Governance

We are governed by a board that was established in July 2012 under the provisions of the *Hospital and Health Boards Act 2011*. The board is committed to improving the health of the community by enabling:

- innovation, flexibility and value for money
- engagement with community and staff
- partnerships and collaboration
- initiatives contributing to research, learning and teaching.

The Queensland Government has given the board responsibility for the delivery of a range of functions and services on behalf of the community.

The framework which defines accountabilities for statutory bodies is set out in the *Statutory Bodies Guide* and includes the *Financial Accountability Act 2009* and its subordinate legislation and the *Statutory Bodies Financial Arrangements Act 1982*.Ministers are accountable to the parliament for the performance of the departments and statutory bodies under their control.

During the year our governance framework was finalised and endorsed by the board. The framework is designed to support the board and the executive leadership team (ELT) to meet their accountabilities to the many stakeholders of public health and hospital services in Queensland, and to encourage performance improvement while delivering on their obligations and legislative requirements.

The framework is built on the six foundations of public sector governance including leadership, accountability, transparency, integrity, stewardship and efficiency. It is administered by the Chief Executive (CE) on behalf of the board. Support for the systems and processes that integrate, implement and promote effective corporate and clinical governance in the functional areas is provided by the Strategy and Performance Unit and the Patient Safety and Quality Unit.

Our governance framework is underpinned by the following six governance framework principles:

- Principle 1 – A common sense of purpose and direction
- Principle 2 – The organisation is functionally and structurally aligned to achieve its objectives
- Principle 3 – Clear understanding of expectation in roles and responsibilities
- Principle 4 – Being clear about the responsibility and authority of individuals and groups
- Principle 5 – Outcomes are expressed in measurable terms and reported in an accurate, reliable and timely manner
- Principle 6 – There are consequences for good and poor performance with emphasis on recognition, learning and improvement

Principle 1 – A common sense of purpose and direction

Highlights

- An evaluation against the operational plan for 2012–13 was undertaken and used to assess organisational performance, as well as to develop the 2013–14 operational plan

Our integrated strategic planning framework

Delivering health services in a large, diverse and rapidly expanding environment requires a concerted and coordinated effort to face the challenges, including an ageing and growing population, set against a context of rising public expectations and finite resources. In order to ensure sustainable services are provided over the long term and are responsive to the environment and community served, we have developed and implemented an effective integrated strategic planning framework.

The planning process is in line with the Queensland Auditor-General's recommendation to implement an integrated service planning process with appropriate governance arrangements and clear linkages between all service plans. Our strategic plan captures the obligations and responsibilities of our service and is used to inform all activities and service developments.

The objectives contained within the strategic plan are cascaded down through the organisation through functional, service, enabling, operational and individual performance plans. The end result is a clear line-of-sight where the strategic objectives are vertically and horizontally aligned to the extent that government policy is reflected in a work area's operational plan and an individual's role description and performance plan.

Accountability for strategic planning

The board is accountable for setting the strategic direction and ensuring our achievement against our key objectives and priorities.

Our CE is accountable and responsible for the establishment of systems and processes to develop and implement the strategic direction, set by the board, into the strategic plan. The CE is further accountable for implementing systems and processes to monitor and report on performance against the strategic plan to the board and the Department of Health.

The CE is supported in meeting the accountabilities established by the board through the sub-delegation of key responsibilities for planning, developing, coordinating, implementing, monitoring, evaluating and reporting all elements of strategic and operational planning to the ELT and their functional areas.

At the end of June 2013, 94 per cent of actions in our 2012-13 Operational Plan were completed, with the remaining carried through to 2013-14. Key achievements against our strategic priorities are highlighted in the total picture section of this report, including priority one on page 52, priority two on page 39, priority three on page 52, priority four on page 80 and priority five on page 63.

Identification and management of strategic risks

Strategic risks are those which could impact on the achievement of our vision and strategic objectives. We recognise the importance of including an enterprise risk management approach to the strategic planning process.

