Unleashing the potential: an open and equitable health system

Healthcare for Queenslanders in a pandemic ready world

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Reform Planning Group | Final Report

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Foreword

This year has presented a huge challenge to the communities' health and to health systems.

Health systems have had to change, sometimes literally overnight. In Queensland tens of thousands of staff working across the health system mobilised together to ready Queensland.

In the face of this unprecedented challenge, the overwhelming feedback shared with us – from staff, consumers and partners – was about the positive change they experienced. Many would like to keep these once in a generation changes to create the health system of the future; a system focused on wellbeing, prevention, value and equity that provides the best possible healthcare to Queenslanders.

This report provides a roadmap for the Queensland health system to build on the potential that was unleashed as Queensland responded effectively to the COVID-19 pandemic in the first half of 2020.

We heard that multi-disciplinary teams worked collaboratively within and across organisational boundaries, clinicians worked to their full scope of practice, sectors engaged more deeply, community controlled organisations responded with incredible speed to their communities, consumers provided real time advice and insight, decisions were made quickly and at lower levels, empowering highly qualified staff, technology helped provide care closer to home; and the community worked together to strengthen the response to the pandemic.

The effective response to the pandemic was achieved through multiple legislative, regulatory, policy and funding changes. But perhaps the most powerful was the level of individual and system wide behaviour change. We have considered expert and insightful advice on how this behaviour change can be maintained, which has significantly informed our recommendations.

The health dividend for the Queensland community from harnessing this potential is a more open and equitable health system. By this we mean a system more open to new ideas, new partnerships and new ways of doing things. A system that achieves genuine equity in health outcomes for all Queenslanders, and especially for First Nations people. This will require new levels of trust to be woven across the health system. This is well within reach.

The roadmap proposes a series of recommendations to achieve a more open and equitable system. They are connected and on their own can improve health care delivery and outcomes, but collectively they can generate lasting reform. Importantly, we include a recommendation on implementation.

The response to the pandemic brought out the best in the system – including incredible commitment and amazing innovation leading to great outcomes for all Queenslanders.

This report is in a sense a thank-you for what has been done so far and a platform to build on that good work.

Of course, there were also lessons learned along the way and we also heard about things that could have been done better and these were shared with a great sense of commitment to continuous improvement of our system. These invaluable and thoughtful insights will position Queensland to be better prepared for future pandemics and other challenges confronting our health system.

We are grateful for the feedback from a wide range of individuals, groups and organisations. They have taken the time to look over the horizon with us and provide insightful feedback and constructive suggestions for improving an already very high quality health system. We recognise that our short time frames precluded more in depth engagement and acknowledge a positive feature of the Queensland system is its advanced systems for clinician and consumer engagement. These arrangements have been an important feature of Queensland's response and will be critical to the success of the roadmap.

As Chair, I have been fortunate to work with a united and committed group with extensive experience across the Queensland health system, the health workforce and the community. The Group has invested huge energy and brought a plurality of views to the table. I am grateful for their expertise, insight and commitment. We are indebted to Dr Stephen Duckett, who as Independent Advisor, contributed enormous knowledge and experience. We are also grateful to our skilful and hard working Secretariat for their extensive support.

Many contributors provided their input while responding to a global pandemic and providing high quality healthcare to the community. The generosity of so many people has been exceptional and Queenslanders are fortunate to have such committed people who make up the Queensland health system.

Many readers of this report will have had a role in previous health system changes. Health is such a complex – and important – sector and change is hard. As one participant said to us "we know now we can change, because we just did it". We hope this report provides a path for those committed to achieving this change.

Meegan Fitzharris
Chair, Reform Planning Group

August 2020

Executive summary and recommendations

The Reform Planning Group (the Group) was established in May 2020 to prepare advice for the Director-General and the Deputy Premier and Minister for Health and Minister for Ambulance Services on how best to harness the opportunities arising from the COVID-19 pandemic response to support the best possible health and healthcare for all Queenslanders.

The Group was provided with the opportunity to look 'over the horizon' while Queensland Health remained focused on the immediate response to the impacts of COVID-19 and ongoing service delivery. We engaged with a range of stakeholders from across the health system to identify the changed practices with the highest potential to improve health outcomes.

This opportunity for reform follows on from numerous changes in the way health services across Queensland were organised and delivered in response to the COVID-19 pandemic. These included:

- expanding use of virtual care
- health system integration and collaboration for new models of care
- flexible work arrangements
- empowering staff to work to their full scope of practice
- less red tape, and
- increasing access to and sharing of data.

Underpinning the effective response to the pandemic was wide-scale behavioural change that was key to a more united, innovative, agile and responsive health system.

The disruption caused by the pandemic provides a once-in-a-lifetime opportunity to reset. It has provided an insight into what's possible in the health system, with positive changes in practices and behaviours and gains in progressing system reforms previously stalled.

There is now an opportunity to embed the positive gains already made and unleash the potential within Queensland's health system.

A core theme underpinning the Group's work is creating a more 'open' health system. This means a system:

- that is focused on consumers
- that is integrated across health providers
- that supports a flexible and empowered workforce
- where clinicians, consumers and providers genuinely work in partnership, and
- where good ideas and practices are evaluated and shared across the system.

We strongly believe that a more open health system should also provide genuine equity in health care and health outcomes, particularly for First Nations people. All recommendations in this report (see Appendix A) have been developed with a view to enhancing equity in access and outcomes.

We propose an integrated set of recommendations that we consider will offer the greatest opportunity for improvement, and where existing momentum created by the disruption of COVID-19 can be leveraged to accelerate reform.

The recommendations are intended to harness changes now for real impact in the short to medium term. We propose a two-year implementation timeframe, with sequencing designed to address priorities and build on success.

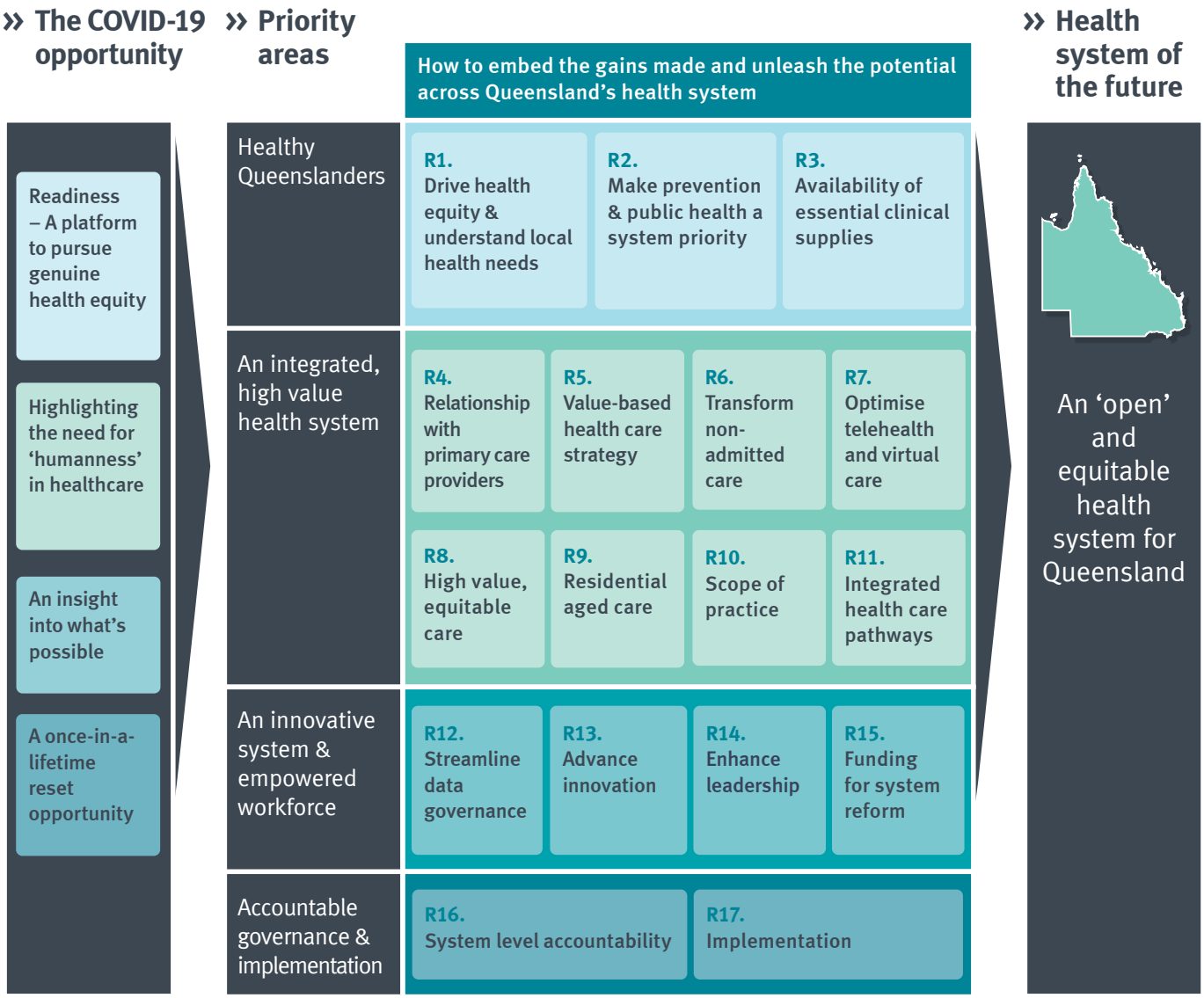
The recommendations span the continuum of health care and all levels of the health system. They identify key enablers and provide guidance about who, when and how they could be implemented.

We recognise that successful implementation requires all individuals within Queensland Health working towards a common goal of reform as well as meaningful engagement with consumers, all levels of government, non-government organisations, health unions and industry groups.

The Group considers it imperative that the implementation approach embraces design principles that contribute to achieving equity of access and equity of outcomes for First Nations Queenslanders. These design principles – First Nations leadership, regional and local decision-making and reorientating local health systems – should be applied across all recommendations in this report.

Finally, the Group has also identified a number of other potential reform opportunities that it did not have the capacity to consider fully in the context and timeframes of this report. These opportunities include sustainability and funding models, capital investment, emergency care, dental services, disability and aged care, and use of *My Health Record*.

UNLEASHING POTENTIAL



1 Introduction

Purpose

The Reform Planning Group (the Group) was established in May 2020 to:

- advise the Director-General and Deputy Premier and Minister for Health and Minister for Ambulance Services on how to harness the opportunities arising from the COVID-19 pandemic to achieve the best possible health and healthcare for Queenslanders, and
- inform the development of a roadmap for reforming Queensland's health system, with recommendations on priority actions to ensure the health and wellbeing of all Queenslanders and sustainability of the health system.

The Group's Terms of Reference are attached at Appendix B.

Scope

The scope of the Group's work was to identify changed practices and innovations in health service delivery initiated as part of the COVID-19 pandemic response that demonstrate improved value and responsiveness for patients, healthcare workers and the broader community and have potential for ongoing implementation.

The Group's activities have focused on developing practical recommendations for reform in the priority areas of:

- Healthy Queenslanders
- An integrated, high value health system
- An innovative system and empowered workforce
- Accountable governance and implementation

Within each of these focus areas, which align with those in the 10-year vision My Health Queensland's future: Advancing health 2026, the Group has examined not only 'what' needs to change, but 'how' to implement and embed these changes, particularly those that emerged in the response to COVID-19 that created the conditions for culture and behaviour change at the individual and organisational level.

A review of Queensland Health's response to the COVID-19 pandemic was not within scope. The Group has considered ongoing health reform activities and previous reviews to improve Queensland Health.

Reform Planning Group membership

The Group is made up of nine health system professionals appointed for their diverse expertise across the health system to ensure a holistic and comprehensive approach to developing a reform roadmap. Collectively, the members' expertise covers health system management and governance, First Nations perspectives, rural health services, data and innovation, clinical services, health consumer and employee perspectives, health economics and behavioural science.

Importantly, members were selected on the basis of their individual standing, professional and personal experience. Members have been engaged personally and to contribute in an individual capacity rather than as representatives of any particular group or organisation. Further details on the members, including biographies, is provided at Appendix C.

2 Opportunity for reform

As a Group we are very mindful that COVID-19 continues to have significant health, social and economic impacts on all Australians, and particularly Victorians, at the time of writing. We are also mindful that Queensland Health, as well as other healthcare providers in Queensland, is focused on continuity of services, including resuming services that were paused during the initial response, prioritising care to patients who may have missed out on treatment in the early months of the pandemic.

We acknowledge the extraordinary work of thousands of people across the Queensland health system who are part of providing skilled, compassionate care every day to the Queensland community.

At the outset of this work, the Group acknowledged the opportunity provided to look 'over the horizon', while Queensland Health remained firmly focused on the immediate response and ongoing service delivery. Despite the many challenges faced by the health system in Queensland, and by health care workers and those who support them, the Group heard from a wide range of organisations and individuals of the many positives that emerged during the response and the very real opportunity to embed these changes and turn the dial further toward a health system that delivers greater value for patients and the community.

Previous health reform agreements and reviews have generally shared many common features, but for multiple reasons, implementation of change has been patchy. Health systems are large and complex, governance and regulation are shared, and care is delivered across a number of different sectors. Yet, despite these challenges the past few months have seen significant change across a number of important areas of health reform.

The Australian Government and the Queensland Health system made rapid changes to health care policy, regulation, funding and delivery in response to the COVID-19 pandemic. In addition, there was also a climate of empowerment, trust, flexibility, agility and proportionate risk taking as the system responded rapidly to changing circumstances.

This sentiment is shared by many individuals and organisations reflecting on the long-term impact of COVID-19 and is broadly expressed in the following way:

> "A remarkable characteristic of the COVID-19 response has been the sheer pace of reform, with major changes such as the expansion of telehealth, the creation of COVID-19 specific clinical services within hospitals, and unprecedented levels of cooperation between private and public hospitals, and state and federal governments. Innovation has flourished, from ventilation hoods to 3D-printed medical parts to vaccine development. We must now determine how we carry forward this "can-do" attitude to health reform when we emerge from the acute crisis."[1]

What changed during COVID-19

The COVID-19 pandemic response led to numerous changes in the way health services across Queensland were organised and delivered. Extensive changes were made across the Australian health system, led by the National Cabinet, supported by Australian Health Ministers, the Queensland Cabinet, the Deputy Premier, Minister for Health and Minister for Ambulance Services.

The scope of our work did not include a comprehensive assessment of the response, but a number of its key features are outlined below, especially those that highlight the opportunity for reform.

Australia's pandemic response

By international standards Australia and Queensland's response to the pandemic has been effective at suppressing the virus and preparing the health system. Although we are mindful to not draw premature conclusions, a number of organisations have provided contemporary analysis of the response which point to indicators of Australia's success, including:

- The Grattan Institute suggests four success factors behind Australia's response: cooperative governance through the formation of National Cabinet, closure of international borders and mandatory quarantine, rapid adoption and acceptance of enhanced spatial distancing measures, and expansion of telehealth.[2]

1 Blecher, Gabriel et al (2020), 'Crisis as opportunity: how COVID-19 can reshape the Australian health system', Medical Journal of Australia, https://www.mja.com.au/journal/2020/crisis-opportunity-how-covid-19-will-reshape-australian-health-system [Preprint, 7 July 2020].

2 Duckett, Stephen and Stobart, Anika (2020), Australia's COVID-19 response: the four successes and four failures, Grattan Institute.

- Similarly, the Australian Healthcare and Hospitals Association, Australia's peak body for public healthcare, has acknowledged the integration of governance through strong, multi-level decision-making as a successful feature of Australia's response. For Australia's First Nations people, there was a positive and collaborative response to fund and support measures created and driven by Aboriginal and Torres Strait Islander health experts and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs).[3]
- Lifeline Australia has highlighted the timely injection of funds by governments which strengthened the capacity to deploy crisis supporters into the community to help close the mental health service accessibility gaps created by COVID-19.[4]

Queensland's health system response

Queensland Health's[5] early preparedness meant it was well positioned to lead the public health response and manage the impact of the pandemic on the delivery of health services.

Queensland was the first jurisdiction in Australia to declare a public health emergency on 29 January 2020. Queensland Health moved quickly to activate established disaster management arrangements, which enabled planning for changes in service delivery to ensure continuity of care and preparations to lift health system capacity for a potential surge in demand. The Minister for Health progressed urgent legislative changes in the early stages of the pandemic response. This strengthened the legislative powers of the Chief Health Officer to make the Public Health Directions necessary to assist in containing or responding to the spread of COVID-19 in the community.

Extensive governance arrangements were enacted and led by the Pandemic Health Leadership Response Team and the Pandemic Health Response Implementation Advisory Group. Together, these two governance mechanisms helped resolve issues impacting the system and guide hospital activities to support the public health response. Across Queensland Health, existing collaborative forums were used, and new forums created, providing key lessons and insights for future response.

In addition, changes to funding, workforce, integrated planning and service delivery, and partnerships also occurred. The behaviour change across the community and the state health system, underpinned by individual behaviour change, contributed strongly to success. A number of these changes are highlighted below.

Funding

All Governments across Australia have provided significant additional funding to support increased health care capacity.

The Queensland Government has committed an additional $1.2 billion in health funding to support the health response to the pandemic. The additional funding supported the expansion of fever clinics, more paramedics and ambulance services, new infrastructure for, and better utilisation of, existing hospitals, expansion of community screening, contact tracing and 13 HEALTH services, backfilling of health staff exposed to the virus, additional regional health services and more aeromedical services for regional and remote communities, as well as the provision of elective surgery in the public and private sector.[6, 7]

In March 2020, The Australian Government provided an additional $2.4 billion health package[8] for the COVID-19 response. This included additional funding for telehealth, purchase of Personal Protective Equipment (PPE), dedicated respiratory clinics and other infection testing and control measures. The health package included an initial Commonwealth payment of $100 million under the National Partnership[9] on the COVID-19 Response, with an additional commitment to fund, on an uncapped and 50-50 basis, the costs incurred by States and Territories for hospital and public health services related to COVID-19.

The Commonwealth also provided funding to support the financial viability of the private hospital sector during the pandemic response and a funding guarantee for Commonwealth public hospital funding for 2019-20 and 2020-21, covering funding under the National Health Reform Agreement and the hospital services component of the National Partnership on the COVID-19 Response. It means that any potential reduction in Queensland's hospital funding caused by the disruption in activity due to the COVID-19 response will not occur while the guarantee is in place. Further funding was also committed to support increased care across a number of sectors.

Health workforce

As part of Queensland Health's COVID-19 pandemic response, several vital workforce changes were made to build a contingent and responsive workforce for Queensland Health. Of the many changes made, examples include the following:

- Existing Queensland Health staff were reassigned internally to support additional work emerging as a result of COVID-19.

3 Australian Healthcare & Hospitals Association (2020), Submission to Senate Select Committee on COVID-19.

4 Lifeline Australia (2020), Submission to the Senate Select Committee on COVID-19.

5 Queensland Health includes the Department of Health, Queensland Ambulance Service, HHSs, the Council of the Queensland Institute of Medical Research, Queensland Mental Health Commission, Health and Wellbeing Queensland and the Office of the Health Ombudsman.

6 Queensland Treasury (2020), 'Queensland's COVID-19 Economic Recovery - Queensland Treasury', https://www.treasury.qld.gov.au/programs-and-policies/covid19-package/ (accessed June 2020).

7 Queensland Government (2020), 'Queensland Health COVID-19 Response Plan', https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/queensland-health-response/queensland-health-response-novel-coronavirus-covid-19 (accessed July 2020).

8 Prime Minister of Australia (11 March 2020), '$2.4 Billion Health Plan to Fight COVID-19', https://www.pm.gov.au/media/24-billion-health-plan-fight-covid-19#:~:text=The%20Australian%20Government%20has%20unveiled,coronavirus%20(COVID%2D19). (accessed June 2020).

9 National Partnership on COVID-19 Response (2020).

- In collaboration with health unions an industrial relations policy framework was developed to support the pandemic response and provide a process to promptly resolve emerging issues.
- Queensland Health identified critical Hospital and Health Service (HHS) workforce requirements and utilised the Public Sector Workforce Mobilisation Service to match employees from other public sector agencies to essential roles across the health system.

  A state-wide COVID-19 Expressions of Interest (EOI) campaign was coordinated by Queensland Health, inviting Queenslanders, especially former health care workers, to express their interest in temporary employment to meet anticipated demand.

These changes and established robust consultative processes enabled Queensland Health to expand the workforce pool to be responsive to the demand that may occur as a result of increases in the number of COVID-19 cases. There was a rapid upskilling of health professionals and a flexible and scalable approach across clinical workforce capacities. For example, nurses and allied health professionals were deployed more flexibly across traditional occupational boundaries whilst being able to work to their full scope of practice.

We congratulate the clinical and non-clinical health workforce for its commitment, flexibility and responsiveness during the pandemic.

Rapid upskilling of health professionals

Australian Government scholarships for the Australian College of Nursing Refresher Program

This course is designed for registered nurses who hold registration with the Nursing and Midwifery Board of Australia who wish to refresh their knowledge of acute care nursing. Completion of this course provided upskilling for registered nurses who are working in non-acute care settings who wish to work in acute care settings. The Australian College of Nursing has confirmed that 563 registered nurses living in Queensland completed this program this year after receiving an Australian Government scholarship.

Australian Government sponsorship for completion of the SURGE Critical Care/High dependency course conducted by Medcast

The SURGE Critical Care course provides education for registered nurses about the necessary minimum knowledge and skills required to work in high dependency or critical care settings. The aim of this Australian Government sponsored program was to rapidly and efficiently deliver education to registered nurses across Australia to meet the demand created by the pandemic.

As at 6 July 2020 a total of 3199 Queensland registered nurses had completed the Medcast critical care/high dependency nursing courses. Completion by type of service is noted below:

Acute public hospital	2220
Other public	36
Acute private	831
Other private	112
TOTAL	**3199**

Virtual care and telehealth

The increase in uptake of virtual care and telehealth across both the primary and acute care sectors has been widely recognised as a significant dividend from the COVID-19 pandemic.

Queensland Health scaled service delivery through virtual care models by building on its existing Clinical Telehealth program. This was done to achieve physical distancing between clinicians and patients where possible for safety, and to reserve physical capacity and equipment for the pandemic response.

Queensland Health's telehealth capacity rapidly increased from approximately 90 concurrent calls to 1,600 supporting over 20,000 telehealth outpatient appointments each month. The number of telehealth service events delivered in April 2020 was triple the average monthly number of telehealth service events delivered in the nine months prior to the COVID-19 response. From February 2020 (pre-COVID-19) to April 2020, there was a 145 per cent increase in midwifery and maternity, a 239 per cent increase in palliative care and 168 per cent increase in paediatrics telehealth service events, with substantial increases in numerous other clinical areas.

Clinicians and the community generally responded flexibly and openly to new ways of delivering and receiving care. While the outcomes of telehealth expansion are still being assessed, anecdotal feedback suggests continued broad support from clinicians and consumers for virtual care models to be expanded and retained into the future.

Elective Surgery and specialist outpatients

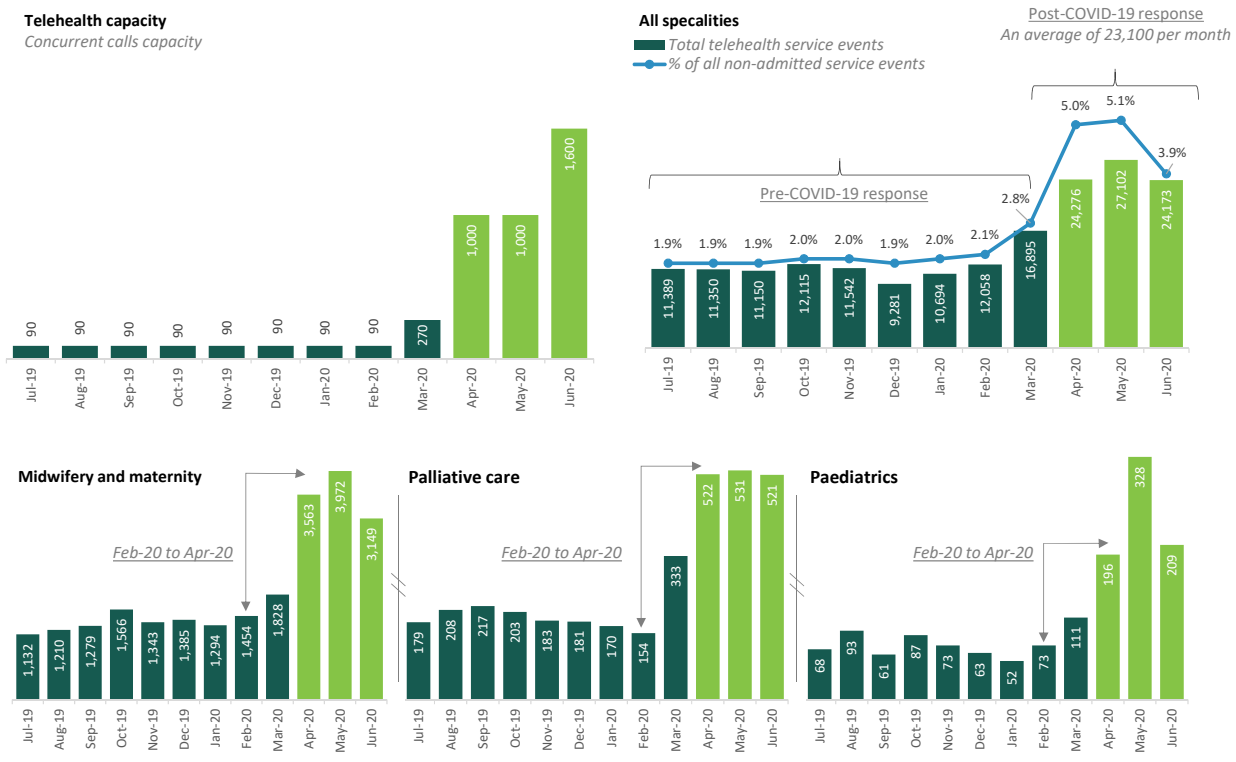
In line with decisions by National Cabinet, Queensland Health suspended all non-urgent elective surgery and specialist outpatient services. On 22 March 2020, HHSs were instructed to:

- Stop all non-urgent Category 2 (90 days) and Category 3 (365 days) elective surgical activity
- Stop all Category 3 outpatient activity from the current waiting list
- Stop accepting any Category 3 outpatient referrals from general practice, and
- Stop any Category 2 and 3 internal (from one specialist to another) referrals and instead, return them to general practice.

Category 1 (30 days) and urgent Category 2 (90 days) elective surgery continued to be delivered in public hospitals.

The temporary suspension of non-urgent elective surgery and specialist outpatient services as part of the pandemic response, led to strengthened agreements between the public and private sectors. Queensland Health enhanced existing Surgery Connect contracts with private hospital providers to enable elective surgery and gastrointestinal endoscopies to be delivered to more Queenslanders.

Under the National Partnership on COVID-19 Response, private hospitals integrated with the state health system to



Source: Pexip Infinity, Monthly Activity Collection and Queensland Non-Admitted Patient Data Collection (Statistical Services Branch)

support the pandemic response. Although not fully utilised (at this stage), this partnership demonstrated the potential of the public and private hospital sectors to operate as a single system, supporting the best use of resources and providing additional capacity across the health system.

Emergency care

Queensland Health introduced new processes to increase the capacity of emergency departments (EDs) in anticipation of an increased demand for COVID-19 related care. This included streamlined pathways for common ED presentations, new or expanded community-based and telehealth ED-substitution programs, improved safety and infection control management processes and enhanced focus on staff training and wellbeing. Many of these changed practices have longer-term benefits in terms of improving patient flow and managing public hospital demand.

Shifting care closer to the community

As part of the pandemic response, the health system was able to create additional capacity by shifting care safely from tertiary hospitals to the patient's home setting. Some examples included:

- Queensland Health adapted its Hospital in the Home (HiTH) program to support follow-up screening for COVID-19 positive patients in their home. For example, Princess Alexandra Hospital's Acute Care at Home team visited confirmed COVID-19 patients recovering at home within the Metro South Health catchment, which enabled continued testing for patients in their home and care for those showing mild symptoms. This improved patient flow and avoided unnecessarily keeping patients in hospital isolation.[10]
- Similarly, Metro North HHS established virtual wards, whereby all COVID-19 positive patients were admitted but remained in their homes, with monitoring and support from a multi-disciplinary team including doctors, nurses and allied health professionals. The virtual wards avoided hospital admission and exposure of health care staff to the disease, while ensuring the safety of patients.
- The Integrated Child Development Service, a partnership between Queensland Child and Youth Clinical Network, Children's Health Queensland and South West HHS, was rapidly mobilised to support metropolitan outpatients in their homes. There was high engagement, with 100 per cent attendance rate (of which 85 per cent of families were identified as Aboriginal and Torres Strait Islander) and the service helped alleviate the risk of long waits due to COVID-19 for children in need of specialist services.[11]

The primary health care response

The Australian Government supported primary care by funding significantly greater access to telehealth. This involved broadening access to the Medicare Benefits Schedule by creating telephone and telehealth item numbers for primary health care professionals.

Primary Health Networks (PHNs) supported general practice-led respiratory clinics in a mix of urban, regional and rural settings. In Queensland, three dedicated PHN run respiratory clinics were established at Northern Queensland PHN, Western Queensland PHN and Central Queensland, Wide Bay and Sunshine PHN. Brisbane South PHN supported four temporary general practice-led respiratory clinics in the Brisbane south region, as did the Brisbane North PHN, including the country's (possibly the world's) first COVID-19 testing clinic for First Nations people. Respiratory clinics were also established by the Gold Coast PHN (four) and the Darling Downs and West Moreton PHN (six). The strategic location of respiratory clinics in the community improved access to care options in a dedicated and safe environment.

Additionally, large primary care practices and some community health centres were able to innovate their care delivery through establishing drive-in clinics in car parks and establishing specialist testing or treatment clinics within their existing infrastructure.

10 Metro South Health (2020), 'PA Hospital begins caring for COVID-19 patients at home', https://metrosouth.health.qld.gov.au/news/pa-hospital-begins-caring-for-covid-19-patients-at-home (accessed July 2020).

11 Queensland Clinical Senate (2020), Innovation and transformation of models of care in response to COVID-19, 18 May 2020 - Meeting Report, Brisbane, Queensland Government.

Primary Care Queensland Network

The Primary Care Queensland network was established as an informal, self-organising alliance of around 15 primary care organisations in late February 2020 to ensure a collective response to the COVID-19 pandemic. The network received support from Clinical Excellence Queensland's Healthcare Improvement Unit. Examples of the network's response included:

- Development of a state-wide HealthPathway for the assessment and management of COVID-19, available to every clinician in Queensland, including 10,000 GPs. Queensland was the first state to develop a HealthPathway and update it regularly.
- Establishment of a rudimentary but effective communication network within primary care. COVID-19 related updates are sent most days and disseminated widely within hours.
- Delivery of webinars, educational resources and support for communities and practices.
- Distribution of Personal Protective Equipment.
- Commissioning respiratory clinics in most areas of Queensland.
- Curating information about COVID-19 testing options in Queensland.
- Dealing with clinical issues such as provision of medical services for patients in quarantine.
- Contributing to Queensland Health's pandemic response efforts by providing advice, through membership of multiple committees and working groups (palliative care; Residential Aged Care Facilities; rural and remote health; indigenous health; Clinical Senate; the Respiratory Network; Pandemic Health Response Implementation Advisory Group; and more).

Behavioural change

Throughout the early months of the pandemic many experts noted that wide-scale behavioural change was key to an effective response. Importantly, the health system was transformed to become more united, innovative, agile and responsive. A detailed analysis of the drivers of behavioural changes observed during COVID-19 is outlined in The New Abnormal report (see Appendix D) and is summarised as follows:

- **Creation of a shared goal:** COVID-19 created a common challenge to all members of the community which called for a united response.
- **Reduced risks associated with behavioural change:** The major perceived barriers to individuals changing their behaviour, namely loss aversion and risk aversion, were largely mitigated by the presence of, and need to respond to, COVID-19.
- **Clear leadership and communication:** Leaders across the health system and government generally fostered a clear and unified approach to tackling the pandemic which was bolstered by clear and straightforward public messaging.
- **Data driven feedback:** During the pandemic response, the community was given regular up-to-date data on the spread of COVID-19 that enabled people to see how their collective actions were making an impact.[12]

In addition to the policy, regulatory, funding and service changes outlined, these behaviour changes provide rich insight into how to maintain positive behaviour changes and advance health reform.

12 Pickering, John (2020), The New Abnormal: COVID-19 and behavioural change in Queensland, Presentation, Brisbane. (see Appendix D).

What we heard

The Group's Engagement

THE GROUP PARTICIPATED IN AROUND **60** **ENGAGEMENTS** WITH STAKEHOLDERS FROM **QUEENSLAND HEALTH** AND OTHER HEALTH SECTOR ORGANISATIONS

98 **WRITTEN SUBMISSIONS** WERE RECEIVED FROM EXTERNAL ORGANISATIONS AND INDIVIDUALS AND QUEENSLAND HEALTH STAFF

The Group engaged with a range of stakeholders from across the health system to gather insights on improvements and innovative practices that occurred during the COVID-19 response and potential reform opportunities for healthcare service delivery.

Engagement was designed to elicit big ideas, promote dialogue about experiences during the pandemic and deliberate on a way forward for health reform.

Given the wide-ranging scope of potential reform, our engagement sought to identify the changed practices with the highest potential to improve health outcomes. We canvassed options and tested recommendations, with a focus on what could readily be implemented.

To gather insights within the timeframes for the report, we used existing Queensland Health networks, committees and forums to engage directly with a broad range of stakeholders (see Appendix E). This included engagement with clinicians, non-clinical staff and representatives of community, professional and industry organisations. We also invited written submissions (see Appendix F) and conducted targeted consultations with communities of interest. The Group was also fortunate to receive interim findings from a Queensland University of Technology (QUT) survey[13] on the experience of frontline health workers and managers during the pandemic.

We heard of an overwhelming desire to reset the system and a readiness to action meaningful improvements. Staff recognised that the new ways worked for them and the patients they were caring for. Preliminary results from the QUT survey show 90 per cent of respondents agree that changes made during the pandemic were positive and worth keeping.

We heard many examples of positive change, including new and strengthened models of care, changed roles and ways of working. Most frequently cited areas for reform included:

- expanding use of virtual care to provide access and greater choice for consumers
- health system integration and collaboration for new models of care that better meet consumer needs and reduce non-urgent admitted care in hospital
- flexible work arrangements to enable remote working and mobilisation of the workforce in both clinical and non-clinical environments
- workforce design to meet current and emerging needs, including empowering staff to work to their full scope of practice,
- shortened chains of decision making and less 'red tape', and
- increasing real-time access to linked data and sharing of data across the health system to support continuity of care and improve health service planning to meet the needs of local populations.

Although we are unable to reflect all the examples shared with us, our recommendations are strongly informed by this consultation. Strong engagement, including co-design, must be a consistent feature of the implementation of this report.

Virtual Care and Telehealth

> "The use of telehealth allowed clients to spend less of their time travelling to and waiting for appointment in outpatient clinics. This should be an ongoing option for care where relevant. Due to the need for fast decision making, there seemed to be better communication, which was open and shared with staff without delay – via TEAMS/Teleconference when required."
>
> *Staff member, Metro South HHS*

> "The Telehealth system was used much more and highly efficient. It allowed patients to still have access to their clinicians in their homes, thus avoiding close proximity with other patients while waiting to see their clinician. Hopefully the Telehealth system will be used more going forward."
>
> *QUT Survey*

13 Yates, Patsy (2020), Health Service Innovation in Response to a Pandemic: A survey of frontline health care workers and health service managers in Queensland, Preliminary Report August 2020, Queensland University of Technology.

Emergency Care

> "As a result of the COVID-19 pandemic, rapid health system transformation has taken place with implementation of solutions advocated for two decades to reduce overcrowding and improve access to emergency care."

Australasian College of Emergency Medicine

Workforce

> "Staff professional development opportunities have actually increased during the pandemic."

QUT Survey

Shifting care closer to the community

> "We should develop "community services" properly. It's important for future sustainability of health services too- we can't just keep adding more hospitals/ beds as the population ages and health needs get more complex, we have to take care to the patients"

Staff member, Gold Coast HHS

Behavourial change

> "A culture of permission for action needs to continue, and that culture to incorporate the value of working in collaboration with consumers as well. Advocacy and alliances should be formed to ensure the consumers best interests are at the heart of all decision-making. Behaviour that is not aligned with this should be held to account."

Health Consumers Queensland

> "I think the way the executive teams trusted the worker at the coal face to innovate and use resources for quality improvement has allowed us to move forward much quicker."

QUT survey

Priorities for change

> "Retaining the focus on culturally safe communications; improving collection and reporting of Aboriginal and Torres Strait Islander Identifier data; learning from our mistakes; implementing a Queensland A&TSICCHO Surgical Pathways pilot; over the longer term - keeping people out of hospitals by re-designing funding systems; developing Regional Network Funding Agreements."

Queensland Aboriginal and Islander Health Council

The system we would like to see

Many reviews and papers have expressed the key features of an 'ideal' health system. Across the Group there is significant experience in considering what this health system should look like and how to achieve it. Broadly speaking it would have elements represented in the two figures below.

Shaping a more sustainable health system[14]

The ingredients of a well-functioning system[15]

However, the Group's remit was not to design a reformed health system, but instead to work quickly to identify opportunities that emerged from and during the COVID-19 pandemic. Due to time constraints, there are various areas that we did not explore that could have significant dividends for the Queensland health system and for Queenslanders. At the end of this report we identify a (not exhaustive) set of opportunities that the Queensland Government may wish to explore further.

14 Sustainable Health Review (2019), Sustainable Health Review: Final Report to the Western Australian Government, Department of Health, Western Australia.

15 Productivity Commission (2017), Shifting the Dial: 5 Year Productivity Review, Report No. 84, Canberra.

We agree with many who consider the disruption caused by the pandemic provides a once-in-a-lifetime opportunity to reset. More than ever before we see an appetite for change matched by readiness to do so.

The disruption has provided an insight into what's possible in the health system, with positive changes in practices and behaviours and gains in progressing system reforms previously stalled. There is opportunity to embed the positive gains already made and unleash the potential within Queensland's health system.

We consider that this potential can be achieved if the health system is more open and equitable.

An open health system

Throughout our work we identified many of the changes as examples of the system 'opening up', with trust an important thread running through these changes. By an open health system we mean one:

- that is focused on consumers
- that is more integrated across health providers, including public and private providers across primary, community and acute care
- that supports a flexible and empowered workforce that can operate to its full potential
- where clinicians, consumers and providers genuinely work in partnership to support their patients and local communities
- where good ideas and practices are evaluated, shared and spread across the system so that as many Queenslanders as possible can benefit from them, and
- where there is rigorous and transparent evaluation of health interventions, with findings publicly reported.

An equitable health system

Throughout our work we also identified the opportunity for an historic shift in how healthcare is provided to advance equitable outcomes for all Queenslanders, but especially for First Nations people.

We strongly believe that a more open health system should also provide genuine equity in health care and health outcomes.

The Group is mindful of the disproportionate effect ill health has on the lives of many people living with disadvantage. In imagining the reform opportunities for the health system, we must take advantage of the opportunity to create an improved system that better meets the needs of the most vulnerable in our community.

A range of people experience health (and other) disadvantage in Queensland, including people living in rural and remote locations, people living in areas experiencing socio-economic disadvantage, people with disabilities or mental illness, concession card holders, lesbian, gay, bisexual, trans, intersex and queer (LGTBIQ+) Queenslanders, refugees and some culturally and linguistically diverse communities.

First Nations people, however, experience the most historic and some of the most extensive disadvantage and, in the Group's view, should be at the forefront of efforts to ensure an equitable health system.

In addition, we emphasise that there are numerous examples of innovative practices by First Nations people and community controlled health organisations that could be scaled and diffused across mainstream health system practices.

All recommendations in this report have been developed with a view to enhancing equity in access and outcomes. For instance, the focus on healthy Queenslanders recognises that health risk factors are generally higher among groups experiencing health disadvantage, and that such groups generally experience significantly higher rates of chronic and complex conditions than other Queenslanders. We also recognise that disadvantaged groups often experience barriers in terms of delayed and inequitable access to services such as non-admitted services and elective surgery, and present later in the course of their illness than other Queenslanders.

Achieving Equity of Health Outcomes for Queensland's First Nations people

While Queensland has made progress in improving health outcomes for First Nations people, it has been too slow. This can be seen by the gaps in health outcomes that persist throughout the State, most starkly in the life expectancy of First Nations people in Queensland.

In 2008, the national Closing the Gap campaign and targets were introduced which include closing the gap in life expectancy by 2031 and halving the gap in child mortality (0-4 years) by 2018. To date, the Queensland gap in life expectancy has narrowed but is not on track to close by 2031, currently at 7.8 years for males and 6.7 years for females 2015-17, down from 11.8 years and 10 years in 2005-2007, respectively. Queensland also did not achieve the target to halve the gap in child mortality by 2018, with fluctuations experienced over the past 10 years and a mortality gap for 2013-2017 comparable to the gap recorded in 2004-2008.[16]

The Group notes the recent release of the National Agreement on Closing the Gap between the Coalition of Aboriginal and Torres Strait Islander Peak Organisations and all Australian Governments, particularly its commitments to the following outcomes:

- Shared decision making: Aboriginal and Torres Strait Islander people are empowered to share decision-making authority with governments to accelerate policy and place-based progress on Closing the Gap through formal partnership arrangements.
- Building the community-controlled sector: There is a strong and sustainable Aboriginal and Torres Strait Islander community controlled sector delivering high quality services to meet the needs of Aboriginal and Torres Strait Islander peoples across the country.
- Improving mainstream institutions: Governments, their organisations and their institutions are accountable for Closing the Gap and are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander people, including through the services they fund.
- Aboriginal and Torres Strait Islander-led data: Aboriginal and Torres Strait Islander people have access to, and capability to use, locally-relevant data and information to set and monitor the implementation of efforts to close the gap, their priorities and drive their own development.

The Group supports the First Nations health equity design principles, which have been recently developed by Queensland Health in partnership with the Aboriginal and Torres Strait Islander community-controlled health sector. These design principles are:

- First Nations leadership—co-design, co-owned and co-implemented with First Nations people.
- Regional and local decision-making—designing and delivering First Nations models of care and pathways to integrate local health systems based on agreed priorities.
- Reorienting local health systems—to increase investment in upstream health interventions and care outside of hospitals.

