Summary of recommendations

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

Chapter 3. Queensland's future health care issues	
3.1	The Queensland Government implement a three to five year funding plan to increase provision of public health services to a level more comparable with other States.
3.2	To address future health care challenges, alternative models of health care must be developed to reduce future pressure on acute hospital services consistent with the directions outlined in the recommendations of this report.
3.3	The Queensland Government to seek a specific national review of the future health care system in Australia, to resolve the respective roles and responsibilities of Commonwealth and State Governments in the provision of integrated health care for the Australian community.
3.4	Within the current Commonwealth-State responsibilities, the Queensland Government should work closely with the Commonwealth Government to address immediate health care priorities including: • implementation of the national system of registration for medical practitioners in conjunction with the other States • urgently examine the feasibility of the Commonwealth becoming the sole funder of doctors to reduce the current Commonwealth financial incentives for doctors to leave the public sector • urgently develop, in conjunction with professional colleges, a timetable for the establishment of all additional specialist medical training positions recommended by the Australian Medical Workforce Advisory Committee, with the Commonwealth Government to provide funding for the training positions • review the Medical Benefits Schedule to improve the alignment of Commonwealth funded services and the public health system including providing incentives to address particular areas of need such as rural health and Indigenous health • develop pilot sites in Queensland to trial arrangements such as pooled funding and general practitioners working in public hospitals..
3.5	The Queensland Government should engage with the Queensland community to clarify what the community expects from its health system, what it is prepared to pay and how it is prepared to pay for it. This needs to occur in the context of Queensland Health developing comprehensive health service planning and development of options with the community.
3.6	Queensland Health in conjunction with local government engage the community on the feasibility of introducing fluoridation to the drinking water, the consequences and cost.

<table>
<tr><th colspan="2">Chapter 4. Culture</th></tr>
<tr><td>4.1</td><td>Appoint a senior executive leadership team able to demonstrate positive leadership behaviours.

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

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

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

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

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

Surveys of workplace culture and staff satisfaction be undertaken regularly across the organisation so that all districts can monitor their progress with cultural change through time.</td></tr>
<tr><td>4.2</td><td>New approaches are developed to deal with staff conflict and grievances to be supported by

• access to training for managers where required to ensure that they have the skills to manage and develop staff and undertake performance assessments
• formalised performance assessment processes for senior executive staff and more flexible approaches for other staff which involve regular discussions with managers and supervisors, monitoring access to agreed training and development opportunities, clarifying expectations and reviewing performance
• local access to industrial and human resource expertise to assist managers in effectively dealing with difficult and complex human resource issues
• a system to monitor the effective and timely resolution of grievances
• a review of the effectiveness of the current internal process of investigation with a view to utilising private sector Human Resource expertise in this area.</td></tr>
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<table>
<tr><th colspan="2">Chapter 5. Queensland Health's structure</th></tr>
<tr><td>5.1</td><td>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.</td></tr>
<tr><td>5.2</td><td>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</td></tr>
<tr><td>5.3</td><td>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.</td></tr>
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<tr><td>5.4</td><td>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.</td></tr>
<tr><td>5.5</td><td>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.</td></tr>
<tr><td>5.6</td><td>Area Health Services review Health Service District boundaries and align district boundaries to Local Government Area and Statistical Local Area boundaries.</td></tr>
<tr><td>5.7</td><td>Area Health Service General Managers rationalise district executive structures to compliment clinical leadership and governance changes recommended to minimise overheads and ensure members of the district executive share equivalent tenure.

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.</td></tr>
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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.
5.9	South Burnett Health Service District be transferred from Central to Southern Area Health Service.
5.10	By 2010 the need for a fourth Area Health Service should be considered.
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.
5.12	Clinical Networks be established within twelve months and be recognised as a legitimate and authorised part of the formal structure.
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.
5.14	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.

Chapter 6. Corporate planning and budgeting	
6.1	Queensland Health to develop a comprehensive Health Services Plan for Queensland to inform clinical service planning, workforce planning, capital planning and information technology planning by the end of 2006.
6.2	Area Health Services to develop an Area Health Services Plan to inform State health service planning, local clinical service planning, workforce planning, capital planning and information technology planning.
6.3	Queensland Health in conjunction with the Commonwealth Government develop the concept of a universal service obligation for small rural communities with a population of less than 5,000 people to outline the minimum level of health service access.
6.4	Clinical networks to play an active role in service planning and in the distribution of available funding to support improving clinical practice.
6.5	Queensland and Area Health Service planning must take account of the minimum requirements necessary to provide quality and safe services, consistent with the Clinical Services Capability Framework.
6.6	Southern and Central Area Health Services to work closely to develop a health services blueprint for South East Queensland by the end of June 2007.
6.7	Queensland Health should sell its residential aged care places and where appropriate associated facilities.
6.8	Queensland Health review its continued provision, or scope of provision, of some health services where there are alternative providers who may be able to provide the service more effectively or provide services to areas of highest need (eg. provision of home and community care services).

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

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

<table>
<tr><td></td><td>coordination between sectors in provision of primary health care.

