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Advice on Queensland Health’s governance framework

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Findings and recommendations

In March 2019, the Department of Health engaged an expert panel comprising Mr Jim McGowan AM, Dr Pradeep Philip and Professor Anne Tiernan (the Panel) to provide advice to the Minister for Health and Minister for Ambulance Services regarding Queensland Health's governance framework.

The *Terms of Reference for the Advice regarding Queensland Health's governance framework* sought the Panel's advice on whether the powers, roles and responsibilities within the health system are appropriately distributed to support achievement of the objectives of the *Hospital and Health Boards Act 2011* (HHB Act), and ensure that Hospital and Health Boards are empowered to, and accountable for, implementing Queensland Government policies and priorities. The Panel was asked to examine areas critical to Queensland Health's ability to meet the needs of the community and implement government policies in a timely manner, including:

- procurement;
- capital and asset management;
- industrial and human resources management;
- service planning;
- reducing variation in costs, structures, outcomes and improving value; and
- managing capital projects within budget and timeframe.

The Panel's findings and recommendations note that the devolved system of governance is maturing. In its next phase of maturity, greater emphasis should be placed on the 'network' characteristics of the system, with those in leadership positions in the devolved governance model taking greater responsibility and accountability for their roles.

The Panel conducted consultation sessions with stakeholders including Departmental officers, Hospital and Health Board Chairs, Health Service Chief Executives, unions representing Queensland Health employees, clinician groups, Health Consumers Queensland and consumer representatives. The Panel also accepted written comments from stakeholders. In addition, the panel considered the health governance frameworks in place in other Australian jurisdictions and, where relevant, pertinent findings of relevant health system reviews undertaken in recent years in Queensland and other jurisdictions.

Queensland's public health system was established to be, and is operating as, a federated model where the 16 Hospital and Health Services (HHSs) provide hospital and health services within their remit, and the Department of Health (the Department) is the system manager. The Queensland Ambulance Service is established under separate legislation – the *Ambulance Service Act 1991* – but through machinery of government arrangements, operates as part of the Department.

Federated models have inherent strengths. They offer flexible and efficient structures that accommodate diversity and difference; they combine the benefits of collaboration and collective action with the capacity to design and deliver services tailored to local communities. When they work well, federal arrangements create opportunities for experimentation, innovation and policy learning. However, they also have shortcomings. Accountability is a major challenge for any federated system. When authority and responsibility is shared, there is inevitably a high degree of overlap. It can also be difficult to determine who is responsible for key aspects of performance – a situation that is often described as the 'blame game'. While federated arrangements offer a useful conceptual foundation for the devolved system, other

guiding principles are required to create an accountability framework consistent with the convention of ministerial responsibility that derives from our system of government.

It was clear from consultation that some stakeholders were concerned the Panel's advice would result in increased centralisation of Queensland's public health system. However, the Panel found the devolved governance structure established by the HHB Act is generally operating well and is appropriate for a system as large, complex and decentralised as Queensland's. Stakeholders acknowledged that the devolved governance structure was a significant improvement on previous models, noting that the model facilitates greater community engagement, decision-making that takes account of local context, and greater engagement and ownership from HHS employees over their HHS's outcomes. Many noted that it is simply not practicable in a state such as Queensland to have a centralised governance structure and that governing Boards had brought greater accountability and local engagement.

The Panel's consultations highlighted numerous examples of collaborations that have developed organically, both within and across the HHS network, and resulted in better health outcomes. The capacity to harness a wider range of resources and expertise demonstrates the devolved system's success and its potential to facilitate cooperation and local problem-solving, as well as wider benefits for the achievement of public health outcomes for Queenslanders.

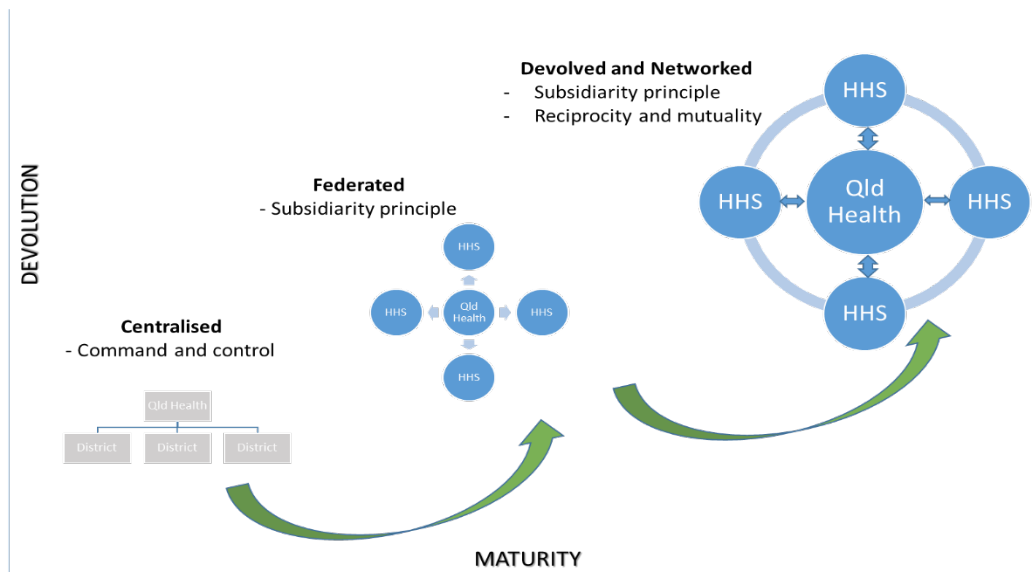
Nevertheless, this devolved system is evolving and maturing. As it does so, its next evolution should be towards a networked governance model, whereby each part of the system recognises its obligations to the system as a whole and to one another.

Any change to Queensland Health's governance framework must support the continuing quality and safety of healthcare delivery. The networked governance model will enhance the accountability of all service providers to deliver the most appropriate care in the most appropriate setting to the citizens of Queensland. A patient's experience, treatment options and quality of care should not be determined by a HHS boundary.

The networked governance model will ensure that the Department, the Queensland Ambulance Service and all HHSs must work together for the good of the public sector health system. It will encourage the sharing of resources across the system to enable more responsive management of demand and patient flows. It will also ensure that Queensland Health better supports patients who require integrated care pathways that cross HHS boundaries.

Inherent in a networked governance model is the principle that good ideas are everywhere. By promoting the sharing of innovation across the system and ensuring data is shared openly and transparently within Queensland Health, the networked model will help to reduce variations across HHSs and drive improvements in clinical practice.

As the system matures, so too must the role and focus of the Department – from one that exercised centralised control, to one where it currently serves as *system manager*, to one where it should serve both as *system leader and manager*.



Aside from recommending a conceptual reset from a federated to an explicitly networked model, the Panel's other recommendations are intended to:

- strengthen governance across the HHSs and the Department;
- improve transparency and the flow of information within the system; and
- ensure the Department operates as the system leader, promoting innovation, setting the strategic direction for the system and linking planning to health service delivery.

Resetting the conversation to embed networked governance and system thinking

The Panel considers it is timely to reset expectations about how Queensland Health's devolved governance system is intended to operate, to impress on all parties that they are part of a networked system that operates on the following principles:

- **Each party has mutual and reciprocal obligations to take a statewide perspective**: The HHB Act establishes the relationship between the HHSs and the Department, but does not deal with the relationship between HHSs. To move more explicitly to a networked model will require recognition that HHSs have obligations not just to the Department and the Minister, but to each other. Flowing from this is a requirement that HHSs consider the impact on the public sector health system when making decisions within their HHS. It also requires an acknowledgement that the Queensland Ambulance Service is an integral part of the health system in Queensland and, through its interface with HHSs, plays an important role in managing demand and patient flows in the public sector health system.

- **Information flows freely throughout the system**: Information must flow not just between the HHSs and the Department, but also between the HHSs. This would allow HHSs to draw on the experience of other HHSs and for lessons and insights to be shared across the system.

- **Local decision-making guided by an 'intelligent centre'**: In a networked model, based on the principles of subsidiarity and non-absorption, decisions should be made at the lowest level possible. In practice, this means empowering HHSs with the authority, information and data necessary to make decisions at the local level, while recognising that

there is a role for the Department to be the system leader (or 'intelligent centre'), setting system-wide direction and priorities.

- **Distributed leadership from across the system**: In a networked model, all parties – the Director-General, the Departmental Leadership Team, Health Service Chief Executives and Hospital and Health Boards – have a role as stewards and leaders of the system.

To support these changes, it is important to ensure that the HHB Act enables and incentivises the Department and the HHSs to take a system approach. The HHB Act should be amended to ensure it reflects that all component parts of Queensland's public health system are a critical part of, and have responsibilities to, the system. This could include amendments to:

- clarify that HHSs and the Department are both individually and collectively responsible for the performance of Queensland's health system;
- a HHS's functions, to clarify that collaboration and coordination with other HHSs is a responsibility of each HHS; and
- provide that, in performing its functions, a HHS must have regard to the best interests of the public sector health system.

The interface between the Queensland Ambulance Service and HHSs is critical to the operation of the health system, particularly with respect to the management of patient flows at emergency departments. However, the current legislative framework does not recognise these important linkages. The Panel recommends that the *Ambulance Service Act 1991* and the HHB Act be amended to acknowledge that the Queensland Ambulance Service and HHSs have mutual obligations to coordinate and collaborate to manage the interface between ambulance service and public sector health services in the best interests of the system.

These legislative changes to the HHB Act and the Ambulance Service Act must be underpinned by cultural and behavioural changes from all parties. The governance forums, such as the Board Chairs' Forum, the HSCEs' Forum and System Leadership Forum provide an opportunity for parties within the system to consider collectively how to implement the networked governance model in practice.

Strengthening the Department's system leadership

The Panel considers that members of the Departmental Leadership Team have an individual and collective responsibility to advocate for the Department's vision, mission and values and for modelling the behaviours consistent with these values. The Departmental Leadership Team has a collective responsibility to assist stakeholders in navigating their interactions with the Department, and to ensure the Department is providing a coordinated response to stakeholders when issues are raised. To provide successful direction to the system, the Departmental Leadership Team must operate as a highly functioning team, where each member of the team has authority to speak for the team and decisions are owned collectively. The Panel recommends that the Departmental Leadership Team better collaborate to deliver coordinated, timely, streamlined and respectful engagement with the HHSs on relevant strategic, operational and performance matters.

Strengthening the capability and effectiveness of Hospital and Health Boards

A Hospital and Health Board is the Minister's point of accountability for a HHS and plays a critical role in ensuring that Government and Ministerial priorities are implemented within their HHS. To ensure that Board Chairs are clear on the Minister's expectations, at the start of each Ministerial term the Minister should issue a Statement of Expectation that:

- sets out the Government and Ministerial priorities relevant to the HHSs; and
- reinforces that the HHSs have mutual and reciprocal obligations to each other as well as to the Department.

Successive Queensland Governments have committed to Closing the Gap between Aboriginal and Torres Strait Islander and other Australians. It is appropriate that the commitment to Closing the Gap be embedded in the HHB Act. Given Boards play a key role in ensuring their HHS is progressing action to achieve health equity for Aboriginal and Torres Strait Islander people, it is also appropriate to ensure that there is Aboriginal and Torres Strait Islander representation on all HHS Boards.

Board Chairs and members must be knowledgeable not only about their local health services but also the current and future challenges for the system. The current induction processes could be strengthened by developing a 'Good Practice Guide' for Boards and an ongoing support program for Board members to build and maintain Boards' capability and effectiveness. Boards should also initiate periodic external reviews of their Boards, to identify skills gaps and development needs and inform the recruitment processes for Board members. As part of a formal discussion on the overall performance of each HHS, the Board Chair and Director-General should meet to share learnings from the performance reviews.

Strengthening system stewardship across Queensland Health

The Panel noted that the governance of Queensland Health's forums, including the System Leadership Team, System Leadership Forum, the Health Service Chief Executives' Forum and Hospital and Health Board Chairs' Forum, are appropriate. However, all members of these forums need to commit to ensuring that the discussions at these meetings are focused on issues of relevance and importance.

The Panel noted there may be benefit in the Health Service Chief Executives and Board Chairs of HHSs with similar contexts, for example, those from rural and remote areas, having the opportunity to meet in smaller groups to discuss issues of mutual interest. This could be either for part of each meeting, or for some of the meetings throughout the year.

Sharing innovation

A number of stakeholders commented on the difficulties of sharing successes and learnings across the system and noted the system has had limited success in taking successful initiatives in one HHS and sharing and scaling them across the system. Inherent in a networked governance model is the principle that good ideas are everywhere. The challenge for the Department is to ensure there are mechanisms in place to identify and test creative approaches, then scale them across the system.

The Department should review current mechanisms to showcase and share innovations in Queensland Health and consider how to embed these across the network, so that they are ongoing, sustainable and part of 'business as usual' for Queensland Health. This review should draw on the experience of other jurisdictions and recognise that clinician and consumer networks also play important roles in promoting and sharing innovation.

Recognising the diversity of Hospital and Health Services

The Panel noted that while the HHB Act establishes all HHSs with identical functions, governance and statutory obligations, there are significant differences between the HHSs in terms of their budget, funding models, models of care and the demographics of their community. The Panel considers that the service agreement process could better account for the specific context for individual HHSs and provide greater flexibility in terms of the HHS's

individual needs and priorities. Additional performance measures may be necessary to reflect the particular contexts of those HHSs.

Information sharing

Data is an important enabler. The Panel found that the health system produces vast amounts of data but there is a lack of clarity about ownership of the data and the accountability for its integrity, reporting and publication. The lack of access to, and ineffectual use of, data is contributing to a lack of understanding about the system's needs and making it difficult to drive more consistent clinical and performance outcomes.

Data should be shared openly and transparently unless there is a reason not to do so, such as to ensure appropriate protections for patient privacy and confidentiality. There is a need to streamline the collection and sharing of information within the system. The Department has an important sense-making role, using the data sets to which it has access in its role as the system leader.

Statewide system planning

The Panel found that the division of planning functions provided for in the HHB Act is appropriate. That is:

- the Department should lead development of statewide planning, including statewide health service plans, workforce plans and capital works plans; and
- HHSs should contribute to, and implement, these statewide plans, and undertake further planning for their individual HHS which aligns with the statewide plan.

The Department should develop a comprehensive integrated statewide plan incorporating health service, workforce and capital works planning. The plan should identify future service challenges, including demand reduction and management strategies, and consider future models of care. Statewide planning needs to be routinised and conducted on a predictable cycle so that HHSs can align their own processes to have maximum input. When planning, the Department needs to welcome local knowledge and input, and to engage with the HHSs in an open and transparent way.

Capital works

The Panel found there was a need for greater clarity and transparency in the capital planning process. The Department should develop a draft major capital works plan with different horizons, integrated into the broader statewide system planning and based on future demand management strategies. As each HHS is best placed to understand its priorities, HHSs' input should be sought to ensure that local factors are considered and adjustments negotiated as necessary. Queensland Health should review the plan annually before it is considered by Government.

To ensure a single point of accountability for the capital program within the Department, consideration should be given to bringing the capital planning, delivery (including oversight of HHSs' delivery) and reporting functions together within the Department.

There were concerns about the Department's Investment Review Committee (IRC) process, with Department and HHS stakeholders noting it was expensive for HHSs and had not improved Queensland Health's reputation for managing major capital projects. The Department, in consultation with the HHSs and Queensland Treasury, should review IRC with a view to streamlining the process and ensuring capital projects are delivered on time and

within budget. A streamlined IRC should consider the management of approved projects, including costings, timeframes and readiness.

There were mixed views from HHSs about where responsibility for managing the delivery of major capital projects should lie. Some HHSs felt confident in their capacity to manage a major capital project, while others felt the Department should be responsible for management of the build but with an agreed transfer of responsibility at the point of commissioning. As it is imperative that capital projects reflect the local context, the HHS's Health Service Chief Executive (HSCE) should be responsible for the governance of capital works, for example, by chairing the steering committee for approved projects. This role should be responsible for the budget, scope and timeframes for the project. Where necessary, a HSCE may seek support to discharge this role from the capability available within the system.

Industrial relations and human resources

The HHB Act provides that:

- the Board is responsible for appointing the HHS's HSCE, although the appointment must be approved by the Minister;
- all HHSs may appoint Health Executive Service and Senior Health Service Employees (executive health service employees);
- a HHS that is prescribed in the *Hospital and Health Boards Regulation 2012* (known as a 'prescribed employer') may employ other non-executive health service employees directly; and
- non-executive health service employees in other HHSs (known as a 'non-prescribed HHSs') are employed by the Director-General as system manager of Queensland Health and effectively seconded to the HHS.

Eight HHSs are currently prescribed employers.

Stakeholders acknowledged the loss of expertise and skills of industrial relations (IR) and human resource (HR) practitioners at both the Department and HHS level. This is seen to exacerbate issues of consistency in the application and interpretation of industrial instruments and HR policies. The Department should work with HHSs to build the capability of HR and IR professionals, and to develop a separate program to assist line managers to understand their industrial obligations and good practice. These programs should be developed in consultation with health unions.

The Queensland Government has made a commitment to encourage union membership among its employees, which includes an acknowledgement that union delegates have a role to play within a workplace. Union members are employees of either the Department or the HHSs. Fair and equitable employment practices and open communication with unions and staff should be expected. Some of the practices described by unions evidenced underlying cultural issues that go beyond a lack of capability. Respectful and constructive relationships are essential and need to be established in all HHSs. HSCEs and their executive teams must model leadership within their HHS. HSCEs should ensure they have formal consultative mechanisms in place so that senior union officials are able to raise issues of concern.

Industrial concerns often arise as a result of operational decisions made at lower levels within the organisation. Strong union engagement at this level has the potential to deliver positive outcomes, including improving the capability of front-line decision-makers and enabling potential issues to be resolved at the lowest level. For this to be effective, HHSs need to afford unions access to these decision-makers, and union leaders and employees need to display a genuine commitment to respectful engagement and trust-based partnerships with HHSs.

Unions employing Queensland Health employees were strongly critical of the devolved governance model, particularly the prescribed employer arrangements. They cited numerous examples of inconsistent practices and behaviours from HHSs, including, for example, HHSs developing their own employment policies that were inconsistent with the Department's policies, and incidents of members returning from maternity leave being either refused part-time arrangements or required to return at a particular part-time employment fraction, in contravention of the *Industrial Relations Act 2016*. The peak bodies representing doctors and nurses did not consider the prescribed employer arrangements had benefited their membership and were of the view that the system would benefit from having a single collective identity.

The Panel considers the current arrangements are confusing and inconsistent. Non-executive health service employees in half of the HHSs are employed by the Director-General as system manager, while employees in the remaining HHSs are employed by individual HHSs. The Director-General remains responsible for the negotiation of industrial instruments and determining the terms and conditions of employment for all health service employees, regardless of a HHS's prescribed employer status. Moreover, irrespective of prescribed employer status, all HHSs retain local responsibility for their staff and make on the ground decisions that have a direct impact on their workforce.

HHSs with prescribed employer status argued that these arrangements are more efficient and important to improving organisational culture and creating a sense of belonging for their staff. However, the Panel was unable to identify any evidence to establish a clear link between those HHSs' prescribed employer status and their performance under the service agreements. The Panel noted all HHSs, regardless of their prescribed employer status, have identified that building organisational culture and staff engagement is critical to improving patient experiences and the quality of care.

The Panel also considers the notion of different employers for Queensland Health staff is inconsistent with the principles that underpin a networked model. For these reasons, the Panel recommends that all non-executive health service employees should be employed by the Director-General, as system manager of Queensland Health, consistent with the arrangements currently in place for the eight non-prescribed HHSs. Even though individuals may identify as working for the Royal Brisbane and Women's Hospital or Central West HHS for example, they should predominantly see themselves as employees of Queensland Health, with a responsibility to support the health needs of all Queenslanders that transcends HHS boundaries. This will also support a system-wide approach to staff movement, advancement and succession planning.

Unions also raised concerns about access to data about the Queensland Health workforce. Unions are entitled to access workforce data relevant to their membership and the system has an obligation to provide it.

Procurement, including the governance of Health Support Queensland

Currently, Queensland Health's procurement model and governance arrangements do not position Queensland's public health system to realise system scale savings and benefits. This position is unsustainable given the current and projected demand and funding pressures on the system.

As a service provider to the HHSs, Health Support Queensland (HSQ) needs to be responsive and accountable to its customers. The Director-General should establish a Stakeholder Board tasked with advising on HSQ's procurement function. The Board should have representation from:

- an independent chair appointed by the Director-General;
- three HSCEs, with one each from the large, regional and rural HHSs;
- a Hospital and Health Board chair; and
- an independent procurement expert.

The Stakeholder Board should be tasked with developing a statewide Procurement Framework for Queensland Health that takes account of whole-of-government priorities with respect to procurement and provides greater clarity about the roles of the HHSs and HSQ. The Procurement Framework should identify those categories of goods and services that should be procured by individual HHSs, and those that should be led by HSQ and/or a HHS with established procurement capability.

It is important that the HHSs are incentivised to participate in statewide procurement processes. The Board's functions should also include recommending to the Director-General how savings resulting from efficiencies through the statewide procurement processes are directed.

While the Chief Executive Officer of HSQ would continue to have a reporting relationship with the Director-General, the Director-General should direct the Chief Executive Officer to act on the Board's advice. The HSQ Stakeholder Board Chair would have a responsibility to advise the Director-General about matters relating to HSQ's procurement function and to report to the system about HSQ's performance function. This model should be underpinned by terms of reference and a governance framework that clearly set out the Stakeholder Board's role and its reporting arrangements across the system.

Management of ICT projects within budget and timeframe

Similarly, eHealth Queensland is a service provider to the HHSs and needs to be accountable to its customers. The Panel considered eHealth's governance structure could be strengthened by establishing a Stakeholder Board for eHealth, similar to the model proposed for HSQ. The Board should include an ICT expert from outside of Queensland Health.

Recommendations

1. That Queensland Health enhance the current governance model to drive greater network and system characteristics such that the Department of Health and the Hospital and Health Services have mutual and reciprocal obligations to take a statewide perspective and to strengthen horizontal linkages across the system by:
   - reaffirming the roles and accountabilities of the Minister for Health and Ambulance Services, the Department of Health and the Hospital and Health Services within the system; and
   - amending the *Hospital and Health Board Act 2011* to reflect that all component parts of Queensland's public health system are a critical part of, and have responsibilities to, the system.