We are committed to the management of risks in a proactive, integrated and accountable manner and as such, ensure risks are identified, analysed, prioritised and managed through continuous improvement and performance management strategies. These commitments along with the guiding principles for risk management are communicated through our Integrated Risk Management Framework (refer to Principle 6). Our strategic plan identifies the key strategic risks and the appropriate responses to mitigate them to prevent or minimise the impact on our ability to deliver sustainable health services into the future.

Principle 2 – The organisation is functionally and structurally aligned to achieve its objectives

Highlights

- Evaluation of committee structures completed
- Organisational structure reviewed

Critical to the success of providing exceptional care in a highly complex environment is the effective and deliberate organisation of services, people and units into functional and professional teams, streams and specialities.

Our structural alignment enables us to be responsive, integrated and efficient, allowing decisions to be made at the most appropriate level. It also facilitates an openness and transparency in key decisions. The organisational and committee structures form the mechanisms within our governance framework that ensures we are functionally and structurally aligned to achieve our objectives.

Board Committees

The board has legislatively prescribed board committees to assist it in carrying out its responsibilities. The committees are:
- Executive Committee
- Audit Committee
- Finance Committee
- Safety and Quality Committee.

Requirements for the board and the board committees are set out in the board and board committee charters.

Executive Committee

The Executive Committee is responsible for supporting the board in its role of controlling our organisation. It functions to work with our CE in strengthening the relationship to progress strategic issues and ensure accountability in the delivery of services.

Membership of the Executive Committee is:
- Emeritus Professor Paul Thomas AM (Chair)
- Dr Lorraine Ferguson AM
- Dr Ted Weaver.

Sunshine Coast Hospital and Health Service Annual Report 2012–2013

The committee meets at a minimum of twice a year and any extra meetings scheduled at the discretion of the Board Chair.

Finance Committee

The Finance Committee is responsible for advising the board on matters relating to financial strategies, financial performance, capital management and sustainability of our health service.

Membership of the Finance Committee is:
- Mr Peter Sullivan (Chair)
- Dr Mason Stevenson
- Mr Brian Anker
- Mr Cos Schuh.

During the year membership also inlcuded Dr Martine Pop and Bradley Elms. The committee meets monthly with the exception of December.

Safety and Quality Committee

The Safety and Quality Committee is responsible for advising the board on matters relating to the safety and quality of health services provided. It is responsible for ensuring a comprehensive approach to the governance of matters relevant to the safety and quality of health services is developed and monitored, and for oversight of processes that ensure deviations from quality standards are acted upon in a timely and effective manner.

Membership of the Safety and Quality Committee is:
- Dr Lorraine Ferguson AM (Chair)
- Dr Ted Weaver
- Dr Mason Stevenson
- Dr Karen Woolley.

During the year membership also included Bradley Elms. The committee meets quarterly, with special meetings held as required.

Audit Committee

The Audit Committee is a key component of the board's governance framework, providing independent, objective assurance and consulting activity designed to add value and improve operations of the HHS. This is achieved by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes, and to ensure our systems and processes function efficiently, effectively and economically.

The committee has an oversight role and does not replace management's primary responsibilities for the management of risks, the operations of internal audit and risk management functions, the follow up of internal and external audit findings or governance of SCHHS generally.

The function of the Audit Committee is to oversee, advise and make recommendations to the board about:
- assessing the appropriateness of the SCHHS Annual Internal Audit Plan having regard to previous audit findings, the existing risk profile, contemporary and emergent issues, alignment with the Institute of Internal Auditors contemporary practice and benchmarks, and views of the Queensland Audit Office
- assessing the adequacy of the financial statements
- monitoring compliance with our obligation to establish and maintain an internal control structure and systems of risk management under the Financial Accountability Act 2009
- monitoring and advising the SCHH Board about the internal audit function
- liaising directly with and overseeing our liaison with the external auditor, the Queensland Audit Office, in relation to proposed audit strategies and annual internal audit plans
- assessing external audit reports and the adequacy of actions taken as a result of the reports
- monitoring the adequacy of our management of legal and compliance risks and internal compliance systems
- seeking information on and assessing complex or unusual transactions or series of transactions, or any material deviation from the budget

Membership of the Audit Committee is:
- Mr Cos Schuh (Chair)
- Mr Peter Sullivan
- Mr Brian Anker.

