

Health Consumers
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Summary of the *Health and Hospitals Network Act 2011*
December 2011

The following is a summary by Health Consumers Queensland (HCQ) of the *Health and Hospitals Network Act 2011* (the Act) passed by the Queensland Parliament on 13 October 2011.

The Act is intended to take full effect from 1 July 2012 and will repeal the *Health Services Act 1991* (Qld). It also amends the *Tobacco and Other Smoking Products Act 1998* (Qld) to ban smoking product displays in retail settings.

The Act's object is to establish a public sector health system that delivers high quality hospital and other health services to persons in Queensland having regard to the principles and objectives of the national health system. Significantly, the regulations under the Act will establish 17 Local Health and Hospital Networks (LHHNs) to deliver public sector hospital and other health services in Queensland, thereby devolving operational management for public hospitals to the local level.

The Act implements the national health and hospital reforms agreed under the Council of Australian Government's August 2011 *National Health Reform Agreement*. The Agreement will deliver major reforms to the funding, delivery and organisation of health and aged care across Australia, and establishes the shared intention of the Commonwealth, State and Territory Governments to partner to improve consumer health outcomes and ensure the Australian health system's sustainability.

In July 2011 HCQ provided a comprehensive submission to Queensland Health in relation to the Health and Hospitals Network Bill 2011, containing consumer feedback on the proposed legislation. The submission can be accessed at: http://www.health.qld.gov.au/hcq/publications/sub_hhnbill2011.pdf . A number of HCQ's recommended amendments relating to the Act's guiding principles, protocols with Medicare Locals and engagement strategies were adopted by the Queensland Parliament. HCQ's recommendations and the amendments adopted in the Act are detailed in Attachment A.

To support the implementation of the reforms, the Director-General of Queensland Health will 'establish a strategic advisory group comprising eminent persons in a range of disciplines relevant to the reforms'. The Minister for Health has also requested HCQ work with Health Service Districts as they transition to LHHNs to support the development of 17 Consumer and Community Engagement Strategies by networks, as required under the Act. Further information about HCQ's Consumer and Community Engagement work with Districts can be accessed at: http://www.health.qld.gov.au/hcq/cce_page_Aug11.asp . HCQ will continue to work with Queensland Health as the Act is implemented.

HCQ has endeavoured to summarise the Act's provisions that are likely to be of interest to Queensland health consumers while remaining faithful to its overall content and wording. The Act has over 300 sections and three schedules. The Act, Explanatory Notes and second reading speech can be accessed at: <http://www.legislation.qld.gov.au/LEGISLTN/ACTS/2011/11AC032.pdf>

1. Overview of Act, Object and Guiding Principles

The *Health and Hospitals Network Act 2011* (the Act) was passed by the Queensland Parliament on 13 October 2011 and is **proposed to be fully operational from 1 July 2012**. This Act repeals the *Health Services Act 1991* (Qld) which, until 1 July 2012, governs the organisation, management and delivery of public health services in Queensland. Significantly, the Act:

- Establishes 17 autonomous **Local Health and Hospital Networks** (LHHNs/Networks) under regulation to replace Health Service Districts, managed by Governing Councils responsible to the Minister for Health for its Network's performance.
- Establishes **Queensland Health as the systems manager** with a focus on system-wide policy and planning to ensure consistent service delivery statewide.
- Requires LHHNs to have **consumer, community and clinician engagement strategies**.

In his Second Reading Speech the Minister for Health stated '*By emphasising local accountability and decision-making, it is expected that the new networks will have both flexibility and incentive to innovate and to pursue quality and efficiency. The new networks will also be required to have strong clinician, consumer and community engagement processes in place to ensure that their decisions are responsive to local needs and priorities*'.

Object

The **object of the Act** is to establish a public sector health system that delivers high quality hospital and other health services to persons in Queensland having regard to the principles and objectives of the national health system (section 5).

This object is mainly achieved by balancing the benefits of strengthened local decision-making and accountability and local consumer, community and clinician engagement with the benefits of State-wide health system management including health system planning, coordination and standard setting. The Act also recognises and gives effect to the principles and objectives of the national health system (section 4).

