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About this handbook

The Handbook for Queensland Hospital and Health Board Members (‘the Handbook’) is a resource outlining the operating context and governance arrangements for Queensland’s Hospital and Health Services (HHSs) and governing Hospital and Health Boards (HHBs).

HHSs were established as independent statutory bodies under the Hospital and Health Boards Act 2011 (the HHB Act) on 1 July 2012. They assumed accountability for the delivery of public hospital and health services previously provided by Health Service Districts. A professional HHB was appointed for each HHS to control their local HHS. A list of HHSs and a map of boundaries is available at Appendix 1.

The Handbook will support the system induction of new HHB members—introducing members to the Queensland health system and their individual roles and responsibilities and prompting further investigation into key matters. It will also be a useful resource for staff and stakeholders to better understand the broad framework for Queensland’s public hospital and health services.

The Handbook is structured in nine sections, starting from broad system information and narrowing to more detailed consideration of HHS funding and governance arrangements and information about Board duties and appointment processes:

- Section 1. Context—overview of the Australian health system
- Section 2. About Queensland Health—roles and responsibilities
- Section 3. Queensland Health funding arrangements
- Section 4. Hospital and Health Service planning
- Section 5. Hospital and Health Service performance management
- Section 6. Hospital and Health Service governance
- Section 7. External regulatory framework
- Section 8. Hospital and Health Board member fundamentals
- Section 9. Hospital and Health Board appointments and procedures

This inaugural edition of the Handbook is current as of June 2016 and will be reviewed annually to ensure the currency of its content. It is available online at:

1. Context—overview of the Australian health system

In this section:
- Levels of government and responsibilities
- Interfaces between levels of government
- Queensland public sector health services

Key points:
- Responsibility for health is shared across the three levels of government
- Collaboration across governments is led by national forums
- HHSs deliver services across the continuum of care

1.1 Levels of government and responsibilities

Responsibility for public sector health services is shared across the three levels of government in Australia:

- **Federal** (more commonly referred to as Commonwealth) Government has a leadership role in policy making and with national issues such as public health, health reform, research and national information management.

- **States and territories** are primarily responsible for the delivery and management of public sector health services and for maintaining direct relationships with most healthcare providers.

- **Local government** is responsible for making decisions on local, town or city matters which may include participation in health-related issues (for example, public health surveillance and action).

The Commonwealth and state governments have specific responsibilities for certain policy direction, funding and provision issues related to healthcare. These are administered through individual departments and respective Ministers for Health.

More information on Australia’s health system and health expenditure is available on the Australian Institute of Health and Welfare website at:

1.2 Interfaces between levels of government

1.2.1 Council of Australian Governments

The Council of Australian Governments (COAG) is the peak intergovernmental forum in Australia, comprising the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association. The role of COAG is to initiate, develop and monitor implementation of policy reforms of national significance that requires cooperation by Australian governments (for example, health, education and training, Indigenous reform, early childhood development and natural disaster arrangements). Issues may arise from, among other things: Ministerial Council deliberations; international treaties which affect the States and Territories; and major initiatives of one government (particularly the Commonwealth Government) which impact on other governments or require cooperation of other governments.

The Queensland Department of Health (the department) continues to work closely with the Commonwealth Government and other states and territories through COAG to achieve its strategic priorities and objectives. Health related initiatives include: health reform; chronic disease prevention; improving access to elective surgery and emergency departments; improving health outcomes for Aboriginal and Torres Strait Islander peoples; supporting immunisation to protect the population’s health; developing and implementing eHealth and supporting information systems; and delivering new and improved infrastructure. The outcomes of COAG meetings are contained in communiqués released after each meeting. Where formal agreements are reached, these may be embodied in Intergovernmental Agreements.

Further information is available on the COAG website at:

1.2.2 Council of Australian Governments Health Council

The COAG Health Council (CHC) is one of eight COAG ministerial councils. It comprises Commonwealth, State, Territory and New Zealand ministers with responsibility for health matters, and the Commonwealth Minister for Veterans’ Affairs. The CHC plays an important role in the inter-jurisdictional management of key health reform issues that arise from COAG. It provides a forum for governments to address issues of mutual interest under healthcare arrangements and share best practice approaches, particularly with regard to health system management.

Further information is available at:

1.2.3 Australian Health Ministers’ Advisory Council

Australian Health Ministers’ Advisory Council (AHMAC) is the advisory and support body to the CHC and considers matters relating to the coordination of health services across the nation. AHMAC is comprised of the Chief Executives, Directors-General and Secretaries of the Health departments of the Commonwealth, Australian states and Territories and New Zealand. Queensland is represented on AHMAC by the Director-General of Queensland Health. AHMAC member jurisdictions collectively annually contribute funds to the AHMAC cost-shared budget to fund health projects of national significance. The projects are generally managed and overseen by AHMAC and its sub-committees.

Further information is available at:
1.3 Queensland public sector health services

HHSs deliver a range of health services across the health continuum. These services encompass services delivered to well populations (such as illness prevention and the promotion and protection of health) through to those delivered to individuals with chronic consequences and conditions (such as rehabilitation and extended care). HHSs are responsible for operating facilities, including hospitals and multi-purpose health service sites. Public sector health services can be stratified into the following categories:

- **Primary healthcare services**—Typically a person’s first point of contact with the health system and most often provided outside the hospital system. These services are delivered in a variety of settings, including community health centres and allied health services, as well as within the community. They include health promotion, illness prevention, care of the sick, advocacy and community development. Primary healthcare services are provided by a range of healthcare professionals supported by integrated referral systems delivered in a variety of health settings including via telecommunications technologies. It includes various health professionals—general practitioners (GPs), dentists, nurses, Aboriginal health workers, local pharmacists and other allied health professionals.

- **Secondary healthcare services**—Healthcare services provided by medical specialists and other health professionals who generally do not have first contact with patients. These services may be delivered in hospitals or other settings. They include acute care for short-term treatment of a serious injury or period of illness which is usually relatively urgent and elective treatment.

- **Tertiary healthcare services**—Highly-specialised consultative healthcare, usually for inpatients and those referred from a primary or secondary health professional. These services are delivered in a facility that has personnel and facilities for advanced medical investigation and treatment. Examples of tertiary care services are cancer management, neurosurgery, plastic surgery, cardiac surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions.

Healthcare provision can also be subdivided into the following core areas:

- **Ambulatory services**—Care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics. It also refers to care provided to patients of community-based (non-hospital) healthcare services.

- **Acute services**—Healthcare in which a patient is treated for: an acute illness, injuries or trauma, or recovery from surgery. Acute care is usually provided in hospitals by specialised personnel.

- **Sub and non-acute services**—Sub and non-acute episodes of care are those that do not meet the definitions for acute care. The sub and non-acute episodes of care include the following types:
  - rehabilitation
  - palliative care

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- geriatric evaluation and management
- psychogeriatric care
- maintenance care
- other admitted care.

- **Mental health**—Mental health services in Queensland are provided in acute settings (on a voluntary and, in accordance with the *Mental Health Act 2000*, involuntary basis) and in community-based residential and non-residential settings. The services can be subdivided into child and youth, adult and older persons' mental health services. The Queensland Government established a Queensland Mental Health Commission on 1 July 2013 to drive ongoing reform towards a more integrated, evidence-based, recovery-orientated mental health and substance misuse system (refer section 2.8.4).

- **Aged care**—The Commonwealth Government takes the lead role for aged-care in most states and territories, resulting in a nationally consistent and better integrated aged-care system. Within Queensland, the Statewide Older Persons Health Clinical Network (SOPHCN) has been established in recognition of the unique care required for many older persons and to initiate improvements in service delivery both generic and specialised, along the healthcare continuum with a particular focus on the provision of acute care of the elderly and Geriatric Evaluation and Management.

- **Oral health**—Oral health is fundamental to overall health, wellbeing and quality of life. Tooth decay is largely preventable but has a significant impact on health and well-being and results in high personal and community costs.

- **Public health**—The organised response by society to protect and promote health, and to prevent illness, injury and disability. The term ‘public health’ is often used interchangeably with ‘population health’ and ‘preventive health’. Public health uses a multi-strategy, inter-agency partnership approach to improve health and wellbeing through:
  - education, screening, immunisation and other interventions
  - promoting and supporting healthy lifestyles and behaviours
  - policy, legislation, regulation and fiscal measures
  - strengthening skills, competencies; systems and infrastructure in communities and organisations
  - ensuring safe and healthy environments
  - surveillance, monitoring and disease control
  - evaluation and research.

Actions to protect and improve health and wellbeing at a population level are collectively referred to as a ‘public health’ approach. An effective public health approach:

- addresses the entire range of modifiable factors that determine health, including individual lifestyle factors, environment and social conditions.
- focuses on the health and wellbeing of populations and specific population groups, rather than individuals, meaning that it differs from other roles of the health system which are

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primarily responsible for treating illness or providing support to people whose health is compromised, and includes cancer screening for targeted population groups.

– recognises that coordinated action is required across geographic boundaries, a broad range of agencies and sections of society to achieve desired health outcomes in the community.

– aims to prevent disease and reduce ill health, so that people remain as healthy as possible for as long as possible. Therefore, public health services are a critical component of the health continuum.

1.3.1 Public Health units

A requirement in each HHS service agreement is that the HHS will provide public health services in line with public health-related legislation and the service and reporting requirements outlined in the Public Health Practice Manual (PHPM). The PHPM provides a framework for the complementary and interdependent roles of the department and HHSs for the delivery of public health programs and services that protect and improve the health and wellbeing of the community. The 2016 edition of the PHPM is available on the Queensland Health Electronic Publishing System (QHEPS) at:


Public health activities in any HHS may include a combination of those delivered directly by the HHS, those delivered by a Public Health Unit (PHU) in another HHS, or in partnership with other agencies. In caring for the communities, the HHS must consider not only mandated functions such as the requirement to administer certain legislative functions or disease control activities, deliver on Government priorities and initiatives to address local priorities, but also local needs and opportunities such as addressing the burden of disease and determinants of health. The balance of resource investment and how this works in practice is a matter for each HHS board to determine.

Each HHS area contains or has a link with a PHU providing health protection, communicable disease and epidemiology functions that focus on health protection, the prevention of disease, illness and injury and the promotion of health and well-being by:

- coordinating disease control initiatives, including response to and notification of disease outbreaks.

- undertaking a range of environmental health initiatives including monitoring compliance with and enforcing public health legislation in relation to food safety and standards, water quality and drinking water fluoridation, regulated drugs, poisons and tobacco control.

- providing specialist public health advice and developing the capacity of health services, other sectors and the community to collaboratively plan and implement effective public health programs.

The Chief Health Officer and the Prevention Division within the department provide system leadership and support to protect and prevent harm to public health and promote wellbeing.
2. About Queensland Health—roles and responsibilities

2.1 Overview

Collectively, the public healthcare system in Queensland is known as Queensland Health and is made up of the department and 16 independent HHSs, governed by HHBs. The relationship between the department and HHSs is governed by the Hospital and Health Board Act and service agreements.

The overall management of the public healthcare system remains the responsibility of the department, through the Chief Executive (Director-General), HHSs as independent statutory bodies are responsible for the delivery of health services in their local area. The department is responsible for purchasing services and ensuring the needs of the broader population are met, while the HHSs are responsible for local service delivery.

The behaviour of both the department and HHSs is governed by the guiding principles outlined in section 13 of the HHB Act, including that:

- The best interests of users of public sector health services should be the main consideration in all decisions and actions under this Act.
- There should be a commitment to ensuring quality and safety in the delivery of public sector health services.
• There should be responsiveness to the needs of users about the delivery of public sector health services.

• Information about the delivery of public sector health services should be provided to the community in an open and transparent way.

2.2 Role of the Minister for Health

The Minister for Health can write to HHB Chairs outlining the Minister’s key health delivery priorities and expectations. Some of these priorities may be outlined in Government policy documents.

Some of the Minister’s key responsibilities under the HHB Act include:

- recommending board members for appointment
- approving the appointment of HSCEs
- appointing an individual to the office of the administrator of the National Health Funding Pool
- deciding the terms of a service agreement where agreement cannot be reached.

The Minister may also, if necessary and in the public interest, give a HHS a written direction about a matter relevant to the performance of its functions under the HHB Act (refer Section 44). The Minister may not give a direction about the health services provided to a particular person or the employment of a particular person.

HHBs are accountable through the Chair to the Minister for local performance. The Minister has powers to establish ancillary boards to give advice to a HHB, or appoint an adviser to a HHB to assist improving the performance of the board or HHS (refer section 44A of the HHB Act). The HHB Act also contains a range of regulation making powers which can be used by the Minister to specify particular issues.

Ministerial advisory councils exist to provide advice and support to the Minister in specific areas. One currently operates in Queensland:

- **Radiation Advisory Council**: established under the *Radiation Safety Act 1999*, the Council's functions are to examine and make recommendations to the Minister about the operation and application of the Act, proposed amendments, radiation safety standards and issues on radiation; and conduct research into radiation practices and transport of radioactive materials in Queensland.

Under Section 278 of the HHB Act, the Minister may establish the Ministerial advisory committees the Minister considers appropriate and decides their functions.

Under Section 44F of the HHB Act, the Director-General is subject to the directions of the Minister in managing the department but not in the decision making for individuals, which must be done independently, impartially and fairly.

2.3 Role of the Director-General and Department of Health

The HHB Act outlines the functions and powers of the system manager with overall system management responsibility resting with the department. This responsibility is discharged through the Director-General. The department, as system manager, is responsible for sole management of the relationship with HHSs to ensure a single-point of accountability in the state for public hospital performance, performance management and planning.
2.3.1 Departmental functions

Section 45 of the Act details the functions of the Director-General, as system manager:

- providing strategic leadership and direction for the delivery of public sector health services in the state
- promoting the efficient and effective use of resources
- developing statewide health service, workforce and capital works plans
- managing major capital works for proposed public sector health service facilities
- managing statewide industrial relations and establishing the conditions of employment for health service employees, including issuing health employment directives
- employing staff of the department and staff of non-prescribed HHSs (there currently remains eight 'non prescribed' HHSs (Cairns and Hinterland, Central Queensland, Central West, Darling Downs, Mackay, South West, Torres and Cape, and Wide Bay), where legal responsibility for staff resides with the department)
- delivering specialised health services
- arranging for the provision of health services to public patients in private health facilities
- entering into service agreements with the HHSs
- providing support services to HHSs
- monitoring and promoting improvements in the quality of health services delivered by HHSs
- monitoring HHS performance and taking remedial action where indicated
- collating and validating statewide performance data and providing performance and other data to the Commonwealth
- developing and issuing binding health service directives.

2.3.2 Departmental structure

The department performs its role through the following divisions:

- Office of the Director-General—includes key overarching departmental functions such as Cabinet and Parliamentary Services, Departmental Liaison and Executive Support, System Secretariat and the Office of Health Statutory Agencies. The Audit, Risk and Governance function reports directly to the Director-General and administratively sits within the Corporate Services Division.

- Internal Audit and Chief Risk Officer—including Risk and Governance which reports directly to the Director-General. Internal Audit provides risk and assurance functions necessary to support both the department and the broader health system to enable it to function effectively. Audit, Risk and Governance (Branch) sits administratively within the Corporate Services Division but has a direct reporting relationship (functionally) to the Director-General.

- Corporate Services Division—including the Office of the Chief Finance Officer, Office of the Chief Human Resources Officer, Office of the Chief Legal Counsel, Business Improvement and the Integrated Communications Branch. This division provides functions necessary to support both the department and the broader health system to enable it to function effectively, including financial services, legal functions and human resource areas.

- Clinical Excellence Division—including the Patient Safety and Quality Improvement Service, Healthcare Improvement Unit, Healthcare Innovation and Research Branch, Mental Health, Alcohol and Other Drugs Branch, Office of the Chief Dental Officer, Office of the Chief
Nursing and Midwifery Officer, and the Allied Health Professions’ Office of Queensland. This division drives the patient safety, quality improvement and clinical improvement agendas for the Queensland health system. It achieves this by identifying, monitoring and promoting improvements in the quality of health services delivered by service providers (both HHSs and private health facilities, globally and within Queensland), and supports and facilitates the dissemination of best-practice clinical standards and processes that achieve better outcomes for patients. The quality improvement agenda is actively supported by a significant research agenda. The division is also accountable for setting and supporting the direction for mental health, alcohol and other drug services in Queensland, as well monitoring and reporting on performance.

- Prevention Division—including the Health Protection Branch, Communicable Diseases Branch, Chief Medical Officer and Healthcare Regulation Branch, Aeromedical Retrieval and Disaster Management Branch and Preventive Health Branch. Prevention Division delivers policies, programs, services, regulatory functions and clinical coordination of all aeromedical retrieval and transfers across Queensland, that aim to improve health outcomes for the people of Queensland. This is done by promoting and protecting health and wellbeing, prevention of disease and supporting high quality healthcare service delivery.

- Healthcare Purchasing and System Performance Division—including the Contracting and Performance Management Branch and the Purchasing and Funding Branch. This Division leads the development of high level planning and forecasting of health services for the Queensland population; acting as purchaser of health services on behalf of the State; and monitoring and managing performance of healthcare providers according to the purchasing model and service agreements.

- Strategy, Policy and Planning Division—including the Strategic Policy and Legislation Branch, Infrastructure Strategy and Planning Branch, System Planning Branch, Statistical Services Branch, Aboriginal and Torres Strait Islander Health Branch, Workforce Strategy Branch and the Funding Strategy and Intergovernmental Policy Branch. The Division provides core system leadership by setting strategy and direction for the health system, developing and responding to high level policy matters, and undertaking planning across the wide-ranging activities of the health system.

- Queensland Ambulance Service (QAS)—established by the Ambulance Service Act 1991, the QAS operates as a statewide service within Queensland Health, and is accountable for the delivery of pre-hospital ambulance response services, emergency and non-emergency pre-hospital patient care and transport services, inter-facility ambulance transport, casualty room services, and planning and coordination of multi-casualty incidents and disasters.

- eHealth Queensland—committed to advancing digital healthcare. eHealth Queensland enables quality patient care by providing seamless technology solutions and services across Queensland Health.

- Health Support Queensland (HSQ)—delivers a wide range of diagnostic, clinical support and payroll services to enable the delivery of frontline healthcare. HSQ’s services, provided to HHSs, other government agencies, commercial clients and the community are delivered by business units which include: Pathology Queensland, Strategic Procurement and Supply, Group Linen Services, Biomedical Technology Services, Forensic and Scientific Services, Health Contact Centre (13 HEALTH [13 43 25 84] and Quitline), Medication Services Queensland, Radiology Support and Clinical Information Systems Support Unit.

2.4 Role of Hospital and Health Services

Queensland’s HHSs and Boards were established as part of national health reforms agreed between Australian Governments in August 2011 and articulated in the National Health Reform Agreement (NHRA). Governments agreed to the implementation of structural and funding reforms, including local governance boards to improve local accountability and responsiveness to the needs of the community (Schedule D, NHRA). The NHRA is available at:


The HHSs are independent statutory bodies, each governed by their own professional HHB and managed by a Chief Executive (referred to in Queensland as a Health Service Chief Executive (HSCE)). In Queensland, the HHB Act sets out the functions and powers of HHSs and their relationship with the department.

2.4.1 Key features of Hospital and Health Services

HHSs, as statutory bodies, are:

- the principal providers of public sector health services
- accountable through the HHB Chair to the Minister for local performance, delivering local priorities and meeting national standards
- subject to the Financial Accountability Act 2009 (‘the FAA’) and the Statutory Bodies Financial Arrangements Act 1982 (‘the SBFAA’)
- units of public administration under the Crime and Corruption Act 2001
- legal entities that can sue and be sued in their corporate name.

HHSs are legally bound by health service directives and health employment directives issued by the Director-General and also by Ministerial directives. Health service and health employment directives are published on the Queensland Health website at:


HHS functions are detailed in section 19 of the Act. A HHS’s main function is to deliver the hospital and other health services, teaching, and research agreed in the service agreement with the department. Other key functions include:

- ensuring the operations of the HHS are carried out efficiently, effectively and economically
- contributing to and implementing statewide service plans that apply to the HHS, including the implementation of national clinical standards
- cooperating with other providers of health services, including other HHSs, the department and providers of primary healthcare in planning for and delivering health services
- cooperating with local primary healthcare organisations

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7 Following the release of the 2014–2015 Federal Budget, COAG Health Ministers agreed that discussions are needed on a framework to replace the NHRA.

8 A key difference between a statutory body and department is that a statutory body does not have an accountable officer who parallels the role of the CEO or DG of a department unless the Treasurer appoints one. The entity itself (represented by the Board) is accountable to the Minister and Parliament for the performance and actions of the entity.
• consulting with health professionals working in the HHS, health consumers and members of
  the community about the provision of health services
• other functions approved by the Minister.

The *Hospital and Health Boards Regulation 2012* (the HHB Regulation):
• declares the service area for a HHS
• makes provisions for employment matters such as movement of employees between health
  system employers
• outlines the requirements for engagement strategies and protocols
• outlines the procedures for quality assurance committees and root cause analysis
• specifies the prescribed committees of boards and their functions.

HHB functions and powers are further summarised in section 8.3 of this Handbook.

**Hospital and Health Boards**

HHBs are responsible for providing strategic direction and leadership, and ensuring HHS
compliance with standards and legal requirements. HHBs have responsibility for decision
making relating to:
• the structure of their organisation
• how services are delivered in their local area
• providing performance data to the department
• establishing systems which support monitoring of performance
• entering into a service agreement with the Director-General.

**Health Service Chief Executives**

Each HHB must appoint a HSCE for the HHS. The appointment is subject to final Ministerial
approval. The HSCE is accountable to the HHB and is responsible for management of
operations of the HHS, and making implementation decisions consistent with the strategic
framework set by the HHB.

The HSCE is accountable for ensuring patient safety through the effective executive leadership
and management of all hospital and health services, as well as any applicable support functions
located within their HHS.

Typical key accountabilities include:
• supporting the HHB in developing and implementing a vision and strategy for the HHS and
  ensuring this is aligned to the Minister’s letter outlining delivery priorities
• establishing and leading a high quality executive team responsible for providing leadership
  and direction for all of the HHS’s facilities and ensuring the delivery of effective, efficient and
  economical healthcare
• ensuring ongoing development of the organisation and promoting a culture of learning,
  innovation, research and development
• ensuring a strong culture of, and commitment to, safety and quality across the HHS to
  underpin health service delivery
• ensuring risk, compliance and governance frameworks operate effectively across the HHS
• providing strategic advice to the HHB to enhance decision making
• ensuring resources are planned, allocated and evaluated to meet service agreement requirements
• establishing a workforce vision, strategies and plans that reflect the workforce needs of the HHS
• ensuring clinicians, consumers and the community are involved in health service planning and evaluation through the implementation of robust engagement strategies.

