Service delivery statements

Department of Health performance statement

The Department of Health is responsible for providing leadership and direction to enable the health system to deliver safe and responsive services for Queenslanders and working in close collaboration with HHSs and other organisations to achieve these goals.

Service area: Queensland Health Corporate and Clinical Support	Notes	2015–16 Target/est.	2015–16 Actual
Percentage of capital infrastructure projects delivered on budget and within time and scope within a 5% unfavourable tolerance	1	95%	95%
Percentage of correct, on time pays	2	97%	96.2%
Percentage of calls to 13HEALTH answered within 20 seconds	3	80%	81.2%
Percentage of ICT availability for major enterprise applications:	4		
• Metro		99.8%	99.9%
• Regional		95.7%	99.9%
• Remote		92.0%	99.8%
Percentage of all high level ICT incidents resolved within targets defined in the Service Catalogue	5	80%	84.0%
Percentage of initiatives with a status reported as critical (Red)	6	<20%	15.5%
Percentage of formal reviews undertaken on Hospital and Health Service responses to significant negative variance in Variable Life Adjusted Displays and other National Safety and Quality indicators	7	100%	100%

Notes:

1. Although all projects were completed within scope, a small number of projects did not meet the time or budget tolerance.
2. The 2015–16 Target/est and Actual data represent a combination of the number of underpayment payroll enquiries received and the number of overpayments identified each fortnight divided by the number of employee pays processed, based on an average across the last six pay periods for the year of reporting.
3. Funding and human resources is calculated to achieve the performance indicator of 80 per cent of calls answered in 20 seconds as this is internationally recognised as a suitable target/grade of service for health call centres.
4. This service standard measures continuity and availability of ICT services via the wide area network.
5. This service standard mesures ICT incidents resolved within recommended timeframes as per the Service Level Agreement between eHealth Queensland and its customers. Major incidents related to eHealth Queensland services resolved by eHealth Queensland staff between 1 July 2015 and 30 June 2016 have been included in the 2015–16 actual figure.
6. This measure relates to all new initiatives and initiatives that are not yet fully operational. The June actual figure is based on actual reported critical (Red) status as at 30 June 2016.

7. Formal reviews by statewide clinical experts are undertaken on HHS responses to significant negative variance in variable life adjustment displays and other National Safety and Quality indicators to independently assess the adequacy of the response and action plans and to escalate areas of concern if required.

Acute inpatient care

Acute inpatient care includes a broad range of services provided to patients under a formal admission process and can refer to care provided in hospital and/or in a patient's home.

Health consolidated	Notes	2015–16 Target/est.	2015–16 Actual
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	1	<2.0	0.7
Percentage of elective surgery patients treated within clinically recommended times:	2		
• Category 1 (30 days)		>98%	97.5%
• Category 2 (90 days)		>95%	94.5%
• Category 3 (365 days)		>95%	98.3%
Median wait time for elective surgery (days):	3		
• Category 1 (30 days)		N/A	12
• Category 2 (90 days)		N/A	48
• Category 3 (365 days)		N/A	139
• All categories		25	29
Percentage of admitted patients discharged against medical advice:	4		
• Non-Aboriginal and Torres Strait Islander patients		0.8%	1.0%
• Aboriginal and Torres Strait Islander patients		1.2%	3.2%
Percentage of babies born of low birth weight to:	5		
• Non-Aboriginal and Torres Strait Islander mothers		4.6%	5.1%
• Aboriginal and Torres Strait Islander mothers		8.1%	8.3%
Average cost per weighted activity unit for Activity Based Funding facilities	6	$4,928	$4,915
Total weighted activity units—acute inpatient	7	989,143	1,024,301

Notes:

1. Staphylococcus aureus are bacteria commonly found on around 30 per cent of people's skin and noses and often cause no adverse effects. Infections with this organism can be serious, particularly when they infect the bloodstream. The data reported for this service standard are for bloodstream infections with Staphylococcus aureus (including MRSA) and are reported as a rate of infection per 10,000 patient days. The Target/est. for this measure aligns with the national benchmark of 2.0 cases

per 10,000 acute public hospital patient days. The actual rate is based on the complete data set for the whole year.

