

# The Hunter Review

*Review of the Department of Health's structure, governance arrangements and high level organisational capability*

Final Report

June 2015

# Executive Summary

In recognition of the importance of the Department of Health's leadership of Queensland's health system, on 2 April 2015 the Minister for Health announced a review to examine the Department's structure, governance arrangements and organisational capability. This report is the outcome of that review.

The review process has been conducted in an open and consultative manner, involving extensive engagement with staff and stakeholders. More than 2,000 individual places at briefing sessions and consultation meetings have been made available to employees, and specific workshops have been conducted with a range of stakeholder cohorts including the Department Management Team, Hospital and Health Board Chairs, Health Service Chief Executives, broader staffing groups within the Department and unions and industrial organisations that represent the workforce across Queensland's health portfolio. Providing all staff the opportunity to have a voice in shaping the future structure and direction of the Department of Health has been an important feature of this work.

The Terms of Reference for this review are as follows:

- (1) Assess the inputs to and recommendations arising from the Future State Alignment (FSA) Project to determine whether the recommendations, if implemented, would align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services;
- (2) Assess the inputs to and recommendations arising from the FSA Project to determine whether the recommendations, if implemented, would deliver on government priorities;
- (3) Consider relevant Labor election commitments and make recommendations in relation to the re-establishment of the Patient Safety and Quality Improvement Service with 20 new positions and 40 positions transferred from the current Patient Safety Unit;
- (4) Transparently and openly invite and assess feedback from Department staff and other agreed stakeholders on governance and organisational structures appropriate for a Department operating in the Queensland Health context;
- (5) Engage the Department Management Team and other key departmental staff in constructive discussion about options for the efficient and effective governance and structure of the Department as well as high level departmental capability gaps;
- (6) Provide advice on governance and organisational structures that will result in the efficient and effective operation of the Department as the system leader and system manager of health services in Queensland; and
- (7) Provide advice on high level departmental capability gaps and options for addressing.

At the outset, it is important to acknowledge that Queensland's implementation of national health reforms – commenced by a Labor Government in 2011 and continued by a Liberal National Government from 2012 onwards – has rightfully been recognised as a success. The devolution of health service delivery has increased responsiveness within the health system, created improved financial efficiency and, importantly, allowed for more localised decision-making which has empowered clinicians to better meet the needs of their patients, health care consumers and communities.

Staff and stakeholders within Queensland's health system (both within the Department of Health and Hospital and Health Services) should be recognised and congratulated for the leadership roles they have played in advancing these fundamentally important health reforms.

While there have been significant resources deployed to strengthen the capability of Hospital and Health Services throughout the reform process, a similar emphasis on the capability of the Department of Health has not been in evidence. This review is responsible for examining the extent to which a 'systems leadership and governance framework' exists to support the strategic direction and operation of Queensland's Department of Health.

The Department has a statutory responsibility for the State's health system. This involves developing and responding to strategic policy priorities, engaging in funding negotiations, and assuring health services across the State. In 2012, the Department of the Premier and Cabinet appointed a Health Renewal Team to work within the Department of Health. The review team understands that the Health Renewal Team was responsible for focusing on the legislative responsibilities, requirements and accountabilities of the Department of Health, with a view to determining how the organisation should fulfil its role within the federated Queensland health system. The Health Renewal Team commenced a project known as "Future State Alignment" (FSA) to determine the future alignment of functions within the Department and Hospital and Health Services.

Consistent with the findings of the Draft FSA Project report, this review has identified the need for a revised organisational structure, clearer and more streamlined governance and approval pathways, and investment in the capability of staff in the Department to address a range of identified organisational capability gaps. Clearly the role of the Department has changed substantially since the establishment of Hospital and Health Services, and these changes need to be reflected in clarity of functions, a new operating model, a revised structure and reformed governance arrangements.

This report provides a high level capability analysis, a business operating model, a proposed functionally-based organisational structure and a systems-focused governance framework for the Department of Health. Each is premised on the need for collaborative leadership, cultural change and a mature 'systems thinking' approach. The recommendations of this report aim to position the Department of Health to commence the rebuilding exercise that is required.

The review team recognises the significant dedication and commitment of staff and stakeholders across the system that was apparent during the extensive consultation activities. In particular, the review found consistent agreement on the need for the Department to assert its leadership role to assure the quality of health services throughout the State and deliver the best possible health care outcomes.

<b>Recommendations</b>	
<b>Vision and Strategy</b>	
<b>1</b>	Establish a vision and purpose for Queensland's health system which clearly articulates the importance of a systems leadership approach to achieving improved health outcomes for patients and health care consumers and which addresses the risk of system fragmentation which reduces overall system capacity.
<b>2</b>	Develop a 'Charter of Responsibility' to be agreed between the Department of Health and Hospital and Health Services setting out agreed roles and responsibilities for each, based on the legislative provisions of the <i>Hospital and Health Boards Act 2011</i> and sufficiently detailed to clearly inform accountability and authority, supported by a combined Department and Hospital and Health Service campaign to communicate the Charter.
<b>Structure</b>	
<b>3</b>	Implement a new functionally-based structure for the Department of Health, as outlined in this report.
<b>4</b>	Create a new Strategy, Policy and Planning Division within the Department.
<b>5</b>	Create a new Clinical Excellence Division within the Department, with future consideration to be given to the transition of the Clinical Excellence Division to a separate statutory entity within the health portfolio.
<b>6</b>	In creating the new Clinical Excellence Division, re-establish the Patient Safety and Quality Improvement Service within this Division and develop a mandatory Patient Safety Health Service Directive based on the approach of the New South Wales Clinical Excellence Commission's Patient Safety and Clinical Quality Program.
<b>7</b>	Elevate the role of the Chief Health Officer to that of Deputy Director-General, creating a new Prevention Division within the Department.
<b>8</b>	Create a new Business Services Division within the Department.
<b>9</b>	Consider the future form of key 'system enablers' – Health Support Queensland, the Health Services Information Agency and the Queensland Ambulance Service – with regard to their status as units of the Department of Health, with consideration to be given to creating those organisations as statutory entities with service provider relationships consistent with the Service Agreement framework that exists between the Department and Hospital and Health Services.
<b>10</b>	Subject to agreement between Ministers, and in accordance with machinery-of-government requirements, transfer the Mental Health Court Registry to the Department of Justice and Attorney-General.
<b>Governance and Risk Management</b>	
<b>11</b>	Implement new governance arrangements for both Queensland's health system and the Department of Health, with a System Leadership Executive taking overarching responsibility for the health system with cascading accountabilities and responsibilities to other parts of the system as appropriate.
<b>12</b>	Establish a system-wide risk management framework, which clearly articulates escalation procedures, defines responsibilities, outlines mitigation approaches, and sets out risk rankings and scales, including defined pathways (based on the risk ranking/scale) for system risk management.

<b>Recommendations</b>	
<b>13</b>	Undertake a review of the current Performance Management Framework – with representatives from both the Department of Health and Hospital and Health Services – to determine improved mechanisms by which ‘cooperative tension’ can be achieved to support Hospital and Health Services’ continued evolution towards provision of integrated care, whilst concurrently maintaining effective levels of responsiveness to meet government and community expectations.
<b>14</b>	Adopt the Investment Management Framework broadly across the health system, facilitated through an agreed governance pathway (recommended as the Investment Review Committee) to improve rigour in relation to funding decision-making and evaluation processes.
<b>15</b>	Consolidate funding pools from across the Department within the Purchasing and Performance Division.
<b>Planning</b>	
<b>16</b>	Led by the Deputy Director-General, Strategy, Policy and Planning, and with input from the Prevention Division, develop an overarching Queensland Health Plan for the State.
<b>17</b>	Led by the Deputy Director-General, Strategy, Policy and Planning, with input from the Business Services Division, develop an overarching Workforce Management Plan for the State.
<b>18</b>	Led by the Chief Health Officer and Deputy Director-General, Prevention, finalise the Public Health Manual to ensure that clear roles and responsibilities are articulated in relation to State-wide public health priorities, including the characteristics of instances where the Division will ‘step in’ to coordinate activities relating to an issue of significance that may have cross-boundary implications for Hospital and Health Services. In finalising the Public Health Manual, it is recommended that appropriate Key Performance Indicators also be incorporated in Service Agreements with Hospital and Health Services.
<b>Organisational culture and development</b>	
<b>19</b>	Implement a Department-led, Hospital and Health Service supported cultural change program which clearly establishes the Department’s responsibility for system-wide leadership and Hospital and Health Service responsibility as statutory bodies that are accountable to the Minister.

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# 01 Review Context

## Background

In 2008, the Australian Government established the National Health and Hospitals Reform Commission (NHHRC) to undertake a comprehensive review of Australia's health system and develop advice on best practice organisational alignments to achieve improved outcomes for patients and better 'value-for-money' public health services for taxpayers. At that time, the health care system was subject to on-going claims about cost-shifting between the Commonwealth and States, inefficient service delivery, and sub-optimal patient outcomes.

In 2011, following release of the NHHRC's recommendations and significant negotiation by governments across Australia, the Queensland Government (along with other States and Territories) entered into the National Health Reform Agreement (NHRA) with the Australian Government. The reforms have led to significant changes in the service delivery, organisational and governance arrangements and funding mechanisms that now characterise Queensland's, and Australia's, health systems.

For Queensland, the changes took effect from 1 July 2012 following passage of the *Hospital and Health Boards Act 2011*. The structural changes to Queensland's health system have seen a major change to the overarching approach to service delivery, with the creation of a network of 17 (now 16) Hospital and Health Services as statutory bodies that are independently responsible for their operations through a Board appointed by Governor-in-Council on the recommendation of the Minister for Health. Concurrently, the role of the Department of Health fundamentally changed, established in the *Hospital and Health Boards Act 2011* as the 'System Manager' with a range of leadership, system-wide direction setting, planning, purchasing, regulatory and other responsibilities.

The reformed arrangements have led to a significant devolution of responsibility to newly created Hospital and Health Services and marked a major shift in the way health care is funded and delivered in Queensland. The intention was to remove inefficiencies created by large bureaucratic processes and allow for more agile responses to the specific needs of local communities. In theory, the reforms were to have the effect of 'pushing down' decision-making activities so that they occur 'closer to the patient', while allowing the overarching health system to act in a manner that ensures consistency of service for patients, to maintain standards of safety and quality, and to provide for transparency and sustainability of funding.

In mid-2014, following a significant emphasis on the creation and support for newly formed Hospital and Health Services, the Department of Health commenced an initiative entitled the Future State Alignment (FSA) Project. The purpose of the FSA Project, as indicated in the Draft FSA Project report, was to seek to ensure the Department's activities were aligned with the State's devolved operating model for the delivery of health services, in order to ensure the best possible care for patients. The full purpose, objectives and scope of the FSA Project are reproduced at Appendix 1. The activities of the FSA Project were also reportedly designed to enable the Department to further support and strengthen Hospital and Health Service decision-making and accountability by ensuring that funding, together with accountability and responsibility, was transferred effectively to Hospital and Health Services.

# Terms of Reference

The Hunter Review (the review) was announced by the Minister for Health on 2 April 2015.

Terms of Reference for the review were established by the Acting Director-General and considered by the project Steering Committee on 27 April 2015. The full Terms of Reference for the review and membership of the Steering Committee are provided at Appendices 2 and 3, respectively.

## Scope of the Review

The Terms of Reference explicitly establish the scope of the review. These are to:

- (1) Assess the inputs to and recommendations arising from the FSA Project to determine whether the recommendations, if implemented, would align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services;
- (2) Assess the inputs to and recommendations arising from the FSA Project to determine whether the recommendations, if implemented, would deliver on government priorities;
- (3) Consider relevant Labor election commitments and make recommendations in relation to the reestablishment of the Patient Safety and Quality Improvement Service with 20 new positions and 40 positions transferred from the current Patient Safety Unit;
- (4) Transparently and openly invite and assess feedback from Department staff and other agreed stakeholders on governance and organisational structures appropriate for a Department operating in the Queensland Health context;
- (5) Engage the Department Management Team and other key departmental staff in constructive discussion about options for the efficient and effective governance and structure of the Department as well as high level departmental capability gaps;
- (6) Provide advice on governance and organisational structures that will result in the efficient and effective operation of the Department as the system leader and system manager of health services in Queensland; and
- (7) Provide advice on high level departmental capability gaps and options for addressing.

This report addresses each of the respective elements of the Terms of Reference. The sequencing of the response to the Terms of Reference follows the manner in which the review was conducted.

## Government commitments

In addition to requiring an understanding of the inputs and recommendations of the FSA Project, the Terms of Reference also require an understanding of the Queensland Government's intentions and strategic priorities for the State's health portfolio.

The Queensland Government has made a number of announcements and commitments in relation to health services across the State, as well as regarding the security of employment for public servants, which are pertinent to the review. These are set out in the following table.



### **Nursing Guarantee**

Fund our Hospital and Health Services (HHSs) to recruit an additional 400 nursing positions, in addition to planned workforce growth to rebuild services cut back by the Newman Government. This includes 30 nurses for the Cairns and Hinterland HHS, 15 nurses for the Central Queensland HHS (with nurses then allocated to Gladstone and Rockhampton hospitals based on need), 10 nurses for the Mackay HHS, 80 nurses for the Metro North HHS, 70 nurses for the Metro South HHS, 25 nurses for the Sunshine Coast HHS, 90 nurses for the Townsville HHS (40 for Townsville and 50 for the Burdekin Region) and 15 nurses for the Wide Bay HHS.

### **Nursing Guarantee**

Legislate in the first term for safe nurse-to-patient ratios, Business Planning Framework (BPF) and workload provisions to ensure patient safety and quality health care. Implement safe nurse-to-patient ratios (one-to-one nurse-patient ratios in intensive care units and four-to-one on general wards) and workload provisions in the new enterprise agreement.

### **Nursing Guarantee**

Audit patient safety and quality improvement functions in our Hospital and Health Services.

### **Nursing Guarantee**

Ensure the system-wide patient safety and quality improvement functions in our hospitals and in the Department of Health are restored.

### **Nursing Guarantee**

Re-establish the Patient Safety and Quality Improvement Service with 20 new positions and 40 positions transferred from the current Patient Safety Unit.

### **Employment Security**

The Government is committed to maximum employment security for permanent government employees by developing and maintaining a responsive, impartial and efficient government workforce as the preferred provider of existing services to Government and the community. The workforce's commitment to continue working towards achievement of best practice performance levels makes this commitment possible.

*(Source: Various Queensland Labor Party election commitments and the Queensland Government Employment Security Policy)*

While the review team notes that certain elements of these commitments are beyond the scope of the review, it remains an imperative that the Department of Health has the capability and authority to ensure all commitments are achieved.

# 02 Stakeholder engagement

## Consultation and feedback processes

The review has been underpinned by an extensive consultation and engagement process, allowing a diverse range of stakeholders to provide input into the deliberations regarding the structure, governance arrangements and future capability requirements of the Department.

The Terms of Reference require that the review, *“Transparently and openly invite and assess feedback from Department staff and other agreed stakeholders on governance and organisational structure appropriate for a Department operating in the Queensland Health context”* and, *“Engage the Department Management Team and other key departmental staff in a constructive discussion about options for the efficient and effective governance and structure of the Department as well as high level departmental capability gaps”*.

To achieve these requirements, the review process has been informed by a range of consultation activities, providing places for more than 2,000 individuals to directly engage with the review team. The review team has held a number of specific workshops with the Department Management Team, Hospital and Health Board Chairs, Health Service Chief Executives and senior executives from across the Department of Health.

Extensive briefing sessions have been conducted throughout the process for employees of the Department of Health, unions and industrial organisations with an interest in the review. Additionally, written submissions in relation to the review were invited, with feedback received from individual staff, organisations and other interested parties.

These wide-ranging consultation activities have enabled stakeholders and staff to provide their views about the expectations, perceptions and understandings of the role and requirements of the Department. The consultations provided valuable input towards the development of a proposed business model, organisational structure and governance arrangements to support the achievement of departmental and broader health system objectives.

The review also took account of the consultation undertaken by the FSA project team. The Draft FSA Project report notes that, *“The stakeholder perspectives were a critical element of this Departmental review. The views of the HHS Chief Executives and Board Chairs on the future roles and functions of the Department were gathered via individual face-to-face and videoconference interviews, an online feedback survey and during two workshops”*.

The broad consensus of departmental officers was that there had been little transparency regarding the consultation activities of the FSA Project. The view was that genuine engagement with a broad stakeholder constituency had not occurred. In some instances, senior officers listed in the consultation schedule of the Draft FSA Project report stated they did not believe they had been provided adequate, or in the case of some any, opportunity to comment or provide feedback.

# Key themes

The key themes that emerged from the engagement activities are set out in the following table.

Theme	Summary of feedback/description of theme
<p>Lack of role clarity between the Department of Health and Hospital and Health Services is leading to reduced accountability</p>	<p>A fundamental theme that emerged from all engagement activities, across various stakeholder groups, was the lack of clarity relating to roles and responsibilities for key functions performed within Queensland's health system. Specifically, there are a number of areas where stakeholders have different views regarding the authority of the Department, the autonomy of Hospital and Health Services and the circumstances where discretion (on the part of either aspect of the system) may exist.</p> <p>Stakeholders expressed their concern regarding the misinformation and confusion around roles, reporting lines, general processes and shared accountabilities. In particular, consultation highlighted the need for absolute clarity around the role of the Department in a devolved system. Consistent references were made to the significant 'grey' area in the current system model, and it was evident in analysing feedback that there remains confusion across a number of areas.</p> <p>A number of stakeholders also suggested the lack of role clarity is resulting in inefficiencies across the system. It was suggested strongly that this, as well as ensuring simplicity is achieved, should be the key focus for the review.</p> <p>Linked to the feedback regarding a lack of role clarity between the Department and Hospital and Health Services was the notion that staff are currently hindered in undertaking their daily tasks due to confusion about specific accountabilities. Various stakeholders expressed that informal channels were the most utilised method of progressing necessary actions and are largely known only as a result of duration of tenure, legacy of relationships or other informal means, rather than a systematic or programmatic approach to functions.</p>
<p>Lack of appropriate governance structures</p>	<p>It was uniformly recognised that governance structures across the Department (and more broadly the health system) require improvement. There was confusion regarding the distinction between, and the accountabilities of, the System Management Team and the Department Management Team, with many stakeholders noting that the activities of both groups needed formalisation, authority and reform. There were wide-ranging reasons suggested for the regression of the existing governance model, but it was noted that the System Management Team had effectively replaced the Department Management Team as the primary governance mechanism of the Department. Some stakeholders recognised the potential for conflicts of interest to arise under such an approach, in light of the membership of the System Management Team, and also highlighted the Department Management Team's informal progression to its current role in the absence of any formal consideration of its necessary functions. It was clearly identified by effectively all stakeholder groups that improvements to the governance model are necessary.</p>
<p>Strategy development and high level strategic policy functions need increased emphasis</p>	<p>The need for more effective strategy development, horizon scanning, forward-thinking strategic policy and whole-of-government influence was another key theme recognised through stakeholder discussions.</p> <p>While it was recognised the Department is responsible for strategy development and the establishment of strategic policy priorities, many stakeholders believed the capability to undertake these functions had diminished over recent years. A range of different views were posited in that regard, from recognition that previous organisational design approaches had not sufficiently emphasised these requirements through to views that Hospital and Health Services were able to provide the necessary inputs to effectively establish system-wide strategy and strategic</p>

Theme	Summary of feedback/description of theme
	<p>policy outcomes. It was, however, broadly articulated by stakeholders that the current strategic policy agenda is non-existent and that policy development is reactive in nature rather than strategically proactive.</p> <p>It was also identified that the definition of 'policy' needs to be clearly articulated (thus the explicit use of the terms strategy and strategic policy, above) as extensive misconception exists about the true meaning of policy as distinct from administrative activities.</p> <p>Further, stakeholders expressed that the Department has lost the capability to deliver strategic policy and requires staff equipped with skills and capabilities in this space to be effective. Strategy development was contextualised in terms that the State (through the Department) should reflect and accentuate national policy as the Department has a direct role with government to drive strategic policy outcomes at all levels.</p>
System leadership and performance management functions are the domain of the Department	<p>All stakeholders recognised the role of the Department in providing leadership and overall direction to the health system, and in being responsible for managing the performance of Hospital and Health Services. There were, as is to be expected, differences of opinion between stakeholder groups regarding the approach to and application of performance management activities. It is important, however, to recognise that the Department has a key role in leading the health system and defining the outcomes (through its performance management activities) that service providers, such as Hospital and Health Services, achieve. It is similarly important to recognise that such a model – with a central Department that holds Hospital and Health Services to account for their activities – necessarily requires a level of cooperative tension to exist in order to achieve the best possible outcomes. Some stakeholders provided feedback that this tension, and the extent of the recognition of the Department's responsibilities for leading the health system (as distinct from actually acknowledging this role), were often misunderstood and commonly resulted in behaviours that were inconsistent with accepted standards.</p>
The importance of a Department that can appropriately service a Minister of the Crown	<p>Throughout consultations, stakeholders spoke to the importance of a Department that can appropriately service a Minister of the Crown.</p> <p>It was deemed essential across all groups that the Minister's responsibilities, responsibilities of the Department and responsibilities of Hospital and Health Services be clearly defined in order for all to understand where risk lies and how it can be managed appropriately. The wide-ranging examples that were provided speak to issues arising due to widespread confusion around roles and responsibilities throughout the system, which in turn influences various aspects at a system level. This was discussed in relation to concerns that the Department is not currently able to service the Minister appropriately.</p> <p>Addressing the provision of services to the Minister requires the Department to ensure it can deliver (or at least facilitate) commitments and objectives, and is linked to other themes (such as the strategy development and strategic policy issues raised previously).</p>
Service quality and the importance of the patient	<p>The State's health system, and ultimately the Minister, is responsible for ensuring the delivery of health services at the highest quality for all Queenslanders. Ensuring the excellence of service quality was embedded in all stakeholder discussions. The importance of the patient was a common theme throughout discussions with various groups. Significant elements of the feedback received during the consultation process were framed in terms of the importance of the patient and ensuring the quality of services. In particular, the quality of the service offered and the safety of services for patients underpinned the notion that the Department and Hospital and Health Services are seeking to improve the health of Queenslanders.</p> <p>It was acknowledged that many stakeholders have adopted a broad approach to service quality which focuses on answering the following: 'How does this ensure the service is quality and that taxpayer's money is being spent in the best possible way to enable quality services to all?' This is fundamentally positive, but requires a more legitimate framework to ensure service quality objectives are met consistently. It was also highlighted that the focus of service quality had become too narrow in a practical sense, and should be broadened to ensure it is a focus of the entire health system.</p>