The HSCE is delegated a range of powers from a number of different sources including: the HHB, the Director-General, and the HHB Act (refer also to section 8.3.2 on delegations).

2.5 Managing the healthcare system

The HHB Act incorporates a number of levers which the department may use to influence or direct matters relating to either individual or all HHSs.

2.5.1 Service agreements

Under sections 35–39 of the Act, the department must enter into a service agreement with each HHS. This service agreement sets out the hospital services, other health services, teaching, research and other services that an individual HHS must deliver. The service agreement must be for a term of no longer than three years and is binding on both the Director-General of the department and the HHS. Amendments can be made with the agreement of both parties. Where agreement cannot be reached, the Minister must decide the terms.

Once the first service agreement is in place, negotiations must commence at least six months before the expiry of the existing service agreement, to agree a new service agreement.

2.5.2 Health service directives

HHSs are legally bound by health service directives issued by the Director-General (see sections 47–51 of the HHB Act). Health service directives may apply to all HHSs, some HHSs, or a stated type of public sector health service facility or public sector health service.

The Director-General may issue health service directives in order to:
• Promote service coordination and integration in the delivery of health services
• Optimise the effective and efficient use of available resources
• Set standards and policies for the safe and high quality delivery of health services
• Ensure consistent approaches to the delivery of health services, employment matters (other than conditions of employment for health service employees) and the delivery of support services
• Support the application of public sector policies, State and Commonwealth Acts and agreements entered into by the State (for example by requesting data).

Health service directives may be about the following:
• standards and policies for the healthcare rights of users of public sector health services
• standards and policies for improving the quality of health services
• the use by HHSs of support services provided by the department, other departments or other HHSs
• the purchasing of goods and services under contracts and agreements entered into by the department, other departments or other HHSs
• the provision of information to the Director-General and other entities
• responding to public health emergencies
• the setting of fees and charges, including for the provision of services to private patients, for residential care, and for the supply of pharmaceuticals
• other matters prescribed under a regulation.

2.5.3 Health employment directives
HHSs are also legally bound by health employment directives issued by the Director-General (see sections 51A to 51F of the HHB Act) about the conditions of employment for health service employees. Health employment directives may apply to the department, a HHS or all HHSs, and to health service employees, or a stated type of health service employee.

The Director-General may issue health employment directives about the following:
• remuneration for health executives and senior health service employees
• the classification levels at which health executives and senior health service employees are to be employed
• the terms of contracts for health executives and contracted senior health service employees
• the conditions of employment for senior health service employees, other than contracted senior health service employees
• the professional development and training of health service employees in accordance with the conditions of employment.

2.5.4 Performance framework
HHSs are individually accountable for their performance, which they are required to report to the department. A Performance Framework has been developed to support the management of the healthcare system in Queensland.

2.5.5 Obligations to consult
The HHB Act places a number of responsibilities on the department to consult with HHSs, for example:
• prior to agreeing annual service agreements
• in advance of issuing a health service directive
• when developing regulations.

The department may also choose to engage and consult with relevant peak bodies and other stakeholders, including the local community. The department will take into consideration—but is not bound by—views expressed during the consultation process.

2.6 Parliamentary Committees and inquiries
2.6.1 Parliamentary Committees
To assist the Queensland Parliament to operate more effectively, the Queensland Legislative Assembly established a number of parliamentary committees in 2011, which mirrored the
various portfolio areas of government. The Parliamentary Committee with primary responsibility for health matters is the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee.

The role of Parliamentary Committees is to investigate specific issues and report back to Parliament. A strong, active Parliamentary Committee system is considered as an asset in any functioning parliamentary democracy providing greater accountability by making the policy and administrative functions of Government more open and accountable. Parliamentary Committees provide a forum for investigation into matters of public importance and give members of the Legislative Assembly the opportunity to enhance their knowledge of such issues.

Further information on Queensland Parliament Committees is available at: www.parliament.qld.gov.au

2.6.2 Submissions to Parliamentary inquiries

From time-to-time, submissions to a particular inquiry are invited by Parliamentary Committees. This is particularly important and the role of the department (as System Manager) is to provide submissions on behalf of the health portfolio. In this regard, HHSs, commercialised business units and divisions of the department may be invited to consider whether they wish to provide input into the portfolio-wide response.

It is anticipated that HHSs may also wish to make a submission to a Parliamentary inquiry where the matters under consideration are relevant to their functions and areas of responsibility. In those cases, there is a need for an appropriate level of clearance and approval of the submission by the Board.

It is a well-established principle that Queensland Health employees, and all public servants, can individually make submissions as private citizens. If a Queensland Health employee makes a submission in an individual capacity, they need to ensure that they contribute to public discussion in an appropriate manner as set out in the Code of Conduct for the Queensland Public Service. In particular, they will need to take responsible steps to ensure their views are clearly understood to be personal views and not those of government, the Department of Health or indeed the HHS.

If you require further information about Parliamentary Committees, please contact Cabinet and Parliamentary Services, Office of the Director-General, via email: cillo@health.qld.gov.au

2.7 Communication and relationships

Interactions between the department and HHSs are guided by an understanding that HHBs are accountable for the delivery and management of HHSs.

Official correspondence and requests are generally directed between Chief Executive Offices. HSCE office contact details are all available on the Queensland Health website at:


Incoming departmental correspondence is directed to the Departmental Liaison and Executive Support Unit, which manages the flow of information to and from other Government departments and statutory bodies. It also manages incoming patient and customer feedback on behalf of the department and the Minister. Contact can be made via email: EXEC SUPPORT@health.qld.gov.au

The Senior Departmental Liaison Officers assist in the management of urgent and critical issues between the Office of the Director-General, Office of the Minister for Health, HHSs and the department. The role also coordinates the provision of advice in response to situations requiring
a rapid turnaround of information coming from and to other government and statutory bodies. Contact can be made via email: SDLO@health.qld.gov.au

The Cabinet and Parliamentary Services Unit is responsible for the coordination and oversight of activities related to Cabinet (and Cabinet-related functions such as Cabinet Committees and Community Cabinet), Executive Council and the Parliament (including the annual estimates process). As the single point of contact for these activities within the Health portfolio, the Unit is responsible for ensuring compliance with whole of government procedures and the timely provision of information and briefing materials to the Director-General and Office of the Minister for Health. Contact can be made via email: CLLO@health.qld.gov.au

These formal processes do not preclude informal or other communication and liaison processes and networks across boundaries that, for example:

• support and enable cooperation and create a common purpose
• promote sharing of information transparently across the system
• resolve issues in the simplest, earliest way and as close as possible to the source
• create opportunities for connection and strengthen communication networks.
2.8 System-level committees and forums

There are a range of groups which have been established to facilitate communication and collaboration across Queensland Health and provide advice on system/statewide matters.

2.8.1 Queensland Health Board Chairs’ Forum

This is a peak forum for HHB Chairs to discuss strategic priorities and exchange ideas and initiatives with the Minister, Director-General, and on relevant matters, Deputy Directors-General. Regular invited guests include the Chair and Deputy Chair of the Health Service Chief Executive Forum and Chair of the Queensland Clinical Senate. Internal and external leaders and experts are also frequently invited to present and discuss matters of interest to the Forum. The forum is held on a quarterly basis and the Secretariat, provided by the Office of Health Statutory Agencies, is contactable via email: statutoryagencies@health.qld.gov.au

2.8.2 Health Service Chief Executives Forum

This is a peak forum for HSCEs to work together on significant collective HHS matters to improve healthcare for Queenslanders. Portfolios are allocated to organise collective activity and promote leadership across the range of shared issues that need to be covered.

The Chair of the Board Chairs Forum and another Board Chair representative are invited to attend the HSCE Forum to discuss key matters of mutual interest. The Secretariat is hosted by Metro North HHS and is contactable via email: HSCE-Forum-Office@health.qld.gov.au

2.8.3 System Leadership Team

The System Leadership Team (SLT) operates at a strategic-level, and provides high level leadership, and strategic and forward-looking advice to the Director-General on policy, strategy, system reform, devolution and other high level issues that affect the broader Queensland public health system. SLT membership includes the Director-General, Deputy Directors-General, and central business unit Chief Executives from the department. It also attends to issues of significance between the department and HHSs. The Chair of the Queensland Health Board Chairs Forum participates as an ex-officio member with full right of discussion and debate but not voting rights.


The Secretariat is contactable via email: SLT_Secretariat@health.qld.gov.au

2.8.4 System Leadership Forum

The System Leadership Forum (SLF) provides a collaborative forum in which the department’s leadership team and HSCEs can openly and robustly discuss and debate the overall leadership, strategy, direction, challenges and opportunities facing Queensland's public health system. The SLF membership includes the Director-General, Deputy Directors-General and central business unit Chief Executives from the department, all HSCEs and the Chief Executive of Mater Health Services.

Further information is available on QHEPS at: http://qheps.health.qld.gov.au/ess/meetings-committees/departmental/slf.htm

The Secretariat is contactable via email: SLF_Secretariat@health.qld.gov.au
2.8.5 Clinical advisory groups

Queensland Clinical Senate

The Queensland Clinical Senate (QCS) operates under the authority of the Director-General and connects clinicians from across the health system in Queensland to provide high-quality, evidence-based and timely advice to the Minister, Director-General and other key stakeholders.

The purpose of the QCS is to represent clinicians in providing strategic advice and leadership on system-wide issues affecting quality, affordable and efficient patient care in Queensland. The vision of the QCS is for clinicians to actively contribute to decision making around the delivery of quality health services through all levels of the Queensland health system. QCS membership consists of consumers and clinicians from across the health system, with experience across a range of practice settings, disciplines and geographical areas.

Further information is available on the Queensland Health website at:

Statewide Clinical Networks

Statewide Clinical Networks are a key initiative of Queensland Health to engage clinicians and consumers in decision making about clinical services planning and implementation, clinical practice improvement and quality and safety enhancements. The networks comprise of clinicians, established to address problems in quality and/or efficiency of healthcare. There are 17 networks including:

- Anaesthesia and Perioperative Care
- Cancer
- Cardiac
- Child and Youth Health
- Dementia
- Diabetes
- Queensland Emergency Strategic Advisory Panel
- General Medicine
- Intensive Care
- Maternity and Neonatal
- Older Person’s Health
- Renal
- Respiratory
- Rural and Remote
- Surgical Advisory
- Stroke
- Trauma.
There is also a range of other clinical advisory groups which provide high-level advice and recommendations on health priorities through clinical leadership, and address specific statewide issues or areas of work as required, such as the: Directors of Medical Service Advisory Committee, Queensland Nursing and Midwifery Executive Council, Health Services Executive Directors of Nursing and Midwifery Services, Directors of Allied Health Professions Advisory Committee, and Directors of Pharmacy Services Advisory Committee.

Further information is available on the Queensland Health website at:

2.9 Interfaces with other organisations

Chairs of HHBs are accountable to the Minister and have a corporate level relationship with the department. Aside from any legislative requirements that are matters for other departments (for example with regard to financial reporting and compliance with health and safety obligations), requests from other organisations, including other government departments, can generally be handled at a Chair’s discretion.

HHBs also have regular contact with a variety of public and private sector organisations, including partnerships to improve the healthcare system to meet the needs and choices of Queenslanders.

2.9.1 Primary health organisations

The Commonwealth Government has lead responsibility for system management, policy and funding for general practice (GP) and primary healthcare services.

A network of 61 Medicare Locals across Australia was established and funded by the Commonwealth Government in 2011-2012 to drive improvements in primary healthcare and ensure that services are better tailored to meet the needs of local communities. Medicare Locals were reviewed in 2014 and ceased on 30 June 2015, when they were replaced by a smaller number of Primary Health Networks (PHNs).

Thirty-one PHNs were established nationally on 1 July 2015, including seven in Queensland. The PHNs are clinically-focused and responsible for improving patient outcomes in their geographical area by ensuring that services across the primary, community and specialist sectors align and work together in patients’ interests. PHNs are expected to align more closely with state and territory health network arrangements, and reduce duplication of effort. HHSs, PHNs and other health service providers work together to better integrate local services and drive improvements in health outcomes.

A list of PHNs in Queensland and link to a map is provided at Appendix 2. Three of the PHNs are established under the auspices of the HHSs as follows:

- Darling Downs and West Moreton Health PHN
- Northern Queensland PHN
- Western Queensland PHN.

2.9.2 Private sector organisations

The private health sector (including both the for-profit and not-for-profit sectors) also plays a significant role in delivering health services. The guiding principles in section 13 of the HHB Act include that providers of public sector health services should work with providers of private sector health services to achieve coordinated, integrated health service delivery across both sectors.
In addition to services provided by private hospitals:

- many medical and allied health practitioners are in private practice (self-employed, in small practices or large corporate practices)
- prescribed pharmaceuticals are dispensed by private sector pharmacies who charge a fee for service
- most high-level residential aged-care beds are provided in private aged-care facilities.

The department’s Private Health Regulation Unit is responsible for monitoring private healthcare sector compliance with the accreditation, licensing and any other regulatory and legislative requirements of the *Private Health Facilities Act 1999*. This includes:

- strategic direction and management of whole of state compliance
- corrective action
- clinical audit
- operational and environmental safety
- an advisory role for the protection of the health and well-being of patients receiving health services at private health facilities.

The public sector health system is also supported by optional private health insurance (and injury compensation insurance) for hospital treatment as a private patient and for ancillary health services (such as physiotherapy and dental services) provided outside the hospital.

Private health insurers provide rebates for ancillary health services (such as physiotherapy and dental services) and hospital treatment as a private patient. Injury compensation insurers providing workers’ compensation and third-party motor vehicle insurance also fund some healthcare.

### 2.9.3 Other State Government departments and agencies

HHSs are subject to a range of whole-of-government legislative requirements and policies in relation to governance, planning, performance and reporting that are administered by other government departments/agencies. For example, HHSs will interface with:

- **Department of the Premier and Cabinet**—in relation to consultation on strategic plans
- **Queensland Treasury**—in relation to approvals for buying land and buildings
- **Queensland Audit Office**—in relation to annual audit of financial statements
- **Department of Housing and Public Works**—in relation to whole-of-government policies such as maintenance of government buildings and procurement
- **Department of Science, Information Technology and Innovation**—in relation to whole-of-government ICT architecture and policy managed by the Queensland Government Chief Information Office
- **Department of Infrastructure, Local Government and Planning**—in relation to asset management and infrastructure planning)
- **Building Queensland**—in relation to investment >$50M
- **Office of the Health Ombudsman**—in relation to managing complaints
- **Crime and Corruption Commission**—in relation to notification of suspected corrupt conduct
- **Public Service Commission**—in relation to ethics and public interest disclosures.
Other organisations

The public sector health system in Queensland is comprised of the HHSs and the department. However, there is also a range of other ancillary public sector organisations with an interest in local health provision that will differ in each HHS area but most likely will include peak bodies, consumer organisations, charities, professional associations, unions, local governments and other institutions such as universities.

Under section 40 of the HHB Act, HHSs must develop and publish engagement strategies to promote consultation with health consumers and members of the community about the provision of health services, and the interests of the above organisations could be considered as part of the HHS’s delivery of this obligation.

Other HHSs

Aside from cross-border issues and at the discretion of individual HHSs, neighbouring or regional organisations may choose to work closely on matters of shared interest.

2.9.4 Other health statutory agencies

Besides HHSs, there is a range of other agencies in the Health portfolio, including statutory bodies\(^9\) such as the Office of the Health Ombudsman (refer section 7.2.2), Queensland Mental Health Commission, Hospital Foundations, and the QIMR Berghofer Medical Research Institute Council; as well as mental health authorities and ministerial advisory committees. Some of the roles and strategic HHS linkages with these entities are described below.

Hospital foundations

Hospital foundations help their associated hospitals provide improved facilities, education opportunities for staff, research funding and opportunities, and support the health and wellbeing of communities. They are overseen by voluntary boards appointed by the Governor in Council on the recommendation of the Minister. Linkages between foundations and their local HHS are ensured via required membership of the relevant HHB Chair (or their nominee) and at least two employees of the local hospital on the hospital foundation.

Further information about Health portfolio statutory agencies and their roles is available on the Queensland Health website at:


Queensland Mental Health Commission

The Queensland Mental Health Commission (the Commission) commenced on 1 July 2013 as an independent statutory body established under the Queensland Mental Health Commission Act 2013 (the QMHC Act). The objective of the Commission is to improve the mental health and wellbeing of all Queenslanders and minimise the impact of substance misuse in our communities by:

- developing a whole-of-government strategic plan to integrate systems and improve services
- monitoring, reviewing and reporting on issues affecting people with mental illness
- promoting prevention, early intervention and community awareness strategies.

\(^9\) Statutory bodies are responsible for specific aspects of government administration and are established under their own separate legislation. Most statutory bodies are administered by Boards or committees, and all must report through the responsible Minister on their operations.
The Commission is supported by the Mental Health and Drug Advisory Council.

In exercising its functions under the Act, the Commission must engage with HHBs. The Act also requires that the Director-General must take the whole-of-government strategic plan into account when negotiating service agreements to the extent the agreements relate to the delivery of mental health and substance misuse services.

**Mental Health Court**

The Mental Health Court is a superior court of Queensland with responsibility to determine issues such as criminal responsibility and fitness for trial and, by its decisions, remove the mentally ill and intellectually disabled offender from the criminal justice system and into the mental health system.

The court is the appeal body to the Mental Health Review Tribunal and has special powers of inquiry into the lawfulness of the detention of persons in authorised mental health services. The Court is constituted by Judges of the Supreme Court of Queensland and is advised by two assisting psychiatrists drawn from a panel.

**Mental Health Review Tribunal**

The primary role of the Mental Health Review Tribunal (MHRT) is to provide independent review of persons subject to involuntary detention and treatment under the *Mental Health Act 2000*. The Tribunal consists of the President and other members appointed by the Governor in Council, including lawyers, psychiatrists and other persons with relevant qualifications and/or experience.
3. Queensland Health funding arrangements

**In this section:**
- Overview
- Healthcare and the purchaser/provider model
- Funding models
- Independent Hospital Pricing Authority and funding flows
- Capital funding allocations

**Key points:**
- The cost of funding the health system is growing
- Queensland Health is funded from a range of sources and has a purchaser/provider model of service delivery
- An activity based funding (ABF) model is currently used
- Capital funding is allocated for some items and applications required for some funding sources

### 3.1 Overview

The Queensland health system is funded from a range of sources including the State Government, Commonwealth Government, private insurers and patient ‘out of pocket’ payments. Under traditional arrangements, which have been partially formalised through several national agreements including, the National Health Reform Agreement (NHRA), the State Government, has major responsibility for funding public hospital services while the Commonwealth has a lead role in funding, primary health and aged care services.

The cost of funding the health system is growing. The 2015/16 budget for Queensland Health is $14.183 billion. The health portfolio receives the largest share of the State Budget, accounting for approximately 29 per cent of spending. Most of the funding comes from the State (approximately 65 per cent), followed by the Commonwealth Government (approximately 25 per cent) and the remainder from user charges, fees and other revenue (approximately 10 per cent) [see Figure 1].
The Commonwealth contribution to the state health budget is comprised mainly of National Health Reform Funding. In the funding model applying from 2014–15 to 2016–17, this funding is based on efficient growth in public hospital services.

A minority (approximately three per cent in 2015–16) of the Commonwealth funding is provided under agreements for defined purposes. The Commonwealth also subsidises health costs through Medicare (the Medical Benefits Scheme), the Pharmaceutical Benefits Scheme and indirectly through the private health insurance rebate.

In the 2014–15 Budget the Commonwealth announced that current Commonwealth funding of public hospitals based on ‘efficient growth’ of actual activity will end in 2016–17. From 2017–18, it will be replaced with an indexation formula based on growth in ‘unweighted’ population and the Consumer Price Index (CPI).

### 3.1.1 Commonwealth funding agreements

The bulk of direct Commonwealth Government funding for public hospitals is provided under two main agreements—the National Healthcare Agreement (NHA) and the NHRA. In addition to national health reform funding, several National Partnership Agreements (NPAs) and Project Agreements (PAs) provide additional Commonwealth funding which can only be used for specific projects/priority areas as detailed in these agreements.

NPAs are intended to promote reform or support the delivery of specified outputs or projects. The agreements include payments for defined periods and consist of up-front facilitation funding and, in some cases, reward funding for the performance against targets. State co-contribution may be required under NPAs. In addition to NPAs, there are a number of smaller-scale and lower value PAs.

NPAs and PAs are agreed at the State/Territory and Commonwealth Government levels and signed by First Ministers and the relevant portfolio Minister (for NPAs and PAs respectively). NPAs are supported by implementation plans where State-specific or project specific information is included. The implementation plans provide greater detail about funding and focus on the achievement of the outcomes sought by the Commonwealth and the State Governments.

Individual Service Agreements between the department and HHSs include both the delivery of local priorities and national priorities identified in NPAs. NPAs and PAs generally include commitments to provide regular performance and financial updates to the responsible...
Commonwealth Government agencies as well a requirement to acknowledge the contribution of the Commonwealth Government in any publicity material (such as signage). Any requirements for statewide data or other reporting are coordinated by the department. The amount of funding provided under NPAs has declined significantly since 2013–14.

Queensland also receives a small amount of Commonwealth funding for specific programs. The Queensland Government Principles for Intergovernmental Activities apply to the negotiation of any inter-governmental (including government agencies and bodies) agreements and outline the criteria that must be considered by the Queensland Government before it becomes party to any new agreement.

In the 2014–15 Federal Budget, the Commonwealth Government announced several major departures from the terms of the NHRA and other key NPAs. These changes will significantly reduce the amount of Commonwealth growth funding for public hospital from 2017–18 if implemented. A number of Commonwealth Government reviews and associated inter-governmental negotiations are also likely to influence the future of Commonwealth health funding.

3.1.2 State funding

The department leads the annual budget submission for the Health portfolio based on an analysis of emergent need. Preparation of the department’s State Budget submission to the Cabinet Budget Review Committee usually occurs between November and March each year prior to the coordination of Queensland Health’s contribution to the State Budget Papers. In the 2015–16 budget, Queensland Health received additional operational growth funding of $2.302 billion over four years.

