QUEENSLAND

COMMISSIONS OF INQUIRY 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF MARK FRANCIS WATERS

1. I, Mark Francis Waters (Dr), Senior Executive Director, Innovation and Workforce Reform, Queensland Health, care of Level 16, 147-163 Charlotte Street, Brisbane, in the State of Queensland, acknowledge that this written statement by me dated 15 August 2005 is true and correct to the best of my knowledge and belief.

2. This statement is made without prior knowledge of any evidence of information held by the Commission of Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

Qualifications and Experience

3. I hold a Bachelor of Medicine, Bachelor of Surgery (M.B.B.S) from the University of Queensland obtained in 1979. I also hold a Diploma of Royal Australian College of Obstetricians & Gynaecologists obtained in 25 October 1986 and a Master of Health Administration from the University of New South Wales obtained in 22 May 1992. I also hold fellowships in the Royal Australian College of Medical Administration (1992) and the Australian College of Health Service Executives (1994). I was also awarded a Fellowship of the Royal Australian College of General Practitioners in 1986. Attached and marked **MFW-1** is a copy of my Curriculum Vitae ("CV").

4. Prior to my obtaining my current position as Senior Executive Director ("SED") of the Innovation and Workforce Reform (IWR) Directorate , I have held various positions within the public and private health sector. These positions ranged from Resident medical officer to Medical Superintendent, District Manager of three large public hospitals within the Brisbane and

Ipswich areas and a General Manager role at the Wesley Hospital, in a career in health care and health care administration spanning 25 years.

5. I was appointed to the newly formed IWR Directorate to set a strategic direction to ensure continuous improvement to healthcare patients and staff and establish sustainable systems for the future to achieve these aims. Attached and marked **MFW-2** is a copy of the position description for the role of SED for the IWR Directorate.

Formation, Structure and objectives of the Innovation and Workforce Directorate

6. The In IWR Directorate was formed in July 2004 as a result of a restructure of Queensland Health ("QH"). I was not involved in the restructure. My initial appointment to the position occurred after the restructure as a result of the IWR Directorate being formed.

7. I understand that the IWR Directorate was formed in response to specific objectives outlined in the Queensland Health Strategic Plan 2004-2010. Attached and marked **MFW-3** is a copy of the QH strategic plan 2004-2010.

8. The purpose of the IWR Directorate is to create a climate for change to meet future challenges of healthcare. It comprises six centres and branches.

9. The 6 Centres and branches which comprise the IWR Directorate are as follows:

   a. Patient Safety Centre – Executive Director- Dr John Wakefield;
   b. Clinical Practice Improvement Centre – Executive Director -Professor Michael Ward;
   c. Skills Development Centre – Executive Director- Adjunct Professor Phil Diver;
   d. Innovation Branch – Executive Director - Jan Phillips;
   e. Workforce Reform Branch – Acting Executive Director-Bron Nardi

10. The six centres and branches each have Executive Directors to manage the day-to-day workings of each centre or branch. I oversee the Executive Directors of the 6 centres and branches of the IWR Directorate.

11. The Patient Safety Centre ("PSC") has a lead role in planning, implementing, managing and evaluating patient safety initiatives and programs as part of the broader system to prevent and address patient harm, and ultimately improve healthcare services. The PSC brings together three units with a common goal of improving patient safety. The 3 units the PSC brings together are:

    a. the Centre for Healthcare related Infections Surveillance & Prevention ("CHRISP");
    b. The Safe Medication Practice Unit ("SMPU");
    c. Safety Improvement Unit ("SIU").

12. Attached and marked **MFW-4** is a copy of an overview of the functions of the PSC, SIU, CHRISP and the SMPU. The Executive Director of the PSC has specific expertise in how the aims and commitments of the PSC are to be achieved.

13. The Clinical Practice Improvement Centre ("CPIC") supports and works with clinicians and health service managers to improve patient care in a number of ways. Attached and marked **MFW-5** to this statement is a copy of an overview of the functions of the CPIC. The Executive Director of the CPIC has specific expertise in how the aims and commitments of the CPIC are to be achieved.

14. The Skills Development Centre (SDC), opened in September 2004, provides doctors, nurses and allied health professionals with tools and training to improve their skills and enhance the quality of patient care. The SDC offers courses for a broad range of heathcare professionals whether they be new graduates or experienced practitioners. There is a focus on simulation skill training as well as communication skills. The formation of the SDC also

included the Centre for International Medical Graduates (CIMG) previously run by University of Queensland (UQ) until July 2004. The CIMG was established by the Commonwealth Government in 1996 to provide assistance to permanent resident Australian International Medical Graduates preparing for the Australian Medical Council (AMC) examination. Recent changes to the consent processes for both Medical Board requests for registration and application to the CIMG for bridging courses will now allow the sharing of information between the CIMG and the Medical Board of Queensland and the CIMG and Queensland Health to better assess skills of international medical graduates both prior to registration and during employment by Queensland Health. Attached and marked **MFW-6** to this statement is a copy of an overview of the functions of the SDC. The Executive Director of the SDC has specific expertise in how the goals of the SDC are to be achieved.

15. The Innovation Branch has the responsibility to position QH as an innovative, adaptable and change ready organisation which drives and supports heathcare improvement. Current projects include an innovation system to identify and support improvements to health service delivery, staff health programs, telehealth services, and training and development services. Attached and marked **MFW-7** to this statement is a copy of an overview of the functions of the innovation Branch. The Executive Director of the Innovation Branch has specific expertise in how the aims and commitments of the Innovation Branch are to be achieved.

16. The Workforce Reform Branch aims to create a climate for change through ensuring the optimal use of workforce skills by aligning service and workforce planning, investigating skills mix and role design and developing the current and future workforce through appropriate education and training. The Workforce Reform Branch delivers services through a Principal Medical Officer, Principal Nursing Adviser, Principal Allied Health Adviser, the Workforce Preparation and Development Unit and the Workforce Design and Participation Unit. Attached and marked **MFW-8** to this statement is a copy of an overview of the functions of the Workforce Reform Branch. The Executive

Director of the Workforce Reform Branch has expertise in how the aims and commitments of the Workforce Reform Branch are to be achieved.

17. The Statewide Health Services Planning Branch works with internal and external stakeholders of QH to manage, co-ordinate and integrate futures – oriented statewide health services planning for health priority areas, population groups and reforms in the health system. Attached and marked **MFW-9** to this statement is a copy of an overview of the functions of the Statewide Health Services Planning Branch. The Executive Director of the Statewide Health Services Planning Branch has specific expertise in how the aims and commitments of the Statewide Health Services Planning Branch are to be achieved.

18. The new initiatives of the IWR Directorate and its 6 branches are fully funded from Commonwealth funding with some state funding. The state funding in the Directorate is related to previously existing functions that were relocated into the directorate with the restructure and some previously agreed (03/04) State funds predominantly around planning. My understanding is that the only new State funds allocated to the Directorate for initiatives resulting from the formation of the Directorate is money being provided via the Directorate to employ additional medical graduates from the new Medical School at James Cook University and some funds to support the allied health care progression initiatives.

19. The Commonwealth funding for the IWR Directorate is provided via the "2003-2008 Australian Health Care Agreement" ("ACHA") Quality and Safety Funds. The 2003 – 2008 AHCA provided to QH funding remitted in annual instalments over 5 years. The purpose of these funds is to improve the quality of healthcare and provide services to patients and staff within a safe environment.

20. The IWR Directorate has adopted a strategic approach to the management of the quality and safety agenda for QH, that was not before in place. Certain

core themes have been identified by the IWR Directorate and a strategic approach which addresses the following priority areas was developed:

a. Improving the standardisation of systems and clinical practice;
b. Developing a culture of safety that will reduce the incidence of preventable adverse events;
c. Exploit the full potential of the Skills Development Centre;
d. Systematically apply innovation through the organisation;
e. Attracting, training and retaining appropriately skilled staff in adequate numbers to prepare for the reducing numbers of available people for future employment.

21. The 6 branches and centres assist in delivering outcomes in the identified priority areas.

22. When I was appointed to the newly formed IWR Directorate in August 2004, in my view, the approach to quality and safety projects appeared to lack co-ordination. The previous Commonwealth funds had been used to run many projects using temporary staff with limited ability to implement and sustain change. There was a need for processes to be implemented so that the projects undertaken were translated into real outcomes at the district level and the processes had to be sustainable.

23. The tasks of the IWR Directorate were devised and have been implemented according to a strategic need identified by QH in advance of the current issues concerning Dr Patel that are the subject of this Commission of Inquiry.

24. Although the systems in the IWR Directorate have only recently been devised and implemented and although some of the 6 branches and centres are still recruiting staff in certain branches to assist in achieving the aims of the IWR Directorate, the system that is now in place in my view, provides Queensland with an excellent opportunity to better achieve safe and quality health services to patients. The systems have been planned based on internationally tested effective ways to achieve clinical change.

Comments in relation to A07 positions-Day 8 of the Commission of Inquiry

25. I note on Day 8 of the Commission of Inquiry, at page 818 of the transcript, certain comments were made in relation to the provision of certain funding for various new A07 and A08 positions.

26. Certainly some of the positions referred to in this evidence referred to positions being recruited to the Innovation and Workforce Reform Directorate. I would like to say that these positions were either existing previously, Commonwealth funded temporary positions now being made permanent using Commonwealth quality and safety funds or new positions in quality and safety using Commonwealth quality and safety funds. These funds are from the Commonwealth through the AHCA agreement. They are specifically marked for quality and safety initiatives. This funding source first commenced in 1999 as the Commonwealth response to the 1996 Report on Quality and Safety in Australia (Runcieman and Wilson). These funds have not, in Queensland, since 1999 been used for routine clinical service provision. They have always been "tagged" for specific issues around quality and safety. Therefore, any suggestion that such funding was directed from a specific clinical budget or could be used to start up additional clinical services is incorrect.

Review of Bundaberg Integrated Mental Health Service and appointment to Queensland Health

27. On 13 May 2004, I was appointed through an Instrument of Appointment commissioned by the Director-General of Queensland Health, Dr Steve Buckland to investigate and report on certain matters in relation to the Bundaberg Integrated Mental Health Service (BIMHS).

28. The matters upon which I was asked to report on were included in a Terms of Reference that formed part of the Instrument of Appointment. The Terms of

Reference are referred to in my final report of the BIMHS. A copy of my report into the BIMHS is attached and marked **MFW-10**.

29. On or around the week commencing 13 July 2004, I met with Dr Buckland to hand him a copy of my report and discuss my report with him to give Dr Buckland the opportunity to ensure I had covered all areas of concern and seek any further clarification he may require.

30. In my view, subject to any further inquiries that Dr Buckland requested I make, I was of the view that the report was finalised.

31. I recall at the meeting Dr Buckland appeared to read the document. I was keen to ensure that from Dr Buckland's point of view, the report had been finalised. This was because I was an independent consultant and was being effectively paid by the hour to complete the report and therefore I wanted to ensure that I would not be called back unnecessarily to incur further costs to the Department. I recall saying words to the effect to Dr Buckland, "Are you satisfied with the report?" I recall Dr Buckland then indicating that he was.

32. I recall he then put the report to one side and said "Now can I talk to you about a job".

33. There had been no talk of a job offer at any time before this meeting or during this meeting until the report had been put aside and concluded from Dr Buckland's point of view.

34. At this point in time, I was still the General Manager of the Wesley Hospital at Auchenflower in Brisbane and I was engaged from mid May 2004 to July 2004 as an independent consultant by Queensland Health to review the BIMHS. I remained in the employ of Uniting Healthcare at the Wesley Hospital as General Manager until August 2004.

35. Dr Buckland then proceeded to discuss with me an opportunity to head the newly formed IWR Directorate within Queensland Health. Until this

conversation I had virtually no knowledge of or understanding of the role he outlined and, at that meeting, had no intention to leave my existing employment with Uniting Healthcare. I informed Dr Buckland that I would consider the offer and provide a response in the near future.

36. On or around 22 July 2004 I posted three copies of my final report to Dr Buckland. Attached and marked **MFW-11** is a copy of the cover letter I sent to Dr Buckland enclosing my final report in triplicate.

37. The report presented under cover of that letter was identical to the one I presented to Dr Buckland at our meeting approximately one week before when Dr Buckland indicated that he was satisfied with the report as it was presented to him.

38. After presenting my report of the BIMHS to Dr Buckland and posting copies to him, I heard nothing more about the report. I expected the report to be released and anticipated that there would be some public attention given to the issues raised in the report. However, this did not occur. As I was engaged as an independent consultant to conduct the report, the report was not my property and I was not responsible to ensure the report was publicly released or responsible for the implementation of the recommendations in the report.

39. In or around early August 2004 I contacted Dr Buckland to indicate I would be pleased to take up the position in Queensland Health as the head of the newly formed IWR Directorate. I commenced acting in this role on 16 August 2004 and was permanently appointed to the role in December 2004

Visiting Medical Officers (VMO) – Public and Private

40. I have been District Manager of several Districts within Queensland Health over a number of years. I have also been General Manager of the Wesley Hospital, a private facility located at Auchenflower in Brisbane.

41. I therefore, had the opportunity over time to observe the role of visiting medical officers (VMOs) in the public and private system and to compare the differences in the two systems over time.

42. In my view, VMOs are important to hospitals as they provide a body of staff large enough to allow an after hours systems of care to occur in the absence of enough work to allow enough full time specialists to occupy these roles. VMOs are usually specialists in a particular field of medicine who spend a majority of their time in private practice.

43. In my observation, a VMO will work in their private practice and if working as a VMO in the public sector, will spend between three and fifteen hours per week providing their specialist services to the public sector.

44. In the public sector, most VMOs are employees with tenure, however VMOs can be engaged through contracting with medical companies.

45. Usually what specialist services are offered at a particular hospital are the result of a combination of perceived needs and availability.

46. It is my experience that very few private hospitals "employ" specialists in the private sector. In the private sector, the specialists' relationship is with the Commonwealth Government and patients, not the hospital itself. In the private sector, the health insurance funds pay for the "hotel care" for the patient. In this context, I mean "hotel care" to be cleaning, provision of a bed and nursing care for the patient and food services to the patient. Depending on individual sites, variable allied health and auxillary services might be provided by the hospital.

47. In the private sector, the specialist is paid by the patient and the Commonwealth on a "fee for service" arrangement via the Commonwealth Medicare Scheme.

48. To my knowledge, in the public sector, the rates of pay of VMOs are largely determined by virtue of their specialist qualifications and years of experience. The rates of pay are contained in an agreement with Queensland Health which deals with hourly rates and conditions in relation to employment.

49. It is my observation that in the private sector, hospitals are keen for specialists to use their hospitals as a site for the referral of patients.

50. I am not aware of any policy of Queensland Health to reduce the number of VMOs in public hospitals. It is my observation that since 1999, with the advent of Commonwealth policies of insurance rebates and "lifetime" cover, specialists have left the public system in greater numbers, for a number of reasons such as the differentials in fee arrangements between the public and private sector. The growth in private insurance coverage has led to a greater "pool" of insured patients and increased demand for private specialists. There was no growth in the "pool" of specialists to provide these services.

51. In the public sector, the specialist is usually contracted to the State system, and their rate of pay is largely dictated by the State Government.

52. In private practice, specialists are able to access the Commonwealth Government Scheme, known as Medicare Plus, which commits the Commonwealth Government to refund eighty percent of any non-hospital fee submitted by a doctor. This refund allowance triggers once a patient reaches a certain threshold of fees spent on medical services.

53. In the public sector, VMOs do not have access to this private arrangement, as they are asked to forego private practice time in order to be subject to the State regime which in my observation, may be viewed as less financially lucrative as compared with the private sector.

54. In the private sector, as specialists are not "employees" but independent self-employed practitioners who use the hospital facilities, the amount of administration required of them is quite different both in nature and volume.

Furthermore, given the "small business" nature of their work, the amount of clerical assistance available to assist the doctor in that aspect of their work is a business decision the specialist makes.

55. It is my view that staff specialists (full-time) and VMO's are both vital to providing public health care. The quality of clinical expertise provided is related to the individual expertise and not the method of employment. The qualifications of both are the same. One advantage of staff specialists is that they can give their undivided attention to the organisation in a continuous manner. The VMO has always the tension that they are running separately their own business and have commitments to that business. One advantage of VMO's is that they allow sufficient individuals to be employed to bring a rich diversity of opinion and skills to the workforce.

56. An ideal workplace, in my view, has a combination of both staff specialists (full-time) and VMO's to provide sufficient staff to allow a sustainable service. Sustainability refers both to sufficiency to adequately do the volume of work but also a sufficient number to allow the specialists to have reasonable after-hours freedom. The interpretation of the latter is difficult however I think many people might suggest that frequency of "on call" should be no greater than one night or weekend in four perhaps reducing to one night or weekend in three during absences or leave. The sustainability of services is becoming more of an issue with the generational change in doctors with the younger doctors choosing to place a greater emphasis on a more balanced life.

....

Mark Waters

15.08.05.

Date

MFW-1

DR MARK WATERS

Personal and Professional Profile

Senior Executive Director
Innovation and Workforce Reform
Queensland Health
GPO Box 48
BRISBANE Q 4001

Telephone: *(07) 3234 0837*
Facsimile: *(07) 3224 7870*
Mobile: [redacted]
Email: *mark_waters@health.qld.gov.au*

CURRICULUM VITAE OF DR MARK WATERS

Senior Executive Director
Innovation and Workforce Reform
Queensland Health
GPO Box 48
BRISBANE Q 4001

Telephone: *(07) 3234 0837*
Facsimile: *(07) 3224 7870*
Mobile: [redacted]
Email: *mark_waters@health.qld.gov.au*

Name: Mark Francis Waters

Date of Birth:

PERSONAL QUALIFICATIONS

- Bachelor of Medicine, Bachelor of Surgery (M.B.B.S.) University of Queensland
- Diploma of Royal Australian College of Obstetricians & Gynaecologists (Dip of R.A.C.O.G.)
- Fellow of the Royal Australian College of General Practitioners (F.R.A.C.G.P.)
- Fellow of the Royal Australian College of Medical Administrators (F.R.A.C.M.A.)
- Fellow of the Australian College of Health Service Executives (F.A.C.H.S.E.)
- Master of Health Administration (M.H.A.) University of New South Wales

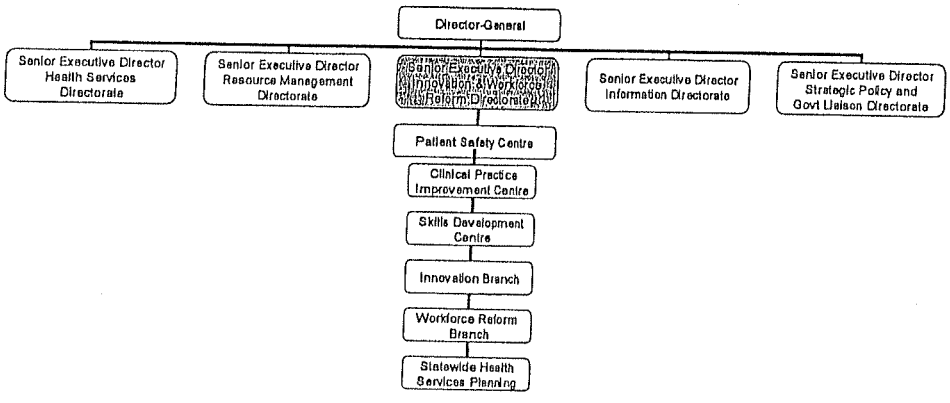
PERSONAL INTERESTS

Trustee, Ipswich Grammar School Board of Trustees	(2002 to date)
Chairman, Ipswich City Soccer Allsports Pty Limited	(1999 to 2002)
Chairman, Youth Reference Group, Wesley Central Mission	(2001 to 2002)

CURRENT ROLE AND RESPONSIBILITY

Senior Executive Director – Innovation & Workforce Reform - acted in the position from August 2004, appointed to the position on 21 December 2004 to present

My current position provides leadership and direction for the Innovation and Workforce Reform Directorate, one of the five Directorates within Queensland Health. In this position, I am a member of Queensland Health's Board of Management.



The purpose of the **Innovation and Workforce Reform Directorate** is to create a climate for change to meet the future challenges in healthcare. It comprises six centres and branches.

The Queensland Health **Patient Safety Centre** has a lead role in planning, implementing, managing and evaluating patient safety initiatives and programs as part of the broader system to prevent and address patient harm, and ultimately improve healthcare services for Queenslanders leading to healthier Queenslanders. The broader patient safety system involves health service providers at a local and state-wide level. The PSC works in partnership with Health Service Districts to coordinate and support state-wide and local patient safety programs.

The PSC brings together three units with a common goal of improving patient safety:

1. Centre for Healthcare Related Infections Surveillance & Prevention (CHRISP)
2. Safe Medication Practice Unit (SMPU)
3. Safety Improvement Unit (SIU)

The **Clinical Practice Improvement Centre** supports and works with clinicians and health service managers to improve patient care by:

- Identifying and understanding the causes of important variances in clinical outcomes
- Using established and innovative improvement techniques to reduce these variances through the implementation of evidence-based best practice
- Measuring progress towards specific targets in these activities
- Developing systems to ensure that such progress is sustainable
- Building upon, integrating and expanding the activities of the many individuals and groups that are already working towards improving the quality and efficiency of healthcare in Queensland

The **Skills Development Centre** assists in the development of a more flexible and safe workforce particularly enhancing the ability to meet the workforce development needs occasioned by the current and projected demographic trends and labour market pressures, and to establish a centre of excellence in the area of health improvement sciences and patient safety.

Innovation Branch has the responsibility to position Queensland Health as an innovative, adaptable and change ready organisation which drives and supports healthcare improvement. It creates opportunities to support strategic priorities, identifies and enables new ideas and innovations, and leads the development of tangible and sustainable improvement responses. Current projects include an innovation system to identify and support improvements to health service delivery; staff health programs; telehealth services; and training and development services.

The **Workforce Reform Branch** creates a climate for change through ensuring the optimal use of workforce skills by aligning service and workforce planning, investigating skills mix and role design, and developing the current and future workforce through appropriate education and training. The Workforce Reform Branch delivers services through a Principal Medical Adviser, Principal Nursing Adviser, Principal Allied Health Adviser, the Workforce Preparation and Development Unit and the Workforce Design and Participation Unit.

Statewide Health Services Planning Branch works with internal and external stakeholders to manage, coordinate and integrate futures-oriented statewide health services planning for health priority areas, population groups and reforms in the health system.

PREVIOUS ROLES

General Manager – The Wesley Hospital Brisbane August 2003 to August 2004

The Wesley Hospital is a 450 bed private hospital – one of the largest in Australia. The Wesley Hospital provides services across the range of specialties with major tertiary services in cancer care and cardiology and cardiac surgery. The Wesley Hospital is part of the Uniting HealthCare Group.

District Manager, Royal Brisbane and Women's Hospital (RBWH) January 2003 to August 2003 (Annual Expenditure $370m - 6000 employees)

I was initially seconded to the RBWH in mid December as "Manager – Herston Complex" at short notice from my substantive position as District Manager, Princess Alexandra Hospital and Health Service District.

The RBWH is the largest hospital complex in Australia.