Theme	Summary of feedback/description of theme
<p>Patient safety responsibilities are unclear, functions are not aligned and significant simplification is required</p>	<p>Clinical quality and patient safety are the first priorities of both the Department and Hospital and Health Services. There were, however, divergent views among stakeholder groups regarding the approach to be adopted to deliver the safest possible clinical outcomes. It was uniformly agreed that Hospital and Health Services, as direct service providers, have a primary responsibility to ensure the safety of patients. The role of the Department of Health was less clearly agreed: some stakeholders recognise a significant role for the Department; while others identify the Department as having a minimal role. The different views regarding this theme have been considered in the context of the review.</p> <p>It was recognised and generally agreed, however, that the current approach with multiple areas of the Department with overlapping responsibility for patient safety – including the Patient Safety Unit, the Office of Data Integrity and Patient Safety and the Patient Safety Board – was clearly inefficient. A system-wide approach, with agreed areas of responsibility and recognising the Queensland Government’s election commitment to re-establish the Patient Safety and Quality Improvement Service, was identified as necessary.</p> <p>Knowledge sharing was considered to be critical to effective improvement of patient safety outcomes. It was highlighted by stakeholders that there needs to be a focus on sharing patient safety learnings and embedding a ‘safety first’ culture in clinical governance initiatives of the Department moving forward. Included in this is the need to revisit the Department’s assurance role relating to patient safety.</p>
<p>Poor data quality and inequitable access is creating inefficiency</p>	<p>The lack of consistent, high quality and reliable data was a common theme raised by effectively all stakeholder groups.</p> <p>Many stakeholders raised the issue that data integrity is poor across the health system – both within the Department and Hospital and Health Services – with competing sets of data and information often being in existence. Given the importance of accurate data in managing performance and improving service outcomes, the inconsistency of data and the differing levels of access to datasets was considered a serious issue which generated concern and was impacting relationships between the Department and Hospital and Health Services.</p> <p>There was clear feedback that the alignment of data integrity and patient safety functions was ineffectual, given that issues associated with data integrity span far broader areas than just patient safety issues. The access to data within the Department (for the purposes of consistent strategic policy decisions and service purchasing activities, as two examples) and the difference in data held by Hospital and Health Services compared to the Department (in performance measures such as waiting lists and achievement of certain requirements under Service Agreements) were emphasised.</p> <p>It was further noted that issues relating to inefficient and ineffective sharing of data had created barriers that hinder staff from carrying out their functions. Data quality must also be ameliorated, which will require clear communication around expectations and standards both within the Department, as well as within Hospital and Health Services.</p>
<p>The Department’s activities need to better inform commissioning functions</p>	<p>The effectiveness of the commissioning function within the Department was an area identified as requiring improvement.</p> <p>With the exception of a very limited number of stakeholders (who held the view that the commissioning function could be removed altogether to achieve direct pass-through of funds and reduced corporate overheads), the role of the commissioning function was broadly recognised. However, the linkages within the Department of Health (aligning with the previous commentary regarding access to, and integrity of, data) were considered to require improvement. There were instances identified where clinical safety and quality information was not adequately shared, and strategy development activities were not clearly articulated, which had both led to inconsistencies in the commissioning process.</p> <p>It is clear that consideration needs to be given to the most effective means by which the commissioning function can formalise linkages within the Department to better support its relationship with Hospital and Health Services.</p>

Theme	Summary of feedback/description of theme
The roles of the Clinical Senate and Clinical Networks require greater transparency, with better linkages to strategy development and whole-of-system outcomes	<p>The existence of the Clinical Senate was not questioned by stakeholders, although the need for an improved linkage to the Department's strategy development and strategic policy initiatives was a clear theme established by a large number of stakeholders. The ability of the Senate to engage clinicians, consider complex issues and support the core business of the system as a whole was considered an important structure and mechanism, but one where further refinement of the processes adopted (both by the Senate and the Department) to make use of those resources would provide an opportunity that is not yet being realised.</p> <p>Feedback about Clinical Networks noted that their true value was not being properly optimised by the Department or Hospital and Health Services, and that their continued independence (like the Senate) was particularly important to ensure clinicians remained engaged. It was noted that both the largest challenge and largest opportunity to properly utilise Clinical Networks rested in being able to provide sufficient structure so that their expertise may be adequately translated to the clinical improvement, strategic policy and service planning activities of the Department.</p>
Communication approaches need to be improved to support more cooperative relationships	<p>Effective communication is a key component of any successfully run system. A number of stakeholders believed communication within the Department, and between the Department and Hospital and Health Services, needs to be drastically improved.</p> <p>The current processes for communication are outdated and many staff rely on long-standing relationships to effectively achieve their roles and perform basic functions. It was clear both on the part of the Department and the part of Hospital and Health Services that communication activities (and the approaches being adopted) have led (and continue to lead) in some instances to the breakdown of relationships. This appears to be an issue for multiple parts of the system: the Department's previous top-down approach needs to continue to change; while Hospital and Health Services need to recognise the authority of the Department and the broader system framework and government context within which they operate.</p> <p>The development of improved communication technology and protocols was considered to be a high priority that emerged from stakeholder discussions which would lead to improved service delivery quality and efficiency.</p>
There is a clear need for cultural reform across the system and within the Department	<p>A key theme generated through stakeholder discussions was that of an unhealthy organisational culture, both at a system-wide level and within the Department.</p> <p>It was evident via discussion outcomes that there is a strong perception of the existence of 'silos' within the Department. In addition, it was highlighted that there are a number of 'unspoken rules and procedures' across the system. This disharmony works against the common goal to improve the health of all Queenslanders.</p> <p>On the premise of this common overarching goal, all elements of the system should ideally be working cooperatively rather than against each other, however, the current cultural climate often does not enable this. Stakeholders also spoke negatively about the downward transactional type of change existing in the organisation and the Department's 'directive' approach to relationships, and the lack of understanding of the role of the Department (particularly with regard to its remit as 'System Manager') on the part of Hospital and Health Services.</p> <p>Others expressed concern that senior executives (of both the Department and Hospital and Health Services) were not active in the change process. This in turn influences culture negatively when it 'filters' down to other groups in the Department. Furthermore, restructure activities were spoken about in a negative light because stakeholders believe there are instances where people have had to continually justify their existence in the organisation.</p>



# 03 Roles and responsibilities across the health system

## Legislative Frameworks

The NHRA, and the legislation associated with it, created a number of new agencies (some at national level) and new roles for State and Territory health agencies. For Queensland, the key elements were:

- the replacement of a centralised 'Head Office' function with a 'System Manager' (interchangeably referred to as the Department of Health) with responsibilities in establishing system-wide strategy, providing leadership and commissioning services across the health system; and
- the creation of Hospital and Health Services as statutory bodies to provide health services to the local geographic area over which they operate, which are independently and locally controlled by a Hospital and Health Board with a range of accountabilities such as those required of the *Financial Accountability Act 2009* and the *Statutory Bodies Financial Arrangements Act 1982*, as units of public administration under the *Crime and Misconduct Act 2001* and as bodies corporate representing the State and with the privileges and immunities of the State.

Importantly, the underlying premise of the *Hospital and Health Boards Act 2011* was that it envisaged an integrated health system, rather than a specific set of discrete organisations that operated in isolation. In passing the Act, the then Minister explicitly indicated that, *"To achieve this goal we need: a system that, in every single instance, puts the needs of patients first; a system that values the local knowledge of our skilled and hardworking front-line staff; a system that gives each and every local community a say in their local health services; and a system that ensures that every taxpayer dollar spent is spent wisely and well"*<sup>1</sup>.

Accordingly, the functions of both the Department of Health and Hospital and Health Services need to be considered in the context of the wider health system, in which a range of agencies and services play interdependent roles. Indeed, unless the Department has an operating model that enables it to conceptualise the system as a whole (as well as its component parts) it will not be possible for it to:

- meet the priorities of the democratically elected government of the day, in representing the expectations established by the community for the health system;
- articulate a vision and a strategic direction for the Queensland health system as a whole;

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<sup>1</sup> The Honourable Geoff Wilson MP, Minister for Health, 2<sup>nd</sup> Reading Speech for the Health and Hospitals Network Bill, 16 June 2011, *Queensland Parliamentary Hansard*, pp 1969

- develop priorities for action across the system that will ensure high quality, consistent outcomes, regardless of location;
- identify, address and respond to issues that may have system-wide implications, ranging from externally imposed matters (such as policy negotiations with the Australian Government) to internally identified issues (such as emergent risks or issues within a single Hospital and Health Service that may impact the system as a whole); or
- monitor system performance: both in terms of the individual performance of Hospital and Health Services; and the system as a whole, compared to established expectations.

While the *Hospital and Health Boards Act 2011* provides a fundamental framework for establishing the functions, responsibilities and operational requirements of key health system stakeholders, the Minister for Health and Minister for Ambulance Services (and through that role, the Director-General of Queensland Health) is also responsible for administering the following Acts of Parliament:

- *Food Act 2006*;
- *Health Act 1937*;
- *Health Ombudsman Act 2013*;
- *Health Practitioner Regulation National Law Act 2009*;
- *Hospitals Foundations Act 1982*;
- *Mater Public Health Services Act 2008*;
- *Mental Health Act 2000*;
- *Pest Management Act 2001*;
- *Pharmacy Business Ownership Act 2001*;
- *Private Health Facilities Act 1999*;
- *Public Health Act 2005*;
- *Public Health (Infection Control for Personal Appearance Services) Act 2003*;
- *Queensland Institute of Medical Research Act 1945*;
- *Queensland Mental Health Commission Act 2013*;
- *Radiation Safety Act 1999*;
- *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003*;
- *Tobacco and Other Smoking Products Act 1998*;
- *Transplantation and Anatomy Act 1979*; and
- *Water Fluoridation Act 2008*.

It is important to recognise that the Department of Health is therefore responsible for administering additional responsibilities beyond those required by the *Hospital and Health Boards Act 2011*, and its structure must support capability to address an extensive range of health-related functions.

## **The Hospital and Health Boards Act 2011**

As previously recognised, the *Hospital and Health Boards Act 2011* is the key statute governing the overall delivery of publicly funded health services within Queensland. The Act details the key responsibilities and functions for both the Department of Health (recognised in the legislation as the ‘System Manager’) including its Chief Executive (the Director-General), as well as each Hospital and Health Service, including its Board and Health Service Chief Executive.

The primary objective of the *Hospital and Health Boards Act 2011* is to establish a public sector health system that delivers high quality hospital and other health services to persons and populations or communities in Queensland, having regard to the principles and objectives of the national health system, including (but not limited to), strengthening local decision-making and accountability; providing for State-wide health system management; and balancing the benefits



of local and system-wide approaches<sup>2</sup>. The Department of Health is responsible for oversight of health services at a State-wide level. Hospital and Health Services are each responsible for the delivery of health services in accordance with their respective Service Agreement with the Department. In addition, each Hospital and Health Service is responsible for contributing to achieve the required government priorities for their respective population in the State.

The provisions of the *Hospital and Health Boards Act 2011* that specifically establish the responsibilities of the Department of Health (the System Manager) and Hospital and Health Services are explored further in the following sections.

## Role of the Department

The *Hospital and Health Boards Act 2011* specifies the Chief Executive (the Director-General) has responsibility for an extensive range of functions. Acting through the Department of Health, the Director-General is responsible:

- a. To provide strategic leadership and direction for the delivery of public sector health services in the State;
- b. To promote the effective and efficient use of available resources in the delivery of health services in the State;
- c. To develop Statewide health service plans, workforce plans and capital works plans;
- d. To manage major capital works for proposed public sector health service facilities;
- e. To employ staff in the department, including to work for Services other than prescribed Services;
- f. To manage Statewide industrial relations, including the negotiation of certified agreements, and making applications to make or vary awards;
- g. To establish the conditions of employment for health service employees, including issuing health employment directives;
- h. To deliver specialised health services;
- i. To arrange for the provision of health services to public patients in private health facilities;
- j. To develop and issue health service directives to apply to the Services;
- k. To enter into service agreements with the Services;
- l. To provide support services to Services;
- m. To monitor and promote improvements in the quality of health services delivered by Services;
- n. To monitor the performance of Services, and take remedial action when performance does not meet the expected standard;
- o. To receive and validate performance data and other data provided by Services;
- p. To provide performance data and other data to the Commonwealth, or an entity established under an Act of the Commonwealth;
- q. Other functions given to the chief executive under this Act or another Act.

As previously noted, in addition to the legislative requirements of the *Hospital and Health Boards Act 2011* and the 19 other statutes for which the Director-General is responsible, there is also a range of other responsibilities assigned to the Department of Health. As an agency of government, serving a Minister of the Crown, the Department has obligations that are both implied in some way by the legislative arrangements that establish the agency, and which are also established by convention for all Queensland Government agencies.

These responsibilities include:

- Support to a Minister of the Crown including contributing to:
  - Cabinet and Parliamentary processes;
  - Preparation of correspondence and contribution to briefing processes;
  - Intra-governmental representation (Working Parties and related meetings with other Queensland Government agencies);

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<sup>2</sup> *Hospital and Health Boards Act 2011*, Part 1, Division 2, s5

- Policy development and response (for example, the Australian Government's announcement regarding compulsory vaccination and the Queensland Government's announcement regarding medicinal cannabis trials).
- Supporting inter-governmental relations through:
  - Input at the Council of Australian Governments' Health Ministers' Meeting;
  - Input into whole-of-government deliberations;
  - Provision of information for the annual Report of Government Services and various other publications.
- Whole-of-government activities such as Election Commitment reporting and responding to Coronial notification matters.
- Fulfilment and oversight of other commitments such as priorities set out in Ministerial Charter letters, actioning responses to emergent issues (both at a State level, such as disaster coordination and response, and at a local level, for matters directed to the Minister for Health in their capacity as the elected representative overseeing Queensland's health services).

## Role of Hospital and Health Services

The *Hospital and Health Boards Act 2011* specifies a Hospital and Health Service's main function is to deliver the hospital services, other health services, teaching, research and other services stated in the service agreement for the Service, and:

- a. To ensure the operations of the Service are carried out efficiently, effectively and economically;
- b. To enter into a service agreement with the chief executive;
- c. To comply with the health service directives and health employment directives that apply to the Service;
- d. To contribute to, and implement, Statewide service plans that apply to the Service and undertake further service planning that aligns with the Statewide plans;
- e. To monitor and improve the quality of health services delivered by the Service;
- f. To develop local clinical governance arrangements for the Service;
- g. To undertake minor capital works, and major capital works approved by the chief executive, in their area;
- h. To maintain land, buildings and other assets owned by the Service;
- i. for a prescribed Service, to employ staff under this Act;
- j. To cooperate with other providers of health services, including other Services, the Department and providers of primary healthcare, in planning for, and delivering, health services;
- k. To cooperate with local primary healthcare organisations;
- l. To arrange for the provision of health services to public patients in private health facilities;
- m. To manage the performance of the Service against the performance measures stated in the service agreement;
- n. To provide performance data and other data to the chief executive;
- o. To consult with health professionals working in the Service, health consumers and members of the community.

Although there certainly are areas of shared responsibility indicated within the *Hospital and Health Boards Act 2011*, the legislative provisions make it clear the Department is responsible for the overall leadership and direction of Queensland's health system, while Hospital and Health Services are responsible for the delivery of health services. Accordingly, the State's health system and health outcomes are dependent upon clarity and surety regarding the Department's leadership role and capability.

# A Health System Framework

The FSA Project did not have a specific remit to consider system-wide aspects of the Department of Health's activities. This is a concern which was raised by stakeholders throughout the course of this review. A 'systems leadership view and management approach' to the complex network of agencies within Queensland's health system is a core responsibility of the Minister, and therefore of the Department.

Adopting a systems approach is most essential to the development of strategy and related strategic policy for the Queensland health sector. Ultimately, the Department of Health and the Hospital and Health Services all remain part of the broader public sector, and accordingly should share a common sense of direction, purpose and overarching priorities. The Department's functions, and therefore its vision and strategy, should act to facilitate and enable the delivery of the highest standards of care to patients.

Effective system leadership involves mature relationship management capability. The Department (as the System Manager) does have a number of control mechanisms at its disposal (for example, Health Services Directives), however they should be used sparingly as levers to achieve outcomes. The Department is empowered to provide guidance in a variety of ways: strategies; plans; policies; and guidelines. These call for interpretation by Hospital and Health Services as indications of intent. New models of collaborative health leadership have been the focus of much international research. More recently in a report produced by the King's Fund in the United Kingdom, researchers found that, "...the NHS needed to move beyond an outdated model based on heroic leadership of institutions by individuals to one where leaders focus on systems of care, and on engaging staff in delivering results. The report argued that, leadership of the 21<sup>st</sup> century health system needed to be 'shared, distributed and adaptive'."<sup>3</sup>

The 'systems thinking' strategy required of the Department extends beyond the activities of Hospital and Health Services. The Department's role in providing leadership across Queensland's health sector includes legislative and regulatory responsibility for private services, and for purchased activity from a range of non-government organisations. The Department's leadership role also imbues responsibility and accountability for whole-of-government and whole-of-State activities, such as supporting a Minister of the Crown and performing the functions of a Queensland Government agency. Again, these are not functions that can simply be ignored or devolved, as they are core accountabilities of an agency of state in a Westminster style system of government.

## Differing roles provide consistent outcomes

The Department of Health must rely upon the network of Hospital and Health Services to achieve service delivery outcomes. Concurrently, it is incumbent on Hospital and Health Services to recognise the distinct leadership role of the Department in providing overall direction to the State's public health system. These respective roles are interdependent. The Department must rely on the knowledge and experience of employees within Hospital and Health Services, and similarly, employees within Hospital and Health Services must rely on departmental staff to ensure leadership that supports overall system effectiveness.

This 'system mutualism' reflects changed relationships introduced by the *Hospital and Health Boards Act 2011*, whereby:

- Hospital and Health Services have statutory independence, but which still requires ultimate responsibility to a Minister and operation within a public service environment;
- devolved control and decision-making is provided to Hospital and Health Services, to the extent that their performance continues to support that devolution;
- devolved control and decision-making requires increased accountability and responsiveness to risk management practices, with an emphasis on the individual Hospital and Health Service, an awareness of potential higher order (system-wide) risks and both the Department's role in managing those and the Hospital and Health Service's obligation to inform the Department and act in accordance with instructions; and
- the Director-General's overall accountability to the Minister for Health for the health system, and the subsequent authority that is established for the role of Director-General (and the Department) irrespective of the specific contractual relationships that exist through Service Agreements.

The health reforms implemented in 2012 have successfully shifted Queensland Health from a single, centralised organisation to a federated system of organisations which provide for the oversight and delivery of more localised health outcomes. The system is led by a System Manager that maintains authority for overall direction-setting and management of performance. Accordingly, one of the most important leadership tasks for the Department is to create conditions that encourage collaboration and alignment of activities across the system.

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<sup>3</sup> Timmins, N., *The practice of system leadership: Being comfortable with chaos*, The King's Fund, May 2015, pp 5  
Hunter Review – June 2015

# 04 Future State Alignment Project

## Overview

The Future State Alignment (FSA) Project was undertaken over mid to late 2014 in response to the Department's commitment to establish the most effective and efficient agency to deliver health services.

It needs to be acknowledged at the outset the FSA Project was not completed. The review team was advised that the recommendations were not endorsed and therefore have no official standing.

There are ten key recommendations made in the Draft FSA Project report, which advise the proposed future direction of the work. There are additional general findings throughout the report. In some cases, there are inconsistencies between the key recommendations and those other findings.