3.1.3 Own source revenue

Own Source Revenue (OSR) plays a critically important role within HHSs’ operating budgets. Revenue generated through the provision of private and compensable patient services aids in the sustainability of current services and funds new initiatives. OSR is made up of the following components:

- Private inpatients (through Granted Private Practice—insured and self-funded)
- Private outpatients (through Granted Private Practice)
- Department of Veterans Affairs
- Department of Defence
- Workers’ Compensation patients
- Motor accident patients
- Other compensation patients (for example, public liability and product liability)
- interstate (cross-border residents)
- Medicare ineligible patients (such as, overseas residents)
- Other patient-related revenue (pharmaceutical recoveries, prosthetic recoveries, pathology and imaging)
- Other goods and services (for example, canteen proceeds, research grants and fee for service/recoveries).
3.2 Healthcare and the purchaser/provider model

3.2.1 Purchaser/provider split and healthcare purchasing

The purchaser/provider model has been adopted globally by many public sector administrations with the aim of separating the roles of purchaser and provider in Government service delivery, where appropriate, to achieve best value service delivery.

The purchaser/provider model of service delivery entails two components. Firstly it involves the existence of purchasing agencies with responsibility for purchasing services and ensuring the needs of the population are covered, but who are not directly involved in the provision of services. Secondly it features service providers, usually with a degree of autonomy and responsibility in relation to their function of delivering services. Providers of services relate to the purchaser through contracts (service agreements) that specify each party's roles and responsibilities.

A formal purchaser/provider model has been in place in Queensland since 1 July 2012.

As system manager, the department has a statutory responsibility under the HHB Act (Part 3 Division 1 s. 45) to promote the effective and efficient use of available resources in the delivery of public sector health services in the State. In its role as purchaser, the department needs to make decisions in allocating funding and paying for healthcare services which reflect this responsibility and ensure that the funding available delivers the best possible outcomes for the Queensland population.

Decisions are made in a rigorous, systematic and transparent way, through a structured governance framework, with the aim of fairly and rationally distributing resources across competing demands. Healthcare purchasing therefore draws upon strategic assessments of needs, including estimated future activity (EFA) and priorities and the best available evidence of clinical and cost-effectiveness in making decisions. The purchasing framework also takes into account HHS specific developments and investments, for example, major capital projects or additional investment to reduce long wait patients.

The activity to be purchased from the HHS is outlined in the service agreement and includes:
- the activity-based funding (ABF) and non-ABF activity volumes to be purchased expressed as weighted activity units (WAUs)
- associated funding (dollars)
- specific funding commitments
- funding adjustments.

The service agreement also includes:
- the key performance indicators
- the services to be provided and teaching, training, and research responsibilities of the HHS.

Healthcare purchasing also develops funding allocation and payment models which aim to incentivise high quality and cost-effective services. This includes activity based funding and other output and population based funding models. Queensland is also represented on key bodies informing national funding models such as the Independent Hospital Pricing Authority (IHPA) to ensure Queensland’s interests are considered and decisions support strategies to improve health outcomes for Queenslanders.
3.2.2 Commonwealth funding

In the 2011 NHRA, it was agreed that both the Commonwealth and the State Governments would be jointly responsible for funding public hospital services, funding growth in public hospital services and the increasing cost of those hospital services, while collecting and providing data to support the objectives of comparability and transparency.

Under the NHRA, the Commonwealth would fund an increasing share of public hospital expenditure relative to the former National Healthcare Specific Purpose Payment (SPP). This would be achieved by linking Commonwealth funding to volumes of activity and an independently determined National Efficient Price (NEP), that is the Commonwealth would fund ‘efficient growth’ by means of activity based funding. The Commonwealth committed to meeting 45 per cent of efficient growth between 2014–2015 and 2016–2017 and 50 per cent of efficient growth from 2017–2018 onwards. The commitments also included guarantees that funding under efficient growth would not be less than the funding that would be received under the SPP.

However, as part of its 2014–2015 Budget the Commonwealth announced that its contribution to public hospital funding, based on efficient growth, would cease on 30 June 2017 and that the NHRA funding guarantees would be removed. From July 2017, the Commonwealth will index its contribution to public hospital services by Consumer Price Index and population growth.

Since July 2012, Commonwealth and each state and territories’ public hospital funding has been paid into and out of the National Health Funding Pool, with payments reported publicly.

3.3 Funding models

3.3.1 Activity based funding

As part of the NHRA, Australian governments committed to work in partnership to:

- improve patient access to services and public hospital efficiency through the use of ABF based on a national efficient price
- ensure the sustainability of funding for public hospitals by increasing the Commonwealth’s share of public hospital funding through an increased contribution to the costs of growth
- improve the transparency of public hospital funding through a national health funding pool and a nationally consistent approach to ABF.

ABF is a management tool that has the potential to enhance public accountability and drive technical efficiencies by:

- capturing consistent information on hospital sector activity and costs
- creating explicit relationships between funding and services
- strengthening focus on outputs, outcomes and quality
- encouraging clinicians and managers to identify and manage variations in costs.

The Independent Hospital Pricing Authority (IHPA) is responsible for establishing a national ABF model and determining a national efficient price (NEP) for public hospital services. The NEP is expressed as a national weighted activity unit (NWAU) and enables performance measurement as well as national benchmarking. To ensure that ABF payments are fair and equitable, the NHRA allows for adjustments to the NEP. This is to reflect legitimate and unavoidable variations in the cost of service delivery, for example, hospital location – remoteness and patient complexity including Indigenous status. See section 3.4 below for more detail on the IHPA.
In 2012–13, Queensland adopted a Queensland-specific ABF model underpinned by the national ABF model with some localisations to fund 35 of Queensland's largest public hospitals, with others being block funded. The 2015–16 ABF model calculates health funding to public hospitals based on the volume of healthcare services (referred to as ‘activities’) purchased. The model promotes smarter healthcare choices and better care by placing greater focus on the value of the healthcare we deliver for the amount of money expended.

Under the Queensland ABF model, Queensland weighted activity units (QWAUs) are used as a measurement unit to determine the relative value of the hospital's activity. In 2015–16, one QWAU is equivalent to the Queensland efficient price (QEP) of $4,597.05. The QEP is lower than the NEP to reflect differences in coverage between the costs underpinning the NEP and the costs that are borne by Hospital and Health Services (HHSs). For instance, it is necessary to reduce the price to remove the effect of costs that are included in the NEP but paid to HHSs as block grants such as clinical education and training or not borne by HHSs (overheads borne by the department rather than HHSs).

3.3.2 Population based funding

Population based funding (PBF) is a method of allocating funding to a service provider based on the expected cost of meeting the healthcare needs of the population being served. Those needs, and hence funding levels, reflect both the size and the health status of the population in question.

Consideration is currently being given to the appropriate funding model for Queensland Health.

3.4 Independent Hospital Pricing Authority and funding flows

The Independent Hospital Pricing Authority (IHPA) is responsible for developing an overall pricing framework to determine levels of Commonwealth funding for public hospital services. Queensland continues to be involved in detailed discussions with the IHPA and other jurisdictions about the parameters for the national ABF model through a range of advisory groups and working groups.

The IHPA released the NEP determination and national ABF model for 2015–16 in February 2015. The annual Pricing Framework and the NEP determination provide information critical to determining Commonwealth funding for public hospital services from 2014–15. When agreed in August 2011 the NHRA included funding guarantees at both the state-specific and national levels, meaning there would be no direct financial risks to Queensland in 2014–15 regardless of the 2014–15 NEP determination. However, as part of its 2014–15 Budget the Commonwealth Government announced it was ceasing the funding guarantees from 2014–15.

The NEP set for each year effectively provides the mechanism for reporting the Commonwealth’s contribution to public hospital services under the NHRA in that year. The annual NEP determination outlines a number of key features of the national ABF model, including the methodology for determining the NEP, the technical parameters of the model (for example, loadings for Indigenous patients and/or rural hospitals) and the scope of public hospital services that will directly affect the level of Commonwealth ‘efficient growth’ funding for public hospital services for the three years from 2014–15 to 2016–17.

3.4.1 National Health Funding Body

The National Health Funding Body (NHFB) provides transparent and efficient administration of funding in the Australian Hospital system. The NHFB is a statutory body recognised by legislation in all jurisdictions, which became operational from 1 July 2012. The primary function
of the NHFB is to assist the Administrator of the National Health Funding Pool in the performance of his functions. The Commonwealth and State Governments contribute funding for hospitals into a dedicated state pool account within a national pool administered by an Administrator.

The Administrator is an independent statutory position established by provisions of State, Territory and Commonwealth legislation. The NHFB assists the Administrator of the National Health Funding Pool to ensure that state and territory deposits into state pool accounts and payments from the state pool accounts to HHSs are made in accordance with directions from the Queensland Health Minister and in line with the Service Agreements.

3.5 Capital funding allocations

State and Commonwealth funding allocations to Queensland Health for capital investment are detailed in the Capital Acquisition Plan (CAP) managed through the department. The CAP details all existing capital investment for the current year and the forward estimates period. Review and monitoring of expenditure against the CAP is undertaken as part of the forward estimates update and annual whole-of-government budget cycle process, resulting in the publication of the Queensland Health capital budget and forecast spend within State Budget Paper 3—Capital Statement (BP3).

HHSs receive an annual distribution of capital funding from two specific programs; Minor Capital Projects and Acquisition Program and the Health Technology Equipment Replacement (HTER) Program. However, a HHS can also make an application for a capital funding allocation in accordance with the department’s Capital Funding Policy.
3.5.1 Minor capital projects and acquisitions program

Capital allocations to an HHS must only be used to cover minor capital needs rather than to fund expensing items.

The Minor Capital Funding provided to HHSs is provided through the service agreement process as a cash payment. Any unspent funding is retained by the HHS to be used in future years and is not returned to the department for redistribution. In accordance with the Capital Funding Policy Implementation Standard, it is mandated that 25 per cent of the funding allocated to HHSs and divisions remains uncommitted, to specifically cover urgent and unavoidable capital needs. Any overspends in annual allocations shall be withdrawn from the HHS’s funding allocation for the following year.

Within the department, Minor Capital Funding is allocated to divisions and commercial business units on a project-by-project basis for which a business case is required. This funding is retained within the department and any underspends are available for redistribution to other projects.

It is an expectation that minor capital acquisition allocations are fully expended each financial year as spends in capital allocations not utilised within the financial year are generally not rolled over to the following year. However, in some circumstances, and on a case-by-case basis, a ‘rollover’ of capital funds may be requested from the Chief Financial Officer.

3.5.2 Health Technology Equipment Replacement Program

The HTER program is a two year, Governor-in-Council (GIC) approved, $140 million capital funding source. It is used for the replacement of existing health technology equipment in all Queensland Health facilities, as well as designated departmental programs and projects.

HTER program funding is utilised to replace aging, obsolescent technology equipment assets to ensure that HHS facilities have the appropriate resources to maintain clinical and service delivery. The program also includes the Health Technology Disposals Program, primarily (but not limited to) facilitating and assisting HHSs in the disposal of surplus equipment replaced under the HTER program.

A funding allocation for HTER is detailed within the CAP and BP3 (Capital Statement) under each HHS.

3.5.3 Applications for an allocation of sustaining capital funding

The Priority Capital Program is intended for capital works which enhance, refurbish or replace existing infrastructure to sustain and/or improve HHS health facilities’ service delivery and continuity. Funding is intended to increase legislative compliance, improve health and safety standards and extend the asset lifecycle.

The department’s Capital Funding Policy, Implementation Standard and Protocol outline the eligibility requirements for approval of an allocation of capital funding from the Priority Capital Program.

HHSs apply for project funding through a two-stage application process. Assessment against the criteria in Stage 1 determines if a proposed project is eligible. This approach limits the effort, cost and input for HHSs in Stage 1 so that HHSs can focus on Stage 2 applications.

Stage 2 applications require greater detail of the project with respect to scope, cost and project planning. Where an HHS invests money on the Stage 2 application for the engagement of consultants or specialist advice, these costs are reimbursed as part of the final project cost if approval is granted.
These projects may be managed and administered by the HHS. However, there are minimum requirements for the project owner to report back to the department including:

- monthly progress status reports
- practical completion/final completion checklists
- project review checklist (following practical completion)
- interim financial reconciliation and final financial close checklists.

Reporting information is used to inform Queensland Health’s BP3 (Capital Statement), identify local projects in the Regional Budget Statement, and in the development of HHS Service Delivery Statement and Estimates hearings briefs.

### 3.5.4 Investment Management Framework

An Investment Management Framework (IMF) has been developed to capture requests for discretionary funding and profile attractiveness and do-ability of initiatives to determine investment priorities. The IMF will ensure identified investments are aligned with Queensland Treasury’s Project Assessment Framework (PAF). Investment priorities are managed to optimise performance, value for money and return on investment.

An expertise-based Investment Review Executive Committee (IREC) has been established to provide advice to financial delegates on whether non-business-as-usual initiatives requiring capital funding should go ahead from an investment perspective. Further information on the IRC is available on QHEPS at:


The IREC, reviewing high value investments, is complemented by the eHealth Executive Committee (eHEC) to cover eHealth ecosystem investment leveraging the entire Queensland Health system (including the Department of Health and Hospital and Health Services), and the collaboration of other complementary players, including partners, suppliers, intermediaries, and non-Health players like universities and government research institutes.

Investment governance over this evolving ecosystem is being established to ensure understanding of the strengths, weaknesses and innovation opportunities, and what needs to be done by interacting jointly to create value and improve system performance to meet key healthcare objectives. It is essential that all eHealth investments adhere to the architectural, legislative and regulatory requirements and represent a prudent and efficient deployment of resources. Where eHealth investment forms part of the Queensland Health eHealth priorities, are co-funded or are identified as high risk, eHEC will provide stewardship oversight for visibility of the investment decision making process and ensure that, where appropriate, programs are established and managed to more efficiently and effectively address multi-HHS issues and capabilities.

eHealth publishes monthly the performance status of active investments on the public facing QGCIO ICT Dashboard:


Additionally, the internal detailed eHealth online dashboard, ‘eHealth at your fingertips’, providing visibility and status of all eHealth current and registered potential pipeline investment, was launched in April 2016.
4. Hospital and Health Service planning

In this section:
- Service delivery statements
- Estimates
- Strategic and operational planning
- Service planning
- Infrastructure planning

Key points:
- HHSs provide information and attend hearings for the overall State Budget process
- HHSs are required to develop a four year strategic plan and an annual operational plan
- HHSs are responsible for comprehensive health service and infrastructure planning at the local level

4.1 Service Delivery Statements

The Service Delivery Statements (SDS) are developed annually as part of the overall State Budget process. The department is responsible for coordinating the State Budget papers including the SDS for the portfolio of the Minister for Health. Each agency’s SDS provides information on its portfolio budgets, future highlights, recent achievements, performance, staffing, administered items and budgeted financial statements. The performance and financial data covers the estimated actuals for the current financial year and the target/estimates for the previous and forthcoming financial year. The non-financial performance information sets out the services each agency will deliver and the service standards to which these will be delivered. HHS service standards and targets are aligned with HHS service agreements. Most HHSs report against the same set of service standards, although not all service standards apply to all HHSs. For example, those HHSs without major hospitals in their regions report against substantially fewer service standards. The system-wide service standards present a consolidated view of the HHS service standards, as well as a number of additional statewide performance measures.

For planning purposes, internal development of the State Budget papers usually begins in February or March. Key dates and timeframes for the Budget documents are announced by Queensland Treasury in a presentation usually held in February or March. These timeframes and dates then inform the development process of the Budget documents.

HHSs are required to provide information for the SDS and, dependent on the governance processes of the HHS, the HSCE and/or the HHB are responsible for endorsing the relevant HHS’s SDS.

The SDS information, like all budget data, is treated as confidential until released by the Treasurer. The SDS is tabled in Parliament and released publicly with the State Budget, usually on the first Tuesday in June (can vary in election years depending on time of election), and
forms the main source document for the Estimates Committee hearings, usually held in July (can also vary in election years depending on the timing of the Budget).
Actual performance results are published in each agency's annual report.

4.2 Estimates
Since 1994, the portfolio committees of the Parliament have had a role in scrutinising the proposed expenditures contained in the annual State Budget.
Each portfolio committee holds an estimates hearing, usually in July, to examine and report on the proposed expenditures of the different Ministerial portfolios.
Ministers, the Directors-General (supported by senior departmental staff), and HSCEs are required to attend these hearings to answer questions from committee members regarding their portfolio’s proposed budget and performance targets for the new financial year. HSCEs may also be asked to answer questions referred to them, or taken on notice, by the Minister during a hearing.
Portfolio committee’s Estimates hearings are open to the public (unless otherwise determined by the committee) and are conducted in accordance with Chapter 31 of the Standing Orders of the Legislative Assembly.
Each committee is required to table a report in the Legislative Assembly stating whether it agrees to the proposed expenditures. The reports are debated by the Parliament as part of its consideration of the Appropriation Bills that inform the State Budget.
HHSs have a role in the Estimates process in relation to the preparation of briefings on their HHS’s financial and non-financial performance to assist the Minister to respond to the committee’s questions during the hearing. The department liaises with HHSs regarding the Minister’s requirements for briefings and attendance at the hearing.

4.3 Strategic and operational planning
Planning at the whole-of-government, agency and individual levels is integral to determining what services to deliver to clients, stakeholders and the community (Queensland Government Performance Management Framework). The Financial and Performance Management Standard 2009 (FPMS) requires statutory bodies to develop a four year strategic plan for the organisation and an annual operational plan.
HHBs are responsible for developing a strategic plan for their local HHS, and for implementing an operational plan to guide the delivery of the services, within the budget agreed under the HHS service agreement. In preparing strategic and operational plans, Boards are required by section 9 of the FPMS to follow the Department of Premier and Cabinet (DPC) publication—‘Agency Planning Requirements - for the 2016 planning period’. This document is updated annually and is available at:
DPC also provides a supporting ‘Strategic planning toolkit’ available at:
It is also mandatory for HHSs to consult with both DPC and Treasury on their strategic plans – in accordance with the timelines in the Queensland Government Strategic Management Planner available at:


The strategic direction of the HHS should align to deliver on the Government’s priorities for health and the HHS’s service agreement with the department. HHSs are also required to ensure their strategic plans identify key strategic risks and/or critical issues that may affect their ability to achieve stated objectives, analyse their potential impacts and set out strategies for mitigating each risk/issue (DPC Agency Planning Requirements).

Strategic plans for HHSs must be approved by the HHB and published online by 1 July each year.

Section 12 of the FPMS requires a statutory body to have systems in place for obtaining information that will allow the body to determine whether the agency is achieving the objectives stated in its strategic plan in an efficient, effective manner, and delivering its services to the standard stated in its operational plan. It is critical that the strategic and operational objectives of the HHS align with the performance measures in the service agreement. The statutory annual report and service agreement reporting processes will be the mechanisms by which performance outcomes are monitored. Section 13 of the FPMS requires that performance information about the agency’s achievement of progress towards delivery of its strategic plan, and of its services in its operational plan, be provided at least every three months to the Board and at least annually to the Minister (or when the Minister asks for the information).

In developing planning documents, HHSs need to consider incorporating the Queensland Government Performance Management Framework (QGPMF). Under the QGPMF, an agency’s:

- strategic plan describes the agency’s objectives (including its contribution to whole-of-government objectives) and how the performance indicators will measure the extent to which the agency’s objectives have been achieved over time
- operational plans translate those agency objectives into service areas (related services can be grouped into the broad types of services delivered by an agency) and services that deliver outputs and generate outcomes for clients, stakeholders and the community. Operational plans also describe the level of performance that is expected to be achieved, appropriate to the service, to demonstrate that services are being delivered efficiently and effectively (service standards).

See further information on the QGPMF in section 5.

Operational plans must be endorsed by the relevant delegated officer within an agency. Once approval has been received, operational plans should be implemented from 1 July each year and evaluated and/or reviewed at least every six months.

4.4 Service planning

Health service planning aims to improve health service delivery and/or system performance to better meet the health need of a population. It encompasses the process of aligning existing health service delivery arrangements with changing patterns of need, making the most effective
use of available and future resources\textsuperscript{10}. Health service planning is future orientated and usually adopts a medium-long term (10–15 years) perspective supporting organisations to respond to:

- targeted population health improvement
- increasing or changing service demand
- improved service delivery models
- emerging trends in service delivery
- new policy initiatives and directions.

### 4.4.1 Role of Hospital and Health Services

As principal providers of public health services, HHSs are responsible for undertaking health service planning for the development of and investment in health services within the defined geographic area of the HHS while considering the impact on the broader health service system.

In developing an HHS service plan, consideration should be given to section 19 of the HHB Act requirements to:

- contribute to, and implement statewide service plans that apply to the service
- undertake further service planning that aligns with the statewide plans.

Comprehensive health service planning at the local level will assist HHBs to respond to the local health service needs of their communities, as well as establish a platform for negotiation with the department, in particular around local level issues that are not able to be addressed within statewide plans.

A key component of health service planning is consultation with key stakeholders. HHSs are responsible for leading all consultation and engagement strategies regarding key issues.

### 4.4.2 Role of the Department of Health

The department as the system manager is responsible for statewide planning, coordination and standard setting for the public health system and for the monitoring of system performance. In addition, planning functions of the System Planning Branch include:

- developing statewide plans in consultation with HHSs and clinical networks
- undertaking analysis to understand the statewide picture of supply, demand and capacity
- development of health service planning guidelines and projection methodologies
- providing technical advice and access to health service planning data (for example, activity projections)
- providing estimated future service activity to inform healthcare purchasing
- supporting system health service planning capacity through the development of frameworks, processes, templates, and educational materials
- reviewing of HHS health service planning outputs and methodology focusing on the alignment with planning processes, tools and frameworks, statewide plans and connectivity between enabler support functions (workforce, funding, ICT and capital infrastructure).

There are a range of resources and training packages to support health service planning which are available on the Queensland Health Electronic Publishing System (QHEPS) at:


\textsuperscript{10} Eagar K, Garrett P and Lin V. Health planning: Australian perspectives. 2\textsuperscript{nd} ed. Sydney: Allen and Unwin; 2001.
4.5 Infrastructure planning

4.5.1 Planning

Infrastructure planning is undertaken by HHSs to determine the broader HHS and specific facility requirements to support the provision of service delivery identified in their health service plans and service agreements. Statewide and multi-HHS planning initiatives are managed through the department’s Infrastructure Strategy Branch (ISB) within the, Strategy Policy and Planning Division and for eHealth Queensland to provide guidance and support to HHSs as required and on request particularly in relation to documentation developed by HHSs to progress initiatives through the Investment Management Framework stage gates (planning and business case stages). Infrastructure Strategy and Planning Branch, in consultation with eHealth Queensland, also coordinates Queensland Health’s inputs and updates to the State Infrastructure Plan (SIP), facilitates development of the Total Asset Management Plan (TAMP), annual updates to the State Health Infrastructure Plan (SHIP) and the Five Year Capital Plan.

