Queensland Health

Queensland Government

Executive Management Team Briefing Note

Agenda Item: 5.5.1

Subject: Queensland Clinical Senate (QCS) Final Report December 2012

Reference No.	**EM001267**
Meeting date:	**12 March 2013**
Submitted by:	**Dr Michael Cleary, Deputy Director-General, Health Service and Clinical Innovation Division**
New Item / Previously Raised:	New item
System Manager / Department:	**State-wide issue**

Recommendation(s):

That EMT:

1. **Note** the QCS Final Report December 2012 (Attachment 1).

Strategic Plan Alignment: The activities of the QCS align with the Queensland Health strategic priorities

Executive Committee Pathway:

☐ Performance Management Executive Committee
☐ ICT Investment Board
☐ Close the Gap Executive Committee
☐ Resources Executive Committee
☒ None

SUPPORTING INFORMATION:

Context:

- This brief is being provided to table the QCS Final Report *December 2012* to provide detailed information on the last QCS meeting.

Issues:

- The QCS met on 6-7 December 2012. The meeting format was designed to identify key issues that would benefit from QCS involvement in the future in relation to:
  - The use of Public Private Partnerships (PPPs) in the Queensland Public Health System
  - The impact of health reforms on clinicians to date
  - Purchasing intentions for 2013/14 – 2015/16
  - Statewide Clinical Networks (SCNs).
- Three clear issues emerged that the QCS will develop further in 2013:
  - The need for improved clinician engagement and partnership in the planning, implementation and review of health services
  - The development and implementation of mechanisms to enable proactive, timely and considered clinician input into the development of future purchasing initiatives
  - The development of principles regarding the type, quality and integration of services across the public and private sectors to support PPPs in health.
- QCS members supported the proposal to review SCNs and provided input which will inform the development of the review's terms of reference

Options:
Not applicable

Health Reform Considerations:

- The contents of this report will help to inform stakeholders of clinician engagement mechanisms within Queensland Health

Risk Assessment:
Not applicable: The QCS is an advisory group. The report provides high level advice only.

Resource Considerations:

- QCS meetings are funded by the Health Service and Clinical Innovation Division

Consultation:

- QCS members, The QCS Executive and the Deputy Director-General, Health Services and Clinical Innovation Division (in his role as QCS Sponsor and Chair of the QCS December 2012 meeting) have endorsed the report. The QCS Executive has requested this report be tabled with the EMT.

Implementation:
Not applicable.

Attachments:

1. Queensland Clinical Senate Final Report *December 2012*

Author: Melleesa Cowie Position: QCS Manager Branch: Health Systems Innovation Branch Telephone No: Date: 28 February 2013	Submitted through: Name: Jan Phillips Position: Executive Director, Health Systems Innovation Branch Telephone No: Date: 1 March 2013	Cleared By: (EMT Member) Name: Michael Cleary Position: Deputy Director-General, Health Service & Clinical Innovation Division Telephone No: Date: 3 March 2013

Queensland Clinical Senate

Attachment 1

Final Report

6 and 7 December 2012
Victoria Park, Herston, Queensland

Queensland
Clinical Senate

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Presenters

- Hon. Lawrence Springborg, Minister for Health
- Michael Cleary, Deputy Director-General, Health Service & Clinical Innovation Division
- Colleen Jen, Senior Director, Planning Branch
- Jan Phillips, Executive Director, Health Systems Innovation Branch
- Nick Steele, Executive Director, Healthcare Purchasing Branch

Panellists

- Julie Hartley-Jones - CE, Cairns and Hinterland Hospital and Health Service
- Liz Kenny –Senior Radiation Oncologist, Metro North Hospital and Health Service
- Richard Royal - Chief Executive Officer, Uniting Care Health
- Mark Tucker-Evans – Chair, Health Consumers Queensland
- Terry White – Chair, Metro South Hospital and Health Board

Executive Summary

The tenth meeting of the Queensland Clinical Senate (QCS) was held on 6 and 7 December 2012, chaired by Dr Michael Cleary – QCS Sponsor. The meeting format was designed to identify key issues that would benefit from QCS involvement in the future in relation to:

- The use of public private partnerships (PPPs) in Queensland Health
- The impact of health reforms on clinicians to date
- Purchasing intentions for 2013/14 – 2015/16
- Statewide Clinical Networks (SCNs).