As one example, the Draft FSA Project report indicates at page 38 that, *"The proposed operational model will enable the development of a robust leading edge organisational structure which allows it to deliver a genuinely dynamic, outcome focussed system leadership and management. This proposed operational model is premised on the implementation of Population Based Funding".* However, the actual recommendations relating to the business model (recommendation one) make no recommendation nor comment regarding population-based funding, and indeed the recommendation relating specifically to population based-funding (recommendation three) commences with advice that the Department, *"Consider in detail the implementation approach"* (in relation to population based funding).

Although the Draft FSA Project report does not specifically indicate a preferred organisational structure, it does contain a high level business model from which an organisational structure was to be considered. That high level business model – which seeks to separate the functions of the Department of Health into 'bureaucracy', 'system leadership' and 'system management' – was tested throughout the consultation process for this review and stakeholders' feedback indicated the model did not sufficiently identify or clarify the integrated and broad-ranging roles, functions, responsibilities and accountabilities of the Department.

It should be recognised the FSA Project has produced a body of valuable analysis and initiatives, including a means to streamline delegations, better inform investment decisions and clarify governance structures within the Department. The overall purpose of the FSA Project was:<sup>4</sup>

- *"To ensure the Department's activities align with Queensland's devolved health operating system to enable HHSs to deliver the best possible care; and*
- *To enable the Department to further support and strengthen HHS local decision-making and accountability by ensuring that funding, together with accountability and responsibility, is transferred effectively to HHSs."*

The organisational areas that were in scope for the FSA Project included the Office of the Director-General, Health Services and Clinical Innovation Division, System Support Services and Health Commissioning Queensland. The Health Service Information Agency, Queensland Ambulance Service and Health Support Queensland were outside the scope of the review.

A series of guiding principles for the review were prepared to inform the development of key change recommendations. Broadly, the guiding principles indicated the outcomes should:

- Drive improvements in the provision of efficient care;
- Ensure more comprehensive and integrated health service delivery; and
- Acknowledge the Department's system leadership responsibilities.

The FSA Project indicates that these guiding principles were used as the framework to develop each recommendation. These recommendations of the Draft FSA Project report are set out in the following table.

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<sup>4</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 2

# FSA Project Recommendations

The specific recommendations contained in the Draft FSA Project report are outlined in the following table.

#	Recommendation	Description
1	<b>Endorse proposed operating model</b>	<ul style="list-style-type: none"> <li>○ The proposed operating model be endorsed so that implementation planning can be undertaken and implementation can occur in a timely manner with the minimum disruption to the delivery of quality health services across the system.</li> </ul>
2	<b>Develop proposed organisational structure</b>	<ul style="list-style-type: none"> <li>○ Commence consultation within the Department to enable the development of a proposed organisational structure based on the roles defined within the proposed operating model. Any amendments in the design should be thoroughly tested against the design principles so as not to compromise the integrity of the model. Organisational design and timing should be considerate of the priority areas of Population Based Funding, the Investment Management, Performance Management and Service Planning Frameworks and consider:               <ul style="list-style-type: none"> <li>○ Strengthening the Corporate Governance function within the department</li> <li>○ Aligning Audit as a direct report to the Director-General</li> <li>○ Data Analytics and providing a single source of truth</li> <li>○ Defining and strengthening the role of the Clinical Networks and Clinical Senate</li> <li>○ Realigning the Mental Health Tribunal to the Department of Justice and Attorney General.</li> </ul> </li> </ul>
3	<b>Consider in detail the implementation approach</b>	<ul style="list-style-type: none"> <li>○ A new Population Based Funding model will replace the existing activity based costing model and be in place from June 2015. In addition, Performance Management, Investment Management and Service Planning frameworks are critical enablers to a functioning Population Based Funding model and these need to be developed by June 2015. Any proposed implementation needs to take into account these interdependencies/enablers to ensure change is appropriately managed to support these priorities. Other interdependencies to be considered and managed include the pace of reform with HSQ and HSIA.</li> </ul>
4	<b>Create workforce strategy and governance group</b>	<ul style="list-style-type: none"> <li>○ Create a new Health Workforce Governance Group that includes representatives of HHSs, Department staff and external representation such as private sector experts and universities.</li> </ul>
5	<b>Develop governance process to enable oversight of all departmental projects</b>	<ul style="list-style-type: none"> <li>○ Consideration be given to all current funding for Business As Usual and one-off projects to be identified and held centrally for investment, where appropriate.</li> </ul>

#	Recommendation	Description
6	<b>Consolidate divisional funding (Funding Pools)</b>	<ul style="list-style-type: none"> <li>○ All discretionary health service funding to reside with Commissioning. Commissioning would then purchase the required outcomes from HHSs.</li> </ul>
7	<b>Collaborative HHS Readiness Assessments</b>	<ul style="list-style-type: none"> <li>○ That Renewal assist the HHSs to undertake a capability / readiness assessment program.</li> </ul>
8	<b>Re-position Queensland Ambulance Service</b>	<ul style="list-style-type: none"> <li>○ QAS to be established as an independent service provider, with the Department extending its role as System Manager to the QAS.</li> </ul>
9	<b>Clinical redesign and process improvement</b>	<ul style="list-style-type: none"> <li>○ Support for a HHS-led clinical redesign and process improvement model. Funding to be provided for a transitional period to the HHSs from the Health Innovation Fund to enable the proposed structure to be effective within 6 months. Work with the HHSs to develop a HHS led system-wide Clinical Innovation Model.</li> </ul>
10	<b>Develop a clear and shared vision and strategy for the Queensland health system</b>	<ul style="list-style-type: none"> <li>○ The Queensland health system is currently undergoing a period of reform and transformation. Whilst significant gains have been made, key stakeholders have commented on the need for a clear, coherent and shared vision and strategy.</li> </ul>

# 05 Assessment of FSA Project recommendations

## Overview

The Terms of Reference for the review require that it, “Assess the inputs to and recommendations arising from the Future State Alignment Project to determine whether the recommendations, if implemented, would align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services” and, “Assess the inputs to and recommendations arising from the Future State Alignment Project to determine whether the recommendations, if implemented, would deliver on government priorities”.

In meeting these two specific elements of the Terms of Reference, a review of the extensive materials developed as part of the FSA Project has been conducted, with analysis and evaluation undertaken against the identified elements and requirements of the specific roles and responsibilities of the Department of Health and Hospital and Health Services as prescribed by the *Hospital and Health Boards Act 2011*, and the identified priorities of the Queensland Government.

A table summarising the outcomes of that review, analysis and evaluation is set out below.



# Summary of findings against FSA Project recommendations

The summary of findings regarding the recommendations arising from the FSA Project is provided in the table below. Further analysis of each of the recommendations, with justification for the findings, is set out following the table.

#	FSA Project recommendation	If implemented, would it align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services? (Yes, Partially, No)	If implemented, would it deliver on government priorities? (Yes, Partially, No).
1	<b>Endorse proposed operating model:</b> The proposed operating model be endorsed so that implementation planning can be undertaken and implementation can occur in a timely manner with the minimum disruption to the delivery of quality health services across the system.	No. The proposed operating model does not sufficiently provide scope for all departmental activities.	No. The proposed operating model would not best facilitate government priorities.
2	<b>Develop proposed organisational structure:</b> Commence consultation within the Department to enable the development of a proposed organisational structure based on the roles defined within the proposed operating model. Any amendments in the design should be thoroughly tested against the design principles so as not to compromise the integrity of the model. Organisational design and timing should be considerate of the priority areas of Population Based Funding, the Investment Management, Performance Management and Service Planning Frameworks and consider: <ul style="list-style-type: none"> <li>o Strengthening the Corporate Governance function within the department</li> <li>o Aligning Audit as a direct report to the Director-General</li> <li>o Data Analytics and providing a single source of truth</li> <li>o Defining and strengthening the role of the Clinical Networks and Clinical Senate</li> <li>o Realigning the Mental Health Tribunal to the Department of Justice and Attorney General.</li> </ul>	No. It is clear a new organisational structure is required, including (in most part) re-alignment of the functions identified. However, it should not be based on the proposed operating model, nor should it solely address the areas indicated.	No. As noted, it is clear that a new organisational structure is required. However, any augmentation of the Department's structure should accord with the Queensland Government's <i>Employment Security Policy</i> , and should be based on a broader business model than the one proposed in recommendation one.
3	<b>Consider in detail the implementation approach (for a new funding model):</b> A new Population Based Funding model will replace the existing activity based costing model and be in place from June 2015. In addition, Performance Management, Investment Management and a Service Planning frameworks are critical enablers to a functioning Population Based Funding model and these need to be developed by June 2015. Any proposed implementation needs to take into account these interdependencies/enablers to ensure change is appropriately managed to support these priorities. Other interdependencies to be considered and managed include the pace of reform with HSQ and HSIA.	No. Implementation of a Population Based Funding model by June 2015 would be a high risk exercise.	No. The Queensland Government has made no commitment to a new funding model.



#	FSA Project recommendation	If implemented, would it align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services? (Yes, Partially, No)	If implemented, would it deliver on government priorities? (Yes, Partially, No).
4	<b>Create workforce strategy and governance group:</b> Create a new Health Workforce Governance Group that includes representatives of HHSs, Department staff and external representation such as private sector experts and universities.	Partially. It is clear a new approach to workforce planning is required, but that approach must align with overarching governance arrangements.	Partially. A new workforce strategy and governance group could be tasked with supporting government priorities.
5	<b>Develop governance process to enable oversight of all departmental projects:</b> Consideration be given to all current funding for Business As Usual and one-off projects to be identified and held centrally for investment, where appropriate.	Partially. It is clear that improved governance over departmental projects is necessary and the centralisation of funds for investment is appropriate; however, broader governance reforms are required to address corporate governance issues beyond those just relating to individual projects.	Partially. Although no specific Queensland Government commitment exists, improved governance and centrally managed investment processes for the Department would allow for better use of resources.
6	<b>Consolidate divisional funding (Funding Pools):</b> All discretionary health service funding to reside with Commissioning. Commissioning would then purchase the required outcomes from HHSs.	Partially. Simplification of the commissioning process by consolidation of funding pools would improve efficiency. Clear operational protocols within the Department would need to be established to ensure commissioning activities were aligned to the requirements of operational areas within the Department.	Partially.
7	<b>Collaborative HHS Readiness Assessments:</b> That Renewal assist the HHSs to undertake a capability / readiness assessment program.	No. There appears no justification for additional Hospital and Health Service readiness assessments to be conducted.	No. The Queensland Government has made no commitment to additional Hospital and Health Service readiness assessments, nor are they being sought by Hospital and Health Services.

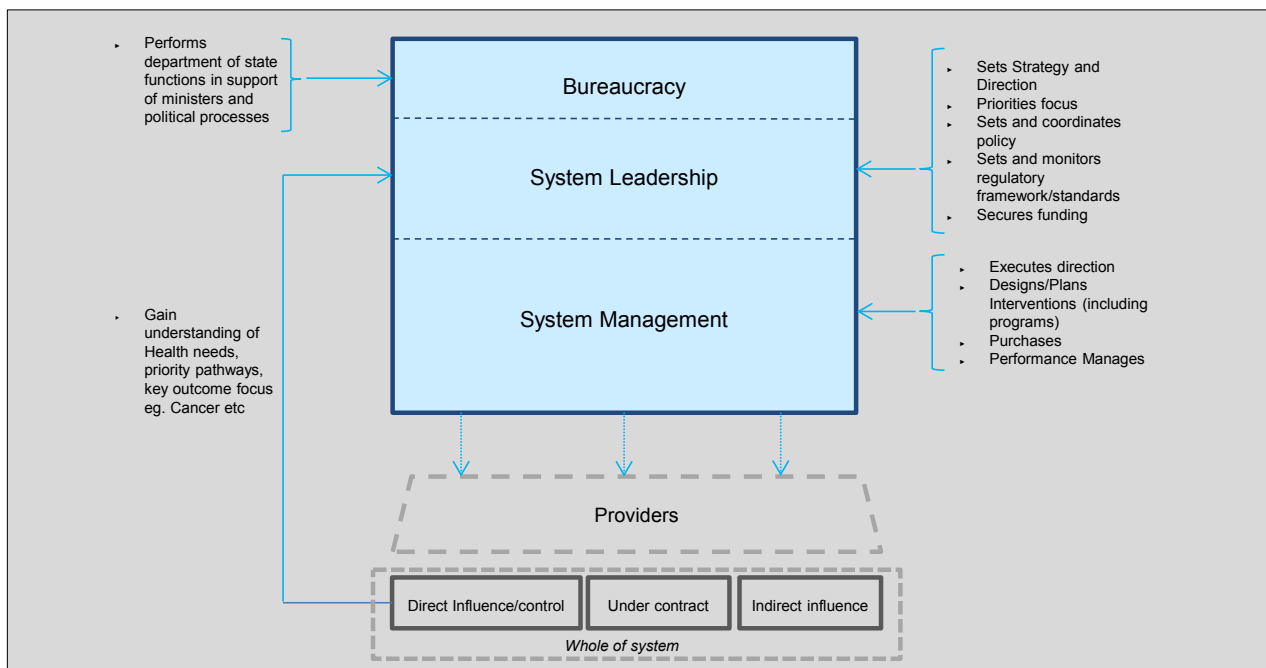
#	FSA Project recommendation	If implemented, would it align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services? (Yes, Partially, No)	If implemented, would it deliver on government priorities? (Yes, Partially, No).
8	<b>Re-position Queensland Ambulance Service:</b> QAS to be established as an independent service provider, with the Department extending its role as System Manager to the QAS.	Beyond scope of FSA Project. It is unclear why this recommendation has been made when the Draft FSA Project report explicitly indicates the Queensland Ambulance Service is beyond the scope of its activities.	Beyond scope of FSA Project.
9	<b>Clinical redesign and process improvement:</b> Support for a HHS-led clinical redesign and process improvement model. Funding to be provided for a transitional period to the HHSs from the Health Innovation Fund to enable the proposed structure to be effective within 6 months. Work with the HHSs to develop a HHS led system-wide Clinical Innovation Model.	No. Clinical redesign and process improvement activities should form the basis of continuous improvement initiatives. The Department's specific support for such activities should be maintained, without the expenditure of significant additional resources to achieve what should be business as usual.	No. Expenditure of additional funds in relation to clinical redesign and process improvement activities in the manner proposed in the Draft FSA Project report does not achieve government priorities, and may in fact be contrary to the benefits already being achieved through existing mechanisms.
10	<b>Develop a clear and shared vision and strategy for the Queensland health system:</b> The Queensland health system is currently undergoing a period of reform and transformation. Whilst significant gains have been made, key stakeholders have commented on the need for a clear, coherent and shared vision and strategy.	Yes. A clear, shared vision and strategy for the health system is required. It would have been of benefit for this recommendation to have been the first priority of the FSA Project.	Yes. The development of a clear, shared vision and strategy for the health system could provide a frame to articulate Queensland Government priorities.

# Recommendation 1 – The operating model for the Department of Health

## The FSA position

The Draft FSA Project report recommended endorsement of a new operating model for the Department of Health so that implementation planning could be undertaken and implementation (of a new organisational structure, to achieve the proposed operating model, as referenced in recommendation 2) could occur.

The proposed operating model is set out in the diagram below.<sup>5</sup>



The Draft FSA Project report sets out the view that (sic):<sup>6</sup>

*“The administration of a public health system tends to imply a range of different kinds of functions, covering:*

- *Bureaucracy: Fulfilling politico-bureaucratic functions supporting political system (Department of state functions)*
- *System leadership: Setting system direction and strategy including evaluating and quantifying health needs, industry/provider intelligence, securing and prioritising funding and interventions, defining policy, setting standards and the regulatory environment, and system planning*
- *System management: Execution of system leadership direction, design of provider interventions and broader relationship management of providers (including planning, purchasing, and performance management) to meet system direction.*
- *Providers: the provision of front line health care services in line with system manager direction and purchasing.*

*To increase system performance the trend internationally among Governments, funders and health system administrators has been to impose greater and greater degrees of separation between these functions, as illustrated in the diagram (above).*

*As in Queensland, the trend towards devolution of managerial responsibility from central bureaucratic agencies to more ‘local’ organisations is one common to leading health systems around the world. International experience suggests that strict organisational separation and isolation of these function is not necessarily required in all cases – these three key component functions do not uniformly require separate execution bodies. Rather, the lesson here is that differences of function need to be carefully considered when designing organisational and functional aspects of a performing body.”*

<sup>5</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 15

<sup>6</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 14

## Findings of this review

In testing the FSA proposed operating model with staff and stakeholders throughout the consultation process, extensive feedback was received about the need to more fully represent the scope of functions of the Department. Stakeholder feedback strongly reflected that the business model did not sufficiently identify the roles, functions, responsibilities and accountabilities of the Department, nor could it easily translate into an organisational structure. The concept that functions could be split into 'System Leadership' or 'System Management' silos was challenged, and similarly the concept of an independent set of functions to service the 'bureaucracy' (versus the system) was not supported. The activities identified previously in this report (the non-legislative functions of the Department) were considered not to have been given sufficient priority, and the demands of those activities on the resources of the Department were not explicitly recognised in the FSA Project.

Similarly, the proposed operating model does not appear to align with the specific legislative requirements of the Chief Executive (the Director-General) of the Department as set out in the *Hospital and Health Boards Act 2011*, and more broadly in conducting the business of a Queensland Government department. As one example, the operating model has made no reference to the capital planning activities of the Department of Health, which are specifically required as a legislated function of the Department.

Although not specifically indicated in the Draft FSA Project report, an organisational structure derived from the proposed operating model is likely to lead to a substantial reduction in the resources and capability of the Department, impacting its ability to deliver on government priorities and, in some circumstances (such as the devolution of Hospital Infrastructure Branch activities) compromise the ability of the Department to meet its legislative obligations.

## Assessment of recommendation contained in the Draft FSA Project report

Based on the various inputs, the review does not believe that, if implemented, this recommendation would align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services. The operating model as proposed in the Draft FSA Review report does not sufficiently contemplate the broader statutory, strategic and administrative functions of the Department. Similarly, the review does not believe the proposed operating model would best facilitate the delivery of government priorities.

# Recommendation 2 – Development of a proposed organisational structure

## The FSA position

The Draft FSA Project report recommended the commencement of consultation within the Department to enable the development of a proposed organisational structure based on the roles defined within the suggested operating model. The recommendation noted the organisational design and implementation should take into consideration the priority areas of population-based funding, and Investment Management, Performance Management and Service Planning Frameworks. The recommendation also suggested the need to: strengthen the corporate governance function within the Department; move the audit function so that it became a direct report to the Director-General; create a data analytics function to provide a single source of truth for information; clearly establish and strengthen the role of the Clinical Senate and Clinical Networks as a function of Hospital and Health Service leadership; and re-align the Mental Health Tribunal to the Department of Justice and Attorney-General. Feedback indicates that the latter reference is incorrect, and instead should refer to the Mental Health Court Registry, which is anomalously housed in the Department.

Although the Draft FSA Project report does not include a proposed organisational structure, a range of options (developed following the process and not included in the Draft FSA Project report) were made available to the review team.

## Corporate Governance

The Draft FSA Project report contains (at Appendix F, pages 75 to 78) a number of early stage, overarching governance models for 'Queensland Health', the Department of Health, a 'Whole-of-System Governance Framework' and a model for Hospital and Health Service governance.

Within the Draft FSA Project report, there is minimal reference to overall corporate governance, and certainly no reference to governance of the broader health system. There is specific reference to development of a governance process which relates to departmental programmes (refer recommendation 5) which could potentially have been extrapolated to include improvements to corporate governance for the Department more broadly. Further, there is acknowledgement of a range of issues relating to corporate governance contained in the section of the Draft FSA Project report that relates specifically to the Department's Legal and Governance Branch. The Draft FSA Project report sets out the view that (sic):<sup>7</sup>

*"There is a lack of focus on corporate services within the Department and in particular a very limited focus on corporate governance. This is demonstrated by the recent need to overhaul delegations, review operational policies, reduce committees etc.*

*Strong corporate governance is essential. Examples of activities traditionally undertaken in Corporate Governance to ensure a well functioning Department include: strategic planning, operational planning, risk management, committee governance, oversight of operational policies, disaster recovery planning and business continuity planning."*

The Draft FSA Project report also indicates that (sic):<sup>8</sup>

*"HHSs have embraced autonomy and are accountable for the implementation of their own governance processes and frameworks. The Department has not kept up with the pace of change needed to provide the level of assurance required within a devolved operating model.*

*There appears to be an inherent lack of understanding or coordination for the full governance process across the Department and as a result the integration between planning, funding, performance management and risk mitigation processes are not clear. There are excessive policies, procedures and red tape, along with an array of committees that inhibit the Departments ability to respond and maintain oversight of risk or other potential issues for Health System. Currently all Divisions input into Governance processes. For example: Finance, The Office of the Director-General, Health Service Clinical Innovation (HSCI) and Health Commissioning Queensland (HCQ) all provide varying degrees of advice in relation to key processes such as the Service Delivery Statements, budget and funding cycle, annual reporting, operational planning, the preparation of the Health Blue-Print, continuity and disaster planning, risk assurance and audit processes.... A new delegations framework has been implemented, a whole of Department policy rationalisation process has commenced and a reduction in the number of committees that are not well governed and/or necessarily aligned to the strategic direction of the Department is progressing."*

## Movement of the audit function

The Draft FSA Project report proposes the re-alignment of the audit function, with a 'recommendation' (not contained within the overall recommendations presented in the report) on page 39 that the, "...audit function will report directly to the Director-General and the Audit and Risk Committee to enable greater accountability and independence" and a further observation that, "The Audit branch will provide a direct report to the Director-General and Audit and Risk Committee. This realignment from previously being located within the Legal and Governance branch will reduce potential conflicts of interest from within the Department."