Among the enablers of improving First Nations health equity is increased First Nations workforce representation, scope and capability. This includes leadership roles and roles across all levels of the system. ('from gardeners to surgeons'). Increased workforce representation will support providing appropriate, trusted and culturally safe care through increased cultural awareness and capability across the workforce.

The Group also recommends the principles are applied across all Queensland Health policies, programs and services to support improved equity of access and health outcomes for First Nations people. This includes a specific focus on expanding the First Nations workforce. Efforts to improve First Nations health should be guided by a commitment from Queensland Health, at all levels, to co-design, co-own and co-implement in collaboration with the Queensland Aboriginal and Islander Health Council and First Nations people, including elders, Aboriginal Medical Services and the broader community.

The Group was given a broad task: identify reforms that would harness the opportunities arising from the COVID-19 pandemic

3 Roadmap to reform

to achieve the best possible health and healthcare for Queenslanders. We propose an integrated set of recommendations that offer the greatest opportunity for improvement, and where existing momentum created by the disruption of COVID-19 can be leveraged to accelerate reform across the health system for the benefit of Queenslanders.

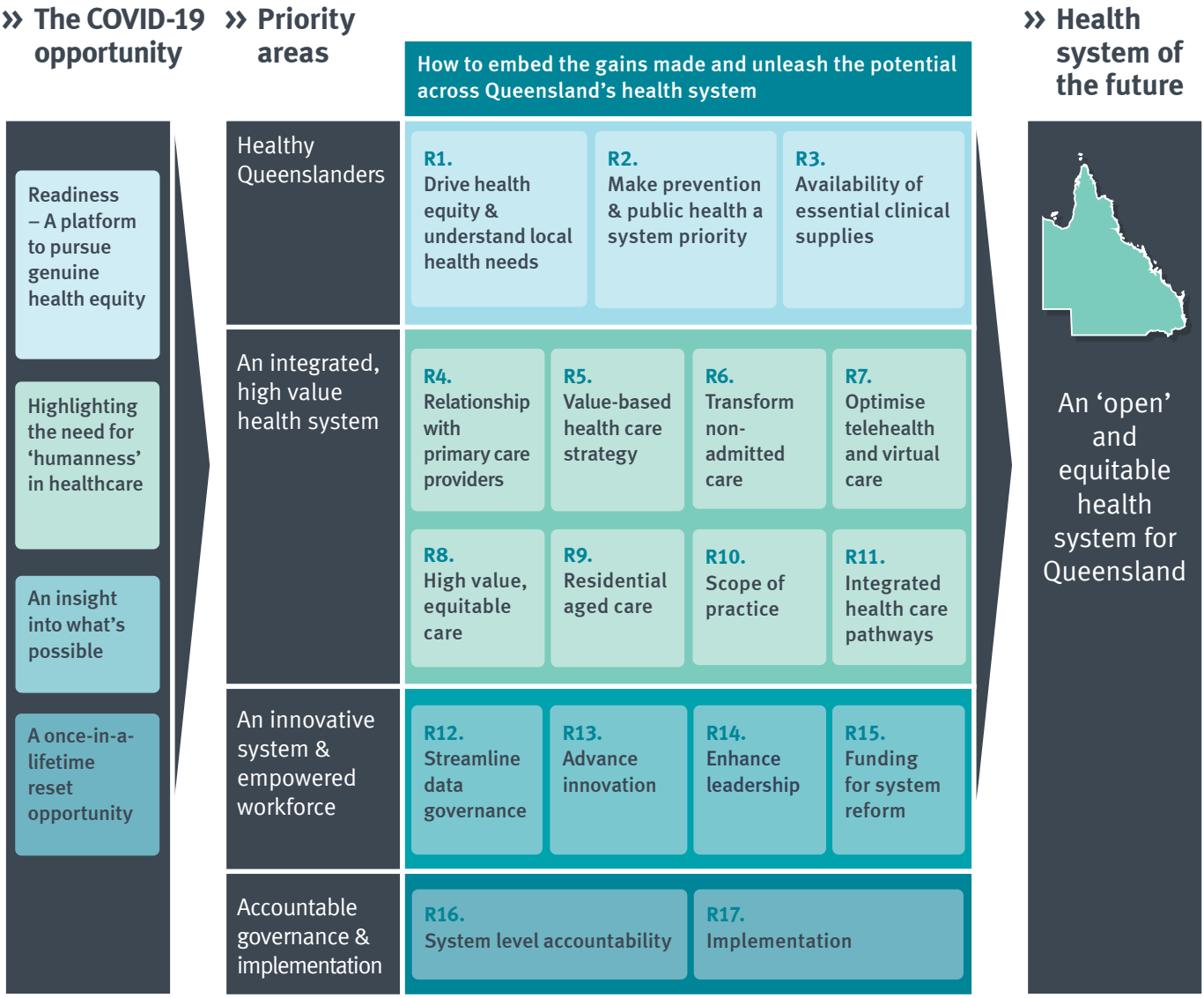
We were not asked to undertake a reform commission style inquiry, but rather a shorter time limited piece of work to harness those changes now for real impact in the short to medium term. We are mindful of the potential for reform 'fatigue' and therefore we propose a two year implementation timeframe, with sequencing designed to address priorities and build on success. We again acknowledge the excellent work and care provided every day by Queensland Health staff. We seek to build on that work, noting that COVID-19 will be present across Australia for the foreseeable future.

In July 2020 we provided an Interim Report to the Deputy Premier and Minister for Health and Minister for Ambulance Services to provide early advice on key principles to inform the resumption of services and strengthen the relationship with the primary health care sector. These recommendations are integrated in this report, and in some cases, have been refined based on additional feedback. A copy of the Interim Report is included at Appendix G.

Our final recommendations reflect what we heard from stakeholders and each has been developed to have the greatest impact on the core themes – unleashing potential and creating an open and equitable health system for all Queenslanders.

In order to realise the potential of an open and equitable health system, the recommendations span the continuum of health care and at all levels of the health system. They identify key enablers across the health system and provide guidance about who, when and how the recommendations could be implemented.

UNLEASHING POTENTIAL



4 Recommendations – Unleashing potential

The Recommendations in this report are grouped into four key areas:

- Healthy Queenslanders
- An integrated, high value health system
- An innovative system and empowered workforce
- Accountable governance and implementation

For some of the recommendations a specific organisation or group that could drive and be held accountable for implementation has been identified. In most cases the Department of Health and HHSs will have principal responsibility for implementation.

Integrated healthcare pathways

We have included a recommendation to develop pathways across three areas of care as a way to drive the implementation of many of our recommendations. We include them because of the number of Queenslanders potentially affected, the work already underway and the distinctive partnership opportunities across each area. These areas are: diabetes, mental health and the first 2000 days.

Engagement is vital

We consider engagement to be an important principle underpinning every recommendation.

Queensland Health has a variety of engagement models, some well established and others in early stages of development, within and across the Department of Health, HHSs and with clinician, consumer groups and health unions, as well as beyond Queensland Health, including with other Government bodies, non-government organisations, industry and community groups.

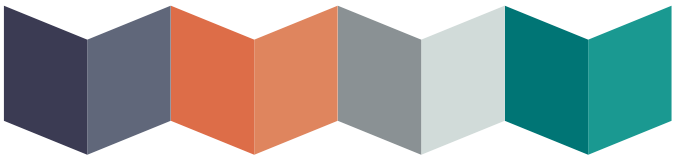
For each recommendation the Group recognises the importance of co-design, co-implementation and co-evaluation. The Group expects that existing engagement across the system, and especially with clinician, consumer groups and health unions, community controlled organisations and the primary health care sector, should be maintained and enhanced where possible in developing the Implementation Plan. More specific engagement is identified in some recommendations.

The recommendations are squarely aimed at improving the health of all Queenslanders and to that end, the Group's view is that an unrelenting and consistent focus on Queenslanders – the health system 'consumers' – will

Healthy Queenslanders

Recommendation 1:

Drive health equity and an understanding of local health needs



ensure a focus on delivering care that matters most and has the greatest impact.

Recommendation 1:

Drive health equity and an understanding of local health needs

Why:

To enable all Queenslanders to have an equitable opportunity to live their healthiest lives.

How:

a) Develop a First Nations Health Equity Framework to guide implementation of the proposed First Nations health equity strategies (Department of Health).

b) Within one year of passing the Health Legislation Amendment Bill 2019 and regulations, each HHS develop a First Nations Health Equity Strategy in collaboration with local A&TSICCHOs.

c) Develop a Queensland Health Equity Framework, building on the First Nations Health Equity Framework.

d) Develop an integrated Local Health Needs Assessment and Plan at every HHS in partnership with the PHNs, A&TSICCHOs, other local partners and consumers.

Each Local Health Needs Assessment and Plan should:

- include specific plans, clear outcome indicators and data on current performance outcomes for
    - children in the first 2000 days of life (including pregnancy)
    - people at risk of developing and those already living with diabetes[17]
    - people with mental illnesses
- include a preventable hospitalisation plan
- be aligned to the First Nations Health Equity Strategy
- be updated every three years, and
- be made publicly available.

Data should be provided for each HHS, and highlight differences in outcomes for vulnerable groups, including First Nations people.

e) Develop a Queensland Health Needs Assessment and Plan based on HHS level plans and as a companion to the Chief Health Officer's Report (Department of Health)

A key theme driving the recommendations in this report is the vision to achieve health equity (both in terms of access to services and healthy outcomes), for all Queenslanders (refer Section 2).

These recommendations are a key element to realising this vision and are intended to set the conditions for a shift toward equity, beginning with a health equity framework and the development of a deeper understanding of local health needs. These recommendations also recognise Queensland's networked and devolved governance and support greater collaboration across primary and acute care. Local Health Needs Assessments and Plans developed by the HHSs in partnership with local organisations, that are data driven and establish accountability for specific outcomes, are intended to inform a Queensland Health Needs Assessment and Plan that better informs system-wide service planning and delivery. Joint planning at the local level is a reform direction within the National Health Reform Agreement 2020-2025 and PHNs are required to do a local health needs assessment. These recommendations also complement Recommendation 4.

17 When referring to diabetes in this report, this includes: Type 1, Type 2 and Gestational diabetes.

Recommendation 1(a):

Develop a First Nations Health Equity Framework to guide implementation of the proposed First Nations health equity strategies

Recommendation 1(b):

Within one year of passing the Health Legislation Amendment Bill 2019 and regulations, each HHS develop a First Nations Health Equity Strategy in collaboration with local A&TSICCHOs

We believe there is an historic opportunity to improve health equity by shifting how healthcare is provided to First Nations people.

First Nations health equity requires targeted approaches to health care to ensure Aboriginal and Torres Strait Islander peoples have a fair and just opportunity to attain their full health potential. It requires co-designing new and different healthcare approaches with Aboriginal and Torres Strait Islander people that responds to health needs and respects the cultural rights of First Nations people.

The Health Legislation Amendment Bill 2019 recently passed by the Queensland Parliament will, among other things, require all HHSs to have a health equity strategy to 'achieve, and specify the Service's activities to achieve health equity for Aboriginal people and Torres Strait Island people in the provision of health services by the Service'. To guide the development of these strategies and shape future health planning for First Nations people, we recommend a First Nations Health Equity Framework is co-designed with the A&TSICCHO sector. This framework will support standard setting, coordination and service delivery for First Nations Queenslanders.

The Group proposes that within one year of passing this legislation and the underpinning Hospital and Health Board Amendment Regulations, HHSs should have their First Nations Health Equity Strategy finalised. These strategies should be developed in partnership with the Aboriginal and Torres Strait Islander health services sector to ensure they are comprehensively co-designed, co-owned and co-implemented with First Nations people.

Recommendation 1(c):

Develop a Queensland Health Equity Framework, building on the First Nations Health Equity Framework

While population health measures can achieve overall gains in health outcomes across the population, without the application of an equity lens, the health gap between the most advantaged and most vulnerable will not improve. Health inequity is linked to social disadvantage, and if health interventions do not address this gap then health inequities will remain.[18]

One simple example that highlights the impact of health inequities is Queensland's potentially preventable hospitalisations (PPH) data. In 2015-16, the rate of PPH was 84 per cent higher in disadvantaged areas compared with advantaged areas.[19]

Building on and incorporating the First Nations Equity Framework, we recommend a Queensland Health Equity Framework is developed to support equitable access to health care to ensure equitable health outcomes for all Queenslanders. This should include addressing equity considerations for people living in rural and remote regions, and those relating to ethnicity, disability, socioeconomic status, age, gender and sexuality.

We recommend the Department of Health lead this work, with expert input from Health and Wellbeing Queensland and HHSs, as well as collaboration with key stakeholders across Queensland's health system, including consumer groups, clinical groups and health unions, whole-of-government, non-government and private sector partners who play a role in addressing the social determinants of health.

The framework should incorporate insights and lessons from existing frameworks such as 'Fair Foundations: The VicHealth framework for health equity' which is based on the World Health Organisation Commission on the Social Determinants of Health conceptual framework.[20] Fair Foundations has been used for evidence reviews looking at the social determinants of health in areas such as child and adolescent mental wellbeing, alcohol-related health inequities, healthy eating and healthy settings (e.g. physical and social contexts for daily activities).

Queensland Health could also consider the engagement process and outcome of the New Zealand Ministry of Health's approach to equity which defines health equity as "*people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes*." [21]

18 Kelly, Michael P. et al (2007), The social determinants of health: Developing an evidence base for political action, WHO Final Report to the Commission.

19 Queensland Health (2018), The health of Queenslanders 2018. Report of the Chief Health Officer Queensland, Brisbane, Queensland Government.

20 VicHealth (2015), 'Fair Foundations Health Equity Framework - Health Inequalities & Health Inequities', https://www.vichealth.vic.gov.au/media-and-resources/publications/the-vichealth-framework-for-health-equity#:~:text=Fair%20Foundations%3A%20The%20VicHealth%20framework%20for%20health%20equity,-can%20be%20used%20for%20any%20public%20health%20issue. (accessed July 2020).

21 Ministry of Health – Manatú Hauora (2019), 'Achieving equity', https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity (accessed July 2020).

This approach will build on the Queensland Government's Our Future State: Advancing Queensland's Priorities which includes health and wellbeing objectives of "Give all our children a great start" and "Keep Queenslanders healthy".[22]

The Queensland Health Equity Framework is intended to underpin the approach to Local Health Needs Assessments and Plans, supporting service planning, agreements and delivery.

Recommendation 1(d):

Develop an integrated Local Health Needs Assessment and Plan at every HHS in partnership with the PHNs, A&TSICCHOs, other local partners and consumers

Collaborative local health needs assessment and planning will support a system-wide approach to meeting local population health needs by identifying agreed, targeted and timely preventive and service measures that deliver for local communities. They should also inform planning for infrastructure and capital requirements at a local level.

> A Health Needs Assessment is a systematic process to assess the health problems facing a local population. This includes determining whether certain groups appear more prone to illness than others and pinpointing any inequalities in terms of service provision. The output is a list of identified priorities that can be used for healthcare planning and service delivery that best suits the needs of the population.[23]

This recommendation also recognises local differences should inform broader service planning that allocates funding based on local need and not only on local hospital activity, which may miss opportunities for more preventive health measures and/or integrated primary care. It also provides an opportunity to better understand local high-risk and vulnerable populations that may vary across the State, better reflect local health needs and in turn contribute towards improving health equity across the State's regions. This recommendation creates an opportunity to embed integration with primary health care, including across the three identified areas of children in the first 2000 days of life, diabetes and mental health.

To do this, regular collaboration and information sharing between HHSs and their districts' PHNs and A&TSICCHOs will need to be embedded consistently across the State, where this is not already the case. Engagement and co-design with local partners, such as local government, community providers, industry and consumer engagement will also play a critical role in the success of the needs assessments and plans.

PHNs already undertake needs assessments as part of their commissioning framework[24] and this could be used as part of the integrated Local Health Needs Assessments with the HHSs, if appropriate.

There is potential to leverage other processes to address health disadvantage. For example, the parties to the current enterprise bargaining agreement covering nurses and midwives have focused on strategies (including innovative models of care and working to full scope of practice) to address the social determinants of health. This approach could be adopted across Queensland Health to support policy priorities, such as health equity.

22 Queensland Government (n.d.), Our Future State: Advancing Queensland's Priorities, https://www.ourfuture.qld.gov.au/ (accessed June 2020).

23 National Institute for Health and Care Excellence (2020), 'Glossary', https://www.nice.org.uk/Glossary?letter=H (accessed July 2020).

24 Department of Health, Australian Government (2018), 'PHN Needs Assessment Guide', https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Needs_Assessment_Guide (accessed July 2020).

We recommend that each Local Health Needs Assessment and Plan should include specific plans for:

- children in the first 2000 days of life (including pregnancy);
- people at risk of developing and living with diabetes;
- people with mental illnesses, and
- a preventable hospitalisation plan.

The Plans should be made publicly available and updated every three years to ensure they address any changes in population need.

To ensure that the local health needs assessments and plans are achieving what they are intended to, we recommend the development of clear outcome indicators for reporting by the HHSs, including for the specific target groups listed above.

The outcomes should be reported at the HHS level and provide breakdowns so differences in outcomes for vulnerable groups, including First Nations people, can be identified. This will highlight whether equitable outcomes are being achieved.

Outcome indicators should be developed in collaboration with clinicians (through the relevant clinical networks and other established processes), PHNs, A&TSICCHOs and consumers to ensure they accurately represent shared goals for local populations.

Finally, the outcome indicators should be included under the HHS Service Agreements as part of their Key Performance Indicators and other public reporting, as appropriate.

Recommendation 1(e):

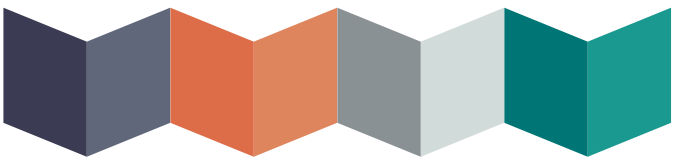
Develop a Queensland Health Needs Assessment and Plan

The Group suggest that locally developed health needs assessments are consolidated into and inform the development of a Health Needs Assessment and Plan for Queensland, which would be informed by and complement the Chief Health Officer's report. This will ensure that local priorities are informing state-wide priorities and planning over the medium term, including approaches to purchasing and commissioning of health services. Additionally, such a plan ensures that system structures and levers are in turn supporting local needs and priorities over time.

> **"We should utilise advances in Population health understanding to inform improved planning, to deliver services where they are going to have the most impact – this will enhance equity of funding rather than a focus on providing the same for all. If we can do this well, we might have the opportunity to really make an impact on Closing the Gap and supporting our most vulnerable populations."**
>
> *Staff member, Children's Health Queensland*

Recommendation 2:

Make prevention and public health a system priority



Recommendation 2:
Make prevention and public health a system priority

Why:

To reorient the health system to prevention and population health so all Queenslanders have the best opportunity to lead healthy lives, including a focus on vulnerable groups who have a higher proportion of ill health.

How:

a) Amend the *Hospital and Health Boards Act 2011* to add prevention and population health as activities and responsibilities of the HHSs, working in partnership with other local agencies to improve population health outcomes.

b) Include an incentive in the Queensland Health funding and purchasing model to reward HHSs for improvements in care and outcomes for:

- children in the first 2000 days of life (including pregnancy),
- people at risk of developing and those already living with diabetes, and
- people with mental illnesses.

c) Develop an approach that sustains increased focus on population health, health promotion and secondary prevention activities across the health system, including within HHSs.

d) Establish additional prevention and public health capacity in, and for, Cape York and Torres Strait, and in, and for, Western Queensland.

e) Create a public health and prevention clinical network.

f) Develop and deliver a multi-disciplinary Queensland Public Health Training Program in consultation with Queensland universities and relevant professional bodies.

g) Expand immunisation capacity across Queensland, especially to prepare for a COVID-19 vaccine.

As demand for hospital services continues to increase at an unsustainable rate, the need to focus on effective preventive and population health measures is a key area for improvement. Around 8 per cent of Queensland's hospitalisations in 2015-16 could have been avoided, or their likelihood reduced, through preventive care and early disease management delivered outside the hospital setting, such as in primary healthcare, general practice and community health centres.[25]

In Queensland, the burden of disease is largely due to non-communicable or chronic diseases, with a number of risk factors able to be modified – and therefore minimise or prevent the impact of the disease – including tobacco use, dietary risks, high body mass, physical inactivity and alcohol use.[26]

There is significant opportunity to reshape and boost public health and prevention to become a system priority. We view prevention broadly, noting that prevention occurs across settings every day and is, and can be, delivered by many providers, clinicians, public health workers and others.

Public health focuses on preventing ill health through activities such as promoting health literacy and health programs. Examples of public health activities include communicable disease control, organised immunisation, food standards and hygiene, cancer screening, prevention of hazardous and harmful drug use, and public health research.[27]

Prevention in healthcare broadly occurs in three forms:

- Primary prevention – intervening before health effects occur, through measures such as changing the impact of social and economic determinants on health, vaccinations, altering risky behaviours (e.g. poor eating habits, tobacco use) and the conditions which create them, and banning substances known to be associated with a disease or health condition.
- Secondary prevention – screening to identify diseases in their earliest stages, before the onset of signs and symptoms, through measures such as mammography and regular blood pressure testing.
- Tertiary prevention – managing disease post diagnosis to slow or stop disease progression through measures such as chemotherapy, rehabilitation, and screening for complications.[28]

As prevention can occur at any stage of an individual's health status, preventive health activities should be seen as everybody's business. Given the significant impact of the potentially avoidable burden of disease being faced by the health system and communities, we recommend system wide measures are put in place to position prevention as a system wide priority.

25 Queensland Health (2018), p. 44.

26 Ibid, p. 45.

27 Australian Institute for Health and Welfare (2019), Health expenditure Australia, 2017–18, Health and welfare expenditure series no.65. Cat. no. HWE 77, Canberra, AIHW.

28 Centers for Disease Control and Prevention (2017), 'Pictures of America: Prevention', https://www.cdc.gov/pictureofamerica/pdfs/Picture_of_America_Prevention.pdf (accessed July 2020).

The Group welcomes the establishment of Health and Wellbeing Queensland and acknowledges there are challenges to expanding prevention efforts across health systems. We note the comment in the recently completed New Zealand Health and Disability System Review and its findings that prevention activities are unlikely to be best achieved by 'carving population health off to the side'.[29]

To ensure the effectiveness of the Queensland public health sector, we recommend the following approach as part of a long-term strategy to boost public health and prevention capacity across the system.

Recommendation 2(a):

Amend the *Hospital and Health Boards Act 2011* to add prevention and population health as activities and responsibilities of the HHSs, working in partnership with other local agencies to improve population health outcomes

To clarify and enhance organisational responsibilities for prevention and population health, we recommend that the *Hospital and Health Boards Act 2011* (which states the functions of the HHSs), is amended to specifically state that HHSs have a shared responsibility for prevention and population health in collaboration with other parts of the health system and broader community, such as local government.

To support implementation, the role and definitions of primary and secondary prevention and population health will need to be clearly outlined and developed in collaboration with the Health Services Chief Executives (HSCE) Forum and Queensland Health Board Chairs' Forum. Once agreed and implemented, service planning, service agreements and funding should be amended to reflect this responsibility.

Recommendation 2(b):

Include an incentive in the Queensland Health funding and purchasing model to reward HHSs for improvements in care and outcomes

Funding incentives can support HHSs to undertake effective prevention and population health activities. In addition to other funding reforms that could be developed, such as under the new National Health Reform Agreement 2020-2025, the Group understands there is capacity within the existing Queensland Health funding and purchasing model to incentivise preventive health care improvements. We recommend that the Queensland Health funding and purchasing model includes incentives to reward HHSs for improvement in care through the incorporation of prevention and early intervention activities. Incentives should initially be developed for the delivery of care for the following patient groups and be included in Local Health Needs Assessments and Plans (Recommendation 1d):

- Children in the first 2000 days (including pregnancy), incorporating prevention and early intervention strategies
- Prevention and management of diabetes, and
- Mental wellbeing and early intervention.

Recommendation 2(c):

Develop an approach that sustains increased focus on population health, health promotion and secondary prevention activities across the health system, including within HHSs

Currently, Public Health Units (PHUs) provide health protection and communicable disease functions. However, prior to 2012 the PHUs also provided prevention and health promotion functions. This capacity should be expanded and re-imagined over time to boost HHS level capacity and to build a modern population and preventive health led approach to health service planning to achieve equitable health outcomes.

We recommend that Queensland Health work with HHSs, Health and Wellbeing Queensland and other partners to develop, resource and implement an agreed approach that sustains increased prevention delivery by the health system, building on locally developed public health plans.

We suggest two options could be explored to achieve a contemporary and expanded public health and prevention capacity (although other options may also emerge in future consultations):

- The role of PHUs could be re-configured to become Public Health and Prevention Units to include population health, health promotion and secondary prevention activities; or
- Prevention expertise could be embedded in HHS-based strategy, planning and engagement structures.

29 Health and Disability System Review (2020), Health and Disability System Review – Final Report – Pūrongo Whakamutunga, Wellington, HDSR.

Recommendation 2(d):

Establish additional prevention and public health capacity in, and for, Cape York and Torres Strait, and in, and for, Western Queensland

In Queensland, there are 11 PHUs working across the 16 HHSs. Some PHUs provide services across multiple HHSs, such as Cairns and Hinterland HHS also providing services to Torres and Cape HHS. Along with Torres and Cape, there are no standalone PHUs sitting within the Western Queensland region.

To ensure greater coverage of public health and preventive health services across Queensland's major regions, we recommend establishing an additional PHU (as well as increased preventive health capability in line with recommendation 2c) for Torres and Cape and additional public health and prevention capacity to service Western Queensland. In Western Queensland, this could be through the establishment of a central public health unit or several small non-medical units, supported by public health medical officers.

As part of the expansion of public health capacity across the system, consideration should also be given to innovative workforce models, particularly the use of nursing to increase capacity in specialist communicable and non-communicable diseases activity.

Recommendation 2(e):

Create a public health and prevention clinical network

Harnessing the required expertise and leadership across Queensland will be essential to reorient the system to population and preventive health. Queensland Health's Clinical Excellence Queensland supports the Queensland Clinical Senate and a number of Statewide Clinical Networks to engage clinicians and consumers in the decision-making process about planning and implementation, practice improvement, and quality and safety enhancements.[30] While there is an informal network of public health unit directors and a formal Statewide Infection Clinical Network, there is an opportunity to expand this current capacity to create a new network to cover prevention and public health for Queensland. We recommend this is achieved through the creation of a public health and prevention clinical network.

The Senate and existing Clinical networks should also be encouraged to consider opportunities for prevention within their remit.

Recommendation 2(f):

Develop and deliver a multi-disciplinary Queensland public health training program in consultation with Queensland universities and relevant professional bodies

There is a broad range of public health skills and professions required to deliver a strong public health and prevention service across Queensland.

Presently, Queensland does not have a public health training program that is available for a broad range of health professionals to undertake and be purposefully deployed.[31]

To build Queensland's public health workforce capacity, we recommend that work commences to establish a state-wide public health training program with eligibility across health professions, including physicians, nurses, allied health professionals and Aboriginal and Torres Strait Islander health practitioners and health workers.

The program should be developed in consultation and collaboration with a broad range of stakeholders, including Queensland universities and relevant professional bodies.

Recommendation 2(g):

Expand immunisation capacity across Queensland, especially to prepare for a COVID-19 vaccine

There has been significant progress in improving immunisation rates across Queensland, and existing Queensland Health programs should continue, especially in population pockets where there have been ongoing challenges to achieve the targets and reach 'herd immunity'.

Queensland Health should commence planning to ensure that in the event of an effective COVID-19 vaccine becoming available, a suitably trained and authorised workforce is can deliver a vaccine to the Queensland community in a range of healthcare settings.

Currently, a wide range of healthcare professionals in Queensland Health and across the Queensland health system have sufficient clinical training to safely provide immunisations. However, a number of practical and regulatory barriers exist that prevent immunisation from being delivered by these healthcare professionals. The population wide delivery of a COVID-19 vaccine must optimise the use of the widest range of healthcare professionals. This would also benefit the delivery of the current range of essential vaccinations for children and adults.

30 Clinical Excellence Queensland, Queensland Health (2020), 'Statewide Clinical Networks', https://clinicalexcellence.qld.gov.au/priority-areas/clinician-engagement/statewide-clinical-networks (accessed July 2020).

31 There is a Queensland Advanced Public Health Training Program which is only available to eligible medical officers, https://www.health.qld.gov.au/employment/work-for-us/clinical/medical/recruitment/training/public-health.

Tracking of COVID-19 vaccination rates would also be vital. Currently childhood vaccinations are well documented through the Australian Immunisation Register, but adult vaccinations are not. Adult immunisation can be more challenging as vaccination requirements may differ depending on an individual's childhood vaccination and medical history and different recommendations depending on a person's circumstances or risk profile.[32]

We recommend that support is given to a wider range of clinicians, including nurses, midwives, nurse practitioners, pharmacists and Aboriginal and Torres Strait Island health practitioners, to provide immunisations as part of their scope of practice (refer also to Recommendation 10).

As outlined in the 'further opportunities' section later in this report, we recommend system-wide encouragement for clinicians and Queenslanders to upload all immunisation and related records into My Health Records. This will support identifying a patient's immunisation status across health care providers.

> "...Nurses should be trained in complete physical examination. ...There are no nursing post-graduate courses specifically in physical assessment. If appropriate courses were created, nurses stationed at more remote areas could conduct relevant, thorough examinations for each patient as well as some clinical interventions whilst consulting with an MO over telehealth."

Staff member, Central West HHS

> 'I think there has been a lot of good will and genuine appetite between organisations to work together towards a common goal - in this instance public health. We would want to keep this going forward.'

QUT report

> "There could be greater capacity building in remote communities, with extra clinicians to support local Allied Health Assistants in communities. This would include a broad range of care such as rehabilitation, nutrition, groups in the community looking at weight loss, mobility, pain management etc ..."

Staff member, Torres and Cape HHS

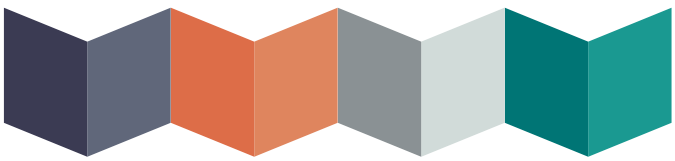
> "Prevent further isolation and ill health of vulnerable cohorts by rolling out social prescribing and care coordination models across primary and tertiary care, targeting those with "rising risk' of hospitalisation and without appropriate support, who may experience unnecessary and avoidable deterioration."

Brisbane South PHN

32 Department of Health, Australian Government (2020), 'Immunisation for adults', https://www.health.gov.au/health-topics/immunisation/immunisation-throughout-life/immunisation-for-adults (accessed July 2020).

Recommendation 3:

Ensure the availability of essential clinical supplies



Recommendation 3:
Ensure the availability of essential clinical supplies

Why:

Ensure health care workers have timely access to essential clinical supplies to safely provide care to Queenslanders.

How:

a) Acknowledge the importance of creating the Clinical Stock Reserve and ensure appropriate input into the whole of government effort to build the reserve.

Similar to other jurisdictions, Queensland experienced shortages of essential from mid-January 2020 as COVID-19 became a worldwide pandemic. These critical stocks included items such as surgical masks, gloves, key pharmaceuticals, hand sanitiser and other goods vital to maintaining services and supporting frontline services. The pandemic has brought into sharp focus the importance of timely access to essential clinical supplies for the safe delivery of healthcare services to all Queenslanders.

As market conditions for PPE and other clinical supplies deteriorated globally, the Queensland Government took a number of steps to address supply shortages for critical items. Queensland Health partnered with other departments to focus on demand and supply of critical PPE items.[33, 34]

Queensland Health launched a COVID-19 supply portal on 20 April 2020 to inform and manage potential suppliers and streamline due diligence for the provision of essential supplies. In April 2020, the interim COVID-19 Supply Chain Surety Division was also established within the Department of Health to oversee and bring an end-to-end response for the Department's supply chain surety response. Daily reporting on pandemic and non-pandemic PPE stock levels was established to enable early identification of supply challenges and equitable distribution, and rapid streamlined procurement processes were put in place to enable procurement teams to secure critical goods.[35]

The COVID-19 response exposed the volatility of global supply chains as production and delivery times grew longer and a global surge in demand increased competition for critical items.[36] The Group notes that many stakeholders were significantly concerned about PPE levels during the early stages of the pandemic, in terms of safety for clinicians and patients.

The experience has highlighted the need for the Queensland Government to establish and implement a Clinical Stock Reserve and new approach for procurement and supply chain management. Traditionally, Queensland Health has relied on international trade relationships and suppliers, as well as domestic supply chains, for its PPE supplies.

COVID-19 has highlighted that the Queensland Government cannot always rely on these arrangements and needs a strategy to mitigate the impacts of emergencies and severely disruptive events.[37] The strategy proposes to introduce long term procurement and supply chain effectiveness, market diversification with increased manufacturing, integration of a reserve of critical supplies and equipment with stronger interjurisdictional relationships to support future supply response.

The Queensland Government is developing a new approach and capability to build supply chain procurement resilience and to be able to manage supply chain risks. This will involve several approaches:

- Moving from a 'just in time' to hybrid 'just in case' supply chain model which is underpinned by clinical reserve.
- Establishing and implementing a Queensland Clinical Stock Reserve to be managed by Queensland Health which is intended to support essential service providers across Queensland Health and other Queensland Government agencies during significant events and periods of supply chain disruption as a first response until their supply chains are established.
- Implementing a two-year procurement transformation blueprint that will build strong partnerships with other State agencies and jurisdictions to create a future market resilient to future catastrophic events.

The Group also acknowledges that security of supply extends beyond PPE to other critical inputs for the health system response. This includes security of medicines and supply of high quality COVID-19 diagnostic testing kits, technology and associated consumables to enable effective population screening interventions as part of public health measures.

33 Other departments included: Department of State Development, Manufacturing, Infrastructure and Planning (DSDMIP) and Department of Housing and Public Works (HPW), supported by the Department of Premier and Cabinet (DPC).

34 Queensland Health (2020), Written submission to the Inquiry into the Queensland Government's health response to COVID-19 Health, Community, Disability Services and Domestic and Family Violence Prevention Committee, Queensland Parliament.

35 Ibid.

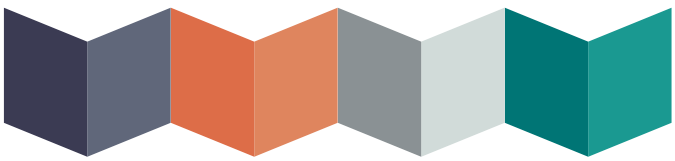
36 Duckett, Stephen et al (2020), Coming out of COVID-19 lockdown: the next steps for Australian health care, Grattan Institute, pp. 63-64.

37 Deputy Premier and Minister for Health and Minister for Ambulance Services: The Honourable Steven Miles (2020), 'Queensland to guarantee protective equipment for health services', https://statements.qld.gov.au/statements/90097 (accessed July 2020).

An integrated, high value health system

Recommendation 4:

Transform the relationship with primary care in Queensland



Recommendation 4:
Transform the relationship with primary care in Queensland

Why:

To improve the link between primary health care and hospital services to ensure a seamless transition between sectors for all Queenslanders.

How:

a) Strengthen the partnership with primary health care by creating a mechanism for governance, networking, engagement and strategic policy in Queensland Health.

b) Encourage transfer of care back to, and treatment in, primary health care where clinically appropriate through consistent, open and equitable processes.

c) Develop incentives in the Queensland Health funding model that support specialist to primary health care consultations, including virtual consultations.

d) Collaborate with primary health care to continue the uptake of consistent care pathways across Queensland, especially through the use of HealthPathways and clinical prioritisation criteria.

e) All clinical networks to include primary care membership and engagement with primary care.

Not surprisingly, a consistent theme from the Group's consultation is the need to improve health system integration and collaboration. The COVID-19 response required speedy collaboration across the health sector to meet the needs of local populations to address the emerging public health risk of the pandemic. Where these partnerships were in place, a more agile and effective response was reported.

For many Queenslanders, primary health care can be the first and most regular contact a person has with the health system. Primary health care can be provided in the home or in community-based settings such as general practices, other private medical practices, pharmacies, community health centres, midwifery group practices, local government, and non-government service settings, such as A&TSICCHOs.[38] Services are varied and provided by a range of health professionals including general practitioners, First Nations health practitioners, remote area nurses, midwives, nurse practitioners, pharmacists and allied health professionals. Queensland Health is also a direct provider of primary health care in many rural and remote areas, as well as providing a broad range of community health services.

Between the hospital and primary care settings there is considerable opportunity to provide patients with improved continuity of care, particularly for First Nations people and other groups experiencing significant health disadvantage.

Research by the Nuffield Trust[39] indicates two areas critical to strengthening the relationship between primary and secondary care, namely hospitals working more closely with general practitioners with special interests (GPwSIs) and access by general practitioners to rapid specialist advice. Queensland Health should continue to advance these areas. This should also apply to other clinical staff including nurse practitioners.

Queensland Health supports and promotes the implementation of integrated care models across hospital and primary care settings. However, HHS relationships with the primary health care sector are often the result of 'pockets of good practice' rather than systemised opportunities to build partnerships. If this changes, and relationships are more systemised and embedded in HHS policy and practice, the health dividend for Queenslanders and clinicians will be significant.

By improving coordination and partnerships with the primary health care sector for non-admitted patient care, patients across Queensland will have more options to access care, which may be closer to home. This is particularly beneficial for patients in regional, rural and remote regions who may not live near a referral hospital and for First Nations people to be able to receive care in their communities and from their local community controlled health service.

While the Commonwealth Government generally holds the levers for primary care funding models, the State can play an important role in establishing appropriate frameworks in areas within its influence and control.

We encourage Queensland Health to continue to strengthen its current partnerships with primary health care by:

- Continuing to expand standardised referral pathways for care delivered in the primary health care setting, both from primary health care to specialist outpatients and from specialist outpatients back to primary health care.
- Linking acute and outpatient services with and nurse practitioners and providing access to rapid specialist advice.
- Establishing a mechanism in the funding model to incentivise/reimburse specialists to consult with primary health care providers on a patient's care pathway, for instance by providing funding for such consultations where the patient is not present.[40]

38 Department of Health, Australian Government (2018), 'Fact Sheet: Primary Health Care', https://www1.health.gov.au/internet/main/publishing.nsf/Content/Fact-Sheet-Primary-Health-Care (accessed July 2020).

39 Imison, Candace et al (2017), Shifting the balance of care: great expectations, Research report, Nuffield Trust.

40 Daley, John et al (2020), The Recovery Book: What Australian governments should do now, Grattan Institute, p. 78.

- Establishing a function in the Department to oversee governance, engagement and strategic policy to facilitate partnerships and coordination with primary health care throughout Queensland Health.

The Group also recommends that all Statewide Clinical Networks should engage with primary health care providers to strengthen the partnership with primary health care across all clinical areas. This should include ensuring that there is primary care membership on all networks. There should also be a mechanism to enable the primary health care members of networks to meet among themselves (e.g. through an annual virtual meeting) to review progress in embedding primary care within the work of the networks.

> "...The changes to the health system to deliver the COVID-19 response aligned with and accelerated the development of the philosophy and service models at the heart of primary health care — getting services to the patients, keeping people out of hospital, working proactively with those most at risk, including First Nations people, older people and people with chronic illness. Primary health care has answers to some of the current problems and stressors in the health system..."

Queensland PHNs

> "HHSs partnering with PHNs to work across primary care sector for targeted purposes expands the geographic reach, workforce distribution and access to communities."

Central Queensland, Wide Bay, Sunshine Coast PHN

> "At a local level on the Gold Coast there has been considerable engagement and collaboration between our professional organisations... This has enabled all organisations to gain a greater understanding of the challenges faced in different contexts – navigating not only the pandemic crisis but also working on breaking down 'silos' within our system."

General Practitioner, Gold Coast general practice

> 'The collaboration between Queensland health and the A&TSICCHO sector with regular teleconferencing has been extremely beneficial and resulted in improved relationships and communications.'

QUT Report

> "...A key opportunity for change is to address the current disconnect between primary, secondary and tertiary care, including communication and collaboration between the acute and primary care sectors and the public and private sectors ... We need to achieve better connectivity and integration in health care; improve the patient journey (particularly for rural and remote patients); and support high quality, continuity of care..."

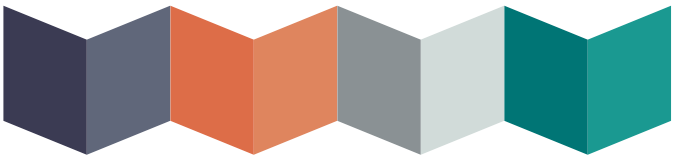
Australian College of Rural and Remote Medicine

> "COVID-19 has highlighted the critical role of the community mental health sector during crises and in business as usual circumstances. It is therefore imperative that the inclusion of community mental health is part of the broader strategic direction of healthcare system reform to meet the continued uncertain environment presented by COVID-19."

Queensland Alliance for Mental Health

Recommendation 5:

Develop and deliver a value-based health care strategy to underpin service improvement across Queensland Health



Recommendation 5:
Develop and deliver a value-based health care strategy to underpin service improvement across Queensland Health

Why:

To co-design, measure and deliver health outcomes that matter to patients and the community.

How:

a) Co-design a strategy for organising Queensland's public health system to maximise value to patients on the outcomes that matter most to them, relative to the cost of achieving those outcomes (Choosing Better Health Together group). Specific actions include:

   i. Develop a whole of system reform approach to implementation, where consumers, clinicians, health workers, providers and the system managers are working toward common goals and supporting the creation of value between patients and clinicians

   ii. Build on extensive clinical and consumer-led work to co-design, implement, scale and continuously evaluate effective patient-centred models of care that put consumers at the centre of their health journey, and

   iii. Prioritise diabetes as one of two nationally agreed priority areas.

b) Develop a pilot program to collect Patient Reported Outcome Measures for all patients in defined groups and evaluate the utility and impact of this approach.

Value-based health care (VBHC) is a strategy for organising and re-focusing health systems to maximise value, where value is defined in terms of the outcomes that matter most to the people receiving care relative to the cost of achieving those outcomes. [41]

In Australia, VBHC is informing health systems as a transformational strategy for tackling significant and complex problems including: a changing and more complex disease profile across the population, persistent health inequalities, rising healthcare costs, persistent unwarranted variation in clinical care, and consumer expectations for more personalised health care that aligns to their individual goals.