Queensland Health released the inaugural eHealth Investment Strategy (eHis) in 2015 to ensure that forward investment in eHealth forms part of a considered and cohesive plan between HHSs and the Department to better enable the delivery of quality and efficient health services. eHis provides greater health system context around Queensland Health’s proposed investment in eHealth and the plan for investment in the digital future of Queensland Health in light of key healthcare challenges including the growing demand for, and cost in supply of, health services.

4.5.2 State Infrastructure Plan

The State Government-released State Infrastructure Plan (SIP) identifies a series of outcomes including required infrastructure investment within Queensland Health to enable the achievement of a digital health system, increased efficiency in the delivery of health services and the provision of purpose built facilities within which modern and innovative healthcare service models can operate. Importantly, it is designed to provide confidence and certainty to business, industry and the community and provides an opportunity for the private sector to develop innovative solutions.

The Department of Infrastructure, Local Government and Planning is responsible for coordinating development of the SIP with input from each Government agency.

4.5.3 Total Asset Management Plan

The purpose of the TAMP is to promote the alignment of HHS assets with their service delivery requirements and to provide a snapshot of asset needs over the 15 year planning period. HHSs are able to identify likely costs associated with ongoing maintenance and operations, renewal of building components and infrastructure at the end of life and costs of upgrade and expansion of facilities through capital investment.

Each HHS TAMP is consolidated into the Queensland Health TAMP and the information provided by stakeholders is used to identify the Queensland Health asset needs across the state.

The HHSs are responsible for preparing their TAMP each year with templates, guidelines and training assistance available to ensure a consistent approach to asset planning across the State. The TAMP provides strategic direction for the management and delivery of HHS assets and is a key enabler to effective asset management, operations planning and decision making.
The department prepares the consolidated Queensland Health response in consultation with individual HHSs, QAS, HSQ and eHealth Queensland. The Minister approves the final TAMP Executive Summary, for submission to DILGP.

Queensland Health’s TAMP informs the State Health Infrastructure Plan (SHIP). More information on the SIP and TAMP is available on the DILGP website at: http://dilgp.qld.gov.au/infrastructure/total-asset-management-plan-framework.html

4.5.4 State Health Infrastructure Plan

The SHIP was initiated by the department for the purpose of developing a coordinated and prioritised approach to addressing infrastructure needs identified predominantly by HHSs. The SHIP is a statewide rolling 10 year plan of priority capital projects informed by the HHS TAMP and direct HHS liaison. It is updated on an annual basis and informs the Five Year Capital Plan. The SHIP is used to inform budget submissions for Queensland Health’s input to the Department of Infrastructure, Local Government and Planning.

4.5.5 Five Year Capital Plan

The Five Year Capital Plan is a requirement set out in the 2015–16 Capital Statement (Budget Paper 3) for Queensland Health. The plan is being developed by the department (through the Infrastructure Strategy and Planning Branch, Funding Strategy and Intergovernmental Relation Branch and eHealth Queensland) together with Building Queensland to inform the Queensland State Budget process for 2016–17.

The Plan provides a comprehensive statewide view of priority health infrastructure and eHealth projects resulting from an assessment, moderation and ranking process applied to Queensland Health’s capital investment priorities as articulated through the TAMPs, eHIS and SHIP, as well as the eHealth Baseline and Work Plan. The process involved consultation with a range of internal and external stakeholders including HHSs and Department of Health business units to ensure the projects not only maximise value but support planned clinical services and needs, health technology enablement and integrated care provision.

The plan is a five year costed schedule of prioritised capital investments across the health portfolio and includes current funded projects and a prioritised list of unfunded projects that will be brought to the Cabinet Budget Review Committee on a case-by-case basis. The following types of investment are included in the plan:

- construction or refurbishment of built infrastructure
- purchase of health technology equipment
- new, upgrade or replacement of ICT infrastructure (both software and hardware)
- sustaining capital.

4.6 Infrastructure Delivery

4.6.1 Major Capital Works

Under section 8 of the HHB Act, the department in its capacity as system manager is responsible for managing major capital works for proposed public sector health service facilities (major capital works are those as defined in section 37 of the HHB Regulation). However, should an HHS seek to deliver a major capital work project locally, then a request can be made to the System Manager.
Section 23(4) of the **Financial and Performance Management Standard 2009 (FPMS)** requires departments and statutory bodies to have regard to the Queensland Treasury Project Assessment Framework (PAF) in preparing evaluations concerning the acquisition, maintenance or improvement of significant assets (>50M).

Commencing in December 2015, Building Queensland, a statutory authority, was tasked by Cabinet to provide a lead role in the business case development on all investments with a total value of >100M, and a support role for investments >50M.

### 4.6.2 ICT Infrastructure

For eHealth (ICT) investment, the QGCIO provides guidance and sets the minimum expectations on the assurance framework, policy and the Queensland Government Enterprise Architecture (QGEA): [https://www.qgcio.qld.gov.au/](https://www.qgcio.qld.gov.au/)

Overarching ecosystem investment governance is supported by eHEC, and its subsidiary governance bodies including the Architecture and Standards Committee. Service providers for capital eHealth project delivery is co-ordinated or delivered by eHealth Queensland, HSQ, Divisions within the Department of Health, or by Hospital and Health Services. eHealth Queensland provides governance support, the P3 Hub—a library of program, project and business change product templates and good practice guiding documents, as well as supportive information on eHealth and Queensland Health governance requirements, IMF, approval pathways, and Queensland Government Enterprise Architecture (QGEA), program and project lifecycle and the gated assurance review process.


Additionally the internal detailed eHealth online dashboard, ‘eHealth at your fingertips’ providing visibility and status of all eHealth current and registered potential pipeline investment by service provider, area serviced, investment type, or funding status will be launched in April 2016.
5.1 National Performance and Accountability Framework and National Health Performance Authority

The key objective of the National Performance and Accountability Framework (NPAF) is to support a safe, high-quality Australian health system through improved transparency and accountability. It applies to all Australian public health and hospital services (through HHSs in Queensland), private hospitals and primary care services (through Primary Health Networks).

The NPAF includes a set of standardised national indicators which are designed to measure local health system performance and drive improved performance. The indicators span four subdomains of health service delivery:

- effectiveness: safety and quality
- equity and effectiveness: access
- efficiency: efficiency and financial performance
- effectiveness: patient experience.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) is responsible for developing indicators for the measurement of safety and quality for approval by Health Ministers.

The NPAF aims to improve accountability, and improve performance reporting through the establishment of the National Health Performance Authority (NHPA).

The NHPA was established in 2012 as an independent statutory body with a role to report on the performance of the health system at a local level, including trends over time. The NHPA is...
responsible for developing and producing reports on the performance of local healthcare organisations, including public and private hospitals, and primary healthcare organisations funded by the Federal Government.

For Queensland HHSs these reports take the form of hospital performance reports, which are published via the MyHospitals website. These reports cover:

- service and financial performance standards and targets agreed by COAG
- the National Access Target and National Access Guarantee, and any new national standards agreed by COAG
- National Clinical Safety and Quality Standards developed by the ACSQHC and endorsed by Health Ministers,

and:

- identify high performing organisations, to facilitate sharing of innovative and effective practices
- identify poorly performing organisations to the Commonwealth and states and territories to assist with performance management
- provide a comparative analysis of the performance of hospitals and HHSs across jurisdictions and across the public and private sectors, in order to identify best practice and ensure focus on the achievement of results.

The NHPA does not report on the performance of individual clinicians.

HHSs are responsible for providing data for the national performance reports to the Director-General. The Director-General validates the data and provides it to the Commonwealth. The service agreement states the performance and other data to be provided by the HHS to the Director-General, including how and how often (as provided by sections 16 and 19 of the HHB Act). The MyHospitals website is accessible at:


5.2 Queensland Government Performance Management Framework

The Queensland Government Performance Management Framework (QGPMF) supports delivery of legislative obligations by establishing the minimum requirements for Queensland public sector agencies (Government departments and statutory bodies) in relation to performance management, including the development of strategic and operational plans and the publication of results through the Service Delivery Statements and an annual report.

‘A Guide to the Queensland Performance Management Framework’ May 2015 (Version 3.2) is available at:

5.3 **Hospital and Health Service Performance Management Framework**

As independent statutory bodies, HHSs are individually accountable for their performance. HHSs and the department each have binding responsibilities with regard to performance management set out in the HHB Act and the FAA and subordinate legislation.

The HHS Performance Management Framework (HHS PMF) supports the management of the healthcare system in Queensland and applies to all HHSs and to public health services provided by the Mater Health Services, South Brisbane.

The HHS PMF establishes a robust system for the reporting and monitoring of performance information and ensures HHSs are locally accountable for the delivery of the services and obligations outlined in their service agreement with the department. The HHS PMF addresses the process through which HHS performance will be assessed, how performance issues will be managed and strategies implemented when performance against targets is not being achieved.

The HHS PMF is consistent with the requirements of the NPAF and current QGPMF. The NPAF establishes the performance indicators and standards against which the NHPA will monitor and report on each HHS’s performance. The key performance indicators within the service agreement align to the national indicators within the NPAF.

The department produces regular reports on HHS performance against the indicators, funded activity and targets set out in the service agreement. The HHS PMF is a supporting document to the HHS service agreements.

### 5.3.1 Governance to support performance management

The HHS PMG outlines the governance to support performance management:

- As set out in the Hospital and Health Boards Act 2011, the Minister may give written direction to HHS about any matter relevant to the performance of its functions under the Act.
- Review the reports from PMGE.
- Discuss the performance of individual HHS and the delivery of public health services from a state-wide perspective with the Department's Senior Executives.
- Meets monthly to review the actions and initiatives in place as an outcome of the relationship management group meetings.
- Executives from the Department of Health and HHS must meet regularly to discuss performance against targets and any actions or interventions required.
- As set out in the Hospital and Health Boards Act 2011, the Service Agreement governs the relationship between the Chief Executive and the Department of Health.
5.3.2 Responding to performance

A range of responses to off-target performance are also outlined in the Framework, including escalation of performance reviews to the Director-General and HSCE and subsequently, if required, the Minister and HHB Chair. Where all options have been exhausted and following discussions between the Minister and HHB Chair, the Minister may appoint an administrator and/or replace the HHB.

5.4 Service agreements

The Service Agreement between the department and HHS is the key accountability mechanism and specifies the:

- number and broad mix of services to be provided by the HHS
- funding that will be provided
- teaching, training and research functions to be undertaken by the HHS.

The Service Agreement also details the key performance indicators that will be measured to ensure the outcomes defined in the service agreement are achieved.

The Agreement is binding on both the department and the HHS and can be for a term of up to three years.

The service agreement must be signed by the Board Chair on behalf of the HHS and the Director-General on behalf of the department and does not take effect until the signature of both parties has been obtained.

The HHB Act requires the service agreement and any subsequent amendments to the service agreement to be publicly released within 14 days of entering into the service agreement or amendment.

A Service Agreement can be amended by following the amendment process which is set out in each service agreement. All agreed amendments to the service agreement are executed through a deed of amendment which is signed by the Director-General and Board Chair. Amendment proposals are negotiated and finalised during set periods of time during the year (Amendment Window). While there have generally been three to four Amendment Windows in a financial year, the number and frequency of these is under review.

The service agreement is underpinned by and is managed in line with the following supporting documents which are also published on the Queensland Health website:

- **Health Priorities for Queensland**
- **HHS PMF**
- **Health Funding Principles and Guidelines**.

The key performance indicators in the service agreement align with Government priorities and national indicators within the NPAF.

Service agreements and supporting documents are published on the Queensland Health website at:


The service agreement does not cover the provision of non-clinical and clinical services by the department to HHSs. Separate arrangements are in place for those services provided by Health Support Queensland and eHealth Queensland.
5.5 Annual Report

Public reporting of the performance of the Queensland public sector is essential for accountability, transparency, to drive continuous improvement in performance, and to influence trust and confidence in public sector delivery (as outlined in the QGPMF). As statutory bodies, HHSs are required by sections 62 and 63 of the FAA to prepare annual financial statements and annual reports. The FPMS specifies how these must be prepared.

Under Section 49 of the FPMS statutory bodies are required to provide an annual report to the Minister covering each financial year (by a date agreed between the statutory body and Minister). The Minister is required to table the report in Parliament within three months of the end of the reporting year (by the end of September). However, the Minister also has discretionary power to extend the tabling period by notice given to the HHS.

The annual report must comply with the DPC document ‘Annual report requirements for Queensland Government agencies’ (updated annually), which mandates the disclosure of specific information, including, for example, actual non-financial and financial performance (against performance indicators and service standard); and the total remuneration payments (fees and on-costs) made to part-time chairs and members of boards.

The FPMS also requires that financial statements must be prepared having regard to the minimum reporting requirements mentioned in Queensland Treasury’s ‘Financial reporting requirements for Queensland Government agencies’. Audited financial statements must be included within the body’s annual report.

After tabling in the Legislative Assembly, annual reports must be distributed and published online as per the annual report requirements.
6. Hospital and Health Service governance

In this section:
- Overview
- Clinical governance
- Financial governance
- Risk management and compliance
- Data integrity
- The Patient Safety Board
- Workforce and employment arrangements
- Land and building asset arrangements

Key points:
- HHSs are responsible for developing their own governance framework
- Boards need to ensure there are appropriate arrangements in place to ensure good governance of areas such as clinical, financial, risk management, compliance, workforce, and land and buildings

6.1 Overview

Under section 7 of the FPMS, the department and HHSs are respectively required to establish their own governance framework, which sets out how the organisation manages the performance of its functions and operations.

Governance includes establishing a performance management system, a risk management system and an internal control structure. Boards need to approve the internal governance arrangements for the HHS, including approving delegations of functions and confirming the committee structure for the HHS.

The sub-sections below focus on key governance-related requirements and arrangements that frame HHS operations and should be taken into consideration when developing a local governance framework.

6.2 Clinical governance

HHSs are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. HHBs are accountable for governance of financial management, business practice and safety and quality. For the HHS this means that the HHB and HSCE are accountable for ensuring that the structures, processes and behaviours are in place to ensure the best possible patient outcomes are achieved, and to take action to safeguard high standards of care. The HHB should ensure they receive regular reports across the spectrum of safety and quality.
assurance activities. The Board should also oversee the clinical risk profile and ensure clinical risks are being effectively managed across the service.

A model framework for Governance of Clinical Safety and Quality (the framework) for use in public sector health services is available on QHEPS at:


The components of the framework are:

- **Planning for safety and quality**
  HHS and executive develop a safety and quality plan to ensure delivery of local safety and quality priorities and key deliverables defined by legislation, System Manager and standards (ACSOHC, OHO).

- **Action for quality and safety**
  Plans are translated to action by ensuring that strategy is supported by the right culture, functions and structures, and by making explicit the behaviours that are expected of all staff in contributing to safety and quality.

- **Appraisal, learning and action**
  Appraisals of HHS performance against key performance indicators are undertaken to determine if performance is acceptable, with an emphasis on recognition, learning and action. This in turn informs the next cycle of planning to shape local safety and quality priorities.

- **Balanced monitoring for quality and safety**
  Key performance indicators aligned to the standards, policies and priorities and outcomes are measured and monitored by HHSs, the System Manager and the Commonwealth.

The Framework seeks to embed the following principles:

- Highest priority must be given to managing the risks of preventable harm with a focus on achieving the greatest gain in quality of care. This translates to a focus on preventable harm which is of high severity and/or high volume
- Outcomes are more important than specific tactical approaches
- Minimum standards have a legitimate role in building safety and quality
- The department should minimise unnecessary compliance burden
- Beyond compliance, the system should strive towards continuous improvement
- The aim of clinical governance is to support behaviours that drive safe, high quality care
- Effective leadership (both executive and clinical) is critical to success.

The HHS environment is complex, with multiple reporting requirements for compliance and reporting. The Framework provides an approach which will assist both HHSs and the department to meet requirements for the governance of safety and quality.

### 6.2.1 Clinical Services Capability Framework

The Clinical Services Capability Framework (CSCF) specifies minimum criteria by service, workforce and support service requirements to safely deliver patient care in Queensland’s Hospital and Health Services and licenced private facilities. This includes private hospitals and day hospitals thereby safeguarding patient healthcare services in the most appropriate clinical settings/services.
The CSCF provides a consistent language for healthcare providers and planners to describe health services, and an agreed tool designed to guide health service planning.

The CSCF describes up to six levels of complexity of clinical services, with a Level 1 service managing the least complex patients and Level 6 managing the highest level of patient care complexity. The service level describes the complexity of clinical activity appropriate to be undertaken, and is chiefly determined by the presence of suitably qualified and experienced medical, nursing, support and ancillary healthcare professionals as well as other support healthcare personnel.

The CSCF is available on the Queensland Health website at:


Information on CSCF levels of facilities in HHSs is available on local HHS QHEPS or internet sites. Under service agreements, all facilities have undertaken a baseline self-assessment in September 2014 against the CSCF to ensure the maintenance and provision of high quality, safe and sustainable services which meet the healthcare needs of the community.

The Department of Health is notified when a change to the CSCF self-assessment occurs through the notification process established by the Patient Safety and Quality Improvement Service.

**Credentialing and scope of clinical practice**

The mandatory credentialing and defining the scope of clinical practice (SoCP) process is conducted to ensure all identified professionals are credentialed and have a defined scope of clinical practice to support the delivery of safe and high quality healthcare within HHSs and the department.

Credentialing and SoCP is covered within a Health Service Directive which can be found at: https://www.health.qld.gov.au/directives/docs/hsd/qh-hsd-034.pdf

The best practice Guide to credentialing and defining the scope of clinical practice for medical practitioners and dentists ensures that each practitioner working in Queensland Health only provides clinical services for which they have demonstrated competence and is available on the Queensland Health website at:


There is also a credentialing guideline specifically for Allied Health professionals and is available on the Queensland Health website at:


**Clinical risk management**

Each HHS is to have in place an effective system for risk management. This system should cover the full spectrum of risks facing the organisation including clinical risks. The approach taken in the assessment of clinical risks should be consistent with the HHS’ risk framework and also take into account accreditation and legislative requirements.
Patient safety and quality of healthcare

Quality of healthcare means monitoring and improving the standard of healthcare provided and patient safety is only one element of quality healthcare. The six domains of healthcare quality are:

- **Safe**
  - Avoiding harm to patients from the care that is intended to help them.

- **Effective**
  - Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

- **Patient-centred**
  - Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

- **Timely**
  - Reducing waits and sometimes harmful delays for both those who receive and those who give care.

- **Efficient**
  - Avoiding waste, including waste of equipment, supplies, ideas and energy ensuring services are cost effective and provide value for money.

- **Equitable**
  - Providing care that does not vary in quality because of personal characteristics such as gender, geographic location and socioeconomic status.

Safety and quality obligations

HHSs have a responsibility under section 19 of the HHB Act to monitor and improve the quality of their health services. As identified in Schedule 1, 8(1) (b) of the HHB Act, the HHB is required to establish a safety and quality committee. Part 7, 32 of the HHB Regulation provides further detail on the functions of a safety and quality committee, such as:

- advising and providing strategies to the Board on the Service’s safety and quality matters, for example minimising preventable patient harm
- monitoring and promoting improvements in the Service’s safety and quality of health services.

HHS service agreements include quality and safety service standards that apply to services delivered by HHSs. These standards are monitored as part of the performance and accountability framework.

The HHB Act authorises the Director-General to issue Health Service Directives that may be issued to set standards and policies for the safe and high quality delivery of health services.

Further, there are accreditation processes, as described in section 14.1 of HHS service agreements, applying to all hospitals and day procedure units, general practices, and residential aged care facilities owned or managed by HHSs.
Statutory Quality Assurance Committees (QACs) play a valuable role in promoting safety and quality in the health system. A QAC may be established by:

- a HHS
- a professional association, society, college or other entity whose functions relate to the provision of health services or to the providers of health services
- the Director-General
- the licensee of a private health facility.

The purpose of a QAC is to improve the safety and quality of health services. The role of a QAC must include:

- assessment and evaluation of the quality of health services
- reporting and making of recommendations concerning those services
- monitoring the implementation of its recommendations.

Under the HHB Act, QACs are subject to what is commonly known as ‘qualified privilege’, that is, strict confidentiality provisions, statutory protections to prevent information from being disclosed in legal proceedings, and protections from liability for members of QACs who act honestly and without negligence. In return, QACs must make suitably de-identified information available to the public at least every three years about their functions, activities and outcomes, along with an annual activity statement to the chief executive (or entity that established the committee) on the anniversary of its establishment.

A register of QACs can be found on the Queensland health website at:


Clinical incident management

The aim of clinical incident management is to effectively manage clinical incidents with a view to learning from incidents to reduce future preventable patient harm. HHSs are responsible for implementing systems to ensure that clinical incidents are recognised, reported and analysed. A
comprehensive guide to clinical incident management has been developed to support HHSs to manage incidents following the introduction of a Patient Safety Health Service Directive.

The guide is available on QHEPS at:


The guide includes a range of methods and tools that HHSs may choose to use in analysing clinical incidents, including root cause analysis and clinical review which are discussed further below.

**Root cause analysis**

Root cause analysis (RCA) provisions are contained in the HHB Act and HHB Regulation. RCA is an internationally recognised approach to the analysis of serious adverse events such as unexpected death or permanent harm as a result of the provision of healthcare.

It involves the use of a multidisciplinary team to retrospectively analyse the sequence of events, identify any contributory factors, and make recommendations for how to prevent similar events occurring in the future.

A RCA utilises quality improvement methodology. It neither seeks to, nor is capable of, determining liability or apportioning blame to individuals. Its purpose is to improve patient safety through the identification of, and elimination or mitigation of latent weaknesses in healthcare systems and processes. It is intended as an addition to, rather than a replacement for, existing systems of individual accountability such as found in administrative, civil, professional, coronial or criminal proceedings.

The RCA provisions require the production of a report that can be made available to a range of parties, such as the Health Ombudsman, a coroner and most importantly to patients and families. The protected environment in which RCA teams perform their functions ensures that this type of information is available for patients and families.

The HHS must maintain a record of the recommendations, actions and outcomes from the RCA reports including the decisions to endorse or reject those recommendations.

**Clinical reviews**

The clinical review provisions under the HHB Act provide an appropriate and confidential vehicle to identify ways to improve safety and quality in a non-adversarial environment.

A clinical review includes an assessment of whether a health service provided to a person was provided in accordance with recognised clinical standards.

