14. Queensland Health reform

14.1 Overview

This Systems Review has confirmed that far reaching reforms are necessary for Queensland's public health service. Reforms are designed to focus systems and resources towards the achievement of higher standards of health service and improved health outcomes for consumers and patients. The reforms collectively will address many of the current deficiencies and help to restore the community's confidence in the Queensland public health system. In many cases, the need for change is urgent as the Review has confirmed that some frontline services in certain locations are under immense pressure and will cease to operate unless promptly supported.

Fourteen programs of reform have been suggested including leadership and culture, workforce, conditions for employees, systems, quality and safety, services and overall performance. These are described more fully in section 14.5.

Reform success will depend on Queensland Health's leaders being able to effectively engage with the workforce which must actively support and drive the reforms. This is essential, as much of the reform will depend on the active participation and leadership of frontline health service personnel.

The Government would also need to ensure that Queensland Health is able to rebuild the community's trust through engagement, genuine consultation and open and honest reporting on the performance of it's health services. The challenge is very significant but achievable. However, overly optimistic short term expectations for meaningful improvement would be unhelpful.

Much of the reform and renewal activity will require additional funding and workforce resourcing. Resources should be targeted to well planned initiatives with quantified health service outcomes that have clear benefits for hospital patients and consumers of other health services. This Chapter contains indicative funding estimates for the highest priority systemic reforms in keeping with this Review's terms of reference. Chapter 6 contains details of how growth funding for enhanced services will be allocations to health service outcome targets developed by clinical networks.

Many of the reforms suggested will require significant input and additional work by frontline health service personnel at a time when they are already experiencing the pressure of excessive workloads and workforce shortages.

In this environment clinicians who are critical to support the delivery of day to day health services cannot be taken off line even for short periods to address reform initiatives without being replaced with relief staff. In many cases, even if funding could be found for the necessary reforms, additional clinical staff may not be immediately available. A range of creative options will be necessary to try and build capacity in the short term to ensure that clinical staff essential to service delivery can fully participate in necessary reform and improvement activity in their local health services whether in a hospital or community based service.

An intensive three year reform period is recommended to lay essential reform foundations and achieve meaningful improvements. At the end of this period, the organisation should be in a better position to sustain a process of continuous improvement, provided it has established the basic systems, is operating from a more appropriate set of values reflected in culture and is achieving target reform outcomes especially training and developing its clinicians and has restored a significant level of trust with its workforce and the broader community.

14.2 Reform success

Reforms could be judged as succeeding if, at the end of three years, the following outcomes are confirmed. The process of continuous improvement should then carry on.

14.2.1 The community has:

- Experienced a new level of engagement and input to plans and decisions about local health services (including the scope of services provided).
- Clearer expectations about what this service will deliver, conditions of delivery and the likely timeframes.
- Access to reports from independent bodies that reflect accurately and truthfully the state of the health service and compares its performance to other comparable services in Queensland and Australia.
- Benefits of an effective population health service.
- Observed significant local effort and results to address current problems such as long waiting times, hospital congestion and bed block and limited access to services.
- Access to coordinated private and public sector health services including primary care and community health services and acute hospital care.
- Access to a more informed and influential District Health Council.

14.2.2 Patients have:

- Confidence that services will be delivered by competent doctors in good hospital environments.
- Greater access to community based care arrangements.
- Higher levels of certainty about what local health services can deliver and can’t deliver.
- Better supported transport arrangements for accessing services away from their local community.
- Clarity about total waiting times preceding elective treatment.
- Experience minimal delays or rescheduling prior to accessing necessary health services.
- Experience a culture that is patient centred and care that is appropriate to their individual needs (both clinical and non-clinical).
- Confidence in the safety of clinical procedures and practice and clear expectations about risks and outcomes.

- Experience of integrated team based approaches to care whether at the primary or acute end of the spectrum and coordination of care with other health service providers.
- Clarity about patient rights and the health service's obligations to the patient.
- A trusting health service environment where clinicians openly disclose to patients if there are any problems.
- A system that confirms whether the patient's health service needs have been satisfactorily and effectively addressed (ie did the procedure or service address the problem).
- Responsive local contact points to address concerns and complaints in a supported environment with a minimum of formality.
- The ability to access local health services or members on the local District Health Council to raise issues and concerns.

14.2.3 Staff are:

- Treated well, valued and fairly paid.
- Supported by the organisation and experiencing positive enabling styles of leadership, management and supervision.
- Contributing directly to the reforms through a broad range of local initiatives facilitated by people from their workplace in whom they have confidence and respect.
- Where possible, members of Clinical Networks and teams which can influence the nature and direction of changes to services.
- Able to participate in a greater range of training, development and reform activities because backfilling and relief arrangements are in place.
- Receiving more responsive and helpful advice regarding HR and IR issues.
- Lead by supervisors and managers who have flexible and relevant ways to resolve concerns.
- Using effective complaint and grievance processes that resolve problems.
- Experiencing a culture that focuses on the needs of patients and providing service to patients in a responsible way so as to maintain financial integrity.
- Experiencing leadership that encourages contribution and continuous improvement.
- Confident that their employer, the Queensland Government and Queensland Health, will support them absolutely if they act in good faith and to the best of their ability in delivering health services.
- Proud to work for Queensland Health and have opportunities for a range of satisfying career pathways.

14.2.4 Leaders, managers and supervisors:

- Believe that the organisation is supporting them.
- Have clear role expectations and have received necessary development and training.
- Are empowered to make decisions locally in the best interests of patients and consumers of health services.
- Are contributing meaningfully to decisions about the allocation of growth funds and the manner in which funding is targeted to specific health service outcomes in the interests of Queenslanders.

- Experience a culture that supports honest reporting of problems and demonstrates genuine interest in finding solutions from the highest levels of Government down.
- Experience a culture that is consistent with the organisation's values, and which enables, encourages and seeks new approaches to address challenges.
- Can speak freely and honestly about local service capability and provide the community and media factual information about local health services.
- Have greater resource flexibility to support staff and make better local decisions to address local needs.

14.2.5 Queensland Health has:

- Developed and implemented the critical health service planning and workforce planning systems to better manage its workforce.
- Made substantial progress with other systemic recommendations especially budget allocation, clinical governance and the appropriate number and mix of tertiary training places.
- A Central Office which focuses on statewide strategy, planning, policy, resourcing and performance monitoring.
- Experienced Area Health Services which achieve integrated services to meet targeted needs in a consistent way.
- District health services that meet the local community's agreed scope of service and are achieving performance targets.
- Improved relationships with major stakeholders and is progressing partnerships for the benefit of the health of the community.

14.2.6 Government would:

- Receive meaningful information about community expectations and preferences in respect to the range of health services to be delivered.
- Receive clear factual advice and analysis about the state of health services and options to better support and or limit services to ensure they are safe and effective for those that have a legitimate entitlement to access.
- Approve five year health services plans which are publicly available.
- Endorse clear and factual health service performance targets with honest reports about outcomes.
- Experience greater acceptance by the community, of the need to debate issues surrounding the scope and quality of health services, funding requirements and how best to address resourcing or demand limiting requirements.
- Make and publish decisions about the scope of services and access arrangements.
- Be confident that the health service is performing to expectation in meeting agreed targeted needs.

The above report card should be used at the end of three years to by the Auditor General, Health Commission and the Reform Steering Committee to assess whether reforms are on track and to identify areas where additional effort will be necessary.