Reference is again made to the audit function being re-aligned (but, in this instance, without reference to the Audit and Risk Committee) in the Draft FSA Project report on page 30, wherein it is indicated that, "Ideally the internal audit function would be realigned as close as is practicable to a direct report to the Director-General as it is integral to promoting accountability and independence within the Departmental governance framework."

## Data analytics and a single source of truth

The Draft FSA Project report identifies that (sic):<sup>9</sup>

*"Stakeholders from within the Department commented on the general lack of confidence in the quality and robustness of the data used in planning, Commissioning and performance management. Data sources often conflict. Departmental staff reported duplication of effort across Divisions and the lack of data governance. Stakeholders reported a fragmented approach to data management and limited accountability for system data quality with data management roles and responsibilities not well defined or understood."*

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<sup>7</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 30

<sup>8</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 31

<sup>9</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 20

Furthermore, in section 4.4 of the Draft FSA Project report, entitled ‘*Overview of the proposed operating model*’, the document sets out a number of conflicting views in relation to the location of data integrity responsibilities.

In that section, the document suggests the ‘Office of Data Integrity and Patient Safety’ should be established under the ‘System Leader’ part of the model, with the purpose of:<sup>10</sup>

*“Providing assurance of data integrity, quality and consistency at a system-wide level for Queensland Health. Responsible for developing a data framework on how Queensland Health reports and represents health service data and trends. Managing the Data Integrity role will need to involve executive-level clinical and strategic input on issues associated with data at a system-wide level. This will enable the data framework to be aligned with the accountabilities of HHSs in a devolved health system. Patient Safety - Providing assurance that the patient safety framework within the Department and system is capable of supporting the delivery of safe health care services. Providing support to the identification of deficiencies within the framework and the subsequent management to immediately improve the integrity of the services that are delivered. Nursing & Midwifery – Responsible for informing health strategy, system planning, system priorities and projects for nursing and midwifery across the system.”*

Subsequently, immediately following this commentary in the same section of the report, the document sets out that a ‘Data and Analytics’ function or branch (not specifically indicated) should be included in the ‘System Manager’ part of the model, with the purpose of:<sup>11</sup>

*“Integrating key data management functions to drive an improvement in data stewardship, data ownership, data quality and discipline.”*

Finally, a ‘Functional connections’ diagram relating to ‘Data Management’ is included in the Draft FSA Project report on page 48. Little clarity about the purpose of this diagram (or others, relating to other ‘Functional connections’) is provided.

### **The Clinical Senate and Clinical Networks**

The Draft FSA Project report establishes the position that:<sup>12</sup>

*“HHSs were in agreement that the current purpose of the networks is largely unclear and the ability of the networks to effectively connect with both the Department and the HHSs was inconsistent and currently ineffective. There is disappointment with the current variability of outputs and influence of the networks on performance, policy, and quality and safety. Furthermore, there was broad agreement among providers and the Department that there needs to be a significant overhaul and improvement in the efficacy of the networks if they are to play a significant role in a devolved Departmental structure. This includes a review of the purpose, governance, membership and terms of reference for all the networks. The review would need to extend to the role and appropriate influence of the clinical senate.”*

A ‘Functional connections’ diagram relating to ‘Clinical Networks’ is included in the Draft FSA Project report on page 47. Little clarity about the purpose of this diagram (or others, relating to other ‘Functional connections’) is included.

There is no specific commentary regarding the Clinical Senate identified in the body of the report. However, suggestions (which also extend to Clinical Networks) have been included in an attachment to the report entitled, *Clinical & Process Improvement – Final proposal*, prepared jointly by two Health Service Chief Executives and dated (erroneously) ‘December 2015’. It is unclear whether the material contained in this attachment has informed the report, as information contained in the Draft FSA Project report’s recommendations draw on this material but, also, contradict some of the proposal’s recommendations.

### **Movement of the Mental Health Tribunal to the Department of Justice and Attorney-General**

The Draft FSA Project report indicates that:<sup>13</sup>

*“The Mental Health Review Tribunal (MHRT) also reports through Legal and Governance. There are significant resources committed to this tribunal and the primary function is to support mental health proceedings conducted in the local court system. There is no real connection between the activities performed by the MHRT and other activities performed by either the Department or Legal and Governance. It would be appropriate to consider re-aligning the MHRT to the Department of Justice and Attorney General.”*

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<sup>10</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 40

<sup>11</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 42

<sup>12</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 20

<sup>13</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 30

There is no evidence of discussions between the Department of Health and the Department of Justice and Attorney-General in relation to this finding, nor to whether the report is actually referring to the Mental Health Court Registry (as opposed to the Tribunal).

## **Findings of this review**

It is clear that a new business operating model and organisational structure is required.

Most changes proposed in the Draft FSA Project report are those where new organisational arrangements should be considered. However, the business model does not easily lend itself to a structure. More broadly, it would seem that in some areas the logic applied in the Draft FSA Project report does not provide a strong rationale for the recommendations. There are sections of the report that are contradictory and sections of this recommendation which make little mention or have little supporting evidence or rationale.

In relation to governance, the review team is in agreement with the Draft FSA Project report that a renewed emphasis on corporate governance is required. However, this should be achieved through a new corporate governance model that supports a system leadership function.

In relation to the audit function, the review team is in agreement that it would be better aligned to the Office of the Director-General. Despite the lack of rationale in the Draft FSA Project report, contemporary best practice would suggest that the independence of the Department's audit function would be improved by its re-alignment within a new organisational structure. The review team were advised by the FSA Project team that this advice had been provided on a number of occasions to the former Director-General.

In relation to the creation of a data analytics function, the review team is in agreement that such a function should be established to provide a means to assure a 'single source of truth'. However, the Draft FSA Project report does not provide sufficient clarity as to where such a function would be located in the organisational structure. In fact, it notes two specific areas: one within the proposed 'System Leader' area and one within the 'System Manager' area. The proposal to combine patient safety and data integrity within the Office of Patient Safety and Data Integrity (which has subsequently occurred) lacks a compelling rationale.

It is patently clear from the almost unanimous feedback received that issues of data integrity and the accuracy of, and access to, information need to be addressed. However, significant issues were raised throughout the consultations about the approach of combining data integrity and patient safety functions in a single unit. It is also unclear as to the distinction between the Office of Data Integrity and Patient Safety and the 'Data and Analytics' elements suggested in the Draft FSA Project report. Further, the inclusion of a priority focus on nursing functions within the Office of Data Integrity and Patient Safety appears contrary to the overall approach of the FSA Project which was to seek to clarify lines of responsibility and accountability rather than create matrix management structures that have potential to create confusion.

In relation to the Clinical Senate and Clinical Networks, the views expressed in the Draft FSA Project report appear to be contrary to the advice provided to this review. The Draft FSA Project report indicates that Hospital and Health Services were in agreement that the purpose of Networks is largely unclear. This view was not supported by the broader consultation process undertaken by this review.

The review team does agree that the role, functions and terms of reference for the Clinical Networks should be clarified, but this should occur with consultation and in a manner that recognises the importance of independent clinical input into the core and strategic leadership activities of the Department. However, in the same way that this applies to Hospital and Health Services more broadly, it will be important to recognise a process that distinguishes engagement and feedback from direct decision-making authority.

It is noted there is minimal discussion of the role of the Senate in the Draft FSA Project report. As part of the stakeholder engagement process, there was extensive support for the activities of the Senate, including it having a more direct link and influence with regard to the Department's overall health strategy and strategic policy development activities.

## **Assessment of recommendation contained in the Draft FSA Project report**

Based on the various inputs, the review does not believe that, if implemented, this recommendation would deliver an organisational structure which would best facilitate a high performing health system focused on Hospital and Health Service operational accountability and the delivery of government priorities. A new organisational structure is required, based on a broader business model, which takes into consideration the full range of departmental functions. The new structure needs to better facilitate the delivery of government priorities. Section 8 of this report sets out design principles and a proposed organisational structure to facilitate improved outcomes for both the Department of Health and the broader Queensland health system.



# Recommendation 3 – Consideration of a new funding model

## The FSA position

The Draft FSA Project report recommends consideration of a detailed implementation planning exercise for a new population-based funding model, which it suggests will replace the existing activity based funding model and be in place from June 2015.

The Draft FSA Project report recommendation further supports the development, by June 2015, of critical enablers to a population-based funding model; being Performance Management, Investment Management and Service Planning frameworks.

Appropriately, the recommendation provides that any proposed implementation needs to take into account these inter-dependencies/enablers to ensure change is appropriately managed to support these priorities, including consideration of reforms underway within Health Support Queensland and the Health Services Information Agency.

The Draft FSA Project report notes that (sic):<sup>14</sup>

*“As an outcome of the engagement with Chairs and CEs the Department has committed to implementing Population Based Funding from 1st July 2015. An analysis of the current Departmental functions identifies that in order to deliver Population Based Funding there are certain components of the system that need to be reviewed and strengthened.”*

## Findings of this review

Given the significance of the potential impact on the Queensland health system of a fundamentally new funding model, the lack of detail in the Draft FSA Project report about the potential impacts of population-based funding is perplexing. The review team notes that the recommendation calls for consideration to be given to detailed implementation planning, but then suggests that a population-based funding model replace existing funding arrangements by June 2015. This would appear to be a high risk strategy.

It is similarly difficult to evaluate the merits of this recommendation given its incongruence. The recommendation (and information within the body of the Draft FSA Project report) establishes that the new funding model *will be* implemented from 1 July 2015 and that detailed planning should be *considered* (thus implying that a decision had not been made).

At the outset of this project, the review team was advised by the Department that consideration of the implementation of a population-based funding model was not yet endorsed by the new Queensland Government and that it remained subject to further advice and consideration.

As part of the consultation process, the review team noted that support for implementation of a population-based funding model was highly variable amongst different stakeholder groups. The observation contained in the Draft FSA Project report, that engagement between Hospital and Health Board Chairs, Health Service Chief Executives and the Department had resulted in a decision to implement a population-based funding model from 1 July 2015, was also questioned by a number of stakeholders. The risk identified by many was that without significant analytical modelling and adjustments to the current Activity Based Funding model, the population-based funding model would lead to ‘winners and losers’ with potential for variable health service outcomes for some communities.

## Assessment of recommendation contained in the Draft FSA Project report

Based on the various inputs, the review does not believe that, if implemented, this recommendation would align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services. Similarly, the review does not believe the adoption of a population-based funding model within the proposed timeframe would best facilitate the delivery of government priorities. Further consideration of the implications of a population-based funding model is dependent on government consideration based on the impacts of such a model informed by analysis, modelling, planning and risk assessment.

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<sup>14</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 4



# Recommendation 4 – Workforce strategy and governance development

## The FSA position

The Draft FSA Project report recommends the creation of a new Health Workforce Governance Group, which is to include representatives of Hospital and Health Services, the Department and external representation such as private sector experts and universities.

In section 4.4 of the Draft FSA Project report, entitled ‘*Overview of the proposed operating model*’, the document sets out that a ‘Workforce strategy’ function or branch (not specifically indicated) should be included in the ‘System Manager’ part of the model, with the purpose of being:<sup>15</sup>

*“Responsible for leading and developing key processes to support the sustainability and capability of the health workforce. Including providing support to developing the strategic workforce strategy, identifying and developing opportunities for clinical enhancements, extended scope capabilities, clinical education and training, through working closely with the HHSs, Chiefs, professional boards, and universities.”*

A ‘Functional connections’ diagram relating to ‘Strategic Workforce Planning’ is included in the Draft FSA Project report on page 46. Little clarity about the purpose of this diagram (or others, relating to other ‘Functional connections’) is provided.

The review team does recognise that additional work has subsequently been undertaken in relation to the approach to be adopted in relation to strategic workforce planning.

## Findings of this review

Stakeholder feedback broadly supported the development of a new approach to strategic workforce planning, but the findings proposed by FSA were not broadly socialised.

It is clear that strategic workforce planning should be a key area of emphasis for the Department of Health, with input from Hospital and Health Services and appropriately qualified external expertise (for example unions, private sector experts and/or universities).

The question of whether a specific ‘governance group’, as recommended in the Draft FSA Project report, is required, should be considered within the context of the Department’s broader corporate governance and structural reforms. It is clear that the Department needs to provide whole-of-system leadership, strategy development and strategic policy advice in relation to issues associated with workforce impacting the health system, and that Hospital and Health Services have a clear role in informing and then implementing agreed workforce policy for the State.

## Assessment of recommendation contained in the Draft FSA Project report

Based on the various inputs, the review believes this recommendation, if implemented, could partially align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services, and could partially facilitate the delivery of government priorities.

The importance of strategic workforce planning is well established as is the need for a mechanism by which input from a range of parties can be garnered. However, prior to the establishment of an appropriate governance group as recommended by the Draft FSA Project report, it would seem more appropriate to agree upon the respective responsibilities for workforce planning functions across the health system, including the functional owner of that responsibility, and then create a governance mechanism that provides appropriate oversight, rigour and involvement of parties in decisions about strategic issues impacting Queensland’s health workforce.

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<sup>15</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 40

# Recommendation 5 – Oversight of Departmental projects

## The FSA position

The Draft FSA Project report recommends the development of a governance process that would enable oversight of the Department's projects. As part of that process, the recommendation further suggests that consideration should be given to the identification of funding for business-as-usual and one-off projects which would be held centrally, if appropriate.

The Draft FSA Project report notes that (sic):<sup>16</sup>

*"The Future State Alignment project has identified an ongoing need for continuous improvement of the Department's governance processes.*

*This is further demonstrated by the Future State Alignment Project identifying 200 projects funded by divisions. This is in addition to approximately 400 previously identified by the Health Renewal Portfolio Office (HRPO). Most projects have been identified by branches as business as usual "BAU". This suggests that branches are holding significant and likely excess funds for investment in operational improvement activities. Whilst encouraged, there needs to be an effective governance process in place to ensure that appropriate investments are made, that implementation is monitored and benefits identified and realised."*

In Appendix E on page 73 of the Draft FSA Project report, entitled 'Investment Management Framework', the document sets out the case for an Investment Management Framework (rather than a specific governance process) for funding of projects, noting: (sic):<sup>17</sup>

*"A governance process needs to be established for internal DoH projects that aligns with the Investment Management Framework (IMF). Consideration be given for all current funding for Business As Usual projects and one-off projects to be identified and held centrally where applicable for investment.*

*Queensland Health is undergoing a process of renewal and transformation to improve patient outcomes, the quality of health services and improve healthcare efficiencies... Queensland Health also needs to re-examine the way in which initiatives are governed, funding is allocated and performance and benefits are tracked. Traditionally investments in Queensland Health have been assessed in siloes with the full funding allocated at the concept stage (when estimates of value, benefits, risk and cost are not well evidenced) and a lack of clear streamlined governance accountability (without any collective view of what is being invested in, by whom or at what level). This has resulted in a failure of investments to deliver the expected benefits, within allocated budgets and timeframes."*

## The findings of this review

The review team strongly agrees that an improved governance process is required to provide visibility, oversight and rigour to the Department's project management process. However, such an approach to projects alone is insufficient to address the overall organisational governance deficiencies that have been identified as part of this review process. It is difficult to understand the Draft FSA Project report's reasoning for a specific recommendation relating to project governance when deficiencies relating to the broader governance of the Department were acknowledged by significant numbers of stakeholders.

Stakeholders also acknowledged the value of the Investment Management Framework developed and implemented by the FSA Project team. This work is to be commended for the contribution it has made to improved funding decisions. The Draft FSA Project report highlighted the importance of a systems approach to investment decisions, confirming:<sup>18</sup>

*"Although now operating in a federated environment, there is still the need to behave as a cohesive health system, together examining and determining the investment needs and priorities which will deliver the greatest value and maximise return on investment."*

The delivery platform for the provision of health services in Queensland is supported by a number of enablers, most clearly the Health Support Information Agency (HSIA) which provides information technology services and Health Support Queensland (HSQ) which provides a range of whole-of-system forensic, scientific, pathology, diagnostic and clinical support services across the health system.

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<sup>16</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 31

<sup>17</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 73

<sup>18</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 73

While these two entities are beyond the scope of the review, and therefore detailed analysis of their operating arrangements has not been undertaken, it is clear that there has been an under-investment in systems essential to their capability to deliver services. The Investment Management Framework provides a means to consider and prioritise investment in these systems.

Accordingly, it is clear that the suggestion to develop a governance process that enables oversight of the Department's projects is only one element of the overall governance reforms that are required, and broader reform of governance structures needs to be undertaken.

### **System leadership**

The terms of reference and membership of the current System Management Team (SMT) are not fit-for-purpose. The *Hospital and Health Boards Act 2011* specifically establishes that, "*The overall management of the public sector health system is the responsibility of the department, through the chief executive*",<sup>19</sup> while specifying that a Hospital and Health Service's main function is, "*To deliver the hospital services, other health services, teaching, research and other services stated in the service agreement for the Service.*"<sup>20</sup>

It is clear a system-wide governance structure with responsibility for strategic decision-making, system leadership, system-wide risk management and overall system performance is required. A system-focused governance body as proposed further in this report is necessary. The current arrangements are conflicted and a source of confusion about how decisions are made by the Department.

It is also clear the current SMT has influence over decisions that have implications for all parts of the Queensland health system. Accordingly, the inclusion of independent service provider (Hospital and Health Service) representatives presents a clear conflict of interest. While both perceived and real conflicts of interest are common and are handled as part of standard business processes, the constituency of the SMT appears to create potential for conflict of interest or duty in effectively all its deliberations. Similarly, and probably even more importantly, by including service providers as part of a governance structure that is intended to provide system-wide decision-making, the core leadership function of the Department – as outlined in the *Hospital and Health Boards Act 2011* – is confounded.

Undoubtedly there is a role for Hospital and Health Services to be consulted, to provide input, to test and ultimately to contribute activity towards the Department's overall strategic direction and leadership of the State's health system. This process may be facilitated in a range of ways. There was majority agreement throughout the consultation period that the SMT had struggled to fulfil its functions and establish its authority. This in turn led to confused accountability and situations where decision-making processes had disempowered executives in the Department. Conversely, in some cases, there were situations where Department decision-making, informed through the SMT's deliberations, had extended into areas which were the domain of Hospital and Health Services.

### **Departmental leadership**

Similarly, the terms of reference for the current Department Management Team (DMT) are not fit-for-purpose. Feedback received as part of the consultation activities identified the confusion that exists within and about DMT regarding its purported role to focus on the capability of the Department internally, as well as its responsibilities to address strategy and address risks across the health system.

The current membership of DMT is considered too large and its remit is unclear and ill-focused. The agenda reflects individual interests rather than collective governance. A smaller and more strategically focussed DMT should be established, as a sub-committee of the new SMT, to focus on departmental governance and system-wide capability issues for which the Department is responsible.

## **Assessment of recommendation contained in the Draft FSA Project report**

Based on the various inputs, the review believes this recommendation, if implemented, could partially align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services, and could partially facilitate the delivery of government priorities. It is clear that improved governance mechanisms with enhanced oversight of the Department's projects are necessary. Similarly, the approach to centralise project funds for prioritised investment is supported. However, broader reforms should be the priority focus to ensure good governance at system-wide and departmental levels. This in turn would lead to improvements in project oversight and investment decisions. Section 8 of this report sets out a proposed governance model to facilitate improved outcomes for both the Department of Health and the broader Queensland health system.

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<sup>19</sup> *Hospital and Health Boards Act 2011*, Part 1, Division 3, s8(2)

<sup>20</sup> *Hospital and Health Boards Act 2011*, Part 2, Division 1, s19(1)

# Recommendation 6 – Consolidation of Departmental funding pools

## The FSA position

The Draft FSA Project report recommends the consolidation of funding pools from across the Department's divisions within the agency's commissioning function. As part of this process, it suggests that all discretionary health service funding should be used to purchase required outcomes from Hospital and Health Services through a single commissioning process.

Little rationale is provided in the Draft FSA Project report for the recommendation, but the review team notes it is a logical flow-on from the previous recommendation (recommendation 5) relating to central management of project funding.