At the time of my secondment it had substantial budget and performance issues. Subsequently the District Manager resigned in January and I was appointed. A number of substantial changes were implemented in staffing and service provision. Informal feedback was that at end August 2003, RBWH was tracking under budget for the first time in memory.

District Manager, Princess Alexandra Hospital and Health Services District (PAHHSD) (Annual Expenditure $320m and 5000 employees) 1999 to 2003.

I was the District Manager at PAHHSD for three and a half years. It is a 750 bed tertiary hospital. The District Manager's role is that of Chief Executive Officer.

It provides a full range of adult services but does not provide obstetric or paediatric services.

It is the Queensland centre for:

- Liver transplants
- Renal transplants
- Spinal injuries
- Melanoma project

It is a complex organisation.

During my tenure we commissioned a new $300 million hospital and shifted all services from the old hospital to the new, whilst continuing to provide clinical services. This shift was completed in March/April 2001.

The hospital is the site of the Southern Clinical School of the University of Queensland Medical School and is involved in graduate and postgraduate studies.

District Manager, West Moreton Health Service District. (Annual Expenditure $145m and 3400 employees)

The West Moreton Health Service District has a catchment population of approximately 170,000 a staff of 3,400 FTE and an annual budget of $145 million.

The services provided included primary community health care across both rural and urban settings, comprehensive secondary health care at Ipswich Hospital and some limited services at hospital at Boonah, Esk and Laidley and tertiary mental health care at Wolston Park Hospital. Worldclass research is conducted at the Queensland Centre for Schizophrenia Research at Wolston Park and post-graduate education occurs throughout the District.

The District has affiliation/agreements with many Universities for both teaching and research.

During my time there I was responsible for the redevelopment of Ipswich Hospital ($80 million completed) and Wolston Park Hospital ($38 million - completed April 2002).

Medical Superintendent, Logan Hospital

I established this health service from its inception to the development of all services as a ninety (90) bed hospital. I was significantly involved with the planning associated with Stage Two, expanding the hospital to 170 beds. It is now a 350-bed hospital.

Medical Superintendent, Gympie Hospital
Medical Superintendent, Ayr Hospital

This was rural practice with widespread clinical skills needed in Obstetrics / Anaesthetics / Internal Medicine and Paediatrics.

Principal House Officer, Mt Isa Hospital

My time at Mt Isa was significantly associated with dealing with indigenous health.

I was seconded for three months from Mt Isa Hospital to the Royal Flying Doctor Service. I was involved during this secondment in providing service to a large number of sites in North Queensland including Doomadgee, Mornington Island, Normanton and Boulia.

Whilst at Mt Isa I was also seconded to be first Medical Officer to provide an on site service at Doomadgee.

I also provided clinical services for annual relief at Normanton and Hughenden.

RECENT NATIONAL COMMITMENTS

- Queensland Health representative on National Burns Working Party (AHMAC Initiative, 2003).
- Executive Member, Australian Safety and Quality Board. (2004/5)
- Member, State Quality Officials forum (2005)
- Chairman, National Falls Prevention Project (2005)

STATE COMMITMENTS

- Clinical Assistant Professor, Bond University (May 2004 to May 2007)
- Medical Superintendents Advisory Committee on Elective Surgery. (I chaired this group from its inception until March 1998).
- Member of Clinical Advisory Committee on Elective Surgery.
- Member of Casemix Steering Committee.
- Member of Clinical Costing Steering Committee.
- Member of Ministerial Advisory Committee for Palliative Care.
- Member of Ministerial Advisory Committee on Elective Surgery.
- Chair of Committee to Review State Funding for the Post Graduate Medical Education Centre.
- Project sponsor for selection committee for a clinical costing system - selection endorsed and Transition II implemented.

PREVIOUS INVOLVEMENT AS MEDICAL SUPERINTENDENT

- I represented the Medical Superintendents' Association in meetings with a previous Director-General, which resulted in the enhancement of conditions of employment for full time staff.
- Convenor of South-East Queensland Medical Superintendents' Conference, 1994.

PUBLIC PRESENTATIONS

- Australian College of Health Service Executives Satellite Broadcast, Feb 2005. "Telehealth update"
- Australian College of Health Service Executives Breakfast Forum 2004 - "A comparison of leadership in both the public and private sector."
- Orator, Jack Richards Oration, Australian College of Health Service Executives (Queensland Branch) Annual Conference, Gold Coast 2003.
- Mentor and Trial Examiner for candidates, Royal Australian College of Medical Administrators 2003.
- PAH Week 1998 - Clinical Risk Management
- Australian College of Health Service Executives Forum Royal Children's Hospital 1998 – "The Clinical/Managerial implications of clinical pathways".
- Australian College of Health Service Executives Breakfast Forum1998 "Clinical Risk Management and Medical Legal Issues" (joint lecture with Mr Peter Crofts, Legal Advis United Medical Protection)..
- Lecturer/Examiner, University of Queensland IV year medical students (1997) on the medico-legal component SM403 medical ethics/legal and forensic medicine. I provided the lecture course, set the examination corrected all papers.
- Queensland Health Developments and Direction Forum - 1997. I spoke on future significant management issues and likely strategies for EBIII.
- Australian College of Health Service Executives Breakfast Forum - 1994 "Quality Management"

CAREER SUMMARY

19 August 2004 to date	Senior Executive Director Innovation Workforce Reform Queensland Health
25 August 2003 to 16 August 2004	General Manager The Wesley Hospital
29 January 2003 to 24 August 2003	District Manager Royal Brisbane and Women's Hospital and Health Services District
2 August 1999 to 28 January 2003	District Manager Princess Alexandra Hospital Health Service District
1996 to 1 August 1999	District Manager West Moreton Health Service District and Medical Superintendent, Ipswich Hospital
1993 - 1996	Director of Medical Services Ipswich Hospital
1990 - 1992	Medical Superintendent Logan Hospital
1989	Senior Medical Officer / Deputy Medical Superintendent Ipswich Hospital
1987 - 1988	Medical Superintendent Gympie Hospital
1986	Medical Superintendent Ayr Hospital
1985	Leave taken to work at the Rose Maternity Hospital, Cambridge, UK, in order to complete a Diploma in Obstetrics
1984	Medical Superintendent Ayr Hospital
1983	Principal House Officer Mt Isa Hospital
1980 - 1982	Resident Medical Officer Ipswich Hospital

MFW-2

Vacancy Reference No: HL147-04
Contact: Dr Steve Buckland
Telephone: 07 3234 1170
Closing: 15/11/2004

Queensland Government
Queensland Health

JOB DESCRIPTION

1	Position Number:	110859
	Position Title:	Senior Executive Director, Innovation and Workforce Reform Directorate
	Unit/Branch/Division	Innovation and Workforce Reform Directorate
	Location:	Brisbane
	Classification Level	DES4.6
2.	Reports to:	Director-General
3.	Date of Review	October 2004
4.	Delegates Authorisation	

DR STEVE BUCKLAND
Director-General
/ /

5. Purpose of the Position

As major change agent and broker of change:

Set the agenda for reform of the health system to ensure Queensland Health meets its goals and the government's agenda of the Smart State 2020 Vision.

Significantly lead and contribute to national health care reform critical to the delivery of sustainable health care in Australia in the next decade.

Participate in and lead national healthcare safety and quality reform processes.

Develop relationships with and influence the major professional craft groups - the Royal Colleges, the universities and major union groups in the reform of scope of practice. This will include influencing the training agendas of independent training bodies.

Provide executive leadership, strategy and governance to Queensland Health through membership of the Department's Board of Management, and position Queensland Health as a world class health care organisation through innovation and workforce reform.

Sponsor develop and implement leadership training and skills development for senior executives of Queensland Health to facilitate the effective implementation of innovative practices and workforce reform agendas.

6. Organisational Environment

Queensland Health is governed by a Board of Management established to focus on service delivery and position the Department to meet its strategic intents:

- Healthier staff
- Healthier partnerships
- Healthier people and communities
- Healthier hospitals
- Healthier resources

The Board of Management comprises the Director-General and five Senior Executive Directors each responsible for one of the following Directorates:

- Strategic Police & Government Liaison
- Health Services
- Innovation & Workforce Reform
- Information
- Resource Management

THE INNOVATION AND WORKFORCE REFORM DIRECTORATE: aims to position Queensland Health as a "leader in health and a partner for life" by ensuring that:

- the design of service plans and models is undertaken with a long term strategic focus, informed by high quality information
- a workforce to deliver on future service requirements is designed, recruited, developed and retained and;
- innovation and improvement in service design and delivery is undertaken to maximise the quality, safety and value of our services.

The Innovation and Workforce Reform Directorate consist of three workgroups;

- Innovation Branch
- Workforce Reform Branch
- Skills Development Centre

The **Innovation Branch** has responsibility to position Queensland Health as an innovative, adaptable and change-ready organisation which drives and supports health care improvement. It identifies opportunities to create and disseminate new ideas and innovations, aligned to strategic priorities, and leads the development of tangible and sustainable improvement responses.

The **Workforce Reform Branch** has responsibility to position Queensland Health to meet current and future service delivery requirements through workforce reform. It leads the development of integrated service planning, encompassing workforce and resource planning, to ensure that service delivery models and locations are compatible with workforce availability. It also leads the development of tangible and sustainable workforce design and industrial relations reforms to support desired future models of health care delivery.

The **Skills Development Centre** has responsibility for training, application and assessment of clinical skills both of individuals and multidisciplinary teams. The Centre will undertake educational activities state-wide, nationally and internationally through local courses, distributed programs and distance education, and will collaborate with clients and stakeholders and develop industry partnerships to support programming capacity and quality. The Centre will also assess the commercial viability of its education programs and facilities and consider market opportunities. A major thrust of the Centre will be in the area of patient safety. The Centre also has a role to create innovation and assist in workforce reform through the training of staff to attain clinical proficiency.

7. Primary Duties

Queensland Health is committed to achieving our mission of promoting a healthier Queensland and our vision to be leaders in health – partners for life. We recognise that Queenslanders trust us to act in their interest at all times. To fulfil our mission and sustain this trust we share four core values of: quality and recognition; professionalism; teamwork; and performance accountability.

In addition we will be successful in promoting a healthier Queensland through the five strategic intents. The primary duties and assessment criteria outlined in this job description reflect the commitment to our mission, vision, values and strategic intents which are required by this position.

7.1 Provide high quality support, advice and information and guidance to the Director-General and Minister and other Senior Executive on key issues impacting on the achievement of government and corporate outcomes, particularly in relation to innovation and workforce reform.

7.2 Provide executive leadership, strategy and governance to Queensland Health through membership of the Department's Board of Management.

7.3 Lead the development and implementation of innovation and workforce reform activities to support the Queensland Health strategic intent, and provide related specialist advice and support to the Minister, Director-General, Corporate Office and District Health Services.

7.4 Provide strategic leadership over the creation and dissemination of new ideas and innovations, aligned to strategic priorities, which will improve the delivery of healthcare services by Queensland Health.

7.5 Provide high level leadership, oversight and guidance over the development and implementation of leadership and management programs, including succession management, and substantial clinical quality and safety strategies and projects.

7.6 Provide strategic leadership in the development of the key strategic framework, policies and processes necessary to ensure that innovations and workforce reforms are implemented to meet government and corporate priorities.

7.7 Drive the key strategic framework and processes in Queensland Health to ensure workforce reforms are implemented to meet government and corporate priorities.

7.8 Provide a strong public and professional profile to innovation and workforce reform strategies in Queensland Health including departmental representation on high level National Boards and taskforces, as well as conducting high level negotiations and liaison with external organisations, other government departments and bodies (State and Commonwealth), major community organisations, non-government service providers and industry representatives, and the media.

7.9 Develop and maintain effective partnerships with central agencies in the development of Queensland Health's workforce management strategies from a reform perspective, ensuring consistency with Government's policy, legislative and industrial awards and agreements.

7.10 Develop the long term capacity, resources and investment approaches required within each of the areas managed, consistent with the Queensland Health strategic intent.

7.11 Provide strategic leadership and innovation in the management of all available resources with an emphasis on the achievement of performance improvement and the implementation of successful change management initiatives across Queensland Health for reforms associated with the activities of the Innovation and Workforce Directorate.

7.12 Provide compliance with corporate governance requirements as specified in legislation and professional standards applicable to all areas of the Innovation and Workforce Reform Directorates.

7.13 Ensure there is a strategic approach to the development of contemporary human resource practices and policies including workplace health and safety, equal employment opportunity and anti-discrimination, performance management and commitment to their implementation consistent with the mission, vision, values and strategic intents of Queensland Health.

8. **Primary Delegations and Accountabilities**

In addition to the responsibilities and accountabilities delegated to this position by the Director-General, this position is accountable for:

- the promotion of the Queensland Health mission, vision, values and strategic intents to staff, related industries and the Queensland public.
- the planning and strategy development necessary to assist in achieving the outcomes required by the Queensland Government and the Queensland Health Corporate Plan, particularly in the areas of innovation and workforce reform.
- the quality and effectiveness of high level policy advice to the Director-General and Minister and other Senior Executives on corporate priorities and strategic directions, complex and sensitive issues, and other matters of corporate policy.
- The establishment of effective mechanisms and processes to engender positive intergovernment relations and linkages with national, interstate and other industry related groups.
- The organisational performance and strategic leadership of the Innovation and Workforce Reform Directorate.
- Managing expenditure in the Innovation and Workforce Reform Directorate ensuring it does not exceed the budget allocated for any financial year.
- The design, quality, procedures and effectiveness of performance arrangements and reporting for all matters associated with Innovation and Workforce Reform Directorate in Queensland Health.

Other delegations as assigned by the Minister and Director-General of Queensland Health.

9. Assessment Criteria

Your application for this position must specifically address each of the assessment criteria listed below. It should also contain the names and telephone numbers of at least two referees one preferably your current supervisor, who may be contacted with respect to your application shortlisting and selection will be based upon these assessment criteria.

		Weighting
AC1	Demonstrated record of successful achievement in setting and achieving corporate goals through the leadership of a large and diverse work group and the effective management of financial and human resources.	10
AC2	Demonstrated high calibre conceptual, analytical and problem-solving ability with sound decision-making skills.	10
AC3	Demonstrated innovation and effective strategic approaches to continually improve service delivery and organisational capabilities to meet current and future demand.	10
AC4	Demonstrated ability to manage a diverse workforce in a complex industrial climate, including the ability to implement equal opportunity in employment, to improve workforce morale and to develop further the effectiveness of a executive management team.	9
AC5	Demonstrated outstanding abilities in policy formulation and strategic planning.	9
AC6	Highly developed interpersonal skills to advance collaborative working relationships with the ability to negotiate and communicate at all levels of government and with relevant outside bodies on complex and sensitive issues.	9

10. Additional Factor

The successful applicant will be expected to enter into a performance based Contract of Employment.

Applications should be sent to: The Vacancy Processing Officer, Corporate Office Human Resource Unit, Queensland Health, GPO Box 48, Brisbane Q 4001

Or placed in sealed box located in foyer of: 12th Floor, Queensland Health Building, 147-163 Charlotte Street, Brisbane Q 4001

MFW-3

Queensland Health Strategic Plan 2004–10

healthier

promoting a *healthier* Queensland

Queensland Government
Queensland Health

Queensland Health's network of health services and programs is provided through a network of 202 acute care facilities, 570 non-inpatient services including mental health, oral health, community health and pathology services and 20 State Government residential aged care facilities.

Every day in Queensland Health

- $12.231 million is spent on health services
- $0.603 million is spent on rebuilding and maintaining health facilities
- 485 women are screened for breast cancer
- 3206 vaccines are distributed
- 92 babies are born
- 185 families receive positive parenting education
- 1550 older people receive residential care in 20 aged care facilities
- 3326 people are treated in accident and emergency
- 6970 patients are cared for in public hospitals
- 42 veterans are treated in public hospitals as inpatients
- 24,152 outpatients receive services
- 954 people receive day-only procedures in a hospital
- 953 adults receive free dental treatment
- 904 school aged children complete dental treatment
- 6456 meals are delivered to people at home
- 10,745 hours of respite care are provided through respite centres or in people's homes

(All statistics are averaged over 365 days in the 2002-03 year.)

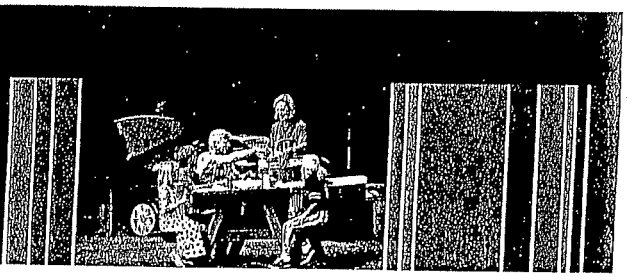


Table of contents

Message from the Minister

One of the Queensland Government's highest priorities is to build and maintain the trust of Queenslanders who expect the health system to work for them when and wherever they need it.

The real challenge is to ensure our health system remains healthy and sustainable. This will not be easy: our population is ageing and increasing, health costs are rising in line with the cost of new technology and drugs, and there is a world-wide shortage of skilled health professionals.

The *Queensland Health Strategic Plan 2004–10* engages all 65,000 Queensland Health staff in meeting these and other challenges, finding new and smarter ways to deliver health services based on need.

Priority staffing initiatives are designed to improve staffing levels across health professions and deliver opportunities for staff and career development.

There is also an emphasis on promoting good health and engaging Queenslanders to take more responsibility for maintaining their health.

The imperative to improve partnerships will help reduce duplication, coordinate services and provide a better mix of services for people at home, in the community or in hospital. By managing chronic and other conditions in the community we will free hospitals to do what they do best – provide acute and emergency care in times of need.

The Queensland Government has committed significant resources for health. Staff have a vital role to ensure the resources entrusted to them produce maximum health outcomes for the community.

The next six years will be an exciting time for Queensland Health.

With your help, public confidence in our health system will grow to new levels and we will maintain and improve the health of the people of Queensland.

Gordon Nuttall MP
Minister for Health

Director-General's introduction

Queensland has one of the best public health systems in the world. It is my intention that we build on this reputation and make it even better.

The *Queensland Health Strategic Plan 2004–10* is timely for our organisation to refocus its direction, restate its commitment to the community and affirm our staff as our greatest asset. It brings all corporate planning processes into line and gives the clear direction on where we are heading in the immediate future.

Queensland Health now has a new mission: *Promoting a healthier Queensland*. Our new vision: *Leaders in health – partners for life*, challenges all staff to retain the confidence of Queenslanders who trust us to look after their health needs throughout life.

Of course, no organisation can achieve the vision of being a leader in their field unless they are very clear about their strategic intention. Over the next six years, we will promote a healthier Queensland through five new strategic intents: *healthier staff, healthier partnerships, healthier people and communities, healthier hospitals*, and *healthier resources*.

It is my intention that staff at all levels of the organisation are involved in making the changes necessary to deliver these strategic intents. We need to have a greater emphasis on prevention and health promotion, while at the same time ensuring our acute services are of the highest quality.

However, we can not do it alone and our partnerships with the community, all levels of government and other health providers will be vital.

Internally we will use the Integrating Strategy and Performance (ISAP) process to engage all staff, drawing on your wisdom, expertise and ideas to make improvements to local services.

In this way the entire organisation and our partners will work together to promote a healthier Queensland.

Steve Buckland
Director-General
Queensland Health

Purpose

This plan outlines our strategic intention for the next six years. It builds on the work of the *Smart State: Health 2020 Directions Statement* released in December 2002 and the strategic planning and performance monitoring process we have progressed since then through our Integrating Strategy and Performance (ISAP) process.

t identifies our strategic objectives, our performance measures and the major nitiatives we will implement to promote a healthier Queensland.

The *Queensland Health Strategic Plan 2004–10*:

- describes to our stakeholders, staff and the community what we aim to achieve over the next six years
- links the Queensland Government's priorities to the health outcomes we plan to achieve
- shares our strategic planning framework with stakeholders and staff
- provides direction to our staff on how their work can contribute to achieving health outcomes
- provides direction to Queensland Health's executives in allocating resources
- identifies the challenges we face as we work towards achieving our mission
- guides the organisation in operational and business planning.

Role

Queensland Health has three major roles:

- a leadership role to protect health and promote a healthier Queensland
- a stewardship role to deliver health services that prevent, alleviate and manage illness and disease, such as programs to protect and promote public health; hospital services; mental health services; community-based support programs; services specific to population groups including older people, women, children and young people, and Aboriginal and Torres Strait Islander peoples; and alcohol, tobacco and other drug, sexual health and oral health services
- a partnership role with consumers, other health providers and other sectors to achieve healthier lifestyles and healthier communities.

Promoting a *healthier* Queensland

Queensland **Health Strategic** Plan **2004-10**

Our strategic intents

We will be successful in promoting a healthier Queensland through five strategic intents.

Healthier staff

Our intent is to optimise staffing levels, provide staff with the right knowledge and skills, and provide an environment that values their experience and supports positive ideas to drive innovation, creativity and health enhancements.

- We will recruit, develop and retain a highly skilled workforce.
- We will support the health of our staff.
- We will encourage and help staff to develop their knowledge, experience, and leadership skills.
- We will promote an organisational culture that supports our values of professionalism, teamwork, performance accountability, and quality and recognition.
- We will give staff the right information, at the right time, at the right place, through the right medium.

Healthier partnerships

Our intent is to work with others to harmonise programs and activities that impact on health.

- We will work in partnership with other federal, state and local governments and non-government organisations to ensure their policies, programs and activities actively support good health.
- We will work in partnership with other health care providers to plan and deliver innovative, cost-effective and integrated health services.

Our mission

Promoting a *healthier* Queensland

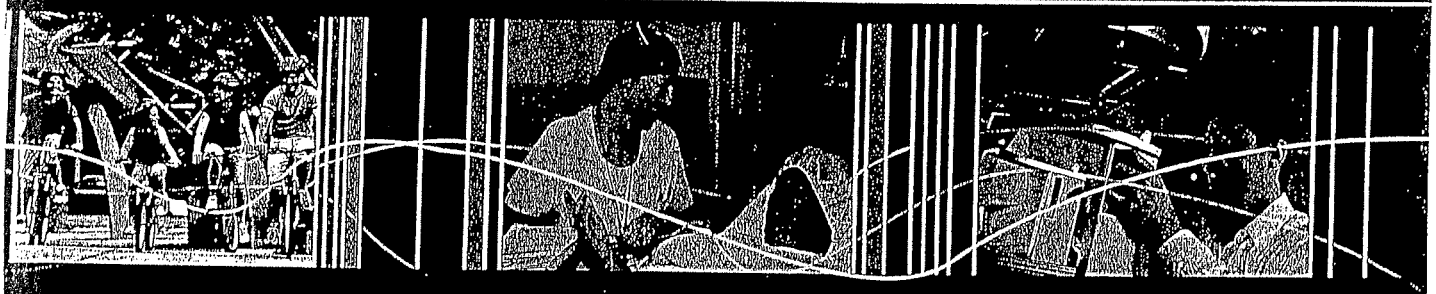
Our vision

Leaders in health – partners for life

Our values

We recognise that Queenslanders trust us to act in their interest at all times. To fulfil our mission and sustain this trust we share four core values:

- professionalism
- teamwork
- performance accountability
- quality and recognition.