14.3 Guiding principles

Queensland Health has developed two helpful guides – "*Managing Organisational Change*" and "*Supporting Employees through Organisation Change*" which contain general organisational change principles. Additional more specific organisational change principles to advance the recommended program of reform in Queensland Health are:

- The package of reform initiatives should be designed and implemented with the needs of patients and consumers of health services foremost, ie patient-centric solutions to many of the current problems.
- Initiatives must address the major deficiencies and opportunities identified by the review in an integrated way. The organisation is large and complex. Changes to systems or parts of the organisation will have ramifications on other parts.
- There is an understandable need to try and do as much as possible as quickly as possible. This urge must be tempered by insights gained by those current leaders in the system who have previously initiated successful improvement and reform. Many of the reforms such as clinical safety and quality and flow process improvements to relieve bed shortages in acute hospitals can only progress at a measured pace.
- Avoid mistakes from the past where many of the well intentioned reforms and changes driven from Corporate Office previously have failed, or have been only partially implemented and supported because of a lack of funding, and or lack of an appreciation of the real needs of Health Service Districts.
- Reform must be led and driven at the highest level, accountable to and directly supporting the Director-General and Minister. Reform programs should be led by personnel who have reform responsibilities as their only responsibilities, and operate outside of the normal executive line structure.
- Drive as much reform as is practical from the new empowered and funded Area Health Services and existing Health Service Districts in acute hospitals, community and population health services.
- Appreciate that there are whole of state initiatives such as quality and safety, the credentialing and privileging of the medical workforce and the recruitment and support of Health professionals, which will need to be driven and coordinated centrally, but implemented in strong partnership with clinicians in Area Health Services and Health Service District.
- The reform process should minimise any disruption to the clinical workforce which is already over-burdened and struggling to maintain a satisfactory standard of health service.
- There will be an intensive process of reform over a period of at least three years which will need to be properly focused and resourced. Reform arrangements and structure could be progressively assigned to regular work units as renewal capability to continue reform is developed within Queensland Health.
- To implement the reforms in a manner that strengthens the continuum of health care from primary care through to post acute care, links with the aged care sector, and strengthen linkages between all of the parties involved in this continuum. This will include the State Government, the Commonwealth Government, a broad range of private sector providers, the non-government sector, local government and most

importantly representatives of local communities with a direct interest in the Health Service District.

- Ensure major community concerns and issues receive priority attention including:
  - quality of clinical services available in public hospitals.
  - speed of access to these services.
  - the capacity for patients to effectively raise concerns and resolve these concerns.
- Involving all categories frontline staff effectively in the reforms with a focus on the interests of the individuals and communities who use their services.

14.4 Reform strategy

Strategies driving reform:

- Emphasise leadership and the development of a culture which strengthens the focus on patients and health service consumers.
- Empower Area Health Service General Managers who will ensure effective levels of planning and integrated service delivery to meet area needs.
- Allow clinical networks to progressively assume responsibility for decisions about how new funding for health service delivery shall be allocated.
- Strategically focus the newly organised Central Office to establish clear strategic intentions, informed by better statewide health service and asset plans, which will influence policy and resourcing decisions.
- Central Office in conjunction with Area Health Service General Managers will establish health service outcome targets and monitor performance accordingly.
- Develop reform program outcomes and targets as the basis for phased allocation of funding with demonstrated success the basis of continued funding.
- Seek a contribution from non Queensland Health staff to help progress certain programs of reform, e.g., leadership and culture.
- The Reform Leadership Team will draw on the experiences of other jurisdictions, both nationally and internationally, in planning and implementing programs of reform.
- Some Health Systems Review staff should form part of the Reform Leadership Team to ensure that the full intentions of the review recommendations are well understood.
- Ensure that the proposed independent Health Commission (accountable to Parliament), and Queensland Health clinicians, make informed decisions about what clinical outcome information should be released to the community and in what form. There is clear international evidence to suggest that imprudence in this area has destroyed progress in advancing clinical safety.
- The Development Unit will continue to have a major role in reform leadership and implementation, especially in assisting with the establishment and functioning of clinical networks, the development of clinical leadership and new clinical governance arrangements.

14.5 Programs of reform

This Report has identified fourteen areas of reform (programs) each consisting of a series of staged projects or initiatives which will require focused attention for an intense three year period and then ongoing development and review. The fourteen reform programs can be conveniently aggregated into three streams of initiatives as follows.

Stream	Workforce Reforms Organisation, Team and Individual Development	Structure/Systems	Service Needs Relationships/ Partnerships
Initiatives	P1 Immediate Workforce Priorities	P4 Hospital/Health Service Improvement	P8 Strengthen Community Sector Partnerships
	P2 Leadership/Culture	P5 Safety Quality Clinical Governance	P9 Health Service Planning and Workforce Planning
	P3 Teaching/Training	P6 Patient Complaints	P10 Service Enhancement • Indigenous Health • Mental Health • Rural Remote • Chronic Disease • Child and Youth Health
	Workforce Planning (see P9)	P7 Central Office Restructuring	P11 Strengthen Commonwealth Partnerships
		P12 Performance Reporting	
		P13 Information Technology	
		P14 Assets	

Reform programs are interdependent. Elements of some must progress before others can commence. For example, leaders need to establish a culture of greater mutual respect and trust with clinical personnel supported by better systems, before real gains in clinical safety and practice achieve full improvement potential. Without this there may be only partial reporting of incidents, with limited opportunity to establish cause or develop and implement solutions. Similarly, hospital and health service improvement projects will require funding for relief clinicians so that other work teams may be released to train, resolve problems, plan for and develop workplace solutions. There is also a priority to build some greater clinical workforce capacity to immediately cope with the increased workload.

As there are 25 major hospitals, all experiencing patient workload pressure with no discretionary funding or staff for backfilling, this is a major problem. Each facility would require between 20 to 60 nurses with complementary medical/allied health staff to progress reforms at only a modest pace. There is therefore a need for immediate growth in numbers of nursing and allied health staff. Staff specialist and registrar time could be freed up by increasing VMO sessions. The key will be local flexibility.

14.6 Funding

Additional funding will be essential to advance reform program areas. Additional funding requirements should be assessed in detail as part of detailed reform planning because:

(i) Reforms primarily should be owned and driven by personnel (all staff categories) within District and Area Health Services who ideally should be involved in reform planning locally and should understand the cost implications.

(ii) The reform strategy requires that allocation of funding should be staged to achieve specified health service improvements or outcomes. Progress and impact should be monitored carefully.

Some broad indicative estimates are offered against the 14 programs. They must be refined during detailed reform planning.