It is intended that clinical reviews will be used to complement the existing quality assurance committee and root cause analysis provisions, by providing a specific mechanism for examination of matters that fall outside the scope of either method.

Primarily, a clinical reviewer is responsible for identifying areas for improvement in the safety and quality of healthcare. For example, clinical reviewers can be appointed to examine:

- individual clinical cases where there are questions about the appropriateness of care
- a series of cases where there may be concerns about patterns of practice.

**6.3 Financial governance**

Section 21 of the HHB Act establishes HHSs as statutory bodies subject to the Financial Accountability Act (FAA) and Statutory Bodies Financial Arrangements Act (SBFAA). The FAA and associated Financial and Performance Management Standard (FPMS) identify the financial
requirements applicable to statutory bodies. The SBFAA establishes the borrowing and investment powers of statutory bodies and addresses the role of the Treasurer in providing guarantees. Section 8.5 ‘investment and statutory approvals’ discusses these powers and where statutory approvals may be required to enter into certain arrangements.

Part 2 Division 4 of the FPMS deals with the agency’s obligations to establish internal financial systems and processes that will allow for the efficient, effective and economic management of the agency’s financial resources. Under Section 15 of the FPMS, each HHS must establish the following systems for efficiently, effectively and economically managing the financial resources of the statutory body:

(a) revenue management system
(b) expense management system
(c) asset management system
(d) cash management system
(e) liability management system
(f) contingency management system
(g) financial information management system
(h) risk management system.

In establishing the systems, the HHS must have regard to the Financial Accountability Handbook published by Queensland Treasury and other related policies and frameworks specified in the FPMS. The Handbook is available at:


The systems must be reviewed regularly to ensure the systems remain appropriate for managing the financial resources of the HHS.

6.3.1 Financial information management

Under section 27 of the FPMS, HHSs must comply with the mandatory principles stated in the Information Standards and ensure that their financial information management systems align with the targets stated in the Queensland Government Enterprise Architecture (QGEA) where applicable, and comply with the Public Records Act 2002.

Internal control structure

Each HHS must establish a cost-effective internal control structure, which must include, for example, an organisational structure and delegations that support the objectives and operations of the HHS (Section 8 of the FPMS). Further, the internal control structure must be included in the HHS’s Financial Management Practice Manual (FMPM). HHBs need to approve the internal governance arrangements for their HHS, including approving delegations of functions and confirming the committee structure for the HHS.

While not mandatory for statutory bodies, it is recommended and encouraged by the QAO that the Chief Finance Officer for each HHS prepares an annual statement about whether the financial internal controls of the HHS are operating efficiently, effectively and economically (Section 77 of the FAA).
6.3.2 Financial Management Practice Manual

Section 16(1) of the FPMS requires a statutory body to prepare and maintain a specific FMPM that complies with related legislation, regulation and policies, for use by all staff in the performance of their financial management roles. As statutory bodies, HHSs are required to develop and maintain an FMPM.

The department provides overarching general policy advice and circulars on mandated accounting/legislative changes.

Financial statements and external audit

HHSs must prepare an annual financial statement as required by the FAA. Sections 43 to 46 of the FPMS describe statutory bodies’ obligations in relation to preparation of statements.

The Auditor-General is legally obliged to audit all public sector entities in each financial year and decide how best to conduct each audit. HHSs’ annual financial statements are audited by the QAO. The HHS must liaise directly with the QAO to coordinate the audit of their financial statements and ensure any issues raised in the auditor’s report are adequately addressed by management and corrective measures undertaken in a timely manner. (See also section 7.3).

Internal audit

Under the HHB Regulation, HHSs are required to establish an audit committee. In establishing an audit committee, HHSs must comply with requirements under section 35 of the FPMS.

The establishment of an internal audit function is discretionary for statutory bodies unless mandated by the Minister (section 29 of the FPMS). All of the HHSs have established an internal audit function.

Depending on the needs and capacity of the HHS, there are various options to consider for establishing and resourcing an internal audit function. Larger HHSs may establish full time internal audit teams appropriate to their risk profile and assurance needs. Smaller HHSs may consider different options of establishing internal audit capacity. For example:

- At first accessing internal capacity/insourcing then may look at outsourcing (in accordance with EB and procurement obligations) the entire internal audit function to a local firm or statewide firm. Where local firms are engaged, the actual internal audit knowledge (as opposed to tax consulting and accounting services) of the firms should be considered.
- Co-sourcing, which is similar to outsourcing but where there is also a small team of local staff in the internal audit unit to work with a local or statewide firm. This model will encompass the business knowledge of staff with the expertise of the contracted firm.
- An in-house team of local staff employed within the HHS.

6.3.3 HHS indemnity and insurance arrangements

Under legislative amendments which took effect on 31 March 2014, Queensland Government (State) employees have automatic legal protection from being civilly sued when acting in their official capacity. The following policies outline the circumstances in which indemnity and legal assistance are provided. They are as follows:


Indemnity

A person’s role and employment status within Queensland Health determines which policy will apply to the individual.

- The HR Policy I2 applies to all Queensland Health medical practitioners only.
- The Guideline applies to all other Queensland Health employees, including Queensland Ambulance Service (QAS) staff, as well as Queensland Health volunteers and persons engaged to participate as members of official committees and boards (other persons).

Under the Guidelines and HR Policy I2, HHSs and the department may also be able to cover the costs of external inquiries and investigations, defending claims and being represented at administrative or investigative tribunals, and/or disciplinary proceedings costs.

While the indemnity cover provided by the State and Queensland Health under these policies is comprehensive, there are certain exclusions and conditions that limit what can be covered. For instance, there is no cover available for internal departmental or HHS investigations or inquiries (for example, matters arising from a complaint to human resources or matters referred to the employing entity by the Crime and Corruption Commission Queensland). The policies also contain conditions that an employee must comply with in order for indemnity to apply.

In the majority of circumstances indemnity cover is able to be provided, with the employee (or other person) receiving legal assistance at the expense of Queensland Health. Where indemnity has been granted, the complaint or claim will usually be handled by Queensland Health or the Queensland Government Insurance Fund (QGIF), if the matter is covered under the QGIF insurance policy. Please see below for more information regarding the QGIF insurance policy.

Additional indemnity and insurance arrangements may be in place within a HHS specifically for members of official committees and boards and HHS executive service staff. Please refer to information sheet 10.6 ‘Indemnity and insurance arrangements for Directors’ and Officers’ for details.

Insurance

In July 2001, Queensland Treasury established QGIF. QGIF is a self-insurance scheme, designed to provide cover for the asset and liability exposures of all State Government departments and eligible statutory bodies (its policyholders). The QGIF operation is based on an insurance company model; essentially an agency transfers the risk of potential loss to QGIF, in exchange for a fee known as the insurance premium. Claims lodged on the insurance policy by an insured agency are managed by QGIF. The management of a claim by QGIF continues until it is resolved, all payments are made, recoveries effected and the file is closed. QGIF, as the claim manager, aims to manage claims so that the best outcomes available are achieved for the State of Queensland.

The QGIF offers seven insurance types that cover a range of risks depending on what the agency insures. For the 2015/16 financial (policy) year, Queensland Health has purchased five insurance policies from QGIF which are:

1. Property:
   a) Part 1—Material loss or damage (Property—Part 1)
   b) Part 2—Loss of revenue and increased Costs (Property—Part 2)
2. General liability
3. Professional indemnity
4. Health litigation (Department of Health/Hospital and Health Services)
5. Personal accident and illness (Volunteers, Board and/or Committee members)

The **QGIF Insurance Policy** document sets out the terms and conditions of cover provided under each insurance policy type offered by QGIF, including any policy exclusions. For a copy of QGIF’s current and previous insurance policy documents, please refer to QGIF’s website:


For further information on QGIF and the QGIF insurance policy, please refer to the **Queensland Government Insurance and Insurance Policy Explanatory Note** available on QHEPS at:


Queensland Health has maintained a collective insurance model for the 2015–16 policy year, with the department and each HHS as named insured parties. Individual Certificates of Currency and Certificates of Insurance are provided to each HHS upon renewal of the insurance policy in July and are also located on QHEPS at:


If further advice is required please contact the Insurance Services Team, Finance Branch, Corporate Services Division, Department of Health at ask_IST@health.qld.gov.au

**Payment of the Insurance Premium**

Insurance provides protection against the financial risk of injury, loss, damage or theft by sharing risk across a community (policyholders). The community pay a premium into an insurance pool. The premium is always less than the total cost of that which you are insuring. This pool is then used to fund the claims of those who suffer an unexpected financial loss. In essence, the premiums of the many pay for the loss of a few, so that no one person suffers an extreme loss. For Queensland Health, that community is each HHS and the divisions of the department.

As a self-insurance fund, QGIF’s goal in premium setting is to collect enough premiums from insured agencies to cover the cost of all claims that occur in the policy year for each policy section, regardless of when a claim will be reported. QGIF utilises actuarial assessments to arrive at the aggregate premium pool required for each policy section for the new policy year. These assessments take into consideration the underlying claim costs along with inflationary factors and economic assumptions. QGIF then allocate the required premium to each insured agency for each policy section. When allocating the required premium to each insured agency, QGIF take into account a number of underwriting factors and the individual policyholder's risk characteristics, utilising the exposure data supplied by insured agencies as part of the Insurance Policy Renewal Program.

While QGIF collects a single premium from Queensland Health, the Insurance Services Team in consultation with the State Actuary’s Office and QGIF, allocate the insurance premium for each policy section to HHSs and departmental divisions. Each policy section has a different method of allocation based on its associated risks and the exposure data available. The data reported by each HHS and department division as part of the Insurance Policy Renewal Program, is one of the components that influence the premium allocation models. The data requirements are determined by QGIF.

For further information on the QGIF insurance premium and premium allocation models, please refer to the Queensland Health Insurance Premium—Discussion Paper available on QHEPS at:


Refer to section 6.7.3 for information about WorkCover arrangements and section 8.8 for information about Directors and Officers indemnity and insurance arrangements.
6.4 Risk management and compliance

6.4.1 Risk management

Risk is an ever-present element within all organisations and the health system. Effective risk management enables organisations to have increased confidence that they can deliver their services, manage risks and threats to an acceptable degree and make informed decisions about the opportunities and challenges they face.

The FPMS (Sections 7 and 28) prescribes the accountabilities of statutory bodies in respect of system-wide risk governance as follows:

- Manage the strategic and operational risks of the statutory body in accordance with the risk management system established for the statutory body.
- A risk management system must provide for:
  - Mitigating the risk to the statutory body and the State from unacceptable costs or losses associated with the operations of the statutory body
  - Managing the risks that may affect the ability of the statutory body to continue to provide government services.

Each HHS must establish a policy framework for risk management that will ensure the HHS’s compliance with legislative requirements and consistency with the Australian/New Zealand Standard AS/NZS ISO 31000:2009 ‘Risk Management—Principles and Guidelines’.

Queensland Treasury’s ‘A Guide to Risk Management—July 2011’ provides practical support and guidance regarding establishing and applying effective risk management practices (it is available at:


HHBs need to assure themselves that appropriate risk management is in place for the HHS, for example by noting that critical documents are in place including a risk management policy, framework, Risk Register/s and processes for monitoring and reporting on risks and their controls and treatments.

The HHS service agreement provides further information on performance related risk management responsibilities, monitoring and reporting requirements.

The HHSs work cooperatively with other HHSs, department and key stakeholders with regard to risks that could impact across the health system / multiple HHSs. HHSs must inform the Minister and Director-General of any major risk that may affect the health service. While health system wide risks are usually the accountability of the department, HHSs will be asked to support health system risk management and contribute to risk management planning through governance arrangements and the Health System Risk Working Group.

6.4.2 Compliance

As outlined in section 8.2, HHSs have a range of legal and administrative obligations. Ensuring compliance with these obligations is central to good governance and due diligence. HHSs should have an effective compliance framework in place to ensure the requirements of all legislation, policies, procedures and code of conduct applicable to the statutory body are complied with. Compliance should be integrated into everyday operational processes, guidelines, manuals and training programs.

All staff have responsibilities for complying with legislation and for monitoring, managing and reporting actual or potential breaches of legislation. HHSs may wish to develop a policy which outlines the intent, scope and principles regarding compliance with portfolio and/or general
legislation. It should be supported by an implementation standard specifying responsibilities at all levels for monitoring, managing and reporting any actual or potential breaches of legislation and a procedure for reporting actual or potential breaches of legislation. The implementation standard should include a legislation schedule which identifies the Acts the HHS must comply with.

The HHS legislated powers and compliance information sheet available on the Queensland Health website is a working document provided for illustrative purposes to assist HHSs in their development of a compliance register. There is also an accompanying illustrative compliance activity calendar template. These documents are available at:


6.5 Data integrity

In order to ensure confidence in data used for measuring health system performance, HHSs are required to implement processes to ensure integrity of all data, including data reported externally by the HHS.

HHBs are accountable for the integrity, timeliness and transparency of data upon which their hospital(s) reports, ensuring that data are subject to appropriate controls over data accuracy. Boards are expected to make this a responsibility of their audit committees.

It is critical that the quality and timeliness of data provided to the department, which are also used by HHSs for clinical care, their own performance monitoring, benchmarking and planning, reflect a strong commitment of all HHSs to data integrity practices supportive of high quality data.

HHSs are required to provide to the Director-General the performance data and other data, including data pursuant to ad hoc requests, set out in schedule 4 ‘Data Reporting Requirements’ of their Service Agreements in accordance with the schedule, including in relation to the form, manner and the times required for the provision of data.*

Accurate, timely and consistent data is required to be reported to the department to ensure that:

• people have equitable and timely access to high quality, efficient services
• Queensland meets its commitments for the supply of data required under legislation and national agreements
• the evidence available for clinical improvement and planning ensures that patients receive timely and safe care
• Queensland receives its share of national health funding
• funds are allocated to HHSs according to performance and needs.
• data on the performance of HHSs are available to governments and the community
• evidence is available for monitoring and measuring improved patient care and outcomes and research.

* Providing performance data and reporting on their performance to the department (HHB Act, s9 and s19).

11 Portfolio legislation are the specific Acts which have been delegated to the Minister for Health (for example, the HHB Act, Food Act 2006) – refer section 8.2.1. General legislation refers to other Acts which the HHS must comply with (for example, Public Records Act 2002) – refer section 8.2. HHSs should be able to demonstrate compliance with these Acts.
6.6 The Patient Safety Board

The Patient Safety Board was established under the authority of the Director-General and is an advisory and decision-making group with the power to endorse or request feedback in relation to patient safety indicators or issues from a HSCE (or delegate).

To contribute to the management and delivery of Queensland Health services and the achievement of the Queensland Government's strategic objectives, the Patient Safety Board undertakes the following:

- Monitors and reviews facility performance against key patient safety indicators and facility compliance to the National Safety and Quality Health Service Standards, initiating remedial action where appropriate
- Identifies, reviews and monitors significant statewide patient safety issues;
- Advises the HHS by way of the Relationship Management Group on HHS patient safety performance and significant statewide patient safety issues.

6.7 Workforce and employment arrangements

6.7.1 Employment framework

The following HHSs are now prescribed employers and the direct employer of all employees (health service employees):

- Children’s Health Queensland
- Gold Coast
- Metro North
- Metro South
- North West
- Sunshine Coast
- Townsville
- West Moreton.

All other HHSs are non-prescribed. It is expected that the prescribing of the other eight HHSs will occur by 1 July 2016.

Common industrial framework

The HHB Act provides for state-wide employment and industrial relations arrangements as determined by the Director-General, including the negotiation of certified agreements which cannot be delegated. This is to ensure parity of working conditions throughout the State, prevent wage competition and support employment mobility between HHSs.

Amendments have been made to the Industrial Relations Act 1999 (IR Act) to modify the application of the IR Act to HHSs (as employers) and to their employees. The amendments provide that the Director-General is to be party to:

- awards instead of the prescribed HHSs, with the award being binding on the HHSs. This includes the Director-General being party to proceedings related to awards and for the making, amending and repealing of awards
certified agreements instead of the prescribed HHSs, with the agreement binding on the HHSs. This includes the Director-General being party to proceedings related to agreements and for negotiating, making, amending and terminating agreements.

any industrial disputes instead of the prescribed HHSs unless the Director-General considers the matter does not affect employment terms and conditions in more than one HHS.

HHSs are involved in the negotiation of statewide certified agreements. Generally, an HHS representative is invited to be a member of the enterprise bargaining negotiation team. In addition to this, the department’s HR Services provide regular updates to the People and Culture Executive network.

Terms and conditions are established through:

- the HHB Act
- applied provisions of the Public Service Act 2008 as specified in the Public Service Regulation 2008
- industrial awards, certified agreements and other industrial instruments
- health employment directives issued under the HHB Act
- health service directives issued under the HHB Act
- current HR policies available on QHEPS
- if an employee is on contract, the terms of that contract.

HHSs have local HR policies/procedures to support statewide instruments and to reflect local practices such as, in relation to dismissal and retirement. HHSs are responsible for their own HR Delegations manual for all employees.

Where the DG determines a Queensland Health HR policy is to continue to apply to health service employees this will be effected via either a health service directive or health employment directive.

All employees (of the department and HHSs) are able to transfer between entities and employers. Part 3 of the HHB Regulation outlines the approvals and conditions related to movements of health service employees and HSCEs between entities. All entitlements transfer with the employee—this does not constitute a termination as per the HHB Regulation.

**Collective Agreement**

In June 2015, legislation was passed in Parliament to transition senior doctors from individual employment contracts to an employment framework built upon the Queensland Employment Standards, a modern award for medical officers and a new medical officers’ certified agreement.

Discussions with unions for a new medical officers’ certified agreement commenced in May 2015. These negotiations took the form of meetings between the parties on 26 occasions, culminating in the parties reaching an agreed position on 4 August 2015.

The Medical Officers (Queensland Health) Certified Agreement (No.4) 2015 was certified on 22 November 2015 and as a result the modern award, the Medical Officers (Queensland Health) Award–State 2015 also became effective from that date. The award and agreement apply to senior medical officers and resident medical officers.

Visiting medical officers are not covered by the award or agreement—just as they were not covered by MOCA3 or the previous, pre-modernised awards. Negotiations continue with
relevant unions to determine how future employment arrangements for VMOs may be agreed and align with the government’s policy agenda.

The Queensland Health Contracts Advisory Committee will continue to provide expert advice and recommendations to the Director-General on matters relating to the implementation of contracts for VMOs, including the contracts’ strategic review.

**Workforce reporting**

Queensland Health Workforce reporting (including Establishment Management Program) is based on the Minimum Obligatory Human Resource (MOHRI) definitions. MOHRI is a whole of Government methodology for producing an Occupied Full Time Equivalent (FTE) and headcount value sourced from the Queensland Health payroll system data for reporting and monitoring.

MOHRI occupied FTE and headcount are used for reporting and monitoring of Queensland Health workforce growth and reductions, and are submitted to stakeholders such as, the:

- Director-General
- Minister for Health
- Public Service Commission
- Premier for Queensland
- State media

Published in the Financial Service Delivery Statements and service agreement performance monitoring.

Workforce reporting and analysis is available from the Queensland Health Decision Support System (DSS). Additionally, whole of Queensland Health and HHSs Monthly Workforce Profile reports are produced and published by the Workforce Informatics Unit within the Finance Branch of Corporate Services Division and are available on QHEPS at:


6.7.2 **Rostering and payroll**

The rostering (Workbrain) and payroll (SAP HR) solution used by HHSs and the department is the largest in the Queensland public sector and one of the largest and most complex in Australia. The delivery of the Queensland Health payroll is a complex activity involving Payroll Portfolio staff located across the state. Queensland Health employs approximately 75,082 FTE staff in a range of occupations, many of whom work on a 24/7 roster.

More than half the employees require complicated payroll adjustments on a regular basis due to changing factors such as shifts and staff absences. Timely lodgement and processing of rosters and forms is critical to achieving the best possible employee pay outcomes. Key performance indicators have been established and reports are issued after each fortnightly pay run to monitor forms lodgement, processing, overpayments and ad-hoc payments.

6.7.3 **Workplace health and safety**

Both the department and HHSs are required to comply with all obligations and responsibilities outlined in the:

- *Work Health and Safety Act 2011* (‘the WHS Act’), and relevant Regulations and Codes of Practice made under the WHS Act
- *Workers Compensation and Rehabilitation Act 2003*
The WHS Act provides a framework to protect the health, safety and welfare of all workers at work and of all others who might be affected by the work. Nationally uniform laws ensure all workers in Australia have the same standard of health and safety protection, regardless of the work they do or where they work. The WHS Act imposes various obligations and duties with respect to the health and safety of workers. The primary duty of care requires a person conducting a business or undertaking (PCBU) to ensure, as far as practicable, the health and safety of workers while the workers are at work.

Both the department and HHSs are PCBUs and share the relevant responsibilities and obligations. The members of the HHB, the HSCE, and the Director-General are ‘officers’ under the WHS Act and hold a responsibility of due diligence that cannot be delegated. They are required to evidence due diligence in the administration of their accountabilities and responsibilities.

Due diligence requires officers to be proactive in ensuring that the organisation complies with its duty. In demonstrating due diligence, officers will need to show that they have taken reasonable steps to:

- acquire and update their knowledge of health and safety matters.
- understand the operations being carried out by the person conducting the business or undertaking in which they are employed, and the hazards and risks associated with the operations.
- ensure that the person conducting the business or undertaking has, and uses, appropriate resources and processes to eliminate or minimise health and safety risks arising from work being done.
- ensure that the person conducting the business or undertaking has, and uses, processes for complying with duties or obligations under the WHS Act.

Safety Management System

HHSs are responsible for having a Safety Management System (SMS) that meets legislative requirements and is aligned to AS/NZS4801:2001 ‘Occupational health and safety management systems—Specification with guidance for use’. HHSs may choose to adopt the department’s SMS.

An integral part of the SMS is the Safety Assurance Model, which consists of a range of lead and lag performance indicators. Safety Assurance is the means in which HHSs and the department demonstrates that organisational arrangements for safety achievement have been met and achieve their intended objective. As outlined in the HHS service agreements, it is an obligation of the HHS to adhere to the statewide safety assurance assessment model including key performance indicators and audit/inspection programs.

WorkCover

Queensland employers are obliged to maintain a Policy of Accident Insurance for persons defined as workers under the Workers’ Compensation and Rehabilitation Act 2003 (‘the WCR Act’). Each HHS fulfils this obligation by maintaining a policy(s) with WorkCover Queensland, the Queensland workers’ compensation insurer for their workers.