More broadly, the Draft FSA Project report provides commentary on commissioning, noting that (sic):<sup>21</sup>

*"There remains significant variability in interpretation, understanding and genuine experience of health Commissioning - across the Department and amongst the HHS Chief Executives and Chairs - ranging from current purchasing and service level agreement negotiations to highly sophisticated market stimulating functions.*

*This review process has suggested limited support from the HHSs for the significant growth of a central Commissioning function. However a promulgation of Commissioning capacity and sophistication across the system was well supported. It was envisaged that a realignment of existing roles and functions from within the Department and increased access to experienced health service Commissioning, analytical and actuarial skillsets externally would support greater sophistication of the Commissioning framework.*

*Larger HHSs indicated a willingness to adopt a lead role as soon as practicable for a local Commissioning function under a Population Based Funding model. Also, HHSs suggested that the timeframes to achieve the required capability to become secondary commissioners varies from 6 months to 3 years."*

Finally, a 'Functional connections' diagram relating to 'Commissioning' is included in the Draft FSA Project report on page 45. Little clarity about the purpose of this diagram (or others, relating to other 'Functional connections') is provided.

## The findings of this review

The review team recognises the benefits of consolidating funding pools across the Department to provide a more consistent funding interface between the purchasing and performance management functions and Hospital and Health Services.

At the highest level, simplification of this process would improve efficiency and create more streamlined performance reporting and oversight of the Department and Hospital and Health Services' performance. However, in order to implement such an approach, clear operating protocols will need to be established within the Department to ensure that the relevant areas of the agency, with the requisite skills and expertise to inform purchasing decisions, have sufficient input into the process.

The review team does not support (and explicitly notes that the Draft FSA Project report is silent on this issue) the concept of aligning all areas of the Department with funding responsibilities within a single 'Commissioning Division'. Rather, the review team recommends a more robust internal governance process to determine purchasing priorities, with input from a range of relevant stakeholders.

## Assessment of recommendation contained in the Draft FSA Project report

Based on the various inputs, the review believes this recommendation, if implemented, could partially align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services, and could partially facilitate the delivery of government priorities. The consolidation of funding pools to provide a 'single point of purchasing' from all departmental areas makes sense. In order to achieve that goal, input from the relevant areas of expertise will be required during the pre-commissioning process.

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<sup>21</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 20

# Recommendation 7 – Further Hospital and Health Service Readiness Assessments

## The FSA position

The Draft FSA Project report recommends that ‘Renewal’ (assumed to be the Business Process Improvement Office) assist Hospital and Health Services to undertake capability and readiness assessments through a standing program.

The Draft FSA Project report confirms that (sic):<sup>22</sup>

*“HHSs expressed that there is a need to be pragmatic about making changes to the alignment of existing Departmental roles and functions. This includes establishing a clear understanding of the transition process, framework and expected outcomes. All key stakeholders reinforced the need for the identification and management of all risks associated with the realignment of roles and functions for both the Department and the HHSs.*

*The Director-General has reinforced that a readiness assessment (refer to section 5.4) \*note, this should refer to section 5.3\* is resourced for the devolution of each identified function to provide assurance that capability and capacity are satisfactory. HHSs were in agreement with this process and suggested that judgements needed to be made to provide assurance for the devolution that considered the Systems risk appetite.”*

Furthermore, in section 5.3 of the Draft FSA Project report, entitled ‘Readiness Assessments’, the document provides additional information in relation to the recommendation, noting (sic):<sup>23</sup>

*“One of the biggest risks of implementing Population Based Funding is the HHSs capability to operate as integrated health services and be responsible for managing the health needs of their population. Also, some HHSs have already indicated concern about their capacity and capability to undertake any additional functions devolved from the department.*

*Some HHSs have expressed concern regarding the Department leading a readiness assessment similar to that undertaken in 2012.*

*It is recommended that Renewal partner with the HHSs to undertake a capability assessment using a process similar to the model below, though enhanced. This will enable both the system leader and the HHSs to agree on the HHS’s level of readiness.”*

## The findings of this review

There appears no specific justification for additional readiness assessments to be undertaken. Although there would appear to be clear intention to devolve additional activities to Hospital and Health Services as part of the FSA implementation process, the Draft FSA Project report does not nominate specific functions for devolution. The review team agrees that Hospital and Health Services should be assessed as ready to undertake additional responsibilities before they are devolved. This assessment could take many forms, including self-assessment, depending on the nature of the devolution. It is worth noting the previous round of readiness assessments cost the Department in excess of \$1M in consultancy fees.

Additionally, the concept that ‘Renewal’ (or the Business Process Improvement Office) should lead this activity is not justified. From the period of the Health Renewal Team’s commencement in the 2012-13 financial year, based on actual expenditure to April 2015 and projected full-year expenditure for all of the 2014-15 financial year, the cost of the Health Renewal Team/Business Process Improvement Office’s activities is expected to be in excess of \$14.2M.

## Assessment of recommendation contained in the Draft FSA Project report

Based on the various inputs, the review does not believe that, if implemented, this recommendation would align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services, as there appears no reason at this time for additional readiness assessments of Hospital and Health Services to be conducted. Similarly, the review does not believe that undertaking readiness assessments (unless for a specific purpose) would best facilitate delivery of government priorities.

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<sup>22</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 19

<sup>23</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 53



# Recommendation 8 – Alignment of the Queensland Ambulance Service

## The FSA position

The Draft FSA Project report recommends re-positioning the Queensland Ambulance Service (QAS) as an independent service provider, in the same manner that Hospital and Health Services are service providers, and the subsequent extension of the Department's role as System Manager to the activities of the QAS.

The Draft FSA Project report confirms that (sic):<sup>24</sup>

*"The Queensland Ambulance Service (QAS) provides timely and quality ambulance services which meet the needs of the Queensland community. QAS is an integral part of the primary health care sector in Queensland, providing patient transport services and emergency pre-hospital care to the Queensland community. In October 2013, QAS transitioned to become a division of the Department, with a view to consider a future transition to separate statutory authority.*

*There are significant gains to be made by establishing the QAS as a 'devolved' service provider, with the Department extending its role as "system manager" to the QAS. This would be more consistent with the intentions of Police and Community Safety Review (PACSR) as well as the operating model of the broader health system. QAS under this arrangement would operate similar to a HHS – a health service provider operating outside a departmental structure, with its own 'service specific' governance arrangements and business systems, a direct line of accountability to the Minister for Health, and direction from the Department as "system manager".*

*Should a devolved model not be pursued, governance, operational and business risks would likely manifest and a degradation of existing QAS business systems, processes and potentially distract the focus on front-line service performance."*

## The findings of this review

The review team notes that, on page 2 of the Draft FSA Project report, it is indicated that, "Areas outside the scope for the purpose of this project are: Queensland Ambulance Service...". Although the report goes on to indicate, on the same page, that, "It should be noted that it was not possible to exclude these areas entirely and therefore some recommendations have been formed for these areas as a result", it remains difficult to understand how an entire organisation that was out of scope for the FSA Project has been the subject of a specific recommendation. The review team believes that the organisational arrangements for the Queensland Ambulance Service are a policy decision for government, and therefore has made no determination in relation to this particular recommendation.

## Assessment of recommendation contained in the Draft FSA Project report

As noted, given that the recommendation regarding the Queensland Ambulance Service has been made in the Draft FSA Project report despite the fact it is specifically indicated to be out of scope for that project, the review team does not believe it is appropriate to make a determination on this recommendation. The organisational arrangements for the Queensland Ambulance Service are a matter for policy consideration by the Queensland Government.

# Recommendation 9 – Clinical re-design and innovation activities

## The FSA position

The Draft FSA Project report recommends that clinical redesign and process improvement activities be supported by a Hospital and Health Service-led model. The recommendation noted that funding should be provided for a transitional period to the Hospital and Health Services from the Health Innovation Fund to enable the proposed structure (including an Academy) to be effective within six months. Further, the recommendation noted that work should occur with Hospital and Health Services to develop a Hospital and Health Service-led 'system wide' Clinical Innovation Model.

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<sup>24</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 32

The Draft FSA Project report suggests that (sic):<sup>25</sup>

*"Discussions between relevant stakeholders on performance improvement and innovation yielded sufficient but not unanimous HHS support for the establishment of a HHS sponsored process improvement and redesign academy. The Department expressed a view that a number of system wide functions and programs supporting innovation and performance improvement, should remain centrally located and aligned to the Commissioning function."*

Furthermore, Draft FSA Project report goes on to indicate that:<sup>26</sup>

*"There have been two options considered.*

*Option 1 – A Service Improvement Collaborative, jointly governed and funded that would collate, develop, manage and coordinate best practice management strategies to facilitate hospital improvements. The Collaborative would be established independent from the Department, either as an independent statutory entity or a semiautonomous organisation with a Collaborative or Cooperative type governing structure (which includes representatives from other HHSs, the Department and the community sector). The Collaborative would report to the Department but maintain a high degree of autonomy.*

*Option 2 – A HHS led Improvement model (Appendix G). The HHS CEs have agreed that they should take on the responsibility for service improvement and provide a Clinical Redesign/ Process Improvement function that is accessible for all HHS service providers and managed by one HHS but governed by a Board incorporating all HHSs."*

In that same section (the same page) of the Draft FSA Project report, it goes on to indicate, as a continuation of Option 2 referred to above:

*"Funding of \$8.25M is sought in Year 1, \$10.17M in Year 2, \$10.82M in Year 3, \$10.99M in Year 4, \$11.14M in Year 5."*

Finally, stemming from that section (but separate to the two options), the Draft FSA report observes:

*"It is recommended that funding of \$8.25M be provided for a transitional period (1 Year) to the HHSs from the Health Innovation Fund to enable the proposed structure to be effective within 6 months. Funding could then be tapered off (over a further 2 year time period) and as resources are freed up that these be released into the population health funding model to enable HHSs then to buy into the new HHS led improvement model."*

Although clearly aligned, the wording of this recommendation (and explicitly the provision of \$8.25M in funding) is inconsistent with the wording of the actual recommendation of the Draft FSA Project report.

In Appendix G to the report entitled, '*Clinical & Process Improvement – Final proposal*', prepared jointly by two Health Service Chief Executives and dated (erroneously) 'December 2015', further detail regarding the proposed option 2 is set out, indicating (various excerpts are included below):<sup>27</sup>

*"...an outline proposal was put forward with support of the HSCE Forum which made the following recommendations:*

- 1 To develop a clinical network structure and functionality that enhances and promotes improved clinical pathways. This will include the development of state service frameworks.*
- 2 The establishment of state service frameworks to be considered as a means to give clarity to clinical direction, enable priorities action of high impact changes and to formally link programmes of redesign with the commissioning framework. This would also drive clinical engagement in priority areas of development.*
- 3 A process improvement academy is established to enable methodology training to be offered for a wide range of health personnel (including clinicians). The development of capacity and capability should also be supported by meaningful academic certification.*
- 4 A process/project management system is established for all projects to record activity. This (sic) to enable aggregation of return on investment, sharing of clinical innovation and to engage and support improved clinical practice.*

*The HSCE Forum wishes to establish an improvement academy which both delivers a substantial increase in capacity and capability within the HHS environment.... The establishment of a comprehensive academic and practical process improvement academy has been discussed at length with representatives of the (name redacted) (tertiary institution).*

*The academic costs over the three years will be year 1 - \$2m, year 2 - \$4m, year 3 - \$4.5m. The costs associated with a staffing support team will be in the region of \$3m per annum. The running costs which would include the employment of a small but experienced team would be structured.... (with 13 full-time equivalent staff)."*

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<sup>25</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 20

<sup>26</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 49

<sup>27</sup> Draft Future State Alignment Report, Queensland Department of Health, pp unnumbered, Appendix G

## The findings of this review

The review team does not support this recommendation. There appears to be extensive potential cost associated with the approach which (at least to the extent included in the Draft FSA Project report) does not include a funding source beyond nomination of funds from the Health Innovation Fund. Feedback from a range of stakeholders suggests the proposal is subject to divergent views and levels of support.

Feedback to the review provided examples of Department and clinician-led re-design activities which had previously been undertaken and which had demonstrated considerable return on investment.

Appendix G in the Draft FSA Project report indicates, *“The establishment of a comprehensive academic and practical process improvement academy has been discussed at length with representatives of the (name redacted) (tertiary institution)”* and, *“The project management system will be web based and supported through Professor (name redacted)’s team at (name redacted) (tertiary institution).”*

The decision to progress an Academy model is one which needs further discussion and analysis. There is inadequate evidence provided by the Draft FSA Project report by way of either a business case or a systems cost-benefit analysis to progress the proposal as currently provided.

## Assessment of recommendation contained in the Draft FSA Project report

Based on the various inputs, the review does not believe that, if implemented, this recommendation would align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services, as it appears to be a significant investment with very little basis or consideration. Extensive clinical access redesign activities have occurred within Queensland’s health portfolio in the past, with major return on investment demonstrated. Clinical redesign and process improvement activities should form the basis of continuous improvement initiatives, and the Department’s system leadership role should be maintained without the expenditure of significant additional resources.

# Recommendation 10 – Establishment of a vision and strategy for the health system

## The FSA position

The Draft FSA Project report recommends the development of a clear and shared vision and strategy for the Queensland health system. Recognising the significant reform and transformation activities that are underway, and the significant gains that have been made in the health system since 2011, the recommendation calls for a clear, coherent and shared vision and strategy for the Queensland health sector, moving forward.

## The findings of this review

The review team strongly supports this recommendation, noting it should be the initial, rather than final, recommendation in the Draft FSA Project report, given it provides the strategic context for other findings.

## Assessment of recommendation contained in the Draft FSA Project report

Based on the various inputs, the review does believe that, if implemented, this recommendation would align the activities of the Department to an operating system where Hospital and Health Services have been transferred accountability for the delivery of public sector health services. Similarly, the review believes preparing a clear, coherent and shared vision and strategy for the system as a whole would facilitate delivery of government priorities.



# 06 Clinical quality and patient safety

## Overview

The Terms of Reference for the review require that it, *“Consider relevant Labor election commitments and make recommendations in relation to the reestablishment of the Patient Safety and Quality Improvement Service with 20 new positions and 40 positions transferred from the current Patient Safety Unit”*.

As previously indicated in this report, the Queensland Government has indicated it will, amongst a range of Election Commitments, *“Audit patient safety and quality improvement functions in our Hospital and Health Services”, “Ensure the system-wide patient safety and quality improvement functions in our hospitals and in the Department of Health are restored”, and “Re-establish the Patient Safety and Quality Improvement Service with 20 new positions and 40 positions transferred from the current Patient Safety Unit”*.

Each of those commitments has some relevance to the conduct of this review, with the latter being explicitly noted as part of the Terms of Reference.

Accordingly, in meeting the Terms of Reference, a range of discussions with stakeholders with particular perspectives on patient safety have been undertaken. These have included Health Service Chief Executives, a number of Executive Directors of Medical Services, representatives of the Clinical Senate and Clinical Networks, representatives of the Office of Data Integrity and Patient Safety, executives and staff of the Patient Safety Unit and a range of interstate experts with an understanding of patient safety systems. Additionally, information contained within the Draft FSA Project report has also been considered.

### The FSA position

The Draft FSA Project report does not contain any specific recommendations relating to patient safety and clinical quality, although various references are made throughout the document in this regard.

In describing the proposed operating model for the organisation, the Draft FSA Project report suggests that:<sup>28</sup>

*“An assessment of options against the design principles indicated a recommended operating model which incorporates structural separation of system leader, and system manager functions. The proposed operating model includes entities which enable greater assurance for patient safety across the health system...”*

In seeking to further expand on that limited reference, the Draft FSA Project report goes on to briefly indicate:<sup>29</sup>

*“The recommended operating model as well as the following key connections and enablers are essential to a well functioning system. These include....Patient Safety and Quality...”*

In the ‘*High Level Implementation Roadmap*’ contained in the Draft FSA Project report, one of the steps suggested is to:<sup>30</sup>

*“Commence realignment of data and patient safety activities to support Office of Data Integrity and Patient Safety.”*

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<sup>28</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 3

<sup>29</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 4

<sup>30</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 6

The Draft FSA Project report does recognise the need to clarify the functions of the Department in relation to patient safety, as follows:<sup>31</sup>

*“The Department recognised the value of better defining, clarifying and bolstering the current assurance function for the Department and across the system for patient safety and quality. This includes a review of the current quality and safety framework and the identification and implementation of enhanced quality and safety processes that support better health outcomes for the Queensland population.*

*The HHSs were in agreement that the Department had a responsibility for monitoring the performance of HHSs against quality and safety standards, and should retain the capability to take action when performance failed to meet the expected standards. There was agreement by HHSs and the Department that responsibility for quality and safety lies with clinicians and their HHS Board. In addition, HHSs need to be proactive in enhancing their capability and performance.”*

In the more detailed breakdown of the operating model in section 4.4 of the Draft FSA Project report, entitled ‘Overview of the proposed operating model’, a preamble is included which indicates that it is a, “...starting reference point for the development of a possible new organisation structure and works towards defining the key components of the System Leader and System Manager functions”. Interestingly, despite the fact that a specific reference to ‘Patient Safety and Quality Improvement Services’ is again made as part of the business model diagram, there is no such subsequent reference in any of the descriptions used in explaining each of the items of the business model, nor in the section that relates to patient safety and clinical quality.

There is, however, a reference to the Office of Data Integrity and Patient Safety in the proposed System Leadership part of the business model, indicating that this Office would be responsible for:<sup>32</sup>

*“Providing assurance that the patient safety framework within the Department and system is capable of supporting the delivery of safe health care services. Providing support to the identification of deficiencies within the framework and the subsequent management to immediately improve the integrity of the services that are delivered.”*

There is no explanation to support the linkage between the data integrity function and the nursing and midwifery functions (which, in fact, are not specifically referenced in the name of this particular Office but which are indicated as being part of its functions within the Draft FSA Project report). Similarly, there is also no reference to the role of the existing Patient Safety Unit (which currently exists within a separate division in the Department of Health).

Finally, a ‘Functional connections’ diagram relating to ‘Patient Safety and Quality’ is included in the Draft FSA Project report on page 44. Little clarity about the purpose of this diagram (or others, relating to other ‘Functional connections’) is provided.

## **Analysis of the FSA materials and broader consultation**

The Draft FSA Project report demonstrates a lack of focus and clarity regarding functions associated with patient safety and clinical quality. While the Draft FSA Project report includes (in part) a recommendation for a dedicated Office of Data Integrity and Patient Safety, there is effectively no explanation for the combination of these functions. Similarly, there is no mention of the existing Patient Safety Unit nor the Patient Safety Board.

It is unclear why the Draft FSA Project report does not specifically seek to address the issue of patient safety in its recommendations, given that consultations undertaken as part of this review yielded widespread commentary (and divergent views) regarding the function. Similarly, it is unclear why the business model contained within the Draft FSA Project report specifically includes a reference to ‘Patient Safety and Quality Improvement Service’, yet does not elaborate on the nature or location of the function.

Feedback on the exercise of functions associated with patient safety and quality emphasised its central importance while reflecting divergent views about its governance. Although (as noted in the Draft FSA Project report) Hospital and Health Services recognised the importance of a centralised patient safety and clinical quality function, there were strong views expressed by Hospital and Health Service stakeholders that any additional resources to undertake patient safety and quality improvement functions should be allocated directly to Hospital and Health Services. This is contrary to the Government’s election commitment, which specifically confirms the re-establishment of the Patient Safety and Quality Improvement Service in order to assure the quality of clinical outcomes in Hospital and Health Services.

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<sup>31</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 20

<sup>32</sup> Draft Future State Alignment Report, Queensland Department of Health, pp 40

To better inform thinking, the experience of other jurisdictions was benchmarked and discussed with stakeholders. There was a level of support for a model similar to that used in New South Wales – the Clinical Excellence Commission. As a result, the review team support an approach based on a model which could evolve towards an independent statutory body, combining a focus on clinical redesign and innovation and patient safety and quality.

## **The New South Wales Clinical Excellence Commission**

The Clinical Excellence Commission was established in 2004 (commencing formal operations in 2005) by the New South Wales Government to drive quality improvement and lead safety initiatives across that State's public health system. The Commission is a statutory health corporation, overseen by a Board, which is established under the *Health Services Act 1997*. It has close working relationships with the Ministry of Health, the Agency for Clinical Innovation (another Board-governed statutory authority within the health portfolio) and Local Health Districts/Speciality Health Networks.

Specifically with regard to patient safety and clinical quality, the Commission is responsible for:

- Coordinating system-wide analyses of issues through audit and review;
- Working collaboratively with clinicians, patients, managers and the community; and
- Implementing programs, projects and initiatives to address identified issues.

Under the remit of a mandatory Patient Safety and Clinical Quality Program which mandates compliance by all public sector service providers (Local Health Districts and Specialty Health Networks), the Commission seeks to improve the quality and safety of health care in NSW by identifying State-wide system gaps and informing effective State-wide strategies for system improvements to clinical care. This includes monitoring, analysis, feedback and reporting about the clinical incidents reported by clinicians and others and associated Root Cause Analysis reports.