Healthier people and communities

ur intent is to increase our focus
promoting healthier lifestyles and
vironments for individuals, families and
mmunities, and improve community-
sed chronic disease management.

We will inform, support and provide Queenslanders with information and skills to improve, maintain and manage their health.

We will invest more in strategies to prevent illness and injury in the areas we can make the greatest difference.

We will systematically identify people at greatest risk of illness, injury or complications from existing health conditions and take steps to reduce their risk and improve their quality of life.

We will work with other health care providers, both government and non-government, and community-controlled organisations, to build a stronger and more responsive primary health care sector.

Healthier hospitals

Our intent is to ensure our hospitals provide high quality, equitable acute and emergency care, integrated with enhanced community-based services.

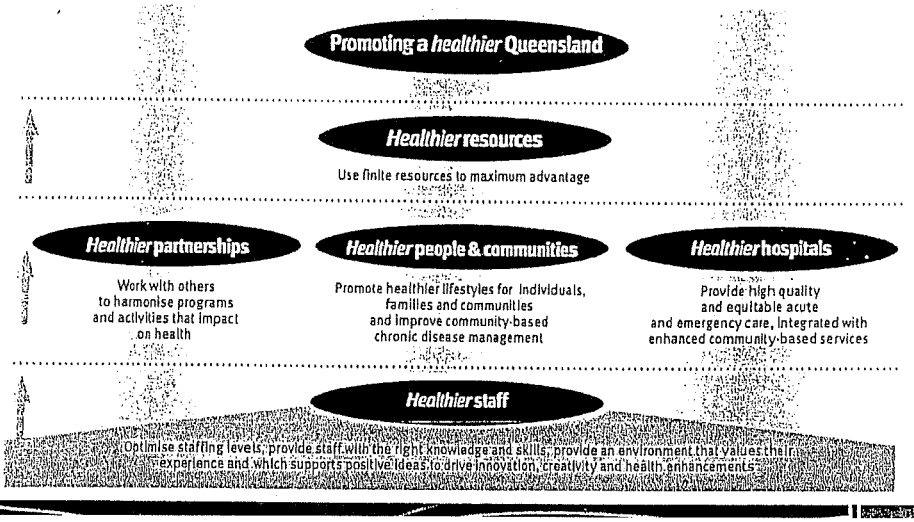
- We will ensure that throughout Queensland Health, treatment is based on evidence-based decisions, policies, and programs.
- We will continuously improve our key business processes.
- Our service and workforce plans will reflect our strategic priorities and demands.

Healthier resources

Our intent is to use our finite health resources to maximum advantage.

- We will provide excellent health service delivery while maintaining balanced budgets.
- We will seek opportunities to work with other industries to ensure their resources, activities and programs support a healthier Queensland.

The following diagram shows the structure of the Queensland Health strategic intents. This structure complements the *Queensland Health Strategy Map* and is designed to be read from the bottom up. (The *Queensland Health Strategy Map* is presented on page 12.)



Our challenges

There are a number of challenges which we must take into consideration in our actions to promote a healthier Queensland.[1]

Population growth, ageing and distribution

Population size and spread

Queensland is the fastest growing state in Australia and will overtake Victoria's population by 2038. Two-thirds of all Queenslanders are likely to live in the south-east corner.

Ageing population

Queensland's population is ageing due to increased life expectancy and declining birth rates.

By the year 2020, one in seven people will live alone, with 25 per cent of people aged 75 years or older being in that category. The demand for aged care and support services will rise sharply, particularly as the number of very old people increases.

The state's workforce is also ageing and more workers will have 'elder care' responsibilities. Workforce shortage will increasingly be commonplace and will affect the health care industry.

Queensland Aboriginal and Torres Strait Islander peoples

Three per cent of Queensland's population are Aboriginal and Torres Strait Islander peoples and it is estimated that the state will have the largest population of Aboriginal and Torres Strait Islander peoples in Australia by 2006.

Queensland Aboriginal and Torres Strait Islander peoples have higher fertility rates, higher mortality rates and have poorer health than the general population.

Improvements in the health status of Aboriginal and Torres Strait Islander peoples requires action to address the social, cultural and environmental factors that affect health and by improving health outcomes through effective health services.

Queenslanders born overseas

Queensland is a culturally diverse state with about one third of residents either born overseas or having at least one parent born overseas.

Queensland Health is committed to principles of equitable access, participation and diversity in service delivery to multi-cultural groups.

People living in rural and remote areas

Across the state the population in rural and remote areas is both declining and ageing. This impacts on our capacity to adequately resource health services in rural locations where the demand for services is increasing, but the workforce, including that of the health sector, is declining. With the added factor of the increasing complexity of care, the challenge for Queensland Health is to provide safe, high quality services for people living in rural and remote areas.

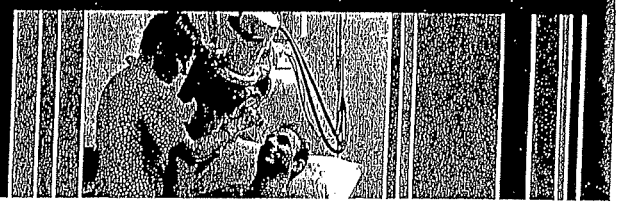
Children and young people

Children and young people (0–24 years) make up more than one third of Queensland's population. While their proportion of the total population is declining (except for Aboriginal and Torres Strait Islander children), the number of children and young people in Queensland is expected to increase by more than 30 per cent by the year 2025.

We know that positive social, economic, educational and environmental conditions improve the growth and development, mental health and the short and longer-term health of children and young people.

In addition, the link between the maternal and infant health and chronic conditions such as diabetes, heart disease and high blood pressure in later life is clear, and that these conditions are appearing at much younger ages.

More detail about these challenges can found in the Smart State: Health 2020 rections Statement available on our website ww.health.qld.gov.au



Economic and workforce conditions

Changing employment
Employment in service and knowledge-based industries is increasing, with more women moving into these areas than in the past. Over the next six years, the proportion of female health professionals and general practitioners will increase in the health sector. This will increase the pressure on our organisation to develop flexible working solutions.

Employment and income are the most important modifiable determinants of health. The extent of income inequality (ie. the size of the gap between the rich and the poor) is also associated with overall mortality. The health sector has a leadership role in policy debate in this area and in responding to the health implications of future employment trends.

Workforce growth
As the population ages and our birth rate declines, employment growth will slow down. Towards the end of the timeframe of this strategic plan, we can expect to see an increasing need for health care and fewer people available to provide that care. We can also expect to see overseas competition for trained health professionals creating challenges for our workforce strategy.

Workforce patterns
Changing workforce patterns will also impact on the economy and on the health care industry, with career changes over a lifetime increasing and a clear trend towards part-time, casual and contracted work. To recruit and retain highly skilled professionals in the workforce, flexible working solutions will need to be developed which take these trends into consideration.

Workforce mix
To address changes in the burden of disease (ie. the increase in chronic disease and the decrease in infectious diseases), we will need to develop models of care that facilitate care being provided by teams that work across health settings.

Rural workforce
The small populations in many small rural centres create challenges for providing health care. Care needs to be accessible and yet we need to ensure that our service provision is of high quality and cost-effective. Workforce shortages in rural areas make it even more difficult to sustain safe, high quality services. Rural, remote and regional communities will be involved in shaping new service models that respond to health needs and make the best use of available resources.

Increasing costs of health care
Health care expenditure will continue to be under pressure with increasing costs of new technologies, drugs and health care innovations, increasing consumer demand for new treatments, and an increase in demand for health services due to an ageing and growing population.

Competition by the public health sector for government resources – both state and federal – will be intense. Transparency relating to expenditure and outcomes will be crucial if public confidence is to be maintained in the sector.

Private health insurance and demand for hospital services
When the Australian Government introduced its private health insurance incentives package in 2000, Queensland's level of insurance coverage increased but is still below the Australian average.
The demand for public hospital services, particularly high cost and complex public health services, has not diminished. Increasing insurance premiums, exclusion provisions, limited distribution of private hospitals and out-of-pocket expenses lead patients to seek treatment in the public rather than the private sector.

Environmental conditions

A wide range of environmental factors impact on health. These include air and water quality, food safety and security, pests, ultraviolet radiation, housing and household devices and environmental tobacco smoke. To safeguard the health of Queensland communities, it is critical to maintain the capacity of and improve systems to monitor and regulate these factors.

We must identify and address environmental challenges including the adequacy, safety and quality of water supplies; waste and water management; materials for housing; more and more people living in cities and in increasing densities; and global climate change which could influence the spread of communicable diseases.

Health system organisation and advances

Changing models of health service delivery
Chronic disease, mental illness, injury and self-harm will account for a significant proportion of the future burden of disease. Service delivery will change to better meet people's needs.

Management of chronic conditions is already shifting from acute treatment in hospital to community services that manage complications and alleviate the need for hospital admission. Changes include an increased focus on community or home-based services such as rehabilitation and strengthened partnerships with primary health care providers.

More emphasis will be given to the primary prevention of disease, illness and injury, and on activities that will protect the health of individuals and communities.

Technological advances
As new technologies become available, difficult decisions must be made relating to the cost-effective and ethical use of high cost technologies and the required level of support, including staff training.

New technologies are already changing things for the better. A Queensland-wide telehealth network provides medical specialist input into care provided in local communities.

Fragmented service delivery
The responsibility for health policy, funding, service planning and delivery is spread across three levels of government (federal, state and local government). Developing partnerships within and across sectors will mean that the money spent on health care can be used to maximum advantage, with services integrated wherever possible.

Community expectations

Consumer expectations of the health system are rising. Increasing numbers of health consumers are better informed and educated, less deferential, and want more control and choice in their health care. These factors impact on perceptions and relationships between consumers and health professionals.

People want to have a greater say in service planning. With the impending retirement of the baby boomers, well-educated retirees will increasingly be available for consultation processes to plan health services. Community engagement at all levels will be integral to the broader government health policy development processes.

Partnerships

Whole-of-government partnerships
Health is dependent on many factors including lifestyles, genes, economic and social conditions, and environment. Queensland Health will use strategic partnerships with other government departments to promote better health outcomes. We will strengthen partnerships with lead agencies responsible for disability, education, employment, housing, local government, transport, sport and recreation, social support services and others, to support the development of healthier communities and healthy lifestyles.

Partnerships in health care
The health care system is a complex one and Queensland Health is only one provider of health services to the community. We will endeavour to work more closely with the Australian Government which shapes the national health policy and finances primary medical care services, pharmaceutical benefits and aged care services. We will also work more closely with health sector partners, including general practitioners, private specialists and private hospitals, and with non-government agencies providing community-based services.

Meeting our key challenges

There are five key challenges which require critical attention for Queensland Health to achieve its mission. Our actions to address these key challenges are now summarised and feature prominently in our initiatives detailed on pages 13-19.

Population growth

A number of strategic initiatives deal with managing the increasing demand for services due to our growing population. These include funding to reduce waiting times for elective surgery, enhanced capacity to provide cancer and cardiac treatment, and new services built through the Smart State Building Fund.

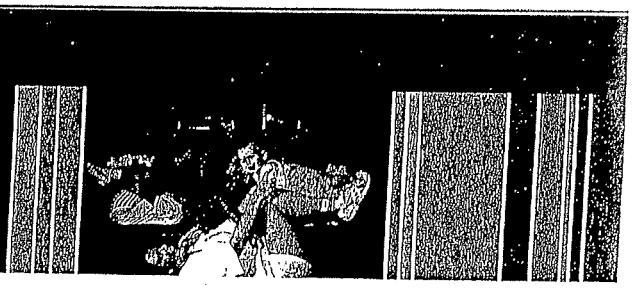
In south-east Queensland where population growth is greatest, we will develop and implement an inclusive planning model, involving other state agencies, the Australian Government, local government and local communities. Our aim is to ensure that planning for growth in new and existing communities will routinely consider opportunities to promote the health of the people in those communities, give appropriate attention to environmental risks to health, and ensure appropriate planning for health services and access to them.

The health of Queensland Aboriginal and Torres Strait Islander peoples

The Queensland Government recognises the poor health status of Aboriginal and Torres Strait Islander peoples across Queensland and in response is building partnerships supported by whole-of-government frameworks.

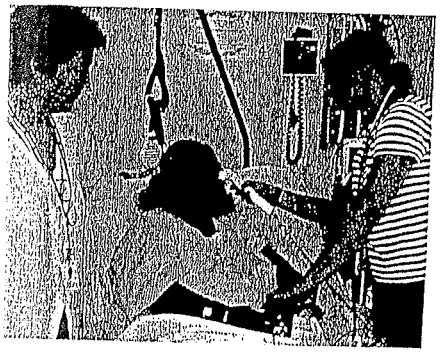
The *National Strategic Framework for Aboriginal & Torres Strait Islander Health* has been endorsed by the Queensland Government and a Queensland implementation plan is being developed to guide health service delivery in conjunction with other services which impact on health.

As the lead agency for health, we will collaborate with other government and non-government agencies as well as Aboriginal and Torres Strait Islander communities to improve health outcomes for Aboriginal and Torres Strait Islander peoples.



Queensland Health is committed to working with other government departments to overcome Indigenous disadvantage to achieve the following outcomes:

- safe, healthy and supportive family environments with strong communities and cultural identity
- improved wealth creation and economic sustainability for individuals, families and communities
- positive child development and prevention of violence, crime and self-harm.



culturally-sensitive workforce is central improving the health of Aboriginal and rres Strait Islander peoples. The *ueensland Health Indigenous Workforce anagement Strategy* and the *Cultural spect Framework 2003–2008* will guide e delivery of accessible, culturally propriate services.

relation to Aboriginal and Torres Strait ander peoples, the challenges for ieensland Health and other agencies 'l be to:

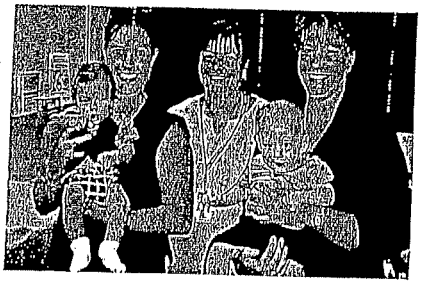
improve physical environments, infrastructure and other essentials for health and working to reduce the multiple causes of illness, injury and disability

improve access to appropriate and affordable housing

promote a whole of life approach to health for individuals, families and communities

provide access to an effective, ntegrated network of services to promote and maintain good health, prevent and injury, detect and manage lisease and illness as early as possible

uild on the existing Aboriginal and orres Strait Islander health and health-elated workforce.



The health of Queensland children

The Queensland Government has endorsed a *Strategic Policy Framework for Children's and Young People's Health 2002 – 2007.* This document supports whole-of-government and early intervention approaches to create safe, supportive family and community environments. It highlights risk reduction and protection during critical developmental stages.

Queensland Health has established early intervention and parenting support programs which improve and integrate services for families with children aged 0–6. Frameworks and guidelines have also been developed for infant nutrition (including breastfeeding), promoting health in schools, the identification and management of child abuse and neglect, and screening for early detection of health conditions. Further work to support implementation of these across the state will continue. Priorities for future action include:

- commitments under the whole-of-government blueprint for child safety
- improving Aboriginal and Torres Strait Islander child and youth health
- intersectoral action to promote healthy weight in children and young people
- a statewide neonatal screening program for hearing
- improved intersectoral integration of support and care for children aged 0–6 with a disability and/or complex conditions.

The ageing of the population

Older people are the greatest users of health services and this demand will continue to rise as our population ages. Queensland Health is committed to providing acute, community and aged care services for the ageing population, including the provision of services to the veteran population. A statewide chronic disease implementation plan will be central to managing the impact of an ageing population, as will be support provided to older people so that they maintain their health and stay healthier longer.

We will continue to implement *Queensland Health's Directions for Aged Care 2004–2011*, which provides the clear direction for the further development of health and aged care service delivery to older people and their carers.

Queenslanders living in rural and remote areas

The health of many rural and remote Queenslanders, notably Aboriginal and Torres Strait Islander peoples, is poor compared with the general population. Faced with changing patterns of need and demand, declining and ageing populations, the increasing sophistication of secondary and tertiary health services, and shortages of appropriately skilled staff, many rural and remote centres are finding it increasingly difficult to provide an appropriate mix of safe, high quality health services.

Queensland Health is developing an integrated health planning framework to guide sustainable models of health care delivery in these communities. At the same time we are developing better ways to address priority health issues closer to where people live by enhancing use of primary health care approaches, expanding clinical outreach models and making better use of telehealth services.

Achieving our mission

Queensland Health consulted widely with stakeholders, staff and the community to develop our strategic intention. This section summarises this consultation and describes the relationship between our strategic intention and the government's policy priorities. It also describes how we will act on the strategic intention through the Integrating Strategy and Performance (ISAP) process. The last part of this section presents the *Queensland Health Strategy Map* and the objectives and initiatives we will progress over the next six years to achieve our strategic intention.

Our strategic planning process

Consultation

The Smart State: Health 2020 Directions Statement and the Queensland Health Strategy Map provided the foundations for this strategic plan. Significant stakeholder, staff and community engagement activities were conducted in the development of both of these direction-setting documents, including visioning workshops in locations across the state, dissemination of a discussion paper for public consultation, and stakeholder working groups. Additional internal consultation was undertaken in 2004 to develop our strategic intents.

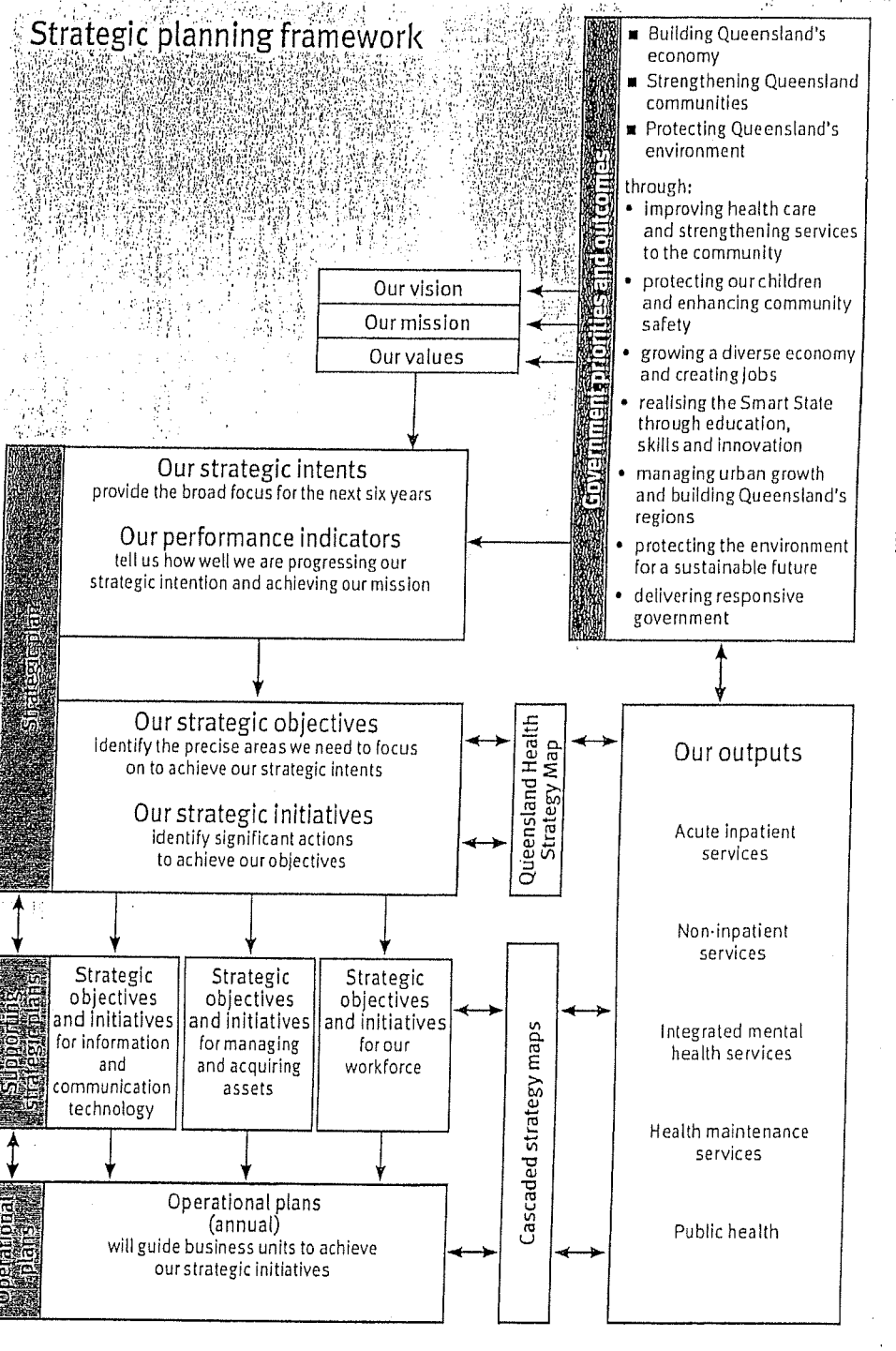
Strategic planning framework

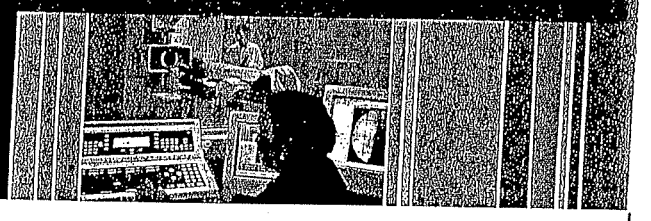
Our strategic planning framework is shown in the diagram on this page. The diagram depicts the influence of the department's strategic plans on our operational planning. The *Queensland Health Strategy Map* underpins our strategic plan. It was developed through the Integrating Strategy and Performance (ISAP) process. The strategy map is currently being cascaded through-out the organisation.

Our contribution to whole-of-government policy priorities

Queensland Health is committed to progressing the Queensland Government's policy priorities. Our outputs directly contribute to the first priority of health care and support each of the other priorities. This is because health is determined by a range of factors including our physical, social, economic, cultural and political environments, educational and employment opportunities, and access to health care.

The influence of the government's policy priorities and our contribution to these is shown in the following diagram. This diagram depicts the department's strategic planning framework.





Our unique contribution to the Queensland Government's priorities and outcomes is detailed below.

nproving health care nd strengthening services) the community

uality health care is an investment in a ealthy population and contributes to the ate's productivity and economy. Across vernment we will take action to improve e social, economic and environmental tors that impact on health.

thin Queensland Health we will:

work with other health care providers to ensure our services are client-centred, integrated and accessible

change the balance of our investment to enable a stronger focus on promotion and protection of health, disease prevention and the maintenance of quality of life

Develop coordinated, whole-of-government approaches to improving he health of Aboriginal and Torres Strait Islander peoples

)lan new services in partnership with ther health care providers and the ommunity.

tecting our children and ıancing community safety

ensland Health will continue to work other agencies to increase the safety ildren at risk and to contribute to the e-of-government blueprint for reform. will involve improving our processes entify child abuse and neglect. We will conduct programs to provide parents ung children with skills to manage ren and other issues in their lives.

community initiatives will be nued, with a focus on alcohol and drug misuse, child injury and ntion of falls in older people. We lso contribute to the safety of our ıunities through improving our ing for disaster preparedness and ıunicable disease pandemics.

f our strategic intents is for healthier We are committed to promoting y and safe environments for our staff.