12 An “officer” means “a person who makes, or participates in making decisions that affect the whole or a substantial part of the business or undertaking.”
From 1 July 2013, an amendment to section 11 of the WCR Act narrowed the definition of a ‘worker’ to a person who:

• works under a contract, and

• in relation to the work, is an employee for the purpose of assessment for PAYG withholding under the *Taxation Administration Act 1953* (Commonwealth), Schedule1, Part 2–5.

The amended ‘worker’ definition under workers' compensation legislation still covers a majority of persons working within an HHS, however contractors will need to review whether they are covered by existing policy arrangements, based on whether they are an employee for PAYG taxation purposes.

Persons who do not meet the definition of ‘worker’— such as HHB Chairs, Deputy Chairs, members of official boards, non-State Government employee members of official committees, and hospital volunteers, may be covered separately under a Contract of Insurance (COI), with WorkCover Queensland or other commercial insurer, or under existing arrangements for Personal Accident and Illness insurance (Volunteers, Boards and Committee Members) [PAI] with the Queensland Government Insurance Fund (QGIF). While insurance coverage for persons who do not meet the definition of ‘worker’ is not mandatory under the presiding legislation, it should be considered by each HHS through a risk assessment approach, in order to meet local requirements.

For more information on the cover provided under the PAI section of the QGIF insurance policy please refer to the Insurance Services Team’s intranet site on QHEPS at:


QGIF Insurance certificates and Certificates of Currency for each HHS and the Department of Health can be obtained from:


Verification of Cover under the separate WorkCover policies held by each HHS and the Department of Health, can be obtained from WorkCover Queensland at:

6.8 Land and building assets

The following summary details the requirements the HHSs must comply with relating to land and building transactions. Additional specific obligations are listed in the sections below. Where an HHS is undertaking to acquire or dispose of land and building assets, consideration must be given to the mandatory requirements associated with property related legislation and whole-of-government policy. Some examples include the *Native Title Act 1993* (Indigenous Land Use Agreements), *Aboriginal Cultural Heritage Act 2003* (Cultural Heritage), *Sustainable Planning Act 2009* (Community Infrastructure Designation) and the Transaction Policy. A complete list can be found in the HHS Property Service Guideline.

Under section 20 A of the HHB Act, approval of the Minister for Health and the Treasurer for a HHS to buy or sell land or buildings is required. Additionally, prior written approval of the Minister and the Treasurer is required to lease land and buildings either owned by the HHS or by another vendor. This is undertaken by way of written assurance from the HHB Chair that all the requirements of the HHB Act have been met. The Minister requires endorsement from the department prior to approval.

6.8.1 Asset naming

There is currently a Real Property Asset Naming Guideline which indicates that all real property asset names need to be approved by the Minister for Health. Contact should be made with Office of Health Statutory Agencies in the first instance prior to undertaking this process.

6.8.2 Acquisition

In addition to the approvals required above, if an acquisition is greater than $10 million the Governor in Council needs to be advised and approve the acquisition before settlement. This is done following approval by the Minister for Health.

Any transaction processed by a government related entity needs to adhere to the whole-of-government Land Transaction Policy, administered by the Department of State Development (DSD) and available at:


6.8.3 Disposal

There are further approvals for the disposal of land required under the Land Transaction Policy depending on the value of the disposal. The value thresholds are as follows, however HHSs should refer to the Land Transaction Policy to ensure these values are current.

- Director-General DSD if greater than $5 million
- Deputy Director-General of DSD if greater than $2 million and up to, and including, $5 million
- Executive Director, Property Queensland for up to, and including, $2 million.
6.8.4 Revenue Leases
The types of leases that require approval include, but are not limited to:

- revenue lease—retail coffee shop, florist, automatic teller machines
- commercial—car park
- third party—university, teaching
- service provider—Red Cross.

6.8.5 Expenditure leases
HHSs can approve expenditure leases within the specified thresholds in the HHB Regulation listed below. However, when securing an expenditure lease above the thresholds, prior written approval of both the Minister for Health and Treasurer must be obtained. The Minister requires endorsement from the department prior to approval. Examples of expenditure leases which require Minister and Treasurer approval are as follows:

Office accommodation:

- Lease or sub lease >$250K pa—Gold Coast HHS; Metro North HHS; Metro South HHS and Sunshine Coast HHS
- Lease or sub lease >$100K pa—all other HHSs.

Non-office accommodation, such as car parking; storage facility; residential premises:

- Lease or sub lease >$100K pa—all HHSs.

In addition, Building Queensland will need to be involved with the preparation of any business cases for infrastructure (including leases) where the net present value of financial commitment entered into is between $50 and $100 million. Building Queensland will lead the business case preparation when the net present value of financial commitments entered into exceeds $100 million. This includes property leases.

6.8.6 Easements
An easement sets rights (not ownership) to use a section of land, for example access, drainage, electricity, and public utilities. The individual HHS’s Real Property Delegations are exercised in the approval of easements and HHSs must adhere to the requirements under the Land Title Act 1984 for creation and easement registration.

6.8.7 Asset management and maintenance
Legal ownership of land and building assets was progressively transferred from the department to HHSs between July 2014 and July 2015.

Each HHS is responsible for maintaining assets (land and buildings) within its service area and must manage assets in accordance with FPM standard requirements, including the development of an asset management plan. The asset management plan should include requirements to ensure evaluations are prepared before acquiring, maintaining or improving a significant physical asset, with completion reviews undertaken to ensure that objectives contained in the evaluations were met.

The term asset management is the coordinated activities that are carried out to realise the full value of the physical assets such as land, buildings, health technology equipment, ICT equipment and vehicles in the achievement of the HHS’s objectives for the delivery of health services to the community. Asset management supports the realisation of value while balancing
the financial, environmental and social costs, risk, quality of service and performance requirements related to assets.

Asset management activities include:

- strategic planning—replacement of facilities
- refurbishment or disposal of under-utilised assets and buildings
- life cycle replacement of building components—generators or chillers
- maintenance of essential infrastructure—lifts
- undertaking everyday maintenance tasks—painting or routine servicing of fire, air conditioning and electrical systems.

Well-maintained, functional buildings and supporting infrastructure are the easily observed outcomes of sound asset management. Effective maintenance of buildings and infrastructure fulfils legislated and statutory requirements.

Maintenance funding is a component of the funding arrangements provided through service agreements; however the quantum of maintenance funding is not identified or specified. HHSs are responsible for allocating sufficient maintenance funding and carrying out appropriate asset management planning activities.

### 6.8.8 Backlog Maintenance Remediation Program

The Backlog Maintenance Remediation Program (BMRP) is a one-off program designed to address $327 million of backlog liability recorded by HHSs at 31 December 2012. Backlog maintenance is necessary maintenance which has not been carried out and often occurs in situations where maintenance expenditure was insufficient or has been diverted to other functions over time. Backlog identified after 31 December 2012 is the responsibility of each HHS to address.

BMRP funding is provided to each HHS over the four years between 2013–2014 and 2016–2017 to address the recorded backlog liability. This funding is in addition to and does not supplement or replace the annual maintenance budgets provided through each HHS service agreement that are required to be spent on buildings and supporting infrastructure. All funded works should be completed by 30 June 2017.

**Depreciation funding**

HHSs will recognise depreciation revenue (from the department) equivalent to their depreciation expense, offset against equity. The department will recognise a corresponding expense entry, offset against equity. This will result in a revenue source to offset the HHS’s depreciation expense without the HHS building up a related cash surplus.

Depreciation funding is as per the current service agreement and is represented by planned depreciation less the depreciation clawback. The depreciation clawback results from a shortfall in the depreciation expense versus the cash funding provided from Queensland Treasury.

The exposure for the HHS to depreciation is limited to the depreciation clawback amount, which is effected through a reduction in cash funding flows to each HHS.

**Asset revaluation**

Individual HHSs must comply with Australian Accounting Standards and Queensland Treasury’s Non-Current Asset Policies for the Queensland Public Sector, which require land and buildings to be valued with sufficient regularity to ensure that they are carried within the financial statements at fair value.
The department has in place an arrangement with a valuation firm to undertake the valuation program. Individual HHSs may choose to engage alternative valuers provided the methodology is consistent with that applied by existing valuers. Interim valuations (utilising indexation) may be applied in years land and buildings are not comprehensively revalued.
7. External regulatory framework

7.1 Accreditation systems

Accreditation is the public recognition by an accreditation body of the achievement of accreditation standards by a healthcare organisation. This is demonstrated through an independent external peer assessment of that organisation’s level of performance in relation to pre-determined standards.

7.1.1 Healthcare facilities

The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme provides for the national coordination of consistent accreditation processes.

In Queensland, HHSs can be assessed against any further standards used by the accreditation agency chosen by the HHS. As articulated in each HHS service agreement, all Queensland public hospitals, day procedure services and healthcare centres (howsoever titled) managed within the framework of HHSs are to maintain accreditation under the AHSSQA Scheme.

For the purpose of accreditation, the performance of the HHSs against the NSQHS Standards can only be assessed by accrediting agencies that are approved by the ACSQHC.

The HHS selects their accrediting agency from among the approved agencies. A list of approved accrediting agencies is available from the ACSQHC website at:

www.safetyandquality.gov.au

Following an accreditation event the HHS will provide the outcome of assessment of each action (core and developmental) to the department within seven days, providing no significant patient risks have been identified.
The AHSSQA Scheme requires accrediting agencies to notify regulators if a significant risk of patient harm is identified during an onsite visit to a health service organisation.

The award recognising that the HHS has met the NSQHS Standards will be issued for a period of up to four years. The HHS must apply to an approved accrediting agency for a re-accreditation assessment prior to the expiry of the current accreditation period.

A Guide to the National Safety and Quality Health Service Standards for health service organisation boards is available on the ACSQHC website at:


Mental health services

Mental health services must maintain accreditation against the NSQHS Standards and the National Standards for Mental Health Services.

Aged care facilities

In Australia, residential aged care homes are required to be accredited to receive Australian Government subsidies. The Australian Aged Care Quality Agency is responsible for accrediting residential aged care services. Providers of residential aged care have responsibilities to provide care and services to meet care recipient needs in accordance with the legislated Accreditation Standards set out in the Quality of Care Principles. All approved providers are assessed against the Accreditation Standards.

General practices

General practices owned or managed by the HHS are to be externally accredited. Accreditations of general practices are in accordance with the current edition of the Royal Australian College of General Practitioners (RACGP) published accreditation standards.

7.1.2 Australian Health Practitioner Regulation Agency

The Australian Health Practitioner Regulation Agency (AHPRA) is responsible for the consistent implementation of the National Registration and Accreditation Scheme of healthcare professions across Australia. Fourteen National Health Practitioner Boards currently exist, across a range of disciplines including:

- Aboriginal and Torres Strait Islander health practice
- Chinese Medicine
- Chiropractic
- Dental
- Medical
- Nursing and Midwifery
- Occupational Therapy
- Optometry
- Osteopathy
- Pharmacy
- Physiotherapy
- Podiatry
Psychology.

The primary role of the Boards is to protect the public and set standards and policies that all registered health practitioners must meet.

For more information visit: [https://www.ahpra.gov.au/](https://www.ahpra.gov.au/)

### 7.2 Complaints and investigation agencies

#### 7.2.1 Coroner

Coroners are responsible for investigating reportable deaths that occur in Queensland, including healthcare related deaths. Health professionals have an obligation under the *Coroners Act 2003* to report certain deaths to the Coroner and to provide relevant information to assist in any subsequent investigation.

If a coroner decides to hold an inquest he/she can make recommendations aimed at preventing similar deaths in the future. Coronial investigations do not focus on laying blame or assigning liability for the death. The emphasis is on the prevention of avoidable deaths through the making of coronial recommendations. Queensland Health is committed to learning from coronial inquests through a system of consistent, coordinated response to coronial recommendations which is provided to the Coroner for their information and future reference. The department’s Patient Safety and Quality Improvement Service coordinate responses to coronial recommendations for interdepartmental annual reports and to share lessons.

#### 7.2.2 Office of the Health Ombudsman

The Office of the Health Ombudsman is Queensland’s independent health complaints agency. It is an independent statutory body established under the *Health Ombudsman Act 2013*, which outlines the key objectives of the Office.

The Health Ombudsman is the single entity to receive all health service complaints in Queensland (including voluntary and mandatory notifications under the Australian Health Practitioner Regulation National Law.) The Health Ombudsman is responsible for deciding the best way to deal with each complaint and can seek the advice of appropriately qualified clinicians and health consumers in informing their decision.

The Health Ombudsman may take immediate action against a registered or unregistered practitioner at any time (whether or not a complaint has been made) if the Health Ombudsman reasonably believes the practitioner poses a serious risk to the health and safety of the public; and for registered practitioners, that registration was improperly obtained, or registration elsewhere was cancelled or suspended under law in another country. The suspension, condition or interim prohibition order will remain in place unless revoked by the Health Ombudsman or the Queensland Civil and Administrative Tribunal (QCAT).

The Health Ombudsman Act places clear timeframes on the handling of health service complaints. The Health Ombudsman must decide whether to accept a complaint within seven days; assess a complaint within 30 days. This can be extended by 30 days due to the size or complexity of a case or time taken to receive submissions, and complete investigations undertaken within 12 months. If this does not occur, the Health Ombudsman is required to publicly report it, including the reasons for delay. If any investigation goes beyond two years, the Health Ombudsman is required to notify the Minister for Health and, the Health and Ambulance Services Parliamentary Committee.

The Health Ombudsman may also identify and report on systemic issues in the way health services are provided, including issues affecting the quality of health services, and provide recommendations with the goal to bring about quality and safety improvements. The Health
Ombudsman may also undertake an inquiry in relation to a health service complaints matter, a systemic issue relating to the provision of a health service or any other matter that the Health Ombudsman sees is relevant. The Minister may direct the Health Ombudsman to undertake an inquiry.

While an independent statutory officer, the Health Ombudsman is accountable to the Minister for Health and the Parliamentary Committee.

Information for health service providers is available at:

### 7.2.3 The Aged Care Complaints Commissioner

Some HHSs are approved providers of residential aged care services and/or providers of Commonwealth funded Home and Community Care (HACC) services.

The Aged Care Complaints Scheme Commissioner (formerly the Aged Care Complaints Scheme) provides a free service funded by the Australian Government for anyone to raise their concerns about the quality of care or services being delivered to people receiving aged care services subsidised by the Australian Government, including: residential care, Home Care Packages, and Commonwealth funded HACC services.

The Scheme uses service provider resolution to resolve concerns where possible to strengthen the relationship between service, complainants and care recipients. The Aged Care Complaints Commissioner can independently review decisions and processes.

### 7.2.4 Crime and Corruption Commission

HHSs are a Unit of Public Administration (UPA) under the Crime and Corruption Act 2001 (the CCA). As a UPA, a HHS is accountable and responsible for consideration, assessment and reporting of suspected corrupt conduct that arises within the HHS. HHSs are required to report allegations directly to the Crime and Corruption Commission (CCC). The HSCE is responsible for referring complaints of suspected corrupt conduct to the CCC.

The CCA defines corrupt conduct. The CCC guide ‘Corruption in focus’ summarises the definition as conduct:

1. that adversely or could adversely affect, directly or indirectly, the performance of a person’s duties that
2. is dishonest or lacks impartiality, or involves a breach of the trust placed in an officer by virtue of their position, or is a misuse of officially obtained information

AND

3. is engaged in for the purpose of providing a benefit to the person or another person or causing a detriment to another person

AND

4. is a criminal offence or conduct serious enough to justify dismissal.

The CCC assesses all referrals it receives and provides advice back to the HHS regarding how the complaint is to be dealt with. Each HHS has nominated a designated CCC Liaison Officer who is the CCC’s key contact for complaint referrals and their management.
7.2.5 Queensland Ombudsman—Public Interest Disclosures

The Queensland Ombudsman investigates complaints about the actions and decisions of Queensland public agencies and their staff that may be unlawful, unreasonable, unfair, improperly discriminatory or otherwise wrong. The Queensland Ombudsman is also the oversight agency for the Public Interest Disclosure Act 2010 (the PID Act), with responsibility for monitoring and reviewing the management of public interest disclosures (PIDs) and providing education and advice about PIDs.

A PID, in general terms, is a report of certain wrongdoing or danger. For the report to be considered a PID and attract the protections under the Public Interest Disclosure Act 2010 (the PID Act), the report must be an appropriate disclosure, made to a proper authority.

The PID Act and the PID Standard applies to and is binding on HHSs as public sector entities and therefore the accountability to assess and report on PIDs rests with each HHS. The HSCE is the ‘chief executive officer’ for the entity with associated responsibilities. The HSCE must develop and implement a management program for PIDs and also develop and implement reasonable procedures for dealing with PIDs. Procedures would include the establishment of reporting mechanisms and assessment procedures.

The HSCE must, so far as is appropriate given the nature and size of the HHS, establish a central point with expertise to be responsible for PIDs. The HSCE must ensure that all disclosures to the HHS are assessed and protective measures are in place which are proportionate to the risk of reprisal, and the potential consequences of a reprisal.

Information on the PID Standard No. 1 and other guides and fact sheets are available on the Ombudsman’s website at http://www.ombudsman.qld.gov.au/

7.3 The Auditor-General

The Auditor-General, an independent Officer of Parliament, is the external auditor of both the state and local government public sectors in Queensland. The independence of the position, enshrined in law, means the Auditor-General and staff of the Queensland Audit Office (QAO) has unfettered access to all government entities, including HHSs, and can examine and report to Parliament on the efficiency and effectiveness of any aspects of public sector finances and administration.

The Auditor-General is legally obliged to audit all public sector entities in each financial year and decide how best to conduct each audit.

The Auditor-General is responsible for both financial statement audits and audits of performance management systems:

- **financial statement audits** provide independent assurances to Parliament and the community that the information contained in the financial statements of public sector entities is presented fairly in accordance with the Australian Accounting Standards and applicable legislation.

- **performance audits** evaluate whether an organisation or government program is achieving its objectives effectively, and doing so economically and efficiently, and in compliance with all relevant legislation.

HHSs must prepare annual financial statements for submission to the Auditor-General and liaise directly with the QAO to coordinate the audit of the HHS’s financial statements. The QAO reports findings directly back to those audited with any significant issues also reported to the Minister for Health, Parliament and the Treasurer.
Under section 46 of the Standard, the HHB is required to consider any issues raised in the auditor’s report at its first meeting after receipt of the report. It is important that any issues identified through the audit process are adequately addressed by management and corrective measures undertaken in a timely manner.

QAO reports to Parliament are available at:

HHSs are required to include a report of their audit committee on the consideration of all audit recommendations by QAO including performance audit recommendations in their annual report.

7.4 Right to Information

The Right to Information Act 2009 (RTI Act) gives the public a right of access to information held by government. The Information Privacy Act 2009 (IP Act) is designed to work in parallel with the RTI Act and provides a statutory right to individuals to apply to access and amend their own personal information.

The legislation is pro-disclosure; therefore unless the information is exempt from release or would be contrary to the public interest if released, documents will be disclosed. The term ‘document’ has an extensive definition and includes (but is not limited to) filed or unfiled papers, drafts, information in electronic form, emails, medical images, diaries and, text and Lync messages.

All documents held by HHSs are subject to the RTI and IP Acts and may be subject to internal and external review. As independent statutory bodies, the HHSs are also required to:

- maintain a publication scheme which sets out the kinds of information the agency makes routinely available (for example, policies, finances, gifts and benefits register)
- maintain a disclosure log outlining RTI decisions made under the RTI Act
- provide annual statistics regarding access and amendment applications to the department for on-forwarding to the Department of Justice and Attorney-General—these are then collated and reported to Parliament
- provide submissions to and liaise with the Office of the Information Commissioner (OIC) regarding external reviews of access and amendment decisions.

The Office of the Information Commissioner also conducts performance reviews of agencies’ compliance with the RTI Act and IP Act. The reports of the performance reviews are tabled in Parliament.

Each HHS has experienced decision-makers in place to manage the RTI/IP application workload.

7.5 Information privacy and confidentiality

Queensland Health is subject to privacy and confidentiality legislation which set the standards for how we handle personal and confidential information. The two primary pieces of legislation are the IP Act and Part 7 of the HHB Act.

Patient confidentiality in Queensland public sector health services is strictly regulated. Section 142 in Part 7 of the HHB Act sets out the duty of confidentiality and exceptions that permit disclosure of confidential information by ‘designated persons’, including Queensland Health staff. It is an offence to disclose confidential information about a person unless one of the exceptions in Part 7 of the HHB Act applies. ‘Confidential information’ is information that could
identify someone who has received, or is receiving a public sector health service (i.e. a patient), including deceased persons.

The IP Act recognises the importance of protecting personal information of individuals. Personal information is defined in the IP Act and can be any information or opinion about an identifiable living individual; including staff, patients and the community more broadly. Queensland Health is required to comply with the privacy principles contained within the IP Act which includes the nine National Privacy Principles (NPPs) and provisions regarding contracted service providers and the transfer of personal information out of Australia. These are essentially rules about how Queensland Health must handle all personal information including collection, storage and maintenance, access and amendment, openness and use and disclosure of personal information.

The IP Act also allows an individual to make a privacy complaint if they believe Queensland Health has breached its obligations under the IP Act. If the complainant is not satisfied with our response, and at least 45 days have passed since the privacy complaint was made, the person can bring the complaint to the OIC. If dissatisfied with the outcome of a complaint to the OIC, the complainant may choose to progress it to QCAT, which may order financial compensation to a complainant, up to $100,000.

The privacy rules that apply to public sector health agencies under the IP Act are subject to the requirements of other laws that specifically detail how personal information shall be collected, stored/secured, used, disclosed, disposed of, etc. For example, the HHB Act about disclosure of confidential information, the Mental Health Act 2000 in relation to moving and transfer of patients, etc.

Both Part 7 of the HHB Act and the IP Act do not apply to de-identified information or statistical datasets that do now allow individuals to be identified.

A breach of the duty of confidentiality in section 142 of the HHB Act or provisions in the IP Act may be dealt with as staff disciplinary matters under the Code of Conduct. Staff privacy and confidentiality obligations are referred to in the Code of Conduct training.

Each HHS has Privacy and Confidentiality Contact Officers (PCCOs) in place to manage privacy complaints and enquiries.