The recommendations from the Queensland Health review of multicultural health policies, in collaboration with community representatives, should be implemented.</td></tr>
<tr><td>7.3</td><td>Specialist outpatient and surgical waiting times should be made available publicly in such a way that it help patients and their health care providers make informed choices about their individual care options.</td></tr>
<tr><td>7.4</td><td>As part of the performance framework, report and monitor activity (weighted for complexity) and waiting times for elective, emergency and other surgery.</td></tr>
<tr><td>7.5</td><td>Consistent with the national approach to reporting elective surgery waiting times, the 5 percent long wait performance benchmark should be abolished consistent with the objective of prioritising patients according to clinical need.</td></tr>
<tr><td>7.6</td><td>Increase access to specialist outpatients by examining opportunities, including those detailed in the report, for specialist outpatient services (surgical and medical) to be provided privately as is done in other States and Territories.</td></tr>
<tr><td>7.7</td><td>Integrate the management and funding of all surgical activity including emergency, elective and other surgery with a view to prioritise patients on the basis of clinical need. This is consistent with recommendations in Chapter 6 where all acute services are proposed to be funded using a casemix funding model.</td></tr>
<tr><td>7.8</td><td>That the following principles be adopted to guide implementation of recommendations to improve timely access to public surgical services:
• Access to both specialist outpatient and surgery services are prioritised based on clinical need.
• All patients requiring trauma surgery receive treatment within 24 hours if clinically appropriate.
• Encourage all patients with private health insurance to use it as private patients in public hospitals or in the private hospital system.
• Any planned increases in surgical activity needs to be considered in the context of bed capacity and the likely impact on medical patients.
• Additional non-emergency surgery should not adversely affect the provision of care for emergency (surgical and medical) cases.
• Patients and their primary health care providers (GPs) should be empowered to make informed decisions about their care which would include access to accurate and timely information about waiting times and costs.
Further development of these principles needs to be considered by the relevant clinical networks to guide a Government position on public surgical services in Queensland.</td></tr>
<tr><td>7.9</td><td>Explore the introduction of means tested measures for non-urgent surgical services to improve the safety and timeliness of public surgical services for those least able to afford care.</td></tr>
<tr><td>7.10</td><td>Increase surgical throughput by 31,195 surgical separations weighted for complexity at an estimated cost of $100.8 million ($61.6 million of which is ongoing).</td></tr>
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<tr><td>7.11</td><td>Expansion of surgical activity, with a view to reducing excess demand, over and above existing targets should involve offering the opportunity to provide extra surgical services to the following (in order of priority):
1. existing staff specialists at overtime rates
2. Visiting Medical Officers currently operating in the public system (at sessional rates)
3. other specialists to operate as Visiting Medical Specialists (at sessional rates)
4. where services are unable to be provided in the public system, activity at an appropriate type and volume should be offered to syndicated private specialists, private hospitals and other interested parties who operate outside the public system (contracted arrangements based on a specific performance agreement).</td></tr>
<tr><td>7.12</td><td>Investigate and pursue the following clinical quality and improvement practices with a view to improve surgical capacity and patient outcomes:
• Pre-admission clinics
• Day of surgery admission procedures
• Discharge planning processes
• Outpatient and surgical waiting list booking processes
• Peri-operative management guidelines and procedures
• Theatre management and utilisation strategies
• Integrated bed management procedures
• Flexible rostering of staff (including 10 hour shifts)
• Post-acute and transitional care services
• Hospital in the home services
• After hours theatre utilisation
• Dedicated trauma / emergency surgery sessions
• Dedicated hospitals for elective surgery
• Expand the ‘Fit for Surgery’ scheme
• Regular administrative and clinical audits of the surgical access waiting list.</td></tr>
<tr><td>7.13</td><td>That as clinical networks become established, they be given responsibility for the implementation of strategies to improve surgical access in Queensland public hospitals. This would involve providing advice and recommendations to the sponsoring Area Health Service General Manager on surgical access issues for implementation.</td></tr>
<tr><td>7.14</td><td>The Queensland Government to encourage the Commonwealth Government to explore alternative funding or service models that would increase access to Commonwealth funded health services in rural and remote communities.
Safe, sustainable service models should be developed in partnership with rural and remote communities, the Commonwealth Government and other service providers. Suggestions should be drawn from innovative service models already in practice.
The report “Access to Services (Transport is the Key)”, should be used as the basis for reforms to patient transport, particularly in rural, remote and regional</td></tr>
</table>

	areas. Education and training providers will be engaged to assist with increasing workforce supply in rural and remote areas and better develop "generalist" roles including rural generalist doctors, advanced rural and remote nurses, nurse practitioners and paramedic primary care providers. The Queensland Government to engage with the Australian Medical Council and the Commonwealth Government to advocate for recognition of rural general medicine as a new specialty. Queensland Health will partner with the Australian College of Rural and Remote Medicine to facilitate procedural training for rural generalist doctors. Remuneration and incentive packages, including better access to professional development should be improved, to attract clinicians to rural and remote areas. Peer support networks should be established at Area Health Service level, for isolated workers, based around professional groups or streams of care. All rural and remote services will need to be networked with larger centres, including a tertiary metropolitan hospital. The purpose will be to provide outreach services and some staffing relief. Area Health Services will establish a register of clinicians willing to perform short or long term country service.
7.15	Better ways will be trialled, to work closely with Indigenous communities, government departments and the non-government sectors to contribute to efforts to reduce Indigenous disadvantage in both urban and remote settings. In particular, Queensland Health will urgently lead the development of alcohol demand management strategies in the nineteen Indigenous communities where Meeting Challenges Making Choices is implemented. There should be a stronger emphasis on health promotion so that Indigenous people have the skills, knowledge and resources to make healthy choices. A more flexible approach to Indigenous health services should be established to support existing and new service models including fund pooling and service coordination models, with an overriding commitment to the principle of self-determination and community control. Partnerships with universities and other providers should be developed to increase Indigenous entry and retention into health professional education and training. The role of Indigenous Health Workers should be further developed, through access to funded training and skills enhancement programs and will aim to recruit local workers to local positions to improve staff retention.
7.16	A review of the current funding arrangements for mental health should occur, and Area Health Services will undertake an immediate mapping exercise to inform further mental health reforms with a view to: • Continuing to increase investment in the community health sector • Increasing provision of supported accommodation including "step up" and "step down" facilities • Developing new models of care with the private and non-government sectors and continuing to increase investment in non-government mental health