2. 2015–16 Actual performance is from 1 July 2015 to 30 June 2016. From 2015–16 the scope of elective surgery has expanded to include Central West HHS (Longreach Hospital), South West HHS (Charleville, Roma & St George hospitals) and Torres and Cape Hospital and Health Service (HHS) (Cooktown, Thursday Island & Weipa Hospitals). Sourced from the Queensland Health Elective Surgery Data Collection.
3. 2015–16 Actual performance is from 1 July 2015 to 30 June 2016. From 2015–16 the scope of elective surgery has expanded to now include Central West HHS (Longreach Hospital), South West HHS (Charleville, Roma & St George hospitals) and Torres and Cape HHS (Cooktown, Thursday Island & Weipa hospitals). Sourced from the Queensland Health Elective Surgery Data Collection.
4. The 2015–16 Actual figure relates to admitted patient data within the reporting database as at 12 August 2016 for 2015–16 year to date preliminary data.
5. The 2015–16 Actual figures relate to all perinatal data within the reporting databases as at 12 August 2016 and covers the period 1 July 2015 to 31 May 2016.
6. Activity Based Funding facilities only (excludes Central West, South West and Torres and Cape HHSs) and excludes Mater Health Services. Excludes specified grants and clinical education and training.
7. For 2015–16, activity is taken using the contracted activity hierarchy. This hierarchy allocates activity based on who has paid for the activity as opposed to the geographical area in which the activity is performed. Phase Q19 July 2016–June 2017, as previously published in the 2016–17 Service Delivery Statement.

Outpatient care

Outpatient services are examinations, consultations, treatments or other services provided to patients who are not currently admitted to hospital that require specialist care. Outpatient services also provide associated allied health services (such as physiotherapy) and diagnostic testing.

Health consolidated	Notes	2015-16 Target/est.	2015-16 Actual
Percentage of specialist outpatients waiting within clinically recommended times:	1		
• Category 1 (30 days)		N/A	63.0%
• Category 2 (90 days)		N/A	55.4%
• Category 3 (365 days)		N/A	80.5%
Total weighted activity units—Outpatients	2	229,878	236,780

Notes:

1. 2015–16 Actual performance is for patients waiting as at 1 July 2016. Sourced from the Queensland Health Specialist Outpatient Data Collection.
2. For 2015–16, activity is taken using the contracted activity hierarchy. This hierarchy allocates activity based on who has paid for the activity as opposed to the geographical area in which the activity is performed. Phase Q19 July 2016–June 2017, as previously published in the 2016–17 Service Delivery Statement.

Emergency care

Emergency Care is provided by a wide range of facilities and providers from remote nurse run clinics, general practices, ambulance services, retrieval services, through to EDs. EDs are dedicated hospital-based facilities specifically designed and staffed to provide 24-hour emergency care.

Health Consolidated	Notes	2015–16 Target/est.	2015–16 Actual
Percentage of ED attendances who depart within 4 hours of their arrival in the department	1, 2	90%	78.2%
Percentage of ED patients seen within recommended timeframes:	1, 2		
• Category 1 (within 2 minutes)		100%	99.2%
• Category 2 (within 10 minutes)		80%	74.7%
• Category 3 (within 30 minutes)		75%	62.9%
• Category 4 (within 60 minutes)		70%	75.7%
• Category 5 (within 120 minutes)		70%	94.5%
• All categories		..	72.3%
Percentage of patients transferred off-stretcher within 30 minutes	3	90%	81.62%
Median wait time for treatment in EDs (minutes)	1, 2	20	18
Total weighted activity units—ED	4	217,541	230,829

Notes:

1. 2015–16 Actual performance is from 1 July 2015 to 30 June 2016.
2. From 2015–16, Queensland Health expanded the centrally collected dataset from 26 EDs to include an additional 32 emergency services in regional and rural areas around Queensland. This expansion to 58 facilities provides a broader representation of the patients who require emergency services. The 2015–16 actual figures are based on the 58 facilities that are in scope of the Queensland Health Emergency Data Collection.
3. This measure is inclusive of major Queensland Health Reporting Hospitals only. Off-stretcher time is defined as the time interval between the ambulance arriving at the ED and the patient transferred off the QAS stretcher.
4. For 2015–16, activity is taken using the contracted activity hierarchy. This hierarchy allocates activity based on who has paid for the activity as opposed to the geographical area in which the activity is performed. Phase Q19 July 2016–June 2017, as previously published in the 2016–17 Service Delivery Statement.

Sub and non-acute care

Sub and non-acute care comprises of rehabilitation care, palliative care, geriatric evaluation and management care, psychogeriatric care and maintenance care.

Health consolidated	Notes	2015–16 Target/est.	2015–16 Actual
Total weighted activity units—sub acute	1	92,248	91,409

Notes:

1. For 2015–16, activity is taken using the contracted activity hierarchy. This hierarchy allocates activity based on who has paid for the activity as opposed to the geographical area in which the activity is performed. Phase Q19 July 2016–June 2017, as previously published in the 2016–17 Service Delivery Statement.

