and management from the perspective of a number of medical and surgical disciplines and applies these along the continuum of care from primary to tertiary.

The Australian College of Rural and Remote Medicine is currently awaiting Australian Medical Council approval of this new medical specialty. It would be helpful for the Queensland Government to engage with the Australian Medical Council and the Commonwealth Minister for Health and Ageing to advocate for recognition of this specialty, which would significantly benefit existing and potential rural doctors employed by Queensland Health.

The Australian College of Rural and Remote Medicine has indicated its interest in working with Queensland Health to implement training towards the Fellowship of the Australian College of Rural and Remote Medicine. It is suggested that Queensland Health explore partnership opportunities with the College, including facilitation of registrar training placements in rural and remote settings that offer a wide range of health services across the continuum of care – for example, a mix of primary and hospital based training.

In small centres lacking a sufficient population base to support a full time salaried medical generalist, there is an opportunity for Queensland Health to help train procedural general practitioners. The Commonwealth Government has contracted the Australian College of Rural and Remote Medicine to administer key components of the MedicarePlus Training for Rural and Remote Procedural GPs program. This program supports procedural rural doctors for skills maintenance and upskilling in anaesthetics, obstetrics and surgery covering both formal (courses) and informal (clinical attachments) delivery modes. It is in the form of a grant of \$15,000 per doctor per financial year based on 10 days training at \$1500 per day. This funding is also available for procedural medical officers undertaking only rural hospital based work.

⁶³ Tracy M, The safety of small maternity unit in Australia- a population based study.2005

Queensland Health could partner with the College in facilitating procedural training for rural generalists, and promoting the Commonwealth funded procedural medicine grants to improve access to professional development for skills maintenance and upskilling for generalist proceduralists. This would increase availability of suitably skilled rural generalists. Additionally, this could be used as an avenue to recruit additional private procedural GPs into public service. For example, Queensland Health could offer training for GPs in return for providing services in the public system either through sessional work or innovative arrangements such as the Longreach group practice model.

Outsourcing hospital services: the Longreach model

The district visit to Longreach identified an innovative outsourcing model used to service the town's hospital. Under this model, the local general practice is contracted to provide a range of services to the hospital including having a doctor present from Monday to Friday during certain hours, undertaking ward rounds, providing cover to the emergency department, performing the duties of a medical superintendent and covering all other medical on call.

The general practice includes procedural GPs with anaesthetic, minor surgery and obstetrics privileging to enable some procedural work to be performed in town, with more complex cases referred to larger hospitals as appropriate. The practice is paid a set annual sum to provide this total service. This means that the general practice rather than the hospital is responsible for arranging annual leave, rostering, professional development etc.

This model maximises the skills and expertise of local doctors, enables a mixed model of public and private practice for the doctors involved and avoids over servicing or duplication of efforts between the public and private sectors.

Advanced nursing and nurse practitioner roles

These workforce roles are discussed in depth in Chapter 10. Advanced nursing roles enable nurses to take on some of the tasks currently performed by doctors, under medical supervision. Rural and isolated advanced nursing roles are already successfully used in Queensland Health and should continue to be developed and expanded. To this end, Queensland Health should increase places in the Rural and Remote Isolated Practice Nurses Program to meet increasing demand. The nurse practitioner role is still in the development stages and enables suitably qualified nurses to practice independently within their scope of practice. Both these roles have the potential to increase availability of safe, quality health services to rural and remote communities in the context of medical workforce pressures.

Paramedic primary care providers

There is interest in Australia and overseas in extending the role of ambulance paramedics, recognising that they are often the "first line" primary health care providers in small rural communities with limited or no local health services. An extended role could include professional responsibilities throughout the cycle of care, such as in the prevention of injury and illness, responding to emergencies, facilitating recovery, and planning future strategies for a healthy community.⁶⁴

James Cook University and the Queensland Ambulance Service have entered into a partnership investigating the extended role of paramedics in rural and remote areas, including assisting rural doctors and nurses to deliver primary health care.⁶⁵ Any future implementation of such a role will need to occur in close consultation with health providers and local communities and ensure that the emergency response function is not compromised in taking on this wider role.

⁶⁴ O'Meara, P, individual submission to the Productivity Commission health workforce study, August 2005.

⁶⁵ Queensland Government submission to the Productivity Commission health workforce study, July 2005

Attracting health professionals to rural and remote areas

The Review heard that clinicians feel isolated and unsupported in rural and remote areas. Measures to attract and support the health workforce in these areas are essential in order to ensure provision of sustainable health services.

Queensland Health does not value junior doctors, where they are left unsupported when sent to isolated areas to relieve and feel unprepared to do so.

Source: Submission to Queensland Health Systems Review, July 2005

Queensland Health does not support, recognise or value the role of the Generalist Practitioner, a doctor who is not a specialist of one procedural type, but someone who can provide a level of practice across many procedures.

Source: Submission to Queensland Health Systems Review, July 2005

I am a remote area nurse, I have a critical care certificate, am RIPRN endorsed an immunisation and women's health nurse and midwife. I am the only registered nurse and am on call 24/7. It is impossible to try and carry the burden of these workloads and keep your head above water ... we all enjoy remote area nursing but burn out/fatigue is a factor of our everyday life. We have no regular contact with our line manager (nurse).

Source: Submission to Queensland Health Systems Review, July 2005

Fair remuneration, conditions and support

Difficulties attracting and retaining health professionals to rural and remote areas are well known. The workforce profile in Chapter 10 highlights the maldistribution of doctors, with an oversupply in south east Queensland at the expense of regional and remote areas.

The Review heard of remuneration anomalies which frustrated and angered clinicians in rural and remote areas. Transparent and consistent "rural and remote packages" should be designed for professional groups working in designated rural and remote health districts.

Whilst transparent remuneration packages should be developed, district health services must also be allowed flexibility to negotiate any other assistance required to attract professionals to the bush. Districts must work with local governments, business and community organisations to facilitate the necessary support for clinicians moving to rural and remote areas – for example, assistance in finding accommodation or support for a spouse in finding employment.

As a retention incentive, consideration could be given to offering a service bonus. For example, clinicians could receive a lump sum bonus or additional recreation leave upon completion of a certain term of service, conditional upon a commitment to a further term of rural and remote service.

In considering such measures, Queensland Health should investigate incentives offered by other Queensland Government agencies to ensure some parity. During consultations, clinical staff indicated that they were aware of more generous remuneration and incentive packages in other government departments.

Training programs appropriate for isolated practitioners must also be established and delivered, before commencement of work in these areas. Ongoing support should also be provided, given that isolated workers often have limited professional supervision and support. Peer support networks could be formed, based around professional groupings

(eg sexual health nurses, isolated practice nurses, allied health professionals, medical generalists) or around streams of care (eg mental health, birthing services). To this end, Area Health Services should create peer networks to provide an avenue to problem solve, share good practice and build collegiate networks.

All rural and remote health services should be linked to tertiary hospitals through “networked services” within an Area Health Service. This would require tertiary hospitals to provide outreach services. A certain level of country service could be included as a condition of employment in key tertiary hospital positions, particularly in specialty or senior positions.

Country service register and incentive package

The Review identified difficulties in relieving rural and remote vacancies and staff leave. The current practice of sending junior doctors to the bush without adequate support and supervision is a major cause for concern.

Some districts have developed a register of metropolitan clinicians willing to perform country service on a short or longer term basis to assist in relieving vacancies and staff leave. A number of doctors, nurses and allied health professionals expressed interest in performing short term rural and remote service on a rotational basis and this goodwill should be used to assist smaller districts. This would provide a means of sending experienced clinicians to provide relief, resulting in a safer service to those communities and reduced risk associated with sending junior doctors to the bush.

Each Area Health Service should establish a register of interested clinicians and develop an incentive package to make the rotations attractive, this would include accommodation, meals, living allowances and travel. Other benefits might include offering additional recreation leave in return for a certain amount of country service, enabling the package to be promoted as a working holiday.

Increased use of GPs

In smaller centres without a sufficient population to support a full-time salaried medical officer, Queensland Health should consider employing procedural GPs on a sessional basis or through outsourcing of medical services under contractual arrangements, in line with the model successfully used in Longreach.

Potentially, this model could be extended to allow doctors to conduct their private practice clinics in public hospital facilities. This type of approach has been used in some areas by providing areas separate from the hospital for private practice, to enable Medicare billing. This approach has been found to work best in communities where there is only one general practitioner or general practice in the community, to avoid perceptions of unfair advantage.

Queensland Health has an existing policy allowing rural and remote allied health professionals in eligible districts to use public facilities for private practice. This entitlement should be well marketed during recruitment of allied health staff and all eligible districts should ensure existing staff are aware of this initiative and supported to take advantage of the opportunity.

7.4.3 Implementation

The above initiatives should be driven at the district level with coordination and assistance from Area Health Services. At the same time, a rural and remote clinical network should be established and funded to stimulate clinician led initiatives for rural and remote communities and assist in planning networks of services. Once established, some of the roles undertaken by districts or Area Health Services might then be devolved to this clinical network.

Strong community engagement is also essential in working through the complex issues around delivery of health services to rural and remote communities. Consultation, working together and seeking advice from community people, their leaders, other service providers and Queensland Health's own staff will significantly improve the feeling of ownership of decisions and empowerment of local providers.

Recommendation 7.14

The Queensland Government to encourage the Commonwealth Government to explore alternative funding or service models that would increase access to Commonwealth funded health services in rural and remote communities.

Safe, sustainable service models should be developed in partnership with rural and remote communities, the Commonwealth Government and other service providers. Suggestions should be drawn from innovative service models already in practice.

The report "Access to Services (Transport is the Key)", should be used as the basis for reforms to patient transport, particularly in rural, remote and regional areas.

Education and training providers will be engaged to assist with increasing workforce supply in rural and remote areas and better develop "generalist" roles including rural generalist doctors, advanced rural and remote nurses, nurse practitioners and paramedic primary care providers.

The Queensland Government to engage with the Australian Medical Council and the Commonwealth Government to advocate for recognition of rural general medicine as a new specialty.

Queensland Health will partner with the Australian College of Rural and Remote Medicine to facilitate procedural training for rural generalist doctors.

Remuneration and incentive packages, including better access to professional development should be improved, to attract clinicians to rural and remote areas.

Peer support networks should be established at Area Health Service level, for isolated workers, based around professional groups or streams of care.

All rural and remote services will need to be networked with larger centres, including a tertiary metropolitan hospital. The purpose will be to provide outreach services and some staffing relief.

Area Health Services will establish a register of clinicians willing to perform short or long term country service.

7.5 Indigenous health

7.5.1 Overview

Queensland has the highest percentage of Aboriginal and Torres Strait Islander peoples in Australia. In 2001, the estimated Indigenous population in Queensland was 125,910, representing 3.5 percent of the Queensland population and 27.5 percent of the total Indigenous population in Australia.

There are key demographic differences between the Indigenous and general populations in Queensland, including a higher proportion of Indigenous people in remote and very remote areas and a younger population profile. However, approximately half of Indigenous people live in urban areas. The types and models of services provided to Indigenous people must take these demographic issues into account.

Aboriginal and Torres Strait Islander people are amongst the most disadvantaged people in Australia, with lower levels of educational qualifications and median incomes in every occupation group, lower home ownership rates and over representation amongst the homeless population or those at risk of being homeless. Indigenous people are also imprisoned at a rate 14 times higher than the non Indigenous population and Indigenous children are over represented in the juvenile justice system.

The health inequities between Indigenous and non-Indigenous people are well documented and have persisted despite efforts by all levels of government to improve Indigenous health. The Interim Report showed that, on average, Indigenous Queenslanders die 20 years earlier than their non-Indigenous counterparts and experience a much higher burden of disease, including chronic diseases, injury and many infectious diseases.

Clearly, new approaches must urgently be developed to address the tragic and unacceptable health inequities facing Aboriginal and Torres Strait Islander people in Queensland today. This includes working with other sectors to try and better address the social and economic determinants of health, many of which are outside the direct influence of Queensland Health.

7.5.2 Addressing the social and economic determinants of health

Queensland Health should trial better ways to work closely with Indigenous communities, government departments and the private and non-government sectors to contribute to efforts to reduce Indigenous disadvantage in both urban and remote settings.

In 2002, the Meeting Challenges, Making Choices (MCMC) initiative was introduced with the intent of making concerted efforts to reduce violence and alcohol abuse in 19 discrete Indigenous communities. Strategies to address alcohol abuse were undertaken together with a range of social, resource management, governance, criminal justice and economic development initiatives. However, early indications are not showing the hoped for improvements in quality of life for people living in these communities.

The intended approach to alcohol management involved supply reduction (eg liquor restrictions) and demand reduction (including rehabilitation, treatment and diversion). Only the supply reduction strategies have been implemented in the past three years, through introduction of liquor restrictions in the communities involved. Given the high rates of alcohol abuse and related violence in the 19 Indigenous communities this is disappointing. Queensland Health must take some responsibility for this failure given its policy role in the area of alcohol abuse and its service roles in rehabilitation and treatment.

There are promising indications that Queensland Health is playing more of a leadership role in Indigenous health. It recently led the development of whole of Government initiatives to improve health in Indigenous communities, including initiatives to improve environmental health and housing quality. This package attracted new funding in the recent 2005-06 Budget and should complement boosted funding for Indigenous health services and the prevention and management of chronic disease.

These initiatives must be subject to rigorous and timely evaluation to identify and build on successful approaches, given the clear failure of many past initiatives to improve social and economic outcomes for Indigenous people.

7.5.3 Health promotion

Queensland Health has a role not only in health service delivery but also in promoting healthy living given the many preventable factors contributing to the high burden of disease amongst the Indigenous population including: low birth weight, obesity, poor nutrition in pregnancy, substance misuse and higher than average rates of cigarette smoking and illicit drug use.

Queensland Health should ensure that Indigenous people have access to information about healthy lifestyles that is culturally relevant. Availability of resources to help Indigenous people make healthy choices are also essential such as aids to help people quit smoking.

Queensland Health should also work with other agencies to make it easier for Indigenous people to make healthy choices. For example, Indigenous people should have access to affordable fruit and vegetables, regardless of where they live and town planning should enable safe and easy use of public spaces and facilities to improve physical activity.

7.5.4 Models of service delivery

There are a number of Aboriginal and Torres Strait Islander controlled health services in Queensland. In keeping with the philosophy of self-determination, these are community controlled health services. The Review visited a number of these which are performing very well but lacking resources.

Aboriginal and Torres Strait Islander controlled health services were introduced nationally in recognition that Indigenous people do not access as many Medicare funded health services as other Australians. Given that they offer an alternative to Medicare funded services, Aboriginal and Torres Strait Islander controlled health services are funded primarily by the Commonwealth Government. Queensland Health provides a much smaller funding contribution (reported to be less than ten per cent), which is lower than the contribution of some other States.

Most Aboriginal and Torres Strait Islander controlled health services are direct service providers, ranging from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services without medical practitioners, relying on Aboriginal health workers and/or nurses to provide the bulk of

primary care services, often with a preventive, health education focus.⁶⁶ However, in one urban area, the Review identified an innovative service coordination model (see boxed text, below). This model may have wider applicability in urban areas where there are a range of locally available health services.

Purchaser/coordinator model for urban Indigenous health services

Under this model, the Aboriginal Medical Service (AMS) acts as a service coordinator by managing referrals and arranging prompt access by Indigenous clients to local primary health care providers (based on a list of approved providers). The model appeared to be well used, with 2,800 of the 3,100 resident Indigenous people registered with the AMS (based on Census data). Key features of this model are:

- using existing, local medical and allied health providers rather than designing a new, Indigenous specific service
- providers treat people with respect
- consumers have a choice of provider and enjoy increased confidentiality as they are not visibly accessing an Indigenous service
- only one referral is required for GP services, with new referrals required for each occasion of service for allied health and dental services
- consumers can access local health service providers rather than face the potential inconvenience of travelling longer distances to a single Indigenous service provider
- providers receive payment in return for collecting information for AMS

In addition to Aboriginal and Torres Strait Islander controlled health services, new models of Indigenous health services could also be considered including fund pooling, where funds from different sources are pooled and managed by an agreed service. Queensland Health has previously resisted the concept of fund pooling, even where it has been demonstrated that there are other providers more able to deliver programs, particularly in the areas of primary care and health promotion. However, there are promising signs that this may be changing. The Cape York Institute for Policy and Leadership is developing a new devolved model of budget holding involving a non-government organisation. Queensland Health is working closely with the Institute with a view to implementing this service model in northern Queensland, including remote Indigenous communities.

The private sector also has a potential role to play in developing new approaches to Indigenous health. The Rio Tinto Child Health Partnership is an example of the private sector, communities, governments, researchers and service providers working together to improve Indigenous health.

In rethinking service models, paternalistic approaches to services such as birthing should be addressed. There is strong international evidence suggesting that birthing can occur in very remote locations safely and with improved outcomes for the Indigenous families living in these areas. Indigenous women generally prefer to birth close to their home, community and extended family. In the absence of local services, some women opt for no care, rather than leave their community, potentially placing both the women and their babies at risk.

Dr Cherrell Hirst AO examined this issue in her March 2005 report of the Review of Maternity Services in Queensland and identified improvements for Indigenous women as a priority. It is understood Queensland Health is progressing the reforms and developing an implementation plan for consideration by the Queensland Government. For this reason, the Review has not developed specific recommendations in this area.

⁶⁶ National Aboriginal Community Controlled Health Organisation website

Given the persistent and unacceptable health inequities facing Indigenous Queenslanders, Queensland Health should increase investment in Indigenous health services with an overriding commitment to the principle of self-determination and community control. This could include:

- a greater emphasis on health promotion
- (whilst recognising that these services were initiated and primarily funded by the Commonwealth) increasing the Queensland Government's investment in Aboriginal and Torres Strait Islander controlled health services
- working collaboratively with Aboriginal and Torres Strait Islander controlled health services to build their capacity and share skills
- developing new service models including fund pooling and/or service coordination in collaboration with Indigenous communities, the Commonwealth Government, and the non-government and private sectors
- reviewing paternalistic approaches to services such as birthing
- prioritising essential services in areas of greatest health inequity and working with other providers to ensure approaches reflect best practice for Indigenous communities in urban or remote settings – for example, mothers and babies services draw on the successful Townsville program as noted in Dr Hirst's report
- together with the Commonwealth Government, increasing investment in the Queensland Aboriginal and Islander Council to build its capacity as the peak body for Indigenous health services in Queensland.

7.5.5 Building the Aboriginal health workforce

Just over one per cent of Indigenous school students attend university.⁶⁷ This relates to a range of factors impacting on Indigenous educational disadvantage including poverty, remoteness and negative experiences in schools.⁶⁹ Furthermore, Indigenous students who relocate from their community to attend university have poor completion rates, given difficulties in living alone and being away from family support. This compounds the social and economic disadvantage experienced by Indigenous people and limits the potential supply of Indigenous health professionals.

To redress this issue, recruitment from, and teaching in Indigenous communities should be a major policy priority for all levels of government. In particular, efforts should be made to:

- provide support and mentoring for Indigenous people throughout their studies.
- develop health professional education and training which involve less travel away from communities (eg by using technology) or, ideally developing training based in Indigenous communities. Queensland Health has developed a registered nurse training program that enables Indigenous people to complete training while remaining in their community.

⁶⁷ Smith Family website

⁶⁹ James Cook University submission to the Productivity Commission Health Workforce Study, 2005

- provide income support during training. Mature age Indigenous students with dependents are in particular need of programs to assist with moving to a distant population centre.

As the Commonwealth Government is responsible for income support and funding public universities, it has a responsibility to fund universities to integrate such initiatives into their learning support and equity programs. Equally, Queensland Health as an employer has a role to play in supporting the development of the Indigenous health workforce and should build on existing initiatives such as community based nurse training.

In terms of the Queensland Health workforce, the roles of Indigenous health workers should be better developed as some districts are experiencing shortages in this role. Indigenous Health Workers must be better remunerated and recognised as professionals, with the capacity to screen for disease, offer some treatments and be engaged in the development and management of services. Too often they are relegated to the role of ancillary worker or case manager, with no real autonomy in their roles. Better funded training programs (particularly in the area of mental health), staff mentoring and career development should all be features of an improved service delivery model.

As a principle, Queensland Health should aim to recruit local workers to local positions. The Review has heard anecdotally of situations where local applicants have been overlooked for positions in favour of outsiders. While applicants must demonstrate appropriate skills and capabilities, local appointments are more likely to result in staff retention. Where outside applicants are appointed, they should be supported to build effective relationships within the community.

I agree that more staff are needed, in particular female, but the key to effective communication with Indigenous people is to know how to link with appropriate community people. I have only been here for 9 months, and have developed a healthy relationship and liaison with the elders and I feel this should be continued as an integral part of strong formalised community links between health and the people.

Source: Submission to Queensland Health Systems Review, July 2005

Recommendation 7.15

Better ways will be trialled, to work closely with Indigenous communities, government departments and the non-government sectors to contribute to efforts to reduce Indigenous disadvantage in both urban and remote settings. In particular, Queensland Health will urgently lead the development of alcohol demand management strategies in the nineteen Indigenous communities where Meeting Challenges Making Choices is implemented.

There should be a stronger emphasis on health promotion so that Indigenous people have the skills, knowledge and resources to make healthy choices.

A more flexible approach to Indigenous health services should be established to support existing and new service models including fund pooling and service coordination models, with an overriding commitment to the principle of self-determination and community control.

Partnerships with universities and other providers should be developed to increase Indigenous entry and retention into health professional education and training.

The role of Indigenous Health Workers should be further developed, through access to funded training and skills enhancement programs and will aim to recruit local workers to local positions to improve staff retention.

7.6 Mental health

Since the early 1990s, Queensland Health has undertaken significant mental health reforms including:

- increased expenditure on mental health initiatives from \$240 million in 1997-98 to \$418.7 million in 2003-04 – an increase of 74 percent⁷⁰
- more equitable distribution of inpatient mental health services across the State - by 2002, Queensland Health had completed a process of decentralising inpatient beds from large psychiatric institutions to 18 districts, enabling more treatment of patients closer to their home
- development of community mental health services, particularly in regional, rural and remote areas where no services had previously existed. Community staffing numbers increased by an estimated 350 percent between 1993-94 and 2004-05.⁷¹
- an expanded range of adult community health services
- increased involvement of consumers and carers in the planning, operation and evaluation of services
- implemented quality management systems including minimum service standards
- improved intersectoral links, particularly with housing and disability support agencies eg through implementation of Project 300
- released a position paper supporting consumer designed, recovery-oriented service models which emphasise that even people seriously affected by mental illness can and do recover to live productive lives in their community.

These reforms have made a significant improvement to the quality of life of many Queenslanders with mental illness and were acknowledged by consumers and clinicians who met with the Review. In particular, the recent release of a position paper on recovery service models has met with universal stakeholder support and should guide future reform in mental health.

Despite these reforms, the most significant concerns expressed to the Review were the lack of access to, and quality of, Queensland Health mental health services. There were numerous tragic accounts of systemic failure within the community and acute settings. As noted in the Interim Report, Queensland has alarming suicide rates, particularly for Indigenous people. Overall, Queensland has the second highest suicide rate of the Australian states, approximately 30 percent above the rates in New South Wales and Victoria. This is an important indirect indicator of the mental health system given that 88 percent of people who die from suicide suffer from a diagnosable mental disorder at the time of their death⁷².

Consumers and consumer advocates believe they should have a much stronger voice in planning, delivery and evaluation of mental health services. Whilst in some services, gains have been made in engaging consumers in management teams, clients and advocates have indicated this is sometimes a token gesture, with many decisions in relation to the service made outside the executive committee.

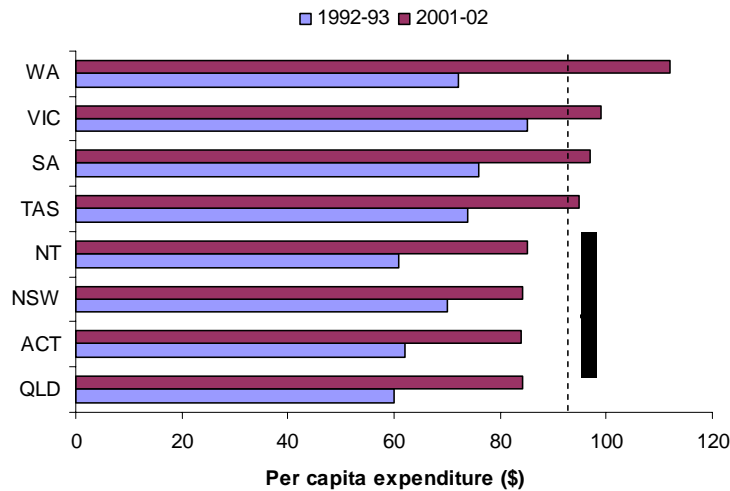
⁷⁰ Queensland Government submission to Senate Select Committee on Mental Health, 2005

⁷¹ *ibid*

⁷² Australian Bureau of Statistics, Mental health and well being: profile of adults, Australia 1997, 1998

The graph below shows that between 1992-93 and 2001-02, Queensland significantly increased mental health funding. Queensland’s per capita expenditure is comparable to NSW, ACT and NT.

Per capita expenditure on specialised mental health services by states and territories, 1992–93 and 2001–02



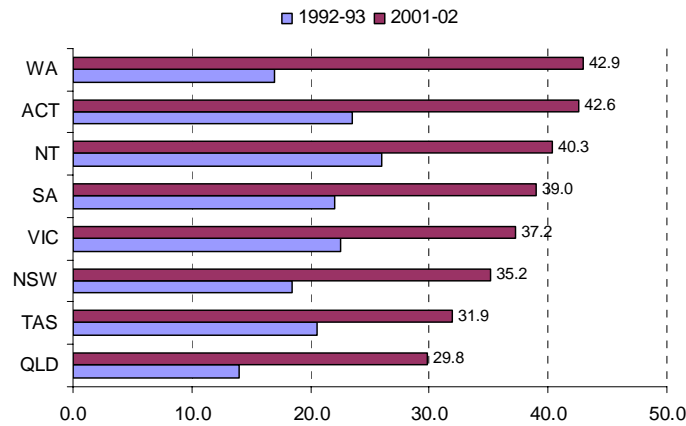
Source: Australian Government Department of Health and Ageing, 2004

Nonetheless, funding for mental health remains comparatively low, despite real funding increases. This is because mental health has had an historically low funding base and funding increases have occurred during a time when population growth in Queensland was twice the national average. In addition to concern about Queensland’s comparative low funding for mental health, there is concern that funding does not reflect the burden of mental illness in Queensland.

This needs to be redressed and, in particular, funding should be directed to enable Queensland Health to meet staffing targets for community mental health services.⁷³ The graph below shows that, despite significant increases in community mental health staff, Queensland has the lowest number of clinical staff employed in non-acute mental health settings. Consideration should be given to updating and providing flexibility in the community health staffing formula to reflect better the particular issues faced by some communities eg levels of drug abuse, socio-economic factors, family breakdown, lack of other support services, lack of alternative care and levels of unemployment.

⁷³ In 1996, planning targets were established at 30 per 100,000 total population for adult mental health services, 25 per 100,000 for the under 19 years population, 10 per 100,000 of the 65+ population, whilst targets set for Indigenous workers are at 5 and 6 per 10,000 for child and youth and adult services respectively.

Clinical staff employed in ambulatory mental health services per 100,000 population



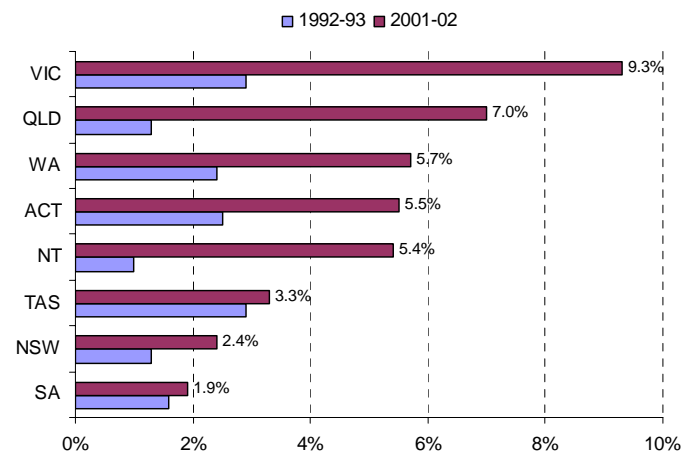
Source: National Mental Health Report 2004

There is a lack of transparency around so called “quarantined” mental health funding and that in some areas, dedicated funding is used for other services or to balance budgets.

Source: Submission to Queensland Health Systems Review, July 2005

Only \$6.9 million is directed to non-government organisations to provide community based social support and non-clinical mental health services.⁷⁴ However, the table below shows that Queensland spends comparatively more in the non-government sector as a proportion of overall mental health expenditure and has significantly increased investment in non-government organisations since the early 1990s. The Review heard directly from mental health consumers about the importance of non-government social support services in their recovery. The role of this sector should be significantly expanded, including stronger partnerships with the non-government psychiatric disability sector.

Funding to non government organisations as a percent of total spending on mental health services



Source: National Mental Health Report 2004

⁷⁴ Queensland Government submission to Senate Select Committee on Mental Health, 2005

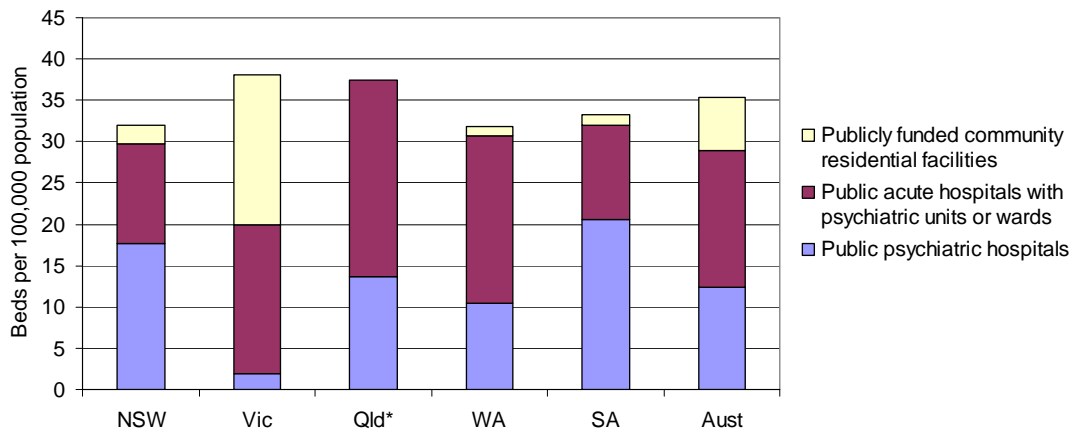
Development of a broader range of care models should take account of the potential contribution that non-government organisations and the private sector can make. Other jurisdictions have adopted models with increased use of private mental health services.

Whilst some links with the housing and disability sectors have been established, these arrangements are immature and there is scope for much improvement. In this respect, reform must be driven at the policy and strategic level as well as at the operational level, to improve alignment between departmental priorities.

Evidence shows that inappropriate discharge and lack of support often leads to adverse outcomes for patients. Tragic first hand accounts were revealed during public consultation sessions. As the graph below illustrates, there is need for improved housing and support for people with mental illnesses, including step down facilities for patients released from acute care. In the absence of a community residential sector, people with mental illnesses are living in inappropriate settings such as private boarding houses.

The non-government sector has a significant role to play in building this sector, given its experience and expertise in managing clients in the community and providing alternative types of supported accommodation. Their contribution cannot be enhanced without funding support. The Logan partnership model noted earlier in this Chapter provides a basis for further work.

Specialised mental health services, number of beds as at 30 June 2003



Source: *Mental Health Services in Australia 2002-03, AIHW 2005*

* Queensland does not fund community residential services, however, it funds a number of campus based and non-campus based extended treatment services. These services are reported either as wards of public acute hospitals or beds in public psychiatric hospitals.

Post-discharge support should also focus on broader issues including employment, rehabilitation and optimising the response to treatment, again through partnership with a range of other sectors. Queensland Health should work with the employment and training sector to develop targeted assistance for people with mental illnesses. Based on international evidence, there is room for much improvement in this area. In Australia, five per cent to nine per cent of public patients are within the workforce compared to other jurisdictions adopting a more holistic model of care which demonstrates 35 percent to 45 percent of patients undertaking some form of employment.⁷⁵

⁷⁵ Cochrane Collaboration, volume 3, 2005

Queensland Health also has a major contribution to make in efforts to reduce homelessness given high rates of homelessness in Queensland and the high prevalence of homeless people with serious mental illness, estimated in some international studies to be as high as 50-80 percent.⁷⁶ It is critical that Queensland Health work across government to implement and evaluate the new initiatives funded in the 2005-06 Budget to establish specialist mental health, general health and drug and alcohol services for people who are sleeping in public places.

Mental health service models must be developed in tandem with alcohol, tobacco and other drug services given the increasing numbers of dual diagnosis (mental illness and drug and alcohol problems) presentations to Queensland Health facilities. In particular, mental health services report increased demand and violence due to use of illicit drugs, consistent with other jurisdictions.⁷⁷ More integrated policy and service planning should be aided by the proposed collocation under the Chief Health Officer of the mental health and alcohol, tobacco and other drugs units in corporate office.

Providing a continuum of care for a widely dispersed population is challenging, particularly in rural and remote communities where local inpatient care is not viable. In these communities, the Review heard of particular difficulties given the lack of after hours care, necessitating travel, sometimes over long distances, to access after hours inpatient care. Queensland Health should provide outreach to rural and remote communities, explore community based alternatives to acute inpatient care and extended hours for community health services, and increase use of telehealth to address this issue.

The Review has also heard of a need for increased and improved services for children and young people, in particular early detection, prevention and intervention for child and adolescent mental health problems. Services catering to young people with dual diagnosis are also required, with services reporting an increase in illicit drug use and increased presentations with first episode psychosis in younger populations.

Indigenous people are over represented in the mental health services. During the Review's consultations, it was repeatedly reported that mental health services offered to Indigenous people were often culturally inappropriate, could not be accessed locally and that staff were very inexperienced in dealing with Indigenous people. This highlights a need for improved models of care developed with the involvement of Indigenous consumers.

There is also a high presentation of mental health clients in the prison system. According to the South East Queensland Prison Mental Health Service, there are 500 to 600 open cases at any one time out of a prison population of 3,500. This is not a stable population as patients come and go from the system with approximately 50 new cases each month. This service is provided by 2.2 psychiatrists and 1.5 allied health practitioners. The discharge and referral process to community mental health is complex and, whilst staff try to follow up they are not always able to trace the client. Additionally, the court liaison service is under-resourced, representing a missed opportunity to provide early intervention and treatment to patients in custodial settings, before they become involved in the criminal justice system.

In line with Queensland Health's increased focus on prevention, there is a need for more investment in preventative measures including mental wellness promotion, early

⁷⁶ "Homelessness and Accommodation", Schizophrenia Fellowship of NSW website

⁷⁷ *ibid*

intervention and relapse prevention. This could include increased “mainstreaming” of primary mental health services including an expanded role for allied health workers in community health settings. This should also involve whole of Government mental health promotion.

Mental health services face significant workforce pressures, including difficulty recruiting specialist nursing, allied health and medical staff. Existing staff report high levels of stress related to dealing with increasingly difficult clients and client aggression. Chapter 10 outlines a program of workforce reform including measures to increase workforce supply, improve recruitment and retention of our clinical staff and provide immediate relief for our stressed and overworked clinical staff.

There is also a perception that mental health is a marginalised issue within Queensland Health. Submissions to the Review highlighted the high turnover in corporate office mental health leadership positions and the need for stability in this regard.

Further mental health reforms will require strong leadership, continued and increased investment and strong involvement of consumers and clinicians. Whilst a mental health clinical network should be used to drive service and workforce planning, it will be essential that consumers, advocates and the non-government sector also participate in this work. As an immediate first step, it is suggested that Area Health Services coordinate a mapping exercise within districts to assess service needs, benchmark service levels and models with other jurisdictions, and identify partnership opportunities with other agencies and the non-government sector. This could inform a renewed reform agenda for mental health.

Recommendation 7.16

A review of the current funding arrangements for mental health should occur, and Area Health Services will undertake an immediate mapping exercise to inform further mental health reforms with a view to:

- Continuing to increase investment in the community health sector
- Increasing provision of supported accommodation including “step up” and “step down” facilities
- Developing new models of care with the private and non-government sectors and continuing to increase investment in non-government mental health services
- Increasing participation of consumers and carers in decision making
- Improving linkages and partnerships with other sectors to improve post-discharge support, improve services for population groups with multiple and complex needs and increase efforts around mental health promotion and prevention
- Improving mental health services for people in correctional facilities and custodial settings
- Increasing integration of mental health and alcohol, tobacco and other drugs services
- Strengthening organisational leadership around mental health including stabilising turnover in key central leadership positions
- Addressing workforce pressures as recommended in Chapter 10.

7.7 Community health services

District visits and consultation identified that many services are offered in Queensland Health community health centres ranging from primary and secondary interventions, particularly in the areas of child and family health, aged care services (Home and Community Care services), some rehabilitation services, such as stroke and cardiac, some health promotion and chronic disease management and some post-acute services. In the districts visited, there was significant variation in the types of services and programs offered in community health centres and in the degree of service growth that had occurred in recent years.

Across Queensland Health, it is not possible to define clearly the scope of community health services. A Community Health Position Statement was developed but there is general agreement it was too broad and has not guided service development or scope definition. There is no person in the organisation, either centrally or in the current zonal structure responsible for community health services. This has made service planning difficult.

There is no information system to record and report collective activity or performance and locally compiled information is not reported above the district level. This prevents any strategic assessment or planning of Queensland Health's community health services, particularly with private health service providers and hinders efforts to drive State-wide programs or reforms through the network of community health services. The paucity of information also prevents effective comparison with other States in terms of expenditure, activity and service models.

In the absence of clear scope definition, community health services are expected to be "all things to all people." The range of roles currently being offered is outlined below.

Promotion, prevention and primary care

Community health services provide health promotion, prevention and primary care services, including alcohol and drug education and counselling, sexual health service, parenting programs and, in some, patient education around disease prevention and chronic disease management. The promotion and prevention role is being expanded through placement of nutrition and physical activity workers in community health centres to address rising childhood obesity. Community health services accept self-referrals, creating potentially unlimited demand from individuals in the community.

Coordination with the acute care sector

Within Queensland Health, there is an expectation that community health services work with public hospitals to ensure that transition to community is facilitated and those services which do not have to be provided in an in-patient service can occur in the ambulatory setting. Some community health services provide post-acute care. However, district visits suggested that this service coordination is not working effectively in all sites. Given the pressure on Queensland Health's acute services this should be an area of priority for community health services and better service planning needs to occur across the hospital and community health settings. A good practice model in Victoria involving community health services is highlighted below. A similar approach in Queensland has been funded in the 2005-06 budget for chronic disease management, building on existing successful models in some Queensland Health service districts.

Victorian model to reduce hospital readmissions through community health services

The Victoria Hospital Admission Risk Program aims to reduce unnecessary hospitalisations for patients with certain conditions who don't always require the medically intensive services that hospitals provide. These people are activity assisted and supported in the community to manage their health conditions. The Program has successfully reduced the need for hospitalisations for the two targeted conditions of chronic obstructive pulmonary disease (COPD) and congestive heart failure. This includes reducing admissions for COPD from over 1,800 to under 400 per year over four years.

Interaction with general practice

As a GP, I am much more concerned about the lack of access to allied health services, services for people with chronic pain, assessment and interventions for children with learning difficulties and behaviour difficulties, parenting support for families, family therapy for those not functioning well, support for families with young disabled people, particularly access to respite and residential care.

Source: Submission to Queensland Health Systems Review, July 2005

The lack of a defined scope for what services are provided by community health means that general practitioners and other private providers have no clear idea of possible duplication or opportunities for collaboration and coordination. Even when GPs are aware of some of the services providers, there is potential for inefficiencies.

For example, some GPs make referrals to community health services to provide nursing and allied health services for patients on low incomes who cannot afford to purchase these services privately. However, some people are able to access Medicare subsidised private allied health services under a treatment plan developed by a general practitioner. As a principle, Queensland Health should not be duplicating allied health service provision where Medicare subsidy is available and should be working with GPs to encourage the development of treatment plans. The boxed text below highlights a good practice example of shared service planning and delivery in south east Queensland.

Shared planning and service provision

The development of the North Lakes and Surrounds Health Precinct is an example of the new way in which services should be planned. The Precinct has been planned through collaboration with local public and private health service providers and is taking a proactive approach to improving the health of the local community, with a focus on reducing avoidable hospital admissions and redirecting services where possible from an acute to community setting.

Local health service providers are collaboratively working towards changing the health care experience of local community members. The aim is for the local community to be screened for lifestyle risk factors as a part of their usual care, to prevent the onset of chronic disease and. The local community will experience greater coordination of their health care across providers. As their care will be based on agreed protocols, local community members will experience less unnecessary intervention and receive more consistent messages about what they can do to be healthier. Their communication with health care providers will be broader than doctor's visits and include telephone contact, email contact and home visiting.

Given limited public resources, there needs to be clarity about the role and scope of community health services and identification of which services are more appropriately offered by other providers. Queensland Health should consider whether it is feasible for community health services to play all of the roles outlined above.

Through district visits, community health services expressed a view that, proportionally, they do not receive as much growth funding as the acute sector. This is attributed to the greater political attention directed towards acute services. Chapter 3 noted there has been higher growth in community health services than the acute sector but consultation findings would suggest that this growth has not been adequate. Future expenditure on community health services should be determined by better scope definition and service planning.

Services also reported that their ability to perform effectively was limited by a lack of computers and other communication tools, vehicles to allow movement in and around communities, and general patient education information. In the districts visited, the Review verified this resource shortfall.

Directions for change

Other Australian jurisdictions use community health services more strategically to:

- provide health promotion
- provide interventions to reduce risk factors for chronic disease
- prevent unnecessary hospitalisations through alternative service provision
- provide post-acute care for those at risk of readmission.

Queensland should similarly adopt a clear, strategic approach to community health service provision. Given the issues identified above, this should involve:

- identifying positions which are accountable for community health services in each Area Health Service
- auditing community health services to identify what services are provided, examples of good practice and service gaps or challenges
- implementing an information system to assess activity, investment and outcomes
- defining the scope of community health centres across the continuum of care and lifespan and clearly delineating the roles of community health services and the population health function in Area Health Services
- aligning new health initiatives announced in the 2005-06 budget with the defined scope for community health services (particularly for the \$151 million over four years for chronic disease management) – this will include a focus on the provision of post-acute care, particularly for those at risk of re-admission
- developing services in collaboration with general practice, non government organisations and community groups, including opportunities for partnerships, outsourcing, service coordination or fund pooling.

Recommendation 7.17

Within 12 months, a clear, strategic approach to community health service provision in line with the directions for change outlined in section 7.7.1. will be adopted.

7.8 Health services for Queenslanders in correctional institutions

The Review has been made aware that the Department of Corrective Services is responsible for the provision of health services to prison populations. These populations have vastly worst health status and outcomes than the average population, and have a much higher representation of Aboriginal and Torres Strait Islander people and people suffering from mental health problems than relative components in the general population. It is also significant that prison populations, on average, turnover in less than six monthly periods when this cohort of people are again part of the general community.

There is need to ensure that health service provision within the correctional system is adequate, and that people although incarcerated are receiving services that will address current needs and most importantly prevent escalating problems once released into the broader community.

There are limitations with the current arrangements in that health services are not considered to be the core business of correctional service management, and there is evidence that health priorities are not being adequately addressed. There is also information to suggest that political and managerial decisions are made about matters that should probably be decided by clinicians.

Whilst it would be imprudent to transfer the responsibility for correctional services population health to Queensland Health at the present time when it is experiencing such service delivery difficulties, it would be reasonable for existing arrangements within correctional facilities to be properly funded and resourced, and for clinicians to make appropriate decisions about the best types of medication regimes that should be provided to these people. Failure to do this will only exacerbate health service problems in the broader community. The Department of Corrective Services and Queensland Health should undertake discussions to ascertain the best model for the delivery of health services to correctional institutions and, if a change is warranted, to ensure this occurs in a timely and appropriate way given all of the other priorities outlined in this report.

Recommendation 7.18

Health care in correctional institutions be resourced adequately and Queensland Health and Department of Corrective Services seek agreement on the best future delivery options.

7.9 Oral health services

Queensland has the worst dental health in Australia and is one of the few States which continued the provision of a free dental health service for eligible adults following the Commonwealth government's withdrawal from providing subsidised access to dental health services nationally.

Approximately 25 percent of the Queensland population is eligible for free dental health services in Queensland, including school aged children and adults with health care cards or pension cards. Despite recent increases in the oral health budget, Queensland Health is unable to meet the demand for oral health services, with emergency rather than routine dental services representing a significant proportion of adult health services provided.

Dentist positions within Queensland Health number around 300. Queensland Health is attracting less graduate dentists and has problems recruiting and particularly retaining its dentists, placing the long term viability of public oral health services at risk. Contributing factors are significantly higher private sector incomes and the less challenging nature of the work performed in the public sector.

An innovative approach to retaining dentists in the public system is a trial being conducted in the Hervey Bay region, using a mixed public/private service model. Public sector dentists are given the opportunity to work one day per week on private patients in Queensland Health facilities. An additional dentist was employed to ensure the public service levels were maintained while the dentists themselves paid the oral health service an hourly fee that covered the use of the facility, staff and materials. This fee represented total cost recovery for Queensland Health.

The benefits to Queensland Health, dentists and patients were seen as very positive, including:

- stabilised staffing as dentists had greater work satisfaction, practiced skills they did not have the opportunity to use in the public sector and enjoyed better remuneration
- increased throughput of public occasions of service by 5 percent
- patients, both public and private, received the initiative very positively
- private dentists and the Australian Dental Association endorsed the trial as it provided them an opportunity to refer patients they could not see due to excessive demands.

To improve provision of equitable, timely and sustainable oral health services, it is proposed that:

- school dental services be continued
- eligibility criteria for adult services be reviewed, to target them to individuals of greatest need in the community
- increased interaction with the private sector be considered including outsourcing and mixed public/private models such as that being trialled in Hervey Bay
- alternative workforce roles be considered, eg enhanced roles for dental therapists.

In respect to outsourcing, persuasive submissions were received from practicing professionals which confirmed that a higher participation by private dentists would be very beneficial, but would require flexible arrangements and fee rates based on each professional's local circumstances.

This is exactly the level of decision authority clinical networks and district health services need to have to ensure highest value use of scarce oral health resources.

Recommendation 7.19

Options to improve provision of oral health services be explored including continuation of school dental services, review of eligibility criteria for adult services, alternative workforce roles and mixed models of public/private practice. There should be an informed public debate about widespread fluoridation of Queensland's water supply.

The involvement of private sector oral health practitioners in delivering public services be encouraged through local fees and arrangements that flexibly address the merits of each case.

7.10 Child and youth

Children and young people have distinctive health needs and priorities that differ from the adult population. Queensland Health provides many services and programs for children, young people and their families across the continuum of care. Key services or programs provided include:

- early childhood health services
- early intervention and parenting support programs including the highly regarded Positive Parenting Program (Triple P)
- school or child care based services such as school nurses and oral health services;
- hospital based paediatric medical and surgical services and associated developmental, allied health and rehabilitation services
- information and support services
- child and youth mental health services.

However, Queensland Health does not have a comprehensive plan for children and young people across the continuum of health, despite children and young people aged 0 to 14 years comprising 20 percent of the population. A child and youth clinical network is suggested to undertake dedicated planning for children and young people's health. This could be informed by reviewing and benchmarking existing initiatives and identifying gaps or opportunities for further focus. Suggested areas for attention are identified below.

One opportunity would be to implement a key recommendation in the March 2005 report by Dr Cherrell Hirst AO on maternity services in Queensland to create "bub-hubs" to provide more seamless transition from maternity services to child health services for families with newborn babies. This would build on the existing integrated maternity, child and youth health services that have been developed in some health districts. There is also an opportunity to develop further the network model in paediatric services, particularly through clinical education and telehealth.

Queensland Health has recently undertaken a mapping exercise and identified a need for investment in:

- increased community based early intervention services for children, in line with international evidence of the benefits of investment in early childhood;
- community based paediatric services for children with chronic conditions, developmental delays and developmental and learning disabilities; and
- health promotion in early childhood and school settings targeting areas of highest need including communities with high Indigenous populations.

In line with discussion throughout this chapter, it is important that Queensland Health works with other providers and organisations in developing new or enhanced children's services. In particular, Queensland Health should continue working with other agencies to build on the Queensland Government's major priorities of education reform and child safety. Continued efforts to identify and assist "at risk" families are required to reduce the risk of child abuse and neglect.

Whilst efforts should be focused on prevention and early intervention for children, there clearly remains a need for high quality acute paediatric services. The duplication of expensive tertiary paediatric sub-specialty services at both the Royal Children's Hospital and the Mater Children's Hospital does not appear to be a sustainable model. Rationalisation is recommended to improve service sustainability, maximise available resources and reduce pressure on staff currently experiencing onerous on-call arrangements.

Recommendation 7.20

A state wide network should be developed for child and youth health across the health continuum involving other major providers and partners. Further expansion of telehealth services should occur where appropriate to maximise availability of paediatric services and clinical education. The development of tertiary paediatric sub-specialty services should be reviewed.

8. Clinical support services

Clinical support services in the terms of reference of the Review generally cover pharmacy, radiology and pathology services. However, administration staff and operational support staff in clinical areas are also being considered as they provide essential support in the delivery of quality health services.

As discussed in the Interim Report, clinical support services need to be available to support quality clinical services. Clinical support arrangements need to maximise the availability of clinicians' time to focus on clinical tasks, not administrative and operational support tasks and clinical support staff need to be used to their greatest benefit within the Queensland Health environment.

The structure proposed for Queensland Health includes the creation of the role of a Chief Operations Officer to lead and manage business and clinical support services on a statewide basis. The creation of the Clinical Support Services Group is intended to provide a strengthened approach to service delivery, with a strengthened approach to coordination radiology and pharmacy services. The creation of the Clinical Support Services Group is not intended to remove any Fringe Benefit Taxation concessions (previously known to staff as "PBI" taxation benefits).

8.1 Provision of pathology services

Queensland Health Pathology and Scientific Services has operated as a separate business unit within Queensland Health since 2001-02 and is the principal provider of public sector pathology services. It employs approximately 1,700 staff and has an annual budget of approximately \$66 million. Expenditure on pathology services in Queensland Health increased by 14 percent per annum between 2000-01 and 2004-05 (estimated).

This Review has not included a systematic assessment of the John Tonge Centre, which is currently the subject of a separate review. The Review has not made specific recommendations regarding the delivery of scientific services, noting that the recommendations of the separate review will be considered in due course.

The pathology fee-for-service arrangement is considered to be working well, although as the model is generally based on a minimum and maximum volume for each district, there is not a completely direct relationship between pathology testing and costs i.e. districts are only charged additional fees if ordering exceeds the maximum negotiated volume. This fee structure provides economies of scale, but does not provide a direct price incentive to improve the effectiveness of pathology ordering.

The key workforce challenges for pathology services are:

- attracting and retaining sufficient numbers of qualified staff to ensure the ongoing provision of services
- ensuring sufficient pathologist training positions
- providing sufficient supervision for overseas trained pathologists.

Clinical workforce issues, including remuneration and training arrangements are discussed in more detail in Chapter 10.

The Interim Report highlighted that some pathologists indicated outsourcing and running pathology services as a private enterprise would be easier in terms of being able to recruit pathologists. However, concerns were also raised about the need to maintain a critical mass of pathology within Queensland Health to ensure rural and remote communities had access to a cost efficient pathology service. A further option identified was to convert the pathology service to a separate Government Owned Corporation (GOC), with a commercial board of directors operating under the *Government Owned Corporations Act 1993*. It is not clear that the creation of the Queensland Health Pathology Services as a separate legal entity (eg. GOC) would provide significant benefits in terms of ensuring the ongoing competitiveness of the service.

Based on the consultations and submissions received, it has been concluded that the Queensland Health Pathology Service model is generally well regarded by Queensland Health districts as providing timely and quality services, although it could improve its cost efficiency in the delivery of services.

It is recommended the Queensland Health Pathology Services be included in the Clinical Support Services Group as a commercialised business under the management of a Chief Operations Officer and overseen by the Business Services Board. A similar model is being implemented in New South Wales for the provision of its pathology services as a statewide support service. Where districts currently acquire services from private providers, their arrangements should be continued.

The Review has noted material provided which has suggested the Queensland Health Pathology Service could reduce its overall costs of service delivery by pursuing more cost efficiency measures including the potential consolidation of laboratory services in Brisbane. Improving the cost effectiveness of pathology services would be the responsibility of the Chief Operations Officer and the Business Services Board, with the objective of ensuring the pathology service is competitive with private sector delivery at a statewide level.

The Review recommends the Queensland Health Pathology Service develops a benchmarking system to allow benchmarking against private sector pathology providers. The benchmarking should be based on the full cost of service provision, consistent with the operations of a commercial pathology provider. In the medium to longer term Queensland Health will need to reassess whether the continued internal provision of pathology services is cost effective compared to comparable private sector options.

Recommendation 8.1

Queensland Health Pathology Service to be included in the Clinical Support Services Group.

Recommendation 8.2

The Queensland Health Pathology Service to develop a benchmarking system to allow for comparison with private sector providers to demonstrate ongoing cost competitiveness with the external providers at a statewide level.

Recommendation 8.3

Queensland Health to review the number of training positions required for pathologists to meet future needs.

8.2 Provision of radiology services

Many Queensland Health hospitals are feeling pressure from radiologist shortages. Eleven districts have access to their own radiology service on a daily basis, while other districts are contracting radiology services to external providers.

The key challenges for the radiology services are:

- attracting and retaining sufficient numbers of radiologists to ensure the timely delivery of radiology services. The critical shortage of radiologists is placing considerable workload pressures on existing staff
- providing sufficient radiology training positions to ensure longer term sustainability of services
- insufficient access to radiology services means some districts are indicating that a percentage of medical images are going unread or in some cases imaging is not occurring because radiology services are not available. This is particularly an issue after hours or on weekends and impacts on the quality of care which can be provided, and in some cases results in significant delays in service
- the absence of a coordinated model for the provision of radiology services throughout Queensland Health. The exception is the Northern Zone where Townsville is attempting to provide a support hub for other districts, although Townsville is accessing some services from South Australia via tele-radiology
- adequate investment in the replacement and upgrade of equipment to provide a quality service. Radiologists have advised in some instances it is the quality of equipment rather than radiologist shortages which is impacting on turnaround time for reporting of medical images.

Continuation of the current arrangements for providing medical imaging services is not a sustainable option and more coordinated and innovative options for providing its clinicians with access to a quality radiology services is required.

The Review recommends Medical Imaging (radiologists) be transferred to the new Clinical Support Services Group. The radiology service would be responsible for providing reporting of medical images at the local hospital level, as well as coordinate out-of-hours reporting service. The Medical Imaging Service may be a combination of internal Queensland Health radiologists and external providers. The service would need to demonstrate it is commercially viable compared to procurement of services from alternative providers generally.

As a number of districts currently have arrangements with private providers, districts should retain the flexibility to purchase reporting services from the statewide radiology service or private provider. However, all radiology reading services should meet a minimum standard of service.

Radiologists shortages are prevalent across Australia, with significant competition between public and private sectors for specialists. If Queensland Health finds its capacity to deliver services consistently is failing due to workforce shortages in specific areas, it may need to consider specific remuneration options to attract and retain specialists, or alternatively pursue options with the private sector for the delivery of services.

Consultation and submissions to the Review indicated the need for additional radiology training positions. This is supported by the AMWAC recommendations for national training positions⁷⁸. These additional positions should be considered within the context of a radiology services plan and in conjunction with the establishment of the statewide radiology service.

Tele-radiology provides the capacity for medical images to be transmitted and reported remotely, although this infrastructure does not currently exist throughout Queensland Health, and some investment would be required. However, this should be done in the context of a fee-for-service arrangement with the statewide service. Management of medical imaging services would remain a district responsibility.

Radiology specialists constitute only 7 percent of Queensland Health employees working in its medical imaging departments. Radiographers and medical imaging nurses are a significant proportion of the medical imaging workforce. In the United Kingdom, radiographers are increasingly being trained to undertake diagnostic reporting of some selected skeletal examinations (plain film x-ray) on accident and emergency patients, while nurses are starting to perform some angiographic and interventional procedures.

In this context, there is scope for development of advanced training programs for radiographers and medical imaging nurses to increase their scope of practice. As part of the overall workforce reform strategy, Queensland Health and the university sector should consider opportunities to expand the training arrangements for radiography and nursing.

Investment in medical imaging equipment has also been raised as an issue with the Review. Capital replacement is an issue across Queensland Health, with districts and area health services needing to prioritise the available capital funds between building infrastructure, health technologies and information and communication technologies. These issues will need to be addressed in the context of the broader asset management and capital works funding and planning arrangements as outlined in Chapter 11.

Recommendation 8.4

Establish a statewide radiology service network, to provide radiology coverage across Queensland Health under the Clinical Support Services Group. Districts to have the option of using the statewide service for radiology services or purchasing services from external providers.

Recommendation 8.5

Queensland Health to consider the requirement for additional radiologists in line with the Australian Medical Workforce Advisory Committee (AMWAC) recommendations.

Recommendation 8.6

Queensland Health to develop an education and training system for radiographer and medical imaging nurse practitioners and the possible development of radiographer practitioners along the proposed nurse practitioner model.

⁷⁸ Australian Medical Workforce Advisory Committee, Annual Report 2003-04

8.3 Provision of pharmacy services

Pharmacy services are an integral part of the delivery of health services. In 2003-04, Queensland Health spent \$189 million on drugs, approximately 4 percent of the total budget. On-site pharmacy services are provided throughout Queensland Health's hospital network with bulk ordering back to a central pharmacy located at Herston, although some pharmaceuticals are acquired through local networks.

At the Central Office level, the Medicines and Pharmacy Services Unit:

- provides professional advisory services and coordinates a range of pharmaceutical services including the Queensland Hospitals Drug Advisory Committee, the Pharmacy Advisory Committee, the Hospital Pharmacy Advisory Committee, the Queensland Drug Information Centre and the Queensland Poisons Information Centre
- manages a range of pharmaceutical programs including the Highly Specialised Drugs Program and pharmacy aspects of the Queensland Health scholarship program
- coordinates the development and application of national and international guidelines/policies especially through the National Coordinating Committee on Therapeutic Goods.

As part of the Commonwealth Pharmaceutical Reform program, Queensland Health is a signatory to the implementation of the principles of the Australian Pharmaceutical Advisory Council (APAC) Quality Use of Medicines Continuum. Queensland Health hospitals have the option of introducing the Commonwealth Pharmaceutical Benefits Scheme (PBS), on the condition they progress Quality Use of Medicines initiatives including meeting APAC milestones.

The key challenges for pharmacy services across Queensland are:

- the ability to attract and retain sufficient numbers of pharmacists in all parts of Queensland, particularly at the pre-registration and senior levels. There are significant vacancy levels across many areas of the State, impacting on the workload and capacity of remaining pharmacy staff. In January 2005 the vacancy rate for pharmacists was 16 percent (down from 25 percent in June 2004).
- recruitment and retention issues for pharmacists in rural and remote areas can be severe. In some cases, a single pharmacist is responsible for a district's pharmacy needs, with nurses managing locally under pharmacist supervision. Although this arrangement in many cases works well this situation is not ideal. Issues in rural Queensland include providing training and relief arrangements, as well as non-clinical support.
- interface with the PBS and achieving the APAC milestone for Quality Use of Medicines
- including pharmacists within multi-disciplinary teams to improve prescribing, safety and medicines management. Pharmacists indicated that with a lower workload they would have improved capacity to become more proactive in providing advice on new and emerging pharmaceutical options, educating on better medicine practice and advising on more cost effective pharmaceutical use.

From a workforce perspective, Queensland universities have increased the output of graduates significantly in the last few years and this growth continues:

- University of Queensland graduations have increased from 70 to 80 per year in the mid 1990s to approximately 140 to 160 per year at present
- James Cook University commenced graduating 50 per year in 2004
- Queensland University of Technology will commence graduating 30 pharmacists per year in 2005
- Griffith University will commence graduating 30 pharmacists per year in 2007.

The additional graduates may have a significant impact on the current level of vacancies within Queensland Health, although hospital pharmacists accounted for approximately 14 percent of pharmacists, with 84 percent of pharmacists working in the community sector.

Queensland Health implemented a number of changes to staffing structures to improve the effective utilisation of pharmacist resources. This included establishment of a career structure for Pharmacy Technicians and Pharmacy Assistants. These roles are now well established within Queensland Health, although there may be scope to expand these roles further.

Queensland Health has used a Central Pharmacy system for a number of years, with the arrangement generally well regarded, although the option of having more pharmaceuticals provided locally, particularly in south east Queensland was flagged. The Review understands that New South Wales is currently moving to a statewide purchasing system for pharmaceuticals.

It is recommended pharmacy services be integrated into the Clinical Support Services Group, reporting to the Chief Operations Officer to provide wider support of pharmacy services across the State.

In creating Pharmacy services as a statewide service the Review is cognisant that pharmacy services are an integral part of clinical care, including improving quality and safety in medication management, improving discharge planning and patient flow. It is essential that pharmacists are an integral part of multi-disciplinary teams in these areas and are able to provide the local focus necessary to support improved integration in this environment.

Issues to be considered by the Clinical Support Services Group include:

- recruitment of pharmacists is a priority. This may include expansion of the number of pre-registration positions offered in hospitals. Queensland Health has highlighted difficulties in attracting pharmacy graduates pre-registration and providing retention incentives following the first year of service.
- at the area health service and district level, consider different models for provision of pharmacy services eg. collaboration with local community-based pharmacists to provide pharmacist review services at the hospital. The experience from the Townsville Hospital and Rockhampton Hospital suggests that local arrangements negotiated with private pharmacists provide viable local solutions to meet pharmacy needs.

- potential collocation of community pharmacies with hospital pharmacies (currently occurring at the Royal Brisbane Hospital). This would require review of the current Queensland Health Pharmaceutical Benefits Subsidy Scheme which provides an additional rebate above the Commonwealth PBS and currently makes collocation potentially unattractive to private pharmacists.
- creation of pharmacy networks needs to be considered, with larger centres developing stronger hub models where pharmacists in provincial centres provide “outreach” services to rural and remote sites.
- strengthening the role of Central Pharmacy to provide specialist support for districts, including providing expert advice and assistance to secure less common, higher cost drugs which do not have the usual supply chains.
- strengthening the corporate governance model for pharmacy and medication management issues within Queensland Health. Responsibility for the Medicines and Pharmacy Services Unit should be shifted to the Clinical Support Services Group and strengthened to provide increased statewide leadership in pharmacy service planning, medication management and working with districts to improve medication quality and safety.

Recommendation 8.7

The responsibility for pharmacy services to be integrated into the Clinical Support Services Group. Districts to have the option of acquiring pharmacy services from the Clinical Support Services Group or from private pharmacy arrangements.

8.4 Operational support services

There are over 8400 operational service staff employed by Queensland Health. The majority of these are employed in the hospital sector and provide a range of essential support services to assist with patient care including cleaners, food service staff, portage, theatre orderlies, therapy aides and phlebotomists.

The Review met with many operational staff who expressed the opinion that they felt their roles were often not valued, they did not have the opportunity express concerns, or where they did so, their concerns were not always listened to or responded to appropriately. On the whole their roles are repetitive and their importance to the system not appreciated by some staff. There has been a view that anyone can do these roles and that training is not important.

In recent years there have been a number of reviews and changes made in an attempt to better integrate some of the roles. The implementation of these changes is very problematic and the effectiveness of these changes has been questioned. There are some legitimate skill and capability issues but there are some questionable demarcation issues which need to be addressed.

A number of staff who were interviewed reported a culture of bullying. It was also reported that there was a lack of support to have matters resolved at the lowest possible level with issues then being raised through the grievance process or industrially. One of the reasons for increased industrial action is some of the grey areas in some awards. These matters are initially taken to the Single Bargaining Unit and if not resolved at that level may then be taken to the Industrial Commission for a ruling.

Responsive and decisive support for staff at a local level is essential. It would be prudent for districts to ensure operational staff are properly supported, with responsive decision making to address staff concerns and issues.

Operational Service staff are important members of the patient care team and have much to contribute to improving patient centred care. The therapy assistant positions have expanded the role of some operational service staff to be more involved in a hands on way with patient care. There is an opportunity for there to be more positions created in this area to assist clinicians meet the increasing workload. There are training courses that are available for staff to upgrade to these positions.

In the future it is important that districts make a special effort to acknowledge the important role that operational service staff make to patient care. This must include training for new staff and existing staff to ensure they have the skills to best meet these roles as well as access to responsive industrial and HR advice when required.

Recommendation 8.8

District Health Services develop initiatives to improve support for operational staff.

8.5 Administrative support for clinical services

Queensland Health has the lowest administrative cost per casemix weighted separation of any Australian State. Queensland has fewer administrators in the hospital environment than other States and Queensland has average lower salaries compared to other States.

The appropriate level of administration versus clinical services has been a vexed issue for the Review. However, the Review has noted that a consistent theme throughout the district consultation process was insufficient access to administrative support at the clinical level. Many people indicated the potential to improve clinical productivity with the addition of more administrative support. Clinicians in particular highlighted that Queensland Health provides a 24/7 service, but much of the organisation (including administrative support) functions nine to five, Monday to Friday. The Review findings include:

- a need for additional administrative support at the ward level (including for patient data entry and telephone queries) after hours and on weekends to better reflect the hours of hospital operation
- increased administrative support for patient related correspondence where there are long delays in timely referral between hospitals and other providers
- a view that increasing levels of clinicians' time is being consumed by the need to deal with administrative issues, in part due to poorly designed and functioning information systems
- administrative staff at the clinical level expressed concerns about workloads and high levels of mobility within the hospital setting, impacting on their ability to become expert in particular clinical areas. Administrative staff also expressed concerns about the absence of career paths within the hospital setting which would support more specialisation and higher levels of proficiency and efficiency.

There is a need to streamline the administrative requirements in Queensland Health, including improving information system design. However, a review of administrative and information systems will take some time to undertake and implement. In the interim, additional administrative resources should be provided for hospitals to free up clinician time to deal with patient issues. Patient flow reviews should also give consideration to the duties best managed by administrative staff as compared to clinical staff.

In the medium term, this may be achieved by transfer of some positions from Central Office to Area Health Services and districts. In any structural transition, administrative support staff positions (AO2, AO3 and AO4) may be reallocated but will not be abolished.

Over the longer term, the transition to a casemix funding model should provide funds to deliver the full cost of providing services, including an appropriate level of administration cost associated with service delivery.

Recommendation 8.9

Additional administrative resources should be provided at the clinical level to free up clinician time to deal with patient issues. This should include extension of administrative support hours in hospitals to reflect the hospital operating environment.

9. Risk management and clinical governance

This Chapter incorporates the terms of reference and issues relating to existing administrative systems and improvements to support health service delivery, focusing on:

- risk management
- quality and safety and
- clinical audit and governance.

These issues are central to improving patient care and clinical outcomes. We know that many people are harmed while receiving care in hospitals. This chapter recommends system changes to maximise the quality and safety of clinical services. Risk management, quality and safety, clinical audit and governance are closely related and are therefore addressed together in this chapter.

The chapter addresses some of the significant risks faced by Queensland Health that have attracted recent media attention. The overall approach to risk management for Queensland Health is described followed by the management of clinical risk through a system of clinical governance. The latter includes quality and safety, clinical audit and feedback on patient experiences. Consideration is also given to the internal and external reporting requirements on the systems to support clinical governance and quality and safety of health services. The greater emphasis given to clinical risk as opposed to other aspects of risk management is because this is where the majority of gains for patient outcomes can be made.

Summary of the reforms recommended in this Chapter are:

- Clinician led quality and safety improvement in the delivery of clinical care, through benchmarking, development of clinical pathways and open disclosure
- Increased access and dedicated resources to training in service improvement techniques
- A more informed public through a number of reporting strategies
- An improved complaints recording and resolution process with external monitoring by a Health Commission with oversight by a Parliamentary Committee.

The reforms recommended in this chapter will:

- improve the quality of healthcare for patients and other healthcare consumers
- ensure that patients using Queensland public health services will be treated by competent and well trained clinicians
- have a health system that is responsive to public input and patient concerns
- report more accurately and regularly to the public on the state of health care.

9.1 Risk management

The concept of risk combines the probability of an adverse event occurring with the seriousness of the consequences of that event. The identification and management of risk is an integral obligation for any organisation. In Queensland Health's case there are a

wide range of risks that must be considered. Examples include adverse outcomes for individual patients, workforce shortages, the ability to deal with pandemics or large numbers of people injured in the event of a natural disaster, loss of supply of electricity and clean water to hospitals and inability to maintain budget integrity.

The features of a good risk management system most of which are set out in the Australian and New Zealand Standard on risk management are:

- the risk management process provides for identification, analysis, evaluation and treatment of risks as well as mechanisms to monitor and review risks
- risk management is applied at facility, district, area and corporate levels (which would include assigning accountabilities for key corporate risks and risk categories)
- risk management is a part of “how we do business” and there is a risk management ethos throughout the organisation
- employees are supported with initial and ongoing training and assistance in risk management
- the risk management process is customised to the organisation, its policies, procedures and culture and
- adequate resources are provided.

A culture of understanding risk in this way has not been achieved in Queensland Health and in the main risk management in districts is a reactive process. Risk registers identifying potential risks have been established in all districts but to some extent are seen as a legislative compliance issue rather than a useful approach to ensuring the quality, safety and sustainability of health services. The effort that has gone into recording and categorising risks has not been followed up with a systematic process of prioritisation and action to prevent or manage the risks concerned. While many risks are most appropriately managed at the district level, some risks are more effectively managed corporately. Systems to identify and manage these corporate risks are not in place.

Risk management should be a standing agenda item at all executive management meetings to enable prioritisation of risks and appropriate allocation of the resources required to address those that are most significant. Risk registers should be used as a tool to inform this process.

Risk management is one of those matters addressed in the report where the options are few and the way forward very clear. As the implementation of risk management in the Queensland public sector is a legislative requirement and the risk management standard AS/NZS 4360:2004 is regarded as world’s best practice, the implementation of a risk management system adhering to the Australian and New Zealand Standard should continue without delay.

Recommendation 9.1

Queensland Health should establish risk registers at all levels in the organisation (District, Area and Central Office) and identify the individuals who are accountable for the management of those risks.

Recommendation 9.2

The importance of the risk management function needs to be recognised by providing recurrent funding for this activity.

9.2 Clinical Governance

9.2.1 What is clinical governance?

Historically the individual clinician has been held accountable for the clinical outcomes of their patients including clinical risks. However this paradigm has been challenged in recent years and the concept of a system of clinical governance has been developed. This has largely been in response to:

- major health system failures (most notably the inquiry into paediatric cardiac surgical deaths at the Bristol Royal Infirmary)
- national and international reports which estimate that one in ten patients admitted to hospitals are harmed as a result of the health care they receive and
- the increasing complexity of the delivery of health services.

Clinical Governance is defined as...*“The system through which health services are accountable for continuously improving the quality of services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish”*⁷⁹.

It seems from the investigation into events in Bundaberg that systems of clinical governance to manage a range of clinical risks were either not in place or were not working effectively.

The Adverse Clinical Outcomes at Bundaberg Health Service District

This Review does not address the specific circumstances that led to concerns about adverse clinical outcomes in Bundaberg but rather considers the systemic issues. However to assist in understanding the interrelationships of the elements of clinical governance, the system failures at Bundaberg Hospital with respect to clinical governance are briefly explored below. This exploration is not intended to pre-empt any findings of the Queensland Public Hospital's Commission of Inquiry.

- Arguably, the world wide shortage of doctors, changes in societal expectations and decreasing competitiveness of medical remuneration were significant factors leading to the need to employ overseas trained doctors in Bundaberg.
- It appears that a single point weakness in the Queensland registration process led to a failure to identify restrictions to registration in the United States.
- It appears that the process of checking credentials did not involve the College of Surgeons and no written clinical privileges appeared to have been granted on appointment. The current process for granting clinical privileges is not specific to a procedural level.
- The prevailing system focused executive attention on budget and production targets rather than clinical outcomes.
- There appears to have been no decision support system in place to support clinical executives and managers in managing individual clinician performance issues.
- Clinical pathways, clinical auditing and open disclosure are only in the early stages of development in Queensland Health. They are not mandated, and are not subject to internal compliance auditing. It is up to the individual clinician and local leadership to implement and sustain.
- Incident reporting and management appeared to receive little leadership support. There appeared to be a culture of not reporting incidents. There was inadequate capacity and resources to develop effective multi-disciplinary root cause analysis processes.
- There appeared to be confusion, and no clear and transparent process for the management of concerns about an individual clinician's performance.

⁷⁹ Based on the definition of clinical governance in the British National Health Service (NHS).

- There appeared to be diffuse accountabilities for monitoring the clinical performance of services, with multiple committees involved.
- An appendix in the Interim Report contained the list of sentinel type events (severe adverse clinical events), in relation to which mandatory reporting and investigation is required. Certainly some of the poor clinical outcomes could have been classified as sentinel events.

Simply developing policy and procedures around clinical governance has not been enough to achieve the reform needed in this area. Clinical professional groups have retained old models of care which have an individual focus rather than a focus on teams and systems of care. At the same time, changes in health service delivery, increased demand and politicisation have significantly increased the production focus of public health services. This has led to immense pressure on clinicians and executives to do 'more with less' at the expense of a focus on improving safety and quality and managing clinical risks.

There has been a national focus on improving Quality and Safety since the release of the 1995 report on the "Quality in Australian Health Care Study" which identified an adverse event rate of 16.6 percent in hospitalised patients (this was later revised to 10.6 percent following a comparison with a similar US study). The first large investment in quality and safety was made under the Australian Health Care Agreement 1998-2003. Until recently national leadership has been provided by The Australian Council for Safety and Quality in Health Care. A new Australian Commission for Safety and Quality in Health Care is currently being established which will take forward implementation of initiatives and extend the quality improvement focus across the continuum of care including the private sector.

9.2.2 Guiding principles of clinical governance

It is instructive to clearly articulate a set of overarching principles to underpin the development of effective clinical governance. The following principles are adapted from the New South Wales Patient Safety and Clinical Quality Program⁸⁰.

1. **Openness about failures:** errors are reported and acknowledged without fear of inappropriate blame, and patients and their families are told what went wrong and why.
2. **Emphasis on learning and support:** the system is orientated towards learning from its mistakes and staff are supported to participate in improvement activities.
3. **Obligation to act:** the obligation to take action to remedy problems is clearly accepted and the allocation of this responsibility is unambiguous and explicit.
4. **Accountability:** the limits of individual accountability are clear. Individuals understand when they may be held accountable for their actions.
5. **Just culture:** individuals are treated fairly by the organisation and are not blamed for failures of the system. "Blameworthy" acts are clearly defined.
6. **Appropriate prioritisation of action:** action to address problems is prioritised according to the available resources and directed to those areas where the greatest improvements are possible; and

⁸⁰ Patient Safety and Clinical Quality Program, First report on incident management in the NSW public health system, 2003-04, NSW Health

7. **Teamwork:** teamwork is recognised as the best defence against any system failures and is explicitly encouraged and fostered within a culture of mutual respect.

Guided by principles such as these other jurisdictions have taken a stepwise approach to introducing clinical governance into health services. The key steps in all of these examples have been the:

1. development of a quality and safety policy
2. development of a clinical governance framework
3. provision of supporting infrastructure
4. establishment of standards and
5. establishment of performance monitoring.

9.2.3 Implementation issues

The clinical governance approach aims to bring the often fragmented, risk management, quality and safety, clinical audit and patient complaints and feedback activities together into the one system. The rationale behind this is that a structured organisational wide approach will be able to address barriers and make it easier for clinicians to provide high quality and safe health services.

The danger in establishing an organisation wide approach to clinical governance is that it becomes very “top down”. However, as clearly identified in recent research and in the Interim Report, the engagement of clinical staff is essential for effective clinical governance. As stated by Degeling et al 2004 “Clinicians are at the core of clinical work, so they must be at the heart of clinical governance”. Many clinicians consulted in this Review argue that clinical governance must employ “bottom-up” approaches and be supported at the unit level with training and resources. Clinicians recognise the need for some “top down” requirements such as setting corporate performance targets, monitoring and reporting but have strong views that this should not be the overarching theme of the clinical governance approach.

Clinical governance must be established at the clinical unit level and be built into the culture, structure and reporting arrangements at all levels of the organisation. If the clinical governance model is ‘top down’ it will be a process of external surveillance and retrospective governance. If however, the process is established at the clinical unit level and is “bottom up” it is necessarily a process of internal development, self government and prospective clinical management.