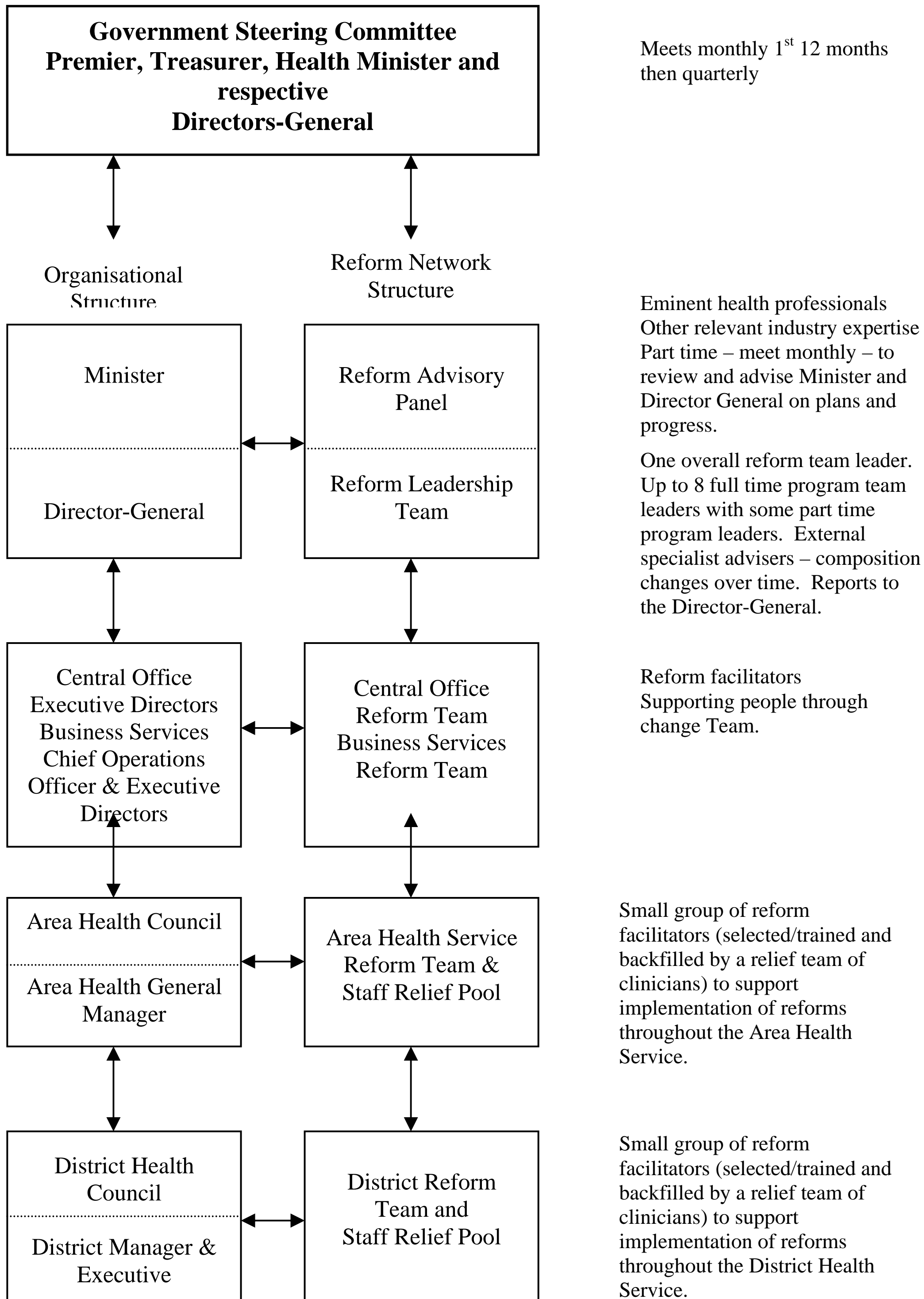
The cost of overall reform is likely to be quite significant and may be beyond the capacity of the Queensland Government alone to fund, even if measures discussed earlier such as limiting demand, means testing access with associated co-payments or raising taxes are possible. Meaningful working relationships between the Commonwealth and State Governments would be essential in jointly developing and delivering better health system outcomes.

From the community perspective, health should be an apolitical, patient and consumer centred issue. However, if the full range of current health services were not able to be funded, the community should be involved in such decisions and honestly advised of the extent to which health services may need to be curtailed.

14.7 Reform process

Leaders in Central Office and Area and District Health Services will ultimately be responsible for implementing reforms. However, they must be supported intensively for three years by a network of Reform Leaders and Facilitators who will have a depth of expertise in reform program areas, and the necessary credibility with their colleagues and managers to perform their role. This will enable leaders to focus on their core day to day responsibilities while supporting the various reform implementation initiatives being undertaken.

The Reform Leadership/Facilitator network is as follows:



Meets monthly 1st 12 months then quarterly

Eminent health professionals
Other relevant industry expertise
Part time – meet monthly – to review and advise Minister and Director General on plans and progress.

One overall reform team leader. Up to 8 full time program team leaders with some part time program leaders. External specialist advisers – composition changes over time. Reports to the Director-General.

Reform facilitators
Supporting people through change Team.

Small group of reform facilitators (selected/trained and backfilled by a relief team of clinicians) to support implementation of reforms throughout the Area Health Service.

Small group of reform facilitators (selected/trained and backfilled by a relief team of clinicians) to support implementation of reforms throughout the District Health Service.

The Reform Leadership Team would require permanent members for the three year period with other members changing through time including personnel both internal and external to Queensland Health. This team would work closely with the Chief Executive and Minister, and with the Executive leaders and managers of Queensland Health. The leader would be accountable to the Director-General and would report to a Steering committee comprising the Premier and Treasurer, the Minister for Health and their respective Directors-General monthly during the first year of reform and then quarterly.

The make up of the Reform Leadership Team would be:

1 Doctor	Full time	Reform Leadership and Team Leader
1 Nurse	Full time	Reform Leadership
1 Allied Health	Part time	Reform Leadership
1 Administrator	Part time	Reform Leadership
1 Doctor	Full time	Workforce Development Expertise
1 Person	Full time	Leadership/Culture Expertise
1 Person	Full time	Hospital/Health Service Expertise
1 Person	Full time	Central Office Restructure and AHS establishment
1 Person	Full time	Special Needs expertise
2 Doctors	Part time	Clinical Governance
3 People	Part time	Special needs expertise

It is suggested that an advisory panel of eminent health service professionals be established to meet periodically and provide guidance and assistance to the reform leadership team and the government by overseeing and contributing ideas to the implementation of reforms in much the same way as the panels of eminent clinicians established to support this Review have performed their task. As clinical networks develop, some of these leaders could be included on such a panel, together with external clinicians including those from educational institutions.

The proposed skill set of external advisors would be

1 Person	Overall reform agenda
1 Person	Leadership/Culture
1 Person	Health Planning
1 Person	Service Improvement

The Reform Leadership Team would help to establish a network of change and Reform Facilitators in each of the three Area Health Services and in each Health Service District to support their respective executives and clinical leaders in the reform tasks that need to be undertaken. Whilst people in the Reform Teams would be selected because of their specific reform expertise and leadership capabilities, it is imperative that Reform Teams in each Area Health Service and Health Service District are selected with the support of their peers and managers, so that they can support their leaders locally and retain the trust and support of their colleagues in helping to implement the reforms.

These personnel must have the capacity to lead/facilitate a range of planning and development initiatives which will need to be coordinated in various centres throughout the State. They would need to be released from their usual clinical and administrative roles so that they might devote sufficient time to the reform initiatives. Some would need a full time commitment, others part time. They should be nominated through a transparent process.

Staff seconded to the reform program should be afforded the opportunity to apply for new positions as they become available during restructuring or organisational change activities. If successful applicants, they could still remain seconded to their roles in the reform process and their position be backfilled until their service with the team ceases. At this stage they should assume the roles which they previously held, or have been successful in filling during the reform process, or alternatively should their former roles have been abolished, to exercise their options to negotiate placement or exit the organisation drawing on entitlements as they existed at the time of this report.

14.8 Monitoring reform

Another significant strategy for the reform process would include independent monitoring of reform progress by parties external to the Queensland Health service and the normal executives structure of government.

It is suggested that the Auditor-General be commissioned to undertake systems and performance audits of the reforms and their ongoing outcomes.

The Review has also suggested the establishment of a Health Commission, comprising independent personnel of the highest calibre to oversee and report upon clinical practice reform especially progress in achieving clinical quality and safety improvements. This Commission will report to the Minister and to a Parliamentary Committee. This would help to ensure that the community is confident that clinical reforms are taking place as envisaged, that Queensland Health's services are operating to the standard expected and appropriate reports are released.

14.9 Reform programs, sequencing and timelines

It would be the role of the Reform Leadership Team in conjunction with the Director-General to develop detailed program and project plans covering all major reform initiatives. This report provides an overview of what is necessary, so that the Government, Queensland Health and bodies like the Auditor-General will have some broad expectations and timeframes against which to monitor particular reform initiatives to ensure that they are properly implemented, integrated and coordinated. Elements of the reform program and suggested sequencing and time lines are outlined below. It is emphasised that these are preliminary, and as such will require modification as new and more detailed information becomes available as reforms progress. Further detailed scheduling of reform programs is provided in Gantt charts in Appendix 14.1. The schedules are just guides to assist the Reform Leadership Team commence the reform process and will need further development.