In addition to the Minister, participants included: the Assistant Minister for Health, Chris Davis MP; the Director-General, Dr Tony O'Connell; the Chief Executive Officer of Uniting Care Health, Mr Richard Royle, several Chairs of Hospital and Health Boards, Chief Executives of Hospital and Health Services (HHS) and Chairs of Medicare Locals; and QCS members.

The Minister for Health, the Hon. Lawrence Springborg acknowledged Dr Bill Glasson and thanked him for his dedication and commitment to his role as Inaugural Chair of the QCS.

The Minister outlined his vision for the use of PPPs in Queensland, describing them as an investment in long-term infrastructure and emphasised the potential to lower healthcare costs through efficiencies.

A panel discussion on PPPs examined the opportunities and challenges that PPP models presented. The concept of contestability for service provision was discussed and key challenges such as variations in industrial relations / enterprise agreements and the provisions of training and research were explored.

The QCS sought feedback from members regarding the impact of Health Reforms to date. While discussion demonstrated a cautiously optimistic, positive mood, there was also a sense that the reforms had not yet been felt at the bedside.

The QCS welcomed an update on the System Managers proposed purchasing intentions for 2013/14-2015/16. Mr Nick Steele, Executive Director, Healthcare purchasing, outlined the minimum requirements for Service Agreements, provided a summary of the framework over its initial two years, discussed needs assessments and growth in projected need, the purchasing priorities for the next financial year and the overarching investment principles.

The recent transition of Corporate Office into the System Manger and the devolution of autonomy to HHSs presented a timely opportunity to reflect on all aspects of the SCNs. Participants supported the proposal to review SCNs and provided input which will inform the development of the terms of reference for the review.

While discussion was passionate and robust, members overwhelming urged that if the benefits of reform are to be realised, a clear vision/strategic direction, true clinician engagement and a focus on new innovative models of care is required.

Three clear issues emerged that require robust development during 2013:

- Clinicians must have a strong voice in the planning, implementation and review of health services in Queensland to ensure the best possible patient outcomes are achieved. True – not symbolic - partnership between clinicians and administrators in each aspect of decision making which impacts clinical service delivery is critical to success. These partnerships need to be at the System Manager and HHS level.
- Mechanisms and processes must be identified and implemented to enable proactive, timely and considered clinician input into the development of the purchasing framework component of HHS Service Level Agreements. Partnership and collaboration between the System Manager, the QCS and Statewide Clinical Networks can contribute positively to ensuring purchasing decisions result in constructive change on the ground. It was suggested that the SCNs are well placed to identify service gaps and determine safety and quality Key Performance Indicators (KPIs) for the service agreements. Clinicians want to work with the purchasing team to develop flexibility and promote innovation which are deemed of great importance to the clinical community.
- PPPs offer the potential for efficiencies and opportunities for the people of Queensland. The QCS recommends that principles regarding the type, quality and integration of services across the public and private sector are developed. The QCS and SCNs are well placed to both inform this work and mentor the development and promotion of collaborative relationships between the public and private sectors.

The QCS is committed to playing a key role in safeguarding high standards of integrated and linked patient care and ensuring continuous clinical practice improvement across Queensland. It acknowledges that the changes to the health system brings both risks and opportunities to HHSs and will continue to provide leadership, high quality, evidence-based and timely advice to the System Manager, Hospital and Health Boards, HHSs and Medicare Locals on issues of strategic importance to patient care. The QCS will provide key stakeholders with its strategic plan over the coming months which will outline the priorities and strategies the QCS will adopt to assist its stakeholders to deliver positive outcomes for the health system in Queensland.

Dr Michael Cleary

Deputy Director-General, Health Service and Clinical Innovation Division

Sponsor of the Queensland Clinical Senate

22 February 2013

1. Introduction and Welcome, Thursday 17 August 2012

Dr Michael Cleary, Sponsor, Queensland Clinical Senate

Dr Cleary welcomed guests and members and acknowledged the traditional owners of the land on which the event took place.