The approach is based upon a core philosophy that openness and sharing of information about risks to patients is pivotal to improving clinical care, and that issues need to be monitored in a manner that allows analysis to occur and mitigation strategies or rectification activities to be implemented. The Commission notes that the Patient Safety and Clinical Quality Program is a key component of its commitment to improving safety and quality of clinical care across the New South Wales health system. The Program has five key components as follows:<sup>33</sup>

*“1. The systematic management of incidents and risks both locally and statewide to identify remedial action and systemic reforms*

*2. The Incident Information Management System (IIMS) to facilitate the timely notification of incidents, track the investigation and analysis of health care incidents, enable the reporting about incidents, particularly the provision of trended information by incident type, and to understand the lessons learned*

*3. The establishment of Clinical Governance Units (CGU) in each Area Health Service (AHS) to implement the NSW Patient Safety and Clinical Quality Program*

*4. The development of a Quality Systems Assessment (QSA) Program for all public health organisations undertaken by an external agency, to determine whether the above components are in place and working well. The focus of the assessments is on AHS patient safety and clinical quality systems*

*5. A Clinical Excellence Commission (CEC) to promote and support better clinical quality and to advise the Minister for Health on where systemic improvements can be made.”*

## **Re-establishment of the Patient Safety and Quality Improvement Service with 20 new positions and 40 positions transferred from the current Patient Safety Unit**

While there are a range of views about the allocation of additional patient safety and quality improvement resources as part of the Queensland Government's election commitment to improve the safety of services, the review team believes that the most appropriate approach is to maximise the value of the current resources by combining them within a single Branch in a division of the Department. The remit of the Branch needs to be re-focused on establishing system-wide clinical standards, to provide overall assurance regarding patient safety outcomes and to fulfil the Department's legislative obligations to monitor and promote improvements in the quality of health services delivered by Hospital and Health Services.

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<sup>33</sup> NSW Health, NSW Patient Safety and Clinical Quality Program, pp 2

Accordingly, the review team believes that a new Patient Safety and Quality Improvement Service should be established as a Branch within the proposed Clinical Excellence Division. The new Branch should be made up of the staff and resources of the current Patient Safety Unit, and be bolstered by the inclusion of the 20 new positions to be funded through the Queensland Government's election commitment. A number of stakeholders suggested, and the review team agrees, these additional 20 officers should have an assurance focus, working in partnership with the patient safety and quality improvement staff of Hospital and Health Services. Additionally, the patient safety resources (including staff and funding) that currently reside within the Office of Data Integrity and Patient Safety should be transferred to the new Branch. Finally, those aspects of Health Commissioning Queensland that have a dedicated patient safety focus (noting that this represents a very small resource base) should also be transferred to the new Branch.

The proposed approach of bringing each of the current disparate areas of the Department into a single, focused Branch with patient safety and service quality responsibilities is expected to improve the capacity and capability of the Branch, drive simpler internal processes for the Department, and better clarify the 'connection points' for Hospital and Health Services dealing with the Department in relation to clinical governance.

# 07 Organisational Capability Assessment

## Overview

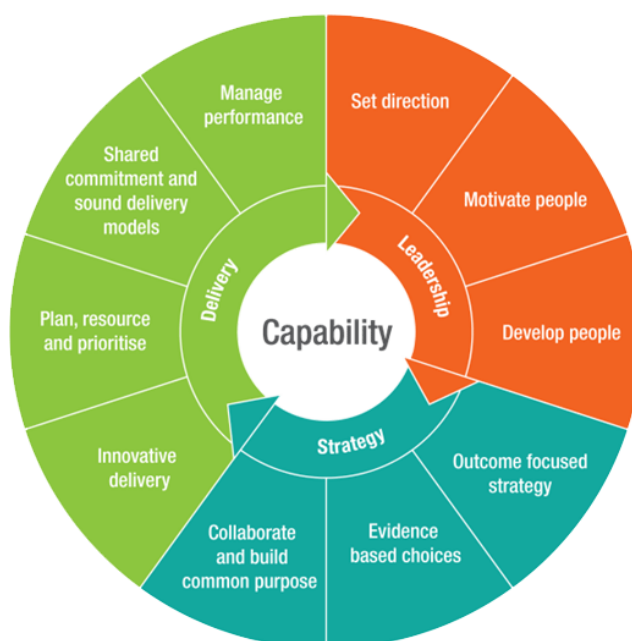
The Terms of Reference for the review require that it, “Provide advice on high level Departmental capability gaps and options for addressing”.

The conduct of an organisational capability review requires a specific methodology and process, which is focused on analysis of an entity’s ability to meet future objectives and strategic priorities.

A capability review is not a report card on the Department’s past performance, nor the Queensland health system as a whole. Rather, it is intended as a focus on organisation development activities considered necessary to meet future operating requirements and to achieve the priorities of the Government.

Review of the materials and inputs used to develop the Draft FSA Project report, combined with an analysis of the evidence presented to this review, enables high level observations about the capability of the Department of Health.

In conducting the high level capability review, reference has been made to the Australian Public Service Commission’s Capability Framework, which is diagrammatically represented below.<sup>34</sup>



<sup>34</sup> Australian Public Service Commission, Capability Framework 2015, <http://www.apsc.gov.au/projects/capability-reviews>

# Capability assessment

## The context

The Department operates in a complex public sector environment.

Between March 2012 and January 2015, 4,243 full-time equivalent permanent Queensland Health staff had their public sector positions abolished and were paid a redundancy. The Department's full-time equivalent workforce decreased by approximately one-third, with a reduction of 2,609 full-time equivalent permanent and temporary staff.<sup>35</sup> There has been no evidence of any subsequent work to map the capability gaps which arose as a consequence of this downsizing. The tight workforce controls exercised through the process of imposing a Minimum Obligatory Human Resource Indicator (MOHRI) cap reflect the fiscal constraints faced by government. This imposes a stronger emphasis on the need to build upon the capability of the existing workforce through a targeted skills development strategy based on gap analysis.

The Queensland Department of Health has a lead role in a federated health model. In that regard, there are a range of contextual challenges that the Department of Health is required to address, such as:

- the need for strong leadership of the State's health system, irrespective of a range of prevailing influences that exist;
- the rising costs associated with healthcare, continued uncertainty regarding future funding arrangements and the growing burden of chronic disease on the health system;
- often unclear boundaries (and therefore responsibilities) between the Australian and Queensland Governments;
- wide-ranging stakeholder groups with diverse and powerful interests;
- growing evidence supporting the need for more integrated healthcare, including improved systems and technologies that may well provide improved health outcomes but for which it often is difficult to demonstrate a positive return on investment;
- increasing demand for acute services that are expected to be prioritised, despite recognition that preventative health outcomes clearly provide better long-term investments;
- an environment where failure has the potential to result in catastrophic outcomes, resulting in a risk appetite that is pre-emptively skewed to being adverse; and
- continuing disparity in quality and equity of health outcomes across wide-ranging geographic distributions.

As previously noted, the Department must rely upon the network of Hospital and Health Services to achieve service delivery outcomes. While it is true that the Department has stronger authority than 'reliance' (in the form of Health Service Directors, step-in powers and other mechanisms) to achieve outcomes, the effective operation of the health system is more a product of leadership and collaborative outcomes-focused relationships and behaviours.

## Leadership capability

The Department has a clear remit to lead the State's health system. This includes establishing strategy for future direction, managing the performance of Hospital and Health Services, and creating a collaborative health services network.

### **Leadership – setting the vision and behavioural expectations**

The Department's leadership responsibilities, as established by the *Hospital and Health Boards Act 2011*, require a vision and narrative for the Queensland health system. The lack of a vision has confounded resolution of the leadership role of the Department in a devolved health system (particularly with regard to public health service delivery, but also to some extent in the private and not-for-profit sector). This in turn has given permission to leadership behaviours across both the Department and Hospital and Health Services which have been described variously as territorial and siloed.

Over the past three years the major focus of the Department and the Boards has been on establishing a functioning network of Hospital and Health Services. This work is to be commended, and is testimony to the leadership provided by Governments, the Department, Board Chairs and Health Service Chief Executives. However, attention to the evolving role of the Department as the system manager was not similarly prioritised. The definition of role and accountabilities for the Department lagged behind the establishment of the operating environment for Hospital and Health Services. Resolution of the functions

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<sup>35</sup> Information provided by the Department of Health based on Queensland Treasury redundancy payments.



and functioning of the Department was subsequently subject to further deliberation by the Health Renewal Team established in the Department of Health by the Department of the Premier and Cabinet. Subsequently known as the Business Improvement Office, the team was responsible for the Draft FSA Project report which recommended the development of a clear and shared vision and strategy for Queensland's health system. This recommendation needs to progress to provide the context in which the Department should exercise its leadership mandate.

### **Leadership – motivating and developing people**

It has been clear throughout the consultation processes that employees within the Department are intrinsically motivated by the importance of their work, the contribution it makes to the health of Queenslanders, and the support that their activities provide to those services and the clinicians that provide health services to patients and health care consumers.

The absence of a clear role for the Department has created difficulty for staff and they are seeking resolution. Staff want clarity in relation to the functions and structure of the Department. They are frustrated by cumbersome approval pathways and outdated systems. They have experienced ambiguity in terms of decision-making processes and faced challenges in their work due to the absence of an agreed authorising environment.

Leadership is key to the future performance of the Queensland health system. Further work needs to focus on system-wide leadership skills that enhance the collaborative efforts of the Department and Hospital and Health Services.

Investment in leadership and management capability development has been historically low in the Department, with the more recent delivery of middle management and talent management programs being exceptions. The Department has recognised the need for further investment to achieve improved organisational performance and ultimately better health care outcomes. The creation of Leadership Profiles – undertaken through a Leader Profiles Working Group consisting of 25 influential leaders from across the Department – has provided a starting point in defining the behavioural foundation for leadership performance across the agency.

## **Strategy development and strategic policy capabilities**

The Draft FSA Project report notes that the health system requires a clear and coherent vision. The review team agrees that the creation of an ambitious, compelling vision for the Queensland health system is an important starting point.

### **Strategy – outcomes focused**

The major strategic focus of the Department since 1 July 2012 has been the responsibility to give effect to the *Hospital and Health Boards Act 2011*. However, this focus now needs to shift to a broader consideration of how to improve health and wellbeing outcomes for Queenslanders in an environment characterised by increasing demand on the health system at a time of a weakening fiscal position for governments.

There is an absence of strategy in this regard. Whether this is a result of previous focus on operationalising the *Hospital and Health Boards Act 2011*, or a consequence of the loss of strategic policy capability post the downsizing activities as described previously, there is agreement that strategy capability must be a priority going forward. There was generally a shared view arising from consultations that the Department has lost valuable policy capability. This includes capability to frame strategic policy for the Minister and the Government which leads to better health outcomes; and organisational strategy which leads to improved departmental, system and sector performance.

### **Strategy – evidenced-based choices**

The Department holds considerable data across the organisation to inform strategy and policy activities. However, knowledge of and access to information remains an issue. As reported throughout the consultations, there have been considerable issues with the integrity of data, which led to the establishment of the Office of Data Integrity and Patient Safety in late 2014.

Feedback throughout the review indicated that the absence of access to data to inform strategy and strategic policy decisions impacted critical functions such as purchasing activity and performance management. Staff who have worked within the Department for prolonged periods spoke about the fact that they often achieved outcomes simply because they knew who to go to in order to access the information they required. Other feedback to the review indicated the Department imposed onerous, frequent and sometimes questionable (in terms of system value) data requests on Hospital and Health Services. There is a clear need to develop a Department-wide knowledge management system to underpin robust, evidence-based strategy.



### **Strategy – collaboration**

The need to build business relationship capability is a priority for the Department in order for it to give effect to its system leadership role. Clearly, the Department retains regulatory powers and directive authority, however much of the strategic work to be done would be greatly advantaged by the early input of key stakeholders, within and external to the broader public health system (that is, Hospital and Health Services and others). Better engagement and collaborative governance are priority capability issues for the Department moving forward.

More broadly, as noted at the outset of this capability assessment, there are increasing numbers of strategic policy and environmental pressures that will reshape the priorities of the healthcare portfolio as governments tackle broader health policy agendas. The environment in which the Department operates is increasingly complex, where full information is often unavailable centrally and solutions need to be derived through processes which rely on shared ownership and accountabilities for outcomes. The capability to collaborate (which is linked to the ability to influence system-wide culture, and more broadly to the prior commentary regarding leadership) will be increasingly important. Effective working relationships with other agencies, with Hospital and Health Services, with the private sector and with a range of other stakeholders, will all be necessary in order to address the funding issues, policy priorities and broader environmental challenges the Department faces.

### **Delivery capability**

The siloed nature of the Department impedes governance, leadership, efficiency, clarity of accountability and fosters an organisational culture which is counter to the collaborative behaviours required of the System Manager.

#### **Delivery – sound delivery models**

The current peak governance body for the State's health system, the System Management Team, has no formal standing. The Terms of Reference note that it is an advisory body to the Director-General, with no official remit.

The overarching governance body for the Department should be aligned to its leadership responsibilities, as set out in the *Hospital and Health Boards Act 2011*. It needs to determine and set the strategic direction of the system, create the appropriate focus on outcomes, and establish the purchaser-provider service relationship.

The Department has been described as siloed and difficult to access by stakeholders and staff. This impacts all operations but, notably, it impedes the efficient and effective purchasing and performance management of services provided by Hospital and Health Services.

Information, communication and technology systems are outdated and unresponsive, with many staff describing the operating environment as one where 'work-arounds' are the only way to get the job done. Priority investment is required to contemporize information technology.

#### **Delivery – innovation and risk management**

There was unanimous agreement, across all stakeholder groups, that the Department is extremely risk averse. It was recognised that previous high profile issues that have arisen in the Queensland health context have likely led to this culture. Risk is both pushed and pulled upwards in the Department. Accordingly, there appears to be no mechanism by which system-wide risk management responsibilities can be discharged, beyond the most senior role in the organisation – the Director-General.

Stakeholders provided feedback regarding the exceptional lengths of time that minor activities – such as the approval of briefing materials or correspondence – could take. The review team regularly heard examples of micro-management, instances of excessive sign-off requirements, tight control of information and multi-level elevation of decision-making. This extremely low appetite for any risk limits the potential for innovation and delivery of optimal outcomes within acceptable timeframes. According to a number of stakeholders, the current treatment of risk actually has the potential to increase exposure of the Department.

#### **Delivery – planning and organisational performance management**

The system leadership functions of the Department rely on system planning and performance management capabilities. In turn, these capabilities are dependent on reliable and valid data and information. There is no evidence of headline performance reporting to the DMT which drives shared collaborative executive accountability for the Department's performance, system performance and capability development.

### ***Delivery – information management and data integrity***

Data integrity was a common theme throughout the review consultation process, and has been acknowledged as an on-going issue for the Department (and Hospital and Health Services) for a significant period.

The sixteen Hospital and Health Services across Queensland have a range of obligations with regard to reporting data, driven principally through Service Agreements in place between each organisation and the Department. Each Service Agreement sets out the requirements associated with the provision of services by Hospital and Health Services, the outcomes that are to be achieved and the way in which these outcomes will be monitored by the Department. In addition to the reporting obligations established by Service Agreements, there are other drivers that confer reporting obligations. These may be legislative, policy, inter-governmental or ad hoc reporting requirements, and relate to material such as Queensland Opioid Treatment Program information, data required under the Australian Health Care Funding Agreement, national MyHospitals reporting information and material published by the Queensland Government. These represent a small sample of the significant reporting obligations that exist, which commonly overlap and draw upon the same datasets, resulting in a diverse range of reporting formats. This overlap has the potential to create significant confusion and workload, and often results in challenges regarding the ownership of data and the responsibility for its accuracy.

Rich sources of data exist across a range of areas within the Department – for example, the Chief Health Officer's biennial report was recognised by stakeholders as one of many significant publications with evidence of clear data availability and analysis. The data sets used to create such materials, and the capabilities required to generate the necessary information thereafter, need to be further developed.

In July 2014, the Department of Health published a document entitled *Data Collection and Provision Requirements* which sets out a summary of the legislative, policy, inter-governmental and other reporting obligations, in addition to those contained within the Service Agreements, which are required to be met by Hospital and Health Services. Regardless, there continues to be a significant need to build the data capture, analytics and related reporting capabilities of the Department.

The building of an Enterprise Data Warehouse, which has been underway for a number of months, is expected to ultimately support the storage of health data. The objective of the system is to provide real-time analysis of the integrity of data provided, enabled sharing of information across the Department (and with Hospital and Health Services) and provide greater accountability and transparency so all stakeholders can have faith in the accuracy of information. This work is vital for the Department's future system leadership performance and should be continued by the proposed Health Statistics and Data Integrity Branch.

# 08 Organisational Structure and Governance

## Organisational structure

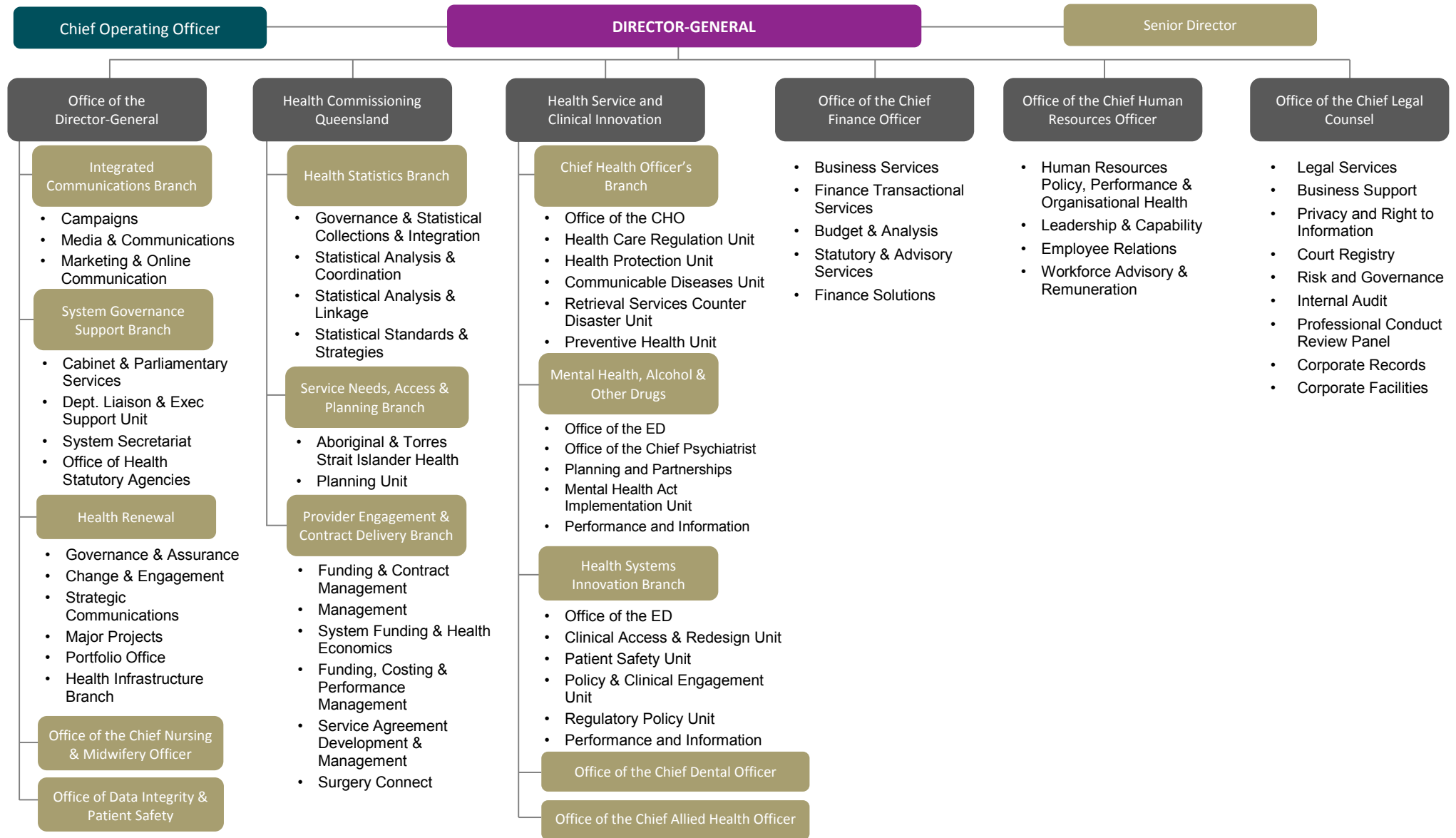
The Terms of Reference for the review require that it, *“Provide advice on governance and organisational structures that will result in the efficient and effective operation of the Department as the system leader and system manager of health services in Queensland”*.

The review has considered multiple inputs in designing an organisational structure and establishing a governance framework that ‘gives effect’ to the intentions of the Department.

This includes analysis and review of the work of the FSA Project, input from the intensive consultation, feedback and engagement activities that were conducted as part of this review, and workshops with the Department Management Team, Board Chairs, Health Service Chief Executives and other departmental executives.

The current organisational structure of the Department of Health is set out in the following diagram.

Current organisational structure (not including HSQ, HSIA or the QAS)



## Department of Health Business Model

As a first step to designing an organisational structure and supporting governance model, a revised business model has been created for the Department of Health.

A business model is a representation of the high level inputs, outputs and operational activities of an organisation, prepared in order to encapsulate the role of that organisation and demonstrate the key elements to its operation. A business model should seek to demonstrate the core, inter-related activities of an organisation, demonstrating how they influence the outputs of that entity.