2. That, to acknowledge that the Queensland Ambulance Service is a critical part of the public sector health system, the *Ambulance Service Act 1991* and the *Hospital and Health Boards Act 2011* should be amended to recognise that the Queensland Ambulance Service and the Hospital and Health Services have mutual obligations to collaborate and coordinate their activities in the best interests of the system.

3. That the Departmental Leadership Team should better collaborate to deliver coordinated, timely, streamlined and respectful engagement with the Hospital and Health Services and stakeholders on relevant strategic, operational and performance matters.

4. That the Minister for Health and Ambulance Services should issue a Statement of Expectations to each Board Chair that sets out expectations around Government and Ministerial priorities and reinforces the mutual and reciprocal obligations of Hospital and Health Services to each other as well as to the Department of Health.

5. That the *Hospital and Health Boards Act 2011* should be amended to embed the Queensland Government's commitment to closing the gap in Aboriginal and Torres Strait Islander health by, for example:
   - mandating Aboriginal and Torres Strait Islander representation on Hospital and Health Boards;
   - requiring Hospital and Health Services to have an Aboriginal and Torres Strait Islander Health Plan; and
   - including a commitment to achieving health equity for Aboriginal and Torres Strait Islander people and delivering responsive, capable and culturally competent health care to Aboriginal and Torres Strait Islander people.

6. That Queensland Health, in collaboration with the Department of the Premier and Cabinet and the Queensland Audit Office, develop a 'Good Practice Guide' for Boards and a supporting program for Board members to build and maintain the capability and effectiveness of Hospital and Health Boards.

7. That, at least once in a three-year cycle, the Chair of each Hospital and Health Board should commission an independent external review of the Board's performance and provide the findings to the Director-General.

8. That the agendas for governance meetings – including the System Leadership Forum, the Health Service Chief Executives' Forum, Hospital and Health Board Chairs' Forum, and the Clinical Senate – should reflect the mutual stewardship obligations by including

opportunities for discussion of strategic issues such as future demand reduction and demand management strategies, new models of care, clinical innovations, health technologies, prevention and wellness challenges and mental health and chronic health issues.

9. That Queensland Health should place greater emphasis on innovation in the system and embed mechanisms to ensure that the innovations in clinical care models, techniques and practices and other service delivery strategies are shared across health services to build capacity and capability in the system and prevent duplication of effort.

10. That in its role as system manager, the Department of Health take account of the different demographic, service needs and strategic and operational capabilities of individual Hospital and Health Services. The Department should ensure these local nuances are reflected in service agreements, performance measures, capital planning and delivery, governance and funding models.

11. That the service agreement process should be sufficiently flexible to enable each Hospital and Health Service to optimise their performance and deliver sustainable and appropriate health services to meet the needs of their populations.

12. That, as a matter of principle and practice, there should be more open and transparent sharing of data between the Department of Health and the Hospital and Health Services to enable benchmarking of performance and costs at the system level and for individual Hospital and Health Services.

13. That the Department of Health should, in consultation with Board Chairs and Health Service Chief Executives, streamline the collection and sharing of information within the system, while maintaining appropriate protections for privacy and confidentiality.

14. That in its role as system manager, the Department of Health should develop a comprehensive integrated statewide plan incorporating health service, workforce and capital works planning, and identifying future service challenges and demand pressures, demand reduction and management strategies, and future models of care.

15. That, while system-wide planning should remain the responsibility of the Department of Health in its role as system manager, the planning process must be collaborative, drawing on the Hospital and Health Services' local knowledge, expertise and capabilities.

16. That Hospital and Health Services should ensure their individual strategic planning aligns with the statewide operations and capital plan developed by the Department of Health.

17. That the capital planning, delivery and reporting functions be brought together within the Department, ensuring a single point of accountability for the capital program, while maintaining strong linkages to other statewide planning functions.

18. That the Department of Health, in consultation with Hospital and Health Services, develop a statewide capital works plan for Queensland Health to guide investment decisions and inform funding submissions to Queensland Treasury.

19. That the Department of Health should streamline the Investment Review Committee process and ensure it is focused on delivering capital projects on time and within budget.

20. That to ensure major capital works reflect the local context, the Health Service Chief Executive should be accountable for the governance of major capital works within their Hospital and Health Service and responsible for managing the budget, scope and timeframes for a project, while drawing on capability within the system where necessary.

21. That Health Service Chief Executives establish formal consultative mechanisms with senior officials of the health unions to discuss, and resolve where appropriate, issues of concern for both parties.

22. That the Department of Health and Hospital and Health Services jointly develop programs to improve the knowledge, skills and capabilities of HR and IR professionals and to assist line managers understand their industrial obligations.

23. That the *Hospital and Health Boards Regulation 2012* should be amended to provide that all non-executive health service employees are employed by the Director-General as system manager of Queensland Health, rather than by prescribed Hospital and Health Services.

24. That the Department of Health clarify the point of accountability for the ownership and provision of workforce data to unions as required under Enterprise Bargaining Agreements.

25. That Health Support Queensland should remain within the organisational structure of the Department of Health, but the Chief Executive Officer should act on advice and direction from a Stakeholder Board whose membership includes an independent chair nominated by the Director-General, representatives of Hospital and Health Services (including Hospital and Health Board Chairs and Health Service Chief Executives), and an independent expert in procurement.

26. That the Stakeholder Board develop a Procurement Framework for Queensland Health that determines the categories of goods and services that should be procured centrally and locally. The Framework should ensure clinician leadership and engagement in procurement decisions relating to relevant high cost clinical equipment, goods and services in order to reduce variation in costs and deliver value for money to the Hospital and Health Services and public health system.

27. That the Stakeholder Board ensure that long term contracts are reviewed on an agreed cycle to ensure value for money.

28. That eHealth Queensland should remain within the organisational structure of the Department of Health, but the Chief Executive Officer should act on advice and direction from Stakeholder Board whose membership includes an independent chair nominated by the Director-General, representatives of Hospital and Health Services (including Hospital and Health Board Chairs and Health Service Chief Executives) and an external member with ICT expertise.

Introduction

In March 2019, the Department of Health engaged an expert panel comprising Jim McGowan AM, Dr Pradeep Philip and Professor Anne Tiernan (the Panel) to provide advice to the Minister for Health and Minister for Ambulance Services regarding Queensland Health's governance framework.

The *Terms of Reference for the Advice regarding Queensland Health's governance framework*[1] sought the Panel's advice on whether the powers, roles and responsibilities within the health system are appropriately distributed to support achievement of the objectives of the *Hospital and Health Boards Act 2011* (HHB Act), and ensure that Hospital and Health Boards are empowered to, and accountable for, implementing Queensland Government policies and priorities. The Panel was asked to examine areas critical to Queensland Health's ability to meet the needs of the community and implement government policies in a timely manner, including:

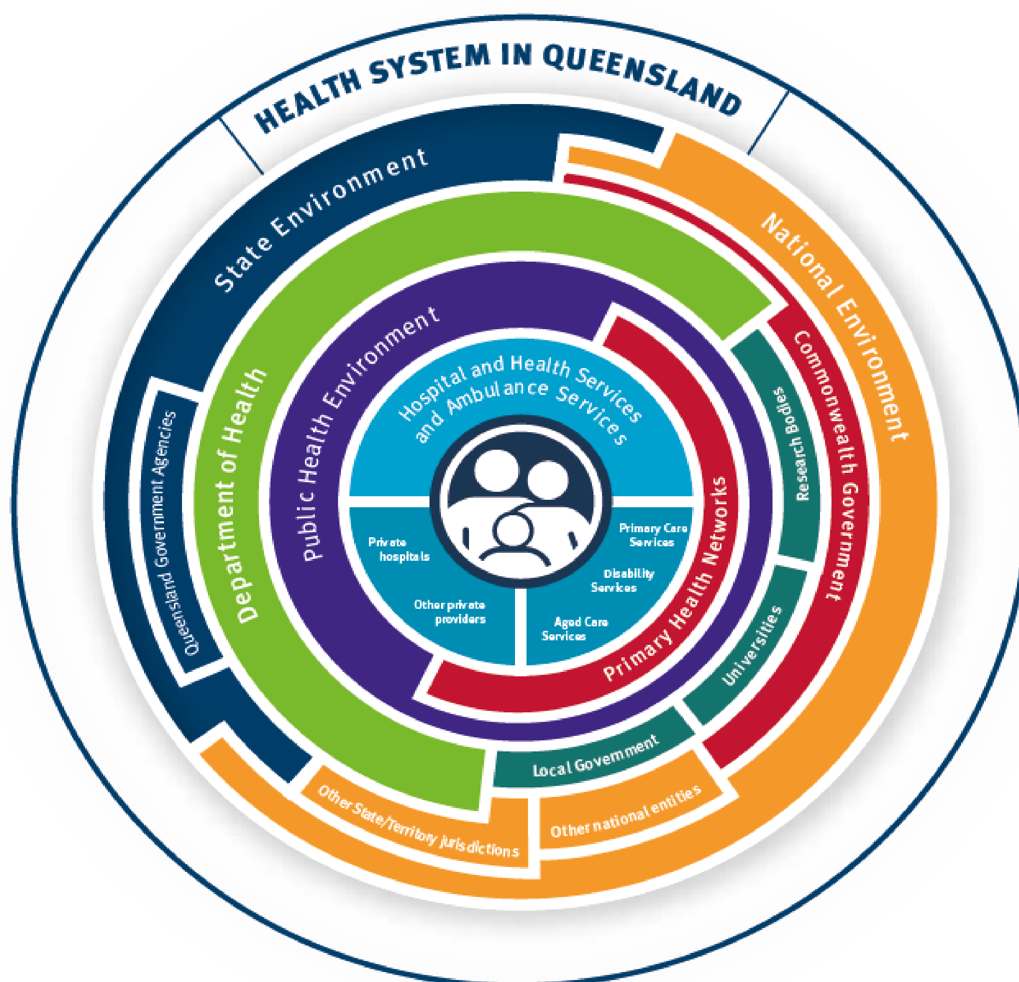
- procurement;
- capital and asset management;
- industrial and human resources management;
- service planning;
- reducing variation in costs, structures, outcomes and improving value; and
- managing capital projects within budget and timeframe.

The Panel conducted consultation sessions with stakeholders including Departmental officers, Hospital and Health Board Chairs, Health Service Chief Executives, unions representing Queensland Health employees, clinician groups, Health Consumers Queensland and consumer representatives. The Panel also accepted written comments from stakeholders.[2] In addition, the panel considered the health governance frameworks in place in other Australian jurisdictions[3] and, where relevant, pertinent findings of relevant health system reviews undertaken in recent years in Queensland and other jurisdictions.

[1] See Appendix 1.
[2] See Appendix 2 for details of the consultation process.
[3] See Appendix 3 for the interjurisdictional scan.

Background

Health services in Queensland are delivered through a shared approach involving multiple jurisdictions (Commonwealth, State and Local) and a broad range of healthcare professionals and private and public sector entities. The relationships between the key components are complex and overlapping, as illustrated below.[4]



The Queensland Government sets the policy framework, outlining the policy priorities and outcomes it expects its health system to deliver for Queenslanders. However, its operating context is impacted by a number of factors including:

- a broader national environment involving a number of key actors and influencers including the Commonwealth Government, other state and territory governments, local government, universities and research bodies, national entities and professional bodies; and
- the shared responsibility of the Commonwealth Government and state and territory governments for the operation and funding of the health system.

The Health portfolio comprises the Department of Health (the Department), including the Queensland Ambulance Service (QAS), and 16 Hospital and Health Services (HHSs) located

[4] Queensland Health (2016a), *My Health, Queensland's future: Advancing health 2026* (Advancing Health 2026), Brisbane, Queensland Government, p. 5.

across Queensland, as well as the Queensland Mental Health Commission, Office of the Health Ombudsman and Council of the Queensland Institute of Medical Research.

The portfolio is overseen by the Minister for Health and Minister for Ambulance Services (the Minister) whose principal ministerial responsibilities comprise hospitals, nursing homes, public health, health promotion, community health services, Aboriginal and Torres Strait Islander Health, health care for special needs groups, offender health services, mental health, oral health, alcohol and drug services, disease surveillance, health rights and registration of health professionals.[5] The Minister administers 23 Acts and associated subordinate legislation.

Queensland Health employs approximately 90,791 full-time equivalent employees[6] across the system. Its total budget is $19.233 billion,[7] which includes an operating budget of $18.455 billion. It accounts for the largest share of the State's operating expenses[8] (31.2 per cent) followed by Education (24.9 per cent). In 2019-20, Queensland Health's budget has been allocated across the system as follows:[9]

- $15.655 billion to HHSs for the delivery of health services—within this, allocations to individual HHSs range from $81.0 million (Central West) to $3.049 billion (Metro North);
- $777.7 million for capital infrastructure;
- $885.7 million for the Queensland Ambulance Service; and
- $1.91 billion for public health, patient safety, non-government organisations and other health expenditure.

Queensland Health's governance structure

The governance structure of Queensland's health system has evolved over many decades to meet community expectations, increasing demand for public health and hospital services and changing funding arrangements and health priorities. In doing so, the system has oscillated between models of centralised control and decision-making, and devolved or shared responsibility to facilitate localised decision making.

- In 1901, the Department of Health was established as a sub-department of the Home Secretary's Office.[10]
- In 1923, hospital districts and boards were established.[11]
- In 1935, the administration of health in Queensland was centralised under the newly established Department of Health and Home Affairs.[12]
- In 1946, the Department became a separate department in its own right.[13]
- In 1991, Queensland's 59 hospital boards were abolished and replaced by 13 regional health authorities responsible for all public health services. Under this model, policy and planning functions remained centralised.[14]

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[5] Department of the Premier and Cabinet, *Administrative Arrangements Order (No. 2) 2018*, Brisbane, Queensland Government, p. 17.
[6] Queensland Treasury (2019a), *Queensland Budget 2019-20 Service Delivery Statements* (Budget Paper No. 5), Brisbane, Queensland Government, p. 27. Figure represents the estimated FTEs as at 30 June 2019.
[7] Queensland Health (2019a), '2019-20 Budget', https://www.health.qld.gov.au/system-governance/health-system/managing/budget (accessed June 2019).
[8] Queensland Treasury (2019b), *Budget Strategy and Outlook 2019-20* (Budget Paper No. 2). Brisbane, Queensland Government, p. 105.
[9] Queensland Health (2019a), op cit.
[10] Office of Statistical and Economic Research (2009), *Queensland Past and Present: 100 Years of Statistics 1896-1996*, Brisbane, Queensland Government, p. 237.
[11] Ibid, p. 243.
[12] Ibid, p. 241.
[13] Ibid.
[14] Ibid, p. 244.

- In 1996, the regional health authorities were abolished and replaced with a centralised structure based on health districts.[15]
- In 2012, Queensland Health moved to the current devolved model comprising the Department of Health and Hospital and Health Services.

The *Hospital and Health Boards Act 2011* (HHB Act) had its genesis in the 2011 National Health Reform Agreement, agreed between the Commonwealth and all Australian States and Territories. In 2008, the Rudd Government established the National Health and Hospitals Reform Commission to review the Australian health system and identify actions to address its current and future challenges. The Agreement, which arose out of this work, established the principles and objectives of the national health system and outlined Commonwealth, State and Territory roles and responsibilities with respect to the provision of health services.

The Agreement outlined a radical and far-reaching reform agenda for Australia's health system to improve health outcomes for all Australians and ensure the system's sustainability. Revised funding models and governance arrangements for Australian public hospital services required the States to devolve operational management for public hospitals and accountability for local service delivery by 1 July 2012 to Local Hospital Networks established as separate legal entities under legislation.

In 2011, the Health and Hospital Networks Bill 2011 was passed by the Queensland Parliament. The Bill gave effect to the then Bligh Government's commitments as a signatory to the Agreement, establishing Local Health and Hospital Networks as separate legal entities from the Department. Following the 2012 Queensland state election, the Newman Government amended the *Health and Hospital Networks Act 2011* before it came into effect, renaming the Act as the *Hospital and Health Boards Act 2011* and strengthening the decentralisation of Queensland's health system.[16] The 2012 amendments enabled HHSs to:

- own land and buildings; and
- employ staff, once the HHS was prescribed in Regulation.

Reviews of the system

The ongoing sustainability of the system in the face of budgetary and service demand pressures has remained a consistent concern for successive Queensland Governments. The system has also delivered high-profile systemic failures in the areas of clinician employment, fraud control, the acquisition and roll-out of ICT, infrastructure delivery and the decommissioning of health services. Since 2005, Queensland Health has been the subject of several reviews and commissions of inquiry:

- Queensland Commission of Audit (Costello et. al) 2012
- Queensland Health Payroll Commission of Inquiry (Chesterman Inquiry) 2013
- Fraud, Financial Management and Accountability in the Queensland Public Sector (Crime and Misconduct Commission) 2013
- Future State Alignment (FSA) Project (Department of the Premier and Cabinet) 2014
- Lady Cilento Children's Hospital Review (Picone et. al) 2015
- Review of the Department of Health's structure, governance arrangements and high level organisational capability (Hunter Review) 2016
- Barrett Commission of Inquiry 2016.

[15] Ibid.
[16] Queensland Health (2012), *Explanatory Notes to the Health and Hospital Networks and Other Legislation Amendment Bill 2012*, Brisbane, Queensland Government, p. 1.

Despite this, the current devolved model provided by the HHB Act has generally proven effective allowing Queensland Health to consistently deliver strong performance. In 2016, the Hunter Review concluded:

> *At the outset, it is important to acknowledge that Queensland's implementation of national health reforms - commenced by a Labor Government in 2011 and continued by a Liberal National Government from 2012…has rightfully been recognised as a success. The devolution of health service delivery has increased responsiveness in the health system, created improved financial efficiency, and importantly, allowed for more localised decision-making which has empowered clinicians to better meet the needs of their patients, health care consumers and communities.*[17]

Meeting future challenges

The *Health of Queenslanders 2018: Report of the Chief Health Officer* notes that while Queensland has become a healthier place to live, Queenslanders' use of health services is increasing and the population is growing and ageing, placing demand and funding pressures on the system.

The Palaszczuk Government has taken a long-term approach to ensuring that the health system is sustainable, appropriately positioned to meet its objectives and delivers value for money for Queenslanders. *My health, Queensland's future: Advancing health 2026* is an overarching vision and strategy[18] to guide the transformation of the Queensland health system over a 10-year period to the year 2026 across four key strategic directions: promoting wellbeing, delivering healthcare, connecting healthcare and pursuing innovation.

In this context, it is important to confirm whether the devolved governance framework for Queensland Health, which has remained largely unchanged since 2012, is appropriate to support the delivery of the Government's priorities for the health system, and ensure that HHSs, through their governing boards, are empowered to, and accountable for, implementing those priorities.

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[17] Hunter, Rachel (2015), *The Hunter Review: Review of Queensland Health's structure, governance arrangements and high level organisational capability*, Brisbane, Queensland Government, p. 2.
[18] Queensland Health (2016b), op cit.

From federation to network governance: design principles for the system's evolution

Federated models have inherent strengths. They offer flexible and efficient structures that accommodate diversity and difference; they combine the benefits of collective action with the capacity to design and deliver services tailored to local needs. Federalism offers a structured approach to democratic participation, decision-making, accountability and problem-solving and an institutional design for sharing power and resources to best serve their national and local communities.

When they work well, federal arrangements create opportunities for experimentation, innovation and policy learning, but they also have shortcomings. Accountability is a major challenge for any federated system. Shared authority and responsibility creates the potential for duplication and overlap. It can also pose difficulties in determining responsibility for performance. The need for greater accountability and to 'end the blame game' is a persistent theme in the federalism literature, particularly in Australia.

Other shortcomings include tensions between local autonomy and centralisation. The principle of 'subsidiarity' offers a guide for allocating roles, responsibilities and authority within a federation. It assumes that decision-making should be made at the level 'that is as close to the people as possible'.[19] Authority should only be allocated to a higher level if the lower level lacks the capacity or capability to make the decision. The subsidiarity principle thus recognises that some decisions are best made centrally, or at higher levels of the governance system due to economies of scale, allocation of resources or expertise.

A key value underpinning subsidiarity is 'non-absorption', which holds that a higher level should not absorb or take over functions of the lower level. However, the experience of Australian federalism reveals centralising pressures associated with funding, the need for national priorities, expectations of consistency and sameness across jurisdictional boundaries, and to address concerns about which tier of government is accountable and responsible for what.

Queensland's health system reflects some elements of a federated model in that Hospital and Health Boards have authority to act in the administration and management of their local hospital area. However, the Minister has overall responsibility and accountability for Queensland's public health system, through the Department and the 16 HHS Boards. Importantly, the Minister is responsible for the public funds invested in health services, both historically and currently, and the substantial portfolio of assets and liabilities that comprise the State's public health system.

While federated arrangements offered a conceptual foundation for the devolved system in its initial design, other guiding principles are needed to create a governance framework that can accommodate both the vertical and horizontal dynamics of Queensland's health system.

Our Westminster-derived system of government creates hierarchical, often siloed, administrative and funding arrangements under the leadership of portfolios Ministers, who are individually and collectively responsible and accountable to Parliament for performance. It privileges vertical over horizontal approaches to organisation and funding over more flexible and adaptive models to address cross-cutting priorities and issues.

[19] Twomey, Anne and Withers, Glenn (2007), *Australia's federal future: delivering growth and prosperity: a report for the Council for the Australian Federation*, Melbourne, Department of the Premier and Cabinet, p. 33.

Vertical arrangements designed to reflect nineteenth century understandings of public administration and the role of the State are increasingly unsuited to the complex demands of modern governance. Globalisation, complexity and interdependence and reforms that have introduced networked arrangements into most areas of public service delivery have fostered broad support for collaboration within and between governments – with multiple agencies (and/or multiple jurisdictions) working together, sharing capacity, resources and expertise to achieve shared goals. The literature on network governance offers a range of insights about how to organise for and manage collaborative arrangements with other tiers of government and partners in the private and for-purpose sectors.

