QNU Submission to the Queensland Health Systems Review

July 2005

Nurses. Worth listening to.

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Full Terms of Reference

Objective:

To undertake a review of the performance of Queensland Health's administrative and workforce management systems with a focus on improving health outcomes for Queenslanders.

To specifically review:

1. Existing administrative systems and recommend improvements to support health service delivery, focusing on:

   - District and corporate organizational structures and layers of decision making
   - Corporate planning and budgeting systems
   - Cost effectiveness of services compared to relevant jurisdictions
   - Effectiveness of performance reporting and monitoring systems
   - Organisation and delivery of clinical support services
   - Risk management systems
   - Quality and safety systems and
   - Clinical audit and governance systems

2. Clinical workforce management systems to deliver high quality health services, with a particular focus on:

   - Recruitment
   - Retention
   - Training
   - Clinical leadership and
   - Measures to assist in improving the availability of clinicians

3. Performance management systems including as they relate to:

   - Asset management and capital works planning and delivery
   - Information management
   - Monitoring health system outcomes

Executive Summary

The Queensland Nurses' Union (QNU) believes that Queensland Health is at a critical crossroad. The recent revelations from the Bundaberg Hospital Commission of Inquiry and the staff and community consultations for this Systems Review of Queensland Health merely highlight what employees of Queensland Health and the health unions who represent them have known for some time—this department is in crisis.

We do not use this term lightly. In the past when concerns about this agency have been publicly raised by the QNU and other health unions we have been accused of hysteria and "shroud waving". We are also very mindful that public criticism can have the effect of under-mining community confidence in our public health system. As staunch advocates for public health services we are careful to ensure that criticism and concerns raised are placed in context and a positive problem solving approach is adopted.

The QNU wants to establish a meaningful partnership with government to address the issues in Queensland Health. We have been requesting this for some years now and again place on record our belief that this review is the only way forward that will rebuild staff and community confidence and pride in the system. It would be devastating for staff and community alike if these current reviews do not result in the needed change. Many members have expressed a cynicism that "things just won't change—they never do". It is imperative that things do change, and we all have a role to play to ensure that significant improvements are made within Queensland Health and that the change is managed well.

There are some issues that need to be acknowledged and addressed by government first before we can move forward. These include:

The culture in Queensland Health is unhealthy and requires urgent remedial action. Improving openness, transparency and accountability and establishing an environment where critical analysis is encouraged will be central to effecting the necessary cultural change within Queensland Health.

Queensland Health services are under-funded and this must be addressed as a matter of urgency. On any examination of the data, Queensland Health is the "leanest" public health system in the country. It is too lean. This spending on public health services in Queensland is even more astounding when you consider the additional costs associated with service delivery in the most decentralised state in the country. For example, in 2003-2004 the Queensland Government's public hospital recurrent per person expenditure was the lowest in the country at $440, with the Australian average being $552. Even though health budgets have continued to increase in the last ten to fifteen years this has been insufficient to keep pace with population growth, increasing community expectations and expanding technology. The sound financial position of Queensland enables us to considerably increase our spending on public health services. An active decision by government to make health its key priority needs to occur.

The public health system in Queensland is the most efficient in the country – but how effective is it? For too long there has been an over-emphasis on efficiency outcomes at the expense of effectiveness. What has been valued is "coming in on budget" and increasing through put of patients. Issues such as quality or effectiveness of care and equity of access are much lower order considerations.

Quality of care suffers as staff are continually forced to do more with less. Queensland Health staff also subsidise the operation of the public health system

through lower wages and working conditions and excessive and unsustainable workloads. Independent research shows that Queensland nurses are becoming increasingly distressed because they cannot deliver individualised quality nursing care due to workload pressures. An examination of nursing staffing numbers in public hospitals for 2002-2003 demonstrates that to reach the Australian average full time equivalent nurse (FTE) per 1000 population ratio Queensland public hospitals would have to employ an extra 1505 FTE nursing staff. To reach the Victorian and New South Wales ratios levels Queensland public hospitals would have required the employment of an additional 2258 FTE nurses. This data only refers to public hospital nursing staff numbers—more nurses are also required in community and other non-acute settings.

Not only are nurses subsidising the continued operation of the system through unsustainable workloads, they are paid far less than their interstate counterparts. Significant improvements in wages and working conditions (including workloads) are needed to stop the wastage of nurses from the system and to improve recruitment of nurses—a vitally important issue given the current nursing shortage and ageing of the population. For example, by the time the current Section 170MX Award for nurses expires in October 2005, a Level 1 Registered Nurse Paypoint 8 (the largest classification group of nurses employed by Queensland Health) will be paid $986.35 per week compared to their New South Wales counterparts being paid $1139.51 per week. This is a difference of $153.16 per week or over 15%.

The Queensland community must be genuinely involved in the debate about health needs and expectations and how these are best funded. This must include a discussion of whether taxes need to be increased to provide the type of health services the community expects. The days of the old paternalistic model of health care are over, as are the days of medical dominance. In future there must be a genuine partnership between the community and health care providers where health needs, policies, priorities and treatments are jointly determined and health services are delivered by a team of health providers. In our view a state wide Health Reform Council that includes representatives of all key stakeholders (including the community and health unions) must be established to drive the change and develop the framework for community input into health decision making processes at the local level.

There needs to be a shift in emphasis towards health promotion and disease prevention. The sustainability of our health system will be determined in large part by the success of strategies that aim to shift the emphasis on to health promotion and prevention. This will require additional emphasis and funding for these areas.

The innately political nature of health care must be publicly acknowledged and issues debated openly. For too long health has been viewed as a political hot potato and every attempt has been made to keep it off the front page of *The Courier Mail*. The obsession with secrecy in Queensland Health has largely been derived from a combined imperative to "put a lid" on controversy and dissent and at the same time manage the unrelenting drive to continue to do more with less. This secrecy has only served to entrench power imbalances in health. Politicians must demonstrate more trust in the community and health care providers to honestly debate the issues and find solutions. The finite nature of resources should underpin decision making but so too should community needs and expectations.

The climate of secrecy in health has enabled a toxic culture to flourish. Priority attention must be afforded to rebuilding a positive and supportive culture in health, one where health workers and patients are treated with dignity

and respect and as equal partners in health care. This will be a significant exercise and the government must acknowledge the magnitude of this task and fund it accordingly.

Abuse of the Queensland Health Code of Conduct must cease immediately. The Queensland Health Code of Conduct is used as a weapon to punish staff and shut down legitimate debate and discussion of concerns. Instead of being used to deal with ensuring privacy in relation to patient confidentiality, the Code of Conduct is utilised to attempt to stifle discussion about serious systems concerns and even stop nurses and other health workers from contacting their union about these concerns. This fundamental misuse of this document must be immediately ceased if we are to create a positive, problem solving and open culture in Queensland Health. It is the right of all Queensland Health staff and citizens to raise concerns in the public domain about the conduct of public institutions including hospitals and other health facilities. It is the department's role to deal with these concerns in a timely and appropriate manner or to refute them. It is not there role to silence criticism and debate through the misuse of documents such as the Code of Conduct. It is essential that the Code of Conduct be reviewed and amended to reflect this and for a penalty to be imposed for the inappropriate use of this document by management.

Attention must be paid to human resource management (HR) and industrial relations (IR) processes and policies. As health workers are the system's most valuable asset they must be properly valued and treated equally and fairly. A consistent HR/IR policy framework must be established within Queensland Health to ensure that this occurs. Adequate systems to provide timely and accurate data upon which to base decisions are a critical component of this framework. Currently Queensland Health cannot state with any degree of certainty the actual number of people it employees. This is a disgrace and must be addressed as a matter of urgency.

Lack of access to meaningful data upon which to make decisions is a fundamental flaw in the system. This systems problem can of course be convenient – how can there be proper scrutiny and debate on issues if the data is not available to inform this? Linked to this is the department's obsession with secrecy that results in those who should be viewed as partners in health care (the general community and groups such as health unions) being denied access to necessary information.

There is a need for a new partnership model in health. For there to be a genuine partnership between health service providers and government there needs to be a fundamental change in approach and this must be reflected in significant changes in industrial relations processes. In it imperative in our view that we recommence the "best practice" approach to health care reform that was abandoned by Queensland Health before it really commenced a decade ago. This approach is one based on a genuine partnership of staff and their unions and a "balanced scorecard" approach to measuring outcomes in health that must incorporate considerations beyond efficiency gains.

Establishing a sound governance framework will be essential to rebuilding community and staff confidence in Queensland Health. This will require significant cultural changes and sound leadership. Most importantly, it will require congruency between stated values and actions—what is said on paper in documents such as strategic plans and mission statements must be matched with behaviour and actions.

The problems in health are significant. But the government has willing partners to rebuild our public health system. The QNU is committed to a strong,

innovative, responsive, sustainable and high quality public health system. To us this is a fundamental feature of a fair society—as citizens we deserve no less. The issues under consideration are very much about values—what we value as citizens and workers in the health system—and the QNU believes that we must position the discussion about the future of Queensland Health within a framework of values.

We need a public health system where:

- The system is patient and staff focused—this requires a shift in focus to quality/effectiveness from efficiency and budget bottom lines.
- There is equity of access to health service and equality of health outcomes —where access to health services is determined by clinical need and not ability to pay.
- Services are integrated across settings and there is support for innovation and improved service delivery.
- A safe and supportive environment for staff and patients is provided.
- Community and staff have genuine input into decision making and health service planning.
- Openness, respect, transparency and accountability are the principles that underpin the operation of the system.
- Words are matched with action and expectations matched with appropriate funding.
- Evidence underpins all decision making and a culture of critical analysis and debate flourishes.
- There is consistency of approach and sound systems upon which to base decision making.
- Staff and patients are treated fairly and with respect and are valued for their contribution.
- Workloads of staff are fair and enable the delivery of high quality patient centred care.
- Health workers receive fair remuneration and conditions of employment— there is pay parity with interstate counterparts and work value is consistently and appropriately determined.
- There is a rigorous, simple and open complaints system established for staff and patients that enables concerns to be promptly and appropriately addressed.

The QNU is hopeful that this inquiry provides a critical watershed for Queensland Health and will enable us to focus on rebuilding the agency based on the above principles. We have made over 70 recommendations in our submission that we believe will help effect the necessary change and have provided significant detailed background to underpin these recommendations.

The QNU is committed to working with the Queensland government to rebuild community and staff confidence in Queensland Health.

Recommendations

Health Reform Council (page 23)

That the Queensland government fund the establishment and continued operation of a state based Health Reform Council that would draw up a framework to enable genuine community consultation on health policy decision making and the planning of service delivery at the state wide and local levels. Further to this, that this body be broadly representative of the Queensland community and include representatives from the QNU and consumer organisations.

Expanding health performance measures (page 27)

That specific funding is allocated to enable the further development of appropriate performance indicators that measure effectiveness and equity of access to health service delivery as agreed to in the Steering Committee for the Review of Government Service Provision (annual *Report on Government Services*) process.

Budget for and supply of health services (page 30)

The Queensland government continues to increase its budget allocation to the health portfolio in order that government per capita expenditure on health services reaches an acceptable level compared to other state/territory governments.

In light of population growth and current high levels of demand for public health services the Queensland government fund an urgent re-examination of demand and supply of public health services (including the number and distribution of public hospital beds, day procedure units and primary health care services) and that the outcome of this review form the basis for future budget allocations for health infrastructure and recurrent funding.

Access to meaningful data (page 30)

Specific funding is allocated to enable the further development of appropriate systems within Queensland Health that will enable timely access to reliable data for health bureaucrats and the broader community including health unions. This would facilitate better planning and accountability and evidence based decision making on clinical and non clinical matters.

Establishing a new partnership in health based on sound principles (page 32)

A new "partnership" approach be developed and adopted for the design and delivery of public health services in Queensland and that this be based on a health care team delivering health services to informed clients who have genuine input into decision making processes. Further to this, that at all times principles of universality, no cost at point of service, timely access, equity of access and equality of health outcomes underpin our public health services in Queensland.

Data on health and safety impact of system stress on health workers (page 33)

This inquiry pay particular attention to examining health and safety and WorkCover data from Queensland Health and from this make firm recommendations aimed at establishing safer systems of work for all Queensland Health employees.

Cultural change in Queensland Health (pages 34)

Specific funding be allocated for training and staff development necessary to affect the necessary change to build positive, supportive and patient and staff

focused culture within Queensland Health. In particular, that current educational programmes for middle and senior management within Queensland Health be reviewed to ensure appropriate content on matters such as encouraging participation, critical analysis and debate, the need for openness, transparency and accountability, the role of the public service, the government's overarching policy framework and the role of unions as legitimate representatives of employees.

The Queensland Health Code of conduct be reviewed and amended as required to ensure that this cannot be used by management to prevent legitimate criticism and debate about health system concerns by employees and citizens and enable staff to contact their union or other relevant institutions in society to discuss their concerns. Further to this, that a penalty be imposed on management representatives who use the Code of Conduct inappropriately to close down discussion and debate.

Establishing a standardised HR/IR framework in Queensland Health (page 35)

As a matter of urgency a standardised organisational HR and IR policy framework be developed in consultation with health unions for the whole Queensland Health that will prevent district by district interpretation of industrial and other related legislative obligations.

Review and improvement to policies and processes relating to public sector management (page 37)

There be an urgent review of human resource policies and processes within Queensland Health and that these are improved to ensure the consistent application of fair and equitable processes, especially in relation to recruitment and selection processes, performance planning and review, management of diminished performance, training and development and fair treatment of employees and other standards applicable to public sector management.

Workplace Health and Safety and Employment Equity considerations (page 38)

Close consideration be given to the prominence of and resourcing for Workplace Health and Safety and Equal Employment Opportunity initiatives when implementing the required cultural change within Queensland Health.

Measuring of work value and establishing consistency of recognition (page 39)

An urgent review of the methodologies used to assess work value be conducted within Queensland Health to ensure consistency between occupational streams and appropriate recognition of the skills and qualifications required.

HR reporting systems (page 40)

As a matter of urgency specific tied funding be allocated to Queensland Health to enable the agency to implement an appropriate standardised HR information reporting system and that the agency be closely monitored to ensure timely and appropriate implementation of this system. Such a system will facilitate the provision of accurate data to better match supply and demand of services, adhere to enforceable award provisions such as those relating to nursing workload management, undertake accurate costings for budgetary and enterprise bargaining negotiations processes and facilitate agency compliance with legislative and policy requirements (e.g. Equal Employment Opportunity reporting and achievement of target group employment targets).

Establishing a new framework for consultative arrangements with health unions (page 43)

Consultative arrangements for the health portfolio be reviewed and amended as required and that an oversight mechanism be established under the auspices of the Department of Premier and Cabinet that involves all relevant agencies and key stakeholders including health unions.

Increasing nursing numbers in Queensland Health (page 45)

As a matter of urgency there be an increase in Full time equivalent registered and enrolled nursing numbers to bring nursing staffing numbers across all settings in Queensland Health up to the national average as an interim measure and then to levels employed in Victoria and New South Wales. For public hospitals alone this equates to an additional 1505.6 FTE registered and enrolled nursing positions to bring Queensland public hospital staffing levels up to the national average. (An additional 2258.4 FTE positions would be required to bring Queensland public hospital nurse staffing levels up to Victorian and New South Wales numbers.)

Improving pay and working conditions for nurses and other employees (page 45)

Urgent action is taken to significantly improve the pay and working conditions (most notably workloads) of Queensland Health employees.

Adoption of new approach to deal with nursing issues (page 47)

Prior to the commencement of the next round of enterprise bargaining with Queensland Health government enter into discussions with QNU regarding the adoption of a new holistic approach to nursing workforce and industrial relations issues.

Analysis of staffing numbers by occupational group (page 48)

There is an urgent analysis of Queensland Health's staffing numbers by occupational group, including a comparative analysis of HSD and corporate office numbers. This must also include a gap analysis of areas of need with respect to support provided in clinical services.

Review of Queensland Health risk management framework (page 50)

There be a review of Queensland Health's risk management framework and that it is amended as necessary to ensure efficacy and staff confidence in it. In particular, there need to be urgent enhancements to the current risk management framework to ensure that all risks are appropriately identified, treated and monitored (eg security and health and safety risks to staff).

Improving safety and quality (page 53)

It is recommended that this review makes specific recommendations aimed at improving safety and quality within Queensland Health. In particular, strategies must be implemented to:

- build a supportive culture within Queensland Health where critical analysis is encouraged;
- provide adequate human and physical resources to ensure that safe care can be delivered and quality can continually improve;

- review current tools used to assess quality and amended as necessary to ensure adequacy;
- encourage genuine teamwork and valuing of the skills and contribution of all team members;
- directly link safety and quality to the agency's industrial relations processes;
- better integration of the multitude of existing agenda that relate to safety and quality;
- address existing inconsistencies in approach with regards to the current regulatory policies and processes for health professionals;
- extend the current regulatory regime for health workers to ensure that all who are delivering health services are appropriately regulated;
- encourage better coordination and consistency between activities regarding safety and quality at the state and national level to ensure that this receives the appropriate level of priority.

Appropriate consultation with health unions on proposed changes in Queensland Health (page 55)

This inquiry recommends that health unions be at first briefed and then consulted about the organisational and governance structures in Queensland Health as soon as possible/practicable given that this review may recommend changes in these areas.

Further consultation with QNU prior to finalisation of systems review (page 57)

The Queensland Health Systems Review team meets with representatives of the QNU as soon as possible to discuss the findings of the University of Southern Queensland research into QNU membership and other matters relating to our submission so that the issues highlighted and possible strategies to address them can be discussed prior to the finalisation of your report.

Strategies to improve nursing recruitment and retention (page 59)

The funding for existing nursing recruitment and retention being progressed by the Peak Nursing Body be continued and that specific additional funding be allocated to address serious deficiencies with respect to:

- establishing appropriate enforceable nursing workloads across all practice settings;
- enabling nurses to access required education, training and development;
- providing adequate support to new nursing graduates and improved coordination of new graduate employment;
- extending the implementation of innovative care models (e.g. Nurse Practitioners) across all practice settings and ensuring appropriate nursing skill mix;
- continue to expand the school based Youth Health Nurse Programme and investigate other innovative primary health roles for nurses such as nurse health and safety screening and immunisation in child care centres;
- reviewing the nursing classification structure to address longstanding anomalies with other like occupational groups (e.g. Professional Officer stream) and include Enrolled Nurses and Assistants in Nursing in the structure;

- improving the Remote Area Nurse Incentive Package both in terms of localities and categories of nurses included (extend to include Enrolled Nurses and Assistants in Nursing);
- extending funding for nursing research to facilitate the development of innovative patient centred models of care;
- undertaking new research on issues on nursing turnover, absenteeism and morale within Queensland Health;
- improving succession planning for nurses.

Addressing nursing workload concerns (page 62)

Queensland Health be directed to use the complete Business Planning Framework: Nursing Resources tool to determine appropriate allocation of budgets for nursing services within Queensland Health.

Specific funds be provided to facilitate the urgent development of a workload management tool for those areas where it is not possible to implement the Business Planning Framework: Nursing Resources in its current form (e.g. community health settings, Emergency Departments and Outpatient Departments, Intensive Care Units, Integrated Mental Health Units, Operating Theatres and Day Surgery Units).

The Business Planning Framework be used to supplement the minimum care hours model used for determining nursing staffing in State Government Nursing Homes.

Resourcing the reform process in Queensland Health (page 64)

The government allocate sufficient funds to fully meet the costs of "reforming" Queensland Health and also to fully meet the cost of necessary improvements in nurses' wages and conditions for the enterprise bargaining negotiations scheduled for the second half of 2005.

Staff education and development and workforce planning (page 68)

The planning and development of future education, training and development programmes for Queensland Health employees be informed by the establishment of an appropriate consultative mechanism involving key stakeholders such as health unions.

Proxy allocations used within the Business Planning Framework: Nursing Resources (e.g. for new graduate support, training leave, other forms of leave) be urgently reviewed to ensure they adequately cover the true costs incurred particularly at peak times of demand; further, that following review of such proxy allocations and necessary amendment of the tool, sufficient budgetary allocation be provided by Treasury to ensure the appropriate and consistent implementation of Business Planning Framework: Nursing Resources across all of Queensland Health.

The Australian Institute of Health and Welfare be commissioned to undertake a Queensland nursing labour force study that will inform nursing workforce planning for Queensland Health.

The Queensland government fund scholarships for undergraduate and post graduate nursing students (based on the recently announced arrangement between the Queensland Government and Griffith University School of Medicine) in order to begin to address nursing skills shortages. Further to

this that the Queensland government enters into urgent discussions with the federal government with respect to health workforce issues and shortages and in particular seeks to address the current inequities that exists with respect to the funding of post graduate health qualifications.

Queensland Health introduce an ongoing staff education, training and development programme (based on the programme for staff at the Department of Child Safety) where all staff are released and backfilled to attend and that all categories of staff receive equitable treatment with regard to access to such ongoing education, training and development.

Funding is allocated to pay the Competence Assessment Fee for all participants in nursing reentry programmes as is the case in other states.

Funding to increase the number of EN course places offered in TAFE should be increased to 400 per year from 2006. Further this this, that at least 50 scholarships that meet the full course costs be funded by government each year and made available to applicants from specific targeted disadvantaged groups.

That there be no further proliferation of new certificate courses for new categories of health workers until such time that there is a comprehensive and evidence based assessment of the training needs of the health and community services sector and whether these needs can instead be met by amending/extending the educational preparation of existing categories of employees. Further to this, that the Department of Employment and Training ensure that the QNU and relevant nursing bodies are invited to participate in course development advisory committees of any proposed health care qualification;

Funding is allocated to enable existing unlicensed care workers in Queensland such as Assistants in Nursing to complete their Certificate level qualification as was provided to child care workers to enable them to meet legislated minimum educational qualifications. Further to this, that at least 50 scholarships that meet the full course costs be funded by government each year and made available to applicants from specific targeted disadvantaged groups who wish to obtain a qualification in order to secure employment in the health and aged care sector.

Specific ongoing funding be allocated for research and consultation with industry regarding important threshold issues for nursing education in the VET sector, including but not limited to examining issues such as articulation, recognised prior learning and evaluating an evaluation of utilising the VET in Schools Programme for the health and aged care sectors.

Priority attention be given to funding workforce education and training needs for nurses.

The QNU be involved in the development any course proposals that involve nursing work.

Specific funding be allocated to establish a broadly representative health and aged care sector industry body (including representation from the QNU) to inform workforce planning for this sector in Queensland.

Work and Family issues (page 70)

Funding be provided to:

- introduce 14 weeks paid maternity leave for Queensland public sector employees;
- establish a broadly representative Queensland Work and Family Forum;

- develop and implement a Queensland "whole of government" portal on work and family matters;
- facilitate a coordinated approach to improving child care services for shift workers across all Queensland government agencies.

Health and safety concerns (page 72)

Adequate funding be provided to ensure the full implementation of all the recommendations arising from the Violence against Nurses Steering Committee review process.

Funding be allocated for a review and a detailed analysis of the initiatives in place relating to manual handling to ascertain their effectiveness and whether any modification is required. Further to this, that funding is allocated for regular servicing, preventative maintenance, maintenance and replacement of equipment necessary for safer manual handling.

The advisory standard relating to workplace harassment is made mandatory and that Queensland Health Districts be allocated funding to enable the development of plans for the implementation of the standard and the provision of mandatory training for all staff on the code within 12 months.

Queensland Health be directed to adopt *Directive 4/99 Medical Deployment and Redeployment.* Further to this, that funding is allocated to properly investigate fitness for work issues for Queensland Health employees and plan strategies to encourage continued workforce attachment given the ageing of the health workforce and significant shortages that exist in nursing and other health occupations.