Growing a diverse economy and creating jobs

Queensland Health is the largest employer in Queensland with around 65,000 staff. To meet the growing demand for health services, we will employ 1500 nursing graduates and additional staff for emergency departments.

With forecasted workforce shortages, a priority for Queensland Health will be to retain our staff in health care jobs. This may involve creating new opportunities for staff and flexible working arrangements. It will also involve innovative recruitment strategies to build our staffing capacity wherever possible. A number of initiatives are already being progressed in regional and rural areas and include the Rural and Remote Nursing Relief Program, the Rural Scholarship Scheme that encourages health professionals to work in rural Queensland, the Allied Health Professional Enhancement Program and the Breaking the Unemployment Cycle initiative.

Realising the Smart State through education, skills and innovation

We recognise the strong link between educational status and health outcomes. As a matter of priority we will educate Queenslanders on healthy choices, behaviours and lifestyles, with an emphasis on educating and motivating children to adopt healthy eating practices and active lifestyles.

We also recognise that the knowledge and skills of our workforce are critical to our ability to prevent disease and to treat illness and disease when it occurs. Lifelong learning will be promoted. We will undertake research to ensure that our workforce has the right skills to manage the changing burden of disease.

Improvements in health care are dependent on an active health and medical research program. We will take a leadership role in developing the Queensland health and medical research effort to give Queenslanders the benefit of the highest quality and most effective health services and programs possible.

We will also encourage and reward ideas, innovation, hard work and collaboration across the health sector, across government and with the non-government

Managing urban growth and building Queensland's regions

We will support Queensland's regions through statewide health service planning, infrastructure development (eg. telehealth) and recruitment and retention initiatives for the rural and remote health workforce.

Our contribution to regional planning will focus on managing the accelerated growth in south-east Queensland so that health is protected and promoted. Development should support lifestyles which encourage people to increase their level of physical activity.

We will also participate in planning for integrated transport options that safeguard air quality and provide equitable access to health services.

Protecting the environment for a sustainable future

Energy efficiency and effective waste management are vital for good public health and ecological sustainability. We will strengthen our collaboration with other state and local government agencies to ensure environmental protection responsibilities are well linked with the government's health protection and promotion responsibilities.

Queensland Health will contribute to sustainable development by continuing to undertake energy audits, replace older energy and waste management systems with more efficient and effective technologies, and work with other agencies such as the Environmental Protection Agency to establish whole-of-government energy, water and waste management strategies.

Delivering responsive government

A strong health system cannot operate in isolation from the Queensland community. Queensland Health will improve its engagement processes with communities in health service policy, planning, priority setting and decision making processes.

We will also improve our responsiveness by identifying future challenges to health and health care and develop strategies to proactively manage these challenges.

Our Queensland Health Strategy Map: strategic intents and objectives at a glance

The Integrating Strategy and Performance (ISAP) process will help us achieve our strategic intention. Through ISAP, we have translated each of our five strategic intents into a series of objectives. These, together with the strategic intents, form the *Queensland Health Strategy Map*. We will routinely measure and review our success in achieving these objectives.

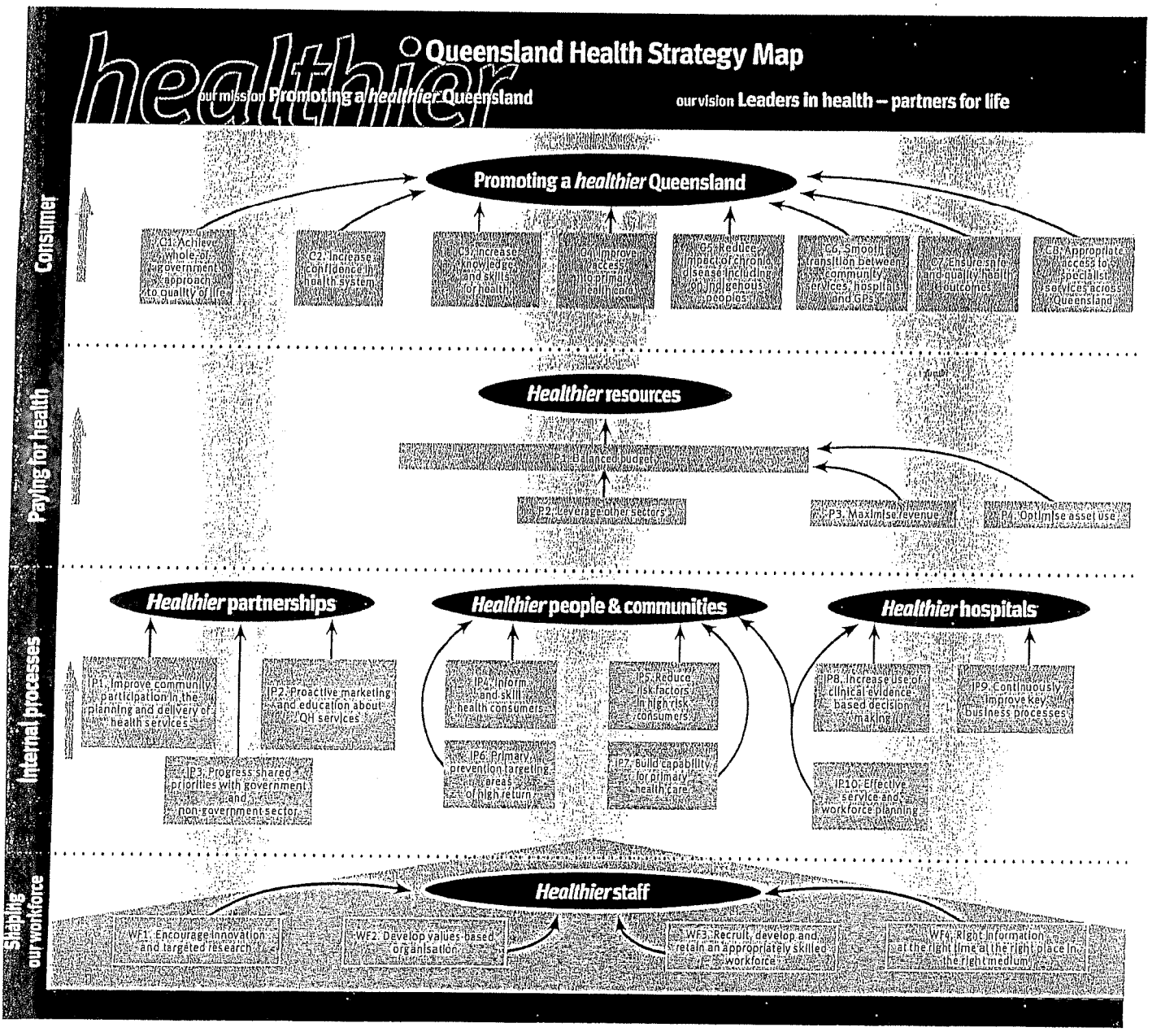
We will also cascade these objectives to health service districts, statewide services and corporate office, to ensure that all parts of the organisation are actively supporting our strategic intention and contributing to realising our mission.

It is important to note that our strategic intents are interrelated and that action in one affects the others. Our initiatives have been planned to ensure that actions are coordinated across the entire health care continuum from primary prevention to secondary prevention, acute treatment, tertiary prevention, rehabilitation and palliation.

Our strategic initiatives

This section of the strategic plan details the initiatives that will be implemented over the next six years to achieve our objectives, and in turn, our strategic intents. The initiatives are presented in the order corresponding to reading the *Queensland Health Strategy Map* from the bottom up.

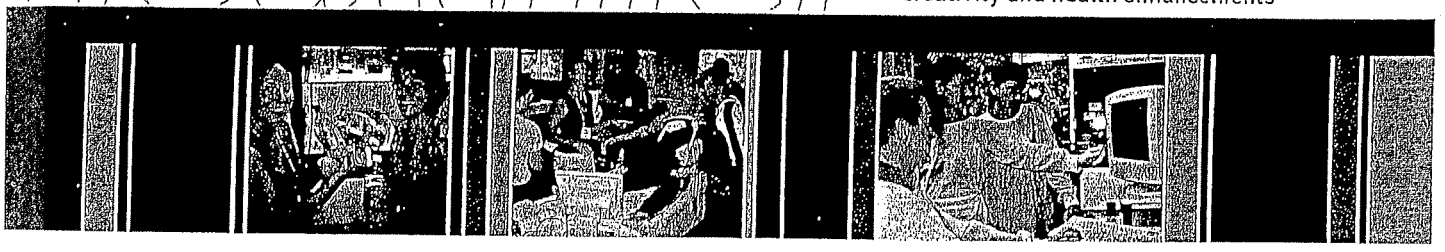
- *Healthier* staff
- *Healthier* partnerships
- *Healthier* people and communities
- *Healthier* hospitals
- *Healthier* resourcing



healthier

Strategic intent
Healthier staff

Optimise staffing levels, provide staff with the right knowledge and skills, and provide an environment that values their experience and supports positive ideas to drive innovation, creativity and health enhancements



icourage innovation and targeted search

Establish the Ministerial Health and Medical Research Council of Queensland to provide strategic direction and leadership for health and medical research in Queensland

Establish an innovation management system to recognise staff creativity and innovation and provide funding to test ideas

Implement nursing research scholarships to promote nursing research

/elop a values-based organisation

Establish a system of routinely canvassing staff feedback and opinion o inform organisational improvement nitiatives to improve the health of our staff and organisational climate, morale nd performance

nplement an enhanced system f performance appraisal and evelopment for all staff in line with rganisational values and goals

nplement workplace initiatives to nprove the health of our staff, with n initial focus on helping staff to stop noking

hat will this mean for you?

a staff member of Queensland lth, we will increase our support to by making your workplace healthier. example, not only are we asking the mmunity to make healthier lifestyle ices but we are making it easier for to make these choices at work. ne initiatives already underway ude the statewide vaccination gram offered to staff, healthy or ter choice' menus in hospital eens, and physical activity grams. We know our staff hold the to positive changes in the way we age and we will act on your back on how to improve ensland Health's work environment.

Recruit, develop and retain an appropriately skilled workforce

- Implement the National Health Workforce Strategy to deliver a sustainable workforce
- Improve our systems, information and strategic partnerships to support workforce planning and develop the future workforce, with an initial focus on:
  - the strategic role of the principal health advisers in clinical workforce recruitment and retention
  - innovative recruitment strategies such as e-recruitment including the dedicated nursing website www.thinknursing.com, and a web-based system to manage graduate recruitment
  - a peak nursing body to monitor and progress nursing recruitment and retention initiatives
  - frameworks for team-based models of care that use the skills of professionals in different ways
  - legislation determined to be necessary to enable registered nurses with expert knowledge and advanced clinical experience to undertake the nurse practitioner role. During the development of this legislation, conduct trials at demonstration sites to identify supporting strategies for the nurse practitioner role
- Implement programs through the Skills Development Centre to enhance the clinical skills of Queensland Health staff
- Employ 1500 new nursing graduates to improve our capacity to provide quality services
- Implement an executive leadership program and a succession management framework for critical leadership roles
- Establish a development program for Mental Health Service leaders to build skills in priority areas
- Establish a Centre for Mental Health Learning to provide coordinated mental health education and training
- Implement the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health* to establish culturally respectful and effective mechanisms, structures and partnerships within the health care system
- Review and update the *Queensland Health Indigenous Workforce Management Strategy* to ensure the implementation of effective strategies to enhance the representation of Aboriginal and Torres Strait Islander peoples at all levels of our workforce

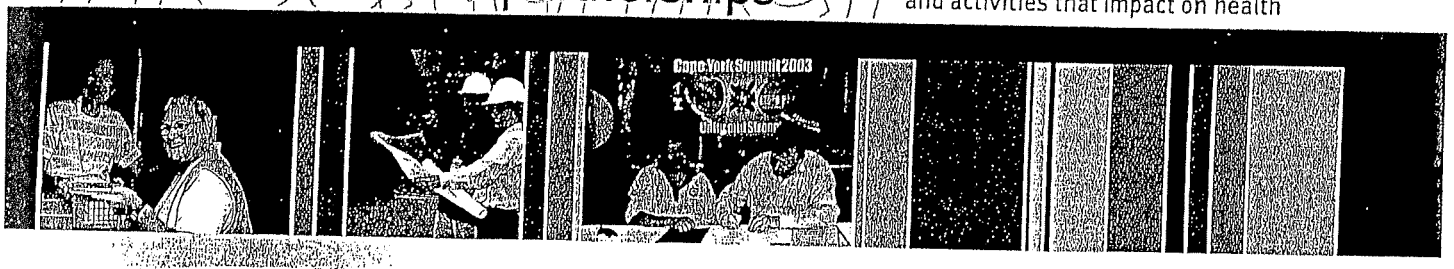
Right information at the right time at the right place in the right medium

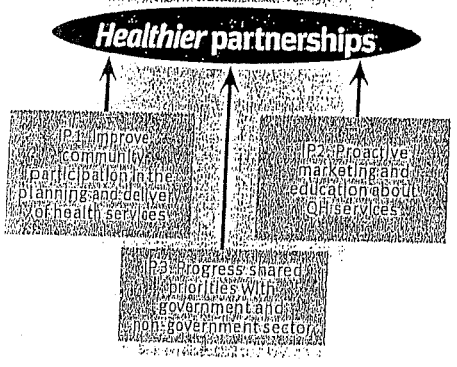
- Develop and implement a client-centric, clinical strategy for the migration of paper-based medical data collection to electronic collection including the development of electronic health records across hospital and community settings. Systems to be developed include:
  - community-based services including oral health, sexual health, mental health, aged care, chronic disease management, alcohol and tobacco and patient administration
  - hospital services including patient administration, pharmacy, pathology, radiology and utilisation of operating theatres

healthier

Strategic intent
Healthier partnerships

Work with others to harmonise programs and activities that impact on health





Improve community participation in the planning and delivery of health services

- Implement enhancements to the functioning of and support for district health councils, Ministerial councils, regional managers' coordination networks and Indigenous regional forums to strengthen community engagement
- Develop and implement improved community engagement processes based on the Government's *Engaging Queenslanders: Get Involved* policy
- Implement more inclusive approaches to service planning, with an initial focus on chronic disease prevention and management and rural and remote health planning

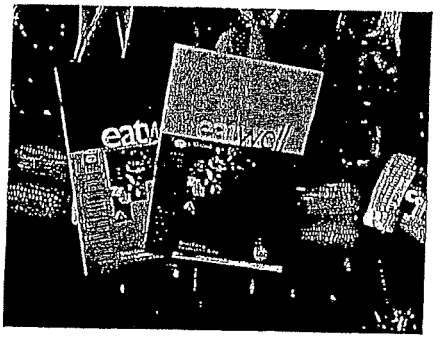
Proactive marketing and education about Queensland Health Services

- Implement a marketing, communication and media plan to inform Queenslanders about the range and quality of Queensland Health services

Progress shared priorities with government and non-government sector

- Work with other governments, departments and the non-government sector to include healthier communities as a goal in policy development and planning for managing population growth and urban development, with an initial focus on:
  - a statewide service planning function
  - progressing whole-of-government approaches to health impact assessments
- Contribute to the National Health Reform Agenda and particularly the reform agenda for chronic disease prevention and management
- Continue to collaborate with other agencies to implement Queensland Health's responsibilities in relation to the *Meeting Challenges, Making Choices* Initiative – the Government's response to the Cape York Justice Study

- Implement the National Rio Tinto Child Health Partnership to link Aboriginal and Torres Strait Islander organisations and communities, business, governments, service providers and researchers to improve the health of Aboriginal and Torres Strait Islander children
- Develop stronger and more formal links with Education Queensland, the Department of Housing, Disability Services Queensland, Queensland Police Service, and the Department of Child Safety to support cross-departmental action on activities that impact on health
- Implement, annually review and update the joint action plan with Education Queensland. Initial priorities are healthy weight in children, skin cancer, alcohol, tobacco and other drugs, sexual and reproductive health and mental health promotion

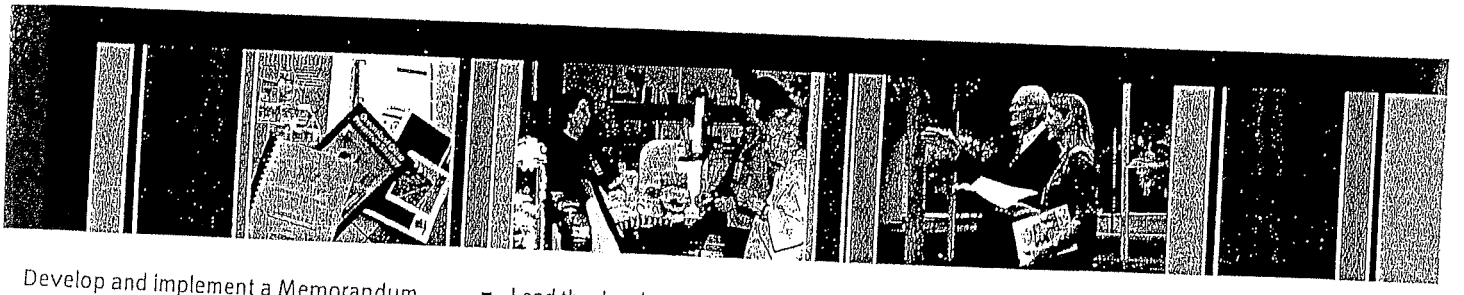


What will this mean for you?

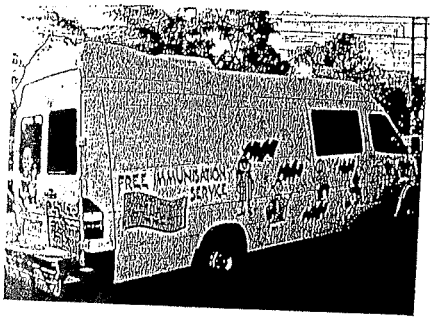
Healthy children grow into healthy adults. Habits formed in childhood influence later life. This is why Queensland children are receiving positive role modelling and information at school.

The curriculum includes learning about good nutrition and physical activity and puts it into action. Learning about the sun safety message starts in pre-school. We are assisting tuckshops to adopt healthier food choices. School-based nurses in secondary schools support programs covering sexual and mental health issues and the responsible use of alcohol and other drugs.

The joint Queensland Health and Education Queensland partnership will continue initiatives such as these so we can grow a healthier Queensland.



Develop and implement a Memorandum of Understanding with the Environmental Protection Agency to enhance collaborative and coordinated responses to environmental health risks



Implement the Queensland Health components of the whole-of-government response to the Crime and Misconduct Commission Report *Protecting Children: An Inquiry Into Abuse of Children in Foster Care*, to increase the safety of children at risk

Lead whole-of-government implementation of the *Queensland HIV, Hepatitis C and Sexual Health Strategy 2004–2007* to improve health outcomes

Continue to lead whole-of-government implementation of the *Queensland Government Suicide Prevention Strategy 2003–2008*

Build on the existing whole-of-government approach to emergency preparedness and business continuity to accommodate emerging issues, including the threat of terrorism, and deliver a coordinated response across services

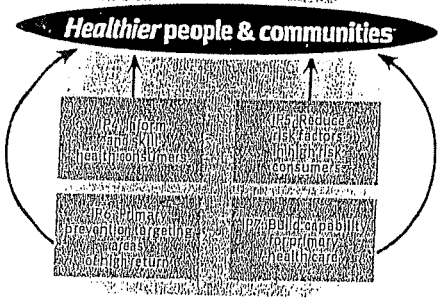
- Lead the development of the whole-of-government implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*

- Review and implement improved collaborative arrangements with the Department of Local Government and Planning, Sport and Recreation, the Local Government Association of Queensland and local councils to address public health issues and, where appropriate, support the development of community public health plans
- Work with the General Practice Advisory Council to progress joint issues around access to primary medical and preventive health care
- Work with the non government sector to develop service models that promote continuity of care and reduce duplication of services

healthier

Strategic intent
Healthier people and communities

Promote healthier lifestyles and environments f
individuals, families and communities and impr
community-based chronic disease management



What will this mean for you?

If you are an Indigenous person living in a rural or remote area of North Queensland, your chances of developing a chronic disease is being reduced. Through regular health checks potential health problems are being picked up early. When these are identified, you will be given consistent care to prevent or manage chronic diseases such as diabetes, renal failure and heart disease. This is all part of the Enhanced Model of Primary Health Care which works in partnership with communities so that Aboriginal and Torres Strait Islander peoples have access to prevention and clinical services in communities. Positive changes include joint health service planning and chronic disease care offered in 35 communities.