Having provided an overview of the meeting agenda, Dr Cleary spoke of the importance of clinician engagement to realising the benefits of health reforms and acknowledged the role the QCS has played in leading clinician engagement within Queensland Health.

Special thanks were extended to the Honourable Lawrence Springborg, Minister for Health; Dr Chris Davis, the Assistant Minister for Health; Tony O'Connell, Director-General; Bill Glasson, outgoing Chair of the QCS Chairs; and panel members – Richard Royal, Terry White, Julie Hartley-Jones, Mark Tucker-Evans and Liz Kenny. Dr Cleary noted the apologies by members and guests, in particular Dr Darren Walters.

Dr Cleary spoke of the state of change within the health care system in Queensland and stressed the importance of vision, courage and innovation to achieving continuous improvement in the quality of health services that are provided.

The Minister for Health, the Honourable Lawrence Springborg was invited to open the meeting.

2. Opening Address

Hon. Lawrence Springborg, Minister for Health

The Minister for Health opened the meeting by welcoming participants, acknowledging the important role of the QCS and his appreciation of the work of the QCS.

The Minister congratulated clinicians and HHSs and Boards on their achievements to date. Using the examples of significant reductions in ambulance bypass, National Emergency Access Targets (NEAT) and National Elective Surgery Targets (NEST), he commended colleagues on implementing innovative ideas and redesigning the way they do business to improve the patient experience of Queenslanders.

The Minister spoke of the importance of clinician engagement and innovation, citing the New Zealand health system as a good example of what can be achieved over the long term. He stated clinician engagement is critical to the principle of a devolved health system and is a core remit of Hospital and Health Boards.

The Minister reminded participants of the challenges Queensland faces, stressing rapid population growth, chronic disease and rising costs as major burdens on the health system. He spoke of the challenges in delivering major health infrastructure efficiently and effectively while delivering the best outcomes for the community. The Minister stressed the implementation of new and innovative ways of delivering health care and a focus on the delivery of core / essential services as critical to creating a safe, sustainable and affordable health system. The Minister stated that for this reason, PPPs are considered an effective method for governments to deliver large, complex and expensive projects or services.

The Minister emphasised that PPPs offer the potential to lower health expenditure as a result of efficiencies gained in the delivery of projects or services. Where evidence supports the use of PPPs, the public sector must leverage the capabilities that exist in the private and Non-Government Organisations (NGOs) sectors.

Joondalup Health Campus in Western Australia was provided as one successful example of what greater collaboration between public, private and NGO and can achieve in healthcare. The Minister provided an overview of the PPP model(s) being considered for the Sunshine Coast University Hospital. He clarified that while government may have a preference regarding the adoption of PPPs in health care, decisions will ultimately be based on evidence and rest with HHSs and Boards to ensure local meeds are met.

Concerns raised by participants with the Minister focused on the impact of PPPs on training, research and information access. While the Minister acknowledged the delivery of training and funding for research, the evaluation of health services and the ability to share information/data may be a challenge in some PPP models, he reassured participants that the delivery of these functions would be a focus for HHSs when entering into PPPs.

In closing, the Minister formally acknowledged the achievements of the QCS under the leadership of Dr Glasson, outgoing Chair of the QCS and commended him for his passion, ongoing commitment to community service and dedication to improving the healthcare of Queenslanders.

The Minister reminded attendees of the enormous reform and change that Queensland is traversing and once again congratulated them on the achievements to date.

In addition to questions regarding PPPs, participants raised pressing workforce issues with the Minister, including graduate placements for Doctors and nurses. The Minister re-iterated his commitment to addressing the issues in collaboration with state and federal colleagues. The Minister challenged the QCS to consider this topic with the view to providing innovative strategies to tackle the problem.

3. Thank you to outgoing Chair

On behalf of the QCS and the QCS Executive Dr Liz Kenny thanked Dr Glasson for his chairmanship over the last 4 years and whished him well for his future endeavours.