During the year membership also included Bradley Elms (Chair), Dr Martine Pop and Dr Mason Stevenson. The committee meets at least quarterly, with special meetings held as required. The Audit Committee has been established and operates in line to the Queensland Treasury's *Audit Committee Guidelines*.

Principle 3 – Clear understanding of expectation in roles and responsibilities

Highlights

- Reviewed and re-endorsed the instrument of delegations
- Performance and development (PaD) plans and process enhanced

A range of mechanisms exist to ensure individuals and groups have a clear understanding of their roles and responsibilities, and how these relate to the achievement of the organisation's strategic objectives.

These mechanisms include a Code of Conduct, role descriptions, health service directives by the Director-General, policies and standards, delegations, terms of reference for committees, service agreements and contracts with service providers, performance agreements, PaD plans, guidelines supporting integrity and ethical behaviours, clinical governance and the risk management framework.

Health Service Directives

The *Hospital and Health Board Act 2011* allows for the Director-General of the Department of Health to issue health service directives. These directives are binding on our organisation and are a lever to ensure system-wide approaches are retained where this is necessary and beneficial. Directives may be issued for a range of purposes including to promote service coordination and integration, to optimise the effective and efficient use of resources, to set standards and policies, or to ensure consistent approaches to the delivery of services across the state.

The *SCHHS Procedural Framework* articulates the system and processes in place for the development, implementation and review of policies, procedures and protocols. The Strategy and Performance Unit maintains a central register of all policies, procedures and protocols.

Integrity and ethical behaviour

We are committed to ensuring the highest level of ethical behaviour through all aspects of our activities. We uphold our responsibility to the community to conduct and report on the affairs of our business transparently and honestly while maintaining processes that ensure our staff, at all levels, understand these responsibilities.

Employees at all levels within our organisation are required by the Queensland Government to follow the standards of behaviour and conduct set out in the *Code of Conduct for the Queensland Public Service* (available at www.premiers.qld.gov.au/publications/categories/policies-and-codes/code-of-conduct.aspx).

The code contains the ethics principles and their associated set of values which are prescribed in the *Public Sector Ethics Act 1994*. It also contains standards of conduct for each ethics principle. The ethics principles are:
- integrity and impartiality
- promoting the public good

- commitment to the system of government
- accountability and transparency.

At the end of 2012-13, 83.5 per cent of our employees had completed the Code of Conduct training (target: 95 per cent). To assist in achieving this target, and other mandatory training targets, this year we developed a DVD containing the majority of our mandatory training sessions, previously only offered face-to-face, to allow a greater opportunity for staff to complete the sessions. The improvement has been evident, with a 25.5 per cent completion increase from 2011–12. Employees are encouraged to participate in the course every two years, or when the code is revised.

This year we developed our draft Standard of Practice to supplement our Code of Conduct. The Standard of Practice identifies key conduct, performance and service delivery expectations, and provides scenarios as a practical resource. Overall it provides advice and guidance for making ethical decisions.

We strongly support and encourage the reporting of Public Interest Disclosures, including fraud, corruption and mal-administration. All employees have a responsibility to disclose wrongdoing and to ensure any disclosure is in accordance with our ethical culture and in particular, acting with integrity. This responsibility is again reinforced by the *Public Sector Ethics Act 1994*, as well as our Public Interest Disclosures Policy and Public Interest Disclosure Management Procedure.

Access to documents and records we hold may be requested under the *Right to Information Act 2009* and the *Information Privacy Act 2009*. Community members wishing to access non-personal documents should apply in writing to our Clinical Information Access Unit either by post or email (details available at www.health.qld.gov.au/sunshinecoast/html/disc_log.asp). This year, 377 applications were received (2011–12: 311), with 26 withdrawn by the applicant and 342 completed in the year. Total number of pages released including full and part access was 78,694, with 1,346 pages refused in full. Fees collected for these applications under the *Right to Information Act 2009* totalled $8,604.