	services • Increasing participation of consumers and carers in decision making • Improving linkages and partnerships with other sectors to improve post-discharge support, improve services for population groups with multiple and complex needs and increase efforts around mental health promotion and prevention • Improving mental health services for people in correctional facilities and custodial settings • Increasing integration of mental health and alcohol, tobacco and other drugs services • Strengthening organisational leadership around mental health including stabilising turnover in key central leadership positions • Addressing workforce pressures as recommended in Chapter 10.
7.17	Within 12 months a clear, strategic approach to community health service provision in line with the directions for change outlined in section 7.7.1 will be adopted.
7.18	Health care in correctional institutions be resourced adequately and Queensland Health and Department of Corrective Services seek agreement on the best future delivery options.
7.19	Options to improve provision of oral health services be explored including continuation of school dental services, review of eligibility criteria for adult services, alternative workforce roles and mixed models of public/private practice. There should be an informed public debate about widespread fluoridation of Queensland's water supply. The involvement of private sector oral health practitioners in delivering public services be encouraged through local fees and arrangements that flexibly address the merits of each case.
7.20	A state wide network should be developed for child and youth health across the health continuum involving other major providers and partners. Further expansion of telehealth services should occur where appropriate to maximise availability of paediatric services and clinical education. The development of tertiary paediatric sub-specialty services should be reviewed.

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

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

Chapter 9. Clinical governance and risk management	
9.1	Queensland Health should establish risk registers at all levels in the organisation (District, Area and Central Office) and identify the individuals who are accountable for the management of those risks.
9.2	The importance of the risk management function needs to be recognised by providing recurrent funding for this activity.
9.3	The Medical Board of Queensland be encouraged to: • ensure that registration processes (current and future) provide a high quality assessment and are implemented in a timely and efficient manner • conduct clinical assessments of non-specialist grade overseas trained doctor with special purpose registration and • continue to conduct the assessment of overseas trained doctors (OTDs) for practice at specialist level via the established Australian Medical College/College pathway. • That Queensland Health implements the Recruitment, Assessment, Placement Training and Support (RAPTS) program for OTDs.
9.4	Credentialing of medical practitioners should occur at Area Health Service level facilitated by the Clinical Governance Unit using National Guidelines. Clinical privileging (the specific services that are suitable for the local health service) should also be performed by the Clinical Governance Unit and should include on the committee a representative of the District Manager of the specific

<table>
<tr><td></td><td>employing health service. Privileging decisions should be based on the Service Capability Framework.</td></tr>
<tr><td>9.5</td><td>Policy, guidelines and training should be developed to support a consistent statewide approach to:
• conduct individual clinician performance assessment and development
• manage concerns about an individual clinician's performance.
Where there are concerns about an individual clinician's performance:
• the Area Clinical Governance Units should take responsibility for the assessment of the clinician and recommendations regarding remediation
• the District Manager will be responsible for decisions regarding the management of an individual clinician.
The Medical Board of Queensland be encouraged to:
• develop a performance evaluation program that is non-punitive and provides a framework for ongoing demonstration of professional competence. This will require new legislation.
• develop guidelines regarding its expectations of medical practitioners to participate in continuing professional development.</td></tr>
<tr><td>9.6</td><td>Queensland Health through the Patient Safety and Clinical Improvement Service should proceed to implement the national Open Disclosure Standard for communication with patients and relatives following an adverse clinical incident or event.</td></tr>
<tr><td>9.7</td><td>Appropriate training in the use of specific service improvement techniques such as incident investigation, clinical audit, benchmarking and clinical pathway variance analysis should be developed and implemented with the support of the Patient Safety and Clinical Improvement Service and involvement of clinical leaders.</td></tr>
<tr><td>9.8</td><td>Evidence based clinical pathways targeting high volume services (where standardisation will improve safety and quality) should be developed (or purchased) and implemented by clinical networks with the support of the Patient Safety and Clinical Improvement Service.</td></tr>
<tr><td>9.9</td><td>Effective quality and safety benchmarking processes should be developed by Clinical Networks facilitated by the Patient Safety and Clinical Performance Service.
Clinicians participating in clinical networks should involve local clinical teams in the discussion and interpretation of benchmarking data.</td></tr>
<tr><td>9.10</td><td>Clinical audit (including routine death review) should be a routine activity for all clinicians, clinical networks and services. The necessary tools, resources, information systems and support should be developed and made available to facilitate this activity.</td></tr>
<tr><td>9.11</td><td>Review and implement the incident management policy.
Address the current issues with PRIME before continuing implementation across the state including improved training for staff. Develop a strategy for future</td></tr>
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	system enhancement (including a review of national progress on the development of incident monitoring systems and potential benefits of national standardisation). Queensland Health in conjunction with the State Coroner should develop a policy and process to enable reporting to the State Coroner of all deaths that are not reasonably expected to be an outcome of a health care procedure. Analyse serious and sentinel events at an area health service and state level (and contribute to national reporting) with a focus on preventing and minimising harm. Based on incident analysis develop and implement state-wide safety initiatives using clinician led networks. Measure and report on safety culture within health services to promote attitudes and behaviours associated with safe practice. Provide an annual public report on sentinel events.
9.12	Endorsed priority programs in medication safety, infection prevention and control, falls, correct site surgery and pressure ulcers should continue to be developed and implemented.
9.13	Development of legislation encouraging and protecting good quality and safety assurance analysis should proceed and be submitted to the Health Minister to progress. Review of the recent confidentiality provisions of the *Health Services Act 1991* should be conducted during 2006 to determine the impact on the effective sharing of information by clinicians for quality assurance purposes.
9.14	Queensland Health should work with health service accreditation agencies to establish more meaningful quality and safety measures for accreditation assessments.
9.15	Revise the Patient Charter to incorporate changes resulting from this Review and communicate patients' rights and responsibilities to patients and their carers. Establish District Health Council and Area Health Council processes for consumer and community input into service planning and evaluation. Establish a strategy for consumer feedback (including but not limited to patient satisfaction surveys) at the District and Area Health Service levels. This should be developed in the context of a statewide framework for consumer and community engagement and supported through the development of appropriate tools and methodologies and appropriate resourcing.
9.16	A complaints model be adopted that provides for local resolution first whilst requiring escalation to an independent complaints body, a Health Commission, if the complaint is not resolved in 30 days. District Complaints Coordinators with the skills and the delegation required be employed to take primary responsibility for complaint resolution and be supported through appropriate training and networks. A Complaints Manager position be created for each of the Area Health Services to support District Complaints Coordinators and ensure all complaints about health care in the Area Health Service are resolved or escalated to a Health Commission