What distinguishes VBHC from other types of improvement effort is:

- Measuring and maximising outcomes that matter from the perspective of the person receiving care, not just those providing or funding it.
- Systematic measurement of outcomes and cost underpinning system design and care delivery. The insights from clinical and patient-reported outcome data are used to evaluate impact, improve care delivery, inform joint decision-making by patients and clinicians, and guide resource allocation decisions and system management.
- Optimising care across the full care pathway, not just individual episodes within it. This approach creates an implicit drive for integration and prevention, as value is maximised by avoiding or limiting the need for unnecessary care and reducing costly fragmentation and duplication.
- A whole-of-system reform approach, with system managers responsible for building the enablers of value and coordinating action across stakeholders, recognising that fundamentally value is created in the interactions between clinicians and consumers.

VBHC also includes reducing 'low value care', or care which delivers little or no health benefit to the consumer. Recommendation 8c calls on Queensland Health to implement processes for independent clinical review of all cases of potentially low value care prior to proceeding.

VBHC is central to the National Health Reform Agreement 2020-2025 as a unifying framework for the Agreement's six long-term health reforms – paying for value and outcomes, joint planning and funding at the local level, enhanced health data, prevention and wellbeing, nationally cohesive health technology assessment and empowering people through health literacy.

States are progressing at varying degrees with VBHC. New South Wales is seeking to launch VBHC at scale and has developed a VBHC Strategy, while Queensland is exploring how to embed VBHC principles into the State's public health system.

Queensland Health, including through the Department of Health, HHSs, Clinical Senate and Clinical Networks, has undertaken considerable work and engagement on progressing VBHC. As system manager, the Department of Health has undertaken initiatives such as demonstrator projects and development of patient-centred performance measures and platforms for reporting. The Clinical Senate and Clinical Networks have shown strong leadership and commitment to VBHC.[42] A wide range of initiatives have been developed or trialled, including Getting it Right First Time, Promoting Value-based Care in Emergency Departments, HealthPathways, National Surgical Quality Improvement Program and the Royal Brisbane and Women's Hospital Choosing Wisely local anaesthetics project. Metro North HHS has developed 'AboutMe' which is a purpose-

41 The Australian Centre for Based Health Care broadly describes VBHC as "the health outcomes that matter to patients relative to the resources or costs required, over a full cycle of care" (https://valuebasedcareaustralia.com.au/resources/defining-value/).

42 Queensland Clinical Senate (2019), Maximising benefits of care, 1-2 August 2019 – Meeting Report, Brisbane, Queensland Government.

built web application to collect and report on Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs).

These initiatives provide a solid foundation for the broader adoption of VBHC, but they are insufficient on their own to produce the large-scale transformation necessary to shift towards VBHC. The Group recognises that fully realising the benefits of VBHC will require long term, coordinated action at all levels of the health system.[43]

Recommendation 5(a):

Develop a strategy for organising Queensland's public health system to maximise value to patients on the outcomes that matter most to them, relative to the cost of achieving those outcomes

We recommend shifting Queensland's public health system more assertively towards VBHC, led by the development of a clear, high-profile strategy that supports the planning and prioritising of health care at the local, provider and system level. A shared framework will ensure the convergence of effort and strategy across Queensland's varied and complex health system.

The strategy should promote a framework for consumer and clinician led work, and create enabling conditions for VBHC such as improved consumer and community engagement; clinical leadership and workforce culture; systematic measurement of outcomes and cost; robust research and evaluation practices; digital health and analytics; as well as funding that supports value and aligned incentives.

An example of Value-based health care - New South Wales Health [44]

Similar to other jurisdictions, New South Wales (NSW) is experiencing growing pressure on its health system from chronic disease and an ageing population. In response, NSW Health is driving a shift towards value-based healthcare (VBHC) with a systemwide vision and strategy; clearly articulated roles and responsibilities across the public health system;[45] investment in eight identified 'enablers' to build capability; and state-wide programs to help accelerate the whole system towards VBHC.

In 2017 the Leading Better Value Care program (LBVC) was established to identify and scale an initial eight (now 13) clinical evidence-based initiatives in all local health districts across the state. New clinics have been established across the state for High Risk Foot Services, the Osteoporosis Refracture Prevention model of care, and the Osteoarthritis Chronic Care Program. The clinics embed patient-centred models of care involving acute, primary and community care services.

Integrated care is a related program that focuses on outcomes for vulnerable and complex patients through linkages between local health districts, PHNs and other service providers. A state-wide initiative to improve health outcomes and experiences for people with diabetes has also been launched with PHNs, Aboriginal and Torres Strait Islander Community Controlled Health Organisations, and Diabetes NSW & ACT to coordinate and integrate care at the local level.

Other key programs include Commissioning for Better Value and Collaborative Commissioning.

NSW is also collecting experience and outcomes data for priority patient cohorts to inform value-based funding models and purchasing. The Registry of Outcomes, Value and Experience links multiple administrative, patient reported measures and clinical datasets for the 13 LBVC patient cohorts. An example is the Osteoarthritis Chronic Care Program, which measures patient outcomes for pain level and hip or knee functional status where previously, the main measures were activity based, i.e. the number of surgeries for knee replacement.[46]

43 NSW Government (2020), 'Value based healthcare', https://www.health.nsw.gov.au/Value/Pages/default.aspx (accessed July 2020).

44 Koff, Elizabeth and Lyons, Nigel (2020), 'Implementing value-based health care scale: the NSW experience', the Medical Journal of Australia, 212(3), https://doi.org/10.5694/mja2.50470.

45 For example, the NSW Ministry of Health provides the strategic framework for health districts and specialty health networks to plan and implement local approaches and the NSW Health Pillar organisations provide support and tools to help clinicians use and apply the best available evidence and implement the initiatives.

46 Koff, Elizabeth and Lyons, Nigel (2020).

Strong clinical and consumer engagement is necessary to deliver health outcomes that matter to patients. Queensland's Clinical Senate and Clinical Networks actively encourage clinicians to engage with patients about 'what matters to them', rather than 'what is the matter with them'. Using frameworks such as B.R.A.N (Benefits, Risks, Alternatives, what if we do Nothing?) are also encouraged to guide patient-clinician conversations about what care is needed, which interventions are helpful, and which are not.[47]

To be successful, the VBHC Strategy will need to be driven by Queensland Health's leadership, including the Executive Leadership Team, Queensland Health Leadership Advisory Board, Health Service Board Chairs and Chief Executives, Clinical Senate and Clinical Networks and Health Consumers Queensland. Extensive engagement with consumers, workforce and other key stakeholders will also be required to support health outcomes that matter to patients and improves the health literacy of patients and the community. Some structures already exist to support this work, but some gaps exist and there is a need to establish mechanisms to enhance collaboration and understanding to support the delivery of strategic policy priorities like VBHC.

Jurisdictions are shifting towards a VBHC system by developing trials to support priority patient cohorts and conditions which apply and test VBHC principles. A priority area identified by Queensland Health and also identified at the national level is developing VBHC trials to support people with diabetes. There are more than 260,000 Queenslanders living with diabetes (or 1 in every 20 Queenslanders)[48] with the most vulnerable and disadvantaged Queenslanders disproportionately impacted. Diabetes encapsulates many of the challenges facing patients and health system sustainability. These include the chronic and, in some cases, preventable nature of the disease, the impact of social determinants and the need for ongoing management and associated morbidities across primary, secondary and tertiary services.

Recommendation 5(b):

Develop a pilot program to collect Patient Reported Outcome Measures for all patients in defined groups and evaluate the utility of this approach

Shifting to VBHC includes promoting and supporting the uptake of 'high-value care' while also ensuring 'low-value care' can be identified and discouraged, as appropriate.

This involves a substantial evidence base of patients' care experiences and health outcomes over time. This is also a shared objective of the Commonwealth, States and Territories under the National Health Reform Agreement 2020-2025.

Queensland Health has already commenced the development of measures for patient experience and outcomes. We recommend the Department of Health commence a pilot program to collect PROMs for defined patient groups (e.g. joint replacements), with a particular emphasis on measures of health equity across various population groups in Queensland.

"Early experiences with the new complementary [maternity] models are showing reduced waiting at outpatient appointments, decreased bed-days, continuity of maternity care, improved access and healthcare engagement with specific groups such as First Nations people and those facing socio-economic disadvantage. New models of care are dependent on aligned resourcing and consideration of longitudinal value within the healthcare system."

Royal Australian and New Zealand College of Obstetricians and gynaecologists (RANZCOG)

"Funding systems have been shown to have serious weaknesses. Volume driven funding mechanisms (MBS and ABF) have demonstrated the vulnerability of key parts of the system to remain afloat; we also know that these systems do not drive efficiency in complex care management (e.g. comorbid chronic conditions); now is an opportunity to consider blended funding models. ..."

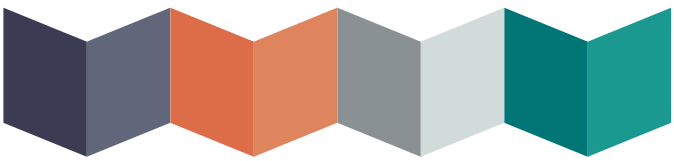
Central Queensland, Wide Bay, Sunshine Coast PHN

47 Queensland Clinical Senate (2019), ps. iv.

48 National Diabetes Services Scheme, Queensland Diabetes Data (July 2020).

Recommendation 6:

Transform non-admitted care to improve patient experience, reduce wait times and improve clinical outcomes



Recommendation 6:

Transform non-admitted care to improve patient experience, reduce wait times, and improve clinical outcomes

Why:

To reduce waiting times for specialist outpatient and non-admitted care.

How:

a) Develop a system-wide program to transform non-admitted care, with an initial focus on specialist outpatient services.

b) Establish consistent, equitable and transparent processes for all referrals to Queensland Health specialist outpatient and non-admitted care based on clinical need:

   i. this would include hubs to coordinate all referrals, and

   ii. hubs would be at a 'cluster' level based on groupings of HHSs that take account of patient flow.

c) Establish consistent referral pathways across Queensland for specialist outpatient services and elective surgery which optimise the use of allied health, nursing, midwifery and general practitioners with special interests (GPwSIs) professional pathways. The initial focus should be in five areas:

   i. orthopaedics

   ii. ear nose and throat (ENT)

   iii. ophthalmology

   iv. gastroenterology, and

   v. pelvic floor health (urogynaecology).

As specialist outpatient services resume, there is an opportunity to transform ambulatory and non-admitted care for Queenslanders. The Group considers that a focus on ambulatory care would present the highest return reform across health service provision, as well as integrate a number of the recommendations in this report, including:

- Partnership with primary care (recommendation 4)
- System wide shift to prevention (recommendations 1 and 2)
- Support for increased scope of practice (recommendation 10), and
- Alternative pathways for care (recommendation 11).

Stakeholder feedback noted the disruption of services during the pandemic led to greater flexibility and workforce mobility, and this should be continued into the future.

While some parts of Queensland's public health system are already implementing the approaches recommended here, there would be significant system wide and community benefit if these approaches were rolled out more fully across the system.

Recommendation 6(a):

Develop a program to transform non-admitted care, with an initial focus on specialist outpatient services

We recommend that Queensland Health develop a program to transform non-admitted care as a matter of priority, with an initial focus on specialist outpatients. The program would have a number of objectives, including to improve patient experience, reduce wait times, and maximise the skills and capability of the health workforce.

A key feature of the program would be the establishment of referral hubs as per recommendation 6b below. However, the program would incorporate a range of additional features over time to enable a more holistic transformation of non-admitted care.

The model should include front-end virtual capability but would operate through multiple channels including telephone and face-to face to reflect consumer preferences and to ensure equitable access for disadvantaged groups. Indeed, a key feature would be to enhance equity of access by ensuring that individual clinicians do not control referral pathways and enabling full visibility of wait times across specialties within 'clusters' and across the State.

The program should also establish strict criteria for review appointments. Rather than developing criteria for referral back to primary care, clinical groups would develop criteria for bringing a patient back for review, with the default position being that patients who do not meet these criteria would be referred back to their primary health care provider.

The model should incorporate GPwSIs, allied health professionals, nurses, midwives and Aboriginal and Torres Strait Islander health practitioners and health workers working to full scope of practice, supported by medical leadership to ensure appropriate clinical standards and governance.

It would form the core of a 'virtual hospital' function that could expand over time to accommodate further functions including urgent care, hospital in the home, and virtual hospital services to rural and regional centres.

Recommendation 6(b):

Establish consistent, equitable and transparent processes for all referrals to Queensland Health specialist outpatient and non-admitted care based on clinical need

As a first step to achieving the transformation of non-admitted care envisaged above, we recommend Queensland Health develop consistent, equitable and transparent processes for all specialist outpatient referrals. This should include a renewed framework for specialist outpatient referrals and reviews that considers referral decisions, intake decisions, and transfer of care.

Centralised hubs should coordinate all patient referrals for specialist and planned care. There are a number of successful models across Queensland and HHSs should seek to implement the model that works best for their local conditions. Existing models include the Metro South HHS central referral hub which embeds General Practitioner Liaison Officers (GPLOs) and clinical specialists to manage all incoming referrals and their care pathways. It is recommended that hubs would be at the 'cluster' level, based on groupings of HHSs that take account of patterns of patient flow.

If implemented well, this approach can simplify referral and treatment processes to and from primary health care, improve communication and integration across providers, and improve patient care and the patient experience. Waiting times from referral to treatment, incorporating both the outpatient wait and the treatment wait, would be better monitored, managed and reported.

For First Nations communities and other vulnerable populations, this approach can significantly improve their access to screening and diagnostic services, appropriate allied health care and treatment within primary health care settings, as well as access to specialist outpatient and non-admitted care. Community Controlled Health Services will play an important role in realising this potential for First Nations communities.

The ability to share referrals across providers would improve efficiency and provide patients with more choice in how, when and where they are seen at a Queensland health facility. In some circumstances, patients may have the option to receive care at an alternative location or through telehealth or virtual care leading to reduced waiting times, travel and accommodation costs. The central hubs would also lead implementation of best-practice, clinically evidenced referral pathways with patients receiving multi-disciplinary team care from highly trained allied health, nursing, midwifery and GP professionals.

Recommendation6(c):

Establish consistent referral pathways across Queensland for specialist outpatient services and elective surgery which optimise the use of allied health, nursing, midwifery and general practitioners with special interests (GPwSIs) professional pathways

We recommend establishing and implementing consistent Queensland-wide referral pathways for specialist outpatient services and elective surgery which optimise the use of allied health, nursing, midwifery and professional pathways. The initial focus should be in five specific areas:

- orthopaedics
- ear nose and throat (ENT)
- ophthalmology
- gastroenterology, and
- pelvic floor health (urogynaecology).

These categories account for a significant proportion of patients on the specialist outpatient and elective surgery waiting lists. For instance, as at 1 June 2020 there were 62,240 patients on the elective surgery waiting list, of whom 14,291 (23 per cent) were waiting for orthopaedic surgery, 7,214 (12 per cent) were waiting for ENT surgery and 6,577 (11 per cent) were waiting for ophthalmology. At the same time, ophthalmology and gastroenterology were the two specialties with the longest waiting lists for specialist outpatient services.

Alternative referral pathways for these five clinical focus areas are currently being implemented within Queensland Health, but generally only in a small number of HHSs or facilities. Research has shown that where these models have been implemented in Queensland Health, they have had a wide range of benefits, including improvements in waiting times, improved clinical outcomes and high patient satisfaction, a majority of patients being discharged and removed from specialist outpatient waiting lists, and reduced costs. Appendix H summarises the research findings.

This shift will also enable allied health, nursing, midwifery and general practitioner professionals to work at their full scope of practice, utilising the skills of our highly trained health professionals more efficiently, and embedding more effective models of care.

Beyond these five initial pathways, the Group considers that additional referral pathways which optimise the use of allied health, nursing and midwifery professionals and should be established over time.

"The need to keep patients out of the hospital system really highlights how much more community services are capable of, how much of what is currently done in hospitals can be delivered outside. There were absolute heroes. We should develop these services properly."

staff member, Gold Coast HHS

"... With elective surgery on hold during the initial pandemic response, alternate pathways to surgery were tried first and utilised more with good success. While the pathways existed prior to COVID-19 there is often a reluctance or resistance by medical staff to utilise these pathways despite evidence of effectiveness. ..."

Staff member, Mater Health

"The cancellation of elective joint replacement surgery heavily impacted people living with arthritis. This highlights the need for the adoption of a model of care (MOCs) that promotes the conservative management of osteoarthritis. Highly successful MOC's exist which should be considered for translation in QLD. Conservative treatment of osteoarthritis is highly effective and can reduce the need for surgery. Steps should be taken now to ensure that any future system disruption does not negatively impact this large group of consumers."

Arthritis Queensland

"We stopped seeing outpatients for extended periods post intervention and returned their ongoing management to primary care GPs where it belongs."

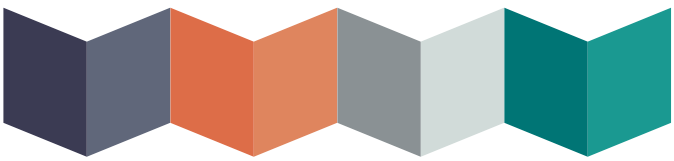
QUT survey

" The blurring of boundaries occurred between primary and acute care, but also between silos in the acute system, which aligned to a common goal."

QUT Survey

Recommendation 7:

Optimise telehealth and virtual care to improve patient experience and outcomes



Recommendation 7:
Optimise telehealth and virtual care to improve patient experience and outcomes

Why:

To deliver better, more timely care closer to home through the use of digital technologies.

How:

a) Develop, fund and implement a sustained approach to increase telehealth in non-admitted care as a priority for a broader virtual care strategy. This would include:

   i. Ensuring that as a minimum, the levels of telehealth and telephone consultations observed during the pandemic are maintained and increased.

   ii. Ensuring all patients are offered the opportunity to receive specialist non-admitted care through virtual technologies where equivalent or improved clinical outcomes can be evidenced.

   iii. Developing a stretch target that 50 to 70 per cent of all non-admitted consultations are delivered through telehealth and/or telephone.

   iv. Developing an integrated suite of key performance indicators on non-admitted services and telehealth, including wait times, new to review ratios, patient travel costs and patient reported measures.

b) Ensure HHSs leverage emerging digital technologies to develop virtual care models that enable home monitoring, virtual consultations and seven-day access to clinical specialists from the patient's home.

Of all the responses we received on reform opportunities stemming from the COVID pandemic, the strongest related to telehealth. Patients, clinicians and other stakeholders across Queensland's health system have indicated clear ongoing support for the provision of care in virtual settings.

Queensland has led Australia on the use of and innovation in telehealth. COVID-19 and the increased funding, availability and adoption of telehealth has supercharged the delivery of care across Queensland. There are clear and multiple benefits from the use of telehealth including improved patient access, a reduction in cost and impact of travel time (particularly for vulnerable patients) and those in rural and remote areas. It is estimated that in 2017-18, telehealth in Queensland led to a reduction of 9 million kilometres and 27,000 days in travel, and to productivity gains of $9 million due to less time away from work.[49] We recognise concerns that for some consumers and clinicians and some communities there is a 'digital' divide in access to reliable technology to support virtual care. We support any effort to boost access to and invest in digital technology, especially to the extent it can also support Queensland's economic recovery.

Telehealth service delivery in Queensland has been influenced by two consumer-led, clinician-driven strategic directions:

- A recognition that although receiving a telehealth consultation at a local Queensland Health facility may offer a significant reduction in travel, many patients would prefer this model to be taken a step further and receive care directly into their homes.
- While telehealth remains largely focused on improving access to clinical services for Queenslanders living in rural and remote locations, it is acknowledged that access to services can also be a challenge for many living in metropolitan areas.[50]

Systemising telehealth across Queensland Health can also add value and transform how services are provided, for example by extending support through maternity and child health follow up, enhanced chronic disease care, rehabilitation and cancer care.

The onset of COVID-19 accelerated the uptake of telehealth and telephone consultations.[51] The number of video-conferencing service events increased from an average of 7220 per month from July 2019 to February 2020 (1.2 per cent of non-admitted service events) to an average of 22,969 per month in April and May 2020 (4.3 per cent of service events).

While a significant percentage increase, they represent a relatively low number of occasions of service, especially when compared to telephone consultations, which vastly exceed the number of telehealth (videoconferencing) consultations. Telephone service events increased from an average of 65,797 per month from July 2019 to February 2020 (11.4 per cent of service events) to an average of 208,722 per month in April and May 2020 (38.9 per cent of service events). Hence more than 40 per cent of non-admitted service events were via telehealth or telephone.

49 [Unpublished] Centre for Online Health (June 2020), Evaluation of the Queensland Health Telehealth Strategy: Draft report 3, University of Queensland

50 Clinical Excellence Queensland (2020), 'Telehealth's Place in Reforming the Health System', Paper prepared for the Reform Planning Group, Queensland Health

51 Within Queensland Health, the term Telehealth is often used synonymously with videoconferencing, with over 150,000 non-admitted service events being provided to Queenslanders in 2019-20FY. In addition to non-admitted telehealth services, the Telehealth Services Unit (TSU) provide Emergency Telehealth, Inpatient Telehealth, eConsultations and Remote Patient Monitoring (RPM).

Patient experience

The increased accessibility of specialist telehealth appointments for all Cystic Fibrosis (CF) patients (not just those who live in rural and remote areas) has meant a reduced risk of cross infection from having to physically present to the hospital. Cross infection is a particularly complex issue for the CF community and can contribute to life expectancy and impacts for CF patients regardless of their location.

> **"At the moment telehealth is continuing in my CF clinic however it has not been communicated to patients whether this will continue long-term. It's been a relief to me not having to go to hospital for my care. I've been getting safe care without the burden of thinking 'I'm healthy and well I don't want to get sick from getting my routine healthcare'. I often put off appointments over winter to avoid getting a cold or virus. This year I haven't had to and without needing to rely on a family member to help get me there."**

Recommendation 7(a):

Develop, fund and implement a sustained approach to increase telehealth in non-admitted care as a priority for a broader virtual care strategy

We recommend that non admitted care be the priority area for the delivery of a broader Queensland Health virtual care strategy, in recognition that telehealth was widely adopted across non admitted care during the pandemic and strongly supported by clinicians and consumers.

At the very least Queensland Health should ensure that the levels of telehealth and telephone services achieved during the pandemic are maintained and increased. In addition, patients should routinely be provided with the option of a telehealth appointment and also have the ability to request a telehealth appointment where there is no clinical imperative for a face to face consultation, especially for review appointments.

Other States and Territories are considering targets. Notably Western Australia, prior to the pandemic, set a target for all metropolitan providers to progressively provide telehealth consultations for 65 per cent of outpatient services for country patients by July 2022, and for telehealth to become the regular mode of outpatient service delivery by July 2029.[52]

It is important that the Department of Health sends a strong signal to HHSs that the levels of telehealth and telephone consultations achieved during the pandemic be increased significantly over time. The Group therefore recommends that Queensland Health establish a stretch target that 50 to 70 per cent of non-admitted consultations be delivered by telehealth and/or telephone.

In coming to this target, we considered that while in many circumstances it may be desirable for some consultations to be face to face, a very high proportion of consultations could be done via telehealth or telephone. With more than 75 per cent of non-admitted consultations currently review appointments, we consider a target in the range of 50 to 70 per cent is achievable.

This target should also be seen in the context of the overall policy framework for non-admitted care. For instance, it will be important to monitor the 'new to review' ratio to ensure that non-admitted patients are referred back to primary health care where clinically appropriate. We therefore recommend that the Department of Health develop an integrated suite of key performance indicators on non-admitted services and telehealth, including wait times, new to review ratios, patient travel costs and patient reported measures.

While the proposed target relates to both telehealth and telephone consultations, it is acknowledged that telehealth and virtual care can often deliver a more holistic patient experience. However, at present they are constrained by lack of digital infrastructure and limited digital literacy among some groups in the community. It would be appropriate for the Virtual Care Strategy currently being developed by Queensland Health to include specific strategies to achieve the target and specifically to promote the use of telehealth, with consideration of regional, rural, remote and metropolitan hospitals. It is important to ensure that First Nations people and other groups experiencing significant health disadvantage have equitable access to telehealth services, including through appropriate digital infrastructure.

Queensland Health should also work with other Government agencies and general practice to support the digital infrastructure for a continued increase in the delivery of virtual care. This would support care in a number of ways and could also support the broader Queensland health and recovery effort by investing in digital infrastructure, especially to support rural, regional and remote areas of Queensland. n advisory body, for example the Telehealth Advisory Group under the governance of Clinical Excellence Queensland, or similar committee, could guide and support implementation of the target. Committee membership would include clinical, workforce, consumer, service provider and rural and remote perspectives with an emphasis on providing timely operational and strategic advice and engaging and educating clinicians. Finally, the Department of Health should review all patient classifications to ensure there is nothing within the classifications and funding weights which inhibit technology-enabled care, and that, if necessary, new items to facilitate technology-enabled care are incorporated. Any changes to the classification should take effect for the 2021-22 funding year.

52 Sustainable Health Review (2019).

Recommendation 7(b):

Ensure HHSs leverage emerging digital technologies to develop virtual care models that enable home monitoring, virtual consultations and seven-day access to clinical specialists from the patient's home

COVID-19 has provided an opportunity to test many claims about the potential benefit of virtual health care, for patients, clinicians and the delivery of health care. While some refinement is still required, virtual care has delivered huge gains for the Queensland community and health system.

Beyond specialist outpatient services, the virtual care model utilises both existing and emerging technologies to enable consumers to manage their care in their own home, and for their condition to be monitored remotely.

As personal wearable technology moves into medical devices, the ability to provide real-time patient monitoring for heart rate, temperature, oxygen saturation, blood pressure and breathing while awake and asleep is quickly becoming a reality.[53]

When added to a the existing virtual capability for patients and their families to access specialists through video-conferencing, virtual care models can bridge the gap, strengthening the relationship between inpatient services and the community, linking patients with hospital specialists, primary care, community services and even mobile medication and pathology services to truly provide patient centred care close to their home or residence.

> "The use of Telehealth in residential aged care has proven to be a useful approach … A recent survey conducted found that more than 80 per cent of those who were offered telehealth services used it, of these a similar proportion viewed the service as excellent or good quality. The survey results highlighted strong support for telehealth to continue in the post-COVID era, this is an opportunity to reset the health/aged care interface."

Aged and Community Services Australia

> "Mental health and alcohol and drug services adapted to a rapidly changing environment by providing access to care via telehealth. Where this option is preferred by consumers, continuation of this should occur via safe and high quality digital and telehealth solutions."

Queensland Mental Health Commission

> "Telehealth consultations provide increased accessibility but not as a total substitute for face to face consultations, particularly for patients with complex care needs. It needs to be underpinned by safety and quality principles and delivered by patient's regular care providers, including primary health care."

CheckUp

> "We learnt that there are many times when a patient's concern or active issue can be dealt with quickly, over the phone, rather than necessitating a trip into hospital (with the associated costs, time off work, etc). Allowing some time for these phone calls in a clinic setting would really improve efficiency over the longer term."

Staff member, Queensland Children's Hospital

> "Obviously Telehealth was well overdue, and everyone knows it has a very important role for regional and rural patients where appropriate."

Staff member, Wide Bay HHS

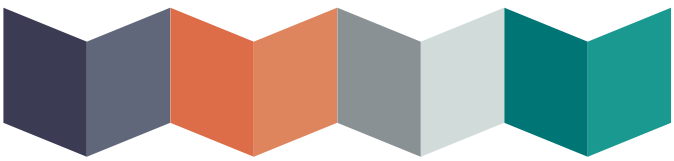
> "The 'new normal' will incorporate models that locate care in the community and at home, leveraging the expanded telehealth capability to provide centralised support from specialist services."

Royal Australian and New Zealand College of Obstetricians and gynaecologists (RANZCOG)

53 Sydney Local Health District, NSW Government (2020), 'RPA Virtual: A new way of caring', https://www.slhd.nsw.gov.au/RPA-Virtual-Hospital/ (accessed July 2020).

Recommendation 8:

Ensure high value, equitable care is prioritised as elective surgery and other procedures are resumed



Recommendation 8:

Ensure high value, equitable care is prioritised as elective surgery and other procedures are resumed

Why:

To ensure patients receive the timeliest access to elective surgery to improve their care outcomes.

How:

a) Ensure access to elective surgery for those experiencing significant health disadvantage, especially First Nations people.

b) Finalise the definition of low value surgical and other procedural care as an immediate priority.

c) Implement processes for independent clinical review of all cases of potentially low value care prior to proceeding.

d) HHSs to ensure that access to public hospital services for both public and private patients is on the basis of clinical need.

Prior to the COVID-19 pandemic, the Queensland health system was already facing sustained high growth in demand for elective surgery, with 49,813 Queenslanders on the waiting list at the beginning of March 2020. Following agreement by National Cabinet, on 22 March 2020 HHSs were instructed to suspend non-urgent surgical procedures (Category 3 and most Category 2), as the health system focused on the response to the pandemic.

In accordance with national advice, category 2 and 3 elective surgery services resumed on 27 April 2020 and on 14 June 2020 the Queensland Government announced an additional $250 million investment to provide extra elective surgery for people currently on waiting lists. Under this investment HHSs were asked to focus on addressing health inequity by prioritising First Nations people who are waiting longer than clinically recommended for planned care and category 2 patients waiting longer than clinically recommended. We believe more can be done to boost equitable health outcomes through this investment, by embedding reforms that will advance equity and high value care for patients.

Recommendation 8(a):

Ensure access to elective surgery for those experiencing significant health disadvantage, especially First Nations people

The Medicare principles require that all patients are prioritised for health care on the basis of clinical need. While this is the foundation of our health system, policy makers and clinicians recognise that disadvantage and other social determinants can have a significant impact on health outcomes. In other words, not all people enter the health system, or receive treatment at a particular time, with the same level of health.

Queensland's First Nations people continue to have significantly poorer health outcomes with a disease and injury burden 2.2 times greater than non-Indigenous people.[54] This reflects poorer social determinants of health and higher risk factors for disease as well as First Nations people being far less likely to receive timely and culturally appropriate health care. By the time First Nations people do receive care, they generally have more acute illness and co-morbidities compared to other Queenslanders.

The COVID-19 pandemic has exacerbated this situation as First Nations people and other disadvantaged groups suffering from an already higher burden of disease, are extremely vulnerable to the impacts of delayed health treatment.

As a result, the clinical prioritisation process for elective surgery and other procedures should take into account the vulnerability status of First Nations people and other disadvantaged populations.

For First Nations people and other disadvantaged populations, we recommend Queensland Health implement regional and metropolitan models for access to elective surgery, which include consistent features:

- Identifying First Nations status during triage and prior to initial consultation
- Extending private contracts or implementing a brokerage model, including scope for specific sessions where appropriate
- Developing a risk stratification for referrals, considering both clinical need and vulnerability, and
- Engaging a case manager to help coordinate navigation through the system including post-surgery care.

The models should ensure that First Nations people achieve higher priority within each of the urgency categories for elective surgery, recognising that on average they present later in the course of their illness than other Queenslanders.

In addition to First Nations people, there are a number of other groups who experience significant health disadvantage, including people living in rural and remote locations, people living in areas experiencing socio-economic disadvantage (e.g. based on the Australian Bureau of Statistics Socio-Economic Indexes for Areas (SEIFA)), concession card holders, refugees and some culturally and linguistically diverse communities. Data for these cohorts is not readily available. Further work should be undertaken

54 Queensland Health (2018).

First Nations Cataract Surgery pathway

In 2013, the Institute for Urban Indigenous Health (IUIH) partnered with the Fred Hollows Foundation to undertake a mapping project, seeking to identify barriers and enablers for Aboriginal and Torres Strait Islander people in accessing prevention, screening, assessment and treatment services in South East Queensland. This project rapidly led to IUIH building a comprehensive eye health program that markedly improved access for Aboriginal and Torres Strait Islander people in SEQ to vision restoring cataract surgery.

Over 300 cataract surgeries have now been performed through this pathway, with only a handful requiring overnight stay or readmission, or having complications or complexities requiring Ophthalmology follow up after discharge. There have been only a few instances where surgery was deferred after assessment on the morning by the operating Ophthalmologist.

Waiting times for surgery through this pathway have been reduced to almost nothing – around 4 surgery days a year is sufficient to keep up with demand. At the same time, feedback from clients has been overwhelmingly positive, with very high rates of attendance including re-attendance for surgery on the second eye if needed. Feedback from hospital staff has also been very positive, with theatre and ancillary hospital staff enjoying and learning from the experience.

as a matter of urgency to build reliable data sets to inform consistent decision-making regarding access prioritisation.

It will be important to build on this recommendation to ensure equitable access to elective surgery for these and other disadvantaged groups. The Health Equity Framework and Local Health Needs Assessments and Plans proposed in recommendation 1 of this report provide an opportunity to identify barriers to equitable access for such groups and to develop targeted strategies to address these barriers.

Recommendation 8(b):

Finalise the definition of low value surgical and other procedural care as an immediate priority

An important element of introducing the concept of value into health systems and services is reducing the level of low value care (although this is not specific only to value-based health care programmes). The Queensland Clinical Senate defines low benefit care as:

"the use of procedures or interventions where the evidence suggests there is little or no benefit to patients, or that the risk of harm exceeds the benefit, or the added cost of the intervention doesn't provide the proportionate additional benefits." [55]

As a core principle, surgery and other procedures should only be performed where there is strong evidence of clinical benefits. As clinical evidence builds over time, certain health interventions and treatments may be shown to confer no or very little benefit to patients. [56] The Group supports the Queensland Clinical Senate recommendation in its report Innovation and transformation of models of care in response to COVID-19[57] to permanently discontinue low benefit care that has been ceased during the pandemic. For the purposes of this report, the Group is focused on low value surgical and other procedures.

A list of 27 low value procedures has been identified by the Menzies Centre of Health Policy. [58] We understand Queensland Health has considered this list through the Choosing Better Care Together program and by individual clinical groups and that some refinements have been suggested. We recommend that the Department of Health finalise a list of potentially low value procedures as a matter of priority. We note that under the processes proposed below, the Group is not recommending that such procedures would never be performed in Queensland public hospitals, but that instances of procedures on the list would be subject to independent clinical review prior to proceeding.

55 Queensland Clinical Senate (2019).

56 Badgery-Parker, Tim et al (2019), 'Low-value care in Australian public hospitals: prevalence and trends over time', BMJ Quality & Safety, 28, pp. 205-214.

57 Queensland Clinical Senate (2020).

58 Badgery-Parker, Tim et al (2019).

Recommendation 8(c):

Implement processes for independent clinical review of all cases of potentially low value care prior to proceeding

Clinical and consumer engagement and shared decision making is essential to reducing low value care. The Group considers that clinical review is an important strategy for reducing specific instances of low value care. A process based on clinical review will not compromise clinical autonomy, but rather provide patients and clinicians with better information and other options for treatment. It also aims to promote shared decision making as better-informed consumers often make different, more conservative, less costly choices about treatment.[59]

Acknowledging the work done to date, and the importance of continuing clinical and consumer leadership in advancing value, we recommend Queensland Health implement a system-wide process for reducing instances of low value care as soon as the definition of potentially low value care has been developed. This process could involve:

- Establishing clinical review teams to identify and review where patients are currently on wait lists for a procedure that may be potentially low value
- Referring potentially low value care procedures back to the referring GP or the specialist recommending the procedure with a request to review the case
- If the procedure is unlikely to have significant clinical outcomes, patients and their GPs would be informed and advised of other treatment that may be more appropriate, and
- Patients should be requested to complete a Patient Reported Outcomes Measures questionnaire before and after any treatment (regardless of whether the procedure is performed or other options are pursued) to enable an assessment of outcomes.

The Department of Health should lead development of the system-wide policy for low value care including governance arrangements for the establishment and operation of clinical review teams. There should be engagement with general practitioners – who initiate referrals – as part of this process.

The process should be reviewed after six months based on outcomes and experience, with a view to revising it if appropriate. It would also be appropriate to develop processes for adding to the list of potentially low value procedures over time. There should also be an education campaign for clinicians and consumers, to empower consumers to ask questions about their care, and to ensure clinicians are open to having these conversations.

Recommendation 8(d):

HHSs to ensure that access to public hospital services for both public and private patients is on the basis of clinical need

Access to public hospital services is determined on the basis of clinical need and guidance about clinically appropriate waiting periods. At present, private patients treated in public hospitals have shorter average waiting times for elective surgery than public patients. In 2018-19 in Queensland, 90 per cent of patients admitted from public hospital elective surgery waiting lists were public patients. Five per cent were funded through private health insurance and five per cent had 'other' funding sources, mainly self-funded. Reported median waiting time for elective surgery was 47 days for public patients, compared to 28 days for patients funded through private health insurance and 14 days for other patients.[60]

There are a number of reasons why waiting times for private and public patients may differ, and such differences do not necessarily mean that private patients are receiving favourable treatment. For instance, unlike other public hospital patients, private patients are often captured as waiting for elective surgery only when surgery is scheduled, not when they are first identified as requiring surgery.[61] Hence differential waiting times may in part reflect measurement issues. Differential waiting times may also in part reflect clinical need.

Given the persistence of differential waiting times, it is important from a health equity perspective to ensure that all patients are being treated on the basis of clinical need. It is recommended that HHSs undertake actions to ensure that access to public hospital services for public and private patients is on the basis of clinical need.

> **"GP presentations have considerably reduced during COVID 19. It would be useful to understand whether public avoidance of GPs has led to negative health outcomes and how many (if any) are presentations of the 'worried well'. The answer to this would potentially aid us to better manage low value primary care and consider outcomes based funding models to incentivise quality over quantity in care."**
>
> *Central Queensland, Wide Bay, Sunshine Coast PHN*

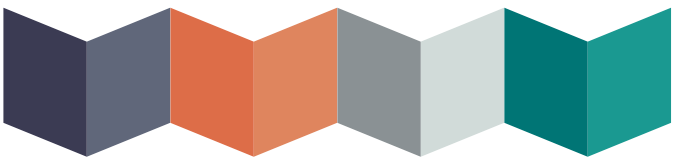
59 Australian Commission on Safety and Quality in Healthcare (2019), 'Shared Decision Making', https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making (accessed July 2020).

60 Australian Institute for Health and Welfare (2019), Admitted patient care 2018-19 Chapter 6: What procedures were performed?, Canberra, AIHW.

61 Queensland Audit Office (2013), 'Right of private practice in Queensland public hospitals', Report to Parliament 1:2013-14, Brisbane, QAO.

Recommendation 9:

Extend existing programs to provide improved in-reach care to residents in residential aged care facilities



Recommendation 9:
Extend existing programs to provide improved in-reach care to residents in residential aged care facilities

Why:

To improve acute care for people in residential aged care facilities by expanding HHS coordinated in-reach services.

How:

a) Extend existing effective programs to provide in-reach services from HHSs to residents in residential aged care to avoid unnecessary transfers of residents to hospitals. Specific programs to consider include:

   i. Residential Aged Care Facility Acute Support Service (RaSS),

   ii. the Geriatric Emergency Department Intervention (GEDI), and

   iii. Eat Walk Engage.

b) Use flexibility within the current funding model to promote virtual care, Hospital in the Home (HiTH), tele-monitoring and non-admitted support programs in residential aged care facilities.

The ongoing Royal Commission into Aged Care Quality and Safety and the devastating impact of the pandemic on residents in a number of aged care facilities in New South Wales and Victoria have highlighted significant issues in residential aged care facilities (RACFs) and the vulnerability of elderly and frail people to COVID-19.

The Group notes Queensland faces a growing and ageing population which will increase demand for aged care and health services. Queensland's public health system is already facing significant pressure as measured by transfers from RACFs to acute health services (notably, hospital emergency departments), and prolonged delays discharging medically fit older patients from hospitals.[62] Many of these presentations and admissions could be avoided and patients discharged more quickly with more innovative and patient-centred care for the elderly and frail.

The aged care sector has been the subject of inquiries by the State and Commonwealth Governments following widespread concerns about the welfare of older people trying to access suitable care at home or in RACFs and the challenges facing providers.[63]

The *Queensland Parliamentary Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying* made several recommendations to drive more innovative models of care which we consider have merit. These include recommendations:

- that the Queensland Government explore opportunities to better utilise nurse navigators in aged care to improve access to primary care for older people and supplement the care provided by general practitioners
- that the Australian Government fund through PHNs nurse practitioner led care in RACFs which could include expanding their scope of practice to prescribe certain medications [64] and order certain pathology tests in consultation with general practitioners, and
- that the Australian Government require residential aged care facilities to provide information and encourage residents to complete an Advanced Health Directive as soon as possible after entry to the facility.

The Group also notes the Inquiry's recommendation that the Australian Government should review the Medicare Benefits Scheme schedule of item numbers that general practitioners, specialists and other allied health professionals can access to claim the costs of care they provided for patients, and their travel to and from residential aged care facilities or patients' homes and the formula used for calculating payment amounts.

62 Health Communities, Disability Services and Domestic and Family Violence Prevention Committee (2020), 'Report No. 33, 56th Parliament', Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying, pp. 9-10.

63 On 8 October 2018, the Commonwealth Government established the Royal Commission into Aged Care Quality and Safety. On 31 October 2019, the Royal Commission handed down an interim report and its final report is due on 12 November 2020. On 24 March 2020, the Queensland Parliament's Health Communities, Disability Services and Domestic and Family Violence Prevention Committee tabled its Report 33, Aged care, end-of-life and palliative care.

64 The Group notes that Nurse Practitioners are already able to prescribe medications under their existing scope of practice.

Recommendation 9(a):

Extend existing effective programs to provide in-reach services from HHSs to residents in residential aged care to avoid unnecessary transfers of residents to hospitals

We recommend extending and consolidating evidence-based alternative pathways for RACF residents across Queensland (state-wide) to support standardised care for all vulnerable frail older persons, including the:

i. Residential Aged Care Facility Acute Support Service (RaSS),

ii. the Geriatric Emergency Department Intervention (GEDI), and

iii. Eat Walk Engage.

Queensland has implemented the Frail Older Persons' Program which includes several initiatives to improve the interface between aged care and HHSs to deliver care closer to peoples' place of residence where clinically appropriate. Benefits of these types of programs include a reduction in unnecessary hospital admissions and hospital acquired complications, less dislocation from peoples' place of residence (ageing in place), improved patient experience and outcomes, and improved sustainability resulting from freed-up capacity in the public hospital system.