We also have a comprehensive Conflict of Interest Guideline and practices in place to facilitate the disclosure and reporting of perceived or actual conflicts of interest.

Delegation

In order to achieve our purpose, authority is given to our executives to develop strategy and direction for approval, as well as to delegate where required. Our delegation policies, practices and procedures ensure the effective delegation of authority in accordance with the *Health and Hospitals Network Act 2011* and the Financial and Performance Management Standard 2009. Delegations must be in place to ensure that officers' responsibilities are matched with the necessary authority to enable them to validly perform their duties.

In accordance with the *Acts Interpretation Act 1954*, delegations are assigned only to officers with the requisite qualifications, experience or standing appropriate to exercise the power. All delegations are assigned in writing and are signed by the delegator in order to provide clear and unambiguous authority for staff to act.

We have formal delegations of authority in place in relation to a number of business activities including finance (expenditure, special payments and loss write-off), contract signing, procurement of goods and services, legal, human resource management and health related matters. Decisions which impact on the core values of our organisation, or have the potential to change or impact our strategic directions and commitments are ultimately referred to our board.

Role descriptions

All positions in the organisation have a role description which outlines the core purpose and responsibilities of the position. Performance is reviewed against the requirements of the role description on an annual basis at a minimum.

Legislative framework

We operate in accordance with the various laws and regulations, the most significant of which are listed below:

- *Anti- Discrimination Act 1991*
- *Auditor-General Act 2009*
- *Births, Deaths and Marriages Registration Act 2003*
- *Child Protection Act 1999*
- *Commission for Children and Child Guardian Act 2000*
- *Coroners Act 2003*
- *Crime and Misconduct Act 2001*
- *Financial Accountability Act 2009*
- Financial Accountability Regulation 2009
- Financial and Performance Management Standard 2009
- *Food Act 2006*
- Food Regulation 2006
- *Health Act 1937*
- Health (Drugs and Poisons) Regulation 1996
- *Health Practitioner Regulation National Law Act 2009*
- *Health Practitioners (Disciplinary Proceedings) Act 1999*
- Health Regulation 1996
- *Hospital and Health Boards Act 2011*
- Hospital and Health Boards Regulation 2012
- Health Practitioners (Professional Standards) Regulation 2010
- *Health Quality and Complaints Commission Act 2006*
- *Hospitals Foundations Act 1982*
- Hospitals Foundations Regulation 2005
- *Industrial Relations Act 1999*
- Industrial Relations Regulation 2011
- *Information Privacy Act 2009*
- Information Privacy Regulation 2009
- *Mental Health Act 2000*
- Mental Health Regulation 2002
- Mental Health Review Tribunal Rule 2009
- *Public Health Act 2005*
- Public Health Regulation 2005
- *Public Interest Disclosure Act 2010*
- *Public Records Act 2002*
- Public Records Regulation 2004
- *Public Sector Ethics Act 1994*

- Public Sector Ethics Regulation 2010
- *Radiation Safety Act 1999*
- Radiation Safety Regulation 2010
- Radiation Safety (Radiation Safety Standards) Notice 2010
- *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003*
- Research Involving Human Embryos and Prohibition of Human Cloning Regulation 2003
- *Right to Information Act 2009*
- Right to Information Regulation 2009
- *Statutory Bodies Financial Arrangements Act 1982*
- Statutory Bodies Financial Arrangements Regulation 2007
- *Transplantation and Anatomy Act 1979*
- Transplantation and Anatomy Regulation 2004
- *Victims of Crime Assistance Act 2009*
- *Workers' Compensation and Rehabilitation Act 2003*
- Workers' Compensation and Rehabilitation Regulation 2003
- *Work Health and Safety Act 2011*
- Work Health and Safety Regulation 2011

Principle 4 – Being clear about the responsibility and authority of individuals and groups

Highlights

- Service group performances reported monthly against KPIs to the ELT
- Maintained our Department of Health performance rating of 'performing'

Our performance and accountability framework (PAF) has been developed in response to and is closely aligned with the National Health Reform – Performance and Accountability Framework and the Queensland Health Hospital and Health Services Performance Framework 2012–13 (QHHHSPF).