Dr Glasson thanked the QCS Executive members, senate members, the Minister for Health, Director-General, Queensland Health Executive, Secretariat and Dr Norman Swan. Dr Glasson congratulated the QCS on its achievements over the past four years and attributed the strong positive relationship between the QCS and Department as being a critical factor in the QCS success.

4. Public Private Partnerships: the good, the bad and the ugly

Dr Swan outlined the objective of the PPP discussion as a chance for the QCS to explore the challenges and opportunities of PPP models in healthcare and to determine what role the QCS might have in progressing the development of PPPs in Queensland Health.

Panellists included:

- Richard Royle - Chief Executive (CE), Uniting Care Health
- Mark Tucker-Evans – Chair, Health Consumers Queensland
- Terry White – Chair, Metro South Hospital & Health Board
- Julie Hartley-Jones - CE, Cairns and Hinterland HHS
- Liz Kenny –Senior Radiation Oncologist, Metro North HHS.

Richard Royle opened the discussion and spoke of the volume and complexity of the work provided in the public sector. Key messages included:

- Within Australia, the private sector: provides 33% of hospital beds, manages 40% of admissions; and delivers 67% of elective surgery
- A significant percentage of the case mix is considered to be complex and includes costly services such as emergency medicine, palliative care, oncology, bone marrow transplantation etc which are provided as part of a comprehensive package of services.
- The private sector is at a point in its development where it can decant some of the traditional pressure points for the pubic system, e.g. teaching and research
- The private sector's ability to deliver capital savings is clearly demonstrated. Operational savings and improved customer satisfaction feedback as a result of that have been demonstrated at other sites e.g. Joondalup, Mildura and Midlands where specific throughput targets and volumes by case mix are being delivered at a discount price to government.

Julie Hartley-Jones described three successful PPP models in use at Cairns and Hinterland HHS which provide radiation oncology, renal dialysis and radiology services.

The panel described their diverse views on PPPs and the associated challenges and opportunities. The concept of contestability for service provision was raised. There was general agreement that:

- PPPs create an opportunity for both sectors to think creatively, deliver services differently and affordably
- Both sectors could learn from each other
- The consumer must be at the centre of service delivery planning. Collaboration between sectors is critical to ensure services are designed that will meet consumers needs.
- Strong partnerships would enable innovative models to deliver multidisciplinary team based care across all sectors.
- PPPs (for hospital services) may be successful in some provincial communities but would require innovative thinking. The use of generalist medical services, new staffing models, blended models of care to better coordinate important services to rural communities (e.g. birthing, aged care, palliative care) were provided as examples. Opportunities for PPPs within the sub-acute /non-acute care sector in rural communities should be explored.

Key challenges raised by panellists and participants included:

- Workforce – variations in enterprise agreements have created differences in staff entitlements. When services are integrated (i.e. not outsourced), how do you remunerate staff who are doing essentially the same job but have different entitlements? It was noted that Joondalup Campus has a separate Enterprise Agreement to ensure arrangements are somewhat equal between public and private
- Targeting efficiencies – better integration between public and private sectors requires identifying the services where there can be value add and services where contractually there can be benefit to government both financially and operationally
- Data and information – a significant investment would be required to enable communication, data collection and information sharing
- Funding – overcoming the difficulties imposed by disparate funding sources and agreements
- Culture – there will need to be a cultural shift that recognises the value of staff and fosters trust. People must be considered to be part of the service, not remote from the service.

Participants considered the QCS role in the evolution of PPPs and where it could add most value. There was consensus that the QCS might:

- Influence the development of principles around type of services and the quality and integration of services across the public and private sector
- Play a role in mentoring the development of collaborative relationships between sectors
- Define checklists for the measurement of PPPs: equity, efficiency clinical outcomes and degree of consumer input and observation.
- Inform the system manager of the information that should be jointly collected across the public / private sectors and Medicare Local / HHS divide to enable benchmarking to ensure there is a focus on outcomes, quality and appropriately considered data to measure success in achieving goals.

5. Evening Session Close

Dr Michael Cleary, Sponsor, Queensland Clinical Senate

Following and update by Dr Mukesh Haikerwal (National Clinician Lead for the National ehealth Transition Authority), Dr Cleary summarised the key themes of the discussion, emphasising the importance of local solutions and strong working relationships to achieving goals. Having provided an overview of Friday's agenda, Dr Cleary thanked guests and members for their participation.