Source: Submission to the Queensland Health Systems Review

The two key issues that need to be considered in deciding the best way forward for effective implementation of clinical governance in Queensland Health are therefore:

- the need for a “bottom-up” approach to engage clinicians which indicates the need for internal education and training, performance monitoring and identification of emerging issues and best practice and
- the need to be open and transparent with the community about the quality and safety of health services which, if provided by an external mechanism, would provide greater independence, be seen as having more ‘credibility’ by the public and greater accountability for providers. Given the level of community concern about the quality and safety of health services following the recent events at Bundaberg, the

community is justifiably likely to have an expectation of some formal external review of the quality and safety of health services.

Separation of the roles and responsibilities for education and training from monitoring is one way of achieving the balance between the “bottom up” and “top down” approaches and facilitating greater clinical involvement (as recently recommended by the NHS)⁸¹.

Professional bodies have provided for all health professional groups avenues to identify and maintain professional standards. Therefore consideration must also be given to the role of these bodies in the overall approach to clinical governance taken by Queensland Health.

Consideration must also be given to the scope of clinical governance approaches in Queensland ie. that it be applied to public and private hospitals.

In Queensland private hospitals are licensed under the *Private Health Facilities Act 1999*. This Act requires that private hospitals meet a number of standards that relate to clinical governance which include having in place:

- external accreditation
- credentials and clinical privileges
- adverse clinical event monitoring, evaluation and improvement strategy implementation
- patient complaints and
- infection control.

Currently, the performance of private hospitals against these standards is audited by the Office of the Chief Health Officer.

As clinical governance is an emerging area and as new approaches are further developed it is important that implementation occurs right across the health sector. This is in line with the directions being taken nationally. Consumers and patients have the right to expect the highest quality and safety of care in all health services whether public or private. This is reflected in Chapter 13 with a Health Commission progressively monitoring implementation of clinical governance in private hospitals.

9.2.4 A framework for clinical governance

Clinical governance is a system with many elements: people, procedures, structures, information and standards. As an aid to understanding the overall concept of clinical governance and the inter-relationships between these elements a framework is helpful. For the purposes of this report a very simple framework is used.

This model is premised on effective clinical governance requiring:

- the *right person*, doing the *right job*
- with the *right skills*
- working in *high-functioning teams*
- supported by *effective organisational systems*⁸².

⁸¹ Robinson M, O'Rourke I and Braithwaite J. 2003 Report on a study tour of the Clinical Governance Support Team of the English National Health System NSW Health, Institute for Clinical Governance, Centre for Clinical Governance Research, UNSW.

The system must

- give careful consideration to the patient's experience, and
- be accountable to the community with regular public reporting against standards and performance indicators.

The following sections use these headings to describe various aspects of clinical governance, what is currently happening in Queensland Health and recommended directions for change.

9.3 The right person doing the right job

Clinicians (doctors, nurses and allied health staff) require appropriate training, experience and ongoing skills development to ensure the delivery of safe and effective health care. This section describes the processes required to ensure appropriately trained and experienced staff are employed and that their ongoing clinical work is performed to the standards required. The specific processes discussed are recruitment and selection, credentialing and clinical privileging, and assessment, development and management of individual clinician performance.

9.3.1 Recruitment and selection

Obviously Queenslanders only want well trained and competent clinicians to be registered and working here. While the following section is specifically about the recruitment of doctors, it is also imperative that all clinicians employed by Queensland Health have appropriate professional registration and that during the process of recruitment and selection their ability to meet the clinical competencies required for the particular job is carefully assessed.

In the context of clinical governance, the recruitment process must have safeguards around professional standards. In the usual context this is achieved through the provision of qualifications recognised by the various registration boards resulting in registration to practice as a professional. The current workforce shortage in medical practitioners has caused a change to this process with doctors receiving special purpose registration based on overseas qualifications not recognised as equivalent to Australian qualifications. This special purpose registration is granted with conditions.

As an employer under pressure to fill medical vacancies, Queensland Health faces a conflict of interest in making objective and transparent determinations of an "area of need" which would allow special purpose registration of Overseas Trained Doctors (OTDs). This registration category is not subject to the same requirements as apply to locally trained doctors. The review supports the recent transfer to the Medical Board of Queensland of responsibility for making area of need determinations. Determination of an area of need should only be made where there is evidence of a genuine shortage of medical practitioners. Area of need determination should be based on transparent criteria and cannot be "portable" across locations or positions.

⁸² Dr Michael Ward, Queensland Health, 2005

Even if recruitment campaigns succeed in attracting doctors from countries such as the United Kingdom, it is likely that Queensland Health will continue to be reliant in the short term on attracting doctors trained in other countries which may not have equivalent teaching standards.

A number of the current concerns in Queensland are based on the rigour and safety associated with the special purpose registration process. For example, the issue of Dr Patel and Bundaberg has created a great deal of concern and some heightened tensions within the medical profession generally. This doctor is reported to have submitted false credentials to the Medical Board which resulted in his appointment. Another specialist from overseas is believed to have been appointed on the basis of falsified credentials. However, it has been Queensland Health that has been most significantly admonished in the media for failure to manage consequent clinical performance.

Recent changes to the Medical Board process are aimed at improving the rigour and validity of the process of special purpose registration for doctors. They include:

- verification of credentials via the Educational Commission of Foreign Medical Graduates International Credentials Service (EICS)
- computer administered screening exam
- English language proficiency
- curriculum vitae review and
- clinical interview.

There will be a need to evaluate whether these changes are sufficient to provide confidence to the Queensland public that all doctors being registered in Queensland are adequately skilled in the absence of recognised equivalence in qualifications and “full registration”.

OTDs seeking special purpose registration may come from different cultural, language and health care backgrounds. It is therefore relevant to have a process for OTDs which assesses language, culture and clinical competence and provides education on the specific issues relevant to working as a medical practitioner in Queensland.

While the recent Medical Board changes will improve the registration process specific resources both for the Medical Board and the relevant employer will be required to address all concerns around clinical competence.

Essentially there are two broad categories of special purpose registration, senior doctors employed in specialist roles and more junior doctors employed in generalist roles.

Special purpose registration processes

Deemed Specialists

Assessment of an OTD for practice at specialist level should be performed via the established Australian Medical Council (AMC)/Specialist College (College) pathway. No OTD should commence employment in a senior position intended to be filled by a specialist prior to this assessment occurring. An OTD deemed not to be at specialist level by the relevant College should then be assessed by the Medical Board of Queensland as for other non-specialist grade doctors.

Non-Specialists

The assessment of non-specialists would focus on four major areas:

- formal written application for a specified vacancy
- performance at clinical interview
- referee checks and
- further on shore assessment including clinical skills laboratory assessment for those going in to positions of high responsibility and low supervision.

The assessment tools used at interview should include:

- specific questions to determine experience and usual practice (eg patient mix; cases seen)
- specific questioning regarding the current facility that the applicant is working in, its capabilities and support structures (ie allied health, nursing; medical imaging, and pathology)
- clinical scenarios (eg patient presentations, requirement to transfer a patient from one facility to another and a description of how this would be undertaken and enacting this over the telephone)
- role plays using particularly Australian situations to make an estimation regarding the applicants ability to communicate and their cultural safety (eg whilst it could not be expected that an applicant from overseas would understand Australian slang, it would be expected that they would indicate that they did not know and ask what something meant)
- questions relating to specific selection criteria and requirements of the position.

There are a group of non-specialist OTDs with special purpose registration who will apply for positions with the requirement for significant procedural skills. These doctors will require additional assessment. This could occur by these doctors spending time in a large hospital (preferably the referral centre to which they will be sending patients) and having an assessment made and/or formal assessment in a simulation environment.

OTDs should not be subjected to unduly intensive critique of their work. The expectations around ability to fulfil the requirements of the position should be those that are used for any medical graduate in the position.

The implementation of these screening processes has the potential to significantly prolong the recruiting process. Efforts must be directed at measures to streamline these processes without affecting the quality of the recruiting process. The Medical Board of Queensland is a key decision maker and should be encouraged to review existing and proposed processes to maximize efficiency whilst safeguarding standards of practice.

Review of special purpose registration for current medical practitioners

In the context of clinical governance it is important to consider those OTDs who are currently working in Queensland who were not subject to the proposed requirements. The two categories of OTD again are deemed specialists and generalists.

Current Deemed Specialists

This group should participate in the usual clinical performance management processes applicable to all doctors (clinical audit etc).

Current Non-specialists

There are many non-specialists currently practicing in Queensland (both in the public and private sector) who have not been through a clinical assessment process as part of registration. At the time of reappointment or re-registration (this group is employed on twelve month contracts) the full recruitment assessment process should occur. This would include the clinical interview, language and cultural assessment and appropriate clinical skills assessment. This process would be informed by the knowledge available from existing supervisors.

The processes outlined focus on special purpose registration requirements in the context of clinical governance. It is obvious that ideally Queensland Health should be growing its medical workforce locally to minimise the need for special purpose registration. Initiatives in this area are described in Chapter 10 on Workforce.

There are obligations on employers of OTDs with special purpose registration to ensure that this group, who are making an important contribution to the Queensland Health workforce are appropriately treated. This should include dedicating funding to assist OTDs professionally, socially and culturally. The employer should commit to appropriate training support to assist OTDs with specialist registration to successfully complete appropriate requirements to achieve full registration.

These processes are more fully detailed in Appendix 9.1 which is a summary of a project proposal for recruitment, assessment, placement, training and support (RAPTS) of OTDs. Queensland Health should consider this proposal to reform the current management of OTDs.

As a matter of principle, the practice of wealthy nations like Australia actively recruiting doctors from developing nations should not be encouraged. In the longer term and in the interests of good global citizenship, Australia must aim to achieve national self-sufficiency in respect of its clinical workforce. This is best achieved through bilateral government action and is identified as a principle in the National Health Workforce Strategic Framework released by Australian Health Ministers in April 2004.

Recommendation 9.3

The Medical Board of Queensland should be encouraged to:

- ensure that registration processes (current and future) provide a high quality assessment and are implemented in a timely and efficient manner
- conduct clinical assessments of non-specialist grade OTDs with special purpose registration
- conduct the assessment of OTDs for practice at specialist level via the established Australian Medical College/College pathway.

That Queensland Health implements the Recruitment, Assessment, Placement Training and Support (RAPTS) program for OTDs.

9.3.2 Credentialing and clinical privileging

The credentials and clinical privileging process is to ensure that only those practitioners who are appropriately qualified, trained and experienced will undertake clinical care within the constraints imposed by the available resources, including staff and equipment, and the physical facilities available within the healthcare facility concerned.

Currently, this process is generally undertaken by the local hospital employing the doctor. In an environment of workforce shortage, this may mean that the local clinical leaders and managers have a conflict between credentialing someone about whom they are uncertain or having no one to deliver the service. It appears that these issues may have been relevant at Bundaberg.

It is therefore important that credentialing is performed by an appropriately constituted group removed from the specific service delivery area. The Clinical Governance Units of the Area Health Service should be responsible for the credentialing of all medical practitioners in the Area Health Service using an appropriately constituted committee (National Guidelines are available).

A doctor, once credentialed, should only work in areas that are appropriate given the support services that are available. The Service Capability Framework provides standards on the complexity of support services required in clinical situations. This process is clinical privileging.

Recommendation 9.4

Credentialing of medical practitioners should occur at Area Health Service level facilitated by the Clinical Governance Unit using National Guidelines.

Clinical privileging (the specific services that are suitable for the local health service) should also be performed by the Clinical Governance Unit and should include on the committee a representative of the District Manager of the specific employing health service. Privileging decisions should be based on the Service Capability Framework.

9.3.3 Assessment, development and management of individual clinician performance

Performance assessment and development

The public service Performance, Appraisal and Development (PAD) process is mandated for all staff. In general, the evidence is that Queensland Health public servants, staff in support roles, allied health staff and nurses comply with this requirement however most do not see PAD as a useful process due to the lack of linkage to training and development opportunities. Chapter 4 makes a recommendation about effective performance appraisal and development processes. These processes are most likely to be meaningful if managers and team leaders engage with their staff in ongoing informal discussion about performance in a supportive environment.

Medical practitioners and medical administrators currently view the generic performance management framework within Queensland Health as unsuitable for the following reasons:

- Medical professionals often consider (rightly or wrongly) that review of their clinical performance as a function of their professional peers (College) and not their employer.
- Seniority is also a factor; it is often the case that younger and less experienced specialists occupy clinical director positions, with senior visiting medical officers officially reporting to them as subordinates which creates genuine difficulty for full-time directors in successfully managing performance.

- There is no clear and transparent process for managing concerns about individual clinician performance.
- The current PAD framework makes it difficult to separate the concepts of human error (due to systems issues), knowledge and skill-based deficits and intentional harm.

According to the current Queensland Health policy each medical practitioner is required to submit an application for credentials and clinical privileging review at least every 3 years. Requirements for credentials and clinical privileging include that medical practitioners subject their clinical performance to quality assurance mechanisms such as clinical audit. They must also demonstrate a commitment to past and continuing professional education, an important part of the PAD framework. The effectiveness of the implementation of credentials and clinical privileging and various other elements of clinical governance will impact significantly on the effectiveness of this process, however it does have potential to be part of a PAD process for medical professionals.

Identifying performance issues

Identification of clinician performance issues using existing clinical indicator monitoring and information systems is rarely of any benefit. This is due to relatively small frequency of adverse outcomes and small overall numbers of procedures. The statistical rigour of such approaches is poor and usually, it would take several years of data to identify with confidence, a significant trend.

The use of statistical process control methodology and CUSUM (cumulative sum control chart) can be applied to individual clinical performance. This can allow clinicians and their supervisors to better self-assess performance in key clinical areas and identify any concerns earlier. However caution is required and this should primarily be used as a tool for self evaluation and peer review for improvement rather than for routine organisation monitoring of individual performance.

Managing concerns regarding individual clinician performance

Concerns regarding the performance of an individual clinician, either as a result of an increased frequency of adverse patient outcomes, complaints from staff/ patients or from the PAD processes must be appropriately and transparently managed. Whilst it is essential that the clinician concerned is afforded natural justice and confidentiality, patient safety must be the basis for decisions.

The Credentials and Clinical Privileging Guidelines enable specified clinicians or relevant professional groups to request a review of a clinician when there are indicators of decreasing clinical competence. This is not intended as a mechanism for initiating disciplinary matters, but findings of the Credentials and Clinical Privileging committee may be a consideration in such matters. However there is currently no established process to provide decision-support to administrators and clinicians in addressing these difficult and complex issues.

The National Health Service in the United Kingdom and New South Wales Medical Board have progressed the issues of performance assessment and development and the management of concerns about an individual clinician's performances. Their work could inform the development of similar processes in Queensland.

Recommendation 9.5

Policy, guidelines and training should be developed to support a consistent statewide approach to:

- Conduct individual clinician performance assessment and development
- manage concerns about an individual clinician's performance.

Where there are concerns about an individual clinician's performance:

- the Area Clinical Governance Units should take responsibility for the assessment of the clinician and recommendations regarding remediation
- the District Manager will be responsible for decisions regarding the management of an individual clinician.

The Medical Board of Queensland be encouraged to:

- develop a performance evaluation program that is non-punitive and provides a framework for ongoing demonstration of professional competence. This will require new legislation.
- develop guidelines regarding its expectations of medical practitioners to participate in continuing professional development.

9.4 The right skills

Safe and effective health care not only requires the maintenance and development of good clinical knowledge and skills but a range of other skills. In our complex health care environment the ability to work well with a team of health professionals and to communicate with respect, openness and transparency must be developed. A more informed community also requires clinicians to be able to communicate with patients about the status of their health condition including adverse clinical incidents. Specific skills are also required to undertake a range of clinical governance processes such as root cause analysis and benchmarking.

While ongoing training and development for clinicians is a life long process which must be supported by Queensland Health this section describes skills that are very specific to clinical governance, open disclosure and service improvement processes.

9.4.1 Open disclosure

Open Disclosure is the practice of timely and accurate communication with patients and relatives following an adverse clinical incident or event. There is evidence that specific use of open disclosure processes can significantly improve patient satisfaction after such an event. Failure to practice open disclosure often leads individuals to explore other avenues of redress via complaints mechanisms or through litigation.

The elements of Open Disclosure are:

- an expression of regret
- a factual explanation of what happened and the potential consequences
- the steps being taken to manage the event and
- prevent recurrence without implication of liability or blame of any individual.

The person providing the disclosure must be someone who:

- the patient and their family or carer are comfortable with and can talk easily

- has been involved in the care of the patient and knows the facts and most importantly
- has enough seniority in the clinical area to be able to raise the issue/s with the hospital executive to begin action to stop the problem from happening again and
- has been trained and is competent to disclose appropriately.

A national Open Disclosure Standard has been developed based on international best practice and a national pilot has been endorsed by Australian Health Ministers. Queensland Health is progressing the pilot in seven Health Service Districts with initial training due to commence in late October 2005.

Recommendation 9.6

Queensland Health through the Patient Safety and Clinical Improvement Service should proceed to implement the national Open Disclosure Standard for communication with patients and relatives following an adverse clinical incident or event.

9.4.2 Training in service improvement techniques

Clinical governance is an emerging area and the skills and capacity to undertake specific techniques to identify and manage clinical risk is variable among the current clinical workforce. Some of these techniques include incident investigation, root cause analysis, clinical audit, benchmarking and clinical pathway implementation and variance analysis⁸³.

Therefore to advance quality and safety initiatives access to education and training will be essential and clinicians will need to be supported to undertake and implement this training. Clinical leaders should be involved in both the development and delivery of training and training approaches should be relevant to the health service delivery environment.

As training modules in relation to quality and safety in health services are developed they should also be incorporated into the undergraduate, post-graduate and leadership curricula for patient safety.

Recommendation 9.7

Appropriate training in the use of specific service improvement techniques such as incident investigation, clinical audit, benchmarking and clinical pathway variance analysis should be developed and implemented with the support of the Patient Safety and Clinical Improvement Service and involvement of clinical leaders.

9.5 Effective organisational systems

Many systems have been developed to assist in the identification and management of clinical risks. These include proactive and reactive processes, the effective coordination of which is an integral part of clinical governance. This section describes a number of the key individual systems.

⁸³ The specifics about each of these processes are addressed in the section on effective organisational systems.

9.5.1 Clinical pathways

It is generally accepted that health care should be delivered using evidence based clinical pathways. Health departments interstate and internationally promote the use of pathways and are working on systems to facilitate this such as electronic records and variance analysis. Various incentive programs are in place to encourage uptake of pathways (eg in the United States insurers favour facilities that use pathways and in New South Wales funding was provided to service networks to develop pathways). Pathway development is generally prioritised to areas of high impact (high frequency, high mortality/morbidity, high cost).

Currently, there is no systematic use of clinical pathways in Queensland Health. The clinical collaboratives have been an important vehicle for facilitating the use of pathways by showing that standard practice can improve patient outcomes (see Interim Report for examples). However, it is not common practice for clinicians statewide to use pathways and analyse variances.

There are few statewide pathways available and some of those that have been developed have been reported to be 25 page documents and not practical for implementation. The Mater Hospital has distilled pathways into a one page document which also acts as a data collection tool, an approach that clinicians have embraced.

Queensland Health should work towards more systematic use of clinical pathways. The focus should be on adopting already developed pathways (eg the Mater hospitals use Millimans in the United States) but the process must be led by clinical networks.

Clinicians need to be supported to implement clinical pathways and provided with tools that facilitate easy adoption (eg information systems that conduct variance analysis, statistical expertise). Clinical networks will be an important means through which clinicians can be supported.

The use of endorsed pathways needs to be monitored by Area Health Services and represents a potential indicator of the quality of health service delivery for reporting. Clinical pathways should take into account the size of the facilities, including the skills and environment within which services are delivered eg rural and remote practice is different to metropolitan practice.

Recommendation 9.8

Evidence based clinical pathways targeting high volume services (where standardisation will improve safety and quality) should be developed (or purchased) and implemented by clinical networks with the support of the Patient Safety and Clinical Improvement Service.

9.5.2 Benchmarking

The Measured Quality Program was the first corporate attempt to introduce statewide benchmarking across a number of domains including clinical outcomes, efficiency, patient satisfaction and system change and integration. This program has reported against these indicators for 60 hospitals since 2002. Health Service Districts have been advised of any significant variation in their performance against these indicators, when compared with their peer hospitals.

Generally speaking clinicians perceive the Measured Quality Program as a corporately driven initiative developed with little clinical input, not timely, using indicators that are not robust, and in a shroud of secrecy that is counterproductive. The Health Round Tables are thought to be a much better example of a useful quality benchmarking exercise where similar hospitals can compare performance and share information while remaining de-identified in the process.

The most difficult aspect of benchmarking is determining the measures. Due to the difficulties of varied casemix and risk adjustment, it is generally much more useful to benchmark key *process indicators* against best practice/evidence based rates. If the measures are clinically relevant, then there is a greater chance of clinician ownership and resulting improvement activity.

It is a requirement of most medical professional bodies that members participate in continuing professional education and development activities including benchmarking. It is also a requirement for ongoing credentialing and clinical privileging for specialist staff. Queensland Health should work with professional bodies to introduce more systemic benchmarking participation. A first step, could be the development of standard processes for evaluating the appropriateness of staff participation in benchmarking activities required by colleges and to include this in performance appraisal processes.

For other clinical streams, participation in benchmarking processes should be pursued through the service networks and the use of incentives for data collection. This process must be led by credible clinicians. Clinicians participating in clinical networks should be encouraged to involve local clinical staff/teams in the analysis of performance compared to other facilities.

As the clinical networks mature and benchmarking becomes routine practice for various health conditions, the performance indicators used by networks for benchmarking should be incorporated into Area Health Service reporting. An example of this is the inclusion of “use of Beta Blockers in eligible patients with congestive heart failure” as a performance indicator in outputs reporting to the Queensland Government. This performance indicator was developed through the Collaborative process.

Recommendation 9.9

Effective quality and safety benchmarking processes should be developed by Clinical Networks facilitated by the Patient Safety and Clinical Performance Service.

Clinicians participating in clinical networks should involve local clinical teams in the discussion and interpretation of benchmarking data.

9.5.3 Clinical audit and death review

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria followed by the implementation of change at an individual team or service level. Further monitoring is used to confirm improvement in healthcare delivery⁸⁴. The clinical areas audited should be high risk, high volume or high cost.

⁸⁴ A Practical Handbook for Clinical Audit, NHS 2005

⁸⁷ Australian Institute of Health and Welfare, Australian Hospital Statistics 2003-04, 2005

While clinical audits are being undertaken in Queensland public hospitals, there is no systematic approach, no formal requirement for districts to perform audits and no formal reporting and monitoring mechanisms. A major barrier to effective implementation of clinical audit at a local level has been the lack of clinical information systems to support the process.

In 2003 a Clinical Quality Unit was established in the Office of the Chief Health Officer with a view to conducting and supervising a statewide program of clinical audit and training clinicians in clinical audit processes. This work has not been substantially progressed to date.

This unit also supports the work of the three Quality Councils - the Queensland Paediatric Quality Council, the Queensland Maternal and Perinatal Quality Council and the Queensland Committee to Enquire into Peri-operative Deaths. These Councils were established under the *Health Services Act 1991* to provide advice to the Minister and the Director-General on benchmarks, and comparative data across regions and populations on morbidity and mortality. The Councils provide legislative protection to the Council members to undertake confidential enquiries.

While the intent of the Councils has merit, the current processes are not effective, due mainly to the lack of timely information and connectedness to change processes within Queensland Health. The councils have recently begun a new three year term and are seeking to address some of these issues.

The Clinical Practice Improvement Centre is currently developing plans to support patient outcome audits that will be clinician driven at the local level.

Death review is a clinical audit process whereby all deaths in a particular hospital are reviewed on a regular basis. Some hospitals already have processes in place to undertake death review but systematic approaches across the state are not in place. Best practice approaches include a multi-level, multi-disciplinary, systems review of deaths led by the clinical service, but oversighted by administration.

Recommendation 9.10

Clinical audit (including routine death review) should be a routine activity for all clinicians, clinical networks and services. The necessary tools, resources, information systems and support should be developed and made available to facilitate this activity.

9.5.4 Incident monitoring and analysis (including sentinel events)

Queensland Health has had an Incident Management Policy in place since June 2004. This policy defines incidents and outlines the processes and accountabilities for the management of incidents. Ten sentinel event types have been specified for investigation by Queensland Health and these are included in the policy. Root Cause Analysis and central reporting of sentinel events is mandated to enable state-wide learning and the development and implementation of statewide safety improvement initiatives.

The effectiveness of the incident management policy has been variable to date due to a range of business processes being used across districts, no comprehensive information system for incident reporting, lack of tools for incident analysis, limited training for staff in analysis techniques and limited resources and capacity in districts to set up and maintain systems. The Patient Safety Centre was established to address these issues.

There is a requirement that all deaths that are not reasonably expected to be an outcome of a health care procedure be reported to the State Coroner for investigation. Queensland Health in conjunction with the State Coroner should develop a policy and process to provide clarification and consistency in the reporting.

Incident reporting

A web based electronic incident reporting system (PRIME) is currently being rolled out across the state (in use in 35 percent of Districts). This system aims to:

- improve the reporting and management of clinical incidents including sentinel events and near misses
- facilitate appropriate action for individual incidents,
- enable the analysis of incident trends, and
- evaluate local and statewide initiatives aimed at reducing adverse events.

The system is consistent with the Australian Standard and uses a risk matrix to prioritise risk of adverse events. This allows a focus on the most serious clinical risks and prioritised resources for analysis and intervention.

There has been a mixed response to PRIME particularly in districts which already had an incident monitoring system in place. Key factors in this dissatisfaction appear to be the length of the incident forms, limited computer access and low computer literacy skills among staff. Middle managers in many districts which had an existing system in place before PRIME have reported receiving fewer incident reports after PRIME was introduced.

PRIME was developed as an interim solution pending progress on a national database, however it is critical that staff have a system for reporting incidents which enables incident analysis to be conducted. The roll out of PRIME therefore must be progressed as a priority and concerns raised in the Interim Report addressed. This will require:

- an evaluation of the implementation to date and improvements implemented in response to findings
- consideration of the overlap with the STOCCA reporting system for adverse drug events and IMS for Workplace Health and Safety events and determination of whether these systems should be migrated to PRIME.

In recognition that PRIME was an interim measure, work needs to commence now on a permanent solution. The AIMS system should be one of the potential systems considered for a permanent solution as it is being used in a number of health systems in other states.

Incident analysis

In many areas, medical and nursing staff advised that they are not reporting incidents (let alone near misses) because they receive no feedback on how the information is used. Many staff considered that there are no clearly defined responsibilities for follow-up and reporting on actions taken. An exception was the Northern Zonal Clinical Review Committee which provides an opportunity to examine critical incident reports from the various districts to assess common themes and share learning/information.

There is a need to standardise the business processes and governance of clinical incidents. The Incident Management Policy is currently being reviewed and as a part of this process will develop standard documentation to assist districts in this regard. This includes the reporting of unexpected deaths to the coroner. Staff need to be educated on the policy and their responsibilities and managers need to promote a just culture to encourage reporting.

There should be area and statewide level analysis of incidents. Staff need to be trained in investigation techniques for serious incidents and sentinel events (root cause analysis). Training commenced in July 2005 and the Patient Safety Centre has recently put a process in place to obtain copies of the incident analysis relating to sentinel events. The development of solutions needs to be done in consultation with clinicians particularly the relevant clinical networks.

The analysis of aggregated incident data to identify trends should be supported with appropriate statistical expertise but interpreted and acted on by clinical leaders.

Area Health Services should monitor incident reporting and analysis and be required to report on the processes in place (eg % serious incidents investigated) to identify and manage clinical risks through this process.

There should be an annual public report on sentinel events as per New South Wales and Victoria. This report should provide a de-identified state wide summary and be available publicly.

Recommendation 9.11

- Review and implement the incident management policy.
- Address the current issues with PRIME before continuing implementation across the state including improved training for staff. Develop a strategy for future system enhancement (including a review of national progress on the development of incident monitoring systems and potential benefits of national standardisation).
- Queensland Health in conjunction with the State Coroner should develop a policy and process to enable reporting to the State Coroner of all deaths that are not reasonably expected to be an outcome of a health care procedure.
- Analyse serious and sentinel events at an area health service and state level (and contribute to national reporting) with a focus on preventing and minimising harm.
- Based on incident analysis develop and implement state-wide safety initiatives using clinician led networks.
- Measure and report on safety culture within health services to promote attitudes and behaviours associated with safe practice.
- Provide an annual public report on sentinel events.

9.5.5 Programs targeting high-risk areas of patient safety

Medication safety, hospital acquired infections, falls, pressure ulcers and procedural practice have been identified nationally as quality and safety priorities. These issues represent areas where major gains in quality and safety can be achieved and have received Ministerial commitments. Queensland Health has developed programs for these areas, some of which are recognised nationally as best practice (eg safe medication practice). These programs should continue to be supported, led by clinical leaders, with appropriate resourcing.

Further work is required to address and prevent the key safety risks associated with mental health adverse patient events. This should be given priority.

Recommendation 9.12

Endorsed priority programs in medication safety, infection prevention and control, falls, correct site surgery and pressure ulcers should continue to be developed and implemented.

9.5.6 Enabling legislation

Within the context of clinical governance there are two areas that require legislation to enable the effective implementation of processes. These are the use of patient data and indemnity issues for clinicians.

Use of patient data

Prior to 2004 confidentiality provisions within the *Health Services Act 1991* placed limits on the use of individual patient medical records for the assessment of the quality and safety of health services. Amendments regarding confidentiality provisions were made to the *Health Services Act 1991* which came into force in early 2005 that now enable use of these records within the Department for the purposes of evaluating, managing, monitoring or planning health services.

The relevant sections of the legislation: 62G (Disclosure for data collection and public health monitoring), 62H (Disclosure for purposes relating to health services) and 62M (Disclosure to approved quality assurance committee) should be broad enough in their scope to enable effective sharing of information by clinicians to ensure there is proper monitoring of the quality and safety of services. However this should be reviewed in June 2006 to assess whether the operation of the confidentiality provision is inhibiting the work of quality and safety processes within Queensland Health.

Indemnity issues

Open disclosure (to patients) and open discussion and learning among clinical teams have also been hampered by the lack of legislation indemnifying clinicians when they are frank and open about adverse clinical incidents. Clinicians need clear advice about how they will be treated when they are involved in an adverse patient event. This requires consistent and coordinated legislation and policy which is primarily focused on:

- defining ‘blameworthy behaviour’ (established in other jurisdictions as intentionally unsafe acts, criminal acts, acting under the influence of alcohol and illicit drugs, and patient abuse)

- focusing on learning from adverse events by taking a systems approach to the analysis and subsequent action to prevent recurrence
- providing privilege to the root cause analysis process so that staff can feel free to speak openly and honestly about what happened without fear that this could be used against them in a court of law
- providing protection to staff from action by their employer in the event of an adverse event occurring as the result of systems failure
- protection for analysis teams against civil actions, privilege of working documents arising from a root cause analysis and from giving evidence associated with the root cause analysis.

Legislation currently operating in New South Wales, protecting Root Cause Analysis of clinical incidents, has been seen to be effective in engaging clinicians in trying to learn from adverse clinical outcomes. Specific legislation granting complete privilege is the most effective way of protecting the Root Cause Analysis outputs. The Legislative Projects Unit in Queensland Health has commenced a project to address this with the advice of the Patient Safety Centre. In the future it would be the role of a Health Commission to recommend to government legislative changes associated with health service improvement.

The review is obliged to sound a note of caution that legislative provision backed by formal policy will not be sufficient to achieve unconditional support of clinicians for the clinical governance systems recommended. Complete open reporting and reconciling of errors, omission and incidents will only occur in a just culture or workplace environment. Clinicians throughout Queensland, especially doctors, expressed very strong reservations to the Review, and in some cases anger, that there was evidence that their employer had not honoured commitments to indemnify staff in undertaking their normal clinical duties where they have acted in good faith but where procedures have resulted in adverse outcomes for patients or their families. The clinical workforce cites several instances where their employer (both Queensland Health and Government) has not been supportive of their actions taken in good faith, but instead, in their view taken a line of least resistance to minimise adverse publicity often at the expense on an individual staff member receiving fair and just treatment.

It is strongly emphasised that the system of clinical governance recommended will only come to fruition with full clinician support which in turn depends on whether the clinicians' employer in fact demonstrates, as opportunities arise, that it does presume professional conduct in good faith by its clinicians until fair and just process prove otherwise.

Clinical staff need to be confident that they have the support of the organisation. This is an essential underpinning for improving the confidence of the community in Queensland Health.

Recommendation 9.13

Development of legislation encouraging and protecting good quality and safety assurance analysis should proceed and be submitted to the Health Minister to progress.

Review of the recent confidentiality provisions of the *Health Services Act 1991* should be conducted during 2006 to determine the impact on the effective sharing of information by clinicians for quality assurance purposes.

9.5.7 Health service accreditation

External accreditation is sought by health services through the Australian Council on Healthcare Standards or the Institute for Health Communities Australia. Health Services Districts are now moving towards ‘whole of district’ accreditation (including primary care, aged care and mental health services). Ninety percent of Health Service Districts have ‘whole of district’ accreditation and districts not currently accredited are progressing towards accreditation. The proportion of public hospitals accredited in Queensland is higher than the national average⁸⁷.

There is doubt about the effectiveness of the current accreditation process in providing assurance of safe healthcare services. Most of the high-profile health system failures in Australia have occurred in facilities that were fully accredited and there is little evidence that accreditation leads to improved safety or outcomes of care. Accreditation agencies are aware of these issues and are seeking to review their accreditation processes accordingly.

Recommendation 9.14

Queensland Health should work with health service accreditation agencies to establish more meaningful quality and safety measures for accreditation assessments.

9.6 The patient experience

Health services have much to gain from listening to feedback from patients and their carers on their experiences with the service provided. This can be achieved through proactively working with consumers to gain feedback and input into how services actually work for them and through effective reactive processes such as patient complaints systems. Western Australia’s model for clinical governance has consumer liaison and participation as one of four critical pillars. Canadian health services also explicitly identify this dimension in their clinical governance frameworks.

9.6.1 Consumer feedback

“Hearing the voices of consumers is an effective way for hospitals to get good information about what needs to be done to improve the quality of their services”⁸⁸

Feedback from patients on their experience of Queensland Health’s services has been recognised as a significant component of monitoring quality and has largely been addressed through complaints resolution processes and patient satisfaction surveys. Statewide patient satisfaction surveys have been conducted by Queensland Health in 2001 and 2005. Individual districts have also undertaken patient surveys in an ad hoc manner. The latter surveys were more likely to be at the clinical unit level which provided staff with more practical feedback in terms of implementing change to improve services.

⁸⁸Mary Draper, *Involving Consumers in improving hospital care: lessons from Australian hospitals*, Department of Health and Family Services, 1997

Patient satisfaction surveys have been a common method for gaining feedback on health services but have largely focused on hotel services, helpfulness of staff and provision of information. A major criticism of the statewide survey currently in use is that it does not evaluate whether the patient's health improved as a result of their interaction with the health service. There are suggestions that patient surveys should add more specific questions about clinical quality (such as whether a person felt safe during hospitalisations) or clinical outcomes. However there is a concern that there are fundamental barriers to integrating perceptions of service and clinical quality.

Health services need to use a range of methods in getting effective feedback from consumers. Some alternative approaches to using surveys include focus groups, workshops, community forums, submissions and hotlines. These approaches provide a rich source of information of the patient's experience that may better inform the improvement of services. Use of these methods requires considerable commitment from senior management, adequate resources and specific skill sets. The latter have been identified as lacking in many Australian Hospitals. The District and Area Health Councils proposed within this report would provide another avenue for consumer feedback on services.

An important element in engaging with consumers is establishing and communicating consumer rights. In 2002 Queensland Health developed a public patient's charter which explains patients' rights and responsibilities.

Recommendation 9.15

Revise the Patient Charter to incorporate changes resulting from this Review and communicate patients' rights and responsibilities to patients and their carers.

Establish District Health Council and Area Health Council processes for consumer and community input into service planning and evaluation.

Establish a strategy for consumer feedback (including but not limited to patient satisfaction surveys) at the District and Area Health Service levels. This should be developed in the context of a statewide framework for consumer and community engagement and supported through the development of appropriate tools and methodologies and appropriate resourcing.

9.6.2 Patient complaints

Queensland Health's complaints policy reflects contemporary best practice but its implementation has been poor and there is a lack of uniformity and quality in complaints systems across the State. Patients are unsure how to progress their concerns about healthcare and who to approach in the health system. District staff advise that they do not feel empowered or confident in handling complaints and Queensland Health has no system to be adequately informed about patient complaints and concerns (or compliments).

Features of an effective complaints and compliments system

A good complaints model should promote "frontline complaints handling"⁸⁹ which advocates timely resolution of complaints at the local level, whilst providing for further internal and external review.

⁸⁹ Queensland Ombudsman "Developing Effective Complaints Management Policy And Procedures", March 2004, p. 4

According to the International Standard (ISO 10002) on complaints management a complaint system should⁹⁰:

- “provide a complainant with access to an open and responsive complaints-handling process
- enhance the ability of the organisation to resolve complaints in a consistent, systematic and responsive manner, to the satisfaction of the complainant and the organisation
- enhance the ability of an organisation to identify trends and eliminate causes of complaints, and improve the organisation’s operations
- help the organisation create a customer-focused approach to resolving complaints, and encourage personnel to improve their skills in working with customers
- provide a basis for continual review and analysis of the complaints-handling process, the resolution of complaints, and process improvements made”.

The complaints model should promote and enable open disclosure. Patients need to be informed of their involvement in clinical incidents, and this should happen in a way that is immediate, open and honest⁹¹.

Further as stated in the Interim Report, the complaints system should adhere to the Australian Health Care Agreement 2003-08 which requires the existence of an independent complaints body (in Queensland this is currently the Health Rights Commission).

The proposed complaints model

Three complaints model options have been considered based on initiatives from other jurisdictions, as well as suggestions from the submissions to the Review, public consultations and meetings with stakeholder groups.

The first option is that all initial complaints should be filtered through an external body which would subsequently pass the matter onto the appropriate body to deal with (whether that is the local district or the mandated statutory body where relevant).

A second similar option is that all initial complaints should be filtered through a single internal body. The concern with both of these options is the potential delays in being able to address complaints in a timely manner locally (as per best practice).

The third option is that all complaints be dealt with by local resolution initially with the ability to be escalated to an external body at any time.

Under this model, if complaints about patient care (other than suspected official misconduct which would be referred to the Crime and Misconduct Commission) are not resolved to the patient’s/complaint initiator’s satisfaction within 30 days, they are to be escalated to a Health Commission with the powers to investigate such complaints. This model is the most conducive to timely local resolution but also provides for external accountability. Every complaint written or oral must be recorded and contact must be

⁹⁰ International Standard ISO 10002:2004 Quality management - Customer satisfaction - Guidelines for complaints handling in organisations

⁹¹ Open Disclosure Standard: A National Standard For Open Communication In Public And Private Hospitals, Following An Adverse Event In Health Care, July 2003, Australian Council For Safety and Quality In Health Care

made with patient/staff member within 72 hours of the date of lodgement. Local resolution is facilitated by open disclosure. Further details of this preferred model are found in Figure 9.1.

A designated District Complaints Coordinator should be responsible for resolving as many complaints as possible themselves. The Complaints Coordinator must be highly skilled in conflict resolution and be given authorisation to engage all district staff in the effective resolution of complaints. In the event that they are unable to resolve the issue the Complaints Coordinator should escalate the matter to the relevant member of the District Executive (for example a complaint involving a nurse should be followed up by the Director of Nursing). Where a complaint is made against a doctor the Complaints Coordinator should also immediately notify the Director of the Area Clinical Governance Unit.

Complaints Coordinators will require on-going training particularly on the *Whistleblowers Protection Act 1994* and how to better support Whistleblowers. The training on complaints handling would be conducted via a partnering arrangement between Queensland Health, a Health Commission, the Crime and Misconduct Commission with significant input from the Ombudsman's Office. A network should also be established for coordinators to support each other and share experiences.

Area Complaints Managers (within the Area Clinical Governance Unit) must ensure that actions taken are appropriate for all complaints and that unresolved matters are escalated within the timeframes.

One statewide complaints and compliments database

Queensland Health should treat complaints and compliments as a data source to improve service delivery but there is currently a lack of uniformity and quality in complaints systems across the Department. Consideration should be given to developing one statewide complaints data base, with a number of security access levels, which would record all complaints and compliments about Queensland Health's provision of healthcare as well as complaints and compliments about other Queensland Health services. To facilitate data analysis Queensland Health should consider recording on this same complaints and compliments database, complaints made to the Minister and Director-General, misconduct complaints, level 2 and 3 grievances, email misuse and if possible suspected official misconduct.

Some work has commenced on a patients complaints module for the incident management system PRIME. This initiative should be evaluated and if it meets Queensland Health's needs be progressed as soon as possible.

Analysis of complaints data to identify systemic issues should be undertaken centrally and feedback provided to Area and District Complaints Coordinators. They would also provide regular reports to Area and District Managers on the status of complaints.

A complaints system in which patients/consumers of healthcare have confidence

The public needs to have confidence that complaints are being actioned and any systemic matters addressed. The role of an independent body such as a Health Commission is impartial adjudication with timely complaints resolution the required outcome. The most transparent way of ensuring this takes place is for this independent body to have closer

involvement in complaints handling involving Queensland Health. This could mean having access to the complaints data base and complaints data for independent monitoring of individual cases and having the power to investigate or to take over the investigation of a complaint at any time. This would provide one source of checks and balances missing in the current system of complaint handling within Queensland Health.

In recognition that consumers of health services sometimes need support to guide them through the health maze, other jurisdictions have introduced the concept of advocacy services whose role it is to support health consumers in reaching clear decisions and taking action as a result of those decisions, with the aim of resolving complaints.

The Western Australian health system has a Health Consumers' Council, an independent community based organisation, which advocates on behalf of consumers to government, doctors and other health professionals. In New South Wales the Health Care Complaints Commission (HCCC) provides a Patient Support Service with officers located in Area Health Services. This service is repositioning itself from what has been perceived as a consumer advocacy service to supplying an impartial complaints resolution service.

In reviewing services to assist patients in other jurisdictions, the Review has concluded that patients/health service consumers would benefit from receiving independent assistance if they should need this. This may be particularly the case with respect to culturally and linguistically diverse groups (often referred to as CALD). Therefore an independent patient support officer service offered by the non-government sector and managed through a Health Commission should be considered.

Numerous non-government organisations provide support and assistance to health care consumers. While complaints management is not their primary role, if these organisations have a clear understanding of the complaints management model they can more effectively work with consumers and communities when they have concerns about the provision of health services. It is therefore important for Queensland Health to make information about complaints management widely available to such organisations.

Interstate experience also shows that a network of locally based Health Commission staff in regional areas can also assist in timely complaints resolution. It is suggested that placing Health Commission officers in centres such as Cairns, Townsville and Rockhampton should be considered. Placing a Health Commission officer in Bundaberg to service the Bundaberg/Fraser Coast Health Service Districts for a period of approximately two years would assist the local communities in regaining confidence that health care concerns will be addressed promptly. Additional Health Commission officers should be considered to improve the service to high growth areas such as Gold Coast, Logan City and Sunshine Coast as well as rural/remote areas of Queensland.

This strategy would help to promote resolution of complaints in a timely way and better meet the patient/consumer of health services' needs in terms of accessibility and understanding of local issues.

Criminal history checking

One strategy to reduce the risk of complaints of a serious nature involving employees is to ensure that the workforce has undergone a prudent degree of screening prior to employment. With that in mind Queensland Health has been working towards a general Criminal History Check policy and process in accordance with the provisions of the

Public Service Act 1996. The Review team was advised that a specific submission is currently with the Office of Public Sector Merit & Equity for consideration. This followed changes to the Public Service Act in 2004 enabling Queensland Health to conduct broad based checks on potential and existing staff - no legislative provision existed prior to that time.

At this point in time Criminal History checks are conducted on certain staff employed within Queensland Health in accordance with the *Commission for Children, Young People and Child Guardian Act 2000* and the *Aged Care Act 1997*.

The “Working with Children Check” or Blue Card is only required in Queensland Health for those staff working predominately with children and young people in a school or school based environment. This includes staff working in school based youth health programs and oral health programs and some Alcohol Tobacco and other Drugs programs. All other Queensland Health staff, including Medical Practitioners and Nurses, are not required to hold Blue Cards at this time.

It is in the interests of patients and other staff, that all current and prospective Queensland Health employees undergo a criminal history check. It should be noted that a prospective employee with a criminal history is not prevented from being appointed to a position for which they apply, provided the conviction is not deemed relevant. As this is a large organisation staff working with the most vulnerable patients/consumers should be considered first.

Whistleblowers

During the review of the complaint systems and having regard to Bundaberg issues generally it is clear that the *Whistleblowers Protection Act 1994* (the Act) could be enhanced. Based on the consultations held and submissions received four changes to the Act have been considered:

- One submission has proposed that just as agencies must refer allegations of suspected official misconduct to the Crime and Misconduct Commission so too agencies should have an obligation to refer disclosures involving serious maladministration to the Ombudsman’s Office and that the Ombudsman should be empowered to investigate these disclosures of maladministration. One concern with this suggestion relates to the possible extension of time to investigate issues. The constant theme repeated by healthcare consumers and past complainants during the Review’s consultation process and in submissions, is the time delays in resolving matters by external complaint bodies such as the Ombudsman’s Office and the Health Rights Commission. Secondly, this proposal does not appear to represent a significant gain for Whistleblowers as maladministration is only one of four types of conduct that constitute a public interest disclosure. No proposal is put forward for two of the four types of conduct:
 - danger to the public health or safety or the environment
 - negligent or improper management affecting public funds

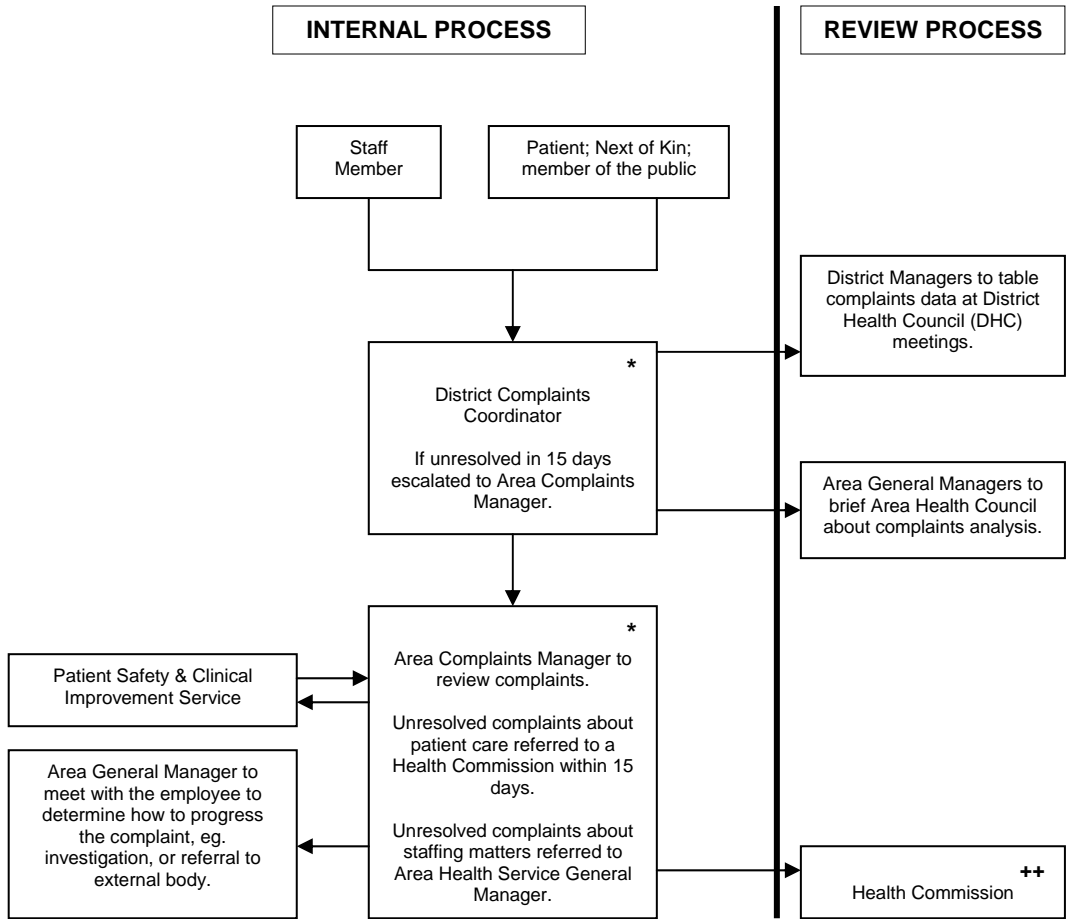
If the proposal was to be endorsed the definition of “Maladministration” under Schedule 6 of the Act would need to be more specific. Public Interest Disclosures could also relate to more than simply maladministration which may cause confusion as to which external body has carriage of the Disclosure. For the above mentioned reasons this proposal is not supported.

- That Whistleblowers should be able to lodge Public Interest Disclosures with Members of Parliament and have protection under the Act. This proposal is supported.
- That Whistleblowers should be able to lodge Public Interest Disclosures with the media and have protection under the Act. This proposal is not supported as there are already a number of options available to Whistleblowers and such a move could allow untested allegations being made public that unjustly impugn those against whom allegations have been made.
- That any person not just a public officer should be afforded protection for disclosing danger to public health and safety. Such a change to the Act would protect for example patients from reprisals, particularly defamation proceedings. This proposal is supported.

Statements have been made that Queensland Health's culture is not conducive to disclosing clinical incidents and treating complaints as learning opportunities. Undertaking a re-education program on the *Whistleblowers Protection Act 1994* is one of the strategies Queensland Health should implement to help to ensure situations like Bundaberg do not occur again. Queensland Health also needs to create an open and responsive complaints system. Several of the strategies considered in developing the proposed complaints model address this concern. The key strategies are:

- rewriting the Code of Conduct so it is not used as a tool to bully or intimidate but rather focuses on a new set of organisational values which are patient/consumer centric
- Queensland Health partnering with external complaints bodies to train Complaints Co-ordinators in complaints handling with a particular focus on how to support Whistleblowers
- a Health Commission should have access to Queensland Health complaints data about patient care and the complaints database, at all times and should be able to take over the carriage of a complaint at any time
- staff of a Health Commission be appointed to have a local presence and improve service to regional Queensland as well as high growth areas and
- there are timeframes for investigation of complaints after which there is mandatory reporting to a Health Commission.

FIGURE 9.1 - RECOMMENDED COMPLAINTS MANAGEMENT & RESOLUTION MODEL



++ Additional Health Commission staff may be located in regional centres
 * Area Complaints Managers and District Complaints Coordinators may need to consult with Human Resource Manager/SSP in resolving staff complaints

Director-General/Ministerial complaints would be forwarded to the Area Health Service General Manager for attention.

The Complaints model above in no way overrides statutory/mandatory reporting requirements.

Recommendation 9.16

A complaints model be adopted that provides for local resolution first whilst requiring escalation to an independent complaints body, a Health Commission, if the complaint is not resolved in 30 days.

District Complaints Coordinators with the skills and the delegation required be employed to take primary responsibility for complaint resolution and be supported through appropriate training and networks.

A Complaints Manager position be created for each of the Area Health Services to support District Complaints Coordinators and ensure all complaints about health care in the Area Health Service are resolved or escalated to a Health Commission and that actions taken in response to such complaints are appropriate.

Recommendation 9.17

District Managers will table regularly at District Health Council meetings de-identified district complaints and compliments data and any Health Service District and Area Health Service trends and learnings to keep community representatives informed.

Recommendation 9.18

Consideration should be given to developing one statewide complaints data base with a number of security access levels which would record all complaints and compliments about Queensland Health's services.

Recommendation 9.19

A Health Commission should have access to Queensland Health complaints data about patient care and the complaints database, and should be able to take over the management of a complaint at any time.

An independent patient support officer service be arranged with the non-government sector and managed through the Health Commission.

Some Health Commission staff be located around the state to assist healthcare consumers in resolving complaints.

Recommendation 9.20

All current and prospective employees should undergo criminal history checks in the interests of patients and staff. Staff working with the most vulnerable patients/consumers should be targeted first.

Recommendation 9.21

Changes considered to the *Whistleblowers Protection Act 1994*

Whistleblowers should be able to lodge Public Interest Disclosures with Members of Parliament and have protection under the Act.

The media should not be approved as one of the bodies to whom Whistleblowers can lodge Public Interest Disclosures and have protection under the Act.

Any person not just a public officer should be afforded protection for disclosing danger to public health and safety.

Complaint oversight bodies

Several external oversight bodies have varying degrees of involvement with healthcare complaints about Queensland Health. The bodies with most involvement are the Health Rights Commission which addresses approximately 1500 complaints annually and the Crime and Misconduct Commission which receives approximately 200 complaints annually. The Health Practitioner Registration Boards and the Queensland Nursing Council also receive a large number of complaints annually but numbers are not currently available.

There are also a number of other bodies that may become involved to a lesser extent in healthcare complaints. These are the Professional Conduct Review Panel, the Queensland Ombudsman, the Coroner, the Adult Guardian, the Public Trustee, the Commission for Children and Young People and the Child Guardian.

The terms of reference for this review are limited to systems within Queensland Health. However, in making findings and recommendations regarding the effectiveness of complaints systems within Queensland Health, it is important to also make comment about the broader system of complaints management faced by health consumers and individuals seeking to raise concerns or have complaints addressed. There are several organisations potentially involved:

The Health Rights Commission

The Health Rights Commission can only undertake a formal investigation about a non-registered provider and is the only Commission in Australia that does not have jurisdiction to investigate a complaint about a registered provider. An effective Commission will keep procedures as informal as possible and focus on resolution via mediation rather than investigation. It should be noted that there are already recommendations contained in the report on the Health Rights Commission Review conducted in 2002, which would make the Commission more effective. Some of these recommendations have not been implemented, one of which relates to the legislative changes which are still required.

Health Practitioner Registration Boards (some 14 in total)

Where a board receives a complaint about a registrant from a user of a service provided by the registrant, it must then refer the complaint to the Health Rights Commissioner. Consultation then takes place to determine whether the relevant board will investigate the matter.

While the registration bodies have the power to investigate the actions of individual registrants, they do not have the power to investigate systemic issues – which comes under the responsibility of the Health Rights Commission. This creates difficulties if an event raises both professional standard issues and systemic issues.

The Crime and Misconduct Commission (CMC)

This role is well established within the Public Sector. Many complaints regarding misconduct made to the CMC are referred back to the agency concerned for investigation. The CMC investigates the most serious matters.

The State Coroner

The Coroner has jurisdiction to inquire into the cause and circumstances of a reportable death. There is no consistent approach within Queensland Health to supporting the role of the Coroner in the investigation of deaths that are not reasonably expected to be an outcome of a health care procedure.

These investigations are performed by police officers. It may be preferable for such investigations to be lead by clinicians.

The Queensland Ombudsman

The Ombudsman is empowered to deal with complaints about the administrative actions of Queensland Government departments including Queensland Health.

The submissions received and feedback from public meetings indicate that complainants are looking for better coordination of the work of these external bodies in resolving their issues. The Review concurs with the above view that interaction of the external bodies needs to work better. For this to occur the working arrangements between external complaint bodies should be the subject of further legislative review.

Recommendation 9.22

A separate and short review needs to be undertaken of the legislation and working arrangements between existing external complaint bodies nominated in the report.

9.7 Clinical Governance – external oversight

The clinical governance system, described in the last section of this chapter, will only be effective if it is embraced by the clinical workforce and most importantly, if it enjoys the trust and confidence of the community.

The Review has concluded that significant effort will be required by the employer, Queensland Health, to restore public and internal faith and trust in its clinical workforce. Comparable effort will also be required by Government to regain the confidence of the community following matters about the Bundaberg Hospital and other hospitals revealed at the former Bundaberg Commission of Inquiry and the Public Hospitals Commission of Inquiry and which have been widely reported.

The Review is also mindful from its statewide consultation that some community members have misgivings about the role and effectiveness of the current Health Rights Commission, even though the Review is aware that there have been recent improvements in the way the Commission operates. However, a number of previously recommended legislative changes have not occurred in respect to this body. There is also a need to review the interface arrangements between the Health Rights Commission and registration boards.

The Review has also considered Commissions that exist in other jurisdictions to oversee issues such as quality and safety and clinical practice improvements and enhancements in acute hospitals. Commissions of this kind can provide independent, expert oversight of clinical practice and set evidence based practice standards for, and monitor compliance by, all health facilities whether public or private.

Independent commissions are well positioned to report honestly to the community about progress being made in developing clinical governance systems and standards, and comment specifically upon performance of such systems and the outcomes. Queensland would be well served by establishing an independent body of this kind.

A commission, called the Health Commission, should be established and have the following functions:

- Oversee the development and implementation of quality, safety and clinical practice standards throughout the State's public and private health facilities
- Monitor the compliance of all public and private health facilities with the above agreed standards including regularly publishing reports on a comparative basis relating to these standards

- Encourage hospitals to ensure that clinical governance systems are in place throughout the public and private hospital network and perform as intended
- Investigate on its own initiative and where necessary report on systemic failures within the State's public and private health facilities
- Investigate matters referred by the Minister or the Committee (see below) where there is a suspicion of systemic weakness or failure
- Receive, investigate and manage complaints about the State's public and private health facilities and health services raised by individuals, patients, clinicians and consumers of services
- To undertake complementary research to inform its other functions
- To report generally to the Parliament or Minister and Committee as deemed appropriate by the Commission on its functions and research.

A Commission of this kind in the Queensland context could assume within its functions the role of the current Health Rights Commission to manage a broad range of complaints and undertake certain investigations.

It is recommended that the Health Commission has the following structure:

- A Commissioner and a small team of Assistant Commissioners to act as the governing board of the organisation
- An Executive Director who would assume the role of accountable officer and the administrator of the organisation
- The current envisaged functional requirements of the Commission would require three Directors, not necessarily all at the same level, each Division being responsible for:
 - existing Health Rights Commission functions including complaints
 - oversight of quality, safety and systemic clinical practice issues (including standards and compliance) and
 - the appointment of District Health Council members throughout Queensland and for community consultation and liaison generally. The Commission will advertise and interview for applicants. Two Commission representatives and a Ministerial representative will form the selection panel with nominations to the Minister for appointment.

The selection, qualification and tenure of Commissioners and Directors will be vital.

- In the first years of the Health Commission, the Commissioner and some of the Assistant Commissioners may need to be full time appointees.
- The Commissioner and Assistant Commissioners would be appointed on a full and part time basis for staggered periods with a maximum tenure of five years but a usual term of service of three years. (This is to ensure retention of corporate knowledge and at the same time, renewal in the organisation.)
- As the Health Commission will have a multi-disciplinary mix, Commissioners will need to reflect this mix and should have the following specific backgrounds:
 - The Commissioner – an eminent medical practitioner not concurrently involved in hospital clinical practice with demonstrated leadership qualities
 - A lawyer with medico-legal experience
 - Two people with extensive clinical background in nursing or allied health not currently involved in delivering health services in Queensland
 - A well respected community representative not previously involved in the delivery of healthcare services

- An industry representative with extensive background experience in systemic quality and safety functions in a large human resource environment.
- Directors would have a tenure limited to between three and five years.

The Commission would require access to source information from:

- Incident management systems
- Coroner's findings and recommendations
- Expert committees' reports
- Quality system assessments
- Complaints database
- Literature and research.

The Commission must have specific expertise to ensure that data provided is managed and interpreted using valid statistical analysis and independent expert interpretation. This is vital for both clinician and public confidence in the Commission's reports.

To ensure this Commission is accountable and has the level of independence necessary to restore the community's trust and faith in healthcare systems within Queensland, it should report to both the Minister and a statutory committee established under the *Parliament of Queensland Act 2001*.

The role and functions of this Committee should include:

- To monitor and review the operations of the Commission to ensure that the Commission is performing its functions as intended
- To receive reports of the Commission, together with the Minister, that it is determined should not be tabled in the Parliament.
- To monitor the outcomes of reports by the Commission.
- To refer matters to the Commission by its own initiative
- To refer complaints to the Commission for investigation in its normal processes
- To oversee the appointment process of Commissioners. (Appointments to the Commission should be on the nomination of the Minister, after extensive advertising, but will require a majority of the Parliamentary Committee to support the appointment of the Commissioner and Assistant Commissioners with that majority including both Government and non-Government members)
- The Parliamentary Committee should expressly not have jurisdiction to investigate particular individual complaints against health facilities or system issues per se (in order to avoid duplication) but would inform itself of its monitoring and review role by consulting more broadly with the community on a range of relevant issues and paying attention to systemic trends and or failures and the effectiveness of remedial and supportive follow-up action being instigated by the Commission
- To liaise generally with the Minister about the operation of the Health Commission and matters under its jurisdiction.

No member of the Parliament with executive functions or non-government spokesperson responsibility for health issues should be a member of the Committee. It is, however, envisaged that the Committee and the Minister liaise closely on the operation of the Commission.

Both the Commission and the Parliamentary Committee would need to be appropriately resourced and funded.

New enabling legislation to establish the Health Commission and the Committee, and reform other bodies mentioned in this report and effect other recommendations will be required.

Recommendation 9.23

The Health Commission recommended in this report, with functions that include the coordination of health care complaints, be established.

A Parliamentary Committee with the role and functions described in this report, be established to provide external oversight.

9.8 Public reporting

Much has been said publicly and in submissions that the general public has the right to be informed about the standard of healthcare that it is being provided. Information should be available to the public at the local district, area health service and statewide level. Just as the public has the right to be informed, Area and District Managers and departmental media personnel must be able to respond to media requests and make factual comments publicly on the circumstance of their respective health service, whilst protecting patient confidentiality.

District and Area Health Councils should be a part of this process so they can report to communities.

In external reporting, health service accreditation status continues to be used by the Queensland and Commonwealth Governments as the key measure for the quality of health services, despite evidence that this is not a particularly robust measure. Chapter 13 addresses this issue and details the suite of indicators for reporting.

In other jurisdictions, the first stage in improved public reporting has been to focus on the implementation of clinical governance functions using a set of standards. These are detailed in the New South Wales Implementation Plan, Western Australian audit tool and Victorian checklist and could be used as starting points for Queensland Health.

Once these structural arrangements are bedded down reporting should transition to the use of indicators to monitor the performance of the various processes of clinical governance. These indicators should be developed by clinicians with leadership roles in the various clinical governance activities.

Reporting on the quality and safety of health services should be included in the public reporting of the performance of Queensland Health as also detailed chapter 13 of this report. These reports would be derived from monitoring activities undertaken by the Area Clinical Governance Units and District Health Services.

Recommendation 9.24

There needs to be public reporting on the performance of health services, as described in Chapter 13. This would include an enhanced role for Area and District Health Councils.

9.9 Proposed roles and responsibilities for clinical governance in Queensland

For clinical governance to be effective it is essential that the roles and responsibilities for the development and implementation of the various elements described in this chapter be clearly articulated. Considerable variation exists in the delegation of these roles and responsibilities in other jurisdictions however all of those examined have some degree of independent external involvement in clinical governance.

The proposed roles and responsibilities outlined below takes into account the implementation issues discussed in section 9.2.3 and the lessons learnt from other jurisdictions.

Clinicians

Function: Implementation of clinical governance processes
 Activities: Participation in local quality and safety initiatives such as using clinical pathways, open disclosure, clinical audit, and incident investigation.
 Participation in clinical networks

District Managers

Function: Local accountability for all clinical governance processes
 Activities: Provide the resources necessary to support clinical governance activities and have accountability for ensuring local responsibilities are met

District Health Councils

Function: Consumer feedback on clinical performance
 Activities: Receives monthly performance information and six monthly performance review reports
 Providing an annual public report on performance.

Area Clinical Governance Units

Function: Area implementation and performance monitoring
 Activities: Based at hub hospitals in each Area Health Service, these units would be responsible for:

- implementation of policy supporting clinical governance
- performance monitoring of the implementation of statewide clinical policies and initiatives
- provision of support, education and training to staff
- operationalising the credentialing and clinical privileging process
- assessing performance of individual clinicians and acting as an escalation point for individual clinician performance issues.

Area Health Councils

Function: Consumer feedback
 Activities: Receives monthly performance information and six monthly performance review reports
 Providing an annual public report on performance.

Patient Safety and Clinical Improvement Service

- Function: Statewide support for clinical governance problems and enablers
- Activities: A state-wide service working collaboratively with clinicians and Area Health Services across a range of clinical content areas to:
- develop clinical governance policy
 - develop the necessary tools, resources, information systems and support to facilitate the implementation of policy and quality and safety initiatives
 - set standards
 - develop and implement measurement systems
 - analyse data
 - identify and advise on priorities
 - develop and trial improvements
 - develop and support the provision of training and education
 - assist Area Clinical Governance Units and clinical networks to implement safety initiatives
 - coordinate the Coroner's recommendations.

Performance Directorate, Central Office

- Function: Performance reporting
- Activities: Development of performance indicators to monitor the implementation of clinical governance and the quality and safety of health services
Coordination of quality and safety of health services reporting in overall health service performance reporting arrangements.

Health Commission

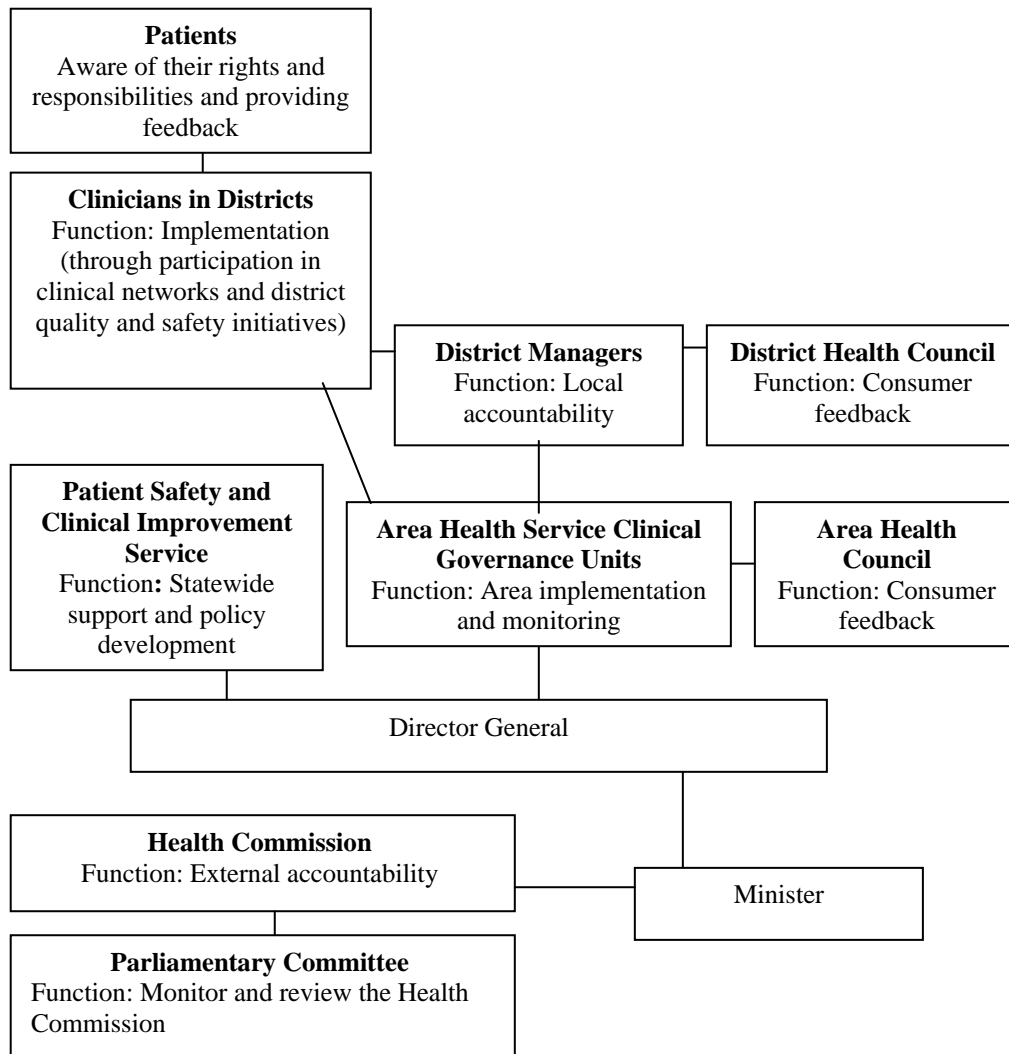
- Function: External accountability
- Activities: An independent external body that would undertake:
- assessment of the quality and safety of health services
 - auditing compliance with clinical governance systems and standards
 - public reporting on systems to support clinical governance and the quality and safety of health services
 - independent investigation of quality and safety issues when required.

Parliamentary Committee

A Parliamentary Committee will ensure that the Health Commission is accountable and has the level of independence necessary to fulfil its role.

- Function: External accountability and Parliamentary oversight
- Activities: The Parliamentary Committee would:
- monitor and review the operations of the Health Commission
 - monitor the outcomes of reports by the Commission
 - refer matters to the Commission by its own initiative
 - refer complaints to the Commission for investigation.

While not incorporated into the structural arrangements for clinical governance, the involvement of professional bodies in implementing the processes and enablers is critical.



Recommendation 9.25

A clinical governance structure be established that is clinician and patient focused with functions as outlined in this section and the following components.

- Safety and quality committees in all districts, chaired by senior clinicians (who are involved in clinical networks)
- Area Clinical Governance Units in each Area Health Service led by a senior medical officer with experience in systems improvement
- A statewide Patient Safety and Clinical Improvement Service
- An independent Health Commission with responsibility to monitor the implementation of clinical governance and the safety and quality of health services and report publicly
- A Parliamentary Committee to provide external oversight.

Professional bodies must be involved in implementing the clinical governance processes and enablers.

The District Manager is accountable for the local implementation of clinical governance.

District Health Councils and Area Health Councils will be provided with performance reports on quality and safety in their monthly performance information and a six monthly performance review report and will be provided with annual public reports on performance for the District and Area respectively (as detailed in Chapter 13).

10. A workforce for the future

10.1 Key findings

This report presents a range of proposals to improve Queensland's public health services. However, quality health services depend on sufficient numbers of competent, skilled clinicians being available at the front line. Patients expect to be treated by staff who are highly skilled and trained, dedicated to patient care and working in safe and supportive environments.

While Queensland Health has managed to grow its workforce in numbers, clinical staff report unsustainable workload levels and Queensland continues to have the lowest number of health professionals per capita of any State or Territory except for Tasmania.

Increasing clinician numbers is a challenging task. As an employer, Queensland Health faces significant challenges including:

- an ageing clinical workforce with major implications as the most senior and experienced clinicians begin to retire in coming years
- reduction in working hours – across the clinical spectrum - requiring more staff (with attendant ancillary costs) to provide the same level of service
- inadequate local supply of doctors and significant attrition rates of doctors employed in public hospitals, driving reliance on OTDs with special purpose registration to sustain workforce growth – likely to be felt for at least fifteen years
- a Visiting Medical Officer (VMO) workforce with potential to assist but feeling marginalised from the public system and already heavily committed to the private sector
- a reasonable local supply of nurses but shortfalls within Queensland Health arising from high attrition rates in the profession (up to 40% in the first two years) and a failure to fund and recruit nursing numbers in line with increasing demand
- insufficient data on allied health professionals to properly analyse supply issues, assess current shortfalls or inform future planning, but clear general indication of significant and critical shortage.

Consultations revealed that many clinical staff are angry, resentful and frustrated towards Queensland Health and feel disconnected from senior managers and leaders who they perceive focus only on budgets rather than patient safety and care. Clinicians felt disempowered, undervalued and marginalised and reported:

- unmanageable workloads and work pressure
- a coercive, bullying work environment
- frustration with too many layers of bureaucracy
- inadequate training and professional development opportunities
- insufficient time for teaching, research, training and professional development

- perceived lower remuneration compared with interstate public health systems
- lack of clinical input into decision making including budget allocations
- the enterprise bargaining system is divisive and escalates differences
- the most basic of entitlements not being provided to some staff
- safety concerns related to patient and carer aggression

The Review concluded that the breakdown of clinically related teaching, training and education for the workforce was the first casualty of an overburdened system. This is one of the most serious deficiencies confronting the organisation.

This poor treatment generally of the clinical workforce must be addressed urgently and comprehensively. Consultations confirmed that many clinicians are awaiting the outcome of this review and the current enterprise bargaining round before determining whether they will remain in the public sector. Additionally, districts are now reporting that some of their services are approaching crisis point and in danger of closing, due to worsening workforce pressures arising from the above issues and the damage to Queensland Health's reputation as an employer following events at Bundaberg.

These factors, in the context of global health workforce shortages and an environment of significant competition between jurisdictions for clinical staff, make intensive recruitment, retention and training initiatives mandatory in order to provide a sustainable public health service.

Below is a snapshot of the proposals put forward in this chapter. The proposed reforms will need to be accompanied by other significant work to create a workplace environment and culture which will attract and retain good clinicians. Many other system improvements recommended in this report, particularly in the areas of budget allocation, service planning and design, information systems and organisation culture, will also be critical in improving work conditions and ensuring clinical staff feel valued and are being genuinely supported. These broader issues are explored elsewhere in the report.

Snapshot of proposed workforce reforms for doctors, nurses and allied health professionals

1. Relief for the clinical workforce through immediate action to recruit more doctors, nurses and allied health professionals in a targeted manner to address service priorities and reforms
2. Immediate and long term measures to retain doctors, nurses and allied health professionals including reforms to improve organisational culture, provision of staff amenities, removing frustrations, providing safe working environments, peer support for isolated practitioners, just salary arrangements, more efficient work practices, simplified industrial awards and increased support for smaller districts through country service rotations
3. Innovative strategies to maximise the skills and availability of the clinical workforce including new workforce roles and increased interaction with the private sector
4. Showing a strong commitment to education and training and providing urgent remedial measures - including more training positions, measures to provide protected teaching time, and enabling all clinical staff to access work relevant training and professional development opportunities
5. Better workforce planning and monitoring of workforce trends including staff conditions and levels of satisfaction
6. Empowering clinicians by building clinical leaders and reconnecting them to service planning and decision making through clinician led networks (Chapter 6)

10.2 Profile of Queensland Health’s clinical workforce

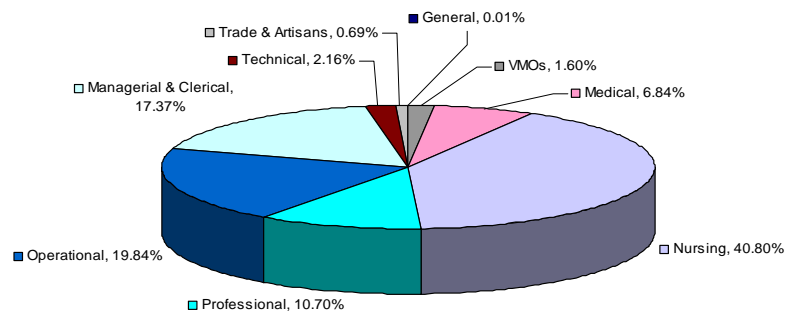
10.2.1 Queensland Health’s workforce

Queensland Health is the largest employer of health professionals in Queensland. In the consultations across Queensland Health districts, their dedication, professionalism and commitment to patient care was clearly apparent. The clinicians currently working in the system are the cornerstone of the public health system and play a critical role in supervising, training and mentoring the health workforce of the future.

Queensland Health currently employs 53,307 people across the organisation which equates to 43,782 full time equivalent (FTE) staff. As shown in the figure below, nurses make up the largest proportion of the health workforce (40.8 percent or 21,750 staff), followed by the operational category (19.8 percent or 10,577 staff) and managerial and clerical staff, (17.4 percent or 9,258 staff). The professional category which includes allied health professionals makes up 10.7 percent or 5,700 staff. There are 3,647 medical staff and 851 VMOs comprising roughly 8.4 percent of the total workforce.