An initial priority for the Innovation Network proposed in Recommendation 13, could be hospital avoidance and substitution models for the elderly and frail. We recommend examples such as Queensland Health's RaSS, GEDI, and the Eat Walk and Engage program to be considered by the Network.

HHSs are implementing these and other programs to provide RACF residents and staff access to hospital-based and in-reach services.

Where it is necessary for an older person from an RACF or from the community setting to come to the Emergency Department (ED,) the GEDI team will, in conjunction with the patient, identify their goals of care and fast track their care needs.

Residential Aged Care Facility Acute Support Service (RaSS)

The Residential Aged Care Facility Acute Support Service (RaSS) model of care is available in 21 hospitals across Queensland, with plans to expand to another three hospitals in 2020-21.

The RaSS model provides care in partnership with GPs and RACFs to improve patient choice of care setting and the quality and safety of care provided across the care continuum. The pandemic is highlighting the need for this service both to protect vulnerable consumers from engaging in activities outside that would put them at risk of COVID-19 transmission, but also as an effective way of managing care closer to consumers places of residence.[65]

The RaSS is a single point of contact for RACF staff and GPs with residents who have acute health care needs beyond existing capabilities. When needed, experienced clinicians are available to provide:

- telephone assessment and matching to the most appropriate service
- acute assessment or care in the RACF environment as an alternative to ED transfer
- Gerontic nursing assessments for RACF residents presenting to ED or admitted to hospital
- Discharge planning, co-ordination and transitional communication, and
- Follow-up services and specialist consultations for RACF residents via telehealth or in-person visits.

65 Acute respiratory illness (suspected COVID-19) in RACF resident.

Geriatric Emergency Department Intervention (GEDI)

The GEDI service provides specialist and targeted care for persons aged 70 years and over who present to the emergency department (ED). The GEDI team comprises of a Clinical Nurse Consultant, ED physician and Clinical Nurses providing 'front load' assessment within the ED to prioritise assessment and management of frail older persons. GEDI nurses aim to avoid inappropriate hospital admissions of older persons whilst streamlining their care to the right place, right person at the right time. The GEDI model builds upon successful interventions, such as comprehensive geriatric assessment by tailoring interventions to the ED environment.[66]

Eat Walk Engage (EWE)

Eat Walk Engage (EWE) is another multi-disciplinary program that improves care for older people in hospital. The program significantly reduces delirium and promotes recovery in acute care wards. The program helps patients, family and staff to provide: optimal nutrition and hydration (Eat); early and regular mobility (Walk); and engagement in meaningful cognitive and social activities (Engage).

We recommend the GEDI program, which is currently situated in 24 EDs across Queensland, is extended into all EDs across Queensland.

In addition, the Group encourages the health and aging sectors to collaborate on developing innovative models of care with a view to scaling effective models across HHSs and through collaboration with other sector providers.

Residential aged care resident 'Liz'[67] and the RADAR program

> "I got sick 13 weeks ago. I was alone in my room during the virus. I had no visitors or [external] support workers visit me. The stress of being isolated in my room has contributed to my stomach issues. My illness has been a three-month nightmare. Sometimes I howl with pain."

"RADAR[68] have been phoning me and pushing the hospital to bring my procedure forward. As requested by my GP, they've arranged that I go into hospital the day before my procedure. I need a lot of assistance if I go into hospital. I want to feel safe in the hospital. I'm very frightened."

"It would be impossible to achieve what's been done if it wasn't for the RADAR team. The RNs here are fantastic, but they can only say so much to the doctors and they don't know what to do for me anymore. My GP has run out of ideas to relieve my suffering and I've run out of ideas about how to get better. They [RADAR] have been marvellous, in particular all the effort the nurse navigator and doctors have put in."

The Residential Aged Care District Assessment and Referral (RADAR) Service is a Nurse Navigator led service facilitating access to hospital and in-reach services for acutely unwell and deteriorating people living in residential aged care facilities in the Brisbane North region. RADAR services include:

- emergency department alternatives
- facilitating hospital presentations and admissions
- RACF resident post discharge medication reviews
- advice for navigating hospital services, and
- access to geriatric and palliative care advice.

https://metronorth.health.qld.gov.au/specialist_service/refer-your-patient

66 Marsden, Elizabeth et al (2017), Geriatric Emergency Department Intervention (GEDI) Toolkit, Brisbane, Healthcare Improvement Unit.

67 Unpublished] Health Consumers Queensland 'Patient stories'.

68 RADAR stands for Residential Aged Care District Assessment and Referral (RADAR) Service at the Royal Brisbane and Women's Hospital. The services helps GPs and RACF staff navigate the hospital system and coordinate care for patients living in RACFs who are acutely unwell. RADAR Royal teams include clinical nurses and doctors, with advanced skills in emergency, geriatric medicine and palliative care, who can provide advice and support in the hospital as well as in the Aged Care facility.

Recommendation 9(b):

Use flexibility within the current funding model to promote virtual care, Hospital in the Home (HiTH), tele-monitoring and non-admitted support programs in residential aged care facilities

We recommend the Department of Health ensures that all HHSs are aware of the flexibility inherent in the current funding model to facilitate better care for residents in RACFs.

An emerging opportunity is the use of virtual technologies to support Hospital in the Home (HiTH) programs. HiTH [69] provides home-based acute care as a substitute for people who would otherwise need to be in hospital. The level of care is equivalent to being in hospital, however it is provided in the comfort of the person's home. [70] Queensland Health is investigating opportunities to integrate virtual home-based acute services that would also interface with primary care. Several HHSs are piloting virtual care models adapted to local needs – including the MeCare (Mobile Enable Care) Pilot in the West Moreton HHS, virtual home monitoring in Metro South HHS, and real time patient monitoring at the Kilcoy Hospital. Other hospital substitution models include hospital in the nursing home, supported by virtual clinics and monitoring technology.[71]

We recommend that examples like those above should be considered across all HHSs; they are able to be funded under the current funding and purchasing model, but this may not be widely understood. There are no barriers to residents in RACFs receiving hospital in-reach as non-admitted patients. Similarly, residents can be treated under HiTH arrangements for more intensive care, provided the patient's general practitioner does not bill Medicare on the days they are counted as hospital inpatients (unless the resident is being treated as a private patient). HHSs should expand their links with general practitioners to integrate them into HiTH programs, but where the HHS pays the general practitioner directly.

The Group encourages the Department of Health and HHSs to identify other non-admitted hospital in-reach programs for elderly and frail people where proven to deliver improved patient outcomes.

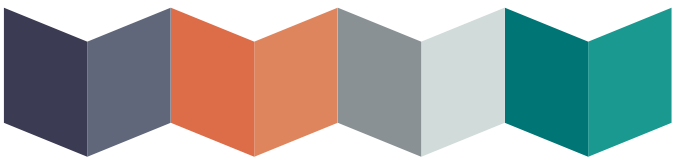
69 HiTH provides care in a patient's permanent or temporary residence for conditions requiring clinical governance, monitoring and/or input that would otherwise require treatment in the traditional inpatient hospital bed. The admission criterion is governed by the authorising officer and as such the HiTH program is focused exclusively on admitted care substitution, (https://www.health.qld.gov.au/__data/assets/pdf_file/0016/147400/qh-gdl-379.pdf).

70 Queensland Health (2020), 'Hospital in the Home', https://www.health.qld.gov.au/sunshinecoast/community/hith (accessed July 2020).

71 Queensland Health (2017), Digital Health Strategic Vision for Queensland 2026, Brisbane, Queensland Government.

Recommendation 10:

Strengthen and embed innovative models identified through the pandemic that enable all clinical staff to work to full scope of practice



Recommendation 10:

Strengthen and embed innovative models identified through the pandemic that enable all clinical staff to work to full scope of practice

Why:

To improve and expand consumers' timely access to care and increase service capacity by optimising the use of Queensland's highly skilled clinical workforce to deliver to its full potential.

How:

a) Implement state legislative or regulatory change to remove any barriers preventing allied health, nursing and midwifery staff and Aboriginal and Torres Strait Islander health practitioners and health workers working to their full scope of practice as authorised by the relevant professional regulatory bodies.

b) Chief Nursing and Midwifery Officer, Chief Allied Health Officer and Chief Aboriginal and Torres Strait Islander Health Officer to:

   i. Implement streamlined and consistent credentialing across Queensland to increase the mobility of a highly skilled clinical workforce, and

   ii. Identify opportunities to increase service capacity though the expansion of allied health, nursing and midwifery services, nurse and midwife led admission and discharge, hospital avoidance models and nurse navigators.

c) Clinical Excellence Queensland to develop state-wide mutual recognition processes.

The pandemic response has highlighted the effectiveness of nurses, midwives, allied health professionals, and Aboriginal and Torres Strait Islander health practitioners working in areas that they were previously restricted, including the areas of community health, hospital admission and discharge, virtual and fever clinics, follow-up services for isolation and quarantine consumers and vaccinations. A key part of the Queensland Health response included a swift increase in Nurse Practitioners managing additional presentations in Emergency Departments and establishing and managing fever clinics. Registered Nurses also took on new roles working to full scope of practice the Hospital in the home (HiTH) program, in RACFs and managing video conferencing to reduce hospital admissions and support patients isolating in their homes.

Clinical evidence demonstrates that patients can benefit from models of care that include clinicians working to full scope of practice as part of a multi-disciplinary team.[72] The Group recognises the significant potential for full scope of practice models and the need to embed, fund and expand these models across Queensland's health system on an ongoing basis.

There are multiple benefits for patients, the community and the health system:

- a broad range of clinically qualified health professionals working to their full scope of practice in a range of settings at all times, not just in emergencies
- improved capacity and workplace satisfaction as senior medical staff can be freed from work which could be done by other professionals – including nurses, midwives, allied health professionals, and Aboriginal and Torres Strait Islander health practitioners and workers
- Improved access for patients (including more timely services) where these models of care are utilised, particularly for vulnerable groups with limited access to services
- access to alternative referral pathways and models of care supported by strong clinical evidence of improved patient outcomes [Recommendation 6]
- more integrated services for patients across the care continuum – acute care, community and people's homes - as nursing and allied health staff have key roles working with multiple health specialists and providers.

A critical enabler will be removing any barriers to nursing, midwifery, allied health staff and Aboriginal and Torres Strait Islander health practitioners with the endorsed skills and expertise, providing these models of care. The Queensland Nursing and Midwives Union (QNMU) recently undertook a midwifery member survey that indicated workplace restrictions lead to almost 25 per cent of all respondents not being able to work to their full scope of practice and that 45 per cent did not use their endorsed scope of practice at all in their workplace. [73]

Many health clinicians across Queensland Health are not currently able to utilise their full scope of practice to benefit patients, the community and the health system. This reflects the legacy of cultural and historical barriers preventing health practitioners from utilising endorsed scope of practice, and inconsistency across and within HHSs in recognising and permitting nursing, midwifery, allied health and Aboriginal and Torres Strait health practitioners? to work to their full scope.

In some cases, Queensland Health state-wide credentialing does not recognise full scope of practice as authorised by the relevant professional regulatory bodies. For example, registered nurses in Queensland are currently still required to seek additional endorsement for remote and isolated practice, and all nurses are required to do this for immunisation and sexual health services.[74]

An example of a multi-disciplinary model of care delivering strong patient outcomes is the 'Birthing in our Community' program.

72 See for instance the studies on alternative referral pathways implemented within Queensland Health at Appendix H.

73 Queensland Nurses & Midwives Union (2020), Check in on Midwifery in Queensland 2019.

74 Nursing and Midwifery Board of Australia (2020), Nursing and Midwifery Board of Australia Registrant data (Reporting period: 01 January 2020 to 31 March 2020).

Birthing In Our Community

Background:

Maternal and infant health disparities have persisted between Aboriginal and Torres Strait Islander people and non-Indigenous Australians, with Aboriginal and Torres Strait Islander women having disproportionately higher rates of: maternal mortality (~ 3 times higher); preterm births (14 per cent vs. 8 per cent); low birth weight infants (liveborn: 12 per cent vs. 6 per cent); and perinatal deaths (12 vs. 9/1000).[75]

As part of the response to this significant gap in First Nations health outcomes, the Birthing in our Community program was established and is changing the lives of pregnant indigenous women and their families.

Birthing in Our Community (BiOC) is a collaboration between the Institute for Urban Indigenous Health (IUIH), Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane, and the Mater Health Service

Midwifery Model of care

This co-designed midwifery led delivery model gives 24/7 care availability to First Nations women throughout their pregnancy, birth and up to 6 weeks postnatally delivered according to the women's preferences including in the home, community- based hub or hospital for women with complex needs or who live outside of the home visiting area.

Indigenous-controlled community-based hub

The Hub provides a culturally enabling environment, where women and families not only access multidisciplinary maternity and infant care, but also connect, interact, share and learn from each other and from elders with community drop-in days, cook-ups and other activities.

Integrated Family Services

Maternity-specific services are centred around the family, offering a 'one stop shop' approach with multidisciplinary providers–employed or engaged by the Indigenous partner organisations–delivering a full range of primary maternity and infant health and related services. [76]

- Since its launch in August 2013, BiOC has reduced preterm births by 50 per cent to 8 per cent - lower than the national non-Indigenous rate - and has increased its Indigenous workforce by 550 per cent.
- More than 600 women have had a 24/7 known midwife and family support worker, and almost nine in 10 of those women had five or more antenatal visits.[77]

75 Hickey, Sophie et al (2018), 'The Indigenous Birthing in an Urban Setting study: the IBUS study', BMC Pregnancy Childbirth, 18(431), https://doi.org/10.1186/s12884-018-2067-8.

76 Kildea, Sue et al (2019), 'Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia', EClinicalMedicine, 12, pp. 43-51, https://doi.org/10.1016/j.eclinm.2019.06.001.

77 Australian Medical Association (2018), 'Mums and Bubs Hubs slash pre-term births', https://ama.com.au/ausmed/mums-and-bubs-hubs-slash-pre-term-births (accessed July 2020).

Recommendation 10(a):

Implement state legislative or regulatory change to remove any barriers preventing allied health, nursing and midwifery staff and Aboriginal and Torres Strait Islander health practitioners and health workers working to their full scope of practice as authorised by the relevant professional regulatory bodies

We recommend introducing legislation or regulatory change to remove any barriers preventing allied health, nursing and midwifery staff working to their full scope of practice as authorised by national bodies. The barriers should be removed across all sectors of healthcare and in areas including medication supply, management and administration, pathology initiation, authorised diagnostics and immunisations. Where professionals have rights to independent practice, such as midwives and nurse practitioners, barriers to their being granted admitting rights should also be removed.

Nurse led admission and discharge clinics, immunisations, virtual and fever clinics as well as remote health practice should become a standard feature supporting the areas of greatest need across the State and improving the relationship with primary care. There is also scope for increasing the availability and support for roles where endorsed nurses and midwives operating under section 19(2) of the Health insurance Act [78] to gain access to Medicare benefits for the services they provide.

Recommendation 10(b):

Chief Nursing and Midwifery Officer, Chief Allied Health Officer and Chief Aboriginal and Torres Strait Islander Health Officer to:

i. Implement streamlined and consistent credentialing across Queensland to increase the mobility of a highly skilled clinical workforce, and

ii. Identify opportunities to increase service capacity though the expansion of allied health, nursing and midwifery services, nurse and midwife led admission and discharge, hospital avoidance models and nurse navigators

We recommend each HHS develop local credentialing that supports the full scope of practice for allied health, nursing and midwifery staff and Aboriginal and Torres Strait Islander health practitioners and health workers.

The Group further recommends Queensland Health's Chief Nursing and Midwifery Officer, Chief Allied Health Officer and Chief Aboriginal and Torres Strait Islander Health Officer identify opportunities to increase service capacity though the expansion of full scope of practice models such as nurse and midwife led discharge, hospital avoidance models and Nurse Navigators. These Chief Health Professions Officers should work with HHSs to design, implement and embed full scope of practice models with the goal of improving efficiency of, and access to, care across Queensland. HHSs should also report annually on implementation of these new roles and models.

78 Directions issued under subsection 19(2) of the Health Insurance Act 1973 (Cth).

Recommendation 10(c):

Clinical Excellence Queensland to develop state-wide mutual recognition processes

While the pandemic highlighted the effectiveness of these practitioners in stand-up fever clinics, emergency departments, remote primary health care clinics, discharge clinics and isolation support, more can be done to advance the scope of these clinicians within Queensland's health system.

We recommend Clinical Excellence Queensland develop and embed a state-wide mutual recognition process that enables the transition of nursing, midwifery and allied health staff across HHS boundaries to rapidly respond to:

- critical situations (such as evidenced through the pandemic), and
- the need to strengthen evidence based models of care state-wide (where historically these have been siloed in pockets of excellence).

This recommendation will only have impact and improve patient outcomes if health leaders and the broader workforce are supportive of the revised working arrangements. There needs to be effective relationships among all members of local HHS clinical teams and senior management to create supportive and collaborative working environments, and address local barriers to implementation.

> "The modern health workforce should be optimized across the system with roles such as Nurse Practitioners (NP). Nurses are the most trusted professions when it comes to health consumers. Highly qualified nursing roles such as the NP, offers the ability to assist with the high volume/low complexity medical workload of each specialty. NPs can assess, order tests, diagnose, prescribe and refer patients; NPs attract the same ABF tier 2/20 revenue as medical consultants at a fraction of the cost."

Staff member, Gold Coast University Hospital

> "For long-term health system reform, the community pharmacy network needs to be empowered to reduce unnecessary hospitalisations."

Pharmacy Guild of Australia

> "Aboriginal and Torres Strait Islander health workers have been and will continue to be pivotal in identifying the issues, setting priorities, and suggesting solutions for culturally informed strategies. There should be a greater investment and focus on the Aboriginal and Torres strait islander workforce including the development of greater career pathways and models of care"

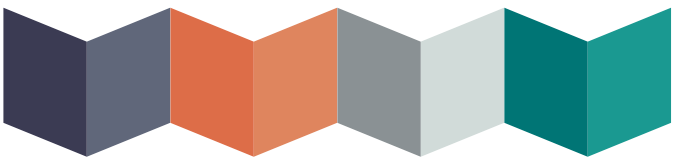
Staff member, Together ASU

> "Empowered staff working fully within their professional scope and capacity, and staff making effective clinical decisions that they previously were unable to or not trusted to make by more senior staff."

Staff member, Queensland Health

Recommendation 11:

Develop integrated health care pathways across three priority areas to support implementation of the report



Recommendation 11:
Develop integrated health care pathways across three priority areas to support implementation of the report

Why:

To improve care in identified priority areas and for specific population groups as part of the implementation of this report.

How:

a) Develop an integrated health care pathway for diabetes

b) Develop an integrated health care pathway for mental health

c) Develop an integrated health care pathway for the first 2000 days, including pregnancy, infancy and early childhood

The Group recognises the recommendations in this report will take time to implement. In some instances, commencing work across multiple care pathways and/or settings may prove too challenging.

Consequently, we recommend three care pathways be prioritised to support implementation and build on existing activities by providing a system-wide (including non-Queensland Health partners) perspective for implementation.

Reforms applied to these priority pathways would help address critical health needs in the community. Better outcomes in these areas would also make an important contribution to enhancing health equity as they impact vulnerable groups disproportionately.

Early focus for developing these integrated care models should include:

- Detailed analysis of, and strategies for, these areas in Local Health Needs Assessments and Plans in partnership with PHNs, A&TSICCHOs, other local partners and consumers
- Linking data and establishing Patient Reported Measures and Outcome indicators for assessing performance and the impact of interventions
- Embedding incentives in Queensland Health funding and purchasing models and accountability structures to drive prevention programs, innovative evidence-based models of care and equitable long-term care solutions for vulnerable communities
- Developing consistent care pathways through strengthened partnerships with primary health care that leverage opportunities for alternative referral pathways and greater use of technology enabled care
- Embedding existing evidence-based models of care that enable allied health, nursing and midwifery staff and Aboriginal and Torres Strait Islander health practitioners and health workers to work to their full scope of practice in these areas.

Each pathway will require slightly different requirements and emphasis on partnerships to support implementation. For instance, diabetes will require more focus on collaboration across HHSs and the primary care sector; mental health will require partnerships with non-government, community and private providers; and for children in their first 2000 days health providers will need to connect with other government partners. This will reinforce the need for a range of effective partnership models for delivering integrated healthcare and shifting the social determinants of health.

Recommendation 11(a):

Develop an integrated health care pathway for diabetes

There are more than 260,000 Queenslanders living with diabetes and one in every 20 Queenslanders is currently facing health challenges due to diabetes.[79] These numbers worsen when looking at the most vulnerable or disadvantaged consumers in our community. Prevalence in people 65 and older is almost 2.5 times the state average[80] and Australia's First Nations communities have one of the highest rates of type 2 diabetes and its complications both nationally and globally.[81]

Complications from diabetes can include kidney, nerve and eye damage, foot damage and skin conditions. Many are potentially preventable, as are many hospital admissions. Indeed, diabetes complications are the leading cause of potentially preventable hospitalisations in Queensland.[82]

While Queensland Health has a broad range of initiatives relating to diabetes, these have not been brought together in a unifying strategy that captures innovative initiatives, digital capability and advanced care models. The proposed integrated pathway would apply the principles and recommendations in this report to inform specific strategies to inform specific strategies for preventing, managing and treating diabetes to achieve better health outcomes.

There are also effective measures for preventing the onset of Type II and gestational diabetes, including the capacity for testing to assess pre-diabetes. Primary prevention activities, such as healthy eating support, access to fresh food and physical activity programs, to reduce or delay the onset of Type II and gestational diabetes are also highly effective in preventing or delaying other chronic conditions.

Developing an integrated pathway for diabetes will prioritise extensive engagement across Queensland Health, the primary health care sector and diabetes specific groups, including Diabetes Queensland. It will also support initiatives to reduce the incidence of gestational diabetes and therefore also link to the integrated pathway for children in their first 2000 days.

Recommendation 11(b):

Develop an integrated health care pathway for mental health

In 2014-15 there were 4.0 million Australians (17.5 per cent) who reported having a mental or behavioural condition[83] and almost one in two Australians between the ages of 16 and 85 will experience mental illness at some point in their lives.[84] Mental Health is now the fourth highest disease burden on both the Australian[85] and Queensland populations.[86]

The mental health impact of COVID-19 has been widely recognised, and its full effect will not be known for some time. However, we do know presentations to hospitals have increased throughout the pandemic with a marked 16.7 per cent increase in mental health and alcohol and other drug related emergency presentations over the height of the pandemic lockdown.[87] Significantly the delivery model for mental health community services shifted with a reduction of in-person presentations by 15.6 per cent and an increase in the uptake of telephone and videoconferencing by 93.8 and 267.4 per cent respectively over the lockdown. In recognition of the importance of effective mental health delivery during the pandemic, the Queensland Government has committed additional funding to support community-based health service groups, including mental health.

The need to improve health equity highlighted elsewhere in this report is particularly relevant to mental illness. First Nations populations are significantly more likely to commit suicide due to a mental health issue than non-Indigenous people.[88] For these populations, mental health issues combined with substance use disorders are the highest disease burden. Suicide rates have seen little improvement in Queensland over the last twenty years.[89] Lesbian, gay, bisexual, transgender and intersex (LGBTI) populations also have significantly higher suicide rates and are the highest risk group due to mental illness attributed to fear of discrimination and exclusion.[90] Mental illness also has a disproportionate impact on other vulnerable communities such as those from culturally and linguistically diverse backgrounds (CALD), particularly those who either do not speak or struggle with English[91] or who are

79 National Diabetes Services Scheme, Queensland Diabetes Data (July 2020).

80 Queensland Health (2018).

81 Department of Health (2015), Australian National Diabetes Strategy 2016-2020, Canberra, Australian Government.

82 Queensland Health (2018).

83 Australian Bureau of Statistics (2018), 'National Health Survey: First Results, 2017-18 (cat. no. 4364.0.55.001)', https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4364.0.55.001Main+Features100192017-18?OpenDocument (accessed July 2020).

84 Australian Bureau of Statistics (2007), 'National survey of mental health and wellbeing: summary of results, 2007 (cat. no. 4326.0)', https://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0 (accessed July 2020).

85 Australian Institute of Health and Welfare (2019), Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015, Canberra, AIHW.

86 Queensland Health (2018).

87 Queensland Health (2020), Mental health and alcohol and other drug related emergency presentations and Consumer Participated Provision of Service Duration, January to June 2020, Consumer Integrated Mental Health Application and Emergency Department Collection (extracted 13 August 2020).

88 De Leo, Diego et al (2010), Suicide in Indigenous populations of Queensland, Brisbane, Australian Institute for Suicide Research and Prevention.

89 National Mental Health Consortium (2008), 'Perinatal Mental Health National Action Plan: 2008-2010 Full Report', Beyond Blue: the national depression initiative, https://www.beyondblue.org.au/docs/default-source/8.-perinatal-documents/bw0125-report-beyondblues-perinatal-mental-health-(nap)-full-report.pdf (accessed July 2020).

90 National Mental Health Consortium (2008).

91 Minas, Harry et al (2013), Mental Health Research and Evaluation in Multicultural Australia: Developing a Culture of Inclusion, Mental Health in Multicultural Australia.

underrepresented in service provision and monitoring. In addition, half of all mental illness starts in children and young people before the age of 14 years.[92]

There are significant initiatives underway such as those from the Queensland Mental Health Commission to improve the mental health and wellbeing of Queenslanders, and PHNs have implemented a range of primary mental health care reform activities. An integrated pathway for mental health, across the traditional health boundaries in Queensland, and in line with the recommendations in this report, should target effective management of mental health and reductions in the alarming suicide rates of vulnerable communities.

An integrated pathway should also include initiatives to prevent mental health conditions from developing and escalating, with a particular focus on providing increased capacity in community settings to prevent presentations to the acute sector. Approaches should prioritise extensive engagement across HHSs, community, primary, non-government and private providers.

"The COVID-19 pandemic provides an opportunity to reduce stigma around mental illness and develop service systems that normalize a focus on wellbeing in all aspects of life. There has been a recognition that in a public health crisis like COVID-19 that care needs to be delivered flexibly, using natural supports closer to home and within the community, without a reliance on Emergency Departments and Inpatient beds. In a mental health sense this has been on the reform agenda for decades and now could see the impetus to develop sustainable community-based alternatives to hospital admission."

Queensland Alliance for Mental Health

Recommendation 11(c):

Develop an integrated health care pathway for children in the first 2000 days of life

There is increasing evidence that the first 2000 days of life, including pregnancy, infancy and early childhood, as well as preconception parental health, is a uniquely important time that can determine long term health outcomes. Australian data shows that children who are behind on their development when they start school rarely catch up to other children.[93] Development in the first 2000 days has also been closely linked to children's involvement in later years with the criminal justice system, drug and alcohol misuse and clinical risks such as obesity, elevated blood pressure and depression.[94]

Queensland Health has a range of programs targeted to these priorities, including the First 1000 Days Australia initiative, a range of initiatives under Making Tracks toward Closing the Gap in Health Outcomes for Indigenous Queenslanders, Get Healthy in Pregnancy, the Quit for You... Quit for Baby program, the Immunise to 95 and Bubba Jabs on Time programs as well as various local initiatives.

The development of an integrated model would supplement these initiatives by using the principles and recommendations underpinning health reform more broadly to inform specific strategies for improving health and wellbeing for children in the first 2000 days of life.

Developing an integrated pathway for the first 2000 days will require an extensive effort to work with other Queensland Government providers, particularly in addressing broader social determinants of health, including social disadvantage, housing, and education and training.

92 Kessler, Ronald C. et al (2005), 'Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication', Archives of General Psychiatry, 62(6), pp. 593-602.

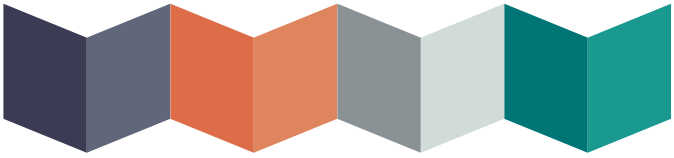
93 Kern, Margaret L. and Friedman, Howard S. (2008), 'Early educational milestones as predictors of lifelong academic achievement, midlife adjustment, and longevity', Journal of applied developmental psychology, 30(4), pp. 419–430, https://doi.org/10.1016/j.appdev.2008.12.025.

94 NSW Ministry of Health (2019), The First 2000 Days: Conception to age 5 Framework, North Sydney, NSW Ministry of Health.

An innovative system and empowered workforce

Recommendation 12:

Streamline data governance arrangements



Recommendation 12:
Streamline data governance arrangements

Why:

Improve data access, and effective use and sharing of data, to enhance population health service planning, support patient-centred decision-making, increase quality and safety of care, and improve patient outcomes and patient experience for all Queenslanders.

How:

a) Enable appropriate access to linked real-time longitudinal data. Specific actions to include:

   i. Develop an enhanced analytics and data linkage capacity to support access to linked health and hospital data

   ii. Develop legislative change to consolidate the provisions that oversee the lawful disclosure of Queensland Health's dataset, and

   iii. Establish data sharing agreements with external organisations and critical partners to standardise and facilitate data sharing.

b) Ensure a 'single source of truth' where data is collected once, with that same data used often, in the appropriate form, for all Queensland Health datasets.

c) Ensure all Queensland Health data is disaggregated by First Nations status and local and regional health data is shared with First Nations people.

Agile data access and sharing across the health system plays a crucial role in ensuring timely identification and response to emerging clinical and public health developments. This was made exceedingly apparent during the COVID-19 response where regular, real-time data updates were in high demand and their impact on health outcomes was clearly visible for both clinicians and the general public.

Improved data access and sharing will support clinical decision-making about individual patient care, and better population service planning for targeting the needs of local populations, especially vulnerable populations.

Similarly, better access to data can help in long-term planning. The Group has recommended above that HHSs prepare needs analyses with an aim of reducing potentially preventable hospitalisations and improving care in areas such as diabetes. These needs analyses will require working collaboratively across the primary care – secondary care divide, engaging general practitioners and other primary care organisations in improving the seamlessness of care. These needs analyses should be based on an understanding of what is happening in the area now, including drawing on information held by the Commonwealth, for example in the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), as well as hospital and cancer data.

A key consideration in undertaking any data governance reform is to ensure the maintenance of patient confidentiality. To not do so would not only breach ethical and legal provisions, but also cause significant loss of trust in Queensland Health and the digital reform agenda.

Queensland Health needs to ensure it has the social license to change how patient data is used. Steps are already underway, including the development of a *Queensland Digital Health Consumer Charter* which has been commissioned by Queensland Health and is being co-designed with consumers through Health Consumers Queensland. The Consumer Charter is currently scheduled for launch in the latter half of 2020 and will include principles for guiding Queensland's digital health strategy, alongside the *Queensland Digital Clinical Charter*.

The Queensland Government has also taken steps to improve access to health information with the passing of the *Health Transparency Bill 2019* on 28 November 2019. The Bill's amendments establish a legislative framework for collecting and publishing information about public and private hospitals and residential aged care facilities (both State-run and private) to improve transparency and support consumers to make informed choices about their health care.

Health data governance and disclosure is overseen both at the State and national level. The Australian Institute of Health and Welfare (AIHW) is overseeing the development of a *National Health Information Strategy* that aims to overcome information gaps and barriers and drive prioritised investments in health information, to ensure national health information assets and infrastructure are fit-for-purpose into the future.[95] The strategy is expected to be finalised in late 2020.

With the new National Health Reform Agreement 2020-2025 recently finalised, Queensland is also a party to a national long-term health reform, 'Enhanced Health Data', which seeks to achieve comprehensive health data access, usage and sharing.[96]

95 Australian Institute of Health and Welfare (2020), 'National Health Information Panel Expert Panel', https://www.aihw.gov.au/our-services/committees/national-health-information-strategy-independent-eka (accessed July 2020).

96 Addendum to the National Health Agreement 2020-2025 (2020).

Key objectives of the Enhance Health Data long-term health reform:

- establishing a national standard approach to govern the creation, access and sharing of data from all Australian governments;
- providing data access to support shared patient-clinician decision making, improved service delivery and system planning;
- working together to better harness data, analytics and evidence in order to drive meaningful improvements in the health system; and
- progressing mechanisms and interoperable systems for secure and comprehensive integration of data across patient journeys, such as the National Integrated Health Services Information Analysis Asset, and a dynamic cyber security framework to ensure security and ethical management of personal health information.

The Group acknowledges that enhanced health data is a critical enabler for all long-term health reforms and for reforming Queensland's health system.

Queensland Health has already made some progress in this regard, but more needs to be done. Clinical leaders within HHSs need to have good access to data to benchmark performance, and to learn where they can improve care outcomes and care processes. Reducing the incidence of adverse events not only benefits the patients directly, but also reduces the overall cost of the health system. Facilitating better access to ongoing analysis of performance is fundamental to improving outcomes.

Throughout the Group's consultation, a common challenge identified during the COVID-19 response was barriers when trying to access and share data to ensure that at-risk populations could be identified, and the right care provided. This occurred both within Queensland Health and for primary health and community care providers.

We recommend a number of specific actions to address the current barriers preventing timely data sharing, moving Queensland Health towards a vision of:

A precision medicine and precision population health platform that is underpinned by an agile data ecosystem, where protecting patient information remains paramount, and gives an unprecedented ability to benchmark performance and drive better quality across the health system.

Recommendation 12a(i):

Develop an enhanced analytics and data linkage capacity to support access to linked health and hospital data

Linked data and dashboards are used across Queensland Health for clinicians and service planners to access data across the system, while still maintaining the required confidentiality and security controls and oversights. For example, there are a series of interactive dashboards of hospital and perinatal data available to staff, and a platform for system performance reporting which collates and reports on data to allow the Department and HHSs to monitor performance. More recently, data dashboards were developed to monitor COVID-19 cases across Queensland. As requirements and expectations of data availability evolve to support changes to service planning and delivery, new approaches and mechanisms are necessary to address shortcomings in data governance.

We recommend that Queensland Health enhances the ability for both clinical and non-clinical staff to use data to meet clinical and health service planning needs by making it easier for all Queensland Health staff to access and use Queensland Health's hospital and health datasets. Access to linked data could also be made available to external partners such as primary health care providers subject to addressing confidentiality and privacy considerations.

Developing solutions to support clinical analytics will ultimately enable patient journeys throughout the health system to be better understood. This may include the development of fit-for-purpose data dashboards and reporting of Queensland's hospital datasets (public and private) and linkage of Queensland Health to datasets not held within Queensland Health such as in primary health and community care. This will enable both system planners and clinicians to more accurately assess the effectiveness of interventions in a timely way and base decisions on more complete data.

Having better access and sharing of linked data about the patient journey is also a key enabler of value-based health care, and specifically, measurement of outcomes and costs to determine the value from healthcare services.[97] This includes datasets required to establish associated value-based payment mechanisms, such as bundled payments which cover a full package of care spanning across episodes and settings of care, and take quality and outcomes into consideration.

More informed clinical decision making will also have significant implications for patient safety and quality. For example, better sharing and access to a patient's medical history could prevent avoidable adverse events such as identification of a known medication allergy.

97 Leung, Tiffany I. and van Merode, G.G. (2018), 'Chapter 14: Value-Based Health Care Supported by Data Science'. Kubben, Pieter, Dumontier, Michel and Dekker, Andre (eds.), Fundamentals of Clinical Data Science, Cham (CH): Springer, pp. 193-212.

Recommendation 12a(ii):

Develop legislative change to consolidate the provisions that oversee the lawful disclosure of Queensland Health's datasets

The lawful disclosure of Queensland Health's datasets varies depending on the dataset and may fall under either the Hospital and Health Boards Act 2011, the *Public Health Act 2005* or the *Private Health Facilities Act 1999*. Each legal disclosure typically requires an individual approval by the Director-General of Queensland Health which can inhibit timely access to data to inform patient care requirements. The complex legislative structure also makes it difficult to understand what the legal requirements are for data access and sharing.

We recommend that a review of the legislation that oversees lawful disclosure of Queensland Health datasets is undertaken as a priority, with the aim of developing amended (or new) legislation that will streamline the disclosure requirements, making them easier to action and for Queensland Health staff and consumers to understand.

Recommendation 12a(iii):

Establish data sharing agreements with external organisations and critical partners to standardise and facilitate data sharing

Queensland Health already utilises a number of data sharing agreements such as Memoranda of Understanding (MoUs) to establish the sharing of confidential information with other agencies to facilitate service coordination across sectors. For example, Queensland Health has established an MoU with Queensland Corrective Services (QCS) to facilitate coordinated health services for prisoners.[98]

We recommend Queensland Health establishes data sharing agreements with key external organisations and other critical partners across the primary health and community care sectors to facilitate data sharing that will aid in local population health planning. A strategic approach and high-level engagement with key stakeholders will be key to implementing this successfully.

This will require extensive consumer and wider public engagement to ensure that there is transparency of data usage with consumers in control of their data and how it is used. Central to this will be ensuring that there is close alignment with the principles of the Queensland Digital Health Consumer Charter that is being developed to improve patient outcomes and experience throughout the patient journey.

Recommendation 12b:

Ensure a 'single source of truth' where data is collected once, with that same data used often, in the appropriate form, for all Queensland Health datasets

Queensland Health's system-level datasets sit across multiple areas across the Department.[99] Understandably, having multiple access points to datasets across the system can lead to confusion and uncertainty for those trying to access them, which can be an impediment to timely data access and sharing. This was acknowledged in the report on *Advice on Queensland Health's governance framework* [100] in which the Panel cited in its final report that:

> **"...there is a lack of clarity about ownership of the data and the accountability for its integrity, reporting and publication. The lack of access to data and the ineffectual use of data is contributing to a lack of understanding about the system's needs and making it difficult to drive more consistent clinical and performance outcomes."**

The Panel went on to recommend *"that the Department of Health should, in consultation with the Board Chairs and the Health Service Chief Executives, streamline the collection and sharing of information within the system, while maintaining appropriate protections for privacy and confidentiality"*.

The Group recognises that Queensland Health is already undertaking steps to improve how data is accessed and shared throughout the organisation. This includes the development of a Clinical and Business Intelligence Strategic Framework which seeks to make it easier to access data from multiple sources that are accurate, timely and provides the actionable information. However, more needs to be done.

We recommend data ownership, collection and sharing pathways within Queensland Health are reviewed with the intent of clarifying ownership and accountability. This will be a critical step to ensuring there is a single source of truth for analysis and reporting across the system.

98 Memorandum of Understanding between the Chief Executive of Queensland Health and the State of Queensland acting through the Department of Justice and the Attorney-General represented by Queensland Correctional Services (2018).

99 Queensland Government (2020), 'Queensland Department of Health and HHS Data Custodians', https://www.health.qld.gov.au/__data/assets/pdf_file/0034/843199/data_custodian_list.pdf (accessed July 2020).

100 McGowan, Jim et al (2019), 'Advice on Queensland Health's governance framework', https://www.health.qld.gov.au/__data/assets/pdf_file/0039/929955/Final_Advice-on-Queensland-Healths-Governance-Framework.pdf (accessed July 2020).

Recommendation 12c:

Ensure all Queensland Health data is disaggregated by First Nations status and local and regional health data is shared with First Nations people

Much Queensland Health data is disaggregated and reported by First Nations status. For instance, key data collections such as the Admitted Patient Data Collection, Non-Admitted Patient Data Collection and Perinatal Data Collection include First Nations identifiers. The Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033[101] provides four guiding principles which apply to the collection of data regarding Indigenous status, namely cultural respect and recognition, communication, relationships and partnerships, capacity building. The Department also maintains a broad range of performance indicators on First Nations Health.

Nevertheless, it is important to build on this data and to ensure it flows freely throughout the system. High quality First Nations identification data is essential to the development and provision of high-quality healthcare services, planning activities and targeted programs. Failure to have good quality identifiers in collections renders First Nations people invisible from any decisions based on that data. COVID-19 has highlighted the limited visibility of First Nations vulnerable populations, resulting in reduced ability to prioritise the care of those most in need, particularly in times of increased health risk. In the establishment of any administrative datasets, and for all existing administrative data sets, there must be appropriate provision and resourcing provided by the custodians to ensure that First Nations status is collected regularly and routinely, and that the identifier is of high quality both in terms of completeness and accuracy.

It is also important that the data collected is available for sharing with First Nations people. Through the sharing of health information and data with First Nations consumers, communities, and organisations, First Nations people will be empowered with evidence when making decisions for their own communities and empowered to hold data-informed discussions when involved in shared decision-making. This will require establishing processes that ensure that there is appropriate and timely provision of data and information to First Nations people, communities and organisations, and will need to align with legislation regarding the provision of data by data custodians.

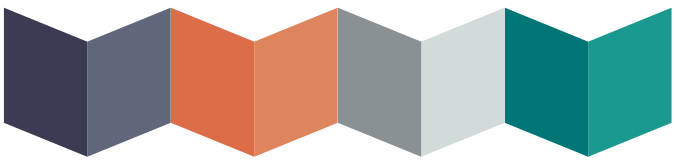
> **"In a busy clinical environment as is occurring worldwide with COVID-19 in intensive care units (ICUs), both a competent multi-patient view and detailed clinical decision support is vital, particularly as clinician resources get stretched across growing patient numbers and severity…"**
>
> *Staff member, Gold Coast HHS*

> **"COVID-19 highlighted the value of 'real-time' data to guide an understanding of dynamic health needs and the effectiveness of system responses. Trauma presents a constantly changing challenge to healthcare systems, with patterns of injury varying according to population distribution and age, road design, alcohol consumption, environmental events, and other factors. During COVID-19, trauma patterns changed. Efficient access to comprehensive time-critical data for analytics to best inform trauma system planning, to assess the effectiveness of new models of care, and to inform prevention activities would similarly help reduce trauma morbidity and mortality."**
>
> *Staff member, Metro North HHS*

101 Queensland Health (2010), Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033, Brisbane, Queensland Government.

Recommendation 13:

Advance innovation across the health system



Recommendation 13:
Advance innovation across the health system

Why:

To improve care for all Queenslanders by building a culture of innovation and developing a system wide approach to innovation.

How:

a) Develop and embed an approach that will prioritise innovation for system leaders, scale clinical and non-clinical innovation across the system and incentivise innovation and creativity in, and across, Queensland Health. Specific actions to include:

   i. Establish an innovation network, with Board Chairs to report annually to the Minister on the take-up of innovation across HHSs (HHS Board Chairs), and

   ii. Develop mechanisms to support development of an enhanced culture of innovation across Queensland Health, including but not limited to, key selection criteria and performance indicators for senior leader appointments (Department of Health).