Inform and skill health consumers: consumers have the knowledge and support to manage health conditions confidently and in an ongoing way

- Improve the availability and currency of health related information to improve people's skills in maintaining good health and managing health conditions, with an initial focus on information for parents, carers and young people
- Establish a 24-hour, seven-day-a-week, statewide health hotline to give easy access to health advice and information about the location of health services

Reduce risk factors in high risk consumers

- Implement a system for identifying consumers at high risk of illness or disease and implement programs across hospital and community settings to reduce their risk. The initial focus will be on stroke, cardiac rehabilitation and the fitness of patients waiting for surgery

Primary prevention targeting areas of high return: promote healthier environments and behaviours focussing on areas where we can achieve the greatest health gains for the population

- Introduce and implement new legislation to protect and promote public health including a new public health Act and a new food Act to promote food safety in the food services, retail, processing and manufacturing sectors
- Implement in collaboration with Education Queensland and the non government sector, initiatives in the areas of healthy weight, skin cancer, alcohol, tobacco and other drugs, sexual and reproductive health and mental health promotion, as per the Joint Action Plan, and expand the School Based Youth Health Nurses Program
- Develop and implement an enhanced *Queensland Tobacco Action Plan* focusing on increased use of social marketing campaigns to complement the existing QUIT Campaign, enhancing tobacco control legislation and its enforcement, youth smoking prevention strategies, quit smoking services and multi-strategy programs to address smoking amongst Aboriginal and Torres Strait Islander peoples
- Lead whole-of-government activity and implement Queensland Health's commitments under *Eat Well Queensland: Smart Eating for a Healthier State* to improve food supply, promote healthy eating, increase consumption of fruit and vegetables; and enhance the health of mothers, infants and children
- Progress the adoption of the Queensland Health guidelines on breastfeeding and infant nutrition, *Optimal Infant Nutrition: Evidence Based Guidelines*, by all relevant health professionals
- Implement the *Queensland Alcohol Action Plan and the Queensland Illicit Drugs Action Plan* with particular focus on young people and meeting our commitments under the *Meeting Challenges, Making Choices* initiative
- Participate in the finalisation of, and implement Queensland Health's commitments under, the *Get Active Queensland* strategy in collaboration with the lead agency, the Department of Local Government, Planning, Sport and Recreation and other key agencies
- Continue to implement the *Statewide Action Plan: Falls Prevention in Older People 2002–2006* to reduce preventable injury from falls
- Develop and implement an enhanced *Queensland Skin Cancer Prevention and Control Strategy*, including additional investment in a skin cancer prevention and early detection community education program

- Promote the use of fluoride, including water fluoridation, particularly in high risk areas
- Lead a whole-of-government approach to strengthen resilience and well-being in children and young people, with a focus on mental health promotion activities targeting the early years, parenting and family functioning
- Implement a marketing and communication strategy to address stigma and discrimination experienced by people with mental disorders and mental health problems

Finalise and implement the position statement and service delivery models for Aboriginal and Torres Strait Islander children's and young people's health (0–24 years) including strategies and partnerships to reduce current health inequities

Expand the growth assessment and action (GAA) program into Aboriginal and Torres Strait Islander communities across North Queensland to address poor growth in infants and help prevent obesity and chronic disease in adult life

Implement evidence-based guidelines for using screening and surveillance for children aged 0–12 years as a tool to detect childhood health conditions as early as possible. Identify and address gaps in program delivery to improve immunisation rates in areas of lowest coverage

Develop and implement a program to improve public awareness of the signs and risk factors for stroke, particularly high blood pressure

ld capability for primary health care

Plan services with staff, local communities and other agencies in North Lakes, Logan and Innisfail to develop and implement innovative community models of service delivery nd health improvement

- Conduct programs to detect and manage risk factors or health conditions as early as possible, with an initial focus on:
  - establishing universal neonatal hearing screening
  - evaluating suicide prevention and dual diagnosis early intervention initiatives
  - implementing the Healthy Women's Initiative, initially in the northern zone, taking a well women's health focus promoting and encouraging Indigenous women's participation in health screening, in particular cervical screening and health maintenance
  - expanding the Queensland BreastScreen Program to achieve the target 70 per cent participation rate among women 50–69 years by 2008–09
  - participating in the evaluation of the national bowel cancer screening program pilot
  - implementing a program to improve detection and management of stroke and stroke risks by health professionals
- Introduce new models of care to improve oral health outcomes, with a focus on increased access to services and adopting population health approaches to complement treatment services
- Undertake research to inform the implementation of strategies to reduce the number of children 0–4 years undergoing general anaesthetic for gross tooth decay
- Expand the *Enhanced Model of Primary Health Care* into Aboriginal and Torres Strait Islander communities across North Queensland to prevent chronic disease, detect it earlier and improve our acute management services
- In partnership with the Australian Government, implement the Primary Health Care Access Program to improve access by Aboriginal and Torres Strait Islander peoples to primary health care services

- Provide assessment and treatment services in the community for people with mental illness to provide them with greater access to their natural support networks in managing their condition
- Implement *Queensland Health's Directions for Aged Care 2004–2011* and continue to develop reforms to meet the health needs of increasing numbers of older people and their carers
- Enhance our capacity for community-based rehabilitation to improve health outcomes for people with heart, stroke and vascular disease

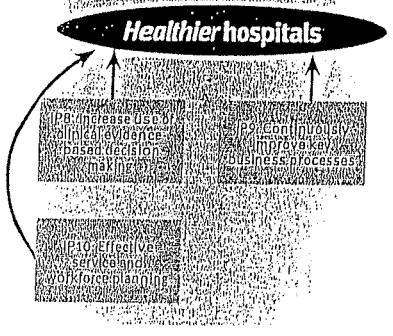
Effective service and workforce planning

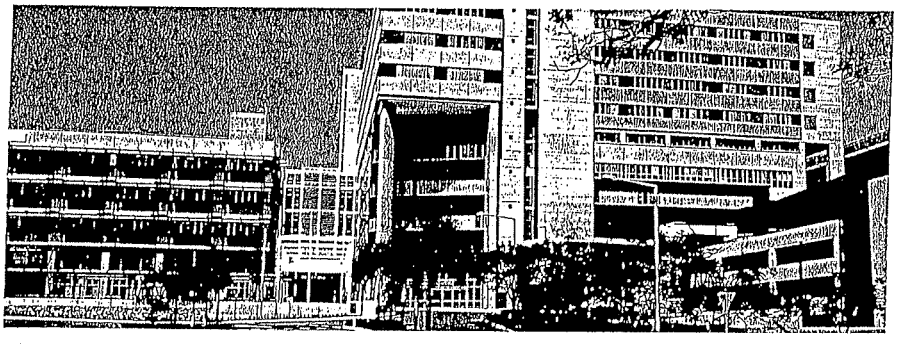
- Develop and implement statewide plans to prevent and manage chronic disease and cancer, with a particular focus on those risk factors most amendable to primary prevention (smoking, diet and physical inactivity)
- Develop and implement an integrated health and workforce planning framework for rural and remote communities
- Develop and implement the *Queensland Health Strategic Framework for Aboriginal and Torres Strait Islander Health*
- Develop and implement an evidence-based model of child health that reprofiles health services to meet the increasingly complex needs of children and young people 0–12 years
- Implement enhanced preparedness planning for disasters, bioterrorism threats and communicable disease pandemics to ensure the capacity for high quality public health and health care responses

healthier

Strategic intent
Healthier hospitals

Provide high quality and equitable acute and emergency care, integrated with enhanced community-based services





Increase use of clinical evidence-based decision making

- Implement the *Safety and Quality Program 2004–2008* as a central component to our strategic approach to plan, monitor and improve patient care. Priorities will be information exchange, education, clinical innovation and reform
- Use evidence-based interventions and targeted resourcing to manage growth in demand for cardiovascular treatment

Continuously improve key business processes

- Through the Safety and Quality Program
  - reform the accessibility, provision and quality use of medicines
  - continue to systematically examine the performance of our hospitals on key indicators
  - monitor the safety of key clinical processes in hospitals by establishing a statewide system for reporting sentinel events and adverse clinical outcomes
- Work with general practitioners and other primary health care providers to improve the continuity of care for individuals across community and hospital care, with a particular focus on information transfer, self-management and the appropriate use of medicines
- Implement step-down care processes and innovative approaches, including infrastructure support through the Pathways Home Program, to improve the transition of people, particularly older people, from hospital to home
- Implement and resource a model of care for renal disease that promotes self-management and provides services in ambulatory settings to increase accessibility of dialysis services

Effective service and workforce planning

- Improve access to surgery to achieve benchmark targets, through increasing available resources, including workforce and improving clinical protocols and audit processes
- Increase the capacity of emergency services in high demand areas and trial alternative models for managing non-emergency conditions such as GP clinics to enhance the responsiveness of our emergency care services
- Expand outreach and telehealth services to improve regional and rural Queenslanders' access to acute health services
- Develop and implement statewide plans for the prevention and management of chronic disease and cancer and establish infrastructure and workforce requirements to support these plans
- Inform and contribute to the ministerial review of maternity services in Queensland
- Implement the Smart State Building Program to improve hospital infrastructure across the state
- Develop and implement joint guidelines for planning multipurpose health services with the Australian Government to improve the targeting and development of flexible, integrated health and aged care services in small rural and remote communities

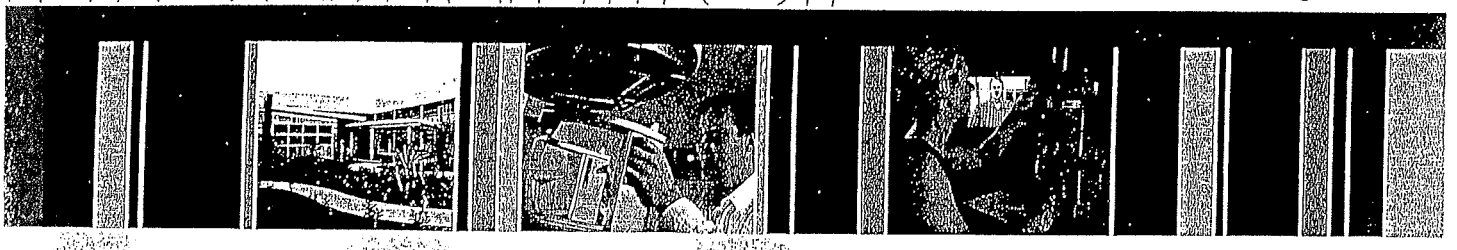
What will this mean for you?

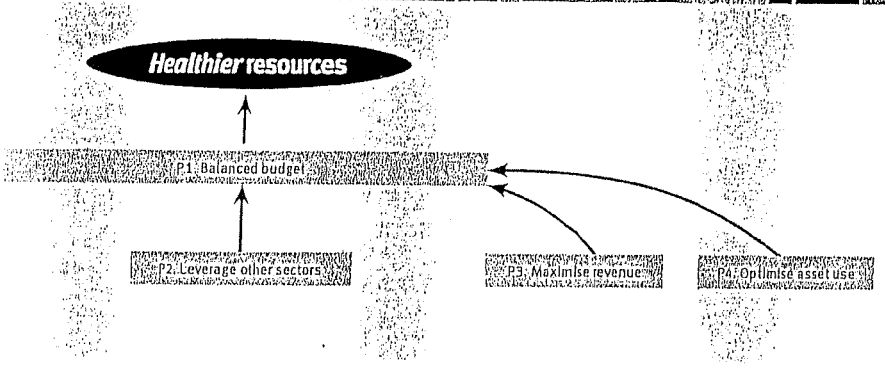
If you suffer a heart attack and are taken to a Queensland Health hospital you will receive high quality care regardless of which hospital you attend. To ensure consistency of treatment in this and other conditions, our senior doctors have established clinician networks in the areas of cardiac care, stroke treatment and rehabilitation, emergency medicine and renal services to share information on treatment right around the state. This Collaborative for Health Care Improvement has more than 450 members across 26 hospitals. In the area of heart attacks and heart failure, clinical audits have shown that participating hospitals have increased the use of potentially life saving treatments.

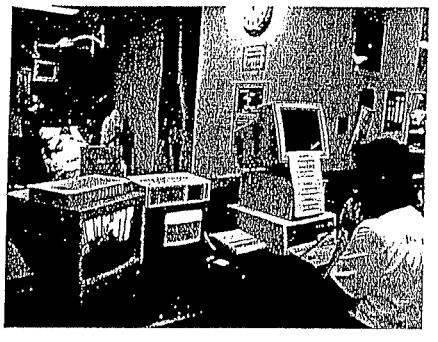
healthier

Strategic intent
Healthier resources

Finite resources used to maximum advantage







Balanced budget: health service delivery is provided and managed within fiscal allocations

- Review and implement improved internal systems of financial management and resource allocation to optimise the use of our resources
- Continue to implement the whole-of-government approach to corporate services delivery (the *Shared Service Initiative*) to standardise business processes, consolidate technology and pool resources and expertise

Leverage other sectors: health and non-health sectors invest to improve health outcomes

- Progress our partnership arrangements with others to ensure our collective resources, activities and programs support health agencies

Maximise revenue: maximise revenue for services provided to clients who are ineligible for public services, not Queensland residents, or who choose to receive private services

- Implement systems that provide for the prompt identification, collection and recording of revenue to comply with the requirements of the *Financial Management Standard 1997*

Optimise asset use: the asset base is aligned to service delivery and consumer and community need

- Review and where necessary improve internal systems of capital investment and management to ensure we are making best use of our resources

What will this mean for you?

he cumulative effect of our initiatives ill lead to a more strategic use of sources, including strengthening reas of high demand. Over the next ree years, the $110 million elective rgery program will treat an additional ,000 patients, further reducing rgery waiting times. Queensland ready has the shortest elective surgery iting times in Australia and this will t a new national benchmark. Our aim to treat all urgent and semi-urgent tients who have waited longer than e recommended time before 30 June 04.

meet this target, we will work in rtnership with the private sector when d where our public system can not vide services.

Our performance measures

All of the preceding initiatives will achieve our mission to promote a healthier Queensland. From a consumer perspective, our objectives are to:

- increase knowledge and skills for health
- increase confidence in health system
- achieve a whole-of-government approach to quality of life
- improve access to primary health care
- reduce the impact of chronic disease, including for Aboriginal and Torres Strait Islander peoples
- ensure safe and quality health outcomes
- smooth transition between community services, hospitals and general practitioners
- appropriate access to specialist services across Queensland

We will measure the impact and outcomes of our services through health status and health system performance measures.

Health status measures [1]

Life expectancy
Life expectancy at birth

Mortality
Infant mortality rate

Mortality rates: all causes, circulatory disease (cerebrovascular and ischaemic heart disease), diabetes, cancer (breast and cervical cancer), suicide

Average annual percentage change in mortality rates for National Health Priority Cancers

Health inequalities
Median age at death for selected population groups including Aboriginal and Torres Strait Islander peoples

Mortality indicators and selected health risk factor indicators for Aboriginal and Torres Strait Islander peoples

Mortality indicators and selected health risk factor indicators by socio-economic status groups [2]

Health risk factors and health enhancing factors
Cancer – participation in the breast screen program; proportion of all breast cancers detected classified as small cancers

Immunisation – age appropriate immunisation coverage rates

Physical activity – rates of sufficient time and sessions of physical activity

Obesity – percent of overweight and obese adults

Nutrition – proportion of the population that consume fruit and vegetables according to endorsed guidelines [2]

Smoking – proportion of population over 14 smoking daily

Alcohol – prevalence of moderate and high risk alcohol consumption amongst adults

Self efficacy
Client's knowledge, ability and confidence to successfully manage their own health and participate in their own health care management.

Health system measures [3]

Community confidence in Queensland Health
Level of confidence that the Queensland population has in the quality of services provided by Queensland Health

Whole-of-government action that supports health
Number and proportion of other sectors implementing their commitments in whole-of-government strategies that impact on health

Category 4 and 5 to Emergency departments
Number/rate of patients who attend Queensland Health Emergency Departments categorised as not requiring immediate emergency care

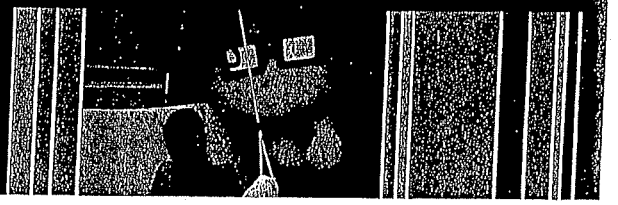
Admissions for acute episodes of chronic conditions
Number/rate of patients who are admitted to Queensland Health facilities with angina, diabetic complications and chronic obstructive pulmonary disease.

Sentinel events
Number/rates of events within Queensland Health facilities in which death or serious harm to a patient has occurred

Patient satisfaction with admission and discharge processes
Client satisfaction with admission and discharge procedures within a hospital stay

Elective surgery access
Waiting times for elective surgery (ie. surgery that, in the opinion of the treating clinician, is necessary but for which admission can be delayed for at least 24 hours)

1. *These are the health status performance measures in the Queensland Government's Priorities in Progress report series, with the addition of self efficacy*
2. *This indicator is not currently in the Priorities in Progress series*
3. *These are the Queensland Health Strategy Map consumer perspective performance measures*



Our performance framework

Queensland Health is committed to measuring its performance to ensure that we are achieving our mission.

Performance measurement occurs at various levels across the organisation. At the highest level we monitor our performance in contributing to the Queensland Government's priorities and outcomes and we measure our performance against achieving our mission outlined in this strategic plan. At this high level, we also report against health status indicators in the Government's *Priorities in Progress* series.

Each year, the *Queensland Health Ministerial Portfolio Statement* details how funds have been allocated to achieve progress towards our strategic intents. This statement is subject to critical examination during the Parliamentary Estimates Committee process.The *Queensland Health Annual Report* formally reports to Parliament the activities and achievements for the preceding year.

As an organisation, we place a high priority on ensuring that the outputs detailed in the *Queensland Health Ministerial Portfolio Statement* best reflect the services that we deliver. In late 2003, we initiated a review of our outputs structure and we are compiling a set of revised outputs and performance measures for Cabinet consideration in late 2004.

Measures of effectiveness, efficiency, equity and a range of other performance indicators are regularly reported and benchmarked at the national level. Queensland's performance in significant health service delivery areas, including hospital inpatient and non-inpatient health services, are compared with the performance of other jurisdictions through a range of formal reporting mechanisms.

These include reporting undertaken by the Australian Government, the Australian Institute of Health and Welfare and the *Report on Government Services*. Information on health status and outcomes, determinants of health and health system performance, including the capability and sustainability of the health system, is also reported to health ministers via *The National Report on Health Sector Performance Indicators* prepared by the National Health Performance Committee.

In addition to external reporting of performance, we are developing ways to improve the internal monitoring of our performance. Internally, regular and timely performance information is needed for corporate governance, strategic planning, policy development, resource allocation, service planning and evaluation. An integrated framework for performance information will link the inputs, outputs and outcomes essential to achieving our mission. We will use the health status indicators from this framework to monitor performance according to the strategic plan. Through our Integrating Strategy and Performance (ISAP) process, we will measure progress towards achieving the strategic objectives outlined in this plan.

This approach will develop a culture that promotes performance measurement as a critical element of all we do. By paying close attention to the success of our activities and the areas in which we can improve, we will be in a better position to deliver sustainable and effective health services to the people of Queensland.

Overview

Our mission	*'Promoting a healthier Queensland'*
Our values	Professionalism, teamwork, performance accountability, quality and recognition
Guiding Principles	We exist to support those delivering healthcare We will evaluate our work to determine value for money We will treat others with honesty, respect and fairness We accept responsibility for our actions

Who we are

The Queensland Health Patient Safety Centre (PSC) has a lead role in planning, implementing, managing and evaluating patient safety initiatives and programs as part of the broader system to prevent and address patient harm, and ultimately improve healthcare services for Queenslanders leading to healthier Queenslanders.

The broader patient safety system involves health service providers at a local and state-wide level. The PSC works in partnership with Health Service Districts to coordinate and support state-wide and local patient safety programs.

The PSC brings together three units with a common goal of improving patient safety:

1. **Centre for Healthcare Related Infections Surveillance & Prevention (CHRISP)**
2. **Safe Medication Practice Unit (SMPU)**
3. **Safety Improvement Unit (SIU)**

Innovation and Workforce Reform Directorate			
Patient Safety Centre	Centre for Healthcare Related Infections Surveillance & Prevention (CHRISP)	Safe Medication Practice Unit (SMPU)	Safety Improvement Unit (SIU)

What we do

The PSC builds on successful state-wide strategies in the specialised high risk areas of medications and infections by:

- Addressing high risk medications and systems, implementing medication review of prescribing, dispensing and administration systems to ensure transfer of accurate and complete medication-related information and appropriately using information technology in medication management.
- State-wide coordination of infection management services through surveillance of healthcare related infections, assessment of the economic impact of infections, undertaking research to determine and influence behaviours associated with infections.

The PSC will be responsible for the implementation of a standardised and coordinated approach to clinical incident management across the state. This will include the deployment and support of twenty five patient safety officers to Health Service Districts.

Working closely together, the three units of the PSC are committed to reducing preventable patient harm by:

- Raising risk awareness and promoting a culture of safety.
- Integrating and building on programs currently in place.
- Building local district capacity for identification of vulnerabilities and implementation of solutions using a human factors approach.
- Providing patient safety tools for consistent use across the State.
- Building a central resource centre that adds value by providing training support, data and trend analysis, and works with local areas to develop solutions for state wide implementation.
- Creating networks for discussion and shared learning.

The Business Plans for the three units of SMPU, SIU and CHRISP are presented in the following document:

Overview

Our mission	*'Promoting a healthier Queensland'*
Our values	Professionalism, teamwork, performance accountability, quality and recognition
Guiding Principles	We exist to support those delivering healthcare We will evaluate our work to determine value for money We will treat others with honesty, respect and fairness We accept responsibility for our actions

Who we are

The Patient Safety Centre is one of six divisions in the Innovation and Workforce Reform Directorate.

The Safety Improvement Unit is one of three units in the Patient Safety Centre.

The Unit consists of five teams
- District Engagement Team
- Patient Safety Tools Development Team
- Patient Safety Information Systems Development
- Patient Safety Data Analysis Team
- Patient Safety Projects

The Unit consists of a central unit within the Patient Safety Centre as well as providing staff (25 Patient Safety Officers) in Health Service Districts.

What we do

The Safety Improvement Unit is committed to reducing preventable patient harm by:

- Raising risk awareness and promoting a culture of safety
- Integrating and building on programs currently in place
- Building local district capacity for identification of vulnerabilities and implementation of solutions using a human factors approach
- Providing patient safety tools for consistent use across the State
- Building a central resource centre that adds value by providing training support, data and trend analysis, and works with local areas to develop solutions for state wide implementation
- Creating networks for discussion and shared learning.

The Safety Improvement Unit aims to:

1 develop, implement and maintain organisation-wide clinical incident management systems that form a part of an effective clinical governance framework
2 develop, implement and maintain patient safety information systems that include clinical incident, consumer feedback and risk management
3 identify emerging patient safety priorities that become apparent from the analysis of incidents and from coronial reports.

The Patient Safety District Engagement Team is to provide training, education, support and coordination of district based Patient Safety Officers and other district based staff. The Team will provide 'just in time' support and training in the application of patient safety tools, patient safety system, ensure integration and consistency of approach across the state.

The Patient Safety Tools Development Team will manage the development of tools to build capacity for clinical incident management and complaints management. They will update the tools as required and also assist in the development of tools and supports for high risk areas and other patient safety projects.

The Patient Safety Information Systems Development Team develops and implements information systems to support the management and reporting of clinical incidents, complaints management and risk management. This Team also coordinates user groups and enhancements, facilitate and lead the training in the system and assists in the re-designing of business systems processes associated with clinical incident and complaints management.

The Patient Safety Data Analysis Team manages the data sets and databases for the PRIME: Clinical Incident and Consumer Feedback Information System. They coordinate the analysis of the information, production of reports and assist in the identification of system vulnerabilities. They also coordinate the provision of information for national groups.

The Patient Safety Projects Team are targeted projects that address issues arising form the state and national agendas as well as approved projects from the Safety and Quality Board.

This plan

This plan provides an overview of the Safety Improvement Unit Operational Plan for the financial year 2005-06. This is a working document which will be modified in response to emerging priorities and needs.

Key priorities

The Safety Improvement Unit contributes to 4 of the 5 key priorities of the Innovation and Workforce Reform Directorate:

1. Standardisation of systems and clinical practice
2. Developing a culture of safety
3. Exploit the full potential of the skills development centre consistent with QH Strategic Intents
4. Systematically applying innovation through the organisation

The work of the Safety Improvement Unit is focused on the following strategic areas contained in the Queensland Health Safety and Quality Strategy Map:

1. standardize processes for high risk areas (C1)
2. improve key business processes and systems (C2)
3. demonstrating culture of safety and quality (C4)
4. influence and operationalise national and state agendas (IP1)
5. improve communication processes (IP3)
6. Partner with educational institutions and professional bodies (IP5)
7. Develop and maintain mechanisms for reporting (IP6)
8. Managers and leaders are actively involved in safety and quality activities (IP7)
9. Skill workforce in continuous quality improvement (LG1)
10. Support mechanisms to share learnings (LG2)
11. Engage clinical and business leaders to drive safety and quality agenda (LG3)
12. Improve knowledge management to support quality and safety (LG4)

These are underpinned by the following:

- Promoting the delivery of safe, quality health services requires a demonstrated culture of patient safety throughout the organisation
- Patient safety will be a leadership and management priority within Queensland Health
- Patient harm from adverse events will be reduced through a coordinated statewide evidence-based approach
- Systems will be developed to monitor, report and respond to safety concerns in a timely and effective way.