Workplace amenities (page 73)

Queensland Health pay particular attention to ensuring that appropriate workplace amenities are provided for staff and that all staff receive equitable treatment with regard to the provision of workplace amenities. Particular attention must be paid to ensuring the provision of appropriate and safe accommodation for all staff (where this is provided), safe and free/affordable car parking, reasonably priced high quality and healthy meals for staff on all shifts and adequate other amenities such as separate meal areas, shower, toilets and change facilities and facilities that promote the health and wellbeing of staff.

Nursing leadership (page 73)

The Office of the Chief Nursing Adviser within Queensland Health be restructured so that it is consistent with the model for the Office of the Chief Nursing Officer in New South Wales. Further to this, additional resources be provided to ensure that the office of the Chief Nursing Adviser within Queensland Health can carry out the functions of their New South Wales counterpart.

Reporting relationships between the Office of the Chief Nurse Adviser and the Minister and Director General for Health be reviewed and amended as necessary to ensure consistency with the reporting relationship applying in New South Wales.

There is clear delineation between Chief Nursing Adviser and Principal Nursing Adviser roles, which will be especially important going forward given the importance of nursing leadership if we are to change the culture of Queensland Health. Further to this, that a merit selection process takes place to permanently fill the position of Chief Nursing Adviser but this cannot take place until such time that matters relating to whole of agency responsibility for nursing leadership

and reporting relationships between the Chief Nursing Adviser and Principal Nursing Adviser roles are clarified.

The Office of the Chief Nursing Adviser be directly involved in negotiations on workforce restructuring within Queensland Health and that this office ensures the establishment of appropriate consultative mechanisms to ensure the ongoing involvement of the QNU in adequate negotiations of such changes.

Capital works and maintenance (pages 79, 80)

Nurses be always included in consultations for the initial design and ongoing commissioning phases of all new capital works and redevelopments to ensure that workplace designs are both patient and health worker friendly.

A consistently applied, equitable and transparent whole of agency approach to prioritising of the development of staff accommodation refurbishment and rebuilding projects and a fair process for determining access to accommodation be developed.

Funding be allocated to facilitate the development of minimum design guidelines for Queensland Health facilities.

Queensland Health urgently review its policies regarding the contacting out of maintenance services in Queensland Health with a view to increasing the direct employment of tradespeople to undertake maintenance in house and be available to supervise apprentice tradespeople within the agency. Further to this that Queensland Health subsequently significantly increase the number of apprentices that it employs to assist the state to address the significant skill shortages that currently exist.

System performance (pages 85, 86, 87)

In consultation with other key stakeholders there be further development of appropriate performance indicators within Queensland Health, especially indicators that relate to equity and effectiveness within Queensland Health.

As a matter of urgency an appropriate and comprehensive framework is developed for the monitoring and implementation of coroner's recommendations regarding deaths in public and private sector health and aged care facilities in Queensland.

The *Clinical Services Capability Framework for Public and Licensed Private Health Facilities*' (SCF) is reviewed as a matter of priority in consultation with the QNU and other stakeholders and amended to include minimum staffing levels and skills mix **required** to ensure safe practice in all service areas.

Any Queensland Health policy related to medication management in residential aged care facilities reference the legislated requirements under the *Health (Drugs and Poisons) Regulation* that dispensed medications are administered by a registered nurse, or by an endorsed enrolled nurse under the supervision of a registered nurse, to any resident in residential aged care facilities who does not have capacity to request help from an assistant in nursing/carer to take their dispensed medication/s.

Introduction

The Queensland Nurses' Union (QNU) welcomes the opportunity to provide a submission to the Queensland Health Systems Review (2005). To us this review represents a significant opportunity to bring about much needed and long overdue improvements to the structure and culture of Queensland Health. We have attempted to provide such feedback in the past—the background materials we have already provided to this review testify to years of concerted activity on our part.

In summary we have been successful at achieving necessary reform only at the margins. This has largely occurred through the activities of the Ministerial Nursing Recruitment and Retention Taskforce processes. To say that the union and our members have been frustrated by lack of progress is an understatement. Through the Taskforce and other processes such as enterprise bargaining (EB) any initiative we have recommended that would have budgetary implications or would threaten existing power relationships within Queensland Health or would result in enhanced transparency, openness and accountability have largely failed to be adequately addressed.

In particular we have been frustrated by the tactic of denial used by Queensland Health. This has manifested itself in many ways. The agency has a longstanding response of denial to nurses because they represent the largest occupational group in Queensland Health (and indeed one of the largest occupational groups employed by the state government as a whole) and therefore granting of claims by nurses has significant budgetary implications for government. It does not matter that inequity exists and that other occupational groups (within Queensland Health and outside of Queensland Health) may already receive what we seek for our members.

Not only is there a denial at the level of initial claim but there is also denial at the implementation level once a claim has been argued, bargained for (or arbitrated) and achieved. When we are finally successful at achieving an enhancement for nurses we then have to continue to fight for the proper and consistent implementation of such lawful entitlements.

Perhaps the most astounding example of denial by Queensland Health in recent years is their position during EB 5 negotiation and arbitration when they steadfastly denied the existence of a nursing shortage in Queensland despite independent evidence to the contrary. The Department of Employment and Workplace Relations (DEWR) annual *National Skill Shortage Survey* has shown for some years (and continues to show) the breadth and depth of the nursing skills shortage in Queensland. Although a Ministerial Taskforce into Nursing Recruitment and Retention was established in the late 1990s in Queensland to deal with anticipated worsening nursing shortages, the agency was of the belief that this process had adequately addressed nursing shortages and wastage

There has in recent years been a refusal on the part of Queensland Health to accept the accuracy of DEWR data on the nursing shortage (despite it being accepted by the 2002 Senate Inquiry into Nursing and the National Review of Nursing Education) as it suited their purposes not to do so given that they obviously had reached the conclusion that to accept the existence of a shortage would "cost them" in enterprise bargaining negotiations. So Queensland Health continued to insist repeatedly in an Orwellian manner that a nursing shortage did not exist. They argued this line despite the fact that Queensland Health's own workforce data is notoriously inaccurate, with the agency being unwilling or unable to state with any degree of certainty how many people they actually do employ.

Government did not have the same difficulty accepting the existence of skills shortages in the Queensland electricity industry not do they deny the existence of a national and international doctor shortage. Only in recent times has Queensland Health acknowledged that a nursing shortage exists. It is our hope that the current reviews into Queensland Health will finally provide the impetus to comprehensively address the nursing shortage. Further inaction will continue to compromise the provision of safe nursing care for the community of Queensland.

About the QNU

The QNU is the principal health union operating and registered in Queensland. The QNU also operates as the state branch of the federally registered Australian Nursing Federation.

The QNU covers all categories of workers that make up the nursing workforce in Queensland—registered nurses, enrolled nurses and assistants in nursing, employed in the public, private and not-for-profit health sectors including aged care. Our members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management.

The union has both industrial and professional objectives. We firmly see nurses and nursing as being situated within a societal context—nurses being both providers and "consumers" of health services. In recent years we have attempted to lead and contribute to the debate within nursing and the wider community about the role and contribution of nursing through the development, implementation and regular review of a *Social Charter of Nursing in Queensland*. The QNU and the Queensland Nursing Council (QNC) are co-sponsors of this charter and we see this document as forming an important foundation for responsive and innovative nursing practice that is based on community needs and expectations and mutual respect and trust.

Membership of the QNU has grown steadily since its formation in 1982 and in June 2005 was in excess of 33,000 and still growing. The QNU represents the largest number of organised women workers of any union in Queensland. Like the nursing profession as a whole, the overwhelming majority of our members are female (93%). As nurses are the largest occupational group within health (nurses make up over 50% of the total employed health workforce and over 40% of the Queensland Health workforce), the QNU is the principal health union operating in Queensland. We estimate our membership density within Queensland Health to be around 90%.

The union has a democratic structure based on workplace or geographical branches. Delegates are elected from the branches to attend the annual QNU conference which is the principal policy making body of the union. As such it is rank and file membership that drives the agenda of the QNU. In addition to the annual conference the QNU has an elected council and an elected executive, which in turn have decision-making responsibilities between conferences. Council is the governing body of the union.

QNU members working in Queensland Health are employed under federal industrial instruments and in the private sector are employed under state industrial instruments. In addition, since 1994 when no enterprise agreements were in place covering nursing workers, the QNU has become party to over 300 enterprise agreements which cover a diverse range of health facilities and other non-health establishments where nursing services are provided (e.g. schools, prisons and factories). We therefore have a clear and comprehensive understanding of the complexity of contemporary health service delivery as well as the diversity of locations where health services are delivered.

Recent trends in nursing

The QNU has already provided background information to this inquiry on recent trends in nursing. However we will briefly summarise the major trends now in order to provide a context for this submission.(The following information is obtained from the Australian Institute of Health and Welfare's (AIHW) *Nursing labour force* publications.).

Nurses are a significant occupational group. Nurses are the largest occupational group in the Australian health workforce, representing 54% of the total employed health occupations in 2001[1] and just over 40% of the total Queensland Health workforce[2] in that same year. Health professionals account for 43% of employment in the health industry (other workers include administrative staff, cleaning, catering and other operational staff and trades people) and nurses are the largest professional group, accounting for just over one quarter of total health industry employment.[3]

Nursing remains a highly feminised occupation. Over 90% of nurses are women.

The nursing workforce (like the health workforce and the community generally) is ageing. The average age of employed nurses was 42.2 years in 2001, having increased from 39.3 years in 1995.[4] The health and community services sector workforce is older and ageing more rapidly than the rest of the workforce.

Over 50% of nurses are working part time. The number of nurses employed in a part-time capacity has steadily increased in recent years. By 2001 this had increased to 53.7%.[5] At the same time the average number of hours worked per week has decreased from 32.4 hours in 1995 to 30.5 hours in 2001.[6]

Nursing numbers in Queensland are lower than the national average. Queensland continues to fall well below the national averages in terms of both the total number of employed nurses and total full time equivalent (FTE) employed nurses. The number of employed nurses (RNs and ENs) per 100,000 of population in Queensland was 1074 in 1995 and 1083 in 2001 compared to the Australian average of 1221 in 1995 and 1176 in 2001.[7] A more meaningful indicator of nursing supply is the number of FTE nurses per 100,000 population: In 1995 the number of FTE employed nurses per 100,000 population in Queensland was 988 (Australian average 1127) and in 2001 this number had decreased to 965 per 100,000 population (Australian average 1024).[8] Although there was a 12% growth in total RN and EN numbers in Queensland between 1995 and 2001, there was a 2.3% decrease in the number of FTE employed nurses per 100,000 population during this period. Significantly the growth in third level unlicensed personnel has been greater in Queensland than any other part of Australia, growing by 47.5% (3.9% per annum) between 1987 and 2001. (Total employment of this category in Queensland in 2001 was 9900.)[9]

1 AIHW (2003), *Health and community services labour force*, 2001, Canberra page xiv
2 Queensland Health (2001), *Annual Report 2000/2001*, page 35.
3 Duckett, S "Health Workforce Design for the 21st century, *Australian Health Review* May 2005 Vol 29 No 2, page 201.
4 AIHW (2003), *Nursing labour force 2002*, Canberra, page 1.
5 AIHW (2003), *Nursing labour force 2002*, Canberra, page 6.
6 AIHW (2003), *Nursing labour force 2002*, Canberra, page 6.
7 AIHW (2003), *Nursing labour force 2002*, Canberra, page 8.
8 AIHW (2003), *Nursing labour force 2002*, Canberra, page 18.
9 Shah C and Burke G, *Job Growth and Replacement Needs in Nursing Occupations*, DEST (National Review of Nursing Education) Canberra, page 40.

Pronounced skills shortages exist in all areas of nursing. According to the Department of Employment and Workplace Relations (DEWR) *National Skill Shortage Survey*, the depth and breadth of the skills shortages in nursing remains the greatest of all occupational groups. Workforce modeling commissioned by the recent National Review of Nursing Education predicts that there will be 31,000 nursing vacancies in Australia by 2006.

At the same time changes have also been occurring in the wider community and health sector that have impacted on nurses and nursing. Queensland's population growth is the highest of all states and territories in recent years. This growth, which is predicted to continue, has put significant pressure on demand for health services. Ageing of the Australian community, technological advances and reform in the health sector in recent years have all significantly contributed to changes to care and work patterns. For example, length of stay in hospitals has declined and this has resulted in significant work intensification for nurses, those they are caring for being more acutely ill while in hospital. There has been an increased level of acuity of people across all care settings be this in the hospital, community or residential care. Community expectations of care and treatment have also increased significantly in recent years.

What does this all mean for nursing? In a nutshell the nursing workforce is ageing and although there are greater numbers of nurses the actual hours they work has decreased which means there are fewer nurses caring for sicker and more demanding patients. This situation is only going to intensify given predicted population growth in Queensland and the ageing of the general population and the nursing workforce. The nature of this crisis in nursing and its causes has been identified—all that is missing is the political will

to address the issues in a comprehensive manner. Some work has been done within Queensland Health through the Nursing Recruitment and Retention Taskforce and subsequent bodies though some areas (especially in relation to establishing appropriate nursing workloads) require further urgent attention. Also, there is an urgent need to establish and support mechanisms to promote appropriate nursing workforce planning across all sectors in Queensland and at the national level.

The nature of nursing work

Many attempts have been made to define the practice of nursing. In October 1998 the Queensland Nursing Council published a document titled *Scope of Nursing Practice Decision Making Framework*, which defines nursing practice as follows:

Nursing practice incorporates the application of knowledge, skills and attitudes towards alleviating, supporting or enhancing actual or potential responses of individuals or groups to health issues. It focuses on the promotion and maintenance of health, the prevention of injury or disease and the care of the sick and disabled so that people with identified nursing needs may maintain optimal well being or achieve a peaceful death. Nursing practice is largely determined by the context in which it takes place.

The role of the nurse is broad and at times difficult to specify. The multi-dimensional nature of nursing work – to be a nurse requires increasingly complex technical knowledge and skills that are balanced and complemented with well-developed interpersonal, written and verbal communication, problem solving and conflict resolution skills. Many of the so-called "soft skills" required by nurses are often not "visible" and therefore are not adequately acknowledged and ascribed value accordingly. Technical skills are more visible and therefore easier to measure than the equally important emotional intelligence component of nurses' work. (Recent pay equity inquiries in both New South Wales and Queensland have acknowledged this difficulty.)

The context in which a nurse does their work is also highly variable – working as an independent professional agent who at any one time can be caring for a number of individuals (and their families) but doing so within a team structure. Multiple transactions between individuals occur during the course of a shift, a complex range of activities are undertaken and the working environment is often unstable. The condition of patients can rapidly deteriorate, in most areas you have a number of patients in your care (all with different needs and health status) so your clinical assessment and reaction skills must be finely tuned. You must have the ability to prioritise and respond appropriately. As they work 24/7 nurses perform the principal surveillance role in the health system – it is nurses who keep patients safe.

There has also been significant work intensification in the last 10-20 years, as evidenced by decreasing length of stay, increased throughput and an increase in the level of patient acuity. Given this changing context the breadth and depth of knowledge required by nurses to perform their role has expanded considerably.

Apart from concern regarding the context of nursing work there are some inherent features of the work that are challenging. The work is physically and emotionally demanding, the rigours of shift work (the performance of work 24 hours a day seven day a week) being just one example of this. It is also personally dangerous work, given the prevalence of blood borne diseases and the incidence of physical and verbal assault on nurses.

It is hard to describe the richness and complexity of nursing easily and succinctly. It is more often than not the case that many do not want to hear what it is that nurses do because it is of such a personal nature. People are embarrassed to listen. Their own sense of physical or personal security may be fundamentally threatened by the very nature of the work that nurses do. Most healthy people do not want to think about being sick - many prefer not to think that they will ever be so vulnerable that they will require nursing care. Giving up such personal power can be confronting. Nurses are aware of this dynamic so their actions seek

to normalise abnormal situations – to make people who are ill feel as physically and emotionally comfortable as possible under the circumstances. It is the very act of normalisation, through reassurance or "down playing" of seriousness that in turn masks the importance and complexity of nursing skills. This complex dynamic is central in our view to the longstanding under valuing of nursing work. The very nature of nursing work and the difficulty in "translating" this for non-nurses perpetuate the inequity.

It is the source of considerable frustration to many nurses that the complexity and richness of their work continues to be undervalued by health bureaucrats and government alike. Nursing is incredibly personally rewarding: nurses love nursing. It is the context of in which they work, one of budgetary constraints and insufficient resources, and their work environment that is the source of angst for many nurses. So many nurses *love nursing* but *hate their jobs*.

The QNU strongly believes that past examinations of the work value of nurses have failed to adequately identify and measure the full range of skills employed by nurses in their work. This is in large part due to a fundamental gender based bias that we believe exists in current job evaluation methodologies. As a result we feel the depth and range of nurse's skills have not been adequately acknowledged and rewarded. This fundamental inequity is compounded by an adversarial wage fixing system based on industrial conflict. Such a framework is counter productive in a system such as health care where cooperation and teamwork are central to achieving outcomes. Relationships are central to the work of nurses, so when these fundamentally break down, as is the case with the current systemic disconnect between nursing and Queensland Health, it is especially frustrating and distressing.

Overall objective of the Systems Review of Queensland Health

To undertake a review of the performance of Queensland Health's administrative and workforce management systems with a focus on improving health outcomes for Queenslanders.

Broader Context

Give that the overall focus of this review is "improving health outcomes for Queenslanders" the QNU believes there are a number of contextual issues that need to be considered before addressing the specific terms of reference of this inquiry.

Queensland's budgetary position enables funding of necessary change

Queensland's current strong economic position, to not only meet the considerable infrastructure needs of the state but also address the particular needs of the Queensland public health system that are being highlighted through this review and the Commission of Inquiry into Bundaberg Hospital. Addressing deficiencies in the structure, culture and funding of public health services in Queensland is now the undisputed priority of the Queensland government. There is an urgent need for additional funding for health services as well as the need to ensure existing services are adequately resourced to meet community needs and expectations. We welcome the Premier's stated commitment following release of the 2005/2006 Queensland Budget to fund initiatives arising from the reviews of Queensland Health from the state's surplus.

Other significant factors impacting on health service delivery

The QNU believes that Queensland's comparatively strong financial position enables us to place particular emphasis on making sustainable and evidence based improvements in health service delivery and infrastructure at this time. This is particularly important given the demographic challenges of continued population growth, the ageing of the population, the decentralised nature of Queensland and changes in community expectations and demand for services. The issues of community needs and expectations should be examined in a coordinated and comprehensive way in view of the challenges confronting us. This is especially important in the areas of health and aged care services given factors such as the potential increase in demand for services because of the ageing population, cost blow outs related to technological advances, increasing consumer demands, lack of integration of services and expectations and structural inefficiencies and duplication related to dual federal/state government responsibilities in this area.

The importance of the Queensland public health system

The history of the Queensland public health system is a long and proud one. Our public health system is an important cornerstone of our universal health system. This is increasingly so given that the federal government is undermining universal health care by shifting emphasis to a "user pays" model for health funding. More and more, those who cannot afford spiralling out of pocket expenses in the private medical system are relying on public health services. This reliance is particularly acute in regional and rural areas, where it is usually the case that the only hospital services (and often primary health services) are public ones. There are no private hospitals west of the Great Dividing Range (i.e. in most rural and all remote areas of Queensland). Given the decentralised nature of Queensland this is a critical point that underscores the significance of our public health system in ensuring equity and access to essential health services.

The QNU is steadfastly committed to the establishment and improvement of the Queensland public health system. The provision of timely, quality, publicly funded health services to all in our community determined on clinical need and not ability to pay is, to us, an essential hallmark of a civil and fair society. Although private health care providers are an important component of the health care system, it should only ever be seen as complementary to the public system.

There needs to be better interface between the public and private systems to ensure better integration of services and improved continuity of care for clients of the health system. This is because clients of health services can and usually do move across sectors. Currently coordination across care settings within and between sectors is inadequate. This is not to say that improvements have not been made in recent years (for example, relationships between the public hospital sector and general practice have improved, especially with the advent of new technologies). But much more needs to be done to ensure seamless care. Some of this fragmentation arises from state and federal government funding and accountability arrangements and these will only be truly addressed by a national coordinated approach to genuine health reform in this country. However more can and must be done as an interim measure to improve the interface between public and private sector health care providers in Queensland.

In our view an important step in achieving this end is the establishment of a state based Health Reform Council which has responsibility for establishing processes to ensure genuine community consultation on health service planning and delivery as well as improving the interface between public and private health sectors. The QNU does not support an *ad hoc* approach to the "restructure" of Queensland Health. The formation of new local health councils or boards in the absence of a coordinated and consistent policy framework will fail in our view.

It is essential to also remember that any consideration of health reform in Queensland must be undertaken in full cognisance of current developments with respect to the national health reform agenda. Most importantly, it is also vitally important that any reform that takes place within Queensland Health must also achieve the objectives that underpin of our universal health system – that of ensuring universal access, access based on need and not ability to pay, equity of access and equality of health outcomes, efficiency and effectiveness. In particular, every effort must be made to ensure that any changes to structures do not adversely affect the achievement of objectives in health priority areas such as indigenous health, mental health and cancer services.

The QNU believes a state wide "peak body" such as a Health Reform Council must be established first to provide a framework for local level community and stakeholder engagement on health reform. Ensuring consistency of approach is paramount in our view and firm guidelines must be established to ensure appropriate community and stakeholder representation on local health advisory services. For example, the QNU also does not support a model whereby there is formal private sector input into the running of public health services unless a similar arrangement is established that enables direct public sector input into the running of private health services (be these hospitals, aged care facilities, general practice or community based not for profit services). We are sure that such direct public sector input into the running of private services would be strenuously resisted and therefore cannot see how an argument for private sector input into the running of Queensland Health could be sustained.

The best model for achieving better coordination and input into decision making is through the initial establishment of a statewide Health Reform Council (with sub working groups dealing with specific priority areas requiring attention). This

group would then be responsible for drawing up a consistent and appropriate model of local consultative arrangements. (Such local consultative arrangements must be rational and consistent with Queensland Health's service delivery geographic boundaries that may change as a result of current reviews.)

It is recommended that:

RECOMMENDATION (Health Reform Council)

That the Queensland government fund the establishment and continued operation of a state based Health Reform Council that would draw up a framework to enable genuine community consultation on health policy decision making and the planning of service delivery at the state wide and local levels. Further to this, that this body be broadly representative of the Queensland community and include representatives from the QNU and consumer organisations.

This review and the concurrent Commission of Inquiry into Bundaberg Hospital are central to rebuilding community confidence in the Queensland public health system. The QNU will play whatever role we can in contributing in a positive way to achieving this end. We are well aware that the continued undermining of the public health system suits the purposes of some players. It is therefore essential that we keep in mind that the systems and cultural problems highlighted by the Morris and Forster inquiries into Queensland Health are also common problems in the private system. It is just that these issues are not currently being exposed there due to the decreased availability of mechanisms for public scrutiny of the private health system.

Although the QNU has serious concerns about the lack of openness and transparency of our public health system it is the case that the public system is more accountable than the private health sector. This is because Freedom of Information (FOI) legislation (deficient though it is in this state) and many public reporting arrangements do not extend to the private sector.

Health and education are the two largest state government portfolio areas and as such account for a significant proportion of government funding. These are two very important areas of government service provision and as such Queensland taxpayers have a clear stake in ensuring both appropriate administration and service delivery. It is also the case that Queensland Health is one of the state's largest employers and therefore fulfils an essential economic function in regional and rural communities in particular. Our public health system also provides an essential training function. Overwhelmingly it is the case that specialist medical officer training occurs in the public sector. Our public system is the primary provider of critical high cost and medical emergency treatments and often is the first provider of "cutting edge" technology. As such, it fulfils many vitally important functions that highlight the many reasons why it is essential to rebuild community trust and confidence in Queensland's public health system.

Decentralised nature of Queensland

The decentralised nature of this state provides particular challenges to government. Not only is it more expensive to deliver services in a highly decentralised state such as Queensland but also geography greatly influences equitable access to appropriate services.