Mental health and alcohol and other drug services

Integrated Mental Health Services deliver assessment, treatment and rehabilitation services in community, inpatient and extended treatment settings to reduce symptoms of mental illness and facilitate recovery. Alcohol, tobacco and other drug services provide prevention, treatment and harm reduction responses in community based services.

Health consolidated	Notes	2015–16 Target/est.	2015–16 Actual
Proportion of re-admissions to acute psychiatric care within 28 days of discharge	1	<12%	13.2%
Rate of community follow up within 1–7 days following discharge from an acute mental health inpatient unit	2, 3	>65%	64.4%
Percentage of the population receiving clinical mental health care	3, 4	>1.9%	2.0%
Ambulatory mental health service contact duration (hours)	3, 5	>879,550	888,889
Total weighted activity units—Mental Health	6, 7	135,317	225,070

Notes:

1. Final data for 2015–16 is not yet available; as such the measure only includes separations up to 31 March 2016. Queensland has made significant progress in reducing readmission rates over the past five years, with continued incremental improvements towards the nationally recommended target.
2. Queensland has made significant progress in improving the rate of community follow up over the past five years.
3. Data provided is for the 2015–16 financial year; however remains preliminary until final validation and data updates occur by the end of the calendar year.
4. Proportion of persons accessing any type of public mental health services over the estimated Queensland population for 2015–16. The indicator provides a mechanism for monitoring population treatment rates and assesses these against what is known about distribution of a mental disorder in the community.
5. This measure counts the number of in-scope service contact hours attributable to each HHS, based on the national definition and calculation of service contacts and duration. The target for this measure is determined using a standard formula based upon available clinical staffing, HHS rurality, and historical performance.
6. Mental health QWAU is impacted by the additional mental health activity reported due to the implementation care standard.
7. For 2015–16, activity is taken using the contracted activity hierarchy. This hierarchy allocates activity based on who has paid for the activity as opposed to the geographical area in which the activity is performed. Phase Q19 July 2016–June 2017, as previously published in the 2016–17 Service Delivery Statement.

Prevention, primary and community care

These services are provided by a range of healthcare professionals in socially appropriate and accessible ways and include health promotion, illness prevention, disease control, immunisation, screening, oral health services, environmental health, research, advocacy and community development, allied health, assessment and care planning and self-management support.

Health consolidated	Notes	2015–16 Target/est.	2015–16 Actual
Percentage of the Queensland population who consume recommended amounts of:	1		
• Fruits		58.4%	57.0%
• Vegetables		9.6%	8.0%
Percentage of the Queensland population who engaged in levels of physical activity for health benefit:	1		
• Persons		64.1%	58.0%
• Male		68.6%	61.0%
• Female		59.7%	54.0%
Percentage of the Queensland population who are overweight or obese:	1		
• Persons		58.4%	58.0%
• Male		64.8%	67.0%
• Female		52.0%	49.0%
Percentage of the Queensland population who consume alcohol at risky and high risk levels:	1		
• Persons		17.9%	22.0%
• Male		27.4%	33.0%
• Female		8.7%	12.0%
Percentage of the Queensland population who smoke daily:	1		
• Persons		13.7%	12.0%
• Male		14.6%	13.0%
• Female		12.2%	12.0%
Percentage of the Queensland population who were sunburnt in the last 12 months:	1		
• Persons		52.7%	52.0%
• Male		55.4%	57.0%
• Female		51.2%	46.0%
Annual notification rate of HIV infection	2	5.0	4.6

Health consolidated	Notes	2015–16 Target/est.	2015–16 Actual
Vaccination rates at designated milestones for:	3		
• All children 12–15 months		95.0%	93.2%
• All children 24–27 months		95.0%	91.4%
• All children 60–63 months		95.0%	92.7%
Percentage of target population screened for:	4		
• Breast cancer		57.3%	n/a
• Cervical cancer		56.3%	n/a
• Bowel cancer		33.3%	n/a
Percentage of invasive cancers detected through BreastScreen Queensland that are small (<15mm) in diameter	4	58.6%	n/a
Ratio of potentially preventable hospitalisations - rate of Aboriginal and Torres Strait Islander hospitalisations to rate of non-Aboriginal and Torres Strait Islander hospitalisations	5	2.0	1.9
Percentage of women who, during their pregnancy were smoking after 20 weeks:	6		
• Non-Aboriginal and Torres Strait Islander women		8.7%	7.8%
• Aboriginal and Torres Strait Islander women		35.8%	37.2%
Number of adult oral health weighted occasions of service (ages 16+)	7	2,400,000	2,891,164
Number of children and adolescent oral health weighted occasions of service (0–15 years)	8	1,300,000	1,222,975
Percentage of public general dental care patients waiting within the recommended timeframe of two years		95%	100%
Percentage of oral health weighted occasions of service which are preventative	9	15%	14.4%
Number of rapid HIV tests performed	10	3000	5069
Total weighted activity units—interventions and procedures	11	141,089	134,603

