RTI 3441 Release Notes

RTI #3441 - The most recent Patient Safety and Quality Audit of Torres Cape Hospital and Health Services (TCHHS)

Background

The TCHHS audit was commissioned by the Queensland State Government as an election promise (Nursing Guarantee) and administered by independent auditors from The Australian Council on Healthcare Standards. The audit was conducted across each Queensland Hospital and Health Service between 1 February 2016 and 30 June 2016. This audit represents the most recent Patient Safety and Quality Audit of Torres Cape Hospital and Health Services (TCHHS)

The TCHHS achieved an excellent audit rating of 127 (98.4%) of a possible 129 criterion.

Inaccuracies in the report

The document erroneously states on page 18 that "15" policies were in place at the time of the audit. This was a typographical error, as the TCHHS had more than 45 policies and over 700 procedures at this time.

Post-audit actions

The audit identified two partially implemented criterions. The TCHHS has implemented the following steps to meet the required criteria:

- The TCHHS has implemented a shared credentialing repository which is now available to TCHHS staff to check credentials and scope of practice online.
- Processes are in place to ensure timely analysis of Severity Assessment Code 1 (SAC1) clinical incidents provision to the Department of Health Patient Safety and Quality Improvement Service.

Queensland Health Patient Safety Audit

Torres and Cape Hospital and Health Service Report

Prepared by:
The Australian Council on Healthcare Standards
Consultancy Services

PATIENT SAFETY AUDIT TOOL (PART 1)

Auditors	Mr Peter Clout and Mr Kevin Freele	**Date**	3-4 May 2016
Organisation	**Torres and Cape Hospital and Health Service**		

Audit title
PATIENT SAFETY AUDIT (QUEENSLAND HEALTH) – Audit Tool

Part 1 - Hospital and Health Boards Regulation 2012

A	**AUDIT CRITERIA**	Reference	**YES**	Partially implemented	**NO**	**NA**
1	There is a prescribed Safety and Quality Committee of the HHS Board	*HHB Regulation Part 7 Section 31*	3			
2	The Committee's functions (Terms of Reference) align to those detailed in Part 7 Section 32 *Hospital and Health Boards Regulation 2012*	*Part 7 Section 32*	3			
3	There is evidence that the Board receives regular reports from the Safety and Quality Committee[17]	*Part 7 Section 32 (a)*	3			

[17] *The Board is required to establish a committee but the committee must still* ***advise*** *the Board on the Service's safety and quality matters*

4	***The reports incorporate:*** ww. In hospital mortality VLAD indicators xx. Unplanned readmission VLAD indicators yy. Healthcare Associated Infections zz. **Rate of Seclusion**[18] aaa. Clinical audit outcomes bbb. Consumer feedback / complaints	*HHS Service Agreement – Schedule 3 KPIs* *HHB Regulation Part 7 Section 32 (a) ii and iii*	3 3 3 3 3			**N/A**
5	The HHS monitors compliance with the Service's policies	*HHB Regulation Part 7 Section 32 (b)*	3			
6	The HHS takes timely action to rescind obsolete policy documents		3			
7	The HHS monitors compliance with the Service's plans	*HHB Regulation Part 7 Section 32 (b)*	3			
8	Policies and plans are easily accessible for all staff		3			
	Rating (maximum = 36) *Overall rating will be adjusted for those HHS where NA is agreed*					**36**
Comments: A4d: TCHHS does not have inpatient mental health beds. All patients requiring admission are transported to Cairns and Hinterland HHS. A4e: National Safety and Quality Health Service (NSQHS) Standards audits are included in the Board subcommittee report to the Board. The TCHHS Strategic Plan 2016 has been sent to the Premier and Cabinet Office for approval. The Board Safety and Quality (S&Q) subcommittee has a work plan 2015-16 which includes performance KPIs on clinical and People & Culture performance. Strategic document reviews regarding clinician engagement, clinical governance and workforce strategy are reported to the Board annually.						