In our 1996 submission to the then Health Minister Hon Peter Beattie the QNU highlighted the need for more rational and consistent service delivery models. We argued at that time (and still hold this view) that it is a nonsense to have inconsistencies between government agencies with regard to geographical boundaries for service delivery. Why is it that the geographical "district" boundaries for all government agencies are not consistent, especially with regard to large service delivery agencies such as Queensland Health and Education Queensland? The aim of the Shared Services Initiative (SSI) was to at least in

part address issues of duplication of effort and service across the agency and public sector as a whole and to improve service standards in rural and remote areas. Unfortunately this has not been achieved and confusion now exists about the relationships and responsibilities between the overall Queensland Health organisational structure and that of the shared services initiative. If this initiative was to be a genuine attempt to ensure consistency of approach and reduce duplication of effort then from the outset a consistent HR/IR policy framework for the whole of Queensland Health should have been established rather than allow the continuance of the existing Health Service District (HSD) autonomy on HR/IR issues. This is a key issue for consideration by this review and therefore will be dealt with in greater detail later in this submission.

Informed community debate

Much needed health reform can only be delivered through proper community debate and engagement. The existing mechanisms for this are obviously inadequate. A new paradigm is needed whereby a holistic approach to health sector reform is adopted, based on a genuine community dialogue about health needs and expectations and how these are best funded. This will not be achieved by retreating back in time to the era of Hospital Boards – a new approach is required. Similarly it is essential that a new approach is required for health service delivery, one founded on a partnership with the staff delivering the services (who are also citizens). The QNU believes that the time has well and truly come to adopt a new approach/culture in health – one based on sharing of information, engagement and debate, openness, transparency and accountability. We are confident that citizens, the staff who provide the service and government are capable of such a shift in approach. It is appreciated that this shift is significant and achieving it will not be without difficulty. However if we are to ensure the delivery of sustainable, evidence and needs based, quality health services into the future then this must occur. The need for this shift will be a recurring theme of this submission.

Undue emphasis on achieving efficiency related outcomes

The Queensland government frequently reminds us that Queensland public hospitals are the most efficient hospitals in the country. This point is reinforced each year by the annual *Report on Government Service* prepared by the Steering Committee for the Review of Government Service Provision. The comparative efficiency of Queensland's public hospitals is highlighted in the 2004 and 2005 reports. For example in 2004 the report highlighted that:

The recurrent cost per casemix-adjusted separation nationally in 2001-02 was $3017. Across jurisdictions it was highest in the ACT ($3769) and lowest in Queensland ($2741)[10]

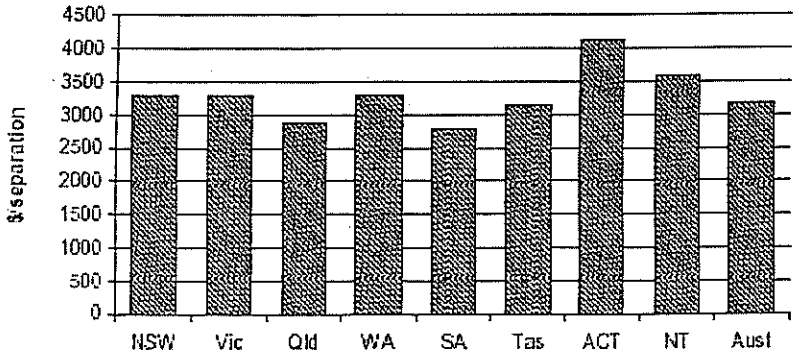
The 2005 report quotes the total recurrent cost per casemix-adjusted separation as being $2885 in Queensland compared to the national average of $3184. [11] This is represented graphically below[12]:

10 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2004*, page 9.47, Canberra.

11 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, Table 9A.4, Canberra.

12 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, page 9.49, Canberra.

Figure 9.14 **Recurrent cost per casemix-adjusted separation, 2002-03**[a, b, c, d, e, f, g]



[a] Excludes depreciation and the user cost of capital, spending on non-admitted patient care, research costs and payroll tax. [b] Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights, from the National Hospital Morbidity Database, are based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2000-01 AR-DRG v4.2 cost weights (DHA 2003). [c] Excludes separations for which the care type was reported as 'newborn with no qualified days', and records for hospital boarders and posthumous organ procurement. [d] Excludes psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute hospitals and multipurpose services. [e] Data for NSW are preliminary. [f] NT data need to be interpreted in conjunction with the cost disabilities associated with hospital service delivery in the NT. [g] All hospitals in the NT, one very small hospital in Victoria and two very small hospitals in SA have had their inpatient fraction estimated using the HASAC ratio (see AIHW 2004a).

Source: AIHW (2004a); table 9A.4.

The 2003-2004 Queensland Health Annual Report quotes the average cost per weighted episode of care at $2631 whereas in 2002-2003 this figure was $2713[13].

In the last 10-15 years there has been significant reform in the public health sector in Queensland that has lead to efficiency gains. [Significantly these gains have been achieved in the context of either tight constraints on or actual decreases in (depending on data relied upon) nursing numbers employed by Queensland Health. See section below on data difficulties in Queensland Health].

These reforms have included but are not limited to:

- Significant technological advances and broadening of the knowledge base of nurses and other health workers (this has coincided with the transfer of nurse education to the tertiary sector)
- Decreased hospital length of stay – from 5.38 days in 1990/91 to 3.0 days in 2003/2004 (target for this year was 3.08 days)[14]
- Increased throughput and patient acuity –

	1990-91	2002-03	2003-04
Total admitted episodes of care	514,635	734,107	749,949
Total day only patients	No data	348,038	352,385
Total non Inpatient Occasions of Service	6,120,632	8,867,807	8,813,831[15]

13 Queensland Health Annual Reports – 2002-2003 p 47 and 2003-2004 p21.

14 Queensland Health Annual Reports.

15 Queensland Health Annual Reports – note data for 2002-2003 and 2003-2004 come from the 2003-2004 Annual Report data pages 22-26.

- A significant capital works programme in the public sector that has also resulted in a decrease in available beds per 1,000 population from 3.3 in 1993-94 to 2.7 in 200-2001[16]
- Significant changes to models of care
- Restructuring of health service delivery
- Implementation of new career structures and roles for health workers and other significant public sector reforms

Hospital activity and patient acuity rates (degree of how ill patients are) have increased over the last ten years. Associated with this increase is a decreasing length of stay. This means that patients treated ten years ago who required a hospital bed for a number of days may now be treated as a day patient. A patient who may have been cared for in an intensive care unit ten years ago may be in a ward today.

Increased throughput and decreasing length of stay in public hospitals combined with significant health and information technology development over the last decade have resulted in work intensification by nurses. As patients are admitted for shorter periods of time, the level of patient dependency for the period of hospitalisation is higher. That is, patients are sicker—as they improve they are discharged for their recovery phase. Patients are discharged sicker and quicker. Nursing work has intensified and is much more complex than what it has been.

In our view an undue emphasis has been placed upon achieving greater and greater efficiency outcomes and insufficient emphasis is being placed upon the quality of care provided or effectiveness of health outcomes. Our members are increasingly reporting that this emphasis on increased efficiency gains is having a negative impact on quality of care as nurses are placed insituations where they are unable to deliver an optimal standard of nursing care. This results in nursing wastage as nurses leave the health system or decrease their hours of work because they can no longer cope with the unrealistic work intensification and the consequences this has for their ethical obligations as health professionals.

The common complaint of nurses today is that that they love nursing but hate their job. (This is backed up by independent research involving QNU members conducted by University of Southern Queensland (USQ) in 2001 and 2004 – findings of research detailed later in this submission.) This has resulted from the unsustainable drive for efficiency that must urgently be re-examined and placed in the context of the expected quality and effectiveness of services provided.

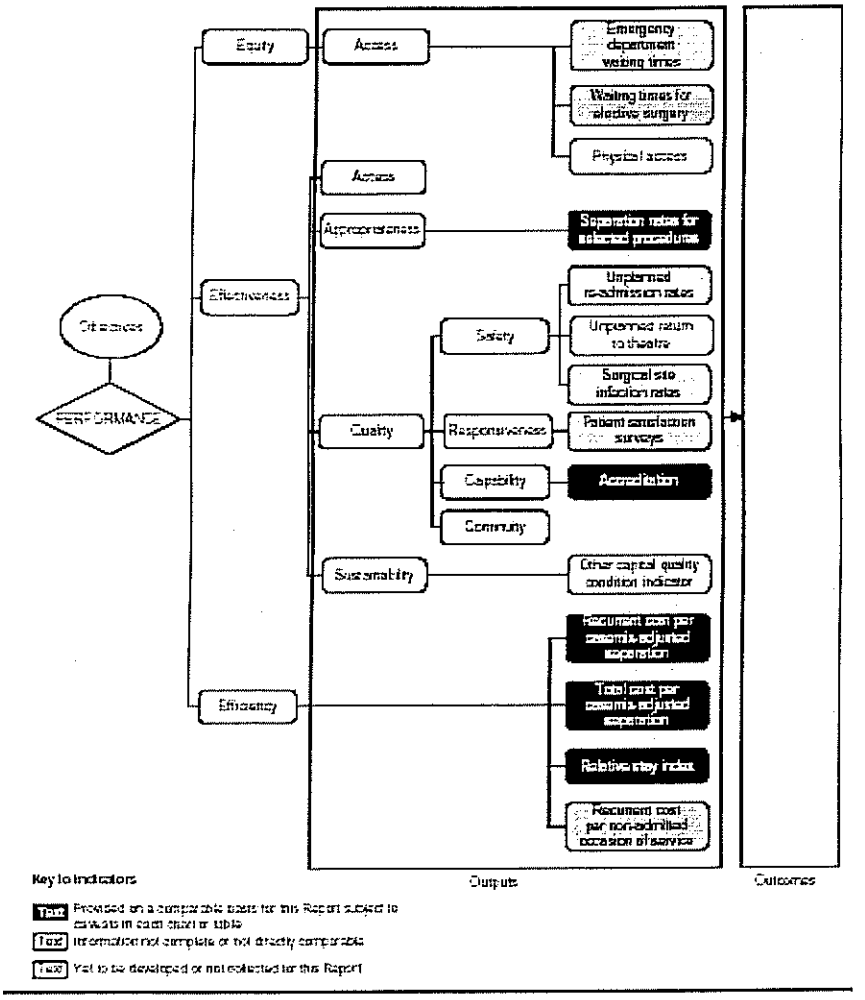
For years now governments have pushed for greater efficiency in areas of service delivery such as health and as a result have failed to develop a truly balanced approach to measuring performance. One mechanism through which governments report progress towards the achievement of agreed performance indicators is to the Steering Committee for the Review of Government Service Provision. This is reported in the annual *Report on Government Services*. Performance indicator frameworks have been designed for all major areas of government service delivery. The current performance indicator framework for public hospitals contained in *Report on Government Services 2005* is reproduced below.[17] It should be noted that the efficiency indicators of this framework were developed first and have been

16 AIHW *Australia's Health* 1996 Table 5.6 and *Australian Hospital Statistics 2002-2003* Table 3.2, Canberra.

17 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, page 9.20, Canberra.

the most refined over time. The development of indicators in the areas of equity and effectiveness still require much more work. Some indicators that are currently utilised to assess quality (for example accreditation) are also seriously deficient in our view. The over emphasis on meeting crude efficiency targets (e.g. elective surgery targets) can and does have serious effects on quality and appropriateness of care. You need look no further than recent experience at Bundaberg Hospital to be reminded that the consequences of taking an unbalanced approach can indeed be dire.

Figure 9.11 Performance indicators for public hospitals



It is recommended that:

RECOMMENDATION (Expanding health performance measures)

That specific funding is allocated to enable the further development of appropriate performance indicators that measure effectiveness and equity of access to health service delivery as agreed to in the Steering Committee for the Review of Government Service Provision (annual *Report on Government Services*) process.

Lower spending on health in Queensland

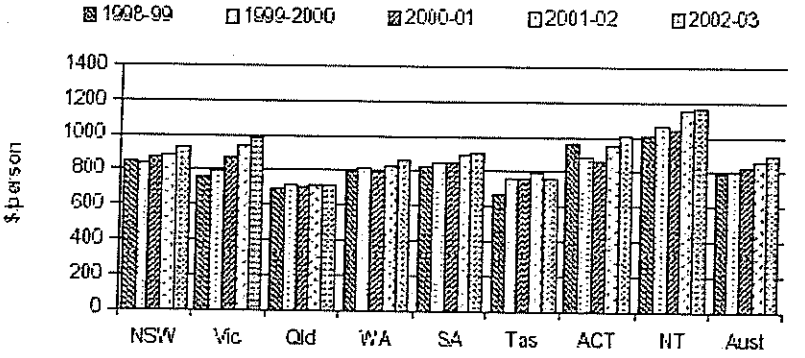
Queensland also continues to have the lowest per capita health expenditure in Australia, despite "record" expenditure in the health portfolio each year. This lower level of expenditure is particularly striking considering the additional costs associated with delivering health services in Australia's most decentralised state. The 2005 *Report on Government Services* prepared by the Steering Committee

for the Review of Government Service Provision repeatedly highlights this continuing trend:

In 2002-03, government real recurrent expenditure on public hospitals (in 2001-02 dollars) was $895 per person for Australia, up from $791 in 1998-99. It ranged from $1165 per person in the NT to $712 per person in Queensland in 2002-03.[18]

Government expenditure trends in public hospitals from 1997/98 to 2001/02 are represented graphically as follows[19]:

Figure 9.2 Real recurrent expenditure per person, public hospitals (including psychiatric) (2001-02 dollars)a, b, c



a Expenditure excludes depreciation and interest payments.

b Data for 2002-03 for NSW are preliminary. NSW hospital expenditure recorded against special purposes and trust funds is excluded. NSW expenditure against primary and community care programs is included from 2000-01.

c For 2001-02, Tasmanian data for two small hospitals are not supplied and data for one small hospital are incomplete. For 2000-01, data for six small Tasmanian hospitals are incomplete. For 2002-03, Tasmanian data for one small hospital were not supplied and data for five other small hospitals were incomplete.

Source: AIHW (2004a and various years); ABS (unpublished); tables 9A.2 and A.2.

A report released by the federal health minister in June 2004 titled *The state of our public hospitals* claims that (based on AIHW and 1998-2003 Australian Health Care Agreement data) the Queensland government's recurrent expenditure per person on public hospitals in 2000-2001 was the lowest in Australia at $440. (Next lowest was South Australia at $487.) The national average expenditure was $552.[20]

The low level of expenditure on health care in Queensland extends beyond expenditure on public hospitals. According to the 2005 *Report on Government Services* (our emphasis added in extract below)[21]:

18 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, page 9.4, Canberra.
19 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, page 9.5, Canberra.
20 Australian Government (June 2005), *The state of our public hospitals*, page 14, Canberra.
21 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, page E8-E9, Canberra.

Health expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics. Nationally, total health expenditure (recurrent and capital) per person in 2002-03 was $3652, rising by 32.9 per cent in nominal terms in the five years since 1998-99 (when it was $2748). Across jurisdictions, it was highest in the NT ($4126 per person) and ***lowest in Queensland ($3392 per person)*** *(table EA.5).*

The most recent data on recurrent health expenditure per person by jurisdiction are for 2001-02. Real recurrent health expenditure per person in Australia increased from $2637 (in 2001-02 dollars) in 1997-98 to $3142 in 2001-02. In 2001-02, total recurrent health expenditure per person was highest in the NT ($3437) ***and lowest in Queensland ($2885)*** *(figure E.4 and table EA.6). If spending on high level residential aged care is removed from these data, then total recurrent health expenditure per person ranged from $3383 in NT* ***to $2659 in Queensland in 2001- 02*** *(table EA.7). Government real recurrent health expenditure per person in Australia increased from $1776 in 1997-98 to $2112 in 2001-02 (in 2001-02 dollars). In 2001-02 it was highest in the NT ($2658)* ***and lowest in Queensland ($1972)*** *(figure E.4 and table EA.6). If spending on high level residential aged care is removed from these data, then government recurrent health expenditure per person ranged from $2614 in the NT* ***to $1784 in Queensland in 2001-02*** *(table EA.7).*

It is also our firmly held view that increases in the Queensland budget expenditure in the health area have failed to keep pace with the significant population growth and increased demand for health services seen in recent years. Indeed the QNU believes the recent Queensland Health Capital Works program process for determining the hospital bed numbers required has significantly under-estimated future demand for services in many areas. This is clearly demonstrated through recent hospital activity data, for example hospital waiting list information.

The government response to the blow out in public hospital waiting lists appears in part at least to transfer demand to the private sector, be this through individual consumers taking out private health insurance (or self funding health services in the private sector) or by Queensland Health contracting services out to private hospitals. The QNU believes this knee jerk approach is fraught with potential problems and we have expressed our concerns about the waiting list strategy to the Minister for Health.

Staying within budget (while at the same time having to meet unrealistic performance objectives) is the overriding imperative in Queensland Health – all else appears to take second place to this. The primacy of the budget bottom line is demonstrated again and again. In 1999 the whole District Executive at Toowoomba Health Service District (HSD) were removed for failing to come in on budget. Not long after that the District Manager in Cairns HSD was dismissed for reportedly failing to come in on budget. These dismissals were powerful symbols for the rest of the system and helped achieved better budget compliance by instilling fear of job loss in senior management across the agency, a fear that was in turn passed down to middle management and beyond. It was strange that these particular districts were singled out for this particular form of harsh treatment, especially when there were other districts that were in greater budgetary difficulties.

It is also disappointing (to say the least) that a similar level of decisive action was not shown towards management at the Bundaberg Health Service District (HSD) when such significant systems failures manifested themselves this year. We are not arguing such draconian dismissal action against the management at Bundaberg HSD but highlight that an obvious and clear double standard exists in this agency. Failure to come in on budget will result in dismissal but failing

to act to correct significant systems failures that result in death and injury to patients results in you being asked to consider whether you should stand aside "while matters are investigated". No one within the system (or outside of it for that matter) is left in any doubt about what is more highly valued when such clear messages are sent. The budget dollar bottom line is paramount.

It is our firm view that the historic under funding of public health services in Queensland has in large part contributed to the current crisis we are experiencing. As the health budget is insufficient to meet public demand for services something has to give. Although it is appreciated that health funding in Queensland has been increasing in recent years this increase has not been sufficient to ensure consistent access to timely and high quality health services. We have argued in our recent budget submission to the Queensland government for the need to increase Queensland's spending on health to the national per capita average, and continue to argue for this outcome. There is a concurrent need to develop improved effectiveness and equity indicators (in addition to existing efficiency indicators) to ensure that additional funding is contributing to achieving desired outcomes.

RECOMMENDATIONS (Budget for and supply of health services)

It is recommended that:

The Queensland government continues to increase its budget allocation to the health portfolio in order that government per capita expenditure on health services reaches an acceptable level compared to other state/territory governments.

In light of population growth and current high levels of demand for public health services the Queensland government fund an urgent re-examination of demand and supply of public health services (including the number and distribution of public hospital beds, day procedure units and primary health care services) and that the outcome of this review form the basis for future budget allocations for health infrastructure and recurrent funding.

Lack of access to meaningful data

The lack of reliable publicly available data from Queensland Health in a range of areas should be a source of significant embarrassment to the Queensland government. This is not only a source of frustration for the QNU - we are advised that other government agencies are also concerned about the lack of meaningful data, especially of a financial and human resource nature. In our view lack of openness and transparency is an issue for the whole of the Queensland government (exemplified by the recent winding back of the FOI regime in this state) but is particularly a problem in Queensland Health. Urgent action is required across government but especially within Queensland Health to improve access to meaningful information to enable better transparency, planning and accountability. Even if reliable data is available it often is not released to key stakeholders such as unions. Issues relating to data are of central significance to this review and will be elaborated on later in this submission.

RECOMMENDATIONS (Access to meaningful data)

It is recommended that:

Specific funding is allocated to enable the further development of appropriate systems within Queensland Health that will enable timely access to reliable data for health bureaucrats and the broader community including health unions. This would facilitate better planning and accountability and evidence based decision making on clinical and non clinical matters.

Politics of health

The entrenched power imbalances within health care make it inherently political and add to the complexity of dealing with issues within the portfolio. The failure of successive administrations to appropriately "manage" the politics of health

has in large part related to their failure to appropriately and openly deal with these power relationships. Openness is the key issue here in our view – if the issues were examined and debated in an open manner then we believe the "politics" would also be subject to greater scrutiny and there would be a far greater potential for resolution of the power imbalances.

The health portfolio provides perhaps the greatest opportunities to cause the downfall of governments. Received wisdom is that the Goss government was brought down because of "reforms" they introduced to the public sector, especially in the health portfolio. However rather than subject the reasons for discontent to proper analysis, admit that mistakes were made and then develop strategies to address problems identified, the response (at least in health) has been knee jerk and punishing. The aim is to shut down critical analysis and debate in health rather than encourage it—to neutralise opponents by playing the person and not the issue (a very entrenched strategy in Queensland political culture). This response has only served to entrench power imbalances and create greater dissatisfaction and a sense of hopelessness. (Successive surveys of our members demonstrate this very clearly.)

Despite attempts in recent years to restructure the culture of health to a team based approach the hierarchies remain. Perhaps it is naive to believe that this will not always be the case, but in our view it is illogical to not acknowledge their existence openly, discuss them and develop appropriate strategies to mitigate against power imbalances. Similarly, it is imperative in our view that a new approach be adopted to genuinely engage citizens in the debate about health needs and expectations and how these should be funded.

It is of particular concern to the QNU that some are now arguing for a return to the "good old days" of a medical model for Queensland Health. We have well and truly moved beyond a time when health care policy and service delivery is determined by the most powerful occupational group in the health industry. Those who fail to realise this are doomed to failure in our view—stuck in an old world paternalistic paradigm of "doctor knows best" that is not an appropriate health care model for the twenty-first century. This is not to say that doctors are not very important service providers in the health system—of course they are. So too are other health professionals and those workers who provide support to clinical services. To have a new sustainable model of health care we must adopt a team approach that acknowledges the contribution of all players.

It must also be remembered that despite recent claims to the contrary by some, it remains the case that medical officers continue to play key leadership roles at the corporate office and HSD levels. For example, over the last 15 years plus all Directors General of Queensland Health bar one (Mr Dick Perrson) have been medically qualified. There are also a number of medically qualified officers holding senior positions within Queensland Health including the Office of the Chief Health Officer (legislation requires that this person be medically qualified) and many other medical officers hold positions at very high levels within corporate office. It is also the case that Medical Directors/Superintendents at the HSD and facility levels continue to form a central role in the Executive of the health service.

Typically the Executive of a HSD comprises the District Manager (who may or may not be a medical officer), the Director of Corporate Services, the Director of Medical Services and the Director of Nursing Services. The QNU fails to see how a sustainable argument can be run that medical officers have been frozen out of decision making and leadership positions at the highest level. There may or may not be issues with the perceived performance of individuals holding these positions but it is essential that the personalities be removed from the

examination and we instead focus on the positions. (If there are performance issue for the incumbents in these positions then deal with that problem – it is nonsensical to create new positions/layers because of a lack of performance management processes or failure in accountability mechanisms. Any problems must be addressed at the source – it is inappropriate to merely treat symptoms.) Medical officers have always had and continue to have appropriate representation at senior levels of Queensland Health at the corporate office and local facility/ HSD level.

Most importantly however the old medical model misses the salient point – the focus should be on "health" services" (in all its forms) not "medical" services. The aim is to promote the optimal health and wellbeing of the community and this is achieved through many mechanisms, one of which is the provision of services by medical officers. The focus must shift to community needs and expectations—the system should not be designed around the particular needs of any provider, though of course the needs and expectations of all health service providers must be adequately met if we are to provide services at all. The key here is a partnership approach—one where there is a genuine partnership between health service providers and a genuine partnership between providers and the community as a whole. Obviously from the rhetoric of some key stakeholders of recent times we are some way from achieving this end. However it is nonetheless essential that this remain the objective and that changes that result from the current review of health services in Queensland do not result in a further entrenchment of the power imbalances that have been a longstanding feature of the health system.