Guiding principles

The guiding principles (section 13) are intended to guide the achievement of the Act's object. They include:

- (a) *the best interests of users of public sector health services should be the main consideration in all decisions and actions under this Act;*
- (b) *there should be a commitment to ensuring quality and safety in the delivery of public sector health services;*

(c) 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;

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

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

...

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

(h) there should be engagement with clinicians, consumers, community members and local primary healthcare organisations in planning, developing and delivering public sector health services;

...

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

Establishment of Local Health and Hospital Networks

The primary purpose of the Act is to establish **Local Health and Hospital Networks** to deliver public sector hospital and other health services in Queensland. LHHNs are:

- Statutory bodies and the principal providers of public sector health services
- Independently and locally controlled by an expertise-based governing council
- Responsible for financial management of the network
- Individually accountable for their performance
- Required to report on their performance to the chief executive (sections 7 and 9).

Management of public sector health system

The **public sector health system** is comprised of the LHHNs and the department (section 8(1)). The overall management of the public sector health system is the responsibility of the department, through the chief executive.

The Chief Executive

The **chief executive** (of the department administering the Act) is responsible for state-wide planning; employing staff and managing state-wide industrial relations; managing land, building and capital works; monitoring network performance and issuing binding health service directives to networks (sections 8(3) and 45). The chief executive is also responsible for collating and validating network data and providing the data to the Commonwealth and its entities (section 9(3)).

The relationship between the chief executive and the LHHNs is also governed by the service agreement between the chief executive and each Network.

Safeguards

The Act provides safeguards and protections for (a) members of **Quality Assurance Committees** and **Root Cause Analysis teams**; and (b) information obtained and reports prepared by the committees or teams (section 11) (discussed further below).

It also provides safeguards to **protect the confidentiality of information** that identifies persons who have received public sector health services (section 12) (discussed further below).

2. Establishment, functions and powers of Local Health and Hospitals Network

Powers

LHHNs will be body corporate with its own seal, and may sue or be sued (section 18). LHHNs have the powers of an individual. Some **key powers** (section 20) include:

- Employing network chief executives and other health executives, but not other staff (they will be employed by the department chief executive).
- Entering into contacts and agreements
- Acquiring, holding, dealing and disposing of property
- Charging for services
- Anything else necessary or convenient to perform its functions.

Land and buildings, and other prescribed assets will not be transferred to Networks and will continue to be owned by the State.

Functions

The **main function of LHHNs** is to deliver the hospital services, other health services, teaching, research and other services stated in the service agreement for the Network (section 19). The **other functions of LHHNs are:**

- (a) to ensure the operations of the network are carried out efficiently, effectively and economically;*
- (b) to enter into a service agreement with the chief executive;*
- (c) to comply with the health service directives that apply to the network;*
- (d) to contribute to, and implement, State-wide service plans that apply to the network and undertake further service planning that aligns with the State-wide plans;*
- (e) to monitor and improve the quality of health services delivered by the network, including, for example, by implementing national clinical standards for the network;*
- (f) to develop local clinical governance arrangements for the network;*
- (g) to undertake minor capital works, and major capital works approved by the chief executive, in the network area;*
- (h) to maintain assets owned by the network or the State in the network area;*
- (i) to cooperate with other providers of health services, including other networks, the department and providers of primary healthcare, in planning for, and delivering, health services;*
- (j) to cooperate with local primary healthcare organisations;*
- (k) to arrange for the provision of health services to public patients in private health facilities;*

(l) to manage the performance of the network against the performance measures stated in the service agreement;
(m) to provide performance data and other data to the chief executive;
(n) to consult with health professionals working in the network, health consumers and members of the community about the provision of health services;
(o) other functions approved by the Minister;
(p) other functions necessary or incidental to the above functions.

Service agreements

Each LHHN will enter into a **service agreement** (for a term no longer than 3 years) between the department (through the chief executive) and the Network to specify the hospital, health and other services to be provided by a Network, the funding to be provided for the services and the performance measures for the provision of the services (including the performance data and other data to be provided) (section 16).

A service agreement may also deal with matters relating to funding provided by the Commonwealth without the Commonwealth being a party to the agreement. Under the COAG agreements, the Commonwealth will be providing funding for the operation of Queensland's hospitals, but will not have a direct service level agreement with LHHNs. As such, the matters specified in the Act will relate to the funding provided by the State and the Commonwealth. Under the agreements, States will be the 'system managers' for the public health system.