	and that actions taken in response to such complaints are appropriate.
9.17	District Managers will table regularly at District Health Council meetings de-identified district complaints and compliments data and any Health Service District and Area Health Service trends and learnings to keep community representatives informed.
9.18	Consideration should be given to developing one statewide complaints database with a number of security access levels which would record all complaints and compliments about Queensland Health's services.
9.19	A Health Commission should have access to Queensland Health complaints data about patient care and the complaints database, and should be able to take over the management of a complaint at any time. An independent patient support officer service be arranged with the non-government sector and managed through the Health Commission. Some Health Commission staff be located around the state to assist healthcare consumers in resolving complaints.
9.20	All current and prospective employees should undergo criminal history checks in the interests of patients and staff. Staff working with the most vulnerable patients/consumers should be targeted first.
9.21	Changes considered to the *Whistleblowers Protection Act 1994* Whistleblowers should be able to lodge Public Interest Disclosures with Members of Parliament and have protection under the Act. The media should not be approved as one of the bodies to whom Whistleblowers can lodge Public Interest Disclosures and have protection under the Act. Any person not just a public officer should be afforded protection for disclosing danger to public health and safety.
9.22	A separate and short review needs to be undertaken of the legislation and working arrangements between existing external complaint bodies nominated in the report.
9.23	The Health Commission recommended in this report, with functions that include the coordination of health care complaints, be established. A Parliamentary Committee with the role and functions described in this report, be established to provide external oversight.
9.24	There needs to be public reporting on the performance of health services, as described in Chapter 13. This would include an enhanced role for Area and District Health Councils.
9.25	A clinical governance structure be established that is clinician and patient focused with functions as outlined and the following components: • Safety and quality committees in all districts, chaired by senior clinicians (who are involved in clinical networks) • Area Clinical Governance Units in each Area Health Service led by a senior medical officer with experience in systems improvement

	• A statewide Patient Safety and Clinical Improvement Service • An independent Health Commission with responsibility to monitor the implementation of clinical governance and the safety and quality of health services and report publicly. • A Parliamentary Committee to provide external oversight. Professional bodies must be involved in implementing the clinical governance processes and enablers. The District Manager is accountable for the local implementation of clinical governance. District Health Councils and Area Health Councils will be provided with performance reports on quality and safety in their monthly performance information and a six monthly performance review report and will be provided with annual public reports on performance for the District and Area respectively (as detailed in Chapter 13).

Chapter 10. A workforce for the future	
10.1	**Provide immediate relief for doctors** Queensland Health should: • implement a local, interstate and overseas campaign to rebuild Queensland Health's reputation as an employer, including focused campaigns in the United Kingdom and other countries with equivalent doctor training (with the aim of recruiting 280 additional doctors to meet the shortfall in local supply and increasing demands for services) • undertake routine exit surveys of staff to determine factors driving loss of staff so as to better inform and target recruitment activities • increase flexibility in recruitment processes including advertising and selection processes • clarify with line managers the range of flexible recruitment processes that can be used under the Recruitment and Selection Directive to recruit doctors • maintain the capacity of local districts to undertake recruitment activities but introduce a centralised process for the recruitment of doctors with special purpose registration • seek to expedite national efforts to establish uniform medical registration arrangements through the Australian Health Ministers Advisory Committee including automatic recognition of graduates from countries with similar educational standards such as the United Kingdom, Ireland, and Canada • develop recommended student intakes in Queensland to inform negotiation with the Commonwealth to increase student places in all Queensland medical schools. Area Health Services should: • through their workforce planning areas, facilitate and support districts to undertake career and succession planning with the existing medical workforce and resource districts to maximise recruitment and retention of younger doctors upon completion of their training or return from training overseas.

<table>
<tr><td></td><td>The Queensland Government should:
• seek from the Commonwealth an immediate increase in medical student places and/or consider funding additional bonded places in Queensland medical schools.</td></tr>
<tr><td>10.2</td><td>Improve retention of the medical workforce
The Queensland Government should:
• encourage enterprise bargaining approaches that are interest based rather than adversarial, which address the lack of flexibility and complexity of the current arrangements and occur as close as possible to clinicians and service delivery
• negotiate with Visiting Medical Officers (VMOs) to achieve a move from award based to contractual arrangements
• pending the outcome of the enterprise bargaining process, adjust the level of clinical loading paid to clinical academics working in public hospitals.
Queensland Health should:
• plan and develop a hospital generalist career structure and work with the university consortium to develop a training program to support this new role
• offer HECS payment in return for a period of bonded service to retain junior doctors and registrars upon completion of their training
• urgently implement strategies to improve organisational culture and foster strong leadership and change management capacity within the department, discussed in Chapter 4
• ensure doctors are provided with timely, quality travel and accommodation services.
Area Health Services should:
• ensure doctors have access to revised and better targeted and resourced training in managing patient and carer aggression
• create peer support networks along professional groupings or streams of care to improve support for isolated workers.
Districts should:
• discuss and agree with VMOs the best way to establish and improve communication
• provide amenities such as meeting and training rooms, tea rooms and personal space (eg lockers) where feasible and in consultation with doctors
• ensure all medical staff are made aware of their entitlements through a clear induction process, that these entitlements are included explicitly in individual performance and development plans and that medical staff are supported to access their entitlements.</td></tr>
</table>