It is nonsense to continue with the pretence that our current approach to health system design and funding is either appropriate or sustainable. To continue to publicly claim year after year that government has provided another record health budget in the absence of a genuine debate on community needs and expectations is simply ludicrous. State and federal governments have a key role to play in generating such a debate by putting aside the fear of political ramifications of "telling it like it is" and showing leadership on what is one of the key challenges confronting us: ensuring an equitable, high quality and sustainable health system for all. This is fundamentally a debate about the values that underpin our society, how health care is best provided and funded and what are our mutual rights and responsibilities. Without providing these underpinnings explicitly we cannot optimally effect a shift towards a preventative (and hence more sustainable) model of health care. A holistic approach is required, one that necessitates a rethinking of our multiple relationships within our health system.

RECOMMENDATION (Establishing a new partnership in health based on sound principles)

It is recommended that:

A new "partnership" approach be developed and adopted for the design and delivery of public health services in Queensland and that this be based on a health care team delivering health services to informed clients who have genuine input into decision making processes. Further to this, that at all times principles of universality, no cost at point of service, timely access, equity of access and equality of health outcomes underpin our public health services in Queensland.

Cultural issues

The QNU believes that the dominant culture that pervades Queensland Health is one of an obsession with secrecy, a failure to embrace differences of opinion and critical analysis, intimidation of those who dare to question and entrenched power imbalances. There is no doubt these are complex and inter-related issues. In our view it is this dysfunctional culture that has largely lead to this review.

The almost paranoid obsession with secrecy and failure to share meaningful data with "partner" organisations such as health unions (not to mention the community as a whole) are seen by us as fundamental barriers to accountability. In the last ten years or so every effort has been made to get Queensland Health off the front page of *The Courier Mail* and this has resulted in those with a genuine interest in information that is required to enable proper scrutiny of the system being denied access to necessary information. The winding back of the Freedom of Information regime in this state has greatly facilitated this culture of secrecy and lack of accountability. The result has been that Queensland Health is well and truly back on the front page of *The Courier Mail* in an unprecedented way. The system has failed the people of Bundaberg and in a wider sense the people of Queensland given the battering of public confidence in our public health system.

The current culture and unrelenting quest for greater efficiencies is unsustainable and must be changed. It is a nonsense for this agency to be charged with a mission of "promoting a healthier Queensland" while at the same time the way those delivering health services are treated contributes to the diminution of their health and wellbeing through the culture of bullying and intimidation and unsustainable workloads. We believe an examination of Queensland Health's WorkCover and health and safety data would demonstrate that significant problems exits in this agency and strongly recommend that this review pays particular attention to ensuring the establishment of a safe system of work for Queensland Health employees.

It is recommended that:

RECOMMENDATION (Data on health and safety impact of system stress on health workers)

This review pays particular attention to examining health and safety and WorkCover data from Queensland Health and from this make firm recommendations aimed at establishing safer systems of work for all Queensland Health employees.

Staff members see this disconnect between the publicly stated values espoused by the department in documents such as their Vision Statement and strategic plans and the behaviour that is actually modelled in their workplaces on a daily basis. It is important that these words on paper are actually given effect. This requires a switch in mindset on behalf of Queensland Health, with staff being truly viewed as an asset rather than a liability.

The real life experiences of employees of Queensland Health do not match their employer's rhetoric. There are great inconsistencies with regard to the way staff are treated within Queensland Health and some of these arise from fundamental and longstanding power imbalances. Why is it, for example, that Dr Patel was able to continue to practice while serious allegations were being investigated by the department earlier this year? Our experience has always been that when a nurse is under investigation for practice concerns of a serious nature they are immediately suspended or moved to alternate (non-patient contact) duties. There appears to be one rule for doctors and another for all other health workers such as nurses.

Another significant cultural problem exits within Queensland Health. In many areas a culture of cronyism exists—enclaves of like personalities and approaches are established. This could of course be positive if the attitudes that dominate are positive ones. Sadly this is often not the case and such negative cultures become entrenched and hard to break down. It is frequently the case that where such a culture exists there is a "play the person not the issue" approach. In such environments there is also not a strong understanding of the proper role of the public service or the overarching government policy objectives/framework. There also is not an acceptance or understanding of the legitimate role of unions

as representatives of their employees. In our view there is a great need for education of middle and senior management within Queensland Health of these matters if we are to be successful in breaking down such negative cultures.

RECOMMENDATION (Cultural change in Queensland Health)

It is recommended that:

Specific funding be allocated for training and staff development necessary to affect the necessary change to build positive, supportive and patient and staff focused culture within Queensland Health. In particular, that current educational programmes for middle and senior management within Queensland Health be reviewed to ensure appropriate content on matters such as encouraging participation, critical analysis and debate, the need for openness, transparency and accountability, the role of the public service, the government's overarching policy framework and the role of unions as legitimate representatives of employees.

The Queensland Health Code of Conduct is used as a weapon to punish staff and shut down legitimate debate and discussion of concerns. Instead of being used to deal with ensuring privacy in relation to patient confidentiality, the Code of Conduct is utilised to attempt to stifle discussion about serious systems concerns and even stop nurses and other health workers from contacting their union about these concerns. This fundamental misuse of this document must be immediately ceased if we are to create a positive, problem solving and open culture in Queensland Health. It is the right of all Queensland Health staff and citizens to raise concerns in the public domain about the conduct of public institutions including hospitals and other health facilities. It is the department's role to deal with these concerns in a timely and appropriate manner or to refute them. It is not there role to silence criticism and debate through the misuse of documents such as the Code of Conduct. It is essential that the Code of Conduct be reviewed and amended to reflect this and for a penalty to be imposed for the inappropriate use of this document by management.

RECOMMENDATION (Cultural change in Queensland Health)

It is recommended that:

The Queensland Health Code of Conduct be reviewed and amended as required to ensure that this cannot be used by management to prevent legitimate criticism and debate about health system concerns by employees and citizens and enable staff to contact their union or other relevant institutions in society to discuss their concerns. Further to this, that a penalty be imposed on management representatives who use the Code of Conduct inappropriately to close down discussion and debate.

How did we end up in this current mess? There are many reasons – a dysfunctional "shoot the messenger" culture: an obsession with secrecy and ensuring that the appearance that all is well is maintained at any cost; a failure to address medical dominance and arrogance; a failure to embrace different views and critical analysis; and perhaps most importantly an overemphasis on efficiency gains rather than effectiveness within the system. The importance of coming in on budget and meeting elective surgery targets receive higher prominence than the equally (or more) important objectives of ensuring optimal, appropriate and timely care. It is the case that what is measured is what is valued and the message is received loud and clear within Queensland Health that what is valued more highly is the dollar bottom line. The current crisis within Queensland Health is a crisis of values as much as anything. Nurses and other health workers can no longer continue to function in a system in which their professional values/obligations are compromised – where they can no longer deliver the care they want to deliver. Responses of QNU members to our most recent survey conducted by USQ in 2004 reinforce our assertion that nurses feel fundamentally compromised by the way in which the system currently functions.

Terms of Reference for this inquiry:

To specifically review:

1. Existing administrative systems and recommend improvements to support health service delivery, focusing on:

- *District and corporate organizational structures and layers of decision making*
- *Corporate planning and budgeting systems*
- *Cost effectiveness of services compared to relevant jurisdictions*
- *Effectiveness of performance reporting and monitoring systems*
- *Organisation and delivery of clinical support services*
- *Risk management systems*
- *Quality and safety systems and*
- *Clinical audit and governance systems*

District and corporate organizational structures and layers of decision making

Queensland Health is a large and complex agency and as such there is bound to be some problems related to structure and decision making processes arising from sheer size alone. There are going to be some layers of bureaucracy. However there are issues that must be addressed regarding organisational structures and decision making within Queensland Health. These include:

The need for a consistently applied policy framework for the agency, especially relating to human resource (HR) and industrial relations) policies and practices. There is not one consistent HR/IR policy framework within Queensland Health. There are 37 Health Service Districts (HSD) within Queensland Health and one Corporate Office. This means that there are 38 different interpretations of HR and IR matters (39 if you include the Mater Public Health Service in Brisbane). Despite the existence of a Industrial Relations Manual policy framework we are advised that Corporate Office only has the ability to "advise" not direct HSD on their HR/IR obligations. This results in significant inconsistency of approach (very much dependent on personalities and the level of expertise at each HSD), duplication of effort on the part of Queensland Health and health unions alike and extreme frustration on the part of health unions and their members with regard to enforcement of lawful entitlements. This is a significant issue must be addressed once and for all through this review. There is not room for flexibility in interpretation of such matters in our view.

It is recommended that:

RECOMMENDATION (Establishing a standardised HR/IR framework in Queensland Health)

As a matter of urgency a standardised organisational HR and IR policy framework be developed in consultation with health unions for the whole Queensland Health that will prevent district by district interpretation of industrial and other related legislative obligations.

Our experience with each of the HSDs (and the Mater) is summarised in feedback we have obtained from QNU officials provided at Attachment 1 to this submission. As you can see, there are great discrepancies with regard to management and the functioning of consultative mechanisms across the state. This information is provided to this inquiry in confidence and we request that this information not be released either to Queensland Health or the general public. These reports do not identify any individual but do identify situations and/or experiences. We provide this information to give an overview of the broad impressions of eleven QNU officials who have responsibility for dealing with Queensland Health at the Corporate Office and HSD levels. To highlight

examples of inconsistent or poor practice by Queensland Health we have also provided a number of Case Studies at Attachment 2. These case studies should not be viewed as exhaustive: rather they exemplify the general approach taken to the management of HR and IR issues by Queensland Health and highlight the frustration felt by the QNU about inconsistencies, lack of standardised process and the "can't do" approach to nursing matters.

Issues relating to the arrangements for the Mater require further attention. There needs to be consistency of approach with regard to that service as well given that the Queensland government totally funds the public service. This goes beyond HR and IR arrangements to fundamental accountability issues such as the need to make Mater Public Health Services subject to Freedom of Information (FOI) and other public sector legislative arrangements. This will not doubt involve complex negotiations between government and the Mater Health Services but the issues at stake are relevant to this review and therefore must be given due consideration.

Confusion also exists about the relationship between the Queensland Health organisational chart (and responsibilities and reporting relationships therein) and that of the Shared Service Initiative (SSI) Provider. There still remains duplication of effort and uncertainty about who handles what types of issues, especially from the perspective of a key stakeholder such as a union.

There is also significant concern about the implementation of functions within the SSI. An example of this is using call centre arrangements for handling unexpected nursing staff leave replacement. The role that nurse managers have traditionally played in this area cannot and should not be replaced by a remote call centre arrangement—it is unfair for the nursing staff being contacted to be "cold called", it is unfair for call centre staff to have to handle an often complex negotiation using a standard script. Such negotiations with casual/pool staff cannot be adequately covered in a standard script—they are complex and require specific knowledge. This includes knowledge of patient conditions and clinical care required as well as knowledge of the skills and personal circumstances (eg family responsibilities) of the nurses being contacted. It certainly does make sense to rationalise support services such as those contained in the SSP but it is nonsensical to do so without a consistently applied organisational policy framework, especially in relation to HR and IR issues. Just why this new structure stopped short of bringing about meaningful reform through establishing such consistency is a mystery to the QNU.

The need for appropriate devolution of authority and accountability within a consistent policy framework. Adequate accountability mechanisms must be in place to ensure achievement of clear, agreed and achievable objectives. This must occur within a consistent policy framework and be underpinned by the provision of adequate training for relevant staff. Currently there is no openness regarding the requirements contained in contracts for District Managers and other Senior Executive staff nor generally is there knowledge of the details of service level contracts entered into by HSDs. Yet it is the case that budgetary and other devolved authority flow from this. How can congruency be ensured if this information is not known?

Some years ago (under the first enterprise bargaining agreement with Queensland Health) this information was made available at consultative forums at the local and central office levels and used to develop strategies to match supply with demand for services. (There was examination of long standing areas of budget blow out, for example in areas such as medical officer overtime payments and restrictive or inefficient work practices.) This was part and parcel of a new "best practice" approach to health service delivery – an approach that was underpinned

by a genuine partnership with staff and their representatives, the health unions. Authority was to be devolved as far as appropriate and (then) PSMC standards ensure a consistent public sector standard of operation based on principles of merit and equity.

These standards helped greatly to ensure consistency of approach and were especially important in ensuring fair and equitable processes, particularly in relation to recruitment and selection, fair treatment, performance planning and review, training and development and management of diminished performance. A number of significant problems with the current unfavourable culture within Queensland Health can be traced back to the demise of the PSMC standards. It is our strong view that the current policies and processes relating to these issues be reviewed as a matter of urgency and that improved human resources policies be implemented to ensure consistent and fair treatment for all employees of Queensland Health and address concerns relating to nepotism and favouritism that are currently levelled against Queensland Health.

It is recommended that:

RECOMMENDATION (Review and improvement to policies and processes relating to public sector management)

There be an urgent review of human resource policies and processes within Queensland Health and that these are improved to ensure the consistent application of fair and equitable processes, especially in relation to recruitment and selection processes, performance planning and review, training and development, management of diminished performance and fair treatment of employees.

It has been our experience that insufficient authority is devolved (within an established policy framework) to decision makers on HR and IR issues within Queensland Health. For example, it is often the case that consultative forums at the central office and HSD levels do not have sufficient authority to adequately deal with matters that should be uncontroversial (e.g. compliance with government policy) and therefore significant time and energy is wasted deferring matters until further advice or an organisational position is obtained. This inefficiency could in large part be addressed through the adoption of a standardised policy framework for HR/IR matters.

Many of the public sector reforms that arose from the Fitzgerald Inquiry have been slowly eroded over time and this slippage in regards to accountability mechanisms must be addressed if the necessary cultural change is to occur and be sustained in Queensland Health. There is not currently a culture of giving frank and fearless advice within the agency. (A culture of bullying and intimidation discourages this, to say the least). Although key selection criteria (KSC) for positions may on the surface appear appropriate, just how adequately is performance against these criteria measured (especially for those in management positions)? For example, it is standard practice that most position descriptions for Queensland Health jobs contain a KSC (usually the last one) on contemporary HR practice. For management positions this usually reads something like: *Demonstrated ability to manage staff in line with contemporary human resource management policies, procedures and practices including anti-discrimination, ethical behaviour and occupational health and safety.* For non supervisory positions the KSC may read: *Demonstrated ability to participate in a working environment supporting quality human resource management practices including employment equity, anti-discrimination, occupational health and safety, and ethical behaviour.*

The QNU firmly believes that these KSCs need to be strengthened (especially for managerial and supervisory positions) and also reprioritised so they become one of the primary essential selection criteria rather than an afterthought that languishes at the end of a position description that applicants pay lip service to

in their application and at interview. For example, the KSC could be reworded along the following lines: *Demonstrated ability to identify, promote, and maintain a working environment free from all forms of discrimination, sexual harassment and workplace harassment (workplace bullying).* But it is insufficient to merely reword and re-prioritise KSC—there also needs to be annual review of performance against such criteria in performance and development reviews. The objective would be to break down the unhealthy culture in Queensland Health and it would follow that if failure to meet this criteria is demonstrated then corrective action is taken. There is of course a current problem related to incumbency—just how do we break down the existing culture when it is already established? The culture perpetuates itself as those on selection panels recruit "like" personalities into subordinate promotional positions.

The provision of adequate resourcing to ensure compliance with legislative requirements that promote a safe working environment. There are a number of areas of activity within Queensland Health that contributs greatly towards the creation and maintenance of sa afe work environment and supportive culture for staff that need close examination. Legislative requirements relating to workplace health and safety (WH and S) and equal employment opportunity (EEO, also known as employment equity) are particular examples. Some years ago these activity areas were promoted quite heavily within Queensland Health and provided with specific resources at corporate office and local facility/district level. A decision was made in 1996 to mainstream these functions within HRM processes for the department, with resources being cut accordingly. The QNU protested these cuts at the time, pointing out to the then Director General how important these areas were to promoting a safe and supportive work environment for Queensland Health employees and thus creating a positive workplace culture. The response from the agency was that these functions would remain mainstreamed but we should rest assured that responsibility for these two areas of activity would be specifically included in the performance contracts for all senior executives including District Managers. (We could never confirm their inclusion in such contracts as they are not made public and are therefore not able to be held up to scrutiny or open monitoring.)

EEO has fared worse than health and safety with regard to resourcing cuts in recent years and has largely stayed on the organisational agenda through the commitment of a small number of HRM staff who have a personal commitment to EEO. It is obvious to the QNU that decision makers within the agency see these areas of activity as "non core" or "soft" functions whereas QNU holds quite the contrary view.

RECOMMENDATION (Workplace health and safety and employment equity considerations)

It is recommended that:

Close consideration be given to the prominence of and resourcing for Workplace Health and Safety and Equal Employment Opportunity initiatives when implementing the required cultural change within Queensland Health.

Ensuring consistent and appropriate remuneration and reward is provided commensurate with the level of responsibility. The QNU firmly believes that inconsistencies exist in relation to the appropriate valuing of work of Queensland Health staff - for example, an examination of the level of responsibility devolved to nurses in management positions at Nursing Officer (NO) Levels 3-4 compared to their counterparts in other streams (such as Professional Officer and Administration Officer streams). The lack of recognition of nurses with management and leadership qualifications in Queensland Health's interpretation of the award's qualifications allowance provisions has also demonstrated that Queensland Health does not value the management and leadership skills demonstrated by these nurses. (Such skills

will be essential if we are serious about achieving the required cultural change in Queensland Health and yet qualifications in these areas are not recognised and appropriately rewarded by Queensland Health. Please see our submission to Queensland Health on the qualifications allowance previously provided to this review for further information on this fundamental lack of valuing on the part of Queensland Health.) There has also been a longstanding anomaly, for example, between nurses in team leader positions within mental health areas compared to Professional Officers in the same area. Nurses must relinquish their nursing classification to take up a team leader position. Also, an anomaly exists between these team leader classification and the Clinical Nurse Consultant and Nurse Unit Manager Classifications in the nursing stream. The QNU recommends that there be an urgent review of the methodologies used to assess work value within Queensland Health to ensure consistency between occupational streams. This is required to ensure that there is equity and devolved responsibility is consistently rewarded.

It is recommended that:

RECOMMENDATION (Measuring of work value and establishing consistency of recognition)

An urgent review of the methodologies used to assess work value be conducted within Queensland Health to ensure consistency between occupational streams and appropriate recognition of the skills and qualifications required.

Whether the layers that currently exist add value and how should this be evaluated. The QNU has been concerned for some time now about the proliferation of positions especially middle to senior level Administration Officer (AO) positions, within Queensland Health, especially those within Corporate Office including those "hidden" Corporate Office positions that are attached to HSDs. This is not an exercise of AO bashing by QNU, far from it. We recognise and value the contribution that administrative staff make to the functioning of Queensland Health. Indeed we frequently argue for additional administrative support in clinical areas. Rather we question whether the volume of positions is needed at such high levels and ask what assessment is made of whether these positions add value to clinical operations. It is extremely difficult to make an assessment of actual numbers as Queensland Health refuses to release such information to us. (When asked they say that such information is not available only later to see data released in other forums.)

Reports of the proliferation of positions at Corporate Office level is of particular concern to the QNU. We have been advised recently of the creation of seventeen AO7 positions within the Workplace Innovation area within Corporate Office (though attached to the Royal Brisbane and Women's HSD). We cannot state whether this represents value adding or not. Nor can we make an assessment of whether these positions are part of a wider proliferation of non-clinical positions within the agency as we cannot get an accurate current picture of the workforce of Queensland Health. With respect to these seventeen positions in particular we do question why these are AO positions given that we are advised that their focus is on innovative clinical practice. Why cannot nursing (or other clinical positions) rather than AO positions be created with remuneration being equivalent to the AO7 level of remuneration if it has been determined that is the appropriate level of pay? We know of nurses who have applied for these positions and if successful they will be forced to relinquish their nursing position and put at risk their ongoing registration with the Queensland Nursing Council because of this change. If the job has been assessed as being worth AO7 equivalent remuneration that is what should be paid, but surely the applicants should not be forced to move outside their clinical stream to take up the role.

An examination of staffing numbers by occupational groups within Corporate Office starkly highlights a disconnect between clinical and administrative

functions and resourcing within the agency. For example, an assessment of a "head count" of positions (not full time equivalent (FTE) positions) within Corporate Office of Queensland Health[22] stated that there are a total of 1301 staff attached to Corporate Office. The breakdown of this "head count" is as follows: Administrative 928, Professional 191, Technical 112, Operational 42, Medical 22 and Nursing 6. Although nursing staff constitute over 40% of Queensland Health staff how can it be that only 0.46% of corporate office staff (by head count) are nurses? A response to that may be that there are nurses in AO positions but we ask why is this the case? Why are nurses converting to AO (or PO) positions if there is appropriate valuing of nursing skills and this is recognised through sufficient promotional positions being available through equitable career structures?

As stated elsewhere in this submission, the lack of data of this nature is a source of considerable frustration to the QNU. Before we can make an assessment of whether any positions are actually needed to support the delivery of clinical services we must start by establishing a reliable mechanism for the open and ongoing analysis of staffing numbers and employment arrangements (permanent employment versus temporary or casual engagement) within Queensland Health. When a major Queensland public sector entity cannot state with any certainty how many staff they employ this should cause significant embarrassment to government as it represents a fundamental lack of accountability to the taxpayer of Queensland. The QNU highlighted this issue in our recent budget submission to the Queensland government and we will rephrase the recommendation contained in that document again here:

RECOMMENDATION (HR reporting systems)

It is recommended that:

As a matter of urgency specific tied funding be allocated to Queensland Health to enable the agency to implement an appropriate standardised HR information reporting system and that the agency be closely monitored to ensure timely and appropriate implementation of this system. Such a system will facilitate the provision of accurate data to better match supply and demand of services, adhere to enforceable award provisions such as those relating to nursing workload management, undertake accurate costings for budgetary and enterprise bargaining negotiations processes and facilitate agency compliance with legislative and policy requirements (e.g. Equal Employment Opportunity reporting and achievement of target group employment targets).

As we have stated previously, there are significant cultural problems that impact upon decision making within Queensland Health. Queensland Health's dysfunctional culture is further entrenched by a "can't do" attitude and lack of appropriately functioning structures. Our experience in the last decade or so is that we have had to fight every step of the way to even achieve the lawful entitlements of our members. This may be due to a number of factors – that nurses are a large occupational group and granting benefits to them will therefore "cost" government or that just saying no is a successful stonewalling tactic (and survival technique) developed to cope with the many unreasonable demands being placed upon the bureaucrats who manage an under resourced system.

It is a significant source of frustration to the QNU and other health unions that the automatic response from Queensland Health with regard to HR and IR issues is to find as many different ways as possible to say "no". The default policy position appears to act from a position to refuse all requests/demands. The alternative rational approach of assessing the merits of each case and seeing if the issue can be acceded to or not is rarely used. The assumption seems to be

22 Provided to the QNU on 8 June 2005 as part of a report on staff who have undertaken Workplace Harassment training.

that there is far less work involved in saying "no" from the outset, despite the consequences of adopting such a position. This is not to say that there are not individuals working within the system who operate from a positive problem solving approach where merit and equity underpin their decision making. There are such individuals (and there have been many past employees of the agency who attempted to operate from such a position) – but they are working against the odds in a crisis ridden system and dominant culture lacking a consistent organisational policy framework.