[18] KPI Rate of Seclusion only applicable at Cairns and Hinterland, Central Queensland, Children's Health Queensland, Darling Downs, Gold Coast, Mackay, Metro North, Metro South, Sunshine Coast, Townsville, West Moreton and Wide Bay

Part 2 - HHS Service Agreement (Section 14)

B	AUDIT CRITERIA	Reference	YES	Partially implemented	NO	NA
1	All persons who provide a clinical service, and who fall within the scope of current credentialing policies (including medical, dental, nursing, midwifery and allied health) have a current documented scope of clinical practice.	*HHS Service Agreement Section 14.2*	3			
2	All persons (as above) practice within that scope and within the scope of the Clinical Services Capability Framework (CSCF)	*HHS Service Agreement Section 14.2*	3			
3	How is this monitored? https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/service-delivery/cscf/cscf-fundamentals-of-the-framework.pdf *(Health Service Chief Executives are responsible for CSCF compliance, monitoring and reporting, provision of services within each service capability level)*	Part 8 (page 23)	Good monitoring in place - 3			
4	The HHS undertook a baseline self-assessment in September 2014 against the CSCF.	*HHS Service Agreement Section 14.2*	3			
5	The HHS has a process in place to ensure approval for any new procedure / technology undertaken by the HHS		3			
6	A process exists to notify the Department of Health regarding any change that occurs to the CSCF	*HHS Service Agreement Section 14.2*	3			
7a	There is a position that is allocated accountability for this process		3			
7b	**The position title is:** Director Quality and Safety					

Rating (maximum = 21)		**21**

Comments:
The TCHHS places a high value on the CSCF and, as such, it is presented at nursing forums to improve understanding.

At the TCHHS S&Q Clinical Governance Committee the CSCF is a standing agenda item to monitor any changes to the CSCF levels.

Part 3 - HEALTH SERVICE DIRECTIVES - **Patient Safety (QH-HSD-032:2014)**

C	AUDIT CRITERIA	Reference	YES	Partially implemented	NO	NA
1	The HHS has a system in place for reporting clinical incidents.	*QH-HSD-032:2014*	3			
2	All SAC1 incidents are reported in PRIME within one (1) business day of becoming aware of the event.	*QH-HSD-032:2014*	3			
3	A SAC1 analysis and report is submitted to the Patient Safety Unit of the Department of Health within 90 calendar days of the initial report.	*QH-HSD-032:2014*		2		
4	Each analysis contains; y. A factual description of the event z. The factors identified as having contributed to the event aa. Recommendations to prevent or reduce the likelihood of a similar event happening again	*QH-HSD-032:2014*	3			
5	The HHS has a clear process for determining reportable deaths and submitting the relevant information to the State Coroner		3			
6	All responses to Coronial recommendations are submitted to the Patient Safety Unit within 90 days of the Inquest Findings.	*QH-HSD-032:2014*	3			
7	All lower level 2 and 3 VLAD flags and statistically significant National Patient Safety Indictors Review Responses are submitted to the Patient Safety Unit.	*QH-HSD-032:2014*	3			
8	The HHS conducts a review of all lower level 2 and 3 VLAD flags and statistically significant National PSI.	*QH-HSD-032:2014*	3			

9	A Review Response (level 2 and 3 VLAD and PSI) is provided to the Patient Safety Unit within 30 calendar days	*QH-HSD-032:2014*	3			
10	Patient safety issues that have the potential to impact on the safety of patients in other health services are reported to the Patient Safety Unit	*QH-HSD-032:2014*	3			
	Rating (maximum = 30)					**29**

Comments:

C3: TCHHS agrees that not all of the SAC1 analysis and reports are submitted to the PSU within 90 days. This is an area where increased effort is being made in order to meet requirements. The lack of a trained Patient Safety Officer to lead the SAC1 analysis is often the reason for delays.

TCHHS has not had any Coronial recommendations or any lower level 2 and 3 VLAD flags to report to the PSU.

Part 4 - HEALTH SERVICE DIRECTIVES – **Credentialing and defining the scope of clinical practice (QH-HSD-034:2014)**

D	AUDIT CRITERIA	Reference	YES	Partially implemented	NO	NA
1	The HHS is accredited against the National Safety and Quality Health Service Standards	*HHS Service Agreement 14.1.1*	3			
	Credentialing and Scope of Practice					
2	The HHS has a policy that describes the process for credentialing and determining scope of clinical practice	***QH-HSD-034:2014***	3			
	Medical Practitioners and Dentists					
3	The HHS has established a Medical Advisory Committee (MAC) to provide advice and make recommendations about matters that relate to medical practitioners.					**N/A**
4	A credentialing sub-committee may be established as a sub-committee of the MAC *(Minutes / evidence of an effective system)*		3			
5	All AHPRA registered medical practitioners and dentists are issued with a current documented scope of practice covering all work performed	*QH-HSD-034:2014*	3			