14.9.1 Addressing immediate clinical workforce shortages

Summary

- Urgently target critical health service priorities and the clinical positions necessary to maintain services.
- Local and overseas medical graduate recruitment enhancement.
- Career enhancement and recognition of generalist positions (eg Career hospital doctors, rural generalists).
- Complete enterprise bargaining to achieve fair salaries relative to other states and remove impediments to reforms.
- Increase nursing and allied health numbers by attracting new graduates and through re-entry programs.
- Develop partnerships with other parts of the health sector across the continuum of care to make effective use of available clinicians.
- Increase utilisation of Visiting Medical Officers and General practitioners.
- Assess, credential, privilege and support new and current doctors with special purpose registration.

Details

The immediate priority is for Queensland Health to continue to target clinical positions that will enable services to be maintained across the State. Districts and Area Health Services should coordinate this process until clinical networks are better established and in a position to advise priorities. The current enterprise bargaining rounds must be concluded. The objectives must be to achieve fair salary, more flexible conditions and simplified awards.

Doctors

Queensland Health must continue to target overseas trained doctors particularly from the United Kingdom. A planned targeted campaign commencing immediately but with a time frame over several years is required. This program should enlist the assistance of the Royal Medical Colleges, professional associations, known Australian contacts working in the United Kingdom and focus on targeting interested individuals. The targeted campaign needs to be supported by appropriate generic marketing and advertising campaigns including opportunities relating to conferences, conventions, expositions etc. A well respected local medical practitioner would lead and coordinate this initiative supported by the workforce planning project assisted by a number of local practitioners who are available to travel to the United Kingdom and inform and assess prospective candidates at regular intervals over the coming years.

Nurses

It is estimated that there are significant numbers of experienced graduate nurses who might be prepared to return to nursing if conditions of employment were more flexible and perceived to be fair and just, and if where appropriate, support arrangements by way of re-training, mentorship, child care etc were more available. For this program to be effective, constraining recruitment processes must be streamlined so that nurses with the right qualifications and confirming referee reports can be immediately employed.

Whilst broadly based media campaigns might be useful for general recruitment, it is considered more appropriate that the existing nursing workforce be commissioned to secure re-engagement of former experienced colleagues in targeted areas of need known

to be still interested in working within Queensland Health but possibly requiring more flexible working arrangements.

Existing nurses could be offered a range of incentives to perform this attraction role including sponsorship at conferences or study, an additional period of development leave, such as review of practice in other jurisdictions or straight out financial incentives. A period of guaranteed service would be sought from returning personnel. Recruitment to build general capacity could target appropriate skills mix across RN, EN and AIN categories. The opportunity for career paths including advanced nursing roles and expanded nurse practitioner roles should also be use as an incentive.

Many clinicians who currently work outside the public sector may have some capacity of to contribute to the delivery of public health services. Strengthening partnerships with the private and non-government sectors to maximise the potential contributions from their respective workforces should be a priority for each Area Health Service and Health Service District need to perform this role.

With respect to allied health professionals there is arguably a greater shortage than for nurses or doctors. James Cook University experience with pharmacists indicates that integrated planning between the university, the public and the private sector is an essential step in building sufficient numbers of allied health professionals. There is also the potential for increased numbers of advanced roles, for example fit for surgery programs in outpatient clinics.

In endeavouring to secure improved utilisation of existing medical practitioners, it would be important to draw on wisdom from the clinical networks being established, but also provide priority to staff specialists and Visiting Medical Officers who are currently performing work within the public health system before seeking the services of additional Visiting Medical Officers from the private sector or outsourcing procedures to private hospitals. In reality all options may be necessary to address the workload.

For example, if internal staff specialists are able to perform their normal range of duties during a four day week, then they may be interested in undertaking additional sessions for elective surgery during another day of the week. If Visiting Medical Officers require additional sessions, this should be extended to those already within the system before being offered externally. Funding must accompany these initiatives, appreciating that it is total theatre and other session related hospital costs that must be funded, and not just salary costs.

A broad range of opportunities for General Practitioners and other primary care providers to strengthen links with the acute hospital system in terms of pre-operative care and post-operative care are required. The North Brisbane Division of GPs Team Care Project is a good example.

As a matter of urgency the schemes described within the report to properly assess and support clinical staff and the clinical governance systems to properly assess, credential and privilege existing and new OTDs with special purpose registration need to be implemented. This includes immediate consolidation of the RAPTS Program and commencement assessment, support and training for existing and new overseas medical graduates through the Development Unit.

Resources

- A doctor to address medical workforce issues full time.
- Supporting project resources in workforce planning in Central Office and in Area Health Services with representation of nursing/allied health on the Reform Leadership Team.
- An overseas recruitment campaign for doctors should be actioned immediately.
- Implementation of RAPTS would require an immediate investment of $3 million.
- Short term workforce planning resources to be assigned for each Area Health Service to review and consolidate immediate clinical and infrastructure priorities.
- Establishment partnerships with GP Divisions and Universities to make better use of existing primary care and allied health workers and devise future recruitment and attraction strategies, including scholarships.
- Develop guidelines for the nurse re-engagement program and recruitment program.
- District Reform Facilitators to assist District Managers in implementing initiatives.
- Clinical capacity building – doctors, nurses, allied over first three years as detailed below.

Staff	**Additional capacity required**	**Recurrent cost by Year 3 ($ million)**
Doctors for service growth	180 per year 540 over 3 years	$90 M
Hospital career Senior Medical Officers to replace current Resident Medical Officers	100 per year 300 over 3 years	$30 M
Visiting Medical Officers to reduce reliance on doctors with special purpose registration and provide additional quarantined teaching time for existing staff (NOTE – this is not for additional service provision)	A doubling of sessions (from current 240 FTE to 480 FTE	$75 M
Generalist GP's working part time in Emergency Departments to reduce reliance on OTD's with special purpose registration	100 per year 300 over 3 years	$30 M
Nursing – general recruitment and target attracting existing nurses for re-entry to address current work load (over and above the 500 new graduates per year growth funded)	500 per year 1500 over 3 years	$112 M
Allied Health to address current workload (over and above the 250 per year growth funded)	2000 over 3 years	$150 M
Total		**$487 M**

Timing

- Reform Leadership Team established promptly.
- Credentialing and Privileging system for existing and new overseas trainied doctors on special purpose registration to commence immediately and be fully functioning by December 2005.
- Assessment and support plan for all special purpose registered doctors by June 2006.
- Network of Area Health Service and Health Service District workforce planning personnel in place by March 2006.
- Longer term recruitment, education and attraction programs and partnership programs fully planned and implemented by July 2006 with milestones and target recruitment levels identified over the next three years.

14.9.2 Developing culture and leadership

Summary

- Appoint a new organisational leadership team.
- All leaders and managers (of staff across all categories in Queensland Health) to attend development workshops.
- Develop commitment to reforms, a new code of conduct and revised values.
- Participation in a statewide leadership development program and commitment to revised leadership behaviours included in employment contracts or conditions of employment for senior executives.
- A formal process of assessment at regular intervals (including feedback from peers, subordinates and supervisors) of whether leaders are setting the right example with external oversight by District/Area Health Councils and the Auditor-General.
- Leadership development will be integrated with clinical/health service/reform imperatives.

Details

Culture changes when people in leadership roles enable the work experience of individuals within the organisation to change. Leadership emerges and is shared at varying levels of the organisation when enabling and encouraging influences and behaviours replace prescriptive and constraining environments.

A Director-General for a transitional period has been appointed to lead the organisation through the first 15 months of reform, especially to oversee restructuring and ensure all reforms are progressed. Senior leadership positions in the new organisation should be advertised and selected as early in the reform process as practical on a merit basis. It is intended that the position of Director-General will be advertised prior to June 2006.

The reform proposes an initial series of two day information workshops for all senior personnel across all disciplines. Working in sets of natural work teams these leaders will explore and thoroughly understand the nature of the reform challenge, the programs and plans for implementation envisaged and the ways that they may plan, organise and deliver reforms locally. Issues such as culture, new values, leadership styles and behaviours will be addressed. These will be followed by a further two workshops of one weeks duration to review local reform issues, explore revised leadership approaches and confirm future plans.