A growing body of literature recognises the ubiquity of networks and the roles they play across all facets of the economy and society. A network governance perspective acknowledges that knowledge, capacity and resources are dispersed; that no individual actor has a monopoly of resources, expertise or authority. Interdependence requires network actors to constantly engage in negotiation, bargaining and exchange to achieve shared objectives:

> *Networks are based on mutually beneficial, recurrent exchanges among flexible yet interdependent actors. Unlike markets, they enable long-term relationships, but they are also nimble enough to adapt to environmental ambiguity in a way that hierarchies cannot.*[20]

As this suggests, trust and reciprocity are the currency of networks. They develop through regular and frequent interaction of individuals and organisations, fostering cooperation and co-ownership of processes and outcomes. Network governance encourages, and indeed depends on, the clear and open flow of communication between the nodes.

Reflecting on the adjustments to traditional hierarchy that the US military adopted as part of the surge against ISIS in Iraq and Afghanistan, McChrystal et al[21] emphasise the twin pillars of 'contextual awareness' and 'radical sharing', where all members of the network receive the same information, constantly updated to allow 'empowered execution', where authority is pushed as far down the chain of command as possible. General guidelines and a sense of shared purpose provide a framework in which team members at all levels can exercise their own judgement – recognising that:

> *Local agents are not only better positioned to* gather information *on specific local conditions, but vested with decision authority and ownership of the result, they are also more likely to look for problems and opportunities.*[22]

The Panel's consultations highlighted numerous examples of collaborations that have developed organically, both within and across the HHS network, and resulted in better health outcomes. The capacity to harness a wider range of resources and expertise than perhaps was originally envisaged, demonstrates the devolved system's success and its potential to facilitate cooperation and local problem solving, as well as wider benefits for the achievement of public health outcomes for Queensland.

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[20] Slaughter, Anne-Marie (2017), *The chessboard and the web: strategies of connection in a networked world*, New Haven, Yale University Press, p. 49.

[21] McChrystal, Stanley et al (2015), *Team of teams: new rules of engagement for a complex world*, New York, Penguin Random House.

[22] Van Alstyne, Marshall (1997), 'The state of network organization: a survey in three frameworks', *Journal of Organizational Computing and Electronic Commerce*, 7(2), p. 5.

However, while network governance offers an opportunity to reset expectations and relationships within the devolved system, it does not and can never replace the hierarchical dynamic that derives from the convention of ministerial responsibility. The two must co-exist, requiring, as Slaughter notes, that 'we must learn to see in stereo',[23] understanding strategies of connection in networks as well as power relations within traditional hierarchies.

An intelligent centre

Network governance requires actors to negotiate over functions that should be centralised and those that more appropriately can be devolved, and to what level of the delivery system. In this context, there is growing recognition that the 'centre' – in this case, the Department – should perform the role of 'system steward', setting and specifying outcomes, assessing performance and taking responsibility for disseminating good practice. This latter role has been described by American performance management expert Shelley Metzenbaum as the centre become a 'learning leader' – using its access to comparative performance data to 'identify what works, motivate uptake of effective interventions and encourage the ongoing search for ever more productive ways to prevent, mitigate and treat problems'.[24]

In this way, 'the centre' – be it a central unit in the Department, or specialist nodes distributed across the network – seeks to shift its focus from monitoring and compliance towards efforts to enhance performance accountability by helping delivery units learn and improve by showcasing promising practices.

Resetting the conversation to embed networked governance and system thinking

Background

The objective of the HHB Act is to establish a public sector health system that delivers high quality hospital and other health services to Queenslanders, having regard to the principles and objectives of the national health system.[25] The delivery of high quality services is intended to be achieved by:

- strengthening local decision-making and accountability, local consumer and community engagement, and local clinician engagement;
- providing for statewide health system management including health system planning, coordination and standard setting; and
- balancing the benefits of local and system-wide approaches.[26]

Under the devolved governance model established by the HHB Act:

- the Department, as 'system manager', is responsible, through the Director-General (DG), for the overall leadership and management of Queensland's public health system, with responsibility for statewide planning, managing statewide industrial relations and major capital works, monitoring the performance of HHSs and issuing Health Service Directives to HHSs;

[23] Slaughter op cit., p. 73.
[24] Metzenbaum, Shelley (2009), 'From oversight to insight: federal agencies as learning leaders in the information age' in Conlan, Timothy and Posner, Paul (eds), *Intergovernmental Management for the 21st Century*. Washington D.C, Brookings Institution Press.
[25] *Hospital and Health Boards Act 2011* (Qld), s. 5.
[26] *Hospital and Health Boards Act 2011* (Qld), s. 5(2). The powers, responsibilities and functions of the Minister, Department and HHSs under the HHB Act, and the Act's guiding principles, are detailed in Appendix 4.

- HHSs, each governed by a Hospital and Health Board and managed by a Health Service Chief Executive (HSCE), are the principal providers of public sector health services and are responsible and accountable for the delivery of those services; and
- the convention of ministerial responsibility provides that the Minister has overall responsibility and accountability for the performance of the Queensland public health system, through the Department and the 16 Hospital and Health Boards.

Each HHS is established as an independent statutory body, responsible for delivering the hospital, health and other services set out in the HHS's service agreement. The HHB Act provides for each HHS to be independently and locally controlled by a Board. With the exception of Children's Health Queensland HHS, which provides services to children and young people across the State, HHSs are responsible for delivering hospital and health services within a geographic region.

Complementing the governance arrangements in the HHB Act is the Charter of Responsibility, a non-legislative and non-binding document.[27] The Charter is intended to support the effective functioning of Queensland's public health system by embedding 'system mindedness' and a culture of respect, and provide further clarity regarding the roles and responsibilities of the Department and HHSs.

QAS is established under separate legislation, the *Ambulance Service Act 1991*. Through machinery of government arrangements, QAS forms part of Queensland Health, with the QAS Commissioner forming part of the Departmental Leadership Team. The Ambulance Service Act and the HHB Act do not address the interaction between QAS and the public sector health system.

Consultation feedback

Importantly, almost all stakeholders considered that the devolved governance model was a significant improvement on the previous centralised model. Localised decision-making was seen to have enhanced community and clinician engagement and given HHS employees a stronger sense of team. Many noted that it is simply not practicable in a state such as Queensland to have a centralised governance structure and that governing Boards had brought greater accountability and local engagement.

Stakeholders reported varying degrees of interaction and collaboration between the HHSs. There was evidence of strong horizontal linkages in some cases. For example, Central West HHS and Metro North HHS are working towards a formal partnership arrangement, where Metro North HHS provides corporate services to Central West HHS. The Northern Collaborative, which arose out of the regional planning process, also meets regularly to consider opportunities for HHSs based in the north of the State to work together to improve results for the region. However, these connections appear to have developed organically, based on either personal relationships or need, rather than being an inherent part of the system.

There were mixed reports about the HHSs' sense of 'system'. Departmental officers considered that while initially following the introduction of the HHB Act, HHSs were inwardly focused and conscious of their status as independent statutory bodies, this was changing over time as the system matured.

[27] Queensland Health (2016b), *A health system for Queenslanders: Charter of Responsibility*, Brisbane, Queensland Government.

Some HHSs clearly recognised the need to make decisions wearing their 'Queensland Health hat' rather than only considering the interests of their own HHS. However, it was acknowledged that this was not universally the case. A number of stakeholders noted that HHSs had been set up to compete, rather than to collaborate, in areas of funding and capital. Others noted that there is little to require or incentivise HHSs to act collaboratively or in the interests of the system. In other words, even though the primary objective of the public sector health system is to deliver high quality hospital and health services to Queenslanders, HHSs' overriding focus has been on maximising their activity, maintaining budget control and maximising their capital budgets.

The devolved governance model also impacts on consumers, particularly for those patients with patient care pathways that require integration across multiple HHSs. One clinician argued that the devolved model had made a statewide approach to integration of care pathways almost impossible, further observing that patient care requiring integration is only currently possible in the system when there are good personal working relationships between the relevant clinicians.

The lack of system thinking also extended to the relationship between the Department and the HHSs. For example, there are a number of Executive Director forums sitting under the HSCEs' Forum, such as the Executive Directors' Nursing and Midwifery Forum and the Executive Directors' Workforce Forum. Departmental officers attend these forums as guests rather than members and any papers from the Department must be sponsored by a HHS member. This, along with the nature of the agendas for these forums, reflects less a trust-based model of information sharing and collective understanding and more of distinct and separate stakeholders – namely HHSs on one side and the Department on the other.

In 2013-14, QAS transferred to the Department to ensure a more integrated, effective and coordinated health system.[28] Given this, it is notable that during the Panel's consultations, very few stakeholders referred to QAS when discussing the health system, with the focus primarily on the relationship and interactions between the Department and HHSs.

Findings

It was clear from consultation that some stakeholders were concerned that the Panel's advice would result in increased centralisation of the system; of greater power and control to the Department at the expense of HHSs. However, the Panel has found that the devolved governance structure established by the HHB Act is generally operating well and is appropriate for a system that is as large and decentralised as Queensland's. There is, however, an opportunity to enhance the operation of the devolved governance structure as the system matures. The Panel's findings reflect the next steps in this maturation process and are designed to ensure that those in leadership positions across the devolved model are individually and collectively responsible and accountable for system performance. By doing so, the system can better realise the benefits of the devolved governance structure.

The move from a centralised Queensland Health to the current devolved governance structure created significant upheaval, requiring a conceptual reset for all parties in the system. In the three years immediately following introduction of the HHB Act, there was an understandable emphasis on the autonomy of HHSs, reflecting their new status as independent statutory bodies. The Hunter Review[29] noted that significant resources were deployed to strengthen the capability of the HHSs, with less focus on the capability of the Department.

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[28] Queensland Health (2014), *Department of Health Annual Report 2013/14*, Brisbane, Queensland Government, p. 5.
[29] Hunter (2015), op.cit., p. 3.

In 2015, the Hunter Review made a series of recommendations designed to strengthen the Department's system leadership and to clarify the roles and responsibilities between the Department and the HHSs, recommending:

- the Department implement a functions-based organisational structure;
- a Charter of Responsibility be developed to set out agreed roles and responsibilities for the Department and HHSs;
- new governance structures be implemented, such as the establishment of a System Leadership Executive; and
- the Department develop an overarching Queensland Health Plan for the State.[30]

While many of these recommendations have been implemented, a number remain outstanding, including the development of an overarching Queensland Health Plan. Others appear to have been implemented in form but more work is needed to reflect the true spirit of the recommendations. For example, while a Charter of Responsibility has been developed and agreed, it seems to have had little practical effect in clarifying the roles and responsibilities of the parties. None of the stakeholders consulted referred to the Charter in their discussions with the panel about the respective roles and responsibilities of the Department and the HHSs.

As noted above, the system is already moving towards a networked model, with examples of collaboration and partnerships arising across the system both organically and within existing governance structures, particularly the Boards Chairs' Forum and HSCEs' Forum. For example, the Board Chairs' Forum and HSCEs' Forum are playing an increasing role in leading implementation of the Minister's Rapid Results Program. Nevertheless, it is timely to reset expectations about how the devolved governance system is intended to operate, and to impress on all parties that they are part of a networked system, drawing on the principles outlined below:

- **Each party has mutual and reciprocal obligations to take a statewide perspective**: The HHB Act establishes the relationship between the HHSs and the Department, but does not deal with the relationship between HHSs or the relationship of QAS with the health sector. To move more explicitly to a networked model will require recognition that HHSs have obligations not just to the Department and the Minister, but to each other. Flowing from this is a requirement that HHSs consider the impact on the Queensland Health system when making decisions within their HHS. It also requires an acknowledgement that QAS is an integral part of Queensland's health system and, through its interface with HHSs, plays an important role in managing demand and patient flows in the system.

- **Information flows freely throughout the system**: Information must flow not just between the HHSs and the Department, but between the HHSs. This would allow HHSs to draw on the experience of other HHSs and for lessons and insights to be shared across the system.

- **Local decision-making guided by an 'intelligent centre'**: In a networked model, based on principles of subsidiarity and non-absorption, decisions should be made at the lowest level possible. In practice, this means empowering HHSs with the authority, information and data necessary to make decisions at the local level, while recognising that there is a role for the Department to act as the system leader (or 'intelligent centre') setting system-wide direction and priorities.

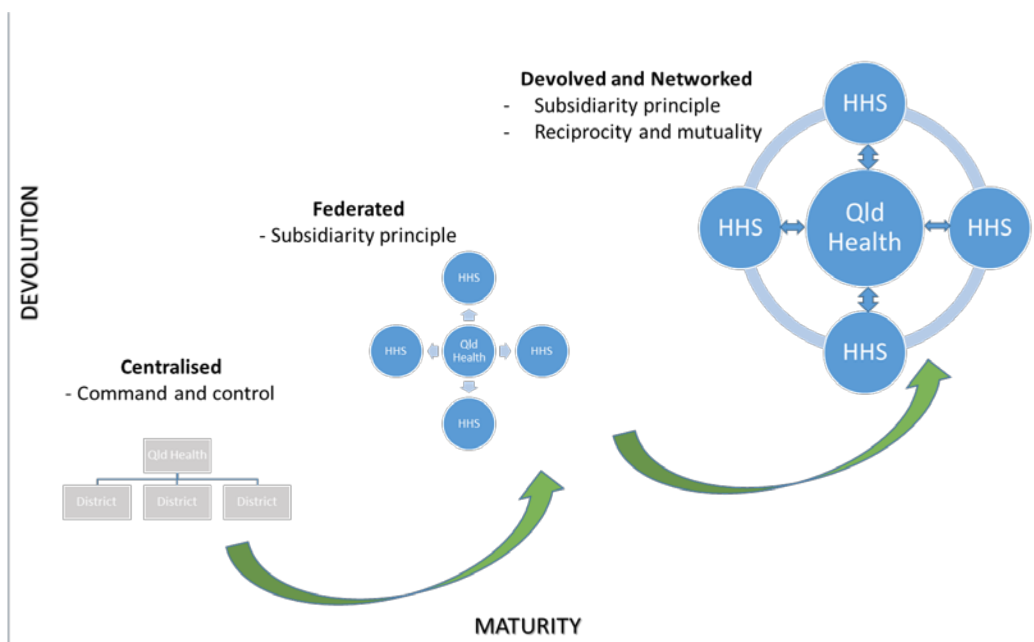
[30] Ibid, p. 4.

- **Distributed leadership from across the system**: In a networked model, all parties – the DG, Departmental Leadership Team (DLT), HSCEs and HHS Boards – have a role as stewards and leaders of the system.

Any change to Queensland Health's governance framework must support the continuing quality and safety of healthcare delivery. The networked governance model will enhance the accountability of all service providers to deliver the most appropriate care in the most appropriate setting to the citizens of Queensland. A patient's experience, treatment options and quality of care should not be determined by a HHS boundary.

The networked governance model will ensure that the Department and all HHSs must work together for the good of the public sector health system. It will encourage the sharing of resources across the system to enable more responsive management of demand and patient flows. It will also ensure that Queensland Health better supports patients who require integrated care pathways that cross HHS boundaries.

Inherent in a networked governance model is the principle that good ideas are everywhere. By promoting the sharing of innovation across the system and ensuring data is shared openly and transparently within Queensland Health, the networked model will help to reduce variations across HHSs and drive improvements in clinical practice.



To support these changes, it is important to ensure that the HHB Act enables and incentivises the Department and the HHSs to take a system approach. The HHB Act envisages that the Department and the HHSs will collectively operate as one system and delineates between the functions of the Department, as system manager, and the HHSs, as providers of health services. However, the Hospital and Health Board's and HSCE's functions are focused on their accountabilities to their individual HHS – there is no clear requirement for the Board and HSCE to consider the interests of the broader system, and to act in the interests of the good of the system as a whole, rather than purely in the interests of their own HHS.

The HHB Act should be amended to ensure it reflects that all component parts of Queensland's public health system are a critical part of, and have responsibilities to, the system. This is particularly important for the HHSs, which, as statutory bodies, are limited in their functions to those prescribed in legislation. Amendments could:

- clarify that HHSs and the Department are both individually and collectively responsible for the performance of Queensland's public sector health system;
- amend section 19 (Functions of Services) to clarify that collaboration and coordination with other HHSs is a responsibility of each HHS; and
- provide that, in performing its functions, a HHS must have regard to the best interests of the system.

The interface between QAS and HHSs is also critical to the operation of the health system, particularly with respect to the management of patient flows at emergency departments. The Minister's Rapid Results Program acknowledges the important role that QAS plays in managing demand, with projects focusing on expanding the non-hospital options available to QAS to reduce the number of presentations at hospitals and improving QAS-clinical handovers at emergency departments.

The legislative framework for the public health system does not recognise the important linkages between QAS and the HHSs. The Panel recommends that the Ambulance Service Act and the HHB Act be amended to acknowledge that QAS and HHSs have mutual obligations to coordinate and collaborate to manage the interface between ambulance service and public sector health services in the best interests of the system.

These legislative changes to the HHB Act and the Ambulance Service Act must be underpinned by cultural and behavioural changes from all parties. The governance forums, such as the Board Chairs' Forum, the HSCEs' Forum and System Leadership Forum provide an opportunity for parties within the system to consider collectively how to implement the networked governance model in practice.

Recommendation

1. That Queensland Health enhance the current governance model to drive greater network and system characteristics such that the Department of Health and the Hospital and Health Services have mutual and reciprocal obligations to take a statewide perspective and to strengthen horizontal linkages across the system by:
    - reaffirming the roles and accountabilities of the Minister for Health and Ambulance Services, the Department of Health and the Hospital and Health Services within the system; and
    - amending the *Hospital and Health Board Act 2011* to reflect that all component parts of Queensland's public health system are a critical part of, and have responsibilities to, the system.

2. That, to acknowledge that the Queensland Ambulance Service is a critical part of the public sector health system, the *Ambulance Service Act 1991* and the *Hospital and Health Boards Act 2011* should be amended to recognise that the Queensland Ambulance Service and the Hospital and Health Services have mutual obligations to collaborate and coordinate their activities in the best interests of the system.

Strengthening the Department's system leadership

Background

The HHB Act provides that the Department, through the DG, is responsible for the overall management of the public health system. The Act provides that:

- the way in which the DG's responsibilities are exercised establishes the relationship between the DG and the HHSs; and
- the relationship between the DG and the HHSs is also governed by the service agreement between the DG and each HHS.[31]

The DG's functions under the HHB Act include:

- to provide strategic leadership and direction for the delivery of public sector health services in Queensland;
- to promote the effective and efficient use of available resources in the delivery of public section health services in Queensland;
- to develop stateside health service plans, workforce plans and capital works plans;
- to manage statewide industrial relations (IR), including the negotiation of certified agreements, and making applications to make or vary awards;
- to establish the conditions of employment for health service employees;
- to monitor and promote improvements in the quality of health services delivered by HHSs;
- to monitor HHSs' performance and take remedial action when performance does not meet the expected standard.[32]

DLT supports the DG in his system manager role. DLT comprises the Department's five Deputy Directors-General (DDGs), the Chief Executives of eHealth Queensland (eHealth) and Health Support Queensland (HSQ), and the QAS Commissioner.

Consultation feedback

HHSs were generally positive about the expertise of DLT members in their individual portfolios. However, many stakeholders noted the challenges of working with the Department on cross-cutting issues that require the involvement of multiple DDGs. HHSs and external stakeholders perceived DLT members were reluctant to step outside of their portfolios. Relationships with DLT members were described in terms of functions—if the issue related to funding, the HSCE would speak to the DDG of Healthcare Purchasing and System Performance (HPSP), for quality and safety matters, the HSCE would speak with the DDG of Clinical Excellence Queensland and so on. For urgent, complex or high-profile issues, HHSs almost universally indicated they would go directly to the DG.

This has the effect of creating and reinforcing silos within the organisation. HHSs reported frustration that important issues are bounced around the Department, with no one prepared to take ownership if the issue crossed Divisional portfolios. The Rural Doctors' Association of Queensland described the challenge of having to negotiate with three Divisions within the Department on workforce issues. This sense of silos was also evident from discussions with DLT members themselves. Other HHSs went further, reporting that the lack of internal cohesion within DLT was evident to those external to the Department. A number reported receiving conflicting advice from different areas of the Department, undermining the Department's credibility.

[31] *Hospital and Health Boards Act 2011* (Qld), s. 84) and (5).
[32] *Hospital and Health Boards Act 2011* (Qld), s. 45.

A common theme of the consultations was the perception that DLT is focused on ‘fighting fires’. This day to day crisis management is seen to detract from the strategic direction setting and engagement that HHSs expect of the Department as system manager. Most HHSs suggested that DLT attendance at meetings such as the HHS performance management meetings and System Leadership Forum (SLF) was sporadic, and often delegated. A significant number of HHSs expressed the view that there was limited engagement from DLT unless their HHS was ‘causing problems’ – that is, appearing in the media or not meeting key performance indicators or staying on budget. Regional and rural HHSs in particular considered the Department lacked insight into the local context that HHSs operated in, with most indicating DLT members rarely visited regional HHSs.

Findings

The Department’s roles and responsibilities, as set out in the HHB Act, are appropriate and provide a sufficient basis for the Department to provide strategic leadership for the health system. While the Department is described as the ‘system manager’ it is clear that the intent of the HHB Act is for the Department to provide strategic leadership and direction to the system.

A certain degree of tension is to be expected between the Department’s leadership team and the HHSs, given the Department’s role in monitoring HHSs’ performance. Regardless, however, there is clearly at the very least a perception that DLT collectively lacks credibility and authority with the HHSs.

Members of DLT have an individual and collective responsibility to advocate for the Department’s vision, mission and values and for modelling the behaviours consistent with these values. To provide successful direction to the system, DLT must operate as a highly functioning team, where each member of the team has authority to speak for the team and decisions are owned collectively. DLT has a collective responsibility to assist stakeholders in navigating their interactions with the Department, and to ensure the Department is providing a coordinated response to stakeholders when issues are raised.

It is clear from consultation with both HHS and Departmental officers that currently only the DG is seen to have knowledge and oversight of all of the Department’s component parts and stakeholders. While DDGs must be experts within their own portfolio, it is also critical that each DLT member has high level contemporary knowledge of all of the Department’s component parts and feels able to speak to issues that are not strictly within their portfolio. This would help to alleviate the perception of buck-passing within the Department.