Two common themes emerged from the Group's consultation:

- how the COVID-19 response enabled various innovations for the delivery of care, and
- there are innovative models and practices across Queensland that have not been effectively scaled up, but have compelling features, e.g. a strong evidence base, clinicians working to the top of scope, strong health outcomes and resource sustainability.

While analysis into how the COVID-19 response changed behaviour is ongoing, a regularly cited reason was the urgency of the situation and the shared common goal of tackling the pandemic and unshackling the system to pursue innovation as a matter of priority.

Building on this, we recommend a system-wide approach to establishing an innovation culture across Queensland Health. This approach should ensure innovation is a priority for system leaders and the right incentives and structures are in place to support the development and spread of effective new ideas, both clinical and non-clinical. This approach should increase the absorptive capacity of Queensland Health to generate, spread and take on new ideas.

Throughout the consultation process, the Group heard many examples of innovation and there are likely many other examples worthy of scaling and embedding as best practice.

The 2019 report *Advice on Queensland Health's governance framework* also recognised the challenge of scaling innovation and recommended the Department review current mechanisms to showcase and share innovations, as well as embed these across the health service network so they are ongoing, sustainable and part of 'business as usual'.

Queensland Health already has good foundations in the Clinical Excellence Queensland's Healthcare Improvement Unit and the Health Innovation, Investment and Research Office. The Group also notes the Rapid Results Program has been effective in promoting innovations beyond clinical care, for example effective procurement and collaboration across government to support the safety and reliability of drinking water in remote communities. These types of innovative approaches should continue to be explored.

Recommendation 13(a)(i):

Establish an innovation network, with Board Chairs to report annually to the Minister on the take-up of innovation across HHSs

The Group believes there is an opportunity for HHS to also drive and be accountable for a more networked culture of innovation and continual improvement. The aim of the Network would be to support:

- innovation leadership
- autonomy to pursue effective new clinical and non-clinical practices that are locally appropriate, and
- accountability for innovation across HHSs and to the Minister.

Reflecting the mutual stewardship of the Queensland Health system, this Network could empower local responses, share innovation across the system and prevent duplication of effort to solve common problems.

The Network would enable HHSs to pursue innovation and better practice, with the expectation that successful models would be reflected in service level agreements and be scaled to peers and partners across the system. This would promote a devolved, networked governance with accountability held by HHS Board Chairs and Chief Executives for embedding local innovations that help achieve improvements towards local and system priorities. Accordingly, Board Chairs would report annually to the Minister on innovations that have been embedded and spread across HHSs.

The Network could also capitalise on HHS partnerships with primary health care, aged and disability care, and community-controlled organisations, as well as across government and non-government agencies, universities and research organisations.

Recommendation 13(a)(ii):

Develop mechanisms to support development of an enhanced culture of innovation across Queensland Health, including but not limited to, key selection criteria and performance indicators for senior leader appointments

For innovation to thrive the environment needs to support the creation and spread of good ideas at all levels across the health system. To address this, we recommend that the Department of Health identifies and establishes supporting mechanisms to embed an innovation culture across Queensland Health. This should include leadership skills and capacity building, as well as accountability and funding structures. For example, to help ensure that innovation is a priority for senior leaders, we propose innovation be a key selection criterion for all senior leadership appointments and a key performance indicator in performance assessments.

Reinforcing this recommendation and recognising the important role of leadership in establishing an innovation culture, Recommendation 14 proposes a more detailed approach to leadership development that aims to shift the culture of Queensland Health to one that identifies, celebrates and scales innovation.

Ultimately, patients and communities will benefit as innovation is created, scaled up, shared and distributed across the State's health system.

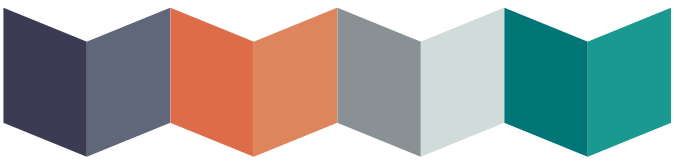
> **"I have a very broad idea of innovation—it has to be ideas that are applied to create impact. Those ideas could be totally new or old ones applied in a different way. The important thing is creating impact."**
>
> *Dr Sarah Pearson, Deputy Director-General for Innovation, Advance Queensland*

> **"An opportunity exists to capture the process and spirit of innovation and improvement, which is what we saw during the COVID response."**
>
> *Staff member, Metro North HHS*

> **"The COVID-19 pandemic saw regulatory authorities being more flexible and accessible to facilitate research innovations. For example, University Ethics Committees scheduling extra-ordinary meetings to speed up the review of COVID-19 related research proposals, and government regulators engaging in active discussion with researchers to guide the application process for therapeutic goods approvals. These examples demonstrate that reducing the distance between researcher and regulators can facilitate increased industry and clinician involvement to achieve health innovations."**
>
> *QUT Institute of Health and Biomedical innovation*

Recommendation 14:

Enhance leadership across Queensland's health system



Recommendation 14:
Enhance leadership across Queensland's health system

Why:

Enhance culture, capability and leadership of Queensland Health to support improved health outcomes for all Queenslanders.

How:

a) Expand the current range of programs and actions to embed the necessary skills, behaviours, capabilities and accountabilities across Queensland Health's leadership to drive reform, innovation and ongoing improvements to care.

b) Queensland Health leadership to make an early, public commitment to embrace and champion the principles of an open and equitable health system. This could include:

   i. Ministerial Statement

   ii. a communique from the Director General, and

   iii. similar statements from the Chairs and CEs of each HHS.

c) Support an empowered and accountable health workforce, by ensuring staff delegations are commensurate with their role responsibilities, through:

   i. Streamlining delegations, in areas such as human resources and financial management, to enable staff to fully deliver on their accountabilities, by devolving sign-off authority through organisational structures, and

   ii. Providing adequate training and ongoing support to build staff confidence and capability in exercising their delegations.

d) Support the delivery of reform and spread of innovative practice across HHSs, through:

   i. supporting decision making at the most appropriate level, and

   ii. developing programs to improve skills in innovation and improvement science, and application of the funding model to support innovative practices and initiatives to improve patient outcomes.

e) Support an enhanced role for multidisciplinary teams, including by ensuring that Clinical Networks are more multidisciplinary in their focus and leadership.

This recommendation supports an open, agile and innovative culture that underpins many of the reforms in this report. Chief among these is improving equity of health outcomes as a core principle, genuine engagement and collaboration across the system to support patient centred care, especially with health consumers (with the embedding of co-design, co-implementation and co-evaluation principles), along with fostering an inclusive and accountable culture that encourages innovation, creativity and curiosity.

Fundamentally, the Group recognises COVID-19 provides an opportunity to revitalise behaviours, culture and leadership practices across the system. One of the most common comments made by stakeholders to the Group, was to the effect of 'COVID-19 enabled me/us to simply do our job fully and things happened in 10 days that might have otherwise taken 10 years'.

> **'We have seen siloes breached and a new level of interdepartmental cooperation in an effort to prepare for the pandemic, this was because practicing clinicians led the process. New leadership philosophy, culture and structure is desperately needed within the public hospital system, an example being 'servant leadership' which responds to needs over wants and understands the difference between authority and power; and leadership and management.'**
>
> *Staff member, Cairns and Hinterland HHS*

> "It was amazing to see how quickly processes could be put in place to accommodate new ways of working (e.g. Telehealth) when there is executive buy-in"

– QUT Survey

> "The collaborative work of the Aboriginal and Torres Strait Islander Health Division along with the Office of Rural and Remote Health demonstrated how planning, policies and decision-making can be improved by working across divisions and with multiple HHSs and the community sector all at the same time... We need a shared understanding that the health landscape is changing (even without COVID-19), we simply can't keep doing what we've done before. In this context, keeping this new attitude to risk might be useful, within a system of transparent and shared governance right across the system and with consumers."

Health Consumers Queensland

> "A new approach to decision-making – faster, less bureaucratic, horizontal (rather than siloed), collaborative and involving consumers and focused on shared and agreed health outcomes and goals for the system, with an eye on the future. A networked system working with partners external to Queensland Health so there is a whole-of-system view. Those in the system must be expected and incentivised to work with each other in this way."

Health Consumers Queensland

COVID-19 unlocked wide-scale change across the health system. These changes primarily involved the specific actions, behaviours and attitudes of leaders, including a focus on decisiveness, evidence informed decision making, collaboration, and increasing the self-efficacy of individuals to carry out their jobs to their full potential. The consequence of these behavioural changes was a health system, generally speaking, that was more united, innovative, agile, and responsive. In other words, the COVID-19 response shed light on just how much potential there is in the health system for change and innovation to occur.

The common denominator was that people were 'unleashed' to their actual potential. Levels of trust and respect were elevated enabling people in the system to 'get on with their job' buoyed by the community's appreciation for frontline health workers. Clinicians across a wide range of professions, particularly in nursing and midwifery, observed respect and recognition for their expertise.

As leadership was a key enabler of the behaviour change that occurred, it is critical that leadership is further developed and strengthened to ensure this change can be maintained and embedded across the system. The Group is therefore recommending a reform of Queensland Health's leadership skills, capabilities and accountabilities to harness the positive changes introduced during COVID-19. To achieve this, leaders must be upskilled and held accountable for the specific behaviours that support ongoing reform and innovation.

This recommendation supports the development of an innovation culture across Queensland Health (refer Recommendation 13) and an empowered workforce through enabling health professionals to work to their full scope of practice (refer Recommendation 10).

Recommendation 14(a):

Expand the current range of programs and actions to embed the necessary skills, behaviours, capabilities and accountabilities across Queensland Health's leadership to drive reform, innovation and ongoing improvements to care

Harnessing the positive changes introduced by COVID-19 and embedding them into the system as 'business as usual' cannot become a missed opportunity. This involves shifting the system's culture, behaviours, leaders, workforce, and governance, in other words 'how we do things around here'.

Critically, leaders need the skills, capabilities and accountabilities to support the specific behaviours needed to drive reform, innovation and ongoing improvements in care. Embedding these skills and accountabilities will require Queensland Health to develop a culture that is focused on rewarding and encouraging leaders who are accountable for risk taking, prioritising equity, supporting consumer and clinician engagement and demonstrating a unified approach.

The Group notes that leaders exist both formally and informally at all levels of the system. In the first instance we recommend that capability be developed at the highest formal levels and then cascade to leaders throughout the organisation. The leadership reform must also focus on the metrics and methods used to recognise and reward all individuals within the Queensland health system, whereby they are recognised and rewarded for making clear and decisive decisions and delivering value for all patients, especially those who are marginalised.

We recommend that programs are implemented to complement existing leadership programs with a specific focus on cultural change, equity, engagement and continuous improvement capability for clinical and non-clinical staff. To be effective, the skills program will need to include the creation of specific accountability metrics for leaders as well as the establishment of reward and recognition metrics for staff that can be tailored to their specific work area. The programming needs to be evidence-based and experience driven, including a range of training and learning modalities that encompass a system-wide approach to change.

Recommendation 14(b):

Queensland Health leadership to make an early, public commitment to embrace and champion the principles of an open and equitable health system

Leaders at the highest level of the Department and HHSs (such as the Queensland Health Leadership Advisory Board, Executive Leadership Team, Board Chairs and HHS Chief Executives) have the most significant influence on the creation of a system wide culture of reform, equity, engagement, performance and innovation. When leaders commit and pledge to change, it is a highly symbolic act that can clearly reset expectations across the system.

We recommend that the Queensland Health leadership make public commitments to the Queensland health system that embraces the principles for embedding reform and shifting culture and practices. A public commitment will be particularly important to harness the positive momentum achieved during the pandemic and create a sense of continuity. We recommend that this public commitment include a Ministerial Statement, a communique from the Director-General and similar statement from the Board Chairs and Chief Executives of each HHS.

Recommendation 14(c):

Support an empowered and accountable health workforce, by ensuring staff delegations are commensurate with their role responsibilities

One of the resounding messages the Group heard during our consultations was that staff felt they could get on with doing the job they needed to do during the pandemic. We also heard of some of the barriers to staff being able to realise their full potential and deliver their accountabilities.

For example, the pandemic highlighted the importance of having nursing leadership at the executive table across the health system where that did not previously exist, providing an alignment between professional accountability for nursing and midwifery services with operational responsibility and authority.

> **'There has been an historical dichotomy between professional nursing and midwifery and the operational space where the two do not meet and it is imperative that operational decision making include EDONMs.'**
>
> *EDONM forum June 2020.*

While financial and human resources delegations are put in place to ensure appropriate authority for expenditure and management of staff, in some places this has become overly bureaucratic and has meant that staff are not empowered to recruit and manage budgets in a manner that is commensurate with their responsibilities. For this reason, we recommend that delegations in HHSs be streamlined, particularly for human resources and financial management, by devolving sign-off authority through organisational structures, with the expectation that staff should be fully able to deliver on their accountabilities (as discussed in Recommendation 10).

For some staff this will give them authority that they are not accustomed to having and we recommend that training and ongoing support is provided to staff to build confidence and capability in exercising their delegations.

Recommendation 14(d):

Support the delivery of reform and spread of innovative practice across HHSs

As noted in Recommendation 13, leaders have a critical role in supporting and driving innovation. One mechanism leaders can support is empowering staff to make decisions commensurate with their responsibilities. When a health professional has the confidence to make decisions in their area of responsibility, they are more likely to innovate, or test new approaches to improve how they deliver on their accountabilities.

Innovating is not just about new ideas, but about how those ideas are distilled and scaled across organisations and systems. This usually requires a range of skills and capabilities, not just those that generate the 'new' idea. Arguably, much energy, opportunity and resources can be spent on the idea, without considering the improvement science program evaluation and change management capability (among others) to ensure success, integration and scalability in the complexity of a healthcare environment.

The success of innovation and improvement efforts across Queensland Health would be strengthened by an uplift in the underpinning innovation and improvement skills of our leaders, including experiential learning and coaching, peer collaboration, and evaluation of return on investment.

In addition, the Group considers that there is considerable flexibility to pursue innovation within the current funding model, and that this flexibility will be enhanced by the reforms currently underway at the national and State levels (as noted in the section on Further Opportunities).

The funding model is often cited as a barrier to the introduction of new models of care, but may not always be such a significant barrier, as discussed earlier in this report. Additional current and potential examples are provided in Appendix I.

There is an opportunity to spread good practice and knowledge on how to better use the current funding model to facilitate health reform, innovative practices and support initiatives to improve patient outcomes. For example, this could be supported by creating an expert panel, under the Innovation Network proposed in recommendation 13, to provide advice and spread this knowledge across HHSs.

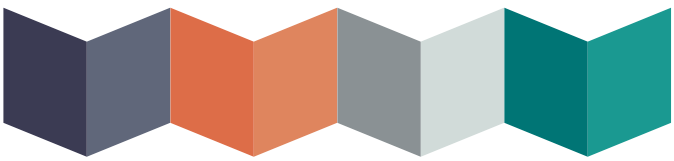
Recommendation 14(e):

Support an enhanced role for multidisciplinary teams, including by ensuring that Clinical Networks are more multidisciplinary in their focus and leadership

The delivery of high quality health care is reliant on a range of clinical (and also non-clinical) staff. More and more, innovative models of care utilise multi-disciplinary teams that include medical specialists, medical generalists, allied health, nursing and midwifery professionals to deliver care to patients. As models of care evolve around patients, requiring teams of different skills and professions, it is important that our Clinical Networks, which often lead and advise on new effective practice, also represent a multidisciplinary skill set. Consequentially, it is important that Clinical Networks include representation from a range of professions including medical, allied health, nursing and midwifery and that leadership of these networks should reflect the diversity of professionals working together to deliver improved patient care.

Recommendation 15:

Allocate a proportion of future growth funding for HHSs to drive system reform priorities



Recommendation 15:
Allocate a proportion of future growth funding for HHSs to drive system reform priorities

Why:

To drive implementation of agreed recommendations through a partial allocation of growth funding

How:

a) Develop a set of principles for the allocation of a proportion of growth funding to drive implementation of the recommendations in this report.

b) Prioritise within the overall allocation funding the following critical areas in 2020-21 and 2021-22:

   i. health equity for First Nations people

   ii. prevention and public health, and

   iii. transforming non-admitted care.

The recommendations in this report focus on system reforms to improve the health of Queenslanders. They are intended to improve health equity and to drive greater integration, value and innovation within the health system.

The recommendations are not about increasing expenditure on the health system. Indeed, it is recognised that the recovery phase of the COVID-19 pandemic response will likely be highly resource constrained and will require a strong focus on value for public money.

The Group considers that the recommendations in this report will provide strong returns within the health budget to Queensland Health and the Queensland community and economy more broadly, through better health outcomes, increased quality of life and higher economic participation and productivity. Many of the recommendations will ensure that the system focuses on high value care, and over time moderate growth in demand for acute services through better population health.

Nevertheless, some of the recommendations will require an upfront investment in order to yield these benefits. It will be necessary to increase investment in areas such as prevention and early intervention, public health and new systems and processes.

Under the current Queensland Health Funding Model, the Queensland Government provides growth funding to Queensland Health to meet projected growth in demand for health services resulting from population growth and ageing as well as other demand drivers. Growth funding is provided for public hospital services, ambulance services and primary and community health services.

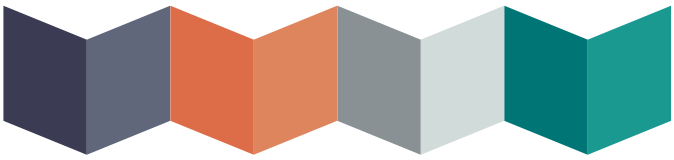
The Group recognises that most of this growth funding will need to be allocated to meet increased service demand. However, it should be noted that potential demand for health services is virtually unlimited, and that it will never be possible to meet all of this potential demand. It is important that a proportion of growth funding is set aside to drive reform priorities and to reorient the system to high value care in order to deliver the best health outcomes for Queenslanders from within the available budget. We recommend that Queensland Health develop a set of principles for the allocation of growth funding to meet these competing priorities.

We also recommend that three areas be prioritised for funding in 2020-21 and 2021-22 – namely health equity for First Nations people, prevention and public health, and transforming non-admitted care. Each of these three areas is of central importance to improving the health of Queenslanders and opportunities for new investment.

Accountable governance and implementation

Recommendation 16:

Ensure system level accountability is connected



Recommendation 16:
Ensure system level accountability is connected

Why:

A more collaborative and integrated health system will deliver better care for all Queenslanders.

How:

a) Ensure a bi-annual Ministerial Statement of Expectations is provided to each HHS Board Chair that sets out expectations around Government and Ministerial priorities, reinforces shared governance across the system, and links clearly to health system priorities, local Health Needs Assessments and Service Level Agreements.

b) Ensure appropriate accountability and reporting in response to the Ministerial Statement of Expectations.

c) The Minister for Health should meet with each Board annually to discuss their performance against the Ministerial Statement of Expectations.

The Group recognises the health sector is complex and efforts at reform can be slow. These challenges are well documented.[102] Yet, the COVID-19 pandemic response has shown that despite significant barriers, with the right conditions and driving force, even the most resistant forces can be moved for effective and rapid change. We have seen innovation flourish through greater respect, understanding and an unprecedented level of trust and cooperation during the pandemic response that has renewed appetite for reform.

Queensland Health should build on these gains by embedding these positive changes into governance structures and processes.

Through the suite of recommendations in this report, the Group has sought to tap into the 'unleashed potential' displayed during the pandemic response to provide a roadmap for reform towards an open and equitable health system.

The reformed health system we envisage is premised on governance structures that enable greater collaboration and integrated pathways for care. This requires strengthened relationships across the health system through system level accountability that is connected.

The Group has considered recent reviews regarding Queensland Health, including the 2015 Hunter Review and 2019 Report on *Advice on Queensland Health's governance framework* on Queensland Health's governance framework, which are instructive on the accountability frameworks needed for reform.

The 2015 Hunter Review emphasised the need for collaborative leadership, cultural change and a mature 'systems thinking' approach to align with a devolved governance structure. The Group notes the devolved governance structure has increased responsiveness of the health system and allowed more localised decision-making, with ownership from HHS employees over their HHS's outcomes.

The Report on *Advice on Queensland Health's governance framework* recommended maturing to a networked governance model, where HHSs have mutual and reciprocal obligations to each other and recognise obligations to the system. The Report highlighted the importance of those in leadership positions taking greater responsibility and accountability in their roles to drive the 'network' characteristics of the system. This includes promoting the sharing of data and innovation across the system to reduce variation and scale good ideas.

The Group's recommendations seek to build on these reviews to further embed positive reform across Queensland's health system. The Group agree with the need for stewardship by system leaders as well as mechanisms that reinforce engagement and innovation. The point of difference is a much greater emphasis on implementation and specifically, a recommendation to develop a detailed implementation plan that clearly identifies accountability and reporting mechanisms.

The Group believes a bi-annual Ministerial Statement of Expectations to each HHS Board Chair would provide a familiar and effective mechanism for connecting system accountabilities around shared priorities. This would involve clearly linking Government and Ministerial priorities to the Queensland Health Needs Assessment and Plan, local Health Needs Assessments and HHS Service Level Agreements.

We also see advantage in using a Ministerial Statement of Expectations to shape governance culture and accountabilities. This would involve each HHS Board being accountable for performance against the Ministerial Statement of Expectations as well as for the *processes* applied to achieve those performance outcomes, with a clear expectation for processes to be inclusive and grounded in values of openness and equity.

Inclusive engagement processes that capture a diversity of views, experience and perspectives to better inform health policy and decision making is an important insight from the pandemic response. Across Queensland's health system,

102 See for example Calder, Rosemary et al (2019), 'Australian health services: too complex to navigate. A review of the national reviews of Australia's health service arrangements', Australian Health Policy Collaboration, Policy Issues Paper No. 1 2019, AHPC, http://vuir.vu.edu.au/38684/1/Australian-Health-Services-Too-Complex-To-Navigate.pdf.

health workers of all disciplines were empowered to 'get on with the job' and work with other key stakeholders, especially consumers, industry groups, unions and providers outside of the public health system.

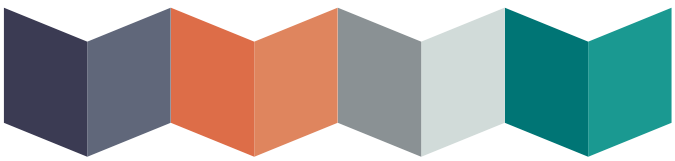
In our view linking accountability to both performance achievement and processes will prompt renewal of engagement mechanisms that are responsive to community needs and expectations. To begin with, a review of current engagement mechanisms is suggested to identify and address any gaps as well as to ensure structures exist and are appropriately integrated to drive necessary system reform.

Regular reporting in response to the Ministerial Statement of Expectations is proposed through appropriate mechanisms, such as the annual report process and service delivery statements. This would set out how each HHS is contributing to government and system priorities, and the consultative approaches in achieving objectives.

We also recommend the Minister for Health meet with each Board annually to discuss its performance against the Ministerial Statement of Expectations. This would reinforce understanding of accountability to the governance culture and help move beyond intent, to the Statement of Expectations being an active document that is formally considered and meaningfully impacts decision-making. We suggest this annual meeting is scheduled soon after finalising HHS Service Agreements. This would provide opportunity for the Board Chair and HHS Chief Executive to present their plan for delivery and articulate contributions towards system reform.

Recommendation 17:

Drive accountable implementation



Recommendation 17:
Drive accountable implementation

Why:

To drive implementation of recommendations in this report.

How:

a) The Queensland Health Leadership Advisory Board (QHLAB) to lead, champion and oversee the implementation of the recommendations in this report.

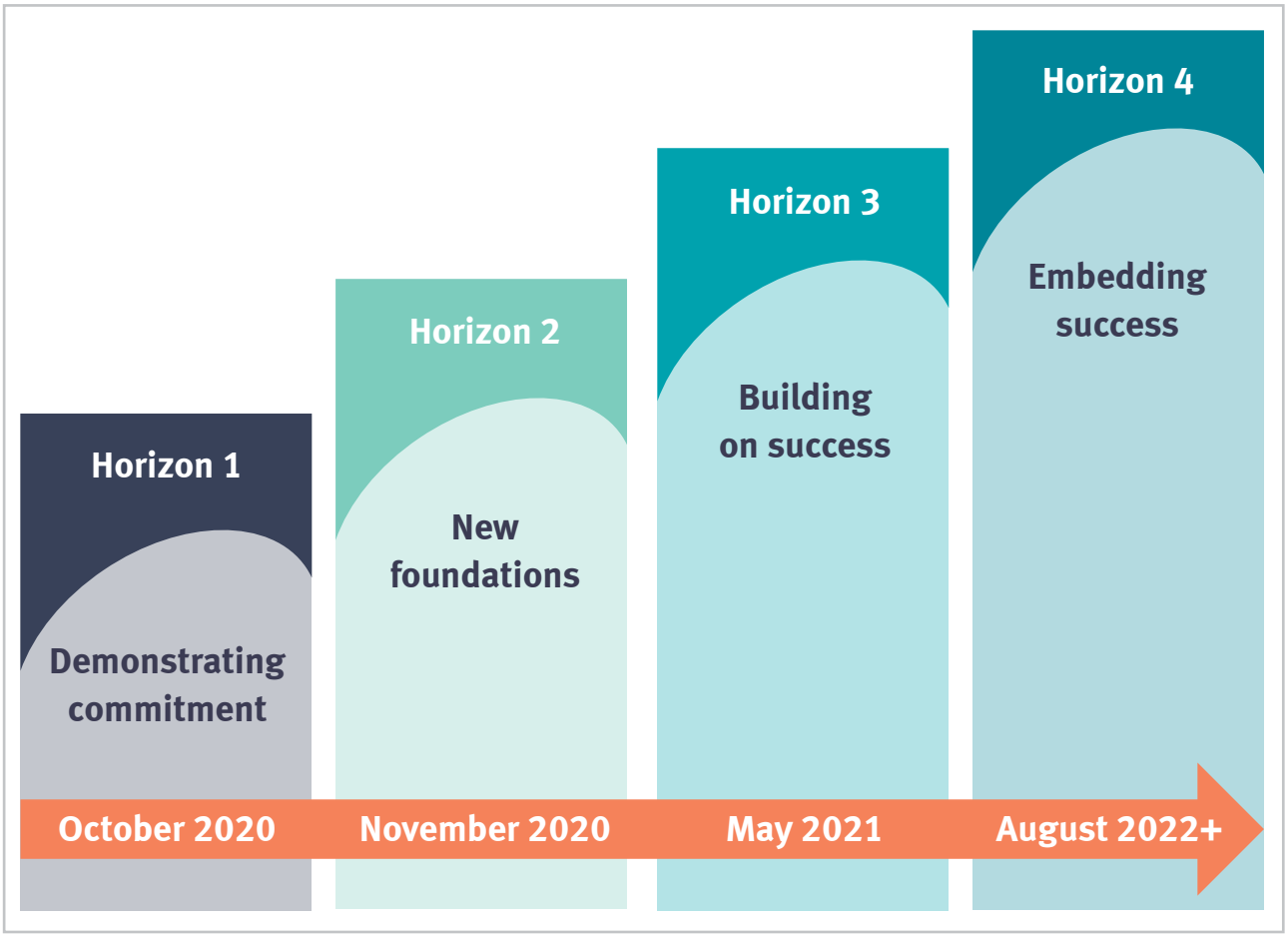
b) An Independent member be appointed to the QHLAB to support and advise on implementation.

c) The QHLAB appoint a new or existing Tier 2 Committee to develop a detailed Implementation Plan by December 2020, including specific consideration under each recommendation of strategies to drive health equity for First Nations people.

d) Queensland Health conduct an internal audit on implementation progress of the Report on Advice on Queensland Health's governance framework recommendations, with any outstanding actions to be combined with implementing recommendations in this report.

Horizons

We envisage four horizons for implementing the recommendations. Each horizon represents a specific time period for sequencing the start of each recommendation (see Appendix J). Given the range of issues necessary to consider, the development of a detailed Implementation Plan by December 2020 is considered critical among the recommendations.



Principles for implementation

The Group recognises that successful implementation requires all individuals within Queensland Health working towards a common goal of reform as well as meaningful engagement with consumers, all levels of government, non-government and peak organisations, health unions and industry groups.

The implementation challenges of previous reforms are also acknowledged along with the fatigue associated with change processes, especially given the ongoing challenges of the pandemic. At the same time, it is critical that Queensland harnesses the opportunity to embed positive change while the window for reform following the pandemic remains open.

We believe a staged approach would provide opportunity for further engagement and capacity building, which will lay the foundation for successful implementation.

The Group suggests principles for implementation be developed by the QHLAB as part of the detailed implementation plan that reflect the themes in this report.

We also consider it imperative that the approach to implementation embrace design principles that contribute to achieving equity of access and equity of outcomes for First Nations Queenslanders. This requires co-designing new and different healthcare approaches with Aboriginal and Torres Strait Islander people that respond to health need and respects the cultural rights of First Nations people.

The Group supports the following design principles:

- First Nations leadership—co-design, co-owned and co-implemented with First Nations people.
- Regional and local decision-making—designing and delivering First Nations models of care and pathways to integrate local health systems based on agreed priorities.
- Reorienting local health systems—to increase investment in upstream health interventions and care outside of hospitals.

These design principles reflect the collaborative efforts of Aboriginal and Torres Strait Islander health leaders in Far North Queensland and North and North West Queensland. The Group acknowledges the efforts of Queensland Health's Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General working in partnership with HHSs, Queensland Ambulance Service and the Aboriginal and Torres Strait Islander community- controlled health sector to drive an integrated and system led approach to First Nations health equity.

We suggest these design principles should be applied across all recommendations in this report. Delivery of a First Nations Health Equity Framework is considered a priority.

> **"All improvements and innovations in this space need to be co-designed with consumers. It is vital that First Nations consumers and people living with a disability are actively involved in co-designing these improvements to ensure they are accepted and usable to them, and support an improvement in their health outcomes."**
>
> *Health Consumers Queensland*

Responsibilities for implementation

We recommend the Queensland Health Leadership Advisory Board (QHLAB) take lead responsibility for oversighting implementation of the recommendations.

We also recommend an independent member, external to Queensland Health, be appointed to the QHLAB to give sustained momentum to implementation within the networked governance model. The independent member would have a specific role in driving the changes, working with the Department of Health's Executive Leadership Team, Health Service Board Chairs and Chief Executives, the Clinical Senate and Clinical Networks. Having an independent member, operating under authority of the QHLAB, would strengthen expectations and galvanise efforts around implementation and the reform agenda. The independent member would also help ensure the recommendations are top of mind during the immediate recovery phase as services resume and over the next 12-24 months to embed changes and realise the benefits of a reformed health system.

The Group notes that Queensland Health's system governance includes Tier 2 and 3 System Advisory Committees, which advise the QHLAB and Queensland Health's Executive Leadership Team.

We propose a Tier 2 committee develop a detailed implementation plan and drive implementation activities, in addition to monitoring and evaluating outcomes.

The Tier 2 committee should include members of the Department of Health's Executive Leadership Team and representatives from the Health Service Chief Executive Forum, the Queensland Clinical Senate, Clinical Network Executive Committee and Health Consumers Queensland. In addition, it should include a primary health representative to inform the implementation approach, particularly in relation to health system integration.

We propose a dedicated team be established within the Department of Health to act as a central coordination point for reform. This dedicated team would provide support for developing the implementation plan, program planning and management, facilitation of stakeholder engagement, communications, ongoing review and evaluation processes, and capacity building to achieve scale. The team would also provide support for the independent member of the QHLAB in promoting the reforms and driving implementation.

Where possible, the Group has identified lead responsibility for the recommendations throughout the Report.

Detailed implementation plan

The detailed implementation plan should be produced by December 2020. The following are considered important components of the detailed implementation plan:

- Principles to guide implementation of the plan derived from the themes in this report
- Strong expectations for health system leaders to create the culture for change and drive reform
- Specific consideration of strategies to drive health equity for First Nations Queenslanders
- A detailed co-designed engagement and collaboration plan
- Endorsed suite of activities for Horizons 1-4 that reflect the reform priorities
- Clear roles and responsibilities
- Identification of resourcing and capabilities to deliver on endorsed activities
- Measures to report on progress and benefits of reform and to evaluate outcomes, and
- Governance arrangements that leverage existing Queensland Health structures and establish accountabilities for delivering each recommendation.

To inform governance arrangements in the detailed implementation plan, the Group suggests Queensland Health conduct an internal audit on the implementation progress of the report on *Advice on Queensland Health's governance framework*. Any ongoing or outstanding actions identified through the internal audit should be combined with implementing recommendations in this report. The Group supports the collaborative intent of a networked governance model and believe this will provide the enabling structures to successfully action recommendations in this report.

The detailed implementation plan should align with the Queensland Health's strategic objectives as reflected in the 10-year vision My Health Queensland's future: Advancing health 2026 and the Queensland Government's policy framework Our Future State: Advancing Queensland Priorities.

Importantly, the implementation plan should link to Queensland's economic recovery strategy Unite and Recover for Queensland Jobs. The Group recognises that economic recovery and growth is inextricably tied to public health, that economic recovery is best supported by a healthy community and that the health system can support the economic recovery, especially through innovation activity and the provision of essential supplies.

Further opportunities

In addition to the recommendations, the Group has identified further opportunities for Queensland's health system. While it has not been possible to consider these fully in the context and timeframes of this report, some of these opportunities are noted below for consideration by the Deputy Premier and Minister for Health and Minister for Ambulance Services and the Director-General.

Sustainability and funding models

Queensland Health is the largest organisation in Queensland, employing nearly 100,000 people and with an $18.5 billion operating budget in 2019-20. Similar to other jurisdictions, the health budget has been increasing significantly in Queensland from 27.3 per cent of the State budget in 2014-15 to 30.7 per cent in 2019-20, driven by factors such as ageing of the population, increased rates of chronic disease and new technologies.

Queensland's health system was facing considerable financial pressure prior to COVID-19 which is expected to intensify as a result of the pandemic. Uncertainty surrounding COVID-19 will remain for some time, requiring ongoing monitoring of the disease and preparedness of the health system to adapt. The recovery phase of the pandemic is likely to be highly resource constrained. At the same time, Queensland Health will be a major contributor to the economic and psychosocial recovery in the broader community.

The Group notes future reform initiatives for the health system need to be financially sustainable. Funding is an important enabler for health reform and many of the Group's recommendations are designed to improve financial sustainability of the system over time.

The Group understands Queensland Health is undertaking a review of the funding model used for HHSs. It is essential the recommendations arising from the funding review support the effective implementation of the recommendations contained within this report, including the priorities of:

- Improved health equity for First Nations people (in both access and outcomes) and for other significantly disadvantaged and vulnerable groups
- Increased emphasis on prevention and public health strategies at the local HHS level
- Transformation of non-admitted patient care, and
- More timely care closer to home through better use of digital technology.

The Group encourages Queensland Health to explore opportunities within the existing funding model to pursue specific recommendations in this report, such as:

- Embedding incentives in HHS service agreements to drive prevention and early intervention measures (Recommendation 2)
- Developing value-based health care interventions for diabetes and, over time, for other priority patient cohorts that would benefit from integrated care pathways (Recommendation 5)

- Innovative models of care for frail and elderly people in their place of residence, including use of virtual technologies where appropriate (Recommendation 9)
- Developing incentives that support improved care in the priority areas of diabetes, mental health and for children in the first 2000 days (Recommendation 11)

Through the existing funding model, the Group has observed a number of opportunities to drive innovation. Appendix I provides a number of examples of integrated healthcare pathways that can be supported through the existing funding model.

While the funding review continues, leaders in Queensland Health should proactively use the flexibility inherent in the existing funding model to shift care closer to home, provide technology enabled care, and increase the proportion of services tied to patient-relevant outcomes.

It will also be important for Queensland to actively develop trials of funding and payment reforms under the new National Health Reform Agreement to support new models of care, including through bilateral agreements with the Commonwealth. It is critical that funding models create the right incentives to drive greater equity, value and integration in Queensland's health system.

National Health Reform Agreement (NHRA)

Since the advent of the National Health Reform Agreement (NHRA) in 2011, activity-based funding (ABF) has been the primary method both for funding public hospital activity within the States and for determining Commonwealth public hospital funding to the States. The vast majority of public hospital services have been funded on an activity basis. However, where ABF has not been practical, such as in the case of small regional and rural hospitals and some services such as community mental health, funding has been provided through block funding arrangements. By linking funding directly to outputs where practical, this model has been successful in driving significant improvements in efficiency and productivity.

Nevertheless, the ABF model as it has been implemented has focused primarily on the volume of activity and has funded episodic care rather than outcomes. It is widely recognised that the model needs to evolve. Since 2017 the national funding model has incorporated funding adjustments for safety and quality. The model also includes some flexibility to adapt to changing models of care.

- For instance, public hospital services which attract a Commonwealth funding contribution continue to be eligible for Commonwealth funding even if they are provided in a community or home-based setting in response to changes in clinical pathways.
- Hospital avoidance programs targeted at people with chronic health conditions are also eligible for funding in certain limited circumstances.

The National Health Reform Agreement 2020-2025 which came into effect on 1 July 2020 is intended to accelerate the shift to value and outcomes, with reforms to funding and payment mechanisms to create stronger incentives to improve health equity, clinical outcomes and value to patients. Key activities include:

- Developing a National Health Funding and Payments Framework.
- Developing and progressing trials of funding and payment reforms such as bundled payments, refinements to ABF, capitation models, outcome-based payments, blended funding models and pooling of payment streams across programs and providers.
- A common approach to evaluation and knowledge sharing to inform scaling of trials and future reform directions.

Capital investment

While social distancing has slowed elements of some projects within Queensland Health's capital program, this has been managed and most projects have continued in line with the planned program. Projects within the bio-security area, in particular the outer islands of the Torres Strait, have been temporarily suspended and will remain so until the public health advice status changes. Some maintenance and renewal work within live patient environments was also suspended at the start of the pandemic and will restart in line with local management decision making.

However, the longer-term implications of the pandemic on Queensland Health's capital program are likely to be far reaching. During the pandemic more than 40 per cent of non-admitted appointments have been conducted via telephone or telehealth. Recommendation 7 in this report calls for HHSs to leverage emerging digital technologies to develop virtual care and the establishment of a stretch target of 50 to 70 per cent to increase the proportion of non-admitted consultations delivered through telehealth and/or telephone. This will have implications for the design and size of future developments, including those already in the planning process. The report notes there is considerable scope to expand the use of technology-enabled care in inpatient settings, for instance through hospital in the home.

The Group notes the recommendations of the *Advice on Queensland Health's governance framework* that the Department of Health, in consultation with HHSs, develop a statewide capital works plan for Queensland Health to guide investment decisions. This plan must be integrated into the broader state-wide system planning and based on future demand management strategies.

The Group supports development of a state-wide capital works plan. In addition, the Group believes the approach to prioritising capital projects should reflect the changes in healthcare delivery during the pandemic. This includes investing in new types of capital, including digital, and thinking differently about partnerships to optimise the use of existing infrastructure across the public, private and non-government sectors. Many private hospitals are experiencing financial difficulties as a result of declining private health insurance coverage and this trend is likely to accelerate as a result of the pandemic. It would be appropriate to consider the opportunity to use available private or non-government infrastructure as a matter of course prior to considering the case for additional public infrastructure.

The big challenge will be resetting the capital portfolio, including deciding which projects get prioritised and how to reallocate capital. This includes implementing a nimbler process for capital allocation that focuses more on projects that are 'shovel worthy' rather than 'shovel ready'.[103]

The Group considers the key aspects of the capital framework will be informed by the ongoing discussions on the funding model. It is understood there is a strong emphasis on developing a capital framework that includes:

- integrated needs-based population information to identify capital solutions that support contemporary models of care;
- optimisation of the current capital mix, with consideration of the different types of assets and different usages of assets across metropolitan, rural and regional areas;
- financial mechanisms for incentivising efficient use of new capital after optimisation has been explored, and
- review of the technology delivery strategy to reflect the technology requirements of the health system into the future.

Emergency care

Queensland Health has been facing strong growth in demand across all service types, particularly emergency care including ambulance services, emergency department presentations and emergency medical and surgical admissions.

The Group has not considered emergency care in detail. Nevertheless, it would be appropriate to ensure that alternative models of care are utilised where appropriate so that ambulance services and emergency care can be targeted to cases of genuine emergency.

Queensland health is trialling alternative models of care under the Care in the Right Setting (CaRS) initiative to improve patient flow and reduce avoidable hospital activity through promoting the right care in the right place at the right time and for the right outcome.

Queensland Ambulance Service has also been pursuing new response models to expand non-hospital care options to address increases in demand. This includes trialling of mental health co-responder models with West Moreton, Metro South and Gold Coast HHSs to support Emergency Health Dispatchers and Paramedics in assisting people experiencing mental health situations.

Dental services

Public dental services are available at no cost to eligible Queenslanders, which include adult concession card holders and almost all children.

The Australian Health Protection Principal Committee (AHPPC) issued a number of national recommendations relating to the restriction of dental services during the COVID-19 pandemic, with restrictions applying from 25 March 2020 until 10 May 2020, which effectively limited services to emergency and urgent dental care only. Since 11 May 2020 there has been a gradual return to all dental procedures being undertaken with appropriate precautions, although overall activity is still 15 to 25 per cent lower compared with the same period in 2019.

Public dental waiting lists have increased significantly since late 2017, partly as a result of reduced Commonwealth funding under successive National Partnership Agreements. With dental service restrictions impacting activity for a number of months, dental waiting list numbers have increased further, with fewer people removed from waiting lists, a backlog of people whose treatment was postponed and increasing demand for emergency care. As at 31 July 2020 there were 136,051 people on the general dental waiting list, of whom 61,572 had waited between one and two years and 1679 had waited more than two years.

103 Brinded, Tom et al (2020), 'Resetting capital spending in the wake of COVID-19', Mckinsey & Company, https://www.mckinsey.com/industries/capital-projects-and-infrastructure/our-insights/resetting-capital-spending-in-the-wake-of-covid-19 (accessed August 2020).

Public dental services for adults are targeted at the most disadvantaged in the community as only concession card holders are eligible, and this target group is increasing as a result of the economic effects of the pandemic.

- Delays in routine dental care result in greater demand for emergency care and more complex care (e.g. fillings become root canal fillings or extractions and potentially dentures to replace missing teeth).
- Delays in dental care also impact on broader health issues, including undiagnosed oral cancer. There are also emerging links to chronic diseases such as diabetes.
- Poor oral health outcomes in children are exacerbated throughout adult life as those additional restorations require ongoing replacement and maintenance.