Leadership will be fostered and culture changed in Queensland Health when staff experience a new working environment which encourages, supports and depends upon multi-disciplinary teams discussing and sharing common values and objectives, developing new ways of addressing old problems, implementing change and experiencing success. New clinical leadership roles within Clinical Networks are an important initiative to support these changes.

It is envisaged that the reform program for Queensland Health will require “wall to wall” training and development activity where the staff and communities that they serve work together to explore new ways of dealing with existing and emerging problems. Participation in team problem solving, workplace redesign, systems improvement and patient centric care can all potentially contribute to the development of an improved culture.

Essential to the change and reform agenda will be a process of training development and workshop activity where staff work in teams (both existing teams and at times across work teams and organisational boundaries) to confront and resolve current workplace problems. They will seek the necessary resourcing to address these problems, implement local reforms, monitor these reforms and in so doing change the culture of the organisation from one which is prescriptive, constraining and enforcing, tending to bring out the worst of human behaviour, to one that is more enabling, encouraging and supportive. In such a culture staff are more likely to model the behaviours more in keeping with those which would typify an organisation committed to improved patient outcomes and successfully dealing with new challenges in a way that retains the public's confidence.

These reforms are to be led and implemented in a decentralised manner in Health Service Districts and Area Health Services across Queensland. Emerging structural forms such as the development of clinical networks and the empowerment of these networks will progressively lessen the reliance on formal mechanical hierarchal chains of authority and control. There will inevitably be tensions, but the end result most worthwhile in terms of health outcomes.

In an organisation already under resourced and struggling to cope with patient workload this will be the most significant reform challenge. Relief staff and relieving arrangements will be essential.

The impact of reform on organisational culture and staff satisfaction should be evaluated over time using staff surveys.

Resources

- One Project Team leader for the Reform Leadership Team.
- A series of leadership development programs focusing on the reform initiatives and leadership behaviours must be designed and run initially for some 500 people currently in senior management or leadership positions.
  - Stage 1- 2 day program
  - Stage 2 - 5 day program conducted 3 to 6 months later
  - Stage 3 - 5day program conducted 9 to 12 months after Stage 1
- Programs must be designed for all other managers and supervisors delivered in a decentralised ongoing way.
- Reform Facilitators need to be selected and trained (some 150 by March 2006)
- Area Health Service and Health Service District training capacity needs to be enhanced.
- Mentoring and collegiate support networks for senior managers and leaders of the clinical networks to be developed.
- Strong links between this program and program 3 teaching/training renewal.
- Workplace culture and staff satisfaction surveys.

Annual costs leadership/reform workshops		
Training	**Staff numbers**	**Cost**
Senior Leaders training: Year 1 2 days, 5 days, 5 days then 5 days annually ongoing	500	Year 1 $ 1.2 M Year 2/3 $ 0.5 M
Reform Facilitator Training annually for 3 years	150	$ 0.3 M
Staff to backfill Reform Facilitators annually for 3 years	150	$15.0 M
Management and supervisor training 5 days annually ongoing (assuming 1 manager to 10 staff)	4500	$ 4.5 M
Staff to 50% backfill managers and supervisors during training	50% backfill for 4500	$ 4.2 M
Total Recurrent by Year 3		**$9.2 M**

Timing

- First leadership segment (two days) for 500 staff including District Health Council Chairs completed by January 2006.
- Follow up more intensive leadership development segments during 2006.
- Follow up senior leadership programs annually thereafter.
- Building leadership development, change facilitation and training capacity in Health Service Districts and Area Health Services by June 2006. Potential values might include information sharing, honesty and accountability.
- Progressive programs completed for all management/supervisory personnel including clinical networks by December 2007 thereafter annually.
- Provisional new values and Code of conduct prepared immediately but refined progressively throughout leadership and workshop series by July 2006.
- Formal review of leaders performance involving chairs of District Health Council peers and managers at three months, six months and twelve months following the leadership development program. Leaders unable to satisfy the new requirements would not be retained in leadership roles. The process to be confirmed by the Auditor-General.
- Workplace culture and staff satisfaction surveys in late 2007.

14.9.3 Teaching and training renewal

Summary

- More registrar places and protected specialist teaching time
- Skills upgrades for all clinicians across the health continuum (primary, secondary and tertiary care)
- More scholarships all categories
- fund re-entry training for nurses
- In-service clinical teaching/training upgrades all categories. Should include exploring local practice changes to better use the skills available e.g. specialist nurses
- Fund/resource the Skills Centre
- Clinician interchanges interstate and overseas
- New training/development pathways – competency based not time based
- New models of care and clinical roles to maximise value from existing clinical teams
- Effective partnerships with the tertiary and vocational educational sectors to develop and maintain relevant programs for health professionals.

Details

This set of reforms must be led by re-established and empowered clinical leaders within Central Office, the Development Unit and Skills Centre, with strong links to all health service facilities. It is suggested that to maintain clinical relevance, the clinical advisors rotate on a 2 – 3 yearly basis from clinical positions within health services.

There is an urgent need to fund and establish more Registrar places and protected specialist teaching time for doctors. Commonwealth funding or joint pilot approaches with the Commonwealth are necessary and the process of targeting initial priorities which has already commenced must continue in earnest. Capacity is essential to teach and train all of the local doctors that are available to work in Queensland especially in an environment where we will be unlikely to recruit sufficient doctors for the next 10 to 15 years.

It will be necessary to arrange numerous clinical and administrative skill upgrade sessions for the workforce particularly the clinical workforce. This includes general programs such as computer keyboard skills to the more specific involving clinical networks and contribution to improved quality and safety, improved clinical practice and outcomes, and enhanced team development leadership and management development initiatives.

Until additional capacity can be created in the numbers of nursing, allied health professionals and doctors needed to relieve their colleagues, little training and development will be possible in the system. Adequate funding must be available to build capability to relieve the existing workforce to enable training and development to occur.

An important foundation in this process will be the Skills Centre which should be appropriately led, staffed, resourced and programmed to support development of clinical skills throughout the state. It will be prudent to fully utilise the capacity of the Skills Centre through both contracting individuals from other sectors to provide training and for training to be offered on a fee for service basis to up skill clinicians working in the private and non-government sector.

Training within existing work teams where the mix of duties and processes of care are fully understood offers greater scope to develop new and enhanced models of care. This will also enable emerging clinical roles to be identified and developed (such as nurse practitioners and physician assistants). Area Health Services and Health Service Districts will have major obligations to facilitate this training and development.

Resources

- This project links with program 1 where the workforce leader will also take responsibility for this program.
- Intensive work required with workforce planning networks throughout Area Health Services and Health Service Districts and the workforce planning team in Central Office.
- Significant contribution expected from the Chief Medical, Nursing, Allied Health and Dental positions.
- Significant capacity building for the Skills Centre – including contracted resources.
- Significant requirement to have funding to develop pools of staff to assist with backfilling, within each Area and District Health Service to enable teaching and training to take place. It may be necessary to develop six monthly or annual training plans for forward planning purposes.

Annual training costs		
Free up Nurse Educators to train/teach	Covered by additional nurses in Program 1	P1
Support new employees and students with a network of preceptors and facilitators	150 FTE across the state	$11.25 M
Develop the Skills Centre to full capacity with a training network through out the state including backfill for contracted educators/teachers and participants	Average 1 day per year per clinician	$65 M
Total		$76.25 M

Timing

- Registrar places and protected teaching time organised by March 2006.
- New teaching requirements with existing staff specialists and VMO’s organised by June 2006.
- Longer term development plans by discipline developed through the Health Service District training networks for community health services and hospital by March 2006 progressively implemented and fully performing by December 2007.
- Relief pools progressively established by December 2008.