The Panel acknowledges the challenges that DLT members face, noting that senior executives are mired in issues management and responding to constant demands for responsiveness. It was clear to the Panel that much of the responsibility for managing the Department’s day to day business is falling on the shoulders of the seven individual members of DLT. The Hunter Review found in 2015 that the Department is extremely risk averse, with risk both pushed and pulled up.[33] This risk aversion, resulting in decision-making being centralised at very senior levels within the Department, is still evident.

The Department’s primary purpose is to provide leadership and direction to the health system and to work collaboratively to ensure the health system, through the HHSs, is delivering safe, responsive and quality services for Queenslanders. Despite this, there is no single point of accountability for the HHSs within the Department. DDGs are responsible for discrete aspects of HHSs’ performance. To overcome this, it is critical that DDGs view their relationships with

[33] Ibid, p. 48.

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the HHSs not purely in terms of their strict portfolio responsibilities, but more broadly, as system stewards responsible for providing leadership and direction. To support this, the Department could consider adopting a portfolio approach, where each DDG is responsible for particular HHSs, providing the HHSs with a key contact within the Department and building DLT's awareness of the local context in which the HHSs operate.

Recommendation

3. That the Departmental Leadership Team should better collaborate to deliver coordinated, timely, streamlined and respectful engagement with the Hospital and Health Services and stakeholders on relevant strategic, operational and performance matters.

Strengthening the capability and effectiveness of Hospital and Health Boards

Background

The Minister is responsible for recommending the appointment and removal of Board members for HHSs,[34] with Board chairs and members appointed by Governor in Council, on Cabinet's approval, for terms of up to three years. A selection process, organised by a recruitment company, is undertaken each year to fill vacancies across the State. Panels established by the Minister consider applications and the skills mix of the Boards, and make recommendations about appointments to the Minister. The Minister has discretion to accept those recommendations or make alternative decisions.

The HHB Act places significant accountabilities on the Boards, as the governing body of an independent statutory body. The Board appoints the HHS's HSCE,[35] and the HSCE is accountable to the Board.

A Board is the Minister's point of accountability for a HHS. The Minister may:

- suspend a Board member,[36] or recommend to Governor in Council that the Board member be removed;[37]
- recommend to Governor in Council that a HHS's Board be dismissed and an administrator be appointed to run the HHS;[38]
- give directions to a HHS about any matter relevant to the performance of its functions, if satisfied this is necessary in the public interest;[39]
- appoint an advisor to a Board to improve the Board or the HHS's performance.[40]

Implementing government priorities

Boards play a key role in ensuring that the Government and Minister's priorities are implemented within their HHS. In the current context, this includes implementation of the

[34] *Hospital and Health Boards Act 2011* (Qld), s. 23. Appointments are formally made by Governor in Council, on the recommendation of the Minister.
[35] *Hospital and Health Boards Act 2011* (Qld), s. 33. The Minister must approve the appointment.
[36] *Hospital and Health Boards Act 2011* (Qld), s. 27A.
[37] *Hospital and Health Boards Act 2011* (Qld), s. 28.
[38] *Hospital and Health Boards Act 2011* (Qld), s. 275.
[39] *Hospital and Health Boards Act 2011* (Qld), s. 44. However, the Minister cannot give a direction about the health service to be provided to a particular person, or the employment of a particular person.
[40] *Hospital and Health Boards Act 2011* (Qld), s. 44A.

Minister's Rapid Results Program. To ensure that Board Chairs are clear on the Minister's expectations, at the start of the Minister's term, the Minister should issue a Statement of Expectation that:

- sets out the Government and Ministerial priorities relevant to the HHSs; and
- reinforces that the HHSs have mutual and reciprocal obligations to each other as well as to the Department.

This Statement of Expectations will provide the Boards with clarity about their obligations to ensure that Government and Ministerial priorities are being implemented and enable Boards to hold their HSCE to account in this regard. The Statement could be updated to reflect newly identified priorities. The Hospital and Health Board Chairs' Forum will provide an opportunity to discuss HHS progress towards implementation of these priorities.

Closing the Gap

In 2008, the Commonwealth and all Australian States and Territories committed to action to 'Closing the Gap' between Aboriginal and Torres Strait Islander and other Australians, through the *National Indigenous Reform Agreement*. Successive Queensland Governments have reinforced this commitment. Queensland Health has released a Closing the Gap Performance Report each year since 2014, reporting on progress on health targets. The Minister has also prioritised this work through Rapid Results Area 4 (supporting closing the health gap through an empowered Aboriginal and Torres Strait Islander Health Workforce).

In 2017, the Boards and the Department developed and agreed the *Statement of Action towards Closing the Gap in health outcomes*, which commits all areas to undertake organisational, system-level changes to build sustainable cultural capability across the system. As part of this, each HHS is required to develop an Aboriginal and Torres Strait Islander (Closing the Gap) Health Plan to demonstrate activities across three key areas:

1. Promoting opportunities to embed Aboriginal and Torres Strait Islander representation in Queensland Health leadership, governance and workforce.
2. Improving local engagement and partnerships between Queensland Health and Aboriginal and Torres Strait Islander people, communities and organisations.
3. Improving transparency, reporting and accountability in Closing the Gap progress.

Responsibility for implementing and monitoring the Plan sits with the Board and the executive team.

These are important mechanisms to improve health outcomes for Aboriginal and Torres Strait Islander people. It is appropriate that these mechanisms, and the commitment to achieving health equity for Aboriginal and Torres Strait Islander people, be embedded in the governance framework established by the HHB Act. Consideration should be given to amending the HHB Act to:

- include a commitment to achieving health equity for Aboriginal and Torres Strait Islander people;
- include as a guiding principle for the Act a commitment to providing for delivery of responsive, capable and culturally competent health care to Aboriginal and Torres Strait Islander people; and
- require each HHS to have an Aboriginal and Torres Strait Islander Health Plan.

Given the Boards' role in ensuring progress towards achieving health equity, it is also appropriate to ensure there is Aboriginal and Torres Strait Islander representation on each

Board. While many Boards already have Aboriginal and/or Torres Strait Islander members, and Ministers have encouraged Aboriginal and Torres Strait Islander representation on Boards, this could be strengthened by mandating in the HHB Act that each Board must include a member who is an Aboriginal or Torres Strait Islander person. Having an Aboriginal or Torres Strait Islander person as a Board member will help connect the Board to the local Aboriginal and Torres Strait Islander community or communities, ensuring the Board is better informed about strategies and actions relevant to their Aboriginal and Torres Strait Islander Health Plans. It will also enhance the Board's credibility in the important area of Aboriginal and Torres Strait Islander health.

It is important to acknowledge that it can be a challenge to attract suitably qualified candidates as Board members, particularly in rural and remote areas, creating a risk that Boards may not be properly constituted. Selection processes for Board members may need to be adjusted to ensure that Aboriginal and Torres Strait Islander candidates are identified and supported through culturally appropriate recruitment practices.

Board capability and effectiveness

It is the responsibility of each Board member to ensure they remain focused on the performance of their HHS so that the benefits of local autonomy continue to be realised. The Boards are a fundamental element of the broader system governance arrangements. Consequently, it is important that Board chairs and members are knowledgeable not only about their local health services but also the current and future challenges for the system.

Just as there are differential capabilities across the HHSs, a similar assessment can be made of Board members. Responsibility for Board performance and members' capability should rest primarily with the Boards. However, the Department has a role in supporting Boards to develop and maintain an appropriate capability at the individual and collective levels. The Board Chairs' Forum is seen as useful but could be enhanced by extending the opportunities for engagement with Departmental officers and members of other Boards.

The current induction processes could be strengthened by developing a 'Good Practice Guide' for Boards and an ongoing support program for Board members to build and maintain Boards' capability and effectiveness. The Department should work with Board Chairs, the Department of the Premier and Cabinet and the Queensland Audit Office to develop these.

The Australian National Audit Office has noted that periodically evaluating board performance can enable a board to reflect on its operations and assess whether it has effectively met its purpose, objectives and obligations.[41] Some Boards have initiated external periodic reviews of their performance. This practice should be extended to all Boards. Reviews should be done at least once every three years. Reviews could be useful in identifying skills gaps and development needs and inform the recruitment processes for Board members. As part of a formal discussion on the overall performance of each HHS, the Board Chair and DG should meet to share learnings from the performance reviews.

Consumer and community engagement

Boards are the cornerstone of local governance to ensure that HHSs reflect and respond to the context of their local community. Consultation with Departmental officers, HHSs and clinical groups concurred with the commentary in the Hunter Report:

[41] Australian National Audit Office (2019), 'Audit Insights – board governance', https://www.anao.gov.au/work/audit-insights/board-governance#0-0-auditinsightsboardgovernance (accessed May 2019).

> *The devolution of health service delivery has … allowed for more localised decision-making which has empowered clinicians to better meet the needs of their patients, health care consumers and communities.*[42]

The HHB Act requires every HHS to have a consumer and community engagement strategy to promote consultation with health consumers and community members about provision of health services by the HHS.[43] Many Board chairs reported that their Boards meet regularly with consumer and community representatives and that consumers participated in project steering committees, clinical recruitment processes and HHS committees.

From the health consumers' perspective, the level of engagement was seen to vary across HHSs. While some consumer representatives felt that their HHS's engagement with consumers was genuine and their input was valued, others perceived their HHS took a 'tick box' approach, where the focus was on quantity rather than quality of engagement. Consumer representatives attributed the success of consumer engagement to leadership from the Board and the HSCE – where the Board chair or HSCE championed consumer engagement, this tended to be embraced across the HHS. Without this personal commitment from the Board Chair or HSCE, there was a perception the level of consumer engagement was more tokenistic.

Enhanced consumer and community engagement is a key benefit of devolved governance and therefore must be a focus for Boards. The need for Boards to champion meaningful consumer and community engagement should be reflected in the Good Practice Guide and supporting program for Board members.

[42] Hunter (2015), p. 2.
[43] *Hospital and Health Boards Act 2011* (Qld), s. 40.

Recommendations

4. That the Minister for Health and Ambulance Services should issue a Statement of Expectations to each Board Chair that sets out expectations around Government and Ministerial priorities and reinforces the mutual and reciprocal obligations of Hospital and Health Services to each other as well as to the Department of Health.

5. That the *Hospital and Health Boards Act 2011* should be amended to embed the Queensland Government's commitment to closing the gap in Aboriginal and Torres Strait Islander health by, for example:
   - mandating Aboriginal and Torres Strait Islander representation on Hospital and Health Boards;
   - requiring Hospital and Health Services to have an Aboriginal and Torres Strait Islander Health Plan; and
   - including a commitment to achieving health equity for Aboriginal and Torres Strait Islander people and delivering responsive, capable and culturally competent health care to Aboriginal and Torres Strait Islander people.

6. That Queensland Health, in collaboration with the Department of the Premier and Cabinet and the Queensland Audit Office, develop a 'Good Practice Guide' for Boards and a supporting program for Board members to build and maintain the capability and effectiveness of Hospital and Health Boards.

7. That, at least once in a three-year cycle, the Chair of each Hospital and Health Board should commission an independent external review of the Board's performance and provide the findings to the Director-General.

Strengthening system stewardship across Queensland Health

Background

Queensland Health has a number of forums that meet regularly to make decisions and share information on system issues.

- System Leadership Team (SLT) is a decision-making body intended to support the DG to oversee the strategic function, capabilities and effective operation of the Queensland Health public health system. SLT comprises DLT members and the Chairs of the HSCEs' Forum, the Board Chairs' Forum and the Queensland Clinical Senate.
- SLF is designed as a collaborative forum in which DLT and public health service chief executives can openly and robustly discuss and debate the overall leadership, strategy, direction, challenges and opportunities facing Queensland's public health system. SLF does not have decision-making authority. SLF comprises DLT members, the HSCEs of all HHSs and the Chief Executive Officer of Mater Health Services. SLF meets once a month.
- The HSCEs' Forum is intended to work collaboratively to influence and advise on statewide strategy for HHSs, to provide mutual support and expertise and to share information. The HSCEs' Forum has no decision-making authority. The HSCEs' Forum meets immediately prior to SLF.
- The Hospital and Health Board Chairs' Forum is designed to discuss strategic priorities and exchange ideas and initiatives with the Minister, DG and, on relevant matters, the

DDGs. The Board Chairs' Forum meets quarterly. The Forum has no decision-making authority.

Consultation feedback

Overall Departmental and HHS officers reported a lack of engagement from participants in the various governance forums. HSCEs noted that DLT members are frequently absent at meetings such as SLF. DLT members reported a reluctance from HSCEs, and at times their fellow DLT members, to engage in discussion on issues critical to the system's performance. Most of the regular meetings were described as a means to share information and business intelligence.

Board chairs were generally positive about the Board Chairs' Forum but noted the challenges of catering to such a diverse group of HHSs. Rural and remote HHSs considered the Forum was focused on the interests of larger metro HHSs, with the issues discussed of less relevance to their HHSs. Chairs noted that while the Forum provides an opportunity to hear from the Minister about the Government's priorities, it could be used more effectively as a mechanism to ensure Chairs are implementing the Ministerial and Government priorities.

The HSCEs' Forum was described as successful as an information sharing forum. However, several stakeholders noted its ability to act as a forum for sharing both successes and learnings within the system was inhibited by the sense of competition between the HHSs. One HSCE suggested there was a reluctance to raise issues that might be seen as critical of the HHSs' performance for fear of drawing attention to themselves. Again, the diversity of the group means that the discussion will not always be of relevance to all HHSs.

HSCEs noted that SLF tends to be less interactive and more the Department sharing information with the HHSs. Conversely, DLT members commented on a lack of engagement from HSCEs in the SLF forum and an unwillingness to debate issues of significance to the system.

Findings

The issues raised in consultation do not appear to stem from the governance of these forums. A review of the Terms of Reference for each indicates their focus is appropriately on collaboration as co-leaders,[44] open and robust discussion and debate about the challenges and opportunities facing the health system,[45] setting Queensland Health's strategic direction to ensure the long term sustainability of the health system,[46] exchanging ideas, initiatives and best practice,[47] sharing experience, advice, good practice and expertise for the benefit of the health system[48] and providing constructive advice to the Minister on the strategic priorities for Queensland's public health system.[49]

However, in practice there appears to be a disconnect between what the Terms of Reference envisage and what is actually discussed. While most DLT members, HSCEs and Board Chairs considered these forums could be more effective, few acknowledged their own role in achieving this. Responsibility for driving debate and collaboration cannot be the sole responsibility of the DG, the Chair of Chairs and the Chairs of the HSCEs' forum – it is incumbent on each participant to take responsibility for their contribution. This is particularly

[44] Queensland Health (2015), *Health Service Chief Executives' Forum: Terms of Reference*, Brisbane, Queensland Government.
[45] Queensland Health (2018a), *System Leadership Forum: Terms of Reference*, Brisbane, Queensland Government.
[46] Ibid.
[47] Queensland Health (2016c), *Hospital and Health Board Chairs' Forum: Terms of Reference*, Brisbane, Queensland Government.
[48] Queensland Health (2015), *Health Service Chief Executives' Forum: Terms of Reference*, Brisbane, Queensland Government.
[49] Queensland Health (2016c), op cit.

the case given the time and expense spent on having members meet regularly, generally in person. To this end, the agendas for these forums should, to the extent they are not already, be developed collaboratively by forum participants to ensure they are focused on issues of relevance and importance.

Consultation feedback indicated these meetings were used primarily as a means to share information. However, there are more effective mechanisms to share information and business intelligence in a large, complex and decentralised system such as Queensland Health. While there is a need for, and an expectation that, these forums will be opportunities for debate about high level strategic issues impacting system performance, a significant amount of development will need to occur to equip the participants to engage in such a process, with leadership from the DG and other DLT members.

As addressed in more detail below, the issues and challenges facing HHSs vary across the State. Therefore, there may be benefit in the HSCEs and Board Chairs of HHSs with similar contexts having the opportunity to meet to discuss issues of mutual interest. This could be either for part of each meeting, or for some of the meetings throughout the year.

Recommendation

8. That the agendas for governance meetings – including the System Leadership Forum, the Health Service Chief Executives' Forum, Hospital and Health Board Chairs' Forum, and the Clinical Senate – should reflect the mutual stewardship obligations by including opportunities for discussion of strategic issues such as future demand reduction and demand management strategies, new models of care, clinical innovations, health technologies, prevention and wellness challenges and mental health and chronic health issues.

Sharing innovation

Consultation feedback

A number of stakeholders commented on the difficulties of sharing successes and learnings across the system and noted the system has had limited success in taking successful initiatives in one HHS and sharing and scaling them across the system.

The Panel noted examples where more than one HHS had engaged an external consultant to deal with the same issue and the findings and recommendations had remained 'in-house'. This approach represents a lost opportunity both to leverage value for money from consultancy engagements and to ensure the system as a whole can leverage innovations and potential efficiencies.

The implementation of the Integrated Electronic Medical Record (ieMR) system was an example where knowledge had been successfully shared across the system. A number of HHSs noted that having staff from other HHSs on hand to support their teams during the rollout was critical to success. However, this type of collaboration appeared to be the exception rather than the norm.

The Minister has recognised the importance of upscaling and accelerating innovations that can deliver better health care and value for money for Queenslanders. Under the Minister's Rapid Results Program, which commenced in 2018, a newly formed Transformation Team within the Office of the Director-General is accelerating the system-wide rollout of 27 existing

projects and good ideas in collaboration with clinical and expert champions, DLT and HSCEs, across eight priority areas:

1. Keeping Queenslanders healthy and tackling obesity
2. Promoting the right care in the right place and at the right time
3. Putting patient care at the centre
4. Supporting closing the health gap through an empowered Aboriginal and Torres Strait Islander Health Workforce
5. Improve the rates of immunisation
6. Maximising benefits of digitisation and capital productivity
7. Efficient and effective procurement
8. QAS improvements.

These projects include expanding the non-hospital options available to the QAS to reduce the number of presentations at hospitals and improving QAS-clinical handovers at Emergency Departments; improving the capital business case process to reduce costs; clinician-lead procurement in pharmaceuticals, cardiology and orthopaedics to ensure the best price, quality and volume; establishing Health and Wellbeing Queensland; modernising supply chain operations throughout Queensland Health; and designing an Aboriginal and Torres Strait Islander career structure to improve employment participation in the Queensland Health workforce.

The Transformation Team aims to embed the practice of taking innovations and applying them across the system, in contrast to the ad hoc organic processes previously in place.

Findings

Inherent in a networked governance model is the principle that good ideas are everywhere. The challenge for the Department is to ensure there are mechanisms in place to identify and test creative approaches, then scale them across the system.

The Sustainable Health Review, chaired by Robyn Kruk AO,[50] identified similar issues in Western Australia, noting that while the uptake of innovation often occurred well at a local level, the health system lacked a "*visible, shared approach to spreading new ideas, innovation and changes in practice across the system*".[51] Kruk notes that "*innovation and research are vital to achieving a more sustainable WA health system*"[52] and points to the benefit of a systemwide approach to innovation, collaboration and service improvement such as that adopted by Victoria, through Better Care Victoria,[53] and the New South Wales Agency for Clinical Innovation.[54] Kruk recommended embedding research and innovation into core business, including through the establishment of:

[50] Kruk, Robyn et al (2019), *Sustainable Health Review: Final report to the Western Australian Government*, Perth, Department of Health. In June 2017, the Western Australian Government announced the Sustainable Health Review. The Sustainable Health Review Panel, chaired by Robyn Kruk AO, was tasked with guiding the direction of the Western Australian health system to deliver patient-first, innovative and financially sustainable care. The *Sustainable Health Review: Final Report to the Western Australian Government* was provided to the Western Australian Government in November 2018.
[51] Kruk et al (2019), p. 109.
[52] Ibid.
[53] Better Care Victoria was established following the 2015 *Travis Review: Increasing the capacity of the Victorian public hospital system for better patient outcomes*. It supports timely and appropriate access to high quality care by identifying, scaling and embedding innovative practice across the Victorian health system.
[54] The Agency for Clinical Innovation works with clinicians, consumers and managers to improve healthcare by rapidly developing and spreading new ways of caring for patients.

- local innovation units, to support a local culture of improvement, experimentation and entrepreneurism where staff are empowered and encouraged to co-create new and innovative solutions with consumers; and
- a WA health system central unit to provide advice and guidance, and to facilitate sharing and connecting of innovative work across the health system.[55]

The Department should review current mechanisms to showcase and share innovations in the Queensland system and consider how to embed these across the network, to ensure they are ongoing, sustainable and part of 'business as usual' for Queensland Health. In doing so, the Department should draw on the experience of other jurisdictions, particularly New South Wales and Victoria. While the Department has a role, as the system leader, in drawing information from across Queensland Health and facilitating the rollout of innovations across the system, the model should also reflect that good ideas will come from across the system, and that clinician and consumers networks also play important roles in promoting and sharing innovation.

It is also incumbent on HSCEs and Board Chairs to ensure they are discussing the problems faced within their HHS to identify common issues across the system and share learnings, both opportunities and challenges. The agendas for the HSCE and Board Chairs' forums should reflect this as a priority. This should minimise the duplication of effort that currently arises where one HHS initiates work to resolve a problem that another HHS has already dealt with.

Recommendation

9. That Queensland Health should place greater emphasis on innovation in the system and embed mechanisms to ensure that the innovations in clinical care models, techniques and practices and other service delivery strategies are shared across health services to build capacity and capability in the system and prevent duplication of effort.

Recognising the diversity of Hospital and Health Services

Background

Service agreements are a requirement under the National Health Reform Agreement. The HHB Act requires the DG and a HHS to enter into a service agreement for the HHS, signed by the Board chair.[56] The service agreement is binding on the HHS and the DG. If the HHS and the DG cannot agree the terms of the service agreement, the Minister may decide the terms.[57] A service agreement must set out:

- the hospital, health and other services that the HHS must provide;
- the funding to be provided to the HHS, and the way in which the funding will be provided – for example, activity-based funding (ABF) or block funding;[58]
- performance measures for the HHS; and
- the performance and other data the HHS must provide to the DG.[59]

[55] Kruk et al (2019), Recommendation 28.
[56] *Hospital and Health Boards Act 2011* (Qld), s. 35.
[57] *Hospital and Health Boards Act 2011* (Qld), s. 38.
[58] In 2018-19, 85 Queensland public hospitals received block funding, 80 of which were small rural hospitals.
[59] *Hospital and Health Boards Act 2011* (Qld), s. 16.