Given the strong link between public dental services and health outcomes and equity, the Group suggests the Department consider whether there is an opportunity to allocate a portion of growth funding to increase investment in public dental services.

Disability and aged care

The health system has important interfaces with other social service systems, specifically the aged care and disability sectors. We were unable to consider issues across the aged care and disability sectors in any depth, but note the important interaction with the public health system as well as the current Royal Commissions in both sectors. Suffice to say people living in aged care facilities, those reliant upon aged care and disability services and the staff of these systems have been significantly impacted by COVID-19. Our recommendations for an improved health system, and notably Recommendation 9, would have benefit for older people and people living with a disability and their experience with the health system. However, we note the important work of each Royal Commission and suggest that the recommendations in this report be considered alongside relevant findings from those commissions.

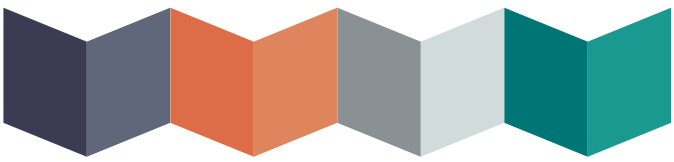
Use of My Health Record

The Group recognises the enormous potential of My Health Record to empower consumers, inform clinicians and integrate care across care pathways. A number of stakeholders also nominated My Health Record as a critical enabler for supporting improve patient care. Queensland Health should continue to support efforts to increase the uploading to and use of My Health Record. Practical applications could include, for example: support for antenatal women and newborn babies to have a My Health Record created, and/or uploaded to with relevant information encourage clinicians and Queenslanders to

upload all immunisation and related records in the My Health records; improved data sharing of primary care/ PHN data with HHSs with the My Health Record including discharge summaries, outpatient appointments, pharmacy and hospital investigations.

Appendix A:

Recommendations



Healthy Queenslanders

Recommendation 1:
Drive health equity and an understanding of local health needs

a) Develop a **First Nations Health Equity Framework** to guide implementation of the proposed First Nations health equity strategies (Department of Health).

b) Within one year of passing the Health Legislation Amendment Bill 2019 and regulations, each HHS develop a First Nations Health Equity Strategy in collaboration with local A&TSICCHOs.

c) Develop a **Queensland Health Equity Framework**, building on the First Nations Health Equity Framework.

d) Develop an integrated **Local Health Needs Assessment and Plan** at every HHS in partnership with the PHNs, A&TSICCHOs, other local partners and consumers.

Each Local Health Needs Assessment and Plan should:

- include specific plans, clear outcome indicators and data on current performance outcomes for:
  - children in the first 2000 days of life (including pregnancy)
  - people at risk of developing and those already living with diabetes
  - people with mental illnesses
- include a preventable hospitalisation plan
- be aligned to the First Nations Health Equity Plan
- be updated every three years, and
- be made publicly available.

Data should be provided for each HHS, and highlight differences in outcomes for vulnerable groups, including First Nations people.

e) Develop a **Queensland Health Needs Assessment and Plan** based on HHS level plans and as a companion to the Chief Health Officer's Report (Department of Health).

Recommendation 2:
Make prevention and public health a system priority

a) Amend the *Hospital and Health Boards Act 2011* to add prevention and population health as activities and responsibilities of the HHSs, working in partnership with other local agencies to improve population health outcomes.

b) Include an incentive in the Queensland Health funding and purchasing model to reward HHSs for improvements in care and outcomes for:

  - children in the first 2000 days of life (including pregnancy);
  - people at risk of developing and those already living with diabetes, and
  - people with mental illnesses.

c) Develop an approach that sustains increased focus on population health, health promotion and secondary prevention activities across the health system, including within HHSs.

d) Establish additional prevention and public health capacity in, and for, Cape York and Torres Strait, and in, and for, Western Queensland.

e) Create a public health and prevention clinical network.

f) Develop and deliver a multi-disciplinary Queensland Public Health Training Program in consultation with Queensland universities and relevant professional bodies.

g) Expand immunisation capacity across Queensland, especially to prepare for a COVID-19 vaccine.

Recommendation 3:
Ensure the availability of essential clinical supplies

a) Acknowledge the importance of creating the Clinical Stock Reserve and ensure appropriate input into the whole of government effort to build the reserve.

An integrated, high value health system

Recommendation 4:
Transform the relationship with primary care in Queensland

a) Strengthen the partnership with primary health care by creating a mechanism for governance, networking, engagement and strategic policy in Queensland Health.

b) Encourage transfer of care back to, and treatment in, primary health care where clinically appropriate through consistent, open and equitable processes.

c) Develop incentives in the Queensland Health funding model that support specialist to primary health care consultations, including virtual consultations.

d) Collaborate with primary health care to continue the uptake of consistent care pathways across Queensland, especially through the use of HealthPathways and clinical prioritisation criteria.

e) All clinical networks to include primary care membership and engagement with primary care.

Recommendation 5:
Develop and deliver a value-based health care strategy to underpin service improvement across Queensland Health

a) Co-design a strategy for organising Queensland's public health system to maximise value to patients on the outcomes that matter most to them, relative to the cost of achieving those outcomes (Choosing Better Health Together group). Specific actions include:

   i. Develop a whole of system reform approach to implementation, where consumers, clinicians, health workers, providers and the system managers are working toward common goals and supporting the creation of value between patients and clinicians,

   ii. Build on extensive clinical and consumer-led work to co-design, implement, scale and continuously evaluate effective patient-centred models of care that put consumers at the centre of their health journey, and

   iii. Prioritise diabetes as one of two nationally agreed priority areas.

b) Develop a pilot program to collect Patient Reported Outcome Measures for all patients in defined groups and evaluate the utility and impact of this approach.

Recommendation 6:
Transform non-admitted care to improve patient experience, reduce wait times, and improve clinical outcomes

a) Develop a system-wide program to transform non-admitted care, with an initial focus on specialist outpatient services.

b) Establish consistent, equitable and transparent processes for all referrals to Queensland Health specialist outpatient and non-admitted care based on clinical need:

   i. this would include hubs to coordinate all referrals, and

   ii. hubs would be at a 'cluster' level based on groupings of HHSs that take account of patient flow.

c) Establish consistent referral pathways across Queensland for specialist outpatient services and elective surgery which optimise the use of allied health, nursing, midwifery and general practitioners with special interests (GPwSIs) professional pathways. The initial focus should be in five areas:

   i. orthopaedics

   ii. ear nose and throat (ENT)

   iii. ophthalmology

   iv. gastroenterology, and

   v. pelvic floor health (urogynaecology).

Recommendation 7:
Optimise telehealth and virtual care to improve patient experience and outcomes

a) Develop, fund and implement a sustained approach to increase telehealth in non-admitted care as a priority for a broader virtual care strategy. This would include:

   i. Ensuring that as a minimum, the levels of telehealth and telephone consultations observed during the pandemic are maintained and increased,

   ii. Ensuring all patients are offered the opportunity to receive specialist non-admitted care through virtual technologies where equivalent or improved clinical outcomes can be evidenced,

   iii. Developing a stretch target that 50 to 70 per cent of all non-admitted consultations are delivered through telehealth and/or telephone, and

   iv. Developing an integrated suite of key performance indicators on non-admitted services and telehealth, including wait times, new to review ratios, patient travel costs and patient reported measures.

b) Ensure HHSs leverage emerging digital technologies to develop virtual care models that enable home monitoring, virtual consultations and seven-day access to clinical specialists from the patient's home.

Recommendation 8:
Ensure high value, equitable care is prioritised as elective surgery and other procedures are resumed

a) Ensure access to elective surgery for those experiencing significant health disadvantage, especially First Nations people.

b) Finalise the definition of low value surgical and other procedural care as an immediate priority.

c) Implement processes for independent clinical review of all cases of potentially low value care prior to proceeding.

d) HHSs to ensure that access to public hospital services for both public and private patients is on the basis of clinical need.

Recommendation 9:
Extend existing programs to provide improved in-reach care to residents in residential aged care facilities

a) Extend existing effective programs to provide in-reach services from HHSs to residents in residential aged care to avoid unnecessary transfers of residents to hospitals. Specific programs to consider include:

   i. Residential Aged Care Facility Acute Support Service (RaSS),

ii. the Geriatric Emergency Department Intervention (GEDI), and

iii. Eat Walk Engage.

b) Use flexibility within the current funding model to promote virtual care, Hospital in the Home (HiTH), tele-monitoring and non-admitted support programs in residential aged care facilities.

Recommendation 10:
Strengthen and embed innovative models identified through the pandemic that enable all clinical staff to work to full scope of practice

a) Implement state legislative or regulatory change to remove any barriers preventing allied health, nursing and midwifery staff and Aboriginal and Torres Strait Islander health practitioners and health workers working to their full scope of practice as authorised by the relevant professional regulatory bodies.

b) Chief Nursing and Midwifery Officer, Chief Allied Health Officer and Chief Aboriginal and Torres Strait Islander Health Officer to:

i. Implement streamlined and consistent credentialing across Queensland to increase the mobility of a highly skilled clinical workforce, and

ii. Identify opportunities to increase service capacity though the expansion of allied health, nursing and midwifery services, nurse and midwife led admission and discharge, hospital avoidance models and nurse navigators.

c) Clinical Excellence Queensland to develop state-wide mutual recognition processes.

Recommendation 11:
Develop integrated health care pathways across three priority areas to support implementation of the report

a) Develop an integrated health care pathway for diabetes.

b) Develop an integrated health care pathway for mental health.

c) Develop an integrated health care pathway for the first 2000 days, including pregnancy, infancy and early childhood.

An innovative system and empowered workforce

Recommendation 12:
Streamline data governance arrangements

a) Enable appropriate access to linked real-time longitudinal data. Specific actions to include:

i. Develop an enhanced analytics and data linkage capacity to support access to linked health and hospital data

ii. Develop legislative change to consolidate the provisions that oversee the lawful disclosure of Queensland's health dataset, and

iii. Establish data sharing agreements with external organisations and critical partners to standardise and facilitate data sharing.

b) Ensure a 'single source of truth' where data is collected once, with that same data used often, in the appropriate form, for all Queensland Health datasets.

c) Ensure all Queensland Health data is disaggregated by First Nations status and local and regional health data is shared with First Nations people.

Recommendation 13:
Advance innovation across the health system

a) Develop and embed an approach that will prioritise innovation for system leaders, scale clinical and non-clinical innovation across the system and incentivise innovation and creativity in, and across, Queensland Health. Specific actions to include:

i. Establish an innovation network, with Board Chairs to report annually to the Minister on the take-up of innovation across HHSs (HHS Board Chairs), and

ii. Develop mechanisms to support development of an enhanced culture of innovation across Queensland Health, including but not limited to, key selection criteria and performance indicators for senior leader appointments (Department of Health).

Recommendation 14:
Enhance leadership across Queensland's health system

a) Expand the current range of programs and actions to embed the necessary skills, behaviours, capabilities and accountabilities across Queensland Health's leadership to drive reform, innovation and ongoing improvements to care.

b) Queensland Health leadership to make an early, public commitment to embrace and champion the principles of an open and equitable health system. This could include:

i. Ministerial Statement

ii. a communique from the Director General, and

iii. similar statements from the Chairs and CEs of each HHS.

c) Support an empowered and accountable health workforce, by ensuring staff delegations are commensurate with their role responsibilities, through:

i. Streamlining delegations, in areas such as human resources and financial management, to enable staff to fully deliver on their accountabilities, by devolving sign-off authority through organisational structures, and

ii. Providing adequate training and ongoing support to build staff confidence and capability in exercising their delegations.

d) Support the delivery of reform and spread of innovative practice across HHSs, through:

i. supporting decision making at the most appropriate level, and

ii. developing programs to improve skills in innovation and improvement science, and application of the funding model to support innovative practices and initiatives to improve patient outcomes.

e) Support an enhanced role for multidisciplinary teams, including by ensuring that Clinical Networks are more multidisciplinary in their focus and leadership.

Recommendation 15:
Allocate a proportion of future growth funding for HHSs to drive system reform priorities

a) Develop a set of principles for the allocation of a proportion of growth funding to drive implementation of the recommendations in this report.

b) Prioritise within the overall allocation funding the following critical areas in 2020-21 and 2021-22:

i. health equity for First Nations people

ii. prevention and public health, and

iii. transforming non-admitted care.

Accountable governance and implementation

Recommendation 16:
Ensure system level accountability is connected

a) Ensure a bi-annual Ministerial Statement of Expectations is provided to each HHS Board Chair that sets out expectations around Government and Ministerial priorities, reinforces shared governance across the system, and links clearly to health system priorities, local Health Needs Assessments and Service Level Agreements.

b) Ensure appropriate accountability and reporting in response to the Ministerial Statement of Expectations.

c) The Minister for Health should meet with each Board annually to discuss their performance against the Ministerial Statement of Expectations.

Recommendation 17:
Drive accountable implementation

a) The QHLAB to lead, champion and oversee the implementation of the recommendations in this report.

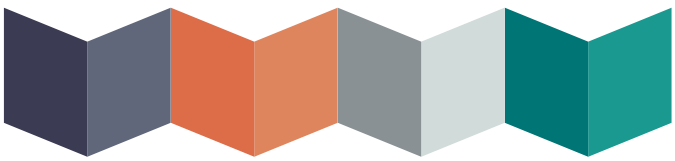
b) An Independent member be appointed to the QHLAB to support and advise on implementation.

c) The QHLAB appoint a new or existing Tier 2 Committee to develop a detailed Implementation Plan by December 2020, including specific consideration under each recommendation of strategies to drive health equity for First Nations people.

d) Queensland Health conduct an internal audit on implementation progress of the Report on Advice on Queensland Health's governance framework recommendations, with any outstanding actions to be combined with implementing recommendations in this report.

Appendix B:

Reform Planning Group terms of reference



1. Purpose

The purpose of the limited-life advisory committee known as the 'Reform Planning Group' (the 'Group') is to advise and inform the development of the Queensland Health System Reform Roadmap (Reform Roadmap) for the Director-General, Queensland Health and the Deputy Premier and Minster for Health and Minister for Ambulance Services, on how best to harness the opportunities arising from the pandemic to achieve the best possible health and healthcare for Queenslanders. Reform activities must focus on preventing ill health and delivering better value for our patients, our workforce and our public health system.

2. Context

The Australian and Queensland Health system has made some rapid changes to health care delivery in response to the COVID-19 pandemic.

The interruption to regular service delivery presents an opportunity to build on the reform and innovation built out of necessity during the COVID-19 pandemic response including changes to existing policy and funding settings and the way services are delivered. This could include adjusting how we fund and what we measure, manage and reward to support new models of care to better meet the needs of consumers, clinicians, providers and funders (for example, expanding virtual care and hospital outreach services, and blended funding models across sectors). Some of these innovations have ongoing potential to the health system benefiting staff, patients and the broader community.

Following the initial pandemic response, Queensland Health will bring services back online in the wake of significant disruption and the build-up of unmet demand for health care. The recovery phase will be highly resource constrained, with reduced government revenues and a need to restore government balance sheets, requiring a strong focus on cost efficiency and value for money.

The disruption to existing models of service delivery during the pandemic also provides an opportunity to accelerate system reforms such as those to promote value-based healthcare, health system integration, prevention and wellbeing and equity of outcomes for groups currently experiencing health disadvantage.

As the largest organisation in Queensland, employing nearly 100,000 people and with an $18.5 billion operating budget in 2019-20, Queensland Health will be a major contributor to the economic and psychosocial recovery in the broader community. While this presents significant challenges, it also presents opportunities. 'Business as usual' for the health system post-pandemic need not be the same as pre-pandemic. A 'window of opportunity' exists for Queensland Health to build on innovations arising from the COVID-19 pandemic that demonstrate improved value for patients, staff and the broader community and have ongoing potential for Queensland's health system.

3. Appointment to the Group

The Group has been established by the Director-General of Queensland Health who will appoint, in consultation with the Deputy Premier and Minister for Health and Minister for Ambulance Services, nine (9) expert members to the Group. This includes the Group Chair and an independent advisor who will provide input and ideas, as well as acting as a 'critical friend'.

Members are to be engaged personally and act, on the basis, of their individual standing, professional and personal experience. Members are not to be engaged as representatives of any particular group or organisation.

3.1. Expertise

The members are to be appointed based on their expertise across the health system to ensure a holistic and comprehensive approach in developing advice to inform the Reform Roadmap. Collectively, the members' expertise is to cover health system management and governance, Aboriginal and Torres Strait Islander health services, rural health services, data and innovation, health consumer and employee perspectives, health economics and behavioural science.

3.2. Formation of sub-committees

Members may form sub-committees to support the work of the Group.

3.3. Engagement and consultation

In developing its advice and input for the Reform Roadmap, the Group is expected to:

- engage and consult across the Queensland health system by using existing consultative forums, including, but not limited to: HHSs, private hospitals, health consumers; non-government organisations; aged care providers; primary healthcare sector; employee representatives; and clinicians.
- work as required with other Queensland Government departments and recovery groups in developing their workplan.

The Group may request Queensland Health employees to participate in informing advice and invite submissions or information from external sources where appropriate to do so.

3.4. Role of the Secretariat

Secretariat and policy research functions for the Group will be provided by Intergovernmental & Funding Strategy (IFS), Office of the Director-General & System Strategy Division.

The Secretariat will lead the development of the Reform Roadmap and other key deliverables, such as supporting reports and briefings, which the Group will advise and inform, as set out in the Group's Work Program.

The agenda for meetings and relevant papers will be distributed by the Secretariat at least two working days before each meeting.

The Secretariat can be contacted at: reformplanning@health.qld.gov.au.

3.5. Roles and decision making

Members are individually and collectively accountable for the Groups decisions, recommendations and advice.

The Chair is responsible for ensuring that matters discussed, and decisions made are strictly within the authority of the Group.

The independent advisor will participate in all meetings and activities of the Group, however will provide independent advice and will not partake in endorsing of the Group's advice.

3.6. Work program

A high-level work program will be developed for endorsement from the Deputy Premier and Minster for Health and Minister for Ambulance Services. This work program must ensure appropriate engagement and consultation on the most significant issues.

3.7. Guiding principles

The panel is strongly encouraged to focus not only on 'what' needs to change but 'how' to create the conditions to create the necessary behavioural change at individual, provider organisations and funder levels. The principles of the Public Service Act 2008 and the Hospital and Health Boards Act 2011 guide the deliberations of the public servant participation of the Group.

In expressing their views, the Group members and participants are to be mindful of the Queensland Government's responsibility to act in the best interest of users of public health sector services. This includes being consistent with the principles, intent and substance of commitments and policy decisions made by the Queensland Government.

3.8. Time commitment

The estimated duration of the program of work is around three months (14 weeks).

The Group will commence in the week of 11 May 2020 and members will be required for approximately five hours per week on average, including weekly meetings, consultations and briefings for the Deputy Premier and Minster for Health and Minister for Ambulance Services and Department as required.

3.9. Remuneration

The Department of Health will remunerate non-Queensland Health employee Group members at an agreed upon fixed rate based on the estimated time commitment (5 hours per week over 14 weeks), with contingencies if the time commitment increases significantly during the group's engagement.

Travel and related expenses are to be paid separately.

3.10 Performance

The Group will be evaluated in terms of its performance against the approved Terms of Reference.

3.11. Confidentiality

Members may receive information that is regarded as 'X-in-confidence', clinically confidential or have privacy implications.

Members acknowledge their responsibility to maintain confidentiality of all Queensland Health information that is not in the public domain and that this obligation continues after their appointment ceases.

3.12. Conflict of Interest

To meet the ethical obligations under the Public Sector Ethics Act 1994, the Group members and guests must declare any conflicts of interest whether actual, potential, apparent, or that appear likely to arise, and manage those in consultation with the Chair. This may relate to a position a member holds (e.g. chair of an external organisation), or to the content of a specific item for deliberation.

Declaration of conflicts of interest must be listed as a standing item in the Group agenda. The Chair will determine whether the member should absent themselves from the relevant part of the meeting. The Secretariat will record any declaration of conflict of interest applicable to that meeting in the minutes of the meeting.

Membership

Core members

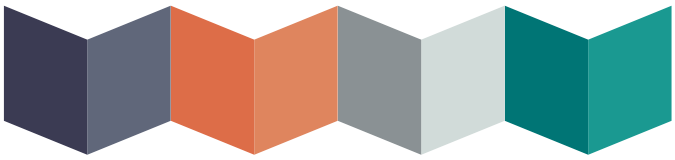
- Ms Meegan Fitzharris (Chair), Senior Fellow in Health Policy and Leadership, College of Health and Medicine, The Australian National University
- Ms Beth Mohle, Secretary, Queensland Nurses and Midwives' Union
- Professor Keith McNeil, Assistant Deputy Director-General and Chief Medical Officer, and Chief Clinical Information Officer, Prevention Division, Queensland Department of Health
- Mr. Adrian Carson, Chief Executive Officer, Institute for Urban Indigenous Health (IUIH) Ltd
- Dr John Pickering, Chief Executive Officer, Evidn Group
- Mr Shaun Drummond, Chief Executive, Metro North Hospital and Health Service
- Professor Sabina Knight, Director, Mount Isa Centre for Rural and Remote Health, James Cook University
- Ms Melissa Fox, Chief Executive Officer, Health Consumers Queensland

Independent advisor

- Dr Stephen Duckett, Health Program Director of Grattan Institute. Dr Duckett will be an independent advisor to the Group providing input and ideas, as well as acting as a 'critical friend'.

Appendix C:

Reform Planning Group member biographies



Group Members	Member Short Biography
Ms Meegan Fitzharris, Chair 	Meegan Fitzharris was a member of the Australian Capital Territory Legislative Assembly from 2015 – 2019. She was the Minister for Health and Wellbeing and Health and Medical Research, Minister for Transport and City Services and Minister for Higher Education. As the Minister for Health, she ordered the Independent Review into the workplace culture within ACT public health services. Ms Fitzharris is currently Senior Fellow in Health Policy and Leadership in the College of Health and Medicine at The Australian National University and is also a member of the Advisory Group for the Australian Centre for Value-Based Health Care. Before commencing a political career, Ms Fitzharris held a variety of public policy roles in State and Territory and Commonwealth departments. She was educated at the University of Otago and the University of Auckland.
Dr Stephen Duckett, Independent Advisor 	Dr Stephen Duckett has held top operational and policy leadership positions in health care in Australia and Canada, including as Secretary of what is now the Commonwealth Department of Health. He has a reputation for creativity, evidence-based innovation and reform in areas ranging from the introduction of activity based funding for hospitals to new systems of accountability for the safety of hospital care. An economist, he is a Fellow of the Academy of the Social Sciences in Australia and of the Australian Academy of Health and Medical Sciences. Dr Duckett is currently the Health Program Director of Grattan Institute.
Professor Keith McNeil 	Prof Keith McNeil is the Acting Deputy Director-General of Clinical Excellence Queensland, Queensland Health and plays a key role in the clinical leadership of the statewide eHealth program. He works closely with key stakeholders to maximise the clinical and patient safety benefits associated with technology in the healthcare setting, while minimising risk. Prof McNeil has previously worked within Queensland Health as the Head of Transplant Services at The Prince Charles Hospital, Chief Executive Officer at Royal Brisbane and Women's Hospital, and Chief Executive Metro North Hospital and Health Service. More recently, Prof McNeil was Chief Clinical Information Officer, National Health Service, United Kingdom following roles as Chief Executive Officer at Addenbooke's Hospital and Cambridge University Hospital Foundation Trust.

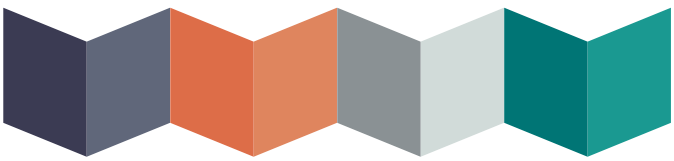
Group Members	Member Short Biography
Professor Sabina Knight 	Prof Knight has been a key figure in the development of rural and remote health, health workforce policy and health reform. She has served on a wide range of ministerial advisory bodies and was a Commissioner on the National Health and Hospital Reform Commission. Prof Knight has been associated with University Departments of Rural Health since their inception 21 years ago and currently leads the Centre for Rural and Remote Health, James Cook University in outback Queensland where she has made significant contributions to innovative service models, education and remote practice. She is an experienced remote area nurse with lifetime roots in outback rural and remote areas. A veteran of remote health in New South Wales, Central Australia and the Northern Territory, Prof Knight has developed expertise in clinical practice, primary health care, public health, research and education. In 1983, Prof Knight was one of the remote advocates instrumental in the founding of the Council of Remote Area Nurses of Australia, then the Central Australia Rural Practitioners Association and then the National Rural Health Alliance.
Dr John Pickering 	Dr John Pickering is the Chief Executive Officer and Co-Founder of the Evidn Group (USA and Australia). He is a behavioural scientist who specialises in the analysis and modification of human behavior at a population level. He has expertise in systems level thinking, behavior change frameworks, psychological theories and models and has experience engaging with complex challenges where system wide change is required. Dr Pickering is the Co Chair of the Nature Sustainability Expert Panel on Behavioral Science and Design; a member of the OECD's expert steering group on agrienvironmental behavioural economics; and he holds appointments at The University of Queensland, Princeton University, and the Darden Business School (University of Virginia). He was an inaugural board member of Health and Wellbeing Queensland and former member of The University of Queensland Senate. Dr Pickering holds a PhD (with distinction), Bachelor's degree in psychological science (with first class honours) and has published in leading peer reviewed journals and international media outlets.
Mr Shaun Drummond 	Shaun Drummond is the Chief Executive of Metro North. He has been Executive Director Operations of Metro North since 2014 and has been a Chief Operating Officer in the Health Sector for 15 years. Mr Drummond's professional background is Industrial Relations and Organisational Development. During his career he has worked in the public health system in New South Wales, Victoria, Queensland and New Zealand.

Group Members	Member Short Biography
Ms Beth Mohle 	Beth Mohle is Secretary of the Queensland Nurses and Midwives' Union, the peak industrial and professional representative body for nurses and midwives in Queensland. The purpose of the QNMU is to grow power, confidence and capacity to improve the industrial and professional interests and wellbeing of nurses and midwives and the health of our community. With over 64,000 members, the QNMU is the largest union in Queensland and is part of the country's largest union, the 280,000 strong Australian Nursing and Midwifery Federation (ANMF). After completing a Bachelor of Arts at Griffith University, Ms Mohle commenced her career in nursing in 1983. Ms Mohle has worked as a registered nurse at the Royal Brisbane Hospital. Ms Mohle joined the QNMU as an Organiser in 1991 and held project and research positions before being elected Assistant Secretary in January 2007 and Secretary in April 2011. Ms Mohle is currently a board member of QSuper, is a Fellow of the Australian Institute of Superannuation Trustees (AIST) and was named AISTs Trustee of the Year in 2008. She was previously a board member and Chair of HESTA and holds a number of superannuation related qualifications and a Graduate Certificate in Health Economics. As Senior Vice President of the Queensland Council of Unions (QCU), Ms Mohle actively contributes to strategy development for the broader union movement. She is also an active founding member of the Queensland Community Alliance.
Mr Adrian Carson 	Adrian Carson has over 28 years' experience working in the Indigenous Health sector, working within government and non-government organisations. As CEO of the Institute for Urban Indigenous Health (IUIH) Ltd, Mr Carson leads the development and integration of health and wellbeing services to Australia's largest and fastest growing Aboriginal and Torres Strait Islander population in South East Queensland. Mr Carson has served as Chief Executive Officer of the Queensland Aboriginal and Islander Health Council (QAIHC) and held senior positions in Queensland Health and the Commonwealth Department of Health & Ageing. Mr Carson is currently a Board Member of the Metro North Health & Hospital Service in Brisbane. Mr Carson holds a Graduate Certificate in Health Service Management from Griffith University and is completing a Master of Business Administration from The University of Queensland.

Group Members	Member Short Biography
Ms Melissa Fox 	Melissa Fox leads Health Consumers Queensland to support consumers and health providers to collaborate together to improve the safety and quality of health services. Ms Fox believes that consumers being involved in decision-making at all levels is essential to achieve consumer centred care and to improve health services. She is an organisational representative on the Queensland Clinical Senate, Chair of the Partnering with Consumers, Australian Commission on Safety & Quality in Healthcare and an Advisory Group member of the Australian Centre for Value-based Health Care. Ms Fox has been a part of the journey of Health Consumers Queensland; she was an original member of the Ministerial Advisory Committee that later became the independent organisation that is now Health Consumers Queensland. Ms Fox is a mother of two gorgeous girls and has previously worked in documentary and reality television. Ms Fox first learnt the importance of individuals advocating for their health needs when she watched her grandparents confidently make choices around their own health needs after they each survived multiple heart attacks and strokes. After starting her own family, she devoted her time as a full time volunteer working on a systemic level to improve access to models providing continuity of midwifery care. Ms Fox has seen first hand from her own consumer representative roles, how valuable the partnerships between consumers and clinicians are in creating healthier people and communities. She is working towards consumers being recognised and valued as leaders in health decision making for their own healthcare as well as at a policy and systems level. Ms Fox is the Vice President of the Queensland Council for LGBTI Health.

Appendix D:

The New Abnormal Report



The New Abnormal

COVID-19 and Behavioural Change in Queensland

John Pickering, Ph.D.

August 2020

PREFACE NOTE: This report was prepared by reform planning group member, John Pickering. The contents of this report, including its interpretations and findings, do not necessarily reflect the views of the reform planning group and were provided as a summary of the insights relating to COVID-19, behavioural science, and behaviour change in Queensland.

Introduction

From a behavioural scientist's point of view, COVID-19 has provided many important insights towards 'behaviour change'. The crisis changed the way we as individuals go about our daily lives, the way workplaces function, the way society functions, and even the way governments operate. In Australia, at least, many of these changes were made in a rapid and effective fashion.

Our success in dealing with COVID-19 has led to the introduction of a commonly used phrase in our vernacular: **"the new normal"**. This phrase implies that COVID-19 has managed to dismantle our understanding of what 'normal' was and provides an opportunity for us to assemble a new, and plausibly better, kind of normal.

The idea of moving to the new normal is exciting. Many of us can point to changes we want to see (typically in other people) and relish the opportunity to see change happen (so long as it is not "me"). If it is true that COVID-19 successfully led to wide-scale behaviour change, then surely there must be many lessons we can learn from these extraordinary times about how we navigate to the new normal.

This report aims to extract these lessons and interrogate COVID-19 for what it can reveal about how we, as a society, can change our behaviour for the better. It is not the intention of this report to examine what specific behaviours changed, nor commentate on what behaviours should change into the future. Rather, this report will examine what the specific mechanisms were that enabled COVID-19 to act as such a powerful force for behavioural change. The hope is that by extracting these lessons we can embed them into the way we undertake reform and shape our systems and structures into the future.

The report is based on an observational case study approach to behavioural change in the state of Queensland, with particular emphasis on Queensland Health. It is imperative to note that this report does not draw on an experimental, research intensive methodology. It is based on general observations and insights of the author as a resident of Queensland, behavioural scientist, and member of the Queensland Health Reform Planning Group (and the insights afforded through membership of that group).

The report will examine behaviour change at two levels:

1. Behaviour change in the community-at-large (i.e., what enabled so many people to change their behaviour so quickly?)
2. Behaviour change within Queensland Health in managing the crisis (i.e., what enabled the health department to work so differently to how it normally might?)

The report is organised around the following three questions:

1. How did COVID-19 catalyse behavioural change?
2. What were the active ingredients of behavioural change?
3. How do we maintain behavioural change into the future?

The investigation of these questions is focused around the changes experienced within Queensland Health as result of the pandemic. While these lessons do have some limitations to their generalisability, the fundamental principles discussed are plausibly transferrable to other jurisdictions and settings.

It is necessary to note four considerations in reading this report.

- The first is that the analysis that underpins the findings in this report does not go anywhere near far enough to addressing the issue of equity in the health system and the way behaviour change has positively (or negatively) impacted groups that fall outside the majority.
- Secondly, this report focuses on instances where voluntary behavioural change was crucial and not exclusively the result of mandatory, regulated, or legislative changes (i.e., the way state border closures modified people's travel behaviour).
- Thirdly, the analysis draws extensively on science and evidence, but given the complexity of the prevailing circumstances the observations in this report are best described as part science and part conceptual interpretation.
- Finally, given we remain in the middle of the pandemic this report is certainly a work in progress.

For those who do not make it to the end, the key finding from this report is that if we are to succeed in changing our behaviour into the future, we must be successful in bringing people together under a shared identity and goal, be willing to champion that which is different, reinforce and reward those who take proportionate risks, lead with decisiveness, reset our personal defaults, and dare our people to deviate from the norm.

We must all champion the new abnormal.

1. How did COVID-19 Catalyse Change?

The onset of the COVID-19 crisis led to a rapid, large-scale shift in the behaviours of Queenslanders, including behaviour within Queensland Health. There are two key psychological factors that explain how COVID-19 catalysed change.

1. Shared Goal

The task of tackling COVID-19 represents a shared goal for the entire population of Queensland – the virus threatens all Queenslanders and all Queenslanders want the threat to be defeated. In other words, we have a clearly defined and commonly shared goal. Key to unlocking this shared goal was that COVID-19 passed the threshold where defeating it was not seen as simply desirable or preferable, rather it was seen as absolutely critical. Situations where the vast majority of the population aligns behind a single common goal are remarkably rare. The main example would be war – and no one wants to lose the war. The key insight here is that COVID-19 represents the extraordinarily unique scenario where a common threat was experienced by the population and all members of that population were united behind the goal of defeating it—regardless of how people thought it should be defeated, no one wants to see it win.

2. Alternate Behaviours Available

Prior to COVID-19 there were many established 'ways of working' in the health system, or the community more broadly, that were known to be sub-optimal where superior alternatives were either already available or were able to be developed rapidly under the right conditions. In other words, many people knew that 'business as usual' was not the best way of doing business. The changes we experienced as a result of COVID-19 were more about unlocking ideas, behaviours or approaches that were already known, rather than inventing new solutions from scratch.

We can begin to understand why readily available alternate behaviours are often not widely adopted by referring to Kurt Lewin's field theory model of human behaviour. Lewin proposes that our behaviour emerges from the forces created by a "field" of interacting personal and environmental traits[1]. There are two broad categories of forces; driving forces, which motivate behaviour, and restraining forces, which inhibit behaviour. To shift people's behaviour and move away from status quo, it is more effective to overcome restraining forces than to enhance driving forces.

In the case of the health system, a significant restraining force existed in the form of deeply grained inertia. We can understand this inertia as a form of status quo bias – the psychological tendency to keep things the same because any deviation from that status quo is perceived as a loss[2].

COVID-19 catalysed change by overcoming this idea of loss, disrupting the status quo bias, and thereby re-engineering a system of thought that created the ingredients for change to happen.

These ingredients are explored further in the following section.

2. Active Ingredients for Change: A Behavioural Model

This section outlines the active ingredients of behavioural change that have emerged as a result of the COVID-19 pandemic. There are five active ingredients, each of which is interlocked with the other, providing a behavioural model for understanding the observed behaviour changes induced by COVID-19.

1. Establishment of a Collective Identity

COVID-19 was a common threat to all members of the target population (specifically, Queensland; and elsewhere, of course) and a shared identity was formed around the common goal of overcoming the COVID-19 threat. Neuropsychologically, different brain circuitry systems are activated when we perceive a threat versus when we formulate a behavioural response to overcome the threat[3]. In other words, it is not the threat itself that unifies and motivates people to action, it is the common objective of overcoming a threat through collective action.

Social identity theory provides an empirical window to understanding the process whereby people identify their sense of self with a broader group unified by a common trait[4]. Identification with the group means that individual attitudes and behaviours become substantially influenced by the normative attitudes and behaviours of the group. This is critical because it means the individual no longer becomes the target, *per se*, of behavioural modification; group norms are now the target.

Queensland Health, and society more broadly, is replete with groups that often have competing interests. To achieve reform, it must be coordinated simultaneously across all interest groups, so that there is a shift from the status quo with a minimum of compromise by various group interests. This means establishing a sense of common purpose and shared goals across clinicians, consumers, and administrators at all levels of the health system.

Previous studies have shown that it is possible to overcome ingroup-outgroup barriers and form a 'common group' when a common threat exists.[5] Social psychology shows that it is possible for such groups to become subordinated for a time to a common group if a common objective is presented, especially if that objective is the overcoming of a common threat. While the common objective exists, the interests of pre-existing identity groups becomes sublimated, and a superordinate group forms with the common trait of pursuing the common objective, temporarily abolishing intergroup conflict and the resistance to compromise thereby created[6].

It is important to note that the establishment of a collective identity acted as glue to unify people and enable each of the other active ingredients of change to be effective.

2. Benefits and Risks of Behaviour Change Transferred from the Individual to the Collective.

The primary benefit of establishing a collective identity in response to COVID-19 was that it allowed for the perceived benefits and risks that people experience when they contemplate changing their behaviour to be transferred from the individual to the collective identity. This transfer was particularly important as it represented the removal of the two most prominent restraining forces to behavioural change, risk aversion and loss aversion, positioning COVID-19 as an effective 'status quo bias buster' as per Lewin's forcefield theory captured in Part 1[7]. This effect was particularly pertinent to the changes experienced within Queensland Health, but also helps explains behaviour change in the community at large.

Risk Aversion

Risk aversion explains the process whereby people make decisions that aim to reduce any risk they are likely to experience[8]. A risk averse individual will typically choose a less risky, more certain course of action over a more risky one, even if the riskier one has a greater potential reward. This explains why change rarely happens as it is always safer to keep things as they are (status quo) as the outcome is a known quantity. While there is inconsistent evidence on whether public sector workers are generally more risk averse than private sector workers[9], there are strong theoretical reasons to believe that public sector workers may be risk averse with innovative ideas that disrupt the comfortable status quo. COVID-19 did not remove the risk associated with disrupting the status quo, but it did transfer that risk from the individual to the collective. In a fascinating example of how shared identity can predict risk taking behaviour, Firing and Ladberg[10] found that creating a shared identity with other people significantly predicted the likelihood of participants jumping into a freezing ocean. In other words, we are more likely to take risks if we share a sense of purpose with those around us.

Loss Aversion

Loss aversion explains the phenomenon of people feeling the pain of losses about twice as much as they would feel the benefit of equivalent gains[11]. Loss aversion leads people to actively avoid losses in situations. In the health system, changing a procedure or process could lead to the loss of something personnel hold to be important – including organisational status, collegiate esteem, security, pride, ego, financial or other resources, control, or even political capital. When we decide to make a change, we can readily identify what it is we will lose and feel it more keenly than what we will potentially gain. In short, people want to keep a hold of whatever it is they currently 'have' and retain as much control as they can. Change invariably raises the possibility of losing something we want to hold on to – hence, why behaviour change can be so hard.

3. Leaders Modelling the Desired Behaviours

Leaders are pivotal in changing the behaviours of groups. According to identity leadership theory[12,13], leaders are particularly effective in facilitating the uptake of new behaviours when they create a sense of shared social identity among followers (a sense of "usness"). Specifically, leaders can drive change by being perceived as being an 'in-group' member (i.e., a Queenslander), prioritising the interests of the group over their own interests, and reinforcing the group's identity through their actions[14]. These leadership actions encourage 'followership' (by citizens, employees etc) and the subsequent adoption of new group norms set by the leader and engage in behaviours that benefit the group[15].

In responding to COVID-19 in Queensland, the primary leadership team was the Premier, Deputy Premier and Health Minister, the Chief Health Officer and the Director-General of Health. Each of these leaders—all of whom are relevant and relatable to different sub-groups—modelled a range of behaviours which helped create new social norms across the group.

These behaviours included -

- **Decisiveness**: The willingness to make clear and bold decisions in the face of voluminous risk and uncertainty.
- **Evidence-informed decision making**: Making decisions that were routinely backed up or cited as medical or scientific advice.

- **Collaboration**: Leaders modelled ways of engaging in collaborative, bi-partisan decision making where traditional in/out group barriers were overcome and hierarchies put aside.
- **Articulating collective benefits via individual action**: Leaders reported the results of "flattening the curve" and provided group members with praise and acknowledgement of how their efforts to abide by the new behavioural norms were making a positive difference for everyone. This helped overcome one of the major barriers to change – learned helplessness, which is characterised by an individual failing to change their behaviour to improve their condition because they have learnt they have no control over what happens to them[16]. Learned helplessness can be overcome by building people's sense of self-efficacy which involves clearly showing people that by doing behaviour X it leads to outcome Y.

4. Clear Behavioural Instructions

To control the spread of COVID-19, people were mostly given clear and concise instructions on what to do to help the group achieve its shared goal. It is easy to overlook that fact that if we want people to change their behaviour, they need to be told very precisely what they need to do differently. Key to behavioural instructions are: (1) specificity (e.g., stand 1.5m apart); (2) flexibility (e.g., being 1.5m apart might not be possible in supermarkets, so adapt as needed) and (3) consistency (e.g., ensuring that instructions remain consistent and, if varied, are clearly explained why the variation is needed).

Often, it is not just one behaviour, but multiple behaviours across a range of settings that need to change to overcome a threat. Behaviour does not occur in isolation, but rather, it is the product of a person interacting with their surroundings. According to ecological systems theory, our behaviour plays out in a broader system of environmental influences (e.g., personal, social, organisational and cultural) which govern our decision making and behaviour.[17] For sustainable behavioural change to occur a behavioural hierarchy needs to be constructed to understand and identify the behaviours that need to change across different layers of the system and a suite of multi-levelled strategies developed to simultaneously target those behaviours.

5. Provision of Clear and Real-time Data Driven Feedback

As COVID-19 started to spread worldwide, clear and frequent updates were provided, including how COVID-19 was spreading (or not spreading) across locations, number of cases, number of deaths, and number of recovered cases. This feedback was crucial to demonstrate how people's efforts were contributing towards containing COVID-19 which helped build efficacy for the group (collective efficacy) and efficacy for individuals within the group (self-efficacy). Importantly, these data were widely accessible across multiple mediums and routinely included in public service announcements.

3. Maintaining Change: A Recipe for Reform

This report has so far documented that COVID-19 was a status quo buster that enabled a rapid behavioural change response in the community and within Queensland Health. However, catalysing and generating change is one thing, maintaining change is another. When considering the longevity of any observed behavioural change/s, there are two important considerations:

1. The 'COVID-19 catalyst' effect will dissipate – that is, once the threat is considered to be defeated, the shared goal will become less salient; and
2. In the absence of catalysing a shared goal, the active ingredients for change are likely to atrophy.