10.3	**Maximise the value of the medical workforce** Queensland Health should: • offer increased sessional work to the existing VMO workforce and increase numbers of VMOs in the public system • offer incentives for existing medical staff and VMOs to perform additional sessions especially surgery • outsource services in areas of acute service and workforce pressure, subject to work first being offered to existing medical staff and VMOs • monitor evaluation of new technologies used in other jurisdictions and undertake cost benefit analysis to determine suitability for local implementation. Area Health Services should: • facilitate trials of consultant led services in a small sample of metropolitan and regional hospitals • facilitate and resource districts to devolve non-clinical tasks to non-clinical categories of staff including provision of adequate secretarial support to doctors • establish a register of clinicians – including doctors – willing to undertake country service rotations and design a country service incentive package • incorporate use of technology such as telehealth within service and workforce planning to maximise opportunities for medical outreach to smaller districts. Districts should: • explore new practice and partnership arrangements with general practitioners, in association with the medical College and the Rural Doctors Association of Queensland, particularly in the management of outpatients clinics and provision of medical services in rural and remote communities by procedural general practitioners on a sessional or outsourced basis • negotiate opportunities to introduce flexible hours of work to increase productivity subject to staff availability and interest. Clinical networks should: • lead implementation of outcome based clinical pathways to improve care and streamline work practices.

10.4	**Improve medical education and training** Under the new structure, Queensland Health should establish a dedicated medical workforce planning group to undertake the following specific tasks: • assess the adequacy of current and planned undergraduate medical student places to meet future workforce needs • review the number, mix and distribution of current medical training places across the public health system • develop a strategic plan for the placement of trainees and detail priority areas and locations to be addressed • explore options with the universities, professional colleges and other relevant agencies to improve education and support of the medical workforce • progressively increase registrar training numbers in line with AMWAC recommendations • develop clinical training networks which link teaching hospitals in metropolitan and provincial centres with non-teaching hospitals in both metropolitan and rural areas • review the suitability of the current apprenticeship based training model to cope with increasing medical graduate numbers and opportunities to fast track training programs • examine avenues for greater private sector involvement in medical training. Queensland Health should: • review the membership and operation of the Queensland Medical Education Council to strengthen its role in providing strategic direction and advice on medical education issues • seek support from the Commonwealth and the State to increase the level of funding available to support the teaching and training of students on clinical placements within Queensland's public health system given this is an area of shared responsibility • explore with the Colleges opportunities to further consolidate teaching and development time under specialist training programs linked to competencies • introduce mechanisms to provide protected time for senior clinicians and trainee specialists involved in teaching and training junior staff and ensure that sufficient resources are available to support this role • work with the Commonwealth to examine strategies for seeking contributions from the private sector and medical practitioners who choose to leave the public sector, towards the costs of clinical training • expedite the implementation of the new training model for overseas trained doctors with special purpose registration so they can achieve full registration within four years.

10.5	**Provide immediate relief for nurses** The Queensland Government should: • increase the number of graduate nurses employed annually • provide infrastructure support to enable Queensland Health facilities to accommodate the clinical placement of larger numbers of student nurses • increase places in the vocational education and training sector for enrolled nurses and assistants in nursing Queensland Health should: • implement a local and interstate campaign to encourage former nurses back into the workforce and promote available support with a target of an additional 1,500 nurses (phased in over three years in addition to the need to continue growing the workforce by an average of 500 to 600 nurses per annum) • undertake routine exit surveys of staff to identify the factors driving loss of nursing staff and to inform recruitment activities • support the existing nursing workforce to attract and recruit senior nursing staff back into the workforce in targeted specialties including critical care, mental health, theatre and midwifery • continue and evaluate the nursing re-entry scholarship scheme as a strategy to attract nurses who are no longer registered or enrolled • increase flexibility in recruitment processes including advertising and selection processes and devolve recruitment responsibility to the facility level • develop recommended nursing student intakes in Queensland to inform negotiation with the Commonwealth to increase student places. Area Health Services should: • be resourced to support districts provide paid nursing refresher courses for registered or enrolled nurses wishing to resume practice • receive funding to support annual growth in the nursing workforce to maximise recruitment of graduate nurses and provide training to support their transition into clinical practice recognising the needs of nurses transitioning into specialty areas such as theatre, intensive care and emergency departments. Districts should: • establish in-house relief nursing pools and implement other strategies to better manage the existing nursing workforce as noted above (where this is not already occurring).
10.6	**Improve retention of nursing staff** The Queensland Government should: • review the process for enterprise bargaining to address the lack of flexibility and complexity of current arrangements and seek to provide fair remuneration and conditions • use nursing awards to create clinical career pathways to encourage advanced and extended practice roles and clinical leadership positions • consider extending paid maternity leave to support female clinicians, in

<table>
<tr><td></td><td>particular the predominantly female nursing workforce

use enterprise bargaining to remove impediments to workforce reform including extending scope of nursing practice, negotiating flexible employment arrangements and creating temporary positions for training purposes.

Queensland Health should:

undertake a feasibility study to determine the level of subsidy that may be required to support viable child care services located on health campuses
enhance clinical career pathways for nurses through creation of advanced and extended positions – including nurse practitioners - under a new award or additional paypoint in the existing award structure
urgently implement strategies to improve organisational culture and foster strong leadership and change management capacity within the department, discussed in Chapter 4
ensure nurses are provided with timely, quality travel and accommodation services.