6. Welcome, Friday 7 December 2012

Dr Michael Cleary, Sponsor, Queensland Clinical Senate

Dr Cleary opened the second day of the QCS meeting by welcoming participants and the traditional owners of the land on which the event took place. After re-capping key themes from the PPP discussion Thursday evening, Dr Cleary provided an overview of the days agenda and objectives.

7. Health reform six month progress check

Facilitated discussion – Dr Norman Swan

With the passage of nearly six months since the implementation of the Health Reforms on 1 July 2012, it was timely to obtain feedback from participants on their views of the impact of reforms. Participants acknowledged broader state government reforms have impacted the healthcare system during this time, in particular the down sizing of the public service and that Queensland remains in the early stages of the health reform process.

Overall the feedback captured a cautiously optimistic, positive mood. Key themes to participant feedbacks included:

- Autonomy – devolution has delivered greater local autonomy however has not been applied to the extent needed. Leadership, from both clinicians and managers, is essential to drive change and realise the benefits of reform.
- Innovation – reductions in service provision was a key theme across most HHS as the primary mechanism to deliver financial efficiencies. To deliver high quality care within a defined budget that meets the needs of consumers and the health professionals delivering it, there must be a focus on innovation. While some HHSs (and specialities within HHSs) have embraced service redesign to deliver outcomes, many have not. Additional funding and resources to support innovation would enable HHSs, Medicare Locals and NGOs to move to a innovation paradigm.
- Clinician engagement – meaningful and broad engagement between clinicians and managers is essential to realise the benefits of reform. While clinicians remain eager to implement new innovative models of care as a mechanism to achieve efficiencies and improve the quality of care delivered to patients, environments where decisions impacting core service delivery are made unilaterally, quickly and with limited/token consultation is impacting negatively on morale. Most participants cited the need to improve communication and clinical engagement as priority issue and that this be integrated into planning.
- Communication - a lack of knowledge in a climate of change creates tension and anxiety. Innovation can thrive and benefits can be realised when communication is clear, the strategic vision is understood, goals are unambiguous and timely data is available which is relevant to outputs and outcomes. Achievements re NEAT and NEST targets are testament to this principle. There are opportunities to improve communication of strategy, intention and feedback from the system.
- Safety and quality – devolution has resulted in a reduction in the coordination of statewide services and decentralisation of core safety and quality functions to HHS. While local autonomy may deliver positive safety and quality outcomes at a micro system level in larger centres, concern was raised for HHSs with less resources.
- Service integration – opportunities exist to improve service integration across sectors (primary care and secondary care) and within HHSs.
- Consumer focus – while there has been a renewed focus on consumer and community engagement the degree of engagement is variable across the system.
- Culture – a cultural change will be needed to foster trust, overcome resistance to change and operationalise reform.

The Director–General spoke of his optimism for health reform and the achievements to date. He acknowledged the anxiety people were feeling and stated some confusion regarding the changes was to be expected. Dr O'Connell described the changes in governance, down-sizing of corporate office, the introduction of ABF and the purchasing framework, changes to processes and austerity measures as essential implements in the change process health must experience to make the system sustainable. Dr O'Connell stated structural reform, devolvement of powers to HHSs, the introduction of Hospital and Health Boards, and improvements in performance as a result of staff's enthusiasm for clinical service re-design as success.

Dr O'Connell acknowledged the stress associated with the reduction in staff and the loss of corporate knowledge as low points and described the integration of care across sectors as a significant challenge – in part due to mal-aligned financial drivers.

The Director-General made a commitment to continue to increase funding. He described the vision for Queensland Health as: HHSs working within budgets, delivering an excellent patient experience, and who have satisfied staff; the Department having minimal influence outside of its role as a purchaser of care; and where patients take more responsibility for their own health but have easy access to services.