Within Queensland Health, one metaphorical explanation for why we are likely to see a return of pre-COVID behaviours is that COVID-19 acted like an invisibility cloak. That is, because individual risks were absorbed by the collective goal, people felt a sense of invulnerability that they would not normally feel with respect to their actions and their consequences. In addition, and not the focus of this report, there were significant stoppages to critical services (e.g., elective surgery) which will also be turned back on creating a sense of 'return to normal'. As the threat of COVID-19 drops, the goal declines, and the volume is gradually turned down on the active ingredients for change where a gradual return to previous behavioural patterns emerges.

The question is, then, given the lessons learned from COVID-19 how do we maintain (or create) behaviour change in Queensland Health into the future? Put differently, given the multiple reforms that need to be adopted (the "what") how can behavioural science provide a means for ensuring such reforms actually see the light of day (the "how")?

Behavioural Science Reform Recommendations

1. Create common identities and shared goals

Reform will be enabled by clearly defined common identities and shared goals. Group identities need to be formed around thematic, conceptual or geographical logical units that bring together all parties—consumers, clinicians, administrators—that have an interest in the outcome. COVID-19 demonstrated that behaviour change occurs when all members of a given group share a common goal and come together under an inclusive, unified group identity that enables collaboration, shared decision making and collective benefits to be realised. While it is unlikely we will see a single common identity emerge across the entire health system as it did with COVID-19, groups will need to be formed within the health system that serve as the basis for a shared identity and goal to be realised. Group division, "us" versus "them", will invariably threaten reform success. The social psychology of group identity is pivotal to the reform process.

2. Leaders must lead for "us" and mitigate risk/loss aversion

Leaders within the health system must work with their groups to establish the common identity and goal and actively seek to remove risk from their group members' decision making. If risk continues to be people's number one concern, behaviour change will not occur. The leader, as a representative of the system, needs to recognise risk and provide meaningful ways of mitigating it on behalf of their group members. Leaders must also model the desired behaviours through being decisive in the face of uncertainty (i.e., taking risks), using evidence-based decision making, and demonstrating how each individual's action maps on to the shared goal of the group.

3. Create a behavioural taxonomy

Each reform recommendation must be accompanied by a behavioural taxonomy that defines which behaviours need to change, by whom, the barriers preventing them from changing, and the benefits associated with the change. Specificity of behaviours and barriers is crucial to success.

4. Control for bias and cognitive fallacies

There are many known biases that exist within experts working in the health system. These biases are discussed in detail elsewhere[18], but there are two particularly significant biases and fallacies from a behavioural change perspective.

The first is what is broadly termed as Nobel Disease. The Nobel Disease is a term loosely used to capture the phenomenon whereby highly intelligent people are at increased risk of having a bias blind spot. Although highly intelligent people are able to subject their thought patterns to higher levels of scrutiny, there is some evidence that they might be less likely to do so because they are more likely to think they are correct. A number of cognitive errors are implicated in this process[19], many of which are potentially prevalent in the health system, such as:

- **Unrealistic optimism and invulnerability** – people are so confident in their intellectual abilities that they believe they are immune to intellectual errors.
- **The sense of omniscience** – individuals believe their intelligence means they know virtually everything.

A further reform fallacy occurs through the false dichotomy effect. The false dichotomy fallacy refers to the situation where it is erroneously believed that there can only be two possible outcomes to a given situation. Financial incentives are the most typical example of the false dichotomy effect. For example, it is often held that if funding for a particular practice is not available and/or clinicians do not get paid to do it, it is very unlikely that they will adopt the practice. However, the false dichotomy is to assume that just because the funding becomes available that clinicians will adopt the practice. There is a strong chance that the funding barrier is just one or multiple barriers, and may not be the most significant.

5. Give clear feedback and encourage positive deviance

Behaviour is unlikely to change if feedback about the behaviour is not provided. COVID-19 provided an excellent example of how real-time, data driven feedback acted as a crucial component of the behavioural changes experienced in the community and in Queensland Health. Once people have their shared goal and identity, they want to know that they are working towards solving it. In providing feedback, leaders must pay particular attention to utilising feedback to encourage the specific behaviours (identified in the behavioural taxonomy) they wish to see in their group members. A key behaviour that will underpin the access of any reform priority is positive deviance. Positive deviance [20] is a phenomenon whereby members of a particular group perform “uncommon” or “abnormal” behaviour/s that bring about a superior outcome to their peers, despite having access to exactly the same environment, context and resources. Such individuals are known as positive deviants as they are willing to deviate from the norm, taking on considerable risk, and finding better ways of doing things that benefit the group. Positive deviance is essential to creating the new abnormal.

Conclusion

This report aimed to extract key lessons from COVID-19 and the behavioural change response that followed to help shape our understanding and provide insights into the reform planning process. The focus was on examining what the specific mechanisms were that enabled COVID-19 to act as a powerful force for behavioural change. The report identified key psychological factors that explain how COVID-19 catalysed behavioural change, described a behavioural model that emerged as a result of COVID-19, and devised ways in which we can maintain behavioural change into the future and bolster the reform process. The hope is that this report helps lay the foundation for how to go about unlocking ongoing behaviour change and champion the new abnormal.

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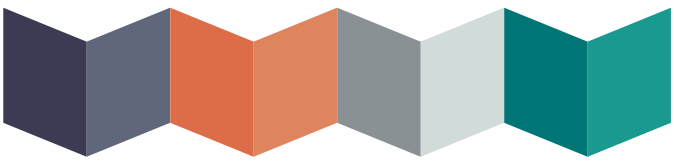
Appendix E:

Consultation list



The consultation process included the participation of the following stakeholders who met with one or more of the Reform Planning Group members and/or provided written submissions for consideration by the Reform Planning Group.

Deputy Premier
Minister for Health and Minister for Ambulance Services, Queensland Government

Queensland Health:

- Director-General
- Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General
- Deputy Director-General, Corporate Services Division
- Deputy Director-General, Clinical Excellence Queensland
- Deputy Director-General, Healthcare Purchasing and System Performance Division
- A/Deputy Director-General, Prevention Division
- A/Deputy Director-General, Health Support Queensland
- Head of Office of the Director-General and Systems Strategy Branch
- Chief Human Resources Officer
- Chief Health Officer
- Hospital and Health Service Chief Executives and Board members
- Deputy Director-General, eHealth Queensland
- Commissioner, Queensland Ambulance Service
- Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch
- Executive Director, Mental Health Alcohol and Other Drugs Branch
- Executive Director Capital and Asset Services
- Senior Director, Strategic Communications
- Chief Allied Health Officer
- Queensland Clinical Senate
- Chief Nursing and Midwifery Forum
- Chief Nursing and Midwifery Officer
- Nurses and Midwives Implementation Group

Clinical Associations:

- Australasian College of Dermatologists
- Australian College of Rural and Remote Medicine
- Australian Medical Association Queensland
- Australian College of Emergency Medicine
- Australian College of Pharmacy
- Australian Seniors Active Doctors Association
- CRANAplus
- Pharmacy Guild of Australia, Queensland Branch
- Pharmaceutical Society of Australia
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- Queensland Clinical Senate
- Queensland Clinical Networks
- Wide Bay Clinical Council
- Primary Health Networks (Australian Government):
    - Brisbane North
    - Brisbane South
    - Central Queensland, Wide Bay, Sunshine Coast
    - Darling Downs and West Moreton
    - Gold Coast
    - Northern Queensland
    - Western Queensland

Other groups

- Arthritis Queensland
- Australian Centre for Value-Based Healthcare
- Aged and Community Services Australia (ACSA)
- Australian Healthcare and Hospitals Association
- Beaudesert Medical Centre
- Bond University
- Brisbane Diamantina Health Partners
- CheckUP
- Children by Choice
- Eastbrooke Family Clinic
- Griffith University
- Health Consumers Collaborative Queensland
- Health Alliance
- Health Workforce Queensland
- Institute for Urban Indigenous Health
- Morningside General Practice Clinic
- My Midwives
- Palliative Care Queensland
- Prism Surgical
- Public Pathology Australia
- Queensland Aboriginal and Islander Health Council
- Queensland Alliance for Mental Health
- Queenslanders with Disability Network

- QUT Institute of Health and Biomedical Innovation
- Respect Inc.
- Royal Flying Doctor Service, Queensland
- St Lucia Medical
- The University of Calgary
- The University of Queensland

Unions:

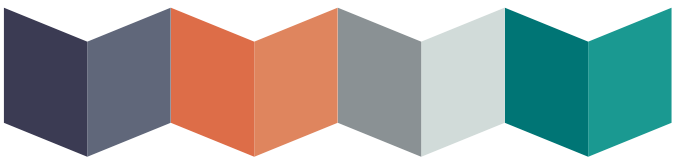
- The Australian Workers' Union
- Queensland Nurses and Midwives Union
- Together Queensland
- United Workers Union

Other government

- Health and Wellbeing Queensland
- Queensland Mental Health Commission
- Australian Government, Department of Health
- Department of the Premier and Cabinet Queensland
- Queensland Treasury
- Department of Education Queensland
- The Public Advocate (Department of Justice)

Appendix F:

Summary of written submissions



Introduction

As part of the Group's engagement and consultation across the Queensland health system, short written submissions were sought in response to the following key questions:

1. In response to the COVID-19 pandemic, a number of changes were implemented with how many health services are delivered. Of these changes, which do you think should be adopted on an ongoing basis, and why?
2. What new opportunities for change have arisen out of the COVID-19 pandemic that you/your organisation would like to see pursued as part of long-term health system reform, and why?

The submission process provided another avenue for advice to the Group.

The submissions and analysis process

Stakeholders and Queensland Health were sent a survey and a link to the survey was provided on Queensland Health's website. Respondents had two weeks to prepare written responses which were due by 26 June 2020.

Responses were reviewed to understand the key themes and topics. A sentiment analysis was also undertaken on the submissions using the analytical platform R. Sentiment analysis uses text mining to count the number of 'positive' and 'negative' words in the text and analyse the mix of these words to automatically detect the emotion of respondents.

Quotes were also extracted from the submissions which are included in this report. Where quotes are used, respondents are identified by position and organisation.

Who responded?

A total of 98 submissions as at the 12th of July 2020. The diverse group of respondents provided a range of unique insights across the whole health system. See Figure 1 for an overview of respondents. In summary:

- 45 from internal Queensland Health staff and 53 from external stakeholders.
    - Of the 45 internal respondents, 34 are from a Hospital and Health Service (HHS) while 11 work within the Department.
    - Most external submissions were received from professional organisations, the education sector, private health organisations and consumer advocacy groups. Twenty-seven of the respondents work in a clinical role with the remaining 68 submissions written by people in non-clinical positions.

Figure 1: Overview of written submissions

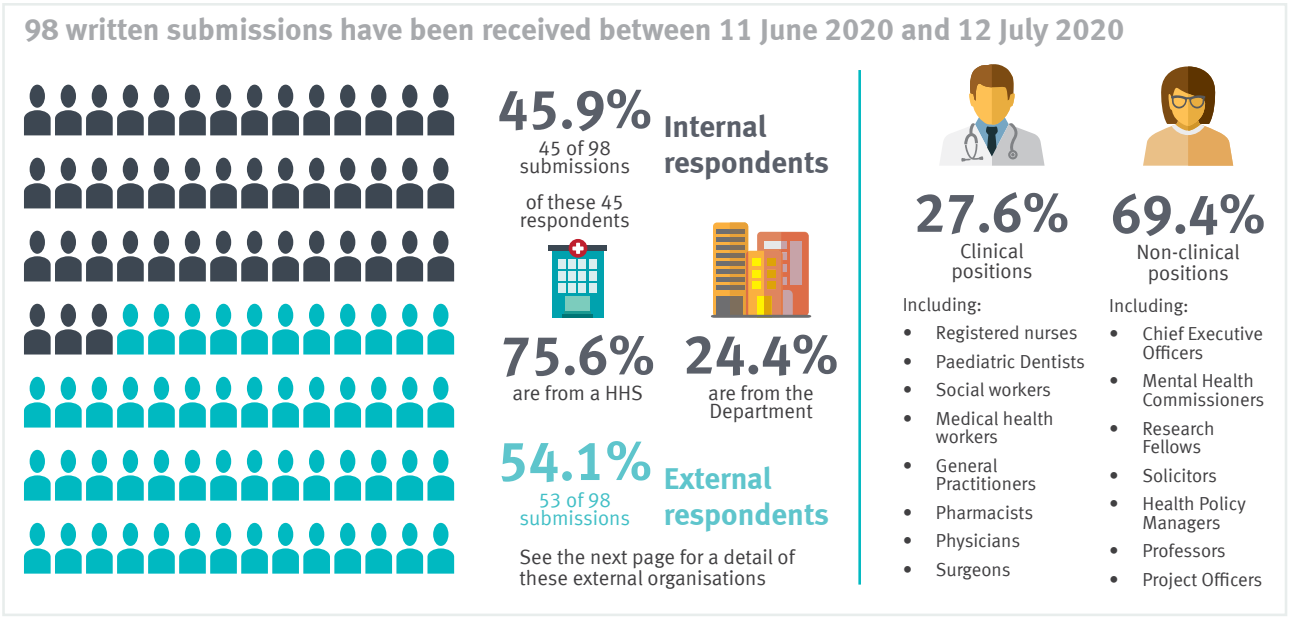


Table 1: external organisations who provided a submission

Education	Professional bodies	Government Organisations
Department of Education	CRANAplus	Queensland Mental Health Commission
QUT Institute of Health and Biomedical Innovation	Pharmacy Guild of Australia	The Public Advocate (Department of Justice)
University of Queensland	Australian College of Remote and Rural Medicine	**Unions**
University of Calgary	Australian College of Pharmacy	Together ASU
Bond University	Australian Senior Active Doctors Association	United Workers Union
Griffith University	Health Workforce Queensland	Queensland Nurses and Midwives' Union
Health Service	Queensland Aboriginal and Islander Health Council	**Consumer advocacy**
Royal Flying Doctor Service	Queensland Alliance for Mental Health	Health Consumers Queensland
Brisbane South Primary Health Network (PHN)	Australian Healthcare and Hospitals Association	Queenslanders with Disability Network
Western Queensland PHN	Australasian College of Emergency Medicine	Children by Choice
Central Queensland, Wide Bay, Sunshine Coast PHN	Australasian College of Dermatologists	Arthritis Queensland
Morningside General Practice Clinic	Pharmaceutical Society of Australia	Palliative Care Queensland
Queensland GP Liaison Network	Australian Medical Association Queensland	Respect Inc.
Mater Health	Aged & Community Services Australia (ACSA)	49. Health and Wellbeing Queensland
Metro South HHS	Public Pathology Australia	**Private Oganisations**
Refugee Health Network Qld	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)	Medical Insurance Group Australia (MIGA)
Eastbrooke Family Clinic Burleigh Waters	Queensland Primary Health Networks (QPHN)	Prism Surgical
Wide Bay Clinical Council	My Midwives	
St Lucia Medical Centre		
CheckUP		
Beaudesert Medical Centre		

Findings

Sentiment of responses

Respondents spoke positively about the opportunities for change that have arisen out of the COVID-19 pandemic with 70per cent of responses using a positive and trusting tone when referring to practice and system reform. Positive emotions include trust, anticipation, joy and surprise. Negative tones are characterised by fear, sadness, anger and disgust.

Emerging themes

Key themes that emerged from the responses were:

- Telehealth and virtual care
- Health system integration and collaboration
- Data and innovation
- Flexible working arrangements
- Workforce reform

Of all the topics, telehealth and virtual care was the most frequently cited by stakeholders (62 of 98 responses). Collaboration and continuity of care were commonly mentioned by external stakeholders while internal staff primarily focused on workforce reform and flexible working arrangements. See Table 2 for the distribution of internal Queensland Health staff and external stakeholders that refer to each key theme in their written submission.

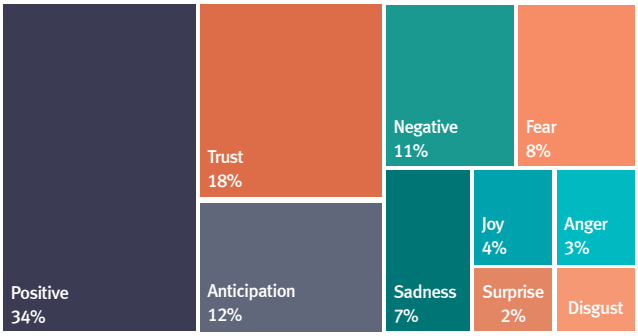


Table 2: Distribution of responses by key themes

Topic	Internal	External	total
Submissions	45	53	98
Telehealth	60.0%	71.7%	66.3%
Health system integration & collaboration	28.9%	69.8%	51.0%
Data & innovation	40.0%	49.1%	44.9%
Flexible working arrangements	33.3%	5.7%	18.4%
Workforce reform	48.9%	39.6%	43.9%
Community-based service delivery	20.0%	24.5%	22.4%

Source: Submissions, note each response could identify more than one topic and percentages will add to more than 100%.

Telehealth and virtual care

Many stakeholders spoke positively about the need to continue telehealth and virtual care after the pandemic. Some strongly caveated that in order to do this, consideration should be given to the ability of different population groups to access this type of care, particularly the elderly and disadvantaged to ensure equitable access to care.

> "...access to telehealth/telephone reviews – we learnt that there are many times when a patient's concern or active issue can be dealt with quickly, over the phone, rather than necessitating a trip into hospital (with the associated costs, time off work, etc)"
>
> *Staff member, Metro South HHS*

The perceived benefits of telehealth services included reduced travel time, cost savings, patient-centred care, reduced hospital admissions, improved information sharing and reduced carbon footprint. The key enablers required for telehealth included: the appropriate provision of technology and education and appropriate funding and reimbursement.

> "... people with sensory processing issues haven't had to sit and wait in large noisy waiting rooms and can wait in their own home to access the clinician"
>
> *Queenslanders with Disability Network*

Health system integration and collaboration

> "A new approach to decision making – faster, less bureaucratic, horizontal (rather than siloed), collaborative & involving consumers and focused on shared and agreed health outcomes and goals for the system, with an eye on the future. A networked system working with partners external to QH so there is a whole-of-system view. Those in the system must be expected and incentivized to work with each other in this way.
>
> *Health Consumers Queensland*

Stakeholders also referred to health system integration and collaboration as a key factor in promoting better health outcomes. Observations on the integration of the health system during the COVID-19 pandemic were particularly noted by external organisations with the reduction of red tape commonly cited as an enabler of collaboration.

The perceived benefits of health system integration included improved service efficiency and communication, the potential for long-term resilience to be built into the health system and better matching supply with demand in the supply chain of consumables. Some recommendations included partnering with Primary Health Networks (PHNs) to expand the geographical reach of the health workforce and improve access to care, and also engaging consumers in healthcare design.

> "... incorporation of GPs within public health, fever clinics – 'bridging the gap' and bringing considerable knowledge of the communities they work in with them."
>
> *General Practitioner*

Data and innovation

The value and importance of data and innovation was emphasised by stakeholders and how the COVID-19 pandemic has enabled various innovations for the delivery of care.

> "COVID-19 highlighted the value of 'real-time' data to guide an understanding of dynamic health needs and the effectiveness of system responses... Efficient access to comprehensive time-critical data for analytics to best inform trauma system planning, to assess the effectiveness of new models of care, and to inform prevention activities would similarly help reduce trauma morbidity and mortality."
>
> *Staff member, Metro North HHS*

Access to real-time and complete data was commonly cited as an effective way to track patients and measure health outcomes. Respondents flagged the need for real-time, linked data collections to guide dynamic health needs and deliver opportunities and value to patients, clinicians and organisations.

Some stakeholders recommended using data linkage to identify 'high risk' patients or patients with specific illnesses or conditions and to utilise electronic prescribing. Responses also spoke to the benefits of data exchanges with external health organisations such as General Practitioners and the National Disability Insurance Scheme (NDIS) to facilitate continuity of care and improve efficiency and effectiveness.

> "The data exchange from the National Disability Insurance Scheme gave Queensland Health valuable insights into the complex needs of our shared consumers... Queensland Health has no reliable data systems to identify consumers with disability; or monitor their complex care needs, patient feedback, safety incidents or service usage."

Staff member, Metro South HHS

Flexible working arrangements

> "...The use of flexible working arrangements offers support for workers to manage work life balance and offers benefits to the organisation as it places less pressure on facilities and amenities at a Health Service."

Together ASU

Flexible working arrangements was predominantly flagged by internal Queensland Health staff. It was suggested by respondents that remote working enabled rapid consultation, continuity of care and mobilisation of the workforce in both clinical and non-clinical environments. Flexible working arrangements was perceived to improve staff morale, improve service delivery and reduce demand on hospital resources such as clinical space. Internal stakeholders commented on how remote working during the pandemic resulted in improved work-life balance and workforce diversity with most respondents indicating a preference for flexible working to continue beyond the pandemic. The provision of appropriate equipment was also noted as a key enabler to facilitating flexible working and it was recommended that laptops be distributed to mobilise the workforce.

> "This includes provision of appropriate equipment – we are still struggling to access computers/cameras/headsets."

Staff member, Department of Health

Workforce reform

Responses also discussed the opportunities for improved models of care and health outcomes resulting from workforce reform. Empowered staff working to the top of their professional scope and capacity was a perceived outcome observed along with better utilising the skills of the health workforce, particularly nurses and pharmacists.

> "QNMU continues to advocate for all classifications of nurses and midwives to have the opportunity to expand nurse-led, midwife-led models of care to their full scope of practice as seen in the pandemic as they improve patient's healthcare and health outcomes."

Queensland Nurses and Midwives' Union

A reduction in red tape and closer alignment between education providers and the health service were noted as key enablers of workforce reform. Key recommendations included increasing the utilisation of nurses for providing primary care and expanding pharmacist-administered vaccinations and prescribing. It is anticipated by stakeholders that this would reduce hospital admissions, improve efficiency and increase access to care.

> "Great use of specialist nurses – provides the opportunity and support for patients with chronic disease to remain at home."

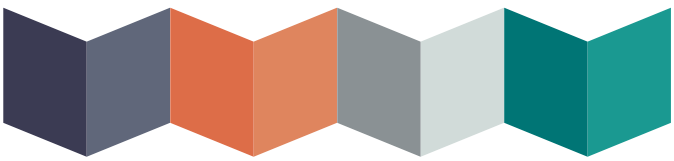
Staff member, Mater Health

Summary

The analysis was presented to the Group and used to inform the Group's recommendations for Queensland's health system.

Appendix G:

Reform Planning Group Interim Report



JULY 2020

Reform Planning

Interim Report for Immediate Action

Supporting information

Queensland Government

Reform Planning Group – Interim Report for Immediate Action

Published by the State of Queensland (Queensland Health), July 2020

For more information contact:

Branch, Divsions, Queensland Health, GPO Box 48, Brisbane QLD 4001,

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23 July 2020

The Honourable Steven Miles MP
Deputy Premier
Minister for Health and Minister for Ambulance Services
PO Box 48
BRISBANE QLD 4001

Dear Deputy Premier

It is my pleasure to present the interim report of the Reform Planning Group, established to advise and inform the development of the Queensland Health System Reform Roadmap on how best to harness the opportunities arising from the pandemic to achieve the best possible health and healthcare for Queenslanders.

The interim report makes three recommendations for immediate action in setting principles for resuming services and strengthening the relationship with the primary health care sector. The Group looks forward to continuing its work and building on these recommendations in its final report.

Yours sincerely

Meegan Fitzharris
Chair, Reform Planning Group

Introduction

2020 has bought unprecedented challenges across Queensland and Australia. The health challenge of the COVID-19 pandemic has upended the community and economy, and caused significant disruption across the health system.

The Queensland health system, and the tens of thousands of people who work in healthcare, are well rehearsed for disasters and extreme events and they will remain at the forefront of Queensland's recovery effort as it ensures a pandemic ready health system and provides healthcare to Queenslanders.

A healthy community is essential to the Queensland recovery effort.

There will be uncertainty for some time, and the health system will need to continue to adapt and develop models that are sustainable. In the meantime, the health challenges facing the Queensland community will continue; the growing burden of chronic disease, preventable illnesses impacting people's lives, and the disproportionate effect ill health has on the lives of many people living with disadvantage, particularly First Nations people. The challenge of a financially sustainable system will be heightened and, as with all sectors, the social and economic impact of COVID-19 means an even greater effort will be needed to ensure sustainability.

Opportunities have emerged from the COVID-19 experience. Across the Queensland health system local and national decisions changed the landscape of health service delivery, long held behaviours and practices changed and reforms that had seemed 'stuck' for years were enacted. The disruption provided momentum for change and significant opportunity to reshape the Queensland health system to pivot toward a system focused on wellbeing, prevention, value and equity.

In short, we witnessed what was possible when the potential within the health system was unleashed.

In this Interim Report we do not cover the full breadth of issues, but instead focus our recommendations on three key areas: the resumption of specialist outpatient services; the resumption of elective surgery and other procedures; and the critical relationship with the primary health care sector.

In our view, the two recommendations regarding resumption of services should be informed by key principles of value and equity to provide a platform for system reform in the medium to longer term and embed these important principles further into Queensland's health system.

The third recommendation recognises one of the most significant opportunities arising from the pandemic; to significantly boost the relationship between the primary health care sector and the Department of Health and Hospital and Health Services (HHSs). While there are examples of strong relationships across Queensland, the enormous potential of deeper trust and a strengthened relationship has not yet been fully realised.

If leaders across the Department of Health, HHSs and the primary health care sector commit to strengthening this relationship at all levels, it has the potential to deliver a significant health dividend for the Queensland community from the pandemic.

Indeed, throughout our work the Group has considered a number of changes to unleash further potential across the Queensland health system. Many of these are based on examples of best practice, innovation and exemplar models. We continue to consider these issues, as well as how changes could be enacted; that is, the leadership and behaviours needed across the system – at all levels – to deliver important health dividends for the Queensland community. The recommendations in this interim report will be built upon in our final report in August. We look forward to providing that report to the Deputy Premier and Director-General.

The Group would like to thank the many individuals, working groups and representatives of organisations and enthusiastic staff of Queensland Health who have provided submissions and shared their expertise and experience directly with the Group. We recognise that our short time frames precluded deeper engagement and acknowledge a positive feature of the Queensland system is its extensive consultative mechanisms and advanced clinician and consumer engagement. These arrangements should continue and will be critical to the success of the Reform Roadmap.

As Chair, I have been fortunate to work with a united and committed group with a breadth and depth of experience across the Queensland health system, the health workforce and the community. The Group has invested considerable energy into the work of the Group and sought to bring a plurality of perspectives to the table. I am grateful for their expertise, insight and commitment. The Group is indebted to Dr Stephen Duckett, who provides considerable experience and knowledge, as an Independent Adviser to the Group. As a Group we are also grateful to our skilful and experienced Secretariat for their support.

A final acknowledgement to all contributors to the Group who have provided their expertise while prioritising a pandemic and providing healthcare to the community. The generosity of so many people has been exceptional and Queenslanders are fortunate to have such committed people who make up the Queensland health system.

Meegan Fitzharris
Chair, Reform Planning Group

Background

The Reform Planning Group was established to develop a Queensland Health System Reform Roadmap for the Deputy Premier and Minster for Health and Minister for Ambulance Services and the Director-General, Queensland Health. The Roadmap, to be delivered in mid-August, will consider how to harness the opportunities arising from the COVID-19 pandemic to achieve the best possible health and healthcare for Queenslanders.

The response to the COVID-19 pandemic led to numerous changes in the way health services were organised and delivered. For instance, there was much greater use of virtual care, including telehealth and virtual wards. The workforce was deployed more flexibly across traditional occupational boundaries, with nurses, midwives and allied health professionals able to work to their full scope of practice. There was also a climate of empowerment and flexibility as the system responded rapidly to changing circumstances. Many of these changes demonstrated real benefits and are worth preserving beyond the pandemic period.

The disruption to existing models of service delivery during the pandemic provides an opportunity to unleash further potential within the Queensland health system and advance reforms such as those promoting value-based healthcare, health system integration, prevention and wellbeing and equity of outcomes for groups currently experiencing health disadvantage. 'Business as usual' for the health system need not be the same as pre-pandemic.

During the pandemic, it was necessary to cease many services to ensure the health system had the capacity to respond to the expected increased demand from the COVID-19 outbreak. In line with decisions by National Cabinet, the Department of Health instructed Hospital and Health Services (HHSs) to stop all non-urgent elective surgery and specialist outpatient services. Measures were also put in place to enable outpatients to be treated in general practice where clinically appropriate.

Importantly for the Queensland community and health workforce, these services are resuming and returning to pre-pandemic levels. As services resume there is an important opportunity to embed positive change while this window remains open. In the absence of urgent action, it is likely that the previous models of service delivery will rapidly be reinstated, and the opportunity for reform will be lost.

This is particularly important given that the recovery phase will likely be highly resource constrained. It will be necessary to deliver the desired outcomes with fewer resources. With the right reforms and commitment, this can be done and lead to an even stronger health system with better outcomes for Queenslanders.

It will also be important to take the opportunity to promote equity in access and outcomes during the recovery phase. A range of population groups, including First Nations people, people in remote and very remote areas and people in disadvantaged areas experience significantly poorer health outcomes than other Queenslanders[1]. First Nations people, in particular, continue to experience a high disease burden. This reflects both social determinants but also in many cases lower access to health services. An overarching principle of this report is the inclusion of recommendations that impact on or improve equity. This will be addressed in more detail in the final report.

There are three recommendations for immediate action:

- Enable faster and fair access to specialist outpatient and non-admitted care as services resume
- Ensure high value, equitable care is prioritised as elective surgery is resumed
- Transform the relationship with the primary health care sector in Queensland

If adopted, these recommendations would make a real and positive difference to the care delivered to patients now, setting the foundation for further health system transformation. They would significantly advance reform to:

- embed processes for value and equity in key parts of the health system, especially for First Nations people.
- establish a framework to enable clinical staff to work to their full scope of practice.
- drive integration within Queensland Health
- send a signal that the health system of the future focuses on value, equity and service integration, not just on throughput.
- significantly strengthen the relationship between Queensland Health and the primary health care sector.

The three immediate recommendations are outlined below in greater detail.

The Group proposes these recommendations are endorsed and implemented immediately, especially in setting principles for funding and resuming services.

The Group also proposes that implementation of these reforms should be prioritised in the allocation of the Queensland Government's additional $250 million boost to elective surgery announced on 14 June 2020 and in the HHS growth funding for 2020-21, yet to be fully allocated in Service Agreements, to ensure that resources are available to support transformed and improved care for Queenslanders.

In its final report the Group will provide further guidance on implementation.

[1] The health of Queenslanders 2018, Report of the Chief Health Officer Queensland, Queensland Health 2018, https://www.health.qld.gov.au/__data/assets/pdf_file/0032/732794/cho-report-2018-full.pdf

Interim Recommendations for Immediate Action

Recommendation 1: Enable faster and fair access to specialist outpatient and non-admitted care as services resume

Recommendation 1: Enable faster and fair access to specialist outpatient and non-admitted care as services resume by:

a. Establishing consistent, equitable processes for all referrals to Queensland Health specialist outpatient and non-admitted care based on clinical need at the HHS or cluster level.
b. Establishing consistent referral pathways across Queensland for specialist outpatient services and elective surgery which optimise the use of allied health, nursing and general practitioner with special interests (GPwSI) professional pathways in four specific focus areas:
    - orthopaedics
    - ear nose and throat (ENT)
    - ophthalmology
    - gastroenterology.
c. Establishing targets for telehealth and non-admitted virtual/technology-enabled care.

As specialist outpatient services resume, there is an opportunity to embed consistent and equitable processes for triaging and assessing patient referrals for specialist care and improve on how patients experience their care across Queensland's health system. Stakeholder feedback noted the disruption of services during the pandemic led to greater flexibility and workforce mobility, and this should be continued into the future:

> *'The need to keep patients out of the hospital system really highlights how much more community services are capable of, how much of what is currently done in hospitals can be delivered outside. There were absolute heroes. We should develop these services properly'*
> Staff member, Gold Coast HHS

While some parts of Queensland's public health system are already implementing the approaches recommended here, there would be significant benefit to the whole community if these approaches were rolled out more fully across the system.

Recommendation 1a: Consistent processes for handling specialist outpatient referrals

The Group recommends Queensland Health develop consistent, equitable processes for all specialist outpatient referrals. This should include a renewed framework for specialist outpatient referrals and reviews that considers referral decisions, intake decisions, and transfer of care. This should include centralised hubs at least at the HHS level for the handling of patient referrals for specialist and planned care. There are a number of successful models across Queensland and HHSs should seek to implement the model that works best for the local conditions. Existing models include the Metro South HHS central referral hub which embeds General Practitioner Liaison Officers (GPLOs) and clinical specialists to manage all incoming referrals and their care pathways.

If implemented well, this approach can simplify referral and treatment processes to and from primary health care, improve communication and integration across providers involved in a patient's care, and improve patient care and the patient experience.

First Nations and other vulnerable populations could also benefit from improved access to screening and diagnostic services, appropriate allied health care and treatment within a primary health care setting, as well as access to specialist care in public hospitals.

The ability to share referrals across providers would improve efficiency and provide patients with more choice in how, when and where they are seen at a Queensland health facility. In some circumstances, patients may have the option to receive care at an alternative location or through telehealth or virtual care leading to reduced waiting times, travel and accommodation costs. These hubs would also lead implementation of best-practice, clinically evidenced referral pathways with patients receiving multi-disciplinary team care from highly trained allied health, nursing and GP professionals.

Recommendation 1b: Alternative referral pathways

The Group recommends establishing and implementing consistent Queensland-wide referral pathways for specialist outpatient services and elective surgery which optimise the use of allied health, nursing, and general practitioners with special interests (GPwSI) professional pathways, initially focused in four specific focus areas:

- orthopaedics
- ear nose and throat (ENT)
- ophthalmology
- gastroenterology.

Alternative referral pathways for the four specific clinical focus areas: orthopaedics; ear nose and throat (ENT); ophthalmology; and gastroenterology are currently being implemented within Queensland Health, but generally only in a small number of HHSs or facilities. The Group is currently giving further consideration to other potential pathways beyond these four areas of focus and will report further on this in our final report.

Research has shown that where these models have been implemented in Queensland Health, they have had a wide range of benefits, including: large improvements in waiting times; improved clinical outcomes and high patient satisfaction; a majority of patients being discharged and removed from specialist outpatient waiting lists; and reduced costs[2].

This shift will also enable allied health, nursing and general physician professionals to work at their full scope of practice, utilising the skills of our highly trained health professionals more efficiently, and entrenching more effective models of care.

Recommendation 1c: Establish targets for non-admitted virtual/'technology-enabled' care

Of all the responses the Reform Planning Group received on reform opportunities stemming from the COVID pandemic, the strongest related to telehealth. Patients, clinicians and other stakeholders across Queensland's health system have indicated clear ongoing support for the provision of care in virtual settings.

> *'Obviously Telehealth was well overdue and everyone knows it has a very important role for regional and rural patients where appropriate'* Staff member, Wide Bay HHS

The onset of COVID-19 accelerated the uptake of telehealth[3], with the number of video-conferencing service events delivered averaging 22,969 per month in April and May 2020, more than three times the average of 7,220 per month from July 2019 to February 2020[4]. This interim report considers the opportunity to embed this increase in the non-admitted setting, while recognising that technology-enabled care can be used effectively across a variety of settings.

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[2] See for instance:

Chang, A., Gavaghan, B., O'Leary, S., McBride, L. and Raymer, M. (2017) Do patients discharged from advanced practice physiotherapy-led clinics re-present to specialist medical services? Australian Health Review 42, 334-339.

Pokorny, M., Wilson, W., Thorne, P. and Whitfield, B. (2018) Is an advanced audiology-led service the solution to the pediatric ENT outpatient waiting list problem? Speech, Language and Hearing. 1-5. 10.1080/2050571X.2018.1447750.

Seabrook, M., Schwarz, E., and Whitfield, B. (2019) Implementation of an extended scope of practice speech-language pathology allied health practitioner service: An evaluation of service impacts and outcomes, International Journal of Speech-Language Pathology, 21:1, 65-74

Unpublished Audit: Optometrist Clinic Case Load And Profile at Queensland's Childrens' Hospital (QCH)

Mutsekwa R., Ostrowski S., Canavan R., et al. Health service usage and re-referral rates: comparison of a dietitian-first clinic with a medical specialist-first model of care in a cohort of gastroenterology patients Frontline Gastroenterology Published Online First: 06 May 2020. doi: 10.1136/flgastro-2020-101435

[3] Within Queensland Health, the term Telehealth is often used synonymously with videoconferencing, with over 150,000 non-admitted service events being provided to Queenslanders in 2019-20FY. In addition to non-admitted telehealth services, the Telehealth Services Unit (TSU) provide Emergency Telehealth, Inpatient Telehealth, eConsultations and Remote Patient Monitoring (RPM).

[4] The number of telephone consultations vastly exceeds the number of telehealth (videoconferencing) consultations. The number of telephone service events increased from an average of 65,797 per month from July 2019 to February 2020 to an average of 208,722 per month in April and May 2020.

Prior to 2020, Queensland has led the use of telehealth across Australia and can continue this leadership beyond 2020. There are clear benefits from the use of telehealth, including a reduction in cost and impact of travel for patients (particularly for vulnerable patients) and in rural and remote areas. It is estimated that in 2017-18, telehealth in Queensland led to a reduction of 9 million kilometres and 27,000 days in travel, and to productivity gains of $9 million due to less time away from work[5].

Recognising these benefits other States and Territories are considering targets, with Western Australia agreeing to a target requiring all metropolitan providers to progressively provide telehealth consultations for 65 per cent of outpatient services for country patients by July 2022, and for telehealth to become the regular mode of outpatient service delivery by July 2029[6].

At the very least, it is important that the Department sends a strong signal to HHSs that the levels of telehealth achieved during the pandemic must be maintained during the recovery phase. Patients should have the opportunity to request a telehealth appointment where there is no clinical imperative for a face to face consultation, especially for review appointments. Moreover, recognising the significant progress made in telehealth in recent months and the benefit of continuing this growth as services resume, the Group recommends that Queensland Health set targets for the percentage of specialist appointments to be provided using telehealth, with a strategy to achieve this in rural, remote and metropolitan hospitals.

Queensland Health is already undertaking considerable work in this area building on the COVID-19 experience. In our final report, the Group will comment further on the issue of technology-enabled care and is undertaking further analysis with a view to recommending a specific target.

[5] University of Queensland, Evaluation of the Queensland Health Telehealth Strategy, draft report 3, unpublished, June 2020.

[6] Sustainable Health Review, Final Report to the Western Australian Government, 2019, https://ww2.health.wa.gov.au/-/media/Files/Corporate/general-documents/Sustainable-Health-Review/Final-report/sustainable-health-review-final-report.pdf#page=1&zoom=auto,-80,842

Recommendation 2: Ensure high value, equitable care is prioritised as elective surgery and other procedures are resumed

Recommendation 2: Ensure high value, equitable care is prioritised as elective surgery and other procedures are resumed by:

a. Ensuring access to elective surgery for those experiencing significant health disadvantages especially First Nations people.
b. Implementing processes for independent clinical review of all cases of potentially low value care prior to proceeding.

Prior to the COVID-19 pandemic, the health system was already facing sustained high growth in demand for elective surgery, with 49,813 Queenslanders on the waiting list at the beginning of March. On 22 March 2020 Health and Hospital Services (HHSs) were instructed to suspend non-urgent surgical procedures, as the health system focussed on the response to the pandemic.

Now that elective surgery is recommencing, with an additional $250 million invested by the Queensland Government, there is an opportunity to embed reforms that will advance equity and high value care for patients.

Recommendation 2a: Ensuring access for those experiencing significant health disadvantage

A core Medicare principle is that all patients are prioritised for health care on the basis of clinical need. While this is the foundation of our health system, policy makers and clinicians recognised that disadvantage and other social determinants can have a significant impact on health outcomes. In other words, not all people enter the health system, or receive treatment at a particular time, with the same level of health.

A core principle informing the Group was that healthcare equity is important, not just equity of access but especially equity of health outcomes. We will consider this further in our final report, but for the time being we note the following definition that has been in place in New Zealand since 2019.

> In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes[7].

Queensland's First Nations peoples continue to have significantly poorer health outcomes with a disease and injury burden 2.2 times greater than non-indigenous people[8]. This reflects poorer social determinants of health and higher risk factors for disease as well as First Nations people being far less likely to receive timely and culturally appropriate health care. By the time First Nations do receive care, they generally have a more acute illness and co-morbidities compared to other Queenslanders.

The COVID-19 pandemic has exacerbated this situation as First Nations people and other disadvantaged groups suffering from an already higher burden of disease, are extremely vulnerable to the impacts of delayed health treatment.

As a result, the clinical prioritisation process for elective surgery and other procedures should take into account the vulnerability status of First Nations people and other disadvantaged populations.

For First Nations people and other disadvantaged populations, the Group recommends Queensland Health implement regional and metropolitan models for access to elective surgery, which include consistent features including identification, brokerage with scope for specific sessions where appropriate, risk stratification and care coordination. The models should ensure that First Nations people achieve higher priority within each of the urgency categories for elective surgery, recognising that on average they present later in the course of their illness than other Queenslanders.

The Group understands this work is being further developed by Queensland Health with key stakeholder groups and may be able to make further recommendations in its final report.

Recommendation 2b: Shifting to value – reducing low value care

The Group was asked to consider the shift to value in health care. The final report will consider this issue in more detail, including the work underway in Queensland to introduce elements of value-based health care into practice. Value based health care is broadly described as

> "the health outcomes that matter to patients relative to the resources or costs required, over a full cycle of care."[9]

Queensland Health, notably through the Clinical Senate and Clinical Networks, has undertaken considerable work and engagement progressing the concept of value in healthcare. This includes the Choosing Better Care Together program and other value-based healthcare initiatives which were necessarily paused during the response to the COVID-19 pandemic. This should be continued, including the extensive engagement with clinicians and consumers.

[7] https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity

[8] The Health of Queenslanders 2018, Report of the Chief Health Officer Queensland, Queensland Health 2018, https://www.health.qld.gov.au/__data/assets/pdf_file/0032/732794/cho-report-2018-full.pdf

[9] https://valuebasedcareaustralia.com.au/resources/defining-value/

One important element of introducing the concept of value into health systems and services is reducing the level of low value care (although this is not specific only to value based health care programmes).