Queensland Health headcount breakdown as at 19/06/2005

■ VMOs ■ Medical ■ Nursing ■ Professional ■ Operational ■ Managerial & Clerical ■ Technical ■ Trade & Artisans ■ General



Source: Queensland Health Human Resource Management Information System

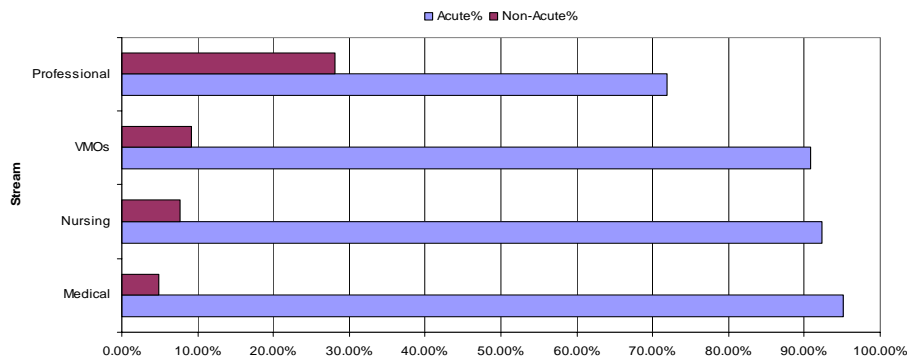
10.2.2 Distribution of staff

The majority of the Queensland Health workforce is located in metropolitan areas with 72 percent of doctors, 60 percent of nurses and 73.5 percent of Queensland Health’s professional staff working in Brisbane or other metropolitan centres. Roughly 60 percent of Queensland’s population live in metropolitan areas with the remainder residing in rural and remote parts of the State.

The nursing workforce is fairly evenly distributed in line with the State’s population needs. Clear mal-distribution of medical and professional staff is evident given the concentration in metropolitan areas at levels in excess of population requirements. For example: doctor to population ratios of 1 to 500 in urban areas and 1 to in excess of 3,000 in rural and remote centres. This reflects the difficulties in attracting and retaining staff in rural and remote areas and poses particular challenges in providing services on an equitable basis across the State.

Queensland Health’s clinicians work predominantly in public hospital facilities. As shown below, around 87 percent of doctors and 90 percent of nurses work in acute hospital settings. Allied health and professional staff represent the highest percentage of staff working in non-acute settings with 35 percent working in non-acute service environments which include community health centres and statewide services such as pathology and public health services. In some instances, community based services are located on the same premises as hospital facilities.

Percentage of staff working in Acute and Non-Acute Settings



Source: Queensland Health Human Resource Management Information System

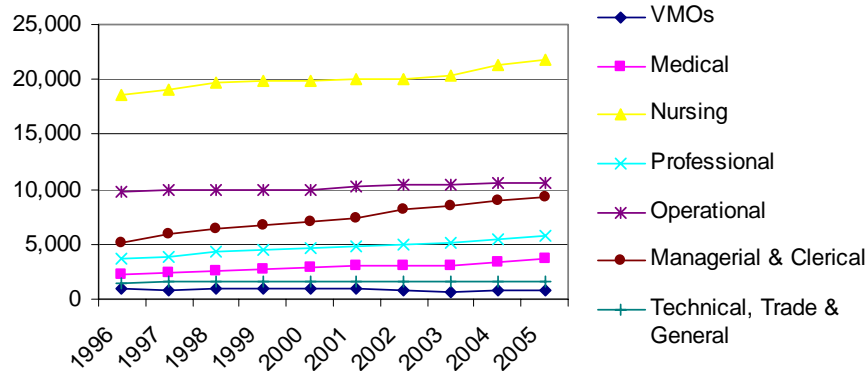
10.2.3 Changes in staff numbers

Despite global workforce shortages, Queensland Health has managed to grow its total workforce over the last nine to ten years. Since 1996, the overall workforce has grown by 27.2 percent or roughly 3 percent per annum, increasing from 34,420 full time equivalent (FTE) staff to 43,785 as at March 2005.

As shown in the graph below, the number of medical practitioners has increased by 69 percent from 2,027 FTE staff in 1996 to 3,434 in 2005. A significant proportion of this growth has been accomplished with the use of OTDs with special purpose registration who now make up 27 percent of Queensland Health’s medical workforce. This high reliance on OTDs is consistent with trends in other decentralised states such as Western Australia and the Northern Territory especially in regional, rural and remote areas.

The number of VMOs has decreased on a FTE basis from 407 in 1996 to 240 in 2005. This reflects reducing hours comprising a combination of budget imperatives and pressure on existing VMOs in the private sector. The overall number of VMOs has decreased from 883 to 851 over this period, reflecting a stable part time workforce.

Queensland Health staff growth 1996-2005



Source: Queensland Health Human Resource Management Information System

Nursing numbers have not shown the same level of growth as doctor numbers. The numbers of nurses working in Queensland Health has increased by 1,825 from 15,118 FTEs in 1996 to 16,943. This is an increase of 12.1 percent which falls short of population growth over the same period.

The professional category, which includes allied health professionals, has increased from 3,112 FTEs in 1996 to 4,961 in 2005, an increase of 1,848 or 59 percent (note the statistics on professional staff include allied health practitioners but also include other professions such as scientists, public health staff and other professions in Corporate Office including lawyers). The highest increase has been experienced in the managerial and clerical category which rose from 4,595 staff in 1996 to 8,433 in 2005, an increase of 3,839 or 83.5 percent.

Despite growth in particular areas, as shown in the table below, Queensland continues to employ fewer doctors, nurses and allied health professionals per head of population in the public hospital system than any other State or Territory except Tasmania.

Full Time Equivalent Staff Numbers, All States and Territories Public Hospitals

| | NSW | VIC | QLD | WA | SA | TAS | ACT | NT | TOTAL |
|--|--------|--------|--------|-------|-------|-------|-------|-----|--------|
| FTE Total Nurses | 31,865 | 24,028 | 14,661 | 8,158 | 7,813 | 1,806 | 1,479 | 941 | 90,751 |
| Rate per 1,000 | 4.8 | 4.9 | 3.9 | 5.3 | 4.0 | 3.8 | 7.4 | 2.9 | 4.6 |
| FTE Total Salaried Medical Practitioners | 6,700 | 5,389 | 3,602 | 1,883 | 1,678 | 367 | 317 | 246 | 20,182 |
| Rate per 1,000 | 1.0 | 1.1 | 0.9 | 1.2 | 0.9 | 0.8 | 1.6 | 0.8 | 1.0 |
| FTE Diagnostic and Allied Health Professionals | 10,005 | 10,784 | 3,231 | 2,230 | 1,965 | 349 | 349 | 261 | 29,174 |
| Rate per 1,000 | 1.5 | 2.2 | 0.9 | 1.5 | 1 | 0.7 | 1.8 | 0.8 | 1.5 |

Source: Australian Hospital Statistics 2003/04 and ABS 3201.0 and 3220.0

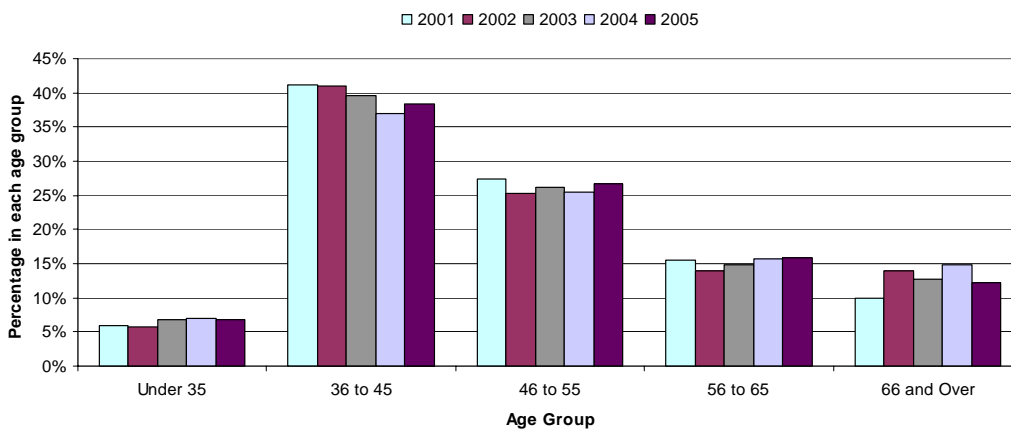
It is instructive to note that the above are hospital comparisons only. In terms of doctor numbers across the public and private sector including primary and acute care, Queensland, as revealed in the interim report, has 1860 less doctors compared to the national average. This is based on registration statistics which rely on each doctor voluntarily re-registering annually.

10.2.4 Age and gender characteristics of the health workforce

Like the broader workforce, Queensland Health’s workforce is ageing. The average age of a registered nurse working in Queensland Health in 2005 is 42 years of age while the average age of a senior medical officer is 46. The graphs below show the age distribution for both the nursing and medical workforce over the last four years. In the case of staff specialists, around 28 percent of the workforce is now aged 56 years or over.

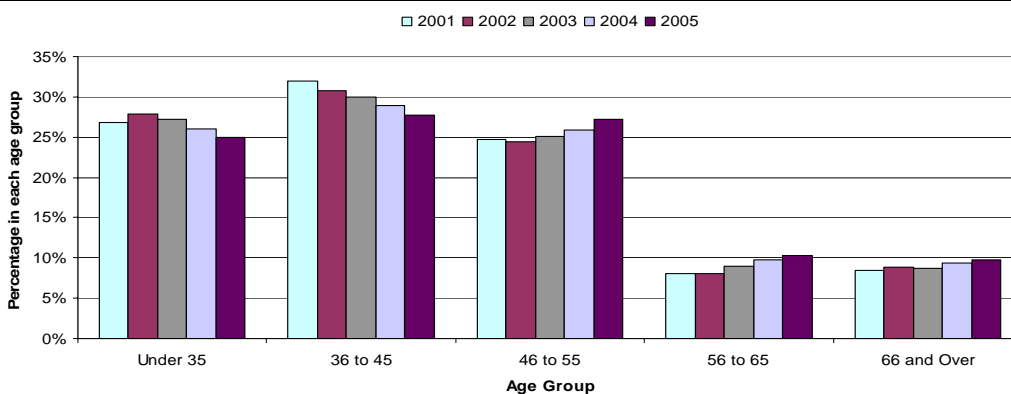
The ongoing impact of ageing is most apparent in the nursing workforce profile. In 2001, the majority of the nursing workforce were less than 45 years of age. It is now the case that almost half or 47 percent of the workforce is over 46 years of age and around 20 percent of nurses are in the over 56 years of age group. This has major implications for the future of Queensland Health in the context of growing workforce shortages as the most qualified and experienced staff can be expected to retire over the coming years.

Staff Specialist Age Profile Trends



Source: Queensland Health Human Resource Management Information System

Nursing Stream Age Profile Trends



Source: Queensland Health Human Resource Management Information System

Nursing remains a predominantly female occupation. Around 88 percent of nurses working in Queensland Health are women. The medical workforce is also becoming increasingly feminised with women making up an estimated 36 percent of the Queensland

Health total medical workforce. This is higher than national trends which show 31.9 percent of female medical practitioners working on a national basis in 2003⁹⁶.

10.2.5 Reductions in working hours

Health professionals are working fewer hours per week than they used to. The latest Australian Institute of Health and Welfare (AIHW) Nursing Labour Force survey shows that more than half or 53.7 percent of nurses are now working part-time with the average number of hours worked per week having decreased from 32.4 hours in 1995 to 30.5 hours in 2001⁹⁷. Queensland Health figures show the average hours worked for nurses is now 29.7 hours per week. This has major ramifications for workforce planning as it means that more staff are required to provide the same level of service.

While the trend is less apparent in the medical workforce, doctors are also reducing their hours worked and with more women entering the profession, the trend is likely to continue, with a further reduction in hours under consideration in the current enterprise bargaining negotiations. Queensland Health data show that the average number of hours which medical staff are contracted to work is 37.7 hours per week while VMOs are contracted to work on average 8.8 hours in the public system. However, in terms of actual hours worked, some specialists are working excessively long hours with many reporting they are working more than 60 hours per week to cope with increasing workloads⁹⁸. A survey of all medical practitioners working in Queensland showed that around 73 percent of doctors work more than 40 hours and 18 percent of doctors are working more than 60 hours per week⁹⁹.

10.2.6 Remuneration and conditions

The amount Queensland Health pays its staff is governed by awards and conditions under the government wide enterprise bargaining framework. It is difficult to draw direct comparisons between salaries paid by the various States and Territories for the different health professional groups as each have different awards, conditions and classifications. The table below shows that average salaries in aggregate are lower in Queensland for nurses and doctors. In the case of diagnostic and allied health professional staff, the national data suggests Queensland is higher than the national average salary range. This is likely to reflect wage differentials within the allied health group, and some constraints to professions within salary scale ranges, as it is generally reported from Queensland sources that this group is paid less than the national average.

⁹⁶ Australian Institute of Health and Welfare, National Health Labour Force Series Number 32 Medical Labour Force 2003

⁹⁷ Australian Institute of Health and Welfare, Nursing labour force survey 2001

⁹⁸ Queensland Health Issue Paper for Bundaberg Hospital Commission of Inquiry Health Workforce Paper 2 Medical Workforce

⁹⁹ Queensland Health, Workforce Characteristics Medical Practitioners Re-registered in Queensland, 2001, 2002 and 2003.

Average salary (\$) of full time equivalent staff^(a), public acute and psychiatric hospitals, states and territories, 2003-04

| Staffing category | NSW ^(b) | Vic ^(c) | Qld | WA | SA ^(b) | Tas ^(d) | ACT | NT | Total ^(e) |
|--|--------------------|--------------------|---------------|---------------|-------------------|--------------------|---------------|---------------|----------------------|
| Salaried medical officers | 116,880 | 133,174 | 105,388 | 138,997 | 107,378 | 102,624 | 133,990 | 130,376 | 120,627 |
| Nurses | 65,284 | 62,315 | 57,422 | 61,407 | 57,546 | 56,202 | 61,661 | 64,828 | 61,969 |
| Other personal care staff | n.a. | n.a. | 38,273 | 39,944 | n.a. | n.a. | 42,712 | 52,350 | 39,134 |
| Diagnostic & allied health professionals | 53,769 | 43,356 | 59,419 | 54,823 | 50,328 | 59,505 | 51,805 | 62,147 | 50,515 |
| Administrative & clerical staff | 50,366 | 44,404 | 42,084 | 45,361 | 42,546 | 40,708 | 50,640 | 54,642 | 46,280 |
| Domestic & other staff | 36,914 | 42,645 | 38,665 | 39,348 | 34,923 | 47,853 | 40,034 | 41,831 | 38,995 |
| Total staff | 61,481 | 60,756 | 56,719 | 61,417 | 56,307 | 56,742 | 64,075 | 65,003 | 60,083 |

- (a) Where average full-time equivalent (FTE) staff numbers were not available, staff numbers at 30 June 2004 were used.
 - (b) *Other personal care staff* are included in *Diagnostic & allied health professionals* and *Domestic & other staff*.
 - (c) FTEs may be slightly under-enumerated with a corresponding overstatement of average salaries.
 - (d) Data for 2 small hospitals not included. *Other personal care staff* are included in *Domestic & other staff*.
 - (e) The totals for *Other personal care staff*, *Diagnostic & allied health professionals* and *Domestic & other staff* are affected by reporting arrangements noted above.
- n.a. Not available.

Source: Australian Hospital Statistics 2002-03

The Australian Nursing Federation (ANF) publishes information comparing pay rates for nurses on a quarterly basis. Some key statistics from the latest ANF publication are reproduced in the table below. It shows that Queensland pays less than the national average at all levels for nursing but is broadly comparable with Victoria and at the higher levels is marginally higher than Victoria. New South Wales generally has the highest rates of pay for nursing staff.

Nursing Wage Comparisons - Public Sector Weekly Salary Data as at 1 June 2005

| | NSW | ACT | QLD | NT | SA | TAS | WA | Vic | National Average |
|------------------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------------|
| Enrolled Nurse Level 1 | \$694.80 | \$717.87 | \$649.25 | \$668.40 | \$666.25 | \$665.42 | | \$669.30 | \$675.90 |
| Enrolled Nurse Top Pay Point | \$756.20 | \$783.55 | \$720.50 | \$755.56 | \$752.45 | \$721.80 | | \$767.00 | \$751.01 |
| Registered Nurse Year 1 | \$787.80 | \$748.20 | \$732.55 | \$755.56 | \$737.40 | \$728.89 | \$737.56 | \$738.40 | \$745.80 |
| Registered Nurse Year 8 | \$1,106.40 | \$1,032.00 | \$986.35 | \$999.60 | \$968.40 | \$975.59 | \$958.53 | \$986.70 | \$1,001.70 |
| CNC RN Level 2 Year 1 | \$1,440.40 | \$1,074.27 | \$1,003.25 | \$1,041.35 | \$1,025.40 | \$1,010.90 | \$1,008.77 | \$1,027.10 | \$1,078.93 |
| RN Level 3 Grade 1 | \$1,525.20 | \$1,209.94 | \$1,150.35 | \$1,158.82 | \$1,210.35 | \$1,161.13 | \$1,217.10 | \$1,039.30 | \$1,209.02 |

Source: ANF, Nurses Paycheck Volume 4, Number 3, June 2005–August 2005

Medical practitioner pay rates are especially difficult to compare across jurisdictions given various classifications, loadings and allowances which are not captured in basic salary entitlements. There is no one formally recognised endorsed comparative data kept nationally, and therefore all local groups compile their own data and invariably include different components on top of base salary which are simply not comparable from State to State.

As enterprise negotiations in respect to medical practitioners' salary are currently progressing, the Review has not sought to favour any particular comparative list, but simply makes the observation that medical practitioners' salaries need to be perceived by all those in the workforce to be fair and just on the basis of fair comparisons with other States. Discussions with medical practitioners throughout Queensland indicated that it is their strong perception that current salary arrangements are below comparable arrangements in other jurisdictions.

Salaried medical officers and VMOs are paid under different terms and conditions within the Queensland Health system. One of the most concerning anomalies in salary rates for medical practitioners is the significantly lower rates that are paid for academic

appointments in medical schools compared to rates now paid within both the public and private sectors. The medical schools report that it is becoming increasingly difficult to attract eminent clinicians for academic posts and that professorial or joint appointments to the public sector are increasingly only possible if there is a significant loading offered to help bridge the difference in salary rates.

Comparable and reliable information on allied health staff salaries is not available and comparisons are difficult due to different progression arrangements based on experience.

When comparing Queensland's pay rates for health professionals with other States and Territories, it is important to note that Queensland wages in general across all occupational groups are lower than the Australian average by an estimated 5 to 6 percent. This in part reflects the lower cost of living in Queensland compared to States like New South Wales and Victoria.

In terms of comparisons with the private sector, specific information is not widely published. However, anecdotal evidence suggests that specialists working in the private sector can access gross incomes up to \$1.5 million per annum. This needs to be offset against the costs of running private practices which are estimated to be between \$250,000 and \$500,000 per annum depending on the type of specialty and practice involved. There are many private practitioners especially general practitioners (GPs) in rural areas who would earn only a fraction of this amount. Public sector specialists, on average, receive between \$200,000 and \$300,000 depending on specialty, hours worked and private practice component.

Fee for service arrangements in the private sector provide opportunities to increase incomes which are not as readily available in the public sector. Anomalies in funding for private and public medicine are a function of Commonwealth/State responsibilities with the States meeting the costs of public sector employed doctors and the Commonwealth meeting the costs of doctors working in private practice through payments under the Medicare Benefits Schedule. This situation is far from ideal and a major impediment to effective utilisation of Australia's medical workforce.

In the case of nursing, it is not possible to make meaningful comparisons between public and private sector remuneration, as the review has heard of significant variations in salaries for nurses working in the private sector, both above and below public sector remuneration.

In terms of allied health professionals, a significant proportion of the workforce is in private practice where services are covered by private health funds and consumer contributions. The ability of allied health professionals to earn higher incomes is therefore much greater in the private sector than the public sector, particularly for pharmacists.

10.2.7 Workloads

A common complaint and consistently recurring theme for this review was the increasing workload being experienced by staff particularly those working in the acute public hospital sector. As shown previously, Queensland has the second lowest numbers of doctors, nurses and allied health professionals working in the public health system per

head of population. Workload intensity is also increasing in association with sicker patients and shorter hospital stays driving increased throughput.

Nursing staff in particular are experiencing major pressures given that nursing numbers have declined in real terms in Queensland Health over the last nine to ten years. During that same time, separations in public hospitals have been increasing in line with population growth leading to intensifying work pressures. The review also found evidence of additional administrative duties being imposed upon clinicians on top of clinical workloads. All categories of clinicians are reporting higher workloads particularly in rural and remote areas where it is difficult to attract and retain staff.

10.2.8 Turnover and absenteeism

Data collected by the Department of Industrial Relations shows that for the March 2005 quarter Queensland Health had higher rates of absenteeism and a higher percentage of employees taking work cover leave as compared with the averages across the Queensland public sector. However, more valid comparisons would be with other health care sectors in other jurisdictions, as working in a health care environment carries its own inherent health risks. These comparisons were not possible due to limited access to interstate data.

A comparison of Queensland Health and Department of Industrial Relations data revealed a higher separation rate for staff in Queensland Health and for each professional group (medical, nursing, dental and professional) as compared with the wider Queensland public sector. (See Interim Report for detailed information for professional groups).

The Interim Report also analysed attrition and growth trends amongst the clinical workforce. This revealed net increases in medical, nursing and professional staff over the past three years. Within these groups, net increases were observed for senior medical staff and resident medical officers, registered and assistant nurses, and lower classifications within the professional streams. However, there was evidence of overall attrition for visiting medical officers, registrars, and enrolled nurses, and higher classifications within the professional stream.

10.2.9 Future requirements

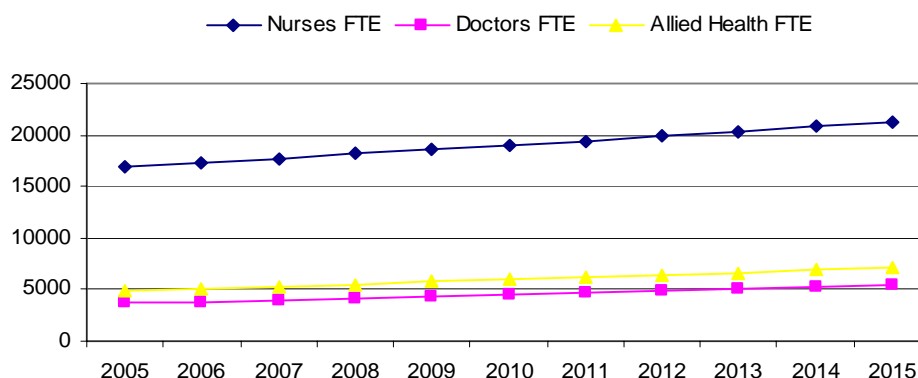
As discussed in Chapter 3, it is expected that demand for health services will steadily increase in line with the State's growing and ageing population at least for the next 20 years. Accordingly, it is expected that the workforce will need to grow in line with that increasing demand.

The following projections have been based on some previous work done by Queensland Health in 2001 which examined zonal workforce requirements¹⁰⁰. The projections have been updated to reflect current workforce levels. They are based on existing patterns of service delivery and do not take into account current workforce shortages. Based on future demand for services in Queensland, it is forecast that Queensland Health will need:

¹⁰⁰ Queensland Health (2004) Forecasted Zonal Workforce Position Requirements

- an extra 4,326 nurses by 2015 on a full time equivalent basis which equates to an additional 5,475 staff taking into account part time work or an extra 500-600 nurses per year;
- an extra 1,870 doctors by the year 2015 or an additional 2,289 staff on a headcount basis or an extra 160-180 doctors per year; and
- an extra 2,597 allied health professional FTE by 2015 equating to an additional 2,985 or 200-250 extra staff per year.

Queensland Health Forecast Staff Requirements



Source: Queensland Health Human Resource Management Information System

10.2.10 Supply of health professional workforce

Overall supply of doctors in public and private sectors

As shown in the table below, the number of doctors registered to practise in Queensland has increased by 18.3 percent over the last five years with an average additional 350 doctors registering each year. Medical graduate numbers from local universities have numbered around 200 per annum. However, these numbers have not been sufficient to replace the number of doctors who retire each year which is estimated to be between 350 to 450 per annum.¹⁰¹ The growth in total medical registrations in Queensland has been achieved by increasing the numbers of OTDs with area of need registrations which have almost doubled from 540 in 1999 to 968 in 2004.

Medical Registrants – Queensland 1999 - 2004

| | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | % Change |
|--|---------------|---------------|---------------|---------------|---------------|---------------|--------------|
| General Registrants | 6,627 | 6,716 | 6,530 | 6,878 | 6,968 | 7,237 | 9.2% |
| Specialist Registrants | 3,425 | 3,529 | 3,635 | 3,742 | 3,738 | 3,801 | 11.0% |
| Internship/surgical training* | 259 | 275 | 266 | 234 | 281 | n/a* | |
| Conditional Specialists | 159 | 172 | 216 | 215 | 285 | 356 | 123.9% |
| Area of Need | 540 | 688 | 843 | 827 | 871 | 968 | 79.3% |
| Area of Need Deemed Specialists | n/a | n/a | n/a | n/a | 58 | 59 | |
| Post Graduate | 111 | 121 | 125 | 128 | 160 | 151 | 36.0% |
| General Practice | n/a | 16 | 41 | 66 | 101 | 168 | |
| Other | 64 | 72 | 60 | 72 | 73 | 180 | 181.3% |
| Total Registered Medical Practitioners* | 11,185 | 11,589 | 11,716 | 12,162 | 12,535 | 12,920 | 15.5% |
| <i>Additional Each Year</i> | | 404 | 127 | 446 | 373 | 385 | |

* This category was absorbed into general registrants in 2004.

Source: Medical Board Queensland Annual Report 2003/04

¹⁰¹ Queensland Health Workforce Characteristics Medical Practitioners Re-registered in Queensland, 2001, 2002 and 2003.

Queensland Health's share of medical workforce

Queensland Health employs roughly 27 percent of the total number of doctors registered to practise in the State and has increased its share from around 24.5 percent in 1999 (noting that not all registered practitioners are actively participating in the workforce). This is consistent with the results of a recent survey conducted which shows that around two-thirds of medical practitioners work in the private sector¹⁰².

As noted previously, Queensland Health has been increasing its medical workforce by an average of 140 additional doctors each year. As with the general medical workforce, this has been achieved with increasing usage of OTDs with special purpose registration. It is estimated that currently 27 percent of Queensland Health's workforce or roughly 740 doctors are OTDs with special purpose registration.

The number of medical graduates is expected to increase from around 232 in 2004 to 540 in 2010. However, this will not address problems being experienced currently due to the long lead times of some 12-15 years needed to produce fully qualified medical practitioners. Until that time, Queensland Health will need to continue relying on OTDs to augment the local supply of doctors as do other States like Western Australia and the Northern Territory.

The gap between local supply and demand for medical practitioners in the public hospital system can be crudely approximated by examining the difference between the number of new entrants and attrition rates. As shown below, the additional graduates coming into the system will not be sufficient to replace the loss of permanent positions with an estimated shortfall of 125 in 2006 (noting the attrition rates are based on permanent separations only). At the same time, Queensland Health needs to employ extra doctors to meet growing demands. In order to fill the gap in local supply and grow the workforce to meet increasing demands for health services, Queensland Health needs to employ an additional 282 doctors in 2006 increasing to 291 in 2008. Note the gap declines as graduate numbers increase over the coming years.

Queensland Health Forecast Gap in Local Supply and Projected Need

| | Projected | | | | Additional | Need to |
|------|-----------|-------------|-----------|-----|------------|---------|
| | Total | Annual Loss | Graduates | Gap | (Net) | Employ |
| 2006 | 3,804 | 437 | 312 | 125 | 157 | 282 |
| 2007 | 3,967 | 456 | 355 | 101 | 164 | 265 |
| 2008 | 4,138 | 476 | 355 | 121 | 171 | 291 |
| 2009 | 4,316 | 496 | 518 | -22 | 178 | 156 |
| 2010 | 4,502 | 518 | 540 | -22 | 186 | 163 |

Overall supply of nurses

In regard to nursing numbers, undergraduate nursing numbers have not been subject to the same constraints as doctor numbers and have increased from 1,323 enrolments in Queensland universities in 2000 to 1,756 enrolments in 2005, an increase of 32.7 percent. In terms of nursing registrations, the increase has not been as high with total registrations increasing from 43,009 in 2000 to 47,375 by 2004, an overall increase of 10.2 percent broadly in line with population growth.

¹⁰² Ibid.

Nurses Registered with the Queensland Nursing Council

| | 2000 | 2001 | 2002 | 2003 | 2004 | % Increase |
|-----------------------|--------|--------|--------|--------|--------|------------|
| Registered Nurses | 35,874 | 36,817 | 37,613 | 38,744 | 40,102 | |
| Enrolled Nurses | 7,120 | 7,095 | 7,111 | 7,106 | 7,232 | |
| Midwives | 15 | 15 | 17 | 37 | 41 | |
| Total | 43,009 | 43,927 | 44,741 | 45,887 | 47,375 | 10.2% |
| <i>Net Additional</i> | | 918 | 814 | 1,146 | 1,488 | |

Source: Queensland Nursing Council Annual Report 2004

A major contribution to shortfalls in nursing supply are the high wastage rates, with many nurses leaving the profession altogether. According to a national survey of the nursing and midwifery labour force in 2003, approximately 10 percent of registered nurses and enrolled nurses were not in the nursing labour force, equating to 22,524 registered nurses and 5,322 enrolled nurses nationally who were not practising in the profession for which they are qualified. This does not include those nurses who have left the nursing workforce and also no longer hold registration. It has been estimated that total wastage rates from the profession could be as high as 40 percent in the first two to three years after graduation.

Queensland Health's share of nursing workforce

Queensland Health currently employs an estimated 21,749 nurses. As shown in the table below, nursing numbers have increased significantly over the last two years but prior to this had not kept pace with demand and in 2002, there was a net loss of 100 nurses. In terms of its share of the overall workforce, the table shows that the proportion of nurses employed by Queensland Health has fallen from 46.1 percent to 44.9 percent suggesting a drift of nurses to the private sector. Further research would be required in order to confirm this.

Proportion of Nurses Employed by Queensland Health

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|--------|--------|--------|--------|--------|--------|
| Employed by Queensland Health (Headcount) | 19,847 | 20,099 | 19,999 | 20,378 | 21,285 | 21,749 |
| <i>Net Additional</i> | | 252 | -100 | 379 | 907 | 464 |
| Proportion of Nurses Employed by QH | 46.10% | 45.80% | 44.70% | 44.40% | 44.90% | n/a |

Source: Queensland Nursing Council and Queensland Health Human Resource Management Information System

To meet increased demand for health services, Queensland Health needs to increase its nursing workforce by an additional 500 – 550 staff per annum over the next three years. Undergraduate numbers will need to continue to increase in line with increasing demands taking into account wastage and turnover rates to avoid shortages developing in the future.

Nursing Forecast Requirement

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|-------------------|--------|--------|--------|--------|--------|--------|
| Nursing Headcount | 21,749 | 22,249 | 22,761 | 23,284 | 23,820 | 24,368 |
| <i>Additional</i> | | 500 | 512 | 524 | 536 | 548 |

There is insufficient data on which to undertake a similar analysis of the supply of the allied health workforce. The review found that Queensland Health does not collect and analyse detailed workforce information for planning purposes on a systematic basis across the organisation. Queensland Health needs to put in place robust workforce data collection and analysis systems and more detailed work needs to be undertaken on future demand and supply projections across all health professional groups.

10.2.11 Estimating current gap in workforce numbers

As noted previously, the forecasts of future staff requirements are based on current staffing levels and do not take into account existing shortfalls in capacity. There are a number of different approaches to estimating the current gap in workforce numbers, none of which provide an entirely accurate or reliable picture of the real level of need.

A standard approach is to use national staff to population comparisons. Queensland has the lowest numbers of health professionals per head of population of any State or Territory apart from Tasmania. Queensland would need to employ an extra 260 doctors, an extra 2,700 nurses and 2,350 extra allied health staff to reach the national average (based on 2003/04 national data which is the latest available).

However, this does not take into account differing workloads across the various jurisdictions. Queensland provides fewer hospital services per head than the national average and has higher levels of efficiency than the other States. Comparing staff workload ratios based on public hospital inpatient separations (2003/04) shows that Queensland Health is short approximately 1,000 nursing staff and 1,780 allied health staff but has similar levels of doctors. This shortfall is in addition to existing vacancies within Queensland Health which have not been filled. The workload measure has some limitations in so far as it does not take into account the demands associated with increasing outpatient and community health services, teaching and supervising junior staff, and rising workload intensity but considered a more realistic basis for comparison for hospital staffing than a staff per population ratio.

It is clear that Queensland Health needs to take immediate steps to increase the number of health professional staff working in the system. There are major gaps with respect to nurses and allied health staff compared to national average workloads and the only reason doctor numbers are comparable is due to the reliance on OTDs with special purpose registration.

Given the global workforce shortages that are being experienced, large one-off increases in staffing numbers will be difficult to achieve. Some Districts are already experiencing difficulties in filling existing positions while larger metropolitan Districts could employ more staff provided additional funding was made available. A staged approach based on the different needs of the various Districts is required to increase staffing levels to meet increasing demands. Recruitment strategies are discussed in more detail later in this Chapter.

10.3 Queensland Health's workforce management systems

An effective workforce management system would be expected to include long term workforce planning, effective recruitment and retention processes, appropriate remuneration and employment conditions, a fair and transparent staff complaints system, quality controls including credentialing and periodic reassessment of skills, access to training and professional development, and up to date workplace health and safety management systems. Most importantly, the workforce management system as a whole should support, value and nurture staff.

10.3.1 Key findings

While Queensland Health has a range of workforce management systems in place, they are not performing effectively. Systems are not integrated and in some cases impose significant additional administrative burden on staff. There is no long term strategy for workforce planning based on future service delivery needs, recruitment processes are drawn out and administratively cumbersome and staff experience difficulties in accessing basic ongoing training.

A high degree of anger and frustration was reported amongst some clinicians who feel under valued and marginalised from the system. The events surrounding Dr. Patel in Bundaberg in particular have highlighted significant problems with Queensland Health's current recruitment and credentialing arrangements as well as issues with the medical registration process, the latter to be addressed by the Public Hospitals Commission of Inquiry.

A range of external bodies play a role in the health workforce including the universities, the registration boards, the Commonwealth, the private sector and professional bodies such as the Australian Medical Association and the Queensland Nurses Union. Frustration was expressed by numerous organisations and stakeholder groups that their efforts to build partnerships and constructive relationships with Queensland Health had not been successful. This feedback highlights the opportunity for revitalised relationships with relevant external bodies as part of the Queensland Health reform agenda.

Administrative systems

Queensland Health operates a number of human resource information management systems including ESP, the rostering system and LATTICE, a personnel and payroll system, as well as systems for determining workloads such as TREND CARE. Staff reported a number of problems with these systems including the lack of training in the use of systems, the need to duplicate information in various systems and the significant administrative burden which reduced the time available for patient care.

Effective management of staff concerns, complaints and grievances is critical to workforce harmony, retention and sound management. Many Queensland Health staff reported that existing grievance systems are not resolving concerns for aggrieved staff or resolving workplace conflict. This issue is discussed in more detail in the context of complaints systems under risk management in Chapter 9, in discussion of performance management in Chapter 13 and organisational reform in Chapter 14.

Workforce planning

While the various systems produce important information, this information is not centrally analysed to inform policy development or workforce planning. Workforce plans have been developed in some districts and zones, and a corporate strategic workforce plan was recently released. However, there is no comprehensive plan which models future workforce needs and scenarios, options to meet future demand or includes specific targets, strategies, timeframes, governance arrangements and evaluative activity.

There is no Statewide assessment of staff satisfaction, with surveys occurring on an ad hoc, district by district basis. Similarly, exit interviews were undertaken on a district by district basis and it was not possible to obtain any clear, system-wide analysis of the results of exit interviews to inform future recruitment and retention strategies.

Quality and safety systems

Thirteen health registration boards are responsible for regulation of health professions in Queensland, including medical, dental and allied health professions. The Queensland Nursing Council plays this role for the nursing profession. These bodies operate independently from Queensland Health and are responsible for ensuring clinicians are safe and competent to practise by determining professional standards, assessing applications for registration and investigating complaints, including proceedings against practitioners for unsatisfactory professional conduct.

Queensland Health has in place credentialing and clinical privileging policies and procedures to determine the scope of practise of doctors. The policies have been recognised as best practice and adopted nationally as a quality and safety initiative. However, events in Bundaberg have clearly raised questions about the adequacy of implementation of these systems. Assessment of current systems and recommendations for improvement are outlined in Chapter 9, as credentialing and clinical privileging are considered to be a critical foundation for effective quality and safety systems.

Recruitment and retention

Queensland Health has implemented a range of strategies to improve recruitment and retention of clinical staff which have met with varying degrees of success. Strategies have tended to be piecemeal and vary according to discipline and location of services. In particular, there are longstanding problems with recruiting and retaining staff in rural and remote areas which are now becoming critical despite efforts to introduce various incentive programs.

One of the main problems in retaining medical staff is the lack of career pathways and the inherent features of the medical training model. As outlined in the workforce profile, the public health system loses significant numbers of doctors each year, with an annual separation rate of 11.5 percent. The public sector loses doctors annually to general practice (upon completion of second or third year postgraduate training) and to private specialist practice (upon completion of registrar training programs). Medical career structures currently follow this training pathway and while not unique to Queensland, they pose particular challenges in looking at ways to improve retention of the medical workforce.

Considerable work has been invested in improving retention of nurses in Queensland Health including more flexible working conditions (noting the majority of nursing staff now work part-time), changes to the career structure to enable progression and monetary recognition of additional qualifications. However, a number of deficiencies remain including a high level of dissatisfaction amongst staff regarding restrictions on the qualifications allowance, and anomalies in pay between Level 2 nurses and Level 3 nursing managers. The failure to address rising workloads for nursing staff in particular is seen as a major barrier to improving retention of the workforce.

A clinical advancement scheme is the main retention strategy recently employed for allied health staff which allows staff to progress to higher levels based on demonstration of outstanding clinical, teaching or research skills. While the scheme has yet to be fully evaluated, early indications are that it has been successful in improving retention of staff although as noted previously there are significant shortages for this group.

Enterprise Bargaining Arrangements

Queensland Health has to deal with a complex range of awards and agreements which limit its ability to manage the workforce effectively and respond to changing service delivery needs.

There are nine parent awards that apply to staff within Queensland Health under the current enterprise bargaining arrangements including two awards for district health service nurses as well as the MX award (the arbitrated outcome of the last enterprise bargaining negotiations), and three awards for medical staff (one for senior medical officers and resident medical officers, one for medical superintendents and medical officers with right of private practice, and a third for public servant medical officers employed in Queensland Health Corporate Office and doctors employed in other government departments). In addition, VMOs are included in the enterprise bargaining arrangements although not subject to a specific award.

There is a separate award for district health services employees, which covers professional, technical, operational, dental and administrative streams and one public service award which applies to administrative, professional, technical, operational and nursing staff employed in Corporate Office (and nurses employed in other government departments) and for public servants employed in other government departments. Finally, there are two awards for building and engineering staff.

Education and training systems

The Interim Report found that increasing service demands were impacting on the quality and level of education and training available in the public health system.

Systems maintained within districts to keep track of the education and training of its clinical workforce were underdeveloped and poorly maintained. In a number of districts visited, the clinical workforce reported that there was no systemic approach to clinical training, that teaching systems for doctors had all but broken down, and that clinical training for the nursing workforce had been replaced by mandatory training sessions relating to corporate office policy requirements. In summary, education and training systems are underdeveloped, and a significant effort will be needed to ensure that the public health system, which has a major obligation to teach and train medical practitioners and to train its clinical workforce, is in a position to do so. At the moment, arrangements are far too informal and subject to the vagaries of work pressures.

Clinicians reported that workload pressures and a lack of funding to backfill the positions of those attending training had resulted in limited opportunities to teach, train and mentor junior staff. Concerns were also expressed about skills shortages in particular areas and the need to enhance the practical clinical skills of new graduates and overseas trained health professionals.

Queensland Health's ability to directly influence and control the level of skills and training of its workforce is constrained in a number of ways. There are numerous institutions involved in health professional education and training including the universities, TAFE colleges, the medical colleges, national bodies such as the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC), the Commonwealth and the private sector, each with differing objectives, roles and responsibilities.

The current arrangements are less than optimal and based more on a loose coalition of interests which have grown over a number of years rather than any coherent or strategic approach. Queensland Health faces major challenges in terms of coordinating efforts across the various agencies and undertaking long term planning to meet future workforce needs.

The Review is suggesting a range of strategies to address health workforce issues. As noted in the interim report, there is no single solution to workforce pressures, hence the range of recommendations outlined below, including immediate to long term initiatives for doctors, nurses and allied health professionals.

10.4 Initiatives for doctors

10.4.1 Relief for doctors: immediate action to recruit more doctors

A single, large increase in doctors is unrealistic at a time of global workforce shortage and inadequate local supply. The following initiatives are suggested to build on existing Queensland Health efforts to increase the medical workforce over time.

Active recruitment locally, interstate and overseas

It is proposed that Queensland Health implement targeted as well as web-based marketing and recruitment campaigns locally, interstate and overseas. Overseas campaigns should focus in particular on the United Kingdom and other countries with doctor training equivalent to Australian standards, in light of feedback that OTDs from English speaking backgrounds and culturally similar environments integrate more easily into health practice in Australia. Automatic recognition of graduates from countries with similar education and training standards such as the United Kingdom, Canada, and Ireland may need to be considered as already occurs for New Zealand graduates. This is discussed further in streamlining the registration process below.

In addition to local medical graduates, fee paying overseas medical students are a potential recruitment pool for Queensland Health. Under changed immigration laws, it is possible for these students to apply for permanent residency upon completion of their degree, as opposed to previously where students had to return to their country of origin and then apply for a skilled migration visa. A targeted campaign promoting employment in Queensland Health could be designed to increase recruitment of locally trained doctors as permanent residents who may otherwise return to their country of origin.

It would also be useful for Queensland Health to routinely undertake exit polling of staff to determine the reasons for staff leaving their positions to inform recruitment activities.

Streamlining assessment and registration

In light of recent events, the Medical Board has introduced more rigorous screening and assessment processes for registration of OTDs. While these reforms are required, they may create significant delays in recruiting an OTD, a process which already requires long lead times. It is estimated that the current length of time to register an OTD in

Queensland is six months for a non specialist and twelve months for a quality overseas trained deemed specialist.

Anecdotal information from the recruitment industry suggests that doctors looking for work are choosing sites which are able to employ them rapidly such as New Zealand, where registration can occur in 21 days. One suggestion has been that Queensland should be able to automatically recognise qualifications from countries with similar educational standards such as the United Kingdom, Ireland and Canada. However, Queensland currently has the same requirements for registration as other States and any changes would need to be made on a national basis given mutual recognition legislation. This proposal should be considered as part of the development of the national registration scheme which has been approved in principle by Health Ministers and expedited as a matter of urgency.

Improving flexibility in recruiting doctors

Anecdotal reports were received of inflexibility in recruiting doctors who return to Queensland after working overseas. Instances were cited where younger doctors had returned to Queensland seeking work in the public sector, only to be advised there were no current vacancies. This led to doctors who had trained in the public system, and were willing to return to full time public sector work, pursuing private sector opportunities.

A range of flexible options to provide for greater flexibility could be explored including:

- a phased retirement and succession process where senior doctors move to part-time work and offer support and mentoring to a younger doctor moving into the senior post
- encouraging younger doctors to perform rural and remote service in return for a guaranteed metropolitan position when a more senior doctor retires
- guaranteeing younger doctors a permanent position or sessional work upon their return from working overseas.

Simplifying Recruitment Processes

The review heard that whole of Government job advertising restrictions impeded wide exposure of clinical vacancies and marketing of hospital reputation in job advertisements. In line with some other government departments, it would be helpful for Queensland Health to negotiate with the Department of the Premier and Cabinet a standing exemption under the advertising guidelines to increase flexibility in advertising positions.

The issue of staff and communities identifying with their local hospital arose frequently during the consultation process. In times of intense competition for staff, barriers caused by bureaucracy should be removed. As a general principle, it is therefore suggested that Queensland Health devolve recruitment to the facility level as far as possible. Centralised recruitment should be limited to those processes where multiple positions are being recruited across many sites eg interns and “area of need” registered practitioners.

Line managers also reported that whole of Government merit selection requirements impeded timely recruitment of doctors. The requirement to complete written applications addressing key selection criteria was seen as a disincentive to applying for public sector jobs. However, the Recruitment and Selection Directive allows significant flexibility in the selection tools that departments can use. It is therefore suggested that Queensland

Health clarify with line managers the range of flexible recruitment practices that can be used to recruit doctors.

Increasing student places

In the long term, the most obvious way to increase supply of locally trained doctors is to increase student intakes in university courses. It would be prudent for Queensland Health to develop recommended student intakes in Queensland and seek from the Commonwealth Government an immediate increase in medical student places.

Recently, the Queensland Government announced state funded increases in placements at the Griffith University medical school of 35 in 2006, increasing to 50 per year from 2007-10. Over eight years, this will cost \$60 million. While funding for university places is a Commonwealth responsibility, Queensland Health could further increase intakes by funding additional bonded student places in all Queensland medical schools.

10.1 Recommendations to provide immediate relief for doctors

Queensland Health should:

- implement a local, interstate and overseas campaign to rebuild Queensland Health's reputation as an employer, including focused campaigns in the United Kingdom and other countries with equivalent doctor training (with the aim of recruiting 280 additional doctors to meet the shortfall in local supply and increasing demands for services)
- undertake routine exit surveys of staff to determine factors driving loss of staff so as to better inform and target recruitment activities
- increase flexibility in recruitment processes including advertising and selection processes
- clarify with line managers the range of flexible recruitment processes that can be used under the Recruitment and Selection Directive to recruit doctors
- maintain the capacity of local districts to undertake recruitment activities but introduce a centralised process for the recruitment of doctors with special purpose registration
- seek to expedite national efforts to establish uniform medical registration arrangements through the Australian Health Ministers Advisory Committee including automatic recognition of graduates from countries with similar educational standards such as the United Kingdom, Ireland, and Canada
- develop recommended student intakes in Queensland to inform negotiation with the Commonwealth to increase student places in all Queensland medical schools.

Area Health Services should:

- Through their workforce planning areas, facilitate and support districts to undertake career and succession planning with the existing medical workforce and resource districts to maximise recruitment and retention of younger doctors upon completion of their training or return from training overseas.

The Queensland Government should:

- seek from the Commonwealth an immediate increase in medical student places and/or consider funding additional bonded places in Queensland medical schools.

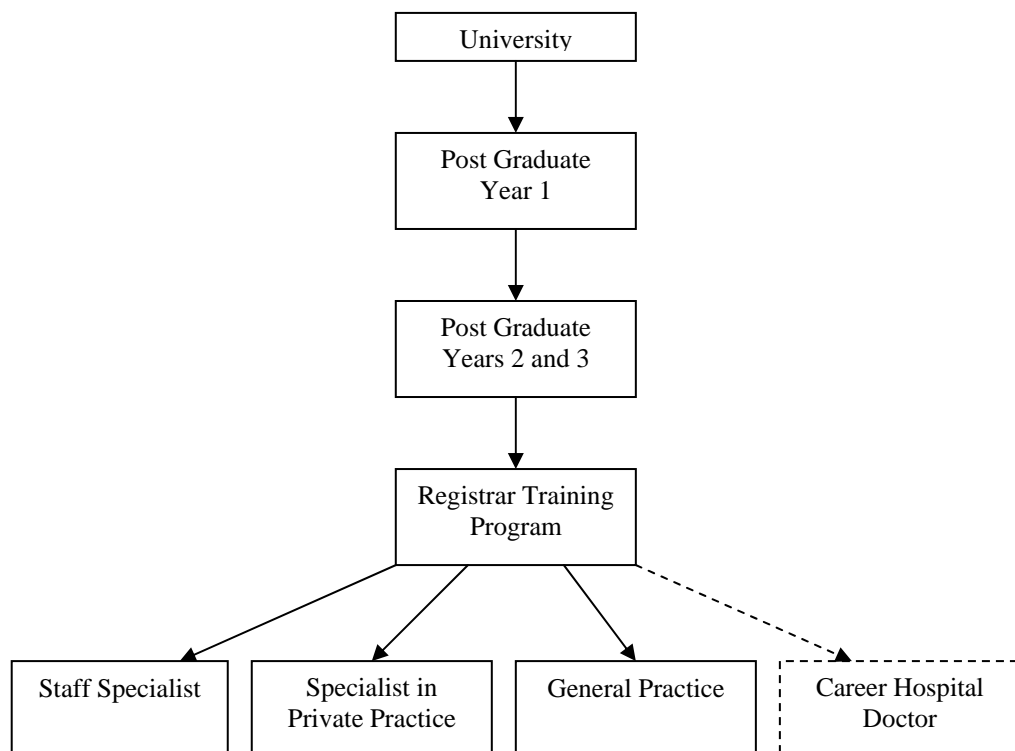
10.4.2 Improved retention measures

Creation of a hospital generalist career pathway

One of the main solutions to Queensland Health’s medical workforce shortages lies in its ability to retain younger staff in the system longer and prevent the drift to the private sector. As noted previously, the public sector loses doctors annually to general practice (upon completion of second or third year postgraduate training) and to private specialist practice (upon completion of registrar training programs).

Illustrated below is the current hospital based medical training model which actually drives constant turnover. The public sector loses doctors annually to general practice (upon completion of second or third year postgraduate training) and to private specialist practice (upon completion of registrar training programs). Medical career structures currently follow this training pathway and while not unique to Queensland, they pose particular challenges in looking at ways to improve retention of the medical workforce.

Hospital Based Medical Training Model



Doctors who do not undertake specialist training can move into Medical Officer and Senior Medical Officer positions. However, these positions are generally used to employ generalists in non-metropolitan hospitals and tend not to feature in larger hospitals. If the number of career medical officer positions were increased in larger hospitals, it may be possible to retain greater numbers of doctors who would otherwise move into specialist training and/or private practice. This in turn could reduce reliance on OTDs with special purpose registration.

To support this, a hospital generalist career structure could be developed, including relevant support such as a training program and attractive remuneration arrangements to recognise the advanced skills and training of these professionals. It is understood that a consortium of universities is currently considering establishing a training course for hospital generalists. It is suggested that Queensland Health therefore work with this consortium to design a career pathway and training course.

Higher Education Contribution Scheme (HECS) Debt Relief

Given the long period of study required to produce medical graduates, many doctors are graduating with significant debts. This increases the attraction of private medical practice which, with higher remuneration, offers a way to repay debts quickly.

In order to retain junior doctors and registrars upon completion of their training in public hospitals, Queensland Health could offer to pay part or all of doctors' HECS debts in return for a period of bonded service.

Visiting Medical Officers

Strategies to recruit more VMOs into the public health system must be accompanied by initiatives to ensure existing and future VMOs feel more valued within Queensland Health and to respond to particular concerns raised by VMOs. Queensland Health needs to improve its communication with VMOs, make the best use of their expertise and take an active interest in their workplace situation. Efforts should be made to include VMOs in key advisory and decision making forums, including scheduling meetings at times that are appropriate for VMOs. Strategies to provide protected teaching time for medical staff, discussed later in this chapter, should include VMOs as well as full time medical staff and should be prioritised for existing staff who have contributed to the public health system in the first instance.

Enterprise Bargaining Arrangements

Based on consultations with staff and unions, the review found a number of deficiencies in previous enterprise bargaining processes. In particular, this process encourages an adversarial approach which limits the potential for negotiation on critical issues including workforce reform. The interest based bargaining approach used in the current round for salaried medical officers provides a more appropriate model particularly given the challenges in managing a large and complex workforce.

Fair remuneration is essential in retaining medical staff in Queensland's public hospital system particularly in an environment of worsening workforce shortages. The review notes these issues are currently under consideration as part of the enterprise bargaining process with salaried medical officers and VMOs. Depending on the outcome of the enterprise bargaining process, Queensland Health will need to review the loading paid to clinical academics working in the hospital system to ensure they remain comparable with salaried medical officers.

Queensland Health needs to continue working constructively with staff and unions to address impediments to workforce reform both within and outside of the enterprise bargaining process particularly with regard to:

- outsourcing work, especially in areas of acute workforce pressures and/or high demand

- negotiating flexible employment arrangements for doctors including reduced and flexible hours, and a mix of public and private work (including appropriate rights of private practice arrangements).

It is suggested that in the future VMO arrangements might best be managed through contractual arrangements. This would be consistent with other employment arrangements between Government and private consultants or contractors and would allow greater flexibility for both parties to manage and respond to service delivery demands.

It is also recommended that Medical Superintendents/Directors of Medical Services be placed on contracts, in line with other members of district health executive teams. This will be particularly important if Medical Superintendents benefit from increased remuneration under the current enterprise bargaining arrangements, as doctors in Medical Superintendent positions may earn more than they would if they aspired to move into other leadership roles such as District Managers or senior leadership roles in corporate office. Queensland Health will need to consider how high performing Medical Superintendents can be encouraged into other senior leadership roles given the potential income disparity that may arise.

Safe working environments

In district visits, all clinical staff, including medical staff, raised serious concerns about patient and carer aggression. Concerns were also raised with the mandatory training in aggression management currently being implemented by Queensland Health. This was seen as another example of a well intentioned corporate office policy failing to meet health service needs. Major concerns included failure to target the training to areas of highest risk, unrealistic training time which cannot be accommodated in front line services, and insufficient resourcing to enable staff participation.

It is therefore recommended that the course be reviewed in light of district feedback and implemented in a modified form as a matter of priority. For example, implementation should be managed locally, linked to district risk management systems, include resourcing to support backfilling, and be targeted to areas of most concern including emergency departments, mental health inpatient wards and paediatric wards.

Other measures to show Queensland Health values its staff

There are a range of measures Queensland Health could introduce to show it values its medical staff including:

- ensuring doctors are not working excessively long hours which compromises safe practice
- improving organisational culture and empowering clinicians to influence service planning and resource allocation decisions
- providing appropriate amenities such as meeting and training rooms, tea rooms and personal storage spaces
- providing appropriate induction programs and information about entitlements, with access to entitlements explicitly recorded in individual performance and development plans
- providing access to timely travel and accommodation services
- establishing peer support networks for isolated workers, as discussed in chapter seven in the section on rural and remote issues.

10.2 Recommendations to improve retention of the medical workforce

The Queensland Government should:

- encourage enterprise bargaining approaches that are interest based rather than adversarial, which address the lack of flexibility and complexity of the current arrangements and occur as close as possible to clinicians and service delivery.
- negotiate with VMOs to achieve a move from award based to contractual arrangements
- pending the outcome of the enterprise bargaining process, adjust the level of clinical loading paid to clinical academics working in public hospitals

Queensland Health should:

- plan and develop a hospital generalist career structure and work with the university consortium to develop a training program to support this new role
- offer HECS payment in return for a period of bonded service to retain junior doctors and registrars upon completion of their training
- urgently implement strategies to improve organisational culture and foster strong leadership and change management capacity within the department, discussed in chapter four
- ensure doctors are provided with timely, quality travel and accommodation services.

Area Health Services should:

- ensure doctors have access to revised and better targeted and resourced training in managing patient and carer aggression
- Create peer support networks along professional groupings or streams of care to improve support for isolated workers.

Districts should:

- discuss and agree with VMOs the best way to establish and improve communication
- provide amenities such as meeting and training rooms, tea rooms and personal space (eg lockers) where feasible and in consultation with doctors
- ensure all medical staff are made aware of their entitlements through a clear induction process, that these entitlements are included explicitly in individual performance and development plans and that medical staff are supported to access their entitlements.

10.4.3 Maximising the value of the medical workforce**Increase interaction and partnership with the private sector**

Two-thirds of Queensland's practising doctors work in the private sector. It is essential that Queensland Health increase its interaction with the private sector to maximise use of the local medical workforce and reduce reliance on OTDs with special purpose registration. Four avenues are suggested.

1. Increase numbers of VMOs

Increasing the use of VMOs has been suggested to increase the availability of medical services in the private sector. Strategies to increase the use of VMOs will obviously be affected by the demands of their private practice. With reports of average weekly working hours in excess of 60 hours, the opportunity for VMOs to totally reduce Queensland Health's reliance on OTDs with special purpose registration seems unlikely to be able to be achieved.

Increased use of VMOs can therefore be considered as only one element of strategies to increase availability of doctors.

2. Incentives for existing medical staff and VMOs to perform additional work

Queensland Health could offer incentives to medical staff and existing VMOs to perform additional work in areas of pressure or backlog, provided this does not result in unsafe working hours and compromise safety.

3. Outsource Selected Services

Queensland Health could explore contracting out some services in areas of extreme service pressure or workforce shortage. It is suggested that contracting out be subject to the principle that additional work should be offered first to full time staff or VMOs to do out of hours (as noted above) before this is offered to practitioners not currently contributing to the public sector.

4. Explore new practice and partnership arrangements with general practitioners

It has been suggested that GPs can have a more supportive and direct role in providing outpatient services for patients pre and post operatively than is currently the case. This is more likely to be feasible in metropolitan areas as some general practitioners in rural and remote areas are working excessive hours to maintain their practice.

Increasing availability of doctors in rural and remote areas

On 24 August 2005, the Queensland Government proposed creation of Rural General Medicine as a specialty career path in an effort to increase the attractiveness of working for Queensland Health in rural and remote areas. This would enable doctors to live in country areas and practice across a number of specialties. This is supported as a strategy to increase recruitment and retention of medical staff within Queensland Health.

However, in small centres lacking a sufficient population base to support a full time salaried medical officer, there is an opportunity for Queensland Health to make better use of private procedural general practitioners. This option may also apply in larger centres requiring additional medical capacity. Procedural GPs could be employed by Queensland Health on a sessional basis or through outsourcing of medical services under contractual arrangements, in line with the model successfully used in Longreach (described in chapter seven in the section on rural and remote issues).

To increase the skill base of rural generalists, the Commonwealth Government has contracted the Australian College of Rural and Remote Medicine to administer key components of the Medicare Plus Training for Rural and Remote Procedural GPs program. This program supports procedural rural doctors for skills maintenance and up skilling in anaesthetics, obstetrics and surgery covering both formal (courses) and informal (clinical attachments) delivery modes. It is in the form of a grant of \$15,000 per doctor per financial year based on 10 days training at \$1500 per day. This funding is also available for procedural medical officers undertaking only rural hospital based work.

There is an opportunity for Queensland Health to partner with the College in delivering training to doctors interested in this opportunity. This would increase availability of suitably skilled rural generalists. Additionally, this could be used as an avenue to recruit additional private procedural GPs into public service. For example, Queensland Health could offer training for GPs in return for providing services in the public system either

through sessional work or innovative arrangements such as the Longreach group practice model. In assessing opportunities, it would be helpful for Queensland Health also to work closely with the Rural Doctors Association of Queensland.

In addition to the above measures, alternative models of care and workforce roles are also required, to reduce reliance on purely medical service models. Workforce roles including nurse practitioners, advanced rural and remote nurses and paramedic primary care providers are discussed in chapter seven and should be developed as a matter of urgency.

Trialling consultant led services

In the interim report, the possibility of adopting a consultant led service model was canvassed. For example, in some parts of Canada specialists provides clinical services directly to patients on a fee-for-service basis, with junior medical staff employed specifically for training purposes rather than service provision. The hypothesis is that adoption of this model would reduce the requirement for OTDs with special purpose registration at resident medical officer level.

A small sample of metropolitan and regional hospitals could trial a mixed medical service model to test this hypothesis. Under this approach, junior doctor places would be retained for training purposes and some wards would therefore continue with the existing service model used in Queensland. However, junior posts that cannot be filled with Australian trained doctors would be converted into consultant positions, drawn from full time medical staff or VMOs. In these instances, wards would adopt a consultant led model, in line with the Canadian approach and Australian private hospitals. Outcomes of such a trial could assist in better medical service design which retains junior doctor positions only to the extent that they serve local training needs.

Redesigning work practices to increase efficiency

District visits highlighted the administrative burden imposed on doctors. There was a consistent view expressed that much of this work could more appropriately be performed by administrative support officers to increase availability of doctors to perform clinical work.

Opportunities to redesign work practice have been identified to increase efficiency and availability of doctors to provide clinical care which include:

- Systematic implementation of outcome based clinical pathways into the health care work environment. This is based on the finding that a major Brisbane hospital which successfully improved clinical care and reduced paperwork, thereby freeing up clinicians' time.
- Devolution of non-clinical tasks to non-clinical categories of staff - for example provision of adequate secretarial support to ensure timely completion of referral letters and management of clinics.
- Negotiating opportunities at the local level to introduce flexible hours of work to increase productivity. For example, negotiation of four day weeks based on 4x10 hour shifts could be used as a basis to increase theatre hours and surgical throughput each day and increase activity after hours and on weekends subject to availability and interest of clinicians.

Development of country service register and incentive package

The review identified significant problems with retention of staff in rural and remote areas. The current practice of sending junior doctors to the bush without adequate support and supervision is a major cause for concern. Some districts have developed a register of clinicians willing to perform country service on a short or longer term basis to assist in relieving vacancies and staff leave. A number of doctors expressed interest in performing short term rural and remote service on a rotational basis and this goodwill should be used to assist smaller districts.

It is recommended that each Area Health Service establish a register of interested clinicians, including doctors, and develop an incentive package to make the rotations attractive. For example, accommodation, meals, living allowances and travel must be provided. Other benefits might include offering additional recreation leave in return for a certain amount of country service, enabling the package to be promoted as a working holiday.

Enhancing technology

There is scope for Queensland Health to better leverage its existing medical workforce using technology to provide “outreach” support to regional or remote facilities experiencing workforce shortages or with insufficient service volume to warrant a local specialist workforce. Use of telehealth was discussed in detail in chapter seven, along with recommendations for enhancement.

In addition to telehealth, a range of new and emerging technologies are being used elsewhere to maximise the health workforce and undertake lower order tasks previously fulfilled by staff, including use of virtual reality and robotic technology. It would be prudent for Queensland Health to monitor evaluation of new technologies and undertake cost benefit analysis to determine their suitability for local implementation.

10.3 Recommendations to maximise the value of the medical workforce

Queensland Health should:

- Offer increased sessional work to the existing VMO workforce and increase numbers of VMOs in the public system
- Offer incentives for existing medical staff and VMOs to perform additional sessions especially surgery
- Outsource services in areas of acute service and workforce pressure, subject to work first being offered to existing medical staff and VMOs
- Monitor evaluation of new technologies used in other jurisdictions and undertake cost benefit analysis to determine suitability for local implementation

Area Health Services should:

- Facilitate trials of consultant led services in a small sample of metropolitan and regional hospitals
- Facilitate and resource districts to devolve non-clinical tasks to non-clinical categories of staff including provision of adequate secretarial support to doctors
- Establish a register of clinicians – including doctors – willing to undertake country service rotations and design a country service incentive package
- Incorporate use of technology such as telehealth within service and workforce planning to maximise opportunities for medical outreach to smaller districts

Districts should:

- Explore new practice and partnership arrangements with general practitioners, in association with the medical College and the Rural Doctors Association of Queensland, particularly in the management of outpatients clinics and provision of medical services in rural and remote

communities by procedural general practitioners on a sessional or outsourced basis

- Negotiate opportunities to introduce flexible hours of work to increase productivity subject to staff availability and interest

Clinical networks should:

- Lead implementation of outcome based clinical pathways to improve care and streamline work practices

10.4.4 Improving medical education and training

Undergraduate medical education

Responsibility for the education and training of medical practitioners rests in the first instance with the universities and the Commonwealth as the primary funder of the tertiary sector.

As noted in the interim report, the shortage of doctors currently being experienced across Australia is a direct consequence of Commonwealth decisions to reduce medical student intakes in the early 1990s. While this situation has been remedied with the increases in student intakes introduced over the last few years, the long time period associated with producing fully qualified medical practitioners means the current shortages and the reliance on OTDs with special purpose registration will need to continue for at least another ten years or more.

The considerable lead times in the ability of universities and other institutions to respond to service delivery needs highlight the importance of undertaking strategic planning so that responses can be put in train to address issues before they reach crisis point.

While it is traditionally the Commonwealth's responsibility to create and fund student places in universities, the State could choose to directly fund additional places and these are typically attached to a bonding requirement which allows the State to direct the placement of practitioners. The Queensland Government has recently announced state funded increases in medical school placements of 35 in 2006, increasing to 50 per year from 2007-10. The need for the State to step in and fund university places underscores the lack of alignment between the Commonwealth funded tertiary education sector and State service delivery needs. If contemplating further placements the State might consider inviting expressions of interest from all Queensland medical schools.

Clinical student placements

During their university study, student doctors spend time working in public hospitals on clinical placements. Universities rely on the health system to provide around 60 percent of teaching in clinical settings.

There is a real concern that the budget pressures on both sectors have detracted from efforts to build cooperative relationships. Universities argue that their funds to support clinical placement are limited noting that in some universities less than 40 percent of university funding is now provided from public monies. While the Commonwealth provides a specific allocation per student to the universities to support clinical teaching, this falls well short of the costs of providing teaching and supervisory support to students in hospitals, the burden of which falls mainly on Queensland Health.

The universities appoint clinical academic staff who are located in public hospitals with responsibility for student teaching and education. These staff often hold joint appointments with the hospital and are involved in direct clinical care provision. This can lead to tensions in serving both the needs of the university as well as the hospital. Universities also report difficulties engaging with Queensland Health on better ways of managing academic appointments with responsibility for decision making spread at various levels across the organisation.

The problem of a lack of funding to support clinical placements of students in the State's public hospitals needs to be urgently addressed.

Queensland Health has recently moved to establish Deeds of Agreement with the medical schools attempting to clarify roles and responsibilities. Unfortunately, neither party is funded to support these agreements and in the absence of this funding, the ideal sought in the Agreements will simply not be realised.

It is recommended that the universities and Queensland Health seek increased financial contributions from the Commonwealth to support the States in meeting the costs of supervising and teaching students on clinical placements. Further consideration also needs to be given to a greater role for the private sector in supporting student placements to reduce the burden on the public system.

Hospital based training – roles and responsibilities

Queensland Health's primary training and education responsibilities begin when health professional graduates gain employment in the public hospital system. In the case of medical graduates, formalised education and training arrangements continue for a number of years in the hospital setting as doctors undertake an apprenticeship based training which leads to the acquisition of specialist qualifications which in the case of some specialties can take 10 years or more (after graduation).

Training medical students in this way has long been the role of the public sector and is reflected in the world-class reputation of our major teaching hospitals in producing highly trained and skilled medical practitioners.

The responsibility for medical practitioner training in the hospitals is shared with the medical Colleges who are responsible for accrediting hospitals to undertake training in particular specialties. As with the universities, these arrangements appear to be based on understandings which have evolved over time. This can lead to a lack of clarity about the roles and responsibilities of the respective parties and concerns about Queensland Health's commitment and ability to financially support medical training in an environment of escalating service demands.

Training needs versus service delivery needs

Numerous reports were received from clinicians about not having sufficient time to teach or train staff as the system copes with increasing service demands. Junior medical staff also reported they were not receiving the appropriate level of support or supervision. Many clinicians felt there had been a deliberate attempt by Queensland Health to diminish the role of teaching and training and increase the focus on meeting service needs. This led to major concerns that workforce shortages would be further exacerbated as the opportunity to undertake teaching and research were considered to be one of the key attractions of working in the public hospital system.

What I cannot accept is the appalling lack of support for junior medical staff in ensuring the development of generic clinical skills in a methodical and standardised approach. ... The only sponsored course in 3 years made available to me was a 2 day preparatory course prior to rural relieving work which is compulsory for all metropolitan based junior doctors.

Queensland Health has evolved a task oriented approach to its workforce and lost its perspective as a training institution. The attitude of our employer is that work comes first and training not at all, yet we are expected to maintain high standards, gain increasing independence of practice, and eventually (if we obtain specialist qualifications..) to work for them as underpaid/overworked specialists.

Source: Submission to Queensland Health Systems Review, July 2005

Teaching and research are central to the ability of the public sector to continue to attract and retain staff. Many clinicians reported that the opportunity to undertake teaching and research was one of the main reasons they sought work in the public sector. Public hospitals treat the sickest and most complex patients and the work provides challenges and opportunities to develop collegiate relationships and contribute to the advancement of medical knowledge and improved outcomes for patients which are not available in the private sector.

It is acknowledged that training and teaching students is an integral part of service provision and difficult to neatly separate out from day to day tasks. However, mechanisms must be established to provide protected time for teaching to ensure that adequate time and resources are dedicated to this task.

Shortages of specialist training positions

As noted in the interim report, Queensland is currently not meeting Australian Medical Workforce Advisory Council recommendations regarding medical specialist registrar training positions in a number of specialities including gastroenterology, haematology, medical oncology, ear, nose and throat, orthopaedics, emergency medicine, obstetrics and gynaecology, pathology, psychiatry and radiology¹⁰³. This translates to future shortages in these specialities.

In addition, as outlined in the interim report, Queensland has a relatively lower share of registrar training positions with 16.5 percent of the total number of recognised training programs compared to the State's 19.2 percent share of the national population. In order to reach the national average, Queensland would need to increase its training positions by an estimated 170 positions.

Training positions are currently not evenly distributed throughout the State with the majority of positions located in metropolitan areas. While trainees undertake some rotations in regional and rural areas, most specialist education programs are conducted in Brisbane which disadvantages trainees in rotation hospitals in outlying areas. There is also a perception amongst trainees that specialist colleges favour metropolitan based experience over rural and regional training which further lessens the attraction of these types of placements.

Training infrastructure is variable across facilities with some hospitals struggling to gain accreditation from colleges. This only compounds workforce shortages in the longer term as evidence suggests that doctors who undergo their training in rural and regional areas are more likely to decide to stay and practise in those areas. The inability to provide

¹⁰³ Australian Medical Workforce Advisory Committee Annual Report 2003-04

adequate training in provincial hospitals will therefore have longer term repercussions in terms of attraction and retention.

There needs to be a strong focus on increasing training numbers outside metropolitan areas. The concept of formalised training networks that link tertiary teaching hospitals with rural and regional hospitals is being examined in other jurisdictions and is something which should also be explored in Queensland.

The Government has recently announced an additional 20 registrar training positions to bolster specialist training in the system. While this goes some way to addressing the problem, further positions are required to meet existing shortfalls.

It is worth noting that the ability to fill specialist training positions is influenced by the supply of available doctors and there are indications that Queensland Health is now experiencing difficulty filling existing training positions. A staged and planned approach to increasing specialist training positions is therefore required to better align training numbers with service priorities.

Both Victoria and New South Wales have established specialist bodies to deal with medical training issues. Victoria set up a Medical Workforce and Training Advisory Committee in February 2004 to devise strategies to address deficiencies with its medical training arrangements and New South Wales has recently announced it will be revamping its Medical Training and Education Council. Given the breadth of issues and the complex nature of the various interrelationships in medical education, Queensland needs to consider adopting a similar dedicated body to progress work in this area and to work with the other States on developing national responses. The Queensland Medical Education Council was established around 12 months ago to focus on medical training and education issues. It is suggested that the role of the Council be strengthened and a program of targeted reform be set.

Increasing medical graduate numbers

As noted in the interim report, the number of medical graduates is expected to increase from 232 in 2004 to 540 in 2010. This will place further strains on the system in terms of the increase in the number of intern positions required and the ability of senior staff to provide sufficient training and support. It is therefore critical that planning commence immediately to deal with the influx of graduates into the system. This planning needs to be coordinated and involve high level commitment from all relevant stakeholders including the colleges, the universities and the private sector.

Alternative models of medical training

The chronic shortage of medical practitioners and the expected influx of new medical graduates over the next five years calls into serious question the ongoing sustainability of the current medical training model to meet future medical workforce needs. It is clearly resource intensive in terms of the supervision requirements placed on hospital staff. The duration of specialist training, which can take up to ten years or more after graduation in the case of some specialties, undoubtedly compounds shortfalls of practitioners in particular areas.

Alternative approaches to the traditional medical training have been suggested during the course of this review. Contemporary education, teaching and training methods tend to be based more on the acquisition of knowledge, skill and competence rather than a focus on

the passage of time and need to form a stronger basis of teaching and training the clinical workforce post-graduation. There are some Colleges which are actively exploring these options. A national approach to this issue would be desirable given the critical role of the medical Colleges and the fact that it would not be desirable to have different arrangements for doctor training across the various States and Territories. It is pleasing to note that a number of Colleges are already seeking ways to incorporate more of an increased competence approach with teaching approaches, including simulation to compress teaching times.

The level of services provided in the private sector has been increasing steadily, primarily in response to the Commonwealth Government's policies to encourage more people to take out private health insurance. This has meant that specialists are also performing more work in the private sector, particularly in the surgical specialties.

Given the trend to increasing private sector activity and increasing medical student numbers, it would be useful to explore greater possibilities for the private sector to be involved in specialist training. The case for private sector training is strong as the majority of the costs of training medical specialists falls on the public sector at a time when specialists are increasingly taking up career options in the private sector and their skills and expertise are being lost to the public sector.

All State Governments are concerned about this issue. In its submission to the Productivity Commission Study into the Health Workforce, Victoria argues that the private sector should make some specific financial contribution for these benefits and that doctors trained in the public system should be obliged to complete a set period of time in the public sector or treat public patients in their private practice¹⁰⁴.

Overseas trained doctors with special purpose registration

Overseas trained medical practitioners with special purpose registration have varying levels of skills and competencies and require specific attention in terms of support and training to ensure safe and competent practice. The current education and training system does not cater adequately to the training and education needs of OTDs with special purpose registration, particularly those who are relatively young and inexperienced, and urgent changes in this area are required.

Queensland Health has developed a proposal to upgrade the Centre for International Medical Graduates to ensure that OTDs receive adequate training assessment and supplementation where necessary prior to employment in Queensland Health. This proposal should be implemented as a matter of priority. Training for OTDs should have a strong clinical component but also be designed to provide familiarity with the culture and operation of Queensland's Health system including processes for prescribing medications and ordering tests.

Additionally, Queensland Health should provide ongoing support, training and professional development to assist doctors with special purpose registration to achieve the Australian standard as identified by Australian Medical Council certification and/or Fellowship of an Australian College.

¹⁰⁴ Victorian Government Submission to the Productivity Commission Study into the Health Workforce July 2005, p.43

10.4 Recommendations to improve medical education and training:

Under the new structure, Queensland Health should establish a dedicated medical workforce planning group to undertake the following specific tasks:

- assess the adequacy of current and planned undergraduate medical student places to meet future workforce needs;
- review the number, mix and distribution of current medical training places across the public health system;
- develop a strategic plan for the placement of trainees and detail priority areas and locations to be addressed;
- explore options with the universities, professional colleges and other relevant agencies to improve education and support of the medical workforce;
- progressively increase registrar training numbers in line with AMWAC recommendations;
- develop clinical training networks which link teaching hospitals in metropolitan and provincial centres with non-teaching hospitals in both metropolitan and rural areas
- review the suitability of the current apprenticeship based training model to cope with increasing medical graduate numbers and opportunities to fast track training programs; and
- examine avenues for greater private sector involvement in medical training

Queensland Health should:

- review the membership and operation of the Queensland Medical Education Council to strengthen its role in providing strategic direction and advice on medical education issues.
- seek support from the Commonwealth and the State to increase the level of funding available to support the teaching and training of students on clinical placements within Queensland's public health system given this is an area of shared responsibility.
- explore with the Colleges opportunities to further consolidate teaching and development time under specialist training programs linked to competencies.
- introduce mechanisms to provide protected time for senior clinicians and trainee specialists involved in teaching and training junior staff and ensure that sufficient resources are available to support this role.
- work with the Commonwealth to examine strategies for seeking contributions from the private sector and medical practitioners who choose to leave the public sector, towards the costs of clinical training.
- expedite the implementation of the new training model for overseas trained doctors with special purpose registration so they can achieve full registration within four years.

10.5 Initiatives for nurses**10.5.1 Relief for nurses: immediate action to recruit more nurses**

Given the lack of growth in nursing numbers in real terms, additional funding should be made available to area health services to enable growth of nursing positions Statewide in line with the forecasting in section 10.2. This should be accompanied by a concerted effort to recruit additional nurses into the public health system along the lines proposed below. High workloads are a major concern for nurses and nursing representatives have reported this to be a major driver of nursing turnover. Immediate increases to the nursing workforce would assist in reducing and managing workloads. As noted previously, it is estimated that Queensland is short around 1,000 nurses based on its workload in public

hospitals compared to other jurisdictions. These comparisons are based on public hospital inpatient workload only and do not include any shortfalls in community, outpatient and other health services.

It is important that planning for an increase in nursing positions includes a specific focus on specialty shortages, including critical care nursing, midwifery, theatre and mental health nursing. In expanding the nursing workforce, it is important that there also be consideration of skill mix requirements by recruiting a mix of registered nurses, enrolled nurses and assistants in nursing. Whilst there is a need to increase use of ancillary staff such as assistants in nursing, studies have shown a clear correlation between positive patient outcomes and appropriate staffing, with sufficient registered nurses. Strong clinical leadership is required to drive statewide nursing workforce planning which aligns with broader services planning.

Refresher and re-entry schemes

There are high wastage rates in nursing, with many nurses leaving the profession to pursue other career opportunities. Given Queensland already faces acute nursing shortages and these are predicted to worsen, every effort must be made to attract nurses back into the profession.

