5. Queensland Health's structure

5.1 Overview of the current structure

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

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

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

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

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

5.2 Problems with the current structure

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

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

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

5.3 Governance structures in Queensland Health

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

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

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

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

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

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

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

5.4 Main features of an improved structure

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

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

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

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

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

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

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

Principles of the proposed organisational structure

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

Features of the structure

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

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

Independent Bodies

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

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

Recommendation 5.1

The current 37 Health Service Districts are retained.

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

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

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

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

Recommendation 5.2

The functions to be retained within Central Office are:

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

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

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

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

Recommendation 5.3

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

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

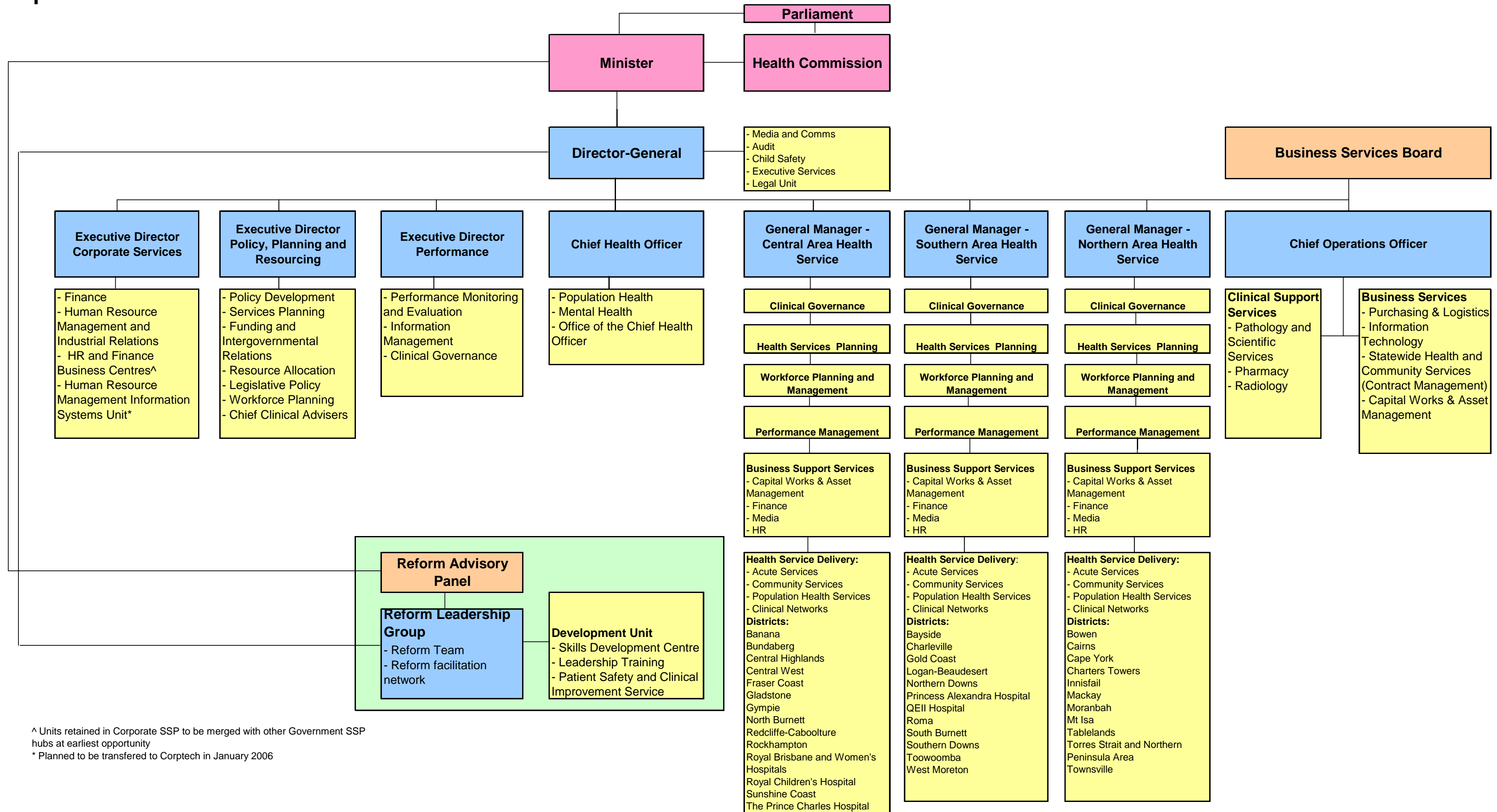
Establish a Business Services Board to oversee activity and advise the Chief Operations Officer and Director-General on commercial issues relating to statewide business and clinical support services to enable contestability for these services.