Team relationships suffer from a widespread culture of bullying and intimidation. Staff members are advised publicly that "you are either with us or against us – if you are against us you can leave". Reasonable critical analysis and debate is stifled. Staff are advised routinely that they should not advise or consult their union about concerns they may have, a strategy aimed at decreasing legitimate external scrutiny of the agency. The level of bullying and intimidation that occurs in this agency is unparalleled in any other Queensland government agency – confirmed by the findings of the *Queensland Government Bullying Taskforce* (2002). There is something seriously wrong with the culture of this agency. There is a significant disconnect between stated and actual values and this results in significant additional stress for employees. If an overall objective of this review is to focus on improving health outcomes of Queenslanders then this must surely include paying particular attention to improving the health of Queensland Health employees.

In our view bringing about necessary cultural change within Queensland Health is a prerequisite to the success of any other reform that takes place within the agency. A new culture must be built based on mutual trust, respect, valuing and inclusiveness. The building of a genuine partnership is required for the successful functioning of a human services agency such as health. This must involve the legitimate representatives of the workers within the system, the QNU and other health unions.

We wish to make one final comment about the structure of the agency. The QNU was concerned to hear that one recent proposal by the Premier to address this issue was to divide the agency in two departments – a Hospitals Departments and a Department of Primary Care and Health Service Integration. Although on the surface it may appear to be an attractive proposition to create two more manageably sized organisations we are fundamentally concerned that such a split would serve to further undermine continuity of care through the creation of two separate "silos". In our view it could be potentially much more difficult to achieve better integration of services in such a structure. It is acknowledged that the current structure of the agency is problematic and also very importantly that primary and preventative care are still the "poor cousins" to the hospital sector within the current system design and budget allocation. However we do not believe that these issues are best addressed by splitting the agency in the manner that has been flagged by the Premier. In our view the priority areas for attention in the structure of the agency relate to its entrenched culture and the lack of a standardised policy framework and approach (especially in relation to human resource and industrial relations matters).

Corporate planning and budgeting systems

The QNU's comments on corporate planning and budgetary systems are constrained by our lack of access to meaningful data and lack of input into genuine consultative processes. In the past, during the brief window of opportunity of the first enterprise bargaining (EB) Agreement with Queensland Health there was indeed the potential for a new era of partnership via a best practice approach that

would underpin the planning and delivery of health services within the budget provided. This approach was not sustained and the agency, its employees, the government and health unions have been paying the price for this failure ever since. The cost has been significant—ten years have been lost and significant damage to relationships and trust has been done as well.

There is an urgent need for far greater openness and transparency and this must be underpinned by a genuine commitment for this to occur from government. Insufficient information is made public at present for an assessment to be made of the adequacy or appropriateness of current planning and budgetary systems. For example, currently the only information that is known about the 2005-2006 Queensland Budget is that provided in the budget papers. The Ministerial portfolio statement for health does not "drill down" adequately to the local or programme areas for us to make an adequate assessment of to what extent the issues raised in our budget submission to government have been addressed. For many years now there has not been a budget briefing provided at the agency level that would facilitate a proper analysis. (The QNU attends the pre budget briefing provided on a whole of government basis on budget day but this is a "higher level" briefing and does not get down to agency specifics.)

A primary concern of the QNU is what is publicly acknowledged and valued in budgetary compliance and achieving set activity/efficiency targets (for example elective surgery waiting lists or decreasing length of stay). As effectiveness indicators are often more difficult to quantify they fail to adequately factor in what us measured. This was perhaps most bluntly demonstrated in recent times by the removal of the entire Executive of the Toowoomba HSD on the grounds of failing to stay within budget. This must be changed if we are to bring about necessary cultural change and rebuild staff and community confidence in the system.

The only way forward as we see it is to attempt to restart the "best practice" approach of the first EB and to have this underpinned by a new empowered consultative framework. (Two documents outlining the approach taken during EB 1 are attached for your information at Attachment 3: *Best Practice and Organisational Change* and *Measuring Productivity in Health Care*.)

In our view there is the need to establish an oversight mechanism in at least the short to medium term and this should occur at the level of Department of Premier and Cabinet. The Premier, Treasurer, Health Minister and the Minister for Industrial Relations (or their representatives if they are empowered with the necessary authority) should participate in this oversight committee as well as all key stakeholders including heath unions. (Indeed there is merit we believe in this mechanism being established on a permanent basis given the challenges confronting this portfolio not only with respect to cultural changes but also external challenges going forward for health with respect to demographic challenges and population growth in Queensland.)

This would create a mechanism to provide the impetus for change and to ensure that the required changes are indeed occurring. It would provide the primary vehicle for raising issues of concern—the days of one on one meetings and dealing with the issues of one group without input from or knowledge of others must cease. This is not to say that there needs to be mechanisms to address issues that may only affect one particular group but rather that in future this must occur within an open and transparent framework. In our view this body should meet quarterly or more frequently as determined appropriate/necessary.

At the agency (Queensland Health) level there is a need to restructure the consultative mechanisms at central office and HSD/local level to ensure these

arrangements must be adequately empowered to drive corporate planning and budgetary processes. This will need to be the subject of further detailed discussion between the parties in the lead up to the next round of enterprise bargaining.

It is recommended that:

RECOMMENDATION (Establishing a new framework for consultative arrangements with unions)

Consultative arrangements for the health portfolio be reviewed and amended as required and that an oversight mechanism be established under the auspices of the Department of Premier and Cabinet that involves all relevant agencies and key stakeholders including health unions.

Cost effectiveness of services compared to relevant jurisdictions

The QNU believes there is no doubt that overall Queensland Health's services are the most cost efficient in Australia. However cost efficiency does not equate to cost effectiveness. The emphasis within Queensland has been unduly on cost containment, so much so that factors such as wages cost and staffing numbers have been kept at unsustainably low levels. This has been at a cost to the quality of health services provided.

Previously in this submission we have highlighted the comparative efficiency of Queensland Health. Queensland spends the lowest amount per capita on public hospital in Australia. (Recurrent expenditure per person for public hospitals (including psychiatric hospitals in 2001-2002 dollars for 2002-2003 in Queensland was $711.80 compared to a national average of $895.2.[23])

This assessment is based on data contained in the annual *Report on Government Services*. The 2005 edition of this report "drills down" to uncover the sources of comparative efficiency by looking at data pertaining to recurrent costs per casemix adjusted separation for public hospitals. The information below is an extract from Table 9A.4, with Queensland and Australian average data only extracted.

Recurrent cost per Casemix adjusted separation, selected public hospitals 2002-2003[24]

Non-medical labour costs per casemix adjusted separation		
	Qld	Aust. Average
Nursing	$ 772	$838
Diagnostic/allied health	$186	$237
Administrative	$199	$235
Other staff	$255	$196
Superannuation	$175	$178
Total non-medical labour costs	$1587	$1683

23 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005, Table 9A.25*, Canberra.

24 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005, Table 9.A.4*, Canberra.

Other recurrent costs per casemix-adjusted separation

Domestic services	$84	$85
Repairs/maintenance	$59	$74
Medical supplies	$299	$265
Drug supplies	$167	$164
Food supplies	$23	$36
Administration	$155	$171
Other	$26	$104
Total other recurrent costs	$814	$899
Total excluding medical labour costs	$2400	$2582

Medical labour costs per casemix-adjusted separation

Public Patients Salaried/sessional staff	$374	$391
VMO payments	$65	$119
Private patients (estimated)	$46	$90
Total medical labour costs	$485	$601
Total recurrent cost per casemix-adjusted separation	**$2885**	**$3184**

An examination of the number of full time equivalent staff per 1000 persons in this report also identifies that staffing numbers in Queensland are lower than the Australian average for every occupational group bar one (Domestic and other staff).

Extract from Table 9A.7 Average Full Time Equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals) 2002-2003[25]

Category of Staff	Qld	Aust Average
Salaried Medical Officers	0.9	1.0
Nurses (all registered and enrolled)	3.9	4.3*
Other personal care staff	0.2	0.1
Diagnostic and Allied Health	0.9	1.4
Administrative and Clerical	1.2	1.6
Domestic and other	1.7	1.5
TOTAL	**8.7**	**9.8**

(Totals do not add up - reproduced as presented in table)

*In Victoria where there is a mandated 1 to 4 nurse/patient ratio in all major public hospitals the number of nurses per 1,000 population is 4.5. This is a significant difference. Resident population for 2003-2003 financial year (i.e. as at 30 June) was 3764000 for Qld and 4894000 for Vic. And the number of nurses employed in Queensland public hospitals can therefore be calculated as 3764 x 3.9 for Qld = 14679.6 FTE and 4894 x 4.5 for Vic = 22023 FTE. To bring Queensland public hospitals to the nurse staffing levels provided in Victorian public hospitals would require an additional 2258.4 FTE and to bring Queensland to the national average in terms of nursing staffing an additional 1505.6 FTE positions would be required. Note, NSW data was not provided for 2002/2003, but according to data provided for 2001/2002 there were 4.5 nurses employed in public hospitals per 1000 population in NSW in that year.

25 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005, Table 9.A.7*, Canberra.

It is essential that the significant deficiency in nursing numbers employed by Queensland Health across all settings be addressed as a matter of urgency to enhance the quality of services provided within the agency and stem the wastage of nurses from the system. Although data that highlights the magnitude of the nursing staffing deficiency in Queensland Health is only available for public hospitals, it is our strong view that similar deficiencies exist across all practice settings, most notably in community health and other non acute care settings. There has been a failure on the part of Queensland Health to devise an appropriate tool for workload management that can be applied in non acute settings such as community health. (This issue will be addressed later in the submission in the section dealing with nursing workload matters.) For some years now there has been an agreed model for establishing nursing staffing numbers (Minimum Care Hours Model) in State Government Nursing Homes and we assume that this is still being appropriately implemented. This does only represent a minimum standard however and we strongly believe that as part of an examination of nursing staffing numbers for the whole of Queensland Health an assessment be made of the Minimum Care Hours Model to ensure adequacy of nursing staffing numbers in that setting.

RECOMMENDATION (Increasing nursing numbers in Queensland Health)

It is recommended that:

As a matter of urgency there be an increase in Full time equivalent registered and enrolled nursing numbers to bring nursing staffing numbers across all settings in Queensland Health up to the national average as an interim measure and then to levels employed in Victoria and New South Wales. For public hospitals alone this equates to an additional 1505.6 FTE registered and enrolled nursing positions to bring Queensland public hospital staffing levels up to the national average. (An additional 2258.4 FTE positions would be required to bring Queensland public hospital nurse staffing levels up to Victorian and New South Wales numbers.)

So in terms of both labour costs and labour numbers Queensland Health costs are much lower than other jurisdictions. These lower staffing cost and numbers are all the more astounding given that additional costs are incurred because of the decentralised nature of Queensland as minimum staffing numbers are required to provide such services in rural and remote Queensland. It is Queensland Health's employees that are subsidising the operation of the system through lower wages and higher workloads. It is our strong view that this is not only inequitable, it is unsustainable and must be addressed as a matter of urgency. This is especially the case when significant shortages exist in nursing and other categories of health workers and attachment to the workforce of those remaining in the system is diminishing because of the increasing incidence of part time work. It is our strong view that one significant strategy of those remaining in the system in coping with unmanageable workloads and the unsatisfactory work environment is by decreasing working hours.

RECOMMENDATION (Improving pay and working conditions for nurses and other employees)

It is recommended that:

Urgent action is taken to significantly improve the pay and working conditions (most notably workloads) of Queensland Health employees.

As we have stated previously in this submission, insufficient attention has been paid to date to the development of appropriate indicators of effectiveness given the undue emphasis paid to the development of efficiency indicators in health. Some effectiveness indicators that do exist (for example, accreditation of health facilities or services) are deficient in some significant aspects and require urgent review and improvement. The QNU believes that particular attention must be paid to the development of more relevant indicators of effectiveness and that much more work is required in this area. This area alone requires significant resources and careful thought and a nationally consistent approach is required.

The impetus for further national reform in health care as promoted by the Australian Health Care Reform Alliance may provide an important opportunity for progress. (QNU is represented on this Alliance by our national union the Australian Nursing Federation.) For example, we believe there is no reason why there cannot be an extension of the methodology utilised to assess cost effectiveness and efficacy of drugs in the Pharmaceutical Benefits Scheme process can not be extended to analyse cost effectiveness and efficacy of other forms of health treatment (such as surgical procedures). In the absence of such a comprehensive and consistently applied approach it is difficult to make an assessment of comparative effectiveness. Yes, assessments can be performed with regard to health outcomes for the population (and the *Report on Government Services* and other reports provide significant data on this) but without a holistic approach that involves examination of the appropriateness of health services provided, it is difficult to fully measure cost or clinical effectiveness or educate the community on such issues in order to engage them in a debate about health service prioritisation.

Effectiveness of performance reporting and monitoring systems

As we have already indicated, we have serious doubts about the effectiveness of current performance reporting and monitoring systems within Queensland Health. This arises from our direct experience of the standard of information that has been provided to us, the difficulty that we constantly experience gaining access to meaningful and timely data from Queensland Health and the over emphasis placed on data that measures efficiency rather than effectiveness.

The adequate measurement of effectiveness is a critically important issue for health unions. The QNU and its members continue to be extremely concerned and frustrated by the way in which we are forced to "do business" with Queensland Health. Lack of access to meaningful and timely information prevents us from participating in a genuine partnership with government to improve the health of Queenslanders. This is a major source of frustration as is an overly bureaucratised "can't do" ethos that pervades the agency. A new approach is required if we are to properly address critically important issues such as nursing skills shortages and improving access to high quality, appropriate and sustainable health services. It is going to become even more critical that we find creative ways to address these challenges given the demographic issues confronting Queensland.

A new paradigm is also required in health given the nature of the work performed and the failings to date of our current systems to appropriately bring together the industrial relations and clinical/quality imperatives at play.

It is especially important that we find mechanisms to adequately capture the contribution made by nurses and other health workers to the effectiveness and quality of health service delivery. With the abandonment of a best practice approach within the enterprise bargaining framework the "quality" agenda within Queensland Health was retained under the guise of its Quality Improvement and Enhancement Program (QIEP) and more recently its Integrating Strategy and Performance (ISAP) Program as well as other programs such as the Clinician Development Program. Effectively this agenda has been taken out of the industrial arena and situated in the "quality" area of the agency. This has significant ramifications for nurses and other "knowledge workers".

It is our firm view that their contribution to the improvement of health services in Queensland Health has not be adequately captured and hence nurses have not been sufficiently rewarded for this contribution. One interpretation of this

change in approach is that this has certainly assisted in the containment of costs and hence sustaining of Queensland's comparatively low spending on public health services.

There has been a multiplicity of agendas and mechanisms within health that in part impinge upon or attempt to amend the work of nurses but there has been a failure to adequately link or consolidate these avenues. For example, we have been heavily involved in recent years in the Ministerial Nursing Recruitment and Retention Taskforce and the implementation of strategies arising from that process. The inter-relationship between this process and established industrial relations consultative processes and the quality improvement agenda have been at times difficult to reconcile because of Queensland Health's reluctance to see the links between the agendas . Indeed parallel processes have in fact been operating and it has not yet been possible to capture everything under one umbrella. The QNU believes that a significant opportunity to integrate approaches was missed when Queensland Health decided to move away from the "best practice" framework that was identified under the first enterprise bargaining agreement. The result has been a lack of integration, piecemeal approaches, duplication of effort, frustration with flawed processes, loss of trust (resulting in damaged relationships) and frustration with lack of progress by all parties. A fresh approach is required prior to embarking on our next round of EB negotiations.

It is recommended that:

RECOMMENDATION (Adoption of new approach to deal with nursing issues)

Prior to the commencement of the next round of enterprise bargaining with Queensland Health government enter into discussions with QNU regarding the adoption of a new holistic approach to nursing workforce and industrial relations issues.

Organisation and delivery of clinical support services

Comment has been made earlier in this submission about the provision of support services to clinical areas, especially with regard to the perception that there has been a proliferation of administrative positions in recent years (in particular those situated in or attached to corporate office). An analysis of Queensland Health's *Finance and Activity Statements* for Public Hospitals, Residential and Related Facilities was conducted as part of the QNU's preparation for the arbitration for EB5. Analysis of data for the period 1991/92 to 1999/2000 shows that employment of staff by Queensland Health in total grew by 9.8% during that period. However, when you look at employment numbers by categories of staff this data indicates that during this period nursing numbers decreased by 0.4%, salaried medical officer numbers increased by 67.8% and administrative staff numbers increased by 59.1%. We do not have access to data beyond 1999/2000 to enable us to extend this comparison to the present time but believe such analysis is essential. Although we have significant reservations about the accuracy of Queensland Health's employment data limited information is available to us upon which to make a judgement.

There is also a critical need for an agency wide analysis of existing gaps in support services. For example, members of the QNU in some areas of Queensland Health complain about inadequate administrative support at the clinical unit level that results in nurses being diverted from clinical duties to undertake administrative work. When this issue is raised with local management the response is often that such support can be provided if it comes out of nursing staffing numbers – that is, nursing numbers have to decrease to provide this support. Nurses are usually reluctant to agree to this given their workload pressures – they cannot afford to

give up needed human resources required for clinical service delivery. There have been similar disagreements over the years with regard to operational staff support, but this usually relates to role boundaries and task demarcations. (We are able to provide numerous examples of role boundary and task demarcations that require further attention. For example, there has been a longstanding problem at Royal Brisbane and Women's HSD about some wards persons refusing to "tie off" linen bags prior to removal from the ward area.)

Given the issues about workforce needs and skill mix outlined in documents such as the Queensland Health strategic plan and *Health 2020* policy documents it is imperative that we have sound data upon which to plan for the future needs of Queensland Health. This must include an ongoing evaluation of the appropriateness of skill mix and numbers to support clinical service delivery.

RECOMMENDATION (Analysis of staffing numbers by occupational group)

It is recommended that:

There is an urgent analysis of Queensland Health's staffing numbers by occupational group, including a comparative analysis of HSD and corporate office numbers. This must also include a gap analysis of areas of need with respect to support provided in clinical services.

Risk management systems

The QNU does not have concerns about the resource materials that we have sighted regarding Queensland Health's Integrated Risk Management Policy. From what we have seen the written documentation appears consistent with Australian and New Zealand Standards on Risk Management.

We are however most concerned about the application of the policy and the level of organisational commitment to the proper implementation of this policy. Despite the fact that the approach aims to achieve good practice with regard to the management of risk it is not surprising to the QNU that staff would view this framework as another management fad (and a complex and lengthy one at that). It can be viewed as management attempting to "force downwards" another responsibility for staff in the absence of a genuine commitment "from above" to resource the process or act on deficiencies in a timely and meaningful way when problems are identified. You need to look no further than the spectacular risk management failures currently being identified through the Bundaberg Hospital Commission of Inquiry to see that there are problems with the implementation of this framework.

Particular issues of concern relating to the implementation of Queensland Health's risk management framework include:

- The complexity of the risk management environment within Queensland Health and the need to make this more "manageable" for staff (and hence "owned" by them) and avoid unnecessary duplication of effort. There needs to be truly one integrated program for quality and risk management – they must not be seen as separate from each other;

- There must be a truly integrated approach to risk management that addresses risks for both patients and staff who work in the system. For example, security and workplace health and safety risks are not captured adequately under the current framework. It is our understanding that clinical systems risks are captured in PRIME and then fed into the Enterprise System. This is funded and managed by Queensland Health and it is compulsory for staff to utilise the system. On the other hand security and workplace health and safety risks (while reported via the IMS system) are then not captured in the Enterprise System. Therefore proper data is not available for review. This means that

serious incidents that affect staff are not being captured and addressed appropriately, resulting in a serious deficiency in the risk management framework. For example, the very recent death of a nurse following an assault by a patient at the Gold Coast Hospital was not reported to Corporate Office of Queensland Health as this is not required under the current system because it involved only one death. This is an extremely serious deficiency that must be addressed as a matter of urgency. As it stands now Queensland Health is failing to meet Australian Standards. The current double standard also sends a clear message that the safety of patients has a higher value to Queensland Health than the safety of their staff;

- The need for significant cultural change within Queensland Health to facilitate the establishment of a culture of risk management. The need for cultural change is paramount given that quality and risk management are primarily workforce activities. Management must demonstrate their support for genuine staff participation in such processes through the provision of sufficient time and resources;

- The need for more resources to be provided for risk management (e.g. the appointment of additional specialised senior staff dedicated to risk and quality, establishment of meaningful feedback mechanisms, provision of ongoing staff awareness and training etc);

- Management must demonstrate a clear commitment to acting promptly and appropriately to address risk for there to be staff confidence in and commitment to risk management;

- There needs to be a more sophisticated and diversified approach to the development of strategies to treat risk—at present there appears to be a tacit acceptance of many risks because alternative (and more appropriate) responses are either too costly or seen as being too complex to address. (Rather than this being a conscious/active decision to accept the risk it is often the case that risk can be accepted for want of making an active decision to do otherwise. In such instances the "doing nothing" option equates to risk acceptance);

- Improvements need to be made to existing policies and processes if there is to be faith in the risk management system. For example, a clear and unambiguous policy regarding staff complaints about clinical practice concerns must be implemented and adhered to. This must include the provision of adequate protections for "whistle blowing" staff;

- More support must be provided to the development of policies and procedures that facilitate the reporting of adverse clinical incidents so these can be quickly identified and addressed appropriately. The QNU is very concerned that recent events at Bundaberg Hospital do not hinder the genuine reform of the health system so that adverse events are appropriately dealt with through the adoption of a genuine "no blame" culture and proper patient/client empowerment;

- There needs to be a much clearer understanding of the responsibilities with respect to risk management, especially regarding accountability areas and the relationship between these areas within the agency;

- It is essential that robust systems be developed to assess compliance and whether those risk management strategies in place are actually resulting in the better management of risk.

To date Queensland Health's risk management policies are in large part viewed as window dressing—documents that look good on paper. They must be given effect if we are to rebuild public (and staff) confidence in Queensland's public health system.

RECOMMENDATION (Review of Queensland Health risk management framework)

It is recommended that:

There be a review of Queensland Health's risk management framework and that it is amended as necessary to ensure efficacy and staff confidence in it. In particular, there need to be urgent enhancements to the current risk management framework to ensure that all risks are appropriately identified, treated and monitored (eg security and health and safety risks to staff).

Quality and safety systems

There are a significant number of concerns that the QNU has regarding current quality and safety systems within Queensland Health, some of which have already been highlighted in this submission. In our view this area requires particular and careful attention by this review given that "Promoting a healthier Queensland" is the reason for Queensland Health's existence and quality and safety systems are central to achieving this objective.

The significant quality and safety systems failures identified in the Bundaberg Hospital Commission of Inquiry highlight significant problems that need to be addressed. There are fourteen separate programs within Queensland Health dedicated to improving the quality and safety of services: Clinical Audit, Clinical Information Systems, Clinical Pathways, Clinician Development, Credentials and Clinical Privileges, Collaborative for Healthcare Improvement, Infection Control, Informed Consent, Integrated Risk Management, Measured Quality, Measuring Quality in the Non-Government Health Sector, Pressure Ulcer Prevention and Wound Management, Queensland Health Medication Management Services and Telehealth. (The Bundaberg investigation is likely to identify issues of concern relating to ten or more of these program areas.) There are also specific projects operating at the Zonal, HSD and facility levels.

These safety and quality programs are essential—indeed we would argue for them to be extended. However, they all amount to nought if the culture and resources are not provided throughout the whole organisation to meet their stated objectives of these programmes. The primary focus of the system should be that of the provision of quality care for the "clients" of Queensland Health. To the QNU the issues that need to be urgently addressed to facilitate a genuine client focus and culture of continuous improvement include:

Cultural changes within the organisation: There is a need for openness and transparency within the agency and a culture that values critical analysis, not dissuades it. Health professionals should be encouraged to think and debate issues. Indeed it is their professional obligation to do so. Adequate human resources and systems at the clinical level must be provided if we are to move beyond a "tick the box" approach to quality and safety.

Provision of adequate human and other resources: Quality health services cannot be provided if there is insufficient staff at the clinical level to do so. Inadequate nursing numbers remains an ongoing serious concern for the QNU and its members.