Unlike the Victorian health system, which distinguishes between regional and metropolitan health services,[60] the HHB Act creates all HHSs as equal with the same functions, governance structure and statutory obligations. However, there are significant differences between the HHSs in terms of budget, funding models, models of care and the demographics of their communities.

The panel considers there are essentially three broad groupings of HHSs.

1. **Rural and remote HHSs – Central West, North West, South West and Torres and Cape**

   These four rural and remote HHSs receive block funding, with the exception of Mt Isa hospital in North West HHS which is funded on the ABF model.[61] In 2017-18, their budgets were between $76 million and $213 million.

   Their service areas generally comprise small communities. As a consequence of the increasing difficulties that private providers of primary and aged care services have in maintaining a presence in rural and remote communities, these HHSs provide primary health care, acute care and aged care. The service issues for rural and remote HHSs centre around the health outcomes for their communities, with life expectancy and rates of chronic disease, low birth weight, obesity, alcohol consumption and smoking rates worse than for regional and metropolitan communities. The social determinants of health are particularly relevant, with geographic isolation, economic and social disadvantage, and high Aboriginal and Torres Strait Islander populations impacting heavily on the consequent health profiles of their communities.

   Recruitment and retention of staff, particularly clinical staff, are of perennial concern and have implications for the capability of services in respect of clinical expertise and experience, workforce management, procurement and capital works.

2. **Large south-east HHSs – Children’s Health Queensland, Gold Coast, Metro North, Metro South, Sunshine Coast, West Moreton**

   The larger HHSs in the south-east corner are primarily focused on acute care delivered through large tertiary and quaternary hospitals. They primarily receive ABF funding based on their activity levels. Their budgets ranged from $600 million to $2.8 billion in the 2017-18 financial year.

   High level specialist clinical care is supported by access to sophisticated medical technology. They provide specialist acute services on behalf of other HHSs. Demand management, particularly in emergency departments, continues to be a major challenge.

   Children’s Health Queensland is unique among the HHSs as it provides specialist services for children and young people from across the State. However, it also provides general paediatric health services to children and young people within the greater Brisbane metropolitan area. While acknowledging these differences, Children’s Health Queensland is considered to most closely align with the other large south-east HHSs.

[60] See the interjurisdictional analysis at Appendix 3.

[61] The ABF framework is based on standardised costs of health care services (known as ‘activities’). The ABF framework applies to facilities that are operationally large enough to support the framework. Block funding is applied to small public hospitals, as they may not have sufficient economies of scale to be financially viable if the ABF framework was applied.

3. **Regional HHSs – Cairns and Hinterland, Central Queensland, Darling Downs, Mackay, Townsville, Wide Bay**

   Sharing characteristics of both the smaller rurally-based HHSs and the larger metropolitan and near metropolitan HHSs is a group that has one or more large tertiary or quaternary hospitals and a number of smaller facilities. They receive a combination of ABF and block funding. Their budgets ranged from $441 million to $983 million in 2017-28. Their capabilities vary.

Findings

Departmental and HHS stakeholders reported the service agreements and performance framework are focused on a few key performance measures – 'budget, MOHRI[62] and NEST[63]', patient off stretcher time and Emergency Department wait times were often mentioned. Stakeholders internal and external to Queensland Health considered it was difficult to get traction with HHSs on an issue unless it was expressly referenced in the service agreement or key performance measures. This was of particular concern as there is often a delay in incorporating Government Election Commitments or Ministerial priorities into service agreements, due to the timeframes for negotiating service agreements. Challenges in implementing commitments around nurse navigators and nurse to patient ratios were mentioned by several stakeholders. Conversely, HHSs noted the challenges of being asked to prioritise unfunded measures in this tight fiscal environment.

HHSs, particularly those in rural and remote areas, considered the service agreements are built on a template that assumes all HHSs are homogeneous based on the characteristics of the larger metropolitan and near-metropolitan HHSs. Rural and remote HHSs noted that the nature of their health services is fundamentally different to HHSs in metropolitan areas, both in the services provided, the demographics of their communities and their funding models. For these reasons, a number of the rural and remote HHSs considered many of the key performance measures, such as Emergency Department wait times, were of limited relevance to the performance of their HHSs.

Service agreements are an important mechanism to link funding to performance. Importantly, service agreements provide for common performance measures, which are capable of aggregation across the system. While it is acknowledged that common and consistent performance measures in all service agreements are necessary to ensure system-wide reporting obligations are not compromised, the need to recognise the specific contexts of each HHS was a common theme in consultation. While service agreements are individually negotiated, the service agreement process could better account for the specific context for a HHS and provide greater flexibility in terms of the HHS's individual needs and priorities. Additional performance measures may be necessary to reflect the particular contexts of those HHSs.

Negotiations around the service agreements could have a broader and more relevant focus through the inclusion of matters such as procurement, capital works, human resource management and clinical capabilities. They could provide a vehicle for discussion between DLT members and the HSCE and Board Chair about the performance of the HHS and identify areas of excellence or areas for attention and/or development. The service agreements could enhance accountability for the HHSs and strengthen relationships between HHSs and the Department.

[62] Minimum Obligatory Human Resource Information, a mechanism for monitoring the number of employees in Queensland Health.
[63] National Elective Surgery Target.

Additionally, the need to acknowledge population health issues and place-based priorities might require different commissioning models. These may need to be underpinned by alternative mechanisms for funding and governance.

Recommendations

10. That in its role as system manager, the Department of Health take account of the different demographic, service needs, and strategic and operational capabilities of individual Hospital and Health Services. The Department of Health should ensure these local nuances are reflected in service agreements, performance measures, capital planning and delivery, governance and funding models.

11. That the service agreement process should be sufficiently flexible to enable each Hospital and Health Services to optimise their performance and deliver sustainable and appropriate health services to meet the needs of their populations.

Information sharing

Data is an important enabler. The EY *Review of Safety and Quality in the WA health system* noted that "[s]*afe, reliable healthcare depends on access to, and the use of, information that is transparent, timely, reliable and attributable*".[64] Comparative data is important in identifying the patient safety and quality performance of the HHSs. It should enable assessment of the efficiency and effectiveness of the health services and provide benchmarking information on the provision of those services.

The Department, as system manager, must also have access to the information that it requires to perform its statewide functions. Accurate, consistent comparison data is critical to the Department's performance management, service planning, workforce planning and procurement functions. The collection, reporting and publication of performance data is a systemic obligation. For individual HHSs, it is a critical planning, performance and reporting tool. Moreover, public confidence stems from the knowledge that their taxes have been used efficiently and effectively.

Queenslanders are also entitled to be able to easily access their own information, including that held by Queensland Health. The Queensland Government has made this a priority under *Our Future State: Advancing Queensland's Priorities*.

The health system produces vast amounts of data but there is a lack of clarity about the ownership of the data and the accountability for its integrity, reporting and publication. Additionally, unions, clinicians, HHSs and the Department all reported difficulties in accessing data in a consistent, accessible format that allows comparisons and benchmarking across the HHSs. Clinicians commented on the challenges in obtaining data across the HHSs, noting that access to system-wide data is critical to reducing variation across HHSs and driving improvements in clinical practice.

The Queensland Nurses and Midwives' Union (QNMU) expressed concern that they were forced to access information through the *Right to Information Act 2009* and that separate applications had to be made to each HHS. Similarly, clinicians noted that access to information for the purpose of clinical registries requires the agreement of each HHS.

[64] Mascie-Taylor, Hugo and Hoddinott, John (2017), *Review of Safety and Quality in the WA health system: A strategy for continuous improvement*, Australia, Ernst & Young, p. 22.

QNMU also expressed concerned about data integrity and the ownership and manipulation of that data, stating:

> *In our view, reporting, analysis and publication of health data must be more streamlined, centralised and focused on value-based outcomes.*[65]

QNMU argued for an independent and specialist unit, similar to the NSW Bureau of Health Information.

Some of the issues raised in consultation appear to stem from the concept that data is 'owned' by the individual HHS and a view that the Department does not have a right to access data from the HHS. The HHB Act supports this in part by setting up a process whereby the DG can request access to data through the service agreement. The HHB Act provides that the service agreement may state the performance data and other data to be provided by a HHS to the DG, including how, and how often, the data is to be provided.[66] Current service agreements require HHSs to provide the Department with 38 clinical data sets, 16 non-clinical data sets and "other data pursuant to ad hoc requests".

Privacy and confidentiality issues will also arise where the data may potentially identify patients. Queensland Health patient identifying information is governed by a complex regulatory environment, with privacy and confidentiality provisions in a number of Health and other portfolio Acts. The HHB Act tightly governs the disclosure of information that may identify people who have received public sector health services, preventing this information from being disclosed to other HHS or Departmental employees except in specific circumstances.

Consultation feedback indicates that even where the Department holds relevant data, little is done to analyse and present the data in a format that is useful for both the Department and HHSs. Service agreements list a Departmental 'data custodian' for each of the data sets that the HHS must provide, indicating that the information provided by HHSs is dispersed across the Department. It is unclear if these data sets are shared with other areas within the Department. Nor is there a central point within the Department responsible for ensuring that data obtained from the HHSs is analysed and presented in a format that is useful for both HHS and Department functions.

The Department has an important sense-making role, utilising the data sets to which it has access in its role as the system leader. In a networked model, the centre has a responsibility to assist HHSs to develop their local capability and skills in data analysis. Universities and other clinical partners also have a role in helping HHSs to more effectively use data to identify areas for improvement.

Data should be shared in an open and transparent manner, unless there is a reason not to do so, such as to ensure appropriate protections for patient privacy and confidentiality. There is a need to clarify ownership and to streamline the collection and sharing of information within the system. The lack of access to data and the ineffectual use of data is contributing to a lack of understanding about the system's needs and making it difficult to drive more consistent clinical and performance outcomes.

[65] Queensland Nurses and Midwives' Union (2019), *Submission to the panel providing advice to the Minister for Health and Ambulance Services*, Brisbane, QNMU, p. 25.
[66] *Hospital and Health Boards Act 2011* (Qld), s. 16.

Recommendations

12. That, as a matter of principle and practice, there should be more open and transparent sharing of data between the Department of Health and the Hospital and Health Services to enable benchmarking of performance and costs at the system level and for individual Hospital and Health Services.

13. That the Department of Health should, in consultation with Board Chairs and Health Service Chief Executives, streamline the collection and sharing of information within the system, while maintaining appropriate protections for privacy and confidentiality.

Statewide system planning

Background

The HHB Act provides that the DG is responsible for statewide planning[67] and developing statewide health service plans, workforce plans and capital works plans,[68] whereas HHSs must contribute to, and implement, statewide service plans that apply to the HHS and undertake further service planning that aligns with the statewide plans.[69]

The Hunter Review recommended the creation of the Strategy, Policy and Planning Division (SPPD) to "*provide core system leadership activities by setting strategy and direction for the health system*".[70] SPPD brought together service needs planning, capital planning and workforce planning into a single division. The intent was that SPPD should feed information about strategic priorities and planning needs into the purchasing functions in HPSP.[71]

Findings

A consistent theme of the consultation was the need for the Department to develop a statewide system plan setting out the direction for Queensland Health in the medium to long-term. Departmental and HHS stakeholders reported that, in the absence of clear direction from the Department on statewide planning, HSCEs and Boards are setting their own direction for their HHS, without necessarily having regard to the impact on the broader system. Examples included HHSs establishing higher level clinical services without regard for the impact on patient flows to neighbouring HHSs, and HHSs putting forward capital projects that did not align with where the system considers new facilities are required.

There was evidence of silos in the system planning process, with stakeholders commenting that the Department's service planning did not appear to link in with the capital planning process or with the purchasing function in HPSP, as envisaged by the Hunter Review. Stakeholders also considered that the clinical networks could play a greater role in the planning function.

In September 2018, the System Planning, Workforce Planning and Capital Planning Branches were brought together into a single Planning Directorate, which sits within SPPD. The intent of this was to enable better integration of the planning functions. The new Planning Directorate has taken steps to embed this integration and ensure it is built into processes such as the Department's Investment Review Committee (IRC). The Department advises that it is now

[67] *Hospital and Health Boards Act 2011* (Qld), s. 8(3).
[68] *Hospital and Health Boards Act 2011* (Qld), s. 45(c).
[69] *Hospital and Health Boards Act 2011* (Qld), s. 19(d).
[70] Hunter (2015), op cit., p. 58.
[71] Ibid, p. 60.

using the Clinical Services Capability Framework as a planning tool to project what services will be needed, where and when, across the State, which will then feed into the capital and workforce planning. While this appears to be a step in the right direction, this work was not referenced by any of the HHSs during the consultation process, suggesting that further progress needs to be made on engaging with the HHSs.

The Department advised that it embarked on a regional planning process in 2018, where HHSs were asked to work with the Department and other HHSs in their region to develop a regional service plan based on patient flows across the State. While the process had some success in the north, sparking the Northern Collaborative, internal competition and a lack of engagement from the HHSs was seen to make the Central and South processes unworkable.

The panel considers the division of planning functions provided for in the HHB Act is appropriate – that is:

- the Department should lead development of statewide planning, including statewide health service, workforce and capital works plans; and
- HHSs should contribute to, and implement, these statewide plans, and undertake further planning for their individual HHS which aligns with the statewide plan.

However, statewide planning needs to be credible to gain the respect and confidence of the HHSs. It needs to be routinised and conducted on a predictable cycle so that HHSs can align their own processes to have maximum input. The Department needs to welcome local knowledge and input, and engage with HHSs in an open and transparent way.

Developing a statewide service plan, encompassing clinical service planning, workforce planning and capital planning, will always be a contested process as it can and should impact on funding and service agreements for HHSs. However, this is a critical function of the Department as system leader. The Department should develop a comprehensive integrated statewide plan, such as the Queensland Health Plan envisaged by the Hunter Review. This plan should incorporate health service, workforce and capital works planning. The plan should identify future service challenges, including demand reduction and management strategies, and consider future models of care.

Recommendations

14. That in its role as system manager, the Department of Health should develop a comprehensive integrated statewide plan incorporating health service, workforce and capital works planning, and identifying future service challenges and demand pressures, demand reduction and management strategies, and future models of care.

15. That, while system-wide planning should remain the responsibility of the Department of Health in its role as system manager, the planning process must be collaborative, drawing on the Hospital and Health Services' local knowledge, expertise and capabilities.

16. That Hospital and Health Services should ensure their individual strategic planning aligns with the statewide operations and capital plan developed by the Department of Health.

NOT GOVERNMENT POLICY

Capital works

Background

Under the HHB Act, the DG is responsible for statewide capital works plans, and managing major capital works[72] for proposed public sector health service facilities.[73] HHSs are responsible for undertaking minor capital works, and major capital works where approved by the DG.[74]

Queensland Health has a large capital works program which represents a significant annual investment.[75] The capital program is important to the Minister and the Government as employment creation is a key policy platform of all State Governments. However, historically Queensland Health has been unable to expend its capital budget within the approved timeframe.

Each year, HHSs, along with HSQ and eHealth, are asked to list their top five projects to address population needs. The Department then undertakes an evaluation process to prioritise the more than 70 projects identified. This prioritised list of unfunded projects is known as the State Health Asset and Infrastructure Plan (SHAIP). Typically, around the top 20 projects from the SHAIP are supported to go through Queensland Health's Investment Management Framework.

IRC is the governance body that endorses the progression of projects through the Investment Management Framework gates. IRC's intent is to ensure government's investment is aligned with statewide directions and plans. IRC makes recommendations to the DG and/or Minister to support funding decisions. It does not provide funding or approve a budget.

While it is accepted that the construction of new hospitals and major renovations is expensive and complex, the planning for capital expenditure demonstrates some significant weaknesses both in the processes and governance. Projects are announced, usually by the Minister or Government, presumably acting on advice from the Department. Initial costings are typically understated, often substantially. This necessitates HHSs having to seek additional funds from the Department, sometimes requiring the Department to seek additional funding from Treasury. Concerns were also expressed that project timeframes often blow out.

Together, the inability to expend its capital allocation and issues with the planning of new capital works has harmed Queensland Health's reputation and resulted in a lack of confidence by the Minister, the Government and central agencies in Queensland Health's capacity to manage its large capital program.

Role clarity for capital planning, delivery and reporting within the Department

Both Departmental and HHS stakeholders expressed significant concern about the processes and governance of capital projects. HHSs did not understand the process used by the Department to prioritise projects and, critically, were not told where their HHS's projects fell in the priority list. The Department indicated this was due to the Cabinet and political processes around determining funding for capital projects. However, this lack of transparency about the

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[72] *Hospital and Health Boards Act 2011* (Qld), s. 45. Major capital works are defined as works that are structural works for the construction of a building, involve alterations to the building envelope of an existing building, or consist of work that requires assessment, certification or approval under an Act (such as assessment by a building certifier): see s. 37 of the *Hospital and Health Boards Regulation 2012*.

[73] *Hospital and Health Boards Act 2011* (Qld), s. 45.

[74] *Hospital and Health Boards Act 2011* (Qld), s. 19.

[75] In the 2019-20 Queensland State Budget, $777.7 million was allocated for health capital infrastructure.

prioritisation of projects has resulted in HHSs expending significant time and resources preparing business cases for projects that are unlikely to be funded, undermining trust between the parties.

As noted above, statewide service planning, including the identification of future major capital works, is, and should remain, a core function of the Department as system manager. The Department should develop a draft major capital works plan with different horizons. This plan must be integrated into the broader statewide system planning and be based on future demand management strategies. As each HHS is best placed to understand its priorities, HHSs' input should be sought to ensure that local factors are considered and adjustments negotiated as necessary. The plan should be reviewed annually by Queensland Health prior to consideration by Government.

Currently, SPPD is responsible for capital planning, while Corporate Services Division manages the Department's role in capital management and delivery. This structure reflects the Hunter Review's recommendation that the Department's planning functions be grouped within a single division. However, this division of responsibility can lead to confusion about accountability for capital issues.

Consideration should be given to bringing the capital planning, delivery (including oversight of HHSs' delivery) and reporting functions together within the Department. This would create an end-to-end process for capital and a single point of accountability for the capital program. Consistent with the networked model, strong linkages would need to be maintained with the Department's workforce and service planning functions, to ensure the capital program is integrated with the statewide plan.

Some of the smaller HHS felt that they might be overlooked in such a process because the high cost of larger facilities in the metropolitan areas and regional centres would absorb most of the capital budget. Consideration could be given to a separate fund that could be accessed for smaller projects that are beyond the financial capacity of the smaller HHSs, including those with rurally-based hospitals.

Streamlining the Investment Review Committee process

Concerns about the IRC process were widespread, with Department and HHS stakeholders noting it was expensive for HHSs and had not improved Queensland Health's reputation for managing major capital projects. A common concern was that IRC does not say 'no' to projects proceeding but instead delays the project or sets more hoops for the HHS to jump through, resulting in wasted resources. Others considered IRC was unduly focused on process, instead of considering whether proposals aligned to system priorities.

There is clearly a need to clarify roles and accountabilities between the Department, HHSs and IRC. The interface between the Department's process to develop the system's major capital priorities and the role of IRC creates more confusion and adds to the duplication of effort and wasteful use of resources. While it is not IRC's role to determine priorities or to say 'no' to proposals, it is not clear to the HHSs where that accountability lies.

The Department, in consultation with the HHSs and Queensland Treasury, should review IRC, with a view to streamlining the process and ensuring capital projects are delivered on time and within budget. A streamlined IRC should consider the management of approved projects, including costings, timeframes and readiness. The Department has a role, as the system leader, for maintaining a database of indicative costings for major capital works. Preliminary business case development should draw on the Department's expertise in this regard. Savings

and efficiencies realised as a result of the streamlined IRC process would be available for reinvestment by the HHSs.

This new capital process would require a level of maturity from all network members, but would demonstrate significant respect and trust across the public health system. It would also foster a commitment to a system view.

Management of the delivery of major capital projects

There were mixed views from HHSs about where responsibility for managing the delivery of major capital projects should lie. Some HHSs felt confident in their capacity to manage a major capital project, albeit recognising that Building Queensland and/or the Department would need to be involved for major hospital projects. Others felt the Department should be responsible for management of the build but with an agreed transfer of responsibility at the point of commissioning. Some HSCEs expressed concern with being responsible for the governance of the project, as the head of the Steering Committee, in circumstances where the Department was providing the technical expertise for the project. This was seen to transfer all of the risk to the HSCE, with none of the control. Many considered the current processes were neither transparent, nor respectful.

The need for the Department to have local contextual knowledge was seen as critical if the Department is to be responsible for projects. One HHS suggested there would be benefits in the Department having an expert team that could be embedded within a HHS to manage a project. Moving this team from project to project across HHSs would enable learnings to be shared across the system. Others noted that more needs to be done to draw on the expertise developed within HHSs through the process of delivering a major capital project.

The capability and capacity of HHSs to manage major capital programs varies significantly. However, because it is imperative that capital projects reflect the local context, the HHS's HSCE should be responsible for the governance of capital works, for example, by chairing the steering committee for approved projects. This role should be responsible for the budget, scope and timeframes for the project. Where necessary, a HSCE may seek support in this role from the capability available within the system.

Lower cost refurbishments and small projects such as staff accommodation should be the responsibility of each HHS, albeit with the capacity to engage with the Department, other HHS or private project managers on a user-pays basis to ensure that capability requirements are met.

Maintenance

Many HHSs commented that the budget for repairs and maintenance is inadequate. It should be acknowledged that a factor in the inadequate budget for repairs and maintenance is a legacy of the allocations at the time the HHSs were created. As a consequence of the funding levels, the focus is directed towards reactive maintenance, with planned maintenance given lower priority. This results in a deterioration in the quality of critical infrastructure, adding to backlog and the costs. Pressure then builds for increased funding to reduce the repairs and maintenance backlog, which was estimated to be almost $600 million in September 2018[76] and continues to grow.