The local framework consists of systems and processes to measure, monitor, and report on performance at all levels of our organisation. The system provides for the identification and escalation of emerging risks associated with performance together with expectations and processes for managing good and poor performance.

This process is facilitated through the organisational and committee structures. Our overall organisational performance is monitored at the board and strategic committee levels. Service group level reporting is monitored by the CE at the 3 on 3 Service Group meetings where each service group provides a monthly performance report with analysis and as required recovery or improvement strategies.

Key Performance Indicators

Key performance indicators (KPIs) provide specific measures of performance and are a basis for monitoring and assessment, as well as forming responses and interventions. They are an important tool in our integrated governance structure. Our KPIs are set out in the service agreement with the Department of Health, aimed at ensuring the delivery of, or substantial progress towards, the key shared objectives of sustainability, financial viability, improved access and quality of service.

Our achievement of the targets against the KPIs is through a devolved management structured, where KPIs are cascaded down through the CE, ELT, senior management, committees, work units and individuals. This is facilitated through the annual operational plan, committee work plans, service level agreements and individual performance and development plans. This supports a shared understanding of responsibilities, expectations and effective monitoring of progress.

Principle 5 – Outcomes are expressed in measurable terms and reported in an accurate, reliable and timely manner

Highlights

- Relationship management meetings with the Department of Health were held every three months
- Service groups continued to report on performance against our KPIs every month, which were provided to the ELT

Our performance is monitored against our key performance indicators, as well as a combination of national and state level targets (refer to page 15). Our KPIs are monitored monthly and reported to the board, board committees, the ELT, and strategic committees.

Principle 6 – There are consequences for good and poor performance with emphasis on recognition, learning and improvement

Highlights

- Developed an internal audit model and charter
- Commenced five internal audits
- SCHHS Enterprise Risk Management Framework endorsed

We have a local performance management framework in place aligned to the Queensland Health Performance Management Framework. The system provides for the identification and escalation of emerging risks associated with performance together with expectations and processes for managing good and poor performance.

Risk Management

Risk management is an integral part of our governance framework. Our risk management processes are built into our daily business activities as well as our future planning processes. Risks are identified and controlled within the management accountabilities of defined positions. The board holds ultimate responsibility for risk oversight and risk management, with the aim of meeting the organisation's strategic objectives. The CE is accountable for the effective implementation of the enterprise risk management framework in the organisation. The Audit Committee reviews our strategic risks quarterly.

The 2013 SCHHS Enterprise Risk Management Framework (ERMFW) is based upon the Australian/New Zealand ISO Standard 31000:2009 for risk management. The ERMFW is aligned to Queensland Health's Integrated Risk Management Framework, Risk Analysis Matrix and the QHRisk (risk reporting) system and is implemented within our organisation. The

SCHHS Framework outlines our risk management approach and the core roles and responsibilities of all positions.

There is a strong and well established risk management culture within the organisation supported by an active reporting culture and risk management training. The SCHHS networks with other Hospital and Health Services (HHS) and the Department of Health through the Health System Risk Working Group (formerly Queensland Health Integrated Risk Management Network) to identify broader system risks and risk system improvements.

In 2012–13, our key risk management activities included:

- Developed and endorsed the SCHHS Enterprise Risk Management Framework
- Reviewed the Integrated Risk Management Procedure
- Reviewed the risk structure, systems and processes through an organisation-wide Risk Management Framework enhancement working party and focus group
- Developed and implemented an incident reporting survey to ascertain employees' level of knowledge regarding risk management, incident reporting and consumer feedback processes and management
- Delivered the Queensland health risk management online learning module: introduction and overview of integrated risk management policy framework to 138 employees
- Delivered our risk management overview and processes presentation to 285 employees.

Evaluation – internal and external audits

In 2012–13, the Internal Audit function is in the process of being established, as required by the Financial and Performance Management Standard 2009, including the assignment of roles and development of processes. During this period, the board agreed with Wide Bay HHS and Central

Queensland HHS to operate under a hub and spoke model, a co-sourced strategy which also utilises support from contracted services for the completion of required internal audits.