6	The HHS has established a Shared Credentialing Repository and a minimum data set for each eligible practitioner	*QH-HSD-034:2014*		2		
7	The HHS undertakes compliance audits related to scope of practice	*QH-HSD-034:2014*	3			
8	There is an appeals process for determinations in relation to scope of clinical practice.	*QH-HSD-034:2014*	3			
9	The HHS has a process in place that ensures any adverse event where the contributing factor related to credentialing or scope of clinical practice, is reported (via a briefing) to the DG	*QH-HSD-034:2014*	3			
	Nurse Practitioners					
10	All nurse practitioners hold a current endorsement as a nurse practitioner under the *Health Practitioner Regulation National Law Act 2009 (Qld)* and have no restrictions on practice	*QH-HSD-034:2014*	3			
11	Health professionals employed or engaged in a position that requires endorsement as a nurse practitioner are credentialed and issued with a current, document scope of clinical practice covering all clinical work performed.	*QH-HSD-034:2014*	3			
12	Credentialing decisions are professionally led with appropriate nursing representation.		3			
	Mental Health Nurses and Mental Health Nurse Practitioners					
13	The HHS supports all registered nurses working with mental health nursing qualifications working within identified mental health and alcohol and drug treatment service settings to be credentialed with the ACMHN 'Credential for Practice Program'	*QH-HSD-034:2014*	3			
	Eligible Midwives					
14	All eligible midwives hold current general registration as a midwife in Australia with no restrictions on practice and a notation on the register as an eligible midwife	*QH-HSD-034:2014*				NA
15	The HHS has appropriate professional indemnity insurance arrangements in place for midwifery practice	*QH-HSD-034:2014*				NA
16	Midwives employed or engaged in a position requiring eligibility are credentialed and issued with a current, documented scope of clinical practice covering all clinical work performed	*QH-HSD-034:2014*				NA
17	Credentialing decisions are professionally led with appropriate midwifery representation.	*QH-HSD-034:2014*				NA

	Allied Health Professionals					
18	The HHS has ensured that all allied health professionals engaging in complex clinical practices not traditionally performed by their profession are credentialed and have a documented defined scope of clinical practice	QH-HSD-034:2014				**NA**
19	Any allied health professional working in the public health system but ***not employed*** by a HHS are credentialed and have a document defined scope of clinical practice.	QH-HSD-034:2014	3			
20	The HHS has mechanisms in place to support activities for all allied health professionals regardless of the allied health professional's clinical area, career stage, location or profession specialty.	QH-HSD-034:2014	3			
	Rating (maximum = 42					**41**

Comments:

D1: The Cape sector of the HHS was accredited in 2013 by QIP with the next review due in 2017. The Torres sector of the HHS was accredited in 2014 by ACHS and due for a Periodic Review in 2016. The entire TCHHS will seek accreditation under QIP in 2017.

D6: The Rural & Remote Clinical Support Unit manages all medical and dental credentialing for TCHHS and three other rural HHHS.

The TCHHS facility nurses cannot access medical or dental officers' credentials and scope of practice online.

General comments:
The Torres and Cape HHS complies well with the obligations pursuant to the legislation and regulations. Additional effort is being made to ensure SAC1 analysis and reports are sent to the PSU within the required timeframe. The HHS noted that the highest CSCF level for any of the three hospital facilities is level 3 and that the majority of the clinical focus is on primary health care and prevention. The EDMS was scheduled for interview but could not attend due to clinical demands.

Section	HHS Score
Part 1	36
Part 2	21
Part 3	29
Part 4	41
Total Maximum Rating = 129	**127 (98.4%)**

SEMI-STRUCTURED INTERVIEWS (PART 2)

Auditors	Mr Peter Clout and Mr Kevin Freele	**Date**	3-4 May 2016
Organisation	Torres and Cape HHS		
Interviewees	Dr Jill Newland - Health Service Chief Executive Dr Ruth Stewart - Board Deputy Chair and Chair Board Safety & Quality subcommittee Mr Leigh Broad - Director Quality & Safety Ms Isobel Moase - Quality Coordinator Mr Gordon Mayne - Credentialing Officer, RRCSU Ms Fiona Hall - Director Allied Health Ms Lyn Wardlaw - ED Nursing & Midwifery		