The level of member concern about this issue is highlighted by the research undertaken by the University of Southern Queensland for the QNU in 2001 and 2004. Nurses are frustrated and angry because they cannot consistently provide a standard of care to their professional satisfaction.

Previous evidence provided in this submission highlights that nursing numbers in public hospitals alone would have to increase significantly to reach the national average or the numbers currently in place in Victoria and New South Wales.

Review of adequacy of current tools to assess quality: The QNU has held concerns for some time now about the adequacy of tools such as ACHS accreditation. In our view this tool does not adequately address issues such as workloads and appropriateness of skill mix for example. There is a requirement that a process is in place to monitor workloads but there is not an examination of the efficacy of such processes. Accreditation is held out to the public to be an indication of quality and we fear that this can be misleading and give a false sense of security. Bundaberg HSD is ACHS accredited.

Genuine teamwork that includes acknowledgement of the contributions made by various team members must be in place: It is crucial that an environment of valuing is established. The twenty first century health system must be based on a genuine model of team work. There is no place for medical dominance (or dominance by any other occupational group) of the system. This is not to say that the contribution of medical officers to the system is not important, but it should not be assumed that they, by pure virtue of their qualification, must always assume the leadership or top management role.

The recent offensive criticism by the AMA about nurses holding the position of District Manager and Head of the Division of Surgery at the Royal Brisbane and Women's HSD highlight the anachronistic attitudes that must be overcome. Just because someone holds a medical degree does not means that they have the necessary skills or aptitudes to hold a management position.

Although there is some commonality, different skill sets are required for clinical and administrative functions. This is not to ascribe a higher or lower value to either—just to acknowledge the difference and value the contribution that each makes. Central to this is the issue of the wielding of power within the system and the need for improved accountability —two significant issues that must be brought out into the open and tackled head on.

Quality and safety initiatives and improvements must be linked to industrial relations processes: As stated previously, the quality and safety enhancements achieved within Queensland Health must be captured for industrial relations purposes. As "knowledge" workers such outcomes are the fruits of the labours of health workers. We must re-establish the best practice approach to such matters that was briefly commenced in EB1. This is of course inextricably linked to improving openness, transparency and accountability mechanisms as well as establishing properly functioning and valued teams.

Processes must be better integrated within Queensland Health and there must be clarity about agendas and linkages: The QNU is concerned that there is no clarity going forward about where responsibility for quality and safety will lie. For example, how does this link in with ISAP (Integrating Strategy and Performance) initiatives arising from the *Smart State Health 2020* directions statement? The philosophy underpinning ISAP is supported but again it is not integrated with other areas of activity.

Health unions are not integrally involved in driving the strategy and it appears (from the outside) that it is being imposed from above rather than being built from below. (Resources are required at the grassroots level to drive genuine reform of the kind envisaged in ISAP.)

The importance of getting this issue back on track cannot be overstated—this is about ensuring sustainable, quality, patient centred health care into the future.

The *Smart State Health 2020* and the resultant current Queensland Health Strategic Plan were mismanaged from the outset and this has resulted in a lack of faith in these important documents by staff and health unions. You can have all the fine words in the world but they must be backed up with actions that are consistent with them.

Inconsistency in approach must be addressed: The inconsistency that exists regarding issues such as processes for the regulation of health professionals within Queensland has been a source of serious concern for the QNU for some time now. Differences between the way in which doctors and nurses are currently regulated in Queensland (the comparative processes/policies of the Medical Board of Queensland and Queensland Nursing Council) have been highlighted at the current Morris inquiry.

Another discrepancy that has recently come to our attention is inconsistency regarding processes to ensure compliance with legislation requiring mandatory criminal history checks for health professionals. We are advised that the Queensland Nursing Council (QNC) has introduced policies and procedures to give effect to this legislation but this has not occurred for other health professionals. Ensuring compliance with such fundamental legislative requirements that impact directly on safety and quality must be urgently addressed.

Existing regulatory mechanisms that underpin safety and quality must be strengthened: In our view there are currently significant systemic inadequacies in the overall regulation of health professionals that seriously impact upon the provision of safe and high quality health services. One such deficiency is the failure of the QNC to regulate so called "third level" nursing workers—those people who are providing nursing services but are currently not licensed to do so by the QNC. These workers may be employed as Assistants in Nursing or under other titles such as Personal Care Workers or Carers. These workers may or may not hold qualifications and they may or may not work under the direct or indirect supervision of a registered nurse. They are primarily employed in the aged care sector in Queensland but in recent years their numbers have been increasing in public and private hospitals and public and private community based services.

For many years now the QNU has argued that these workers must be regulated by the QNC—failure to do so provides a real opportunity for the undermining of standards of care. It has been our experience that substitution of licensed workers with unlicensed personnel has been increasing in recent years as a response to budgetary pressures and workforce shortages. This lack of appropriate regulation of all people who provide nursing services is a serious deficiency that must be addressed as a matter of urgency.

Quality and safety initiatives must regain prominence at the national level: It appears that the national agenda for safety and quality in health care has stalled in recent times. For example, the Safe Staffing Project of a few years ago conducted by the Australian Council for Safety and Quality in Health Care appears to have gone nowhere. A consultation paper was produced, organisations like the QNU made submissions and participated in local consultations and since that time have heard no more.

It appears to us that issues such as staffing levels are too politically contentious and therefore are placed in the too hard basket. Similarly the safety and quality movement nationally has to us at least, not appeared to have responded adequately to serious systems issues highlighted by the McArthur Health Service issues in NSW and now the Bundaberg Hospital Inquiry in Queensland. The QNU has always been a strong supporter of the work and objectives of the Australian Council for Safety and Quality in Health Care but now we fear that

confidence in their work could be being undermined by perceived inaction on vitally important issues.

It is recommended that:

RECOMMENDATION (Improving safety and quality)

This review makes specific recommendations aimed at improving safety and quality within Queensland Health. In particular, strategies must be implemented to:

build a supportive culture within Queensland Health where critical analysis is encouraged;

provide adequate human and physical resources to ensure that safe care can be delivered and quality can continually improve;

review current tools used to assess quality and amended as necessary to ensure adequacy;

encourage genuine teamwork and valuing of the skills and contribution of all team members;

directly link safety and quality to the agency's industrial relations processes;

better integrate the multitude of existing agenda that relate to safety and quality;

address existing inconsistencies in approach with regards to the current regulatory policies and processes for health professionals;

extend the current regulatory regime for health workers to ensure that all who are delivering health services are appropriately regulated;

encourage better coordination and consistency between activities regarding safety and quality at the state and national level to ensure that this receives the appropriate level of priority.

Clinical audit and governance systems

The QNU does not claim to have detailed knowledge of Queensland Health's clinical audit and governance system. This arises in large part from the disconnect that has existed for some years now between industrial relations processes and the clinical activities of the agency. While we see these issues as inextricably linked, there has in large part been a failure by management in Queensland Health to acknowledge this.

These concerns have been dealt with in some depth in this submission. The main point that we wish to reiterate is that we cannot be expected to have a detailed position on such issues given that we have been effectively excluded from deliberations about these matters and denied access to meaningful information about them. We will however make some broad points about what we believe constitutes good governance and how this can be improved in Queensland Health.

It is the case that defining the principles of good governance is difficult and can be controversial. There are some models that appear to be almost universally accepted, one of these being principles espoused in the United Nations Development Program (UNDP "Governance and Sustainable Human Development, 1997"). The five principles of good governance contained in this document have been summarised is the table below.

Five Principles of Good Governance[26]

The five good governance principles	The UNDP text on which they are based
1. Legitimacy and Voice	**Participation** – all men and women should have a voice in decision-making, either directly or through legitimate intermediate institutions that represent their intention. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively. **Consensus orientation** – good governance mediates differing interests to reach a broad consensus on what is in the best interest of the group and, where possible, on policies and procedures.
2 Direction	**Strategic vision** – leaders and the public have a broad and long-term perspective on good governance and human development, along with a sense of what is needed for such development. There is also an understanding of the historical, cultural and social complexities in which that perspective is grounded.
3 Performance	**Responsiveness** – institutions and processes try to serve all stakeholders. **Effectiveness and efficiency** – processes and institutions produce results that meet needs while making the best use of resources.
4. Accountability	**Accountability** – decision-makers in government, the private sector and civil society organizations are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organizations and whether the decision is internal or external. **Transparency** – transparency is built on the free flow of information. Processes, institutions and information are directly accessible to those concerned with them, and enough information is provided to understand and monitor them.
5. Fairness	**Equity** – all men and women have opportunities to improve or maintain their wellbeing. **Rule of Law** – legal frameworks should be fair and enforced impartially, particularly the laws on human rights.

The QNU believes that Queensland Health falls short of exhibiting good governance with respect to each of the five areas detailed above. This is not to say that improvements in governance have not been made in the past 10-20 years, but rather that much more needs to be done.

The deficiencies with regard to governance arise primarily from problems with culture (discouraging critical analysis, debate and genuine input into decision making), lack of openness and transparency and lack of consistency of approach

26 Graham, J, Amos, B and Plumptre, T, *Principles for Good Governance in the 21st Century* Policy Brief No. 15. - Institute on Governance, Ottawa, Canada, page 4.

that relates in large part from the failure to establish one policy framework, especially in relation to management of the agency (e.g. the handling of HR and IR matters). We cannot see any way that this can be improved until there is one accountable employing entity established for the agency rather than the plethora of HSD decision makers that currently exist. Although we support the devolution of authority and the promotion of innovation at the local level this must occur within a consistent policy framework.

Our concerns outlined above in the section on quality and safety are also of relevance to the consideration of clinical governance matters. Queensland Health appears to have greater success at devising clinical protocols that should be consistently implemented (although the extent to which there is compliance with these is unknown by QNU) but the same cannot be said in relation to HR/IR matters. There are HR/IR policies that are devised at the corporate office level but these are subject to interpretation at the local level. There is no mechanism to ensure compliance.

Recently the QNU became aware that a "Board" has been established at Corporate Office level. It is our understanding this is a large board of over 20 members that reports directly to the senior management team in corporate office and therefore is a key influencer of policy and direction and would obviously fulfill an important governance function. (To our knowledge there is no nursing representation on this board.)

The QNU has not been formally advised (let alone consulted) of the function and terms of reference for this group. This is of concern to us as this is obviously a key group. The lack of consultation with the QNU on the establishment of such an important body highlights to us the extent to which our relationship with the agency has broken down. This is despite one of the strategic intents of the current Queensland Health strategic plan being to "build healthier partnerships", including partnerships with health unions. In recent times the QNU has made numerous requests to representatives of Queensland Health for a briefing on their new organisational structure and governance structures as we do not have a clear understanding of this. To date these requests have not been met.

It is appreciated that this systems review of Queensland Health may recommend changes to the structure and governance of Queensland Health. In any case, health unions will need to first be briefed and then consulted on any proposed structure (even if the structure remains unchanged). Given that we have not been able to secure such a briefing and consultation to date we request that this inquiry recommends that this occurs.

It is recommended that:

This inquiry recommends that health unions be at first briefed and then consulted about the organisational and governance structures in Queensland Health as soon as possible/practicable given that this review may recommend changes in these areas.

RECOMMENDATION (Appropriate consultation with health unions on proposed changes in Queensland Health)

Terms of Reference for this inquiry

To specifically review:

2. *Clinical workforce management systems to deliver high quality health services, with a particular focus on:*
   Recruitment
   Retention
   Training
   Clinical leadership and
   Measures to assist in improving the availability of clinicians

In recent years the QNU has been particularly active in campaigning on nursing recruitment and retention issues. Our campaign started in earnest with the production of a detailed submission *Issues of Concern to Nurses (1997)* prepared as a political lobbying document in the lead up to the 1998 Queensland election. It was through lobbying around this document that the QNU secured a commitment from the then Labor opposition to establish a Ministerial Nursing Recruitment and Retention Taskforce. This taskforce and its successor (the Peak Nursing Body) have improved coordination between various key stakeholders in nursing in Queensland and have facilitated the implementation of a variety of strategies that have in some ways improved the recruitment and retention of nurses in this state. However, it is our firm view that strategies implemented to date have been insufficient to adequately stem wastage from nursing from the health and aged care sectors in Queensland. More urgent attention is required.

Recruitment and retention activities have been greatly undermined by Queensland Health's continued insistence (until recent times) to deny the very existence of a nursing shortage in Queensland. This has been despite irrefutable independent evidence to the contrary. The significance of the impact of this denial cannot be overstated. The impact has been felt in a number of ways. Firstly, it has resulted in nurses and the QNU feeling as if they inhabit a parallel universe to Queensland Health. The department's stated position (that there is no nursing shortage because the Nursing Recruitment and Retention Taskforce had addressed all the issues and there was no need for further action) was diametrically opposed to the daily lived experience of nurses.

This has had a powerful demoralising effect and resulted in a fundamental breakdown in trust. How can you trust someone who constantly denies your reality, especially given the obvious reason for this is to contain costs as the shortage happened to coincide with a bargaining period for nurses? How can trust be rebuilt when the acrimony arising from this denial has been so sustained? The damage to the relationship with those nurses who remained in the system while their employer repeatedly denied that there was any problem will be hard to repair. Of course some have been lost from the system totally or have decreased their hours of work in order to cope with the work intensification arising from the refusal to address such an obvious problem. Many of those remaining in the system suffer from extreme cynicism. A response that the QNU has heard from many members about this inquiry is "why should we bother to have a say as nothing ever changes".

Nurses interpreted the subtext of the denial of the nursing shortage as being a denial of the contribution and worth of nurses. The other important consequence of this denial is that valuable time has been lost for the development and implementation of strategies to aid recruitment and retention. This will require additional resources to repair relationships and damage done by failing to acknowledge the very existence of the problem.

The impact of the failure to implement adequate strategies to improve nursing recruitment and retention of nurses across all sectors in Queensland is highlighted by the findings of the latest research on QNU members conducted by the University of Southern Queensland (USQ). The first USQ research project was conducted late in 2001. (The QNU has already provided you with a copy of the summary of findings from this research.) The latest research was conducted in October 2004 and the report from this research has only recently been finalised and will be launched at the QNU conference on 13 July 2005.

When we met with Mr Forster shortly after the announcement of his inquiry he advised us that he was keen to be provided with a copy of the research findings as soon as it is available. We are therefore providing this inquiry with a copy of the full report prior to its public release **on the proviso that it be treated in strict confidence and not provided to Queensland Health.** The full report of this research can be found at Attachment 4. The department is keen to receive a copy of the findings of this research and we wish to determine when this is provided to them. It certainly will not be provided to Queensland Health prior to it being presented to members at conference. We request the opportunity to meet with the inquiry separately to discuss the findings of this research and how it may be incorporated into this review.

It is recommended that:

RECOMMENDATION (Further consultation with QNU prior to finalisation of Systems Review)

The Queensland Health Systems Review team meets with representatives of the QNU as soon as possible to discuss the findings of the University of Southern Queensland research into QNU membership and other matters relating to our submission so that the issues highlighted and possible strategies to address them can be discussed prior to the finalisation of your report.

This research supports the QNU's contentions that serious problems exist that impact upon the recruitment and retention of nurses in Queensland Health. These problems include, but are not limited to the following:

- unsustainable workloads impact upon the ability of nurses to deliver quality individualised care;
- unsupportive and unsafe work environments (especially the current high levels of workplace violence) must be addressed as a matter of urgency;
- remuneration and conditions of employment must be improved and inequities addressed;
- deteriorating morale of nurses that contributes to wastage of nurses from the system;
- ensuring access to appropriate ongoing education and development for nurses.

Please refer to the attached research report for further details of the findings of this important research. The report includes an excellent literature review that provides a comprehensive summary of the issues affecting contemporary nursing and the recruitment and retention of nurses. It should be noted that the USQ research findings are supported by other independent Queensland research on nursing recruitment and retention conducted by Dr Gary Day from Queensland University of Technology (*The determinants of staff morale among registered nurses in a convenient sample of acute health care facilities*). We have a copy of Dr Day's research findings and would be happy to provide this to you should you experience difficulty accessing this.

It is obvious to us that the work environment of nurses must be fundamentally changed if we are to address nursing shortages by improving the recruitment and retention of nurses. Central to this is changing the existing culture of

Queensland Health, an issue that has already received considerable attention in this submission. It is of extreme concern to the QNU that it appears that Queensland Health continues to deny the root causes for the wastage of nurses from the system. For example, the recently released paper prepared by Queensland Health for the Morris Inquiry titled "Enhanced Clinical Roles" refers to unidentified "research" that indicated *"that nurses were leaving the profession due to a lack of opportunities to fully utilise skills, experience and knowledge gained through their university training."*[27] Some nurses may be leaving nursing for this reason, but our research indicates that the principal reason for nurse wastage is unsustainable workloads and nurses feeling unable to deliver high quality individualised patient care. Wastage of nurses will not be addressed until such time as this is acknowledged and addressed.

Likewise, talk of expanded roles for nurses is premature until deficiencies in the actual number of nurses employed by Queensland Health are first addressed. As we have demonstrated earlier in this submission, for Queensland public hospitals alone to reach the nursing FTE staffing numbers of Victoria and New South Wales it would require an additional 2258.4 FTE nurses and to reach the national average an additional 1505.6. FTE nurses must be employed. Genuine role expansion for nurses cannot occur until this is rectified.

Some of the specific issues highlighted above will be elaborated on in more detail later in the report. Firstly however, we wish to provide some background information on the Peak Nursing Body and specific strategies that can be progressed through that body to improve the recruitment and retention of nurses.

The QNU wishes to place on record our support for the continued operation of the Peak Nursing Body (PNB) and funding of those existing initiatives that have been implemented under its auspices. The issue of the relationship between the PNB and other consultative mechanisms (e.g. those associated with enterprise bargaining) need further close examination and should be the subject of further negotiations. This will certainly be required if Queensland Health proceeds down the path of interest based bargaining. Linkages to other (potential external) mechanisms will also be required if nurses are to play, as has been suggested recently by the Premier, a key role in the re-building of Queensland Health.

It is our strong view that although the Nursing Recruitment and Retention Taskforce has been in many ways successful, the funding allocated to date for recruitment and retention strategies has not been sufficient. The actual structure of the Taskforce process and collaborative approach this engendered meant that some very good and important work was undertaken jointly between Queensland Health and the QNU. Most of the work that has been done to date through this process has largely related to improving processes or HR matters. These required little funding but improved functioning.

When it has come to the implementation of recommendations that would require funding (such as addressing workload pressures through the employment of more nurses or reducing services to match demand with supply of nurses) then progress has been inadequate in most Queensland Health workplaces. We strongly believe that significant improvements will not be made in recruiting and retaining nurses until this is adequately budgeted for.

Importantly a number of recommendations of the Queensland Nursing Recruitment and Retention Taskforce (which reported in 2000) have only in part been implemented and some have not implemented at all. We therefore

27 Queensland Health (2005) *Enhanced clinical roles* (paper provided to Morris Inquiry), page 4.

believe it is essential that specific targeted funding aimed at improving nursing recruitment and retention be provided. This should include the allocation of funding to address areas of particular priority including strategies to:

- ensure the maintenance of appropriate nursing workloads for nurses in all practice settings, with particular attention being paid to the funded backfilling of nurses for periods of planned and emergent leave and the appropriate allocation of non-clinical time for nurses;
- provide sufficient resources to enable nurses to access in-service training, education and professional development (e.g. the backfilling of nurses to enable them to be released from their wards/units to attend education and training as well as the provision of appropriate ongoing clinical support at the ward/unit level);
- plan and implement appropriate nursing skill mix and workforce redesign, with particular emphasis on the expansion of innovative roles such as Nurse Practitioners (in all practice settings) and other advanced practice roles for both Registered Nurses, Midwives and Enrolled Nurses;
- continue to expand the number of school based Youth Health Nurse Programmes and investigate other innovative primary health roles for nurses such as nurse health and safety screening and immunisation programmes in child care centres;
- improve the level of clinical support provided to new graduates;
- better coordination of the employment of new graduates;
- undertake a review of the current classification structure with particular emphasis on comparative analysis of roles and responsibilities with other occupational streams in health (in particular there is an urgent need to address the longstanding anomaly that exists between Nursing Officer 3 and Professional Officer 4) and the appropriate integration of Enrolled Nurses and Assistants in Nursing into the current Nursing Career Structure in conjunction with the review of skill mix and workforce redesign foreshadowed by the *Queensland Health Strategic Plan 2004-2010;*
- extend the Remote Area Nurse Incentive Package both in terms of including new locations and extending coverage to include Enrolled Nurses and Assistants in Nursing;
- extend funding allocated for nursing research projects to aid the development of innovative patient focused models of care;
- specific funding be allocated to undertake new research on issues on nursing turnover, absenteeism and morale within Queensland Health given that research on these matters was undertaken some years ago under the auspices of the Nursing Recruitment and Retention Taskforce and that this data is now not current;
- improve succession planning for nurses (This cannot be addressed adequately until such time as deficiencies in the areas of training and skill development for nurses are addressed.).

It is recommended that:

RECOMMENDATION (Strategies to improve nursing recruitment and retention)

The funding for existing nursing recruitment and retention being progressed by the Peak Nursing Body be continued and that specific additional funding be allocated to address serious deficiencies with respect to:

- establishing appropriate enforceable nursing workloads across all practice settings;
- enabling nurses to access required education, training and development;
- providing adequate support to new nursing graduates and improved coordination of new graduate employment;

- extending the implementation of innovative care models (e.g. Nurse Practitioners) across all practice settings and ensuring appropriate nursing skill mix;
- continue to expand the school based Youth Health Nurse Programme and investigate other innovative primary health roles for nurses such as nurse health and safety screening and immunisation in child care centres;
- reviewing the nursing classification structure to address longstanding anomalies with other like occupational groups (e.g. Professional Officer stream) and include Enrolled Nurses and Assistants in Nursing in the structure;
- improving the Remote Area Nurse Incentive Package both in terms of localities and categories of nurses included (extend to include Enrolled Nurses and Assistants in Nursing);
- extending funding for nursing research to facilitate the development of innovative patient centred models of care;
- undertaking new research on issues on nursing turnover, absenteeism and morale within Queensland Health;
- improving succession planning for nurses.

Nursing workloads

Work intensification and the need to establish safe nursing workloads continue to remain the principal issues of concern for QNU members in all sectors. The recent findings of research conducted by the USQ confirm this. Data from the *Report on Government Services 2005* quoted earlier in this submission highlighted starkly that the number of FTE nurses employed in Queensland public hospitals per 1000 population (data was only provided for public hospitals) falls well below the numbers provided interstate.

This data indicates that to bring Queensland public hospitals to the nurse staffing levels provided in Victorian public hospitals in 2002/2003 (and in 2001/2002 for NSW) would require an additional 2258.4 FTEpositions. To bring Queensland to the national average in terms of nursing FTE staffing an additional 1505.6 FTE positions would be required. As there are no significant Casemix or activity differences in Queensland this must mean that Queensland nurses are working much harder than their interstate counterparts. We fear that quality of care and nursing morale is suffering because of work intensification. This gross inequity could be easily addressed if Queensland Health would appropriately implement the agreed nurse staffing tool.

Despite the fact that we reached agreement with Queensland Health some years ago now on a tool that would facilitate the matching of supply with demand for nursing services, the issue of appropriate workload management for nurses has not been satisfactorily resolved for the whole agency. Queensland Health has repeatedly failed to show good faith in negotiations with the QNU regarding the implementation of an agreed mechanism to manage nursing workloads—the Business Planning Framework: Nursing Resources (BPF:NR). In particular there has been a reluctance to consolidate "whole of agency" data that would enable the matching of nursing resources with demand for nursing services within Queensland Health. The BPF:NR requires each unit/ward where it can be applied (there are some limitations to its application) to draw up a service profile which should incorporate the matching of demand for services with supply of nursing personnel and thus safely manage nursing workloads.