Notes:

1. The 2015–16 Actual is the 2015 Queensland preventive health survey result.
2. The annual notification rate of HIV infection is a reflection of the number of notifications of HIV per 100,000 population. The 2015–16 Actual rate has been calculated using 2014 Estimated Residential Population. The Estimated Actual was based on calendar year data. The Actual is the financial year data.

3. The 95 per cent target is aspirational and aligns with the Immunisation Strategy. The definition of fully immunised at 24–27 months was revised on 1 October 2014 to include three additional vaccines, resulting in a decreased coverage rate.
4. The 2015–16 actual data is not available in the required timeframe for publication of the 2015–16 Department of Health Annual Report.
5. The 2015–16 Actual figure reflects data recorded between 1 July 2015 and 30 June 2016. The 2015–16 Actual figure relates to admitted patient data within the reporting database as at 12 August 2016 for 2015–16 year-to-date preliminary data. Due to changes in national coding standards, the 2015–16 Actuals cannot be compared to previously published reports.
6. The 2015–16 Actual figures relate to all perinatal data within the reporting databases as at 12 August 2016 and covers the period 1 July 2015 to 31 May 2016.
7. The 2015–16 Actual is over target primarily due to Medicare payments claimed directly by HHSs under the Child Dental Benefits Schedule that were invested in additional adult dental services.
8. The 2015–16 Actual is below target in part due to the Medicare Child Dental Benefits Schedule which has reduced demand for child and adolescent oral health services by allowing eligible children to receive free basic dental treatment at private dentists.
9. Preventative treatment is reported according to item numbers recorded in each patient's clinical record. This measure includes procedures such as removal of plaque and calculus from teeth, application of fluoride to teeth, dietary advice, oral hygiene instruction, quit smoking advice, mouthguards and fissure sealants. All of these items are important to improve and maintain the health of teeth, gums and soft tissues within the mouth, and have general health benefits.
10. The number for estimated-actual rapid HIV point-of-care tests 2015–16 is based on the number of 2015 calendar year tests. It is higher than previous estimates because of an increased uptake in the community sector, where the tests are largely performed by peers. This rise is expected to stabilise at current levels and should be maintained at this higher level on the basis that the program and the demand for testing continues. The roll-out of rapid tests across the health care and community sector is an initiative funded by the Department of Health.
11. For 2015–16, activity is taken using the contracted activity hierarchy. This hierarchy allocates activity based on who has paid for the activity as opposed to the geographical area in which the activity is performed. Phase Q19 July 2016–June 2017, as previously published in the 2016–17 Service Delivery Statement.

Ambulance services

The QAS achieves this objective by providing pre-hospital ambulance response services, emergency and non-emergency pre-hospital patient care and transport services, inter-facility ambulance transport, casualty room services, and planning and coordination of multi-casualty incidents and disasters.

Queensland Ambulance Service	Notes	2015-16 Target/est.	2015-16 Actual
Time within which code 1 incidents are attended:	1, 2		
• 50th percentile response time	3	8.2 minutes	8.6 minutes
• 90th percentile response time	4	16.5 minutes	17.1 minutes
Percentage of Triple Zero (000) calls answered within 10 seconds	5	90%	91.6%
Percentage of non-urgent incidents attended to by the appointment time	2, 6	>70%	85.1%
Percentage of patients who report a clinically meaningful pain reduction	7	>85%	88.6%
Patient satisfaction	8	>97%	100%
Gross cost per incident	2, 9	$632	$645

Notes:

1. A Code 1 incident is potentially life threatening necessitating the use of ambulance vehicle warning devices (lights and/or siren) enroute.
2. An incident is an event that results in one or more responses by the ambulance service.
3. This measure reports the time within which 50 per cent of the first responding ambulance resources arrive at the scene of an emergency in Code 1 situations.
4. This measure reports the time within which 90 per cent of the first responding ambulance resources arrive at the scene of an emergency in Code 1 situations.
5. This measure reports the percentage of Triple Zero (000) calls answered by ambulance service communication centre staff in a time equal to, or less than 10 seconds.
6. This measure reports the proportion of medically authorised road transports (Code 3) (excluding Queensland Health and aero-medical transports) which arrive on time for a designated appointment, or are met for returned transport within two hours of notification of completion of an appointment (Code 4).
7. Clinically meaningful pain reduction is defined as a minimum two point reduction in pain score from first to final recorded measurement. Includes patients aged 16 years and over who received care from the ambulance service which included the administration of pain medication (analgesia). Includes patients where at least two pain scores (pre and post-treatment) were recorded and, on a numeric rating scale of one to ten, the initial pain score was at least seven.
8. This is the total number of patients who were either 'satisfied' or 'very satisfied' with ambulance services they had received, divided by the total number of patients that responded to the National Patient Satisfaction Survey of the Council of Ambulance Authorities.
9. This measure reports ambulance service expenditure divided by the number of incidents. The increase in cost per incident relates to additional costs associated with frontline staff enhancements to meet increasing demand for ambulance transport services and additional investment in information and communication technology.

Our governance

Government bodies

The following tables outline the annual reporting arrangements for government bodies in the health portfolio. For more information about each government body, including their achievements, please refer to their annual reports.

Government bodies (statutory bodies and other entities)	Act	Functions	Achievements	Remuneration	No. of scheduled meetings / sessions	Total out-of-pocket expenses	Financial Reporting
Mental Health Court	The Mental Health Court is required to prepare its own annual report. Details can be found in the Mental Health Court's annual report 2015–16.						Financial transactions are included in the Department of Health's annual report 2015–16.
Mental Health Review Tribunal	The Mental Health Review Tribunal is required to prepare its own annual report. Details can be found in the Mental Health Review Tribunal's annual report 2015–16.						Financial transactions are included in the Department of Health's annual report 2015–16.
Radiation Advisory Council	The Radiation Advisory Council is required to prepare its own annual report. Details can be found in the Radiation Advisory Council's annual report 2015–16.						Financial transactions are included in the Department of Health's annual report 2015–16.
Queensland Mental Health Commission	The Queensland Mental Health Commission is required to prepare its own annual report, including independently audited financial statements. Details can be found in the Queensland Mental Health Commission's annual report 2015–16.						
Queensland Mental Health and Drug Advisory Council	The Queensland Mental Health and Drug Advisory Council support the Queensland Mental Health Commission, and details can be found in the Queensland Mental Health Commission's annual report 2015–16.						

Government bodies (statutory bodies and other entities)	Act	Functions	Achievements	Remuneration	No. of scheduled meetings / sessions	Total out-of-pocket expenses	Financial Reporting
Hospital and Health Services (16)	HHSs are required to prepare their own annual reports, including independently audited financial statements. Details can be found in the HHSs' respective annual reports 2015–16.						
Hospital Foundations (14)	Hospital Foundations are required to prepare their own annual reports, including independently audited financial statements. Details can be found in the Hospital Foundations' respective annual reports 2015–16.						
Council of the QIMR Berghofer Medical Research Institute (QIMR)	QIMR is required to prepare its own annual report, including independently audited financial statements. Details can be found in the QIMR's annual report 2015–16.						
Office of the Health Ombudsman	The Office of the Health Ombudsman is required to prepare its own annual report, including independently audited financial statements. Details can be found in the Office of the Health Ombudsman's annual report 2015–16.						
Panels of assessors (14)	Full details provided in the tables that follow.						
Queensland Boards of the National Health Practitioner Boards	Full details provided in the tables that follow.						

Name of government body: Queensland Boards of the National Health Practitioner Boards comprised of the Queensland Board of the Medical Board of Australia; the Queensland Board of the Nursing and Midwifery Board of Australia; and the Queensland Board of the Psychology Board of Australia.	
Act or instrument	*Health Practitioner Regulation National Law Act 2009* ('the Act')
Functions	On behalf of the National Health Practitioner Boards, the Queensland Boards' functions include making individual registration and notification decisions regarding health practitioners based on national policies and standards.
Achievements	Details of this can be found in the Australian Health Practitioner Regulation Agency's annual report 2015–16.
Financial reporting	Details of this can be found in the Australian Health Practitioner Regulation Agency's annual report 2015–16.