Area Health Services should:

create peer support networks along professional groupings or streams of care to improve support for isolated nurses
ensure nurses have access to revised and better targeted and resourced aggression management training.

Districts should:

make every effort to accommodate flexible working hours and part-time work
explore with private child care providers opportunities to collocate child care centres on large health campuses
take a Statewide view of recruitment and retention and facilitate mobility at level between districts for existing nursing staff
provide amenities such as meeting and training rooms and safe car parking where feasible and in consultation with nurses
provide all new nursing staff with an induction which includes information about entitlements, with access to entitlements supported and monitored through individual performance and development plans.
</td></tr>
<tr><td>10.7</td><td>Maximise the value of the nursing workforce
The Queensland Government should seek from the Commonwealth:

access to the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme for community based nurse practitioners, in recognition that these roles are taking on functions traditionally performed by doctors.

Queensland Health should:

undertake urgent assessment with clinical networks and area health services of the size and nature of the potential nurse practitioner workforce
begin immediate negotiations with universities to ensure relevant course content for nurse practitioner master degrees
work with the Queensland Nursing Council to ensure appropriate registration and endorsement systems are established.
</td></tr>
</table>

	Area health services should: • be resourced to facilitate local, team based development and implementation of advanced nursing and nurse practitioner roles in areas of workforce or service pressures and managed through clinical networks where feasible • facilitate and resource districts to devolve non-clinical tasks to non-clinical categories of staff including provision of roster clerks, and support for advanced nurses with less time for non-clinical work • establish a register of clinicians – including nurses– willing to undertake country service rotations and design a country service incentive package. Districts should: • negotiate opportunities to introduce flexible hours of work to increase productivity subject to staff availability and interest. Clinical networks should: • lead implementation of outcome based clinical pathways to improve care and streamline work practices.
10.8	**Improve nursing education and training** Queensland Health should: • adopt a strategic and proactive approach to influencing the direction of under-graduate nursing education to ensure it continues to meet service delivery needs and to adequately prepare graduates for entry to the workplace • strengthen relationships with universities through adjunct or conjoint appointments and review the role of clinical facilitators at ward level to support nursing education • negotiate with the Department of Employment and Training and the Commonwealth Government to increase funding for enrolled nurses, assistants in nursing and other certificate based health workers with a focus on also attracting these workers to rural and remote communities • seek support from the Commonwealth and State governments to increase the level of funding available to support the clinical teaching and training of nursing students within the Queensland public health system given this is a shared area of responsibility • support nurses undertaking post-graduate study through scholarships and/or paid study leave • expand its transition to work programs so that new graduate nurses receive appropriate supervision and support • establish an ongoing education and training program for nursing staff which is linked to service delivery needs, addresses identified skills gaps and supports advanced clinical practice roles • review the number of nurse educators working in the system and provide adequate resourcing and support for them to undertake their roles • ensure adequate backfilling of positions to allow clinicians to attend training and education programs.

<table>
<tr><td>10.9</td><td>Provide immediate relief for allied health professionals
The Queensland Government should:
seek from the Commonwealth an immediate increase in allied health student places and/or consider funding additional bonded places in Queensland tertiary institutions
seek support for the State to immediately increase the employment of allied health personnel in Queensland's health system with an emphasis on a willingness to teach allied health students.
Queensland Health should:
implement a local and interstate campaign to position itself as an employer of choice for allied health staff with the aim of increasing staffing numbers by around 2,000 over the next three years
increase flexibility in recruitment processes including advertising and selection processes and devolve recruitment responsibility to the facility level except where staff are being recruited across a number of facilities
develop recommended student intakes in Queensland to inform negotiation with the Commonwealth
create leadership positions in the Areas Health Services which focus on workforce planning and recruitment activities.</td></tr>
<tr><td>10.10</td><td>Improve retention of the allied health workforce
The Queensland Government should:
review the process for enterprise bargaining to address the lack of flexibility and complexity of current arrangements and remuneration levels
use enterprise bargaining to remove impediments to workforce reform including extending scope of practice, outsourcing work, negotiating flexible employment arrangements and creating temporary positions for training purposes.
Queensland Health should:
enhance clinical career pathways for allied health professionals through creation of advanced and extended positions under a new award or additional paypoint in the existing award structure
increase the scale and flexibility of the Clinical Advancement Scheme as suggested in 10.6.2
implement strategies to improve organisational culture and foster strong leadership and change management capacity within the department, discussed in Chapter 4
provide allied health staff with timely, quality travel and accommodation services.
Area Health Services should:
create peer support networks along professional groupings or streams of care to improve support for isolated allied health workers
ensure allied health staff have access to revised and better targeted and resourced aggression management training.</td></tr>
</table>

<table>
<tr><td></td><td>Districts should:
• provide amenities such as meeting and training rooms where feasible and in consultation with allied health workers
• provide all new allied health staff with an induction which includes information about entitlements, with access to entitlements supported and monitored through individual performance and development plans.</td></tr>
<tr><td>10.11</td><td>Maximise the value of the allied health workforce
Area Health Services should:
• be resourced to facilitate local, team based development and implementation of advanced and extended allied health roles in areas of workforce or service pressures and managed through clinical networks where feasible
• be resourced immediately to implement alternative models of care using allied health professionals to reduce pressure in outpatient clinics and accident and emergency departments, as discussed in 10.6.3
• facilitate and resource districts to devolve non-clinical tasks to non-clinical categories of staff including support for advanced allied health professionals with less time for non-clinical work
• establish a register of clinicians – including allied health workers– willing to undertake country service rotations and design a country service incentive package.
Districts should:
• negotiate opportunities to introduce flexible hours of work to increase productivity subject to staff availability and interest eg community health services running clinics out of business hours.
Clinical networks should:
• lead implementation of outcome based clinical pathways to improve care and streamline work practices.</td></tr>
<tr><td>10.12</td><td>Improve education and training for allied health workers
Queensland Health should
• facilitate better linkages with external agencies including the tertiary sector and professional associations to develop a long term education, training and professional development program for allied health staff
• ensure the provision of clinical placements for allied health students is coordinated and able to cope with continued increases in student numbers
• negotiate with the State and Commonwealth to address the issue of an adequate teaching and support environment during clinical placements, and funding models that reflect student retention and clinical placement costs
• consider expanded peer support programs for young allied health professionals working in rural and remote areas and ensure they have access to professional development opportunities
• identify areas of skills shortages amongst its allied health professional staff and consider providing financial subsidies in targeted areas of post-graduate study.</td></tr>
</table>