In Victoria, provision of free refresher, re-entry or supervised practice programs for former nurses has resulted in over 2,200 nurses re-entering the public health system. The initiative involves funding being allocated by the health department directly to public health care facilities through a submission based funding round for up to 240 nurses per annum.

In New South Wales, the Nurse Reconnect Program has encouraged 1,186 nurses back into the nursing workforce since its launch in 2002. This program offers paid, individualised, supported transition back into the workforce for both full-time and part-time positions, in general and specialty areas.

In Queensland, former nurses fall into two categories with differing arrangements in place to support return to practice:

- Nurses who have been absent from the workforce for under five years and remain registered or enrolled require refresher courses in order to resume practice. Currently, such nurses can apply for employment in a Queensland Health facility and arrange access to a government funded refresher course (of approximately six weeks duration). Whilst this training is free of charge, nurses are unpaid for any supervised practice undertaken during the training.
- Nurses who have been absent from the workforce for more than five years and are no longer registered or enrolled must undertake re-entry education and undergo competence assessment by the Queensland Nursing Council. Currently, such nurses can apply for up to \$3,000 through a Queensland Health nursing re-entry scholarship scheme to assist in meeting the costs of re-entry education and competence assessment. As this scheme only commenced in February 2005 it is too early to assess its success. The scheme replaced previous arrangements where nurses were provided with re-entry courses by Queensland Health facilities. Feedback from health facilities was to discontinue this arrangement as many of the re-entry candidates were considered unsuitable to return to practice.

Based on the New South Wales model, take up of refresher courses may be increased if a base level salary is offered to nurses for the duration of the course. No change is proposed to the re-entry scholarship scheme as this is a new initiative designed to address concerns with prior arrangements. Additionally, a focus on nurses who have been absent for five years or less is recommended given that nurses with recency of practice are more favourably placed to re-integrate into nursing.

Whilst broadly based media campaigns might be useful, it is considered more appropriate that the existing nursing workforce be commissioned to secure re-engagement of former experienced colleagues known to be still interested in working within Queensland Health but possibly requiring more flexible working arrangements. Existing nurses could be offered a range of incentives to perform this attraction role including sponsorship at conferences or study, an additional period of development leave, such as review of practice in other jurisdictions or straight out financial incentives. A period of guaranteed service would be sought from returning personnel. The opportunity for career paths including advanced nursing roles and expanded nurse practitioner roles should also be used as an incentive.

Based on the successful Victorian and New South Wales models, it would be useful for a support program to include:

- Funding support for districts to enable them to develop customised, tailored refresher courses for former nurses;
- Availability of support for return to full-time or part-time positions;
- Payment of a base grade wage for nurses participating in refresher courses;
- Continuation and evaluation of the scholarship scheme for nurses absent more than five years; and
- Establishment of quantitative and qualitative data collection from nurses who access support, to enable ongoing evaluation of the success of the initiative and opportunities for improvement.

It would be helpful for Queensland Health also to undertake routine exit polling of staff to determine the factors influencing nurses' decisions to leave the system so that recruitment activities can be better targeted.

These initiatives are likely to offer diminishing returns over time, as there will be a finite pool of former nurses who can be attracted back into the workforce. This initiative should therefore be seen as a short-term effort to boost nursing numbers and will need to be supplemented with longer term strategies to increase supply of nurses overall.

It is important that sufficient new nursing positions are created to ensure that former nurses are not competing with nursing graduates. Given the significant shortfalls in nursing numbers, an immediate expansion of the nursing workforce is required which can accommodate both groups.

Maximising the recruitment of graduate nurses into Queensland Health

Queensland Health has established a centralised, online recruitment system for graduate nurses. The web based system is highly efficient and may be replicated in other states. However, Queensland Health has been unable to maximise the number of graduate nurses recruited into the public health system because appointments can only be made to existing junior nursing vacancies. Given the limited growth in the Queensland Health nursing workforce, this means there is limited capacity to recruit all interested graduates into the

system. At the end of recruitment processes in the past two years, Queensland Health estimates there have been between 100 and 150 graduates for whom there have not been positions available, with some of these nurses going interstate to seek employment. This represents a lost opportunity each year to grow the nursing workforce.

In future years, it is recommended that Queensland Health budget for additional growth in the nursing workforce to better accommodate interested graduates and maximise the recruitment of younger nurses with contemporary education and training. This expanded recruitment will require a commensurate increase in resourcing to districts to support transition programs to improve the “work readiness” of graduate nurses recognising the particular needs of specialty areas such as operating theatre, intensive care and emergency departments. Provision of such training could be prioritised in larger districts in recognition of the economies of scale offered in larger facilities.

To this end, it is recommended that each Area Health Service assess the potential to resource major metropolitan and regional hospitals to support a larger intake of graduate nurses and provide transition to work training. Once the graduate nurses were “work ready” some could then be appointed to more remote districts and the required number retained by the larger hospital to meet service requirements.

Stabilising the nursing workforce

Anecdotal reports were received of a high reliance on agency nursing staff to meet workforce shortfalls. An analysis of State-wide Queensland Health data revealed that in 2003/04, 185 full time equivalent (FTE) agency nurses were used and in 2004/05, 187 FTE agency nurses were used – respectively, this accounted for 1.09 percent and 1.08 percent of the full time equivalent nursing workforce in those years.¹⁰⁵

One rural hospital and several metropolitan hospitals were found to be relying on significant numbers of agency nurses. Anecdotally, the review heard that one metropolitan hospital was using agency nurses to the extent that nearby hospitals were unable to access agency nurses on occasion.

Nursing relief pools comprising permanent staff are successfully used in some Queensland Health hospitals to reduce reliance on more expensive agency nursing staff. To address the high reliance on agency nurses in particular hospitals, it is recommended that relief pools be established as a matter of priority. Other strategies successfully used in Queensland Health hospitals are:

- operating at full nursing establishment numbers to enable build up of the casual and part-time workforce to provide additional capacity during peak times and back up sick leave; and
- encouraging and approving more annual leave during summer months to increase availability of the workforce during winter months when demand increases.

A review of staff/nursing ratios would also assist in ensuring there are sufficient numbers of permanent staff to cope with fluctuating workloads.

¹⁰⁵ This data is indicative only. Queensland Health advises there may be some under-reporting of agency staff where they are placed on short-term contracts in health districts.

This highlights the importance of strong management and leadership in solving workforce problems, in addition to more obvious structural or funding solutions which, on their own, may not improve workforce management.

It would be prudent also to explore opportunities to work more cooperatively with the private sector to maximise the use of the existing nursing workforce through job sharing and other types of flexible arrangements.

Simplifying recruitment processes

In line with the suggestions for doctors, recruitment processes for nurses could be simplified through:

- negotiating a standing exemption under the advertising guidelines to increase flexibility in advertising nursing positions
- devolving nursing recruitment to the facility level as far as possible, with centralised recruitment limited to those processes where multiple positions are being recruited across many sites eg graduate nurses
- clarifying for line managers the range of recruitment techniques that may be used to recruit nurses including a review of the appropriateness of current selection criteria

Increasing student places

The most obvious option to increase supply of nurses in Queensland is to increase student intakes in university and vocational education and training courses. It is therefore recommended that Queensland Health urgently develop recommended student intakes to enable the Queensland Government to:

- seek from the Commonwealth Government an immediate increase in university nursing places to boost numbers of registered nurses;
- provide increased support to accommodate the clinical placement of larger numbers of student nurses including in acute hospital settings, community, aged care and outreach services; and
- increase places for nursing students in the vocational and education sector (eg TAFE colleges) to boost numbers of enrolled nurses and assistants in nursing.

10.5 Recommendations to provide immediate relief for nurses

The Queensland Government should:

- Increase the number of graduate nurses employed annually
- Provide infrastructure support to enable Queensland Health facilities to accommodate the clinical placement of larger numbers of student nurses
- Increase places in the vocational education and training sector for enrolled nurses and assistants in nursing.

Queensland Health should:

- Provide incentives to the existing nursing workforce to encourage former nursing colleagues back into the workforce and promote available support (such as paid refresher courses), with a target of an additional 1,500 nurses (phased in over three years in addition to the need to continue growing the workforce by an average of 500 to 600 nurses per annum).
- Undertake routine exit surveys of staff to identify the factors driving loss of nursing staff and to

inform recruitment activities.

- Support the existing nursing workforce to attract and recruit senior nursing staff back into the workforce in targeted specialties including critical care, mental health, theatre and midwifery
- Continue and evaluate the nursing re-entry scholarship scheme as a strategy to attract nurses who are no longer registered or enrolled
- Increase flexibility in recruitment processes including advertising and selection processes and devolve recruitment responsibility to the facility level
- Develop recommended nursing student intakes in Queensland to inform negotiation with the Commonwealth to increase student places

Area Health Services should:

- Be resourced to support districts provide paid nursing refresher courses for registered or enrolled nurses wishing to resume practice
- Receive funding to support annual growth in the nursing workforce to maximise recruitment of graduate nurses and provide training to support their transition into clinical practice recognising the needs of nurses transitioning into specialty areas such as theatre, intensive care and emergency departments

Districts should:

- Establish in-house relief nursing pools and implement other strategies to better manage the existing nursing workforce as noted above (where this is not already occurring)

10.5.2 Measures to improve retention of the nursing workforce

Remuneration and Conditions

It is important that nurses perceive that they are being paid justly and fairly. As a principle, it would be prudent for Queensland Health to remain competitive with other public health systems interstate in respect of remuneration and conditions, taking into account cost of living and other jurisdictional differences.

The review notes that issues around remuneration and conditions will be addressed as part of the up-coming enterprise bargaining process. As noted previously, the review has concluded that it would be helpful for the enterprise bargaining process to be reviewed to address the lack of flexibility and complexity of current arrangements.

Given the need for urgent workforce reform, enterprise bargaining processes could be used to remove impediments to:

- extending the scope of practice for nursing;
- negotiating flexible employment arrangements; and
- creating temporary positions for training purposes eg temporary positions could be created for a cohort of allied health or nursing graduates to provide them paid work experience and skill development (as occurs for medical interns) until permanent opportunities arise for which the graduates would be able to apply more competitively.

It would also be prudent to consider extending paid maternity leave to support the predominantly female nursing workforce, as part of whole of Government enterprise bargaining.

Clinical career pathways

During district visits, some nursing staff highlighted the limited career pathways for nursing wishing to continue clinical practice rather than take on management/operational duties. Both Assistants in Nursing and Enrolled Nurses can progress to advanced positions within current award structures. For registered nurses, there are currently nine nursing levels (NO1-9). From the NO3 level onwards, nursing duties tend to combine clinical with management roles. This means there are limited opportunities for advancement for highly skilled and advanced nurses beyond the highest paypoint at the NO2 level. In other states, there are clinical nurse specialist roles which allow for clinical advancement.

There are also anomalies with NO3 nurse unit managers receiving less than NO2 nurses due to the fact that NO2 level nurses receive penalty rates. This could be addressed through either extending the working hours of NO3 nurses so they can also access penalty rates or increasing the pay rates of NO3 nurses.

The nursing qualification allowance offered some incentive for remaining in clinical roles. For this reason, managerial qualifications do not attract the allowance given that managerial skills can be rewarded through management career progression. However, the outcomes of the implementation of the allowance have led to serious disaffection amongst many nurses. This situation could be remedied in one of two ways. Either the allowance should be paid to any nurse with a university or equivalent qualification relevant to their current job or the allowance should be ceased and replaced by better clinical career pathways, discussed below.

To keep the most highly skilled nurses in clinical practice, it may be useful to create a new position recognising and rewarding advanced or highly specialised nurses. This would recognise advanced skills used within the existing scope of practice for nurses and would be separate from any new award arrangements negotiated in the next enterprise bargaining round for nurse practitioners, who will be qualified and endorsed to work beyond the existing scope of nursing.

Recognition of advanced nurses could be done through new award arrangements or through a Clinical Advancement Scheme, in line with the model used for allied health professionals. The advantage of such a scheme is that each candidate could be assessed on a case by case basis with a range of criteria such as qualifications, experience, excellence in research or training and clinical leadership. However, this would be a profession-driven advancement process.

In contrast, a new award for advanced nursing could allow Queensland Health as an employer greater capacity for workforce redesign, including clinical leadership positions that can support training and development of the junior workforce as well as advanced nursing positions to perform tasks under medical supervision that are currently performed by doctors. For this reason, it is recommended that Queensland Health plan the number and distribution of its potential advanced nursing workforce and recognise this through a new award or additional paypoint within existing award structure.

Increasing flexible working arrangements

Section 10.2.5 showed the increasing tendency for nurses to work fewer hours per week, suggesting a high degree of flexibility for nurses in accessing part-time work. However, the review heard anecdotal reports from nurses who had not been able to negotiate part-time work or access leave entitlements. As an employer, it would be prudent for Queensland Health to maximise retention of its nursing workforce by accommodating flexible working hours and part-time work.

Additional flexible options could also be implemented such as job sharing, four day 40 hour weeks and initiatives to facilitate work and family balance.

A coordinated approach across the public sector was also recommended by key nursing representatives in respect of child care assistance for shift workers. Many individual nurses proposed that Queensland Health establish and manage child care centres on health facility campuses as has been done at the Alfred Hospital in Victoria.

It is important that Queensland Health support the predominantly female nursing workforce, as well as females in other professions and fathers who are juggling work and parenting responsibilities. However, it is questionable whether Queensland Health should enter the business of establishing and running child care centres at a time when major reform activity is needed to improve the core business of running health services.

It is suggested that Queensland Health discuss with the child care sector opportunities to collocate privately operated child care centres with health campuses. Precedents exist where other private businesses have located on hospital campuses and this model enables Queensland Health to focus more appropriately on health promotion and service delivery. This option may also require some level of subsidy as child care centres built on hospital campuses have previously not proven to be viable as private businesses.

Enabling mobility for nurses within Queensland Health

Anecdotal reports were received of nursing staff wishing to transfer at level between districts being required to compete in merit based selection processes to win an equivalent position in another district. Given the tendency to appoint local applicants, it was contended that external applicants – including Queensland Health employees from other districts – were being prevented from transferring between districts. This was seen to result in aggrieved employees seeking employment outside the public system.

It would be helpful for districts to take a State-wide view of recruitment and retention and facilitate mobility at level between districts for existing Queensland Health staff. Through their enhanced role in workforce monitoring and planning, Area Health Services should ensure that this occurs.

Improving organisational culture

Queensland Health must urgently implement strategies to improve organisational culture and foster strong leadership and change management capacity within the department. This is essential in retaining nurses in Queensland Health particularly in the current environment. Proposed clinical networks will provide an avenue to reconnect nurses to decision making, service planning and budget allocation.

Other measures to value nursing staff

The review found that nursing staff feel particularly undervalued as employees of Queensland Health. The organisation needs to take immediate steps to show support for its nursing staff including:

- the provision of appropriate amenities such as training and meeting rooms and access to safe car parking;
- recognition and consistent application of employment conditions;
- providing appropriate induction programs and information about entitlements, including training and development, with access to entitlements monitored through individual performance and development plans;
- providing peer support networks and professional supervision for nurses who currently work in positions with little peer support including isolated practice and sexual health nurses (as discussed in chapter seven);
- ensuring a safe working environment including training for aggression management as discussed in measures to value medical staff; and
- improving travel and accommodation services.

10.6 Recommendations to improve retention of nursing staff

The Queensland Government should:

- Review the process for enterprise bargaining to address the lack of flexibility and complexity of current arrangements and seek to provide fair remuneration and conditions
- Use nursing awards to create clinical career pathways to encourage advanced and extended practice roles and clinical leadership positions
- Consider extending paid maternity leave to support female clinicians, in particular the predominantly female nursing workforce
- Use enterprise bargaining to remove impediments to workforce reform including extending scope of nursing practice, negotiating flexible employment arrangements and creating temporary positions for training purposes

Queensland Health should:

- Undertake a feasibility study to determine the level of subsidy that may be required to support viable child care services located on health campuses
- Enhance clinical career pathways for nurses through creation of advanced and extended positions – including nurse practitioners - under a new award or additional paypoint in the existing award structure
- Urgently implement strategies to improve organisational culture and foster strong leadership and change management capacity within the department, discussed in chapter four.
- Ensure nurses are provided with timely, quality travel and accommodation services.

Area Health Services should:

- Create peer support networks along professional groupings or streams of care to improve support for isolated nurses
- Ensure nurses have access to revised and better targeted and resourced aggression management training.

Districts should:

- Make every effort to accommodate flexible working hours and part-time work
- Explore with private child care providers opportunities to collocate child care centres on large health campuses
- Take a Statewide view of recruitment and retention and facilitate mobility at level between districts for existing nursing staff.

- Provide amenities such as meeting and training rooms and safe car parking where feasible and in consultation with nurses
- Provide all new nursing staff with an induction which includes information about entitlements, with access to entitlements supported and monitored through individual performance and development plans

10.5.3 Measures to maximise the skills and availability of the nursing workforce

Creation of advanced nursing and new or extended nursing roles

Nationally and internationally, workforce roles are being redesigned to better align skill level with task complexity and improve patient outcomes. This work falls into two broad categories:

- 1) *Advanced practice roles*, where clinicians use their skills to an advanced level. In this situation, clinicians work within the existing scope of practice for their profession.
- 2) *New or extended roles*, where clinicians may require additional training and competency assessment before performing new tasks and legislative change may be required eg to allow limited prescribing rights.

Such roles may enable unsupervised practice by non medical staff (eg nurse practitioners) or extended practice under medical supervision (eg advanced nurses). This section first highlights opportunities for advanced nursing practice roles and then explores opportunities for new or extended nursing roles.

The review has deliberately not prescribed the nature of advanced and extended nursing roles because these need to be developed in the workplace in the context of service planning and developing new models of care. One approach to developing new health workforce roles is designing university courses, as has been adopted in the case of nurse practitioners. However, the review considers that the best way for all new and future roles is to identify the competencies required and the best way to obtain them, which may be either through university training, training in the workplace, simulation/procedural training (eg at the Skill Development Centre), or a combination of these.

1) *Developing advanced nursing roles – for immediate implementation*

Within their existing scope of practice, advanced nurses can perform some roles currently being undertaken by medical staff such as cannulation, patient discharge, ordering investigations such as pathology and performing colonoscopies. In some hospitals, advanced nurses are taking on these roles. In particular, Queensland has a well developed system to enable appropriately trained registered nurses to receive endorsement for advanced practice in rural and isolated areas, including administering and supplying some drugs under a therapeutics protocol.

There has been no modelling undertaken within Queensland Health to identify how many advanced nursing roles could be created or in which clinical settings or geographic areas. Advanced nursing is therefore emerging on an ad hoc rather than systemic basis. Urgent work needs to occur within Queensland Health to identify and plan an advanced nursing

workforce. It is important that planning involves medical and nursing leaders to enable design of team based care with appropriate training and supervision for advanced nurses.

For example, it is understood there are doctors within Queensland Health interested in training nurses to perform colonoscopies under medical supervision. This would create more interesting work for nurses whilst increasing the availability of doctors to perform more complex tasks. It is recommended that State-wide planning immediately occur involving doctors and nurses identifying: the settings in which this role enhancement could safely occur, appropriate training arrangements for nurses and systems to assess competency and credential nurses. Such modelling could be undertaken for advanced nursing opportunities which could occur in the areas experiencing the greatest medical workforce pressures, including rural and remote areas and specific specialties such as gastroenterology.

It is essential that such reforms are driven by teams of doctors, nurses and allied health professionals, not people removed from front line clinical work. Under the proposed structural arrangements for Queensland Health, workforce reform has been devolved to area health services. As a starting point, it is recommended that these areas be resourced to facilitate local, team based development and implementation of advanced nursing roles in areas experiencing service pressures or workforce shortages. Where relevant, this work should be managed by clinical networks with local clinical champions to drive change.

2) *Extended roles for nurses– nurse practitioners*

The nurse practitioner role is distinct from advanced nursing in that it enables nurses to operate without medical supervision within agreed protocols. Queensland Health is already trialling the nurse practitioner role, has amended legislation to support the role and, in anticipation of nurse practitioner Master's degree courses commencing in 2006, has announced 20 scholarships per annum to support nurses wishing to undertake this course.

Some of the scholarships could be full-time to expedite availability of qualified nurse practitioners from 2008. Equally, some scholarships could be made available to support nurses studying part-time while working in Queensland Health to avoid losing them entirely from the workforce during their training. In addition to scholarships, Queensland Health could consider providing paid study leave to existing nursing staff to support them undertake the Master's degree course.

However, planning or modelling has not been undertaken to identify the number of nurse practitioners that could be accommodated within the public health system or in what geographic areas or clinical networks. This would be helpful to inform workforce planning and development of university curricula commencing in 2006.

It is recommended that Queensland Health undertake urgent assessment of the size and nature of the potential nurse practitioner workforce and begin immediate negotiations with universities to ensure alignment between Queensland Health's needs as an employer and course content. Additionally, it would be helpful for Queensland Health to work with universities to establish a longitudinal study of nurse practitioners to assess outcomes of the nurse practitioner model and impacts on workforce retention and satisfaction.

It is acknowledged that nurse practitioners may also work in private practice settings in addition to Queensland Health. It is therefore recommended that the Queensland

Government lobby the Commonwealth Government to provide access to the Medicare Benefit Schedule and the Pharmaceutical Benefits Scheme for nurse practitioners, in recognition that these roles are taking on functions traditionally performed by doctors. This would increase the likelihood that nurse practitioners can work in community settings and offer affordable care.¹⁰⁶

Under mutual recognition, qualified nurse practitioners from New South Wales could already move to Queensland to practice. Given the potential to employ these nurse practitioners now and in anticipation of Queensland graduates entering the workforce from 2008, it is recommended that Queensland Health work with the Queensland Nursing Council to ensure appropriate registration and endorsement systems are established. Queensland Health will similarly need to establish credentialing and clinical privileging systems for the nurse practitioner role.

Redesigning work practices to increase efficiency

District visits highlighted the administrative burden imposed on nurses in managing workforce information and rostering systems. As with doctors, there was a consistent view expressed by nurses that these systems could be far more efficient and that management of some of these systems might be more appropriately performed by administrative support officers.

Opportunities to redesign work practice have been identified to increase efficiency and availability of clinicians to provide clinical care which include:

- Systematic implementation of outcome based clinical pathways into the health care work environment. This is based on the finding that a major Brisbane hospital which successfully improved clinical care and reduced the paperwork done by nurses by 44 percent, thereby freeing up clinicians' time.
- Devolution of non-clinical tasks to non-clinical categories of staff - for example creation of roster clerks to manage nursing rosters (supervised by nurses able to ensure appropriate skill mix) and answer telephones.
- Negotiating opportunities at the local level to introduce flexible hours of work to increase productivity. For example, negotiation of four day weeks based on 4x10 hour shifts could be used as a basis to increase theatre hours and surgical throughput each day and increase activity after hours and on weekends subject to availability and interest of nurses.

Development of country service register and incentive package

Nurses expressed interest in performing short term rural and remote service on a rotational basis. This goodwill should be used to assist smaller districts through establishment of a register of clinicians, including nurses, willing to undertake rotations and concurrent development of an incentive package to make the rotations attractive (refer to discussion under initiatives for doctors for further detail on the proposed register and incentive package).

¹⁰⁶ Nurse practitioners are distinct from practice nurses, who already work in some general practices under the supervision of doctors. In contrast, nurse practitioners are able to practise independently within their scope of practice.

10.7 Recommendations to maximise the value of the nursing workforce

The Queensland Government should seek from the Commonwealth:

- Access to the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme for community based nurse practitioners, in recognition that these roles are taking on functions traditionally performed by doctors

Queensland Health should:

- Undertake urgent assessment with clinical networks and area health services of the size and nature of the potential nurse practitioner workforce
- Begin immediate negotiations with universities to ensure relevant course content for nurse practitioner master degrees
- Work with the Queensland Nursing Council to ensure appropriate registration and endorsement systems are established

Area health services should:

- Be resourced to facilitate local, team based development and implementation of advanced nursing and nurse practitioner roles in areas of workforce or service pressures and managed through clinical networks where feasible
- Facilitate and resource districts to devolve non-clinical tasks to non-clinical categories of staff including provision of roster clerks, and support for advanced nurses with less time for non-clinical work
- Establish a register of clinicians – including nurses– willing to undertake country service rotations and design a country service incentive package

Districts should:

- Negotiate opportunities to introduce flexible hours of work to increase productivity subject to staff availability and interest

Clinical networks should:

- Lead implementation of outcome based clinical pathways to improve care and streamline work practices

10.5.4 Improving nursing education and training

Nursing education has undergone fundamental changes over the last twenty years, the most significant of which has been the introduction of university based degree programs for registered nurses and the move away from traditional hospital based education models. There are now a number of tertiary institutions providing nursing education across the State. Nursing enrolment numbers have averaged around 1400 per annum over the last five years and will need to continue to increase in line with the State's growing and ageing population and to offset the impacts of increasing part-time work and high wastage rates from the profession.

It is therefore critical that Queensland Health develops effective mechanisms for ongoing engagement with the tertiary sector. The long lead times associated with the expansion of student numbers and the introduction of new courses (the first post-graduate degree nurse practitioner courses in Queensland are set to commence in 2006) demonstrate the importance of coordinated strategic planning between the State's public health services and the tertiary sector. This needs to be underpinned by robust workforce projections and identification of specific areas of skills shortages.

Health 2020, Queensland Health's Directions Statement, sets out the need to develop flexible workforce models and make better use of our existing workforce. The potential

for changes to work practices and skills mix is greatest with the nursing profession given they make up the bulk of the health workforce. Enrolled nurses and assistants in nursing are not being sufficiently utilised to meet Queensland Health's workforce needs particularly in the context of overall nursing shortages. Queensland Health needs to pursue an expanded role for the VET sector to increase the number of enrolled nurses, assistants in nursing and other health workers.

Concerns were expressed to the review that nursing graduates are often not "work ready" and have not received sufficient practical and hands-on clinical experience as part of their health education programs. There are also concerns that the move away from hospital based training has resulted in student nurses having unrealistic expectations regarding the nature and demands of health work leading to further losses from the younger workforce entrants.

Best Practice Example

There are recent examples of best practice collaborative approaches between the universities and Queensland Health which attempt to better integrate service delivery and academic needs.

The University of Queensland and Queensland Health have recently collaborated to develop a new undergraduate nursing program which integrates classroom and clinical learning. The program incorporates increased clinical practical hours (1320) in total and is aimed at improving the "work readiness" of nursing students. The program commenced in 2004 with two pilots at the Princess Alexandra and West Moreton Health Service Districts with 60 students increasing to 130 in 2005. Student nurses spend considerable amounts of their time on the hospital campus and attend lectures on site. Most of their last year is spent working in a clinical environment.

Queensland Health and the University have jointly developed a new program including the overall structure of the teaching program, the use of practice settings for clinical placements, the involvement of Queensland Health staff in the academic program and sharing of costs

Queensland Health has been working with the universities to establish agreed standards for clinical placements to ensure there is sufficient support for students. Queensland Health nursing staff provide direct supervision and training of students and in some cases undertake formal assessments of the performance of individual students. Many nursing staff reported they did not have the time to provide adequate supervision of university students on clinical placements and that insufficient resources were being made available to support this role.

Queensland Health needs to strengthen its relationships with the universities through adjunct and conjoint appointments and support a model which encourages the employment of clinical facilitators at the ward level. Queensland Health has recently negotiated with the universities to provide increased financial support to hospitals providing clinical staff to supervise students. However, additional resources are required and it is suggested that Queensland Health negotiate with the Commonwealth and the tertiary sector to increase funding in this area. This is particularly important in light of the review's recommendation to increase nursing student numbers.

It is imperative that nursing graduates have the appropriate level of supervision and gain enough practical experience to be able to practise safely and competently. Queensland Health has introduced transition to work programs for graduate nurses. However, the programs are not applied on a consistent basis across the Health Service Districts and need to be expanded.

Ongoing training and professional development

Queensland Health has a responsibility to ensure nurses receive appropriate ongoing training and professional development during their careers once they become employees of the public hospital system.

Unlike doctors, nurses do not undertake further hospital based training to gain registration or to attain specialist qualifications. Instead, nurses acquire specialist qualifications through post-graduate study at university. Nursing groups argue they are disadvantaged because they have to meet the costs of ongoing education themselves whereas doctors are effectively subsidised by the State because their post-graduate education occurs in public hospitals under the specialist training programs rather than in the tertiary sector. Queensland Health could consider providing support in the form of scholarships or paid study leave for post-graduate qualifications in targeted areas including advanced practice roles.

The review received numerous reports from nursing staff about deficiencies with the current on the job training offered by Queensland Health. As noted in the interim report, access to training was variable across the State and particularly poor in rural and remote areas. Training was not targeted to service delivery needs and nurses considered they were not being treated equitably with other health profession groups.

One of the main complaints from nursing staff was that they could not be released for training as there were no staff available to backfill their positions. Clearly, there needs to be a balance between the employers' need to have sufficient staff coverage to meet patient needs, and the needs of staff for access to appropriate levels of training. However, to foster a learning culture, Queensland Health should ensure that sufficient backfill is made available for staff to undertake approved courses and training.

Most of the large hospitals employ nurse educators who are specifically charged with responsibility for providing clinical training and education support to nursing staff. Many educators complained of increasing workloads and a lack of recognition of the importance of their role in promoting safe and quality services. Queensland Health needs to ensure there are sufficient numbers of nursing educators available across the State to meet training needs and that they receive appropriate levels of support including administrative support.

10.8 Recommendations to improve nursing education and training

Queensland Health should:

- Adopt a strategic and proactive approach to influencing the direction of under-graduate nursing education to ensure it continues to meet service delivery needs and to adequately prepare graduates for entry to the workplace.
- Strengthen relationships with universities through adjunct or conjoint appointments and review the role of clinical facilitators at ward level to support nursing education.
- Negotiate with the Department of Employment and Training and the Commonwealth Government to increase funding for enrolled nurses, assistants in nursing and other certificate based health workers with a focus on also attracting these workers to rural and remote communities.
- Seek support from the Commonwealth and State governments to increase the level of funding available to support the clinical teaching and training of nursing students within the Queensland public health system given this is a shared area of responsibility
- Support nurses undertaking post-graduate study through scholarships and/or paid study leave

- Expand its transition to work programs so that new graduate nurses receive appropriate supervision and support.
- Establish an ongoing education and training program for nursing staff which is linked to service delivery needs, addresses identified skills gaps and supports advanced clinical practice roles.
- Review the number of nurse educators working in the system and provide adequate resourcing and support for them to undertake their roles.
- Ensure adequate backfilling of positions to allow clinicians to attend training and education programs.

10.6 Initiatives for allied health professionals

10.6.1 Relief for allied health professionals: immediate recruitment initiatives

Active recruitment locally, interstate and overseas

Based on the analysis in section 10.2.11, Queensland Health's most critical area of workforce shortage is arguably the allied health group. Allied health staff comprise a diverse group of professionals including physiotherapists, occupational therapists, speech therapists and pathologists, pharmacists, psychologists, dieticians, radiographers, podiatrists, social workers and optometrists. Queensland would need an additional 2,350 allied health staff to reach the national average of allied health professionals per head of population. On a workload basis, Queensland Health would need an additional 1,780 allied health staff to meet the national average workload ratios for public hospital inpatient services. This figure does not take account of outpatient or community services, settings where allied health professionals are also likely to work.

Expansion of the allied health workforce will require concerted recruitment efforts over a number of years and cooperative planning with universities and the Commonwealth Government in respect of student numbers and priority disciplines. Given the significant work required across the various allied health disciplines, it is recommended that allied health leadership positions be created in Area Health Services to drive workforce planning, recruitment and reform activities.

As a starting point, it is suggested that Queensland Health implement targeted as well as web-based marketing and recruitment campaigns locally, interstate and overseas to attract major allied health groups employed in the public health system such as physiotherapists and radiographers. Overseas campaigns could focus in particular on the United Kingdom and other countries with training equivalent to Australian standards. Other suggestions in this section aim to improve allied health recruitment, retention, career pathways and long term workforce planning.

Simplifying recruitment processes

In line with the suggestions for doctors and nurses, recruitment processes for allied health professionals could be simplified through:

- negotiation of a standing exemption under the advertising guidelines to increase flexibility in advertising

- devolving allied health recruitment to the facility level as far as possible
- clarification for line managers of the range of recruitment techniques that may be for recruitment

Increasing student places

As for doctors and nurses, it would be prudent to develop recommended allied health student intakes in Queensland to enable the Queensland Government to seek from the Commonwealth Government an immediate increase in student places focussing particularly on formulas that reflect the true cost of training. Additionally, the Queensland Government could consider funding bonded allied health student places as it has done at the Griffith University medical school.

As noted previously, many allied health professionals complained about not having sufficient time to supervise and mentor students and junior staff. In expanding allied health personnel in the system, it is suggested that Queensland Health target recruitment efforts on those staff with a willingness to engage in teaching allied health students in addition to their service delivery tasks.

10.9 Recommendations to provide immediate relief for allied health professionals

The Queensland Government should:

- seek from the Commonwealth an immediate increase in allied health student places and/or consider funding additional bonded places in Queensland tertiary institutions
- seek support for the State to immediately increase the employment of allied health personnel in Queensland's health system with an emphasis on a willingness to teach allied health students

Queensland Health should:

- implement a local and interstate campaign to position itself as an employer of choice for allied health staff with the aim of increasing staffing numbers by around 2,000 over the next three years
- increase flexibility in recruitment processes including advertising and selection processes and devolve recruitment responsibility to the facility level except where staff are being recruited across a number of facilities
- develop recommended student intakes in Queensland to inform negotiation with the Commonwealth
- create leadership positions in the Areas Health Services which focus on workforce planning and recruitment activities.

10.6.2 Retention measures for the allied health workforce

Remuneration and Conditions

It is important that staff perceive they are being paid justly and fairly. As noted previously, the review has concluded that it would be helpful for the enterprise bargaining process to be reviewed to address the lack of flexibility and complexity of current arrangements.

It is suggested that allied health awards be used to create clinical career pathways for advanced and extended practice roles and clinical leadership positions (see separate

section on advanced and extended roles). Given the need for urgent workforce reform, enterprise bargaining processes could be used to remove impediments to:

- extending the scope of practice for allied health professions
- outsourcing work, particularly in areas of acute workforce pressures and/or high demand
- negotiating flexible employment arrangements for allied health professionals including a four day week and a mix of public and private work
- creating temporary positions for training purposes eg temporary positions could be created for a cohort of allied health graduates to provide them paid work experience and skill development (as occurs for medical interns) until permanent opportunities arise for which the graduates would be able to apply more competitively.

Improving clinical career pathways

The Clinical Advancement Scheme is recognised as a key strategy to retain and reward highly skilled allied health professionals seeking career advancement in clinical rather than managerial settings. The scheme enables eligible professionals at the PO3, PO4 or PO5 level to advance by one or more classifications – in effect, the scheme allows a significant promotion on the basis of outstanding clinical skills, research or education.

It is appropriate that applicants undergo an assessment process as would any professional applying for a promotion. It is also appropriate that the scheme rewards clinical excellence rather than years of service. Arrangements such as long service leave or the proposed retention bonus for clinicians in rural and remote settings (see Chapter 7) are more appropriate means of rewarding long service.

The program currently benefits only a small number of clinicians, with 20 advancements offered each year. Given the acute shortages in allied health professionals, it would be helpful for consideration to be given to increasing the scale and flexibility of the scheme to encourage more nominations and reward more clinicians. Suggestions include:

- increasing the number of advancements offered
- expanding the eligibility criteria to recognise priorities suggested by this review, including outstanding clinical leadership or mentoring skills
- establishing standing assessment panels in order to accept applications throughout the year rather than in one annual intake
- better marketing the scheme and providing practical assistance to prepare applications
- requiring supervisors and Area Health Service allied health leaders to support and encourage applications from outstanding clinicians rather than relying on clinicians to self-identify as candidates and incorporating this consideration into performance and development plans
- involving recognised allied health leaders in making the above changes to the scheme
- evaluating the changed scheme from a process perspective after 12 months' operation and in terms of impact after two years' operation.

Queensland Health is also at risk of losing other highly specialised professional staff who cannot easily be replaced because they are national and world leaders in their field. It is suggested that the scheme be expanded to include all professional groups on the professional officer pay scale:

- which have limited advancement opportunities offering continued professional practice (as opposed to managerial advancement) and
- whose work has direct impact on health outcomes or clinical practice eg epidemiologists, environmental health or public health professionals.

The limitation of the Clinical Advancement Scheme is that it is driven by individual initiative rather than workforce and service needs. It is therefore suggested that an additional recruitment and retention strategy be the creation of advanced allied health roles, as outlined below, in areas which would offer maximum benefit in alleviating workforce pressures and improving patient services. This would have twofold benefits in creating new clinical career pathways whilst also allowing Queensland Health to address workforce and service pressures. It would be helpful for a career structure to be created for such advanced roles, either rewarding staff through higher paypoints on the existing award or through creation of a new advanced practice award.

Other measures to support allied health staff

Given the shortages being experienced with regards to allied health staff in Queensland Health, it is important that exiting staff feel valued and supported by their employer. There are a range of relatively simple measures which Queensland Health could implement to support its staff including:

- improving organisational culture to foster strong leadership and reconnect allied health staff to decision making, service planning and budget allocation;
- providing suitable amenities such as training and meeting rooms;
- providing appropriate induction programs and information about entitlements, including training and development, with access to entitlements monitored through individual performance and development plans;
- providing appropriate peer support and professional supervision particularly for allied health staff working in rural and remote areas;
- ensuring a safe working environment including access to appropriate parking and training in aggression management; and
- providing access to suitable travel and accommodation

10.10 Recommendations to improve retention of the allied health workforce

The Queensland Government should:

- Review the process for enterprise bargaining to address the lack of flexibility and complexity of current arrangements and remuneration levels
- Use enterprise bargaining to remove impediments to workforce reform including extending scope of practice, outsourcing work, negotiating flexible employment arrangements and creating temporary positions for training purposes

Queensland Health should:

- Enhance clinical career pathways for allied health professionals through creation of advanced and extended positions under a new award or additional paypoint in the existing award structure
- Increase the scale and flexibility of the Clinical Advancement Scheme as suggested in 10.6.2
- Implement strategies to improve organisational culture and foster strong leadership and

change management capacity within the department, discussed in chapter four.

- Provide allied health staff with timely, quality travel and accommodation services.

Area health services should:

- Create peer support networks along professional groupings or streams of care to improve support for isolated allied health workers
- Ensure allied health staff have access to revised and better targeted and resourced aggression management training.

Districts should:

- Provide amenities such as meeting and training rooms where feasible and in consultation with allied health workers
- Provide all new allied health staff with an induction which includes information about entitlements, with access to entitlements supported and monitored through individual performance and development plans

10.6.3 Maximising the value of the allied health workforce

Redesigning work practices to increase efficiency

District visits highlighted the administrative burden imposed on allied health professionals and the potential for administrative support officers to increase availability of allied health professionals to perform clinical work.

As noted previously, opportunities to redesign work practice have been identified to increase efficiency and availability of clinicians to provide clinical care which include:

- Systematic implementation of outcome based clinical pathways into the health care work environment
- Devolution of non-clinical tasks to non-clinical categories of staff
- Negotiating opportunities at the local level to introduce flexible hours of work to increase productivity. For example, allied health workers in community health services running clinics out of hours to better meet patient needs.

Development of country service register and incentive package

As for doctors and nurses, it is suggested that each Area Health Service establish a register of allied health professionals interested in performing country service rotations and develop an incentive package to make the rotations attractive.

Role redesign

Nationally and internationally, workforce roles are being redesigned to better align skill level with task complexity and improve patient outcomes. This work falls into two broad categories:

- 1) *Advanced practice roles*, where clinicians use their skills to an advanced level. In this situation, clinicians work within the existing scope of practice for their profession.
- 2) *New or extended roles*, where clinicians may require additional training and competency assessment before performing new tasks and legislative change may be required eg to allow limited prescribing rights.

Such roles may enable independent, unsupervised practice by non medical staff (eg podiatric surgeons) or extended practice under medical supervision (eg surgical assistants). This section first highlights opportunities for advanced allied health roles and then explores opportunities for new or extended roles. In developing more advanced roles, Queensland Health will also need to consider increasing the use of assistant allied health positions to take on lower order tasks that may previously have been performed by allied health professionals.

As noted in section 10.5.3 in the discussion of advanced and new nursing roles, the review has deliberately not prescribed the nature of advanced and extended health workforce roles, nor the education and training requirements to develop them. Whilst there are some proven initiatives that can immediately be implemented more widely (outlined below), there are other new and extended allied health roles that require development and assessment at the local level. An incremental implementation approach is suggested in this section for development new and extended roles.

1) Developing advanced practice roles – for immediate implementation

Within the existing scope of practice of health professionals, there is an opportunity to better align skill level with task complexity and improve patient outcomes. Three examples are explored below. These examples are illustrative only and are by no means exhaustive.

It is essential that such reforms are driven by teams of doctors, nurses and allied health professionals, not people removed from front line clinical work. Under the proposed structural arrangements for Queensland Health, workforce reform has been devolved to Area Health Services. As a starting point, it is suggested that these positions be resourced to facilitate local, team based development and implementation of advanced practice roles in areas experiencing service pressures or workforce shortages. Where relevant, this work should be managed by clinical networks with local clinical champions to drive change.

(i) Use of allied health professionals to reduce outpatient and elective surgery waiting times

Modelled on an initiative in the United Kingdom, Queensland Health is trialling a “Fit for Surgery” program at Ipswich, Royal Brisbane and Townsville Hospitals at an approximate cost of \$250-\$300,000 per site. The program uses physiotherapists, occupational therapists, dieticians and psychologists to maximise the number of people who are “fit for surgery” on elective surgery waiting lists. The program also helps improve quality of life for those category three patients who are unlikely to receive surgical intervention or for whom alternative treatment may be preferable. The program aims to improve cardiovascular and musculoskeletal fitness, help people stop smoking and manage chronic pain and disability.

The Fit for Surgery initiative has been labelled as a trial not due to lack of an evidence base but due to limited funding, meaning it could only be implemented in three sites, which were badged as “trial” sites. Given that this initiative has been well tested in the United Kingdom and other Australian jurisdictions, this could immediately be rolled out more widely. This initiative does not require changes to the scope of the allied health professionals involved and could feasibly commence pending start up resources and recruitment of additional staff.

It would be prudent for this initiative to be complemented with boosted investment in, and integration with, community health services to provide post-operative support to patients and undertake preventative work in the community.

(ii) Use of physiotherapists in accident and emergency department

Consistent with advanced roles in the United Kingdom, there is scope for physiotherapists to provide first contact assessment and treatment to patients with musculoskeletal traumatic injuries in accident and emergency departments. Within their existing scope of practice, physiotherapists could undertake examinations, x-ray requests, referrals to specialists, immediate treatments and patient discharge. This role would better use the expertise and training of physiotherapists, shorten elective surgery waiting lists, reduce the time required by doctors or, in some cases, avoid or reduce the need for medical intervention.

Given the weight of evidence from the United Kingdom supporting the effectiveness of this role, it is suggested that Queensland Health immediately analyse facilities where the volume of presentations of musculoskeletal traumatic injuries could warrant a physiotherapist and resource districts to implement this initiative.

(iii) Podiatric services including podiatric surgery

Podiatrists could play a role in clinical networks planning service models for people with diabetes, given the link between diabetes and development of serious foot problems.

Additionally, a small number of appropriately qualified podiatrists could be used to perform below the knee surgery. Some podiatrists are already recognised by the Australian College of Podiatric Surgeons as being qualified to perform ankle and foot surgery and, recently, have been allowed access to private health insurance rebates by the Commonwealth Government. This is in line with existing practice in the United States and United Kingdom where appropriately qualified podiatrists perform below the knee surgery.

Use of such practitioners by Queensland Health could assist in reducing waiting lists for elective orthopaedic surgery. Practically, this could achieve only modest outcomes in the short term given estimates that as at 30 August 2005, only 300 of the 9,500 patients were on the orthopaedic waiting list were awaiting procedures commonly performed by podiatrists. Additionally, there are only three podiatrists registered in Queensland who are recognised by the Australian College of Podiatric Surgeons, with a further three understood to be training with the college.

As noted in Queensland Health's submission to the Bundaberg Commission of Inquiry, the key impediments to the use of surgical podiatrists are the cost of training, which is self funded, and the limited numbers of orthopaedic surgeons or anaesthetists willing to work with podiatric surgeons. Nonetheless, Queensland Health could explore opportunities either for direct employment of surgical podiatrists or outsourcing less complicated foot and ankle surgical cases to appropriately qualified podiatrists. Queensland Health could also consider offering funding support for podiatrists currently employed by Queensland Health to undertake training with the Australian College of Podiatric Surgeons, thereby increasing the pool of qualified surgical podiatrists.

2) *New and extended roles for nurses and allied health professionals – for incremental implementation*

This section outlines opportunities to extend the scope of practice for allied health professionals to create new health workforce roles. Such reforms, unless managed well, may meet with resistance and will require clear communication strategies to assure the community that new and extended roles will be implemented with an overriding interest in ensuring patient safety and quality of care.

Given that these reforms involve new workforce roles, an incremental approach to implementation has been recommended by key stakeholders including universities. The suggested implementation approach is allocation of a pool of money to the workforce reform function within area health services to facilitate local, team based trials of new or extended roles. Where relevant, this work should involve clinical networks to build clinician support for the roles. Localised pilots have been successful in trialling and building support for the nurse practitioner role in Queensland Health.

Under this approach, area health services would work with districts and clinical networks to identify new workforce roles that could support service priorities. For example, clinicians in a regional centre experiencing difficulty providing local radiology services might develop an initiative to train a radiographer to read plain films. In establishing this new role, the centre would need to develop suitable training and credentialing arrangements and may require legislative reform to support the new role. Subject to a positive evaluation, resources would be made available to support wider implementation of the roles through area health services or clinical networks.

In trialling new roles, it will be important that all three Area Health Services work together to minimise cost duplication and role variation that may arise if the same role is trialled in a number of different sites. Close links will also be required with the corporate office workforce planning unit and to facilitate enabling policy such as changed legislation.

The three examples outlined below are illustrative only and by no means exhaustive. It will be important for Queensland Health to consider other opportunities for new workforce roles where they support service requirements and offer relief in areas of workforce shortage. Examples may include paramedic primary care practitioners in rural areas (discussed in chapter seven), prescribing and immunisation roles for pharmacists, and new roles to manage care for people with chronic diseases.

(i) optometrists in outpatient clinics

Optometrists tend to work in private practice settings, with only three currently employed in the public health system on a sessional basis. Private optometry services have minimal waiting times and are financially accessible due to availability of Medicare rebates. Some optometrists are employed by ophthalmologists in private practice to provide initial patient assessments and free up the ophthalmologist's time for complex interventions.

Optometrists' scope of practice has recently been extended in Queensland through introduction of therapeutics legislation enabling limited prescribing rights for optometrists who complete appropriate training (although the list of approved drugs is still to be finalised). This creates the potential for optometrists to diagnose and treat many urgent and non-urgent conditions and decrease waiting lists.

There is scope for public outpatient clinics to use optometry services by diverting patients to privately practising optometrists and/or engaging optometrists to provide direct patient services, triage and diagnostic services. Equally, it would be possible in accident and emergency settings to divert patients to private optometrists (particularly those who are therapeutically qualified), use optometrists for on call arrangements to assist with triaging or directly employ optometrists for service provision to patients presenting with ophthalmic conditions.

Given the extensive ophthalmology outpatient and elective surgery waiting lists, it is recommended that these possibilities be immediately investigated. Additionally, it would be prudent for Queensland Health to analyse presentations to emergency departments to identify whether use of optometry services may ease pressure and consider implementing some or all of the above options.

(ii) radiographers reading plain films

The National Health Service in the United Kingdom has successfully trained radiographers to read plain films to alleviate pressures arising from radiologist shortages. There is a clear body of evidence demonstrating that appropriate trained radiographers can perform this role safely and accurately. Immediate trialling of this is suggested in districts with capacity for supervision and training to ensure safety and quality.

(iii) surgical/ physician assistants or clinical associates

In the United States of America, surgical and physician assistant roles are well developed and work in team based settings under medical supervision (as opposed to independent practice). Practice in these professions requires training in a nationally accredited course and passing a national certification examination. As their title suggests, surgical assistants assist surgeons in theatre and perform less complex aspects of surgical procedures to free up the time of highly skilled surgeons. Physician assistants practice under supervision of a physician and can conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and in virtually all states can write prescriptions. Opportunities to trial and develop these roles in Queensland should be explored through clinical networks.

10.11 Recommendations to maximise the value of the allied health workforce

Area Health Services should:

- Be resourced to facilitate local, team based development and implementation of advanced and extended allied health roles in areas of workforce or service pressures and managed through clinical networks where feasible
- Be resourced immediately to implement alternative models of care using allied health professionals to reduce pressure in outpatient clinics and accident and emergency departments, as discussed in 10.6.3
- Facilitate and resource districts to devolve non-clinical tasks to non-clinical categories of staff including support for advanced allied health professionals with less time for non-clinical work
- Establish a register of clinicians – including allied health workers– willing to undertake country service rotations and design a country service incentive package

Districts should:

- Negotiate opportunities to introduce flexible hours of work to increase productivity subject to staff availability and interest eg community health services running clinics out of business hours

Clinical networks should:

- Lead implementation of outcome based clinical pathways to improve care and streamline work practices

10.6.4 Improving allied health education and training

The allied health workforce is made up of a diverse range of professions including physiotherapists, occupational therapists, speech therapists and pathologists, pharmacists, psychologists, dieticians, radiographers, podiatrists, social workers and optometrists. Each of these groups is a product of a profession specific undergraduate program for which there are generally more applicants than places and academic entry standards remain high.

While there are concerns with shortages of particular groups such as pharmacists, the overall local supply of allied health professional staff has been improved with the expansion of programs in regional universities over recent years. Student numbers will need to continue to increase in line with increasing demands. The numerous different faculties and institutions involved in allied health professional education present particular challenges in terms of Queensland Health's ability to undertake long term planning for its allied health professional workforce. Professional associations also play a role in determining the number of practice hours to be completed by students and provide professional development opportunities. It is vital that Queensland Health engages effectively with external stakeholders to develop a coordinated and strategic approach across the various professional groups.

Concerns have been raised about the adequacy of undergraduate education programs in preparing allied health professional students for the workplace as have been previously canvassed in regard to nursing education. While it is generally considered the current courses provide a good foundation of overall general knowledge, they are not seen as being sufficiently focussed on preparing students to meet the specific service needs of employers.

Clinical placements

There is considerable variability in the approach to clinical placements for allied health staff across the organisation. Many allied health staff complained that increasing workloads limited the time available to provide adequate supervision and there were differing views about the perceived benefits of making resources available for the clinical placements of graduates. Universities have put in place a number of different arrangements to support students including joint appointments of academic staff, and training support for clinical staff to undertake clinical supervision.¹⁰⁷

Allied health professionals have been particularly affected by changes to Commonwealth funding arrangements with respect to universities. Prior to 2000, universities employed their own staff to train physiotherapy students in Queensland Health facilities. This workload now falls on clinicians who are already busy coping with patients and has been compounded by increasing student numbers in recent years. Queensland Health needs to come to similar arrangements for allied health professional staff with universities as has occurred with medical and nursing clinical placements. In relation to Commonwealth funding to universities, special attention needs to be given to a realistic funding formula that reflects the high retention in most of these programs and adequate funds for quality clinical placements. Queensland Health needs to ensure that the teaching and support environment is appropriate for quality training and academic quality.

¹⁰⁷ Queensland Health, Summary Report, Director-General's Allied Health Recruitment and Retention Taskforce 1999-2000.

Ongoing training and development

Allied health staff work across a variety of settings in Queensland Health including community, rehabilitation and acute hospital inpatient settings. Training programs for these groups need to be organised around the different demands of these service areas.

Because allied health staff make up a relatively small proportion of the workforce and often work as individuals with little peer support, it is important they have training programs tailored to individual needs. However, many staff report difficulties in accessing professional development programs and post-graduate education opportunities.

A number of allied health staff complained they had to finance their own professional development without any assistance from Queensland Health. They also reported having limited opportunities to attend courses and training programs as there were insufficient staff to provide cover in their absence.

Many young allied health professional graduates are likely to fill rural and remote vacancies as a means of gaining entry level employment. Their needs for sufficient support and access to professional development are particularly high and should be given priority. This has been partially recognised with the provision of a special professional development incentive package for rural and remote allied health employees. However, similar problems arise with covering staff absences to enable staff to take advantage of these opportunities. Some staff were also unaware of their entitlements.

10.12 Recommendations to improve education and training for allied health workers

Queensland Health should

- Facilitate better linkages with external agencies including the tertiary sector and professional associations to develop a long term education, training and professional development program for allied health staff.
- Ensure the provision of clinical placements for allied health students is coordinated and able to cope with continued increases in student numbers.
- Negotiate with the State and Commonwealth to address the issue of an adequate teaching and support environment during clinical placements, and funding models that reflect student retention and clinical placement costs.
- Consider expanded peer support programs for young allied health professionals working in rural and remote areas and ensure they have access to professional development opportunities.
- Identify areas of skills shortages amongst its allied health professional staff and consider providing financial subsidies in targeted areas of post-graduate study.

10.7 Addressing organisational and cross-disciplinary education and training issues

To date, educational institutions have tended to structure their health education programs around the traditional professional boundaries of medicine, nursing and the allied health professions. However, in the context of significant workforce shortages, there is a growing need for new types of health workers who are multi-skilled and can work across various clinical settings. Queensland Health needs to engage effectively with educational institutions and other partners to look at ways of fast tracking health education and developing multi-disciplinary approaches in order to address workforce and skills

shortages. This includes pursuing a greater role for the Vocational Education and Training (VET) sector to expand the pool of available health workers in the short term.

While there have been attempts to increase the focus on education and training in response to particular professions or in the context of specific workforce pressures, it is clear there is no organised or strategic approach to professional development across the agency. Training programs are organised and delivered at various levels throughout the organisation and access to, and availability, varies depending on the location of services and the commitment of the clinical and administrative leadership.

Health service needs should guide the direction and scope of education and training programs within Queensland Health. Priorities should include the clinical practices and activities carried out frequently in team settings. Although there are networks of training coordinators throughout Queensland Health, these positions often focus on clinical training within streams, rather than the team environments which deliver holistic patient care and services.

In more remote settings, there are rural health training units which operate to deliver a range of clinical and non clinical training. These units provide valuable education and training for staff in rural settings, but are not presently part of a broader statewide education teaching and training strategy. This strategy would include focus on clinical training in team settings to ensure service needs are addressed and patient outcomes improved. The education and training systems established would include curricula based education and competency based training in the workplace and in other settings. Adult education approaches, simulation environments and multi disciplinary settings would be defining features.

The Skills Development Centre

The Skills Development Centre was established to provide a teaching Centre of Excellence for the enhancement of clinical competence and skill on a commercial fee for service basis.

The Centre has been effectively designed and delivered, but its development has been constrained by the service approach. Frequently there is no funding to engage sufficient educators or trainers or to backfill the positions of participants who attend.

It is imperative that the Skills Development Centre be adequately funded to reach its potential. It should be conceived as the hub of a decentralised network of education, teaching and training programs. The Skills Development Centre should be able to make a significant contribution to the reform program within Queensland Health by advancing clinical training in team settings not only in Brisbane but throughout the State.

Contracted external resources should be used to help develop its service capability to deliver programs within South-East Queensland as well as other State centres.

It should also progressively increase its own capacity to educate, teach and train, and do this in conjunction with the three Area Health Services to ensure appropriate attention is provided to needs in centres outside South-East Queensland.

The Herston Centre would ideally operate on a two shift a day basis six days a week to make full and best use of its excellent medical and surgical simulation environment. This

environment has relevance for a very broad range of clinical teaching and training settings from undergraduates through to postgraduate specialists and clinical leaders.

The Centre has been capably managed to date but would now benefit from a greater level of clinical leadership in keeping with reform themes. It would be appropriate for a specialist medical practitioner with necessary adult education and teaching experience to lead the Centre and oversee the development of clinical curricula and clinical skills education development and training programs. The Centre should link closely with tertiary educational bodies across all health disciplines and to the Medical Colleges. It is instructive to note that the University and Skills Centre have already jointly engaged staff. It might also be appropriate to appoint on a three yearly basis an eminent clinician as patron and chair of an advisory group of clinicians, educators and trainers drawn from the clinical networks who might best advise on priorities and needs to help shape the future programs to be offered throughout the State by the Centre.

Additionally, the Centre will continue to require senior managerial, commercial and entrepreneurial skills to ensure clinical programs are delivered effectively and innovation and commercial partnerships continue to develop.

Funding for training

As noted previously, there is considerable variability in access to training across Queensland Health. Some training and study leave are included in award entitlements while others are less formalised and dictated by local District arrangements. For instance, senior medical officers have access to 13 weeks study leave and travel every 5 years and conference leave of 1 week each year. Radiation therapists receive a development allowance as an award entitlement and there is a professional development incentive package for rural and remote allied health employees.

All health employees have access to study and research assistance as does the rest of the Queensland public sector. However, Queensland Health offers more limited assistance than other agencies. For example, employees can apply for study leave but cannot claim an employer contribution towards HECS costs. Expanded assistance could offer a means of Queensland Health supporting staff to move into more advanced clinical roles. For example, HECS subsidy could be used as an incentive for an enrolled nurse to undertake tertiary study and become a registered nurse.

The 2003-04 Measured Quality Report highlighted disparities between districts in expenditure on professional development and education. While these figures should be treated with some caution, they provide an indication of inequities for staff in different districts. The cost of paid training and study leave per FTE varied markedly from the State median of \$461, ranging from approximately \$200 in some hospitals to over \$1000. The cost per FTE of education courses and conferences similarly varied from the median of \$198, ranging from below \$100 in some hospitals to over \$400 in others.

As noted earlier, the majority of the cost burden of meeting education and training costs currently falls on Queensland Health. However, the benefits of that training are enjoyed much more broadly by the private sector and by individual practitioners who leave the public sector to work in the private sector.

10.13 Recommendations to address organisational and multi-disciplinary education and training issues

Queensland Health should establish a central coordination point for training and education in the organisation to facilitate better linkages with external agencies. The central coordinating area would be responsible for training and education across all health professional groups and would be charged with:

- establishing the overall strategic direction for training and skills development across the State based on future service needs;
- providing input into curriculum development to ensure sufficient levels of practical experience are incorporated in under-graduate health education programs;
- examining the feasibility of fast-tracking health professional education to meet workforce shortages;
- exploring opportunities to train multi-skilled health workers in the VET sector with a range of competencies to provide a more flexible and adaptable workforce; and
- expanding transition to work programs so that health professional graduates receive sufficient supervision when first entering the workplace.

Queensland Health should refocus the operation of the Skills Development Centre and staff and resource the Centre to enable it to operate on an expanded basis to promote skills enhancement and training for clinical staff across the State. A clinical director should be appointed and increased resourcing be provided so the Centre can operate as the training hub for staff across the State at least six days a week.

Queensland Health should foster a learning culture across the organisation by:

- designing in-hospital training programs which are linked to service needs and provided equitably across professional groups;
- providing standard entitlements to ongoing training and professional development;
- expanding assistance under the Study and Research Assistance Scheme to include subsidisation of HECS costs
- streamlining approval processes for study leave and professional development attendance.

Queensland should review the level of funding available for education and training across the organisation and seek increased support for teaching clinical students from the Commonwealth.

Districts should receive dedicated budgets to support education and training and these should be linked to student and staffing numbers.

10.8 Planning for the future

It is essential that comprehensive workforce planning underpin all of the above initiatives. Submissions to the review recommend a 10 year planning horizon as it is difficult to anticipate new technologies and treatments beyond this timeframe.

To this end, it is recommended that Queensland Health ensure the workforce planning unit in corporate office includes the following roles:

- 10 year modelling of future workforce needs reflecting projected demographic changes, service planning and models of care and taking account of emerging technology and treatment methods

- Planning for adequate workforce supply across disciplines, in partnership with universities, the vocational education and training sector, medical colleges, professional bodies and the Commonwealth Government
- Monitoring and analysis of key workforce trends including: regular staff satisfaction surveys and exit interviews; long term vacancies by district and discipline; turnover and absenteeism trends; attrition rates; identification of OTDs by district and classification/specialty; and targeted research to improve understanding of nurse wastage rates, factors that would attract former nurses back into the workforce, and longitudinal tracking of a cohort of graduate health professionals to track their career choices and distribution in terms of geographic location and public/private sector
- Working through national forums including AMWAC and AHWAC to undertake more robust, future focused workforce planning including modelling of alternative workforce roles and streams of care and improved data collection for allied health professions.

It would be helpful for the work of this unit to be overseen by a clear governance structure with representation from corporate office, area health services, district representatives and external stakeholders. Whilst this unit would drive high level workforce modelling and planning, area health services will also have a workforce reform function to undertake more detailed local planning and redesign of workforce roles, in alignment with service needs and the Service Capability Framework.

10.14 Recommendation to improve workforce planning

Queensland Health should ensure the Central Office workforce planning unit undertakes the specific roles outlined in section 10.8, to be overseen by a governance structure comprising corporate office, area health services, district representatives and representatives of external stakeholders such as universities, the Commonwealth Government, professional and regulatory bodies.

10.9 The way forward - relationships between Queensland Health and educational organisations

The development of teaching health systems in Queensland and in most western countries has been dependent on the joint development and integration of health service delivery (hospitals, teaching hospitals) with the university sector. This co-development has resulted in a culture of teaching, research, critical analysis, peer review and openness. These have been the hallmarks of health developments in Anglo-American countries and have been characterised as a 'Teaching Health or Learning System'. One system is enmeshed with the other.

As noted previously, Queensland Health provides the teaching, training, educational and developmental environment for universities to educate the clinical workforce. This is a long standing practice. These organisations have not been provided with adequate funding to ensure teaching and training effectiveness for clinical placements in any discipline. Fragmented funding arrangements provide a very modest level of training. The Commonwealth and State Government have long held differing views on their respective funding responsibilities. Observations throughout the State's hospitals reveal a

totally inadequate level of educational, teaching, training and research support compared with what would be regarded as satisfactory, acceptable or safe.

The Review saw repeated instances where doctor, nurse and allied health professional education training was breaking down in work pressured environments, where conflicting objectives and differences of viewpoint about funding abound. In keeping with many of the fragmented and dysfunctional arrangements in the health system, differing Commonwealth and State funding responsibilities and capabilities are inexorably linked in this issue. There has been an on-going argument for over thirty years concerning where responsibility lies for funding clinical placements. In the 1975 Medibank arrangements, the Commonwealth agreed to meet 50% of the net operating costs of State public hospitals. It was inferred that most of the costs of the clinical component of medical training would be assigned to the States' public hospital systems, and so it remains.

Extensive consultation with the education sector has confirmed that these institutions lack of funding to adequately teach and train in clinical settings. In the context of the impending health workforce crisis, the Commonwealth in 2004 acted to provide a contribution towards the practicum component of the training of nurses, formalised in 2005 by designating Nursing and Education (teacher education) as areas of National Priority within the new *Higher Education Support Act*. The issue of funding for the clinical component of training remains unresolved in relation to Allied Health and Dentistry. Notwithstanding this, the amount allocated by the Commonwealth per student seems quite inadequate (some \$1080 for medicine and \$659 for nursing) to provide significant input into the true costs of quality clinical training. Universities are also faced with funding levels that underestimate the true costs of teaching in the clinical health disciplines in the modern clinical environment. For example, universities receive funding for only 75 % of students from one year into the subsequent year, on a compounding basis over four years, (i.e. an initial intake of 10 EFT students into the first year of a program is only funded in the fourth year of the degree for 4.219 EFT students, regardless of actual retention)

A suggested way forward would require meaningful consideration, discussion planning and action along the following lines:-

- Responsibility for undergraduate education and training programs in the health sector has been divided between State and Commonwealth jurisdictions. Significant energy has been spent on blame shifting in relation to this issue. At a time of dire clinical workforce shortage in Australia, a measure of commitment to our future workforce would be to properly fund undergraduate training including essential periods spent in public health systems. This should include teaching and supervision time, the resourcing of necessary program coordinators and the real costs of teaching, training and educational infrastructure, including a reflection of the real student retention rates which approach 90 % in most disciplines.
- The State Government should ensure that the necessary human resources and associated physical infrastructure are provided to ensure effective service delivery whilst accommodating essential teaching and training responsibilities. In a vibrant teaching health system, teaching and research provides the intellectual stimulus to sustain high quality health care. It is unacceptable that staff already overly stretched with workload, should have the additional burden of teaching and training with no compensation or backfilling support.

Infrastructure includes contribution to training rooms and facilities, necessary access to practical application and procedural classes requiring particular equipment and technology and most importantly, the time of senior professionals who can ensure the junior workforce is properly trained and able to deal with the increasing challenges of this sector.

The State should develop a comprehensive training plan across all clinical domains including the opportunity for more team based and group practical training in the workplace, and should engage the Commonwealth in discussions to ensure the best way forward. The cost of this initiative will be significant, but if it is not properly funded, the inevitable consequence will be the breakdown of teaching and training capability, increasing difficulty in attracting and retaining appropriately qualified staff, escalating threats to patient safety and quality, and a deterioration of the health system at a time when greater strength and capacity to handle enormous future challenges is paramount.

Australia surely has an obligation to educate and train its future workforce adequately. Differences of viewpoints about funding do not address problems. The following may provide a way forward.

Recommendation 10.15

Queensland Health needs to explore the following range of jointly funded initiatives or initiatives funded in innovative ways:

- In recognition of the national importance of medical workforce training, the Commonwealth Government be approached to accept responsibility for funding all training posts for doctors (registrars within the public hospital system) and for the funding of dedicated teaching time and/or new positions for specialists, teaching VMOs, as well as trainees (registrars, senior health officers and interns).
- The support infrastructure, medical equipment, practical sessions etc. must be properly planned and funded across the continuum of nursing, allied health and medical training with adequate human resources to support training and service continuity. The investment is significant. International experience suggests that these costs may be approximately 20% of total recurrent costs.
- Networking of teaching and training across hospital and sector boundaries to ensure consistency and access to comprehensive training. For example, trainee specialists accessing learning opportunities in the private sector and private hospital based specialists providing teaching support for specialist trainees in the public sector.
- Unilateral recognition for trained health professional graduates (including medical graduates) with qualifications from countries with similar training requirements and standards, e.g. the United Kingdom, Ireland, Canada and New Zealand.
- Supernumerary preceptor positions and a network of facilities throughout the State to cope with student nursing places and undergraduate allied health workforce placements.
- Pilot programs for new types of health practitioners and new models of care including clinical associates' positions such as physician's assistants and nurse practitioners etc.
- Use simulation, telehealth and teleeducation linkages to enhance integration of clinical placement and academic teaching models with service provision, in a strong Area Health teaching network.
- Integrated models of vocational and university education and training to deliver mainstream health professional qualifications in the more remote parts of the State.
- To ensure Area Health Services are resourced to provide a decentralised Skills Centre network which provides for the clinical needs of health professionals and trainee health professionals in that Area Health Service. Each Area Health Service Skills Centre network would be resourced to provide equitable access to basic clinical skills training and team based training.

11. Asset management and capital works planning to support service delivery

11.1 Overview

- Queensland Health manages an extensive portfolio of assets with a replacement value of some \$6.3 billion and a depreciated value of \$3.5 billion. Seventy nine percent of Queensland Health's assets are buildings, with health technologies accounting for an additional ten percent of the asset base.
- Queensland Health's capital budget for 2005-06 is \$549 million including \$221 million in base funding (for depreciation and amortisation) plus \$328 million for new capital projects. The major focus of the 2005-06 capital program is community and hospital projects, health technology and information and communication technology infrastructure.
- In 2003-04 Queensland Health completed the \$2.8 billion Statewide Hospital Rebuilding Program (SHRP), which replaced and/or refurbished many of the State's metropolitan and regional hospitals. This program was the second largest capital program in Australia, second only to the infrastructure developed for the Sydney Olympics.
- The \$2.8 billion SHRP was unable to address all areas of need, with some areas (eg Mt Isa Hospital and mental health services) being disadvantaged in the setting of priorities with a perception of over-investment in other areas relative to service demand.
- There is a perception that Queensland Health did not receive best value for money from its investment in the SHRP due to a range of factors primarily related to a lack of comprehensive health service planning to inform asset strategic planning and the development of project briefs. In many instances, deficient service planning has resulted in facilities with inadequate capacities.
- Future capital investments will benefit from a greater emphasis on comprehensive health service planning, enhanced asset strategic planning, and development and use of standard design guidelines. This should ensure delivery of health service facilities that integrate best practice design features leading to efficient service delivery. Importantly, the standard design guidelines must reflect the needs of stakeholders ranging from health workers to patients and be informed by learning and experience from previously completed projects from the Statewide Hospitals Rebuilding Program.
- The quality of decision making in relation to selection of locations of new health facilities and whether to build new or refurbish existing facilities was also questioned. Decisions regarding the future location of health facilities must be based on a more transparent patient focused process with location/siting decisions for major new health facilities audited by the Auditor-General on an annual basis.
- The Asset Strategic Plan (ASP) is the primary mechanism for linking service need with asset investment and results in the development of programs of capital works for the department. A more comprehensive asset performance reporting system, supported by post-occupancy evaluations on all projects, is required to facilitate effective monitoring of asset performance and to ensure past learning informs development of better design capability for future projects.

- District concern in relation to a lack of transparency surrounding decision making for the allocation of capital funds and prioritisation of projects on the ASP will be addressed through greater involvement of area health services and districts in the development of the ASP, including increased representation on the Capital Works and Asset Management Committee.
- Queensland Health faces many challenges in funding the capital works program including an unfunded maintenance backlog (once off cost) estimated at over \$300 million. The department has also identified a backlog of maintenance of health technology at between \$7 million to \$10 million.
- There is a general perception within Queensland Health that projects are managed to a budget rather than to a required scope of work. As a consequence, districts across the state have reported that the scope of work delivered did not adequately meet their needs or expectations. The primary cause of this problem is that budgets are set too early in the project development cycle and are based on very preliminary estimates of cost.
- Funding pressures caused by poor project budget definition and unfunded escalation in construction costs on projects has required Queensland Health to redirect base capital funding for use on high priority development projects and to draw on funding from out-years within the rolling capital works budget. These approaches have contributed to under-investment in refurbishment work required to maintain the service capability of existing assets and has created significant shortfalls in funding for the capital works program and ASP in future years.
- The gap between asset funding need and available capital budgets will deteriorate further unless Queensland Health and Queensland Treasury establish a sustainable funding arrangement for the capital works program that will maintain the service capacity of existing assets, the timely replacement of minor and major assets, the recurrent cost associated with capital works projects and to ensure adequate levels of funding are available for the Queensland Health Asset Strategic Plan.
- Several management and organisational characteristics and issues are impacting on the operational efficiency and effectiveness of the Capital Works and Asset Management Branch including a lack of effective business integration and cooperation between some staff and units, and high staff vacancy levels. These management issues are problematic to establishing an organisation adaptable and responsive to delivery of a significant capital works program and meeting the service needs and expectations of health services, and should be addressed.

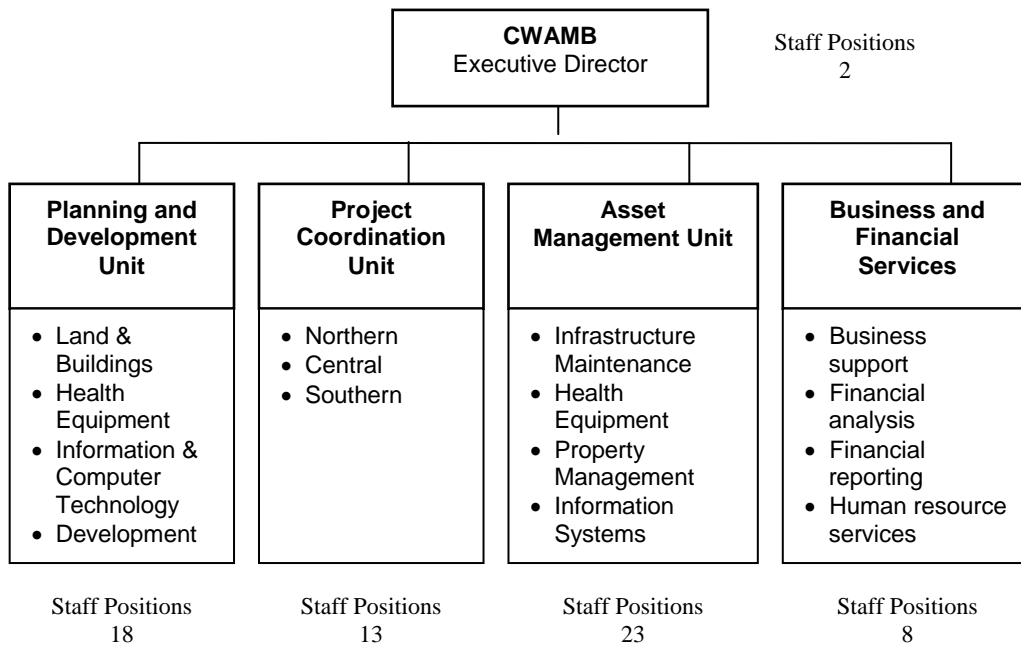
11.2 The focus of the Capital Works and Asset Management Branch (CWAMB)

From 1993/94 the primary focus of CWAMB has been on delivering capital works and asset management projects and services under the \$2.8 billion Statewide Hospital Rebuilding Program. Since completion of this program, several key personnel have left the CWAMB. The loss of corporate and process knowledge and moves to a new organisation structure sees the branch entering a new phase with many management challenges.

The role of CWAMB is to ensure that Queensland Health's physical assets in the form of properties, buildings, and plant and equipment are appropriate for the effective delivery

of health services. A review of CWAMB by external consultants in late 2004 recommended realignment of functions within the branch. The revised structure has an approved staff establishment of 64 permanent positions and five units indicated in the figure below.

Capital Works and Asset Management Branch Current Organisational Structure



Several management and organisational characteristics and issues are impacting adversely on the operational efficiency and effectiveness of CWAMB.

The various organisational units comprising CWAMB appear to have operated historically (personality and culturally based) with a high level of autonomy and insularity which impacts on the effectiveness of communication and cooperation amongst the units. This lack of business integration may partly stem from the recent instability in leadership in the branch which also appears to have hindered development of a team culture in CWAMB.

The recent high vacancy rate (17 percent) in CWAMB, and with approximately 30 percent of total staff positions occupied by short-term acting appointees, together with the current transitional management structures, has undoubtedly contributed to staff uncertainty and impacted on productivity. Not all staff have embraced the new branch structure and management arrangements. Concerningly, some individuals appear to have tended to pursue their own interests and direction and work priorities.

These management issues are problematic to establishing an organisation adaptable and responsive to delivery of a significant capital works program and meeting the service needs and expectations of health services, and should be addressed.

Major building projects for Queensland Health have historically been managed by CWAMB with assistance from the Department of Public Works (DPW) and external consultants. Generally DPW is engaged to manage procurement risk associated with the delivery of built assets. This is in contrast to other Queensland Government departments

where DPW is commissioned and responsible for total project delivery, including project management, design and documentation and procurement risk services.

It is usual practice to outsource the delivery phase of capital works and asset management projects and services. It is more problematic to outsource the planning and design phase, as this work requires a detailed working knowledge of Queensland Health's core business, service plans, asset portfolio structures, and network of relationships with key stakeholders. A model which sees a greater interface and support of CWAMB by DPW and industry is therefore supported. It is also important that specialist knowledge of health service infrastructure design requirements is retained by Queensland Health staff. Although the branch should continue to have a high level responsibility for the three core stages of an asset life cycle (i.e. 'plan it, build it, maintain it'), its involvement should have a strategic planning and coordination focus. The future role of CWAMB should not include the direct management of projects in order to ensure that it maintains a strategic focus and only operates within its demonstrated areas of expertise.

Due to the heavy workload and tight timeframes associated with the Statewide Hospital Rebuilding Program, the branch has not been able to commit sufficient resources to the planning and analysis work required prior to the delivery phase of many projects. If the planning and analysis (strategy) phase is not done well, there is a major risk that the project delivery (implementation) phase will not achieve the desired results, no matter how well project managers manage time, cost and quality or how well service providers deliver services.

The recent restructure of CWAMB strengthens its planning role through creation of a Planning and Development Unit. The new Planning and Development Unit is only partially established. Temporary appointments have been made to senior management roles however many other positions remain unfilled. The role of this unit and linkages to other units (internal and external to CWAMB) has not yet been articulated in sufficient detail to assess whether an appropriate focus on planning and analysis will be achieved.

While the restructure envisaged that enhanced planning would be undertaken within the Planning and Development Unit, the role of the Unit will need to change to reflect the increased responsibility and involvement of districts and areas in project planning and delivery, as recommended in this report.