8. Purchasing intentions: 2013/14 – 2015/16

Mr Nick Steele, Executive Director, Healthcare Purchasing Branch

Ms Colleen Jen, Senior Director, Planning Branch

Mr Steele provided an update on the development of the healthcare purchasing framework for 2013/14-2015/16. Having acknowledged the stresses on the healthcare system (increasing demand for services; commitments to major capital projects e.g. the new Gold Coast University Hospital; heightened financial pressures), Mr Steele confirmed that discussions are in progress to negotiate a 3 year service agreement by the end of March 2013.

Mr Steele descried SLAs as the primary tool used by the System Manger and HHSs, specifying: the number and broad mix of services that are to be provided by HHSs; the quality and service standards to be delivered; the level of funding to be provided through Activity Based Funding (ABF) and block funding; and the teaching, training and research functions to be undertaken by HHSs.

Mr Steele clarified the roles and responsibilities of parties. System Manager roles include:

- Understanding health service need and current healthcare provisions
- Identify what services are in scope for the State (e.g. primary/community care)
- Identifying the purchasing priorities for the State
- Ensure a transparent criteria based investment strategy is developed and applied (i.e. investment of growth money)

- Applying ABF and purchasing/performance levers to realise strategic priorities
- Ensure increasing efficiency in service delivery (through incentives for service modernisation and quality improvements across the state)
- To best align, in an equitable way across the system, identified demand with available resources.

HHS responsibilities include:

- The production (e.g. models of care) of services, inputs and setting for care delivery
- Generating a surplus for local reinvestment (subject to KPI achievements)
- Meeting SLA KPIs (budget, access, safety and quality).

Mr Steele provided an overview on the current proposal to change SLAs which includes:

- Slim-lined agreements for 2013/15 – 2015/16, published on the internet
- Three supporting documents: health system priorities; HHS performance framework; funding principles and guidelines (the later accessible to the specific HHS only via the intranet)
- Ten schedules will be reduced to four: Hospital and Health Service Profile; Purchased Activity and Funding Schedule; Key Performance Indicators; Workforce Management.

Mr Steele provided a summary of the impact of the purchasing framework over the last two years, noting that: financial balance was achieved across the system in 2011/12; and an additional $237M was invested in growth in 2012/13. Stakeholder feedback on the framework raised the need for:

- a more tailored approach in terms of purchasing (e.g. growth) and in terms of KPIs
- rules and monitoring mechanisms regarding Inter-HHS patient flows
- the System Manager to recognise the autonomous role of HHSs and therefore should not unnecessarily constrain the HHSs e.g. by prescribing inputs (e.g. MOHRI) or reducing price (e.g. Hospital in the Home) or devolve services without negotiation.

No new purchasing initiatives will be introduced in 2012/13, instead the System Manager will seek to be more targeted in terms of growth in the system and how health need will be identified.

Ms Colleen Jen provided an overview on the assessment of health need, confirming that health need assessment is being projected to 2016/17 for services funded via ABF (inpatients, critical care, sub and non-acute, mental health, outpatients, emergency department and ambulatory care). This will enable targets to be identified within the three year service agreement period. Preliminary projections indicate that health need will exceed the funding available, hence a process to priorities purchasing will be required.

Ms Jen explained that currently HHSs are funded on place of treatment (health assessment includes patient flow assumptions). A preliminary review of purchasing activity in comparison to health need for 2012/13 identified statewide, less than 80% of assessed need was purchased for: palliative care, special care nursery and neonatal intensive care; and less than 70% of mental health need.

Ms Jen identified growth in projected need for 2011/12 to 2016/17 and advised projections had been distributed to Chief Executives of HHSs for review.

Mr Steele presented a summary of the purchasing priorities for 2013/14 – 2015/16, citing an increase in growth funding of 2.5% for 2012/13 (~$250M) and 4.5% for the following 2 years (which will include funding to cover growth in activity and growth in cost). Key themes included:

- The goal of improved transparency in the allocation of resources fairly between HHSs in a way that maximises health gain
- The application of the national ABF model (with localisation where required) from 1 July 2013
- Activity targets will be set at HHS level, cover all public hospital services and all service streams (e.g. inpatient, outpatient, emergency department, subacute etc). Facility activity targets will be determined by HHSs
- Movement to equitable activity targets will depend on a range of factors, including activity targets in the previous year (purchased levels). To achieve equity across HHSs growth funds will be targeted at those HHS most in need but there will be no disinvestment compared to 2012/13 recurrent purchased levels (unless as a result of a specific service change).