14.9.4 Hospital/health service improvement

Summary

- New models of care and clinical roles progressively implemented.
- Redesign of patient flow process from primary care to acute care and within hospitals
- Addressing waiting times for appointments and waiting lists for elective surgery – transparent reporting, new care models, better logistics and efficiency in procedures
- Better connecting GPs to hospitals - more involved in patient pre and post procedural care (these initiatives must be driven locally by clinicians supported administrators
- Create an environment for clinical teams to spontaneously improve work practices and develop skills.
- Revised funding and budget allocation systems (casemix) over time to ensure fairer allocation for all Queenslanders.

Details

The centralised network of Reform Facilitators will work with their local health service facilities to renew patient referral and flow and ensure that facilities are designed and services are provided in a patient centric manner. This must be focused on connecting the full range of services across the primary to tertiary healthcare continuum in a targeted way for greatest impact and efficiency.

Work design studies typically require collaborative team based approaches where staff and patients work together to identify and resolve problems and redesign flow process. Formal projects take typically between six and sixteen weeks to assess, plan, resolve and redesign followed by some six to eighteen months implementation time depending on the complexity of the system being reviewed. However in a culture where shared leadership and continuous improvement is the norm, many shorter less formal projects would be occurring. Local leaders need a small amount of discretionary funding to action improvements.

Waiting times and waiting lists will only be successfully addressed once some very basic but urgent patient flow processes have been addressed in every Queensland hospital, and additional workforce capacity exists to ensure full productivity for operating theatres and hospital beds. As all of these resources are unavailable currently, there will be some lead time needed to gear up this initiative.

Once these are in place it is envisaged that clinical networks and clinical teams will be responsible for planning strategies to address waiting time and waiting list problems. This should be achieved by both greater throughput in the short term but improved prevention and primary care initiatives in the long term which reduce the need for some types of surgery.

As work redesign progresses new and innovative models of care will be identified and different clinical roles will evolve. The development of these initiatives is discussed in Section 14.9.3.

Better step-up and step-down facilities are an important part of this initiative where there are some significant long lead times. The IT enhancements, the supply of support staff for the clinical work place, revised funding and budgeting arrangements will all take some time to implement. The set of reforms are complex, highly interdependent and will require clinicians investing significant time away from frontline working obligations.

This set of reforms will only be able to be addressed if relief clinical teams and funding are available to support every major hospital in its reform task. Partnership arrangements with general practice and all primary healthcare providers including the non-government sector are also an important part of this process. The Chair of the local Divisions of General Practice (or nominee) should be paid to participate in service planning and patient flow initiatives.

Resources

- Part time member Reform Leadership Team.
- External expertise required first six months.
- Funding for support/data analysis for Clinical Networks secured until 2008 (Commonwealth Quality and Safety Funding).
- Each Clinical Network requires **$300,000** to cover leadership, administrative support and immediate initiatives. For some 20 networks this is **$6 million** per annum.
- Work redesign funding (includes part time backfill, patient involvement, analysis and implementation costs funded from the Innovation Fund (or if large a separate allocation) at $**15 million** per annum.
- Continue elective surgery additional funding –
    - Year 1 **$100.8 million**
    - Ongoing **$61.6 million**

Timing

- All Reform Facilitators and other Health Service District capacity building by March 2006.
- Health Service District project priorities identified by March 2006 followed by project implementation.
- Clinical networks identified and priorities and plans in place by March 2006.
- Budget reform (casemix funding model) and funding team implementation commencing Budget 2006-2007.
- Urgent elective surgery plan by December 2005, implemented by March 2006
- Clinical network team plans for addressing patient flows, alternate surgical management and longer term waiting list issues by June 2006. Intense implementation to March 2007.
- Progressive improvement plans by Health Service Districts and Clinical Networks over a three year period.

14.9.5 Safety, quality and clinical governance

Summary

- Urgently implement recommended privileging and credentialing arrangements for existing and new doctors
- All improvements must be progressed in a just culture
- Must be driven through clinical networks so as to address issues with the highest potential to improve practice and outcomes
- External oversight provided by the Health Commission reporting to a Parliamentary Committee.
- Statewide timetable but led clinically both centrally and in each local health service.
- Must quickly establish the Clinical Governance Units to facilitate Area implementation by December 2005.
- Plan for and establish the Health Commission.

Details

The Department is already implementing clinical collaboratives using processes that will establish the formalised structure of clinical networks envisaged. As these processes rely on the willing input and contribution from clinical teams across the state, it cannot be accelerated at a pace more than it is practical and possible for individuals to contribute.

The role of Central Office, Area Health Service and Health Service District executives is to be one of support and encouragement rather than traditional prescriptive requirement and decision making.

There are significant challenges here as the community expects high standards of quality and safety and the traditional approach which demands behavioural change and conformance may have popular appeal but experience elsewhere has found that this approach fails to achieve the impact required and in fact causes considerable harm to efforts to improve quality and safety in acute hospital settings. Providing a "just" and enabling environment including necessary legislation to protect individual clinicians acting in good faith and appropriate funding models are key requirements. The clinical governance units in the Area Health Services will oversee the clinical governance system.

Detailed planning will be necessary to create the Health Commission including:

- Review existing Health Rights Commission Function and resourcing.
- Design Health Commission to discharge full clinical governance role including HRC functions.
- Review legislative interface issues between Health Commission and Registration Bodies, MC, Ombudsman, Queensland Police Service and State Coroner.
- Develop legislation, role, membership and structure for the Health Commission.

Resources

- Two part time senior medical practitioners from the Development Unit in the Reform Leadership Team to develop networks for patient safety and clinical practice.
- Training of part time senior clinicians as network leaders.
- Training in clinical governance for all Medical Superintendents and Directors of Clinical Divisions in hospitals so they are an integral part of the system.
- Development Unit personnel involved intensively.

- Support resources and time allowance required for Clinical Network leaders.
- Immediate appointment and training of Area Health Service Clinical Governance leaders.
- Criminal history checking a priority for those working with children.
- Health Commission staffing and operations.

Timing

- Clinical networks fully functioning by December 2006.
- Incident monitoring (using techniques such as CUSUM) and incident investigation (using techniques such as root cause analysis) and internal reporting fully functioning by December 2006 in all hospitals.
- Audit review of systemic issues by the Health Commission June 2006.
- Health Commission plan of operation by March 2006 to commence in July 2006 (growing incrementally).

14.9.6 Patient complaints and responding to concerns

Summary

- Local resolution as the basis for complaint management (over 20,000 annually)
- Systemic improvements and dedicated trained personnel for the process
- Patients and clinicians engaged from the outset
- Open disclosure of problems to be the accepted norm
- Clear escalation processes and efficient referral process in place
- Simplify, integrate and strengthen existing review mechanisms eg Health Rights Commission/Medical Board/CMC/Ombudsman as part of planning the new Health Commission.

Details

Local resolution will be the cornerstone of the contemporary complaints process in Queensland Health. Local Complaints Coordinators, highly skilled in mediation must be properly selected, trained and developed so they can undertake this task. It is important that all clinicians understand they have a responsibility to personally assist in the timely resolution of complaints involving them. A database for recording all complaints is required to enable tracking of individual complaint resolution and monitoring patterns.

Local Complaints Coordinators must be able to mediate and resolve issues between patients and the health service, and to do this in a manner sufficiently independent from the workforce to show a fair, just and impartial approach in their task.

Escalation processes will then lead within 30 days to a locally based empowered Health Commission Officer, who will then deal with the complainant and the health service representative in a direct way to try and resolve the matter. The Complaints Coordinator and Health Commission personnel must have extensive expertise in understanding the proper role of all other regulatory and oversight bodies including all of the Registration Boards for clinicians, the CMC, the Ombudsman, the State Coroner and the Queensland Police Service so that matters that are appropriately the responsibility of these bodies can be referred promptly to them.