The Minister may decide on the terms of the service agreement where the Minister is notified of a disagreement between the LHHN and the departmental chief executive.

3. Governing Councils of LHHNs

A Governing Council will control each LHHN (section 22). The Councils will consist of five or more members appointed by the Governor in Council on the recommendation of the Minister (section 23). Members may include persons with:

- Expertise in health management, business management, financial management, human resource management;
- clinical expertise;
- legal expertise;
- skills, knowledge and experience in primary healthcare;
- knowledge of health consumer and community issues relevant to the operations of the network;
- where relevant, persons from universities, clinical schools or research centres with expertise relevant to the operations of the Network; and
- other expertise the Minister considers relevant to the network performing its functions.

The Minister must advertise for expressions of interest from suitably qualified persons (section 24). Members of Governing Councils can hold office for a maximum of four years (section 26). Governing Councils will have a chairperson and deputy chairperson appointed by the Governor in Council on the recommendation of the Minister (section 25).

Members must act impartially and in the public interest (section 31). The way in which a Governing Council is to conduct its business is stated in schedule 2 of the Act.

Each LHHN Governing Council is to appoint a network chief executive to manage the network. A Network chief executive will be subject to the Network's Governing Council in exercising his/her powers or performing his/her functions (section 33) and may delegate his/her functions to an appropriately qualified network health executive or employee (section 34).

4. LHHN engagement strategies and protocols with Medicare Locals

Engagement strategies

Each LHHN must develop and publish a **clinician engagement strategy** and a **consumer and community engagement strategy** (section 40). The clinician engagement strategy must be developed in consultation with health professionals working in the network, while the consumer and community engagement strategy must be developed in consultation with health consumers and members of the community.

Importantly, **LHHNs must give effect to the strategies in performing their functions under the Act**. The strategies must also meet the requirements prescribed under a regulation and be published in such a way that it allows public access, for example, on the internet. The strategies are to be reviewed at least once every three years, with further clinician, consumer and community consultation to take place in reviewing the strategy (section 41).

Protocol with local primary healthcare organisations (Medicare Locals)

Each network must **use its best endeavours to agree on a protocol with local primary healthcare organisations** (Medicare Locals) to promote cooperation between the network and the organisations in the planning and delivery of health services (section 42). A protocol must also meet the requirements prescribed under a regulation and be published in a way which enables the public to access it i.e. the internet.

Similarly to engagement strategies, **LHHNs must give effect to the protocols in performing their functions under the Act**. The protocols are to be reviewed at least once every three years, with the review to be conducted with Medicare Locals (section 43).

5. Performance reporting and auditing

Performance reporting

Each LHHN will be individually accountable for its performance, and are required to provide performance data and other data to the departmental chief executive who may validate it and provide relevant data to the Commonwealth or an entity established under a Commonwealth Act (section 54).

Under the COAG Agreements, the relevant Commonwealth entities are anticipated to be the Australian Commission on Safety and Quality in Healthcare, the National Health Performance Authority, an Independent Hospital Pricing Authority and a National Health Funding Body.

Health service audits

The Act also provides for the departmental chief executive or the network chief executive to appoint a person as a health service auditor to undertake a health service audit in the Network (section 56). The functions of health service auditors include examining the accuracy of performance data, investigating the circumstances leading to the inability of a Network to meet relevant performance measure and investigating any other relevant matter (section 55).

A health service auditor may enter a public sector health facility at any time the facility is open for business or otherwise open for entry; and request documents, including documents containing confidential information (section 60). The auditor must prepare and provide a report to the appointer for each health service audit, which may include recommendations about the ways in which the accuracy of performance data and other data, and the performance of a Network or a specialised health service can be improved, or whether there should be any changes to the way in which public sector health services are provided (section 64). Following consideration of the report, the departmental chief executive may issue directions to the LHHN.