Unfortunately we have experienced widespread difficulties with the implementation of the BPF:NR. In some cases senior management at the facility level have refused to sign off on many individual service profiles. We have also experienced difficulty in accessing all service profiles. There is also

no consolidation of this information into one document (or if it is, the QNU is not provided with it) that would facilitate meaningful discussions on required nursing staffing numbers on a "whole agency" basis that could then feed into budget submissions to Treasury.

Although Queensland Health should be acknowledged for the resources provided to date to train nursing staff on the implementation on the BPF:NR, a fundamental issue of concern remains—the level of commitment from Queensland Health to the actual implementation of this agreed workload management tool. The approach from most District Health Services is to use the tool to ensure that they stay within budget for nursing resources rather than match demand for nursing services with supply of nursing personnel. Again, it appears to our members that the rhetoric espoused during the training provided by Queensland Health is not matched with the management response when it comes to actual implementation of the tool. The cynicism of nurses that results from this failure to yet again appropriately implement an agreed tool has significant potential to undermine the confidence of nurses in it and therefore pressure will increase for the implementation of blunt tools such as a 1 to 4 patient nurse ratio that has been introduced in major Victorian public hospitals.

Components of the tool are also utilised in isolation and this results in the objective—establishment of safe nursing workloads—not being achieved at most Queensland Health facilities where it is applied. This results in our members, who have received education on how the tool should be utilised, becoming increasingly despondent and cynical as they see the management manipulation of this tool. In summary our major concerns about the inappropriate implementation of the BPF:NR are:

- the lack of preparedness of management at many facilities to "sign off" on the service profiles that have been developed at unit level;
- delays in implementation, selective utilisation of aspects of the tool and the creation of deliberate confusion by some in management positions;
- lack of adequate provision for backfilling to allow for mandatory training for nurses—to our knowledge no facility or district has allocated sufficient hours in their calculation of "non-productive nursing hours" to cover even the mandatory education/in-service that nurses are required to attend each year (a minimum of five days);
- in some Districts nurses cannot take annual leave or long service leave because there is no capacity to provide backfill;
- the backfilling of nurses taking emergent sick leave is becoming an increasing problem. This is because budgetary restrictions do not enable the engagement of casual/agency staff (e.g. insufficient allocation has been made to cover sick leave in non-productive nursing hours calculations);
- there are also increasing reports of attempted manipulation of the BPF-NR process through creative rostering. For example, we are seeing more "swiss cheese rosters", a phenomena whereby the roster is produced with the correct number of nurses for the bed occupancy but many of the nurses on the roster are not actually available to present to work due to other commitments. This is a slightly different scenario to the general problem with backfilling where it is assumed that the roster was prepared with the intent of everyone being available. In the case of "swiss cheese rostering", it is known beforehand that many of the shifts won't actually be worked.

Since 1999 minimum nursing staffing levels at State Government Nursing Homes have been calculated with reference to the 'entitled hours per day by resident

category' model that was in place for all nursing homes prior to enactment of the *Aged Care Act 1997*. The minimum rostered care hours for residents are:

RCS Category 1	3.857hrs
RCS Category 2	3.357hrs
RC3 Category 3	2.786hrs
RC4 Category 4	1.857hrs

The number of residents at each RCS category is multiplied by the minimum hours provided for that category to calculate the total minimum care hours for a roster period. **Given that this model has been in place for some years now we believe that it is appropriate for it to be enhanced by utilising other agreed workload management tools. It is our view that** the Business Planning Framework processes **should/**may be used to supplement the minimum care hours to be rostered.

RECOMMENDATIONS (Addressing nursing workload concerns)

It is recommended that:

Queensland Health be directed to use the complete Business Planning Framework: Nursing Resources tool to determine appropriate allocation of budgets for nursing services within Queensland Health.

Specific funds be provided to facilitate the urgent development of a workload management tool for those areas where it is not possible to implement the Business Planning Framework: Nursing Resources in its current form (e.g. community health settings, Emergency Departments and Outpatient Departments, Intensive Care Units, Integrated Mental Health Units, Operating Theatres and Day Surgery Units).

The Business Planning Framework be used to supplement the minimum care hours model used for determining nursing staffing in State Government Nursing Homes.

Funding for future increases in wages and conditions of employment

There is general acceptance, both nationally within Australia and internationally, that there is a current shortage of nurses willing to work in the nursing profession.

The only exception to this was, until recently, Queensland Health, as they consistently refuse to recognise any nursing shortage in Queensland. This is even despite the finding of the Australian Industrial Relations Commission (AIRC) in its arbitration under Section 170MX of the *Workplace Relations Act 1996* regarding Queensland Public Health nursing (Print PR931289) in which the Commission found that "... our acceptance that there are shortages and there are consequences of these shortages causes us to also accept that public interest and industrial merits considerations are raised by the circumstances of this case" (PR931289 at [58]).

In considering the necessary funding for wages and conditions for nurses in the lead up to the imminent enterprise bargaining negotiation, government must be mindful that the recognised nursing shortage is projected to be exacerbated over time. Government must also be mindful of the movements in wages and conditions throughout Australia that will result in Queensland public sector nurses falling significantly behind their interstate colleagues by October 2005. (The Section 170 MX Awards covering nurses employed by Queensland Health and the Mater Public Hospitals in Brisbane expire on 25 October 2005.)

It is useful to observe the views expressed by the AIRC in relation to interstate comparisons of wage rates as a relevant consideration. The AIRC stated: *It is appropriate, almost necessary, to have regard to the market rates applying*

to nurses as reflected in the enterprise bargains which cover them. This is especially so in circumstances where there is a national shortage of nurses and some mobility and transference of skills and qualifications. (PR931289 at [93])

While at the time of this arbitration the Commission believed it was placing Queensland in a relatively competitive position in the national market as far as wage rates were concerned (PR931289 at [95]), the following tables strongly indicates that this position will have changed substantially by October 2005. Three tables (EN highest pay point, RN Level 1 highest pay point and RN Level 3 highest pay point) have been compiled by the QNU from the various applicable certified agreements in each state/territory. For the sake of brevity only three examples have been selected. These are representative of the majority of Queensland Health's nursing employees. Comparisons of nursing positions can be provided to this inquiry upon request.

INTERSTATE COMPARISON

INTERSTATE COMPARISON – 1 October 2005
Enrolled Nurses Pay Point 5

State	$ per wk	$ diff/wk	% diff/wk	Rank
QLD	697.85			7
NSW	778.91	81.06	11.6%	4
VIC	790.00	92.15	13.2%	3
SA	790.45	92.60	13.3%	2
WA	NA			
TAS	721.80	23.95	3.4%	6
ACT	814.84	116.99	16.8%	1
NT	778.23	80.38	11.5%	5

INTERSTATE COMPARISON – 1 October 2005
Level 1 Registered Nurse Pay Point 8

State	$ per wk	$ diff/wk	% diff/wk	Rank
QLD	986.35			7
NSW	1139.51	$153.16	15.53%	1
VIC	1040.40	$54.05	5.48%	4
SA	1041.07	$54.72	5.55%	3
WA	1,034.86	$48.51	4.92%	5
TAS	975.59	-$10.76	-1.09%	8
ACT	1106.50	$120.15	12.18%	2
NT	1029.59	$43.24	4.38%	6

INTERSTATE COMPARISON - RN L3.4 as at 1 October 2005

State	$ per wk	$ diff/wk	% diff/wk	Rank
QLD	1233.35			8
NSW	1537.67	304.32	24.7%	1
VIC	1328.90	95.55	7.7%	5
SA	1394.00	160.65	13.0%	3
WA	1420.37	187.02	15.2%	2
TAS	1242.90	9.55	0.8%	7
ACT	1351.50	118.15	9.6%	4
NT	1282.40	49.05	4.0%	6

As at 1 October 2005, an Enrolled Nurses Pay Point 5 in Queensland will rank seventh in Australia – the lowest in the country. (Please note: no strictly comparable data is available for Enrolled Nurses in WA as they are not covered by one nursing award/agreement in that state. However, the weekly rates of pay for

ENs in WA as at 1 October 2005 are: EN Point 4 - $751.10 and Advanced Skills EN - $801.00. [28]) As at 1 October 2005 a Registered Nurse Level 1 Pay Point 8 in Queensland will rank seventh on a national wage comparison, marginally ($10.76) in front of Tasmania. Similarly, as at 1 October 2005 a Level 3 Pay Point 4 Registered Nurse will rank eighth on a national comparison. It is evident throughout Queensland Health that the differential wage increases awarded by the AIRC in their arbitration relating to Queensland public health nurses has resulted in relativities between nursing classifications being significantly disturbed and that pre-existing anomalies between the Clinical Nurse classification (NO2) and those nursing classifications at the NO3 level have been exacerbated. The outcome of this compression of relativities has been a significant increase in the inability of Queensland Health to attract Clinical Nurses into higher positions, either through higher duties arrangements or through open merit selection.

It is in the interests of both nursing and the Queensland Government to correct these wage inequities created by the compression of these relativities to ensure that the incentive for career enhancement is maintained throughout the nursing career structure. Funding will need to be specifically earmarked in the budget to address these inequities and anomalies.

The creation of the Enrolled Nurse (Advanced Practice) classification has also resulted in an impediment for Enrolled Nurses progressing to the Advanced Practice level. Unfortunately, Queensland Health, at facility level, has failed to embrace this classification by creating sufficient numbers of positions to allow all Enrolled Nurses deserving of movement to this level the ability to advance. This is despite the minimal wage differential between the top paypoint of the Enrolled Nurse classification and that of the Enrolled Nurse (Advanced Practice). The artificial cap placed upon the number of Enrolled Nurse (Advanced Practice) positions has created significant disenchantment amongst Enrolled Nurses that is unnecessary and avoidable.

Just as it is appropriate, indeed necessary, to have regard to market rates applying to nursing rates of pay, such consideration needs to expand to nursing conditions of employment also. It is in the interests of both the nursing profession and the Queensland Government to ensure that in the current environment, both the wages and the conditions of employment applicable to nurses in Queensland are such that Queensland maintains a competitive position to ensure that we can attract and retain highly skilled nurses into the Queensland public health system. This includes key entitlements such as qualifications entitlements being applied equitably across nursing classifications.

RECOMMENDATION (Resourcing the reform process in Queensland Health)

It is recommended that:

The government allocate sufficient funds to fully meet the costs of "reforming" Queensland Health and also to fully meet the cost of necessary improvements in nurses' wages and conditions for the enterprise bargaining negotiations scheduled for the second half of 2005.

Funding for nursing education

It is appreciated that the bulk of responsibility for the funding of registered nurse education lies with the federal government given the transfer of this to the university sector some years ago. The state government can however make a significant difference in some discrete areas of nursing education by providing targeted strategic funding.

Three particular areas requiring targeted funding are ongoing education and training for employees of Queensland Health; refresher and re-entry courses

28 AG 290 of 2004, *LHMU Enrolled Nurses and Nursing Assistants Department of Health Industrial Agreement 2004*, clause 15 (2).

for nursing; Enrolled Nurse and Assistant in Nursing education. Although the responsibility for some of this will fall to the TAFE sector it is relevant that the issues be raised in this submission as it is hoped that this review can make recommendations to government on issues that will improve the functioning of Queensland Health even though responsibility for delivering the strategy will lie with another agency. The QNU made recommendations to the Queensland government on these matters in the budget submission we provided in the lead up to the 2005/2006 state budget. As we cannot determine from the budget papers whether the government has decided to act upon our recommendations, we believe that it essential for us to restate these issues now given that the budget may not have allocated funding to address these issues. (We have requested clarification of the status of our recommendations from the Minister for Health.)

Queensland Health has a responsibility for skill enhancement and ongoing education and training for its existing employees. This will be particularly important given the significant agenda for workforce reform pre-empted in the *Smart State Health 2020* document and Queensland Health's current strategic plan. It is essential that this education, training and development be based on identified areas of skill shortage yet at the same time seek to bring about the necessary cultural change required within Queensland Health. Given that it is likely there will be some potentially significant role changes or enhancements or an increase in the number of advanced practice roles (for example the introduction of more Nurse Practitioner positions) it is essential that health unions be involved in the planning of the education, training and development agenda from the outset. It is therefore essential that mechanisms be established to facilitate adequate consultation with health unions.

Better use of the skills of existing nursing personnel will be critical to the future health service delivery in Queensland Health. It is therefore extremely important that research of existing and needed skills underpins the health workforce planning process. The lack of available data to accurately plan future nursing workforce needs has been acknowledged by the Victorian government. They commissioned the Australian Institute of Health and Welfare (AIHW) to undertake a Victorian nursing workforce study to underpin future workforce planning, especially in relation to existing skill levels and skill gaps. This study (*Nursing Labour Force Victoria 2003*) was released in late 2004 and is available from the AIHW website. The QNU strongly believes that such independent research is required in Queensland and recommends that the AIHW be commissioned to undertake a Queensland nursing labour force study.

It is our understanding that current budgetary processes allow for the inclusion of "proxy" funding amounts to cover issues such as provision of support to new graduates to facilitate an appropriate transition to work. The allocation that is determined at central office level for built in funding for support of new graduate nurses is now insufficient. It has not been increased from the amounts initially determined some years ago ($1500 for metropolitan based new graduates and $3000 for rural/remote based new graduates). Insufficient funding has also been allocated for support of nursing students while on clinical placement. Current levels of support for new graduates and nursing students are woefully inadequate. Queensland Health has been advised repeatedly of our concerns on this issue at both the facility and corporate office level and yet insufficient action has been taken to address these concerns.

We have no doubt that significant resources will need to be allocated by Queensland Health towards education and ongoing development of their staff. Queensland Health's staff are, after all, their most valuable asset. Longstanding

inequities between health occupational groups regarding access to ongoing development and training must be addressed as a matter of urgency. It is often difficult, for example, for nurses with a clinical case load to be released to attend training and education, especially if there is no established standard entitlement to leave for this purpose. Often they are forced to do this in their own time and at their own expense by accessing external education providers.

Why is it, for example, that the majority of the cost of obtaining a post graduate nursing qualification is met by the individual nurse through the PELS scheme whereas medical officers undertaking post-basic specialty education have the majority of their educational expenses paid for by tax payers as Queensland public hospitals remain the primary setting for ongoing medical specialty training and development? The cost burden for ongoing education for nurses is largely borne by them whereas this expense for ongoing medical education is largely met by government. How can this inequity be sustained, especially given the longstanding nursing skills shortages? In the past we have often argued unsuccessfully that PELS fees for post graduate nursing qualifications in areas of nursing skills shortage be ceased until such time as the shortages are addressed. The federal government has refused to implement this option, instead implementing a small number of part and full scholarships.

The state government has recently acknowledged the need to address the shortfall in undergraduate medical student numbers when they announced the bonded scholarship arrangement with Griffith University School of Medicine. The QNU strongly believes that such a scholarship arrangement is also warranted for both undergraduate and postgraduate nursing positions. Now that the precedent has been set for medicine in Queensland we eagerly await a similar response from the Queensland government to address the nursing skills shortage.

There is also a precedent for the Queensland Government acknowledging and funding the ongoing training, education, development and support needs of staff in other government departments (see the recommendations arising from the review of child safety in Queensland).

Frontline staff in the Queensland Department of Child Safety now receive a comprehensive orientation and annual specified minimum time "off line" each year to undertake ongoing staff development and education. We understand that funding for this staff support is factored into the budget for this department and it is our strong view that a similar minimum entitlement must be introduced for Queensland Health staff. Like the contact front line staff in the Department of Child Safety, frontline clinical staff in Queensland Health must be backfilled to enable them to attend such education, training and development and this backfilling must be adequately factored into budgets.

Re-entry and refresher courses

There are thousands of qualified nurses in Queensland who are currently not employed in nursing who may be able to be attracted back into the profession if adequate recruitment and retention strategies are put in place. One strategy utilised successfully by other state governments is to meet the costs associated with refresher and re-entry courses for registered and enrolled nurses. Queensland Health facilitates the placement of re-entry programmes for nurses absent from the workforce for more than five years but does not meet costs of the Competence Assessment Service Fee for participants as other states do. Instead Queensland Health offers interest free loans to participants to meet this cost. We believe this cost impost provides an unreasonable barrier and should be waived until such time as nursing shortages within Queensland Health are fully addressed.

EN education

The role of the Enrolled Nurse (EN) in Queensland has expanded significantly in recent years (e.g. the course curriculum has been expanded to include medication endorsement) and yet we believe that insufficient use is currently being made of ENs in this state. This is in part due to reluctance by some in management to fully utilise the expanded role and also because Queensland is in our view producing insufficient numbers of ENs at present.

We firmly believe that nursing shortages could in part be mitigated by better skill mix of nursing staff and increasing the number of funded places for EN training would go a long way to achieving this. (We understand there certainly is the demand for such courses to justify additional places being offered.) Queensland Health and the Department of Employment and Training jointly fund 150 places for EN training per year. QNU believes the number of funded EN training places offered should be increased to 400 per year from 2006.

The fee for service costs of EN courses ranges from $8000 to more than $10,000 and are full fee paying as HECS does not apply. Given the significant demand for these courses we believe the government will easily be able to fully recover costs associated with increasing place numbers. However increasing place numbers is only part of the solution and targeted scholarships that pay full course costs should be provided for particularly disadvantaged groups (e.g. Aboriginal and Torres Strait Islander people, long term unemployed and low income earners) to enable them to undertake the study. The QNU is Currently involved in discussions in relation to a proposal for a pilot Enrolled Nurse cadetship program to be funded by the Department of Employment and Training and is fully supporting this initiative.

Training for Assistants in Nursing

The nationally endorsed Community Services Training Package and Health Training Package include a range of qualifications that have been developed for unlicensed health care workers. For example, an area requiring particular funding attention is that of Certificate courses for Assistants in Nursing (AINs). These are offered by the TAFE sector and private training providers.

The *National Nursing Education Review Report* released in 2004 has recommended that all currently unlicensed nursing workers be required to attain a mandatory minimum qualification (at Certificate 3 level) and undergo criminal history checking by police. Given that it is likely that state and territory governments will soon be called upon to demonstrate how they intend to address this recommendation we believe that the necessary funding be allocated to meet this requirement as soon as possible.

There is a precedent for this in Queensland: when changes to the *Child Care Act* mandated similar requirements the then Minister secured funding to meet the cost of providing the necessary minimum educational requirement for all existing child care workers in Queensland. We believe similar funding is now required for all existing unlicensed workers in aged care, including AINs. Although Queensland Health has allocated funding to some of its existing employees to enable them to undertake certificate courses, there is a need for such support to be provided for those AINs employed in the private and not-for-profit sectors in Queensland, especially in aged care. Just as a community safety issue exists for children in Queensland a similar community safety issue also exists for similarly vulnerable older Queenslanders in care. A scholarship programme should also be established to meet the full course costs for those from targeted disadvantaged groups not already in the health and aged care workforce who wish to obtain a qualification to secure employment in that sector.

We welcome the fact that the Queensland government is committed to addressing areas of significant skill shortages through its Smart VET programme. This has been exhibited by the recent release of the Green Paper *Queensland's proposed responses to the challenges of skills for jobs and growth.* There certainly is potential to address skills shortages in nursing through innovative educational programmes that provide for a pathway into nursing. However further specific attention must be paid to a number of issues that will need to be addressed before this can be properly facilitated such as articulation, recognised prior learning issues and an evaluation of utilising the VET in Schools Programme for the health and aged care sectors. The depth and breadth of the skills shortages in nursing remains the greatest of all occupational groups. In view of the predicted increased demand for nursing personnel arising from population growth and the general ageing of the population, we strongly urge the government to give priority attention to funding workforce education and training needs for nurses.

The QNU is particularly concerned about the introduction of new vocational education and training qualifications which involve nursing work that are being approved by the Department of Employment and Training without adequate consultation with the QNU. For example, a diploma in medical assisting qualification has recently been approved by the Department of Employment and Training. This qualification incorporates nursing activities into the role of receptionists in medical centres. The course was developed and approved without consultation with the QNU, and we understand that there was no consultation with any nursing body in Queensland in relation to the course content.

It appears that courses are being developed and then rolled out in a very *ad hoc* manner. There is an urgent need for this to be better coordinated and based on unambiguous and cogent evidence from the health and community services sector on actual workforce skills needs rather than anecdotal and one off advice. Why should new courses be developed when there are existing categories of health personnel (such as Assistants in Nursing) that currently are not supported in achieving existing certificate based qualifications? The QNU recommends that this Union be involved in the development of any course proposals that involve nursing work.

Separate work has and is being done within Queensland Health and outside it to address workforce concerns in the health and aged care sectors. We believe tere is an urgent need for government to facilitate a coordinated approach to this issue through funding the establishment of a representative industry body involving all key stakeholders. (There is a precedent for this in other sectors: the Queensland Child Care Forum facilitated workforce planning and the development of a strategic plan for the child care sector.) Such a body would also facilitate the achievement of the broad objective of improving partnerships and coordination of services across sectors as is envisaged in the current Queensland Health Strategic Plan.

RECOMMENDATIONS (Staff education and development and workforce planning)

It is recommended that:

The planning and development of future education, training and development programmes for Queensland Health employees be informed by the establishment of an appropriate consultative mechanism involving key stakeholders such as health unions.

Proxy allocations used within the Business Planning Framework: Nursing Resources (e.g. for new graduate support, training leave, other forms of leave) be urgently reviewed to ensure they adequately cover the true costs incurred particularly at peak times of demand; further, that following review of such proxy allocations and necessary amendment of the tool, sufficient budgetary

allocation be provided by Treasury to ensure the appropriate and consistent implementation of Business Planning Framework: Nursing Resources across all of Queensland Health.

The Australian Institute of Health and Welfare be commissioned to undertake a Queensland nursing labour force study that will inform nursing workforce planning for Queensland Health.

The Queensland government fund scholarships for undergraduate and post graduate nursing students (based on the recently announced arrangement between the Queensland Government and Griffith University School of Medicine) in order to begin to address nursing skills shortages. Further to this that the Queensland government enters into urgent discussions with the federal government with respect to health workforce issues and shortages and in particular seeks to address the current inequities that exists with respect to the funding of post graduate health qualifications.

Queensland Health introduce an ongoing staff education, training and development programme (based on the programme for staff at the Department of Child Safety) where all staff are released and backfilled to attend and that all categories of staff receive equitable treatment with regard to access to such ongoing education, training and development.

Funding is allocated to pay the Competence Assessment Fee for all participants in nursing reentry programmes as is the case in other states.

Funding to increase the number of EN course places offered in TAFE should be increased to 400 per year from 2006. Further this this, that at least 50 scholarships that meet the full course costs be funded by government each year and made available to applicants from specific targeted disadvantaged groups.

There be no further proliferation of new certificate courses for new categories of health workers until such time that there is a comprehensive and evidence based assessment of the training needs of the health and community services sector and whether these needs can instead be met by amending/extending the educational preparation of existing categories of employees. Further to this, that the Department of Employment and Training ensure that the QNU and relevant nursing bodies are invited to participate in course development advisory committees of any proposed health care qualification;

Funding is allocated to enable existing unlicensed care workers in Queensland such as Assistants in Nursing to complete their Certificate level qualification as was provided to child care workers to enable them to meet legislated minimum educational qualifications. Further to this, that at least 50 scholarships that meet the full course costs be funded by government each year and made available to applicants from specific targeted disadvantaged groups who wish to obtain a qualification in order to secure employment in the health and aged care sector.

Specific ongoing funding be allocated for research and consultation with industry regarding important threshold issues for nursing education in the VET sector, including but not limited to examining issues such as articulation, recognised prior learning and evaluating an evaluation of utilising the VET in Schools Programme for the health and aged care sectors.

Priority attention be given to funding workforce education and training needs for nurses.

The QNU be involved in the development any course proposals that involve nursing work.

Specific funding be allocated to establish a broadly representative health and aged care sector industry body (including representation from the QNU) to inform workforce planning for this sector in Queensland.