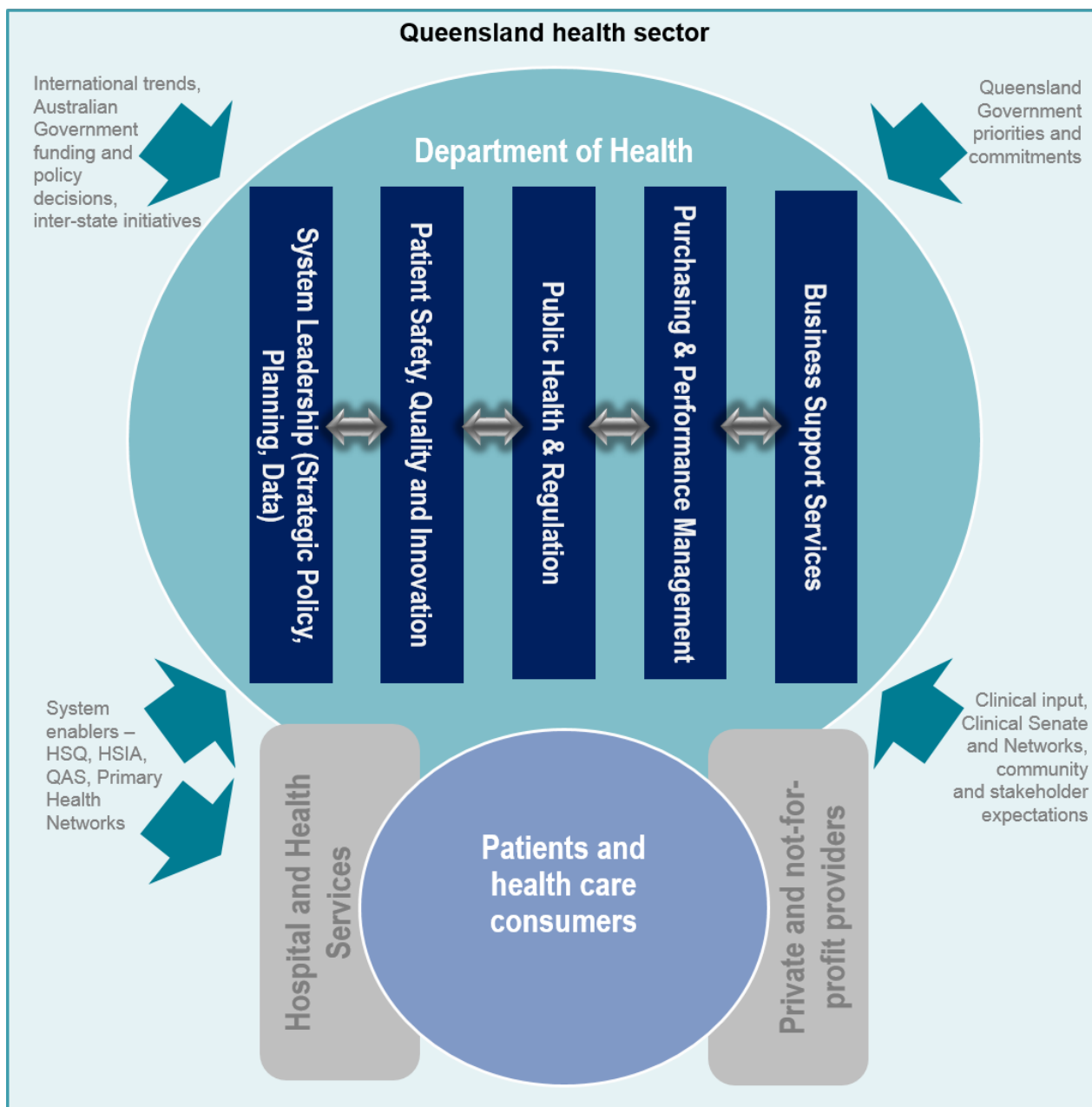
In Queensland's health context, given the legislatively mandated role of the Department of Health as the overall manager of the State's health system, the organisation's business model should showcase its role within the overall health system and its impact on 'end users' – patients and health care consumers.

The business model developed as part of the FSA Project was tested with stakeholders. Broadly, stakeholders acknowledged that the 'System Leader'/'System Manager' functions conceptualised in the FSA business model were functions of the Department. However, the bifurcation of these functions created scope for duplication. There was a general view that the proposed business model did not easily lend itself to a structure; that the creation of an entity based on 'System Leader' and 'System Manager' nomenclature did not sufficiently clarify the respective functions; and a view that the broader functions of the Department were not sufficiently contemplated.

The revised business model was derived from outputs developed at a specific co-design workshop attended by the Department Management Team, Board Chairs, Health Service Chief Executives and the Chairs of the Clinical Senate and Clinical Networks.

### **Business Model notes**

- The model depicts certain key inputs into Queensland's health system, but is not intended to represent every aspect or input into the system.
- Health Support Queensland, the Health Service Information Agency and the Queensland Ambulance Service are included as key enablers of the activities of the Department and Hospital and Health Services. All three entities should remain as part of the public health system. However, consideration could be given to their individual structures and to their potential establishment as statutory bodies, accountable through Service Agreements, similar to those between the Department and Hospital and Health Services.
- The model showcases the role of service providers (Hospital and Health Services, private sector and not-for-profit) as the main service delivery organisations, noting the Department continues to have some direct interaction with patients/health care consumers.
- The model evidences five business drivers which influence the Department's operations.
- The model provides for an ongoing link between the Department and the Clinical Senate and Clinical Networks.



An initial version of the business model was considered by the project’s Steering Committee, and feedback was incorporated. The above diagram represents the version noted by the Steering Committee which captures the amendments arising through the feedback that was provided.

The business model, combined with design principles which have guided the creation of the proposed organisational structure for the Department of Health (and which have also been endorsed by the project Steering Committee), form the basis of the proposed organogram.

## Design Principles

The draft organisational structure recommended in this report is based on a number of key design principles which emerged as pervasive themes over the consultations and research phase of the review.

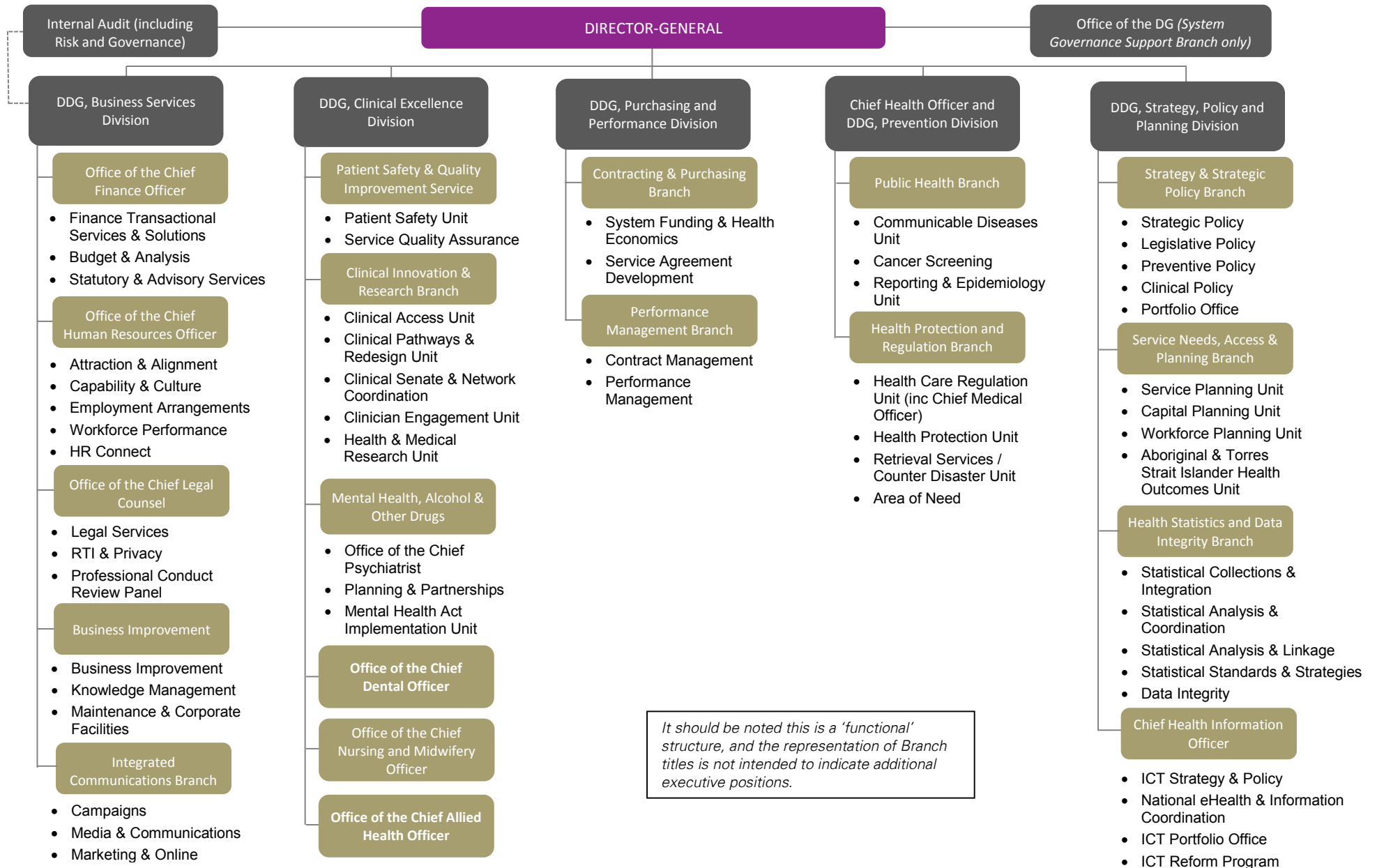
These principles have been considered in designing the proposed organisational structure, which follows.

#	Principle	Rationale	Implication of principle on final design options
1	<b>Design must facilitate leadership of Queensland's health sector within Australian and State federated systems</b>	The Department's structure should provide the strategy, policy, leadership, clinical direction-setting, education, corporate support and other functions that provide Queensland's health system with the ability to deliver holistic responses that improve health outcomes for citizens. It should support the capability to establish a clear vision, strategy and coordinated approach to State-wide issues across the Department, Hospital and Health Services and other service providers. It should recognise the evolution of Hospital and Health Services into comprehensive and integrated health services, with a community-based focus.	<ul style="list-style-type: none"> <li>• Department requires a structure that supports:               <ul style="list-style-type: none"> <li>- Addressing future health priorities ('looking out')</li> <li>- Leadership of, and response to, State and national initiatives ('looking across')</li> <li>- Performance management of HHSs ('looking in')</li> </ul> </li> <li>• The structure must support cooperative relationships with Hospital and Health Services, and recognise their continued evolution into organisations that provide comprehensive, integrated health services for their communities.</li> </ul>
2	<b>Design must simplify structures wherever possible</b>	The Department's structure should not be split into multiple entities with different responsibilities. The role of 'System Manager' (as defined in the <i>Hospital and Health Boards Act 2011</i> ) clearly sets out the role of the 'strategic centre'. It does make sense that certain service delivery activities are separate to the functions of the Department (such as HSQ), but it does not make sense to structurally separate different core functions of the Department into different entities.	<ul style="list-style-type: none"> <li>• Strategy, policy, regulatory, health protection, commissioning and corporate support functions can all reside within the Department of Health.</li> <li>• Alignment of these functions to allow maximum outcomes and reduce complexity will be sought.</li> <li>• Areas of the Department that undertake the same functions should be evaluated to determine if there is benefit in aligning their activities. There will, however, be certain circumstances where sound reasoning does not always support this approach.</li> </ul>
3	<b>Design should support devolution of functions where doing so outweighs the impacts</b>	Frontline services should continue to be devolved to Hospital and Health Services unless there are demonstrable advantages in operating them on a State-wide or regional basis, such as clear economies of scale (more efficient, higher quality, safer outcomes) or the need to standardise systems.	<ul style="list-style-type: none"> <li>• Frontline service delivery areas should be tested to determine if devolution is beneficial.</li> <li>• There may continue to be service delivery activities within the Department of Health, if clear benefits support such a structure.</li> </ul>



#	Principle	Rationale	Implication of principle on final design options
4	<b>Design should align functions to promote effective teams, better communication and improved coordination</b>	Combining, or improving, the governance of functions of the Department that have similar functional responsibilities will provide better opportunities for staff (improved professional development), greater economies of scale, clearer lines of communication and a more coordinated interface between the Department and Hospital and Health Services.	<ul style="list-style-type: none"> <li>• Alignment of common functions will be preferred, unless there are demonstrable reasons why that should not occur.</li> <li>• Internal communication (within the Department) and external communication (with Hospital and Health Services, in particular) should be simplified and coordinated.</li> </ul>
5	<b>Design should reduce change impacts as far as possible</b>	The Queensland Government's <i>Employment Security Policy</i> notes that it is, "committed to providing stability to the government workforce by curbing organisational restructuring.... focus on pursuing performance improvement strategies... to achieve "best value" delivery of quality services to the community, in preference to restructuring, downsizing or simply replacing government workers with non-government service providers."	<ul style="list-style-type: none"> <li>• Staff will not experience a reduction in their terms and conditions of employment as a result of any changes.</li> <li>• Any change to structures will demonstrate a pathway to achieving "best value" and efficiency improvements through productivity benefits, not as a result of down-sizing or reduction in staff numbers.</li> </ul>
6	<b>Design should clarify roles as far as possible, in accordance with the provisions of the <i>Hospital and Health Boards Act 2011</i></b>	The <i>Hospital and Health Boards Act 2011</i> provides clarity regarding the responsibilities of the Department, and the responsibilities of Hospital and Health Services. Accordingly, the Department's structure should seek to provide clarity (to the extent possible through an organisational design) as to the location of the functional responsibilities of the Department within Queensland's health system.	<ul style="list-style-type: none"> <li>• Those core aspects that are the responsibility of the System Manager, as defined by the <i>Hospital and Health Boards Act 2011</i>, should be located within the Department of Health.</li> <li>• Where other statutes provide a legislative basis for establishing a functional area, they too should be located within the Department of Health.</li> <li>• There will be instances where certain service delivery, corporate support or clinical support functions operate solely to service Hospital and Health Services (or other health services providers), and in such circumstances they may be considered for inclusion in separate organisational structures (either hosted by Hospital and Health Services or in alternative areas such as HSQ or HSIA).</li> </ul>

Recommended organisational structure (not including HSQ, HSIA or the QAS)



## Summary of proposed changes

As noted within the design principles, the Queensland Government's *Employment Security Policy* explicitly indicates that the Government is committed to providing stability to its workforce.

There is no reduction in full-time equivalent staffing numbers intended by the proposed organisational structure. To be clear – no reduction in permanent or temporary public service positions is intended in the implementation process.

Similarly, it is clear the fiscal constraints faced by the Government mean that capability gaps will need to be addressed within existing resources. Accordingly, professional development and capability-building opportunities for staff should be provided where necessary, to deliver the requisite workforce expertise.

The new organisational arrangements would be facilitated by the following movements of employees and resources. Where terms such as 'reduced' or 'increased' are used to describe the size of a function, these are used in reference to the overall size of the organisational unit compared to its current status. That is, an organisational unit may be 'reduced' in size by moving resources to another area (which will, logically, therefore be 'increased' in size).

### Office of the Director-General

It is proposed the Office of the Director-General be reduced in size. The office will comprise the current System Governance Support Branch.

The Department's Internal Audit function (including risk management and governance improvement) would report directly to the Director-General, but be administratively located within the Business Services Division for day-to-day operational support.

The Integrated Communications Branch moves into the Business Services Division.

The Office of Data Integrity and Patient Safety is disbanded, with:

- patient safety employees and resources currently within that office moving to the Patient Safety and Quality Improvement Service within the Clinical Excellence Division; and
- data integrity employees and resources currently within that office moving to the Health Statistics and Data Integrity Branch within the Strategy, Policy and Planning Division.

The Office of the Chief Nursing and Midwifery Officer moves into the Clinical Excellence Division.

The Health Renewal Team (recently renamed the Business Improvement Office) is disbanded, with:

- Governance and Assurance employees and resources currently within that office moving to the Internal Audit Unit;
- Change and Engagement and Strategic Communications employees and resources currently within that office moving to the Strategy, Policy and Planning Division;
- Portfolio Office employees and resources currently within that office moving to the Strategy and Strategic Policy Branch within the Strategy, Policy and Planning Division;
- Health Infrastructure Branch employees and resources being split between:
  - the Service Needs, Access and Planning Branch within the Strategy, Policy and Planning Division (for those with capital planning responsibilities); and
  - the Business Improvement Branch within the Business Services Division (for those with maintenance/facilities responsibilities).
- Major Projects employees and resources currently within that office being moved to the Strategy, Policy and Planning Division.

## **Strategy, Policy and Planning Division**

It is proposed a new Strategy, Policy and Planning Division be established to provide core system leadership activities by setting strategy and direction for the health system, developing and responding to high level policy matters faced by the health system, planning across the wide-ranging of activities of the health system (service needs planning, capital planning, workforce planning, information and communications technology and other planning functions) and collating and providing the health information required of the Department in its system leadership role (both for external purposes, such as reporting in accordance with National Health Performance Agreements and Council of Australian Government requirements, and internally for the purposes of supporting strategic policy development and input into performance management activities). It is explicitly not intended that the Division provide a repository of all data across the organisation, but rather that it will act as a common point of truth for data requests and activities which are facilitated by the areas of the organisation that are responsible for that data.

The Division will also have a key role in advising the process of purchasing activity from health service providers, as it will set the strategic priorities of the system and work with the proposed Purchasing and Performance Division to ensure those strategic needs are met.

Resources to establish the Division will come from a range of sources.

The Strategy and Strategic Policy Branch will be created through allocation of employees and resources from:

- the Health Renewal Team/Business Improvement Office (specifically the Change and Engagement, Strategic Communications, Portfolio Office and Major Projects areas);
- the policy-related elements of the Policy and Clinician Engagement Unit within the Health Service and Clinical Innovation Division;
- the Regulatory Policy Unit within the Health Service and Clinical Innovation Division; and
- the policy-related elements of the Preventative Health Unit within the Health Service and Clinical Innovation Division.

The Service Needs, Access and Planning Branch will move from Health Commissioning Queensland, and will be supplemented with additional employees and resources from the Health Infrastructure Branch (those dedicated to capital planning activities) within the Health Renewal Team/Business Improvement Office.

The Health Statistics and Data Integrity Branch will be created by moving the Health Statistics Branch from Health Commissioning Queensland, and will be supplemented with additional employees and resources from the Office of Data Integrity and Patient Safety (those dedicated to data integrity activities).

The Office of the Chief Health Information Officer, and those functions that are related to strategy, policy and planning in relation to information, communication and technology (such as the eHealth agenda) will move to the Strategy, Policy and Planning Branch.

## **Clinical Excellence Division**

It is proposed a new Clinical Excellence Division be established, to provide core patient safety and service quality assurance within the Department, in addition to facilitating health service innovation and research outcomes and providing professional leadership to major service areas and cohorts within the health system.

Like the Strategy, Policy and Planning Division, the Clinical Excellence Division will have a key role in advising the process of purchasing activity from health service providers, as it will set clinical quality and service standards across the health system and work with the proposed Purchasing and Performance Division to ensure those standards are met. Furthermore, through its focus on innovation, the Division will be in a position to support the promulgation of best practice approaches to clinical pathways and activities by working with the proposed Purchasing and Performance Division to ensure informed purchasing choices based on best practice approaches evidenced across different parts of the health system.

Finally, the Division will play a key role in facilitating clinical input and engagement in the Department's activities, by maintaining the interface between the Department and the Clinical Senate and Clinical Networks. It is expected that this interface will be across a range of areas of 'Clinical Excellence' which will be supported and championed by the Division across the Department.

Resources to establish the Division will come from a range of sources.

The Patient Safety and Quality Improvement Service will be created through allocation of employees and resources from:

- the current Patient Safety Unit within the Health Service and Clinical Innovation Division;
- the addition of 20 new positions through the Queensland Government's election commitment;
- the Office of Data Integrity and Patient Safety the Health Renewal Team/Business Improvement Office (specifically those employees and resources relating to patient safety); and
- any patient safety specific resources that exist within Health Commissioning Queensland (noting that this is likely to be a very small resource allocation).

The Mental Health, Alcohol and Other Drugs Branch moves into the Division from the Health Service and Clinical Innovation Division.

The Clinical Innovation and Research Branch will be created through movement of the Health Systems Innovation Branch into the Division, with the exception of those policy employees and resources moved to the Strategy, Policy and Planning Division (and noting the patient safety employees and resources within the Health Systems Innovation Branch will move into the Patient Safety and Quality Improvement Service, which is located within the same Division). It is also proposed that the Health and Medical Research Unit, currently located within the Health Service and Clinical Innovation Division, be moved to this Branch.

The Office of the Chief Dental Officer moves into the Division from the Health Service and Clinical Innovation Division.

The Office of the Chief Nursing and Midwifery Officer moves into the Division from the Office of the Director-General.

The Office of the Chief Allied Health Officer moves into the Division from the Health Service and Clinical Innovation Division.