The Safety Improvement Unit is also committed to meeting the following commitments made at the April and July 2004 Australian Health Ministers' Conferences (AHMC):

- That all public hospitals have an incident management system in place by January 2005 incorporating incident management, monitoring, investigation, analysis and action arising.
- To require all public hospitals to report all sentinel events, either to the state department or to an agreed third party, no later than the end of 2005.
- That all states and territories will contribute to a national report on sentinel events to be produced by the end of 2005.
- That all public hospitals will adopt the 5 step right patient, right site, right procedure protocol for verifying the site of surgery and other procedures to reduce the risk of wrong site procedures by the end of September 2004.
- That all public hospitals will have in place a patient safety risk management plan by the end of 2005.
- The National Open Disclosure Standard: A National Standard for open communication in public and private hospitals, following an adverse event in health care will be implemented by June 2006.
- The development of a Minimum Data Set for safety and quality.

Overview

Our mission	*'Promoting a healthier Queensland'*
Our values	Professionalism, teamwork, performance accountability, quality and recognition
Guiding Principles	We exist to support those delivering healthcare We will evaluate our work to determine value for money We will treat others with honesty, respect and fairness We accept responsibility for our actions

Who we are

CHRISP undertakes the state-wide coordination of infection management services through surveillance of healthcare related infections, assessment of the economic impact of infections, undertaking research to determine and influence behaviours associated with infections.

What we do

CHRISP can be described as a clinical governance support unit which delivers services through the Administrative Director, Medical Director and team leaders in areas of surveillance, health economics and behavioural research.

Patient Safety Centre					
CHRISP	Administrative Director	Medical Director	Team Leader Surveillance	Team leader Health Economics	Team Leader Behavioural Research

The Administrative Director is responsible for providing high-level advice, developing, implementing and managing CHRISP initiatives and activities aimed at preventing patient harm by improving infection control practices in strategic priority areas.

The Medical Director leads the co-ordination of the state-wide surveillance and prevention of healthcare associated infection with the provision of information regarding the impact on Queensland Health, with subsequent research into areas of enquiry.

The Team leaders manage and coordinate activity in their respective areas with outcomes being used to further enhance and support existing systems and structure, and/or stimulate the review of infection control programs, interventions, policy and practice.

This plan

This plan provides an overview of the CHRISP Work Plan for the financial year 2005-06.

Key priorities

CHRISP directly contributes to 2 of the 5 key priorities of the Innovation and Workforce Reform Directorate:

1. **Standardisation of systems and clinical practice**
2. **Developing a culture of safety**
3. Exploit the full potential of the skills development centre consistent with QH Strategic Intents
4. Systematically applying innovation through the organisation
5. Attracting, training and retaining appropriately skilled staff in appropriate numbers

The following services, organizations and professional groups contribute to CHRISP:

Staff within the Patient Safety Centre, Infectious Diseases Physicians and Microbiologists, Zones, Health Service Districts, Communicable Diseases Unit and business units within Public Health Services, Office of the Chief Health Officer, Information Directorate, Infection Control Managers and portfolio holders, Statewide Quality Coordinators, Queensland Health Pathology and Statewide Services, business units of the Innovation and Workforce Reform Directorate.

Australian Council for Safety and Quality in Healthcare, professional associations such as the Infection Control Practitioners Association, Australian Infection Control Association, Australian Society of Microbiologists and the Australian Society of Infectious Diseases.

Objectives

CHRISP has four key objectives:

1. Sustain and enhance a healthcare associated infection surveillance system. This enables Health Service Districts to continuously monitor their own performance using longitudinal data, with subsequent comparison against the statewide aggregated data set provided in the CHRISP Report.
2. To provide algorithms and resources to assist healthcare workers to determine both the cost of healthcare associated infection and cost effectiveness of prevention programs with outcomes informing local and state policy and guidelines.
3. Develop and applies Theoretical Behavioural Models, strategies and processes to improve and sustain compliance with interventions known to reduce the transmission of infection i.e. handwashing.
4. To strengthen and build upon internal and external partnerships to promote cultural/behavioural change, with focus on strategies that minimise preventable harm through the development and/or enhancement of new and/or existing systems, structures and processes to provide decision support for clinicians.

The key priorities for achieving those objectives are:

- Enhance the surveillance system and processes to promote the timely review of outcomes and detailed analysis of data which leads to an evaluation of interventions to reduce the risk of preventable healthcare associated infection.
- Develop tools, resources and processes that support the delivery of cost effective programs and strategies aimed at reducing preventable healthcare associated infection.
- Develop strategies and resources to support compliance with infection control protocols.
- Formalise partnerships through agreements such as a Memorandum of Understanding.

The first priority involves a business analysis of the CHRISP surveillance software *electronic Infection Control Assessment Technology* (eICAT) to be undertaken by Development Services / InfoSolutions, Information Directorate. It is anticipated the business analysis will be completed by 30 June 2005. This work will provide clear direction regarding the enhancements

(interfacing with other information technology systems to improve automation) that are required to be made. The process will enable Queensland Health to quantify and qualify the benefits of the system. Further, the information contained within the Business Case will allow the Information Service Investment Board to make an informed decision regarding ongoing investment in this capital asset and endorsement of eICAT as a standard application.

Priority 2 is underway. A proposal has been submitted to Innov8 to consider the development of Infection Control with Economic Decisions (ICED) to enable infection control personnel to calculate (and provide confidence intervals around) the:

- bed days lost to infection
- cash costs lost to infection
- overall economic cost of infection; and

Identify prevention strategies in terms of:

- the cost of the strategy
- the effectiveness of the strategy (% reduction in risk)

Estimate:

- number of infections prevented
- number of bed days saved
- cash savings
- whether the cost of the prevention strategy is offset by the savings
- which strategies are cost-effective strategies and which are dominated
- the optimum level of investment in prevention, and so the optimal infection rate

Priority 3 and 4 are in-progress with input from external collaborators such as the World Health Organisation and the Infection Control Service South Australia and the Communicable Diseases Unit, Queensland Health.

The fluid nature of the work described above and dependant variables which include the appointment of Team Leaders will require this plan to be reviewed immediately prior to the commencement of the 2005/2006 year.

Further information

For further information contact:

Dolly Olesen
Administrative Director of CHRISP
Patient Safety Centre
t: 07 3234 0706
f: 07 3227 6627
dolly_olesen@health.qld.gov.au

Copies of the plan are available from:
http://qheps.health.qld.gov.au/

Overview

Our mission	*'Promoting a healthier Queensland'*
Our values	Professionalism, teamwork, performance accountability, quality and recognition

Who we are

The aim of the Safe Medication Practice Unit is to improve the health of Queenslanders through quality use of medicines (QUM)[1], with a focus on the prevention of adverse drug events, by means of multidisciplinary enhancement of medication-related services and moving to best practice medication management. This goal will be obtained through FIVE major areas in the QH Medicines Management Program:

1. High Risk Medications and Systems
2. Medication Continuum
3. Medication Review
4. Electronic Medication Management Strategy
5. Data Management

The Safe Medication Practice Unit (SMPU) evolved and will build on successful work initiated by the Quality Use of Medicines (QUM) and Queensland Health Medication Management Services (QHMMS) Projects. These projects and the continuing goals of the SMPU will ensure safety initiatives outlined in the Health Minister's Joint Communique 23 April 2004. The SMPU reports directly to the Patient Safety Centre which has been established to implement and coordinate a patient safety reform agenda across the state.

The SMPU intends on building on the success and lessons learned from the QUM and QHMMS Projects funded out of the previous health care agreement under the Quality Improvement and Enhancement Program.

Background

The medication use system involves multiple health care providers and is constituted of multiple steps (see figure 1); each with a risk of associated patient harm. This program aims to bring together a range of initiatives that focus on **improving safety** of the processes involved or **improve the effectiveness** of medicines use, or the **improving efficiency** of services – a systems approach. Each of the proposed projects is directly dependant on the other with common goals of QUM.

This program therefore, intends to use a **systems approach** to medicines management in addressing the proposed four areas for targeting in the following three-four years; ie

1. a strategy for electronic medicines management for QH
2. improving pharmaceutical review services across the state
3. improving the continuum of medicines use between hospital and community
4. targeted medication interventions on high risk medications.

Strategic Alignment

This program aligns with a number of important strategic directives and goals from a national level, state level, QH corporate level and locally for each health service district, including alignment with:

NATIONAL

National Medicines Policy
National Strategy for Quality Use of Medicines
National Medication Safety Taskforce
Health Minister's Joint Communiqué 23 April
Australian Pharmaceutical Advisory Council's National Guidelines to Achieve the Continuum of QUM between Hospital and Community
Pharmaceutical reform

STATE

QH Strategy Map

The program aligns with a number of the QH priorities for healthier Queenslanders, including by not exclusively:
C6 – Ensuring safe and quality health outcomes – all projects: Medication Safety, Pharmaceutical Review, Medication Continuum, E-medicines management
IP5 – Reduce risk in high risk consumers – Medication Safety Initiatives, Introduction of APAC continuum principles, Introduction of pharmaceutical review for prioritised high risk patients
WF1 – Encourage innovative and targeted research – Use of research into medication safety initiatives. Involvement in Centre for Research Excellence in Patient Safety submission
WF3- Recruit, develop and retain appropriately skilled workforce – Training in pharmaceutical review and medication safety risk awareness. Involvement in Medical / nursing / pharmacy schools undergraduate training to ensure "work-ready" workforce.
IP9 – Increased use of clinical evidence-based decisions – Development of guidelines for medication safety initiatives for use at point of prescribing for high risk medicines.
IP10 – Continuous improvement of key business processes – as determined by Electronic Medicines Management Strategy development, Introduction of APAC Continuum guidelines
IP2 – Improve community participation in the planning and delivery of health services. This is a fundamental principle of the APAC Continuum guidelines. Working with GPAC, General Practice and Community Pharmacy
C1 – Increase knowledge and skills for health – Fundamental requirements of APAC Continuum and pharmaceutical review

ELECTRONIC MEDICINES MANAGEMENT AGENDA (State and national)
Health Connect Program
- **Practice guidelines and standards**

State-wide incident management and integrated risk management
WORKFORCE ISSUES

Workforce strategic framework

The Medicines Management Program will utilise the following building blocks on which to base the proposed strategies:

1. Policy development and implementation
2. Facilitation and coordination of QUM initiatives
3. Provision of objective information and assurance of ethical promotion of medicines
4. Education and training
5. Provision of services and appropriate interventions
6. Strategic research, evaluation and routine data collection

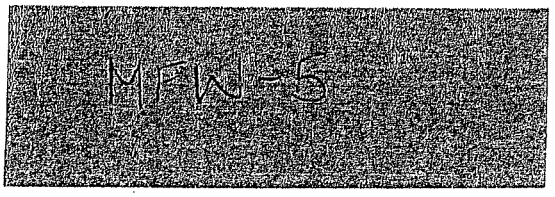
Please see Table 1 for summary.

What we do

Preventing and addressing adverse drug events resulting in patient harm by improving medication-related practices in FOUR main areas:

1. High risk medicines and processes
   - standardised processes for ordering, supplying and administering of high risk medicines
   - increasing awareness of risk of patient harm in medication management
2. Medication continuum
   - ensuring transfer of accurate, comprehensive and complete, standardised information relating to medications on admission and discharge from QH facilities
3. Medication review
   - Reviewing therapy decision to ensure safe, effective medication treatment
4. Electronic Medicines Management Strategy
   - a strategy for the implementation of electronic solutions and standards to address medication safety issues

Overview



Our mission	Promoting a *healthier* Queensland
Our values	Professionalism, teamwork, performance accountability, quality and recognition
Guiding principles	We exist to support those delivering healthcare We will evaluate our work to determine value for money We will treat others with honesty, respect and fairness We accept responsibility for our actions

Who we are

The Clinical Practice Improvement Centre currently comprises several teams: Collaboratives, Centre Management, District Liaison, Facilitation and Group Learning, Measurement Systems and Analysis, Processes & Pathways, and Queensland Audit of Surgical Mortality.

What we do

The Clinical Practice Improvement Centre supports and works with clinicians and health service managers to improve patient care by:

- Identifying and understanding the causes of important variances in clinical outcomes
- Using established and innovative improvement techniques to reduce these variances through the implementation of evidence-based best practice
- Measuring progress towards specific targets in these activities
- Developing systems to ensure that such progress is sustainable
- Building upon, integrating and expanding the activities of the many individuals and groups that are already working towards improving the quality and efficiency of healthcare in Queensland.

This plan

Scope

This plan provides an overview of the Centre's work priorities for the 2005-2006 financial year.

Framework

The plan has been developed using a framework that addresses all 4 critical organisational characteristics that are known to determine the sustainability of clinical quality improvement initiatives:[1]

- Strategic linkage (– with high level organisational direction and priorities)
- Workplace culture (– as part of change processes)
- Technical support (– mostly information systems)
- Structural / Operational linkage (– with management / communication / education systems)

Embedded within this framework are a variety of methods designed to facilitate the 3 core elements of any improvement process:

- Problem definition
- Measurement
- Change

[1] Shortell, SM Bennett CL, and Byck GR Assessing the impact of Quality Improvement on Clinical Practice: What it will take to accelerate progress. The Millbank Quarterly 1998; 76(4) 593-624

Objectives

This Centre has been formed through the merger of a number of separate groups and their associated programs (Collaborative for Healthcare Improvement [CHI], Clinician Development Program [CDP] and the Clinical Pathways Project). The objectives are therefore described in 2 parts:

1. *Systems Development* – Realignment of all current systems supporting the projects of the above groups and development of all new systems within the above framework.

2. *Specific Applications* – Review and re-direction of all existing projects, and specification of all new projects within this framework.

Although systems development must generally precede the specific applications, much of the work in each part of the plan will need to occur in parallel.

Key priorities

CPIC directly contributes to 2 of 5 priorities of the Innovation and Workforce Reform Directorate:
1. **Standardisation of systems and clinical practice**
2. Developing a culture of safety
3. Exploiting the full potential of the skills development centre consistent with QH strategic intents
4. **Systematically applying innovation through the organisation**
5. Attracting, training and retaining appropriately skilled staff in appropriate numbers

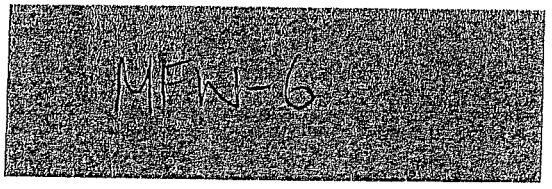
1. Systems Development

- Strategic linkage
    - Develop a unified approach to prioritising all projects
    - Link CPIC activities with those of other IWR branches and external partners
- Workplace culture
    - Develop a new work team / group dynamics assessment system
    - Develop team development program based on this system
- Technical support
    - Develop new measured pathway systems to track variances
    - Develop skills in, and applications of, statistical process control
    - Investigate and develop new methods of clinical data capture
- Structural / Operational Linkage
    - Integrate all prior district CDP, CHI, and Pathways clinician and management links and groups into a single CPIC communications channel
    - Clarify and publicise CPIC services and methods
    - Develop and pilot new outcomes based funding models

2. Specific Applications

The above systems will be used to support the following specific applications
- Queensland Audit of Surgical Mortality
- Re-alignment / refinement of existing COLT
    - Cardiac (expansion to include surgical interventions; implantable defibrillators)
    - Renal (expansion to include pre-dialysis population)
    - Stroke (expansion to include stroke rehabilitation)
    - Emergency Department (re-focus on pathways and patient flow)
- Realign / refine existing pathways projects and develop new ones in measured variance format
- New priorities
    - Diabetes collaborative
    - Patient flow project (from Emergency Department collaborative)

Overview



Our mission	Promoting a *healthier* Queensland
Our values	Professionalism, teamwork, performance accountability, quality and recognition
Guiding principles	We exist to support those delivering health care We will evaluate our work to determine value for money We will treat others with honesty, respect and fairness We accept responsibility for our actions

About us

VISION

To be recognised as one of the leading clinical skills development centres in Australasia, with a reputation for highly relevant curriculum, for pushing the frontiers of workforce development and for innovation especially in the sphere of patient safety and human factors.

- linking curriculum to strategic need;
- collaboration with other stakeholders, industry and other skill centres;
- the application of sound business and management principles; and
- innovation particularly in the sphere of human factors and patient safety.

In pursuing its vision, mission and goals the SDC is committed to:

- **best practice:** in terms of the development and delivery of coursework, the technology and intellectual property deployed and the managerial arrangements that underpin this;
- **collaboration:** with other agencies and stakeholders to avoid duplication and enhance the precision, content and reach of the Centre;
- **flexibility and adaptability:** responsiveness to the challenges of demographic change, changing workforce patterns, technology and customisation;
- **innovation:** in terms of curriculum, educational delivery and entrepreneurship;
- **evaluation:** to ensure that the courses are relevant, addressing real need, making a difference and that standards of teaching and managerial performance are maintained at an optimum level;
- **sound governance:** to ensure proper stewardship, leadership and accountability are exercised;
- **accessibility:** to be a State-wide resource that provides services that are available to staff across the State as well as beyond; and
- **linking:** in terms of linking strategy with performance by addressing strategic needs through practical coursework.

What we do

- assist in the development of a more flexible and safe workforce particularly enhancing the ability to meet the workforce development needs occasioned by the current and projected demographic trends and labour market pressures;

- are known as a centre of excellence in the area of health improvement sciences and patient safety and in doing so play an integral role in the Institute for Health Improvement;
- collaborate with a wide range of stakeholders to expand the reach of the Centre and with universities to create an innovative approach to the delivery of skills;
- provide a service in, through and from the Centre to meet the needs and demands from rural and remote areas as well as other major conurbations;
- match coursework to the strategic needs of Queensland Health;
- provide improved outcomes through the evaluation measures put in place;
- innovate in training and education especially in flexible and e-learning environments;
- remain at the leading-edge of skill centre technology;
- foster an on-going partnership with industry to secure sponsorship and the access to best practice;
- provide an on-going arts involvement that reflects the nature of the Centre and makes connection between the Centre and the general public of Queensland;
- develop markets outside of Queensland and outside Australia and in doing so raise the profile of Queensland Health;
- provide academic rigour around courses; network with other skill centres through membership of SESAM etc and play a role in the foundation of an Australasian association; and
- to provide a centre for the fermentation of ideas to enable the production of innovative courses whose outcomes are properly evaluated.

This plan

This plan provides an overview of the Unit's work plan for the 2004-2005 financial year.

Objectives

The SDC will achieve the following in the 2004/5 financial year.

- Opening of the SDC on time and budget by close of September 2004 by State level senior politician/s
- Create then embed systems such that the SDC can cover the accounting of operations by December 2004
- Finalise infrastructure such that the SDC has a fully functioning service that reflects iterations from stress-testing by end of June 2005.
- Development of curriculum such that a production line exists for on-going courseware by end of March 2005
- Create and cement networks and marketing by end of May 2005
- Secure new project funding and commence new projects by end of March 2005
- Opening of the art collection and creation of art award by end of March 2005 (subject to Ministerial availability)

Key priorities

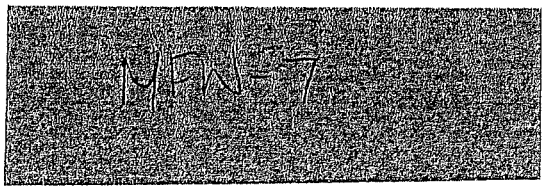
As above. Each of the objectives is a key priority.

Further information?

For further information contact: Phil Diver CEO on 36366500 or visit our website at www.sdc.qld.edu.au

Abbreviations

SDC - Skills Development Centre



Overview

Our mission	Promoting a *healthier* Queensland
Our values	Professionalism, teamwork, performance accountability, quality and recognition
Guiding principles	We exist to support those delivering health care We will evaluate our work to determine value for money We will treat others with honesty, respect and fairness We accept responsibility for our actions

This plan outlines iBranch's 2005-6 program of work that contributes to Queensland Health's strategic priorities. It is a working document that states what iBranch expects to achieve over 2005-6 and the initiatives in which it will invest in order to achieve its objectives.

Who we are

The purpose of the **Innovation and Workforce Reform Directorate** is to create a climate for change to meet the future challenges in healthcare.

The **Innovation Branch** (herein referred to as iBranch) is one of six divisions of the Directorate of Innovation and Workforce Reform:

Innovation and Workforce Reform Directorate					
Innovation Branch	Workforce Reform Branch	Skills Development Centre	Clinical Practice Improvement Centre	Patient Safety Centre	Statewide Health Services Planning

iBranch has the responsibility to position Queensland Health as an innovative, adaptable and change ready organisation which drives and supports healthcare improvement.

It creates opportunities to support strategic priorities, identifies and enables new ideas and innovations, and leads the development of tangible and sustainable improvement responses.

What we do

iBranch undertakes this work through four units:

Analysis & Evaluation

Clinical Services Analysis

Costing & Analysis

Measured Quality Service

Identifying **opportunities for improvement** through analysis, benchmarking, evaluation

Innovation Strategy

Innovation Team

Workforce Strategy

Quality Strategy

Health Technology Assessment

Change Strategy (proposed)

Developing **strategy** and supporting the Innovation, Safety and Quality and Workforce Boards

Innovation Development

Healthier Staff

Organisational Culture

TeleHealth

Funded Innovation projects

Delivering Board approved **projects** and programs

Learning Services

Health Executive Leadership Program

Program Coordination

Business Development

Designing learning **and development initiatives** approved by the Boards and maximising the benefit from Queensland Health's investment in learning and development

Analysis and Evaluation Unit:
The Analysis and Evaluation Unit analyses, benchmarks and evaluates health system performance, business processes and issues to identify opportunities for improvement.

The unit:

- costs and analyses health service products, and provides information to support evidence based change to clinical and financial management;
- measures and monitors multi-dimensional organisational performance indicators and provides advice and recommendations on priority areas of strategic and operational need;
- analyses, evaluates and develops clinical service frameworks and best practice models of service delivery;
- supports those delivering health services through sourcing and provision of resources (eg. data, information and tools) to facilitate decision making and service planning.

Innovation Strategy Unit:
The Innovation Strategy Unit reviews approaches to healthcare delivery within and outside Queensland Health, to set direction for change through:

- leading and managing the development of Queensland Health strategy in the areas of innovation, safety and quality, workforce and health technology;
- prioritising initiatives associated with the strategies above in line with current evidence, resources and required outcomes;
- supporting governance for the Innovation, Workforce and Safety and Quality Boards.

Innovation Development Unit
The Innovation Development Unit translates workforce, innovation and improvement strategies into programs, projects and activities including:

- progressing approved and funded innovation projects;
- Telehealth services;
- development and implementation of Healthier Staff programs;
- measurement of organisational climate and morale and development of action plans and improvement activities.

Learning Services Unit
The Learning Services Unit leads the development and implementation of innovative learning and development services within Queensland Health, including;

- executive leadership and middle management development;
- existing Enterprise Bargaining learning and development commitments;
- new state-wide learning and development initiatives identified by the Workforce Board.