10.13	**Address organisational and multi-disciplinary education and training issues** Queensland Health should establish a central coordination point for training and education in the organisation to facilitate better linkages with external agencies. The central coordinating area would be responsible for training and education across all health professional groups and would be charged with: • establishing the overall strategic direction for training and skills development across the State based on future service needs • providing input into curriculum development to ensure sufficient levels of practical experience are incorporated in under-graduate health education programs • examining the feasibility of fast-tracking health professional education to meet workforce shortages • exploring opportunities to train multi-skilled health workers in the Vocational Education and Training (VET) sector with a range of competencies to provide a more flexible and adaptable workforce • expanding transition to work programs so that health professional graduates receive sufficient supervision when first entering the workplace. Queensland Health should refocus the operation of the Skills Development Centre and staff and resource the Centre to enable it to operate on an expanded basis to promote skills enhancement and training for clinical staff across the State. A clinical director should be appointed and increased resourcing provided so the Centre can operate as the training hub for staff across the State at least six days a week. Queensland Health should foster a learning culture across the organisation by: • designing in-hospital training programs which are linked to service needs and provided equitably across professional groups • providing standard entitlements to ongoing training and professional development • expanding assistance under the Study and Research Assistance Scheme to include subsidisation of HECS costs • streamlining approval processes for study leave and professional development attendance. Queensland should review the level of funding available for education and training across the organisation and seek increased support for teaching clinical students from the Commonwealth Government. Districts should receive dedicated budgets to support education and training and these should be linked to student and staffing numbers.
10.14	**Improve workforce planning** Queensland Health should ensure the Central Office workforce planning unit undertakes the specific roles outlined in section 10.8, to be overseen by a governance structure comprising Central Office, Area Health Services, district representatives and representatives of external stakeholders such as universities, the Commonwealth Government, professional and regulatory bodies.

10.15	**Way Forward – Relationships with Educational Organisations**

Queensland Health needs to explore the following range of jointly funded initiatives or initiatives funded in innovative ways:

- In recognition of the national importance of medical workforce training , the Commonwealth Government be approached to accept responsibility for funding all training posts for doctors (registrars within the public hospital system) and for the funding of dedicated teaching time and/or new positions for specialists, teaching VMOs, as well as trainees (registrars, senior health officers and interns).
- The support infrastructure, medical equipment, practical sessions etc. must be properly planned and funded across the continuum of nursing, allied health and medical training with adequate human resources to support training and service continuity. The investment is significant. International experience suggests that these costs may be approximately 20 percent of total recurrent costs.
- Networking of teaching and training across hospital and sector boundaries to ensure consistency and access to comprehensive training. For example, trainee specialists accessing learning opportunities in the private sector and private hospital based specialists providing teaching support for specialist trainees in the public sector.
- Unilateral recognition for trained health professional graduates (including medical graduates) with qualifications from countries with similar training requirements and standards, e.g. the United Kingdom, Ireland, Canada and New Zealand.
- Supernumerary preceptor positions and a network of facilities throughout the State to cope with student nursing places and undergraduate allied health workforce placements.
- Pilot programs for new types of health practitioners and new models of care including clinical associates' positions such as physician's assistants and nurse practitioners etc.
- Use simulation, telehealth and tele-education linkages to enhance integration of clinical placement and academic teaching models with service provision, in a strong Area Health teaching network.
- Integrated models of vocational and university education and training to deliver mainstream health professional qualifications in the more remote parts of the State.
- To ensure Area Health Services are resourced to provide a decentralised Skills Centre network which provides for the clinical needs of health professionals and trainee health professionals in that Area Health Service. Each Area Health Service Skills Centre network would be resourced to provide equitable access to basic clinical skills training and team based training.

<table>
<tr><th colspan="2">Chapter 11. Asset management and capital works planning to support service delivery</th></tr>
<tr><td>11.1</td><td>The direct management of construction projects presently undertaken within the Project Coordination Unit should be outsourced to the Department of Public Works who in turn will outsource where appropriate to private sector firms.

Consolidate Capital Works and Asset Management Branch staffing levels and position relativity in light of expected reduction in workload as Areas and Health Service Districts assume more responsibility for asset management functions.

Establish a Design Standards Unit within Capital Works and Asset Management Branch with responsibility for developing and maintaining standard design guidelines and planning practices for building health service assets.</td></tr>
<tr><td>11.2</td><td>The Capital Works and Asset Management Branch form part of Business Services reporting directly to the Chief Operations Officer.

The Capital Works and Asset Management Committee be reconstituted as a decision making body (rather than as the current advisory body) with powers to determine project priorities and to allocate funding within the approved limits of the Capital Works Program and Asset Strategic Plan.

The governance role and functions of the Capital Works and Asset Management Committee be broadened to include responsibility for monitoring performance of the Capital Works and Asset Management Branch for delivering physical infrastructure and assets that support health service outcomes.