This shift in responsibilities should lead to a reduction in the Planning and Development Unit's resourcing. To enable the greater devolution of decision making to local levels across Queensland Health will require each area health service to establish capability in asset management. The restructure of Corporate Office recommends the transfer of three planning officer positions from CWAMB to the Area Health Services which will provide a staffing nucleus for the proposed capital works and asset management sections, business support services branches in the areas. The longer term staffing requirement within areas will be determined in the context of the restructure of Queensland Health and the extent of devolution of functions from Corporate Office to the area or district.

As it is expected that creation of the Area Health Services will impact on workload of the CWAMB, staff numbers and skills mix will need regular reappraisal to reflect the shift of responsibility and functions to area and district staff. In this context, once the areas have been established, a review of CWAMB structures, staffing levels and relativity between positions would be warranted.

In hindsight, the lack of standardisation in the design of major health facilities is viewed as a significant shortcoming of the Statewide Hospital Rebuilding Program.

Historically Queensland Health has depended heavily on external architectural expertise for the design of major health facilities. Detailed and considered design briefs were often not provided to architects, instead the department relied on external consultants to confirm current best practice on a project by project basis. This has resulted in the development of health facilities of variable design and criticism that many facilities are not fit-for-purpose or do not support efficiency in infrastructure and health service delivery. It is also purported that, in some instances, the design team was pressured into accommodating design requirements of individual clinicians where views could widely differ, while in other instances the design deficiencies could be attributed to the architectural industry's limited experience and knowledge of the delivery of health services in public hospitals.

CWAMB needs to develop the capacity to provide expert advice and guidance on the design, planning and functionality of health built assets. This expertise is critical in managing the requirements and expectations of clinical personnel and directing health design specialist's inputs to ensure that the built solution considers national and international best practice.

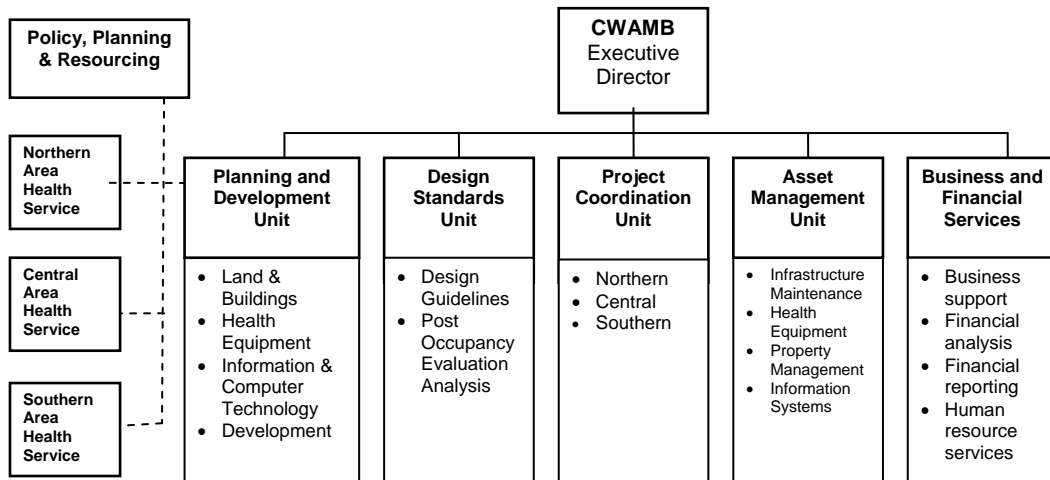
Establishment of a Design Standards Unit within CWAMB is recommended. The unit will be responsible for the development of a comprehensive suite of design guidelines and the maintenance of this asset knowledge through analysis of Post Occupancy Evaluation reviews and stakeholder satisfaction surveys discussed in section 11.7 of this report. The unit will also work with other areas to identify asset planning implications of clinical service best practice approaches.

A unit of five staff positions is envisaged. No increase to the branch staff establishment would be required, with the extra positions sourced from existing units with excess capacity following the transfer of functions to areas and districts.

While it is not envisaged that the unit be staffed by design specialists (eg architects), it would be valuable for staff to possess technical training and understanding of health service delivery and design principles. Staff would be required to brief contract architects on design requirements of health facilities; assist area and district staff to interpret technical plans and project documentation; and facilitate inclusion of health service delivery requirements into capital project design specifications.

A revised organisation chart of the CWAMB incorporating the Design Standards Unit is shown in the following figure.

Capital Works and Asset Management Branch - Proposed Organisational Structure



Recommendation 11.1

- The direct management of construction projects presently undertaken within the Project Coordination Unit should be outsourced to the Department of Public Works who in turn will outsource where appropriate to private sector firms.
- Consolidate Capital Works and Asset Management Branch staffing levels and position relativity in light of expected reduction in workload as area and district health services assume more responsibility for asset management functions.
- Establish a Design Standards Unit within Capital Works and Asset Management Branch with responsibility for developing and maintaining standard design guidelines and planning practices for building health service assets.

11.3 Capital works and asset management governance structures

Concern was expressed by districts in relation to a lack of transparency surrounding decision making for the allocation of capital funds and prioritisation of projects on the Asset Strategic Plan (ASP).

The ranking of projects presented in the ASP often did not reflect priorities assigned by districts and/or zonal offices. Reasons for the reprioritisation of projects were generally not provided giving rise to a sense of disenchantment by district staff with the ASP development process and perceptions of centralised decision making by the Capital Works and Asset Management Branch (CWAMB). Some areas (i.e. Mt Isa Hospital and mental health services) appear to have been disadvantaged in the setting of priorities with a perception of over-investment in other areas relative to service demand.

Prior to December 2004, development of the ASP and capital budget was primarily controlled by the Executive Director, CWAMB with reporting directly to the Director-General. Since December the CWAMB has reported to the Senior Executive Director, Resource Management. This latter position is assisted by the Capital Works and Asset Management Committee (the Committee). The role of the Committee is to ensure that the investment in physical infrastructure and assets is optimized and to achieve the strategic outcomes of Queensland Health, and that the asset base of the department is

sustainable into the long term. Membership of the Committee comprises seven representatives from Corporate Office directorates plus a Zonal Manager. The Committee has no decision making powers, being an advisory committee only.

Under the restructure of Queensland Health recommended in Chapter 5, the CWAMB would form part of Business Services reporting directly to the Chief Operations Officer.

To be fully effective, the Capital Works and Asset Management Committee must have decision making powers to determine individual project priorities and to allocate funding within approved budget limits. Accordingly, in addition to its current responsibilities its governance role must be broadened to encompass performance review of the CWAMB and the monitoring of its accountability for delivering physical infrastructure and assets that support health services outcomes.

Membership of the Committee should be revised to include the Chief Operations Officer responsible for business support services, plus one Area Health Service General Manager and three District Managers (one from each Area Health Service). The area and district members will strengthen health service input and representation and ensure the alignment of investment in capital infrastructure and assets with health service delivery.

Appointment of the Area Health Service General Manager as Chair of the Committee would further encourage a focus on state wide health service outcomes and help to address districts' perceptions that CWAMB has had too much influence over decisions affecting the allocation of capital funding and prioritisation of projects on the ASP.

The CWAMB is dependent on several services provided by the building and construction industry for the effective delivery of Queensland Health's capital works program. Services contracted from industry range from architectural design through to project management and the construction of facilities. The cost and timeliness of completing projects on the program is significantly influenced by the availability and willingness of industry to undertake Queensland Health projects.

Industry is presently reporting that it is operating at near full capacity and facing growing demand nationally and internationally. For the near future, Queensland Health's capital works program will be delivered in competition with other large infrastructure demands in Queensland and interstate which will increase cost pressures and lengthen construction timeframes for projects.

For this reason, it is important that Queensland Health establish closer relationships with industry and seek greater awareness of the challenges faced by the capital works program in the current construction environment. These demand pressures may necessitate that Queensland Health review current infrastructure delivery processes including consideration of closer partnerships with industry and more innovative approaches for project procurement and delivery.

The Department of Public Works, amongst other responsibilities, provides whole of Government advice on planning and investment in government building infrastructure. It is recognised as an authoritative source of advice and intelligence on current developments and emerging trends in the building and construction industry in Queensland that would better inform Queensland Health's current capital works and asset planning processes. To this end, it is recommended that a relevant senior officer from the Department of Public Works be appointed to the Capital Works and Asset Management Committee to provide specialist advice on industry's capability and to guide development

of capital works design and delivery solutions that the contracting sector can most competently deliver. Moreover, the Committee would benefit from appointment of a member with extensive knowledge and experience at a senior level within the building and construction industry. Appointment of a retired senior executive from the industry would avoid any potential conflict of interest issues.

The Committee would have a core structure of eight members with full decision making power. Members on the core committee would be the Chief Operations Officer, one Area Health Service General Manager, three District Managers, Executive Director CWAMB, the representative from the Department of Public Works and the industry expert. The remaining members of the current committee structure would become non-executive (advisory) members with a primary role to contribute to committee deliberations within their areas of special interest.

Recommendation 11.2

- The Capital Works and Asset Management Branch form part of Business Services reporting directly to the Chief Operations Officer.
- The Capital Works and Asset Management Committee be reconstituted as a decision making body (rather than as the current advisory body) with powers to determine project priorities and to allocate funding within the approved limits of the Capital Works Program and Asset Strategic Plan.
- The governance role and functions of the Capital Works and Asset Management Committee be broadened to include responsibility for monitoring performance of the Capital Works and Asset Management Branch for delivering physical infrastructure and assets that support health service outcomes.
- Membership of the Capital Works and Asset Management Committee be revised to strengthen health service delivery representation with inclusion of: the Chief Operations Officer, an Area Health Service General Manager, three Health Service District Managers, a senior officer from the Department of Public Works and an expert from the building and construction industry to provide specialist advice on industry's capability and to guide development of capital works design and delivery solutions that the contracting sector can most competently deliver.

11.4 Health service plans as vital inputs to asset strategic plans

Decisions regarding health facilities in Queensland have often been adversely impacted by a lack of accurate and timely information on current and future health services requirements. Over the last ten years, the main catalyst for the preparation of health service plans has been to support the development of design briefs for specific capital works initiatives (i.e. individual project plans were often not integrated with statewide service needs or priorities). Districts frequently relied on capital works project budgets to fund health service planning as they have had limited funding and expertise in this area. Health service plans were therefore generally prepared by external consultants, engaged by the then Capital Works Branch, with the agreement of the relevant Queensland Health districts.

The lack of an integrated planning approach has contributed to a range of difficulties during the delivery of many capital works projects including scope of work and budget increases, delays to programs and the delivery of facilities with incorrect capacities and functional misalignment. For example, a criticism of the \$2.8 billion Statewide Hospital Rebuilding Program was its failure to provide adequate numbers of acute beds in new and

redeveloped facilities. This has largely been attributed to inadequate service planning including underestimation of future population growth in Queensland, the impact of an ageing population and unrealised expectation that demand for acute beds would reduce as a result of an increased focus on day surgery. Also the expected reduction in service demand at inner-city base hospitals from strategies designed to increase the provision of health services in suburban locations and increase investment in sub-acute and rehabilitation services, has not eventuated. These outcomes have resulted in clinicians being dissatisfied with some facilities provided. A legacy of this previous approach is that health service planning is fragmented and lacks clear corporate leadership within the department.

In recognition of the importance of health service planning to effective delivery of future patient care services, the department formed the Statewide Health Service Planning Unit (SHSPU) in July 2004. SHSPU is responsible for the delivery of discrete health planning projects but is not resourced or responsible for coordinating comprehensive health service planning across all areas of the department.

Some of the larger districts have prepared health service plans, with the zones also assuming some responsibility for health service planning. Whilst this work is to be commended and further work encouraged, Queensland Health personnel report that the quality of the planning is mixed as there is currently a range of different approaches to health service planning used across the department. Service planning needs to be more integrated and the development of a consistent approach is required.

Health service plans should be an integral part of the department's planning processes. Unless there is a commitment to developing and implementing comprehensive patient-focused health service planning, asset plans and the budgets incorporated within them will continue to be flawed. Health service plans not only inform decisions relating to new facilities, but also those relating to existing facilities: what to increase, reduce, modify, replace, what to maintain to a low, average or high quality – in order to provide the right services in the right place at the right time - cost effectively.

Strategies to enhance health service planning within the department are addressed in more detail in Chapter 6 of this report.

The ASP is the mechanism for linking health service need with investment in assets. An analysis of the department's current asset management framework was provided in the Capital Works and Asset Management Branch's (CWAMB) report titled *Capital Investment Review* (November 2004). This report highlights the critical importance of service planning preceding capital planning and the integration of the two processes. The report also found that there is considerable improvement required in the asset strategic plans prepared by health service districts. Identified areas of weaknesses include poor methodologies for estimating capital investment need and failure to link asset need to service requirements. The CWAMB report also notes that ASP has a relatively short time horizon (5 years), relies on a bottom up approach, and lacks a framework for assessing the relative priorities and benefits of different types of services, locations and assets.

CWAMB report that several factors contribute to this situation including:

- The lack of articulation in strategic plans, service plans, and policy documents as to the capital implications or potential capital solutions
- The lack of service plans, particularly at the local level

- Competing forces for the time and attention of senior officers to the ASP process, including a focus on immediate issues rather than long term planning
- Frustration with the level of unmet funding demand
- The lack of skilled officers, and the turnover of those officers, to undertake the ASP process, and more recently
- The structural disconnect from the introduction of the shared services provider model where finance officers in Shared Services, involved in developing the ASP, no longer report directly to asset controllers/owners in districts.

Whilst the current approach relies primarily on districts and business units identifying asset needs, the decision making and notional funding allocation process is centralised in Corporate Office. Alternative models that take account of the corporate strategic position as well as providing local flexibility in decision making are required.

Health planning and asset planning areas need to work collaboratively to explore, understand and agree on the asset implications of their proposals. The CWAMB have recognised the need to liaise closely with Statewide Health Service Planning Unit to ensure that asset planning and asset investment decision making are linked to health service needs. CWAMB will similarly need to link their work to other groups across Queensland Health responsible for developing health service plans, particularly at area health service and district levels and provide a support service to asset controllers/owners.

The Northern Zone has developed a Clinical Services Planning Framework that reflects an approach of defining the service need, determining how the service will be provided and assessing the infrastructure/resources required to deliver the service (human resources, equipment, technology and built assets). This approach would seem to offer a useful model for improving the linkage between health service planning and the asset strategic planning and as such CWAMB should engage with the Northern Zone to define and document the process.

Recommendation 11.3

- The Capital Works and Asset Management Branch develop and implement an improved Asset Strategic Planning process for 2006-07 which recognises the restructure of the department and enhanced capability within areas and revised roles and responsibilities of stakeholders.
- Capital Works and Asset Management Branch conduct an immediate review of the justification and priority assigned to all projects on the current Asset Strategic Plan in the context of Queensland Health's patient service needs and seek re-approval from the revised Capital Works and Asset Management Committee of all Asset Strategic Plan projects.
- Capital Works and Asset Management Branch evaluate the current Northern Zone's Clinical Service Planning Framework as a model for strengthening alignment and linkages between current health service planning and asset planning within Queensland Health.

11.5 Locating facilities to meet health service needs

Several District Managers questioned the quality of decision making in connection with capital works projects including the selection of location for new health facilities and/or whether to build new or refurbish existing facilities. Such decisions should be informed by health service plans that identify what services are required, where and in what quantities and identify the facilities, building services, equipment and other resources needed to deliver those services.

Queensland Health has established health service planning systems that provide high integrity in deciding on locations of new health facilities and ensuring value for money is achieved. Unless location decisions are based on health service planning information, it is all too easy for decision makers to let subjectivity influence the decision, which can lead to dislocation in health service provision and higher capital and operating costs for facilities.

A transparent patient focused decision making process that encourages balanced involvement of stakeholders and technical experts, including clinicians, supported by comprehensive service planning and needs assessment, with independent review by the Auditor-General, is essential to ensure the integrity of decision making surrounding the choice of locations for future health service facilities.

The decision making process should consider a range of factors including those listed below:

- access for patients/consumers to public transport and other transportation infrastructure
- access to other government and non-government health services in the district, area or state
- patient demand drivers
- suitability of sites already owned by the state
- size, accessibility, topography
- suitability of existing buildings for extension or upgrade
- requirement to be collocated with other related entities (such as tertiary teaching institutions)
- space required for future expansion
- nature of development surrounding available sites
- location of a suitable workforce relative to the site.

Judgement will need to be exercised by decision makers about the relative importance of the above factors. Facilitated workshops designed to assist stakeholders work through the evaluation process are an effective mechanism to ensure transparency, document rationale and allow stakeholders to develop a shared understanding. It is important that decisions made in relation to capital works projects are fully documented to enable review from an accountability perspective.

Recommendation 11.4

- Queensland Health base all future decisions regarding the location of health facilities on a transparent, patient focused process that ensures wide community and stakeholder involvement together with relevant advice from technical experts. All decisions should be supported by full documentation, to enable independent review and ensure accountability and probity of decisions.
- It would be appropriate that the Queensland Auditor-General have regard to asset planning and infrastructure decisions in undertaking the annual audit of Queensland Health.

11.6 Capital works program funding arrangements

11.6.1 Alignment of the budget and the scope of work for capital works projects

There is a general perception within Queensland Health that capital works projects are managed to a budget rather than to a required scope of work. As a result, districts and their clinical workforce across the state have reported that the scope of work delivered did not adequately meet patient needs or clinical requirements. Other impacts include higher ongoing maintenance and operating costs and a requirement for further investments in infrastructure shortly after completion of projects. Some districts suggested that it would have been preferable not to proceed with capital works projects rather than deliver them within the constraints of an inadequate budget.

Two main factors contribute to this situation. The first being the process by which the works program is developed and second, the alignment between a project's scope and budget.

Formulating the works program

In the past there have been multiple processes by which projects were identified, approved and allocated capital works budgets within Queensland Health. The department is progressively improving this situation by endeavouring to ensure that the annual asset strategic planning process is the primary mechanism for developing the capital works program. To ensure greater alignment between service need and capital works solutions, it is essential that health districts and areas have a greater role in major facility planning decisions in the context of the annual asset strategic planning process. It is also important that they are closely involved in deciding the priority of projects on the annual works program and the allocating of funding between projects. Bringing the decision making closer to the people delivering and receiving health services should facilitate better outcomes for patients and the health service overall.

Setting budgets for projects

A problem with the current Asset Strategic Plan (ASP) and project approval process is that budgets are often set too early in the project development cycle and are based on very provisional estimates of cost. As a consequence, projects incur budget overruns or their scope is reduced to contain expenditure within budget limits. Budgets associated with capital works initiatives increase in accuracy as project planning progresses. As the design of the site, building and infrastructure progress early assumptions are changed or confirmed and the project cost can be estimated with greater certainty and accuracy. Queensland Health therefore needs to introduce a process that enables capital works initiatives and their associated cost estimates to be progressively refined before a final project budget is formally adopted.

This process for developing appropriate project budgets should be driven at district level and commence with a brief articulation of the specific service need. Such proposals should be incorporated within the District's Asset Strategic Plan and, subject to area endorsement, progress to a more formal business case. The business case is where project scope is better defined and alternative service delivery options canvassed. Area

ASP initiatives should then be refined and prioritised by the Capital Works and Asset Management Committee (CWAMC) to form Queensland Health's ASP. Then and only then should agreed initiatives be subject to a detailed scoping and funding submission and upon endorsement be included in the Department's Capital Acquisition Plan.

Recommendation 11.5

- Health service districts and area health services take a greater role in developing the department's capital works program and associated funding allocations.
- Queensland Health implement a process that enables capital works initiatives and their associated cost estimates to be progressively refined before the final project budget is formally adopted.

11.6.2 Capital and recurrent funding for assets

Maintenance expenditure

The Gross Book Value of Queensland Health's asset base is approximately \$6.3 billion. The department's projected expenditure on maintenance across all asset classes (buildings, information technology, medical equipment and plant and equipment) for 2005-06 is approximately \$100 million and is predicted to average some \$106 million per annum until 2008-09.

Queensland Health's current policy requires a minimum expenditure benchmark of 2.5 percent of operational budgets be spent on maintenance, which is reported as being achieved and in some cases exceeded. Maintenance expenditure on building assets in 2004-05 is reported as \$60 million or approximately 1.2 percent of the gross value of buildings, which appears to be below the level of expenditure recommended by the American Management Association.¹⁰⁸ It recommends that funding at a minimum of 2 percent of replacement value is required to avoid degradation of building inventory over time and recommends funding for maintenance and repair of up to 4 percent of asset replacement value. This appears broadly consistent with Australian research¹⁰⁹ indicating that annual expenditure of 3.77 percent of replacement value is required to maintain the current stock of health assets including buildings, equipment and furniture/furnishings.

Despite Health's current spending level, districts report large backlogs of maintenance tasks and some health facilities are obviously in poor condition. This suggests that maintenance planning processes have failed to identify all priorities or that under funding of maintenance has occurred in the past. Queensland Health has established a backlog maintenance program administered by CWAMB. Base funding for the program is \$3 million per annum. In 2003/04, Queensland Health and Queensland Treasury jointly increased funding for the maintenance backlog program to a total of \$33 million over the three years to 2005/06 with an offer from Queensland Treasury to provide additional (matched) funding of up to \$5 million per annum for the three years to 2008/09. District requests for backlog maintenance funding (for buildings and plant and equipment asset classes) in 2005/06 totalled over \$199 million with approximately \$82 million categorised as priority tasks. The backlog maintenance budget for 2005/06 is \$13.3 million.

¹⁰⁸ American Management Association, D. Coutts, *The Facility Management Handbook*, 1999, p 219.

¹⁰⁹ John Deeble 2002, "Capital Investment in Public Hospitals", *Australian Health Review*, Vol 25, No 5, p 52.

More detailed information is required regarding the current condition and suitability of existing facilities to make an informed assessment of whether this program is adequately funded. CWAMB stated that the district estimates are very conservative and estimate the backlog of maintenance across all districts to be more than \$300 million. Based on these assessments of asset funding need, it would appear that significant additional funding is required to adequately maintain the current built asset base in Queensland Health.

CWAMB are currently working with the Department of Public Works to develop a more useful approach to condition assessments that will provide valuable maintenance planning information. It is important that this issue is pursued to ensure that priority maintenance tasks are identified, funded and addressed before they adversely impact the delivery of health services.

Funding for major assets (new or replacement)

Confusion exists in health districts regarding funding sources for the purchase of major assets (both new or replacement). Queensland Treasury funding of the Queensland Health capital works program has two main components. First an equity component which funds new infrastructure developments, and a second component for maintaining the service capacity of the existing asset base.

In recent years, funding provided as equity has increasingly been tied to specific government initiatives including Election Commitments 2004 and the Smart State Building Fund. For 2005/06, the Capital Acquisition Budget of \$549 million includes an amount of \$328 million equity funding (60 percent) and \$221 million base level of capital funding (40 percent).

Queensland Health is required to prepare submissions (including business cases) as and when required in order to secure special purpose equity/growth funding from Queensland Treasury. This approach allows the Cabinet Budget Review Committee (CBRC) the opportunity to assess whether the investment is consistent with current government policy and consider the priority in a whole-of-government context. In some instances districts have funded significant asset investment projects from operational budgets, in preference to applying for additional funding. This approach reflects the view that there is a significant lead time involved in securing funding and that the likelihood of success is minimal. Whilst expedient, this approach may lead to underspending in other important areas such as maintenance.

Queensland Health has re-directed base capital funds (ie depreciation funding) for use on high priority infrastructure development projects. This practice has contributed to under investment in refurbishment works required to maintain the service capacity of existing assets. Securing adequate levels of funding for the capital works program has been problematic. Factors contributing to past funding pressures include inadequate planning and design guidelines, and poor scope definition and budget setting processes through to impacts largely beyond the control of Queensland Health such as the significant escalation in construction costs.

While Queensland Treasury has provided budget supplementation for some projects in the past, it does not generally provide additional funding for escalation in building costs, thus Queensland Health has been forced to re-scope projects to remain within approved

capital budget allocations and/or to draw funding forward from future base funding provisions within the rolling capital works program budget.

Continued reliance on out-year budgets to fund current projects has created significant shortfalls in funding for the capital works program and ASP in future years. For example, the forward estimates for 2007-08 and 2008-09 of \$242 million and \$191million respectively, are almost fully committed to fund current projects. Uncommitted funding to undertake new works is estimated at only \$49 million for 2007-08 and \$14 million for 2008-09.

The gap between asset funding need and available capital budgets will deteriorate further as facilities constructed over the past 10 to 12 years under the \$2.8 billion Statewide Hospitals Rebuilding Program progressively become due for major refurbishment.

Funding for the routine replacement of assets

The Health Technology Equipment Replacement Program (HTERP) was established by Queensland Health in 1998-99 to provide a mechanism for securing funding to replace major items of health technology equipment. The program's budget varies between \$40 million to \$60 million per annum. The HTERP is funded from within the Department's average annual base capital allocation of \$151 million. There is presently no similar funding provision available to support the replacement of general non-medical equipment. While the HTERP has assisted districts to replace high priority health technology items, CWAMB has identified a backlog of maintenance of health technology at between \$7 million to \$10 million. Currently there is no funding source to address this maintenance backlog.

Comparison between capital demand and available funding

The following table compares the level of funding required to meet capital demand for new and replacement assets with capital budget forward estimates for the period 2005-06 to 2008-09.

| Capital Funding Demand vs Budget | | | | |
|---|----------------|----------------|----------------|----------------|
| | 2005-06 \$M | 2006-07 \$M | 2007-08 \$M | 2008-09 \$M |
| 2005-06 ASP funding requirement | 699.6 | 448.9 | 329.6 | 285.1 |
| Budget (Capital Acquisition Plan) | 498.9 | 312.8 | 241.8 | 191.2 |
| Shortfall | 200.7 | 136.1 | 87.8 | 93.9 |

Source: 2005-06 Queensland Health Asset Strategic Plan

Based on demand and funding projections presented in the table above, Queensland Health is facing a capital funding shortfall of \$518.5 million over the four years to 2008-09. As highlighted above, the department also has an unfunded infrastructure maintenance backlog (once off cost) of between \$200 million and \$300 million and a backlog of maintenance of health technology estimated at \$7 million to \$10 million. While it is recognised that further work is required to confirm the accuracy of the forecasted demand and funding levels, they provide a useful indication of the magnitude of future capital funding problems that, if not addressed, will see further deterioration of the department's asset stock.

Commitment of funds for recurrent costs

In the capital works planning and approval process there is inadequate recognition given to the recurrent cost implications of projects. There is a poor connection between the processes for approving capital works budgets and those for approving operating budgets within Queensland Health. A recognition and commitment is needed to fund districts and areas for increased non-labour recurrent costs associated with a replacement or new building solution. These costs including cleaning, power, security, gas, maintenance and the like should be based on professional analysis of the operating requirements at the time of project planning. In the past, regardless of whether capital works project submissions identified the predicted (non-labour) recurrent costs, approval of funding for the operating costs has not occurred in conjunction with the project approval. Whilst some factors such as predicting operational efficiencies may make it difficult to pursue budgetary issues at the time of project approval, the issue remains that districts do not receive recurrent funding recognition at the time of project endorsement. They may or may not receive additional funding at a later date after the project has been committed, and where additional funding is not forthcoming or is insufficient, districts are forced to reduce expenditure on health services or commit inadequate funds to maintaining the asset.

Recommendation 11.6

- Queensland Health and Queensland Treasury establish a sustainable funding model designed to maintain the service capacity of existing assets, the replacement and purchase of minor and major assets, the recurrent costs associated with capital works projects and to ensure adequate levels of funding are available for the Asset Strategic Plan.
- Revised funding arrangements for the Asset Strategic Plan be established and implemented for the 2006-07 financial year.
- Queensland Health confirm and further refine cost and funding estimates furnished in the report on the Capital Investment Review (November 2004) in respect of future capital investment need, maintenance of the asset base and backlogs of asset maintenance with a view to submission of a consolidated funding request for consideration and discussion with Queensland Treasury by December 2005.

11.6.3 Funding arrangements for planned future health projects

Public pronouncements by Government of planned future health projects (eg. Smart State Building Fund) have caused funding problems to Queensland Health in the recent past. Public announcements of new infrastructure developments invariably include details of the planned facilities and proposed project cost. Generally, the announcements are made several years before construction is due to commence and often prior to the department having conducted any formal planning studies on the projects. As a consequence, the project cost estimates are often only a “best guess” and are not supported by project briefs, detailed service plans or pre-design studies normally used as the basis for developing accurate cost estimates on physical infrastructure projects.

Experience from the recently completed Statewide Hospital Rebuilding Program shows that provisional project cost estimates included in Government announcements often become the default project cost for Queensland Treasury’s forward estimates and the basis of capital budget allocations to Queensland Health.

Detailed planning studies and design work undertaken to progress projects often reveal that the initial project budgets are significantly underestimated. The response by Queensland Health has generally been to reduce a project's scope to contain costs within available budgets. This budget driven approach to project delivery has, on some occasions, resulted in construction of facilities of sub-optimal design, with compromised serviceability and functionality and significant long-term maintenance cost implications as discussed above.

Clearly, the interest of Queenslanders is not served by developing sub-optimal health service facilities built to an unrealistic budget rather than to meet service need and without due consideration of future maintenance costs and total project cost from a whole-of-service life perspective.

Should the Government and Ministers wish to make pronouncements on planned future health projects which include proposed project costs, then these figures should not be used for the purpose of capital funding allocations to Queensland Health. Project budgets and funding allocations should be based on detailed project scoping and preliminary design work subsequently undertaken by the Department.

An initial project budget would need to be established to fund the preliminary planning work and development of accurate cost estimates. Queensland Treasury may also need to maintain a contingency fund to cover necessary increases in project budgets when cost estimates developed during the detailed planning studies exceed the initial publicly announced cost of a project.

In cases where project budgets are fixed and where budget supplementation is not forthcoming from Queensland Treasury, Queensland Health should have the flexibility to delay the commencement and/or completion dates of previously announced health projects where the additional project costs are to be funded from the department's rolling budget for capital works projects.

Queensland Health recently introduced a long term planning strategy aimed at developing preliminary scoping, demand and cost estimates for projects identified on the Asset Strategic Plan. In the near future, Queensland Health will be better placed to furnish indicative cost estimates for Asset Strategic Plan projects should extra funding become available to meet government election commitments or for new priority initiatives of government (eg. Residential Aged Care Funding Program).

Recommendation 11.7

For planned future capital works projects announced by Government, Queensland Treasury and Queensland Health establish and implement funding approaches that will resolve the present under funding of capital works projects which arises when the initial publicly announced cost of a project is significantly less than the cost required to actually deliver the project.

11.7 Information on the performance of existing assets to support planning

There is currently limited meaningful measurement of asset characteristics or structured analysis of how well assets are supporting the delivery of health services in the department. Current measures, where they exist, are inadequate. Queensland Treasury requires that agencies monitor the performance of their assets and report results annually

in their Asset Strategic Plan. Queensland Health's current Asset Strategic Plan only reports information on asset value and capital and maintenance expenditure. No information is currently provided that would enable assessment of the contribution of assets to meeting service needs or whether value for money was achieved from past investment in assets.

Without access to accurate and timely information about the performance of existing assets, it is very difficult for the department to make informed investment decisions that will ensure value for money and alignment between assets and service need. To this end reporting systems are required that measure and track asset performance from both a financial and non-financial perspective.

An identified weakness in management of the Asset Strategic Plan is the absence of a rigorous post-occupancy evaluation (POE) process for capital works projects. Past experience and learning from projects, including satisfaction surveys from asset users, should be captured in order to prevent the recurrence of problems encountered on earlier projects and to inform decision making on future projects and for development of better design capability. POEs should be part of a continuous improvement cycle and asset performance monitoring and reporting system. POEs should be undertaken at the completion of all major construction projects to evaluate delivery processes and facility functionality and maintainability.

Evaluation of delivery performance should involve reviewing the way in which the facility was delivered including procurement methodology, timeframes and stakeholder engagement. Such reviews should include responses from key project stakeholders including area and district management and clinical staff. Where identified as key project stakeholders community and patient groups should also be included in the review process.

Facility functionality should assess how well the facility meets its intended need and expectations developed during the planning phase. Assessments by key project stakeholders including clinical and nursing staff, patient groups and district administration personnel are a crucial component in the evaluation of functional performance. Where standard design guidelines are utilised to inform capital works planning processes, feedback on functional performance, both positive and negative, should be analysed and used to further refine design standards.

The evaluation of facility maintainability should focus on obtaining feedback from maintenance and cleaning personnel on the acceptability of decisions made in respect of the material finish, colour selection and material serviceability (including whole of life). The evaluation should also include the suitability of major plant and equipment selection decisions. CWAMB should develop and maintain a schedule of acceptable products and materials to inform and support planning on future projects.

For smaller projects (e.g. less than \$5 million) the comprehensiveness of the POE process would vary depending on an evaluation of risk and potential to impact on future project delivery, design and serviceability.

CWAMB has advised that it is represented on the National Health Capital and Asset Management Consortium which has been formed with responsibility to formulate standard design guidelines and to develop a POE methodology for use across all Australian health agencies.

The lack of a comprehensive asset performance reporting system has been identified as a problem for many agencies within the public service. A number of Queensland Government departments, including Queensland Health, have been participating in the Queensland Government wide Facilities Management Improvement Initiative (FMII). The aim of one of the component projects is to develop a building asset reporting framework to enhance performance reporting at an agency and whole-of-Government level. The proposed asset reporting framework would appear to be a useful decision support tool for Queensland Health to prioritise capital investments and assess the performance of existing assets.

The performance metrics and performance indicators identified within the FMII *Asset Reporting Framework Report* (June 2005) are listed below. The report also includes proposed measures and measurement scales for each of the following categories:

- *APPROPRIATENESS* in meeting service delivery requirements
 - Capacity (*physical capacity to support level of current and future service activity*)
 - Functionality of facilities (*suitability and flexibility of internal and external facilities for current and future service delivery*)
 - Location (*physical location relative to current and future demand for services*)
 - Condition (*physical condition appropriate for current and future service activity*)
 - Service Potential (*remaining useful/economic life*)
- *FINANCIAL* impact of asset
 - Operating cost
 - Maintenance cost
 - Deferred maintenance
 - Net return on asset value (*revenue-generating assets only*)
- *STATUTORY COMPLIANCE* liability
 - Extent of compliance with Australian Standards, Codes, Laws and Regulations
- *EFFECTIVE USE* of asset as a resource
 - Utilisation Rate of asset
 - Compatibility of use compared to the design purpose of the asset
- *ENVIRONMENTAL* impact of asset
 - Impact of asset on the environment (including site contamination issues)
 - Status in complying with environmental impact ratings against agreed criteria
- *SOCIAL* significance of asset
 - Significance in meeting Government priorities or community obligations (e.g. iconic, heritage, community attachment, cultural significance, Native title etc)

Recommendation 11.8

- Queensland Health, with assistance from the Department of Public Works, immediately trial the implementation of the asset reporting framework developed under the Facilities Management Improvement Initiative in one health district to test the methodology and assess its potential for statewide implementation.

- Capital Works and Asset Management Branch continue development of standard design guidelines and post occupancy evaluation frameworks and implement both approaches as a matter of priority.

11.8 Asset management systems

Queensland Health currently have a multitude of computer based systems supporting asset management operations across the department.

Such systems include:

- **FAMMIS** A SAP R/3 financial and asset management system which captures asset financial accounting information.
- **CMMS** Computer Maintenance Management System, also a SAP R/3 solution focused on supporting planned and responsive maintenance activities.
- **HTCPS** Health Technology Capital Planning System provides information on the replacement planning for Health Technology assets.
- **ASP** The Asset Strategic Planning system is an application currently being trialled within Queensland Health and focused on providing longer term asset planning information upon which to make informed investment decisions. The Asset Strategic Plan has been developed by the Government Asset Management System team and reflects a whole of government approach.
- **HECS** Health Equipment Control System is used by the Biomedical Technology Services Group in the servicing and maintenance of health technology equipment across the Department.
- **DSS** Queensland Health's enterprise decision support system environment.

The Review has indicated a clear lack of integration across the systems with districts highlighting the need to enter similar data into a number of different computer based applications. This duplication of data entry, together with the limited staffing available within a district to adequately maintain the level of information required, highlights concern with the quality of asset information available to support informed decisions.

Previous consultant reviews have confirmed the lack of system integration and recommended a halt of further system development pending a functional review of all major asset systems. This review concluded with the submission of a final draft report dated 15 August 2005. Within this report a total of eight recommendations are proposed, aimed at eliminating duplication, clarifying roles and responsibilities and interfacing and enhancing current systems. In summary, these recommendations propose:

- the replacement of HTCPS with its current functionality being delivered by enhancements to the existing FAMMIS module (including CMMS) and the corporate DSS system
- establishment of a program governance framework to oversee the new work required in transitioning away from the HTCP system
- development of a consistent set of policies and guidelines on asset management and in particular the financial treatment of assets

- the need to clarify roles and responsibilities between districts and the shared services provider.

It is noted that the recommendation to discontinue HTCPS and enhance the functionality of other systems will require a funding commitment in the order of \$1 million, however the report reflects the view that the investment would likely have a pay back period of less than two years.

Whilst yet to be implemented, the recommendations have received overall endorsement within Queensland Health and an implementation funding proposal is being advanced.

Recommendation 11.9

- Capital Works and Asset Management Branch should continue to develop a program for implementing the approved Asset Management Systems Review recommendations throughout Queensland Health, with a finalisation date no later than December 2006.
- Capital Works and Asset Management Branch report quarterly to the Capital Works and Asset Management Committee on progress of implementation of the approved recommendations.

12. Information management to support service delivery

12.1 Overview

Information is a key enabler in the delivery of health outcomes within Queensland. Information management services are distributed across Queensland Health, however information and communication technologies (ICT) are governed and delivered at the corporate level by the Information Directorate. The Information Directorate is responsible for all information technology (IT) development and support functions across the state. This is provided through local information technology support units located in districts to support local infrastructure and systems, and a central IT group responsible for enterprise wide infrastructure and systems. Information Directorate also has a significant role in information management by providing epidemiological, statistical and library services to the organisation.

The Information Directorate has been recently formed with the objective of better managing and integrating information services, in response to concerns regarding the current performance of the information technology function in Queensland Health. These concerns include:

- long timeframes for applications developments
- inability to implement major systems and deliver capital investments within desired timeframes
- high growth of local applications, potentially duplicating corporate investments
- no basis for benchmarking operational costs
- perceptions that the IT ‘tail’ wags the business ‘dog’
- poor benefits realisation processes
- recurrent funding implications of the IT capital works program have not been considered
- understanding the value of many IT investments
- a general focus on process not outcomes
- governance processes that may inhibit innovation
- inadequate IT system support provided in districts
- limited training of users during systems implementation
- unclear funding models leading to a variety of pricing approaches for cost recovery.

The Information Directorate was formed out of separate information management functions that existed in Queensland Health that included a separate strategy/policy function, a statistical and epidemiology function, a central ICT service delivery function and 16 information services units around the state. This environment was characterised by varying service levels, inconsistencies in the breadth of services and standards and a lack of coordination needed to resolve ICT problems.

Information management functions, with responsibility for data analysis and interpretation, also sit within various other Corporate Office units, public health networks and in districts.

The Information Directorate has commenced the process of reforming its governance and service delivery capability in response to the concerns outlined and the needs of districts. At the time of this Review, the Information Directorate reform initiative had not had time to be visible at the district level. This is both acknowledged by Information Directorate and evident through the district consultation.

12.1.1 Information technology governance

The Information Directorate oversees an annual budget of approximately \$191.5 million based on 2005-06 figures. This consists of an operating component of \$107 million and a capital budget of \$84.5 million. The responsibility for ICT investments is governed by the Information Directorate and sponsoring directorates through the Information Strategy and Investment Board.

The Information Strategy and Investment Board, being the peak management body for ICT in Queensland Health, is charged with ensuring that the investment in ICT is optimised to achieve the strategic objectives of Queensland Health.

12.1.2 Information technology planning

Queensland Health undertakes an annual information management planning process that results in the Queensland Health Information Management Strategic Plan. This plan is required to be developed under the *Financial Management Standard (FMS) 1997*. The Queensland Health Information Management Strategic Plan has a five year planning horizon and is one of four strategic plans that underpin the overall Queensland Health Strategic Plan. The other three supporting plans are for Assets, Workforce, and Safety and Quality.

Information Directorate also develops an annual Operational Plan that describes how they will deliver on the directions set out in the Information Management Strategic Plan.

12.1.3 Organisation of Information Directorate

Information Directorate has a total of 984 staff, consisting of 606 permanents, 232 temporary employees, 118 contractors and 28 trainees/graduates.

The Information Directorate is currently in transition from a previous structure to a new model of operation. The new model is based around the four key functions of Planning, Brokerage, Utility and Performance. These functions are implemented as four key Branches as follows:

Planning

The InfoInvestment Branch is responsible for information strategy, governance, planning, pricing, standards and compliance. This Branch also has a leadership role in relationship management with key customers, in research to track emerging technologies and learning from other organisations.

Brokerage

The InfoSolutions Branch is responsible for working with system sponsors to acquire and deliver systems that are affordable, functional, sustainable and that meet business needs. The focus is on developing the capability required to broker solutions and manage project delivery through partnerships with the ICT industry. This area assists the business to develop requirements and facilitates procurement processes. They will ensure appropriate governance over the acquisition process and manage architectures and alignment. Their role will include limited internal development, where the focus is on innovation, new technologies, and where the business cannot get better value elsewhere.

Performance

The InfoService Centre provides the point of contact for IT support and advice across the state by providing a single point of contact for customers. The Centre aims to resolve calls at the point of contact with minimal referrals to other specialists. The Service Centre is responsible for monitoring and reporting on service performance.

Utility

The InfoOperations Branch is responsible for the technical management of networks, hardware, desktops, software, and enterprise wide applications. This Branch aims for operational excellence in delivering a complete ICT service. InfoOperations is also aiming to harness economies of scale in managing ICT assets.

The Information Directorate has proposed transforming the Health Information Branch (which has data management, statistical, epidemiological and library functions) into a fifth area called InfoAccess. This process was put on hold pending the outcome of this Review.

The Information Directorate is focusing on enterprise wide applications which are defined as applications that:

- perform specific functions to directly support mandated health service functions, processes and procedures; or
- store data for which policy, regulation or legislation requires a level of security that cannot be assured locally; or
- have been categorised as very high or extreme risk in the Queensland Health Integrated Risk Management Framework.

Applications that do not fit this definition are classified as local applications. Local application services are planned to be located in Health Service Areas and Districts, and a process is underway to separate out staff of the InfoOperations Branch that support enterprise systems from those supporting local applications. Staff supporting local applications will become district employees.

The Transformation project has been established as the change agent to improve performance and encourage a more customer focused culture in Information Directorate. The Transformation project is structured around a program of work aimed at defining new functions, processes and systems needed to attain a quality service delivery capability in Information Directorate. The Transformation project is positioning the Directorate for the two to five year horizon.

12.2 Current project initiatives

There are currently 44 projects being managed within the ICT Capital Acquisition Program. A general update of these projects is provided to each Information Strategy and Investment Board meeting. A more detailed formal assessment was undertaken in January 2005. At that point in time there were 45 projects underway with the following status:

- 5 projects were progressing successfully and given a green status
- 28 projects were assessed as having some risk of failure and required assistance to improve the outcome. These projects were given a yellow status
- 12 projects were identified as having significant risks and were given a red status.

The 44 current projects have been consolidated into five major programs being:

- the Clinical Informatics Program (CIP)
- the Resource Management Program
- the Decision Support program
- IT Infrastructure
- Infostructure.

Each of the projects in these five programs is briefly described in Appendix 12.1.

12.3 Key systems

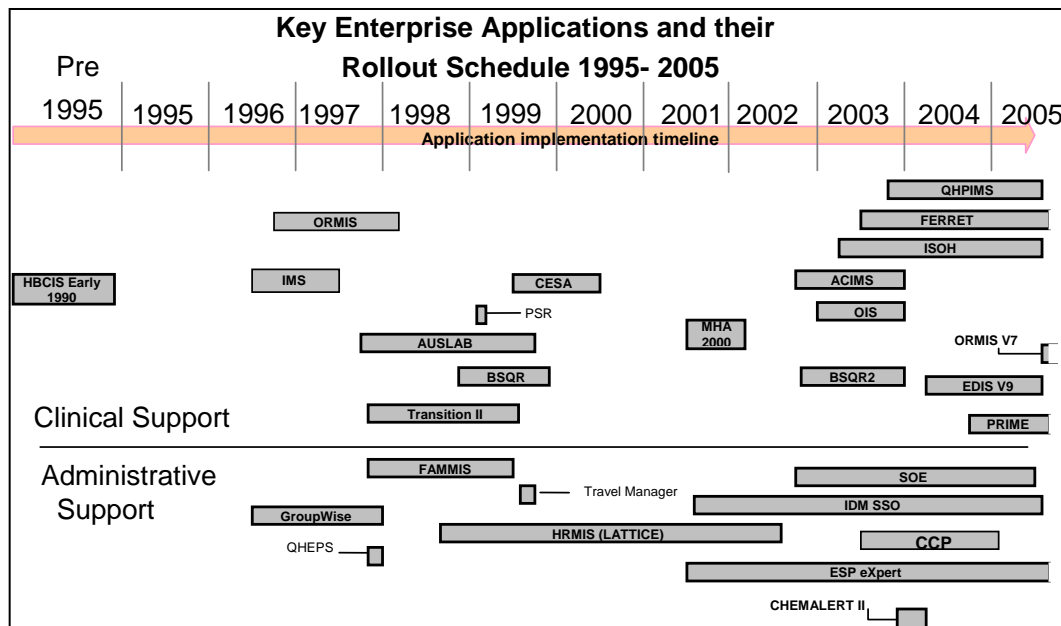
Within Queensland Health, applications are classed as either enterprise wide or local. There are estimated to be in excess of 7,000 local applications in use in districts and this figure is growing quickly with many small applications being developed to meet specific local needs and/or to cover the slow delivery of enterprise systems supporting clinicians.

For a system to be classified as enterprise wide, it must be endorsed by the Information Strategy and Investment Board.

Not all enterprise wide systems are supported by the Information Directorate. For example, systems such as the AUSLAB pathology system, the FAMMIS financial and materials management system and the Lattice human resource management system are used across the state, but they each have support units within directorates other than Information Directorate.

The table in Appendix 12.2 provides a list of currently supported enterprise wide systems, including their acronyms and descriptions.

A broad timeline for the historical rollout of enterprise systems is provided in the following diagram:



The above rollout schedule of enterprise systems and the 44 projects listed on the IM/ICT Capital Acquisition Program suggests priority has been given to development of administrative and clinical activity reporting systems rather than to systems that provide point-of-care support for clinicians.

Whilst the Clinical Information System Project has a clinical systems focus, its development has been protracted and core information needs of clinicians remain largely unmet.

Higher priority needs to be accorded to providing point-of-care support systems for clinicians. If this need cannot be met in a timely way through the enterprise wide strategy, then a short-term strategy that will achieve rapid implementation of clinical point-of-care applications (for example in targeted areas such as medical specialty, surgical specialty, allied health and community health etc) must be instituted as a practical demonstration of Information Directorate’s capacity to effectively deliver support systems for clinicians.

12.4 Governance of ICT

12.4.1 The Information Strategy and Investment Board (ISIB)

The ISIB was formed in recognition of the need to improve ICT governance through better alignment of IT strategies with health service needs and improved investment processes. The ISIB has three primary roles:

1. directing strategy, priority and sequence of programs and projects ensuring the ICT portfolio is relevant and supports corporate and operational outcomes
2. monitoring, evaluating and supporting ICT investment and benefits management within a governance and investment environment to achieve effective outcomes

3. approving and endorsing strategic information plans, frameworks and policies that support legislative obligations and improve health outcomes.

The governance required to bring the portfolio of planned investments back under strict project controls and into alignment with the evidence based needs for clinical and administrative systems should not be underestimated. The formation of the ISIB, under new terms of reference and with senior representation, is fundamental to achieving alignment between ICT directions and the health services provided by Queensland Health.

The InfoInvestments Branch of Information Directorate is now responsible for supporting the ISIB and is in the process of developing new strategies, processes and practices to assist the ISIB to effectively manage ICT in Queensland Health. Areas of notable gaps, such as budgeting recurrent costs as part of original investment proposals and managing benefits realisation, are being addressed by the InfoInvestments area.

The overall proposed governance approach for ICT investments and strategies appears sound. With a strong focus on governance, there is a lesser attention to innovation and generating enthusiasm for what might be possible as a result of advances in ICT. While no ICT initiative should proceed until it is adequately sponsored and resourced, Information Directorate's role must also include scanning of the market place and innovations occurring in districts so as to educate and alert the ISIB and potential sponsors to the possibilities.

The view encountered in districts was that a disconnect exists between Corporate Office decision making and districts in regard to ICT investments. Districts feel alienated from the decision making process.

The current membership of the ISIB may be contributing to the view being expressed by districts. The membership is currently heavily weighted to Corporate Office decision making, with six members being from Corporate Office, one being the State Manager of Pathology and Scientific Services, and one zonal manager.

If improvement in health outcomes are to be achieved, particularly through development of clinical support systems, a dominant representation on ISIB is required from area health services and districts. Increasing the service delivery representation will also help to remove the tendency to blame ICT failures on Corporate Office decisions and encourage greater buy in and ownership from area health services and districts in the implementation process. Dominant representation by area and district staff on ISIB will strengthen alignment between ICT directions and health services delivered by districts.

It is important for the proposed Chief Operations Officer position, responsible for business services, to be an active member of the ISIB if this committee is to ensure ICT is appropriately supporting clinicians and health service delivery within Queensland Health.

Recommendation 12.1

The current membership of the Information Strategy and Investment Board is immediately revised to include the Chief Operations Officer and to ensure a dominant representation from area health service and district managers.

The terms of reference of the ISIB broadly cover all aspects included in the delivery of ICT in Queensland Health. The two major components making up expenditure in ICT are:

- a capital expenditure of approximately \$85 million per annum on ICT
- an operational expenditure of over \$107 million per annum on support of ICT.

In practice, the role of ISIB has been heavily focused on managing ICT strategy and the major investments covered in the Capital Investment Program. There is no specific reference in the terms of reference to managing operational expenditure, and this has been confirmed by Information Directorate management as being outside the scope of ISIB.

The majority of this operational expenditure is incurred by Information Directorate, who is an internal provider within Queensland Health. Information Directorate's service delivery capability has attracted a high level of criticism from districts. This is acknowledged by Information Directorate management as a critical area for performance improvement by the new organisation.

This service delivery capability must be sourced appropriately and performance managed to ensure value for money is also being achieved for the operational expenditure on ICT. Information Directorate is progressing to develop an appropriate performance management framework to ensure that the quality, service delivery, costs, and capabilities are in line with health service needs and industry benchmarks. If this is not successful, there is a significant risk that basic service delivery quality issues will overshadow attempts to focus more strategically on ICT governance.

The InfoInvestments area in Information Directorate is currently responsible for performance monitoring of the Directorate's service delivery capability. This arrangement lacks independence from Information Directorate. The proposed arrangement also lacks openness and accountability to customers. Information Directorate are currently required to report performance only through line management accountability mechanisms.

This provides customers in health service districts with no visibility of service delivery performance of Information Directorate, who are mandated to provide internal services. Customers do not have the opportunity to purchase enterprise wide services elsewhere. In an internal model, such as that with the Information Directorate, a service delivery framework is required that gives customers both visibility of performance and the ability to performance manage the supplier in the event of poor performance.

The ISIB must have a role in governing the performance of operational expenditure and its' terms of reference must explicitly state this. The ISIB should establish a separate Operations Board of senior district and area health service representatives to provide independent advice to them on the performance of Information Directorate's service delivery function. This would allow the ISIB to include this within their terms of reference without overly burdening the committee with operational performance issues. The Operations Board would be chaired by a district or area health service representative and supported by the InfoInvestments Branch.

This Operations Board must have a charter to determine if Information Directorate are operationally focused in the right areas including supporting staff to provide better health services and is providing a cost effective service to customers. This will require the Operations Board to have access to service level metrics and costing data. The

Operations Board should be given a direct accountability to advise ISIB on the appropriate level of annual operational funding for ICT and any productivity dividends that could be expected as a result of quality improvements.

Recommendation 12.2

An Operations Board, chaired by a district or area health service representative and with strong district representation is to be immediately formed as an independent advisor to the Information Strategy and Investment Board on the performance of the Information Directorate.

There is a significant body of work to be finalised before Queensland Health can effectively manage its investment in ICT. The InfoInvestments Branch has been charged with implementing processes to ensure better management of investments, particularly around concept and business case development, monitoring performance and managing benefits realisation. The need for this work is essential and strongly supported by the Review findings. The recommendations above are aimed at further strengthening the governance of ICT through better alignment of investment with health service need and enhanced performance monitoring and accountability to customers.

12.4.2 Planning and performance management

The Queensland Health Information Management Strategic Plan 2005-2010 provides a clear overview of the principles and objectives that guide Information Management in Queensland Health. It also provides basic information on seven strategic initiatives, some internal to Information Directorate. These initiatives document strategies and processes that will be developed rather than deliverables. The strategic initiatives do not strongly link to priorities around health outcomes and clinical practice. The focus of the initiatives is on getting the ICT architecture and infrastructure in order. It is recognised that these areas do currently need attention, but this must not be to the exclusion of initiatives that are based on patient and clinical centric outcomes.

The current Information Management Strategic Plan does not provide a clear picture of the outcomes that will be achieved with the capital investment occurring over the next five years. Further, the plan does not document any measurable performance indicators for Information Management in Queensland Health. These gaps need to be corrected in future strategic plans, with the primary focus of strategic initiatives being to support improved clinical practice and health outcomes through providing effective information systems to doctors and clinicians delivering health services to Queenslanders.

The next layer of planning involves developing an Operational Plan. The Information Directorate Operational Plan describes the role and functions of the Information Directorate and maps out in more detail the activities that each of the Branches will undertake in delivering the initiatives identified in the Strategic Plan. There is a strong linkage between the Strategic Plan initiatives and the Operational Plan. This is working well. There are, however, no performance measures documented in the Operational Plan.

The overall planning processes for IM/ICT appear to be basic in nature, which reflects the current maturity level of the newly formed Information Directorate. The strategic planning process does not provide the required five year view of how an estimated \$400 million spend on ICT initiatives will support health outcomes and clinical practices, or how performance will be measured. The Information Directorate need to develop the

capability and capacity to gather and analyse the ICT needs across Queensland Health as a basis for strategic planning.

The long term implications of the ICT capital program on recurrent costs are also not currently well understood. The ICT capital program is creating new assets, beyond those that exist today. This will result in an increased expenditure on ICT support over the coming years. For example, if \$400 million is invested over five years then, based on a 15 percent support cost, this would increase ICT support costs by \$60 million per annum. It is not currently known if the cashable savings generated from the investments will generate enough annual savings to fund this increase or if there will be a shortfall. This needs to be monitored and managed closely by ISIB and investments with no commitment to fund recurrent expenditure need to be avoided.

The InfoInvestments area is currently in the process of implementing a clear methodology to prioritise potential investments balanced against risks, benefits and strategic priorities. This process will provide better strategic management of bids for capital expenditure, with a focus on matching bids against strategic needs and managing ongoing benefits realisation.

The major concern identified through investigating the planning process is the lack of performance measures found. This seems to be endemic through the planning and governance arrangements. A framework needs to be established that links strategic performance indicators for ICT down through operational performance indicators. The ISIB needs to be able to assess if ICT strategies and initiatives are effectively supporting the organisation (through operational delivery of ICT services) and make adjustments where necessary.

Recommendation 12.3

The Information Management Strategic Plan initiatives focus on priority areas that will improve clinical practice and health outcomes which is built from detailed gathering and analysis of needs in districts. This must include CHIME and PRIME.

12.5 Organisational structures

The overall Information Systems Delivery environment in Queensland Health is recognised as being in need of improvement. This is evidenced by many factors including:

- A history of significant problems with enterprise applications, which can be partly attributed to quality issues in the central IT function.
- Clinical staff in Queensland Health often lack the information management skills to specify their needs and manage the associated change required for successful delivery of ICT eg ICT projects are often viewed as technical solutions that are the responsibility of IT to deliver, rather than as an opportunity to improve work practice and productivity afforded by use of new technology.
- A very low satisfaction level with the delivery and support of ICT services, which is not underpinned with performance monitoring or quality support processes.

The Information Directorate has specifically recognised the quality issue concerns and is investing significant resources into leaping forward in maturity in terms of both governance and service delivery capabilities. This is being addressed through an initiative called the Transformation Project. This project has been thorough in its assessment of the issues and put in place a structured program of work that, if successful, should turn around the performance of Information Directorate.

The Transformation Project is positioning the Information Directorate for the two to five year horizon, with little tangible short term results for clients. This is a complex change management initiative aimed at reforming the business processes and practices of Information Directorate. This project has a higher likelihood of succeeding than many of the IT initiatives reviewed, as the project has appropriately resourced the business process standardisation and change management, prior to implementing the internal IT systems proposed for Information Directorate. This project is, in fact, following a similar model to the one that has been proposed by the Review for all IT initiatives in the Department.

The major risk faced by the Transformation Project is the long lead time before tangible results will accrue. Implementing the IT recommendations of this Review will produce the needed short term results. The longer term gains from the Transformation Project will be less at risk if they can leverage off some short term tangible results.

There is a further risk that Information Directorate, even post the transformation project, will become overly bureaucratic and control focused. The Operations Board, recommended in section 12.4.1 must have a role in mitigating this risk and ensuring Information Directorate focus on service delivery outcomes.

12.5.1 Benchmarking

Information Directorate currently has 984 full time equivalent staff. This number is broadly broken down as follows:

- There are 580 staff providing the operational support (i.e. keeping the systems running) for all Queensland Health applications, infrastructure, networks and computers. 407 of these staff are located in districts, with the remainder being in Corporate Office supporting enterprise wide applications and infrastructure. It is expected that 70 staff in Information Directorate will be devolved back into districts as a result of the devolution of local applications support.
- There are 41 staff involved in providing a first point of contact Help Desk for ICT problems.
- There are 153 staff involved in managing or developing new applications.
- There are 89 staff in the Clinical Informatics Program, which is the largest IT initiative currently underway in Queensland Health. These staff should be surplus to requirements (or available for new project) at the conclusion of this project.
- There are 41 staff involved in managing IT strategy, policy and investment decisions.
- There are 68 staff involved in Epidemiology, Statistical Analysis and Library services.
- There are 12 staff involved in administering the Information Directorate.

The following table provides a breakdown of Information Directorate staff who are located outside of Corporate Office. It must be noted that staff in these locations often provide service to more remote locations e.g. support for Roma is provided from Toowoomba.

| Southern Zone | | Central Zone | | Northern Zone | |
|-----------------------------|------------|---------------------------|------------|----------------------------|-----------|
| Southern Zone Office | 4 | Central Zone Office | 12 | Northern Zone Office | 7 |
| Bayside | 6 | Brisbane City | 16 | Cairns | 23 |
| Gold Coast | 22 | Central Qld | 22 | Townsville | 32 |
| Logan-Beaudesert | 11 | Chermside | 30 | Mackay | 13 |
| Princess Alexandra Hospital | 46 | Herston | 70 | | |
| QEI | 10 | Sunshine Coast | 23 | | |
| Toowoomba | 20 | Wide Bay Burnett | 17 | | |
| West Moreton | 23 | | | | |
| Southern Zone Total | 142 | Central Zone Total | 190 | Northern Zone Total | 75 |
| Total: 407 | | | | | |

Separate from Information Directorate, there are also 30 staff performing IT related duties for human resource and financial systems that transferred to the shared service provider.

In summary there are 621 in operations (estimated to reduce to 550), 242 in projects, 41 in strategy, 12 in administration, 30 in Finance and Human Resource systems, and 68 staff are not IT related (i.e. Information management staff recommended in section 12.6.1 to be located in the Performance Directorate). Excluding the 68 staff not performing IT duties, Queensland Health has a total of 946 staff in the IT function.

The Information Directorate oversees a total budget of approximately \$191.5 million based on 2005-06 figures. This consists of an operating component of \$107 million and a capital budget of \$84.5 million and represents 3.5 percent of the total Queensland Health budget. The operating budget of \$107 million can be further categorised into:

- Information Directorate labour and administrative costs of \$64 million.
- Asset replacement (e.g. PC replacement) for Queensland Health of \$13 million.
- System hardware maintenance and licensing fees of \$19 million.
- Communications (e.g. Wide Area Network) of \$7 million.
- Other (e.g. grants, library subscriptions etc) of \$4 million.

It is estimated that the total healthcare IT market in Australia is worth \$1.7 billion. Given total health system expenditure of approximately \$55.3 billion this represents an investment of approximately 3.2 percent in IT.¹¹⁰

This shows Queensland Health slightly above the national average, although it must be noted that benchmarks vary greatly in the health IT area ranging from 1.5 percent reported in the UK up to 6 percent reported in USA.¹¹¹

The Queensland Government's total annual expenditure on ICT is approximately \$1 billion, on an estimated \$25.67 billion total expenditure for 2005-06. Therefore, on average, Queensland Government spends 3.8 percent on ICT. Queensland Health (3.5 percent) is slightly below this average and accounts for 19.2 percent of the total

¹¹⁰ Fujitsu, Achieving Benefits from Investments in Health IT, 2003

¹¹¹ Derek Wanless, Securing our Future Health: Taking a Long Term View, 2002

Government spend on ICT. Queensland Health makes up 23.6 percent of the Queensland Government workforce and 20.8 percent of Queensland Government expenditure. These comparisons do not show a significant variation from average, albeit Queensland Health's ICT expenditure is slightly below the average.

A general international benchmark for the health sector for total IT spending is 4.9 percent of budget, with capital spending accounting for 1.7 percent. Queensland Health's comparative expenditures are 3.6 percent and 1.6 percent respectively. On this international benchmark, Queensland Health compares well with the capital spending, but is more in line with a lower Australian Health Sector and the Queensland Government benchmark for operational spending.

In the area of staffing numbers, Queensland Health employs 946 staff in information technology roles. This equates to approximately one IT staff member to every 46 Queensland Health full time equivalent employees. This is slightly above a general "all industries" benchmark of one IT staff member to every 50 staff. The differential on this benchmark suggest that there are approximately 75 too many staff.

There are estimated to be 3,960 ICT employees in the Queensland Public Sector. Queensland Health accounts for 23.8 percent of these staff, noting that the total number excludes several agencies that have outsourced their ICT. This again compares well in regard to Queensland Health's relative size (23.6 percent of Queensland Government workforce and 20.8 percent of Queensland Government expenditure).

Comparative staff numbers in the IT area have also been made available from New South Wales Health. Recognising that New South Wales Health employs approximately double the number of staff that Queensland Health does, it would be expected that Queensland would have a proportionally smaller IT area. Looking at the three broad IT areas of strategy, projects, and operations, this assumption holds true only in the strategy area. In the projects area, Queensland has more staff than New South Wales, however this is directly related to the level of project work underway, and is of no major concern. Staff numbers in the project area will increase and decrease depending on the number of projects underway. In regard to the operations area, base staff numbers are similar, highlighting that Queensland may have opportunities for productivity improvements in the operations area. This comparison can not be used to draw a conclusive recommendation, as the systems in place for support of IT are considerably different between New South Wales and Queensland, making direct comparisons difficult.

General benchmarking data indicates that the ICT function in Queensland Health is broadly resourced to an appropriate level, but does point to the potential for productivity improvements in the operations area. However, due to the general nature of benchmarks, and the lack of detailed benchmarks that compare other factors such as complexity and industry specific factors, this conclusion should be taken as a guide only.

12.5.2 Centralising versus decentralising the IT function

The question of a centralised versus a decentralised IT function must be considered in terms of delivering the best outcome for patient and clinical needs. It is these outcomes that must drive ICT priorities and strategies.

The benefits of a more decentralised approach to the ICT function include:

- The ICT support for clinical and patient needs would be close to the coalface, resulting in responsiveness to needs.
- New systems that are developed would be more likely to be owned and optimally designed to meet clinical and patient needs.
- IT strategies and priorities would be conceived by those responsible for health services, rather than by IT people.
- The ICT function would be more flexible and agile in meeting local needs.

The benefits of a more centralised approach to the ICT function include:

- Much greater ability to interchange data and support external connectivity across the continuum of care.
- Efficiencies can be achieved from one system servicing 37 districts as opposed to 37 different solutions.
- Greater consistency in data capturing, interpretation and analysis to support area and corporate service planning.
- Systems integration is feasible and more cost effective.
- Removes overlap and duplication.
- Easier to maintain ICT skills with a larger scale.
- Greater consistency in ICT support processes.

It is clear that to achieve the best result for clinical and patient needs requires a balance to be struck between the level of centralisation versus decentralisation. Either extreme would result in many of the important outcomes being missed. To deliver these outcomes, the model proposed is one of centralised coordination and management of the ICT function, but with ICT services being delivered as close to the coal face as possible (i.e. decentralised physically).

The proposed model is captured as follows:

- The overall management and coordination of the ICT function is centralised.
- ICT strategies and priorities are determined by the ISIB with support from the central ICT group. Strong processes of engagement are needed to ensure ICT priorities and strategies are driven by clinical and patient needs. The central IT groups focus in supporting ISIB must be to drive processes that ensure strategies and priorities are developed and owned by the stakeholders (i.e. strategies and priorities should not be developed by IT staff, they should be reflecting the needs identified through strong engagement processes).
- ICT service delivery performance is managed by an Operations Board with independent accountability to the ISIB.
- The development of new IT systems must operate as a decentralised function, although working to consistent and coordinated processes from the central group. ICT development projects would exist within a business group under a sponsor for the duration of the project. This could be a district taking on the role of developing and piloting a new solution prior to it being rolled out enterprise wide, or a system wide sponsor driving the project at a state wide level. The ICT expertise for these projects needs to be coordinated and sourced from the central

pool, but is accountable to the business sponsor for the duration of the project. The business sponsor is accountable back to ISIB for the projects performance. Information Directorate would source the ICT skills and expertise and provide methods, architectures and standards for the ICT development. Information Directorate still have a significant role to play to ensure the system integrates with the overall ICT environment and to ensure the ICT project has appropriately skilled resources. Project related issues are discussed in more detail in section 12.7.

- The operational ICT service delivery function continues to be provided by IT staff who are on the ground in districts, but accountable back to the central ICT management group for consistency and quality of service.
- In the problem resolution area, there needs to be a shift to more remote resolution of problems to increase efficiency and timeliness of problems being fixed. The number of ICT staff stationed in districts is unlikely to alter greatly if the numbers of supported devices increase in line with the recommendation of this Review. The recommendation to increase the number of devices in districts is documented in section 12.8.2.

Structurally, this model is not dissimilar to that being implemented by Information Directorate. However, there is a distinct difference in the organisation of governance and accountability. There is a much stronger accountability placed on Information Directorate for meeting service delivery expectations, managed through the Operations Board. Conversely there is a much greater accountability on area health services and districts for driving ICT strategies, priorities and delivering new systems.

Recommendation 12.4

Queensland Health continue to centrally manage and coordinate ICT resources with specific ICT functions delivered within the following parameters:

- ICT strategies and priorities are to be driven by clinical and patient needs, which are gathered and reported to Information Strategy and Investment Board by Information Directorate.
- New ICT systems are developed by systems sponsors, with all project staff reporting to the system sponsor for the duration of the project. The sponsor is accountable to Information Strategy and Investment Board for the performance of the project. Information Directorate will source the ICT skills and provide the methods, architectures and standards to be met in the ICT development.
- Information Technology Units will continue to be located in districts to meet the on the ground needs for ICT support.

12.5.3 Alignment with organisational structures

Having established that there is a requirement for centralised management and coordination of the ICT functions, it now needs to be determined where this function should fit within the organisational structures. Sourcing strategies for a centralised ICT function also need to be considered.

The ICT function has both a policy/strategy coordination role and an operational role. These functions are best kept together to ensure that the operations areas are delivering technical services that meet the overall strategy for ICT in Queensland Health. A separation of these functions would likely result in a larger ICT strategy/policy role and

the need for additional compliance activities to ensure the operations area(s) are delivering appropriate solutions. Given the complexity of the ICT agenda and the importance of it being successful, the additional layer of bureaucracy associated with separating strategy and operations is not warranted and would add little value to the outcomes.

The fundamental accountability for performance and strategic alignment of the ICT function sits with the ISIB. This is a subcommittee of the board of management. While this governance arrangement continues at this level in the organisation, the ICT function should be held directly accountable to the Board. The performance of ISIB will be a key determinant in the success of ICT in Queensland Health.

The Information Directorate is predominantly providing a support service to the organisation. Structurally therefore, the Information Directorate would logically fit within the proposed Chief Operations Officer section of Corporate Office.

Recommendation 12.5

That the Information Directorate structurally report to the Chief Operations Officer, but is directly accountable to the Information Strategy and Investment Board for ICT strategies, priorities and performance.

Sourcing options for information technology services include internal provision, outsourcing or a combination of the two. The current approach of Information Directorate is largely internally sourced, with the exception of large system developments which are often tendered for in the open market.

A fully outsourced model for ICT services would be difficult to pursue, given the current maturity of ICT services in Queensland Health. Significant productivity and improvement can be expected from Information Directorate over the coming years, particularly in the InfoOperations area. Outsourcing a service in an environment where the longer term ICT needs are not well known or defined would place the organisation at significant risk of ICT being more costly and not well aligned to needs.

In the current environment, an internal approach, which is focused and rewarded for improving service delivery, will produce greater dividends. Supplementing internal capabilities for large projects or where skills are not available internally should also be pursued. It is acknowledged that Information Directorate are currently supplementing skills with external partners, and this approach should continue.

In particular, alternative sourcing arrangements need to be pursued for new applications development. Sourcing internal skills in project management, web development and other applications disciplines has proven problematic. Particularly in project management, public service pay rates do not equate with the size and complexity of many projects, resulting in contractors being used. This means increased costs with arguably greater internal risk, due to the temporary engagement of contractors. An appropriate methodology for project managing contractors should be established by the Information Directorate covering project planning, performance standards, reviewing progress, monitoring achievement of deliverables and target dates, achieving skills transfer to internal staff and controlling contracts expenditure.

The ability to be flexible and agile in meeting new needs for project development is problematic due to the bottleneck in internal skills available and Public Service Award

constraints. An example is the PRIME system, which is a small web style development being released in three stages. The timeframes for release of stages are constrained by the internal availability of web developers and along with many other priorities need to be scheduled in a sequential manner. Alternate sourcing strategies, that allowed external capabilities to be engaged for individual developments would result in much greater parallelism, shorter delivery times for clients, and greater ability to keep pace with the capital program. These external engagements would need to be done with organisations with suitable capabilities and pre-qualified to deliver to Queensland Health standards. A preferred supplier panel for applications development and project management services would provide the greatest flexibility and agility in meeting demands for ICT developments, with internal staff focusing on overall project management, contract management, requirements specification and technical due diligence.

Recommendation 12.6

The InfoSolutions Branch establish pre-qualified panels to provide applications development and project management services for the Department.

The InfoOperations Branch, of Information Directorate, is being restructured around providing holistic management of services in preference to being structured around specific technology areas (eg networks, desktops and hardware support).

This area has the greatest potential to reap productivity improvements. It is acknowledged by Information Directorate management that opportunities exist in this area, as no significant productivity dividend has been gained from the amalgamation of 16 separate Information Services Units into a single management environment. Modern technologies that allow remote diagnostics and resolution of problems can reduce the need for on site visits and increase efficiency and turn around times. However, this approach would result in a reduced number of IT staff employed in districts. The InfoOperations Branch recognises that these productivity dividends exist, but concerns over reducing regional employment have not yet been addressed.

The potential productivity dividends are very broadly estimated to be between 75 and 100 staff in the InfoOperations area. While the recommendation to increase the number of desktops will offset some of these productivity dividends, it is also clear that the new systems of support will require different skill sets to be successful.

If Information Directorate is not able to make these skill set adjustments and productivity savings quickly, then the ability to reach efficient and effective service levels will be compromised. Longer term, if these adjustments are not made, the option of outsourcing operational service may become the only viable alternative to achieve the level of service and efficiency required.

While there will be industrial issues to consider, these need to be addressed in order to make small staffing adjustments now, rather than facing the longer term threat to all staff from outsourcing.

The proposed approach is for Information Directorate to expand the scope of the Transformation Project to make determinations on the levels of staffing required. The current approach of the Transformation Project is only to consider a split of staff between local and enterprise support, based on an assessment of what staff are doing today, rather than considering the level of staff required to deliver the function, and adjusting resourcing to that level. The scope of this activity needs to be changed to consider the

appropriate level of staff required for the function, so that specific functions can be targeted and positions abolished that are surplus.

It is acknowledged that the increase in desktop numbers, recommended in section 12.8.2, will likely increase the staff numbers again, but in different locations and with different skill sets.

To fully realise these productivity dividends will require additional investment in technology tools and processes for the management, support and administration of the computer fleet. Information Directorate will need to immediately progress this as a priority capital infrastructure project.

Recommendation 12.7

Information Directorate pursue productivity dividends from the InfoOperations area by:

- Immediately implementing a project to improve work practices and implement technology tools, including remote diagnostics and resolution of problems.
- Undertaking an assessment of the resource levels required in each functional area and identifying surplus positions, and as productivity gains are progressively realised, by
- Abolishing surplus positions, with incremental increases of staff occurring in other areas, with different skill sets, in line with any demonstrable requirements arising from the desktop expansion.

12.6 Information Management

12.6.1 Information management responsibilities

The term information management is being used here in the context of the manipulation, re-organization, analysis, graphing, charting, and presentation of data for specific management and decision-making purposes. Information management in the broader context also includes administration tasks associated with creating, modifying, managing and disposing of information.

The focus of information management should be on making appropriate information available for use in planning, decisions making, and performance monitoring. This includes information derived from within the organisation and the facilitation of access to and use of information external to the organisation.

The information management function is not well understood or resourced across Queensland Health. The Information Management Strategic Plan recognises this and has flagged a strategic initiative aimed at improving information management competencies.

The two primary issues that have been identified relate to quality of data and levels/competency of resourcing.

Firstly, the quality of data held in many systems has been questioned by the people who input or use the data. This occurs for a number of reasons including:

- Clinicians who are entering the data are often not the beneficiaries and do not see value in data entry
- Inadequate training has occurred on systems

- Systems themselves are slow or cumbersome resulting in minimal entry of data or systems not being used
- The data is not analysed or interpreted for local use and therefore the value of initial input is questioned.

Secondly, the impact on local staff is not being adequately defined or planned for when new systems are implemented. Competencies in managing information are scarce. This has been evidenced in district visits as follows:

- The impact of data entry, data analysis and reporting from new systems needs to be understood and planned for in the implementation process, rather than expected to be added to existing workloads.
- Business cases should identify changes to work patterns and any resource shifts needed to gain the benefits of the new system.
- The implementation of information systems should be adequately resourced including data entry, analysis and reporting.
- The role of managing information, including extracting, analysing and interpreting data for use in decision making in districts, area health services and Central Office needs to be appropriately resourced and skilled.

Recommendation 12.8

New enterprise wide ICT projects need to identify the impact on end users in terms of data entry, data analysis and reporting. Resources for any additional workload must be built into the business case and agreed before systems development commences.

Recommendation 12.9

Information management, including extracting, analysing and interpreting data for use in decision making across the organisation must be appropriately resourced and skilled.

The analysis and interpretation of information that is occurring in Queensland Health is currently performed in a disparate environment with little overall coordination. The analysis and interpretation of information is broadly resourced as follows:

- The Health Information Branch in Information Directorate provides statistical analysis, epidemiology services, data standards, ad hoc data analysis, surveying services and library functions. Staff include data managers, statisticians, epidemiologists and librarians. The major focus of this group is corporate level reporting (eg to Queensland Treasury and the Commonwealth) and support for policy, planning and program evaluation, although services are provided to districts when requested, within workload capacities and limited reports are made available for all Queensland Health staff to access.
- Staff are employed in districts to undertake benchmarking, trending of data and clinical coding. The role of these staff is focused on using data available from decision support systems such as Transition II, to report on clinical and financial indicators.
- Some staff exist in zones and statewide service areas, who are undertaking detailed analysis and interpretation of data to assist with service planning.
- Public Health Services Branch in Health Services Directorate has epidemiologists employed in the central planning and research area as well as a small number of epidemiologists and data managers within the Public Health Unit Networks.

- The Innovation and Workforce reform Directorate also have a data analysis group.

These groups work independently in servicing their clients, but often overlap in the data they are analysing and interpreting. A level of tension exists between some of these groups over the accurate definition and interpretation of underlying data.

Further, there is often no single reference point and a lack of standardisation of data, resulting in different results depending on data sources used, assumptions made and interpretation.