The Learning Services Unit provides a central point of coordination for learning and development activities statewide, to achieve standardisation, reduction of duplication and the effective management of intellectual property.

We optimise partnerships with internal and external suppliers of training and e-learning services and other Government agencies and jurisdictions to achieve maximum benefit from learning and development investment.

This plan

This plan provides an overview of iBranch's work plan for the 2005-6 financial year.

Key priorities

iBranch directly contributes to 2 of the 5 priorities of the Innovation and Workforce Reform Directorate:

1. Standardisation of systems and clinical practice
2. Developing a culture of safety
3. Exploit the full potential of the skills development centre consistent with QH strategic intents
4. **Systematically applying innovation through the organisation**
5. **Attracting, training and retaining appropriately skilled staff in appropriate numbers**

The work of iBranch is focused on five areas:

IWR Directorate priorities	iBranch objectives
Systematically applying innovation through the organisation	1. Innovation – programs such as Innov8 2. Sustainable improvement – focusing on sound governance and strategy, use of evidence and measurement of return on investment
Attracting, training and retaining appropriately skilled staff in appropriate numbers	3. Healthy staff – staff health programs 4. Happy staff - organisational culture, staff morale, reward and recognition 5. Skilled staff – learning services such as leadership programs

The objectives chosen by iBranch were based on significant evidence proving that work in these areas directly contributes to the priorities of the Directorate:

Innovation

- Better quality and safety outcomes for patients as a result of implementing ideas relating to improved service delivery
- Improved patient satisfaction as a result of enhanced employee morale
- Improved clinical service delivery resulting from our ability to attract, develop and retain the best employees as Queensland Health becomes a preferred employer

Sustainable Improvement

- Approximately 70% of all strategies fail without the alignment of organisational capabilities, adequate resourcing, communication, buy-in and leadership.[1]
- Performance measures linked to strategy are more effective[2]

Healthy staff

- Healthier staff contributes directly to improved patient care through increased availability of staff. There are potential benefits to patient satisfaction from a healthier employment environment that supports staff and improves morale implications.

[1] Sterling, 2003, Translating strategy into effective implementation, Strategy and Leadership
[2] McAdam and Bailie, 2002, Business performance measures and alignment impact on strategy, International Journal of Operations and Production Management

Happy staff

- A participative, team based culture is shown to support development of trust and psychological safety to the extent that it supports open communication and identification of mistakes.[3]
- Organisational climate has a strong association with organisational performance (NHS studies demonstrate a strong association between advanced human resource practices, including staff appraisal, teamwork, and learning and development with lower patient mortality)[4];
- Staff satisfaction has a very strong positive correlation (0.89) with patient satisfaction[5];
- Staff satisfaction is negatively related to absenteeism and turnover[6];
- Organisational improvement strategies can be designed and evaluated based upon analysis of data from climate surveys

Skilled staff

- Effective leadership is identified as a prerequisite for leading change and improving organisational performance.[7]
- The use of staff performance appraisal is associated with reduced patient mortality and improved productivity.[8]

[3] National Institute of Clinical Studies 2003. Factors Supporting high performance in health care organisations. NICS Melbourne.
[4] West, Borrill, Dawson, Scully, Carter & Anelay, et al. The link between the management of employees and patient mortality in acute hospitals. Int J Human Resource Manage 2002.
[5] Press Ganey Associates 2001
[6] Robbins et al, 1994 Organisational Behaviour, Prentice Hall.
[7] National Institute of Clinical Studies 2003. Factors Supporting high performance in health care organisations. NICS Melbourne.
[8] West & Michie, Measuring Staff Management and Human Resource Performance in the NHS.

Objectives

(What are we seeking to achieve?)

The work of iBranch is described as a series of objectives:

Outcome objectives: What we hope to achieve
Output objectives: What we need to do in order to achieve our outcome objectives

Each output objective has at least one initiative/project which is the body of work or service we are providing in order to achieve the objective.

IWR Directorate Priority	Outcome Objectives	Output Objectives	Initiatives
Systematically applying innovation through the organisation	1. Drive and support innovation and change	a) Foster, develop and apply the best ideas	▪ Innov8 ▪ Intellectual Property and commercialisation ▪ Innovation partnerships ▪ Innovation projects approved by Innovation Board or Committee ▪ Telehealth ▪ Health technology assessment
	2. Drive and support sustainable Improvement	a) Develop organisational strategy that directs and enables outcome evaluation	▪ Workforce, Safety and Quality, and Innovation strategic plans and scorecards
		b) Provide structures and mechanisms to ensure strong governance arrangements	▪ Establishment and maintenance of the Workforce, Safety and Quality, and Innovation Boards and the Innovation Committee
		c) Develop methodologies for analyses and evaluation to ensure key clinical and business decisions are evidence based	▪ Benchmarking of health service performance, analysis and evaluation of variation; Service Capability Frameworks and plans

		d) Develop methodologies and systems to measure the return on investment of Directorate strategies	▪ Identification of best returns on investment - emphasis on Diabetes (in partnership with the Centre for Burden of Disease and Cost Effectiveness - UQ);
Attracting, training and retaining appropriately skilled staff in appropriate numbers	3. Healthy Staff 4. Happy staff	a) Promote staff health b) Measure organisational climate and culture c) Facilitate / support / manage organisational improvement strategies	▪ Staff health programs (10,000 steps, WORC) ▪ Culture and climate assessment and improvement strategies ▪ Reward and recognition strategy ▪ Initiatives resulting from culture and climate assessment
	5. Skilled staff	a) Develop leadership capability b) Invest in sustainable learning and development	▪ Executive Leadership Program ▪ Enhanced corporate development programs - for example, Management Development Program ▪ Central coordination of learning and development ▪ Improvement of staff performance measurement and development processes

Further information?

For further information contact:

Vicki Brand
iBranch
t: 07 3234 1915
f: 07 3234 0208
Vicki_Brand@health.qld.gov.au

Copies of the plan are available from:
http://qheps.health.qld.gov.au/masters/QHUnits_innovate.htm

Overview

Our mission	*Promoting a healthier Queensland'*
Our values	Professionalism, teamwork, performance accountability, quality and recognition
Guiding Principles	We exist to support those delivering health care We will evaluate our work to determine value for money We will treat others with honesty, respect and fairness We accept responsibility for our actions

Who we are

The purpose of the Innovation and Workforce Reform Directorate is to create a climate for change to meet the future challenges in healthcare.

The Workforce Reform Branch creates a climate for change through:

- Ensuring the optimal use of workforce skills by aligning service and workforce planning, investigating skills mix and role design.
- Developing the current and future workforce through appropriate education and training

The Workforce Reform Branch is one of 6 divisions of the Directorate of Innovation and Workforce Reform:

Innovation and Workforce Reform Directorate					
Workforce Reform Branch	Innovation Branch	Skills Development Centre	Clinical Practice Improvement Centre	Patient Safety Centre	Statewide Health Services Planning

The Workforce Reform Branch delivers services through a Principal Medical Adviser, Principal Nursing Adviser, Principal Allied Health Adviser, the Workforce Preparation and Development Unit and the Workforce Design and Participation Unit.

The **Principal Advisers** will provide expert advice on, and input into strategic issues relating to their professional group and will work together and with the two units to support the development of integrated service delivery models.

The functions of the **Workforce Design and Participation Unit** will include:

- Development of initiatives for skill mix, workforce configuration and roles through environmental scanning, consultation and targeted projects
- Workforce Design consultancy for all service development and planning
- Continuous development of workforce planning methodologies and sharing of workforce information between services and nationally across jurisdictions

The functions of the **Workforce Preparation and Development Unit** will include:

- Establishment of close partnerships with tertiary, VET sector and internal education/training providers to ensure sufficient numbers of appropriately skilled staff, and for the development of new courses identified through skill mix analyses, and new methods of delivering training/education

- careers promotion and counselling to school, TAFE and university students, and Queensland Health staff
- Promotion of lifelong learning including equitable access to quality education and training
- Development of strategies for recruitment, retention and re-entry, including career pathways, professional development, professional governance, role flexibility, supporting the older worker, flexible working environments and conditions

This plan

This plan provides an overview of the Workforce Reform Branch's work plan for the 2005-6 financial year.

Key priorities

The Workforce Reform Branch directly contributes to 3 of the 5 key priorities (highlighted) of the Innovation and Workforce Reform Directorate:

1. **Standardisation of systems and clinical practice**
2. **Developing a culture of safety**
3. Exploit the full potential of the skills development centre consistent with QH Strategic Intents
4. Systematically applying innovation through the organisation
5. **Attracting, training and retaining appropriately skilled staff in appropriate numbers**

We also rely upon the work of each of the other 5 divisions of the directorate to inform our priorities and our actions. We rely upon the Clinical Practice Improvement Centre, the Patient Safety Centre and Statewide Health Services Planning to inform the type of new roles and the need for new workforce skills; we partner with Statewide Health Services Planning in integrating service and workforce planning; we rely upon Innovation Branch to create well led, healthy and happy workplaces that facilitate the acceptance of new roles and which enable improved recruitment and retention; and we work with the Skills Development Centre in delivering the training required to implement new roles.

Objectives

(What are we seeking to achieve?)

The Workforce Reform Branch has three key objectives arising from the Workforce Strategy:

1. Recruit, develop and retain an appropriately skilled workforce
2. Deliver integrated workforce design, planning and policy
3. Optimise external partnerships.

The key priorities for achieving those objectives are to:

- Develop a strategic framework for workforce design that will allow Queensland Health to best meet population needs (Objective 1&2);
- Develop a strategic framework for workforce preparation and development that will enable Queensland Health to employ sufficient numbers of an appropriately skilled workforce (Objective 1&2);
- Develop a standard approach to governing joint appointments (Objective 3).
- Oversee an "Alert Doctors" strategy
- Create innovative approaches to clinical placements
- Develop a model for training and employing Indigenous nurses
- Provide Queensland Health's input into the COAG health workforce study
- Develop an integrated recruitment strategy.

The first two priorities (i.e. developing strategic frameworks for both workforce design, and for workforce preparation and development will be completed before the 2005/2006 financial year. This work will set a clear direction for the branch and will then enable us to map existing strategies, policies and projects against these new directions. Accordingly, this will enable us to prioritise existing and new projects and will require us to realign our resources to meet these new challenges. This work plan will therefore need to undergo a substantial review immediately prior to the commencement of the 2005/2006 year.

The Branch is also completing a transition from the previous business units to a new structure. As this new structure develops, some of the responsibilities may move within the Branch.

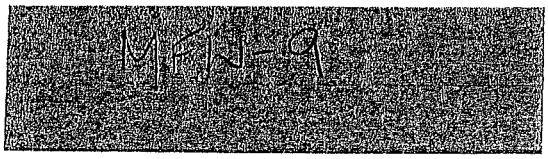
Further information?

For further information contact:

Peter McKay
Executive Director
Workforce Reform Branch
t: 07 3234 1789
f: 07 3234 0314
peter_mckay@health.qld.gov.au

Copies of the plan are available from:
http://qheps.health.qld.gov.au/masters/QHUnits_innovate.htm

Overview



Our mission	Promoting a *healthier* Queensland
Our values	Professionalism, teamwork, performance accountability, quality and recognition
IWR Purpose	*'Creating a climate for change to meet the future challenges in healthcare'*
IWR Guiding principles	We exist to support those delivering health care We will evaluate our work to determine value for money We will treat others with honesty, respect and fairness We accept responsibility for our actions

Who we are

Statewide Health Services Planning currently comprises several project teams, including both employed staff and commissioned consultants:

- Planning for Healthier (small) Rural and Remote Communities
- Planning for population growth in South East Queensland
- Planning for Indigenous Health in Queensland, and
- Preparation of Statewide Services Plans for specialised services – Urology, Cardiac

What we do

Statewide Health Services Planning (SHSP) works with internal and external stakeholders to manage, coordinate and integrate futures-oriented statewide health services planning for health priority areas, population groups and reforms in the health system through:

- analysis of data and information, together with internal or commissioned research to inform projections and modelling,
- development of innovative approaches to services planning,
- whole of government partnerships and development of positive and productive partnerships with all stakeholders with a responsibility for, and role in, health services planning in Queensland.

SHSP provides high level, authoritative advice to the Minister, Director-General and senior Departmental management, on statewide health services planning for specific health priority areas, population groups and reforms in the health system.

This plan

Scope

This plan provides an overview of SHSP's work priorities for the 2005-2006 financial year. As this is the first operational plan prepared, it also incorporates the current period March to June 2005.

Objectives

Statewide Health Services Planning Branch Statewide has been established to work collaboratively with internal and external stakeholders to provide a whole of organisation focus to services planning activities. This group plays a key role in providing value adding information to support and inform the Department's service delivery and workforce planning.

SHSP undertakes this work in two components:

1. *Specific Applications* – In response to Ministerial or Director-General requests, emerging priorities for Queensland Health or whole-of-government - Review of all existing projects, and specification of all new projects within the framework established for IWR.

2. *Systems Development* – Development of planning and analysis systems to support projects, both within IWR and QH more generally.

Key priorities

SHSP provides information and analysis to support each of the Branches/Centres within our Directorate to contribute to the priorities established for the Innovation and Workforce Reform Directorate:

1. Standardisation of systems and clinical practice
2. Developing a culture of safety
3. Exploiting the full potential of the skills development centre consistent with QH strategic intents
4. Systematically applying innovation through the organisation
5. Attracting, training and retaining appropriately skilled staff in appropriate numbers

1. Specific Applications

Current projects include:

- Planning for Healthier (small) Rural and Remote Communities
- *Discussion Paper to inform consultation*
- Planning for growing population in South East Queensland
- *Health and Social Impact Assessment of the SEQ Regional Plan Preferred Settlement Pattern*
- *SEQ Infrastructure Plan*
- Planning for Aboriginal and Torres Strait Islander health
- *Development of a consistent statewide regional health planning framework*
- Development of Statewide Services Plans for selected specialist services
- *Statewide Services Plan for Urology*
- *Statewide Plan for Cardiac Services*

2. Systems Development

- Strategic linkage
    - Develop and maintain strong working relationships with other planning areas within QH (including Strategic Policy, Zonal Management Units, Public Health Planning and Research, Capital Works and Asset Management Branch)
    - Develop and maintain strong working relationships with other planning areas within State Government Agencies (including Premier and Cabinet, Treasury, Local Government and Planning, Office of Urban Management)
    - Develop and maintain strong working relationships with other planning areas within Australian Government Agencies (including Department of Health and Ageing)
    - Develop a unified approach to prioritising all projects
    - Link SHSP activities with those of other IWR branches, and external partners
- Workplace culture
    - Develop processes and mechanisms for work teams with both employed staff and commissioned consultants to maximise individual and organisational learning
    - Develop team development program based on this methodology
- Technical support
    - Investigate and develop new methods of accessing and analysing demographic and other planning data
    - Investigate the development and utilisation of spatial information technology to inform planning and decision making at all levels and locations across Queensland Health
- Structural / Operational Linkage
    - Develop and pilot new planning tools to assist QH stakeholders with planning activities

MFW-10

REVIEW OF MENTAL HEALTH SERVICES BUNDABERG

DR MARK WATERS

JULY 2004

INTRODUCTION

This report has been commissioned by the Director-General of Health through an Instrument of Appointment dated 13 May 2004.

I wish to thank the many people who assisted by being interviewed. I wish to note the assistance provided by Mr Herb Greenwood, Team Leader, Integrated Bundaberg Mental Health (BIMHS) and Ms Auriel Robinson – Queensland Nursing Union Organiser (QNU) for arranging interviews and providing venues for interviews to take place. In particular I would like to thank Mr Bill Pepplinkhouse, Director, Princess Alexandra Mental Health Service for his expert assistance.

I accept full and sole responsibility for the content, findings and recommendations of this report.

This report is structured under the headings of Terms of Reference, Methodology, Findings and Recommendations.

TERMS OF REFERENCE

The Terms of Reference are attached (Attachment 1).

Essentially they required a review of:

a) the safety of the physical surroundings of the Mental Health Service for both patients and staff in the context of policies and practices and

b) any evidence of bullying and / or harassment of staff in management practices or organisational culture and

c) not investigate or focus upon but notify to the Director-General any instance of concern regarding individual patient care that might be uncovered during the review process.

METHODOLOGY

The report is based on interviews and a review of relevant available documentation.

Approximately fifty-eight (58) interviews were conducted at Bundaberg, Brisbane or by telephone. The interviews at Bundaberg were conducted at two (2) sites – The Bundaberg Integrated Mental Health Service (BIMHS) and the Queensland Nursing Union (QNU) Offices in Maryborough Street. The interviews were arranged at the hospital site by Mr Herb Greenwood, Team Leader, BIMS and at the QNU offices by Auriel Robinson (QNU). The interviews at the QNU offices were not arranged via the Mental Health Service, rather all contact was made through the QNU and other union organisers or representatives.

All interviewees were advised that individual's identities or individual comments would not be noted in this report, so that full and frank responses could be obtained. The list of people interviewed is therefore not provided. Interviewees were predominantly current staff, some ex-staff and a limited number of consumers and carers.

The following documents were reviewed as part of this report process:

1. Multiple written statements by staff (not identified or attached).
2. Briefing to District Manager, Bundaberg District Health Service – Dr P Brown, Dr E Leitch; Mr Laurie Isaacs June 2000 (Brown Report 2000).
3. Letter of resignation Dr M May - May 2000.
4. Letter of response Mr Martin Jarman - June 2000.
5. Investigation of November 2001 by Dr Louis Prado and Ms Lisa Fawcett into a grievance against Dr Scott Jenkins and Ms Judith McDonnell.
6. Preliminary Conference Report – Fair Treatment Appeal Nos: 5436, 5441 and 5442.
7. QNU Cursory Inspection July 2003 (sent to Bundaberg District Health Service September 2003).
8. Investigation Report by Viv Pocklington and Jean Devine July / August 2003.
9. EQUiP Organisation Wide Survey Bundaberg Health Service August 2003.
10. Operation of Psychiatric Intensive Care Unit (PICU) Dr A Waugh August 2003.
11. Report on the Health and Safety issues at Bundaberg Mental Health Unit – Megan Kreis September 2003.
12. BIMHS Response to Cursory Inspection – October 2003.
13. QNU letter to Mr P Leck 17 November 2003.

14. QNU letter to Dr S Buckland 10 December 2003.
15. QNU Response to BIMHS response to safety issues March 2004.
16. Audit and Operational Review Report March 2004.
17. Zonal Manager (D Bergin) letter to QNU of 5 April 2004.
18. Bundaberg Health Service District (BHSD) response of April 2004.
19. BIMHS Policy Manual.
20. BIMHS Adult Services Protocol Guide.
21. Information provided on staff turnover, sick leave and workers compensation claims.
22. "Tipping the Scales from Hospital to Community Service Delivery" H Greenwood, M Laurie.
23. Data on Ward Occupancy.
24. National Mental Health Standards reporting Central Zone.
25. Service Development Framework Central Zone 2002 and 2003.
26. Documents as reviewed by Mr W Pepplinkhouse

- Protocol and Procedure – Serious Incident Review Procedure (QHEPS No 20422) (October 2001)
- Seclusion Policy October 2001/March 2003.
- Protocol for Psychiatric Intensive Care Unit – Acute Services (January 2003)
- Protocol for Acute Services – Admission (June 2003)
- Protocol for Acute Services – Duress Alarm System (June 2003)
- Protocol for Acute Services – CMH Alarm System (June 2003)
- Protocol for Acute Services – Direct Observations by Nursing Staff (June 2003)
- Protocol for Challenging Incidents (Psychiatric Emergencies/Management) (July 2003)
- Policy and Procedure – Adverse Event Management (QHEPS No 21906) (June 2004)
- Nursing Education Program (last 6 months)
- Top 20 DRG's for Mental Health
- Protocol for Work Practice Supervision (June 2004)
- Seclusion Register (last 6 months)
- Occupancy Report (last 12 months)
- Hours per Patient Day (HPPD) as per EBV requirement under Business Planning Framework.
- ACHS Audit Reporting Tool to Qld Health Central Zone.

27. Plan of the Inpatient Mental Health Unit, Bundaberg and suggested alterations (Appendix Y)

I understand that two other issues are being investigated by Audit Branch but are not yet complete.

FINDINGS

This review must commence by noting the enormous change process this health service has undergone since (at least) the report by Dr Peggy Brown et al of June 2000 (Brown Report 2000).

These changes, in terms of community focus, consumer involvement and achievement of National Mental Standards were necessary for the BIMHS to be seen both internally and externally as a contemporary mental health service. Achievement of organisational and clinical change has been noted to have been successfully achieved by reference to the stated objectives of the Brown Report 2000 and the EQUIP Organisation Wide Survey of August 2003 as well as the continuous Zonal reporting on the National Mental Health Standards.

The EQUIP Organisation Wide Survey under the auspices of the Australian Council of HealthCare Standards (ACHS) noted that the BIMHS had successfully implemented all recommendations from the previous survey and went further to commend it in a number of areas including amongst others, commendations on community and consumer participation, the integration of services and the development of outreach services.

This is in stark contrast to the situation in 1999 when an audit by the Mental Health Branch of the old Mental Health Act found it to be the most non-compliant in the State.

There is widespread support within the BIMHS for the contemporary direction the BIMHS has moved and continues to explore. Indeed it is noteworthy that staff who have concerns about the implementation of the change process, do not, significantly, dispute the direction the service is now heading or dispute the need for change (from the June 2000 situation) or dispute that significant change has been implemented.

The concerns expressed as relevant to this report, are around the implementation process of these changes and their relationship with organisational culture and management action and if these constitute harassment and bullying. The other relevant issue for this report is if, during the change process, policies have been introduced or physical changes made, which result in safety concerns for staff or patients.

I will address the issue of physical safety first. There have been many changes to the structure and function of the Mental Health Inpatient Unit over the past four years. It is timely to stop and look at the current situation in the mental health building.

SAFETY REPORT JULY 2004

SERVICE DELIVERY

The model of care provided to patients of the BIMHS was reviewed in terms of safety, work practice and whether policies/protocols/procedures were documented to support it. Only the adult component of the service was reviewed.

In general terms, the model of care is contemporary practice which is meeting the state and national standards for treating people with a mental disorder. The service provides continuity of care from the single point of contact through the continuum of community and inpatient care and vice versa. The success of this model has seen the service provide an average use of the sixteen (16) beds at 40% for 2003/2004. Policies and supporting documentation were reviewed and have been listed on Page Four (4). Documentation reviewed supported the model of care and service delivery, including the risk management of patients. There is a review process in place for all policies/protocols and procedures. Of all the documents reviewed and listed, three (3) issues need to be addressed or revisited to meet safe guidelines.

- Protocol for Psychiatric Intensive Care Unit (PICU) mentions staffing minimum to be one (1) staff member per two (2) patients. This is considered by the reviewer not to be a safe practice in a PICU type area.
- The Serious Incident Review process does not allow for a review by someone external to Mental Health or a process such as Root Cause Analysis.
- Protocol for work practice supervision is noted. Evidence shows that not all staff in the Adult BIMHS are receiving clinical supervision. The service plans to have all staff receiving clinical supervision by August 2004.