For more information about privacy and confidentiality, please visit QHEPS at:

8. Hospital and Health Board member fundamentals

In this section:
- Role of the Board Chair and board members
- Legal and administrative framework for operation
- Public health portfolio legislation
- Powers and functions including delegations
- Board committees
- Investment and statutory approvals
- Ethics and confidentiality
- Conflicts of interest
- Insurance and indemnity arrangements
- Fiduciary responsibilities
- Executive remuneration and employment arrangements

Key points:
- Board Members have significant responsibilities and operate within a complex framework of legislation and policy
- Board members should be aware of their powers and functions including delegations, as well as their ethical and fiduciary duties as members of a public sector entity

8.1 Role of the Board Chair and members

Although referring to some actions which can be taken by the Chair such as signing of service agreements on behalf of the HHS, the HHB Act does not outline the specific roles of Chairs and members. The Queensland Government publication, *Welcome Aboard: A Guide for Members of Queensland Government Boards, Committees and Statutory Authorities* (‘Welcome Aboard’) provides general guidance for current and intending Government Board members including the role of key players, summarised below as applicable to HHBs.

Welcome Aboard is available at:
8.1.1 Board Chair

The Chair of the HHB leads and directs the activities of the board. Responsibilities of the Chair will usually include:

- setting the board agenda
- facilitating the flow of information and discussion
- conducting board meetings and other business
- ensuring the board operates effectively
- liaising with and reporting to the Minister
- reviewing board and organisational performance
- inducting and supporting board members.

The Chair must be fully conversant with the business of the HHB and ensure compliance with all legal and statutory obligations. The Chair may be invited to have input to the nomination/selection/recruitment process for new board members, however, responsibility for selection ultimately rests with the Minister, Cabinet and Governor in Council. Refer also to section 9.2 ‘Board appointments’.

8.1.2 Board members

Members of HHBs are required to familiarise themselves with the work of the HHB, including their legal and statutory obligations. They must take reasonable steps to ensure that they are knowledgeable about the business of the HHB and can make informed decisions. Individual HHB members are responsible collectively for, and should support and adhere to, all HHB decisions. Members however can exercise a dissenting view on particular decisions which should be appropriately minuted.

8.2 Legal and administrative framework for operation

Government boards operate within a framework of legislation and policy which influences how they operate and wield power.

HHB members have legal obligations derived from:

- the HHB Act (the enabling Act constituting the Board) – HHBs are established by the HHB Act to control the Service for which they are established (section 22). The HHS itself (represented by the HHB) is accountable to the Minister and Parliament for the performance and actions of the HHS.
- other State and Commonwealth legislation applying to all statutory bodies. For example, relevant sections of the:
  - Auditor-General Act 2009
  - Financial Accountability Act 2009
  - Financial and Performance Management Standard 2009
  - Statutory Bodies Financial Arrangements Act 1982
Aside from specific legislation applying to Queensland statutory bodies and their boards, additional responsibilities and obligations may be placed upon them by a number of pieces of other legislation, for example, the:

- Crime and Corruption Act 2001
- Information Privacy Act 2009
- Public Service Act 2008
- Public Sector Ethics Act 1994
- Public Records Act 2002
- Right to Information Act 2009.

Obligations are also imposed on boards by the broader policy and administrative framework they operate within. The diagram below is an example illustration of the key legal and administrative framework a HHS as a statutory body must operate within. Some of these key governance elements are outlined throughout the Handbook.

HHS members should familiarise themselves with all legislation and policy relating to their specific responsibilities and obligations. Further information on key HHS legislated powers and compliance obligations is available at:

The Queensland Audit Office best practice document ‘Leading accountability – Governance’ (March 2015) also provides a useful overview of the framework applying to statutory bodies in Queensland available at:


8.2.1 Public health portfolio legislation

The Director-General of the department is the Chief Executive for those Acts for which the Minister for Health is responsible, unless otherwise provided for in the Act. Therefore, the Director-General is the accountable person for the administration of legislation. The statutory role for HHSs is related to the provision of services. However, public health legislation does not provide for the HHS as a statutory entity or regulatory agency in its own right.

The Prevention Division is the legislative custodian for 12 of the 17 Acts administered by the department. These Acts contain offences and associated compliance and enforcement provisions. In carrying out its role as regulator, the department establishes systems and processes which promote and protect safety within the community and provide confidence in the regulator by licensees and other regulated entities and the wider community.

Administration of public health legislation includes the management, review and development of operational guidelines to support the:

- Food Act 2006
- Health Act 1937, Health (Drugs and Poisons) Regulation 1996 and Health Regulation 1996
- Pest Management Act 2001
- Pharmacy Business Ownership Act 2001
- Public Health Act 2005
- Public Health (Infection Control for Personal Appearances Services) Act 2003
- Radiation Safety Act 1999
- Tobacco and Other Smoking Products Act 1998

Authorised persons and inspectors (authorised officers) appointed under the public health Acts include staff employed in the department and those employed in HHS PHUs who are located in a diverse geographical area across Queensland who are responsible for undertaking monitoring, compliance and enforcement on behalf of the department.

Public health legislation also provides for the delivery of specific regulatory functions to be devolved to local government. These include the management of local public health risks within their areas of responsibility, licensing and monitoring hygiene in food businesses and regulation of personal appearance businesses, and activities related to mosquito control. However, the Director-General retains accountability for ensuring that local government undertakes these devolved functions.

The Public Health Regulatory Framework outlines the regulatory approach and principles underpinning regulatory compliance and enforcement activity to ensure a responsive, coordinated and consistent public health regulatory system. The Framework is available on QHEPS at:

8.3 Powers and functions including delegations

8.3.1 Powers

The HHB controls the HHS for which it is established and has the powers specified in the HHB Act for its HHS. In summary these powers derive from:

- HHSs’ status as independent legal entities (section 18), that is, they:
  - are bodies corporate
  - may sue and be sued in their corporate name
  - represent the State and have all the privileges and immunity of the State.
- The nature of their statutory status (section 21), that is, they are:
  - statutory bodies under the *Financial Accountability Act 2009* and *Statutory Bodies Financial Arrangements Act 1982*
  - units of public administration under the *Crime and Corruption Act 2001*.

Further powers of a HHS are detailed in section 20 of the HHB Act and include, for example the ability to:

- enter into contracts and agreements
- appoint agents and attorneys
- charge for the services they provide
- do anything else deemed necessary or convenient to be done in performing their functions.

Each HHB has significant responsibilities at a local level, including controlling the financial management of the HHS, the management of the HHS’s land and buildings, and for a prescribed Service, the management of the HHS’s staff (section 7 of the HHB Act).

To safeguard assets in the longer term the Minister and the Treasurer must approve any request for a HHS to buy or sell land or buildings (section 20A of the HHB Act). The Minister and Treasurer are also required to approve the lease of land and buildings from another person, or the lease of land and buildings owned by the HHS, unless the lease is a type prescribed in the HHB Regulation (refer sections 3AB and schedule 1AB).

HHS staff subject to statewide enterprise bargaining agreements and awards, and other statewide employment terms and conditions as determined by the Director-General (refer section 10 of the HHB Act). This is to prevent wage competition between HHSs, and allow easy transfer of staff between HHSs.

8.3.2 Delegations

Section 30(1) of the HHB Act provides that the HHB of a HHS may delegate the HHS’s functions under the HHB Act and the *Financial Accountability Act 2009* to:

- a committee of the Board if all members of the committee are board members; or
- the executive committee established by the Board; or
- the HSCE.

In doing so, the Board must ensure that local policies, practices and procedures for the delegation of authority comply with the requirements of the *Acts Interpretation Act 1954*, the *Financial and Performance Management Standard 2009* (‘the FPMS’) and the HHB Act.
Some examples of decision-making powers Boards may choose to delegate are:

- discharging the responsibilities of a prescribed or other committee
- progressing strategies and implementing the performance and governance frameworks of the HHS
- financial and procurement approvals
- signing deeds, contracts, agreements, indemnities, guarantees, Memoranda of Understanding and other legal documents.

A statutory function or power is delegated via an ‘instrument of delegation’ – a formal, written document signed by the delegator. Template delegation instruments are available on request from the Office of Health Statutory Agencies, Department of Health, via:

statutoryagencies@health.qld.gov.au

It is likely that decisions on delegated matters that impact on the core values of a HHS, or that have the potential to change or impact the strategic direction/commitments of the HHS, would be reserved for the Board or, at a minimum, provided to the Board for consultation.

Section 30(2) of the HHB Act provides that, with the written approval of the Board, the HSCE may also sub-delegate functions delegated to them by the Board to an employee of the HHS or to a health service employee employed in the department and working for the Service who is appropriately qualified to carry out the delegated function.

Section 46(5) of the HHB Act provides that, with the written approval of the Director-General, the HSCE may also sub-delegate functions delegated to them by the Director-General to a health executive employed by the HHS or to a health service employee employed in the department and working for the HHS. It is important to note that the HSCE cannot sub-delegate a function of the Board or DG unless the Board or DG has delegated that function to the HSCE.
Delegations—local governance protocols

Boards should approve and suitably monitor the internal governance arrangements for their HHS, including approving delegations of functions and confirming the committee structure for the HHS. This might be assisted by maintaining and keeping under review a central record of delegations as may be specified in the HHS’s Financial Management Practice Manual.

Section 8 of the FPMS requires that statutory bodies establish a cost effective internal control structure with a strong emphasis on accountability and with delegations that support the objectives and operations of the statutory body.

The Acts Interpretation Act 1954 requires that delegations are assigned only to officers with the requisite qualifications, experience or standing appropriate to exercise the power. Section 27A of this Act provides specific requirements in relation to the delegation of a statutory function or power.

HHSs should seek their own independent legal advice in relation to their delegation obligations under the Act, including the content of any delegation instruments that have been provided to them by the department or by another HHS as a guide.

8.4 Board committees

As it is unlikely that HHBs will be able to make every decision required to exercise their legislative powers and functions, it may be necessary to delegate some of these decision making powers, such as discharging the responsibilities to a prescribed or other committee.

Schedule 1 of the HHB Act specifies that the functions of a committee are to:

- advise and make recommendations to the board about matters, within the scope of the board’s functions, referred by the board to the committee
- exercise powers delegated to it by the board.

An HHB may only delegate powers to a committee if all the voting members of the committee are HHB members (refer section 30 of the HHB Act). Non-Board members can be on a committee but are non-voting committee members.

A committee is required to keep a record of the decisions it makes when exercising a power delegated to it by the Board. The HHB may decide matters about the committee, including, for example, the way a committee must conduct meetings.

A member of a committee is entitled to the fees and allowances fixed by the Governor in Council for performing his or her functions as a committee member. At this stage, annual fees have only been approved for board members participating on prescribed committees.

8.4.1 Prescribed committees

The HHB Act and supporting HHB Regulation require HHBs to establish four committees, including an executive committee, safety and quality committee, finance committee, and audit committee. The functions of these prescribed committees are outlined in the HHB Act and HHB Regulation.

In establishing the committees a HHB may assign a different name as long as it is consistent and appropriate with the functions of the prescribed committee. Apart from the executive committee, membership of the prescribed committees is not legislated.
Executive Committee functions
Clear lines of accountability and strong lines of communication between the HHB and HSCE are essential. To facilitate this, under section 32A of the Act, each HHB must establish, as a committee of the Board.

The function of the executive committee is to support the HHB in its role of controlling the HHS, by working with the HSCE to progress strategic issues identified by the HHB. The executive committee should also strengthen the relationship between the HHB and the HSCE to ensure accountability in the delivery of services by the HHS. In addition, at the direction of the HHB, an executive committee may:

- oversee the performance of the HHS against the service agreement
- support the Board in developing the required engagement strategies and protocols
- support the Board to develop service plans for the HHS and monitor their implementation
- work with the HSCE in responding to critical emergent issues
- perform any other functions given to the committee by the Board or prescribed in regulation.

The executive committee at minimum comprises either the HHB Chair or Deputy Chair (who will Chair the committee) and at least two other HHB members, of whom one must be a clinician. It is a requirement that the HSCE attend all meetings of the executive committee.

Safety and Quality Committee functions
The functions of the Safety and Quality Committee as detailed in section 32 of the HHB Regulation:

- Advise the Board on the safety and quality of health services provided by the HHS, including strategies for:
  - minimising preventable patient harm
  - reducing unjustified variation in clinical care
  - improving the experience of patients and carers
  - ensuring compliance with national and state strategies, policies, agreements and standards such as the National Safety and Quality Health Service Standards.
- Monitoring HHS safety and quality governance arrangements.
- Monitoring safety and quality and promoting improvements.
- Collaborating with other safety and quality committees, the department and state-wide groups.
- Any other function given to the committee by the Board.

Finance Committee functions
The functions of the Finance Committee as detailed in section 33 of the HHB Regulation are to advise the Board on the following matters:

- assessing the HHS budgets to ensure they are consistent with organisational objectives and appropriate relative to the HHS’s funding
- monitoring HHS cash flow
- monitoring financial and operating performance
- monitoring the adequacy of financial systems to ensure requirements and obligations under the FAA are met
- assessing and monitoring financial risks and concerns
• assessing complex or unusual financial functions
• any other function given to the committee by the Board.

Audit Committee functions
The functions of the Audit Committee as detailed in section 34 of the HHB Regulation are to advise the Board on the following matters:
• assessing the HHS’s financial statements in regard to:
  i. appropriateness of the accounting practices
  ii. compliance with accounting standards prescribed under the FAA
  iii. external audits of the HHS’s financial statements
  iv. information provided by the HHS regarding the accuracy and completeness of its financial statements.
• monitoring the HHS’s compliance with internal control structures and systems of risk management under the FAA
• if the HHS establishes an internal audit function, monitoring and advising the Board about its internal audit function
• overseeing the HHS’s relationship with the QAO
• assessing external audit reports and ensuring an appropriate response to any required actions
• monitoring the HHS’s management of legal and compliance risks
• assessing complex or unusual financial functions
• any other function given to the committee by the Board.

An HHS must comply with the requirements in section 35 of the FPMS in establishing an audit committee. Section 35 of the Standard requires that the HHS must:
• have regard to the Queensland Treasury document ‘Audit committee guidelines – improving accountability and performance’
• develop terms of reference
• include members of the Board
• provide an annual report of the committee’s operations to the Board.

Queensland Treasury publishes Audit Committee Guidelines: Improving Accountability and Performance to assist agencies with the establishment and maintenance of audit committees. The guidelines are available at:

The QAO issues an occasional ‘Audit and risk committee series’ newsletter which may be useful for audit committee members available at:
8.4.2 Non-prescribed committees

HHBs may choose to establish additional advisory committees or groups as needed to assist them to effectively and efficiently perform their functions, for example as part of clinician, community, and consumer engagement strategies.

In general, the Government’s position is that members of government advisory bodies should not be remunerated, however, at minimum, out of pocket expenses may be paid.

Should an HHB choose to deviate from this policy, it is recommended that a transparent process and an appropriate paper trail or policy authorising the appointments and remuneration of members of such a committee is put in place in order to justify such expenditure for audit purposes and to ensure compliance with any requirements in the HHS’s Financial Management Practice Manual. In addition, there may be a need for additional technical or professional expertise on committees from time-to-time, in which case a contractor arrangement may be appropriate.

8.5 Investment and statutory approvals

Certain HHS activities may require the prior approval of the portfolio Minister, the Treasurer or Governor in Council.

HHSs derive their powers from their enabling legislation, the HHB Act. In addition, HHSs have been granted Category 2 investment powers under the *Statutory Bodies Financial Arrangements Regulations 2007* (SBFA Regulation). Under these legislative arrangements, HHSs have the powers to undertake all the functions expressly provided for in the HHB Act and the powers to invest in certain relatively short term secure investment products (refer section 45 of the SBFAA).

Entering into investments other than those detailed in section 45 of the SBFAA and other financial arrangements, such as borrowing, leasing, purchasing/selling land and/or buildings, entering into a joint venture, partnership, forming a company, entering into alliance contracts etc. requires additional approvals under the HHB Act, SBFAA and/or other Government approval, such as Cabinet Budget Review Committee, State Borrowing Program. Likewise, contract expenditure over the specified amounts may require approval from the Governor in Council.

As noted in section 6.8 ‘Land and Building Assets’ above, the Minister and the Treasurer must approve any request for a HHS to buy or sell land or buildings (section 20A of the HHB Act). The Minister and Treasurer are also required to approve the lease of land and buildings from another person, or the lease of land and buildings owned by the HHS.

On 23 March 2006 the Treasurer delegated certain powers under the SBFAA to the Under-Treasurer. The powers delegated are for approval requests under sections 31(2), 34, 53, 59, 60A, 61A(1) and Part 9 division 1 to 3 of the SBFAA.

The SBFAA, Operational Guidelines, Queensland Treasury requires that a statutory body proposing to enter into a financial arrangement, that requires approval under the SBFAA is to approach its administering department with complete details of the proposal and request that the department seek any necessary approvals on behalf of the body.

Retrospective approvals cannot be given for investments or other financial arrangements that require the prior approval of the Treasurer under the SBFAA.
Ethics and confidentiality

HHB members are expected to uphold the Code of Conduct for the Queensland Public Service (the Code of Conduct), which applies to all public service agencies. The Code applies at all times when a HHB member is performing official duties including when representing the Queensland Government at conferences, training events, on business trips and attending work-related social events. The Code contains four principles for ethical behaviour fundamental to robust public sector integrity and accountability:

1. Integrity and impartiality
2. Promoting the public good
3. Commitment to the system of government
4. Accountability and transparency

The Code of Conduct imposes a strict duty of confidentiality on all people who work in an HHS. HHB members may from time to time be in receipt of information that is regarded as ‘commercial in confidence’, clinically confidential or as having privacy implications. All persons employed in any capacity in the HHS must maintain confidentiality of all information that is not in the public domain. Section 1.2 of the Code of Conduct makes provision for the identification and management of conflicts of interest and duty.

The Code of Conduct for the Queensland Public Service is available at:

HHB members also have a duty of confidentiality under Part 7 of the HHB Act, namely, that they must not disclose, directly or indirectly, confidential information to another person unless the disclosure is required or permitted under the Act.

8.6 Conflicts of interest

Members of Government Boards must act ethically and observe the highest standards of behaviour and accountability to support the continuation of public trust in the government. Welcome Aboard outlines the obligations of members of government boards and those involved in the good corporate governance of government boards. It states that:

‘Members of government boards should avoid actual or potential conflicts between their duties to the government board and their personal interests or their duties to others. Members of government boards should also be aware of possible perceived conflicts of interest.’

Section 31 of the Act also states that Board members are to act impartially and in the public interest in performing their duties.
Schedule 1, Section 9 of the HHB Act outlines the way in which HHBs and their committees are to deal with disclosure of interests at meetings. For example, that a disclosure must be recorded in the minutes of the board and that unless the board decides otherwise, the interested person must not be present when the board considers the issue. It also requires that Board members disclose the nature of any interest to a board or committee meeting as soon as practicable after they become aware of the relevant facts.

Boards are locally responsible for determining an appropriate process for declaration, variation and management of interests.

A conflict of interest guideline for HHSs has been developed and provides a tool for managing conflicts of interest at the Board level, particularly where Queensland Health and other public sector employees are also members of the Board. The Guideline and a series of declaration templates are available on the Queensland Health website at:


HHBs and HSCEs are eligible under the Integrity Act 2009 to ask for the Queensland Integrity Commissioner’s advice on an ethics or integrity issue, including conflicts of interest (by written request).

8.7 Indemnity and insurance arrangements

Members of official boards and committees have automatic legal protection from being civilly sued when acting in their official capacity. The Public Service Act 2008 provides immunity to state employees from civil liability. Members of official boards and committees are considered state employees and are entitled to protection of the State when acting within the scope of their duties and functions. The Queensland Government Indemnity Guidelines (the Guidelines) set out the application and circumstances for when a public officer will be provided indemnity and legal assistance. The guidelines are available at:


The guidelines will not extend to cover internal departmental or HHS investigations or inquiries, for example, matters arising from a complaint to Human Resources or matters referred to the employing entity by the Crime and Corruption Commission.

Once indemnity is in place, the HHS will pay any relevant costs pertaining to the indemnity. Whether the HHS can recover these costs under insurance will be determined by the terms and conditions of the QGIF insurance policy. If the QGIF insurance policy does not respond, the applicable HHS will be required to cover the associated indemnity costs. Queensland Health holds one insurance policy with QGIF, with the department and each HHS named as insured parties.

In addition, HHSs may have separate indemnity and Directors’ and Officers’ insurance arrangements in place for their board/committee members. HHS may have chosen to extend a Deed of Indemnity, Insurance and Access to board members and senior executive officers to cover any identified liability gaps. Each HHS may decide, through a risk assessment approach and having sought legal advice, to seek additional insurance for board members, or it may be that individual members make their own insurance arrangements.

It is important to be aware that where an HHS has other indemnity and director’s and officer’s (D&O) insurance arrangements in place, the QGIF insurance policy will only respond to cover loss, damage or legal liability which is in excess of the cover available under the other insurance policy (excluding excess obligations). In effect, the commercial D&O insurance policy becomes the primary insurance policy and must first be used and cover exhausted before a claim can be made under the QGIF insurance policy. Before implementing other indemnity and insurance arrangements, HHSs should check the extent of cover already available under the QGIF
insurance policy and where possible have only sought insurance for loss, damage or liability that would not be covered by the QGIF insurance policy.

For more information on Queensland Health’s insurance and indemnity arrangements please refer to the Insurance Services Team’s intranet site on QHEPS at:


8.8 Fiduciary responsibilities

Members of government agencies and statutory authorities assume a public trust and confidence by virtue of their role in public administration. Good governance means that an organisation’s leadership, its staff, the Government, the Parliament and the public can rely on the organisation to do its work well and with full probity and accountability.

As a member of a government or statutory board acting in a fiduciary capacity, you have an obligation (under general law) to:

- Act honestly and to exercise powers for their proper purpose
- Avoid conflicts of interest
- Act in good faith
- Exercise diligence, care and skill

8.9 Executive remuneration and employment arrangements

The Board is responsible for appointing a HSCE for the HHS, subject to final Ministerial approval.

A person appointed as an HSCE must also be appointed as a health executive.

The HHB Act provides for the Director-General to establish the terms and conditions of employment for health service employees.

The HHB Act provides for the Director-General to issue health employment directives about the conditions of employment for health service employees.

The Director-General is required to set the classification and remuneration framework and terms and conditions of employment for health executives. The head of power to do this is a health employment directive.

Remuneration for HSCEs is managed under a total remuneration package arrangement (TRP). The TRP is inclusive of all traditionally separate benefits and allowances such as superannuation, leave loading, motor vehicle allowance and other miscellaneous allowances. In accordance with the principles approved under the HSCE Governance and Reward Framework, upon appointment a successful candidate should be appointed between the minimum and middle TRP range. This provides room for increases in remuneration based on performance.