Complaints concerning doctors must all be notified to the Area Director of Clinical Governance at the time local resolution is commencing.

Resources

- Skilled facilitators/trainers to prepare Complaints Coordinators and Health Commission officers for their local complaints resolution role.
- Develop consistent complaints resolution and escalation systems for both patient and staff complaints involving executive teams in all locations including Central Office.
- IT support systems developed and rolled out.

Timing

- Complaints systems development by December 2005 and operational by July 2006.
- Appoint and train Complaints Coordinators by March 2006 (linking to new arrangements with Health Commission).
- Complaint system database with access arrangements to Health Commission in place by July 2006.

14.9.7 Restructure Central Office and devolve personnel, positions, resources and authority to Area Health Services/Districts

Summary

- Empowered local Area and District Health Services
- Area integration of service planning, resourcing clinical networks, partnerships, performance support and monitoring
- Restructure and refocus Central Office – key functions include strategic direction, governance, policy (integrated across continuum), funding and resource allocation, legislation, regulation, performance, targets and monitoring
- Enhanced collaborative Central Office/Area Health Service model for strategic planning, service planning, resourcing and industrial relations, human resource management
- Business units for statewide support services – IT, capital projects, radiology, pharmacy (new) and pathology (as at present).
- Redesign/renew human resource side of shared services before new SAP solutions implemented.

Details

A restructuring team should be established to form new Central Office Units, oversee the devolution of resources from Central Office to Area Health Services and Health Service District and reduce positions in Central Office.

As executive leadership positions have new responsibilities and obligations in Central Office, and in Area Health Services, positions need to be advertised as soon as practical. Existing executive directors positions to remain with incumbents to continue in roles until new appointments are made. Stability and consistency to be maintained whilst restructuring is occurring. Planned and staged restructuring processes will be necessary, including important workforce planning tasks to ensure all staff are treated fairly as the change process evolves.

As this is a significant down-sizing, special consideration and arrangements are suggested to properly support the staff. For example in addition to the usual public sector approach a team will be established to support staff through change.

The restructuring process envisaged is as follows:-

- Principles of dignity, fairness and respect to apply.
- Support for staff through the “Supporting People Through Change Team” including provide a hotline and outplacement services to cater for special needs.
- Consultation with unions to achieve the best process.
- Retain existing staff in senior Area Health Service and Central Office leadership roles until new positions are advertised and filled.
- Managers immediately below these levels continue to serve in their existing capacity until structural change evolves.
- Existing managers to work with restructuring team to identify positions to remain in Central Office to be reallocated and those to be abolished. The number and allocation of positions are noted in Chapter 5. No AO2, AO3, A04 support positions to be abolished.

- For positions and staff to remain in the new Central Office Units a closed merit process is used to minimise formal written application requirements to greatest extent possible.
- Discussions should be held with staff to canvass preferences and views
- Arrange all public sector entitlements
- Area Health Services and Business Services to secure and establish necessary accommodation before positions relocate
- A review should be undertaken of the HR side of Shared Services to streamline award conditions and arrangements before the new SAP system for HR in 2007-2008
- As noted in Chapter 5, population health and mental health positions re-allocated from Central Office to Area Health Services must be used within those respective services.

The Central Office Reform Team leader would be a full time member of the Reform Leadership Team to ensure that structural change occurs as effectively as possible and is well integrated.

Executive Directors and Area Health Service General Managers would coordinate movement of positions and staff.

The Supporting People Through Change Team and program needs to be established to support all staff during the process and ensure they are treated with fairness, respect and dignity.

Resources

- Central Office Reform Team leader to be part of the Reform Leadership Team.
- A restructuring team comprising HR representatives and members from each major directorate affected within the former Corporate Office structure and a representative from each of three Area Health Services (estimate ten FTE for nine months).
- Cost estimates for accommodation and fit out for Area Health Services and Business Services, savings from abolished positions (where they are currently filled) and voluntary early retirement to be developed.

Costs Central Office Restructure		
Restructuring Team	10 FTE for 9 months	$1 M
Outplacement services		$1 M
		$ 2 M

Timing

- Senior executive positions advertised and Reform Leadership Team personnel selected as soon as practical after 30 September 2005
- Central Office Reform Team established early in October 2005
- New senior appointments by November 2005
- New accommodation determined by end November 2005. Positions progressively assigned.
- Re-allocation of positions and associated resource determined by December 2005
- Central Office restructuring completed June 2006
- Area Health Service and Business Services established June 2006.

14.9.8 Strengthen community and sector partnerships

Summary

- District Council Chairs to attend leadership program.
- District Health Councils meet with a representative from each Area Health Service responsible for input into service planning, service quality, complaints resolution, service performance relative to other health services.
- Working arrangements between District Health Council and Area Health Council to be clarified.
- New community/patient centred partnerships developed
- New community, non-government organisation partnerships for primary care and pre and post acute care especially mental health
- New partnerships with local government and other human services providers (government and non-government) to support non clinical needs of patients particularly in Indigenous Health and Mental Health.

Details

This report has discussed the importance of strengthening partnerships across the health service continuum with the community, non government sector and private sector providers to gain synergy between existing services. Leaders within each Area Health Service and each Health Service District need to perform this role.

Queensland has limited formal partnerships and community linkages compared to those evident in New South Wales and Victoria. The new Area Health Services and Health Service Districts need to do a great deal to put these partnerships and community linkages into place.

The first priority will be to define new roles for District and Area Health Councils which will legitimately involve them linking with their local communities to provide feedback to their health service about:

- health service needs of people in the District/Area
- scope of service being offered, the responsiveness and the quality of that service.
- the extent to which health service expectations and needs are being addressed across the continuum of primary through to tertiary care for the local community
- the extent to which the health service is responsive to community feedback and priorities about service delivery issues
- satisfaction with the complaints resolution process
- providing significant input into the health service planning process which needs to be updated annually.

The Reform Facilitators could work with District and Area Health teams and their Health Councils to ensure new roles are supported, assimilated and implemented. Representatives on District Health Councils need to be able to develop their own community networks and work with these networks to contribute effectively at District and Area Health Council Meetings. Councils should receive a regular consistent set of reports about performance of their local health service compared with standards being achieved in other comparable health services throughout the State and possibly interstate. The information system, database and reports necessary to support Councils appropriately

will be developed by the Performance Directorate working with the Development Unit and Area Clinical Governance Units.

District and Area Health Service Councils will have a priority to advance health service planning including service obligations for different sized communities that need to be developed in conjunction with clinicians. Councils will need to be resourced and supported to do this.

With respect to new partnerships with general practice, the non-government health services and private health services, Queensland Health must ensure that its clinicians and administrators developing these partnerships are appropriately trained for their role. They must have clear expectations about the concept of equal partnerships and the way in which the various groups need to work together to resolve common problems and contribute significantly to the initiatives to improve continuity of patient care and service in a patient centric way. These initiatives link to those hospital, health system and service redesign and improvement programs, including projects to strengthen primary care and limit patients entering acute care. Developing new step up and step down facilities that limit acute admissions and re-admissions to hospital would feature prominently in these partnerships.

Resources

- Driven by Area and District Health Services
- District/Area Health Council will have increased costs to enable significant community engagement **$10 million**
- Step up/step down facilities and other partnerships and plans may require signification allocation of funds

Timing

- Area and District Health Council Chairs involved in initial leadership workshops pre December 2005 to inform them on the organisations intentions.
- New role of councils discussed and formalised by March 2006.
- Targeted program of reform to be prepared by each District and Area Health Service including step up and step down facilities by December 2006 in conjunction with health service plans.

14.9.9 Health service planning and workforce planning

Summary

- Plans developed by District, Area and State
- Universal service obligations defined
- Review and improve transport arrangements
- Transparency in decision making about the scope of local health service provision (where service not available, indicate whether due to clinical capability or funding)
- Plan to address critical workforce shortages intensively for three years and a longer term plan for the next ten years.
- Maximise value of existing health workforce through increased advanced and new workforce roles and increased linkages with the private sector.