[76] Parliament of Queensland (2018), *Question on Notice No. 1186*, https://www.parliament.qld.gov.au/documents/tableOffice/questionsAnswers/2018/1186-2018.pdf (accessed May 2019).

NOT GOVERNMENT POLICY

Some HHSs noted that the Backlog Maintenance Remediation Program Framework, which ended in 2017, had been an important source of funding, providing some compensation for the inadequate annual allocations for repairs and maintenance.

The Panel notes that these issues are outside of the Terms of Reference and therefore the Panel makes no recommendations in relation to the backlog maintenance process. However, the Department may wish to consider reviewing how backlog maintenance is managed to ensure that it supports the sustainability and cost-effectiveness of the system's capital infrastructure.

Recommendations

17. That the capital planning, delivery and reporting functions be brought together within the Department of Health, ensuring a single point of accountability for the capital program, while maintaining strong linkages to other statewide planning functions.

18. That the Department of Health, in consultation with Hospital and Health Services, develop a statewide capital works plan for Queensland Health to guide investment decisions and inform funding submissions to Queensland Treasury.

19. That the Department of Health should streamline the Investment Review Committee process and ensure it is focused on delivering capital projects on time and within budget.

20. That to ensure major capital works reflect the local context, the Health Service Chief Executive should be accountable for the governance of major capital works within their Hospital and Health Service and responsible for managing the budget, scope and timeframes for a project, while drawing on capability within the system where necessary.

Industrial relations and human resource management

Background

The employment arrangements established under the HHB Act are complex. The HHB Act provides that:

- the HHS Board is responsible for appointing the HHS's HSCE, although the appointment must be approved by the Minister;[77]
- all HHSs may appoint Health Executive Service and Senior Health Service Employees (executive health service employees);[78]
- a HHS that is prescribed in the *Hospital and Health Boards Regulation 2012* (known as a 'prescribed employer') may employ other non-executive health service employees directly;[79] and
- non-executive health service employees in other HHSs (known as a 'non-prescribed HHSs') are employed by the Director-General as system manager of Queensland Health and effectively seconded to the HHS.

[77] *Hospital and Health Boards Act 2011* (Qld), s. 33.
[78] *Hospital and Health Boards Act 2011* (Qld), s. 20(3).
[79] *Hospital and Health Boards Act 2011* (Qld), s. 20(4).

Eight HHSs are currently prescribed employers under the *Hospital and Health Boards Regulation 2012*:[80]

- Children's Health Queensland
- Gold Coast
- Metro North
- Metro South
- North West
- Sunshine Coast
- Townsville
- West Moreton.

Non-executive health service employees in the remaining eight HHSs are employed by the Director-General.

The HHB Act establishes a statewide industrial relations (IR) and employment framework, which is intended to ensure consistency, avoid inequities in the pay and conditions across HHSs, and prevent competition between the HHSs. The Act expressly provides that health service employees are employed on the same terms and conditions, regardless of whether they are employed by a HHS or the Department.[81]

The Director-General's functions with respect to IR and human resources (HR) are:

- to employ staff in the Department, including to work for other than prescribed HHSs;
- to manage statewide industrial relations, including the negotiation of certified agreements, and making applications to make or vary awards; and
- to establish the conditions of employment for health service employees, including issuing health employment directives.[82]

Consultation feedback

Not surprisingly, the greatest degree of polarisation of views among the stakeholders was on issues related to HR and IR.

Unions representing Queensland Health employees, along with the peak bodies representing both doctors and nurses, were strongly critical of the outcomes of the devolved model. The unions pointed to commitments provided to them by the then Labor Government around the time the HHB Act was introduced, about consistency of employment conditions and access by unions to the HHSs. They believed that previous commitments had not been honoured and argued for the some of the reforms to be wound back, in particular, the prescribed employer provisions. The peak bodies representing doctors and nurses did not consider the prescribed employer arrangements had benefited their membership and were of the view that the system would benefit from having a single collective identity.

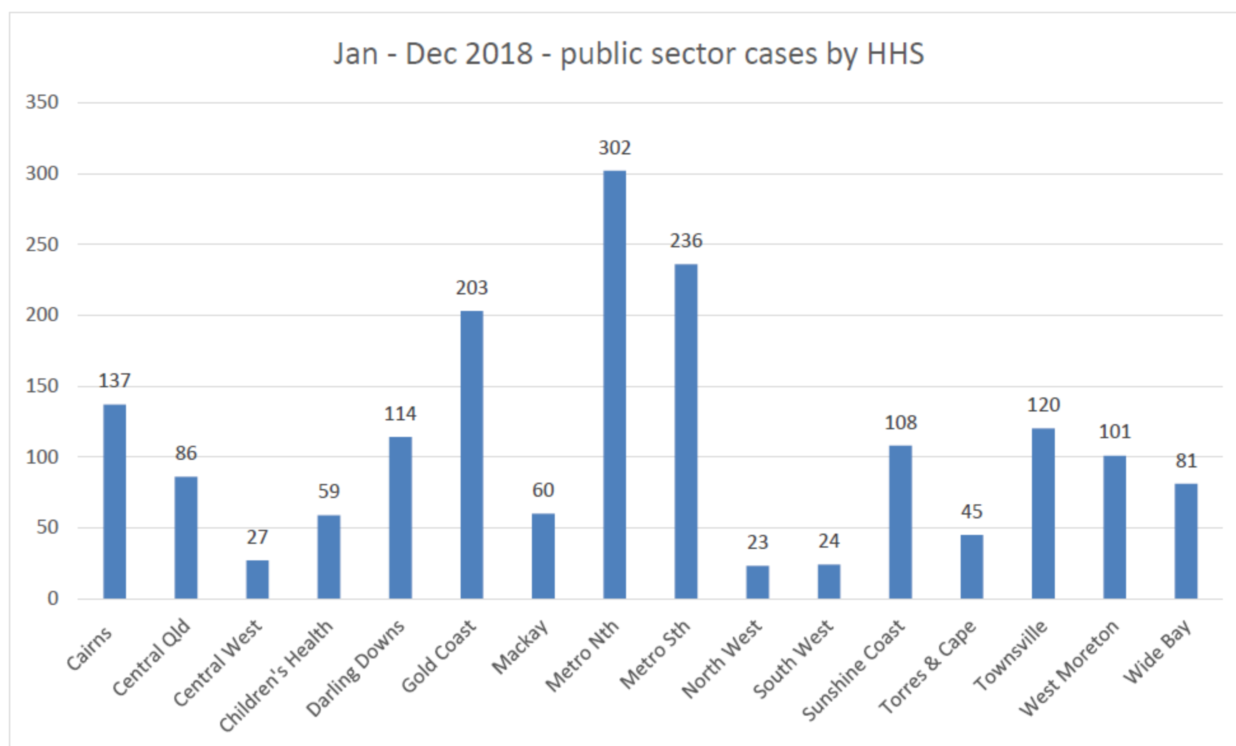
Unions expressed frustration that they negotiate at great length with the Department over the terms and conditions in industrial instruments, only to have responsibility for implementing the instrument transferred to the individual HHSs. Unions reported that even when the Department was sympathetic to union concerns, it was reluctant, unwilling or, in the case of the prescribed

[80] Schedule 1AA.
[81] *Hospital and Health Boards Act 2011* (Qld), s. 10(2).
[82] *Hospital and Health Boards Act 2011* (Qld), s. 45.

employers, felt unable, to intervene. The unions cited numerous examples which they believed demonstrated inconsistent practices and behaviours from the HHSs:

- Several unions reported that HHSs had developed their own employment policies on issues such as carer's leave and drug and alcohol testing policies, which were inconsistent with the Department's policies.
- The QNMU reported that one HHS required a person to resign before taking a position in another, thereby losing continuity of service benefits.
- The Australian Salaried Medical Officers' Federation Queensland reported inconsistent interpretation of the entitlements relating to professional development leave.
- Several unions reported incidents of members returning from maternity leave being either refused part-time arrangements or required to return at a particular part-time employment fraction, in contravention of the *Industrial Relations Act 2016*.
- Even though both the award covering nurses and midwives and the current certified agreement provide a commitment to the Business Planning Framework (BPF), the QNMU claims that incorrect or inconsistent interpretation and/or funding decisions by HHSs have resulted in the BPF becoming a major cause of disputation.
- A number of unions reported that consultation provisions in the certified agreements were either ignored or given lip service.
- Several unions claimed that some HHSs were ignoring or frustrating broader State Government policy directions citing the 'no contracting out', 'union encouragement' and 'maximisation of permanent employment' policies.

The QNMU[83] provided information about the number of formal requests for assistance to support its recommendation to the Panel to remove the prescribed employer status and reestablish a central HR function.



[83] QNMU (2019), op cit., p. 17.

The QNMU's submission indicates that industrial matters dominated these requests over occupational health and safety, professional registration and legal issues. It concludes that:

> *These referrals are the result of inefficient, time-consuming and unpredictable practices that have arisen through the decentralised employment framework that not only produces inconsistency but also duplication of effort and no single point of accountability.*[84]

By contrast, prescribed employer HHSs argued that these arrangements are more efficient and important to improving organisational culture and creating a sense of belonging for their staff. Some HHSs felt constrained by the 'centralised' IR framework, which they consider restricts their ability to respond flexibly to the challenging financial environment in which they operate. Most HHSs, whether prescribed or not, viewed prescribed employer arrangements to be more efficient and less bureaucratic. A number cited performance management processes as an example, with the Department's process seen to be overly bureaucratic, costly and time consuming to finalise. HHSs also considered that being a prescribed employer better enables the HHS to build a sense of identity and team culture within the HHS.

Improving HR and IR capability

Most stakeholders acknowledged the loss of expertise and skills of IR/HR practitioners at both the Departmental and HHS level. This is seen to exacerbate the issues of consistency in the application and interpretation of the various industrial instruments and HR policies. In response, the Department's Human Resources Branch has initiated training and engagement activities to support and enhance HHS capability relating to system-wide employment arrangements. These have been well attended.

However, many IR disputes are not the result of actions of HR/IR professionals but of line managers with limited knowledge of broader workforce policies and industrial instruments. These line managers may be more influential than the people providing advice. In an organisation the size of Queensland Health, many day to day HR and IR decisions will inevitably be made on the ground in HHSs, regardless of whether responsibility for HR and IR is centralised or devolved under the HHB Act. These issues must therefore be managed by building HR and IR capability throughout the system.

The Department should work with HHSs to build the capability of HR and IR professionals and to develop a separate program to assist line managers to understand their industrial obligations and good practice. These programs should be developed in consultation with health unions.

Concerns were expressed about the relationship between the Department and some HHSs. Some HHSs felt resentful of interventions by the Department in matters they felt were the HHS's responsibility, or did not appear to see the importance of engaging meaningfully with the Department on HR and IR matters. As noted above, this is evidenced by the fact that the Department's Chief Human Resources Officer is a guest of the Executive Directors' Workforce Forum, rather than a member. This binary 'us' and 'them' approach is a barrier to developing and maintaining IR and HR capability within the system and may be symptomatic of broader relationship issues between the Department and HHSs. If Queensland Health is to move towards a networked governance model, it is critical that HR/IR teams in the Department and the HHSs work collaboratively. One step towards this would be to ensure the Department's Chief Human Resources Officer is a member of the Executive Directors' Workplace Forum.

[84] Ibid, p. 18.

Engagement with unions

The Queensland Government has made a commitment to encourage union membership among its employees, which includes an acknowledgement that union delegates have a role to play within a workplace.[85] Union members are employees of either the Department or the HHSs. While HHSs may not all be model employers, the Government expects that they should be 'good' employers. Fair and equitable employment practices and open communications with unions and staff should be expected. Some of the practices described by unions evidenced underlying cultural issues that go beyond a lack of capability.

There are risks to the HHSs if they do not engage effectively with unions. The Queensland Health workforce is highly unionised, particularly in nursing and medical streams. The unions have indicated that their response to concerns about inconsistent application and interpretation of employment policies and industrial instruments will be addressed by an even more rigorous attempt to further codify matters in the future enterprise bargaining process. While regrettable, the strategy is understandable. Such an outcome would adversely impact on the flexibility that many HHSs believed to be so important. In simple terms, the benefits which were identified from being a prescribed employer cannot be realised.

In this context, respectful and constructive relationships with unions are essential and need to be established in all HHSs. HSCEs and their executive teams must model leadership within their HHS. The unions identified that their leaders have regular meetings with the DG. While these meetings were described as useful, they generally dealt with more system-level issues. HSCEs should ensure they have formal consultative mechanisms in place so that senior union officials are able to directly raise issues of concern.

As noted above, industrial concerns are likely to be the result of operational decisions made at lower levels within the organisation. Strong union engagement at this level has the potential to deliver positive outcomes including improving the capability of front-line decision-makers and enabling potential issues to be resolved at the lowest level. For this to be effective, HHSs need to afford unions access to these decision-makers, and union leaders and employees need to display a genuine commitment to respectful engagement and trust-based partnership with HHSs.

Prescribed employers

While some prescribed employer HHSs argued that being a prescribed employer better enables them to build a sense of identity and team culture within the HHS, no evidence was presented during consultation to confirm this claim. Indeed, the strategic plans of all HHSs either explicitly or implicitly identified the need to build organisational culture and staff engagement as critical to improving patient experiences and the quality of care. The Panel was unable to identify any evidence to establish a clear link between prescribed employer HHSs and their performance under the service agreements.

The current arrangements are confusing and inconsistent. Non-executive health service employees in half of the HHSs are employed by the Director-General as system manager, while employees in the remaining HHSs are employed by individual HHSs. While prescribed employer HHSs are responsible for employing health service employees directly, the DG remains legally responsible for these employees under the *Work Health and Safety Act 2011*. The DG is also responsible for negotiation of industrial instruments and determining the terms and conditions of employment for all health service employees, regardless of a HHS's prescribed employer status. Moreover, irrespective of prescribed employer status, all HHSs retain local responsibility for their staff and make on the ground decisions that have a direct impact on their workforce.

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[85] Department of the Premier and Cabinet (2015), *Queensland Government Commitment to Union Encouragement*, Brisbane, Queensland Government.

The Panel considers that the notion of different employers for Queensland Health staff is inconsistent with the principles that underpin a networked model. As Slaughter notes, "*the boundaries of a network are best understood as boundaries of identity rather than separation. The flows between nodes that give the network life connect them as part of a larger whole; thus nodes, clusters and larger structure are distinct but not separate entities*".[86] The multiple identities that citizens inhabit – as Queenslanders and Australians, for example – provides a relevant analogue to this point. Consistent with this is the notion that even though individuals may identify as working for the Royal Brisbane and Women's Hospital, or Central West HHS for example, they should predominantly see themselves as employees of Queensland Health, with a responsibility to support the health needs of all Queenslanders that transcends HHS boundaries. This will also support a system wide approach to staff movement, advancement and succession planning.

For these reasons, the Panel considers all non-executive health service employees should be employed by the DG, as system manager of Queensland Health rather than by individual HHSs. This can be achieved by amending the *Hospital and Health Boards Regulation 2012* to omit the list of 'prescribed employer' HHSs. This would mean the arrangements for all non-executive health service employees across the system would be the same, consistent with the arrangements already in place for non-executive health service employees in non-prescribed HHSs currently.

The panel acknowledges that concerns have been raised about the timeliness, responsiveness and consistency of the Department's HR functions, particularly with respect to performance management. The changes to prescribed employer status should be supported by the measures identified above to strengthen relationships across the system and with unions, and to build HR and IR capability in the system. This will provide an opportunity for the Department and HHSs, in consultation with unions, to review some of the practices that have been identified as unduly burdensome or bureaucratic. Goodwill from all players will be needed to develop streamlined procedures that remain consistent with natural justice and fairness principles.

Access to workforce data

Concerns were also raised by unions about access to data about the Queensland Health workforce. The QNMU reports significant difficulties accessing workforce data from Queensland Health, even where the disclosure is mandated by the certified agreement. Data about conversion of casual and temporary employees to permanency was a particular issue. The QNMU expressed frustration that their requests were denied by the HHSs or that they were referred to the Department, which often referred them back to the HHS. They argued that access to this type of information is an industrial right. This was used as another example of the confused accountabilities between the Department and the HHSs.

The unions are entitled to access workforce data relevant to their membership and the system has an obligation to provide it. This obligation could be reiterated in the Minister's Statement of Expectations. Equally, it could become an operating principle of networked model premised on contextual awareness and empowered execution.

Executive contracts

Almost every HHS raised concerns about the delegations and processes related to executive contracts. The HHB Act provides that while all HHSs can employ health executives,[87] the DG sets the terms and conditions of employment for all health service employees, including health executives.[88] The Department considers every executive contract to determine if the terms

[86] Slaughter, Anne-Marie (2017), *The chessboard and the web: strategies of connection in a networked world*, New Haven, Yale University Press, p. 65.
[87] *Hospital and Health Boards Act 2011* (Qld), s. 67.
[88] *Hospital and Health Boards Act 2011* (Qld), s. 45(g).

and conditions are consistent with the *Health Executive Service: Terms and Conditions of Employment* framework, with the DG required to approve any terms or conditions outside of this framework.

Similarly, while the Board is responsible for appointing the HSCE, the appointment has no effect until the Minister approves the appointment. These provisions apply to temporary appointments, including where the HSCE takes short periods of leave. The Minister has delegated power to approve appointments to the DG where the appointment is for less than four weeks to streamline the processes for short term leave.

HHSs reported that the lengthy delays resulting from these processes had adverse impacts on the leadership of the HHSs. The Department believed that these delays were often the result of the HHS failing to appropriately justify requests for special arrangements. These issues should be capable of resolution through discussions between the HSCEs and the Office of the Director-General.

Recommendations

21. That Health Service Chief Executives establish formal consultative mechanisms with senior officials of the health unions to discuss, and resolve where appropriate, issues of concern for both parties.

22. That the Department of Health and Hospital and Health Services jointly develop programs to improve the knowledge, skills and capabilities of HR and IR professionals and to assist line managers understand their industrial obligations.

23. That the *Hospital and Health Boards Regulation 2012* should be amended to provide that all non-executive health service employees are employed by the Director-General as system manager of Queensland Health, rather than by prescribed Hospital and Health Services.

24. That the Department of Health clarify the point of accountability for the ownership and provision of workforce data to unions as required under Enterprise Bargaining Agreements.

Procurement, including the governance of Health Support Queensland

Health Support Queensland governance

The HHB Act does not specify accountabilities or governance arrangements with respect to procurement. However, the Act does enable the DG to issue a Health Service Directive for the purchasing of goods and services under contracts and agreements entered into by the Department, other departments or other HHSs.[89]

Currently, HSQ leads the statewide procurement of goods and services (with the exclusion of ICT and infrastructure) for the Department and HHSs, primarily through establishing Standing Offer Arrangements (SOAs).

HSQ is a division of the Department. It has a diverse service delivery remit, covering strategic procurement and supply logistics, statewide pathology, biomedical technology services, forensic and scientific services, statewide pharmacy services, linen and laundry services for

[89] *Hospital and Health Boards Act 2011* (Qld), s. 47.

south-east HHSs, the Health Contact Centre (providing services such as the 13HEALTH and 13QUIT call centres), radiology support and statewide payroll services. It employs over 4,000 staff across Queensland with a budget of approximately $1.3 billion.

HSQ is led by a Chief Executive Officer (CEO) who reports directly to the DG and is a member of DLT and SLT. The CEO is supported by four executive committees (Safety Quality and People, Finance, Compliance and Risk, and Strategic Governance) which provide advice on matters relating to HSQ's performance, assurance and conformance.

HSQ provided the panel with a copy of HSQ's position paper on the future of HSQ,[90] which suggests there is an opportunity to improve the governance, and therefore performance of HSQ. The paper suggests that, as a service provider, HSQ would benefit from transitioning to being independent from the Department and governed by a board of directors, with a governing board seen to generally result in:

- more informed and considered strategic direction;
- independent monitoring and evaluation;
- greater accountability of executive management; and
- greater organisational credibility.

The position paper notes that HSQ is a service provider and its functions are more aligned with those of a HHS than the Department. The paper suggests HSQ has been structured to operate independently and therefore corporate functions are duplicated between the Department and HSQ. It also notes that the Hunter Review and a review by Queensland Treasury Corporation[91] have recommended that consideration be given to transitioning HSQ to a statutory body.

Many HHSs raised concerns about HSQ's performance, describing it as inefficient and unresponsive and lacking a service culture. Certainly, its relationships with the HHSs have been problematic. HHSs suggested it was too 'south east corner-centric' and did not have a good appreciation of the needs of more distant and rural and remote HHSs. The tension between value for money and the Government's local purchasing policy was not well managed.

HHSs' feedback on HSQ primarily related to the procurement services of HSQ. The HHSs were generally supportive of the statewide pathology services, which was described as a good system with lower costs than the distributed models in Victoria and New Zealand. The statewide payroll arrangements were supported. There was little commentary about its other functions. However, even in the areas regarded positively, it was argued that they could be further improved with more input from HHSs, as customers, into the governance.

HSQ was aware of the concerns about HSQ's performance and reputation but had a significant challenge to address its cultural issues. HSQ understood the need for better engagement with HSQ's customers.

Health Support Queensland's strategic procurement function

There is a Health Service Directive in place with respect to the use of the Department's contract and supply arrangements which applies to all HHS (the Procurement Directive).[92] Its purpose is to direct HHSs to use the Department's contract and supply arrangements, which are intended to provide reliable and best value for money procurement and logistics services across HHSs.

[90] Queensland Health (2019b), *Position Paper: HSQ Governance Options*, Brisbane, Queensland Government.
[91] Queensland Treasury Corporation (2018), *Procurement Rules of Engagement Project Final Report*, Brisbane, Queensland Government.
[92] *Procurement and Logistics – Use of Contract and Supply Arrangements Health Service Directive.*

The Procurement Directive is binding on all HHSs.[93] Hence, it should enable HSQ to make volume commitments and achieve the best possible prices in negotiations with suppliers, thereby delivering significant savings and efficiencies for the system. However, HSQ argues that while the Procurement Directive requires all HHSs to "procure a range of goods and services" from the list of contracts and supply arrangements specified, the phrase "a range of goods and services" is vague and, in practice, enables HHSs to exercise full purchasing discretion.