SUPERVISION / ORGANISATIONAL STRUCTURE

As stated in the introduction, the BIMHS has established a contemporary model of practice that would be the envy of most mainstream mental health services. This is highlighted by the low occupancy of the adult inpatient beds, allowing the service to concentrate its efforts in the community and hence keep bed occupancy low. It is also a defined catchment with very few outliers in terms of admissions from other regions. The low occupancy does however, create other issues, namely inefficiencies and currently staff skill mix concerns.

The nursing structure at present has an NO3 as the highest level nurse and this position is only involved on the inpatient unit. Following the principle that each nurse reports professionally to a senior nurse, BIMHS cannot achieve this using the Unit Manager. There are eleven (11) community nurses and seventeen (17) EN/RN's on the inpatient profile, of these seventeen (17), ten (10) do not receive clinical supervision. The highest level nurse

in the community is an NO2. There is also an OT assistant on the inpatient unit that does not receive clinical or professional supervision. At the time of this review there were three (3) of the Clinical Nurses on some type of leave and they were largely replaced by EN's. This could create issues with skill mix when rostered numbers are quite low.

The BIMHS needs to address the organisational structure to ensure adequate professional / clinical supervision.

INPATIENT UNIT STAFFING

The inpatient unit is operating at 40% occupancy, which is well below state average. The accepted hours per patient day (HPPD) for an acute unit are 5.5-6.5 HPPD and for a PICU 8-9 HPPD. Bundaberg service is averaging 8.9 HPPD for the low dependency beds. The difficulty for the unit is that the low bed day rate means inefficiencies occur in staffing levels. It is noted that a number of the NO2 level nurses are on various types of prolonged leave and are not available for rostering. EN's have filled these gaps. The effect is that the skill mix is compromised for the unit.

There is one (1) Allied Health assistant (OT) who works in isolation and appears to receive no supervision for her role. At least one (1) inpatient nurse is refusing clinical supervision and this potentially compromises patient care.

SAFETY AUDIT – ACUTE UNIT BUNDABERG IMHS ADULT UNIT (16 BEDS)

Generally, the ward design is dated and does not meet contemporary standards in Mental Health Care. These include access to privacy, four-bed rooms, no ensuites and shared toilet and shower facilities for the sixteen (16) beds. All patients need to leave their room and walk a corridor to use the bathroom.

The general ward layout is difficult in terms of observation of patients. The lounge, diningroom and activity room are located at opposite ends of the building. Seclusion and PICU (HDU) are both in the same corridor as the activities area. As these areas are often occupied by noisy and behaviourly disturbed patients, it makes the activities area a less therapeutic environment. The activities area has no windows.

The low number of patients means a low number of staff. Whilst this still equates to 8.9 HPPD, it only means two (2) staff per shift. The nurses' station is an open area and during the review, nurses were completing patient files and there were a lot of items (some confidential) on this bench. Should a nurse be in distress, the other would

respond. Between the hours of 5pm and 8am, this would mean that a staff member at the desk would need to collect and secure confidential information before responding to a colleague's distress. The extra time taken is an issue.

SPECIFIC ISSUES

1. PICU

PICU has not, so far, been used as a PICU and is part of this external review. In summary it can be stated that this area is not suitable for its intended purpose (managing aggressive and difficult behaviour). The PICU area is small, with difficult access issues and has a number of fixtures and fittings that could compromise staff and patient safety.

Issues for the PICU area include:

- The space for lounge/food consumption is inadequate for four (4) people;
- The courtyard is less than 1200mm wide. This is too small and confined for aggressive patients;
- The sliding door to the courtyard can be snibbed from the inside. There is no key or way to access if a worker is locked outside;
- The courtyard external door is not marked as a fire egress. It has no key to enter from outside (i.e. no key tumbler);
- Entrance doors to PICU both operate inwardly and provide no egress. Also, these doors can be barricaded and as such, this area should not be used until this is resolved;
- The sliding door to bedroom has particle board barriers which the reviewer was able to move or demonstrate capacity to pull off;
- Bathroom has tile finish to 1800mm high. This type of finish for these patients is not ideal as tiles could be prised free;
- Folding plastic table could easily be ripped from wall and used inappropriately;
- An alternative shelf/rail needs to be considered for coat hanger space; and
- The television is installed so high that patients would need to strain their neck to watch it in the confined space.

2. SECLUSION SUITE

The seclusion policy is lengthy and not in keeping with contemporary practice for this function. The staff appear to disagree on "when is seclusion broken". This occurs due to the toilet being located inside the seclusion room. Having stated this, the reviewer noted that the seclusion register demonstrates a very low usage. The average seclusion is lower than one (1) episode per month and further analysis indicates one (1) episode of eight (8) hours or more duration in the last year.

Issues for the Seclusion area include:

- Poor observation from one door;
- Door uses only standard lock and hinges. This would not provide a safe barrier for a very aggressive person;
- Doorway to seclusion is only 820mm. Standard is 1200mm for ease of patient safe handling; and
- Cupboard inside entry to foyer contains chemicals and other objects. These cupboards should be removed or locked as appropriate. .

DURESS SYSTEM

There is currently a punch button alarm and pendant system in place. The reviewer noted that no one was wearing the pendants. There is not a systems approach to a psychiatric emergency within psychiatry or with security or the hospital. This is a particular issue at night.

SAFETY REPORT RECOMMENDATIONS

Recommendation 1

Consideration be given to review the organisational structure so that appropriate professional reporting is in place. This will be further commented on in Recommendation 9 in comments on the role of the Service Director.

It is suggested that the current organisation might be improved by:

a) The NUM of the inpatient unit reporting operationally and professionally to NO4 Level nurse.

b) NO4 Level nurse (new position) report operationally to the Service Director and professionally to the Director of Nursing (DON) Bundaberg District Health Service (BDHS).

c) The existing Team Leader be responsible for the community aspects of the BIMHS and report to the Service Director.

d) One of the existing NO2 nurse levels in the community part of BIMHS be reclassified as NO3 for professional reporting for the NO2 nurses in the community. The NO3 position (upgrade of existing) would report operationally to the Team Leader and professionally to the new NO4 position.

The net effect is that clinical and professional issues can now be delegated appropriately by the Service Director.

This issue is also discussed in recommendations under organisational culture.

Recommendation 2

That the current PICU not be utilised for the management of aggressive and violent patients (this area could be readily commissioned for use as a special purpose suite, for admission of mother and baby, young adults, inpatient at risk i.e. elderly depressed). Further that egress issues be remedied prior to any occupation of this area.

Recommendation 3

The nurses station be made secure so that confidential material is not compromised when nurses need to leave the area in an emergency.

Recommendation 4

Consideration be given to changing the function of the seclusion room to that of seclusion/PICU type function (see appendix Y floor plan).

Recommendation 5

Review policies and procedures as required and commented on in this report.

Recommendation 6

The recently purchased duress system be installed and appropriate training and systems supporting psychiatric emergencies be implemented.

ORGANISATIONAL CULTURE

It is impossible to report on the present situation clearly without reviewing the past four years.

The Brown Report 2000 et al could be summarised as dealing with two issues of substance. The first was the requirement to change the processes, policies, structure and emphasis to result in the BIMHS evolving into a contemporary service which would serve the community well. The evidence of success or failure of the recommendations of this report was to be measurable and reportable against the National Mental Health Standards and the Australian Council of Healthcare Standards (ACHS) EQUIP review process. The second major thrust of recommendations referred to the need for a process to deal with the cultural issues already obvious in 2000 of staff conflict arising out of the changes already actioned.

The Brown Report 2000 identified ten significant issues:

1. **Lack of stability in key management positions**
   Unfortunately, for a variety of reasons this has not, over the past four years, been able to be addressed. It is noted that the initial appointment of the Service Director was a twelve-month secondment, not a permanent appointment. The position of Team Leader and Nurse Unit Manager (NUM) have recently taken a prolonged period to fill permanently (approximately twelve months). The NUM process is still underway. Whilst there may be valid reasons for these prolonged gaps in permanent appointment, the result on team building and conflict resolution is still a problem.

2. **Lack of definition and recognition of roles, responsibilities and duties of key positions**
   The daily actions of the Service Director (A08) engender some ambiguity amongst staff.
   It is apparent that the Service Director (an administrative, non-clinical role) does become involved in clinical matters because of the significant clinical expertise of the incumbent. This practice, for example attending clinical hand overs or commenting on the clinical competence of staff, continues to blur the roles and accountabilities of key positions. It obviously effects the clinical and professional roles of the Clinical Director and nursing professional leaders within the service.

3. **Management processes and organisational structure**
   This issue has been significantly addressed however the current clinical and professional roles assumed by the current Service Director require resolution and are referred to in Recommendations 1 and 9.

4. **Strategic service direction and development**

This issue seems to have been significantly addressed.

5. **Contemporary practice**

Enormous positive changes have occurred in this area.

6. **Consumer and carer focus**

This issue seems to have been embraced.

7. **Service Quality**

There is demonstrated achievement in this area.

8. **Staff Skills**

Significant training and skills development has occurred.

9. **Identification within the wider District**

This seems to have been addressed.

10. **Change Management**

Unfortunately the requirement for specific training in change management does not seem to have occurred. Suggestions for external facilitation of the change also seems not to have been taken up.

The current review is significantly about the change process, the appropriateness of the methods used, the scope of change and time frames and the affect of this process on the staff involved.

The BIMHS has gone through great change and is now a service of which the Bundaberg District Health Service can be proud. It is demonstrably a benchmark service in contemporary mental health delivery. External review by the ACHS praises the current service.

Unfortunately, given that a major emphasis of the Brown Report 2000 recommends dealing with the already existing conflict resulting from the change process at that time, an acceleration of the change process in the absence of training, resources and support for a difficult change project perhaps inevitably led to the current situation. That the service change achieved occurred in this environment is an extraordinary testament to the people involved.

The unfortunate side affect is that there now exists a legacy of intra-organisational conflict which has escalated to being highly personal. Indeed, many people readily identified the protagonists and referred to how personalised the current situation was.

Simply put, some inpatient staff, whilst accepting that change is in the right direction, believe that the implementation has occurred inappropriately. Specifically that there has been management harassment and bullying.

The conflict is now reported to largely be between staff in the inpatient unit and the management of the service.

This bullying is alleged to take the form of withholding information, being derisive of staff in the inpatient unit and "splitting" staff between "good staff – bad staff". It should be noted that most of the changes over the past four years have increased the emphasis on community management and the opening of an inpatient unit at Maryborough, which effectively halved the population catchment of the service, further reduces inpatient needs. As previously noted, the inpatient unit now averages 40% occupancy (of 16 beds) – leaving a small average number of inpatients to be managed in a stand alone unit.

As importantly as the reduction in the actual size of the unit is a perception by staff in the inpatient unit that they are not as important, as skilled, as worthwhile, as staff in the community arm of the service. The fulltime equivalent inpatient staff members number approximately eleven (11) out of a total of approximately fifty (50) staff in the whole service.

Recently, Bundaberg has been accepted as a pilot site for a "Recovery" model of care which is suggested to lead to a further reduction in the future for the requirement of inpatient care.

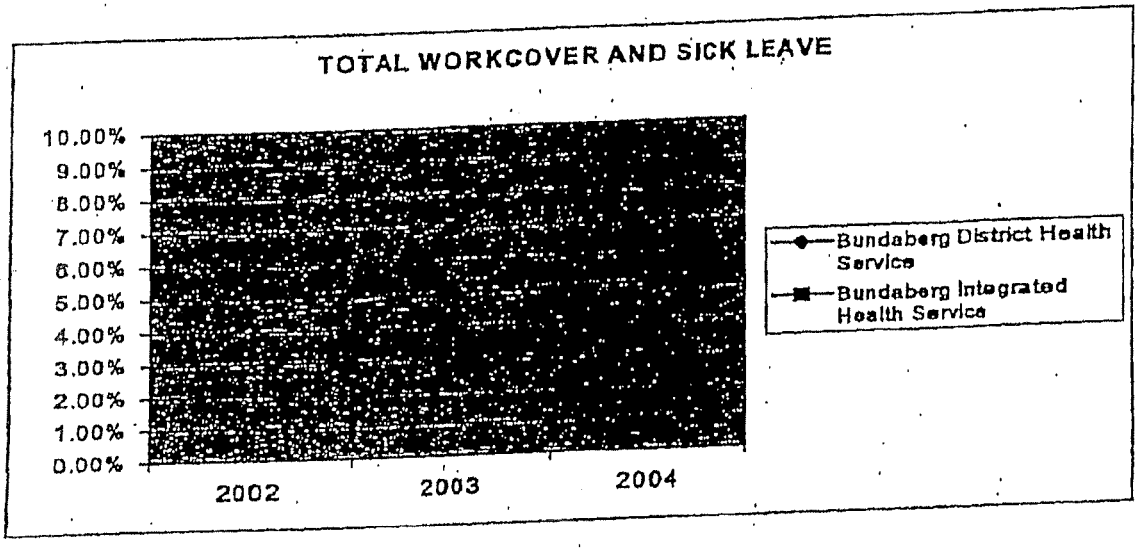
The alternative proposition by people interviewed is that some staff (in the inpatient unit) have personalised issues such that they use incident reports and issues not to improve the running of the service, but as a source of complaint to pursue agendas. Specifically, that concerns are raised to diminish the authority of management and 'get rid of the Service Director".

There is no doubt that the conflict arising out of the change process is now personalised between individuals. This cannot continue for many reasons.

Obviously, such a work atmosphere is not conducive to good morale or a positive work environment for health staff. Importantly, given the polarisation between some in the inpatient unit and management and to some extent, between the inpatient unit and community staff, achieving close integration of patient care between inpatient care and community care is unlikely to be optimal.

It is therefore fundamental that this situation be resolved justly.

Of interest, the sick leave / workers compensation data for the BIMHS is higher than for the Bundaberg Health Service District as a whole (see graph below):



The Terms of Reference require comment on management practice, organisational culture or leadership which may amount to workplace bullying or harassment of staff.

The issue of management bullying / harassment has been formally tested on a number of occasions as the result of allegations:

1) Stage 2 Grievance reviewed by Prado and Fawcett 2002 – not sustained.
2) Stage 3 Grievance reviewed by Pocklington Devine 2002 – not sustained.
3) Fair Treatment Appeal relating to the above two reports declined 2003
   Note 1, 2 and 3 related to the same initial allegations
4) Internal audit report March 2004 (separate allegation) – not sustained.

Specific incidents with specific individuals are also being examined in the usual way through other avenues such as WorkCover. Whilst some WorkCover claims have been accepted, my understanding is that WorkCover has not found unambiguously that management practices constitute harassment or bullying.

There were a significant number of interviewees who believe that the workplace is not healthy and that management does bully and intimidate and harass staff. The theme of these allegations is that staff who do not agree with managerial direction are nominated as "incompetent or resistant to change". They are then subtly bullied through withholding of information or withholding of opportunities for career advancement. Concerns in this regard were raised about a perceived lack of transparency in recruitment and selection.

I remain unaware of any specific findings which endorse categorically, behaviours consistent with management workplace harassment or bullying. There are references, both in previous reviews and by many interviewees of a "direct", "confrontational" and "controlling" management style. This seems likely to be valid. There are also references in previous reviews to "errors of judgement" on the part of management. There was no evidence provided to show staff appointments have been outside Queensland Health guidelines.

It is obvious however, that an unacceptable workplace situation exists. It is clear that many inpatient staff feel undervalued, intimidated and unappreciated and that considerable personal animosity exists within the service which requires resolution.

There is clearly now a loss of trust, a loss of respect and sensitivity around communication which must be resolved for the service to "be the best it can be" and to be truly integrated in all facets of service delivery. This problem is most evident in the relationship between some members of the inpatient unit and management and between some members of the inpatient unit and other mental health workers.

THE WAY FORWARD

The following recommendations suggest a mechanism to move the service forward and to establish a healthy workplace. Some of the recommendations echo some of those of the Brown Report of 2000.

1. **The permanent appointment of key leadership positions:**

   Recommendation 7

   Key leadership positions within the BIMHS be filled on a permanent basis as soon as possible. In the current situation it may be prudent to ensure significant external overview of the selection process to provide the successful applicants with credibility within all parts of the service.

Recommendation 8

It is also recommended that all vacant permanent positions within the BIMHS be reviewed, and if considered necessary positions, that they be filled along similar lines to those referred to above. The requirement for transparency of process is critical to the future credibility of the successful applicants.

2. Role Definition

Recommendation 9

The role of Service Director is already clearly defined as administrative, not clinical. The Service Director should not be involved in clinical situations, should not be asked for or provide clinical advice or comment on clinical issues. If the primary purpose of the meeting is to discuss clinical issues it is inappropriate for the Service Director to be present. This recommendation should be seen in association with Recommendation 3. These recommendations are interdependent, as it is critical that the Service Director has the structure to delegate clinical issues to clinical staff. It would then be mandatory that these delegations occur.

The adequacy of a parttime Clinical Director, in terms of available time should be considered.

3. Change Management

Recommendation 10

All senior staff should be provided with change management training.

4. Mediation

Given the current situation, significant mediation is now required within the service. A prerequisite of this is a clear statement on the role, importance and likely future of the inpatient unit. The statement must be unambiguous. The determination of the role, importance and likely future is likely to require high level facilitation from the Mental Health Branch.

The central issues for mediation centre around issues of mutual trust, respect, affirmation of worth and behaviour modelling these aspects.

Successful mediation is critical to the future smooth functioning of an integrated unit.

Recommendation 11

It is recommended that extensive, expert mediation be sourced and resourced to deal with the existing interpersonal conflicts.

5. **Conflict Resolution**

The presence of a Local Consultative Forum (LCF) may provide a forum where the many issues that arise might be addressed.

Recommendation 12

That consideration be given to establishing a Local Consultative Forum (LCF).

6. **Period of Consolidation**

There is clearly significant change which has already occurred within this service which appears to place it at the forefront of mental health services in Queensland. A proposal for further significant change in being a pilot site for a new model of care "Recovery" is currently planned for Bundaberg. The wisdom of embarking on further significant change at this time is questionable.

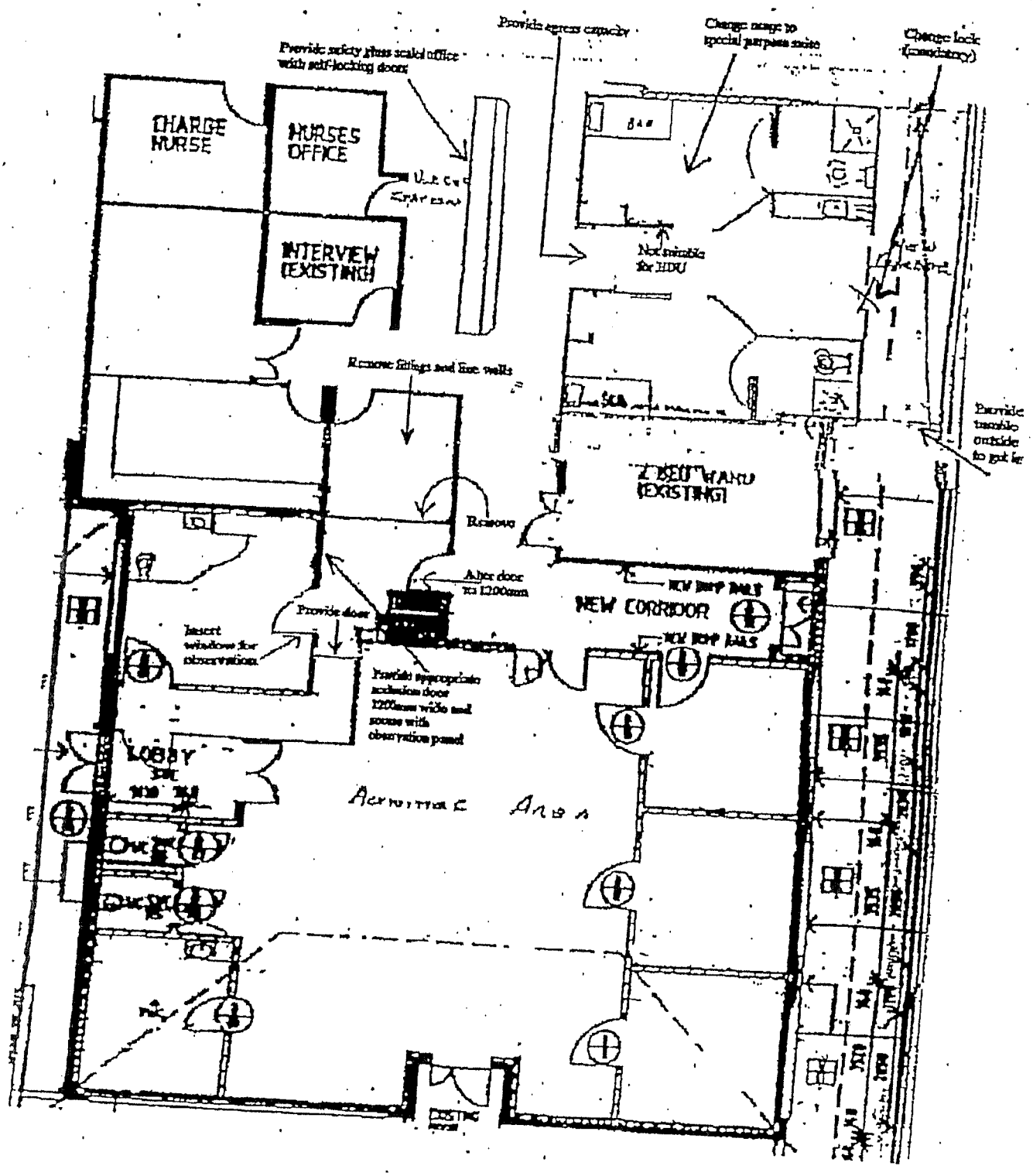
Recommendation 13

It is recommended that further consideration be given to the suitability of BIMHS as the pilot site for the Recovery Model. A period of consolidation of recent achievements should be considered until the recommendations in this report have been addressed.

Clinical Issues

There were no specific issues of patient care that I became aware of that required referral to the Director-General. I note one item of correspondence of potential concern had already been sent to the Health Minister.

APPENDIX Y


Provide safety glass sealed office with self-locking doors
Provide egress capacity
Change usage to special purpose suite
Change lock (mandatory)
CHARGE NURSE
NURSES OFFICE
INTERVIEW (EXISTING)
Not suitable for HDU
Remove fittings and fire walls
Provide movable partition to get in
2 BED WARD (EXISTING)
Remove
Alter door to 1200mm
Provide door
NEW CORRIDOR
Insert window for observation
Provide appropriate exclusion door 1200mm wide and screen with observation panel
LOBBY
ACTIVITIES AREA

MFW-11

The
WESLEY HOSPITAL

22 July 2004

Dr Steve Buckland
Director-General
Queensland Health
GPO Box 48
BRISBANE QLD 4001

Dear Dr Buckland

Please find attached three (3) copies of my Review of the Mental Health Service Bundaberg as requested.

I trust this review will provide some assistance for Queensland Health.

Yours sincerely

Dr Mark Waters
GENERAL MANAGER

Encl.

www.wesley.com.au

ABN 87 842 457 440 THE WESLEY HOSPITAL

451 Coronation Drive, Auchenflower QLD 4066 Telephone: 617 3232 7000 Fax: 617 3371 6834