Remuneration

The Australian Health Workforce Ministerial Council sets the fees for Board members in accordance with Schedule 4, section 3 of the Act. The following rates were effective from 1 September 2012:

Role	Daily sitting fee (more than 4 hours day)**	Extra travel time	
		Between 4-8 hours	Over 8 hours
Board Chair	$702	$351	$702
Board member	$576	$288	$576

** includes preparation and up to 4 hours travel time. For meetings less than four hours, half fee payable

Actual fees received	Details of this can be found in the Australian Health Practitioner Regulation Agency's annual report 2015–16.
No. scheduled meetings/sessions	Details of this can be found in the Australian Health Practitioner Regulation Agency's annual report 2015–16.
Total out of pocket expenses	Details of this can be found in the Australian Health Practitioner Regulation Agency's annual report 2015–16.

Name of government body Professional Panels of Assessors comprised of the Aboriginal and Torres Strait Islander Health Practitioners Panel of Assessors; Chinese Medicine Practitioners Panel of Assessors; Chiropractors Panel of Assessors; Dental Hygienists, Dental Therapists and Oral Health Therapists Panel of Assessors; Dentists Panel of Assessors; Medical Practitioners Panel of Assessors; Medical Radiation Practitioners Panel of Assessors; Nursing and Midwifery Panel of Assessors; Occupational Therapists Panel of Assessors; Pharmacists Panel of Assessors; Physiotherapists Panel of Assessors; Podiatrists Panel of Assessors; and Psychologists Panel of Assessors and Public Panel of Assessors (collectively, 'Panels of Assessors')	
Act or instrument	*Health Ombudsman Act 2013* ('the Act')
Functions	The Panels of Assessors are established to assist the Queensland Civil and Administrative Tribunal (QCAT) by providing expert advice to judicial members hearing disciplinary matters relating to healthcare practitioners. QCAT deals with serious disciplinary matters which, if substantiated, may result in the cancellation or suspension of a practitioner's registration.
Achievements	Assessors provided expert advice to QCAT in 45 matters contributing to QCAT's achievement of 104 per cent clearance rate in its Occupational Regulations List.
Financial reporting	The Panels of Assessors' financial transactions are not included in the Department of Health's annual report 2015–16 as their transactions are funded by the Australian Health Practitioner Regulation Agency.
Remuneration Adjudication and Determination—Category Level 1—$550 per four hour session per member.	
Actual fees received	$87,276.37 (fully recovered from the Australian Health Practitioner Regulation Agency)
No. scheduled meetings/sessions	45
Total out of pocket expenses	Nil (fully recovered from the Australian Health Practitioner Regulation Agency).

Boards and committees

Description	Total on-costs
Emergency Services Management Committee The committee provides policy advice to the Minister for Health and Ambulance services and the Minister for Communities, Women and Youth, Child Safety and for the Prevention of Domestic and Family Violence, on issues affecting consumer access to, and delivery of, public hospital emergency services.	Non-remunerated advisory body
Health Support Queensland Advisory Board The board was established on 1 August 2014 to provide advice to the Director-General on the provision of health support services, to enable improved patient outcomes across the Queensland public health system. Key achievements 2015–16: • Contributed to the strategic direction and management of HSQ through the development of the strategy to action key performance indicators. • Assisted in the development of business improvement strategies and internal governance arrangements to support improved efficiency and benefits for HSQ's customers. Two board meetings were held in 2015–16. The board was discontinued in early 2016 subsequent to consideration of recommendations in the Hunter Review.	Non-remunerated advisory body
Patient Safety Board The board was established in 2013, under the *Hospital and Health Boards Act 2011*, to monitor the performance of HHSs pertaining to patient safety and take remedial action when patient safety performance does not meet the expected standard. Key achievements 2015–16: • monitored the performance of HHSs pertaining to patient safety • initiated remedial action when patient safety performance of HHSs did not meet the expected standard. Two board meetings were held in 2015–16. In recognition that patient safety performance and issues are now monitored and discussed directly between the Department Executive and individual HSCE on a quarterly basis, the Patient Safety Board has ceased. A Patient Safety and Quality Executive Advisory Committee will commence in September 2016 to ensure that the department has a mechanism to engage with key consumer, clinician and management stakeholders to provide advice on divisional priorities and to promote improvement across the health system.	$935

Queensland Clinical Senate Represent clinicians from across the health system Provide strategic advice and leadership on system-wide issues affecting quality, affordable and efficient patient care within the health system in Queensland. The senate is about connecting clinicians to improve care.	Expenditure totalled $320,000. This included remuneration of the Chair and health consumer representatives, and three forums.

Public Sector Ethics Act 1994

The *Code of Conduct for the Queensland Public Service* applies to all Queensland Health staff. The code is based on the four ethics principles in the *Public Sector Ethics Act 1994*:

- integrity and impartiality
- promoting the public good
- commitment to the system of government
- accountability and transparency.