Audit title
PATIENT SAFETY AUDIT (QUEENSLAND HEALTH) – semi structured interview

	Aspect	Question	Response
Structure	**Responsibility / Accountability for Clinical Governance** *A key accountability of the chief executives of public health organisations is to ensure that the clinical governance and quality assurance structures and processes are known, respected and followed by all staff.*	**Are you aware of the regulations that govern safety and quality in Queensland Health? Does the legislation and regulations contribute to effective clinical governance of the HHS?** Yes – the regulations and legislation support a clear governance structure. There are challenges in the TCHHS however the clinical governance structure is working - challenges in implementing quality in remote areas, it takes time to implement. One respondent's view was that QLD Health KPI reports are not particularly helpful in this HHS as its services are more primary care focused and less acute hospital focused. **Are you confident that the HHS complies with these regulations? Describe why you are confident.** TCHHS is confident that it complies and knows this by the reports, performance measures, feedback and investigations conducted. **Do you believe that there are clear lines of responsibility and accountability for clinical care in your health service and that these are well communicated?** Yes – the Board receives a monthly report from the Chair of the Safety & Quality subcommittee which distils key safety and quality issues. The Director S&Q provides a comprehensive report from the HHS to the Board S&Q subcommittee which is rigorously reviewed. Full copies of RCA reports, analysis and recommendations are made available to the Board S&Q subcommittee. **How does clinical governance operate within the organisation's overall governance system?** Two Health Service Districts (HSD) - Cape York HSD and the Torres and Northern Peninsula HSD - merged in 2014, becoming the TCHHS under one Board. There is a General Manager for the north and a General Manager for the south. It was reported that there is a slightly different governance structure for the north and south tailored to the unique community needs. It was reported that the structure works well for the TCHHS.

		There are leadership teams in Weipa, Cooktown and Thursday Island – where the three hospitals are situated. The teams include the Director of Nursing, corporate services, Medical Superintendent and senior doctors. The Board has 1 in 3 board meetings outside of Cairns in Weipa, Cooktown or Thursday Island, providing opportunity to consult with staff and the community. Comprehensive S&Q reports are provided to the Board and Executive team. These include incidents, KPI performance, Office Health Ombudsman reports, credentialing, work plan progress updates and clinical outcome data.
	Resources to support Clinical Governance *To attract clinicians with leadership capability to clinical management roles, the positions need to be genuinely supported by management, and recognised and promoted as having influence*. *There should be clear rules of engagement between clinical directors, general managers and the local health district executive to ensure that all parties have appropriate input into the development, operation and standard of clinical services within their facilities and across their*	**Describe how clinical governance is supported in your health service? What positions exist?** Director Q&S – 1 FTE – position reports to EDMS Reporting to this position are: Patient Safety Officer - 2 FTE CNC Infection Control & Prevention – 2 FTE Policy & Clinical Document Manager – 1 FTE Quality Coordinator – 1 FTE Compliance & Risk Coordinator – 1 FTE Records Management Officer – 1 FTE Quality Data Officer – 1 FTE Community Liaison Officer - 1 FTE Business Support Officer – 1 FTE **Describe how clinician engagement occurs?** There is a Clinician Engagement Strategy ("Getting There"), recently reviewed and available on the intranet. Through the multidisciplinary M&M meetings, Medical Superintendent's meetings and S&Q meetings at each facility. There is no Clinical Council but there are plans to establish a multidisciplinary Council shortly.

	local health district.	**How are clinicians promoted as having influence?** Clinicians are involved in determining how to best engage with remote aboriginal communities. A doctor will go to the same island community for continuity and will stay once a month on the island over a weekend, often taking their family, to engage with the community. The experience and learnings are reported back up the line of management.
	Committee structure • *QAC* • *Qualified Privilege*	**Describe the committee structure that supports safety and quality / clinical governance** RCAs are privileged; no other committees are privileged. **How is the effectiveness of the committee structure monitored and individual committees formally assessed for achieving their terms of reference?** All terms of reference (TORs) are reviewed annually. A view was expressed that the effectiveness of some committees (not named) could be improved.
	Plans	**How much time/effort/resources/ community consultation is invested in developing the quality agenda?** TCHHS provided examples at local community level of the development and consultation on the quality agenda. The Board drives the community engagement across the HHS. The HHS is in the process of developing a ten year service plan which has had community input. It was reported that the Torres communities are more likely to be vocal and seek input compared to the Cape communities. **What attempts are made to look beyond the organisation for collaboration and innovation?** Examples included North QLD Primary Health Network, RFDS, Apunipima Cape York Health Council (a community controlled Aboriginal Health Organisation), James Cook University (dental), Cairns and Townsville regional 'ehealth' for primary health and the Papua New Guinea partnership with TCHHS on tuberculosis relations.
	Training and skills	**How, why and when are education and training programs about patient safety developed?**