Mr Steele explained that the allocation of new funding will be in the following priority order:

1. State government commitments including election commitments (e.g. patient travel subsidy scheme)
2. Commitments under national agreements up to minimum required level
3. Full year effect of investment made in 2012/13 e.g. Regional Council Centre developments
4. Investment to address identified health need where capacity is available or can be sub-contracted (e.g. Sub and non-acute care, endoscopy)
5. Investment in innovation to support demand management (e.g. development of more efficient/effective models of care, use of technology, a focus on rural and remote facilities and community mental health).

Mr Steele emphasised the aim of purchasing a minimum growth in activity of 3% per annum (i.e. c46,000 Weighted Activity Units and $200M). Other key changes for 2013/14 include:

- Hospital in the Home (HITH) – 100% funding for HITH to go back into the system to fund HITH strategies. The performance KPI for HITH will be retained, with the target held at 1.5% of all inpatient separations for 13/14 but rising in successive years
- Outpatient new to review ratio –new ratios will not be specified. Instead of reducing outpatient occasions of service the national ABF model will be localised to have separate new and review prices and the review price will subsequently be discounted to incentivise a significant reduction in

reviews. Outpatient activity related to Chronic Disease Management hospital avoidance is coded to a discrete clinic type and excluded along with targeted areas.

- NEAT/NEST Quality Improvement Payment - will continue but will link directly to reward payment and consideration being given to how best to support MEDAI recommendations.

Participants suggested the SCN play a role in the development of KPIs for Service Agreements.

In closing, Mr Steele requested feedback from participants on the purchasing intentions by 21 December 2012.

9. Statewide Clinical Networks: a framework for the way forward

Ms Jan Phillips, Executive Director, Health Systems Innovation Branch

Ms Phillips provided an overview of the genesis of networks and informed participants that since the inception of SCN and area networks in 2006, over 20 SCNs have been created to foster statewide quality improvement.

A SCN Policy and Implementation standard was developed in 2007and included criteria to establish a SCN and the requirement of a SCN council to undertake a high level strategic review of SCNs.

Ms Phillips acknowledged that while some aspects of the policy have been implemented, some – including the evaluation component have not.

Ms Phillips noted that the concept of review and evaluation was discussed again on 4 June 2012 at a combined Chairs meeting where participants supported the need SCNs to have consistent terms of reference, KPI and adequate but equitable resources.

It has been suggested (but not confirmed) that a SCN costs ~$250k/yr. If recent requests to establish numerous new networks were approved, this would impact on the funds available to existing networks.

With the transition of Corporate Office into the System Manager, the governance and coordination of SCN now fall under the Clinical Access and Redesign Unit of the System Manager.

While SCN have continued to develop innovative solutions to HHSs, challenges exist. These include:

- Variation in role and function, number, type and frequency of meetings
- Variation in the processes and criteria to establish networks
- Variation in representation of HHSs
- Not all key clinical leaders are members
- Disparity in resourcing: Chair payments, Support staff, Funding
- Network alignment with QH strategic priorities

- No minimum standard for outcomes

Ms Phillips identified equity, transparency, outcomes and deliverables as the drivers behind the proposed review.

Ms Phillips suggested that if the QCS advised a review should proceed, that the terms of reference might describe a review of all existing SCNs with the objective of evaluating and making recommendations on the role of the networks within the context of the new organisational structure, including number, focus, support, operations and outcomes. She clarified that no decisions has been made as to who would conduct the review.

Dr Tony Russell, Chair of SCNs spoke of the opportunities that a review of SCNs might provide and the importance of defining a structure for SCNs that would enable them to have a greater influence on the System Manager and HHSs to improve quality standards across the system.