As a result of the concerns noted above with respect to HSQ's performance, HHSs are increasingly undertaking their own procurement, with some of the larger HHSs committing to resourcing and developing their own procurement capability. Central West is developing a relationship with Metro North to access its enhanced procurement capability. HSQ estimates that approximately 40 per cent of system procurement spend occurs 'off-contract'. While HSQ acknowledged that HHS purchasing discretion is vital for the procurement of goods and services for which there is a high degree of local specialisation and community benefit, it is concerned that 'off-contract' procurement significantly reduces the spend on SOAs, increasing the prices for smaller HHSs, inhibiting the realisation of system savings.

In principle, most HHSs agreed that a 'whole of Queensland Health' approach could deliver benefits of scale, which, if effective, has the potential to deliver significant savings. A number acknowledged, by way of example, that the whole-of-government energy contract had delivered real savings. However, there was a strong perception among some HHSs that they had been able to deliver far greater savings for their HHS by engaging external consultants to review procurement contracts, rather than working through HSQ.

As noted above, many of the regional and rural HHSs considered HSQ lacked an understanding of local context and noted that HSQ's contracts often failed to take account of transport costs, impacting on the savings generated for HHSs outside the south-east. Outposting of staff in some HHSs had enhanced understanding of local needs for those HHSs.

HHSs spoke positively of the results achieved through a partnership approach, pointing particularly to the role the cardiac clinical network played in delivering savings on procurement of cardiac supplies. HHSs noted that the success of procurement strategies is dependent on getting clinicians 'on board' with changes, which requires on the ground engagement with the clinicians. External consultants were seen to be more effective at this engagement than HSQ.

Findings

Currently, Queensland Health's procurement model and governance arrangements do not position the Queensland public health system to realise system scale savings and benefits. This position is unsustainable given the current and projected demand and funding pressures on the system.

The issues raised by stakeholders during the consultation phase are consistent with the findings of a joint project undertaken by the Boston Consulting Group and Queensland Treasury Corporation in 2018, which concluded that:

> *The Procurement Operating Model currently in place is ineffective, with unclear responsibilities, duplication and poor buying practices. HHSs are critical of the service provided centrally by the Strategic Procurement (SP) team and increasingly making independent procurement decisions. Together this is making it challenging for Queensland Health to deliver on the significant savings potential identified from procurement.*[94]

[93] *Hospital and Health Boards Act 2011* (Qld), s. 50.
[94] Queensland Treasury Corporation (2018), op cit., p. 1.

The project estimated that annual savings of between $180 million and $330 million per year could be realised from improving Queensland Health's procurement approach.

The Panel did not identify a compelling reason to establish HSQ as an independent statutory body at this time, noting statutory bodies are typically costly to establish and maintain. Given the budgetary pressures faced by the system, any changes to HSQ's governance should instead focus on ensuring it is performing its functions as efficiently and effectively as possible.

As a service provider, HSQ needs to be responsive and accountable to its customers, the HHSs. The DG should establish a Stakeholder Board tasked with advising on HSQ's procurement function. The Board should have representation from:

- an independent chair appointed by the DG;
- three HSCEs, with one each from the large, regional and rural HHSs;
- a Hospital and Health Board chair; and
- an independent procurement expert.

The Stakeholder Board should be tasked with developing a statewide Procurement Framework for Queensland Health that takes account of whole-of-government priorities with respect to procurement[95] and provides greater clarity about the roles of the HHSs and HSQ. The Procurement Framework should identify those categories of goods and services that should be procured by individual HHSs, and those that should be led by HSQ and/or a HHS with established procurement capability.

By way of example, perishables and regularly purchased non-clinical consumables and low-cost equipment should be the responsibility of each HHS, perhaps with benchmarked pricing done by HSQ. Medical consumables and high cost non-clinical equipment might be the responsibility of HSQ or one or more HHSs with acknowledged procurement capability. Clinically-led procurement though the clinical councils should play a significant role in determining the procurement arrangements for high cost medical equipment and specialist clinical supplies. Again, tasks could be assigned to HSQ or one or more HHSs acting on behalf of all HHSs. Utilities and single supply services and equipment would be best managed through HSQ. The Stakeholder Board should ensure that long term contracts are reviewed on an agreed cycle to ensure value for money.

It is important that HHSs are incentivised to participate in statewide procurement processes. The Board's functions should include recommending to the DG how savings resulting from efficiencies through the statewide procurement processes are directed.

While the HSQ CEO would continue to have a reporting relationship with the DG, the DG should direct the CEO to act on the Board's advice. The HSQ Stakeholder Board Chair would have a responsibility to advise the DG about matters relating to HSQ's procurement function and to report to the system about HSQ's performance function. This model should be underpinned by terms of reference and a governance framework that clearly set out the Stakeholder Board's role and its reporting arrangements across the system.

This model would reflect the relationship between HSQ as a service provider and its stakeholders, and be consistent with a networked public health system. It would strengthen accountability and responsiveness. HHSs would have 'skin in the game' which should drive a determination to deliver the benefits of scale in purchasing.

[95] See the *Queensland Procurement Policy 2018.* Government targets and commitments under the Policy include, for example, requiring the use of local contractors and manufacturers in significant Queensland Government infrastructure projects worth $100 million and above, wherever possible.

Recommendations

25. That Health Support Queensland should remain within the organisational structure of the Department of Health but the Chief Executive Officer should act on advice and direction from a Stakeholder Board whose membership includes an independent chair nominated by the Director-General, representatives of Hospital and Health Services (including Hospital and Health Board Chairs and Health Service Chief Executives), and an independent expert in procurement.

26. That the Stakeholder Board develop a Procurement Framework for Queensland Health that determines the categories of goods and services that should be procured centrally and locally. The Framework should ensure clinician leadership and engagement in procurement decisions relating to relevant high cost clinical equipment, goods and services to reduce variation in costs and deliver value for money to the Hospital and Health Services and the public health system.

27. That the Stakeholder Board ensure that long term contracts are reviewed on an agreed cycle to ensure value for money.

Management of ICT projects within budget and timeframe

Background

eHealth was established in 2015 in recognition of the growing importance of ICT in delivering healthcare.[96] Like HSQ, eHealth is a division of the Department, overseen by a CEO. eHealth's key functions are to:

- develop and provide advice on statewide eHealth innovation, strategy, planning, standards, architecture and governance;
- deliver clinical, corporate and infrastructure ICT programs in line with the eHealth vision and investment priorities; and
- provide modern ICT infrastructure and customer support.

The HHB Act is silent on the roles and responsibilities of the Department and the HHSs with respect to ICT.

Consultation feedback

Concerns were expressed about the need for better engagement between the HHSs and eHealth, with many HHSs considering eHealth needed to have more of a consumer approach. HHSs were concerned about the lack of transparency in eHealth's charges. eHealth noted that these charges are often out of its control, as they are passed on from third parties. However, HHSs noted the difficulties in managing these increasing costs, particularly where the HHS has limited say in when and how the costs are incurred.

Until recently, relationships with some HHSs had been strained, with a perception that eHealth did not value collaboration with the HHSs. More recently, relationships with eHealth had improved, particularly with the rollout of ieMR, where the HHSs commented that there had been good support not only from eHealth but also other HHSs.

eHealth noted it does not have full visibility across the system as it does not have data on the total investment in ICT across the system, nor knowledge of all applications used on

[96] Queensland Health (2017), *Department of Health Annual Report 2016/17*, Brisbane, Queensland Government, p. 19.

Queensland Health's systems. It also noted there is significant variability in the capability of the HHSs. eHealth noted the challenge of being responsible for a single ICT system, where individual HHSs can make their own decisions on the ICT applications used on the system. eHealth considered there could be benefits to the system in terms of consistency, economies of scale and security if eHealth had more visibility over the use of the Queensland Health network.

Findings

ICT is an expensive but critical enabler for the delivery on health services. It provides significant opportunities to improve access to, and the safety and quality of, those services particularly in rural and remote areas of a decentralised state. Community expectations and clinical innovations are driving investment in modern medical technologies.

While not wishing to oversimplify the critical role of eHealth, it is essentially a procurement and technical service provider to the HHSs, particularly for larger ICT projects such as ieMR implementation. eHealth has significant specialist expertise in a very complex and expensive environment. Like HSQ, eHealth acts as a government monopoly but the benefits of this centralised approach are generally accepted for statewide and larger ICT projects.

Arguably, the issues identified in consultation are the result of poor relationships and the existing governance arrangements across the system. A number of HHSs commented that the governance model could be improved with more HHS involvement. eHealth is a service provider to the HHSs and needs to be accountable to its customers. It needs to better understand its obligations as a monopolistic supplier.

A similar model to that suggested for HSQ would go some way to addressing these concerns. An ICT expert from outside of Queensland Health would be of value on an eHealth Stakeholders Board. Large ICT projects should have governance arrangements that involve and value the contribution of the HHSs.

Recommendation

28. That eHealth Queensland should remain within the organisational structure of the Department of Health, but the Chief Executive Officer should act on advice and direction from a Stakeholder Board whose membership includes an independent chair nominated by the Director-General, representatives of Hospital and Health Services (including Hospital and Health Board Chairs and Health Service Chief Executives) and an external member with ICT expertise.

NOT GOVERNMENT POLICY

Appendix 1: Terms of Reference

ADVICE REGARDING QUEENSLAND HEALTH'S GOVERNANCE FRAMEWORK

TERMS OF REFERENCE

1. Purpose

To prepare advice for the Minister for Health and Minister for Ambulance Services (the Minister) regarding Queensland Health's governance framework; in particular, the extent to which the powers, roles and responsibilities within the health system are most appropriately distributed to support achievement of the objectives of the *Hospital and Health Boards Act 2011* (the Act) and ensure Hospital and Health Boards (HHBs) are empowered to, and accountable for, implementing Queensland Government policies and priorities.

2. Background

The overarching governance framework for the delivery of publicly funded health services in Queensland is provided for in the Act.

On commencement of the Act, Queensland Health moved from a centralised system, to a federated system constituted by the Department of Health (the Department) and 16 independent Hospital and Health Services (HHSs) where:

- the Department is responsible for the overall management of Queensland's public health system and establishment of a consistent policy framework at a statewide level, and
- HHSs are responsible for the delivery of public sector health services as independent statutory bodies, governed by their own professional HHB and managed by a Health Service Chief Executive (HSCE).

The Minister provides leadership and direction for the health sector to create an environment that improves health service delivery. The Minister has administrative responsibility and is ultimately accountable for Queensland Health's performance.

The HHS structure has proven effective, allowing Queensland Health to deliver very strong performance in the face of increased service demand.

The current environment in which Queensland Health delivers public health services is also characterised by challenges such as:

- continual strong growth in service delivery demand and increasingly tighter budgetary conditions over the forward estimates,
- growth in service delivery demand creating a resultant demand for health infrastructure creation and renewal,
- nationally, a high degree of uncertainty around the future funding arrangements with the Commonwealth which is contributing to budget pressures,

- the need to implement government policies such as local procurement, best practice industrial relations, preventative health care, reduced variation and better value health outcomes, and
- significant variation in costs and outcomes between HHSs.

Being able to respond to these challenges requires a framework in which each part of the system – the Minister, the Director-General, the Department, HHBs and HSCEs – have the right powers, roles and responsibilities to optimise the overall functioning of the system.

3. Appointment

The Minister has engaged a panel of experts to prepare the advice sought within these Terms of Reference:

- Mr Jim McGowan AM – former Director-General, Queensland Government
- Dr Pradeep Philip, Partner, Deloitte Access Economics
- Professor Anne Tiernan – Dean (Engagement), Griffith Business School.

Secretariat support will be provided by the Office of the Director-General, Queensland Health.

4. Scope of advice sought

The advice is to consider areas critical to Queensland Health's ability to meet the needs of the community and implement government policy in a timely manner, when delivering public health services, including:

- Procurement (including the organisational governance of Health Support Queensland)
- Capital and asset management
- Industrial and human resources management
- Service planning
- Reducing variation in costs, structures and outcomes and improving value
- Managing capital projects within budget and timeframe, including IT projects.

In relation to each of these critical areas the advice will:

- assess and benchmark the decision-making processes and timeframes,
- consider the appropriateness of the decision-making processes and respective roles as between the Minister, the Director-General, the HHBs and the HSCEs, and
- consider how to strengthen the ability of HHBs to implement government policy and priorities.

The panel will make findings and recommendations in a written report to be provided to the Minister. The report will inform a Cabinet submission.

5. Powers of the panel

The panel may request Queensland Health employees to participate in informing the advice. However, participation by employees is not legislatively mandated.

The panel may invite submissions or information from external sources where it is relevant to these Terms of Reference.

At minimum, the panel is expected to consult with:

- The Minister
- The Director-General
- HHB Chairs
- HSCEs
- Unions representing Queensland Health employees
- Health consumers via Health Consumers Queensland.

6. Timeframe

The final written report is to be provided to the Minister within three months of the panel being appointed.

At least two weeks prior to the submission of the report, the panel will provide the Minister with a verbal briefing and/or draft report including recommendations with respect to their preliminary findings. Updates may occur at other times at the request of the Minister.

Appendix 2: List of stakeholders

The following stakeholders participated in the consultation process either by meeting with one or more Panel members or by providing written comments for the Panel's consideration:

Minister for Health and Minister for Ambulance Services
Queensland Health

- Director-General
- Deputy Director-General, Strategy, Policy and Planning
- Deputy Director-General, Clinical Excellence Division
- Deputy Director-General, Healthcare Purchasing and System Performance
- Deputy Director-General, Corporate Services Division
- Chief Health Officer and Deputy Director-General, Prevention Division
- Chief Executive Officer, Health Support Queensland
- Acting Chief Executive Officer, eHealth Queensland
- Commissioner, Queensland Ambulance Service
- Hospital and Health Service Board Chairs (or their representatives)
- Hospital and Health Service Chief Executives
- Executive Directors' Nursing and Midwifery Forum
- Executive Directors' Allied Health Forum
- Internal Auditors' Forum
- Chief Information Officers' Forum
- Chair of the Statewide Clinical Network
- Office of the Chief Nursing and Midwifery Officer
- Executive Director, Capital and Asset Services, Corporate Services Division
- Chief Human Resources Officer, Corporate Services Division

Clinician associations

- Queensland Clinical Senate
- Australian Medical Association Queensland
- Rural Doctors Association of Queensland

Unions representing Queensland Health employees

- Queensland Nurses and Midwives' Union
- Australian Salaried Medical Officers' Federation of Queensland
- Together Union
- Australian Workers' Union
- United Voice
- Electrical Trades Union

Health Consumers Queensland
Statewide Consumers Network
Office of the Premier
Public Service Commissioner

Appendix 3: Interjurisdictional scan

	Queensland	New South Wales	Victoria	South Australia	Western Australia	Tasmania	Northern Territory	Australian Capital Territory
Legislation	*Hospital and Health Boards Act 2011*	*Health Services Act 1997*	*Health Services Act 1988*	*Health Care Act 2008* Note: this Act will be amended by the Health Care (Governance) Amendment Bill 2018, which commences on 1 July 2019.	*Health Services Act 2016*	*Tasmanian Health Service Act 2018*	*Health Services Act 2014*	*Health Care Act 1993*
Governance framework	Queensland's public sector health system operates under a devolved federated model, implemented in 2012. Queensland Health comprises: • the Department of Health • 16 independent Hospital and Health Services. The Hospital and Health Services are established as statutory bodies under the *Hospital and Health Boards Act 2011*. They are the principal providers of public sector health	In 2011, the NSW health system underwent significant reform designed to deliver greater local decision-making. The 15 Local Health Districts and three Specialty Networks (focused on children's and paediatric services, justice health and mental health services, and the provision of public health services provided by St Vincent's Hospital) are responsible for managing all aspects of hospital and health service delivery for their local district or speciality network. Local Health Districts and Specialty	Since 2003, Victoria's health system has had a devolved governance model. There are over 80 hospital and health services in Victoria. Health services are established as statutory bodies, overseen by boards of directors appointed by Governor in Council, on the Minister's recommendation. The Health Services Act categorises health services into various types: • public health services • public hospitals • multipurpose services (in	South Australia is reforming the governance of SA Health. The reforms will establish ten Local Health Networks, each with its own governing board: • a statewide Women and Children's Health Network • three metropolitan Networks • six regional Networks. The six regional Networks replace Country Health SA Local Health Network. The Department for Health and Wellbeing will continue to have responsibility for the overall management and strategic direction	On 1 July 2016, Western Australia introduced a devolved governance model for the WA health system, with the Department as system manager and Health Service Providers as separate statutory authorities. Six Health Service Providers have been established. Five are governed by Health Service Boards, with members appointed by the Minister:[101] • East, West and North Metropolitan Health Services • Child and Adolescent Health Service • WA Country Health Service.	On 1 July 2018, Tasmania introduced new governance arrangements designed to ensure closer collaboration to improve service delivery and support statewide coordination and management of health services. Under the new model the Tasmanian Health Service (THS) remained a separate legal entity but the Governing Council and Chief Executive Officer role were abolished. THS now reports directly to the Secretary of the Department of Health.[104]	The Northern Territory health system operates under a hybrid model between devolution and centralisation. The Northern Territory Health system comprises: • the Department of Health • two Health Services. The Health Services are established as statutory bodies under the *Health Services Act 2014* and are the principal providers of public health services. The Department of Health has a 'system manager' role with responsibility for Territory-wide planning, managing	The ACT was exempted from the requirement to establish Local Health Networks as part of the National Health Reform Agreement.[106] Until recently, ACT had the most centralised health system in Australia, with the Canberra Hospital and Health Services being a division of the ACT Health Directorate.[107] On 1 October 2018, ACT Health transitioned to a new governance structure, comprising two distinct agencies under the

[101] Western Australian Department of Health, 'Health Reform', https://ww2.health.wa.gov.au/Improving-WA-Health/Health-reform (accessed May 2019).
[104] Tasmanian Department of Health and Human Services (2018), *Annual Report 2017-18*, Hobart, Tasmanian Government, p. 9.
[106] Chief Minister's Directorate (2018), *New health governance arrangements for the ACT*, Canberra, ACT Government, p. 6.
[107] Ibid, p. 6.

	Queensland	New South Wales	Victoria	South Australia	Western Australia	Tasmania	Northern Territory	Australian Capital Territory
	services and are governed by boards appointed by the Minister for Health and Minister for Ambulance Services. The Department of Health has a 'system manager' role and is responsible for statewide planning, managing statewide industrial relations and major capital works, monitoring the performance of Services, and issuing Health Service Directives.	Networks are established as statutory corporations under the *Health Services Act 1997*. They are governed by boards appointed by the Minister for Health. The Ministry for Health was significantly reduced following the 2011 reforms, consistent with the devolved model of health service governance. The Ministry is responsible for, relevantly, statewide planning, purchasing and performance monitoring of hospitals and health services.[97]	essence, small rural hospitals), and • early parenting centres.[98]	of the South Australian health system.[99] The governing boards will become fully operational on 1 July 2019. The reforms are intended to support local decision-making. Governing board members are appointed by the Minister.[100]	Health Support Services is established as a Health Service Provider to provide shared services to the Department and Health Service Providers. Health Support Services is a chief executive governed provider – it is not overseen by a board.[102] The Department of Health is the system manager, responsible for the overall management, performance and strategic direction of the WA public health system to ensure the delivery of high-quality, safe and timely health services.[103]	The Department has a system manager role. THS's role is to provide and coordinate public sector health services and health support services across Tasmania. THS operates as a single statewide service through a network of hospitals, primary and community care services, aged care services and mental health services across three regions.[105]	capital works, developing system-wide policy, system performance reporting and issuing Health Service Directives. In 2017, the Northern Territory streamlined its health governance arrangements to improve accountability across the system and reduce costs. The boards of the two Health Services were abolished and replaced with interim Service Administrators who will fulfil the functions of the Boards until the *Health Services Act 2014* is amended. Each Health Service now reports directly to the Chief Executive Officer of the Department of Health through its respective Chief Operating Officer. Health Advisory Committees have been established for each Health Service to advise the	Administrative Arrangements: • ACT Health Directorate, which is responsible for stewardship of the system, developing strategies and setting direction for the system. • Canberra Health Services, which is focused on the delivery of high quality, safe, effective, person centred care.[108] Canberra Health Services is overseen by a Chief Executive Officer.

[97] New South Wales Ministry of Health, 'Governance Review', https://www.health.nsw.gov.au/healthreform/Pages/governance-review.aspx (accessed May 2019).
[98] Victorian Department of Health and Human Services (2017), The Director's Toolkit: a resource for Victorian health service boards, Melbourne, Victorian Government, p. 12.
[99] SA Health, 'About the SA Health governance reforms', https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/governance+reforms/about+the+reforms (accessed May 2019).
[100] SA Health, 'SA Health Governance reforms', https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/governance+reforms (accessed May 2019).
[102] *Health Services (Health Service Providers) Order 2016* (WA), part 7.
[103] Western Australian Department of Health (2016), *Health Reform Fact Sheet: The Role of the Department of Health*, Perth, Western Australian Government.
[105] Tasmanian Health Service (2018), *Ministerial Charter*, Hobart, Tasmanian Government, p. 3.
[108] Australian Capital Territory Health Directorate, 'Organisational Structures', https://www.health.act.gov.au/about-our-health-system/organisation-structures (accessed May 2019).