	development	The Board supports Aboriginal and Torres Strait Islander staff to gain tertiary qualifications. In excess of 30 indigenous health workers are supported to gain Cert III or IV qualifications which achieve APHRA registration for Cert IV. **What do staff think of them?** Positive – good incentive. **How does the Board and the Executive of the HHS manage risk associated with introduction of new procedures and therapies?** There is a committee which monitors all requests before final approval is sought from the Executive Management Team. The TCHHS's new birthing service underwent full risk assessments and approval mechanisms prior to implementation.
	Consumer input	**How do consumers participate in health service governance, priority setting, strategic and quality planning? And assessment of outcomes?** Community participation is a "challenge", particularly in small remote communities in the Cape and on the Torres Strait islands. The indigenous communities are complex to engage with but the HHS is working with the North Queensland PHN and Apunipima on community engagement strategies that are relevant to each community. It was stated that what may work in one community may not necessarily work in the neighbouring community. TCHHS has a Consumer & Community Engagement strategy 2015-2018.
	Human resources	**Is a staff development and performance management system in place? Describe how the system is reviewed and continually improved to ensure its on-going appropriateness for clinical service provision?** A Performance Appraisal and Development system is in place and completed annually. This provides an

		opportunity for staff to identify clinical professional development goals. **How does the organisation manage credentialing and establishing scope of practice (in accordance with QH-HSD-034:2014)?** The Rural & Remote Clinical Support Unit provides credentialing for all medical and dental staff. There are separate credentialing committees for Nursing and Allied Health.
Process	Written protocols and procedures	**How does the HHS establish and monitor compliance with the Service's policies?** There are in excess of 15 TCHHS policies. It has been a major task, still in progress, to align procedures and protocols across the Cape and Torres areas. Monthly newsletters are published which list new and reviewed procedures and PRIME incidents. This has led to new educational sessions being offered. **Does the HHS facilitate use of evidence-based guidelines and tools? How is this done?** The Primary Clinical Care Manual and the Chronic Condition Manual are evidenced-based guidelines for all staff and are consistently used in service provision.
	Audit	**The HHS has a system for clinical audit? Describe** The service has an audit schedule referencing the ten National Safety and Quality Health Service (NSQHS) Standards as well as other clinical KPIs. **How are clinical audit outcomes reported and to who/which committee?** Audit outcomes are reported to the HHS S&Q committee and then reported to the Board S&Q subcommittee.
	Incident reporting *There is a system in place*	**Which incident reporting system is in place?** PRIME is the reporting system. The HHS is a pilot site for RiskMan commencing in June 2016.

	*for clinical incident reporting, investigation (**RCA** or other method appropriate to the severity of the incident) and clinical incident management*	**How are reports of incidents received?** By email – all unconfirmed SAC1 incidents are reported directly to the EDMS, EDDON and HSCE. **How are incidents viewed – as an opportunity to blame or improve?** As an opportunity to improve. **Who investigates incidents and how are they investigated?** The Director S&Q initiates the investigation. Depending on the severity of the incident, a lower level manager might investigate. If the incident is SAC1 then Director S&Q will initiate team of three clinicians to conduct an investigation. It was acknowledged that additional staff need to be trained in RCA methodology.
	Clinical review	**Does the HHS monitor significant gaps between evidence-based best practice and current practice?** Monitored by the use of the Primary Clinical Care Manual which is updated every two years. Also monitor via PRIME incidents, complaints and KPI measures. **Is there a policy for clinical review and is training to undertake clinical review provided to clinicians?** There is a procedure for clinical review. The Clinical Incident policy has a flow chart which assists in determining which clinical review type is to be conducted (RCA, HEAPS or Clinical Review).
Outcome	Peer review and benchmarking	**Does the HHS benchmark core organisational safety and quality indicators and if so, how is this done and to whom is it reported?** It was stated that the HHS 'could do better' in benchmarking with other rural and remote services. Closing the Gap benchmarking, Queensland Bedside Audit and small hospital data reports. The Service would like to benchmark on rheumatic heart disease prophylaxis compliance.