Training and education in relation to the Code of Conduct for the Queensland public service and ethical decision making is part of the mandatory training provided to all employees at the start of employment and then every two years.

Education and training in public sector ethics, the Code of Conduct and ethical decision making is provided through:

- The online ethics, integrity and accountability training which focuses on the four ethics principles and ethical decision-making, and incorporates competencies relating to fraud, corruption, misconduct and public interest disclosures. In 2015–2016, 2243 employees completed this training.
- Online training covering the Code of Conduct and ethical decision-making with 391 QAS employees completing this training in 2015–2016.
- Online training covering fraud and ethic awareness with 488 QAS employees completing this training in 2015–2016.

In addition, the department has a workplace conduct and ethics policy that outlines the obligations of management and employees to comply with the Code of Conduct for the Queensland public service. Staff are encouraged to contribute to the achievement of a professional and productive work culture within the Department of Health, characterised by the absence of any form of unlawful or inappropriate behaviour.

Queensland public service values

In 2015, the department undertook work to define its aspirational culture which incorporated the public service values. Work will continue through 2016–17 to change work practices in line with this cultural direction.

In 2015–16, in consultation with the Public Service Commission, the QAS undertook a process to define its organisational values. Specifically, this process saw the QAS

further define the values of the Queensland public sector, having regard for the organisation's unique operating environment, and service delivery requirements. In addition to this, a new value of 'Health and Safety' was added, and the value of 'Customers First' was further defined with a priority focus on the needs of patients.

Risk management

The department's Risk Management Framework provides the foundation and organisational arrangements for managing risk within the department. It aligns with the *AS/NZS ISO 31000:2009 Risk management—principles and guidelines*. The framework aims to streamline and embed risk management to support the department in achieving its strategic and operational objectives through:

- proactive executive involvement
- assessment and response to risk across the whole department
- analysis of risk exposures and meaningful reporting.

During 2015–16, the department:

- established a framework to support risk management across the health system
- improved risk management and governance processes
- enhanced risk reporting used to inform decision-making
- tested its Crisis and Continuity Plan to improve disruption risk management
- increased staff awareness of fraud-related issues, including cyber security, physical access security, delegations and conflicts of interest via its annual Fraud Awareness Month initiative developed and implemented a Fraud Control Assurance Plan to monitor and track the effectiveness of the department's fraud control program.

Ethical Standards Unit

The Ethical Standards Unit enables the Director-General to fulfil a statutory obligation to report public interest disclosures to the Queensland Ombudsman and allegations of suspected corrupt conduct to the Crime and Corruption Commission. Allegations referred back to the department by the Commission are managed or monitored by the unit. The unit managed 53 complaints of corrupt conduct comprising 177 allegations, and reviewed and advised the department's executives and work units on a further 119 matters. A further nine complaints were received and reviewed by the unit relating to HHS staff or were not within the department's jurisdiction. These were referred to the Crime and Corruption Commission for consideration and necessary action. In addition to managing investigations for the department, the unit provided 464 instances of advice to HHSs, the department's executives and work units regarding corrupt conduct and public interest disclosures. Throughout the year, 941 staff completed face-to-face ethical awareness, managing corrupt conduct and managing public interest disclosure (PID) training as part of the unit's focus on misconduct prevention by raising ethical awareness and promoting integrity. The unit's development and release of comprehensive PID online training allows employees who work shift work or those who are remotely located to complete the required mandatory training. In total, 758 HHS staff and 1400 department staff completed the PID online training.

Audit and Risk Committee

The Department of Health Audit and Risk Committee (ARC) operates in accordance with its charter, having due regard for Queensland Treasury's *Audit Committee Guidelines: Improving Accountability and Performance*. The ARC provides the Director-General with independent audit and risk management advice in relation to the department's risk, internal control, governance and compliance frameworks. In addition, the ARC assists in the discharge of annual financial management responsibilities as required under the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2009*.

The ARC met on seven occasions during 2015–16, with five meetings addressing general governance activities and two meetings dedicated to discussion of the department's annual financial statements. Remuneration paid to independent committee members during the financial year totalled $20,780. ARC membership during 2015–16 is detailed below:

Name	Committee role	Position	Term
Michael Walsh	Chair	Director-General	July 2015 – June 2016
Len Scanlan	Deputy chair	Independent	July 2015 – October 2015
Ken Brown	Member	Independent	July 2015 – June 2016
Lisa Dalton	Member	Independent	July 2015 – June 2016
Chris Johnson	Member	Independent	July 2015 – June 2016
Dr Judy Graves	Member	Executive Director, Medical Services, Royal Brisbane and Women's Hospital	July 2015 – June 2016
David Eeles	Member	Deputy Commissioner, QAS	July 2015 – September 2015
Libby Gregoric	Member	Acting Deputy Director-General, Corporate Services Division	May 2016 – June 2016
Ian Wright	Member	General Manager, Corporate Services, HSQ	May 2016 – June 2016
Darren Hall	Member	Director, Executive Services, Office of the Commissioner, QAS	May 2016 – June 2016

In addition to the membership listed above, the Chief Finance Officer, Chief Risk Officer, Chief Audit Officer and representatives from the Queensland Audit Office have standing invitations to attend all committee meetings.