	Queensland	New South Wales	Victoria	South Australia	Western Australia	Tasmania	Northern Territory	Australian Capital Territory
							Chief Operating Officers and undertake local community engagement and consultation. The Department of Health has also established a Clinical Senate to advise on system-wide policies and plans.	
Infrastructure	The Director-General is responsible for managing major capital works.[109] Hospital and Health Services are responsible for maintaining land, buildings and assets they own[110] and undertaking minor capital works, and major capital works approved by the Director-General, in the health service area.[111]	Under the *Health Administration Act 1982*, the Secretary is given corporate status as the Health Administration Corporation for the purpose of certain statutory functions. Health Infrastructure is established under the Health Administration Corporation. Health Infrastructure is responsible for the delivery of NSW Health's major capital works. Health Infrastructure is overseen by a board	In July 2017, the Victorian Health and Human Services Building Authority was established to lead planning, management and delivery of major health infrastructure.[113]	The Infrastructure Directorate, within the Department of Health and Wellbeing, supports the Department and Local Health Networks in, relevantly: • planning and evaluating health infrastructure requirements • managing SA Health's capital program including delivery of major projects • providing executive leadership for SA Health's built assets.	The Department's Director-General is responsible for commissioning and delivering capital works and maintenance works for public health service facilities[114].	In its system manager role, the Department is responsible for planning and purchasing capital resources.[115] Capital works for the THS are delivered by Asset Management Services within the Department and the Royal Hobart Hospital Redevelopment team.[116] The Department also provides shared services, including asset management, for THS under a shared	The Chief Executive Officer is responsible for the planning, approval and management of capital works.[118] Services may undertake capital works approved by the Department.[119] The Department of Health provides infrastructure services for the health system.[120] The Chief Executive Officer is advised by the NT Health Capital Asset Management	Capital works delivery in ACT Health occurs under the administration of Health Infrastructure Services Division within the ACT Health Directorate.[122] The Business Support and Infrastructure Committee provides oversight and leadership for ACT Health's facilities management and infrastructure investment, ensuring it appropriately

[109] *Hospital and Health Boards Act 2011* (Qld), s. 8(3)(c).
[110] *Hospital and Health Boards Act 2011* (Qld), s.19(h).
[111] *Hospital and Health Boards Act 2011* (Qld), s.19(g).
[113] Victorian Health and Human Services Building Authority, 'About Us', https://vhhsba.vic.gov.au/about-us (accessed May 2019).
[114] *Health Services Act 2016* (WA), s.20(1)(g).
[115] Tasmanian Department of Health and Human Services, op cit., p. 14.
[116] Ibid, p. 53.
[118] *Health Services Act 2014* (NT), s.15(k).
[119] *Health Services Act 2014* (NT), s.18(f).
[120] Northern Territory Department of Health (2018), *Annual Report 2017-18*, Darwin: Northern Territory, p.28.
[122] Australian Capital Territory Health Directorate (2018), *Annual Report 2017-18*, Canberra, Australian Capital Territory Government, p.246.

	Queensland	New South Wales	Victoria	South Australia	Western Australia	Tasmania	Northern Territory	Australian Capital Territory
		appointed by the Secretary.[112]				services arrangement.[117]	Committee comprising relevant Departmental staff and the Chief Operating Officers of the Health Services.[121]	supports the achievement of ACT Health's strategic and operational objectives.[123]
Employment arrangements	The Director-General is responsible for: • managing statewide industrial relations including the negotiation of certified agreements and making applications to make or vary awards[124] • establishing the conditions of employment for	A Local Health District cannot employ staff.[129] Staff are employed in the NSW Health Service.	Public hospitals, public health services and multipurpose services are independent legal entities and employ their own staff.	The 'employing authority' under the Act is the Chief Executive of the Department unless the Governor proclaims another entity as an employing authority for particular employees.[130] The employing authority is responsible for employing staff at incorporated hospitals.[131]	A Health Service Provider may employ and manage employees for and on behalf of the State.[132]	THS staff are employed by the Department under the *State Service Act 2000*. THS may make arrangements with the Secretary of the Department of Health, for State Service Officers, or State Service Employees, of the Department to be made available to THS for the purpose of THS.[133]	The Chief Executive Officer is responsible for providing Health Services with appropriate staff and corporate services to allow the Services to perform their functions and contributing to the negotiation of Territory-wide industrial agreements for the terms and conditions of employees (as required by the Office of the Commissioner	Canberra Health Services is a separate agency under the Administrative Arrangements but is not an independent statutory body.

[112] New South Wales Ministry of Health (2018), *Annual Report 2017-18*, Sydney, New South Wales Government, p. 5.
[117] Tasmanian Department of Health and Human Services, op cit., p. 16.
[121] Northern Territory Department of Health (2018), op cit., p. 91.
[123] Australian Capital Territory Health Directorate (2018), op.cit., p.17.
[124] *Hospital and Health Boards Act 2011* (Qld), s. 45(f)
[129] *Health Services Act 1997* (NSW), s. 22(2).
[130] *Health Care Act 2008* (SA), s 3.
[131] *Health Care Act 2008* (SA), s 34.
[132] *Health Services Act 2016* (WA), s. 140.
[133] *Tasmanian Health Service Act 2018* (Tas), s. 23.

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	health service employees [125] • employing staff in the Department, including to work for Hospital and Health Services not prescribed by regulation. [126] Hospital and Health Services can employ health executives and senior health employees. [127] Services prescribed by regulation may also employ other health service employees. [128] There are currently eight Services prescribed as employers.			The Local Health Networks have not been declared to be employing authorities.		A person who was, immediately before the commencement of the Act, an employee within the meaning of the Tasmanian Health Organisations Act 2011 is to be taken to be a person made available under s.23 to the THS for the purposes of the THS, until the Secretary determines otherwise or the person ceases to be a State Service officer or a State Service employee, as the case may be.	for Public Employment).[134] The Chief Operating Officers of Health Services are public sector employees.[135]	

[125] *Hospital and Health Boards Act 2011* (Qld), s. 45(g)
[126] *Hospital and Health Boards Act 2011* (Qld), s. 45(e)
[127] *Hospital and Health Boards Act 2011* (Qld), s. 20(3)
[128] *Hospital and Health Boards Act 2011* (Qld), s. 20(4)
[134] *Health Services Act 2014* (NT), s. 34.
[135] *Health Services Act 2014* (NT), s. 30.

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Procurement	The Act does not specify responsibilities with respect to procurement. However, it enables the Director-General to issue a binding Health Service Directive for the purchase of goods and services under contracts and agreements entered into by the Department, other departments or Hospital and Health Services.[136] Health Support Queensland (a division of the Department of Health), provides frontline support services across the Queenslandpublic health, including procurement and supply services. These include strategic procurement,	Under the *Health Administration Act 1982*, the Secretary is given corporate status as the Health Administration Corporation for the purpose of certain statutory functions. HealthShare NSW is established under the Health Administration Corporation.[137] HealthShare NSW is responsible for procurement functions. The Secretary has delegated functions to the HealthShare Board. [138] The HealthShare Board includes senior representatives from Local Health Districts, the Ministry of Health and independent members with commercial experience. The board's functions are defined in the Secretary's instrument of delegation. [139]	Health Purchasing Victoria (HPV) is established under the Health Services Act. Its functions include: • supplying or facilitating access to the supply of good and services to public hospitals and other health services on best value terms • to monitor public hospitals' compliance with purchasing policies and HPV directives and report irregularities to the Minister.[140] HPV is legislatively obliged to have regard to matters including: • clinical needs of patients • the effect of tendering and contracting processes on the viability of small and medium-sized businesses	The Procurement Supply Chain Management Directorate within the Department for Health and Wellbeing leads procurement practices across SA Health and is responsible for the processes, practices and services that underpin procurement and supply chain operations across SA Health. .	Health Support Services is established as a Health Service Provider under section 32 of the *Health Services Act 2016* (WA). Health Support Services is governed by a chief executive, who is responsible to the Director-General.[142] Health Support Services' functions include: • ICT services • Procurement and supply • Employee and payroll services • Financial services including accounts payable.	In its system manager role, the Department is responsible for contract management. It also provides shared services, including procurement services, for THS under a shared services arrangement.[143]	The Department of Health provides strategic procurement and contracting services for the health system.[144] The Chief Executive Officer is advised by the NT Health Strategic Procurement Governance Committee comprising relevant Departmental staff and the Chief Operating Officers of the Health Services.[145]	Corporate Services Division within the ACT Health Directorate is responsible procurement and contract management.

[136] *Hospital and Health Boards Act 2011* (Qld), s.47(2)(d).
[137] New South Wales Ministry of Health (2018), op cit., p. 6.
[138] New South Wales Health Administration Corporation (2012), *Delegation of Functions: HealthShare NSW Board*, Sydney, NSW Government.
[139] HealthShare NSW, 'Our Governance', http://www.healthshare.nsw.gov.au/about/governance (accessed May 2019).
[140] *Health Services Act 1988* (Vic), s. 131.
[142] Queensland Health (2019b), op cit., p.12.
[143] Tasmanian Department of Health and Human Services (2018), op cit., p. 16.
[144] Northern Territory Department of Health (2018), op cit., p. 28.
[145] Northern Territory Department of Health (2018), ibid, p. 90.

	Queensland	New South Wales	Victoria	South Australia	Western Australia	Tasmania	Northern Territory	Australian Capital Territory
	warehousing, distribution and supply and medical and non-medical consumables. Hospital and Health Services also directly procure some goods and services.	In addition to procurement, HealthShare NSW's functions include: • linen services • food and patient support services • payroll • contact centres • financial shared services. Under section 126B of the *Health Services Act 1997*, the Health Secretary may provide services: • to support the public health system and public health organisations and the public hospitals they control • to enable the coordinated provision of health services involving more than one public health organisation or on a statewide basis. The Secretary may delegate their functions under this provision to a person or appointed body. The Secretary may appoint members of an appointed body, such as a board.	• local employment growth or retention.[141] HPV can develop purchasing policies. Public hospitals must comply with these policies unless exempted. HPV comprises members appointed by Governor in Council, on the Minister's recommendation. The membership must include: • a chair with expertise in purchasing, logistics or supply chain management • a CEO of a public health service • a CEO of a public hospital • a Treasury department officer and a Department of Health and Human Services officer.					

[141] *Health Services Act 1988* (Vic), s. 133.

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Innovation	A Rapid Results Program within the Department of Health is coordinating the acceleration and scaling across the system of 27 projects across eight Ministerial priority areas.	The Agency for Clinical Innovation works with clinicians, consumers and managers to design and promote better healthcare in NSW. The agency works with other public health organisations to improve healthcare by rapidly developing and spreading new ways of caring for patients which represent evidence-based best practice.[146] The agency is a board governed statutory health corporation established under section 41 of the *Health Services Act 1997*. The agency's role and functions are set out under a Ministerial Determination made under section 53 of the Act.[147]	Better Care Victoria supports timely and appropriate access to the highest quality care for Victorians through the identification, scaling and embedding of innovative practice across the Victorian health system. It funds healthcare provider-led innovation and improvement projects and provides a platform for sharing knowledge.[148] Better Care Victoria was established following recommendations made by the 'Travis Review: Increasing the capacity of the Victorian public hospital system for better patient outcomes' which found "*… there is no shortage of good ideas. What is missing is the capacity to harness these ideas*	The SA State Government has committed to establishing a Commission on Excellence and Innovation in Health. The commission will provide leadership and advice on clinical best practice with a focus on: • maximising health outcomes for patients • improving care and safety • monitoring performance • championing evidence-based practice and clinical innovation • supporting clinical collaboration.[150] A review of similar interstate and overseas organisations is underway, to inform the design of a Commission.[151]	The Sustainable Health Review recommended: • the establishment of local innovation units that support a local culture of improvement, experimentation and entrepreneurism where staff are empowered and encouraged to co-create new and innovative solutions with consumers • establish a central unit to provide advice and guidance on innovation (such as marketing, legal) and facilitates sharing and connecting of innovative work across the health system.[152]	Health Services Innovation Tasmania (HSI Tas) is a stand-alone statewide research and implementation centre at the University of Tasmania which works with the Tasmanian Government to implement clinical redesign across the Tasmanian hospital system.[153] Its key objectives are to: • build capacity and capability for clinical redesign in Tasmania • enable clinicians and health system managers to identify and drive changes to hospital and healthcare processes • identify and implement clinical redesign projects • contribute to skills knowledge and transfer in clinical		

[146] New South Wales Ministry of Health (2009), *Determination of functions: Agency of Clinical Innovation*, Sydney, New South Wales Government.
[147] Ibid.
[148] Victorian Government, 'What does Better Care Victoria do?', https://www.bettercare.vic.gov.au/about/what-does-bcv-do (accessed by May 2019).
[150] SA Health, 'Commission on Excellence and Innovation in Health', https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/governance+reforms/commission+on+excellence+and+innovation+in+health (accessed May 2019).
[151] SA Health, 'Commission on Excellence and Innovation in Health', https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/governance+reforms/commission+on+excellence+and+innovation+in+health (accessed May 2019).
[152] Kruk et al (2019), op cit., Recommendation 28, p. 23.
[153] University of Tasmania, 'Health Services Innovation Tasmania', http://www.healthinnovation.tas.edu.au/ (accessed May 2019).

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			and amplify the potential to achieve better patient outcomes through a whole-of-system focus on delivering these outcomes".[149]			redesign to help develop a clinical redesign culture within Tasmania. The program is managed by HIS Tas and involves THS and other healthcare providers and planners across Tasmania.		

[149] Travis, Douglas (2015), *Travis Review: Increasing the capacity of the Victorian public hospital system for better patient outcomes*, Melbourne, Victorian Government, p. 7.

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Other relevant provisions		Section 31 of the Health Services Act – a local health district may establish, close, or cease to provide any hospital, health institution, health service or health support service under its control but, before doing so, must notify the Health Secretary of the decision.	The Health Services Act provides that, in performing its functions and exercising its powers, the board and chief executive officer of a public hospital, public health service and multipurpose service must have regard to: • the needs and views of patients and other users of health services • the need to ensure that the public hospital uses its resources in an effective and efficient manner, and • the need to ensure that resources of the Victorian health sector generally are used effectively and efficiently.[154] The board of a public hospital, public health service and multipurpose service must monitor the performance of the CEO, including through at least one formal assessment per year.[155]			Section 4 of Tasmanian Health Service Act provides that the Minister must issue a Ministerial Charter that specifies the Minister's broad policy expectations for the Secretary of DHHS and the THS.	Section 12(3) of the Health Services Act provides that, although governed independently of each other, and operating independently from the Department, each Service has a responsibility to cooperate with each other Service and the Department to ensure that public health services across the Territory are provided in an integrated way. Section 27(2)(b) of the Health Services Act provides that the Minister may give written direction to the Board for a Service in order to ensure provision of health services across the Territory in accordance with Territory Government policies and the requirements of national health agreements to which the Territory is, from time to time, a party *(to be repealed on commencement of the Health Services Amendment Act 2018).* Section 71(2) of the Health Services Act provides that the	

[154] *Health Services Act 1988* (Vic), ss.33(2B), 40I(2), 65S(4), 65XB(4), 115E(2A) and 115JC(2).
[155] *Health Services Act 1988* (Vic), ss.33(2)(f), 65S(2)(f) and 115E(2)(i).

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							required skills and experience of members of the Board include expertise, knowledge or experience in Aboriginal health issues *(to be repealed on commencement of the Health Services Amendment Act 2018).*	

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Recent reviews			*Targeting zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care* was commissioned by the Minister for Health following a cluster of avoidable perinatal deaths at Djerriwarrh Health Services.[156] The review considered how the Department oversees and supports quality and safety of care across the Victorian hospital system. The Victorian Government accepted all recommendations in principle.[157]		In June 2017, the Government of Western Australia announced the Sustainable Health Review to prioritise the delivery of patient-centred, high quality and financial sustainable healthcare across the State. The Final Report makes 30 recommendations which seek to drive a cultural and behavioural shift across the health system.[158] The *Review of Safety and Quality in the WA Health system: a strategy for continuous improvement* was commissioned following the reforms to devolve governance of WA's health system.[159]	Tasmania embarked on a significant reform program subsequent to the Delivering Safe and Sustainable Clinical Services White Paper (2015) which concluded that Tasmania should have a single statewide system with facilities and people networked to achieve high quality safe and efficient services. As part of the reforms three separate regionally-based statutory public sector health organisations were merged in 2015 to form a single statutory Tasmanian Health Service governed by a Governing Council and managed by a Chief Executive Officer. In 2018, further reforms resulted in the passage of the Tasmanian Health Service Act 2018 which provides the current model.		

[156] Duckett, Stephen et al (2016), *Targeting zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*, p. vii.
[157] Victorian Department of Health and Human Services (2016), *Better, Safer Care: Delivering a world-leading healthcare system*, Melbourne, Victorian Government, p. 6.
[158] Western Australian Department of Health, 'Sustainable Health Review: Final Report released', https://ww2.health.wa.gov.au/Improving-WA-Health/Sustainable-health-review (accessed May 2019).
[159] Mascie-Taylor, Hugo & Hoddinott, John (2017), op. cit.

Appendix 4: *Hospital and Health Boards Act 2011* – Guiding principles, functions of the Department and Hospital and Health Services and Ministerial responsibilities

Guiding principles

Section 5 provides that the object of the Act is to establish a public sector health system that delivers high quality hospital and other health services to people in Queensland having regard to the principles and objective of the national health system. This is mainly achieved by:

- strengthening local decision-making and accountability, local consumer and community engagement, and local clinician engagement;
- providing for Statewide health system management including health system planning, coordination and standard setting; and
- balancing the benefits of local and system-wide approaches.

Section 13 of the Act sets out the principles intended to guide the achievement of the Act's objective:

- the best interests of users of the public sector health services should be the main consideration in all decisions and actions taken under this Act;
- there should be a commitment to ensuring quality and safety in the delivery of public sector health services;
- providers of public sector health services should work with providers of private sector health services to achieve coordinated, integrated health service delivery across both sectors;
- there should be responsiveness to the needs of users of public sector health services about the delivery of public sector health services;
- information about the delivery of public sector health services should be provided to9 the community in an open and transparent way;
- there should be a commitment to ensuring that places at which public sector health services are delivered are places at which:
    - employees are free from bullying, harassment and discrimination; and
    - employees are respected and diversity is embraced; and
    - there is a positive workplace culture based on mutual trust and respect;
- there should be openness to complaints from users of public sector health services and a focus on dealing with the complaints quickly and transparently;
- there should be engagement with clinicians, consumers, community members and local primary healthcare organisations in planning, developing and delivering public sector health services;
- opportunities for research and development relevant to the delivery of public sector health services should be promoted; and
- opportunities for training and education relevant to the delivery of public sector health services should be promoted.

Hospital and Health Services

Section 19 of the Act provides that the main function of a Hospital and Health Service (HHS) is to deliver the hospital services, other health services, teaching, research and other services stated in the service agreement for the HHS. It also provides that the other functions of a HHS are:

- to ensure the operations of the HHS are carried out efficiently, effectively and economically;
- to enter into a service agreement with the Director-General of the Department;
- to comply with the health service directive and health employment directives that apply to the HHS;
- to contribute to, and implement, statewide service plans that apply to the HHS and undertake further service planning that aligns with the statewide plans;
- to monitor and improve the quality of health services delivered by the HHS, including, for example, by implementing national clinical standards for the HHS;
- to develop local clinical governance arrangements for the HHS;
- to undertake minor capital works, and major capital works approved by the Director-General, in the health service area;
- to maintain land, buildings and other assets owned by the HHS;
- for a prescribed HHS, to employ staff under this Act;
- to cooperate with other providers of health services, including other HHSs, the Department and providers of primary healthcare, in planning for, and delivering, health services;
- to cooperate with local primary healthcare organisations;
- to arrange for the provision of health services to public patients in private health facilities;
- to manage the HHS's performance against the performance measures stated in the service agreement;
- to provide performance data and other data to the Director-General;
- to consult with health professionals working in the HHS, health consumers and members of the community about the provision of health services;
- other functions approved by the Minister;
- other functions necessary or incidental to the above functions.

Department of Health

Section 45 of the Act provides that the functions of the Director-General of the Department are:

- to provide strategic leadership and direction for the delivery of public sector health services in the State;
- to promote the effective and efficient use of available resources in the delivery of public sector health services in the State;
- to develop statewide health service plans, workforce plans and capital works plans;
- to manage major capital works for proposed public sector health service facilities;
- to employ staff in the department, including to work for HHSs other than prescribed HHSs;
- to manage statewide industrial relations, including the negotiation of certified agreements, and making applications to make or vary awards;
- to establish the conditions of employment for health service employees, including issuing health employment directives;
- to deliver specialised health services;
- to arrange for the provision of health services to public patients in private health facilities;
- to develop and issue health service directives to apply to the HHSs;
- to enter into service agreements with the HHSs;
- to provide support to HHSs;
- to monitor and promote improvements in the quality of health services delivered by HHSs;
- to monitor the performance of HHSs, and take remedial action when performance does not meet the expected standard;

- to receive and validate performance data and other data to the Commonwealth, or an entity established under an Act of the Commonwealth;
- other functions given to the Director-General under this Act or another Act.

Minister's powers and responsibilities

The HHB Act provides that the Minister is responsible for:

- recommending appointments to Boards;[160]
- recommending the appointment of a chair and deputy chair of a Board;[161]
- suspending a Board member,[162] or recommending to Governor in Council that the Board member be removed;[163]
- recommending to Governor in Council that a HHS's Board be dismissed and an administrator be appointed to run the HHS;[164]
- approving a Board's appointment of a HSCE for the service;[165]
- establishing an ancillary board to give advice to a Hospital and Health Board in relation to a particular hospital, health service or part of the State.[166]

The Minister may:

- give directions to a HHS about any matter relevant to the performance of its functions, if satisfied this is necessary in the public interest;[167]
- appoint an advisor to a Board to assist the Board to improve either the Board or the HHS's performance.[168]

[160] See *Hospital and Health Boards Act 2011* (Qld), ss. 23 and 24A. Board members are appointed by Governor in Council, on the Minister's recommendation (s. 23). The Minister can also make a temporary appointment to a Board, where this is necessary to ensure the Board is properly constituted (s. 24A).
[161] *Hospital and Health Boards Act 2011* (Qld), s. 25. Governor in Council must appoint the chair and deputy chair, on the Minister's recommendation.
[162] *Hospital and Health Boards Act 2011* (Qld), s. 27A.
[163] *Hospital and Health Boards Act 2011* (Qld), s. 28.
[164] *Hospital and Health Boards Act 2011* (Qld), s. 275.
[165] *Hospital and Health Boards Act 2011* (Qld), s. 33.
[166] *Hospital and Health Boards Act 2011* (Qld), s. 43A.
[167] *Hospital and Health Boards Act 2011* (Qld), s. 44. However, the Minister cannot give a direction about the health service to be provided to a particular person, or the employment of a particular person.
[168] *Hospital and Health Boards Act 2011* (Qld), s. 44A.