The disjoint nature of data analysis and interpretation leads to a lack of focus on strategic information management and use of data to guide decision making in the organisation. In the future, more attention will be required to ensure that the data captured is aligned with the strategic needs of the organisation and the knowledge generated is captured and managed across the organisation. As a first step, Queensland Health would benefit from a more coordinated approach to analysis and interpretation of data, with a specific goal of supporting service planning, quality and safety and monitoring performance. This should be allowed to mature over time to provide greater levels of knowledge generation and dissemination that supports the strategic needs for service planning and performance.

The central Health Information Branch is well positioned to support corporate level activities and data standards setting. This group provides a corporate centre of excellence in data analysis and interpretation. It is proposed that this group focus on core central needs of the organisation as follows:

- support for corporate level reporting to Queensland Government and the Commonwealth
- corporate data analysis and interpretation to support the central policy development and planning function
- corporate data analysis and interpretation to support the central performance monitoring and evaluation function
- data standards
- library services
- leadership in information management capacity building across Queensland Health.

In delivering these functions, Health Information Branch would be best aligned with the corporate planning and performance monitoring areas. This will ensure that Health Information Branch is closely aligned with the needs of the people it is supporting and has a clear purpose and role in the organisation.

Area health services will require a stronger capability in data analysis and planning to support area health service planning and performance reporting. Staff undertaking these roles need to be situated in area health services. However they should have close links and networks with the central Health Information Branch. Information produced by area health services will need to be rolled up in a consistent manner to a corporate level by Health Information Branch, so it is important that these groups work closely together.

Further, it is critical to develop and maintain skills and corporate knowledge in data management, statistical and epidemiological services across the organisation. Area health services may find it difficult to source and maintain skills in statistical and epidemiological services. A data management and epidemiology analysis network could

be created to address this issue. This network would take on a capacity building role, including:

- Programs of rotation between area health services and Health Information Branch
- Succession planning across organisational and bureaucratic boundaries
- Structured training activities focused on lifting the level of information management skills and standardisation of data

A similar relationship needs to be developed with district staff undertaking local analysis and benchmarking roles. While these staff will have a core responsibility for providing information at the district level, greater coordination and skills development is required in order to ensure the analysis and interpretation of data becomes more consistent over time.

Generally the staff involved at a district level in analysis and management of information are finance officers (largely using Transition II) and Health Information Managers (HIMs). There is much to be gained from these groups of staff working together to enhance the provision of relevant information to local clinical units. In particular the information management skills of HIMs could be utilised in a much broader range of roles including but not limited to:

- working with clinical staff to identify information needs for clinical units
- working with finance staff to maximise the clinical relevance of reporting using the Transition II system
- supporting clinicians by managing the information aspects of a range of quality and safety processes including death, clinical and complications audits
- providing a timely and responsive audit of local data quality and
- providing training in a range of information management skills.

Recommendation 12.10

Health Information Branch focus its role to service central policy, planning, performance and evaluation, and leadership in information management standards. The function is to be structurally incorporated into the Performance Directorate.

Recommendation 12.11

A data management and epidemiology analysis network should be established to develop and maintain critical skills across the organisation in data management, statistical and epidemiological services.

12.6.2 Information islands

Queensland Health has many IT systems with a wealth of data stored for various service delivery and reporting needs. Access to this data in a manner that assists districts in service delivery planning has been identified as an issue - “we are drowning in data but have no information”. Information exists in silos across the organisation with no current integration, data standardisation or data warehousing solution that can bring this information together to support local decision making. This is a weakness in the current environment that needs to be architected and planned for in future systems developments.

Many systems are not integrated, resulting in duplicated time spent entering data into different systems. It has been recognised for some time that a unique patient identifier is a primary key to integrating information across systems e.g. if a patient presents at two different health services, a patient identifier would facilitate the matching of records. The

current Client Directory Project aims to provide common patient identifier functionality within the Hospitals Based Corporate Information System (HBCIS). It has been rolled out to seven of the current thirty-two HBCIS sites across Queensland Health. The issue of a patient identifier needs to be progressed as an urgent business priority for all patient related information systems. In the medium to long term, resolving this issue will provide a fundamental building block for system integration and will lead to simpler clinical care, as it begins to eliminate the need to locate multiple medical records. Enhanced data standards settings and consistency in data interpretation will complement the integration of data across information systems.

Recommendation 12.12

The definition and agreement to a standard way of identifying patients across ICT systems needs to be progressed as a high priority initiative, as this forms the basic building block from which IT systems integration can begin to occur.

The technology implemented by Queensland Health not only needs to support internal processes, but needs to be able to connect to external providers such as general practitioners, private hospitals and non government organisations to streamline the management of consumers across the care continuum. This is well understood at the strategic level, but has not yet been evidenced in business models and supporting technology capability to make this happen.

Recommendation 12.13

Systems need to be designed with connectivity to external providers, such as general practitioners, private hospitals and non-government organisations, as a key consideration.

12.7 Delivering ICT projects

12.7.1 Business sponsorship of projects

Sound project management dictates that a project sponsor is identified prior to commencing a project initiative. A project sponsor is someone that has ultimate accountability and responsibility for the project and advocates the project at a senior level to ensure the necessary financial and human resources are available. The sponsors' role includes overseeing the business and project issues and chairing a Project Steering Committee. A sponsor generally needs to be someone who can fund and be accountable for the outcome. The sponsor ideally should have ownership of the business processes and the control or influencing power to deliver change in the business areas affected by the new IT system.

In Queensland Health, in some instances it has been difficult to identify sponsors for projects involving enterprise wide applications. Three scenarios exist in the Queensland Health environment, as follows:

- The system is infrastructure related, servicing multiple 'business areas'. Examples include services such as GroupWise, Client & Provider Directories, and the Standard Desktop Operating Environment. In these circumstances, Information Directorate has taken on the sponsorship role in the past. In the future, Information Directorate must have no role as a sponsor, and the Chief Operations Officer (or nominee) will take on the sponsorship of these systems.

- The business area is a statewide service with a clear owner e.g. Pathology is run on a statewide basis. In these circumstances, a statewide sponsor is easily identified, who has responsibility and accountability for the business on a statewide basis.
- The business area is not run as a statewide service. It is this scenario that provides the most difficult of circumstances, where there is no overall responsibility or accountability for the business area.

In the third scenario above, a need for a new system is often identified, with districts agreeing it is a priority, but the lack of a sponsor can inhibit initiation and progress of the initiative. With the lack of a clear sponsor, with the power to drive change and business process standardisation, projects are highly unlikely to succeed as an enterprise wide initiative.

The emergence of clinical networks provides an opportunity for these projects to be progressed through a network of skilled people with the influencing power to affect change in the business. This does not negate the need for a sponsor, but provides the sponsor with a mechanism to affect the necessary change that will be associated with the implementation of a new IT system. To be successful, projects will require a senior sponsor, who may be elected from within the clinical network or be someone responsible for the success of the clinical network.

Queensland Health has not progressed ICT initiatives in the absence of a sponsor. However, in some cases the appropriateness of the sponsor has been questioned in regard to their level of influence in the area being progressed. Any proposal for an ICT initiative that cannot identify a sponsor who has the control or influencing power to implement any changes required in the business area should be rejected by the ISIB. The assessment of new ICT initiatives should include an evaluation of the appropriateness of the proposed sponsor.

The role of a sponsor is often a demanding one. When placed on top of an existing job, without adequate support resources, it can be difficult to do justice to the role. Sponsors need to be resourced appropriately and may require training and development support to effectively perform the role. The overarching culture needs to be one where sponsors are supported so that they can be successful in implementing major initiatives, rather than a culture of pinpointing someone to blame in the event of failure.

Recommendation 12.14

New enterprise wide ICT projects should not be progressed until a system owner (sponsor) is identified with the control or influencing power to drive the associated business change across the organisation. Provision of adequate funding and resources for sponsors must be identified and funded through initiative budgets prior to commencement.

12.7.2 System and process standardisation/simplification and change management

There was a clear message of support for common enterprise wide approaches to information systems. This view was maintained regardless of the delivery issues being experienced with many enterprise wide IT initiatives.

To achieve enterprise wide information systems will, by its very nature, require business areas to agree standard ways of doing things. Processes and business practices need to be streamlined and standardised if the goal of implementing statewide systems is to be achieved.

In practice, the business areas of Queensland Health often leave business process standardisation and change management as issues to be resolved by an IT initiative. This is a 'throw the project over the fence to IT' mentality which has contributed too many projects being slow to deliver, having cost overruns or failing altogether.

If large enterprise wide IT implementations are to be successful, project sponsors need to be resourced and accountable to define, agree and implement standardised business processes. This definition and agreement should happen prior to the commencement of any IT development.

No project should be approved as an enterprise wide IT development until it can be demonstrated that a consistent and agreed business process has been designed. For clarification purposes, standardising business processes does not equate to building inflexible IT solutions. Areas of flexibility should still be incorporated, particularly where one size does not fit all eg small hospitals may be undertaking simpler procedures that require less information to be captured.

Queensland Health needs to adopt an approach of piloting redesigned business processes and associated IT systems in one Hospital or Health Service District first. The results of pilots need to be evaluated and built back into the final solution before enterprise wide implementation occurs. Project plans must build in time and budget contingency to allow for rework as a result of pilot learnings. In the past, this has not always occurred.

The effort involved in delivering the business change should not be underestimated.

There are few examples of IT developments that are driven as a component of a business focused reform initiative. Where this has happened, success has followed. A good example is the pharmaceutical system which was lead by a team of dedicated pharmacists who drove business change, standardised processes and tackled difficult issues to clear the path for an enterprise wide IT system.

Generally though, the existing structures within Queensland Health require a tripartite agreement between two Corporate Office Directorates and the sponsoring area in order to be successful. In order to drive the appropriate reform, a program approach that brings together the technology, business and change skills is required. Within the current structures, this would involve the Information Directorate for the technology skill, the Innovation & Workforce Reform Directorate for the change skills and the relevant sponsoring area as the owner and driver of the initiative. Given competing priorities, bringing these three entities together and aligning resource availability, timing, and direction to a given program can be difficult. Yet this is a fundamental requirement that should be in place before commencing any large IT project that involves changes to business processes. Under the newly proposed model these three functions are to be brought together under the sponsor.

There are many indicators of insufficient attention being given to delivering business change including:

- District staff have reported that systems are often developed based on insufficient clinical input and that clinicians need to be more closely involved in the development/acquisition of IT solutions. In practice, however, all systems development activities appear to have had a level of input from clinical staff. This problem appears to reflect more on a lack of effectiveness of the clinical input to influence directions and a lack of communications and change management processes being employed to the broader audience.
- Historically there has been little focus on benefits realisation or consideration of the benefits realisation capabilities in districts. For example, their capability to manage change and the ability to deliver both cashable and productivity based benefits.
- Business cases, when developed, do not have commitment to the outcomes from district management responsible for managing benefits realisation. Consultation and robust debate appears constrained to the formal structures of a project, such as the Steering Committee.
- There is no process in place for the ongoing evaluation of IT systems to ensure they are operating as planned, benefits are being realised and the systems are not negatively impacting on staff. It is noted that Information Directorate have acknowledged this issue and are proposing new processes for evaluating benefits realisation.

The culture of independence and autonomy that is associated with professional knowledge workers, such as those making up Queensland Health's workforce, makes communication and change a more complex task than it would be in a process based industry, as the initiatives are trying to overcome a culture of specialised professional independence.

This leads to broad communication and engagement processes being a critical part of change initiatives. The level of effort involved in consultation, requirements gathering and business process standardisation will be significant. Done properly, the cost of initiatives will increase; however, the ability to achieve the benefits possible through the application of IT will also increase.

A program approach is required for large initiatives where sponsors are identified and resourced to deliver changed business processes in conjunction with the IT initiative. There is clear support for an enterprise wide approach to ICT systems where there is a common need across Queensland Health.

Recommendation 12.15

Enterprise wide development of ICT systems should continue where there is a common need across Queensland Health. Investment in the design and implementation of standardised processes and practices must occur as a precursor to initiating ICT developments.

12.7.3 Tailored solutions

Districts frequently raised a concern regarding the amount of tailoring of IT solutions undertaken in Queensland Health. A common view expressed was that Queensland

Health cannot be that much different to other states or other health organisations, so why can't Queensland Health just implement an off-the-shelf solution that is working somewhere else. An example of this is the AIMS system used for incident reporting in other states. Rather than use this solution, in place in three other Australian states, Queensland Health developed PRIME, which was not viewed positively by staff in district visits. It is noted that the decision to implement PRIME was appropriately made by senior management as an interim solution based on timeframes set by the Commonwealth and cost issues with other options, resulting in choosing the least cost option.

A further view expressed was that Queensland Health spends considerable money in ensuring the last 20 percent of nice to have functions are developed into IT solutions yet significantly under fund the implementation and change process. A potential solution to this issue is to accept systems will only meet the core requirements (ie meet 80 percent of user needs) in the initial implementation and promote hard-lined decision making around this minimal functionality. Saved investment could then be used to ensure implementation issues were adequately dealt with.

The current approach is trying to do too much and ending up not doing it well. This also leads to concerns with the time to rollout systems in Queensland Health. Long information technology development lead times can result in technology being dated before it is implemented.

These issues all point to a need to implement minimal functionality well in the first pass and get a working solution on the ground and evolving over time, rather than a big bang approach.

Recommendation 12.16

When implementing new ICT systems, a more robust decision making process is required to balance the costs and benefits of tailoring solutions, with a strong bias towards implementing core functionality only in the initial implementation.

12.7.4 Training

There is a general lack of computer proficiency across Queensland Health, particularly in clinical areas. Although it was observed that some clinicians are highly skilled in the use of computers, there are also a significant number of people in the workforce with limited understanding or exposure to information technology. This includes lacking general keyboard skills, making entry of data difficult, and general awareness of computer systems and tools, such as word processing, spreadsheets and the Internet. This exasperates the level of frustration experienced with IT systems and causes difficulty in providing system specific training due to the vast differences in general proficiency.

An investment in general computer skills is required for clinical staff that have lower proficiency in IT systems. This needs to be separate to any training provided with new computer systems. The goal is to lift the general ICT capabilities across Queensland Health in preparation for a greater dependence of clinical systems that support work processes into the future. Continuing to deliver major new clinical systems in the current environment will lead to further issues with training, system acceptance and the quality of data being captured.

It is estimated that half of the clinical workforce, including VMO's is in need of some level of basic computer training. At one extreme are those with very little exposure to computers, where it is estimated that 5 days (40 hours) of training spread over a year would be beneficial. The other area of training need are staff that have had some exposure to computers but lack the level of skill or confidence to undertake their role effectively. In this case it is estimated that 3 days (24 hours) of training would assist in raising their level of proficiency.

Averaging these assumptions leads to about 50,000 days of training required to lift the level of computer proficiency for clinical staff.

There is limited internal capacity or capability in Queensland Health to deliver ICT training of this scale over a short period. There are some ICT trainers employed in districts, but in general, it is only the large districts that have the required capability. These groups normally operate on a fee for service basis.

The only other internal training function identified was Rural Health Training Units, which have qualified trainers, but do not currently provide training in the area of ICT. Expanding the role of these groups to include training in basic ICT skills would be advantageous in that ICT training could be included as an adjunct to other training being delivered. In the smaller rural locations, providing a holistic training service that can be delivered in line with the needs of the district is a distinct benefit.

The option of using external organisations to develop and deliver training is also an option. Organisations that specialise in training, such as TAFE colleges, Learning Network Queensland or other qualified ICT training organisations, could partner with Queensland Health to design and deliver ICT training.

A major consideration in designing an ICT training program is the delivery mode. That could include distance education; self paced learning, individual tutoring, classroom programs or a combination of these. In the case of classroom delivery, suitable facilities also need to be identified.

A training exercise of this scale would be expected to be delivered for around \$100 per person, per day. This cost should include an analysis of training needs and tailoring of delivery to meet local requirements, but is based on classroom style delivery for small groups.

The total estimated cost of such a training program is \$5 million.

In order to achieve the best training outcome for individual areas and districts, a single statewide approach is not recommended. Rather each area should determine the most suitable delivery option(s) to meet the needs of the area. This may leverage existing capability available from ICT trainers in districts or Rural Health Training Units or involve partnering with external organisations. Each area would also need to conduct a training needs audit to ensure that training is appropriately targeted.

The timing for delivery of this program would be best linked into the desktop expansion process recommended in section 12.8.2. By linking these two recommendations together, it will ensure that training coincides with an increased availability of desktop devices on which clinical staff can put new skills into practice.

Recommendation 12.17

\$5 million is provided to improve the basic ICT proficiency of clinical staff through the state. Areas are to determine the method of training delivery. The delivery of this training is to coincide with the planned program for computer expansion recommended in section 12.8.2.

The level of training provided in new IT systems has also been raised as a concern. In some cases there was insufficient training provided to system users and in some cases the training occurred weeks before the system was installed, resulting in training being forgotten. There was a case where training was reported as being too extensive, and a lesser amount would have been more appropriate. It is expected that different users, due to their different levels of IT proficiency, will view training as either too little or too much.

The more important issue is to ensure training occurs at an appropriate time and there is follow up support in place, post the implementation, to assist those users who are experiencing difficulties. This could be in the form of on site support for a period of time or a locally acknowledged 'super user' that staff can turn to. Training by classroom style delivery does not always work in with busy clinical staff, resulting in training being missed by users. In some cases, pursuing on the job training strategies may be more effective in reaching all potential users.

Recommendation 12.18

Training users, on the job in new systems needs to coincide with the implementation of the system and be backed up with on the ground support, particularly over the initial months of running a new system. Full training costs need to be included in the project business case.

12.7.5 Project management capability

Project management disciplines and methodologies are lacking in Information Directorate which is contributing to the poor delivery capability of Queensland Health for large IT system implementations. The capability of a project manager for a given project is a key determinant of success, as there is no guidance to ensure consistency outside an individual's capability. This issue has been recognised by Information Directorate who are in the process of resourcing a project Delivery Office to manage governance, methodologies, logistics and provide core capabilities to project initiatives. The aim of the Delivery Office is to provide a primary skill set required to successfully deliver large corporate IT Projects. The progress of the Delivery Office needs to be monitored to ensure that project management disciplines do not contribute to project failure in the future.

Queensland Health has a track record of utilising staff, such as clinicians, with appropriate content knowledge but little project management experience to run large ICT initiatives. This practice has led to insufficient project management skills in delivering projects in the past, and should be discontinued unless the individual has appropriate project management skills.

Further, project funding arrangements do not lend themselves to skills continuity and attraction of highly skilled resources for projects. Project funding is temporary by its very nature. Attempts to attract high quality applicants to temporary public servant positions have not been overly successful, often resulting in the employment of highly paid contractors as an alternative. Further, whether temporary public servants or

contractors are used for projects, skills continuity and knowledge loss is problematic when projects close down after completion.

To successfully manage large ICT projects that involve external organisations in the development and delivery of the system will require strong contract management skills. Selecting an appropriate partner, for the size and scale of projects likely to be run in Queensland Health, will require a high calibre of skills in undertaking due diligence processes, contract negotiation and contract management. The lack of skills in this area, particularly in exercising appropriate due diligence, has significantly contributed to failure of IT initiatives in Queensland Health. Similarly to project management skills, high calibre contract management skills are also difficult to maintain in temporary roles at public service pay rates.

Concern was raised as to whether value for money was achieved through use of short term contractors and consultancies. In respect to contract project management services, areas of perceived concern include insufficient monitoring of contractor performance and inadequate definition of project scope, deliverables, project methodology and project timelines. There are 118 contractors currently engaged by Information Directorate representing 12 percent of total staff (984). Several contractors have been engaged for extended periods and a review of the contract term would appear warranted.

Recommendation 12.19

Information Directorate should:

- seek commercial partners with proven expertise in project management and contract management in preference to employing temporary or contract staff as an alternate model for project management.
- undertake an immediate review of the contract term of current contractor and consultancy services and confirm the ongoing need for each service.

12.8 Technology gaps

12.8.1 Application priorities

There have been a number of gaps reported in the coverage of IT systems during the Review. The following were identified as priorities:

- An enterprise wide system(s) to support ambulatory and community care.
- A focus on point-of-care support systems for clinicians including infrastructure solutions to support the mobility of users both within the hospital environment (eg tablet devices that can be used as a nurse moves around a ward) and for external access (e.g. VMO's being able to remotely access information systems or Community Health workers being able to access systems when on home visits).

In addition to these gaps, two existing systems warrant special mention as priorities for improvement, as follows:

- The ESP rostering system is an unsatisfactory solution for rostering and nearly all districts continue to use EXCEL for rostering and then duplicate the information into ESP. A suitable system needs to be implemented as an immediate priority to remove the non-productive entry of data through the current ESP interface. This priority

needs to be actioned separately from any long term project to replace the Lattice Payroll system.

- There is an urgent need to roll out the PRIME solution across the state in line with recommendation 9.8. Recognising that PRIME was proposed as an interim system and that new requirements are evolving in the Quality and Safety area, it is unlikely that PRIME will meet longer term requirements without significant enhancement or redevelopment. A review of functionality of PRIME (including proposed future releases of complaints and risk management functionality) needs to be undertaken in light of the recommendations made in this Review and a strategy for future systems enhancements or replacement needs to be identified and agreed. This should be considered a priority decision area. This decision must also consider the benefits of pursuing a standardised solution in line with the system (AIMS) being adopted by other states and territories.

Further, Queensland Health has experienced difficulties with delivering new clinical systems in the past. Since development of the Hospitals Based Corporate Information System (HBCIS) in the early 1990s, Queensland Health's successful experience with implementing large information systems has principally focussed on administration systems (eg finance and human resource management) rather than on implementing front end clinical support systems. The current high profile Clinical Information System Project (CIS) offers opportunities to improve outcomes around clinical practice. The CIS is a core module of the strategically important Clinical Informatics Program and the Information Directorate's reputation amongst clinicians and district staff and support for the enterprise system approach will be significantly influenced by their assessment of how well the CIS initiative is delivered.

The current capital acquisition program for ICT needs to be reviewed in light of the recommendations of this Review. Decisions to invest in systems have been made based on Queensland Health priorities at the time. The results of this Review will impact on the strategic priorities for developing ICT systems, particularly those within the Clinical Informatics Program, the Resource Management Program, and the Decision Support Program. Each of the projects in these areas needs to be reviewed in light of the recommendations of the Review and the reconstituted ISIB needs to determine if they should proceed or not.

Projects within the IT Infrastructure and Infostructure Programs are core ICT requirements and should proceed without need for formal review.

In determining the program of ICT investments, consideration needs to be given to the level of change occurring within Queensland Health and the base skills of clinical staff in operating ICT systems. A purposeful slowdown in release of new systems, while basic needs are met, such as access to computers and training of staff would be advantageous. It is recognised that priority developments need to occur.

Recommendation 12.20

Reprioritisation of ICT initiatives in line with the recommendations and priorities outlined in this Review is to be agreed through the reformed Information Strategy and Investment Board within 3 months.

12.8.2 Desktop facilities

A Standard Operating Environment (SOE) is in place for the Queensland Health desktop environment. This ensures a level of consistency and ease of support of the IT environment.

However, access to desktop computer facilities (desktop computers, laptops and printers) is a concern in most districts. Clinical staff reported issues with gaining access to a computer to undertake their duties. Examples include doctors not being able to access a computer on a weekend because the only workstation is locked by a user who has not logged out and staff needing to book computer time in advance to get access to the Internet for research purposes.

The current environment encourages restrictions in the number of computers available in districts as they are managed as a financial line item in district budgets. When new systems are rolled out they do not consider the needs for desktop access. This is left for districts to budget. This can lead to systems not being implemented or used effectively because districts do not have the budget flexibility to increase the number of desktop devices. This is counterintuitive after spending significant funds in developing an enterprise wide application.

Currently there are 23,743 desktop computers and laptops and 6,800 printers servicing a total of 43,782 full time equivalent staff in Queensland Health.

The penetration of devices in the corporate and administrative areas is 100 percent with all staff having full time access to computer facilities. In clinical areas of districts the penetration would be much lower. Districts (including administrative and clinical functions) have, in general, desktop or laptop computer numbers equivalent to between 45 percent and 50 percent of the FTEs employed.

An annual PC levy is used in Queensland Health to fund the full cost of running a desktop device including its replacement. Once penetration of desktop devices reach 100 percent, the PC Levy presents less of a problem as the funds are established as a recurrent expenditure. While in a growth phase (increasing to 100 percent penetration), the PC levy results in districts having to redirect recurrent funds from other areas to fund the PC Levy associated with any increase in computer numbers. No other source of recurrent funds has been identified to assist districts with managing the requirements to grow their computer fleet.

The PC levy is being openly directed back into the desktop environment. On current numbers, the PC levy would raise \$37 million in revenue of which \$18.3 million is allocated to Information Services Units for staff to support the desktop, \$11.6 million is allocated to Information Services Units to replace computers and printers, and \$7.1 million is used to fund license fees associated with software on the desktop and servers.

A process needs to be established to raise the level of computer availability in districts to ensure the availability of desktop equipment for those needing access. This will require an injection of money into the provision of desktop devices in a manner that does not place an additional burden on district budgets.

As a broad indication, it is estimated that raising the desktop availability to around 65 percent should meet immediate needs. This would provide an additional 5,000 units across the state for deployment in clinical areas. It must be stressed that this is a broad indication of scale and a more detailed process of determining needs has to be followed before finalising cost estimates.

However, based on this indicative requirement, increasing the desktop fleet by 5,000 units will incur both a one-off and recurrent cost. The one-off cost of 5,000 units including on costs such as Local Area Network devices, cabling and infrastructure required, is estimated at around \$25 million. The additional annual cost is approximately \$7 million based on the current PC levy.

In addition to being only broadly indicative of numbers, in practice the use of mobile devices, which can be carried around wards etc, may be used in preference to desktop computers. This may alter the financial equation slightly. By undertaking a more detailed analysis of needs, Queensland Health can ensure the computer expansion, which is clearly necessary, is done in a way that meets the most urgent needs first and does not over service any areas.

Once a base level is established, all future enterprise wide ICT projects must consider any impacts of the desktop fleet and identify a source of operational funding in the business case, if there are any significant impacts.

It is proposed that a pilot upgrade to meet the optimum desktop needs is undertaken in a cross section of hospitals and community health centres and used to project better estimates across the state. This would include a small rural hospital (e.g. Laidley), a hospital and community health centre in a regional district (e.g. Bundaberg), a hospital and a community health centre in a larger regional district (e.g. Redcliffe) and a very large teaching hospital (e.g. Royal Brisbane and Women's). The pilot would be expected to take 6 months including the time to access the outcomes, affirm to government the full cost of rollout and undertake planning for the ensuing rollout.

Recommendation 12.21

A pilot upgrade for desktop expansion is undertaken in 4 representative hospitals and 2 community health centres within 6 months and rolled out to all districts over the following 12 months. The results to be used to project total needs across the state. This is indicatively estimated at around \$25 million in once off funding and \$7 million per annum in recurrent expenditure.

Internet access in Queensland Health is not freely available to all staff. Besides the issue of access to a computer, staff need to apply for and be granted permission to access the Internet, which is password restricted. This practice is aimed at ensuring staff have a legitimate reason for Internet access and reducing lost time from personal use and adverse implications from inappropriate or illegal use of the Internet from work provided facilities. The maturity model that is evident as organisations go through the adoption of the Internet as a tool available to staff generally follows a cycle of initially restricting access to only those with a business case. Then, as the numbers increase, it becomes evident that the processes of approval and managing moves, adds and changes to staff are extremely costly and the original reasons for restricting access are no longer relevant as the majority of staff have access. It is usually at this point in time that organisations choose to provide Internet access to all employees and manage exceptions rather than continue trying to manage the initial access process.

In Queensland Health there are currently 4,183 staff with access to the Internet. While this is less than 8 percent of staff, it still represents a significant number of people. With this level of access, processes would need to have been established to monitor usage and manage exceptions as well as continuing with managing the process of moves, additions and changes.

Internet access is a tool to support clinical research into best practice interventions. Staff need adequate access to information technology including computers, the internet and printers. Consideration should be given to opening up full Internet access to all staff and monitoring usage rather than managing access. A whole of Government policy exists that provides guidance for the appropriate usage, training, and processes around providing Internet access from work computers. The policies and guidelines need to be implemented to ensure the Department's risks are managed.

Internet access is currently charged back to users at \$360 per annum. This would generate approximately \$1.5 million in revenue for Information Directorate. This fee should be removed and associated bandwidth costs need to be managed as a corporate responsibility. It should be noted that productivity gains are expected by removing the administration associated with maintaining registers of approved users that will offset some of this revenue loss. Upgraded access to the internet should be piloted in one district to assess the service (eg network bandwidth) and cost impacts and related risks prior to its expansion to all areas within Queensland Health.

Recommendation 12.22

All staff with computer access need to be given access to the Internet, with appropriate policies and training being established to manage the associated risks. Any associated infrastructure costs (e.g. network bandwidth) need to be managed as a corporate cost.

12.9 Supporting the IT environment

12.9.1 Problem resolution

The zonal based Help Desk structure for reporting IT problems was not viewed as being responsive to the needs of districts. The Help Desk provides the initial point of contact for the majority of IT users throughout the state and the quality of service delivered through this interface is often how IT sections are assessed. This interface is not currently providing a high level of service and is detracting the image of the Information Directorate. Statistics on number of faults and resolutions times for the month of May 2005 are presented in the following table.

| Zone | Number of incidents per day | Average time to log and resolve fault | Fault s resolved at point of contact |
|---------------|-----------------------------|---------------------------------------|--------------------------------------|
| Northern Zone | 260 | 2.9 min | 32 percent |
| Central Zone | 529 | 5.6 min | 40 percent |
| Southern Zone | 310 | 5.7 min | 34 percent |
| Total | 1099 | 5.1 min | 36 percent |

Information Directorate has acknowledged this area as a problem prior to this Review and is in the process of amalgamating the zonal help desk structure, and developing consistent processes and service levels. This includes developing new processes to track reported

problems through to resolution (rather than a hand off and forget) and increasing transparency of performance through reporting.

The Help Desk is proposing to provide a one stop shop for all information management needs. The Help Desk provided the full gambit of services for enterprise wide systems but provides a referral service only for issues that relate to local applications. The Help Desk currently operates from 7:30am to 5pm and is planning a trial of extending the service to 10pm at night. The Help Desk is aiming to achieve higher resolution of issues at the initial point of contact in order to be successful in adding value to the IT support function. Targets have been set for increasing the current 36 percent resolution rate up to 60 percent in the next 12 months. If this can be achieved, Information Directorate will be approaching best practice benchmarks.

The second level of support is provided by the InfoOperations Branch in Information Directorate., which is the largest area of Information Directorate consisting of 580 staff. This group consists of a central group and 16 Information Support Units located across the state. Service delivery and support capabilities of the 16 Information Support Units is variable across the state and there is an identified need to improve consistency in service delivery outcomes.

Historically, when issues arose, coordination of resources required to resolve the issue was problematic. The resolution of IT problems occurred more as a result of the tenacity and dedication of staff rather than a coordinated and designed process to effectively respond to problems raised by customers.

This area has a high potential for productivity improvement as detailed in section 12.5.3.

12.9.2 Service level agreements

The model for service level agreements follows that of system development sponsorship, with a statewide system sponsor proposed to take responsibility for enterprise level negotiations on service levels. In some cases the system sponsor will be someone with statewide responsibility for delivery of a service and in other cases it may be a chair of a clinical collaborative/network. There is no direct negotiation and agreement with districts, other than through the system owner.

This model creates a distance between districts and the level of service being negotiated on their behalf. It is important the information technology systems are meeting the needs of users who are delivering front line patient care. Any proposed model needs to ensure the IT systems perform in line with the needs of these users and must at least have processes in place to gather these requirements – even if a statewide service level is the final product. Information Directorate see this as the role of the system sponsor. However, evidence from the field indicates that this is not occurring in many cases.

Further, other than through the Help Desk, the only mechanism for a district to raise performance or support issues is to escalate them through a system sponsor. Districts therefore have a lesser influence on Information Directorate's resource allocation. This environment leaves districts somewhat powerless to directly influence the level of service they receive. The interests of districts must be paramount in Service Level Agreements established between Information Directorate and system sponsors, detailing the range of services provided and performance standards expected from enterprise systems. The

respective responsibility and accountability of Information Directorate and system sponsors to districts must be clearly articulated in those Agreements. Districts should be encouraged to highlight instances of poor system performance directly to the sponsor, Information Directorate and the Operations Board.

Recommendation 12.23

Head agreements for individual applications should be negotiated with the system sponsor for inclusion into an overall Service Level Agreement with each district specifying all services delivered in that district. Management and reporting on service levels needs to occur directly with both districts and sponsors and will also be monitored by the proposed Operations Board.

12.9.3 Enterprise wide versus local applications

The model being proposed for information technology responsibilities is to clearly delineate between systems deemed as enterprise wide and those in place for local use only. This delineation is aimed at quarantining the resources and budget associated with providing robust enterprise wide applications, which otherwise could be eroded over time through the growth of local applications. A further objective is to create accountability in districts for resourcing the support of locally grown applications, a discipline that generally does not currently exist, and to not stifle local innovation. The primary concern from Information Directorate of proceeding with the current model is that they are trying to be all things for all people and not doing anything well. The aim of the Information Directorate is to focus on quality outcomes in the enterprise wide environment.

Enterprise wide systems broadly include the applications, infrastructure and networks. Further, the infrastructure and networks provided by Information Directorate would also support local applications. However the development and maintenance of local applications is the responsibility of districts.

The Transformation Project underway in Information Directorate is in the process of separating resources in the 16 Information Services units, located in districts, into those that support local and those that support enterprise applications. The resources involved in supporting local application are then proposed to be devolved back to the districts.

The early indications from this process are that it will be successful in the larger districts as the resources significant enough to effectively make a split. In smaller districts, there is often only one resource, and splitting is not pragmatic. The result in these circumstances is that the resource remains with Information Directorate and a 'best endeavours' service level is to be agreed for support of local applications ie priority will always go to enterprise wide applications work.

This situation represents a risk to both Information Directorate, who need to provide 'best endeavours' support for an unknown and fast growing list of local applications and districts, who have no understanding of the overheads being incurred as a result of well meaning staff trying to improve their work environment.

There is also a risk that the ISIB will not have a clear picture of the total ICT assets in the organisation and there could be some duplication in costs through local application development. However, the ISIB is appropriately focusing on governing the major strategic enterprise wide investments. This risk is considered small in relation to the overall information technology environment in Queensland Health.

13. Performance monitoring of health system outcomes

This chapter addresses the terms of reference to review performance management systems including their effectiveness and as they relate to monitoring health system outcomes.

An effective performance monitoring and reporting system is one that enables an organisation to report on all dimensions of service delivery and the outcomes achieved. It uses systems that are robust and processes that are open and transparent and which meet the expectations of staff, government and the community for honest and factual performance reporting.

The outcomes of the health system are to improve the health of the population. As the Interim Report detailed, health is defined as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”. Monitoring health system outcomes therefore needs to consider the best ways to assess and measure:

- health status such as life expectancy and deaths
- determinants of health such as education levels, employment levels and healthy behaviours including smoking
- health services including the safety, effectiveness, accessibility and efficiency of services provided
- the capability and sustainability of the service such as the adequacy of the health workforce, capital infrastructure and information technology.

With escalating costs of health services and increasing community demand for information on health systems, governments around the world have a keen interest in examining how health systems are performing. Most governments desire a consolidated simple set of performance indicators that can be used at all levels within the health system.

This has led to the development of a number of systems and frameworks to monitor outcomes and long lists of indicators. A summary of indicator sets being used in the United States, United Kingdom and Canada, written by the New South Wales Health Department¹¹² is provided in Appendix 13.1. Broad themes across these international indicator sets, identified in the New South Wales report¹¹³, include:

- a focus on coordination and alignment of indicator sets across national systems
- increasing emphasis on public disclosure of indicators for sub national organisational units (United States, Canada, United Kingdom)
- recognition of the need for a balanced set of indicators rather than focusing on one aspect of performance over others eg. financial performance
- moves to systematically review the evidence base for indicators.

In Australia, the National Health Performance Framework has been endorsed as the framework for monitoring the performance of the health system at the national and state

¹¹² New South Wales reviewed these indicator sets in 2003. However, they remain largely current.

¹¹³ New South Wales Health System Performance Indicators, August 2003

levels and national reporting is increasingly aligned to this framework (eg Report on Government Services).

National Health Performance Framework

| Health status and outcomes | | | | |
|----------------------------|-----------------------|-------------------------------|-------------------|------------------------|
| Healthy conditions | Human functions | Life expectancy and wellbeing | | Deaths |
| Determinants of health | | | | |
| Environmental factors | Socioeconomic factors | Community capacity | Health behaviours | Person-related factors |
| Health system performance | | | | |
| Effectiveness | Responsiveness | | Continuity | |
| Appropriateness | Accessibility | | Capability | |
| Efficiency | Safety | | Sustainability | |

The Interim Report identified that this framework was only one reporting framework used for monitoring the performance of Queensland Health. The Interim Report identified a number of the frameworks Queensland Health uses to monitor its performance and suggested that one framework be considered for monitoring health system outcomes. The following elements are a useful framework for internal and external reporting:

| Health system outcomes | Examples |
|---|--|
| Health status and determinants | life expectancy, percent of the population smoking, employment rates |
| Patient outcomes | improved functioning following surgical intervention |
| Health service activity, expenditure and efficiency | total patients admitted, bed days, weighted separations |
| Health workforce | workforce numbers by clinical streams, absenteeism, turnover, satisfaction, culture, grievances |
| Health service quality and safety | credentialing and privileging, quality and safety (incident and sentinel events), patient complaints, adherence to evidence based guidelines, clinical audit |
| Health service responsiveness | elective surgery and emergency department waiting times, patient satisfaction |
| Health service sustainability | coordinated health programs, learning culture, capital infrastructure and information communication technology. |

13.1 Improvements to health system performance monitoring arising from this Review

The recommendations made in the preceding chapters will result in an improved capacity to monitor health system outcomes. Queensland Health will develop strategic planning processes that relate more specifically to services, and a statewide services plan will be available that integrates clinical service, workforce, capital and information technology planning. In addition, the clinical networks to be established will also develop a number of statewide service plans for priority health conditions such as cardiovascular disease. These plans will specify targets to be achieved under new funding arrangements,

particularly for patient outcomes, the responsiveness of services (eg waiting times), the quality and safety of services and workforce capacity. These targets will be central to new health system performance monitoring and reporting arrangements which will be the responsibility of the Performance Directorate located in Central Office.

Targets have been used within Queensland Health in the past but within a punitive culture. Targets must be used as an enabler in the future performance monitoring system. Targets are to be used to assist the organisation to identify what it can reasonably achieve within reasonable timeframes. Targets will assist the organisation to assess whether its performance is on track and whether timely remedial action is required.

13.2 Current performance monitoring and reporting arrangements in Queensland Health

13.2.1 Health system outcomes being monitored

Queensland Health regularly reports **externally** on health system outcomes against hundreds of performance measures to the Commonwealth and State governments, many of which are required under funding agreements. It also contributes performance data to many national reports (eg produced by the Australian Institute of Health and Welfare and the Productivity Commission).

Queensland Health reports annually on its performance to the State Government in two ways:

- the outcomes of its services, reported through the Government's Priorities in Progress report series, using the following health status measures:
 - health and well being (life expectancy, mortality, health inequities)
 - health status (mortality, injury hospitalisations, cancer survival)
 - health services
 - health behaviours (health risk factors and health enhancing factors)

These outcomes are also used as the performance measures for the *Queensland Health Strategic Plan 2005-11* which implements the Health 2020 Directions Statement.

- the Department's outputs, reported through the Ministerial Portfolio Statement (planned outputs) and the Annual Report (produced outputs). The outputs have had a strong focus on hospital services, particularly activity, access and expenditure. Partly in recognition of this focus, Queensland Health recently reviewed its outputs and will in future report against revised outputs (shown below) that better reflect the services provided across the care continuum.

Outputs reported through the Ministerial Portfolio Statement and the Annual Report

| Existing outputs | Revised outputs |
|---|--|
| Treatment and Management – Acute Inpatient Services | Protection, Promotion and Prevention |
| Treatment and Management – Non-Inpatient Services | Treatment – Specialised and Referral Hospitals |
| Integrated Mental Health Services | Treatment – Non-specialised Hospitals |
| Health Maintenance Services | Community Treatment and Care |
| Public Health Services | Long Term Accommodation and Care |

In terms of monitoring and reporting workforce indicators, the Queensland Health Annual Report and the annual Ministerial Portfolio Statement report on total FTE staff employed per output (eg total FTE for Treatment and Maintenance – Acute Inpatient Services). Given the importance of workforce issues in the current environment of workforce shortages and global workforce competition, this level of workforce monitoring is not considered sufficient. As detailed later in this chapter, other jurisdictions monitor a greater range of indicators.

In the last two years, Queensland Health has used a different set of measures to **internally** monitor its performance against strategic priorities, in recognition that the Department has focused too heavily on monitoring financial performance (reflecting external reporting requirements). It has used the balanced scorecard approach to set strategic directions and targets which achieve greater balance and a focus on patient centred care. Performance measures have been developed to measure progress against four sets of strategies:

- Shaping the workforce (6 measures) eg recruiting the right staff and ensuring they have the right skills
- Internal processes (10 measures) eg using evidence based processes to improve patient care
- Paying for health (3 measures) eg achieving a balanced budget
- Consumers (10 measures) eg improved access to care.

Some of the consumer measures have not yet been developed. This reflects the relative immaturity of Queensland Health (like other Australian health jurisdictions) in measuring the performance of health services from a patient or community perspective. Forays into monitoring consumer measures have included two patient satisfaction surveys (2001, 2005) but with a focus on services (eg food and comfort) which although important, do not replace outcomes (eg the extent to which a patient's treatment resolved or addressed that patient's health needs).

Assessment of health status before and after undergoing procedures in hospital provides a direct measure of the degree of effective performance of a health service. This approach has been piloted at The Prince Charles Hospital among patients admitted for selected surgical procedures. Significant improvements in physical and mental functioning, comparable to some of the best results achieved internationally were demonstrated. This model of assessing patient outcomes has not been explored for wider adoption across Queensland Health.

13.2.2 Current performance monitoring and reporting system

Monitoring health system outcomes using strategic indicators

The impact of achieving greater balance in performance reporting (ie not only focused on hospital activity and financial matters) has been variable, with no real flow-on to district monthly reporting which remains budget and activity focused. Budgets are monitored for hospital, oral health, mental health and community health services but activity is limited to hospital and oral health services. While information on community health activity is collected (manually in many cases) and this information is discussed by district

executives in some districts, there is no routine reporting about community health activity at the district, zone or corporate levels.

Zonal Management Units provide commentary on district monthly reports to the Finance Committee which also receives district monthly reports. The Finance Committee provides a monthly financial report to the Board of Management which approves the information on financial performance being forwarded to Queensland Treasury. Zonal Management Units meet with district executives if performance is significantly below expectation. Regular zonal forums are conducted.

Monitoring health system outcomes using operational indicators

As previously described, Queensland Health is required to report on hundreds of indicators, most of which are required by funding agreements and few of which are reflected in strategic indicators (eg few are included as measures in the Queensland Health Strategy Map). Consultation undertaken for the Review indicated that this operational level reporting consumes many clinical resources, particularly in community based settings. For example, many staff spend time entering data into a number of information systems for use in reporting to the Commonwealth for Home and Community Care (HACC) funding and mental health funding. While some of this data entry relates to outcomes being achieved with funding (ie. mental health outcomes), many staff have indicated the need to review existing indicators to reduce the number required and to automate information systems to reduce the reporting burden. Of note, Queensland Health has recently initiated a review of operational indicators with a view to reducing the reporting burden, particularly duplication.

What we need to do is get away from the situation where middle management waste time (and it is wasted) reporting routine data up, and give them the information and free up the time they need to make good decisions. This wouldn't have to cost a bomb. There are already structures available for report delivery. It's just a matter of figuring out the sorts of information that people need and bringing it together.

Source: *Submission to Queensland Health Systems Review, July 2005*

13.2.3 Current performance information made public

There is limited routinely reported information available to the public on the performance of the Queensland public health system. The Ministerial Portfolio Statement (planned outputs) and the department's Annual Report (actual outputs) provide the basis of performance information provided to the public. The only other routinely reported public information is the quarterly reports on waiting times for elective surgery, available on the Queensland Health website, and selected health status indicators in the *Priorities in Progress* report series.

Queensland Health also publishes the *State of Health of the Queensland Population* series of reports but on an irregular basis, the most recent being 2005. The reports identify the burden of disease for Queensland and highlight areas of potential health improvement. A more detailed analysis of health determinants was published in 2004 (*Health Determinants Queensland*).

As the following section will show, compared to New South Wales and Victoria, Queensland Health provides less routine public information about a range of health

services including access, the quality and safety of health services, patient outcomes and population health outcomes.

13.3 Performance monitoring and reporting arrangements in other jurisdictions

Other jurisdictions' approaches to measuring health system outcomes are in various stages of development. Like Queensland, health departments in other jurisdictions:

- have similar requirements under a range of funding agreements to report on many operational level indicators (eg for HACC funding) which consumes considerable resources
- are dealing with the complexity of measuring patient outcomes with no jurisdiction as yet regularly measuring pre and post functional capacity (eg did knee replacement surgery improve patients' functional capacity).

The following table summarises the approaches being taken in New South Wales, Victoria and Western Australia. Appendix 13.2 provides a detailed description of current arrangements in place in these jurisdictions.

Particularly good aspects of the New South Wales performance system, which Western Australia is moving towards, is the use of a standard set of indicators across all services (ie hospitals, community services etc). New South Wales also has a well developed system of interactive performance reviews in which the Director General and the Executive Director, Performance visit Area Health Services every six months to discuss performance and collaboratively identify strategies to improve performance where required. This interactive, solution-seeking and collaborative process is similar to the performance review process being used by the Queensland Police Service, described in Appendix 13.2.

A particularly good aspect of the Victorian performance system is the extent of publicly available information. For example, Victoria publishes:

- 6 monthly hospital performance reports which include broader performance measures than the annual report (expenditure, efficiency, public health insurance, GP bulk billing, access, patient satisfaction, avoidable admissions, workforce)
- from October 2005¹¹⁴, annual quality of care reports from each Board (progress on surgical issues, clinical governance framework, credentialing, infection control, medication errors, falls, pressure wounds plus other indicators that Boards considers important to report on)
- annual report on outputs
- annual departmental quality reports (sentinel events, infection control)
- annual trauma report
- burden of disease reports
- avoidable admission reports.

¹¹⁴ Quality of Care Reports – guidelines and minimum reporting requirements for 2004-05.

External monitoring processes being used in other jurisdictions include the Clinical Excellence Commission in New South Wales, which reports on the quality and safety of clinical services, and external review of the appropriateness of performance indicators in Western Australia by the Department of Treasury and the Auditor General. The Auditor General also audits the performance information provided by the health department in its annual report.

| | New South Wales | Victoria | Western Australia |
|---|-----------------|----------|---------------------|
| Health system outcomes monitored - moving to standard indicator set for use at all levels | ✓ | ✓ | ✓ |
| Targets are identified for each indicator | ✓ | ✓ | ✓ |
| Performance agreements are in place with service managers | ✓ | ✓ | ✓ |
| The use of an interactive reporting process | ✓ | ✓ | |
| Regular departmental public reports on performance | ✓ | ✓ | Under consideration |
| Reporting by external agencies – quality and safety | ✓ | | ✓ |
| Reporting by external agencies– health system performance | ✓ | | ✓ |

From the above table, there are clear trends across these jurisdictions towards developing performance monitoring and reporting systems that:

- monitor and report on health system outcomes through a standard set of strategic indicators
- use this standard set of indicators for reporting at all levels (ie from services to the department and from the department to Government)
- recognise the need for a balanced set of indicators rather than focusing on one aspect of performance over others eg financial
- use performance agreements with service managers
- use interactive performance review processes that are problem-solving and collaborative
- provide regular public reports on performance
- include performance assessment by external agencies, including quality and safety matters.

These trends are in line with the principles for performance monitoring and reporting detailed in the Interim Report.

13.4 Directions for change

13.4.1 The health system outcomes that should be monitored

Using a standard set of strategic indicators

Health system outcomes should be monitored using a standard set of strategic indicators that provide an overview of performance and act as an early warning sign on areas where performance needs to be improved or policy requires review or development.

As described in the beginning of this chapter, a useful framework for monitoring health system outcomes is:

- health status and health determinants
- patient outcomes
- health service activity, expenditure and efficiency
- health workforce
- health service quality and safety
- health service responsiveness
- health service sustainability.

Using indicators in New South Wales, Victoria and Western Australia, the following table lists the types of indicators that should be used to routinely monitor and report health system outcomes. This table should be used as a starting point for consultation in determining a standard set of indicators for routinely reporting system outcomes.

| Health system outcomes | Possible indicators | Desired outcome | Based on indicators used by... | Currently reported by Queensland Health* |
|--------------------------------|---|---|--|--|
| Health status and determinants | Potentially avoidable deaths | Increase life expectancy through health promotion, screening and early intervention | NSW, Canada, UK | √ |
| | Chronic disease risk factors | Reduced chronic disease through target programs | NSW, Vic, Canada, UK | √ |
| | Ante natal visits before 20 weeks (Aboriginal and non-Aboriginal women) | Higher birth weight babies reducing the risk of ill health in later life | NSW, Canada, UK | √ |
| | Falls in older people | Reduced illness and death from fall related injuries in older people | NSW, Canada, UK | |
| | Self reported mental health | Improved mental health and wellbeing of the community | NSW, Vic, Canada, UK | |
| | Education levels, employment rates | Develop partnerships with lead agencies for employment and education to improve levels and associated health status | Canada | |
| Patient outcomes | improved functioning following health intervention | Health interventions improve patient outcomes | Nil – based on The Prince Charles Hospital project | |
| | Participation rates for breast and cervical cancer screening | “ | Vic | √ |
| | Child and adult immunisation | Reduced illness/death from vaccine preventable diseases in children and older people | NSW, Vic, Canada, UK | √ |

| Health system outcomes | Possible indicators | Desired outcome | Based on indicators used by... | Currently reported by Queensland Health* |
|---|---|---|---|--|
| | Avoidable hospitalisations for selected ambulatory care sensitive conditions | Greater independence and health for people who can be kept well at home | NSW, WA, Vic, Canada, UK | |
| | Inpatient clients who are contacted by community service provider following discharge | " | Vic, WA | |
| Health service activity, expenditure and efficiency | Staying on budget | Continued sound financial management and efficient use of resources | NSW, WA, Vic | √ |
| | Maximising service output (total admitted patients, bed days) | " | NSW | √ |
| | Weighted output measure (Cost per casemix adjusted separation) | " | NSW, WA, Vic, | √ |
| Health workforce | Workforce capacity (proportion of staff by clinical streams, absenteeism, separate rates, junior doctor hours) | Workforce available to provide required health services for the community | Vic, NSW, Canada | |
| | Staff climate (staff satisfaction, organisational culture, grievances lodged and number resolved within timeframes) | Positive workforce climate to attract and retain staff | NSW, Vic | |
| Health service quality and safety | Planned and unplanned re-admission rates (overall, operating theatre, ICU, mental health facility) | Improved care and health outcomes for patients | NSW, WA, Canada | |
| | Staff credentialed in accordance with policy | " | Most jurisdictions are currently developing quality and safety indicators | |
| | Number of incidents including sentinel events; Number of incidents fully investigated (RCA) | " | | |
| | External accreditation | " | | √ |
| | Adherence to evidence based guidelines | " | | √ |
| | Patient complaints (total and resolved within timeframes) | " | | |
| Health service responsiveness | Elective surgery and emergency department waiting times (% seen within agreed benchmarks) | More timely access to treatment to improve health outcomes | NSW, WA, Vic, Canada, UK | √ |
| | Consumer feedback (patient satisfaction) | Greater satisfaction with health care experience | NSW, Vic, Canada, UK | √ |

| Health system outcomes | Possible indicators | Desired outcome | Based on indicators used by... | Currently reported by Queensland Health* |
|-------------------------------|---|--|--------------------------------|--|
| Health service sustainability | Partnership plans developed and reviewed | Improved coordination of care to improve health outcomes | Vic | |
| | Discharge summaries provided to GPs within 24 hours | " | Nil | |
| | Involvement in research | Improving the culture to that of a learning organisation | Nil | |
| | Asset utilisation | Making sure the right assets are in place and effectively used | NSW, WA, Vic | |

* Through Priorities in Progress reporting or Annual Report

There are a number of areas which will require significant work in terms of developing appropriate indicators to measure system outcomes:

- Patient outcome** - the example of patient outcomes measures provided earlier in this chapter (ie functional outcomes following selected surgical procedures in The Prince Charles Hospital) involves surveying patients before and after their procedure. This requires resources to develop the survey (or purchase an existing survey), administer the survey, follow up responses, data entry and analysis, and report writing. The measurement of patient outcomes can therefore be an expensive process. However, the measurement of the effectiveness of services is an essential performance measure. A program for measuring patient outcomes must be developed. This may be a rolling program across a number of high volume procedures over time.
- Workforce** - given the importance of workforce issues in the current environment of workforce shortages, indicators of workforce capacity will be vitally important to being able to provide health services to the community. Workforce indicators should include FTEs across clinical streams. Indicators should also include issues correlated with staff retention: staff satisfaction, vacancies/turnover, absenteeism, number of staff with performance plans in place, number of grievances and number of grievances resolved within timeframes. In particular, the culture of the organisation must be monitored to ensure it improves and that these improvements are achieved in the shortest possible time. As described in Chapter 4, the performance of any organisation is dependent upon the performance of its staff. These indicators are therefore vitally important and must be routinely monitored so that timely remedial action can be taken if required.
- Quality and safety** - the quality and safety of clinical services is an issue of great community concern following the events at the Bundaberg Base Hospital. Quality and safety indicators must be essential elements in the standard set of indicators. To be robust indicators, the focus must be a mixture of numbers (eg total complaints) and processes (eg number of incidents fully investigated). There are few existing measures of quality and safety in other Australian jurisdiction's indicator sets other than accreditation. Most jurisdictions are currently developing these indicators.
- Adherence of evidence based practice** - Chapter 6 described the introduction of clinical networks to improve the planning and delivery of services for priority health conditions such as cardiovascular disease. As the clinical networks mature and

benchmarking becomes routine practice for various health conditions, the performance indicators used by networks for benchmarking should be incorporated into the standard set of strategic indicators as measures of the quality and safety of clinical services (adherence to evidence based practice). An example of this is the inclusion of “use of Beta Blockers in eligible patients with congestive heart failure” as a performance indicator in outputs reporting to the Queensland Government. This performance indicator was developed through the Collaborative process and over time become accepted practice among clinicians in evaluating service provision.

- **Priority population groups** - there are a number of population groups that currently have health inequities compared to the general population or require different approaches for health. Priority populations are Indigenous people, children and young people, people living in rural and remote areas, the aged, people with mental health conditions and people with culturally and linguistically diverse backgrounds. The standard set of indicators should include at least one indicator for priority populations eg Indigenous people.

The setting of targets to be achieved also needs careful consideration to ensure that perverse incentives are not introduced. Examples of such perverse incentives identified in written submissions to the Review included:

- the prioritisation of elective surgery over other services
- unnecessary recall of patients for dental treatments to meet activity targets rather than treatment completion targets (eg filling one cavity at a time rather than all cavities in the one visit in order to meet activity targets).

Reviewing operational indicators required to be monitored

There will continue to be a range of indicators that are reported against, to a number of funding bodies. The reporting of these indicators needs to be reviewed for usefulness to achieving better health outcomes for the population. If indicators meet this criterion, they need to be linked to the standard set of strategic indicators (but not routinely reported). If indicators are found to be of minimal usefulness in terms of health outcomes, the Department should undertake negotiations with funding bodies to cease the reporting requirement, moving instead to reporting on fewer and more strategic indicators.

To reduce the reporting burden and free up clinician time, data collation for all performance indicators should be automated and integrated and the performance information be made available to staff and management to inform service planning.

13.4.2 The performance monitoring and reporting system that should be in place

Performance agreements should be in place with service managers

Performance agreements should be in place between the:

- Government and Director-General
- Department and Area Health Service General Managers
- Department and senior executives within Central Office
- Area Health Service General Manager and District Managers.

Performance agreements with Area Health Service General Managers and District Managers should be based on the standard set of strategic indicators plus other indicators as considered necessary in line with local or area priorities. For Central Office senior executives, indicators will need to focus on reform priorities including the first statewide health services plan and workforce plan. These indicators will need to be developed in the short term.

Proposed *internal* performance monitoring and reporting process

Diagram 13.1 presents the recommended monitoring and reporting arrangements.

District level monitoring and reporting should comprise:

- Monthly reports to the Area Health Services using a standard set of indicators plus other indicators as per performance agreements. The monthly reports should be available to all staff in the district.
- Participation in six monthly Interactive Performance Review process involving district executive, Area Health Service General Manager, Director-General and other senior Central Office staff to enable exploration of performance variations (positive or negative) and discussion as to actions to address any areas of concern. The Queensland Police Service's Operational Performance Review model (very similar to the New South Wales model) is a good example of an interactive process and should be implemented within Queensland Health with six monthly performance review meetings.

Area Health Services level monitoring and reporting should include:

- the development and implementation of a framework that defines the level of intervention required (re monthly reports) to assist districts in meeting their performance targets
- monthly reports to the Department (Central Office) using standard set of indicators plus other indicators as per performance agreement
- participation in six monthly Interactive Performance Review process with Director-General and other senior Central Office staff such as the Executive Director, Performance
- production of an annual report on the performance of the Area Health Service, based on the standard set of indicators and comparing Area Health Service performance to the state average.

Central Office level monitoring and reporting should include:

- Quarterly report to Director-General on indicators in performance agreement
- Given that this report suggests significant reallocation of resources from Central Office to Area Health Services, it will be important to monitor the balance of resources in Central Office for the first two years following restructure
- Given that there will need to be some "bedding down" for the re-organised Central Office, it is not proposed that six monthly interactive performance reviews occur within Central Office in the first year of reform. The performance reporting process will therefore be the quarterly reports referred to above in the first year.

Department level monitoring and reporting should include:

- Monthly report to Queensland Treasury on standard set of indicators
- Annual report to Government on the standard set of indicators and strategic priorities as per Director-General performance agreement
- Annual report to Government on the health of the population by the Chief Health Officer.

At all levels, performance against indicators must be interpreted and required actions and accountabilities identified.

Proposed *external* performance monitoring and reporting process – Public transparency of health system performance

Consultation undertaken for this Review identified that community members and stakeholder groups consider the current performance reporting arrangements to government to be unsatisfactory. They further believe that a deficit exists in the current performance monitoring and reporting system, namely the absence of any statutory body to oversee the performance of the health system. Four arrangements are proposed to address this deficit:

Community review of performance

District Health Councils should review District Health Services' monthly and six monthly performance reports and provide comment to Area Health Councils. They should also produce an annual public report on the performance of the District Health Services.

Area Health Councils should review Area Health Services' monthly and six monthly performance reports, considering comments provided by District Health Councils and provide comment to the Health Commission on any areas of concern regarding the quality and safety of clinical services. They should also produce an annual report on the performance of the Area Health Services.

A particular area of focus for the District and Area Health Councils should be monitoring the performance of leaders (ie District Managers and Area Health Services General Managers).

Health Commission

A new independent body should be established to monitor the systems which support effective clinical governance in the State's hospitals. Chapter 9 describes the role of the Health Commission which includes the following performance monitoring and reporting functions:

- Monitoring the compliance of all public and private health facilities¹¹⁵ with agreed clinical standards including regularly publishing reports on a comparative basis relating to these standards
- To report generally to the Parliament or Minister and the proposed parliamentary committee as deemed appropriate by the Commission on its functions.

¹¹⁵ Queensland Health licences private hospitals. To be licensed, private hospitals must meet a number of standards that relate to clinical governance which are described in Chapter 9 and this is regularly audited. The immediate focus should be on the public system with monitoring of the private system progressively implemented. The timeframe for this should be negotiated with the private sector.

Parliamentary Committee

A parliamentary committee should be established to monitor and review the operations of the Health Commission to ensure that the Commission is performing its functions as intended. Chapter 9 describes the role of the parliamentary commission in more detail.

Performance audits conducted by the Auditor General

The Auditor General should conduct performance audits of the health system. This audit should identify what services have been provided and what outcomes achieved with the funding provided. The Auditor General should have regard to the adequacy of the indicators being used to monitor and assess performance, the systems that are in place to monitor performance and the level of outcomes achieved compared to interstate benchmarks.

Diagram 13.1 presents the recommended monitoring and reporting arrangements.

The implementation of these four arrangements will reassure the public that the performance of the health system is being closely monitored and that the performance information available is unfettered.

13.4.3 The information on health system outcomes that should be public

Information on the performance of the Queensland public health system in achieving health system outcomes should be made available to staff and the community. This will inform all parts of the system as to how each part is performing relative to the whole and will inform local communities about how their system is performing relative to the whole. It will also provide an avenue for local communities to be informed about the range of services that realistically can be delivered in local communities.

As Diagram 13.1 shows, information on the performance of the health system should be provided to the public on a number of levels:

District level

- District Health Councils' annual reports

Area Health Services level

- Area Health Services annual reports
- Area Health Councils' annual reports

Department level

- Six monthly statewide health service performance report including elective surgery waiting lists (rolled up six monthly Area Health Services reports)
- Annual reports on outputs, aspects of service quality (sentinel events, infection control), trauma
- Biennial reports by the Chief Health Officer on health status and burden of disease.

External

- Health Commission reports on the implementation of clinical governance systems and the quality and safety of clinical services
- Auditor General performance audits of the Queensland public health system.

Government level

- Priorities in Progress annual report (health related sections).

Recommendation 13.1

The health system outcomes that should be monitored are: health status and health determinants; patient outcomes; health service activity, expenditure and efficiency; workforce, the quality and safety of services, service responsiveness, and health service sustainability.

Health system outcomes should be monitored using a standard set of strategic indicators. The example set of indicators detailed in this report should be used as a guide in determining the appropriate set of indicators. The standard set of indicators include targets and should be reported on at all levels eg Districts to Area Health Services, Area Health Services to Department, Department to Government.

A review of the operational indicators which Queensland Health is required to report against under various funding arrangements should be conducted within 12 months with the aim of negotiating with funding bodies to reduce the number of indicators and report more strategically.

The administrative burden associated with performance monitoring and reporting against all performance indicators (ie strategic and operational) should be minimised by automating systems where possible.

Recommendation 13.2

The performance monitoring and reporting system should comprise:

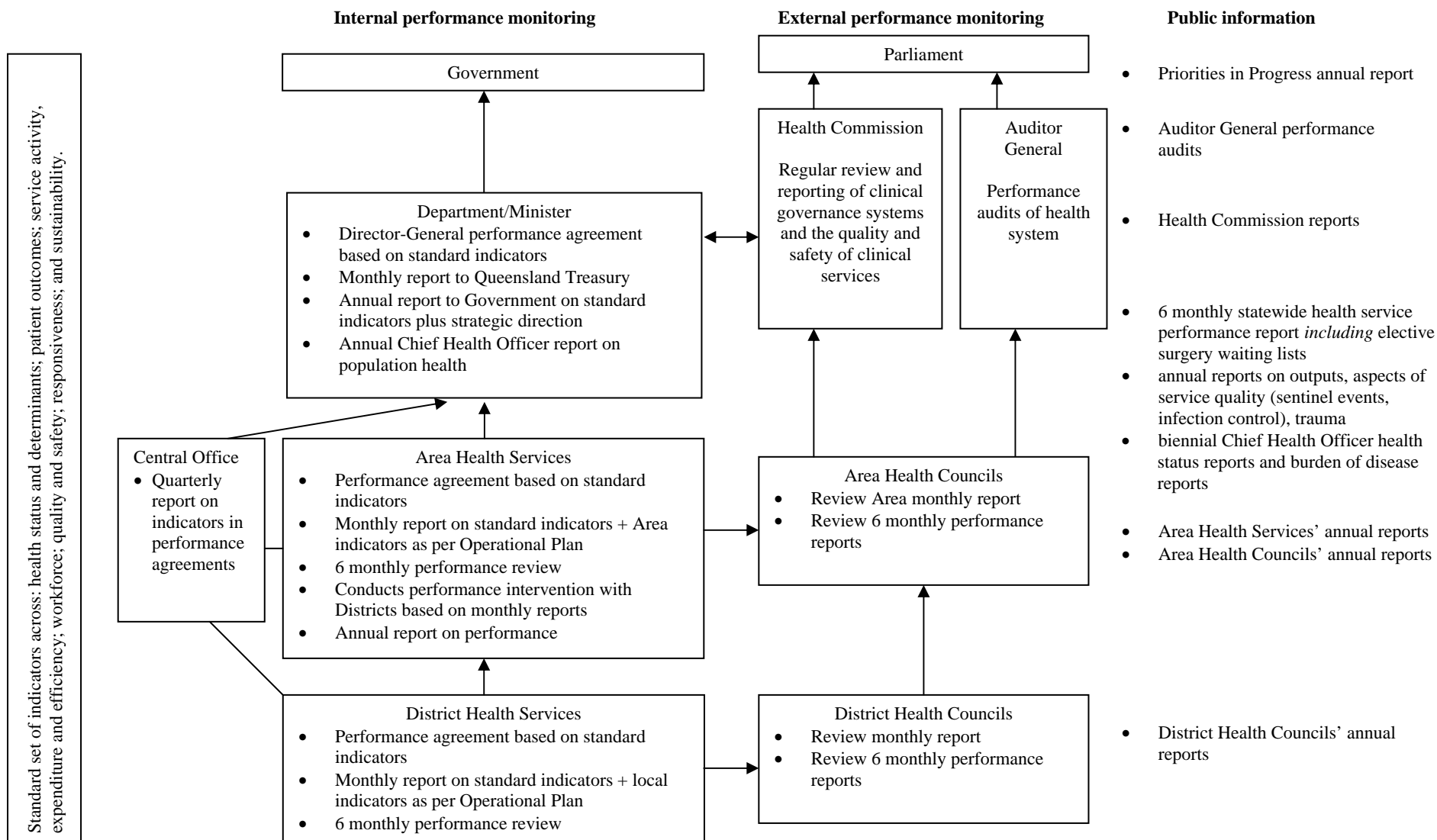
- the use of performance agreements with District Managers and Area Health Service General Managers and Central Office senior executives
- monthly reports and participation in a six monthly interactive performance review process for Health Service Districts and Area Health Services
- quarterly reports to Director-General for Central Office for the first year then participation in six monthly interactive performance reviews
- community review through District and Area Health Councils' comment on monthly and six monthly performance reports
- independent regular review and reporting by the Health Commission on the implementation of clinical governance systems and the quality and safety of clinical services, and the Auditor General on the performance of the health system
- external oversight of the Health Commission by a parliamentary committee.

Recommendation 13.3

A six monthly statewide health service performance report should be published including elective surgery waiting lists, annual reports on outputs, aspects of service quality (sentinel events, infection control) and biennial reports by the Chief Health Officer on health status and burden of disease.

The public should have access to external reviews of the performance of the health system including annual reports by District Health Councils and Area Health Councils. The independent Health Commission should publish reports on the implementation of clinical governance systems and the quality and safety of clinical services and the Auditor General should report on the performance of the Queensland public health system.

Diagram 13.1 Recommended monitoring and reporting arrangements



14. Queensland Health reform

14.1 Overview

This Systems Review has confirmed that far reaching reforms are necessary for Queensland's public health service. Reforms are designed to focus systems and resources towards the achievement of higher standards of health service and improved health outcomes for consumers and patients. The reforms collectively will address many of the current deficiencies and help to restore the community's confidence in the Queensland public health system. In many cases, the need for change is urgent as the Review has confirmed that some frontline services in certain locations are under immense pressure and will cease to operate unless promptly supported.

Fourteen programs of reform have been suggested including leadership and culture, workforce, conditions for employees, systems, quality and safety, services and overall performance. These are described more fully in section 14.5.

Reform success will depend on Queensland Health's leaders being able to effectively engage with the workforce which must actively support and drive the reforms. This is essential, as much of the reform will depend on the active participation and leadership of frontline health service personnel.

The Government would also need to ensure that Queensland Health is able to rebuild the community's trust through engagement, genuine consultation and open and honest reporting on the performance of its health services. The challenge is very significant but achievable. However, overly optimistic short term expectations for meaningful improvement would be unhelpful.

Much of the reform and renewal activity will require additional funding and workforce resourcing. Resources should be targeted to well planned initiatives with quantified health service outcomes that have clear benefits for hospital patients and consumers of other health services. This Chapter contains indicative funding estimates for the highest priority systemic reforms in keeping with this Review's terms of reference. Chapter 6 contains details of how growth funding for enhanced services will be allocations to health service outcome targets developed by clinical networks.

Many of the reforms suggested will require significant input and additional work by frontline health service personnel at a time when they are already experiencing the pressure of excessive workloads and workforce shortages.

In this environment clinicians who are critical to support the delivery of day to day health services cannot be taken off line even for short periods to address reform initiatives without being replaced with relief staff. In many cases, even if funding could be found for the necessary reforms, additional clinical staff may not be immediately available. A range of creative options will be necessary to try and build capacity in the short term to ensure that clinical staff essential to service delivery can fully participate in necessary reform and improvement activity in their local health services whether in a hospital or community based service.

An intensive three year reform period is recommended to lay essential reform foundations and achieve meaningful improvements. At the end of this period, the organisation should be in a better position to sustain a process of continuous improvement, provided it has established the basic systems, is operating from a more appropriate set of values reflected in culture and is achieving target reform outcomes especially training and developing its clinicians and has restored a significant level of trust with its workforce and the broader community.

14.2 Reform success

Reforms could be judged as succeeding if, at the end of three years, the following outcomes are confirmed. The process of continuous improvement should then carry on.

14.2.1 The community has:

- Experienced a new level of engagement and input to plans and decisions about local health services (including the scope of services provided).
- Clearer expectations about what this service will deliver, conditions of delivery and the likely timeframes.
- Access to reports from independent bodies that reflect accurately and truthfully the state of the health service and compares its performance to other comparable services in Queensland and Australia.
- Benefits of an effective population health service.
- Observed significant local effort and results to address current problems such as long waiting times, hospital congestion and bed block and limited access to services.
- Access to coordinated private and public sector health services including primary care and community health services and acute hospital care.
- Access to a more informed and influential District Health Council.

14.2.2 Patients have:

- Confidence that services will be delivered by competent doctors in good hospital environments.
- Greater access to community based care arrangements.
- Higher levels of certainty about what local health services can deliver and can't deliver.
- Better supported transport arrangements for accessing services away from their local community.
- Clarity about total waiting times preceding elective treatment.
- Experience minimal delays or rescheduling prior to accessing necessary health services.
- Experience a culture that is patient centred and care that is appropriate to their individual needs (both clinical and non-clinical).
- Confidence in the safety of clinical procedures and practice and clear expectations about risks and outcomes.

- Experience of integrated team based approaches to care whether at the primary or acute end of the spectrum and coordination of care with other health service providers.
- Clarity about patient rights and the health service's obligations to the patient.
- A trusting health service environment where clinicians openly disclose to patients if there are any problems.
- A system that confirms whether the patient's health service needs have been satisfactorily and effectively addressed (ie did the procedure or service address the problem).
- Responsive local contact points to address concerns and complaints in a supported environment with a minimum of formality.
- The ability to access local health services or members on the local District Health Council to raise issues and concerns.

14.2.3 Staff are:

- Treated well, valued and fairly paid.
- Supported by the organisation and experiencing positive enabling styles of leadership, management and supervision.
- Contributing directly to the reforms through a broad range of local initiatives facilitated by people from their workplace in whom they have confidence and respect.
- Where possible, members of Clinical Networks and teams which can influence the nature and direction of changes to services.
- Able to participate in a greater range of training, development and reform activities because backfilling and relief arrangements are in place.
- Receiving more responsive and helpful advice regarding HR and IR issues.
- Lead by supervisors and managers who have flexible and relevant ways to resolve concerns.
- Using effective complaint and grievance processes that resolve problems.
- Experiencing a culture that focuses on the needs of patients and providing service to patients in a responsible way so as to maintain financial integrity.
- Experiencing leadership that encourages contribution and continuous improvement.
- Confident that their employer, the Queensland Government and Queensland Health, will support them absolutely if they act in good faith and to the best of their ability in delivering health services.
- Proud to work for Queensland Health and have opportunities for a range of satisfying career pathways.

14.2.4 Leaders, managers and supervisors:

- Believe that the organisation is supporting them.
- Have clear role expectations and have received necessary development and training.
- Are empowered to make decisions locally in the best interests of patients and consumers of health services.
- Are contributing meaningfully to decisions about the allocation of growth funds and the manner in which funding is targeted to specific health service outcomes in the interests of Queenslanders.

- Experience a culture that supports honest reporting of problems and demonstrates genuine interest in finding solutions from the highest levels of Government down.
- Experience a culture that is consistent with the organisation's values, and which enables, encourages and seeks new approaches to address challenges.
- Can speak freely and honestly about local service capability and provide the community and media factual information about local health services.
- Have greater resource flexibility to support staff and make better local decisions to address local needs.

14.2.5 Queensland Health has:

- Developed and implemented the critical health service planning and workforce planning systems to better manage its workforce.
- Made substantial progress with other systemic recommendations especially budget allocation, clinical governance and the appropriate number and mix of tertiary training places.
- A Central Office which focuses on statewide strategy, planning, policy, resourcing and performance monitoring.
- Experienced Area Health Services which achieve integrated services to meet targeted needs in a consistent way.
- District health services that meet the local community's agreed scope of service and are achieving performance targets.
- Improved relationships with major stakeholders and is progressing partnerships for the benefit of the health of the community.

14.2.6 Government would:

- Receive meaningful information about community expectations and preferences in respect to the range of health services to be delivered.
- Receive clear factual advice and analysis about the state of health services and options to better support and or limit services to ensure they are safe and effective for those that have a legitimate entitlement to access.
- Approve five year health services plans which are publicly available.
- Endorse clear and factual health service performance targets with honest reports about outcomes.
- Experience greater acceptance by the community, of the need to debate issues surrounding the scope and quality of health services, funding requirements and how best to address resourcing or demand limiting requirements.
- Make and publish decisions about the scope of services and access arrangements.
- Be confident that the health service is performing to expectation in meeting agreed targeted needs.

The above report card should be used at the end of three years to by the Auditor General, Health Commission and the Reform Steering Committee to assess whether reforms are on track and to identify areas where additional effort will be necessary.

14.3 Guiding principles

Queensland Health has developed two helpful guides – “*Managing Organisational Change*” and “*Supporting Employees through Organisation Change*” which contain general organisational change principles. Additional more specific organisational change principles to advance the recommended program of reform in Queensland Health are:

- The package of reform initiatives should be designed and implemented with the needs of patients and consumers of health services foremost, ie patient-centric solutions to many of the current problems.
- Initiatives must address the major deficiencies and opportunities identified by the review in an integrated way. The organisation is large and complex. Changes to systems or parts of the organisation will have ramifications on other parts.
- There is an understandable need to try and do as much as possible as quickly as possible. This urge must be tempered by insights gained by those current leaders in the system who have previously initiated successful improvement and reform. Many of the reforms such as clinical safety and quality and flow process improvements to relieve bed shortages in acute hospitals can only progress at a measured pace.
- Avoid mistakes from the past where many of the well intentioned reforms and changes driven from Corporate Office previously have failed, or have been only partially implemented and supported because of a lack of funding, and or lack of an appreciation of the real needs of Health Service Districts.
- Reform must be led and driven at the highest level, accountable to and directly supporting the Director-General and Minister. Reform programs should be led by personnel who have reform responsibilities as their only responsibilities, and operate outside of the normal executive line structure.
- Drive as much reform as is practical from the new empowered and funded Area Health Services and existing Health Service Districts in acute hospitals, community and population health services.
- Appreciate that there are whole of state initiatives such as quality and safety, the credentialing and privileging of the medical workforce and the recruitment and support of Health professionals, which will need to be driven and coordinated centrally, but implemented in strong partnership with clinicians in Area Health Services and Health Service District.
- The reform process should minimise any disruption to the clinical workforce which is already over-burdened and struggling to maintain a satisfactory standard of health service.
- There will be an intensive process of reform over a period of at least three years which will need to be properly focused and resourced. Reform arrangements and structure could be progressively assigned to regular work units as renewal capability to continue reform is developed within Queensland Health.
- To implement the reforms in a manner that strengthens the continuum of health care from primary care through to post acute care, links with the aged care sector, and strengthen linkages between all of the parties involved in this continuum. This will include the State Government, the Commonwealth Government, a broad range of private sector providers, the non-government sector, local government and most

importantly representatives of local communities with a direct interest in the Health Service District.