The Queensland Clinical Senate defines low benefit care as:

> "the use of procedures or interventions where the evidence suggests there is little or no benefit to patients, or that the risk of harm exceeds the benefit, or the added cost of the intervention doesn't provide the proportionate additional benefits."[10]

As a core principle, surgery and other procedures should only be performed where there is strong evidence of clinical benefits. The Group supports the Queensland Clinical Senate recommendation in its report *Innovation and transformation of models of care in response to COVID-19*[11] to "Permanently discontinue low benefit care (LBC) that has been ceased during the pandemic". For the purposes of this report, the Group is focused on low value surgical and other procedures.

Acknowledging the work done to date, and the importance of continuing clinical and consumer leadership in advancing value, the Group recommends Queensland Health implement a system-wide process for reducing instances of low value care.

The Group considers that clinical review is an important strategy for reducing specific instances of low value care. A process based on clinical review will not compromise clinical autonomy, but rather provide patients and clinicians with better information and other options for treatment. It also aims to promote shared decision making as better-informed consumers often make different, more conservative, less costly choices about treatment[12]. The Reform Planning Group recognises that clinical and consumer engagement will be essential to the development and implementation of this proposal.

On that basis, the Group recommends Queensland Health implement a system wide process for clinical review of low value care for procedures, especially those that were discontinued during COVID-19. The recommended approach for implementing the clinical review process will be outlined in the final report and will complement and leverage the existing work in the area.

[10] Maximising Benefits of Care, Queensland Clinical Senate, Meeting Report, August 2019

[11] Queensland Clinical Senate, May 2020

[12] Australian Commission on Safety and Quality in Healthcare, https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making

Recommendation 3: Transform the relationship with primary care in Queensland

Recommendation 3: Transform the relationship with primary care in Queensland by:

a. Strengthening the partnership with primary health care by creating a mechanism for governance, networking, engagement and strategic policy in Queensland Health, including a primary-acute care clinical network to support planning and collaboration at the system and local level.
b. Encouraging referral back to, and treatment in, primary health care where clinically appropriate through consistent, equitable processes.
c. Developing incentives in the Queensland Health funding model that support specialist to primary health care consultations, including virtual consultations.
d. Collaborating with primary health care to continue the uptake of consistent care pathways across Queensland, especially through the use of HealthPathways and clinical prioritisation criteria.

Not surprisingly, a consistent theme from the Reform Planning Group's consultation is the need to improve health system integration and collaboration. The COVID-19 response required speedy collaboration across the health sector to meet the needs of local populations to address the emerging public health risk of the pandemic. Where these partnerships were in place, a more agile and effective response was reported.

> *'Recognising that primary care is an enormous network for HHS' to partner with and work through (e.g. fast tracking to establish respiratory clinics which redirect consults from hospitals). HHSs partnering with PHNs to work across primary care sector for targeted purposes expands the geographic reach, workforce distribution and access to communities.'*
> Central Queensland, Wide Bay, Sunshine Coast PHNs

> *'At a local level on the Gold Coast there has been considerable engagement and collaboration between our professional organisations... This has enabled all organisations to gain a greater understanding of the challenges faced in different contexts – navigating not only the pandemic crisis but also working on breaking down 'silos' within our system.'*
> General Practitioner, Gold Coast general practice

Primary health care is generally the first and most regular contact a person has with the health system. Primary health care can be provided in the home or in community-based settings such as general practices, other private medical practices, community health centres, local government, and non-government service settings, such as Community Controlled Health Services[13]. Services are varied and provided by a range of health professionals including general practitioners, First Nations health practitioners, nurse practitioners, pharmacists and allied health professionals.

Between the hospital and primary care settings there is considerable opportunity to provide patients with improved continuity of care, particularly for First Nations people and other groups experiencing significant health disadvantage.

Research by the Nuffield Trust[14] indicates two areas critical to strengthening the relationship between primary and secondary care include hospitals working more closely with general practitioners with special interests (GPwSI) and access by general practitioners to rapid specialist advice. Queensland Health should continue to advance these areas. This should also apply to other clinical staff including nurse practitioners.

Queensland Health supports and promotes the implementation of integrated care models across hospital and primary care settings. However, HHS relationships with the primary health care sector are often the result of 'pockets of good practice' rather than systemised opportunities to build partnerships. If this changes, and relationships are more systemised and embedded in HHS policy and practice, the health dividend for Queenslanders and clinicians will be significant.

By improving coordination and partnerships with the primary health care sector for non-admitted patient care, patients across Queensland will have more options to access care, which may be closer to home. This is particularly beneficial for patients in regional, rural and remote regions who may not live near a referral hospital and for First Nations peoples to be able to receive care in their communities and from their local Community Controlled Health Service.

While the Commonwealth Government generally holds the levers for primary care funding models, the State can play an important role in establishing appropriate frameworks in areas within its influence and control.

Queensland Health is encouraged to enhance its current partnerships with primary health care by:

- Continuing to expand standardised referral pathways for care delivered in the primary health care setting, both from primary health care to specialist outpatients and from specialist outpatients back to primary health care.
- Linking acute and outpatient services with general practitioners with special interests (GPwSI) and nurse practitioners, and providing access to rapid specialist advice.

[13] https://www1.health.gov.au/internet/main/publishing.nsf/Content/Fact-Sheet-Primary-Health-Care

[14] Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), Shifting the balance of care: great expectations. Research report. Nuffield Trust.

- Establishing a mechanism in the funding model to incentivise/reimburse specialists to consult with primary health care providers on a patient's care pathway, for instance by providing funding for such consultations where the patient is not present[15].
- Establishing a function in the Department to oversee governance, engagement and strategic policy to facilitate partnerships and coordination with primary health care throughout Queensland Health.
- Establishing a primary-acute care clinical network in collaboration with groups such as Statewide Clinical Networks, the recently established Primary Care Queensland Network (PCQ), Primary Health Networks, Community Controlled Health Services, the Queensland Aboriginal and Islander Health Council and consumer representatives.

[15] Dailey, J., Wood, D., Coates., Duckett, S., Sonnemann, M.T,. and Wood, T., The Recovery Book: What Australian governments should do now., Grattan Institute Report No. 2020-10, June 2020, p 78

Conclusion

The Group looks forward to continuing its work and building on the recommendations in this Interim Report. The roadmap and final report will elaborate on the Group's engagement with stakeholders across Queensland's health system and will include guidance on how all recommendations could be implemented, including by examining the underlying factors that predict reform success. Above all, the Group will continue to consider recommendations to improve healthcare delivery and how best to achieve equity in health outcomes for Queenslanders.

Appendix 1: Terms of Reference

1. Purpose

The purpose of the limited-life advisory committee known as the 'Reform Planning Group' (the 'Group') is to advise and inform the development of the Queensland Health System Reform Roadmap (Reform Roadmap) for the Director-General, Queensland Health and the Deputy Premier and Minster for Health and Minister for Ambulance Services, on how best to harness the opportunities arising from the pandemic to achieve the best possible health and healthcare for Queenslanders. Reform activities must focus on preventing ill health and delivering better value for our patients, our workforce and our public health system.

2. Context

The Australian and Queensland Health system has made some rapid changes to health care delivery in response to the COVID-19 pandemic.

The interruption to regular service delivery presents an opportunity to build on the reform and innovation built out of necessity during the COVID-19 pandemic response including changes to existing policy and funding settings and the way services are delivered. This could include adjusting how we fund and what we measure, manage and reward to support new models of care to better meet the needs of consumers, clinicians, providers and funders (for example, expanding virtual care and hospital outreach services, and blended funding models across sectors). Some of these innovations have ongoing potential to the health system benefiting staff, patients and the broader community.

Following the initial pandemic response, Queensland Health will bring services back online in the wake of significant disruption and the build-up of unmet demand for health care. The recovery phase will be highly resource constrained, with reduced government revenues and a need to restore government balance sheets, requiring a strong focus on cost efficiency and value for money.

The disruption to existing models of service delivery during the pandemic also provides an opportunity to accelerate system reforms such as those to promote value-based healthcare, health system integration, prevention and wellbeing and equity of outcomes for groups currently experiencing health disadvantage.

As the largest organisation in Queensland, employing nearly 100,000 people and with an $18.5 billion operating budget in 2019-20, Queensland Health will be a major contributor to the economic and psychosocial recovery in the broader community. While this presents significant challenges, it also presents opportunities. 'Business as usual' for the health system post-pandemic need not be the same as pre-pandemic. A 'window of opportunity' exists for Queensland Health to build on innovations arising from the COVID-19 pandemic that demonstrate improved value for patients, staff and the broader community and have ongoing potential for Queensland's health system.

3. Appointment to the Group

The Group has been established by the Director-General of Queensland Health who will appoint, in consultation with the Deputy Premier and Minister for Health and Minister for Ambulance Services, nine (9) expert members to the Group. This includes the Group Chair and an independent advisor who will provide input and ideas, as well as acting as a 'critical friend'.

Members are to be engaged personally and act, on the basis, of their individual standing, professional and personal experience. Members are not to be engaged as representatives of any particular group or organisation.

3.1. Expertise

The members are to be appointed based on their expertise across the health system to ensure a holistic and comprehensive approach in developing advice to inform the Reform Roadmap. Collectively, the members' expertise is to cover health system management and governance, Aboriginal and Torres Strait Islander health services, rural health services, data and innovation, health consumer and employee perspectives, health economics and behavioural science.

3.2. Formation of sub-committees

Members may form sub-committees to support the work of the Group.

3.3. Engagement and consultation

In developing its advice and input for the Reform Roadmap, the Group is expected to:

- engage and consult across the Queensland health system by using existing consultative forums, including, but not limited to: Hospital and Health Services, private hospitals, health consumers; non-government organisations; aged care providers; primary healthcare sector; employee representatives; and clinicians.
- work as required with other Queensland Government departments and recovery groups in developing their workplan.

The Group may request Queensland Health employees to participate in informing advice and invite submissions or information from external sources where appropriate to do so.

3.4. Role of the Secretariat

Secretariat and policy research functions for the Group will be provided by Intergovernmental & Funding Strategy (IFS), Office of the Director-General & System Strategy Division.

The Secretariat will lead the development of the Reform Roadmap and other key deliverables, such as supporting reports and briefings, which the Group will advise and inform, as set out in the Group's Work Program.

The agenda for meetings and relevant papers will be distributed by the Secretariat at least two working days before each meeting.

The Secretariat can be contacted at: reformplanning@health.qld.gov.au.

3.5. Roles and decision making

Members are individually and collectively accountable for the Groups decisions, recommendations and advice.

The Chair is responsible for ensuring that matters discussed, and decisions made are strictly within the authority of the Group.

The independent advisor will participate in all meetings and activities of the Group, however will provide independent advice and will not partake in endorsing of the Group's advice.

3.6. Work program

A high-level work program will be developed for endorsement from the Deputy Premier and Minster for Health and Minister for Ambulance Services. This work program must ensure appropriate engagement and consultation on the most significant issues.

3.7. Guiding principles

The panel is strongly encouraged to focus not only on 'what' needs to change but 'how' to create the conditions to create the necessary behavioural change at individual, provider organisations and funder levels. The principles of the *Public Service Act 2008* and the *Hospital and Health Boards Act 2011* guide the deliberations of the public servant participation of the Group.

In expressing their views, the Group members and participants are to be mindful of the Queensland Government's responsibility to act in the best interest of users of public health sector services. This includes being consistent with the principles, intent and substance of commitments and policy decisions made by the Queensland Government.

3.8. Time commitment

The estimated duration of the program of work is around three months (14 weeks).

The Group will commence in the week of 11 May 2020 and members will be required for approximately five hours per week on average, including weekly meetings, consultations and briefings for the Deputy Premier and Minster for Health and Minister for Ambulance Services and Department as required.

3.9. Remuneration

The Department of Health will remunerate non-Queensland Health employee Group members at an agreed upon fixed rate based on the estimated time commitment (5 hours per week over 14 weeks), with contingencies if the time commitment increases significantly during the groups engagement.

Travel and related expenses are to be paid separately.

3.10 Performance

The Group will be evaluated in terms of its performance against the approved Terms of Reference.

3.11. Confidentiality

Members may receive information that is regarded as 'X-in-confidence', clinically confidential or have privacy implications.

Members acknowledge their responsibility to maintain confidentiality of all Queensland Health information that is not in the public domain and that this obligation continues after their appointment ceases.

3.12. Conflict of Interest

To meet the ethical obligations under the *Public Sector Ethics Act 1994*, the Group members and guests must declare any conflicts of interest whether actual, potential, apparent, or that appear likely to arise, and manage those in consultation with the Chair. This may relate to a position a member holds (e.g. chair of an external organisation), or to the content of a specific item for deliberation.
Declaration of conflicts of interest must be listed as a standing item in the Group agenda. The Chair will determine whether the member should absent themselves from the relevant part of the meeting. The Secretariat will record any declaration of conflict of interest applicable to that meeting in the minutes of the meeting.

Appendix 2: Membership

Core members

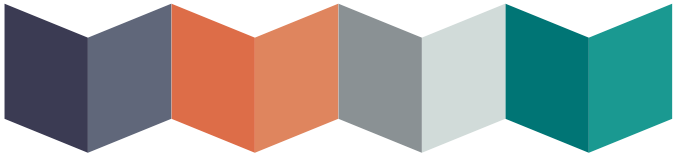
- Ms Meegan Fitzharris (Chair), Senior Fellow in Health Policy and Leadership, College of Health and Medicine, The Australian National University
- Ms Beth Mohle, Secretary, Queensland Nurses and Midwives' Union
- Professor Keith McNeil, Assistant Deputy Director-General and Chief Medical Officer, and Chief Clinical Information Officer, Prevention Division, Queensland Department of Health
- Mr. Adrian Carson, Chief Executive Officer, Institute for Urban Indigenous Health (IUIH) Ltd
- Dr John Pickering, Chief Executive Officer, Evidn Group
- Mr Shaun Drummond, Chief Executive, Metro North Hospital and Health Service
- Professor Sabina Knight, Director, Mount Isa Centre for Rural and Remote Health, James Cook University
- Ms Melissa Fox, Chief Executive Officer, Health Consumers Queensland

Independent advisor

- Dr Stephen Duckett, Health Program Director of Grattan Institute. Dr Duckett will be an independent advisor to the Group providing input and ideas, as well as acting as a 'critical friend'.

Appendix H:

Outcomes of alternative referral pathways implemented within Queensland Health



Orthopaedics

Neurosurgical and Orthopaedic Physiotherapy Screening Clinic and Multidisciplinary Service (N/OPSC&MDS) is an integral component of specialist outpatient services in 19 public hospitals and one community-based service within ten HHSs in Queensland, helping to alleviate specialist outpatient demands by managing new case referrals. Within this service, the physiotherapist undertakes comprehensive initial assessment and completes diagnosis and management planning for patients who would otherwise be seen by a medical specialist and then coordinates the delivery of an evidence-based multidisciplinary intervention.

The service is a cost-effective addition to usual care.[104] Program data for the period 1 July 2018 to 30 April 2020 indicates that:

- 68% of patients seen within the service achieve a clinically meaningful improvement in their condition[105]
- 73% of patients are discharged and removed from specialist outpatient waiting lists
- 11% of patients are escalated for more urgent medical review
- No adverse events have been reported

Research also indicates that 95% of patients managed within the service do not represent within 12 months of discharge,[106] and that increasing capacity of the screening clinic is an efficient use of resources compared to usual care.[107]

The physiotherapist-led Soft Tissue Injury Clinic is an alternative pathway for patients who have been assessed in emergency departments and require non-surgical management of soft tissue injuries without the need for a specialist orthopaedic team review in a fracture clinic. It has been implemented as a pilot at Queensland Children's Hospital. Program data indicates the following outcomes compared to the traditional fracture clinic model:

- Improved access with shorter wait times for care (eight fewer days to care)
- Fewer orthopaedic clinic appointments per person, however more physiotherapist appointments
- Less orthopaedic clinic cost per person[108]

Ear Nose and Throat

A number of successful and emerging audiology-led models of care have been implemented in seven HHSs showing evidence-based improvements for patients on waiting lists for ENT specialist care.

Audiology services positioned first in the ENT pathway for patients with defined ear-related conditions. Audiology assessment is provided, and patients are discharged, remain on the waiting list based on the agreed criteria or escalated for more urgent medical review. This model has been found to improve access to timely assessment and care, and efficiency for HHSs, with clinical data showing:

- Approximately 30% of patients on the Category 2 and 3 ENT waiting list were triaged to the audiology first model of care
- 50% of patients were discharged without ENT review
- 40% required ENT review
- 10% were referred for ongoing audiology monitoring

The **Integrated ENT model** enables the audiologist working to full scope of practice to take

patients directly off the ENT waiting list and provide assessment, treatment and then autonomous discharge without medical review. The audiologist is also able to escalate patients for more urgent ENT review as required. A review of the outcomes found that:

- Approximately 50% of children were assessed and removed from the ENT waiting list without medical specialist review
- The audiology-led clinic contributed to improved access to timely care, with reduced waiting times to initial assessment
- Increased proportion of patients that proceeded to surgery from 57% to 82% compared with the
- standard medical model
- Children followed up by the advanced audiologists after grommet insertion were more likely to be discharged and at the first postoperative review appointment, compared with the standard medical service

No reports of adverse events or long-term bilateral hearing loss after discharge from the audiology-led Service [109]

104 Comans, Tracy et al (2014), 'Cost-effectiveness of a physiotherapist-led service for orthopaedic outpatients', Journal of Health Services Research & Policy, 19(4), pp. 216–223, https://doi.org/10.1177/1355819614533675

105 Queensland Health (2020), Neurosurgical & Orthopaedic Physiotherapy Screening Clinics activity benchmarking report, 1 July 2018 – 30 April 2020.

106 Chang, Angela T. et al (2017), 'Do patients discharged from advanced practice physiotherapy-led clinics re-present to specialist medical services?', Australian Health Review, 42(3), pp. 334-339, https://doi:10.1071/AH16222.

107 Standfield, L. et al (2016), 'The Efficiency of Increasing the Capacity of Physiotherapy Screening Clinics or Traditional Medical Services to Address Unmet Demand in Orthopaedic Outpatients: A Practical Application of Discrete Event Simulation with Dynamic Queuing', Appl Health Econ Health Policy, 14(4), pp. 479–491, https://doi:10.1007/s40258-016-0246-1.

108 [Unpublished research] Smith, Natasha et al (n.d.), Soft Tissue Injury Clinic model improved access to care and reduced hospital costs for patients presenting to emergency departments with soft tissue injuries.

109 Pokorny, Michelle A. et al (2018), 'Is an advanced audiology-led service the solution to the paediatric ENT outpatient waiting list problem?', Speech, Language and Hearing, 22(3), pp. 1-5, https://doi.org/10.1080/2050571X.2018.1447750.

The **Speech Pathology-led ENT clinic** is a first point of contact service that provides alternative assessment and treatment for identified Category 2 and 3 patients on the ENT waiting list with suspected voice or swallowing concerns (but without complex medical issues or risk factors for laryngeal disease). Most patients seen within this service are discharged from the ENT waiting list without medical specialist review. A smaller proportion of patients are escalated for more urgent ENT review. Research has shown that:

- Approximately 70% of patients managed in the Speech Pathology-led ENT clinic were discharged without separate ENT appointments
- No adverse events were reported
- Compliance with recommended waiting times improved from 4% for Category 2 referrals, and 10%
- for Category 3 referrals at the commencement of the study, to 90% in the final three months of the study.[110]

Ophthalmology

The **Paediatric optometrist/orthoptist/ophthalmologist clinic** was established at Queensland Children's Hospital in 2016 (the first clinic of this type in Australia), to provide assessment and management for children with refractive errors, amblyopia and strabismus without ophthalmologist review. All new referrals to the ophthalmology waiting list are triaged by a senior orthoptist and ophthalmology registrar and seen within the weekly paediatric optometrist/orthoptist/ophthalmologist clinic in appropriate. Assessment and management are provided by the optometrist or orthoptist and children are discharged, referred to community providers or escalated for more urgent medical specialist review.

- 28% of children were assessed and discharged following a normal eye examination
- 40% were discharged following assessment and management in the clinic, without requiring medical specialist review
- 8% were escalated for review by an ophthalmologist
- 10% were discharged and referred to a community provider for follow-up.[111]

110 Seabrook, Marnie et al (2019), 'Implementation of an extended scope of practice speech-language pathology allied health practitioner service: An evaluation of service impacts and outcomes', International Journal of Speech-Language Pathology, 21(1), pp. 65-74, https://doi.org/10.1080/17549507.2017.1380702.

111 [Unpublished audit] Bhushan, Shreya and Rana, Sahil (2020), Optometrist Clinic Case Load And Profile at Queensland Children's Hospital, data prospectively collected from 7 consecutive clinics from 31 January – 13 March 2020

Gastroenterology

In the **Dietitian-First Gastroenterology Clinic**, dietitians, working in collaboration with a gastroenterologist, undertake assessment and screen for underlying pathology and order and interpret stool and blood tests. Most low risk patients are managed by dietitians before being transferred back to the care of their General Practitioner with satisfactory resolution of symptoms, without requiring specialist review. Where dietitian assessment indicates concerning features, patients are expedited for a gastroenterology consultant review. Results have included:

- Decreased waiting times, with an average of 204 fewer days for the dietitian clinic when compared to the traditional medical model
- Reduced treatment times (170 fewer days) and usage of other services (1.4 vs 2.1) for the dietitian first clinic when compared to the traditional medical model
- Reduced costs of $1,770 for patients seen within the dietitian first clinic
- 11% of patients were expedited for gastroenterology review
- Low rates of re-referral at 12, 18 and 24 months [112]

Pelvic floor health (urogynaecology)

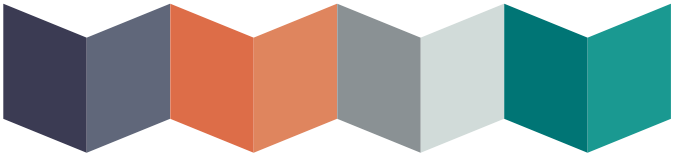
Physiotherapy-led pelvic health clinics have been implemented in eight Queensland Health facilities in four HHSs for Category 3 patients referred for urological, gynaecological and colorectal specialist opinion, with conditions responsive to physiotherapy intervention. New patients are assessed by the clinical lead physiotherapist who develops an evidence-based treatment plan and initiates required referrals and/or escalates the patient for earlier urogynaecology medical review if required. Ongoing treatment and assessments are provided by the physiotherapy team which include pelvic floor muscle rehabilitation, lifestyle advice and pessary fitting, as appropriate. Research has shown:

- Improved access with shorter wait times (117 days) for initial assessment when compared to the traditional medical model (779 days)
- Improved clinical outcomes and high patient satisfaction
- 47-65% of patients were discharged without requiring medical review (number variance across facilities)
- 27% of patients seen within a physiotherapy-led service were escalated for medical review and subsequently required surgery (compared to 90% of patients seen within the traditional medical model)

112 Mutsekwa, Rumbidzai et al (2020), 'Health service usage and re-referral rates: comparison of a dietitian-first clinic with a medical specialist-first model of care in a cohort of gastroenterology patients', Frontline Gastroenterology, pp. 1-7, https://doi: 10.1136/flgastro-2020-101435.

Appendix I:

Integrated health pathways supported by existing funding models



The following examples demonstrate how alternative and/or integrated healthcare pathways can be used under the current funding arrangements.

1. Chronic Obstructive Pulmonary Disease (COPD) patient with complexities – integrated pathway
2. Pre and post-natal dental care – integrated pathway
3. Kidney health – shared care pathway
4. Diabetes – shared care pathway

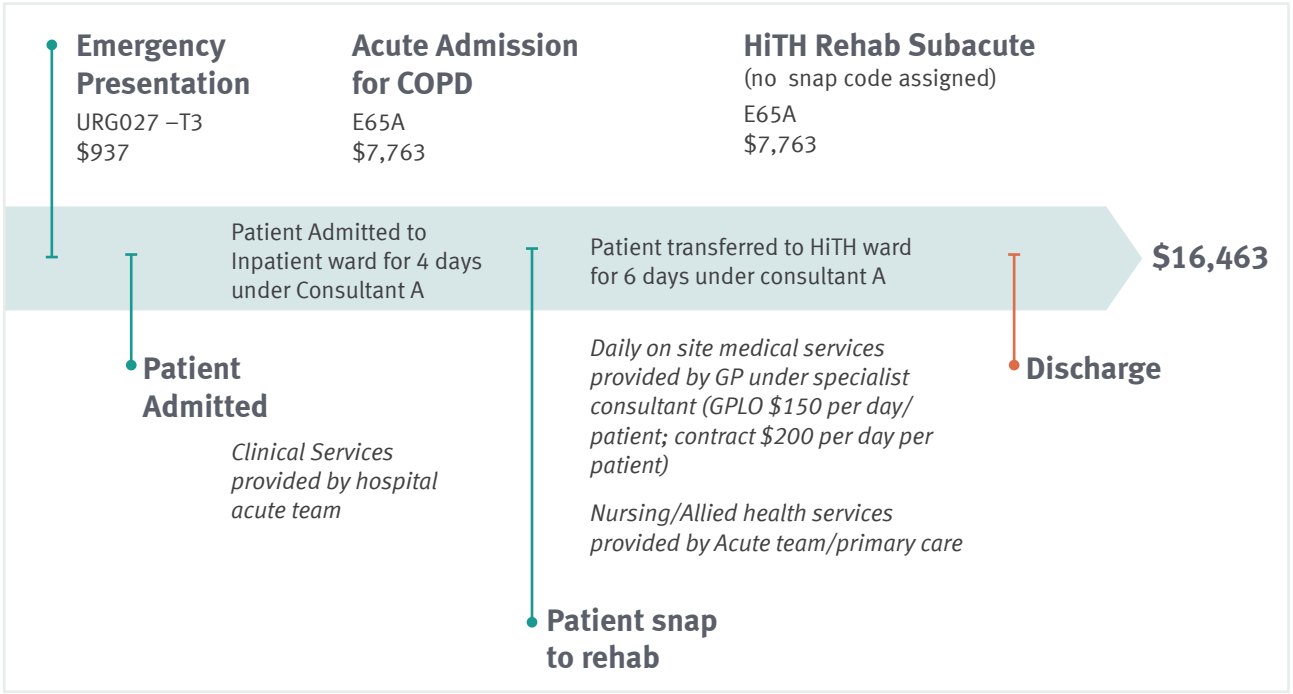
Models 1 and 2 are currently implemented by Metro North HHS

Models 3 and 4 are currently implemented in New Zealand but could readily be implemented under current Queensland Health funding and purchasing models

They are **evidence-based** and **consumer focused**, providing alternatives to care that are supported by the HHS, but may in part or whole be delivered in a community and/or primary care setting. They link to the following recommendations in the report:

- **Recommendation 4c** to develop incentives to support specialist to primary care consultations (including virtual)
- **Recommendation 9b** to promote innovative models for residential aged care
- **Recommendation 13a** to support sharing and scaling of innovative models through the innovation network
- **Recommendation 14d.ii** to develop the skills within HHSs to implement such models.

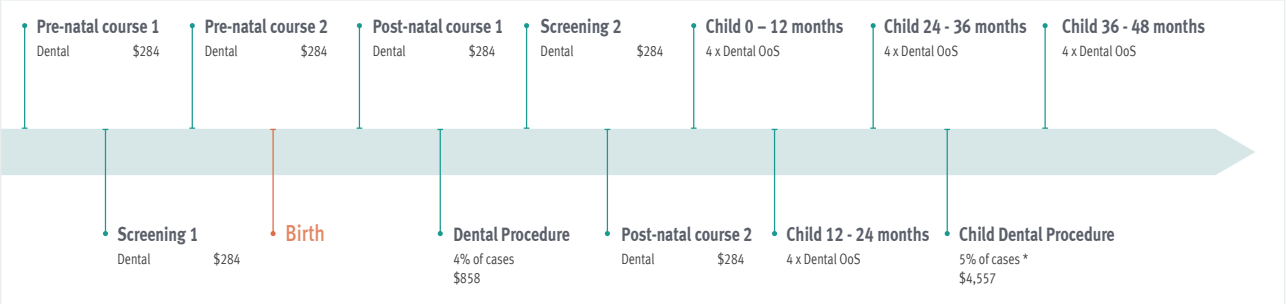
1. COPD patient with complexities – Integrated Pathway



- Rehabilitation provided in patient's home via Hospital in The Home (HiTH), rather than traditional hospital
- Patient's GP contracted to provide daily on-site medical services, funded by HHS through funding received under Queensland ABF model for rehabilitation episode (note GP cannot claim MBS rebate)
- Specialist consultant and nursing/ allied health services are provided by HHS (or could be provided by private providers)
- Advantages include:
  - Better utilisation of HHS (free ups physical capacity, targets workforce to higher complexity etc)
  - Transfer of care occurs during admission
  - Builds relationship with GP for shared post discharge care
  - Integrates with rapid access to specialist advice models

2. Pre and post-natal dental care – Integrated Pathway

Adult Pathway



- All services under integrated pathway provided by Metro North HHS public dental service
- Funded through range of sources
- Adult pathway funded through QH funding and purchasing model and Commonwealth NPA
  - Child pathway not eligible for funding under QH funding and purchasing model (only applies to children >4)
  - Child services 24-48 months may be eligible for funding under Commonwealth Child Dental Benefit Schedule (means tested)
- Model successful example of prevention and early intervention and focus on first 2,000 days
  - Some parts of integrated pathway not eligible for State of Commonwealth funding
  - However it has high returns , and reduces need for acute interventions in later life

3. Kidney health – Shared Care Pathway

CKD Stage	Standard GPwSI Pathway	Shared Care Pathway	Funding Implications	Cost implications
Stable Stage 1 and 2	Discharge to referring GP for ongoing management	Discharge to referring GP for ongoing management with future rapid access review if/ when circumstances change.	Minimal	Based on NHCDC non admitted cost line items, about 30-40% of costs would be avoided for GP visit. -Stage 3a $132 (@30%) -Stage 3b/4/5 $264 (@30%) Allied health services to be community provided. ($1076)
Stable Stage 3a	6 monthly	12 monthly by GPwSI and 12 monthly by GP. 4 per annum allied health (1x social work, 1x podiatrist, 1x pharmacist, 1x dietician)	2 x medical appts & 4 allied health appts per annum “Bundled” stage 3a funding = $1,956 per annum	
Stable Stage 3b	3 monthly	6 monthly by GPwSI and 6 monthly by GP 4 per annum allied health (1x social work, 1x podiatrist, 1x pharmacist, 1x dietician)	4 x medical appts & 4 allied health appts per annum “Bundled” stage 3b funding = $2,836 per annum	
Stable Stage 4 & 5	3 monthly	4 – 6 monthly by GPwSI and 6 monthly by GP 4 per annum allied health (1x social work, 1x podiatrist, 1x pharmacist, 1x dietician)	5 x medical appts & 4 allied health appts per annum “Bundled” stage 4/5 funding = $3,276 per annum	

- Pathway coordinated by HHS for identified patients
- Non-admitted episodes eligible for funding under QH funding and purchasing model but patient’s GP contracted to provide services (note cannot claim MBS rebate)
- Better utilisation of HHS resources and builds relationship with GP

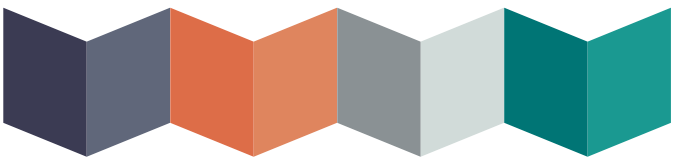
4. Diabetes – Shared Care Pathway

Diabetes Stage	Shared Care Pathway	Funding Implications	Cost implications
Newly Diagnosed diabetic	4 x GP, 4 x nursing / indigenous health worker, 1 x specialist, 4 x allied health (Dietitian, exercise physiologist, optometrist, podiatrist), 2 x diabetes education, 8 x prevention & self management group programs.	5 x medical appts, 4 x nursing, 4 x allied health and 10 x education per annum bundled = $6,226 per annum.	Based on NHCDC non admitted cost line items, about 30-40% of costs would be avoided via integrated models if community provided for GP visits - all stages $366 (@30%) Education & prevention - $1,302 (newly diagnosed, @30%) Allied health services if community provided ($482 – $1,681)
Low risk ongoing care	4 x GP, 4 x nursing / indigenous health worker, 1 x specialist, 8 x allied health (Dietitian, exercise physiologist, optometrist, podiatrist), 2 x diabetes education	5 x medical appts, 4 x nursing, 8 x allied health and 2 x education per annum bundled = $3,118 per annum.	
High risk or with complications	4 x GP, 4 x nursing / indigenous health worker, 4 x specialist, 4 x allied health (Dietitian, exercise physiologist, optometrist, podiatrist), 2 x diabetes education , 12 x high risk foot clinic (other specialties to be captured outside bundle if required)	8 x medical appts, 4 x nursing, 4 x allied health, 2 x education and 12 x high risk foot clinics per annum bundled = $6,637 per annum.	
Paediatric	4 x GP, 4 x nursing / indigenous health worker, 4 x specialist, 3 x allied health (Dietitian, optometrist), 3 x diabetes education	8 x medical appts, 4 x nursing, 3 x allied health and 3 x education per annum bundled = $4,441 per annum.	

- Pathway coordinated by HHS for identified patients
- Non-admitted episodes eligible for funding under QH funding and purchasing model but patient's GP contracted to provide services
- Better utilisation of HHS resources and builds relationship with GP

Appendix J:

Horizons table



		Horizon 1	Horizon 2	Horizon 3	Horizon 4
		Demonstrating commitment Now – Oct 20	New foundations Nov 20 – Apr 21	Building on success May 21 – Jul 22	Embedding success Aug 22
#	**Recommendations**				
1	**Drive health equity and an understanding of local health needs**				
	A. Develop a First Nations Health Equity Framework to guide implementation of the proposed First Nations health equity strategies.		●		
	B. Within one year of passing the Health Legislation Amendment Bill 2019 and regulations, each HHS develop a First Nations Health Equity Strategy in collaboration with local A&TSICCHOs.			●	
	C. Develop a Queensland Health Equity Framework, building on the First Nationals Health Equity Framework.			●	
	D. Develop an integrated Local Health Needs Assessment and Plan at every HHS in partnership with the PHNs, A&TSICCHOs, other local partners and consumers.				●
	E. Develop a Queensland Health Needs Assessment and Plan based on HHS level plans and as a companion to the Chief Health Officer's Report.				●
2	**Make prevention and public health a system priority**				
	A. Amend the *Hospital and Health Boards Act 2011* to add prevention and population health as activities and responsibilities of the HHSs, working in partnership with other local agencies to improve population health outcomes.			●	
	B. Include an incentive in the Queensland Health funding and purchasing model to reward HHSs for improvements in care and outcomes.			●	
	C. Develop an approach that sustains increased focus on population health, health promotion and secondary prevention activities across the health system, including within HHSs.		●		
	D. Establish additional prevention and public health capacity in, and for, Cape York and Torres Strait, and in, and for, Western Queensland.			●	
	E. Create a public health and prevention clinical network.		●		
	F. Develop and deliver a multi-disciplinary Queensland Public Health Training Program in consultation with Queensland universities and relevant professional bodies.				●
	G. Expand immunisation capacity across Queensland, especially to prepare for a COVID-19 vaccine.		●		
3	**Ensure the availability of essential clinical supplies**				
	A. Acknowledge the importance of creating the Clinical Stock Reserve and ensure appropriate input into the whole of government effort to build the reserve.	●			
4	**Transform the relationship with primary care in Queensland**				
	A. Strengthen the partnership with primary health care by creating a mechanism for governance, networking, engagement and strategic policy in Queensland Health.	●			
	B. Encourage transfer of care back to, and treatment in, primary health care where clinically appropriate through consistent, open and equitable processes.	●			

		Horizon 1	Horizon 2	Horizon 3	Horizon 4
	C. Develop incentives in the Queensland Health funding model that support specialist to primary health care consultations, including virtual consultations.			●	
	D. Collaborate with primary health care to continue the uptake of consistent care pathways across Queensland, especially through the use of HealthPathways and clinical prioritisation criteria.	●			
	E. All clinical networks to include primary care membership and engagement with primary care.	●			
5	**Develop and deliver a value-based health care strategy to underpin service improvement across Queensland Health**				
	A. Co-design a strategy for organising Queensland's public health system to maximise value to patients on the outcomes that matter most to them, relative to the cost of achieving those outcomes (Choosing Better Health Together group).			●	
	B. Develop a pilot program to collect Patient Reported Outcome Measures for all patients in defined groups and evaluate the utility and impact of this approach.			●	
6	**Transform non-admitted care to improve patient experience, reduce wait times and improve clinical outcomes**				
	A. Develop a system-wide program to transform non-admitted care, with an initial focus on specialist outpatient services.		●		
	B. Establish consistent, equitable and transparent processes for all referrals to Queensland Health specialist outpatient and non-admitted care based on clinical need.		●		
	C. Establish consistent referral pathways across Queensland for specialist outpatient services and elective surgery which optimise the use of allied health, nursing, midwifery and general practitioners with special interests (GPwSIs) professional pathways.		●		
7	**Optimise telehealth and virtual care to improve patient experience and outcomes**				
	A. Develop, fund and implement a sustained approach to increase telehealth in non-admitted care as a priority for a broader virtual care strategy.		●		
	B. Ensure HHSs leverage emerging digital technologies to develop virtual care models that enable home monitoring, virtual consultations and seven-day access to clinical specialists from the patient's home.			●	
8	**Ensure high value, equitable care is prioritised as elective surgery and other procedures are resumed**				
	A. Ensure access to elective surgery for those experiencing significant health disadvantage, especially First Nations people.	●			
	B. Finalise the definition of low value surgical and other procedural care as an immediate priority.		●		
	C. Implement processes for independent clinical review of all cases of potentially low value care prior to proceeding.		●		
	D. HHSs to ensure that access to public hospital services for both public and private patients is on the basis of clinical need.		●		
9	**Extend existing programs to provide improved in-reach care to residents in residential aged care facilities**				
	A. Extend existing effective programs to provide in-reach services from HHSs to residents in residential aged care to avoid unnecessary transfers of residents to hospitals.	●			
	B. Use flexibility within the current funding model to promote virtual care, Hospital in the Home (HITH), tele-monitoring and non-admitted support programs in residential aged care facilities.		●		

		Horizon 1	Horizon 2	Horizon 3	Horizon 4
10	**Strengthen and embed innovative models identified through the pandemic that enable all clinical staff to work to full scope of practice**				
	A. Implement state legislative or regulatory change to remove any barriers preventing allied health, nursing and midwifery staff and Aboriginal and Torres Strait Islander health practitioners and health workers working to their full scope of practice as authorised by the relevant professional regulatory bodies.		●		
	B. Chief Nursing and Midwifery Officer, Chief Allied Health Officer and Chief Aboriginal and Torres Strait Islander Health Officer to: i. Implement streamlined and consistent credentialing across Queensland to increase the mobility of a highly skilled clinical workforce, and ii. Identify opportunities to increase service capacity though the expansion of allied health, nursing and midwifery services, nurse and midwife led admission and discharge, hospital avoidance models and nurse navigators.		●		
	C. Clinical Excellence Queensland to develop state-wide mutual recognition processes.		●		
11	**Develop integrated health care pathways across three priority areas to support implementation of the report**				
	A. Develop an integrated health care pathway for diabetes.			●	
	B. Develop an integrated health care pathway for mental health.			●	
	C. Develop an integrated health care pathway for children in the first 2,000 days of life, including pregnancy, infancy and early childhood.			●	
12	**Streamline data governance arrangements**				
	A. Enable appropriate access to linked real-time longitudinal data.		●		
	B. Ensure a 'single source of truth' where data is collected once, with that same data used often, in the appropriate form, for all Queensland Health datasets.		●		
	C. Ensure all Queensland Health data is disaggregated by First Nations status and local and regional health data is shared with First Nations people.		●		
13	**Advance innovation across the health system**				
	A. Develop and embed an approach that will prioritise innovation for system leaders, scale clinical and non-clinical innovation across the system and incentivise innovation and creativity in, and across, Queensland Health.		●		
14	**Enhance leadership across Queensland's health system**				
	A. Expand the current range of programs and actions to embed the necessary skills, behaviours, capabilities and accountabilities across Queensland Health's leadership to drive reform, innovation and ongoing improvements to care.			●	
	B. Queensland Health leadership to make an early, public commitment to embrace and champion the principles of an open and equitable health system.	●			
	C. Support an empowered and accountable health workforce, by ensuring staff delegations are commensurate with their role responsibilities.		●		
	D. Support the delivery of reform and spread of innovative practice across HHSs.			●	
	E. Support an enhanced role for multidisciplinary teams, including by ensuring that Clinical Networks are more multidisciplinary in their focus and leadership.		●		

		HORIZON 1	HORIZON 2	HORIZON 3	HORIZON 4
15	**Allocate a proportion of future growth funding for HHSs to drive system reform priorities**				
	A. Develop a set of principles for the allocation of a proportion of future growth funding to drive implementation of the recommendations in this report.	●			
	B. Prioritise within the overall allocation funding the following critical areas in 2020-21 and 2021-22.	●			
16	**Ensure system level accountability is connected**				
	A. Ensure a bi-annual Ministerial Statement of Expectations is provided to each HHS Board Chair that sets out expectations around Government and Ministerial priorities, reinforces shared governance across the system, and links clearly to health system priorities, local Health Needs Assessments and Service Level Agreements.		●		
	B. Ensure appropriate accountability and reporting in response to the Ministerial Statement of Expectations.		●		
	C. The Minister for Health should meet with each Board annually to discuss their performance against the Ministerial Statement of Expectations.				●
17	**Drive accountable implementation**				
	A. The Queensland Health Leadership Advisory Board (QHLAB) to lead, champion and oversee the implementation of the recommendations in this report.	●			
	B. An Independent member be appointed to the QHLAB to support and advise on implementation.	●			
	C. The QHLAB appoint a new or existing Tier 2 Committee to develop a detailed Implementation Plan by December 2020, including specific consideration under each recommendation of strategies to drive health equity for First Nations people.	●			
	D. Queensland Health conduct an internal audit on implementation progress of the Report on *Advice on Queensland Health's governance framework* recommendations, with any outstanding actions to be combined with implementing recommendations in this report.		●