Participant supported the proposal to review SCNs and provided the following suggestions:

1. How should networks influence service integration and planning – including cross HHS issues?

    - Given SCN are advisory, credibility in the advice provided to stakeholders will be key. Strong relationships and effective two-way communication is required between SCNs and HHSs. This should be at an Executive level, vertical and horizontal across the membership. Forums SCN could use to report outputs and outcomes include: the QCS, Executive Management Team meetings within the System Manager, Chief Executive HHS forums and Chairs of HHB forums
    - Explore options to embed SCN KPI in HHS SLAs
    - SCNs should review their individual Terms of Reference and ensure they clearly articulate the role and services they will/can provide to and stakeholders (i.e. evidence based advice, consultancy, clinical advice and advocacy, clinical engagement up and down the system, a statewide knowledge of successful models of care)
    - All SCN should develop communication plans.

2. What governance and management arrangements are needed to support such a function?

    - Management – what ever it takes to get the job done
    - Governance – to CARU and the QCS
    - Need high level executive officers with the skills to support SCN and assist them to articulate information to various stakeholders
    - Explore the models used in other jurisdictions to support SCN activity (e.g. in NSW).

3. What role should networks play when HHS performance deteriorates (e.g. audit/review)?

    - Moral obligation for SCN to advise/intervene when poor performance threatens patient safety

- Provide 'external' strategic consultancy to HHSs where the area of poor clinical performance aligns with a SCN (eg Emergency Department SCN)
- Communication of successful models of care across the systems, proactively sharing this information with HHS who have been identified to be struggling to perform in a specific area
- Dependent on the ability access data which is timely, reliable and interpretable
- The invitation from HHSs to participate in addressing clinical performance issues with an HHS will depend on the development of good communication and trusting relationships.

4. How should network activity be determined, measured and reported?

- SCN should determine its activity and include the development of KPIs. The recent NSW review of SCN KPIs should be examined for key learnings
- All SCN should develop a work plan which includes the prioritisation of work, strategies to measure outputs and outcomes, and a communication strategy
- Scorecards could be developed to identify the critical measures needed to monitor performance of the system that they have a responsibility for. Measure should be transparent and used to inform SCN work plans and action plans.

5. What is the relationship between networks and the QCS? What role if any should the QCS play in evaluating performance of SCNs?

- SCN undertake a regular self audit, and possibly an independent review, of there performance that is reported back formally to the QCS
- QCS should develop mechanisms to showcase and communicate SCN activity and to develop solutions to issues common across SCNs. This might include dedicated time at QCS meetings
- QCS could have a role in: informing the System Manager on the number and focus of SCN; informing and monitoring SCN performance.

Other suggestions:

- Taskforces could be established and should be time limited to address specific issues
- Need statewide representation on SCNs to be effective.

10. Emergent issues for QCS Consideration

Discussion facilitated by Dr Norman Swan

In closing Dr Swan asked participants for feedback on the meeting format and next steps for the QCS. Participants:

- Expressed support for the 'multi-topic' approach to QCS meetings
- Identified the need for QCS advice that has been implemented by HHS or the System Manager to be monitored and the outcomes measured
- Emphasised the need for the QCS meeting to deliver expert advice – not just debate
- Requested greater clarity for guests re how they can contribute to QCS debates
- Identified a desire for QCS topics to include issues of relevance to primary care. This could be achieved by inviting Medicare Locals to set QCS meeting topics on occasion.

Topic suggestions for future QCS meetings included:

- NEAT
- Queensland Health's role in Primary Health care – to inform the development of the System Primary Health Care Plan (due June 2013)
- Investment in service delivery: which services are critical / essential / desirable? Which should be considered out of scope for Queensland Health given the financial constraints?

11. Closing Remarks

Dr Michael Cleary, Sponsor, Queensland Clinical Senate

Dr Cleary thanked all participants, panellists, presenters, Dr Norman Swan, the QCS Secretariat, sound technicians and Victoria Park staff, for their contribution. Dr Cleary summarised they key issues raised at the meeting and advised participants that the QCS Executive would continue to detail advice on behalf of the broader QCS and that this would be forwarded to stakeholders and members in the new year.

Dr Cleary informed members that QCS membership will renew over the coming months. In closing he once again thanked inaugural members for their commitment over the past 4 years.