Upon appointment, remuneration may be considered between the middle and maximum range, though should be based on the candidate having exceptional knowledge and experience and proven capability. The Director-General is required to approve remuneration and benefits for a HSCE.
9. Hospital and Health Board appointments and procedures

In this section:
- Board composition
- Board appointments
- Remuneration
- Board induction
- Board performance
- Conduct of Board business
- Publishing Board meeting outcomes

Key points:
- The HHB Act specifies the composition of Boards and how they are to be appointed and remunerated
- Ministerial guidelines outline expectations in relation to recruitment and selection processes for Board members
- Processes should be in place locally to ensure board members are appropriately inducted, the performance of the board is regularly evaluated and that board meeting outcomes are made available to stakeholders

9.1 Board composition

The HHB Act requires HHBs to consist of a minimum of five board members, including the chair, at least one of whom is a clinician (including the chair). The skills mix considered necessary for boards, includes persons:

- with expertise in health management, business management, financial management and human resource management
- with clinical expertise
- with legal expertise
- with skills, knowledge and experience in primary healthcare
- with knowledge of health consumer and community issues relation to the operations of the HHS
- where relevant, from universities, clinical schools or research centres with expertise relevant to the operations of the HHS
- with other areas of expertise the Minister considers relevant to a HHS performing its functions.
9.2 Board appointments

Under section 23 of the HHB Act, appointments of board chairs, deputy chairs and members are made by the Governor in Council, by gazette notice, on the recommendation of the Minister.

On the recommendation of the Minister, individual members may concurrently be appointed by the Governor in Council to serve as chair or deputy chair. The deputy chair is to act as chair during a vacancy in office of the chair and during all periods when the chair is absent from duty or for another reason cannot perform the duties of the office.

Length of tenure is a matter for the Governor in Council to determine, based on the recommendation of the Minister. The maximum term of appointment is four years. There is no limit to the number of times a member may be reappointed, as long as each appointment is no longer than four years in duration. Appointment terms are generally staggered to ensure business continuity as well as provide an opportunity for Boards to gain additional skills and knowledge with new members.

Section 24A of the HHB Act also provides for temporary HHB member appointments to be made for a period of six months, with the option for a further six month extension up to a total appointment of 12 months. Before making a temporary appointment, the Minister must believe it is necessary to urgently appoint a person as a member for one of three reasons:

- that the Board does not consist of at least five members, as required under section 23(1) of the HHB Act;
- that the Minister considers the members of the board do not have the skills, knowledge or experience to perform the boards functions effectively or efficiently, as required under section 23(2) of the HHB Act, or
- none of the members are clinicians, as required under section 23(3).

The Minister is not required to advertise for members of the HHB before making a temporary appointment. Temporary appointments are advised via gazette notice, as soon as practicable after appointments are made.

9.2.1 Recruitment process

All recruitment activities must be conducted in an open and transparent manner, and with the purpose of generating a pool of suitable candidates, consistent with the Minister’s Guidelines for recruitment, selection and nomination of persons to health statutory agencies (Recruitment Guidelines) available at:


The Recruitment Guidelines outline the Minister’s expectations in relation to the processes for recruitment and selection of HHB members, including, for example:

- requirements for advertising for expressions of interest
- requirement for performance of a HHB skills assessment to inform shortlisting and selection
- requirements for selection panels.

For HHB scheduled expiries (in May each year), a department-managed recruitment and selection exercise will be conducted. The department may engage independent recruitment expertise to support this process. For ad-hoc HHB vacancies (for example, to fill a vacancy in

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13 Section 24 of the HHB Act requires that the Minister, prior to recommending persons for membership of a HHB, must advertise for expressions of interest from suitably qualified persons interested in being members of board. The department or HHBs undertake this activity on behalf of the Minister.
office due to the resignation of a member) that cannot be grouped with scheduled expiries, recruitment is generally managed locally unless otherwise agreed.

Selection panels will be convened centrally for all recruitment rounds and provide their recommendations to the Minister.

The Minister may decline recommendations of nominees for any reason. Confirmation of appointment is subject to the successful completion of probity checks (see below) and approval by the Premier, Cabinet, and the Governor in Council.

The department’s Office of Health Statutory Agencies coordinates the management of recommendations to the Minister and works with HHB Chairs, HHB Secretariats, the Cabinet and Parliamentary Services Unit and Department of the Premier and Cabinet to facilitate and support the timely processing of nominations.

The diagram below provides an indicative timeline for key steps:

9.2.2 Probity checks

Nominations to the Governor in Council are made by way of a Significant Appointment briefing to Cabinet. To inform Cabinet consideration, and to ensure the required eligibility requirements of HHBs are met, the Office of Health Statutory Agencies undertakes a number of background checks, including:

- criminal history search
- consideration of declarations of interest and other matters as outlined in a personal particulars form
- review of Australian Securities and Investments Commission (ASIC) insolvency, and banned and disqualified registers
- review of lobbyist and consultancy registers
- general internet search.

These checks are consistent with the legislative requirements for members, recruitment guidelines, and with the selection process and due diligence checks required to be undertaken on potential nominees to all Health portfolio statutory agencies. It is a requirement that all members seeking reappointment to statutory bodies in Queensland also undertake these required checks, regardless of their length of prior service.

Following the successful completion of probity checks, and dependent on other business scheduled, the Cabinet submission process and consideration by the Governor in Council may take a further six to eight weeks to complete.
9.2.3 Board member resignation or removal from office

Members may resign from office at any time by written notice. A member who has been appointed as chair or deputy chair may choose to resign from their respective positions yet may still continue to serve as a board member for the remainder of their original tenure.

Under sections 27A and 28 of the HHB Act, a member may be suspended or removed from office by the Governor in Council if a member is insolvent, disqualified from managing corporations, convicted of an indictable offence, or convicted of an offence against the Act.

The Minister may recommend the removal of a member if they are satisfied the member has been guilty of misconduct, is incapable of performing their duties, has neglected their duties or performed them incompetently, or has been absent without permission of the HHB from three consecutive meetings of which due notice was given. The Minister may also suspend a member from office by written notice to the member if a matter arises and the matter is/may be grounds for removal under section 28 or is alleged misconduct and the Minister considers it necessary in the public interest.

Based on the recommendation of the Minister, the Governor in Council may appoint a replacement chair, deputy chair or member to the board. Recruitment and selection of replacement nominees would generally be undertaken locally in accordance with the Recruitment Guidelines and submitted to the Minister for consideration. The replacement board member would initially be appointed for the duration of the tenure of the person they are replacing (after which they may be nominated for a further term).

9.2.4 Leave of absence

Members are to provide notification of any pending leave to the Board Chair. If the member is the Chair, then notification of pending leave and acting arrangements must be provided to the Minister and Executive Workforce Services. Note, section 25(6) of the HHB Act provides that the deputy chair is to act as chair during all periods when the chair is absent from duty or for another reason cannot perform the duties of the office.

9.2.5 Appointment of Administrator

In the event of a vacant HHB, due to dismissal, resignation or expiry of all members, the HHB Act enables the Governor in Council to appoint either the Director-General or other person to act as an Administrator of an HHS.

If appointed, an Administrator assumes the role of the HHB, which includes oversight of the HSCE. Operational responsibility for patient care remains with the HSCE. The Governor in Council may revoke the post of Administrator, either to appoint a different person or to appoint a new HHB, at any time.

9.3 Remuneration

The Governor in Council approves the remuneration arrangements for HHB chairs, deputy chairs and members. Chairs, deputy chairs and members are paid an annual board fee and annual sub-committee fee (for each statutory committee) consistent with the Government procedures titled: Remuneration procedures for part-time chairs and members of Queensland Government bodies (the Remuneration Procedures). The Remuneration Procedures are available at:

HHBs have been assessed as ‘Governance’ entities under the Remuneration Procedures and grouped into different levels of a remuneration matrix based on a range of indicators including: revenue/budget, net and total assets, independent, risk and complexity. HHBs in the higher level have been allocated into two sub-groups based on the weight of their indicators.

The table below outlines annual fees effective from 18 May 2014, applicable for the payment of board chairs, deputy chairs and members under the Remuneration Procedures. All fees are assessable for income tax purposes.

<table>
<thead>
<tr>
<th>HHB</th>
<th>Annual board fees</th>
<th>Annual sub-committee fees (per statutory committee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold Coast, Metro North, Metro South,</td>
<td>Chair: $85,714</td>
<td>Chair: $4,000</td>
</tr>
<tr>
<td>Sunshine Coast, Townsville</td>
<td>Deputy chair and members: $44,503</td>
<td>Member: $3,000</td>
</tr>
<tr>
<td>Cairns and Hinterland, Central Queensland,</td>
<td>Chair: $75,000</td>
<td>Chair: $4,000</td>
</tr>
<tr>
<td>Children’s Health Queensland, Darling</td>
<td>Deputy chair and members: $40,000</td>
<td>Member: $3,000</td>
</tr>
<tr>
<td>Downs, Mackay West, Moreton, Wide Bay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central West, North West, South West,</td>
<td>Chair: $68,243</td>
<td>Chair: $2,500</td>
</tr>
<tr>
<td>Torres and Cape</td>
<td>Deputy chair and members: $35,055</td>
<td>Member: $2,000</td>
</tr>
</tbody>
</table>

9.3.1 Payment procedures

HHB chairs, deputy chairs and members are paid via the HHS’s payroll system on a fortnightly basis directly into a bank or building society account. A pay advice slip is available via the Payroll Self Service or where requested, sent to the member’s nominated (usually home) address when they have been paid.

Employment Commencement Forms to establish HHB members on the payroll system and other relevant forms are coordinated at a local HHS level. HHB chairs, deputy chairs and members are allocated an employee ID number and a position ID number—these numbers are to be referred to in all documentation regarding payments and expenses.

9.3.2 Superannuation

HHB members will be eligible for superannuation payments at the employer contribution rate of 9.50 per cent (as of 1 July 2014) of ordinary time earnings where he/she:

- works more than 10 hours per week
- receives more than $450 remuneration in a single calendar month
- earns 50 per cent or more of the tax-free threshold in a continuous 12 month period
- is less than 75 years of age.

The Queensland Government industry superannuation fund is QSuper, however members may choose their own superannuation fund by completing a Standard Choice Form (NAT 13080). There is also the option of additional voluntary employee contributions.

9.3.3 Taxation

The fees paid to chairs and members of government boards are assessable under the Income Tax Assessment Act. The employer (the department) also has PAYG withholding obligations.

The HHB chair and members are treated as ‘employees’ for Fringe Benefits Tax (FBT) purposes and are subject to the normal FBT rules.
However they may be eligible to access the Public Benevolent Institution (PBI) FBT Exemption Cap (currently $17,000 grossed-up). This will depend on whether the member has another ‘non-FBT concessional’ position and may also be impacted by other non-salary packaging fringe benefits.

Individuals should seek advice from the HR department of the HHS and their own financial adviser to clarify their personal financial circumstances.

### 9.3.4 Board members who are public sector employees

Public sector employees, employed either part-time or full-time, who are appointed as part-time chairs or members of government boards (including HHBs) are not to be paid daily or annual fees except where this is approved by the government (through a submission to Cabinet). The approval can be sought for board nominees where the employee’s chief executive provides a certification.

The certification specifies that the named individual’s appointment to a HHB is not connected in any way with his/her employment and he/she is eligible to receive fees when he/she attends meetings and undertakes board business:

- outside the hours he/she normally would be expected to work
- when he/she is on unpaid leave.

A copy of the certification is sent to the individual board member and the board secretariat for on-forwarding to the board chair and the local payroll area.

Where a public sector employee is not certified to receive fees and attends board meetings during the employee’s ordinary work hours, normal public service conditions apply. The employee’s chief executive may approve overtime or time off in lieu for attendance at meetings, where the employee has such an entitlement. Other conditions such as travel allowance might also apply.

In accordance with the remuneration procedures, public sector employees are defined as employees of federal, state or local governments, employees of semi-government organisations, either federal or state, including statutory authorities and employees of state and local government owned corporations and colleges. For the purposes of these procedures members of any parliament within Australia, elected local government representatives, judges, magistrates and other judicial and quasi-judicial officers are also regarded as public sector employees. Paid officials or employees of universities are not included in this category.

### 9.3.5 Significant travel

The annual fees are an all-encompassing fee which accounts for the time taken for significant travel. Chairs and members of HHBs are therefore not to be paid an additional fee for significant travel.

### 9.3.6 Out of pocket expenses

Chairs and members are eligible to be reimbursed for all necessary and reasonable expenses incurred while travelling on approved HHB business and to attend meetings including:

- economy class air travel
- motor vehicle allowances as varied from time to time by the Governor in Council (refer to the rates outlined in Attachment 3 of the Remuneration Procedures)
- domestic travelling and relieving expenses as varied from time to time by the Governor in Council (refer Attachment 3 of the Remuneration Procedures).
Legitimate HHB chair/member expenses will be paid either directly by the HHS, or reimbursed to the chair/member (where initially paid personally) upon provision of original tax invoices and/or other appropriate supporting documentation.

HHB Chairs, Deputy Chairs and members should ensure they are compliant with whole-of-government policy related to personal expenses, such as the allowances listed above.

9.3.7 Corporate cards

Queensland Treasury has previously advised that issuing Queensland Government corporate credit cards to HHB members would be inconsistent with Treasury’s guidelines and therefore not appropriate.

9.4 Board induction

HHBs are locally responsible for comprehensively inducting new board members. The department provides this Handbook outlining system-wide issues related to health service delivery, which might usefully supplement local induction content.

DPC publishes general guidance for current and intending Government Board members called Welcome Aboard: A Guide for Members of Queensland Government Boards, Committees and Statutory Authorities. It includes guidance on the induction of Government Board members, including induction checklist. Welcome Aboard is available at:


To ensure board effectiveness, boards should also identify, plan and fulfil the ongoing training and education needs of members. The department is committed to working in partnership with boards to strengthen the skill mix and expertise of Board members. There are a range of development opportunities coordinated and co-funded by the department from time to time that may support the induction and professional development of board members.

9.5 Board performance

It is best practice governance to routinely evaluate board and committee performance. An effective assessment would ideally identify areas for improvement in the practical operations of the board (such as format and length of meetings) as well as individual or collective skills gaps where board development programs should be targeted.

HHBs are accountable to the Minister for their performance and conduct. The Board and Board Committee Charters/Terms of Reference generally specify any requirements in relation to regular performance review or assessment of collective HHB performance and individual HHB member performance. These assessments may take a variety of forms and be conducted internally or with external assistance.
9.6 Conduct of Board business

The HHB may conduct its business, including its meetings, in the way it considers appropriate and in line with the matters outlined in schedule 1 of the HHB Act. The table below summarises some of the requirements.

<table>
<thead>
<tr>
<th>Board business</th>
<th>Requirements (as per Schedule 1 of the HHB Act)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Times and places of meetings</td>
<td>The Chair is responsible for deciding the times and places of meetings and must call a meeting if asked in writing, to do so by the Minister or at least the number of members forming a quorum for the board.</td>
</tr>
<tr>
<td>Quorum</td>
<td>A quorum for a meeting of the board is one-half the number of its members, or if one-half is not a whole number, the next highest whole number.</td>
</tr>
<tr>
<td>Presiding at meeting</td>
<td>If present, the Chair presides, or in the Chair’s absence the Deputy Chair. Where neither the Chair nor Deputy Chair are present at a meeting, a member of the board chosen by the members is to preside.</td>
</tr>
<tr>
<td>Voting at meetings</td>
<td>A question at a meeting of the board is decided by a majority of the votes of the members present. Each member present at the meeting has a vote on each question to be decided, and if the votes are equal, the member presiding also has a casting vote. A member present at the meeting who abstains from voting is taken to have voted for the negative.</td>
</tr>
<tr>
<td>Use of technology for meetings</td>
<td>The board may hold meetings, or permit members to take part in meetings, by using any technology that reasonably allows members to hear and take part in discussions as they happen, for example, teleconferencing. A member who takes part in meetings via technology is taken to be present at the meeting.</td>
</tr>
<tr>
<td>Out of session resolutions</td>
<td>A board may make valid resolutions outside of a board meeting if a majority of board members gives written agreement to the resolution, and notice of the resolution is given under procedures approved by the board.</td>
</tr>
<tr>
<td>Minutes</td>
<td>The board must keep minutes of meetings and any resolutions made out of session. If asked to by a member who voted against the passing of a resolution, the board must record in the minutes that the member voted against the resolution.</td>
</tr>
<tr>
<td>Committees of the Board</td>
<td>The board must establish prescribed committees and may establish and determine the terms of reference of other committees for effectively and efficiently performing its functions. The board may decide the way a committee must conduct meetings. Refer to section 7.4 of the Handbook for more information on committees.</td>
</tr>
<tr>
<td>Disclosure of interests at board or committee meetings</td>
<td>If a member of the board or committee has a direct or indirect conflict of interest in an issue being considered, or about to be considered, by the board or committee, the person must disclose the nature of the interest to a board or committee meeting. The disclosure must be recorded in the board or committee minutes. Unless the board or committee otherwise directs,* the interested person must not be present during consideration of the issue or take part in a decision about the issue. If the absence of the interested person affects the quorum, the remaining persons present are a quorum of the board or committee for considering or deciding the issue or whether to give a direction. The interested person must not be present when the board or committee is considering whether to give a direction to the interested person.</td>
</tr>
</tbody>
</table>

The HHB Charter would generally outline the governance arrangements and HHB processes

9.7 Publishing board meeting outcomes

The HHB Act requires each HHS to develop and publish a clinician engagement strategy, a consumer and community engagement strategy, and a protocol with local primary healthcare organisations (see Part 2 Division 4 of the Act). The engagement strategies and protocol must comply with minimum requirements prescribed in Part 4 of the HHB Regulation. As part of the engagement strategies and protocol, the Regulation requires a summary of the key issues discussed and decisions made at each board meeting to be made available (subject to the Board’s obligations relating to confidentiality and privacy) as follows:

- to health professionals working in the HHS
- to consumers and the community
- to the HHS’s local primary healthcare organisations.
- Most HHSs fulfil this requirement by publishing meeting summaries on their local website.
Appendix 1: List and map of Hospital and Health Services

Hospital and Health Service names and service areas are declared in the HHB Regulation.

- **Statewide**
  - Children’s health Queensland Hospital and Health Service

- **Metropolitan**
  - Gold Coast Hospital and Health Service
  - Metro North Hospital and Health Service
  - Metro South Hospital and Health Service
  - Sunshine Coast Hospital and Health Service
  - Townsville Hospital and Health Service

- **Regional**
  - Cairns and Hinterland Hospital and Health Service
  - Central Queensland Hospital and Health Service
  - Darling Downs Hospital and Health Service
  - Mackay Hospital and Health Service
  - West Moreton Hospital and Health Service
  - Wide Bay Hospital and Health Service

- **Rural and Remote**
  - Central West Hospital and Health Service
  - North West Hospital and Health Service
  - South West Hospital and Health Service
  - Torres and Cape Hospital and Health Service
A more detailed interactive map of the hospital and healthcare facilities in each HHS is available on the Queensland Health website at:

Appendix 2: List and map of Queensland Primary Health Networks

- Brisbane North
- Brisbane South
- Gold Coast
- Darling Downs and West Moreton
- Western Queensland
- Central Queensland, Wide Bay and Sunshine Coast
- Northern Queensland

Link to map and further information available on the Australian Government Department of Health website:

## Appendix 3: Abbreviations/acronyms

This table provides a list of abbreviations and acronyms used frequently throughout the Handbook.

<table>
<thead>
<tr>
<th>Abbreviation/acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>The department</td>
<td>Queensland Department of Health (unless otherwise indicated)</td>
</tr>
<tr>
<td>Director-General</td>
<td>Director-General, Department of Health (unless otherwise indicated)</td>
</tr>
<tr>
<td>DPC</td>
<td>Department of the Premier and Cabinet</td>
</tr>
<tr>
<td>FAA</td>
<td>Financial Accountability Act 2009</td>
</tr>
<tr>
<td>FPMS</td>
<td>Financial and Performance Management Standard 2009</td>
</tr>
<tr>
<td>HHB</td>
<td>Hospital and Health Board</td>
</tr>
<tr>
<td>HHB Act</td>
<td>Hospital and Health Boards Act 2011 (HHS enabling legislation)</td>
</tr>
<tr>
<td>HHB Regulation</td>
<td>Hospital and Health Boards Regulation 2012</td>
</tr>
<tr>
<td>HHS</td>
<td>Hospital and Health Service</td>
</tr>
<tr>
<td>HSCE</td>
<td>Health Service Chief Executive</td>
</tr>
<tr>
<td>Minister</td>
<td>Queensland Minister for Health (unless otherwise indicated)</td>
</tr>
<tr>
<td>NHRA</td>
<td>National Health Reform Agreement</td>
</tr>
<tr>
<td>QHEPS</td>
<td>Queensland Health Electronic Publishing Service (intranet)</td>
</tr>
<tr>
<td>SBFAA</td>
<td>Statutory Bodies Financial Arrangements Act 1982</td>
</tr>
<tr>
<td>SDS</td>
<td>Service Delivery Statement/s</td>
</tr>
<tr>
<td>Treasury</td>
<td>Queensland Treasury</td>
</tr>
<tr>
<td>QAO</td>
<td>Queensland Audit Office</td>
</tr>
</tbody>
</table>
Appendix 4: Useful websites and resources

Queensland Government websites

- Contact details for all Hospital and Health Service CEOs and HHBs
  [link]
- Office of the Information Commissioner [link]
- Office of the Integrity Commissioner [link]
- Queensland Audit Office website [link]
- Queensland Health website [link]
- Queensland Legislation [link]
- Queensland Public Service Commission [link]

Useful reading and resources

Chief Health Officer reports
[link]
The health of Queenslanders is a report from the Chief Health Officer to inform Queenslanders about the health status of the population. This report is published every two years and commenced in 2006. With the goal to continue to improve health outcomes, information from these reports informs and guides Queensland Health, Hospital and Health Services and other key stakeholders around service planning.

Queensland Regional Profiles and Statistical Reports (Queensland Treasury)
[link]
The profiles are informative statistical reports on a range of Queensland community types, for example, local government areas and are generated automatically using the latest demographic, social and economic data available.

Queensland Aboriginal and Torres Strait Islander Economic Participation Framework
[link]
This framework will be used to engage with communities, industries and across different levels of government to identify actions and strategies to increase Aboriginal and Torres Strait Islander economic participation.

Queensland Treasury Publications and Resources
[link]

Queensland Audit Office: Leading Accountability—Governance
[link]

Queensland Audit Office: ‘Audit and risk committee series’ newsletter
[link]