6. Safety and Quality

Quality assurance

A quality assurance committee (QAC) may be established by a network, the departmental chief executive, a professional association, society, college or other entity, or a private health facility (section 82). The departmental chief executive may establish a QAC for a matter relating to a network or the department. These entities may also jointly establish a committee. A QAC may only be established where:

- if the committee is established by an entity other than an individual—under a resolution or in accordance with the rules or official procedures of the entity; and
- the committee’s functions include the assessment and evaluation of the quality of health services, the reporting and making of recommendations concerning those services and monitoring the implementation of its recommendations; and
- the committee comprises individuals with training and experience appropriate to the services to be assessed and evaluated by the committee; and
- the exercise of the committee’s functions would benefit from the immunities and protections afforded by this division.

The departmental chief executive must establish a register of committees, which is to be made publicly available.

A QAC may give a copy of a report or other document to a prescribed patient safety entity whose responsibilities include the planning, implementation, management and evaluation of patient

safety initiatives and programs (section 85). There is a duty of confidentiality on a patient safety entity that receives a report or document.

The Act prohibits a person who is or was a member of a QAC from disclosing to someone else information acquired while a committee member, other than in the circumstances provided in the Act (section 84).

The Act also provides statutory protection to documents and information created by or for the committee, or acquired by a person as a member of a committee. Such a document or information cannot be accessed under any judicial or administrative order and is not admissible in any proceeding, other than a proceeding for an offence under that division of the Act (section 87). Further, a person cannot be compelled to produce the document or information or give evidence relating to the document or information.

A person who is or was a QAC member is also protected from civil liability for an act done or omission made honestly and without negligence under the division of the Act relating to QAC (section 88).

A person who gives information to a committee is not liable for giving the information and no action, claim or demand can be made against that person for giving information. Further, the person cannot be held to have breached any code of professional etiquette or ethics or departed from accepted standards of professional conduct for giving the information (section 89). A provider of information cannot be compelled to divulge or communicate in a proceeding or in accordance with any legal process particular information, including whether or not they gave information to a committee; what information they gave; a document given by the person to a committee or information the person was given or questions asked by a committee (section 90).

Root cause analysis

Root Cause Analysis (RCA) of a reportable event is a systematic process of analysis of the factors that contributed to the happening of the event and remedial measures that could be implemented to prevent a recurrence of a similar event (section 95). It does not include investigating the professional competence of a person or finding out who is to blame for the happening of the event. It is a quality improvement technique to assess and respond to reportable events that happen while health services are being provided (section 93).

The Act provides guiding principles for the conduct of a RCA, including that participation in an RCA should be voluntary and that people providing health services should be accountable for their actions (the full list of guiding principles is detailed in section 97). Members of the RCA team must have the appropriate skills, knowledge and experience to conduct an RCA of the event, and must not have been directly involved in providing the health service (section 99). Before appointing an RCA team the commissioning authority proposing to make the appointment must be satisfied the potential benefit in disclosing the relevant information is outweighed by the benefit of restricting disclosure of the information (section 99).

The departmental chief executive, the network chief executive or the individual with the day to day management of the facility may appoint members of an RCA team, depending on whether it is

the department, network of a private health facility which provides the service the subject of the RCA (section 98).

An RCA team must prepare a report after conducting a RCA of a reportable event describing the event, providing a statement of the factors which contributed to the happening of the event and any recommendations about changes or improvements to a policy, procedure or practice relating to the provision of the health services to prevent or reduce the likelihood of it occurring again (section 100). In addition, the RCA team may prepare a chain of events document that represents the chain of events identified by the RCA team as having led to the happening of a reportable event. A copy of the report must be provided to the commissioning authority and, if a chain of events document has been prepared, a copy of that document also (section 101).

If, in conducting a RCA, the RCA team believes that the reportable event involves a blameworthy act or that a person directly involved in the event was impaired by alcohol or drugs, it must stop the RCA and give written notice to the commissioning authority that the RCA has been stopped (section 102). Similarly the commissioning authority must notify the RCA team if it intends to stop the RCA for these reasons (section 103).

RCA team members or a relevant person for an RCA team are prohibited from disclosing to someone else information acquired by the person as a member of the RCA team (section 105). A similar duty of confidentiality applied to a commissioning authority (section 106). Both of these sections specify exceptions to the duty of confidentiality.