### **Prevention Division**

It is proposed a new Prevention Division be established, to provide oversight of the public health, population health, private sector regulatory and other major legislative responsibilities of the Department of Health. The Chief Health Officer should lead the Division.

It is noted that not all legislative responsibilities (for example, the *Mental Health Act 2000*) will be the responsibility of this Division, but the majority of those technical, public and population health responsibilities are intended to reside here. It is also proposed that the Deputy Director-General accountable for the Division also be designated the Chief Health Officer, and it is noted that the Division is effectively a smaller version of the current Chief Health Officer's Branch within the Health Service and Clinical Innovation Division.

The Division does not 'gain' any resources, but it is reduced in size compared to the current Chief Health Officer's Branch by movement of the policy aspects of the Preventative Health Unit into the Strategy, Policy and Planning Division. It is intended that the Cancer Screening, epidemiology and reporting (including Chief Health Officer reporting) and Chief Medical Officer position remain within the Division.

Like other Divisions, the new Prevention Division would have a role in facilitating input into the purchasing and performance management processes of the Department, and will draw upon and work closely with the Strategy, Policy and Planning Division to ensure consistent policy positions and system-wide leadership is demonstrated through consistent advice about major health impacts, burdens of disease, national and international trends and evidence and other related matters for which the Chief Health Officer is responsible.

The Division will also be responsible for leading disaster response and coordination activities of the Department, linking into whole-of-government activities and maintaining the current State Health Emergency Coordination Centre. This unit will lead emergent health responses (such as pandemic planning or response).

### **Purchasing and Performance Division**

It is proposed the Purchasing and Performance Division reduce in size from the current Health Commissioning Queensland, with the current Provider Engagement and Contract Delivery Branch split into two discrete elements – one relating to purchasing of activity, and the other consisting of performance management functions.

The shift of some resources to other divisions will drive improved collaborative behaviour and necessitate cross-divisional activities in the establishing of purchasing priorities and in managing and lifting the performance of Hospital and Health Services.

The role of the purchasing and performance management branch will continue in its current form, and it should lead performance management activities (including facilitating three-on-three performance management meetings). However, a new emphasis on formalised internal mechanisms to access necessary information – for example, patient safety and service quality information from the Clinical Excellence Division; strategic priorities and planning needs from the Strategy, Policy and Planning Division; and key population health requirements from the Prevention Division – will be required. This interaction will be managed through agreed and formalised collaboration and a governance body.

### **Business Services Division**

It is proposed the Business Services Division be established (with a Deputy Director-General overseeing its operations) to provide corporate services within the Department and in some instances (such as industrial relations and certain human resources functions) across the health system.

The Business Services Division would consist of the existing Chief Finance Officer, Chief Human Resource Officer and Chief Legal Counsel functions, and be joined by the Integrated Communications Branch. The Division would also consist of those remaining aspects of the Health Renewal Team/Business Improvement Office that were not moved to other parts of the Department.

The Chief Finance Officer and Chief Human Resources Officer functions would remain, while the Chief Legal Counsel functions would be reduced by movement of the Mental Health Court Registry to the Department of Justice and Attorney-General (subject to Ministerial negotiations and the Premier's agreement to necessary machinery-of-government changes). The Knowledge Management and Corporate Facilities functions would move (within the same Division) to the Business Improvement Branch. Additionally, those aspects of the Health Infrastructure Branch that were responsible for maintenance and oversight of building activities (other than capital planning activities) would also move to the new Business Improvement Branch.

A range of business services activities have been distributed throughout the Department and there is scope to review these arrangements to determine the most efficient and effective model of service delivery. This would be a priority project for the newly created Division.

As previously noted, the Department's Internal Audit function (including risk management and governance improvement) will be administratively located within the Business Services Division, with a direct reporting line to the Director-General for the purpose of reporting on internal audit activities.

# Governance arrangements

The governance arrangements for the organisation will be particularly important in 'giving effect' to the new organisational structure. Governance reflects the structures and processes by which the organisation is managed, directed and controlled. It includes the obligations of stewardship, ensuring that the system is well sustained for the future as well as serving the needs of the present, and matches responsibility with accountability.

The current governance arrangements for both the health system and the Department are cause for confused accountability and authority.

The *Hospital and Health Boards Act 2011* provides that the Department of Health is responsible for the system as a whole through its role as System Manager. Similarly, Hospital and Health Services are responsible for the provision of health services. Governance structures for the health system need to reflect the role of the Department in establishing overall responsibility for the system, with opportunity for input from constituent parts. Within the Department, governance needs to ensure that the relevant functional areas with responsibility and accountability for specific outcomes are clearly aligned, and that processes requiring distributed leadership are sufficiently robust to allow for that approach to occur.

As previously indicated, a System Leadership Executive needs to be established. It is proposed that the System Leadership Executive be established comprising representatives of the Department of Health's executive group that have system-wide responsibilities. Membership is proposed as the Director-General and the Deputy Directors-General for: Clinical Excellence; Purchasing and Performance; Prevention; Business Services; and Strategy, Policy and Planning. The Chief Health Technology Officer (as the head of the Health Services Information Agency), the Chief Executive Officer of Health Support Queensland and the Queensland Ambulance Commissioner would, in the immediate term, also be part of the System Leadership Executive. The Chair of the Hospital and Health Board Chairs' Forum would be an ex-officio member of the System Leadership Executive, recognising the direct reporting relationship between Board Chairs and the Minister. As an ex-officio member, the Chair of the Board Chairs' Forum would have full rights of discussion and debate, but not voting (in recognition of the potential for perception of conflict of duty). The Chief Risk Officer and the leader of the Office of the Director-General would provide secretariat support at meetings.

The System Leadership Executive should have responsibilities aligned to those legislative System Manager requirements set out for the Chief Executive (and the Department) as prescribed by the *Hospital and Health Boards Act 2011*. It needs to determine and set the strategic direction of the system, provide leadership on system-wide issues, manage system-wide risk, address high level strategic issues requiring strategic policy decisions and maintain the relevant tension between service provider compliance and performance (across the health sector as a whole, not simply the public health system). These activities need to be clarified through the vision, established through strategies and operationalised via a representative sub-committee structure.

The System Leadership Executive would take advice from the Board Chairs' Forum, the Health Service Chief Executives' Forum and a recast Departmental Management Group. In addition, a range of sub-committees would be established to consist of cross-system representation from Hospital and Health Services, the Department of Health and, in certain circumstances, broader groups such as the tertiary education sector or private service providers.

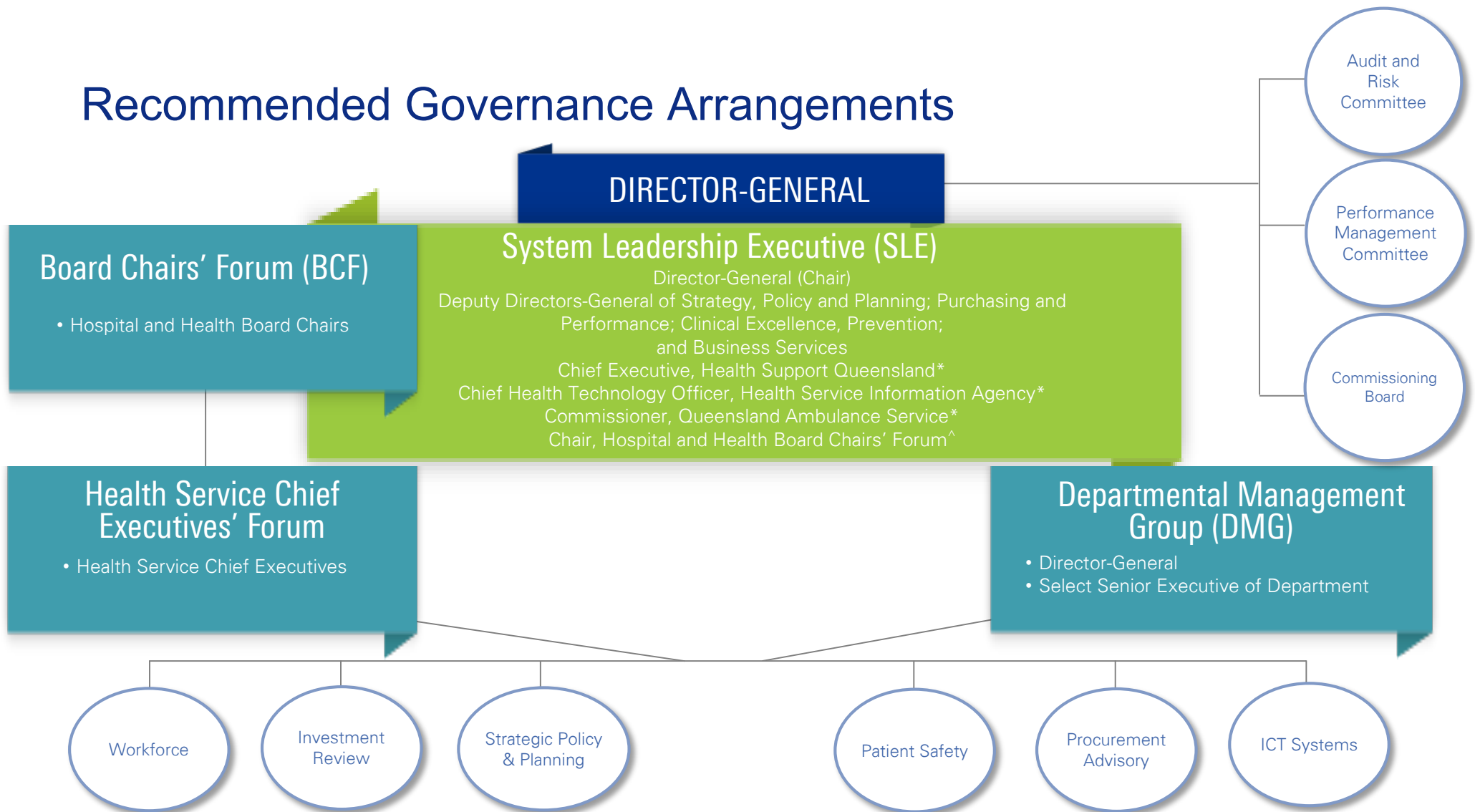
The Departmental Management Group should be re-focused to perform as a sub-committee of the System Leadership Executive, with an emphasis on addressing the strategic functions and capabilities of the Department of Health that are required to deliver its role of System Manager.

Ultimately, the overarching governance structure needs to support clear pathways for system-wide decision-making with input from the key stakeholders who should have a place at the table.

A proposed diagram setting out the revised governance arrangements follows.



# Recommended Governance Arrangements



\*Attendance of these three positions is recommended while consideration is given to the future organisational arrangements of their respective parts of the Department. In the event that they are transitioned to statutory entities with Service Agreements, they should simultaneously transition to be members of the Health Service Chief Executives' Forum. This will avoid any potential conflict of interest that may arise through their status as service providers.

^The Chair of the Hospital and Health Board Chairs' Forum would be an ex-officio member of the System Leadership Executive, recognising the direct reporting relationship between Board Chairs and the Minister for Health. As an ex-officio member, the Chair of the Board Chairs' Forum would have full rights of discussion and debate, but not voting (in recognition of the potential for perception of conflict of duty).

# 09 Recommendations

The review process has been extensive, involving wide-ranging consultation and engagement activities, the review of materials prepared by the FSA Project, extensive interaction with specific stakeholder groups such as the Department Management Team, and independent research and analysis activities.

The following recommendations respond to the Terms of Reference for the review, and the prevailing evidence provided to the review team.

<b>Recommendations</b>	
<b>Vision and Strategy</b>	
<b>1</b>	Establish a vision and purpose for Queensland's health system which clearly articulates the importance of a systems leadership approach to achieving improved health outcomes for patients and health care consumers and which addresses the risk of system fragmentation which reduces overall system capacity.
<b>2</b>	Develop a 'Charter of Responsibility' to be agreed between the Department of Health and Hospital and Health Services setting out agreed roles and responsibilities for each, based on the legislative provisions of the <i>Hospital and Health Boards Act 2011</i> and sufficiently detailed to clearly inform accountability and authority, supported by a combined Department and Hospital and Health Service campaign to communicate the Charter.
<b>Structure</b>	
<b>3</b>	Implement a new functionally-based structure for the Department of Health, as outlined in this report.
<b>4</b>	Create a new Strategy, Policy and Planning Division within the Department.
<b>5</b>	Create a new Clinical Excellence Division within the Department, with future consideration to be given to the transition of the Clinical Excellence Division to a separate statutory entity within the health portfolio.
<b>6</b>	In creating the new Clinical Excellence Division, re-establish the Patient Safety and Quality Improvement Service within this Division and develop a mandatory Patient Safety Health Service Directive based on the approach of the New South Wales Clinical Excellence Commission's Patient Safety and Clinical Quality Program.
<b>7</b>	Elevate the role of the Chief Health Officer to that of Deputy Director-General, creating a new Prevention Division within the Department.
<b>8</b>	Create a new Business Services Division within the Department.
<b>9</b>	Consider the future form of key 'system enablers' – Health Support Queensland, the Health Services Information Agency and the Queensland Ambulance Service – with regard to their status as units of the Department of Health, with consideration to be given to creating those organisations as statutory entities with service provider relationships consistent with the Service Agreement framework that exists between the Department and Hospital and Health Services.
<b>10</b>	Subject to agreement between Ministers, and in accordance with machinery-of-government requirements, transfer the Mental Health Court Registry to the Department of Justice and Attorney-General.

<b>Recommendations</b>	
<b>Governance and Risk Management</b>	
<b>11</b>	Implement new governance arrangements for both Queensland's health system and the Department of Health, with a System Leadership Executive taking overarching responsibility for the health system with cascading accountabilities and responsibilities to other parts of the system as appropriate.
<b>12</b>	Establish a system-wide risk management framework, which clearly articulates escalation procedures, defines responsibilities, outlines mitigation approaches, and sets out risk rankings and scales, including defined pathways (based on the risk ranking/scale) for system risk management.
<b>13</b>	Undertake a review of the current Performance Management Framework – with representatives from both the Department of Health and Hospital and Health Services – to determine improved mechanisms by which 'cooperative tension' can be achieved to support Hospital and Health Services' continued evolution towards provision of integrated care, whilst concurrently maintaining effective levels of responsiveness to meet government and community expectations.
<b>14</b>	Adopt the Investment Management Framework broadly across the health system, facilitated through an agreed governance pathway (recommended as the Investment Review Committee) to improve rigour in relation to funding decision-making and evaluation processes.
<b>15</b>	Consolidate funding pools from across the Department within the Purchasing and Performance Division.
<b>Planning</b>	
<b>16</b>	Led by the Deputy Director-General, Strategy, Policy and Planning, and with input from the Prevention Division, develop an overarching Queensland Health Plan for the State.
<b>17</b>	Led by the Deputy Director-General, Strategy, Policy and Planning, with input from the Business Services Division, develop an overarching Workforce Management Plan for the State.
<b>18</b>	Led by the Chief Health Officer and Deputy Director-General, Prevention, finalise the Public Health Manual to ensure that clear roles and responsibilities are articulated in relation to State-wide public health priorities, including the characteristics of instances where the Division will 'step in' to coordinate activities relating to an issue of significance that may have cross-boundary implications for Hospital and Health Services. In finalising the Public Health Manual, it is recommended that appropriate Key Performance Indicators also be incorporated in Service Agreements with Hospital and Health Services.
<b>Organisational culture and development</b>	
<b>19</b>	Implement a Department-led, Hospital and Health Service supported cultural change program which clearly establishes the Department's responsibility for system-wide leadership and Hospital and Health Service responsibility as statutory bodies that are accountable to the Minister.

# 10 Appendices

## A.1 Future State Alignment Project Purpose, Objectives and Scope

Page 2 of the Draft FSA Project report sets out that the purpose, objectives and scope of that project were as follows.

### **Purpose**

- *The purpose of the Future State Alignment Project is to ensure the Department activities align with our devolved operating system to enable Hospital and Health Services to deliver the best possible care.*
- *Enable the Department to further support and strengthen HHS local decision-making and accountability by ensuring that funding, together with accountability and responsibility, is transferred effectively to HHSs.*

### **Objectives**

- *To provide an assessment of the Department of Health activities to ensure they are appropriately aligned, to the evolving and emerging needs of the broader health system*
- *To enable the Department to further support and strengthen local HHS decision making and accountability*
- *To clearly define and articulate roles, responsibilities and delineation between the Department and the HHS*
- *To support the reduction in bureaucracy and the redirection of resources to frontline service delivery*
- *Ultimately, the outcomes will further support and strengthen local decision-making including supporting the transfer of funding, accountability and responsibility to the HHSs.*

### **Scope:**

*This review was undertaken between August and December 2014. Areas in scope for the review include:*

- *Office of the Director-General*
- *Health Services and Clinical Innovation*
- *System Support Services*
- *Health Commissioning Queensland*

*NB - \*Health Services Information Agency structural options are being informed by separate review and reform process currently underway*

*Areas outside the scope for the purpose of this project are:*

- *Queensland Ambulance Service*
- *Health Support Queensland*

*It should be noted that it was not possible to exclude these areas entirely and therefore some recommendations have been formed for these areas as a result.*

# A.2 Hunter Review Terms of Reference

## 1. Purpose

The purpose of this Review is to assess the appropriateness of Departmental governance and organisational structures, as well as high level capability gaps.

## 2. Background

The former Director-General initiated a Future State Alignment (FSA) Review to align the activities of the Department to a more devolved operating system where Hospital and Health Services (HHS) have been transferred funding, accountability and responsibility for the delivery of public sector health services.

The FSA review was undertaken between August and December 2014. Areas in scope for the review included:

- Office of the Director-General
- Health Services and Clinical Innovation
- System Support Services
- Health Commissioning Queensland

Areas outside of scope included:

- Health Services Information Agency (informed by a separate, concurrent review)
- Queensland Ambulance Service
- Health Support Queensland

Although these areas were out of scope some recommendations were made in relation to these areas.

The FSA review resulted in the delivery of a report to the former Director-General. The report has not been released.

The Department Management Team (DMT) has provided feedback to the incoming Minister for Health and Minister for Ambulance Services (the Minister) on issues with current governance and organisational structures.

The DMT have advised the Minister the FSA review commenced under the previous administration needs to be brought to a conclusion so that further organisational realignment can be implemented from 1 July 2015.

However, DMT members have also made it clear that this needs to be done in an open and consultative manner that provides key internal stakeholders with the opportunity to validate and provide feedback on the recommendations arising from the FSA review.

During the election Labor committed to re-establish the Patient Safety and Quality Improvement Service with 20 new positions and 40 positions transferred from the current Patient Safety Unit.

### 3. Appointment

The Director-General has administrative responsibility for the Department and has appointed Ms Rachel Hunter as a Reviewer for the purposes described within these Terms of Reference.

### 4. Scope of the Review

The Review will:

- (1) Assess the inputs to and recommendations arising from the Future State Alignment (FSA) Review to determine whether the recommendations, if implemented, would align the activities of the Department to an operating system where Hospital and Health Services (HHSs) have been transferred accountability for the delivery of public sector health services;
- (2) Assess the inputs to and recommendations arising from the FSA Review to determine whether the recommendations, if implemented, would deliver on government priorities;
- (3) Consider relevant Labor election commitments and make recommendations in relation to the reestablishment of the Patient Safety and Quality Improvement Service with 20 new positions and 40 positions transferred from the current Patient Safety Unit;
- (4) Transparently and openly invite and assess feedback from Department staff and other agreed stakeholders on governance and organisational structures appropriate for a Department operating in the Queensland Health context;
- (5) Engage the Department Management Team (DMT) and other key Departmental staff in constructive discussion about options for the efficient and effective governance and structure of the Department as well as high level Departmental capability gaps;
- (6) Provide advice on governance and organisational structures that will result in the efficient and effective operation of the Department as the system leader and system manager of health services in Queensland; and
- (7) Provide advice on high level Departmental capability gaps and options for addressing.

The Reviewer will provide to the A/Director-General with a final report by early June 2015 detailing recommended governance and organisational structures, as well high level Department capability gaps and options for addressing by 29 May 2015.

### 5. Powers of the Reviewer

The Reviewer may ask Queensland Health employees to participate in informing the Review. However, participation by employees is not legislatively mandated.

## A.3 Hunter Review Steering Committee members

A Steering Committee was established to oversee the review. The members of the Steering Committee are set out in the following table.

Name	Position	Organisation
Dr Michael Cleary	Acting Director-General	Department of Health
Robert Setter	Acting Commission Chief Executive	Queensland Public Service Commission
Ian Langdon	Chair	Gold Coast Hospital and Health Board
Julia Squire	Health Service Chief Executive	Townsville Hospital and Health Service
Bill Brett	Deputy Director-General, Office of the Director-General	Department of Health
Philip Davies	Deputy Director-General, Health Commissioning Queensland	Department of Health
Jeannette Young	Chief Health Officer	Department of Health
Susan Chrisp	Executive Director, Business Improvement Office	Department of Health
Bronwyn Nardi	Senior Director, Policy and Clinician Engagement	Department of Health
Susanne Le Boutillier	Senior Director, System Governance Support	Department of Health