Culture	Mission statements and values	**Were consumers involved in developing the missions and values of the HHS?** The Community Action Network (CAN) and the Health Action Team are advisory groups which were consulted. **How does the HHS uphold its values?** The Code of Conduct and values are emphasised at orientation and by leading by example 'living the values'. **Are the mission and values considered when engaging the media and communicating outside the HHS?** Yes **Are values considered in staff performance review?** The HHS values and the Code of Conduct are components of the performance appraisal tool.
	Induction programs	**Are all staff required to attend induction programs?** Yes, following which staff have a specific work site induction. **How is attendance monitored and reported?** Learning & Development monitor attendance. The Training Manager (an IT program) maintains records of staff mandatory training compliance. **How are the executive involved?** The HSCE attends every staff orientation program to welcome staff and give an overview of the TCHHS.
	There is a transparent and just culture that supports open disclosure and staff involved in	**How do you know a just culture exists in the HHS?** By reflective practice, asking questions. At the time of the two Health Districts amalgamation staff were "traumatised" but now there is strong movement towards a just culture.

	clinical incidents	Positive and negative feedback is given without fear of reprisal. The HSCE is very visible across the HHS spending 2-3 days each week out in the services. **What happens after an event/incident?** Incident reports go to the General Managers and Director S&Q and they report back to HSCE until all recommendations are implemented. HSCE sends out a memo or communiqués about learnings from clinical incidents.
	Team building	**What strategies does the HHS use to build effective teams?** The HHS has reviewed the management structure to improve team building and leaders have been identified and supported. There is a single point of accountability.
	Organisational learning ***Organisational learning*** *is the collective education in an organisation that has the capacity to impact an organisation's operations, performance and outcomes*	**What systems does the HHS have in place to maximise organisational learning?** Fruitful Friday is a monthly event by video link to discuss training opportunities, a current clinical topic and/or general issues for staff. Increased line manager training is being implemented.
	Conflict resolution *Not managing conflict can impact on patient safety*	**How is conflict viewed and managed in the HHS?** The views expressed were that yes, the HHS manages conflict well and is getting better at it. Policies and procedures support conflict management and resolution. **Are there/has there been examples of unresolved conflict that is negatively impacting on clinical care and patient safety?**

		None known.
Knowledge	Information management	**Does the IT system strategy include ensuring effective and efficient clinical management and decision support?** The iEMR is two years from implementation. The ICT strategy has been reviewed but not yet approved by the Board.
	Information technology	**Do all staff have easy access to information systems including email, internet, intranet, HHS drives?** Staff have access to email, inter and intranet sites and the IT drives within each site. An IT issue raised was that there are different drives used at each site but none can be accessed outside of the site. Bandwidth issues in remote sites and power supply can be a problem at times. Infrastructure advances have been made. TCHHS, RFDS and Apunipima all provide primary care but cannot share clinical documents between each other.
		What knowledge management strategies are in place to support evidence-based care and access to evidence-based guidelines and tools? Access to QH guidelines and tool on QHEPS.

From your perspective, how has clinical governance has produced specific changes to the delivery of care in the HHS? And what have these changes been?
(Fewer patient complaints Less unjustified variation in clinical practice/Less use of ineffective investigations and treatments/Better use of resources/Increased patient satisfaction/Documented changes in clinical practices/Specific improvements in patient care/Closer working between clinicians and managers/Positive changes in organisational culture/Better at managing changes in clinical practice/Board now more informed about quality of care)

- The Service has used data to improve speech pathology and podiatry services and increased FTE.
- A Telepharmacy service in Weipa is in trial phase.
- New models of care in renal, maternity and TB management have been introduced.
- The recognition of unique KPIs which this service needs to check e.g., diabetes, smoking rates and rheumatic heart disease.

OTHER COMMENTS

TCHHS is the most rural and remote HHS in Queensland, with large distances to cover but with a low population density.

The amalgamation of two rather distinct, culturally different HSDs into one HHS, with a single Board, has been challenging, however solid clinical governance and a focus on safety and quality at all levels from the Board down has seen improved health outcomes.