- Ensure major community concerns and issues receive priority attention including:
 - quality of clinical services available in public hospitals.
 - speed of access to these services.
 - the capacity for patients to effectively raise concerns and resolve these concerns.
- Involving all categories frontline staff effectively in the reforms with a focus on the interests of the individuals and communities who use their services.

14.4 Reform strategy

Strategies driving reform:

- Emphasise leadership and the development of a culture which strengthens the focus on patients and health service consumers.
- Empower Area Health Service General Managers who will ensure effective levels of planning and integrated service delivery to meet area needs.
- Allow clinical networks to progressively assume responsibility for decisions about how new funding for health service delivery shall be allocated.
- Strategically focus the newly organised Central Office to establish clear strategic intentions, informed by better statewide health service and asset plans, which will influence policy and resourcing decisions.
- Central Office in conjunction with Area Health Service General Managers will establish health service outcome targets and monitor performance accordingly.
- Develop reform program outcomes and targets as the basis for phased allocation of funding with demonstrated success the basis of continued funding.
- Seek a contribution from non Queensland Health staff to help progress certain programs of reform, e.g., leadership and culture.
- The Reform Leadership Team will draw on the experiences of other jurisdictions, both nationally and internationally, in planning and implementing programs of reform.
- Some Health Systems Review staff should form part of the Reform Leadership Team to ensure that the full intentions of the review recommendations are well understood.
- Ensure that the proposed independent Health Commission (accountable to Parliament), and Queensland Health clinicians, make informed decisions about what clinical outcome information should be released to the community and in what form. There is clear international evidence to suggest that imprudence in this area has destroyed progress in advancing clinical safety.
- The Development Unit will continue to have a major role in reform leadership and implementation, especially in assisting with the establishment and functioning of clinical networks, the development of clinical leadership and new clinical governance arrangements.

14.5 Programs of reform

This Report has identified fourteen areas of reform (programs) each consisting of a series of staged projects or initiatives which will require focused attention for an intense three year period and then ongoing development and review. The fourteen reform programs can be conveniently aggregated into three streams of initiatives as follows.

| Stream | Workforce Reforms Organisation, Team and Individual Development | Structure/Systems | Service Needs Relationships/ Partnerships |
|--------------------|--|--|---|
| Initiatives | P1 Immediate Workforce Priorities | P4 Hospital/Health Service Improvement | P8 Strengthen Community Sector Partnerships |
| | P2 Leadership/Culture | P5 Safety Quality Clinical Governance | P9 Health Service Planning and Workforce Planning |
| | P3 Teaching/Training | P6 Patient Complaints | |
| | Workforce Planning (see P9) | P7 Central Office Restructuring | P10 Service Enhancement <ul style="list-style-type: none"> • Indigenous Health • Mental Health • Rural Remote • Chronic Disease • Child and Youth Health |
| | | P12 Performance Reporting | |
| | P13 Information Technology | P11 Strengthen Commonwealth Partnerships | |
| | P14 Assets | | |

Reform programs are interdependent. Elements of some must progress before others can commence. For example, leaders need to establish a culture of greater mutual respect and trust with clinical personnel supported by better systems, before real gains in clinical safety and practice achieve full improvement potential. Without this there may be only partial reporting of incidents, with limited opportunity to establish cause or develop and implement solutions. Similarly, hospital and health service improvement projects will require funding for relief clinicians so that other work teams may be released to train, resolve problems, plan for and develop workplace solutions. There is also a priority to build some greater clinical workforce capacity to immediately cope with the increased workload.

As there are 25 major hospitals, all experiencing patient workload pressure with no discretionary funding or staff for backfilling, this is a major problem. Each facility would require between 20 to 60 nurses with complementary medical/allied health staff to progress reforms at only a modest pace. There is therefore a need for immediate growth in numbers of nursing and allied health staff. Staff specialist and registrar time could be freed up by increasing VMO sessions. The key will be local flexibility.

14.6 Funding

Additional funding will be essential to advance reform program areas. Additional funding requirements should be assessed in detail as part of detailed reform planning because:

- (i) Reforms primarily should be owned and driven by personnel (all staff categories) within District and Area Health Services who ideally should be involved in reform planning locally and should understand the cost implications.
- (ii) The reform strategy requires that allocation of funding should be staged to achieve specified health service improvements or outcomes. Progress and impact should be monitored carefully.

Some broad indicative estimates are offered against the 14 programs. They must be refined during detailed reform planning.

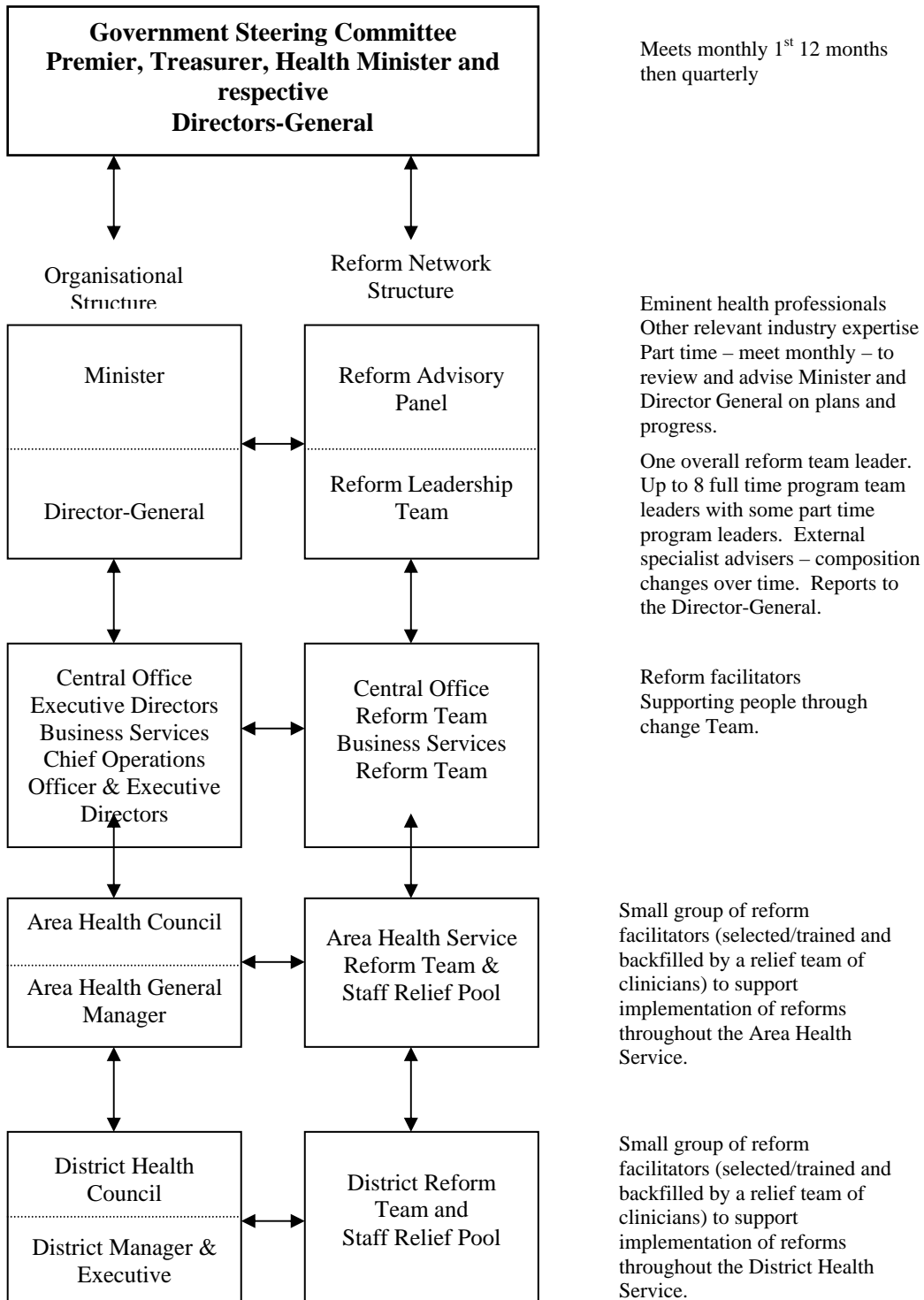
The cost of overall reform is likely to be quite significant and may be beyond the capacity of the Queensland Government alone to fund, even if measures discussed earlier such as limiting demand, means testing access with associated co-payments or raising taxes are possible. Meaningful working relationships between the Commonwealth and State Governments would be essential in jointly developing and delivering better health system outcomes.

From the community perspective, health should be an apolitical, patient and consumer centred issue. However, if the full range of current health services were not able to be funded, the community should be involved in such decisions and honestly advised of the extent to which health services may need to be curtailed.

14.7 Reform process

Leaders in Central Office and Area and District Health Services will ultimately be responsible for implementing reforms. However, they must be supported intensively for three years by a network of Reform Leaders and Facilitators who will have a depth of expertise in reform program areas, and the necessary credibility with their colleagues and managers to perform their role. This will enable leaders to focus on their core day to day responsibilities while supporting the various reform implementation initiatives being undertaken.

The Reform Leadership/Facilitator network is as follows:



The Reform Leadership Team would require permanent members for the three year period with other members changing through time including personnel both internal and external to Queensland Health. This team would work closely with the Chief Executive and Minister, and with the Executive leaders and managers of Queensland Health. The leader would be accountable to the Director-General and would report to a Steering committee comprising the Premier and Treasurer, the Minister for Health and their respective Directors-General monthly during the first year of reform and then quarterly.

The make up of the Reform Leadership Team would be:

| | | |
|-----------------|-----------|--|
| 1 Doctor | Full time | Reform Leadership and Team Leader |
| 1 Nurse | Full time | Reform Leadership |
| 1 Allied Health | Part time | Reform Leadership |
| 1 Administrator | Part time | Reform Leadership |
| 1 Doctor | Full time | Workforce Development Expertise |
| 1 Person | Full time | Leadership/Culture Expertise |
| 1 Person | Full time | Hospital/Health Service Expertise |
| 1 Person | Full time | Central Office Restructure and AHS establishment |
| 1 Person | Full time | Special Needs expertise |
| 2 Doctors | Part time | Clinical Governance |
| 3 People | Part time | Special needs expertise |

It is suggested that an advisory panel of eminent health service professionals be established to meet periodically and provide guidance and assistance to the reform leadership team and the government by overseeing and contributing ideas to the implementation of reforms in much the same way as the panels of eminent clinicians established to support this Review have performed their task. As clinical networks develop, some of these leaders could be included on such a panel, together with external clinicians including those from educational institutions.

The proposed skill set of external advisors would be

| | |
|----------|-----------------------|
| 1 Person | Overall reform agenda |
| 1 Person | Leadership/Culture |
| 1 Person | Health Planning |
| 1 Person | Service Improvement |

The Reform Leadership Team would help to establish a network of change and Reform Facilitators in each of the three Area Health Services and in each Health Service District to support their respective executives and clinical leaders in the reform tasks that need to be undertaken. Whilst people in the Reform Teams would be selected because of their specific reform expertise and leadership capabilities, it is imperative that Reform Teams in each Area Health Service and Health Service District are selected with the support of their peers and managers, so that they can support their leaders locally and retain the trust and support of their colleagues in helping to implement the reforms.

These personnel must have the capacity to lead/facilitate a range of planning and development initiatives which will need to be coordinated in various centres throughout the State. They would need to be released from their usual clinical and administrative roles so that they might devote sufficient time to the reform initiatives. Some would need a full time commitment, others part time. They should be nominated through a transparent process.

Staff seconded to the reform program should be afforded the opportunity to apply for new positions as they become available during restructuring or organisational change activities. If successful applicants, they could still remain seconded to their roles in the reform process and their position be backfilled until their service with the team ceases. At this stage they should assume the roles which they previously held, or have been successful in filling during the reform process, or alternatively should their former roles have been abolished, to exercise their options to negotiate placement or exit the organisation drawing on entitlements as they existed at the time of this report.

14.8 Monitoring reform

Another significant strategy for the reform process would include independent monitoring of reform progress by parties external to the Queensland Health service and the normal executives structure of government.

It is suggested that the Auditor-General be commissioned to undertake systems and performance audits of the reforms and their ongoing outcomes.

The Review has also suggested the establishment of a Health Commission, comprising independent personnel of the highest calibre to oversee and report upon clinical practice reform especially progress in achieving clinical quality and safety improvements. This Commission will report to the Minister and to a Parliamentary Committee. This would help to ensure that the community is confident that clinical reforms are taking place as envisaged, that Queensland Health's services are operating to the standard expected and appropriate reports are released.

14.9 Reform programs, sequencing and timelines

It would be the role of the Reform Leadership Team in conjunction with the Director-General to develop detailed program and project plans covering all major reform initiatives. This report provides an overview of what is necessary, so that the Government, Queensland Health and bodies like the Auditor-General will have some broad expectations and timeframes against which to monitor particular reform initiatives to ensure that they are properly implemented, integrated and coordinated. Elements of the reform program and suggested sequencing and time lines are outlined below. It is emphasised that these are preliminary, and as such will require modification as new and more detailed information becomes available as reforms progress. Further detailed scheduling of reform programs is provided in Gantt charts in Appendix 14.1. The schedules are just guides to assist the Reform Leadership Team commence the reform process and will need further development.

14.9.1 Addressing immediate clinical workforce shortages

Summary

- Urgently target critical health service priorities and the clinical positions necessary to maintain services.
- Local and overseas medical graduate recruitment enhancement.
- Career enhancement and recognition of generalist positions (eg Career hospital doctors, rural generalists).
- Complete enterprise bargaining to achieve fair salaries relative to other states and remove impediments to reforms.
- Increase nursing and allied health numbers by attracting new graduates and through re-entry programs.
- Develop partnerships with other parts of the health sector across the continuum of care to make effective use of available clinicians.
- Increase utilisation of Visiting Medical Officers and General practitioners.
- Assess, credential, privilege and support new and current doctors with special purpose registration.

Details

The immediate priority is for Queensland Health to continue to target clinical positions that will enable services to be maintained across the State. Districts and Area Health Services should coordinate this process until clinical networks are better established and in a position to advise priorities. The current enterprise bargaining rounds must be concluded. The objectives must be to achieve fair salary, more flexible conditions and simplified awards.

Doctors

Queensland Health must continue to target overseas trained doctors particularly from the United Kingdom. A planned targeted campaign commencing immediately but with a time frame over several years is required. This program should enlist the assistance of the Royal Medical Colleges, professional associations, known Australian contacts working in the United Kingdom and focus on targeting interested individuals. The targeted campaign needs to be supported by appropriate generic marketing and advertising campaigns including opportunities relating to conferences, conventions, expositions etc. A well respected local medical practitioner would lead and coordinate this initiative supported by the workforce planning project assisted by a number of local practitioners who are available to travel to the United Kingdom and inform and assess prospective candidates at regular intervals over the coming years.

Nurses

It is estimated that there are significant numbers of experienced graduate nurses who might be prepared to return to nursing if conditions of employment were more flexible and perceived to be fair and just, and if where appropriate, support arrangements by way of re-training, mentorship, child care etc were more available. For this program to be effective, constraining recruitment processes must be streamlined so that nurses with the right qualifications and confirming referee reports can be immediately employed.

Whilst broadly based media campaigns might be useful for general recruitment, it is considered more appropriate that the existing nursing workforce be commissioned to secure re-engagement of former experienced colleagues in targeted areas of need known

to be still interested in working within Queensland Health but possibly requiring more flexible working arrangements.

Existing nurses could be offered a range of incentives to perform this attraction role including sponsorship at conferences or study, an additional period of development leave, such as review of practice in other jurisdictions or straight out financial incentives. A period of guaranteed service would be sought from returning personnel. Recruitment to build general capacity could target appropriate skills mix across RN, EN and AIN categories. The opportunity for career paths including advanced nursing roles and expanded nurse practitioner roles should also be use as an incentive.

Many clinicians who currently work outside the public sector may have some capacity of to contribute to the delivery of public health services. Strengthening partnerships with the private and non-government sectors to maximise the potential contributions from their respective workforces should be a priority for each Area Health Service and Health Service District need to perform this role.

With respect to allied health professionals there is arguably a greater shortage than for nurses or doctors. James Cook University experience with pharmacists indicates that integrated planning between the university, the public and the private sector is an essential step in building sufficient numbers of allied health professionals. There is also the potential for increased numbers of advanced roles, for example fit for surgery programs in outpatient clinics.

In endeavouring to secure improved utilisation of existing medical practitioners, it would be important to draw on wisdom from the clinical networks being established, but also provide priority to staff specialists and Visiting Medical Officers who are currently performing work within the public health system before seeking the services of additional Visiting Medical Officers from the private sector or outsourcing procedures to private hospitals. In reality all options may be necessary to address the workload.

For example, if internal staff specialists are able to perform their normal range of duties during a four day week, then they may be interested in undertaking additional sessions for elective surgery during another day of the week. If Visiting Medical Officers require additional sessions, this should be extended to those already within the system before being offered externally. Funding must accompany these initiatives, appreciating that it is total theatre and other session related hospital costs that must be funded, and not just salary costs.

A broad range of opportunities for General Practitioners and other primary care providers to strengthen links with the acute hospital system in terms of pre-operative care and post-operative care are required. The North Brisbane Division of GPs Team Care Project is a good example.

As a matter of urgency the schemes described within the report to properly assess and support clinical staff and the clinical governance systems to properly assess, credential and privilege existing and new OTDs with special purpose registration need to be implemented. This includes immediate consolidation of the RAPTS Program and commencement assessment, support and training for existing and new overseas medical graduates through the Development Unit.

Resources

- A doctor to address medical workforce issues full time.
- Supporting project resources in workforce planning in Central Office and in Area Health Services with representation of nursing/allied health on the Reform Leadership Team.
- An overseas recruitment campaign for doctors should be actioned immediately.
- Implementation of RAPTS would require an immediate investment of \$3 million.
- Short term workforce planning resources to be assigned for each Area Health Service to review and consolidate immediate clinical and infrastructure priorities.
- Establishment partnerships with GP Divisions and Universities to make better use of existing primary care and allied health workers and devise future recruitment and attraction strategies, including scholarships.
- Develop guidelines for the nurse re-engagement program and recruitment program.
- District Reform Facilitators to assist District Managers in implementing initiatives.
- Clinical capacity building – doctors, nurses, allied over first three years as detailed below.

| Staff | Additional capacity required | Recurrent cost by Year 3 (\$ million) |
|--|--|---------------------------------------|
| Doctors for service growth | 180 per year 540 over 3 years | \$90 M |
| Hospital career Senior Medical Officers to replace current Resident Medical Officers | 100 per year 300 over 3 years | \$30 M |
| Visiting Medical Officers to reduce reliance on doctors with special purpose registration and provide additional quarantined teaching time for existing staff (NOTE – this is not for additional service provision) | A doubling of sessions (from current 240 FTE to 480 FTE) | \$75 M |
| Generalist GP's working part time in Emergency Departments to reduce reliance on OTD's with special purpose registration | 100 per year 300 over 3 years | \$30 M |
| Nursing – general recruitment and target attracting existing nurses for re-entry to address current work load (over and above the 500 new graduates per year growth funded) | 500 per year 1500 over 3 years | \$112 M |
| Allied Health to address current workload (over and above the 250 per year growth funded) | 2000 over 3 years | \$150 M |
| Total | | \$487 M |

Timing

- Reform Leadership Team established promptly.
- Credentialing and Privileging system for existing and new overseas trained doctors on special purpose registration to commence immediately and be fully functioning by December 2005.
- Assessment and support plan for all special purpose registered doctors by June 2006.
- Network of Area Health Service and Health Service District workforce planning personnel in place by March 2006.
- Longer term recruitment, education and attraction programs and partnership programs fully planned and implemented by July 2006 with milestones and target recruitment levels identified over the next three years.

14.9.2 Developing culture and leadership

Summary

- Appoint a new organisational leadership team.
- All leaders and managers (of staff across all categories in Queensland Health) to attend development workshops.
- Develop commitment to reforms, a new code of conduct and revised values.
- Participation in a statewide leadership development program and commitment to revised leadership behaviours included in employment contracts or conditions of employment for senior executives.
- A formal process of assessment at regular intervals (including feedback from peers, subordinates and supervisors) of whether leaders are setting the right example with external oversight by District/Area Health Councils and the Auditor-General.
- Leadership development will be integrated with clinical/health service/reform imperatives.

Details

Culture changes when people in leadership roles enable the work experience of individuals within the organisation to change. Leadership emerges and is shared at varying levels of the organisation when enabling and encouraging influences and behaviours replace prescriptive and constraining environments.

A Director-General for a transitional period has been appointed to lead the organisation through the first 15 months of reform, especially to oversee restructuring and ensure all reforms are progressed. Senior leadership positions in the new organisation should be advertised and selected as early in the reform process as practical on a merit basis. It is intended that the position of Director-General will be advertised prior to June 2006.

The reform proposes an initial series of two day information workshops for all senior personnel across all disciplines. Working in sets of natural work teams these leaders will explore and thoroughly understand the nature of the reform challenge, the programs and plans for implementation envisaged and the ways that they may plan, organise and deliver reforms locally. Issues such as culture, new values, leadership styles and behaviours will be addressed. These will be followed by a further two workshops of one weeks duration to review local reform issues, explore revised leadership approaches and confirm future plans.

Leadership will be fostered and culture changed in Queensland Health when staff experience a new working environment which encourages, supports and depends upon multi-disciplinary teams discussing and sharing common values and objectives, developing new ways of addressing old problems, implementing change and experiencing success. New clinical leadership roles within Clinical Networks are an important initiative to support these changes.

It is envisaged that the reform program for Queensland Health will require “wall to wall” training and development activity where the staff and communities that they serve work together to explore new ways of dealing with existing and emerging problems. Participation in team problem solving, workplace redesign, systems improvement and patient centric care can all potentially contribute to the development of an improved culture.

Essential to the change and reform agenda will be a process of training development and workshop activity where staff work in teams (both existing teams and at times across work teams and organisational boundaries) to confront and resolve current workplace problems. They will seek the necessary resourcing to address these problems, implement local reforms, monitor these reforms and in so doing change the culture of the organisation from one which is prescriptive, constraining and enforcing, tending to bring out the worst of human behaviour, to one that is more enabling, encouraging and supportive. In such a culture staff are more likely to model the behaviours more in keeping with those which would typify an organisation committed to improved patient outcomes and successfully dealing with new challenges in a way that retains the public's confidence.

These reforms are to be led and implemented in a decentralised manner in Health Service Districts and Area Health Services across Queensland. Emerging structural forms such as the development of clinical networks and the empowerment of these networks will progressively lessen the reliance on formal mechanical hierarchal chains of authority and control. There will inevitably be tensions, but the end result most worthwhile in terms of health outcomes.

In an organisation already under resourced and struggling to cope with patient workload this will be the most significant reform challenge. Relief staff and relieving arrangements will be essential.

The impact of reform on organisational culture and staff satisfaction should be evaluated over time using staff surveys.

Resources

- One Project Team leader for the Reform Leadership Team.
- A series of leadership development programs focusing on the reform initiatives and leadership behaviours must be designed and run initially for some 500 people currently in senior management or leadership positions.
 - Stage 1- 2 day program
 - Stage 2 - 5 day program conducted 3 to 6 months later
 - Stage 3 - 5day program conducted 9 to 12 months after Stage 1
- Programs must be designed for all other managers and supervisors delivered in a decentralised ongoing way.
- Reform Facilitators need to be selected and trained (some 150 by March 2006)
- Area Health Service and Health Service District training capacity needs to be enhanced.
- Mentoring and collegiate support networks for senior managers and leaders of the clinical networks to be developed.
- Strong links between this program and program 3 teaching/training renewal.
- Workplace culture and staff satisfaction surveys.

| Annual costs leadership/reform workshops | | |
|---|-----------------------|--------------------------------------|
| Training | Staff numbers | Cost |
| Senior Leaders training: Year 1 2 days, 5 days, 5 days then 5 days annually ongoing | 500 | Year 1 \$ 1.2 M Year 2/3 \$ 0.5 M |
| Reform Facilitator Training annually for 3 years | 150 | \$ 0.3 M |
| Staff to backfill Reform Facilitators annually for 3 years | 150 | \$15.0 M |
| Management and supervisor training 5 days annually ongoing (assuming 1 manager to 10 staff) | 4500 | \$ 4.5 M |
| Staff to 50% backfill managers and supervisors during training | 50% backfill for 4500 | \$ 4.2 M |
| Total Recurrent by Year 3 | | \$9.2 M |

Timing

- First leadership segment (two days) for 500 staff including District Health Council Chairs completed by January 2006.
- Follow up more intensive leadership development segments during 2006.
- Follow up senior leadership programs annually thereafter.
- Building leadership development, change facilitation and training capacity in Health Service Districts and Area Health Services by June 2006. Potential values might include information sharing, honesty and accountability.
- Progressive programs completed for all management/supervisory personnel including clinical networks by December 2007 thereafter annually.
- Provisional new values and Code of conduct prepared immediately but refined progressively throughout leadership and workshop series by July 2006.
- Formal review of leaders performance involving chairs of District Health Council peers and managers at three months, six months and twelve months following the leadership development program. Leaders unable to satisfy the new requirements would not be retained in leadership roles. The process to be confirmed by the Auditor-General.
- Workplace culture and staff satisfaction surveys in late 2007.

14.9.3 Teaching and training renewal

Summary

- More registrar places and protected specialist teaching time
- Skills upgrades for all clinicians across the health continuum (primary, secondary and tertiary care)
- More scholarships all categories
- fund re-entry training for nurses
- In-service clinical teaching/training upgrades all categories. Should include exploring local practice changes to better use the skills available e.g. specialist nurses
- Fund/resource the Skills Centre
- Clinician interchanges interstate and overseas
- New training/development pathways – competency based not time based
- New models of care and clinical roles to maximise value from existing clinical teams
- Effective partnerships with the tertiary and vocational educational sectors to develop and maintain relevant programs for health professionals.

Details

This set of reforms must be led by re-established and empowered clinical leaders within Central Office, the Development Unit and Skills Centre, with strong links to all health service facilities. It is suggested that to maintain clinical relevance, the clinical advisors rotate on a 2 – 3 yearly basis from clinical positions within health services.

There is an urgent need to fund and establish more Registrar places and protected specialist teaching time for doctors. Commonwealth funding or joint pilot approaches with the Commonwealth are necessary and the process of targeting initial priorities which has already commenced must continue in earnest. Capacity is essential to teach and train all of the local doctors that are available to work in Queensland especially in an environment where we will be unlikely to recruit sufficient doctors for the next 10 to 15 years.

It will be necessary to arrange numerous clinical and administrative skill upgrade sessions for the workforce particularly the clinical workforce. This includes general programs such as computer keyboard skills to the more specific involving clinical networks and contribution to improved quality and safety, improved clinical practice and outcomes, and enhanced team development leadership and management development initiatives.

Until additional capacity can be created in the numbers of nursing, allied health professionals and doctors needed to relieve their colleagues, little training and development will be possible in the system. Adequate funding must be available to build capability to relieve the existing workforce to enable training and development to occur.

An important foundation in this process will be the Skills Centre which should be appropriately led, staffed, resourced and programmed to support development of clinical skills throughout the state. It will be prudent to fully utilise the capacity of the Skills Centre through both contracting individuals from other sectors to provide training and for training to be offered on a fee for service basis to up skill clinicians working in the private and non-government sector.

Training within existing work teams where the mix of duties and processes of care are fully understood offers greater scope to develop new and enhanced models of care. This will also enable emerging clinical roles to be identified and developed (such as nurse practitioners and physician assistants). Area Health Services and Health Service Districts will have major obligations to facilitate this training and development.

Resources

- This project links with program 1 where the workforce leader will also take responsibility for this program.
- Intensive work required with workforce planning networks throughout Area Health Services and Health Service Districts and the workforce planning team in Central Office.
- Significant contribution expected from the Chief Medical, Nursing, Allied Health and Dental positions.
- Significant capacity building for the Skills Centre – including contracted resources.
- Significant requirement to have funding to develop pools of staff to assist with backfilling, within each Area and District Health Service to enable teaching and training to take place. It may be necessary to develop six monthly or annual training plans for forward planning purposes.

| Annual training costs | | |
|--|---|------------------|
| Free up Nurse Educators to train/teach | Covered by additional nurses in Program 1 | P1 |
| Support new employees and students with a network of preceptors and facilitators | 150 FTE across the state | \$11.25 M |
| Develop the Skills Centre to full capacity with a training network through out the state including backfill for contracted educators/teachers and participants | Average 1 day per year per clinician | \$65 M |
| Total | | \$76.25 M |

Timing

- Registrar places and protected teaching time organised by March 2006.
- New teaching requirements with existing staff specialists and VMO's organised by June 2006.
- Longer term development plans by discipline developed through the Health Service District training networks for community health services and hospital by March 2006 progressively implemented and fully performing by December 2007.
- Relief pools progressively established by December 2008.

14.9.4 Hospital/health service improvement

Summary

- New models of care and clinical roles progressively implemented.
- Redesign of patient flow process from primary care to acute care and within hospitals
- Addressing waiting times for appointments and waiting lists for elective surgery – transparent reporting, new care models, better logistics and efficiency in procedures
- Better connecting GPs to hospitals - more involved in patient pre and post procedural care (these initiatives must be driven locally by clinicians supported administrators)
- Create an environment for clinical teams to spontaneously improve work practices and develop skills.
- Revised funding and budget allocation systems (casemix) over time to ensure fairer allocation for all Queenslanders.

Details

The centralised network of Reform Facilitators will work with their local health service facilities to renew patient referral and flow and ensure that facilities are designed and services are provided in a patient centric manner. This must be focused on connecting the full range of services across the primary to tertiary healthcare continuum in a targeted way for greatest impact and efficiency.

Work design studies typically require collaborative team based approaches where staff and patients work together to identify and resolve problems and redesign flow process. Formal projects take typically between six and sixteen weeks to assess, plan, resolve and redesign followed by some six to eighteen months implementation time depending on the complexity of the system being reviewed. However in a culture where shared leadership and continuous improvement is the norm, many shorter less formal projects would be occurring. Local leaders need a small amount of discretionary funding to action improvements.

Waiting times and waiting lists will only be successfully addressed once some very basic but urgent patient flow processes have been addressed in every Queensland hospital, and additional workforce capacity exists to ensure full productivity for operating theatres and hospital beds. As all of these resources are unavailable currently, there will be some lead time needed to gear up this initiative.

Once these are in place it is envisaged that clinical networks and clinical teams will be responsible for planning strategies to address waiting time and waiting list problems. This should be achieved by both greater throughput in the short term but improved prevention and primary care initiatives in the long term which reduce the need for some types of surgery.

As work redesign progresses new and innovative models of care will be identified and different clinical roles will evolve. The development of these initiatives is discussed in Section 14.9.3.

Better step-up and step-down facilities are an important part of this initiative where there are some significant long lead times. The IT enhancements, the supply of support staff for the clinical work place, revised funding and budgeting arrangements will all take some time to implement. The set of reforms are complex, highly interdependent and will require clinicians investing significant time away from frontline working obligations.

This set of reforms will only be able to be addressed if relief clinical teams and funding are available to support every major hospital in its reform task. Partnership arrangements with general practice and all primary healthcare providers including the non-government sector are also an important part of this process. The Chair of the local Divisions of General Practice (or nominee) should be paid to participate in service planning and patient flow initiatives.

Resources

- Part time member Reform Leadership Team.
- External expertise required first six months.
- Funding for support/data analysis for Clinical Networks secured until 2008 (Commonwealth Quality and Safety Funding).
- Each Clinical Network requires **\$300,000** to cover leadership, administrative support and immediate initiatives. For some 20 networks this is **\$6 million** per annum.
- Work redesign funding (includes part time backfill, patient involvement, analysis and implementation costs funded from the Innovation Fund (or if large a separate allocation) at **\$15 million** per annum.
- Continue elective surgery additional funding –
 - Year 1 **\$100.8 million**
 - Ongoing **\$61.6 million**

Timing

- All Reform Facilitators and other Health Service District capacity building by March 2006.
- Health Service District project priorities identified by March 2006 followed by project implementation.
- Clinical networks identified and priorities and plans in place by March 2006.
- Budget reform (casemix funding model) and funding team implementation commencing Budget 2006-2007.
- Urgent elective surgery plan by December 2005, implemented by March 2006
- Clinical network team plans for addressing patient flows, alternate surgical management and longer term waiting list issues by June 2006. Intense implementation to March 2007.
- Progressive improvement plans by Health Service Districts and Clinical Networks over a three year period.

14.9.5 Safety, quality and clinical governance

Summary

- Urgently implement recommended privileging and credentialing arrangements for existing and new doctors
- All improvements must be progressed in a just culture
- Must be driven through clinical networks so as to address issues with the highest potential to improve practice and outcomes
- External oversight provided by the Health Commission reporting to a Parliamentary Committee.
- Statewide timetable but led clinically both centrally and in each local health service.
- Must quickly establish the Clinical Governance Units to facilitate Area implementation by December 2005.
- Plan for and establish the Health Commission.

Details

The Department is already implementing clinical collaboratives using processes that will establish the formalised structure of clinical networks envisaged. As these processes rely on the willing input and contribution from clinical teams across the state, it cannot be accelerated at a pace more than it is practical and possible for individuals to contribute.

The role of Central Office, Area Health Service and Health Service District executives is to be one of support and encouragement rather than traditional prescriptive requirement and decision making.

There are significant challenges here as the community expects high standards of quality and safety and the traditional approach which demands behavioural change and conformance may have popular appeal but experience elsewhere has found that this approach fails to achieve the impact required and in fact causes considerable harm to efforts to improve quality and safety in acute hospital settings. Providing a “just” and enabling environment including necessary legislation to protect individual clinicians acting in good faith and appropriate funding models are key requirements. The clinical governance units in the Area Health Services will oversee the clinical governance system.

Detailed planning will be necessary to create the Health Commission including:

- Review existing Health Rights Commission Function and resourcing.
- Design Health Commission to discharge full clinical governance role including HRC functions.
- Review legislative interface issues between Health Commission and Registration Bodies, MC, Ombudsman, Queensland Police Service and State Coroner.
- Develop legislation, role, membership and structure for the Health Commission.

Resources

- Two part time senior medical practitioners from the Development Unit in the Reform Leadership Team to develop networks for patient safety and clinical practice.
- Training of part time senior clinicians as network leaders.
- Training in clinical governance for all Medical Superintendents and Directors of Clinical Divisions in hospitals so they are an integral part of the system.
- Development Unit personnel involved intensively.

- Support resources and time allowance required for Clinical Network leaders.
- Immediate appointment and training of Area Health Service Clinical Governance leaders.
- Criminal history checking a priority for those working with children.
- Health Commission staffing and operations.

Timing

- Clinical networks fully functioning by December 2006.
- Incident monitoring (using techniques such as CUSUM) and incident investigation (using techniques such as root cause analysis) and internal reporting fully functioning by December 2006 in all hospitals.
- Audit review of systemic issues by the Health Commission June 2006.
- Health Commission plan of operation by March 2006 to commence in July 2006 (growing incrementally).

14.9.6 Patient complaints and responding to concerns

Summary

- Local resolution as the basis for complaint management (over 20,000 annually)
- Systemic improvements and dedicated trained personnel for the process
- Patients and clinicians engaged from the outset
- Open disclosure of problems to be the accepted norm
- Clear escalation processes and efficient referral process in place
- Simplify, integrate and strengthen existing review mechanisms eg Health Rights Commission/Medical Board/CMC/Ombudsman as part of planning the new Health Commission.

Details

Local resolution will be the cornerstone of the contemporary complaints process in Queensland Health. Local Complaints Coordinators, highly skilled in mediation must be properly selected, trained and developed so they can undertake this task. It is important that all clinicians understand they have a responsibility to personally assist in the timely resolution of complaints involving them. A database for recording all complaints is required to enable tracking of individual complaint resolution and monitoring patterns.

Local Complaints Coordinators must be able to mediate and resolve issues between patients and the health service, and to do this in a manner sufficiently independent from the workforce to show a fair, just and impartial approach in their task.

Escalation processes will then lead within 30 days to a locally based empowered Health Commission Officer, who will then deal with the complainant and the health service representative in a direct way to try and resolve the matter. The Complaints Coordinator and Health Commission personnel must have extensive expertise in understanding the proper role of all other regulatory and oversight bodies including all of the Registration Boards for clinicians, the CMC, the Ombudsman, the State Coroner and the Queensland Police Service so that matters that are appropriately the responsibility of these bodies can be referred promptly to them.

Complaints concerning doctors must all be notified to the Area Director of Clinical Governance at the time local resolution is commencing.

Resources

- Skilled facilitators/trainers to prepare Complaints Coordinators and Health Commission officers for their local complaints resolution role.
- Develop consistent complaints resolution and escalation systems for both patient and staff complaints involving executive teams in all locations including Central Office.
- IT support systems developed and rolled out.

Timing

- Complaints systems development by December 2005 and operational by July 2006.
- Appoint and train Complaints Coordinators by March 2006 (linking to new arrangements with Health Commission).
- Complaint system database with access arrangements to Health Commission in place by July 2006.

14.9.7 Restructure Central Office and devolve personnel, positions, resources and authority to Area Health Services/Districts

Summary

- Empowered local Area and District Health Services
- Area integration of service planning, resourcing clinical networks, partnerships, performance support and monitoring
- Restructure and refocus Central Office – key functions include strategic direction, governance, policy (integrated across continuum), funding and resource allocation, legislation, regulation, performance, targets and monitoring
- Enhanced collaborative Central Office/Area Health Service model for strategic planning, service planning, resourcing and industrial relations, human resource management
- Business units for statewide support services – IT, capital projects, radiology, pharmacy (new) and pathology (as at present).
- Redesign/renew human resource side of shared services before new SAP solutions implemented.

Details

A restructuring team should be established to form new Central Office Units, oversee the devolution of resources from Central Office to Area Health Services and Health Service District and reduce positions in Central Office.

As executive leadership positions have new responsibilities and obligations in Central Office, and in Area Health Services, positions need to be advertised as soon as practical. Existing executive directors positions to remain with incumbents to continue in roles until new appointments are made. Stability and consistency to be maintained whilst restructuring is occurring. Planned and staged restructuring processes will be necessary, including important workforce planning tasks to ensure all staff are treated fairly as the change process evolves.

As this is a significant down-sizing, special consideration and arrangements are suggested to properly support the staff. For example in addition to the usual public sector approach a team will be established to support staff through change.

The restructuring process envisaged is as follows:-

- Principles of dignity, fairness and respect to apply.
- Support for staff through the “Supporting People Through Change Team” including provide a hotline and outplacement services to cater for special needs.
- Consultation with unions to achieve the best process.
- Retain existing staff in senior Area Health Service and Central Office leadership roles until new positions are advertised and filled.
- Managers immediately below these levels continue to serve in their existing capacity until structural change evolves.
- Existing managers to work with restructuring team to identify positions to remain in Central Office to be reallocated and those to be abolished. The number and allocation of positions are noted in Chapter 5. No AO2, AO3, A04 support positions to be abolished.

- For positions and staff to remain in the new Central Office Units a closed merit process is used to minimise formal written application requirements to greatest extent possible.
- Discussions should be held with staff to canvass preferences and views
- Arrange all public sector entitlements
- Area Health Services and Business Services to secure and establish necessary accommodation before positions relocate
- A review should be undertaken of the HR side of Shared Services to streamline award conditions and arrangements before the new SAP system for HR in 2007-2008
- As noted in Chapter 5, population health and mental health positions re-allocated from Central Office to Area Health Services must be used within those respective services.

The Central Office Reform Team leader would be a full time member of the Reform Leadership Team to ensure that structural change occurs as effectively as possible and is well integrated.

Executive Directors and Area Health Service General Managers would coordinate movement of positions and staff.

The Supporting People Through Change Team and program needs to be established to support all staff during the process and ensure they are treated with fairness, respect and dignity.

Resources

- Central Office Reform Team leader to be part of the Reform Leadership Team.
- A restructuring team comprising HR representatives and members from each major directorate affected within the former Corporate Office structure and a representative from each of three Area Health Services (estimate ten FTE for nine months).
- Cost estimates for accommodation and fit out for Area Health Services and Business Services, savings from abolished positions (where they are currently filled) and voluntary early retirement to be developed.

| Costs Central Office Restructure | | |
|---|---------------------|--------|
| Restructuring Team | 10 FTE for 9 months | \$1 M |
| Outplacement services | | \$1 M |
| | | \$ 2 M |

Timing

- Senior executive positions advertised and Reform Leadership Team personnel selected as soon as practical after 30 September 2005
- Central Office Reform Team established early in October 2005
- New senior appointments by November 2005
- New accommodation determined by end November 2005. Positions progressively assigned.
- Re-allocation of positions and associated resource determined by December 2005
- Central Office restructuring completed June 2006
- Area Health Service and Business Services established June 2006.

14.9.8 Strengthen community and sector partnerships

Summary

- District Council Chairs to attend leadership program.
- District Health Councils meet with a representative from each Area Health Service responsible for input into service planning, service quality, complaints resolution, service performance relative to other health services.
- Working arrangements between District Health Council and Area Health Council to be clarified.
- New community/patient centred partnerships developed
- New community, non-government organisation partnerships for primary care and pre and post acute care especially mental health
- New partnerships with local government and other human services providers (government and non-government) to support non clinical needs of patients particularly in Indigenous Health and Mental Health.

Details

This report has discussed the importance of strengthening partnerships across the health service continuum with the community, non government sector and private sector providers to gain synergy between existing services. Leaders within each Area Health Service and each Health Service District need to perform this role.

Queensland has limited formal partnerships and community linkages compared to those evident in New South Wales and Victoria. The new Area Health Services and Health Service Districts need to do a great deal to put these partnerships and community linkages into place.

The first priority will be to define new roles for District and Area Health Councils which will legitimately involve them linking with their local communities to provide feedback to their health service about:

- health service needs of people in the District/Area
- scope of service being offered, the responsiveness and the quality of that service.
- the extent to which health service expectations and needs are being addressed across the continuum of primary through to tertiary care for the local community
- the extent to which the health service is responsive to community feedback and priorities about service delivery issues
- satisfaction with the complaints resolution process
- providing significant input into the health service planning process which needs to be updated annually.

The Reform Facilitators could work with District and Area Health teams and their Health Councils to ensure new roles are supported, assimilated and implemented. Representatives on District Health Councils need to be able to develop their own community networks and work with these networks to contribute effectively at District and Area Health Council Meetings. Councils should receive a regular consistent set of reports about performance of their local health service compared with standards being achieved in other comparable health services throughout the State and possibly interstate. The information system, database and reports necessary to support Councils appropriately

will be developed by the Performance Directorate working with the Development Unit and Area Clinical Governance Units.

District and Area Health Service Councils will have a priority to advance health service planning including service obligations for different sized communities that need to be developed in conjunction with clinicians. Councils will need to be resourced and supported to do this.

With respect to new partnerships with general practice, the non-government health services and private health services, Queensland Health must ensure that its clinicians and administrators developing these partnerships are appropriately trained for their role. They must have clear expectations about the concept of equal partnerships and the way in which the various groups need to work together to resolve common problems and contribute significantly to the initiatives to improve continuity of patient care and service in a patient centric way. These initiatives link to those hospital, health system and service redesign and improvement programs, including projects to strengthen primary care and limit patients entering acute care. Developing new step up and step down facilities that limit acute admissions and re-admissions to hospital would feature prominently in these partnerships.

Resources

- Driven by Area and District Health Services
- District/Area Health Council will have increased costs to enable significant community engagement **\$10 million**
- Step up/step down facilities and other partnerships and plans may require significant allocation of funds

Timing

- Area and District Health Council Chairs involved in initial leadership workshops pre December 2005 to inform them on the organisations intentions.
- New role of councils discussed and formalised by March 2006.
- Targeted program of reform to be prepared by each District and Area Health Service including step up and step down facilities by December 2006 in conjunction with health service plans.

14.9.9 Health service planning and workforce planning

Summary

- Plans developed by District, Area and State
- Universal service obligations defined
- Review and improve transport arrangements
- Transparency in decision making about the scope of local health service provision (where service not available, indicate whether due to clinical capability or funding)
- Plan to address critical workforce shortages intensively for three years and a longer term plan for the next ten years.
- Maximise value of existing health workforce through increased advanced and new workforce roles and increased linkages with the private sector.

Details

Queensland Health should place greater effort into health service planning and workforce planning. Health service and workforce planning units will be established in the Policy, Planning and Resource Directorate of Central Office, complemented by service and workforce planning capability in Area Health Services. The clinical networks to be established will play a role in health service planning, as will input from the community through the community partnerships and input from Councils as described above.

Difficult questions need to be addressed including the range and scope of health services to cover current and emerging community health service needs, the need to constrain certain services due to challenges of clinical capability, geographic areas or financial issues. The community through District Health Councils should be involved in recommendations to government about health service plans. Services must prioritise and target the most urgent needs. Issues such as increased tax, means testing and service prioritising are a legitimate set of issues where the community in time should be in a better informed position to provide advice through its local District Health Council to Government. The Area Health Councils because of their reports to the Minister could be able to provide this input directly.

Long term workforce plans should be informed by all stakeholders, including clinical networks, professional associations and academic institutions who have responsibility for teaching, training and development of undergraduates and graduates.

Workforce planning must complement health service planning. Comprehensive strategies are necessary. Workforce plans will address sources for recruitment, workforce retention, conditions of employment, the need to streamline current award structures and career progression.

Plans should also include all of the career and role enhancing arrangements necessary to ensure that the existing clinical workforce can be used to greatest value during the next decade when clinical resources are likely to be in short supply. The private and non-government sectors should be actively involved in the planning.

Resources

- Expert advice may be necessary to establish health service planning networks.
- Reform Leadership Team position links to Program 1.
- Full time appointments to health service planning positions in Central Office/Area Health Service with links to Health Service Districts and District/Area Health Councils.
- Strengthen strategic HR/IR function in workforce planning.

Timing

- First iteration of Area Health Service Plans involving all Health Service Districts by December 2006. Initially an indicative budget should be established and agreed for 2006-2007 financial year.
- Link workforce planning to Program 1 and 3 with the first iteration of a comprehensive workforce plan by December 2006.

14.9.10 Service enhancement to address special needs

Summary

- Indigenous health issues
- Rural and remote issues
- Mental health
- Chronic disease prevention and management strategies
- Child and youth health

Details

A range of recommendations have been made in respect to Indigenous health, rural and remote, mental health, chronic disease prevention and management issues and child and youth health. Specific networks need to be established to support all of these initiatives involving clinicians throughout the state. Policy planning and resourcing capability in Central Office focusing on these specialities should support these networks in developing immediate plans and implementing the most urgent priorities.

Resources

- Full time member of the Reform Team is necessary in the first instance with part-time specialist input.
- Networks need to be formed or strengthened for Indigenous, rural and remote, mental and child and youth health.
- Funding implication quite significant but will be developed by networks.

Timing

- Revised strategies must be developed using these networks and Area and District Health Services, the first strategy and plan by June 2006 to secure some funding from the 2006-2007 budget.
- A specific Chronic Disease Prevention and Management Strategy to be developed in Policy Planning and Resourcing Directorate.
- A large number of Health Service District specific projects/initiatives to be developed for each of these health sectors over the 2006-07 period prioritised and phased in.

14.9.11 Negotiating new partnerships with the Commonwealth

Summary

- Teaching and training.
- Primary care/acute care linkages and enhancement.
- New care pathways with pre and post acute services and involving non-government organisations.
- Integrated approaches to health service delivery for rural and remote communities.
- National standards for registration of medical practitioners and recognition of qualification from certain international jurisdictions.

Details

It would be important to enter into ongoing discussions with the Federal Government to try and secure commitment to joint projects and funding which might help to pave the way for addressing some of the most concerning long term issues confronting Australian health services. In the first instance, focus should be upon better funding support for teaching and training of medical practitioners in public hospitals and new primary care/acute care partnerships in both rural remote and urban settings.

Both Commonwealth and State Governments place priority on delivering health services. The different arrangements on the ground however cause confusion. The complexity of Commonwealth and State funding arrangements might not be such a significant problem if both entities worked well together in an integrated, patient centred manner.

Unfortunately this is not the community's perception nor the reality based on public forum feedback and review of recent Commonwealth/State performance and funding issues. This Report has highlighted areas where the two levels of Government could work together in an improved spirit of cooperation to address patient and community need. If this could occur, then better overall value for money for health service expenditure would be the likely outcome. This will be an ongoing initiative which must commence immediately.

14.9.12 Strengthen governance and reporting to government and the community

Summary

- Reform and performance KPI's for new services linked to new funding
- Statewide regular performance reports (Auditor-General oversees)
- Statewide regular clinical outcome reports (Health Commission)
- Consideration about preferred reporting and public accountability processes for Queensland Health, existing statutory boards such as Registration Boards, the CMC, Ombudsman and new Health Commission. Reporting links to the Director-General, Minister, Steering Committee and Parliamentary Committee also relevant.

Details

Recommendations have been made to broaden the focus of performance reporting for Queensland Health, particularly in regard to quality and safety and the effectiveness of services. Reporting will only be useful if the outcomes are relevant to the delivery of services. Therefore performance reporting is closely linked to planning processes and performance agreements with senior leaders in the organisation. Performance review processes that provide feedback to the frontline to assist in service improvement and that provide accountability to government and the public must be in place. A range of reports at the District, Area Health Service and State wide level have been recommended.

Of particular importance will be monitoring progress of the reform initiatives. Reforms should be sequenced, implemented progressively, and with staged funding based on achievement of earlier agreed milestones or targets. As new service models and services are developed and implemented a similar approach should be taken.

Resources

- Establishment of Health Commission

Timing

- Performance Directorate development of new approaches by March 2006. Progressive roll out 2006-2007
- Escalation and re-development in time for 2007-2008 budget allocation discussions
- Links with Area Health Service and district executive teams, clinical networks and Development Unit essential
- Review of role and interface of external review bodies March 2006

14.9.13 Information management

Summary

- Current transformation project to realign priorities consistent with reform recommendations focus on improving clinical support systems such as community health, allied health, solutions for viability of ESP, PRIME and Complaints System
- Increase efficiency of work practices and use of remote diagnostic tools
- Information Strategy and Investment Board and Operations Board to prioritise in line with Review
- Staff internet access provided
- Expansion of access to desktop computers and mobile technology
- Alternate sourcing models for project and contract management
- Pre-qualified panels established for applications development
- Support training in both computer literacy and for specific applications for clinical staff
- IT system enhancements and support staff for clinical personnel

Resources

- | | |
|--|-------------|
| • Additional computers (one off) | \$25million |
| • Recurrent | \$7million |
| • Training to increase computer literacy | \$5million |

Timing

- Re-align priorities and structures and governance within Information Directorate within 3 months
- Pilot staff training and increased desktop computer availability within 6 months and complete within 18 months.

14.9.14 Assets, capital and maintenance

Summary

- Establish asset planning in Area Health Services and Central Office Design Unit
- Function as part of Business Support Services Group
- Implement revised governance arrangements, reporting and post occupancy evaluation frameworks
- Transfer project management role to the Department of Public Works

Details

Clinicians perceive that there is little to no clinical input in the decision making in regard to the capital works and asset management program within Queensland Health. If we are to reverse this view, and engage the Health Service Districts and their staff in appropriate planning and execution of capital works programs, relationships must be developed between these groups of staff.

The previous State Hospital Rebuilding Program was problematic from all perspectives, but especially as there were limited resources allocated to planning, analysis and there was no standardisation of design.

The move of some of the capital works staff to the Area Health Service will enable a closer link to be established between clinicians directly, clinical networks, Area and District Health Councils. Clinicians lack the understanding about the processes involved in the development of the Asset Strategic Plan and the setting of priorities in particular. This would also enable direct clinician input into the development of the Asset Strategic Plan.

As new models of care are developed, capital works funding for services outside of hospitals (such as step up and step down facilities) will be required. Existing hospitals will also need additional bed and theatre capacity to address patient flow issues.

Resources

- A part time member of the Reform Team
- Part of the organisational structure initiative
- Ongoing dialogue with Area Health Service and the Department of Public Works in shaping new arrangements
- The December review of the maintenance needs will list revised priorities

Timing

- Immediately revise current asset strategic plan and review immediate priorities
- Conclude ongoing review of capital and maintenance requirements by December 2005
- Complete systems enhancement in Queensland Health by December 2006

Appendix 1.1 Bundaberg Hospital Commission of Inquiry Terms of Reference

Under the provisions of the *Commissions of Inquiry Act 1950*, Her Excellency the Governor, acting by and with the advice of the Executive Council, hereby appoints Mr ANTHONY JOHN HUNTER MORRIS QC to make full and careful inquiry with respect to the following matters—

- (1) The role and conduct of the Medical Board of Queensland in relation to the assessment, registration and monitoring of overseas-trained medical practitioners, with particular reference to Dr Jayant Patel or other overseas-trained medical practitioners.
- (2) The circumstances of:
 - a. the employment of Dr Patel by Queensland Health; and
 - b. the appointment of Dr Patel to the Bundaberg Base Hospital.
- (3) Any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by Dr Patel or other medical practitioners at the Bundaberg Base Hospital.
- (4) The appropriateness, adequacy and timeliness of action taken to deal with any of the allegations, complaints or concerns referred to in (3) above, both:
 - a. within the Bundaberg Base Hospital; and
 - b. outside the Bundaberg Base Hospital.
- (5) In relation to (1) to (4) above, whether there is sufficient evidence to justify:
 - a. referral of any matter to the Commissioner of the Police Service for investigation or prosecution; or
 - b. referral of any matter to the Crime and Misconduct Commission for investigation or further action; or
 - c. the bringing of disciplinary or other proceedings or the taking of other action against or in respect of Dr Patel or any other person.
- (6) The arrangements between the Federal and State Governments for the allocation of overseas-trained doctors to provide clinical services, with particular reference to the declaration of 'areas of need' and 'districts of workforce shortages'.

AND, as a result of any findings in respect of the above matters, to make recommendations in relation to:

- (1) Appropriate improvements to the functions, operations, practices and procedures of the Medical Board of Queensland, in particular in regard to the assessment, registration and monitoring of overseas-trained medical practitioners.

- (2) Any necessary changes to the Queensland Health practices and procedures for:
- a. the recruitment and employment of medical practitioners (particularly overseas-trained medical practitioners);
 - b. the appointment of medical practitioners (particularly overseas-trained medical practitioners) to regional and remote hospitals; and
 - c. the supervision of, and maintenance of the standards of professional practice of, medical practitioners, with particular reference to:
 - (i) overseas-trained medical practitioners; and
 - (ii) medical practitioners (particularly overseas-trained medical practitioners) appointed to regional and remote hospitals.
- (3) Mechanisms for receiving, processing, investigating and resolving complaints about clinical practice and procedures at Queensland Health hospitals, particularly where such services result in adverse outcomes, both:
- a. within the hospital concerned; and
 - b. within Queensland Health generally; and
 - c. through other organs and instrumentalities of the Queensland Government, including the State Coroner, the Health Rights Commission, the Medical Board of Queensland, the Queensland Police Service, and the Crime and Misconduct Commission; and
 - d. otherwise.
- (4) Having regard to any unacceptable situations or incidents revealed in evidence, whether at the Bundaberg Base Hospital or at other Queensland Health hospitals, any systems of accountability necessary or appropriate to prevent the recurrence of such situations or incidents.
- (5) In reference to (6) above, measures which could assist in ensuring the availability of medical practitioners to provide clinical services across the State.
- (6) Any other action which should be taken properly to respond to the findings of the inquiry.

AND directs that, in conducting such inquiry:

1. without limiting in any manner the generality of the above, the Commissioner may have regard to and take account of the functions of:
 - a. the State Coroner;
 - b. the Health Rights Commission;
 - c. the Medical Board of Queensland;
 - d. the Queensland Police Service;
 - e. the Crime and Misconduct Commission; and
 - f. any Queensland Health investigation under s.55 of the *Health Services Act 1991*.
2. the Commissioner shall liaise and co-operate with the parallel Queensland Health Systems Review, and may refer to such Review any matter which, in the opinion of the Commission:

- a. has implications for the broader public health system; or
- b. can more conveniently or effectively be considered and dealt with by such Review.

AND directs that the Commission make full and faithful report and recommendations concerning the aforesaid subject matter of inquiry and transmit the same to the Honourable the Premier and Minister for Trade by 30 September 2005.

Applicable Act

3. The provisions of the *Commissions of Inquiry Act 1950* shall be applicable for the purposes of this inquiry except for section 19C—Authority to use listening devices.

Deputy Commissioners

4. Under section 27 of the *Commissions of Inquiry Act 1950*, Her Excellency the Governor, acting by and with the advice of the Executive Council approves the appointment Sir Llewellyn Edwards AC and Miss Margaret Vider as Deputies to the abovementioned Commission.

Conduct of Inquiry

5. The Commissioner may hold hearings in such manner and in such locations as may be necessary and convenient. The Commissioner may:
 - a. hold hearings constituted by the Commissioner, whether sitting alone or with one or both of his Deputies; or
 - b. authorise his Deputies or either of them to hold hearings or exercise powers pursuant to section 28 of the *Commissions of Inquiry Act 1950*.

Ministerial Directions

6. The Honourable the Premier and Minister for Trade is to give the necessary direction herein accordingly.

ENDNOTES

1. Made by the Governor in Council on 26 April 2005.
2. Published in an Extraordinary Gazette on 26 April 2005.
3. Not required to be laid before the Legislative Assembly.
4. The administering agency is the Department of Justice and Attorney-General.

Appendix 1.2 Membership of Queensland Health Systems Review Reference Panels

HEALTH REVIEW PANEL MEMBERS

Professor Ken Donald , School of Medicine, University of Queensland
Dr Bill Glasson, former National President, Australian Medical Association
Dr Chris Davis, Director Geriatrics, The Prince Charles Hospital
Ms Janelle Taylor, Queensland Nurses Union representative
Ms Cheryl Herbert, Chief Executive Officer, St Lukes Nursing Service
Mr Ken Lewis, former Executive Director, Safety, Qantas Airlines
Mr Pat Grier, Managing Director, Ramsay Healthcare
Dr Shane Sondergeld, General Practitioner
Professor Wendy Chaboyer, Director Research Centre for Clinical Practice Innovation, Griffith University
Mr Brian Johnston, Chief Executive Officer, Australian Council of Health Care Standards
Dr John Aloizos, General Practitioner

REGIONAL, RURAL & REMOTE PANEL MEMBERS

Ms Lynn Sheehan, Executive Officer, Mater Hospital, Rockhampton
Dr Ross Maxwell, President, Rural Doctors Association Qld
Professor Desley Hegney, Director of Centre for Rural & Remote Area Health, University of Southern Queensland
Ian Wronski, Executive Dean, Faculty of Medicine, Health and Molecular Sciences, James Cook University, Townsville
Ms Vicki Sheedy, Australian College of Rural and Remote Medicine
Dr Dennis Pashen, Associate Professor James Cook University, Mt Isa
Dr Mark Wenitong, Director, James Cook University
Ms Mary Martin, Chief Executive Officer, Queensland Aboriginal & Islander Health Forum
Mr Rod Stuart, Director of Physiotherapy, The Townsville Hospital

Appendix 1.3 List of Queensland Health Service Districts visited during consultation

QUEENSLAND HEALTH SYSTEMS REVIEW

District Visits

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--------------------------------|---------------------------------|---------------------------------|----------------------------------|----------------------------------|----------|--------|
| 23 May | 24 | 25 | 26 | 27 | 28 | 29 |
| | | | Corporate Office Redcliffe | Corporate Office Redcliffe | | |
| 30 | 31 | 1 June | 2 | 3 | 4 | 5 |
| | Corporate Office | Corporate Office | Corporate Office | Corporate Office | | |
| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| Corporate Office | Corporate Office Sunshine Coast | Corporate Office Sunshine Coast | Corporate Office Sunshine Coast | Corporate Office | | |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| Queens Birthday Public holiday | | | Logan West Moreton South Burnett | Logan West Moreton South Burnett | | |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| Mt Isa TPCH | Mt Isa TPCH | Central West Townsville TPCH | Central West Townsville TPCH | Central West Townsville TPCH | | |
| 27 | 28 | 29 | 30 | 1 July | 2 | 3 |
| Toowoomba | Toowoomba Mater Cairns | Mater Cairns | Rockhampton Mater Mackay | Rockhampton Mackay | | |
| Cairns | 5 | 6 | 7 | 8 | 9 | 10 |
| PAH Bundaberg RBWH | PAH Bundaberg RBWH | PAH Gold Coast RBWH | PAH Gold Coast RBWH & RCH | PAH Gold Coast RBWH & RCH | | |

Appendix 1.4 List of community forums held

| Day/date of Community Forum | Time | Venue and address | Health Service District |
|-----------------------------|-----------------|--|-------------------------|
| Thursday 16 June 2005 | 7.00pm – 8.30pm | Ipswich Civic Hall Cnr Limestone & Nicholas Streets Ipswich | West Moreton |
| Thursday 16 June 2005 | 7.00pm – 8.30pm | Town Hall Reception Room Glendon Street Kingaroy | South Burnett |
| Friday 17 June 2005 | 7.00pm – 8.30pm | Logan Entertainment Centre 170 Wembley Road Logan Central | Logan |
| Monday 20 June 2005 | 7.00pm – 8.30pm | PCYC, CS Energy Room 67 Isa Street Mt Isa | Mt Isa |
| Tuesday 21 June 2005 | 7.00pm – 8.30pm | Civic & Cultural Centre Fairmont Room, 96 Eagle Street Longreach | Central West |
| Wednesday 22 June 2005 | 7.00pm – 8.30pm | PCYC Wellington Street Aitkenvale | Townsville |
| Monday 27 June 2005 | 7.00pm – 8.30pm | Unara Conference Rooms Community Health Building Toowoomba Hospital Campus Toowoomba | Toowoomba |
| Monday 27 June 2005 | 7.00pm – 8.30pm | Cairns City Library 151 Abbott Street Cairns | Cairns |
| Thursday 30 June 2005 | 7.00pm – 8.30pm | Rockhampton Leagues Club Brown Park, Cambridge Street Rockhampton | Rockhampton |
| Thursday 30 June 2005 | 7.00pm – 8.30pm | Souths Leagues Club Milton Room, 181 Milton Street Mackay | Mackay |
| Monday 4 July 2005 | 7.00pm – 8.30pm | Brothers Sports Club Takalvan Street Bundaberg | Bundaberg |
| Wednesday 6 July 2005 | 7.00pm – 8.30pm | Robina Community Centre 196 Town Centre Drive Robina | Gold Coast |
| Wednesday 13 July 2005 | 7.00pm – 8.30pm | Sherwood Room Brisbane City Hall Brisbane | Brisbane |
| Tuesday 23 August 2005 | 7.00pm – 8.30pm | Nambour Civic Centre Centenary Square, Currie Street Nambour | Sunshine Coast |

Appendix 1.5 Excerpt from the Queensland Health Systems Review Interim Report, July 2005

Executive Summary

Chapter 1: Describes our public health system and Queensland Health's role and services as part of that system

- Australia's health system is a complex mixture of public and private sector health service providers and a range of funding and regulatory mechanisms that are reflected in Queensland's health system.
- There would be considerable benefit if a far higher degree of integration between public and private health services throughout Queensland could be achieved, including much better linkages between general practice and public hospitals, between public and private hospitals, and between the public sector and the non-government sector. The present fragmentation in the system makes it difficult for consumers to navigate, creates disparities in pay rates for public and private doctors and compromises the best possible health outcomes.
- The impact of current funding arrangements in producing conflicting incentives is most apparent in funding for the public and private hospital sectors. For example, an efficient private hospital welcomes increased patient loads within capacity constraints, as additional patients bring an additional source of revenue to the hospital. Whereas under Queensland's current funding arrangements, an efficient public hospital with a capped budget when confronting additional workloads does not attract additions to revenue with the real prospect of escalating costs and exceeding budget allocations. This latter feature may lead to delays and queuing and/or limitation and cancellations of certain kinds of procedures and services.
- Although there have been wide-ranging changes to Commonwealth funding arrangements over the years, successive Queensland governments have remained highly committed to the public health system and in particular providing universal access to hospital services throughout the State at no charge. Appendix 5 summarises this history.
- Queensland Health provides services across the continuum of care including health promotion and illness prevention activities, primary and community health care, secondary and tertiary hospital care and aged care. Queensland Health also has significant regulatory responsibilities including legislation involving public health services, the licensing of private hospitals and the registration of medical, nursing and health practitioners.
- Queensland Health is one of the largest organisations operating in Queensland, with some 53,000 staff, 178 public hospitals and 277 primary and community health centres. In 2005-06, Queensland Health's recurrent budget is \$5.4 billion with a capital budget of \$549 million. The recurrent budget has grown by an average of 7 percent per year since 1996-97 which broadly reflects the escalation of health costs and population growth over the same period. Some 65 percent of the recurrent

budget is allocated to acute hospitals, 23 percent is allocated to preventive, primary and mental health and community care with the remainder covering clinical and statewide services such as pathology services, regulatory functions and corporate functions.

- Public hospital admissions in the State have grown by 4.7 percent since 2000-01, with some 720,000 admissions annually. People aged 65 years and over account for some 29 percent of total public hospital admissions and some estimated 43 percent of the public hospital patient days. The ageing population therefore creates an enormous future challenge for our acute hospital sector. Queensland Health has active public health services, and it is in areas such as prevention of chronic disease and promoting health and well-being where significant potential for reducing our dependence on acute hospital activity lies.
- Queensland Health employs some 53,000 staff comprising 43,782 full time equivalents (FTEs). In the last 10 years major trends in Queensland Health's workforce include:
 - the proportion of clinical (60 percent) and non clinical (40 percent) staff has remained relatively stable
 - managerial and clerical staff have grown from 13 percent to 19 percent of the total Queensland Health workforce noting that this category of staff includes medical records staff, ward clerks, clinical coders, information technology staff, project officers and administrative staff
 - medical staff have increased from 6 percent to 8 percent of all staff
 - nursing staff have reduced from 44 percent to 39 percent of staff
 - Visiting Medical Officers (FTEs) have decreased by 41 percent.
- Queensland is experiencing a clinical workforce shortage across the board, including medical practitioners, dentists, allied health professionals and nursing staff.
- Queensland Health has employed overseas trained medical practitioners for many years. Some of these professionals are Australian registered having satisfied fully the requirements of their respective Colleges. However, in recent years because of increasing shortages of doctors worldwide, Queensland Health has recruited 737 doctors with provisional area of need registration, comprising approximately 20 percent of the total public hospital medical workforce.
- Queensland Health is working towards implementing a more comprehensive statewide approach to the recruitment of OTDs, and this Review has further work planned to assess any current workforce concerns.

Chapter 2: Assesses the health status of Queenslanders and explores how well Queensland Health is performing relevant to other jurisdictions

- The State's public health service, embracing the full range of services and activities from primary and community health care through to secondary acute hospitals and tertiary hospitals, is in many respects delivering good standards of care and achieving reasonable outcomes. There is however scope for improvement.
- In respect to health status, the states and territories have an annual comparative publication on a number of key health status indicators for their communities.

- Queensland's strengths are in the following areas:
 - Less overdose deaths from illicit drugs, lower breast cancer deaths, and higher immunisation rates.
- Queensland has performed to the Australian average on:
 - Infant and perinatal deaths, deaths due to diabetes, most cancers, motor vehicle accidents and "all cause" death rates.
- Queensland is performing second worst or worst on the following:
 - Life expectancy at birth for males, male survival to 50 years, death due to heart disease, stroke, skin cancer and suicide, smoking and high risk drinking for males, overweight and obesity rates for males and females.
- These results, together with other Chapter 2 conclusions reinforce the continued need to invest in health promotion and prevention activities targeting major risk factors where these strategies have the potential to reduce over half of the estimated 6,300 preventable deaths from these causes in Queensland each year. These strategies are not solely the responsibility of Queensland Health but require partnerships across government and non-government organisations.
- Primary and acute health services have the potential to account for the other half. Queensland currently spends 66 percent less per capita on community health and 23 percent less per capita on public health services compared to the Australian average expenditure. As far as can be ascertained, Queensland has been a lower cost provider of public health services than most of the other states for many years.
- Overall, our public hospital expenditure is some 20 percent or \$183 less per person than the Australian average. Some of this difference can be attributed to the following:
 - 7 percent fewer admissions to public hospitals per capita including 4 percent lower public patient admissions and 3 percent lower private patient admissions treated per capita.
 - Relatively lower salary structures for public hospital staff (5.6 percent lower than the national average noting Queensland's average weekly earnings are 6 to 7 percent lower on average than national weekly earnings)
 - Relatively lower numbers of staff per capita with 11 percent less than the national average
 - 11 percent more efficient than the national average in weighted hospital separations (an indicator which enables different hospital procedures to be compared equivalently).
- Apart from these factors, there are broader influences which also impact on the level of expenditure on hospital services including the health profile of the population, access to other health services including private hospital services and primary care services, and doctor and patient preferences about the type of care required. These issues are being further analysed but it does seem that at least some of Queensland's greater efficiency and relatively lower expenditure can be attributed to lower staff numbers dealing with equivalent workloads compared to the national average.
- Queensland Health has recently undertaken a review of its acute hospital services and prioritised urgently needed clinical resources. Based on the district visits there are

clear and apparent shortages in particular disciplines reported especially for hospitals in major growth corridors. The tertiary referral centres have reported higher than usual transfers of patients from other centres. It would be prudent for Queensland Health to consider addressing the most pressing priorities identified in the short term. This would provide stop gap relief pending final report recommendations which are expected to include initiatives to address patient flow process redesign in acute hospitals among other things.

- Queensland, like the rest of Australia, is only just starting to implement systems which will provide continuous assessment of safety and quality in acute hospitals. Specific issues at Bundaberg are being addressed by the Commission of Inquiry. Queensland Health has established a number of clinical collaboratives involving the departmental personnel, medical colleges and senior specialists to advance quality and safety initiatives. The cardiac collaborative is one such example. Another is medication safety where Queensland is providing national leadership.

Chapter 3: Rural, regional and remote issues, Indigenous communities and community/patient advocates

- One of the highest areas of need in the State relates to Indigenous health issues, where Aboriginal and Torres Strait Island people have life expectancy rates some 20 years less than the community average. Queensland Health has been directing increased resources to this need, but much more needs to be done. The Review is to address this issue in further detail.
- Queensland is a large decentralised state which faces particular challenges in providing health care to people living in rural and remote settings where there are access and service limitations. The Review is considering a broad range of initiatives including more effective transport arrangements, allowances and incentives to build clinical capability in rural settings, partnerships with the private (hospital and general practice), non-government and university sectors and the Commonwealth government and stronger links between tertiary centres and rural hospitals, to better address these issues.
- The report highlights patient concerns which generally relate to delays in accessing service, a concern that care is not sufficiently integrated and managed, and where because of work pressures and part time staffing arrangements it is difficult to develop any relationship with carers who are constantly changing, or simply too busy to spend time with patients. Issues surrounding waiting lists for elective surgery and the referral waiting times to see a specialist are frequently raised as concerns. The Review is focussing on patient concerns in addressing its terms of reference.

Chapter 4: Administrative systems

District and corporate organisational structures and layers of decision making

- Queensland Health is a centrally controlled multi layered organisation where many decisions are escalated to levels where further added value is not evident. Decision making, especially in respect to patient care and priorities, should be made as close as possible to the patient interface with the active involvement of clinicians.

- The Queensland Health structure works imperfectly as the 37 districts are not sufficiently integrated to provide a genuine statewide health service. However, there is value in properly informed local communities having meaningful influence over the standard of care and scope of their local health services.
- Research to date indicates that a health system can viably and sustainably support only a limited number of large (1 million people approximately) health service delivery aggregates based around critical clinical capability and referral patterns. It would be prudent to devolve most service decisions to these aggregates and the smaller health services within them.
- Some services, for reasons of efficient statewide delivery may need to be drawn from a central location, but not necessarily always from Brisbane.

Corporate planning and budgeting systems

- There is a need to strike an appropriate balance between meeting acute care priorities and redirecting the health system by investment in prevention, early intervention and changing models of care to meet the future challenges posed by the increasing prevalence of chronic disease and an ageing population. This is a real dilemma for policy makers and practitioners.
- Improving service planning generally across Queensland Health has been identified as a key challenge. Including clinicians and the community in a more systematic approach to planning at a local, regional and statewide level, and improving the links with other health service providers including general practice, private health care providers and non-government organisations are all worthy objectives.
- Over the last ten years, Queensland Health has moved from an organisation which routinely recorded deficits to one which now operates within its budget. While Queensland Health does perform exceptionally well in respect to managing budget, there are signs throughout the State of a dysfunctional downside of this budgeting rigour, in that financial considerations and in particular cost curtailment are seen to be driving decisions at the expense in some instances of clinical service and patient care.
- The need to ensure budget allocation within Queensland Health is more responsive to population need, including high population growth and geographic locations was consistently raised as an issue. Staff were concerned that there appeared in some cases to be an inequitable allocation of resources across districts and a more transparent means of allocating funding internally is required.
- In all health systems where there are limited resources and unlimited demand for services, rationing and waiting lists will be inevitable. This is a challenge recognised by all public health systems nationally and internationally.
- Clinicians and administrators expressed concern that the community expectations of what Queensland Health should provide were unrealistic within the resources available and that Queensland Health's scope of services is not clearly defined. These pressures impact directly on patients and staff on a daily basis. Staff expressed a need for Queensland Health to provide more open and public information about the services which can reasonably be provided, including implications for quality and

safety, to allow the Government and community to better understand and consider expectations and service options.

Cost effectiveness of services compared to relevant jurisdictions

- Overall, Queensland Health is a cost efficient provider of acute hospital services and on average is comparable to other Australian states in the clinical outcomes it achieves. There is limited comparable information available nationally to compare the cost effectiveness of community health and public health.
- Staff generally reported the health system as being under significant pressure, and with insufficient resources to meet increasing demand. However, many staff identified opportunities for improvement of current health service delivery, including clinical and service improvement, administrative improvement and better integration with the other health sectors to improve the cost effectiveness of service delivery.

Organisation and delivery of clinical support services

- Pathology services are quality assured, generally well regarded and the internal fee for service arrangements are considered to work reasonably well. Similar models and/or outsourced opportunities will be explored for pharmacy and radiology. All of these services face staff supply shortages.
- The Review noted the lack of administrative support staff for clinical leaders and managers in front line services. This issue could be addressed in the first instance by streamlining some of the administrative requirements of clinicians.

Clinical governance

- Risk management, quality, safety and clinical audit are addressed as clinical governance issues in this report.
- Queensland Health has experienced three phases of development effort to enhance clinical governance since the early 1990s. The first two phases did not deliver the expected systemic approach or improvement. The revised strategic plan for quality and safety for 2005 contains elements of the comprehensive statewide approach necessary.
- There are signs that the initial work of the clinical collaboratives show the most likelihood of success. This principle being a clinician led approach in a blame free environment where error provides a learning opportunity and continuing improvement.
- These systems are in their very early stage of development in Queensland and nationally. The continued joint work of the Medical Colleges and Queensland Health will be essential to progress clinical safety and quality initiatives. Further work is now necessary to assess appropriate governance arrangements such as whether accountability to the Safety and Quality Board should be internal or external.
- Queensland Health's current complaints management system is not serving community, patient needs, staff needs, nor informing Queensland Health adequately about concerns. Revised arrangements are being explored.

Chapter 5: Clinical workforce management systems

- Queensland Health has a dedicated and professional workforce. District visits confirmed through wide ranging discussion and observation of elements of work practice across the occupations, that staff are committed to delivering high standards of services for those in their care.
- The public health system in Queensland depends not only upon permanent public sector employees, but a broad range of staff from the private and non-government sectors as well, who also contribute significantly to the delivery of public health services throughout the State.
- Staff at forum discussions expressed feelings of concern, frustration and anger about resource constraints. This was often directed towards managers, other clinical groups or Corporate Office (synonymous with Queensland Health).
- Many staff within districts visited by the Review Team concede that in pressured working environments, risks to patient safety do increase despite the high standard of professional care provided.
- A significant number of districts visited reported extremely high work loads associated with increasing patient demand which is creating very real pressures for both full and part time personnel working within Queensland Health, especially in larger metropolitan and regional hospitals and health services.
- The Review heard numerous reports of clinicians working in Queensland Health who feel undervalued and marginalised from a system which does not allow them sufficient time to undertake teaching and research, where they face ever increasing patient loads, where their skills are not appreciated, where junior staff feel unsupported and where they have limited ability to influence the way the health system is run.
- While Queensland Health has established workforce management systems, the systems are not performing effectively and in some cases there are major gaps. For instance, while detailed workforce data is available at the central level through sophisticated information systems, there is limited central monitoring or analysis of the data to inform workforce planning. Workforce planning is not linked to service delivery needs and access to training and professional development for staff varies across the State.
- In an environment of global competition for health professionals, Queensland Health faces significant and growing workforce pressures. Queensland has the lowest number of doctors per head of population in Australia. Despite this, Queensland Health has managed to increase its clinical workforce across all professional groups in the past decade.