ARC achievements for the year include:

- endorsement of the annual internal audit plan prior to approval by the Director-General and monitored the ongoing delivery of the internal audit program
- endorsement of the annual financial statements prior to sign-off by the accountable officer

- provision of direction on departmental business matters relating to business improvement activities, internal control structures, strategic and corporate risk issues, project governance and accountability matters
- oversight of implementation of agreed actions in relation to recommendations from both internal audit and external audit activities.

Internal audit

The department's Internal Audit Unit provides independent assurance and advisory services to the Director-General, executive management and the ARC to assist in improving departmental business operations. During 2015–16, the Internal Audit Unit again operated under a co-sourced service delivery model endorsed by the ARC.

All internal audit work is performed in accordance with the unit's charter, (developed in accordance with the Institute of Internal Auditors standards, and progressed in-line with the approved strategic and annual audit plan (as endorsed by the ARC and approved by the Director-General).

The unit supports management to achieve its goals and objectives by applying a systematic, disciplined approach to review and improve the effectiveness of risk management, internal control and governance processes, together with strengthening the overall control structures operating throughout the agency.

The unit undertakes a series of review types including operational (effectiveness), compliance, performance (efficiency), financial management, governance and information technology to identify areas of risk and to improve departmental outcomes. Systems are also in place to ensure the effective, efficient and economic operation of the audit function, which includes regular reports to the department's ARC regarding the unit's performance and outputs, and regular briefings to the Director-General regarding its operations.

During 2015–16, Internal Audit Unit achieved the following:

- developed an audit plan based on strategic and operational risks and client needs with the plan approved by the Director-General
- provided secretariat support to the ARC
- supported management by providing advice on corporate governance and related issues, including accountability, risk and best practice issues
- monitored and reported on the status of the implementation of internal audit recommendations, together with those of the Queensland Audit Office (QAO) financial and performance reviews
- provided reports on results of internal audits and assurance review to the ARC and the Director-General
- executed the approved annual audit plan and additional assurance engagements at the request of management.

External scrutiny

In 2015–16, the department was engaged in two QAO reviews:

- QAO Report No. 3: 2014–15 *Emergency department performance reporting*. All recommendations have been completed following the publication of the CLEAR report in the Medical Journal of Australia on Monday 16 May 2016.
- QAO Report No.15: 2015–16 *Queensland public hospital operating theatre efficiency*. The department will establish an oversight committee to lead a system-wide response to ensure a consistent approach to implementing the 10 recommendations of the report.
- QAO Report No. 11: 2015–16 *Management of privately operated prisons*. The department is working with the Department of Justice and Attorney-General to ensure an appropriate plan is developed to address the three cross-sector recommendations raised in this report.

Information systems and recordkeeping

The department implemented Stage 1 of an electronic Documents and Records Management System (eDRMS) in 2015 and will continue further staged rollouts throughout 2016 and 2017.

The eDRMS will assist the department in implementing the Queensland Government Digital Continuity Strategy and innovative business processes such as 'Born Digital: Stay Digital' records. It will also assist in implementing best practice and cost efficient procedures such as Electronic Approval and Digital Signatures, and measuring compliance responsibilities legislated by the *Public Records Act 2002* and the Principles of *Queensland Government Information Standards 40: Recordkeeping and 31: Retention and Disposal of Records.*

The department is committed to building capability in Information Management to better protect the information for the future.

The department also improved record keeping through major enhancements to the Consumer Integrated Mental Health Application (CIMHA) including:

- the introduction of tablet device compatibility that allows mental health staff in the community to document clinical notes directly into electronic records without the need to return to a Queensland Health facility. The use of tablet devices also gives mental health staff timely access to demographics, encounter history, diagnosis data and alert notifications
- the *Mental Health Act 2000* module was enhanced to improve functionality, reporting and electronic form recording
- the move to a high-availability hardware and software configuration that ensure the application is accessible in the event of natural disasters or network disruptions.