Culture

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

The proposed functional structure is shown on the following page.

Proposed functional structure



5.5 Review of Central Office

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

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

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

The following principles are suggested for the Central Office restructure:

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

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

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

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

Recommendation 5.4

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

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

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

Under the proposed structure the following staffing profile is recommended:

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

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

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

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

5.6 Roles of the different levels

5.6.1 Health Service Districts

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

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

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

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

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

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

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

Table 5.1 Health District Population and Area, June 2004

Health District	Estimated Resident Population	Area (km^2)	Health District	Estimated Resident Population	Area (km^2)
Banana	14,266	15,750	Mt Isa	30,772	223,447
Bayside	193,823	851	North Burnett	10,280	17,350
Bowen	31,202	26,230	Northern Downs	30,857	50,860
Bundaberg	87,933	12,590	Princess Alexandra Hospital	*	-
Cairns	144,309	35,747	QEII Hospital & District	443,629	319
Cape York	8,252	115,161	Redcliffe-Caboolture	182,499	2,708
Central Highlands	24,038	58,570	Rockhampton	102,251	20,060
Central West	13,340	396,600	Roma	18,216	89,970
Charleville	8,736	229,900	Royal Brisbane & Women's	**	
Charters Towers	15,495	136,500	Royal Children's	**	
Fraser Coast	83,070	7,783	South Burnett	33,596	11,690
Gladstone	44,713	6,709	Southern Downs	59,080	33,520
Gold Coast	403,703	887	Sunshine Coast	275,143	3,125
Gympie	35,624	2,967	Tablelands	37,802	132,200
Innisfail	34,513	5,621.5	The Prince Charles Hospital	581,465	1425
Logan-Beaudesert	298,235	3,625	Toowoomba	144,835	7,435
Mackay	113,175	13,620	Torres	10,419	1,857
Mater	n/a	n/a	Townsville	169,956	6,618
Moranbah	19,505	55,550	West Moreton	177,801	7,779
			Queensland (a)	3,882,037	1,734,949

(a) The area for Queensland is not equivalent to the sum of the component Health Service Districts due to rounding at the SLA level.
* The population and areas for the Princess Alexandra District overlaps with the QEII District.
** The population and areas for the Royal Brisbane District overlaps with the Prince Charles District.
Source: Office of Economics and Statistical Research, Queensland Treasury
ABS, Regional Population Growth, Cat no 3218.0, (unpublished data)

Recommendation 5.5

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

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

Table 5.2 Rural and Regional Health Service Districts

Northern Area Health Service	Central Area Health Service	Southern Area Health Service
• Bowen • Cape York • Charters Towers • Innisfail • Moranbah • Mt Isa • Tablelands • Torres Strait & Northern Peninsula	• Banana • Central Highlands • Central West • Gladstone • Gympie • North Burnett	• Charleville • Northern Downs • Roma • Southern Downs • South Burnett

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

Recommendation 5.6

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

District Organisational Structure

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

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

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

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

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

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

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

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

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

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

There are several options at least for these larger districts:

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

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

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

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

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

Recommendation 5.7

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

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

District Managers

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

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

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

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

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

Recommendation 5.8

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

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

5.6.2 Area Health Services

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

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

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

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

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

Recommendation 5.9

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

Recommendation 5.10

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

Table 5.3 Districts in proposed Area Health Services

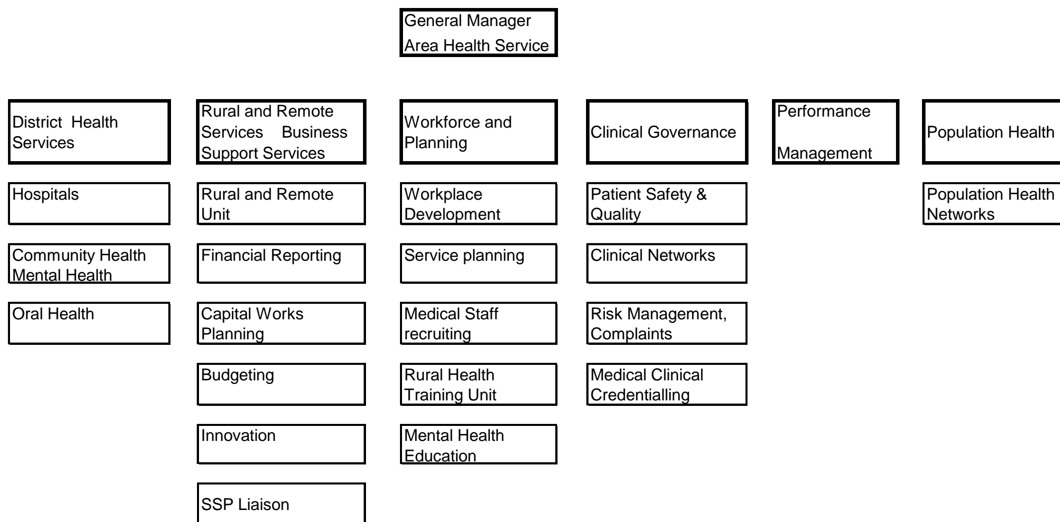
Northern AHS	Central AHS	Southern AHS
Bowen	Banana	Bayside
Cairns	Bundaberg	Charleville
Cape York	Central Highlands	Gold Coast
Charters Towers	Central West	Logan-Beaudesert
Innisfail	Fraser Coast	Northern Downs
Mackay	Gladstone	Princess Alexandra Hospital
Moranbah	Gympie	QEII Hospital
Mt Isa	North Burnett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

Key functions of Area Health Services

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

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

Proposed Functional Chart for Area Health Services



General Manager Area Health Service

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

Recommendation 5.11

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

The General Manager Area Health Services will be responsible for:

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

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

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

5.6.3 Clinical Networks

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

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

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

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

Implementation would include the following:

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

The networks are further described in Chapters 6 and 9.

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

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

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

Recommendation 5.12

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

5.6.4 Central Office

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

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

Director-General

Key functions of the Director-General are:

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

Policy, Planning and Resourcing Directorate

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

- policy development
- health services planning

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

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

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

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

Performance Directorate

The following functions are proposed for the Performance Directorate:

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

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

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

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

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

Chief Health Officer

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

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

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

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

Chief Operations Officer

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

Clinical Support Services

- Pathology and Scientific Services
- Pharmacy
- Radiology

Business Services

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

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

Corporate Services

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

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

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

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

5.7 Minister

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

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

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

5.8 Involving the community

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

5.8.1 District Health Councils

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

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

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

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

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

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

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

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

Recommendation 5.13

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

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

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

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

District Health Councils meet monthly.

District Health Councils to publish an annual report.

5.8.2 Area Health Councils

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

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

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

Recommendation 5.14

Area Health Councils be established in each Area Health Service.

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

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

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

Area Health Councils to publish an annual report.