For medical staff, this has been achieved through a high reliance on OTDs given the limited availability of locally trained doctors, as Queensland had until recently, only one medical school. Recent events highlight the need for urgent reform of credentialing, registration and training for overseas doctors to ensure the safety and quality of the medical workforce. In the medium term, Queensland Health will also

face challenges in offering adequate training and supervision for the increased number of locally trained medical graduates that will enter the public hospital system (numbers will double by the year 2010).

- Visiting medical officers' contribution to Queensland's public hospital system has fallen by 40 percent over the last decade. As a group they are feeling undervalued and marginalised from the system. Greater utilisation of this group provides one avenue to help alleviate the shortage of medical practitioners, however this will solve only a portion of the total problem.
- Allied health professionals, dentists and experienced nursing personnel are also in short supply in Queensland and targeted strategies will be necessary to address these shortages.
- There are concerning levels of attrition of clinical staff from the public health service, the most concerning being younger specialists medical practitioners and graduate nurses. Their attrition levels, although acceptable in more normal times, are reported to be increasing and this will have a significant adverse service impact.
- There are no simple solutions to the workforce pressures facing Queensland Health. For the final report, the Review will investigate a range of short, medium and long term opportunities to: improve recruitment and retention; consider incentives, particularly in rural and remote areas; improve access to training; increase the scope and value of contribution of all clinicians; and use the capacity of the private sector to the greatest practical extent.
- The public health workforce has an average age of nursing staff and medical practitioners of 46 years. It is this level of the workforce that is carrying high workload pressures which prevent them from teaching, mentoring and supporting more junior personnel who are the future of our health service in Queensland. This is perhaps the most concerning issue revealed so far during the review.
- While it can be expected there will be a worsening shortage of clinicians for the public hospital system over the next decade, when reliance will remain on the recruitment of doctors from other places and enhanced utilisation of local doctors, there are positive future signs as new medical and allied health schools strengthen supply in the years ahead.
- The Medical Board has introduced heightened assessment and registration processes for recruiting OTDs in recent months. This will be complemented by some time spent initially under the supervision of an Australian registered specialist. The processes will add several months to processing time (for good reason) which will cause some gaps in filling doctor vacancies during the next twelve months at least.
- The colleges, Australian Medical Association and Queensland Health are also in the process of developing a training and development program for existing OTDs to ensure they are prepared as expeditiously as possible for Australian registration.

Chapter 6: Performance management systems

Asset management and capital works planning and delivery

- Whilst facility standards are excellent, capacity in many cases has been under-provided due to misguided health planning assumptions both locally and nationally that failed to reflect sufficiently the increased demand for acute hospital beds because of an ageing population, enhanced life-saving and life enhancing procedures not related to day surgery and in the case of South East Queensland, an 80,000 a year influx from southern states.

Information management

- There is a perception that Queensland Health has many information systems that provide a wealth of data yet little information that assists districts in service planning and performance evaluation. Some data systems appear to be developed without sufficient clinical input or consideration of how the information will be managed and used.
- There appear to be deficiencies in planning for IT with little examination of business processes before systems are designed. Systems are generally not implemented well with little evaluation of the impact of systems on staff. The lack of integration between systems and the inability to integrate systems to external stakeholders (eg general practice) results in duplication of data entry and introduces risks for patient care.
- Information systems to support clinical care are needed and clinicians need to be involved in their development. This will improve Queensland Health's capacity to monitor the quality and safety of its services and patient outcomes.

Monitoring health system outcomes

- Queensland Health is required to report on a large number of performance measures. It reports this information according to various frameworks which make it difficult to evaluate performance as a whole. One framework is needed for performance reporting.
- Current performance monitoring and review is skewed to activity, budget and efficiency. There are gaps in monitoring the performance of Queensland Health's workforce and the quality, responsiveness, sustainability and continuity of services provided. There is very little performance evaluation of service outcomes. A performance assessment framework needs to be developed that measures the things that matter.
- Little information on district performance is shared with staff. There is also little comprehensive information about the quality and outcomes of services provided to the public at the local or state level. Staff and the community have a legitimate right to be informed about these matters.
- Many clinical staff attempt to measure the quality of clinical interventions but are hampered by information systems that do not provide information on clinical care.

- Staff perceive a culture of not managing performance issues well. Performance appraisal and development plans are in place for many staff but are not seen as adding value by the majority of staff. Issues of clinical competence need to be dealt with in a framework which is appropriate for both the clinician and the community.

Chapter 7: Culture

- Culture has a profound impact on health service and system performance. The Review Team heard consistent allegations about more serious behaviour problems including intimidation and bullying. A recent independent culture survey commissioned by the Review in two districts and in a part of Corporate Office provides greater insight into this problem.
- When assessing the results of this survey, it is clear that staff are experiencing very significant work pressures, and in this environment are experiencing a higher than usual rate of dysfunctional interpersonal relationships. The survey confirms the direct reports received about bullying and intimidation but suggests that this may not be as prevalent as portrayed and reveals that it is much more prevalent in districts than in Corporate Office.
- In pressured work environments, it is necessary for an employer to respond as promptly as possible to minor frustrations and annoyances that can easily be addressed, before they develop into major problems. There is evidence to suggest that organisational culture, the extended hierarchy, layers of decision making and budget considerations make this very difficult to achieve in the current organisational arrangements.

Whilst this interim report has identified many significant issues, it will be the final report where integrated recommendations are framed together with a strategy for organisation improvement and renewal for Queensland Health.

Appendix 6.1 Leadership and clinically managed networks

Professor Michael Ward
September 2005

New types of clinical leadership

There are basically 2 types of clinical leadership, the first as yet much more common and widely accepted than the second

- *Traditional professional* This type is derived from the central ethical responsibility of ensuring the best possible outcomes for an individual patient. The key ingredients are high levels of knowledge, technical and cognitive skill, wide experience, and an ability to communicate these professional attributes to a peer group in a form consistent with their ethos and aspirations. Leadership of this type is measured through the volume of patient referrals from colleagues, election to office in professional associations, acclaim as a teacher, published peer reviewed research, and invitations to speak at scientific conferences. It places high value on competitive success and unfettered autonomy and less on standardised team based approaches to health care¹.
- *Systems improvement* In recent times it has become apparent that the above type of leadership, though still necessary, is no longer sufficient. This is due in part, and ironically, to the successes of the traditional leadership of research driven innovation. This has stimulated exponential growth in the range and power of diagnostic and therapeutic interventions. Although these have brought enormous benefits for patients there have also been substantial costs, both direct and indirect. The direct costs are well recognised, both in total financial burden, and lost opportunity costs within capped budgets. The indirect costs are less obvious and arise from the interactive complexity of all these interventions.

This special and unpredictable form of complexity contributes to the increasing difficulty of managing healthcare within conventional bureaucratic organisational structures, and to deficiencies in safety and quality of care.² It has also generated increased specialisation and fragmentation of services. This often leads to a mindset known to economists as 'bounded rationality'.³ This occurs where individuals who are part of a larger, complex, and incomprehensible system restrict their activities and interest to the immediate environment that they can understand and control. Their behaviour may be locally quite rational but globally irrational.

There is thus a need for more sophisticated forms of service integration and new forms of leadership for this environment⁴. In this context it is relevant that:

- deficiencies in team development, inter-professional communication, coordination and standardised care processes are associated with higher hospital mortality^{5,6}
- the need for clinician education in organisational systems, processes and interdependencies, collaborative communication for clinicians to reduce these risks has been identified⁷

- the Royal College of Physicians and Surgeons of Canada has expanded the role expectation of specialist physicians, beyond the traditional professional, scholar, and medical expert, to include communicator, collaborator, manager, and health advocate.⁸
- the ex-president of the UK General Medical Council has suggested that the collegiality and professional ethos that evolved for valid reasons in an earlier age may no longer be sufficient for today's complex healthcare environment.⁹
- practical guides to the required skill sets for service improvement leadership of this type have been published^{10,11}

This new type of service improvement leadership thus requires a willingness to acquire and promote a new set of organisational skills, and to consider opportunity costs and cost-benefit equations for whole populations as well as the needs of the individual patient. It is essential to recognise however that this type of leadership may generate a dilemma for clinicians as the overall benefits for a population may conflict with the optimal care for individual patients. This may diminish the status of the new type of leader in the eyes of colleagues more attuned to traditional leadership.

Resolving clinician disaffection

It is widely acknowledged that it is essential but difficult to engage clinicians in the broad managerial aspects of service improvement. This is part due to the intrinsic conflicts discussed above, but recent reforms based on financial and efficiency targets as primary goals at the cost of quality of care has probably led to further disaffection that has been recognized worldwide,¹² as well in this review. This has led to suggestions that healthcare organisations should compete on outcomes rather than costs alone.¹³ As discussed below alternative delivery systems are emerging that seem to provide a better vehicle for engaging clinicians in improving the integration and quality of health care, and for exploring new and more usefully focused funding models.

New network structures as vehicles for new leadership roles

Coordination of any complex inter-related set of tasks is generally managed in one of 3 ways – markets, hierarchies and networks.¹⁴ It is well known that markets have significant limitations when applied to health care because of:

- the asymmetry of information between healthcare professionals and patients, and
- community expectations of access exceeding their ability or willingness to pay the real costs directly or via taxation.

It is also recognised that orthodox hierarchies or bureaucracies are no longer sufficient for the rapidly changing and interactive complexity of the healthcare.^{15,16} Any organisation with a large professional workforce will also manifest asymmetry in control and authority:

*“The more general lesson here is that hospitals and other health-care organisations have an inverted power structure, in which people at the bottom generally have greater influence over decision-making on a day-to-day basis than do those who are nominally in control at the top. In these disconnected hierarchies, organisational leaders have to negotiate rather than impose new policies and practices. Failure to recognise this fact and to carry professionals along with change will invariably result in part implementation of reform efforts”.*¹⁷

It is not surprising therefore that attention has recently turned to networks:

*“In general, the differences between hierarchical and network relations can be summarised as follows: in hierarchies, people look to their superior for authority; in networks, people look to their most competent colleagues wherever they may be. Hierarchies are focussed on formal control, accountability and extrinsic motivation, while networks are based on expertise, collegial values and intrinsic motivation. Hierarchies bring structure, control and accountability, while networks bring knowledge, innovation and capability. Managers, politicians and policymakers tend to be more comfortable with hierarchies while professionals gain more from networks.”*¹⁸

Networks can take many forms from loose voluntary associations of clinicians who cooperate and exchange ideas about service improvement such as Queensland Collaborative for Healthcare Improvement,¹⁹ through the flat structures of the postgraduate colleges that focus on education and professional standards, to the various clinical service networks that have been developed as advisory bodies to the zonal authorities in Queensland.

Over the last few years another interesting hybrid type of network has emerged that would seem to combine a number of desirable elements, most notably active clinician leadership, service planning and improvement and outcome based funding. The most advanced networks of this type are the Managed Clinical Networks in the UK (Scotland) NHS^{20, 21, 22}, and those developed by the New South Wales Greater Metropolitan Clinical Taskforce:^{23, 24}

UK NHS Managed Clinical Networks

These networks originated as recommendation of the Report on Acute Services in Scotland in 1998 and have been defined as :

*“.. linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and Health Board boundaries, to ensure equitable provision of high quality clinically effective services”*²⁵

They have been designed to integrate primary, secondary and tertiary care and are guided by some important principles:

- Clinician management and leadership of the networks.
- A primary focus on improving the patient care in terms of quality, access and appropriateness.
- All programs are evidence based.
- All outcomes are measured.
- All quality improvement activities are consistent with national standards
- An annual report is produced.

- A multidisciplinary approach is used.
- Patients are involved in shaping the network
- An active role is required in service planning
- Standardised best practice pathways and guidelines are used at each stage of the patient journey.

These networks have been implemented in a wide range of conditions including stroke, cardiac disease and cancer, and have been found to have several advantages including flexibility, speed of implementation, and responsiveness to a rapidly changing environment.^{26, 27, 28, 29}

New South Wales Greater Metropolitan Transition Task Force

The NSW networks were developed as a consequence of a Government Action Plan published in 2002 and the work of subsequent Greater Metropolitan Services Implementation Group. This gave rise to 3 key principles that have guided the development of the networks, and which were to improve:

- The quality of care and safety of patients
- Equity of access and equity of outcome within the hospital system
- Clinician and consumer driven planning

15 programs or networks were initially established:

- Severe burns
- Spinal cord injury
- Complex transplantation
- Ophthalmology
- Cardiac
- Brain Injury rehabilitation
- Bone marrow transplantation
- Neurosciences including stroke
- Renal
- Maternity
- Gynaecological oncology
- Major trauma
- District (Metropolitan) hospitals
- Metropolitan / Rural networking

8 other programs have since been added:

- Cochlear implantation
- Orthopaedic services
- Imaging services
- Acute traumatic hand surgery
- Transitional care for young people with chronic childhood injury
- Bone and soft tissue sarcoma
- Care of the acutely ill older person in metropolitan hospitals
- Home enteral nutrition

In a short space of time these programs seem to have generated a remarkable degree of clinician involvement in service planning and improvement. A recurrent budget of \$64.6 million and a capital budget of \$9 million have been allocated for this work. The overall program was externally evaluated in 2004, the consultants finding substantial evidence of success:

“ The GMTT process has created a fundamental change in health service planning in NSW. This is being achieved by providing meaningful clinician engagement in planning and decision making by broadening the base of this engagement. There has been real diversification of the involvement which previously didn’t exist. The process has diluted the influence of traditional networks and vested interests. This broad based engagement, which includes all health professional groups, is fostering a high level of cooperation and consideration of all aspects of care delivery. One discipline’s priority is now more likely to be seen in the context of the whole rather than the discipline specific component. In other words, the process has exposed a greater number of clinicians to the ‘bigger picture’ of health. “ (Embracing Change report)

Areas in need of attention or with potential for future gains were noted to be:

- project planning, evaluation and monitoring
- clarification of line of financial accountability
- increased linkage with primary health care providers
- lack of coordination / interaction with Area Health Services

Nonetheless the achievements of GMTT in a short space of time demonstrate the impact of clinician leadership in networked structures that are specifically constructed around service improvement objectives.

Opportunities for ‘Clinically Managed Networks’ in Queensland

There are thus valuable opportunities in Queensland at the moment for the development of Clinically Managed Networks. These should be encouraged and should:

- Utilise the experience, and combine the best features of the Scottish and NSW networks.
- Integrate the service improvement roles of the existing Queensland collaboratives and the operational / service improvement roles of the networks that have been developed in the zones (Table 1). These networks should also be closely integrated with, or subsume other relevant state wide and programs such as the Cardiac Plan, Chronic Disease, and Election commitment initiatives. In many cases the same limited pool of clinicians is used as source of leaders and advisors for all these activities, often with significant duplication and waste of energies.

Operational Principles and Practice

1. The primary purpose should be to improve :

- Health care outcomes
- Equity of access
- Service planning
- Staff learning and skills development in service improvement

2. The model should :

- Be clinician led
- Be multidisciplinary
- Involve and integrate primary / secondary / tertiary services
- Involve healthcare consumers
- Explore innovative models of service delivery, education and staffing

3. Implementation mechanisms should include:

- Designated operational funds for pre-defined clinical outcomes
- Statistically robust outcome measurement and analysis systems
- 3 yr term (renewable) clinical chairs with paid sessions
- Adequate managerial support
- Service improvement and outcome measurement to utilise the skills and capacities of the Clinical Practice Improvement Centre
- High level line management reporting ie to area manager or to DG or deputy
- Single state-wide format in most cases
- A staged implementation on a rolling 3 year basis subject to successful review at 24-30 months after commencement.

4. Subject Selection

Subjects for networks should be selected from a combination of strategic and operational priorities that would be broadly determined by:

- A high impact disease burden eg high incidence, mortality, or morbidity.
- The presence of significant inter-district variances in clinical outcomes or access inequities, rapidly increasing demand for services, or other substantial gaps between evidence based best practice and current practice.
- The ability to recruit clinician leaders with the ability to generate solutions for these problems

It would be advisable to develop the first set of networks by combing the service improvement and operational components of existing and successful collaboratives and zonal networks.

5. Recommended networks

Based on the above criteria the following networks are therefore recommended in the first stage implementation:

- Cardiac
- Renal
- Stroke
- Diabetes
- Orthopaedics
- Surgical mortality
- Cancer
- Mental health
- Aged care
- Maternal care
- Neonatal care

- Critical care
- Patient flow – inpatient access

6. Funding criteria

For this new type of networks to succeed it is essential that:

- The funding model is shifted from the present historical / activity basis to an outcomes derived formula
- The desired outcomes are pre-defined in a measurable form and agreed by all parties so that the success may be judged.
- Service agreements with both clinicians and managers are defined in these terms.

If this does not occur, the service improvement activities of the present collaborative networks will remain the preserve of a small band of enthusiasts, and the operational service delivery activities of the present zonal networks will remain essentially advisory and subject the conflicting pressures of day to day activities and budgets.

The choice of appropriate targets and measurements will obviously vary from network to network but the essential principles are that:

- process measurements should be used in the short term
- only those processes that are known to improve patient outcomes should be selected.
- patient outcomes should be measured in the longer term

As an example, and purely for illustration, - it is known that there is a high rate of amputation of limbs in patients with diabetes in Queensland, and that poor control of diabetes, blood pressure and blood lipids, and inadequate management of foot ulcers are all contributory factors to the loss of limbs. A diabetes network might therefore be funded and judged in the short term on whether all the relevant evidence based markers of control and complications were regularly being measured and care was following best practice. It is important to emphasise that funds would be required in this model for operational resources as well as improvement activities. In the longer term the rate of amputation and other vascular complications would be assessed.

Table 1

| | SERVICE IMPROVEMENT | OPERATIONAL | | |
|---------------------------|-------------------------------|---------------|--------------|---------------|
| | Collab/ (C) Pathways (P) | Southern Zone | Central Zone | Northern Zone |
| Cardiac (including rehab) | + (C) | | | |
| Renal | + (C) | + | + | + |
| Stroke (acute and rehab) | + (C) | | | + |
| Emergency Dept | + (C) | + | | + |
| Maternal care | + (P) | + | + | |
| Orthopaedics | + (P) | + | + | |
| Cancer | + (C) | | | + |
| Diabetes | + (C) | | | |
| Mental Health | Planned (C) | | | + |
| Oral Health | Planned (C) | | | + |
| | | | | |
| Child Health | | + | | + |
| Intensive care | | + | + | + |
| Imaging | | | | + |
| Perinatal | | | | + |
| Rehabilitation | | | | + |
| Surgical | (Audit of Surgical Mortality) | | | |
| Primary care | | | | + |
| General Medicine | | + | | |

References

1. Degeling, P., S. Maxwell, et al. (2003). "Medicine, management, and modernisation: a "danse macabre"?" *Bmj* 326(7390): 649-52.
2. Plsek P. Redesigning health care with insights from the science of complex adaptive systems. *Appendix B Crossing the Quality Chasm: A New Health System for the 21st Century (2001) Institute of Medicine (IOM)*.
3. Simon, H. (1979). "Rational decision making in business organizations." *The American Economic Review* 69(4): 493-513.
4. Anderson, R. A. and R. R. McDaniel, Jr. (2000). "Managing health care organizations: where professionalism meets complexity science." *Health Care Manage Rev* 25(1): 83-92.
5. West, M., C. Borril, et al. (2002). "The link between the management of employees and patient mortality in acute hospitals." *Int J of Human Resource Management* 13(8): 1299-1310.
6. Young, G. J., M. P. Charns, et al. (1997). "Best practices for managing surgical services: The role of coordination." *Health Care Management Review* 22(4): 72
7. Moss, F. (2004). "The clinician, the patient and the organisation: a crucial three sided relationship." *Qual Saf Health Care* 13(6): 406-7.
8. Skills for the new millennium: report of the societal needs working group CanMEDS 2000 Project http://repsc.medical.org/canmeds/CanMEDS_e.pdf (Accessed 08-07-05)
9. Irvine DH. Time for hard decisions on patient-centred professionalism. *Med J Aust* 2004;181(5):271-4.
10. Berwick D. A primer on leading the improvement of systems. *BMJ* 1996;312:619-622.
11. Reinersten J. Physicians as leaders in the improvement of health care systems. *Ann Intern Med* 1998;128:833-838.
12. Perkins, R. J., K. J. Petrie, et al. (1997). "Health service reform: the perceptions of medical specialists in Australia (New South Wales), the United Kingdom and New Zealand." *Med J Aust* 167(4): 201-4.
13. Porter, M. E. and E. O. Teisberg (2004). "Redefining competition in health care." *Harv Bus Rev* 82(6): 64-76, 136.
14. Thompson G, Frances J, Levacic R, Mitchell J. *Markets, Hierachies and Networks*. London: Sage, 1991.
15. Glouberman S, Mintzberg H. Managing the care of health and the cure of disease--Part I: Differentiation. *Health Care Manage Rev* 2001;26(1):56-69; discussion 87-9.
16. Glouberman S, Mintzberg H. Managing the care of health and the cure of disease--Part II: Integration. *Health Care Manage Rev* 2001;26(1):70-84; discussion 87-9.
17. Ham, C. (2003). "Improving the performance of health services: the role of clinical leadership." *Lancet* 361(9373): 1978-80.
18. Southon, G., R. Perkins, et al. (2005). "Networks: A Key to the Future of Health Services." *Australian Health Review* 29(3): 317-326
19. CHI web site <http://www.health.qld.gov.au/chi/default.asp>
20. What are Managed Clinical Networks ? <http://www.pfizer.co.uk/pdf/MCN%208pp.pdf>
21. Managed Clinical Networks: a guide to implementation <http://www.pfizer.co.uk/pdf/MS1651%20MCNs.pdf>
22. Networks – Overview <http://libraries.nelh.nhs.uk/healthManagement/viewResource.asp?categoryID=4033&dg=59&uri=http://libraries.nelh.nhs.uk/common/resources/?id=29633>
23. <http://www.health.nsw.gov.au/gmct/index.html>
24. Embracing Change : Report of the Greater Metropolitan Transition Taskforce 2004 http://www.health.nsw.gov.au/gmct/pdf/embracing_report.pdf
25. <http://libraries.nelh.nhs.uk/healthmanagement/viewResource.asp?mr=10&searchText=&categoryID=4033&dg=59&attributeOptionID=&keywordID=&offset=20&uri=http%3A//libraries.nelh.nhs.uk/common/resources/%3Fid%3D29543>
26. Stroke and Cardiac managed clinical networks <http://www.nhsayrshireandarran.com/uploads/2335/ARjan05chdstroke.pdf>
27. Evaluation of cardiac managed clinical network http://www.show.scot.nhs.uk/sspc/pub_articles/pdf/sehdintrep.pdf
28. http://www.nhsayrshireandarran.com/view_item.aspx?item_id=2332&open2=false
29. Edwards N. Clinical networks. *BMJ* 2002;324:63.

Appendix 9.1 RAPTS summary

RAPTS

Recruitment, Assessment, Placement, Training, Support For International Medical Graduates

Executive Summary and Recommendations from the detailed project proposal Prepared by Dr Susan O'Dwyer and

Janet Thornton

Queensland Health, 12 August 2005

Executive Summary

Queensland Health will require the services of highly skilled International Medical Graduates (IMG) to provide health services to Queensland communities for the foreseeable future. The National Health Workforce Strategic Framework¹¹⁶ identifies ethical overseas recruitment as a short term strategy to reduce immediate health workforce shortages in Australia. A comprehensive workforce plan for medical staff in Queensland will need to consider the large and ongoing requirement to fill positions with IMG.

RAPTS aims to deliver a standardised process for the recruitment; assessment; placement; training and support of IMG based on minimum standards of knowledge; skills; abilities; communication and cultural safety, that can be delivered centrally or in satellite sites.

Each element of RAPTS requires adequate resource allocation. It is the opinion of the authors that partial funding of select elements of the proposal in isolation will not deliver on the goal to provide quality and safe medical services to the communities of Queensland.

Attraction of the highest quality medical graduates requires a coordinated marketing and recruitment strategy that endeavours to proactively support health care facilities to provide services. For the recruitment of IMG, commitment to the development of a standardised assessment and increased resources for processing of immigration, medical board and Specialist College requirements will be of particular benefit to the smallest health care facilities struggling to interpret and keep pace with the ever changing environment of medical staff employment.

Appropriate use of existing resources such as job descriptions and service capability knowledge will enable placement of IMG in environments that are commensurate with their level of clinical decision making and supervision requirements.

¹¹⁶ Australian Health Ministers' Conference (2004), National Health Workforce Strategic Framework, Sydney

Training in the areas mandated by the Medical Board of Queensland as well as the proposed mandatory Queensland Health orientation and training should be delivered prior to the commencement of employment. The Centre for International Medical Graduates should continue its role in the preparation of IMG for the Australian Medical Council (AMC) multiple choice question and clinical exams with enhancements around flexibility in mode of delivery.

Ongoing support for OTDs, personal and professional, to achieve the Australian standard as identified by AMC certification and/or Fellowship of an Australian College should be assisted by terms and conditions of employment that support ongoing training and professional development. The Association of International Medical Graduates of Australia and New Zealand will be developing a mentoring scheme to OTDs through a Commonwealth grant. Support provided should encompass the social and family needs of the OTD.

There is considerable work to be done to achieve all that is proposed. The commitment of the staff Queensland Health to achieving that end has always and will continue to be, present.

Key Statements

Queensland Health recognises the valuable and necessary contribution that IMG make to the provision of health services to the communities of Queensland, now and in to the future.

The RAPTS process will enable Queensland Health to provide quality, safe and accessible health services through the recruitment and retention of a highly skilled international medical workforce.

RAPTS will be the process for recruitment of all IMG regardless of residency or registration status, to Queensland Health.

RAPTS will be a standard process that can be administered centrally or in satellite sites.

RAPTS will provide a single entry point for recruitment of IMG regardless of method of introduction.

The final decision to offer employment to a suitable applicant to a nominated vacancy will remain with the employing Health Service District or Unit

RAPTS processes will be accountable to the Queensland community, Queensland Government, international medical workforce and service providers through service agreements, regular reporting and qualitative and quantitative program evaluation.

2.0 Recommendations

It is recommended that the following key objectives be adopted by Queensland Health:

- Implementation of a well resourced best practice process for the recruitment, assessment, placement, training and support of all international medical graduates in Queensland based on minimum standards of clinical knowledge, skills and ability, communication, cultural safety and preparedness for practice in the Queensland Health System.
- Queensland is identified as a destination of choice for medical graduates.
- Improvement in community confidence in the provision of quality, safe and accessible health care by the public health service in Queensland.

These will be achieved through the following projects and recommended actions:

2.1 Projects

The RAPTS project is funded **immediately** to develop, implement and evaluate a best practice process of recruitment, assessment, placement, training and support for international medical graduates in Queensland for staggered implementation from January 2006.

It is recommended that the development of the RAPTS project be managed through six (6) subprojects under the following headings. The project statements for these sub projects are summarised below:

2.1.1 RAPTS – Marketing

To develop an annual coordinated marketing and advertising strategy to attract medical graduates including IMG to employment opportunities in Queensland.

2.1.2 RAPTS – Recruitment

To develop, implement and evaluate a standard entry and recruitment process for IMG seeking employment opportunities in Queensland Health.

2.1.3 RAPTS – Assessment

To develop a standardised process and supporting resources for the screening and assessment of international medical graduates seeking employment opportunities in Queensland Health based on minimum standards of knowledge, skills, ability, communication and cultural safety.

2.1.4 RAPTS – Placement

To develop a standardised process and resources to ensure that IMG are recruited to positions that are commensurate with their knowledge, skills and abilities scope of practice and support the supervision conditions of their registration and which also considers the social and personal needs of the IMG and family.

2.1.5 RAPTS – Training

To investigate options for providing pre employment training and orientation required for IMG to deliver safe and quality medical services to the Queensland community.

2.1.6 RAPTS – Support

To develop and implement effective support mechanisms for international medical graduates (IMG) wishing to reside long term in Australia and achieve career goals that will benefit the health services in Queensland.

2.2 Recommendations for Immediate Action

1. Public Affairs in consultation with stakeholders consider opportunities for the timely and sensitive acknowledgement of the valuable and necessary contribution that International Medical Graduates make to the provision of health services in Queensland.
2. Review and update of the content available on the Queensland Health Internet site to promote the attractions and opportunities for employment in Queensland
3. Department of Immigration, Multicultural & Indigenous Affairs is engaged in discussion at a senior management level of Queensland Health to consider options for streamlining the immigration process for the international health workforce through central sponsorship.
4. Queensland Health requests that the Australian Medical Council and relevant Specialist colleges clarify their current position in relation to recognition of international medical qualifications.
5. Queensland Health implements a policy of only accepting applications from graduates of medical schools currently listed by the World Directory of Medical Schools or the International Medical Education Directory.
6. Queensland Health investigates options for partnering with Department of Health & Ageing and/or another state to formalise existing bridging courses available to IMG into a postgraduate qualification in Australian Health practice accredited by the relevant authority.
7. Clarification is sought from the Director General for detail of the recent funding announcements under the Forster-Morris Fund relating to:
 - training and career pathways for rural doctors
 - database to enable sharing of information about doctors credentials
 - flexibility granted to Queensland Health in its recruitment techniques
8. Liaise with Corporate HR/IR Policy and Strategy Centre in relation to award conditions to:
 - Facilitate flexible working arrangements to encourage Australian graduates to retain and return to work
 - Support equitable access to professional development opportunities for IMG on temporary contracts (>12 months)

9. Investigate the number of Queensland residents currently studying medicine at interstate universities and explore future strategies to encourage a return to Queensland for Intern training.
10. Immediate consideration needs to be given to those IMG with special purpose registration presently employed in Queensland Health and assistance provided to help them achieve AMC certification or Fellowship of an Australian College
11. Queensland health reviews the framework and resources for the assessment and remediation of medical graduates whose performance and competence has been questioned.

Key Performance Indicators

- Proportion of IMG seeking employment with Queensland Health who are case managed through a consistent state-wide process that requires minimum competency standards in key areas regardless of point of contact. (95% by June 2006)
- Satisfaction rating from IMG who are managed through the RAPTS process based on qualitative survey feedback (Above average rating from 75% at June 2007)
- Satisfaction rating from service providers who utilise the RAPTS process for recruitment based on qualitative survey feedback (Above average rating from 75% at June 2007)
- Proportion of IMG placed via RAPTS who are deemed not suitable for employment (<10% by December 2007)

Appendix 12.1 Information management project initiatives

There are currently numerous projects being managed within the IM/ICT Capital Acquisition Program. In January 2005 a detailed assessment was undertaken of the 45 projects underway at that time, resulting in the following status being reported:

- 5 projects were progressing successfully and given a green status
- 28 projects were assessed as having some risk of failure and required assistance to improve the outcome. These projects were given a yellow status
- 12 projects were identified as having significant risks and were given a red status.

The information management projects have been consolidated into five programs being:

- the Clinical Informatics Program (CIP)
- the Resource Management Program
- the Decision Support program
- IT Infrastructure
- Infostructure.

Each current project and the status is outlined below.

Clinical Informatics Program

The Clinical Informatics Program was formed in 2004 by initially amalgamating a number of separate initiatives under an umbrella program. Each of these initiatives has a clinical system focus in a specific speciality area with the exception of the overall Clinical Information System (CIS) project. The CIS provides an overarching solution that manages information flows and summary information from each of the specialist systems. It also provides patient administration services and is to be a replacement for the Hospital Based Corporate Information System (HBCIS). There are 17 projects within this program as follows:

| System or Project Name | Description | Status |
|--|--|--------|
| Clinical Information System (CIS) | TrakCare (formerly called MedTrak) will provide a suite of clinical and patient administration systems. The system will provide electronic order entry and results reporting for pathology and radiology services, discharge summaries, clinical worklists, simple rules-based decision support (including alerts and allergies), and replacement of some legacy Hospital Based Corporate Information System (HBCIS) applications. | Red |
| Primary Care Information System (PCIS), formerly CHIME | A Community Health information system to provide patient centric information across the continuum of care. | Red |
| QPACS - Radiology Information System (RIS) | A statewide Radiology Information System which is coordinated and consistent with existing Queensland Picture Archiving and Communication Systems sites. | Red |
| QPACS - Picture Archiving Communication System (PACS) | The QPACS Project will initially review the maintenance and contractual arrangements of the existing QPACS sites. This will include analysing financial and human resource requirements for upgrading of software and hardware. | Red |
| Quality Use of Medicines, | i.Pharmacy, is being implemented in the 49 state hospital pharmacies to support all business areas including | Red |

| System or Project Name | Description | Status |
|--|---|--------|
| Pharmacy | administration, clinical pharmacy, dispensing, inventory management and manufacturing. | |
| Provider Directory | Provider Directory is an enterprise-wide master index which will enable internal and external health providers to be uniquely identified across different systems in Queensland Health. | Yellow |
| Client Directory | Client Directory is an enterprise-wide master person index which links information about the same persons (patients/clients) in different facilities and systems in Queensland Health. | Yellow |
| Information System for Oncology - SZP | Proposed enterprise information management system to support the delivery of oncology services across the state | Yellow |
| Operating Room Management Information System (ORMIS) | To improve operational service delivery effectiveness and enhance management of Operating Theatres and Theatre Bookings Areas as a consequence of implementing a modern, integrated, functionality "fit for purpose" application software suite (ORMIS V7), across hospitals. | Yellow |
| Emergency Department Information System (EDIS) | To improve operational service delivery effectiveness and enhance management of Emergency Departments as a consequence of implementing a modern, integrated, functionality "fit for purpose" application software suite (EDIS V9), across Emergency Departments. | Yellow |
| Incident Monitoring /Risk Management (PRIME) | A system that will capture clinical incidents and risks and enable Queensland Health to proactively reduce the likelihood of recurrence. The PRIME system has been developed for this purpose and phase one for capture clinical incidents has been rolled out. Phase two for capturing consumer feedback and phase three for risk management are currently in development. | Yellow |
| Infection Control | To establish an infection control tool and reporting capability to facilitate a total quality approach to infection control. | Yellow |
| Measuring Quality in NGHHS | A web based application to enable electronic reporting of standardised data from funded non government health service providers | Yellow |
| Oral Health Information System | Provides accurate and timely information for the efficient administration, monitoring and evaluation of Oral Health Services in Queensland and a seamless statewide service | Green |
| Credentials and Clinical Privileges - SZP | Proposed system for the recording and management of clinicians' credentials and clinical privileges. Supports the ISAP requirement for reporting this information. | Yellow |
| Information System for Orthopaedics - SZP | Proposed system to replace a legacy system not capable of being distributed to other sites. | Yellow |
| Health Contact Centre | Establish a 24 hour, seven day a week, statewide health contact centre to provide access to health information, referral and triage services. This new health service will be based in Queensland and staffed by clinicians using clinical proven protocols. | Yellow |

Resource Management Program

There are three projects within the Resource Management Program, as follows:

| System or Project Name | Description | Status |
|---------------------------------|--|--------|
| Public Health Licensing System | There is a legislative requirement (at a minimum) to continue managing licenses. The existing systems will not run as it is not SOE compliant. | Yellow |
| FOI Replacement Database System | TBA | Yellow |
| Computerised | A system that will enable full life-cycle asset management, to | Green |

| System or Project Name | Description | Status |
|-------------------------------|--|--------|
| Maintenance Management System | ensure the return on the Government's significant investment in the statewide Health Building Program and meet asset maintenance requirements. | |

Decision Support Program

There are six projects within the Decision Support Program, as follows:

| System or Project Name | Description | Status |
|---|---|--------|
| Library Information Management System | The final phase of the LiMS project. | Yellow |
| Infobank Development | Infobank provides access to predefined summary health and health related information for all Queensland Health staff (predefined statistical reports). | Yellow |
| Non-Admitted Patient Data Collection | Develop and implement a data collection process for non-admitted patients. | Yellow |
| Corporate Reference Data System (CRDS) Phase II | To enhance the functionality and increase the range of datasets available within the CRDS to maximise client uptake of CRDS capabilities. | Yellow |
| Monitor Priority Populations – QHOID | Implement a dissemination tool for timely reporting of health and health related outcome indicators on QHEPS. | Yellow |
| HIC Core Systems | To ensure that Queensland Health has the infrastructure in place to support the ongoing processing and dissemination of the data it currently collects, as well as supporting new data collection/information requirements. | Green |

IT Infrastructure

There are eleven projects within the IT Infrastructure Program, as follows:

| System or Project Name | Description | Status |
|-----------------------------------|---|--------|
| Local Area Network Upgrade | A fully integrated IS network using a standard set of equipment across each Local Area Network. | Red |
| Wide Area network Upgrade | The objective is to bring the WAN up to a standard where it will adequately support Queensland Health administrative and clinical information systems | Red |
| Telephone Systems Replacements | This project will provide a planned and managed approach to the upgrade and/or replacement of 177 telephone systems within Queensland Health. | Red |
| Server Consolidation | The project is designed to consolidate Windows/Intel (WINTEL) data processing power at an enterprise level to ensure the maximum usage of servers and related technology. | Red |
| Data Centre Consolidation Project | Provide two Enterprise Data Centres capable of delivering high-availability application service statewide, with provision for continuity of service in the event of disaster at one data centre. | Red |
| HBCIS Consolidation | Replace the aging HBCIS Infrastructure to ensure sustainability of the HBCIS Application and to maximise system availability and effective disaster recovery capability, whilst seeking to reduce costs to Queensland Health. | Red |
| AUSLAB Server Replacement | Significant growth in usage of the AUSLAB system surpassed the ability of the existing platform to meet demand resulting in poor performance and outages. | Yellow |
| Desktop Tools and | Introduce a comprehensive statewide Departmental capability | Yellow |

| System or Project Name | Description | Status |
|---|---|--------|
| Technology | to manage workstation technology requirements. | |
| Standard Operating Environment | The Standard Operating Environment Project is implementing a standard desktop environment to reduce operational costs and enable remote support. | Yellow |
| Software Licensing and Asset Management | Implementing a software license registration, tracking and management system. This project is aiming to avoid litigation due to license agreement breaches. | Yellow |
| File, Print and Messaging | The File, Print and Messaging Project is implementing infrastructure to support local file and print management as well as enterprise messaging. | Yellow |

Infostructure

There are seven projects within the Infostructure Program, as follows:

| System or Project Name | Description | Status |
|--|---|--------|
| IT Service Management | To develop a sustainable organisational capability to undertake IT Service Management better. | Red |
| I-Net Project | Extend the I-Net infrastructure by developing reusable components to enable new types of business system to support the continuum of care. | Yellow |
| Single Sign on | Implementing a capability to minimise the number of login IDs and passwords used by Queensland Health staff. | Yellow |
| Customer Support | Standardised customer support methodology supported by an Information System capable of the logging, reporting and managing of customer incidents and problems. It is used by ISUs and the Help Desk. | Yellow |
| Integrated Test Environment (ITF) | The ITF project is to establish and operational IT test environment, replicating production environment, for all IT systems. | Yellow |
| University Connectivity, Remote Access | Implementation of the SDN External Access system and deliver a support framework for University connectivity to Queensland Health. | Green |
| Secure File Transfer (PKI) | To implement a security architecture that will enable fully managed secure access services, including Public Key Infrastructure. | Green |

Appendix 12.2 Approved enterprise wide Information systems

The table below provides a list of the currently approved enterprise wide information systems:

| APPROVED ENTERPRISE APPLICATIONS | | |
|----------------------------------|---|---|
| System Name | Full Name | Description |
| ACIMS | Aged Care Information Management System | Used for resident management and billing |
| ATODS | Alcohol Tobacco and Other Drug Substances | Allows collection of the alcohol treatment and other drug services to the minimum data set required for commonwealth reporting. Also provides instructions relating to the Queensland Opioid Treatment Program. |
| ASP | Asset Strategic Planning | Provides a means of planning the life cycle of assets and provides Treasury with annual Capital Acquisition Plan. This is to be implemented across all state government departments. |
| AUSLAB | AUSLAB | Reporting and laboratory management software system |
| BSQR2 | BreastScreen Queensland Register | Register of Pap smear clients and related follow-up results |
| EDIS V9 | Emergency Department Information System | Emergency department management |
| ESP ERV eXpert SL&P | Environment for Scheduling Personnel Roster generation Report viewer module Staffing levels and productivity | Scheduling staff, generating rosters and determining staffing levels and productivity levels |
| FAMMIS | Finance and Materials Management Information System | Corporate finance and materials management information system |
| GroupWise | GroupWise | Corporate e-mail system |
| HBCIS | Hospital Based Corporate Information System | Patient administration system for hospitals |
| HRMIS (Lattice) | Human Resource Management Information System | Human resource management information system |
| IDM SSO | Identity Management System Single Sign On | Improves the security associated with the use and management of user credentials |
| ISOH | Information System for Oral Health | Collects data and reports information to government and other agencies on Queensland public adult oral health services |
| MHA2000 | Mental Health Act 2000 Information System | Register of Notifiable Forensic Mental Health Clients |
| MODDS | Monitoring of Drugs of Dependence System | Monitoring of dangerous drugs. |
| NOCS | Notifiable Conditions System | Stores notifications of diseases required to be notified to Queensland Health under legislation. These notifications are validated by Public Health Units |
| ORMIS V7 | Operating Room Management Information System | Computerised management tool for recording patient details on waiting lists and scheduling surgery |

APPROVED ENTERPRISE APPLICATIONS

| System Name | Full Name | Description |
|----------------|---|--|
| PRIME | Patient Related Incident Management System for clinical incidents | Allows the capturing and analysis of information related to consumer feedback, clinical (patient) incidents and risk data |
| PSR | Pap Smear Register | Register of Pap smear clients and related follow-up results |
| QHEPS | Queensland Health Electronic Publishing Service | Provides access to documents, policies, procedures, clinical information and resources for Queensland Health staff |
| QHPIMS | Queensland Health Pharmacy Information Management System | Information system for contemporary pharmacy requirements |
| RAS | Remote Access Service | Provides secure access to Queensland Health information and applications from locations other than the normal place of work. Generally this will be from locations outside the Queensland Health wide area network (WAN) |
| SATR | Surgical Access Team Reporting | Reporting system for Elective Surgery Coordinators |
| SOE | Standard Desktop Operating Environment for Queensland Health workstations | Includes Windows OS and utilities, applications and other software required for everyday PC operations with Queensland Health |
| VIVAS | Vaccination Information and Vaccination Administration System | Vaccination immunisation verification system records vaccinations provided in Queensland and records orders and distribution of vaccines to service providers in Queensland |
| WCMS | Web Content Management System | Automated authoring, approving, indexing, deploying and maintaining information published on Queensland Health's internet and intranet web services |
| CESA | Client Events Server Application | Mental Health client events such as Episodes of Care |
| MH OIS | Outcomes Information System | Clinical Tool for Assessing Efficacy of Intervention |
| 3M Encoder | 3M Codefinder | Tool for determining the optimal ICD codes and DRG for an admitted episode of care. Also used in Clinical Costing analysis processes. |
| TII | Transition II (SDSM-Core) - Clinical Benchmarking | Activity (Casemix) Based costing and budgeting, Clinical Pathways and clinical indicators |
| Travel Manager | QH Travel Information System | Supports the coordinated management of patient and staff travel across Queensland Health |
| FERRET | FERRET | Primary Health Information System for Indigenous and Rural Health Communities. Supports standardised clinical practice, and is driving clinical reforms for chronic disease management and prevention. |
| MAIS | Medical Aids Information System | Database for tracking equipment, clients and processing client applications. Supports the statewide administration of the Medical Aids Subsidy Scheme. |
| LIMS/VOYAGER | Voyager Library Management System | An enterprise wide system providing a searchable catalogue of all Queensland Health library resources and a whole of |

APPROVED ENTERPRISE APPLICATIONS

| System Name | Full Name | Description |
|-----------------------|---|---|
| | | state lending process |
| CHEMALERT II | Chemical Information System. | Modules include product information, stock management, risk assessment and security. The database contains over 40,000 chemical products. |
| XMAN JMAN PAYMAN | Financial transaction System | Statewide system to support financial transactions across cost centres within Queensland Health. |
| S8 ONLINE | Schedule 8 Online | Web based system for community pharmacists to enter data into MODDS. Part of Secure Transfer Services |
| CCP | Credentials and Clinical Privileges | A central repository to provide a single point of access to information regarding the credentials and privileges of staff across the State, with high levels of security and control over access to the data. |
| CFOC | Clinical Forms On-line Catalogue | A central repository for all official clinical forms. Will support the storage and access to standardised clinical forms. |
| INNOV8 | Innovate | System that supports Queensland Health staff to submit ideas to the INNOV8 program. Used to register and track innovations in QH, so that ideas can be assessed and reviewed. |
| Health Contact Centre | Includes: Health Service Provider Directory; Clinical Decision Support System; and Health Information Database. | Initiative as part of election commitments. Will provide a single point of contact for Queenslanders for health information. |
| IMS | Incident Management System | Statewide system that records and collates Workplace Health and Safety incidents throughout Queensland Health. Includes modules for Workers Compensation and Workplace Rehabilitation. |

Additionally, the applications in the Clinical Informatics Program are proposed as enterprise wide applications, but have not been approved at this point in time.

Appendix 13.1 International Indicator Sets

(from NSW Health System Performance Indicators, August 2003)

| NSW Health dashboard | Australian National framework* | Canadian published indicators | English National health Service published indicators |
|--|---|--|--|
| 1. Potentially avoidable deaths | Potentially avoidable deaths | Life expectancy | Life expectancy |
| 2. Chronic disease risk index | Multiple indicators | Multiple indicators | Multiple indicators |
| 3. Antenatal visits <20 weeks | Antenatal visits <20 weeks | % low birth weight babies | Infant mortality rate |
| 4. Child and adult immunisation | Child and adult immunisation | Child and adult immunisation | Child and adult immunisation |
| 5. Falls in older people | Deaths from injury (all causes) | Potential YLL due to unintentional injury | Deaths from accidents |
| 6. Self reported mental health | Self reported mental health | Self reported health | Suicide rates Prescribing rates for some drugs |
| 7. Ambulance response Triage response | % patients seen within triage category times | No published indicator | No published indicator |
| 8. Coronary revascularisation Major joint replacement Radiotherapy rates | Coronary revascularisation Major joint replacement | Major joint replacement Waiting time for radiotherapy – breast and prostate cancer | Coronary revascularisation Major joint replacement |
| 9. U1/U2 admitted to hospital <30 days All ready for care list patients waiting <12 months Access block | Median waiting time - all on waiting list - coronary revascularisation - hip replacement | Median waiting time - surgery - cardiac procedures - hip and knee replacement - diagnostic services - specialist visits | % waiting <6 months for inpatient admission % seen <13 weeks of GP referral for first OPD appt % seen <2 weeks of urgent GP referral to OPD specialist for cancer % admitted through ED not n ward bed within 4 hours of decision to admit |
| 10. Av distance from RDF target | No draft indicator | No published indicator | No published indicator |
| 11. Length of stay >outlier Unplanned readmission <28 days Unplanned readmission ICU <72 hours Unplanned return to OR | Hospital separations for a reported adverse event (not supported for state reporting) | Unplanned readmission for - Acute myocardial infarction - pneumonia | Length of stay >outlier Unplanned readmissions <28 days |
| 12. Staff separation rate | % of workforce aged >50 years Graduates as a % of workforce | No published indicator | Junior doctor hours Vacancy rates – allied health, nurses, consultants Sick leave Number of GPs |
| 13. Potential avoidable hospitalisation | Potential avoidable hospitalisation | Potential avoidable hospitalisation | No published indicator |
| 14. Priority care process – stroke | Mortality following stroke | Mortality rate for stroke 30 days survival rate following stroke Potential YLL from stroke | Returning home <56 days following hospital treatment for stroke >50 years Emergency readmission to hospital <28 days following stroke Death <30 days of admission for stroke |
| 15. Priority care process – cancer | Five-year cancer survival rate | For selected cancer types - five-year survival rate - Potential YLL | Mortality rate all cancer types Five-year survival rate |
| 16. Patient satisfaction <i>Overall, inpatient, emergency, community health, early childhood centre, public dental clinic</i> Consumer experience | No draft indicator | Patient satisfaction <i>Overall, hospital, family doctor, community services</i> | % written complaints resolved locally within 4 weeks |
| 17. Net cost of service general fund (general) | No draft indicator | No published indicator | No published indicator |
| 18. Weighted output measure Cost per case mix adjusted separation | | No published indicator | Index of actual cost of activity using national averages |
| 19. Effective resource index Relative stay index by medical/surgical and other DRGs | Relative stay index by medical/surgical and other DRGs | No published indicator | Ratio of observed to expected day case rate for a basket of 25 case mix adjusted procedures |
| 20. Asset utilisation | No draft indicator | No published indicator | No published indicator |

Appendix 13.2 Detailed description of performance monitoring and reporting arrangements in other jurisdictions

This section provides an overview of our understanding of the performance monitoring arrangements in place in other jurisdictions. As performance monitoring arrangements vary state by state and are reported by various means, not always in one report, a significant proportion of the following information was obtained through discussions with staff working in health departments in New South Wales, Victoria and Western Australia. The Review is appreciative of these staff for their willingness to provide advice as to current arrangements.

Other jurisdiction's approaches to measuring health system outcomes are in various stages of development. Like Queensland, health departments in other jurisdictions:

- have similar requirements under a range of funding agreements to report on many operational level indicators (eg for HACC funding) which consumes considerable resources
- are dealing with the complexity of measuring patient outcomes with no jurisdiction as yet regularly measuring pre and post functional capacity (eg did knee replacement surgery improve patients' functional capacity).

New South Wales

Health system outcomes being monitored

In 2003, the New South Wales Health Department recognised it was measuring health system outcomes using too many indicators and developed a "dashboard" of 32 indicators to focus the department on monitoring its performance on the things that mattered. Under this approach, the central department monitors its outcomes using a small number of indicators that have strategic importance and Area Health Services continue to measure indicators important at the local health service delivery level and as required by funding agreements.

Dashboard indicators form the basis of performance reporting between Area Health Services and the Department (central elements of performance agreements) and between the Department and New South Wales Government (eg annual report).

Area Health Service performance agreements contain targets to be achieved for each indicator. These are derived from:

- national standards (eg immunisation rates)
- professional bodies (eg Australian College of Emergency Medicine's emergency triage benchmarks)
- policy decisions (eg x percent of patients with mental health conditions readmitted within 28 days).

Where no standards or benchmarks exist, targets are directional (eg “reduce”). Some indicators are process based, as reporting outcomes may impact on the robustness of the indicator. For example, if the number of incidents was reported as an outcome indicator, clinicians may report fewer indicators making this indicator unreliable. Process measures such as the number of root cause analyses conducted for incidents are considered to be more robust.

Quality and safety indicators are currently being developed and will be included in the standard indicator set.

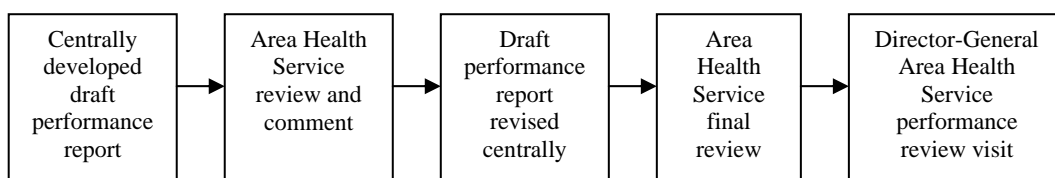
In terms of workforce indicators, the standard set of indicators includes the proportion of clinical staff employed (medical, nursing, allied, dental), staff turnover and culture (staff climate survey).

Performance monitoring and reporting system

Currently, monthly reporting from Area Health Services to the New South Wales Department of Health has a focus on financial and activity performance. Hospital activity is monitored in terms of access and quality of care and medical and surgical waiting list activity. Non-admitted activity (community health) is also monitored. The Department is aiming to refocus monthly reporting towards the standard indicator set.

Area Health Services are required to report on the standard set of indicators on a six monthly basis. All data required for reporting is collected in central databases (sources include administrative databases and statewide surveys). This was planned to reduce the reporting burden for Area Health Services. Every six months, a central unit collates and analyses data on each indicator and sends out the data to Area Health Services with comments and requests for explanations of performance variation. Area Health Services review the data and provide explanations. The central unit reviews this information, revises the report accordingly and again seeks Area Health Services review of the final draft. This process ensures that any data issues are sorted before the report is provided to the Director-General. The Director-General and senior departmental officers visit each Area Health Service to review six-monthly performance and identify strategies to address any areas of concern. In 2005, this review process is being extended to include presentations by Area Health Services on innovative service delivery approaches. Community representatives will be invited to participate in this extended process.

The focus of the performance review visit is on learning and performance improvement. The following diagram shows the six monthly performance review process.



Performance information made public

The major source of information for the public on the New South Wales Department of Health's performance is the Department's Annual Report and the Area Health Services' annual reports. Performance is reported against the standard set of indicators.

Waiting times for elective surgery and emergency departments are published on a quarterly basis.

In addition to this the Chief Health Officer produces a report on "The Health of the People of New South Wales" which provides an overview of the health status and determinants of health, presents trends in key health indicators, demonstrates health inequalities and highlights emerging health priorities.

As from this year, Area Health Advisory Councils are required to provide an annual report to parliament on the performance of Area Health Services and the Clinical Excellence Commission is required to report to the New South Wales parliament on the safety and quality of public health services.

Victoria

Health system outcomes being monitored

The Victorian Department of Human Services is required to report to the Victorian Government on the services it provides (outputs) to achieve agreed outcomes. The outputs are similar but broader than those in Queensland: acute services, mental health, aged care, primary health care, dental and public health.

Each year, the Department produces a publicly available Departmental Plan which details strategic directions, priorities for the year and targets to be achieved.

For metropolitan health services, performance agreements called 'statements of priorities', are in place between the Chair of each Health Service Board and the Minister for Health. These statements detail:

- planning priorities
- expected deliverables for strategic priorities and timeframes
- financial performance indicators and targets including one staffing indicator
- service performance indicators and targets including mental health, access, and quality and safety
- activity targets across hospitals, mental health, aged care and community health.

In terms of workforce indicators, the Department of Human Services reports on the number of doctors, nurses and dentists in the hospital system in its six monthly statewide hospital report. Through its annual report, the Department reports on staff training and development performance measures for each output. The number of grievances and grievance finalisation rates are also reported.

Separate performance monitoring and reporting processes are in place for rural hospitals, public health and community health services.

Performance monitoring and reporting system

The Victorian Department is moving towards monthly reporting against the indicators in the Statement of Priorities.

For metropolitan health services (hospitals), a performance management framework is being developed to identify the level of intervention required for health services and the associated regularity for performance review meetings. For example, if a health service is meeting performance targets, then no intervention is required and therefore no monthly meeting is conducted. At the other end of the performance continuum, if a health service is not meeting any targets, the highest intervention is required and a schedule of regular meetings is developed. The frequency of performance meetings therefore depends on performance. When conducted, the meetings involve the Director of Performance and senior executives of the health service including Chief Executive Officer, the Chief Financial Officer and directors of operations.

Performance information made public

The Victorian Department of Human Services publishes the following public reports:

- 6 monthly hospital performance report which includes broader performance measures than the annual report (expenditure, efficiency, public health insurance, GP bulk billing, access, patient satisfaction, avoidable admissions, workforce)
- from October 2005¹¹⁷, annual quality of care reports from each Board (progress on surgical issues, clinical governance framework, credentialing, infection control, medication errors, falls, pressure wounds plus other indicators that Boards considers important to report on)
- annual report on outputs
- annual departmental quality reports (sentinel events, infection control)
- annual trauma report
- burden of disease reports
- avoidable admission reports.

Western Australia

Health system outcomes being monitored

The Western Australian Government has recently changed reporting requirements and now requires the Department of Health to report against outcomes in terms of effectiveness and cost effectiveness or cost efficiency. The Department was previously required to report against outputs.

Through performance agreements currently being developed between Area Health Services and the Department of Health, Area Health Services will be required to report on a common set of performance indicators which address the department's six strategic directions (hospitals, resources, community, workforce, partnerships, leadership). This common set is currently being developed and will include a number of quality and safety

¹¹⁷ Quality of Care Reports – guidelines and minimum reporting requirements for 2004-05.

indicators. The set of indicators will align to government reporting requirements and the performance agreement between the Director General and the Minister for Health.

Area Health Service performance agreements contain targets which are either standard or historically based.

Performance monitoring and reporting system

Currently, Area Health Services are required to report monthly to the Department of Health on activity and financial position. A new monthly reporting arrangement is being developed to align with the above process, expanding the indicators reported on to include other areas such as access.

The process used to monitor performance is based on meetings with Area Health Services to discuss monthly reports.

Performance information made public

The annual report is the major source of information available to the public on the performance of the health system. The Department of Health is currently consulting with stakeholders including the Western Australian Health Consumers Council to develop a regular Community Report.

External review is held in terms of the appropriateness of performance indicators and outcome statements to adequately report on the activities of the health department. The Department of Treasury, the Auditor General and a rotational department CEO conduct this external review. In addition, the Auditor General audits the performance information provided in the annual report.

A good Queensland performance monitoring and reporting example

The performance monitoring and reporting system being used by the Queensland Police Service is included in this report as it has resulted in significant improvements in performance. The process is similar to the New South Wales Health Department:

- performance indicators are set in line with the strategic plan and communicated
- data is centrally collected and continually analysed by District Officers to identify trends
- performance data is centrally reviewed every six months
- review data is sent to District Offices for commentary prior to the six monthly review meeting
- the Commissioner and deputies meet twice yearly with Districts to discuss performance with a focus on continual service improvement
- new strategies to address performance issues are explored
- non-adversarial review providing a supportive environment
- creates a positive culture that is open to learning and innovation.

One of the most important aspects of this process is its interactive nature.

Appendix 14.1 Detailed scheduling of reform programs

| PROPOSED IMPLEMENTATION SCHEDULE OCTOBER 2005 - DECEMBER 2007 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|-------------|-----|-----|------------------------|-----|-----|-----|-----|-----|-----|-----|-----|------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----------|-----|-----|-----|-----|
| Legend | Development | | | Intense Implementation | | | | | | | | | Ongoing Implementation | | | | | | | | | M | Milestone | | | | |
| | 2005 | | | 2006 | | | | | | | | | 2007 | | | | | | | | | | | | | | |
| | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| 1 Immediate Workforce Issues | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Overseas Recruitment (Medical) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RAPTS Program | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Network of workforce planning personnel | | | | | | M | | | | | | | | | | | | | | | | | | | | | |
| New VMO Offers | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| VMO Arrangements | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recruit additional allied health | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recruit former nurses & graduates | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Expand nursing & allied health roles | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Partnership development - private providers & NGOs | | | | | | | | | | | | | | | M | | | | | | | | | | | | |
| Select and train reform facilitators | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 Leadership/Culture | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Leaders Program Stage 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Leaders Program Stage 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Leaders Program Stage 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Managers and Supervisors Program | | | | | | | | | | M | | | | | | | | | | | | | | | | | M |
| Values and Code of Conduct | M | | | | | | | | | M | | | | | | | | | | | | | | | | | |

| PROPOSED IMPLEMENTATION SCHEDULE OCTOBER 2005 - DECEMBER 2007 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|-------------|-----|-----|------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|---|-----------|--|--|
| Legend | Development | | | Intense Implementation | | | | | | | | | | | | Ongoing Implementation | | | | | | | | | | | | M | Milestone | | |
| | 2005 | | | 2006 | | | | | | | | | | | | 2007 | | | | | | | | | | | | | | | |
| | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | | | | |
| Review Leadership Performance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Culture & staff satisfaction surveys | | | | | | | | | | | | | | | | | | | | | | | | | | | | | M | | |
| 3 Teaching & Training Renewal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Registrar Places | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | |
| Specialist/VMO Training Time | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Discipline specific development plans | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | M | | |
| Relief Pools/Backfill all categories | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 Hospital/Health Service Improvement | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reform facilitators recruited & district capacity building | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | |
| District Project Plans | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | |
| Clinical Network Priorities/Plans | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | |
| Budget Reform | | | | | | | | | | | | | | | | | | | | | | | | | | | | M | | | |
| Urgent Elective Surgery Plan | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient flow and waiting list plans | | | | | | | | | | M | | | | | | | | | M | | | | | | | | | | | | |
| 5 Safety & Quality & Clinical Governance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Continue Patient Safety & Clinical Improvement initiatives | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Establish Area Clinical Governance Units | | | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | |
| Clinical Networks Functional | | | | | | | | | | | | | | | | | | | | | | | | | | | | M | | | |
| Incident monitoring and analysis system | | | | | | | | | | | | | | | | | | | | | | | | | | | | M | | | |
| Establish Health Commission | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | |
| Establish Parliamentary Committee | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | |

| PROPOSED IMPLEMENTATION SCHEDULE OCTOBER 2005 - DECEMBER 2007 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|-------------|-----|-----|------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|---|-----------|
| Legend | Development | | | Intense Implementation | | | | | | | | | | | | Ongoing Implementation | | | | | | | | | | | | M | Milestone |
| | 2005 | | | 2006 | | | | | | | | | | | | 2007 | | | | | | | | | | | | | |
| | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | | |
| 6 Patient Complaints | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Appoint Area Complaints Managers | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | |
| Training | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Complaints System Database | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | |
| Training Complaints Co-ords & Patient Liaison Officers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Complaints system development | | | M | | | | | | M | | | | | | | | | | | | | | | | | | | | |
| 7 Corporate Office Restructure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reform leadership team formed | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Central office restructuring | M | | | | | | | | M | | | | | | | | | | | | | | | | | | | | |
| Fill Senior Positions | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Re-allocation of positions & funding | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Accommodation | | M | | | | | | | M | | | | | | | | | | | | | | | | | | | | |
| Establish Area Health Services | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | |
| Establish Business Services | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | |
| 8 Strengthen Partnerships | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Leaders Program - DHC chairs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Area Health Council formation and implementation | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | |
| Monthly meetings under new role DHC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Estab community partnerships | | | | | | | | | | | | | | | | | | | | | | | | | | | M | | |
| Performance review by DHCs & AHCs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Service Ptn Progs (step up/step down) | | | | | | | | | | | | | | | | | | | | | | | | | | | M | | |

| PROPOSED IMPLEMENTATION SCHEDULE OCTOBER 2005 - DECEMBER 2007 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|-------------|-----|-----|------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|---|-----------|
| Legend | Development | | | Intense Implementation | | | | | | | | | | | | Ongoing Implementation | | | | | | | | | | | | M | Milestone |
| | 2005 | | | 2006 | | | | | | | | | | | | 2007 | | | | | | | | | | | | | |
| | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | | |
| 9 Health Service & Workforce Planning | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Appoint planning staff - Central Office & AHS | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | |
| AHS Health Service Plans | | | | | | | | | | | | | | | | M | | | | | | | | | | | | | |
| AHS Workforce Plans including strategic HR IR function | | | | | | | | | | | | | | | | M | | | | | | | | | | | | | |
| Trial and implement new and extended health worker roles | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 Service enhancements for special groups | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Identify Reform Team Member | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Form Network - Indigenous Health | | | | | | | | | | | | | | | M | | | | | | | | | | | | | | |
| Form Network - Rural & Remote | | | | | | | | | | | | | | | M | | | | | | | | | | | | | | |
| Form Network - Mental Health | | | | | | | | | | | | | | | M | | | | | | | | | | | | | | |
| Chronic Disease Strategy | | | | | | | | | | | | | | | M | | | | | | | | | | | | | | |
| Child & Youth Health | | | | | | | | | | | | | | | M | | | | | | | | | | | | | | |
| 11 Commonwealth Partnerships | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12 Governance & Reporting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Performance KPIs & review processes | | | | | | | M | | | | | | | | | | | | | | | | | | | | | | |
| New service models funding KPIs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reform Program funding KPIs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| External reporting | | | | | | | M | | | | | | | | | | | | | | | | | | | | | | |
| 13 Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Realign priorities & structures | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Computer literacy training | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | |
| Increased desktop availability | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | |

| PROPOSED IMPLEMENTATION SCHEDULE OCTOBER 2005 - DECEMBER 2007 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|-------------|-----|-----|------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----------|
| Legend | Development | | | Intense Implementation | | | | | | | | | | | | Ongoing Implementation | | | | | | | | | | M | Milestone |
| | 2005 | | | 2006 | | | | | | | | | | | | 2007 | | | | | | | | | | | |
| | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Internet Access | | | | | | | M | | | | | | | | | | | | | | | | | | | | |
| Systems enhancements (eg PRIME, ESP) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 Assets | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Establish function in Business Services & AHS | | | | | | | | | M | | | | | | | | | | | | | | | | | | |
| Implement revised governance arrangements | | | | | | | | | M | | | | | | | | | | | | | | | | | | |
| Revise asset strategic plan and priorities | | | | | | | M | | | | | | | | | | | | | | | | | | | | |
| Revised funding in line with strategic planning | | | | | | | | | M | | | | | | | | | | | | | | | | | | |
| Review capital and maintenance requirements | | | | | | | | | | | | | | | M | | | | | | | | | | | | |

Abbreviations and acronyms

| | |
|--------|--|
| AHCA | Australian Health Care Agreement |
| AHMAC | Australian Health Ministers' Advisory Council |
| AHMC | Australian Health Ministers' Conference |
| AMC | Australian Medical Council |
| AMWAC | Australian Medical Workforce Advisory Council |
| ASP | Asset Strategic Plan |
| BOM | Board of Management |
| C&CP | Credentialing and Clinical Privileging |
| CAHS | Central Area Health Service |
| CBRC | Cabinet Budget Review Committee |
| CMC | Crime and Misconduct Commission |
| CMMS | Computer Maintenance Management System |
| CNC | Clinical Nurse Consultant |
| CWAMB | Capital Works and Asset Management Branch |
| CWAMC | Capital Works and Asset Management Committee |
| DM | District Manager |
| DPW | Department of Public Works |
| DRG | Diagnostic Related Group |
| DSS | Decision support system |
| ESP | Staff rostering systems |
| FAMMIS | Finance and Materials Management Information System |
| FMII | Facilities Management Improvement Initiative |
| FTE | Full time equivalent |
| GDP | Gross Domestic Product |
| GP | General Practitioner |
| GST | Goods and services tax |
| HACC | Home and Community Care |
| HECS | Higher Education Contribution Scheme |
| HECS | Health Equipment Control System (Assets) |
| HIC | Health Insurance Commission |
| HR | Human Resources |
| HTCPS | Health Technology Capital Planning System |
| HTERP | Health Technology Equipment Replacement Program |
| ICT | Information and Communication Technology |
| ICU | Intensive Care Unit |
| IM | Information Management |
| IR | Industrial Relations |
| ISIB | Information Strategy and Investment Board |
| IT | Information technology |
| LGA | Local Government Area |
| MBS | Medical Benefits Scheme |
| NAHS | Northern Area Health Service |
| NGO | Non Government Organisation |
| NHS | National Health Service (United Kingdom) |
| OECD | Organisation for Economic Co-operation and Development |
| OTD | Overseas Trained Doctor |
| PADs | Performance Appraisal and Development Plans |

Abbreviations and acronyms

| | |
|-------|--|
| PBI | Public Benevolent Institution |
| PBS | Pharmaceutical Benefits Scheme |
| POE | Post-occupancy evaluation |
| SAHS | Southern Area Health Service |
| SHRP | Statewide Hospital Rebuilding Program |
| SHSPU | Statewide Health Service Planning Unit |
| SLA | Statistical Local Area |
| SMO | Senior Medical Officer |
| SSP | Shared Service Provider |
| VET | Vocational Education and Training |
| VMO | Visiting medical officer |
| WHO | World Health Organisation |

Glossary

| | |
|-----------------------------------|---|
| Acute care | Health care in which a patient is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Acute care is usually given in hospitals by specialised personnel using complex and sophisticated technical equipment and materials. Unlike chronic care, acute care is often necessary for only a short time. |
| Allied Health staff | Professional staff with qualifications and ongoing competence in one or any combination of the following specialties: audiologist, clinical measurements scientist, dietician, medical imaging technologist, occupational therapist, orthotist, pharmacist, physiotherapist, podiatrist, prosthetist, psychologist, social worker and speech pathologist. It may also include access to an Aboriginal and Torres Strait Islander Health worker. |
| Avoidable deaths | Deaths that <i>potentially</i> could be avoided either through prevention or through early medical intervention. |
| Avoidable hospitalisation | Conditions for which hospitalisations are thought to be avoidable if timely and adequate preventive care and early disease management is provided. |
| Benchmark | A standard or point of reference for measuring quality or performance. See also benchmarking. |
| Benchmarking | A continuous process of measuring quality or performance against the highest standards. See also benchmark. |
| Bulk billing | The process by which a medical practitioner or optometrist sends the bill for services direct to Medicare. Also known as direct billing. |
| Capital expenditure | Expenditure on large-scale fixed assets (for example, new buildings and equipment with a useful life extending over a number of years). |
| Casemix | The range and types of patients (the mix of cases) treated by a hospital or other health service. This provides a way of describing and comparing hospitals and other services for planning and managing health care. Casemix classifications put patients into manageable numbers of groups with similar conditions that use similar healthcare resources, so that the activity and cost-efficiency of different hospitals can be compared. |
| Casemix funding model | A funding approach based on the casemix of a health service. |
| Chronic disease management | Improving the health of those people who already have chronic conditions and includes strategies designed to: |

| | |
|--------------------------------------|---|
| | <ul style="list-style-type: none"> improve health-related quality of life for people with chronic disease, particularly those with more than one condition improve the use of the health care system by people with chronic conditions enhance communication between health professionals, family/carers and patients. |
| Chronic disease/condition | Diseases which have one or more of the following characteristics: 1) is permanent and leaves residual disability; 2) is caused by non-reversible pathological alteration; 3) requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care. |
| Clinical Collaboratives | Collaboratives - informal voluntary groups of clinicians from different healthcare organisations who work together in a structured way to improve some aspect of the quality of their service. |
| Clinical Governance | The system through which health services are accountable for continuously improving the quality of services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish. |
| Clinical Networks | Linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, to ensure equitable provision of high quality clinically effective services with formal authority to plan services, allocate funds and be accountable for clinical quality. |
| Community setting | A place that has no inpatient facilities and associated support services eg. home, outpatient clinic, community health centre. |
| Competence | The demonstrated ability to provide health care services at an expected level of safety and quality. |
| Credentials | The qualifications, professional training, clinical experience and training, and experience leadership, research, education, communication and teamwork that contribute to a medical practitioners competence, performance and professional suitability to provide safe, high quality services. |
| Divisions of General Practice | An Australian Government program that supports “doctors working with doctors” to promote a “wellness culture” over an “illness culture”. Divisions are involved in programs to enhance the quality of general practice and to promote community health (such as immunisation, optimal use of drugs and the provision of after hours care). |
| Elective surgery | Surgery that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours. It does not cover emergency surgery or treatment, nor does it cover medical treatments or diagnostic procedures. |

| | |
|---|---|
| Elective surgery categories | <p>Categorisation is based on a clinical assessment of the need with which a patient requires elective surgery. There are 3 main categories of urgency:</p> <ul style="list-style-type: none"> • <i>Category 1: Urgent</i> Admission within 30 days desirable for a condition that has the potential to deteriorate quickly, to the point that it may become an emergency. • <i>Category 2: Semi-urgent</i> Admission within 90 days acceptable for a condition causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency. • <i>Category 3: Non-urgent</i> Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency. |
| Elective surgery waiting list | A register of people who have been clinically assessed as needing elective surgery in a hospital. It includes patients both with and without a scheduled date of admission to hospital. |
| Elective surgery waiting times | The time elapsed for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to the date they were admitted to hospital for the procedure. |
| Emergency department waiting times | The time elapsed for each patient from presentation to the emergency department to commencement of service by a treating medical officer or nurse. |
| Episode of care | A hospital stay from admission to discharge, transfer or death. Or a portion of a hospital stay beginning or ending in a changed type of care. |
| General Practitioner (GP) | A medical practitioner who provides primary comprehensive and continuing care to patients and their families within the community. |
| Health outcome | The change in health status of an individual or population attributable to an intervention or series of interventions. |
| Health promotion | Organised efforts to make individuals and communities aware of healthy lifestyle choices and to enable them to make these choices. |
| Health protection | Legislative or regulatory measures to minimise exposure to health risks for individuals or communities. |
| Human services | Services provided by governments to address the health, welfare and broader societal needs of individuals and communities. |

| | |
|--|--|
| Indicator | A key statistic chosen to describe (indicate) a situation concisely, help assess progress and performance, and act as a guide to decision making. It may have an indirect meaning as well as a direct one; for example, Australia's overall death rate is a direct measure of mortality but is often used as a major indicator of population health. |
| Indigenous | A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander and is accepted as such by the community with which he or she is associated. |
| Infant mortality | The rate of deaths occurring in the first year of life. |
| Medicare | A national, government-funded scheme that subsidises the cost of personal medical services for all Australians and aims to help them afford medical care. |
| Multidisciplinary team | Teams that may contain a range of medical disciplines, nurses, nurse practitioners, Allied Health professionals, mental health workers and other practitioners working together to deliver integrated health care. |
| Nursing homes | Establishments which provide long-term care involving regular basic nursing care to chronically ill, frail, disabled or convalescent people or senile inpatients. |
| Occasion of service | Occurs when a patient receives some form of service from a functional unit of the hospital, but is not admitted. |
| Organisation for Economic Co-operation and Development (OECD) | An organisation of 30 developed countries, including Australia. |
| Overseas trained doctor with special purpose registration | The Medical Board of Queensland has a number of registration categories to enable overseas trained doctors to practice in Queensland on a temporary basis. This form of registration is not subject to the same requirements as general or specialist registrants. Queensland Health is most reliant on doctors with special purpose area of need registration, which enables doctors to practice in an area the Minister for Health has decided is an area of need for a medical service. |
| Palliative care | Care which does not attempt to cure a condition, but seeks to ease pain, discomfort and other complications while maintaining dignity and optimising independence and quality of life. |
| Pharmaceutical Benefits Scheme (PBS) | A national, government-funded scheme that subsidises the cost of a wide range of pharmaceutical drugs, and that covers all Australians to help them afford standard medications. |
| Population health | Collective actions by society to assure the conditions in which people can be healthy. This includes organised community efforts to prevent, identify, pre-empt, and counter threats to the public's health and to promote physical, social and cultural environments conducive to health. |

| | |
|--------------------------------------|---|
| Prevention | Actions taken to reduce susceptibility or exposure to health problems (primary prevention), detect and treat disease in early stages (secondary prevention), or alleviate the effects of disease and injury (tertiary prevention). |
| Primary health care | First level health care provided by a range of health professionals in socially appropriate and accessible ways and supported by integrated referral systems. It includes health promotion, illness prevention, care of the sick, advocacy and community development. |
| Private hospital | A privately owned and operated institution, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. The term includes private freestanding day hospital facilities. |
| Private patient | Person admitted to a private hospital, or person admitted to a public hospital who decides to choose the doctor(s) who will treat them and to have private ward accommodation. This means they will be charged for medical services, food and accommodation. |
| Public hospital | A hospital controlled by a state or territory health authority. In Australia public hospitals offer free diagnostic services, treatment, care and accommodation to all Australians who need it. |
| Public patient | A patient admitted to a public hospital who has agreed to be treated by doctors of the hospital's choice and to accept shared ward accommodation. This means that the patient is not charged. |
| Recurrent expenditure | Expenditure on goods and services which are used up during the year, for example, salaries and consumables. It may be contrasted with capital expenditure, such as expenditure on hospital buildings and large-scale diagnostic equipment, the useful life of which extends over a number of years. |
| Regional distribution formula | A mechanism for rectifying funding imbalances and redirecting funds based on the population's need for health services and not historical precedent. Recommended shifts in funding are often applied to solely to growth funding. |
| Registered nurse | A registered nurse is registered with the Queensland Nursing Council (QNC) to practice nursing without supervision, assumes accountability and responsibility for their own actions, and acts to rectify unsafe nursing practice and/or unprofessional conduct. It is essential that the nurse hold a current practicing certificate. |
| Registrar | A medical practitioner admitted to a training program by a specialist college and employed as such. |
| Risk Factor | Environmental issues, personal characteristics and behaviours, or events, which make it more or less likely that |

| | |
|------------------------------------|--|
| | one might develop a given disease or experience a change in health status. |
| Risk Management | Risk management is defined as the culture, processes and structure that are directed toward the effective management of potential opportunities and adverse effects in order to promote a healthier Queensland. |
| Same-day patients | Admitted patients who are admitted and separated on the same day. |
| Separation | When an episode of care is completed, it is referred to as a 'separation'. |
| Specialist | A specialist is a medical practitioner who is registered by the Medical Board of Queensland to practice in that specialty in Queensland, and whose training has been acknowledged by the relevant Australian specialist college via the award of a fellowship of that college or demonstrated equivalent. This includes general surgeon and general physician specialists. |
| Telehealth and telemedicine | The use of telecommunications to facilitate diagnosis, patient care, the organisation of health services and education of health professionals. |