The commissioning authority is required to provide a copy of an RCA report to the Health Quality and Complaints Commission (section 108). However, this is not required if the commissioning authority is a private health facility and the commissioning authority has agreed that the chief health officer may give a copy of the report to the commission. An RCA report is to be given to the director of mental health where the reportable event happened at an authorised mental health service (section 111). If the commissioning authority is a network chief executive or the departmental chief executive it must give the report to a prescribed patient safety entity, which is an entity prescribed under regulation whose responsibilities include the planning, implementation, management and evaluation of patient safety initiatives and programs (section 112).

Section 116 provides statutory protections for RCA team members or a relevant person for an RCA team such that in any proceedings, the person must be indemnified by the entity that established the RCA team. Similarly, a person who honestly and on reasonable grounds give information to an RCA team or a relevant person for an RCA team is not subject to any liability for giving the information and no action may be taken against the person for giving the information (section 117).

A person cannot be required under an Act or legal process to divulge whether or not the person gave information to an RCA team, or divulge any document or information given to the RCA team (section 118). Statutory protections also apply to documents and information in relation to RCA teams: such a document or information cannot be accessed under any judicial or administrative order and is not admissible in any proceeding, other than a proceeding for an offence under this division (section 119). In addition, a person cannot be compelled to produce the document or information or give evidence relating to the document or information.

A person must not cause, or attempt or conspire to cause, detriment to another person because anybody has provided assistance to an RCA team (section 120) and it an offence to take a reprisal against anyone (section 121).

Clinical reviews

The Act contains provisions regarding clinical reviews, which include an assessment of whether a health service provided to a person was provided in accordance with recognised clinical standards.

The functions of clinical reviewers are to conduct a clinical review and to provide expert clinical advice to the departmental chief executive, a Network chief executive, an entity whose role includes maintaining and improving the safety and quality of health services, or a health service investigator (section 124).

A clinical reviewer may enter a public sector health facility at any time the facility is open for business or otherwise open for entry, and may require an employee of the department or a Network health executive to give the reviewer a document, including a document that contains confidential information (section 129).

A clinical reviewer must prepare and provide a report to the person who appointed them to undertake the review which may include recommendations on ways in which the safety and quality of public sector health services can be maintained and improved (section 135). The chief executive may subsequently issue directions to the Network as result of the review.

Where a clinical review is undertaken to provide clinical advice to a health service investigator, the clinical reviewer must prepare and provide a report to the investigator (section 136). The report may include recommendations on ways in which the safety and quality of public sector health services can be maintained and improved.

Clinical review reports prepared for matters (other than reviews to provide clinical advice to a health service investigator) cannot be accessed under any judicial or administrative order and are not admissible in any proceeding. In addition, a person cannot be compelled to produce the document or information or give evidence relating to the document or information (section 138).

7. Confidentiality

A designated person (which includes a public service employee in the department, a health service employee, a health professional and a member of a governing council) must not disclose any confidential information unless the disclosure is required or permitted by the Act (section 142). 'Confidential information' is information acquired by a person in the person's capacity as a designated person, from which a person who is receiving or has received a public sector health service could be identified (section 139). Exceptions to this duty of confidentiality include:

- if the disclosure is required or permitted by an Act or another law
- the person to whom the confidential information relates is an adult and provides consent, or is a child and the circumstances specified in section 144(b) apply
- the disclosure is for the care and treatment of a person to whom the information relates

- the disclosure is in about the condition of a person and is communicated in general terms
- the information is disclosed by a health professional to a person who in the professional's reasonable opinion has sufficient interest in the health and welfare of a person.
- the disclosure is necessary to assist in lessening or preventing a serious risk to the life, health or safety of a person, or to public safety
- the disclosure is to a person for the protection, safety or wellbeing of a child (sections 143 – 161).

8. HCQ recommendations adopted in the Act

In July 2011 HCQ provided a comprehensive submission to Queensland Health in relation to the Health and Hospitals Network Bill 2011, containing consumer feedback on the proposed legislation.

A number of HCQ's recommended amendments relating to the Bill's guiding principles, protocols with Medicare Locals and consumer and community engagement strategies were adopted by the Queensland Parliament. HCQ's recommendations and the amendments adopted in the Act are detailed in the table at **Attachment A**.