The model currently being established will have a Director of Internal Audit position overseeing the internal auditors at each of the three HHS. The director position will report to each HHS audit committee, coordinate audits and utilise information and risk profiles from each HHS to inform each HHS's internal audit plan in each year.

The director position will operationally report to the Executive Director of Strategy and Performance, and will also have the right to directly refer matters to each HHS chief executive, the board and the audit committees.

Internal audits help us to achieve our objectives and are concerned with evaluating and improving the effectiveness of risk management, control and governance processes within the health service.

Once established, our internal audit function will form a key component of the board's governance framework. It will provide independent, objective consulting, and assurance activities that our risk management, control and governance processes are adequate and functioning in a manner which ensures the achievement of our objectives.

The function will also assist management to improve the effectiveness and efficiency of our risk management, control and governance processes.

The Internal Audit Charter was developed this year, in line with the International Professional Practices Framework. We will also be required to report to our external auditor, the Queensland Auditor-General. In accordance with the Internal Audit Framework, our internal audit function will be subject to a documented quality assurance and improvement program, including an external assessment at least once every five years and an annual internal assessment. The results will be reported to the Audit Committee, our CE and the board.

Table 9: Internal audits by external bodies commenced in 2012–13 and are currently ongoing

Audit	Purpose
Credentialing audit	The credentialing audit ensures medical practitioners, dentists and facilities comply with the principles contained in the standards issued by the Australian Council for Safety and Quality in Health Care (ACSQHC) and the Health Quality and Complaints Commission (HQCC). Credentialing also ensures we operate within our defined clinical services capability.
	The audit includes a review of our current practices and processes, ensuring medical and dental practitioners are credentialed and have their scope of clinical practice or clinical privileges defined, documented and reviewed as required and at a period not exceeding five years.
Leave records and process validation	The audit reviews the accuracy of recreation, long service and other leave taken and recorded over the past three years. The objective of the audit is to ascertain why leave taken in the 2013 financial year is substantially higher than it was in 2011 and 2012.
Financial ledger integrity audit	An audit highlighting the access to our financial ledger by the Department of Health employees external to the SCHHS. The objective of the audit is to ascertain the extent to which the integrity of our financial ledger is compromised through access available to external users and to report on the associated issues and risks.
Procurement practices audit	This audit involves a review of procurement practices with a specific assessment of the appropriateness of procurement practices, adequacy of internal controls, and value for money aspects of the use of system orders versus general purpose vouchers.
Roster effectiveness and efficiency audit	This audit reviews, by appropriate sample, the effectiveness and efficiency of unit rosters. The objective of the audit is to ascertain the extent to which unit rosters are award compliant and whether they result in efficient and effective use of resources. All service streams will potentially be included in the sample audit. Initial areas selected include Department of Emergency Medicine, Specialist Outpatient Department and Theatres.

Our strategic committees

We have established several strategic committees to assist in carrying out the CE's responsibilities. Each strategic level committee has terms of reference clearly describing their respective purpose, functions and authority. These committees are all chaired by an ELT member who has the appropriate sub-delegation relevant to the function and purpose of the committee. Membership comprises those with the knowledge, skills and expertise required for the committee to fulfil its functions. Most committees include a representative from each clinical service delivery stream.

The committees facilitate standardisation of processes in regards to communication, reporting and escalation of issues. They are a vehicle for providing essential integration and uniformity of approach to health service planning, patient safety and quality, service development, workforce, resource management, information, communication and technology, performance management and reporting.

The ELT is the overarching body within our committee structure. This committee, through the CE, provides the link between the board and board committees and the operations of the organisation.

Our strategic committees include:
- Clinical Leadership Group
- Patient Flow Committee
- Patient Safety and Quality Committee
- Health Planning and Infrastructure Committee
- Workforce and Human Resource Committee
- Safe Practice and Environment Committee
- Resource Management Committee
- Information, Communication and Technology Committee.