Membership of the Capital Works and Asset Management Committee be revised to strengthen health service delivery representation with inclusion of: the Chief Operations Officer, an Area Health Service General Manager, three Health Service District Managers, a senior officer from the Department of Public Works and an expert from the building and construction industry to provide specialist advice on industry’s capability and to guide development of capital works design and delivery solutions that the contracting sector can most competently deliver.</td></tr>
<tr><td>11.3</td><td>The Capital Works and Asset Management Branch develop and implement an improved Asset Strategic Planning process for 2006-07 which recognises the restructure of the department and enhanced capability within Areas and revised roles and responsibilities of stakeholders.

Capital Works and Asset Management Branch conduct an immediate review of the justification and priority assigned to all projects on the current Asset Strategic Plan in the context of Queensland Health’s patient service needs and seek re-approval from the revised Capital Works and Asset Management Committee of all Asset Strategic Plan projects.

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

Chapter 12. Information management to support service delivery	
12.1	The current membership of the Information Strategy and Investment Board is immediately revised to include the Chief Operations Officer and to ensure a dominant representation from Area Health Services and District Managers.
12.2	An Operations Board, chaired by a district or Area Health Service representative and with strong district representation is to be immediately formed as an independent advisor to the Information Strategy and Investment Board on the performance of the Information Directorate.
12.3	The Information Management Strategic Plan initiatives focus on priority areas that will improve clinical practice and health outcomes which is built from detailed gathering and analysis of needs in districts. This must include CHIME and PRIME.
12.4	Queensland Health continue to centrally manage and coordinate information and communication technology (ICT) resources with specific ICT functions delivered within the following parameters: • ICT strategies and priorities are to be driven by clinical and patient needs, which are gathered and reported to Information Strategy and Investment Board by Information Directorate • new ICT systems are developed by systems sponsors, with all project staff reporting to the system sponsor for the duration of the project. The sponsor is accountable to Information Strategy and Investment Board for the performance of the project. Information Directorate will source the ICT skills and provide the methods, architectures and standards to be met in the ICT development. • Information Technology Units will continue to be located in districts to meet the on the ground needs for ICT support.
12.5	That the Information Directorate structurally report to the Chief Operations Officer, but is directly accountable to the Information Strategy and Investment Board for ICT strategies, priorities and performance.
12.6	The InfoSolutions Branch establish pre-qualified panels to provide applications development services for the Department.
12.7	Information Directorate pursue productivity dividends from the InfoOperations area by: • immediately implementing a project to improve work practices and implement technology tools, including remote diagnostics and resolution of problems • undertaking an assessment of the resource levels required in each functional area and identifying surplus positions • abolishing surplus positions, with incremental increases of staff occurring in other areas, with different skill sets, in line with any demonstrable requirements arising from the desktop expansion.

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

12.19	Information Directorate should: • seek commercial partners with proven expertise in project management and contract management in preference to employing temporary or contract staff as an alternate model for project management. • undertake an immediate review of the contract term of current contractor and consultancy services and confirm the ongoing need for each service.
12.20	Reprioritisation of ICT initiatives in line with the recommendations and priorities outlined in this Review is to be agreed through the reformed Information Strategy and Investment Board within 3 months.
12.21	A pilot upgrade for desktop expansion is undertaken in 4 representative hospitals and 2 community health centres within 6 months and rolled out to all districts over the following 12 months. The results to be used to project total needs across the state. This is indicatively estimated at around $25 million in once off funding and $7 million per annum in recurrent expenditure.
12.22	All staff with computer access need to be given access to the Internet, with appropriate policies and training being established to manage the associated risks. Any associated infrastructure costs (e.g. network bandwidth) need to be managed as a corporate cost.
12.23	Head agreements for individual applications should be negotiated with the system sponsor for inclusion into an overall Service Level Agreement with each district specifying all services delivered in that district. Management and reporting on service levels needs to occur directly with both districts and sponsors and will also be monitored by the proposed Operations Board.

Chapter 13. Performance monitoring of health system outcomes	
13.1	The health system outcomes that should be monitored are: health status and health determinants, patient outcomes, health service activity, expenditure and efficiency, workforce, the quality and safety of services, service responsiveness, and health service sustainability. Health system outcomes should be monitored using a standard set of strategic indicators. The example set of indicators detailed in this report should be used as a guide in determining the appropriate set of indicators. The standard set of indicators include targets and should be reported on at all levels eg Districts to Area Health Services, Area Health Services to Department, Department to Government. A review of the operational indicators which Queensland Health is required to report against under various funding arrangements should be conducted within 12 months with the aim of negotiating with funding bodies to reduce the number of indicators and report more strategically. The administrative burden associated with performance monitoring and reporting against all performance indicators (ie strategic and operational) should be minimised by automating systems where possible.

<table>
<tr><td>13.2</td><td>The performance monitoring and reporting system should comprise:

the use of performance agreements with District Managers and Area Health Service General Managers and Central Office senior executives
monthly reports and participation in a six monthly interactive performance review process for Health Service Districts and Area Health Services
quarterly reports to Director-General for Central Office for the first year then participation in six monthly interactive performance reviews
community review through District and Area Health Councils' comment on monthly and six monthly performance reports
independent regular review and reporting by the Health Commission on the implementation of clinical governance systems and the quality and safety of clinical services, and the Auditor General on the performance of the health system
external oversight of the Health Commission by a parliamentary committee.
</td></tr>
<tr><td>13.3</td><td>A six monthly statewide health service performance report should be published including elective surgery waiting lists, annual reports on outputs, aspects of service quality (sentinel events, infection control) and biennial reports by the Chief Health Officer on health status and burden of disease.

The public should have access to external reviews of the performance of the health system including annual reports by District Health Councils and Area Health Councils. The independent Health Commission should publish reports on the implementation of clinical governance systems and the quality and safety of clinical services and the Auditor General should report on the performance of the Queensland public health system.</td></tr>
</table>