Details

Queensland Health should place greater effort into health service planning and workforce planning. Health service and workforce planning units will be established in the Policy, Planning and Resource Directorate of Central Office, complemented by service and workforce planning capability in Area Health Services. The clinical networks to be established will play a role in health service planning, as will input from the community through the community partnerships and input from Councils as described above.

Difficult questions need to be addressed including the range and scope of health services to cover current and emerging community health service needs, the need to constrain certain services due to challenges of clinical capability, geographic areas or financial issues. The community through District Health Councils should be involved in recommendations to government about health service plans. Services must prioritise and target the most urgent needs. Issues such as increased tax, means testing and service prioritising are a legitimate set of issues where the community in time should be in a better informed position to provide advice through its local District Health Council to Government. The Area Health Councils because of their reports to the Minister could be able to provide this input directly.

Long term workforce plans should be informed by all stakeholders, including clinical networks, professional associations and academic institutions who have responsibility for teaching, training and development of undergraduates and graduates.

Workforce planning must complement health service planning. Comprehensive strategies are necessary. Workforce plans will address sources for recruitment, workforce retention, conditions of employment, the need to streamline current award structures and career progression.

Plans should also include all of the career and role enhancing arrangements necessary to ensure that the existing clinical workforce can be used to greatest value during the next decade when clinical resources are likely to be in short supply. The private and non-government sectors should be actively involved in the planning.

Resources

- Expert advice may be necessary to establish health service planning networks.
- Reform Leadership Team position links to Program 1.
- Full time appointments to health service planning positions in Central Office/Area Health Service with links to Health Service Districts and District/Area Health Councils.
- Strengthen strategic HR/IR function in workforce planning.

Timing

- First iteration of Area Health Service Plans involving all Health Service Districts by December 2006. Initially an indicative budget should be established and agreed for 2006-2007 financial year.
- Link workforce planning to Program 1 and 3 with the first iteration of a comprehensive workforce plan by December 2006.

14.9.10 Service enhancement to address special needs

Summary

- Indigenous health issues
- Rural and remote issues
- Mental health
- Chronic disease prevention and management strategies
- Child and youth health

Details

A range of recommendations have been made in respect to Indigenous health, rural and remote, mental health, chronic disease prevention and management issues and child and youth health. Specific networks need to be established to support all of these initiatives involving clinicians throughout the state. Policy planning and resourcing capability in Central Office focusing on these specialities should support these networks in developing immediate plans and implementing the most urgent priorities.

Resources

- Full time member of the Reform Team is necessary in the first instance with part-time specialist input.
- Networks need to be formed or strengthened for Indigenous, rural and remote, mental and child and youth health.
- Funding implication quite significant but will be developed by networks.

Timing

- Revised strategies must be developed using these networks and Area and District Health Services, the first strategy and plan by June 2006 to secure some funding from the 2006-2007 budget.
- A specific Chronic Disease Prevention and Management Strategy to be developed in Policy Planning and Resourcing Directorate.
- A large number of Health Service District specific projects/initiatives to be developed for each of these health sectors over the 2006-07 period prioritised and phased in.

14.9.11 Negotiating new partnerships with the Commonwealth

Summary

- Teaching and training.
- Primary care/acute care linkages and enhancement.
- New care pathways with pre and post acute services and involving non-government organisations.
- Integrated approaches to health service delivery for rural and remote communities.
- National standards for registration of medical practitioners and recognition of qualification from certain international jurisdictions.

Details

It would be important to enter into ongoing discussions with the Federal Government to try and secure commitment to joint projects and funding which might help to pave the way for addressing some of the most concerning long term issues confronting Australian health services. In the first instance, focus should be upon better funding support for teaching and training of medical practitioners in public hospitals and new primary care/acute care partnerships in both rural remote and urban settings.

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

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

14.9.12 Strengthen governance and reporting to government and the community

Summary

- Reform and performance KPI's for new services linked to new funding
- Statewide regular performance reports (Auditor-General oversees)
- Statewide regular clinical outcome reports (Health Commission)
- Consideration about preferred reporting and public accountability processes for Queensland Health, existing statutory boards such as Registration Boards, the CMC, Ombudsman and new Health Commission. Reporting links to the Director-General, Minister, Steering Committee and Parliamentary Committee also relevant.

Details

Recommendations have been made to broaden the focus of performance reporting for Queensland Health, particularly in regard to quality and safety and the effectiveness of services. Reporting will only be useful if the outcomes are relevant to the delivery of services. Therefore performance reporting is closely linked to planning processes and performance agreements with senior leaders in the organisation. Performance review processes that provide feedback to the frontline to assist in service improvement and that provide accountability to government and the public must be in place. A range of reports at the District, Area Health Service and State wide level have been recommended.

Of particular importance will be monitoring progress of the reform initiatives. Reforms should be sequenced, implemented progressively, and with staged funding based on achievement of earlier agreed milestones or targets. As new service models and services are developed and implemented a similar approached should be taken.

Resources

- Establishment of Health Commission

Timing

- Performance Directorate development of new approaches by March 2006. Progressive roll out 2006-2007
- Escalation and re-development in time for 2007-2008 budget allocation discussions
- Links with Area Health Service and district executive teams, clinical networks and Development Unit essential
- Review of role and interface of external review bodies March 2006

14.9.13 Information management

Summary

- Current transformation project to realign priorities consistent with reform recommendations focus on improving clinical support systems such as community health, allied health, solutions for viability of ESP, PRIME and Complaints System
- Increase efficiency of work practices and use of remote diagnostic tools
- Information Strategy and Investment Board and Operations Board to prioritise in line with Review
- Staff internet access provided
- Expansion of access to desktop computers and mobile technology
- Alternate sourcing models for project and contract management
- Pre-qualified panels established for applications development
- Support training in both computer literacy and for specific applications for clinical staff
- IT system enhancements and support staff for clinical personnel

Resources

- Additional computers (one off) $25million
- Recurrent $7million
- Training to increase computer literacy $5million

Timing

- Re-align priorities and structures and governance within Information Directorate within 3 months
- Pilot staff training and increased desktop computer availability within 6 months and complete within 18 months.

14.9.14 Assets, capital and maintenance

Summary

- Establish asset planning in Area Health Services and Central Office Design Unit
- Function as part of Business Support Services Group
- Implement revised governance arrangements, reporting and post occupancy evaluation frameworks
- Transfer project management role to the Department of Public Works

Details

Clinicians perceive that there is little to no clinical input in the decision making in regard to the capital works and asset management program within Queensland Health. If we are to reverse this view, and engage the Health Service Districts and their staff in appropriate planning and execution of capital works programs, relationships must be developed between these groups of staff.

The previous State Hospital Rebuilding Program was problematic from all perspectives, but especially as there were limited resources allocated to planning, analysis and there was no standardisation of design.

The move of some of the capital works staff to the Area Health Service will enable a closer link to be established between clinicians directly, clinical networks, Area and District Health Councils. Clinicians lack the understanding about the processes involved in the development of the Asset Strategic Plan and the setting of priorities in particular. This would also enable direct clinician input into the development of the Asset Strategic Plan.

As new models of care are developed, capital works funding for services outside of hospitals (such as step up and step down facilities) will be required. Existing hospitals will also need additional bed and theatre capacity to address patient flow issues.

Resources

- A part time member of the Reform Team
- Part of the organisational structure initiative
- Ongoing dialogue with Area Health Service and the Department of Public Works in shaping new arrangements
- The December review of the maintenance needs will list revised priorities

Timing

- Immediately revise current asset strategic plan and review immediate priorities
- Conclude ongoing review of capital and maintenance requirements by December 2005
- Complete systems enhancement in Queensland Health by December 2006