Work and family issues and the impact on recruitment and retention

Given that the majority of Queensland Health employees are women, strategies that facilitate the balancing of work and family are particularly important to ensure ongoing workforce attachment for employees of this agency. The QNU has argued for many years that the implementation of a comprehensive work and family strategy for Queensland Health is vitally important if this agency is to recruit and retain staff. Rather than this being a "non core" activity (as family friendly initiatives such as child care have been presented by some in the past) this constitutes a core HRM function for the agency. As such significantly more attention must be provided to the implementation of work and family initiatives, especially if Queensland Health is to adequately meet the challenges that are being posed by the ageing of the health workforce.

There are a number of glaringly obvious priority issues requiring attention. These were highlighted in the QNU submission to the Queensland government prior to the 2005-2006 budget and we will briefly restate these in this submission. These are whole of government issues in the main, but are of particular importance to the functioning of Queensland Health given its gender and age profile. To maintain momentum that has been recently lost with regards to progressing the work and family agenda for Queensland, the QNU believes that the following priority areas require attention:

- immediately increasing the paid maternity leave entitlement for public sector employees from six to fourteen weeks , as has recently been granted to public sector employees in New South Wales;
- establishing a representative Queensland Work and Family Forum to continue to drive necessary work and family reform and encourage community debate. This Forum be constituted under the auspices of the Department of Premier and Cabinet so that a "whole of government" approach is taken to this issue;
- establishing a "whole of government" information portal (one stop shop) on services and support available to assist Queenslanders balance their work and family commitments. This would bring together information on services, legislation and helpful information from all relevant state government departments;
- establishing a coordinated approach across all public sector agencies employing shift workers to assist these employees to better meet their child care needs. (This is necessary because the needs of shift workers are largely inadequately met by the existing child care system. It is also an essential strategy to retain those nurses in the 25 to 35 age group, a critical demographic to retain if we are to begin to address the ageing of the nursing workforce.)

RECOMMENDATION (Work and family issues)

It is recommended that:

Funding be provided to:

- introduce 14 weeks paid maternity leave for Queensland public sector employees;
- establish a broadly representative Queensland Work and Family Forum;
- develop and implement a Queensland "whole of government" portal on work and family matters;
- facilitate a coordinated approach to improving child care services for shift workers across all Queensland government agencies.

Safe working environment

The provision of a safe and supportive working environment for Queensland Health staff should be a priority objective of this review. There are significant issues of concern relating to violence towards nurses and other health workers, be this from patients or visitors, management or other workers within Queensland Health. The culture is a sick one and it will take a concerted effort and significant resources to turn it around. The recent research conducted by the USQ on nursing in Queensland highlights the critically important nature of this issue. This review should pay particular attention to the section of this report pertaining to workplace violence towards nurses. Urgent action is required to address this dangerous state of affairs. The importance of this issue cannot be overstated.

Violence

It is acknowledged that the Minister for Health had previously accepted our concerns about the current unacceptable level of violence towards nurses and established a Violence Against Nurses Steering Committee to investigate this issue and report by the end of 2004. The report is still in the process of finalisation and the final recommendations were not publicly available to us at the time of writing. As the QNU is represented on this group we are confident that our concerns will be highlighted in the final report or through a minority report submitted by the union should we be unable to reach agreement on all recommendations. We therefore recommend that adequate funding be provided to ensure full implementation of all the recommendations arising from this review process. It is also likely to be the case that other issues relating to workplace violence will be highlighted through this review, so it may be necessary to augment the recommendations of the Violence Against Nurses Steering Committee report in light of this.

Manual tasks

Queensland Health has invested substantial resources in this area which remains the predominant hazard within the health care environment. While manual tasks still contribute to injuries, anecdotal evidence indicates that the severity of the injuries appears to be decreasing. We believe there is a need for a review and a detailed analysis of the initiatives in place to see if they are working and see if any modification is required. Consideration should be given to funds being made available for regular servicing, preventative maintenance, maintenance and replacement of equipment necessary for safer manual handling.

Workplace harassment

Workplace harassment or workplace bullying is also a major issue for nurses and is no doubt a significant focus of your review. As stated previously, the dominant culture within Queensland Health is one of bullying and intimidation. A "shoot the messenger" attitude is common place and, in general, positive critical analysis is discouraged. There are policies and procedures in place within Queensland Health but these are generally seen as ineffectual, especially given that some in management positions operate from a mindset of bullying and intimidation. Positive behaviour is often not modeled by those in management positions and this has the effect of such behaviour becoming the norm and therefore replicated throughout the system.

Although Queensland Health has a training programme to address the issue of workplace harassment, minimal numbers of nursing staff have received training in this area despite its introduction nearly two years ago. As stated above, clinical demands often make it difficult for nurses to be released to attend such training. If we are to change the culture of Queensland Health much more will need to be done to ensure that all staff access appropriate training and support. All

areas within the department must be instructed to address this issue as a matter of priority and they should all be directed to develop training and development plans to ensure that all staff receives the required training and support within 12 months. The department must demonstrate clearly and unambiguously that workplace harassment will not be tolerated. We believe that one mechanism to help demonstrate this commitment is through the mandatory adoption of the code of practice relating to workplace harassment.

Fitness for work issues

The way in which nursing continues to be treated as a "disposable" workforce is of significant concern to the QNU. This is clearly demonstrated by the number of nurses being retired from Queensland Health Districts because of ill health. The reason given is that they cannot carry out the *full duties* required of them even though many have carried out a meaningful role up until the time they are retired. The QNU intends testing this requirement with the Anti Discrimination Commission in the near future. We do not believe that the issues of general occupational requirements and reasonable adjustment have been sufficiently investigated by this agency. The unfitness from work may result from a work related illness or injury or it may not. If the affected nurse is in the WorkCover system the only avenue available to them is to lodge a claim against Queensland Health under common law and instigate this action if applicable.

It is significant that Queensland Health has not yet adopted *Directive 4/99 Medical Deployment and Redeployment.* (This is unacceptable in our view given Queensland Health's lead agency status and their aim to improve the health of all Queenslanders, including their own employees.) This directive would allow for ill or injured nurses who are able to work to be appropriately deployed to another area with required support. We believe these issues need to be further investigated. As the average age of nurses is now over 42 years and it is become increasingly important to retain older workers in this workforce, particular urgent attention to this matter is required.

RECOMMENDATIONS (Health and safety concerns)

It is recommended that:

Adequate funding be provided to ensure the full implementation of all the recommendations arising from the Violence against Nurses Steering Committee review process.

Funding be allocated for a review and a detailed analysis of the initiatives in place relating to manual handling to ascertain their effectiveness and whether any modification is required. Further to this, that funding is allocated for regular servicing, preventative maintenance, maintenance and replacement of equipment necessary for safer manual handling.

The advisory standard relating to workplace harassment is made mandatory and that Queensland Health Districts be allocated funding to enable the development of plans for the implementation of the standard and the provision of mandatory training for all staff on the code within 12 months.

Queensland Health be directed to adopt *Directive 4/99 Medical Deployment and Redeployment.* Further to this, that funding is allocated to properly investigate fitness for work issues for Queensland Health employees and plan strategies to encourage continued workforce attachment given the ageing of the health workforce and significant shortages that exist in nursing and other health occupations.

Other issues relating to the workplace environment

There are a number of basic workplace amenity issues that continue to be the source of frustration and anger for nurses in Queensland Health. These

relate to issues of inconsistent treatment of staff and failure of Queensland Health to introduce a standardised and equitable response to the concerns of staff. The concerns may not exist at every workplace, but it is the case that a significant number of Queensland Health workplaces do have concerns about basic workplace amenities that are the source of great anger and frustration for staff and hence greatly contribute to deteriorating morale. In our view these issues are easy to fix—there may be some small costs involved but the costs the agency through deteriorating staff morale is a far greater cost to bear (though often difficult to quantify in dollar terms). This should be a high priority for Queensland Health if it is committed to the stated strategic intent of its current strategic plan of supporting the health of their staff.

Commonly areas of particular concern are the provision of:

- appropriate and safe accommodation be provided to staff on an equitable basis where Queensland Health provides this (e.g. in rural and remote areas);
- safe and free/affordable car parking for Queensland Health staff and the equitable treatment of staff with regards to the provision of safe and appropriate car parking. (This may not be a significant problem for all Queensland Health facilities but is a significant issue for many, especially for larger metropolitan hospitals.);
- reasonably priced, high quality and healthy meals for staff, especially ensuring that these are available for shift workers;
- adequate other amenities for staff such as separate meal areas, changing, toilets and showering facilities and access to facilities that assist stress reduction and promote the health of staff (such as access to quiet area, gyms and swimming pools etc);

It is recommended that:

RECOMMENDATION (Workplace amenities)

Queensland Health pay particular attention to ensuring that appropriate workplace amenities are provided for staff and that all staff receive equitable treatment with regard to the provision of workplace amenities. Particular attention must be paid to ensuring the provision of appropriate and safe accommodation for all staff (where this is provided), safe and free/affordable car parking, reasonably priced high quality and healthy meals for staff on all shifts and adequate other amenities such as separate meal areas, shower, toilets and change facilities and facilities that promote the health and wellbeing of staff.

Nursing leadership

The QNU strongly believes that nursing leadership is going to be central to the rebuilding of a positive culture in Queensland Health that will in turn assist recruitment and retention. It is critically important that nurses are lead by strong and innovative nurses. It is especially important that nurses continue to control nursing resources in the system. We are concerned that a view may have formed that the number of nurses in management positions could be decreased and some roles currently performed by nurses in management/coordinating positions (such as rostering of nurses) can be transferred to other categories of staff to perform as this "frees" up nurses to perform a clinical role. Such a view demonstrates a fundamental knowledge deficit about the complexity and variability of the roles that nurses perform in the health system and why career structures have been developed to encompass the richness and complexity of nursing roles.

Nursing encompasses clinical, management, research and educational skills and our career structure has been developed to reflect this. It is disappointing and frustrating in the extreme that nurses must continually be forced to defend the

integrity of our career structure and the multi-dimensional nature of the nursing role. We had this battle in the 1990s when the Goss government attempted to unilaterally dismantle the management stream of the career structure. The arguments have been raised again recently with the lack of recognition provided to nurses with management and leadership qualifications in our dispute with Queensland Health over the payment of qualifications allowance. In the very recent past non-nursing organisations such as the AMA have publicly denigrated the role nurses play in management of the health system. This constant requirement of nurses to justify their roles within the system is indicative of a fundamental lack of valuing of the contribution that nurses make, the multi-dimensional nature of this contribution (beyond the "hands on" clinical role) and the complexity of their roles. Nurses must continue to manage nurses and nursing in the totality. This is fundamental to the delivery of quality nursing services.

Take the example of rostering of nurses. It may appear on the surface that this is a mere scheduling function that can be provided by administrative support officers. It is the case that administrative support and IT systems can assist the performance of this function. However it is vitally important that nurses retain control of this function overall as it is the nursing knowledge of the skill mix and numbers required that are essential to the provision of adequate numbers of nurses with sufficient skills to undertake safely the nursing work required.

There are issues of concern to members about their career structure but these relate to issues such as lack of promotional opportunities and inequities of remuneration compared to other occupational groups rather than a fundamental problem with the career structure itself. Nurses are autonomous health professionals and like other autonomous health professionals they should be the ones to determine if any changes should be made to their career structure and nursing roles. It is not that nurses are not amenable to change, especially if it can be demonstrated that the change results in improved health services or outcomes. Again and again nurses have demonstrated their responsiveness.

Prior to the announcement of this review we wrote a detailed letter to the Director General of Queensland Health expressing our concerns about lack of an integrated and comprehensive nursing strategy and requested that this be addressed as a matter of urgency. The Secretary of the QNU met with the Director General after he received this letter and had a general introductory discussion on the matters raised in our letter. However, shortly after this the Systems Review of Queensland Health was announced and so no further action has been taken to address our concerns.

Although we have provided this review with a copy of the letter sent to the Director General on nursing strategy, we believe it is important that we restate the contents of this correspondence again now given that the issues raised are of direct relevance to the terms of reference for this review. In this letter (dated 20 April 2005) the QNU raised the following concerns with the Director General of Queensland Health which remain of concern to the QNU and must be considered by this inquiry:

1. Model for the office of Chief Nursing Adviser

The QNU has stated on numerous occasions in the past that we favour a restructuring of the office of Chief Nursing Adviser based on the New South Wales Chief Nursing Officer (CNO) model. In New South Wales the CNO is the professional link between the Minister for Health, the Director General and the public, private and education sectors of the nursing and midwifery professions. This position is supported by a number of staff in the Nursing and Midwifery Office (NaMO). Currently there are seventeen staff employed in this unit,

including the CNO, Adjunct Professor Kathy Baker. The role of the CNO and NaMO is to provide advice on professional nursing and midwifery issues and on policy issues, monitor policy implementation, manage state-wide nursing and midwifery initiatives, represent the department on various committees and allocate funding for nursing and midwifery initiatives. Specifically, the CNO and NaMO:

- provide advice on professional nursing and midwifery issues and on policy issues that impact on nurses and midwives, and their practice
- provide advice to the nursing and midwifery professions on the implications of health policy
- manage statewide nursing and midwifery initiatives, for example:
  - promotional activities and career advice
  - recruitment and retention strategies
  - a number of education strategies
  - a number of research projects
  - strategic planning
  - Nurse Practitioner Project
- monitor policy implementation
- manage Nursing DOHRS (Department of Health Reporting System)
- develop and analyse policies on a broad range of nursing and midwifery issues
- provide a resource on nursing, midwifery and related issues to other divisions/ branches within the Health Department
- facilitate effective consultation and communication channels
- represent the NSW Health Department and the nursing and midwifery professions on national and state committees. [29]

This role is much wider than the current role of the Nursing Advisory Unit within Queensland Health. It is our firm view that the role and function of the Chief Nursing Adviser and Nursing Advisory Unit must be expanded along similar lines to the New South Wales model. It will be particularly important that this change takes place to ensure the success of the ambitious agenda for workplace reform and health service delivery (especially managing the inter-relationship between the public and private and not for profit health sectors) outlined in the Queensland Health Strategic Plan and the *Health 2020* Strategy.

2. Reporting relationships

In our view it is essential that the reporting relationships for the Chief Nursing Adviser and their office are clear and unambiguous. Not only is it essential that this position report directly to the Minister for Health and the Director General for Health in the same manner that their NSW counterpart does, it is also essential that nurses within the health system are able to report concerns they may have about critical local nursing matters to the Chief Nursing Adviser if they are unable to resolve concerns with local management. Such a reporting relationship would in our view would help to prevent (or at least more promptly address) systems failures such as those highlighted in the recent Bundaberg Base Hospital debacle.

3. Delineation between Chief Nursing Adviser and Principal Nursing Adviser roles

There currently exists great confusion about the role delineation between the Chief Nursing Adviser and Principal Nursing Adviser roles. The QNU is unsure about who we should contact and in which circumstances and there also appears

29 Source NSW Health NaMO website.

to be similar widespread confusion within Queensland Health and the nursing community at the state and national levels about this issue. This confusion must be resolved as a matter of urgency.

4. Merit selection process for permanent appointment of Chief Nursing Adviser position

In our view it is also essential that the Chief Nursing Adviser position be filled on a permanent basis through an open merit selection process as soon as possible. It is not only the QNU that is concerned about the need for this to occur, many nurses have contacted us to express their concern about this issue. The process for permanent appointment must be open and transparent if there is to be confidence in the independence and integrity of this position. It is noted that this position has recently been advertised locally and nationally. However, confusion still exists with regard to the reporting relationships for the Chief Nursing Adviser and Principal Nursing Adviser roles. This must be clarified as a matter of urgency. It is of great concern to the QNU and our members that the Chief Nursing Adviser position is being permanently filled given the current uncertainty with regard to Queensland Health's structure and in the absence of any review of the current functions and relationships of roles with responsibility for whole of agency nursing advice and leadership. It is therefore recommended that the position of Chief Nursing Adviser not be permanently filled until such time that these matters have been clarified.

5. The provision of adequate resourcing for the Nursing Unit

It is our strongly held view that resources allocated to date to the Nursing Advisory Unit have been woefully inadequate. We have expressed this view in multiple submissions to government in recent years. Our most recent submission to the Queensland government provided late last year in advance of the 2005-2006 state budget preparation outlines our current views with regard to priority resourcing issues for the Nursing Advisory Unit and more widely. Much more can be achieved in terms of the implementation of a rational and sustainable nursing strategy for Queensland if even a modest increase in resourcing were to be provided.

Although progress has been made in recent years as a result of the Ministerial Nursing Recruitment and Retention Taskforce established by the previous Minister more resources must now be provided to properly progress nursing workforce issues in Queensland. The QNU remains extremely concerned that significant momentum has been lost in recent years with regard to the implementation of strategies to address the significant longstanding nursing shortages that currently exist. Inaction and "short-termism" in health and nursing policy are creating self-perpetuating downward spirals of shortages that threaten not only the quality of care provided to the community of Queensland but also the very future of quality nursing services. For this to be addressed there needs to be a clear strategy developed in consultation with all key stakeholders (including the QNU) and adequate resources must be allocated to ensure accountability for the achievement of nursing objectives. This must be properly coordinated and driven by an adequately resourced Nursing Advisory Unit.

6. The role of the Nursing Unit with regard to health workforce restructuring

As the largest single occupational group within Queensland Health and the health workforce generally nurses have a critical role to play in developing innovative, responsive and sustainable models of health care for the community of Queensland. This is even more critical given the demographic challenges confronting us. There is no doubt that there will be a need for new ways of doing things. This has been identified in both the current Queensland Health

strategic plan and the *Health 2020* strategy document. Nurses are committed to providing high quality nursing services now and into the future. Likewise the QNU is keen to collaborate closely with Queensland Health and other providers of health and aged care services in this state to ensure the provision of high quality, appropriate and responsive nursing services.

To do this we need to be closely involved in consultations about the changes that will be required to health service delivery going forward. We are concerned however that the space does not exist for us to do so in a meaningful and ongoing manner. We are concerned that changes in service delivery are occurring without an appropriate framework being in place to ensure adequate input from both nursing services within Queensland Health and the QNU. For example, in recent times it appears that a significant number of clinical service coordination positions have been created at the AO7 level within Queensland Health. To our knowledge there has been no consultation with health unions about these new positions. This is of concern to the QNU as we believe this may point to a more widespread "genericisation" within health that would in our view undermine both the provision of quality health services and the nursing career structure. It is therefore essential that wider issues of health workforce reform feature prominently in our discussions about Queensland Health's nursing strategy and the role of the Nursing Services Unit.

It is recommended that:

RECOMMENDATIONS (Nursing leadership)

The Office of the Chief Nursing Adviser within Queensland Health be restructured so that it is consistent with the model for the Office of the Chief Nursing Officer in New South Wales. Further to this, additional resources be provided to ensure that the office of the Chief Nursing Adviser within Queensland Health can carry out the functions of their New South Wales counterpart.

Reporting relationships between the Office of the Chief Nurse Adviser and the Minister and Director General for Health be reviewed and amended as necessary to ensure consistency with the reporting relationship applying in New South Wales.

There is clear delineation between Chief Nursing Adviser and Principal Nursing Adviser roles, which will be especially important going forward given the importance of nursing leadership if we are to change the culture of Queensland Health. Further to this, that a merit selection process takes place to permanently fill the position of Chief Nursing Adviser but this cannot take place until such time that matters relating to whole of agency responsibility for nursing leadership and reporting relationships between the Chief Nursing Adviser and Principal Nursing Adviser roles are clarified.

The Office of the Chief Nursing Adviser be directly involved in negotiations on workforce restructuring within Queensland Health and that this office ensures the establishment of appropriate consultative mechanisms to ensure the ongoing involvement of the QNU in adequate negotiations of such changes.

Terms of Reference for this inquiry

To specifically review:

3. Performance management systems including as they relate to:

Asset management and capital works planning and delivery
Information management
Monitoring health system outcomes

We have addressed many performance management issues previously in this submission. We will therefore not provide detailed comment on issues relating to this specific term of reference. Rather, we will briefly restate concerns already raised and highlight other relevant issues that have not yet been covered.

Performance management is vitally important, and it is an area where the QNU believes there is room for considerable improvement. Appropriate performance management is made virtually impossible in our view where there is a culture of secrecy and a fundamental lack of openness and transparency as is the case with Queensland Health.

Changing the culture and governance of Queensland Health to ensure that it is open and therefore much more accountable is of critical importance. This is not going to occur easily if there is not a wider systemic change of approach on behalf of government with regard to improving the openness of government in Queensland. Both sides of politics have failed to achieve an adequate degree of openness in our view and it is time for the blaming and buck passing between the parties to stop. When in government political parties try to limit openness and disclosure and when in opposition they cry for more openness and disclosure. The time for political point scoring is over. The problems in Queensland Health demonstrate clearly to us at least what happens when openness and transparency are eschewed and critical analysis and debate discouraged. This is not only dangerous to democracy itself, it can also result in loss of lives when this is the culture in a vitally important public service such as health.

Asset management and capital works planning and delivery

Given the size and complexity of Queensland Health issues such as asset management and capital works are going to present particular challenges. The QNU has certainly noticed some improvements in recent years with regard to asset management by Queensland Health. The government must also be congratulated for the significant capital works programme of the last 15 years. This has been one of the most comprehensive health system capital works programmes in Australia's history. The health service stock had been neglected for decades under National Party rule, so the capital works programme was long overdue.

The Goss and now Beattie governments must be acknowledged for undertaking such a significant rebuilding of public infrastructure, and, importantly, for achieving this through appropriate public borrowings rather than through alternative funding arrangements such as Public Private Partnerships (PPPs). (The experience both in Queensland and interstate has shown that PPPs in health have proved to be a spectacular failure and an expensive exercise for government.) It must also be acknowledged that this capital works programme is continuing and will be boosted further through infrastructure programmes recently announced for south east Queensland. The critical issue for nurses with respect to capital works programmes is that we have early and ongoing input into facility design and commissioning processes.

There are a number of concerns that we wish to highlight regarding capital works planning and delivery and asset management. These relate to the problems that QNU has experienced with regard to building design and the contracting out of maintenance services for many Queensland Health facilities in recent years, and the impact this has had on adequacy of ongoing maintenance and the maintenance of an appropriate number of tradesperson positions and apprenticeships within Queensland Health.

Building design

Our strong view is that it is essential to involve nurses in a meaningful and ongoing way in the design of new buildings and refurbishments. This should occur from the initial planning phases and continue until final commissioning. It has been our experience that when this does occur problems are minimised and the final result is better design and a more user friendly working environment for nurses and care environment for patients. When this does not occur then we encounter sometimes significant problems.

Over the past few years the QNU has spent considerable time negotiating on behalf of members for building designs to be modified or fixed because of health and safety concerns. Examples of issues that have required our intervention include: amenities for staff, redesigning toilets to allow a toilet chair to fit over the bowl, suitable wheels for trolleys that don't require excessive force when pushed over carpet, modifications to plumbing and air-conditioning where chemicals were being drawn through the system, and significant modifications to building design at Bundaberg, Gold Coast and Logan Mental Health Units, to name a few.

Another issue of concern to the QNU is that it appears there is not a consistently applied process for determining and prioritising capital works projects. This specifically applies to rebuilding and refurbishment works for staff accommodation in rural and remote areas. The QNU receives frequent contact from members in these locations about priority afforded to projects and the inequitable treatment of staff with respect to access to staff accommodation. This situation contributes to problems recruiting and retaining nursing staff to work in remote and rural locations. A consistently applied and transparent policy and process for determining access to accommodation is required.

It is important to note that the Beattie government amended the *Workplace Health and Safety Act 1995* in 2003 to extend the obligations of various parties including "designers of buildings or other structures used as a workplace". The aim was to prevent injuries caused by inappropriate design. We believe that minimum design guidelines should be developed specifically for Queensland Health facilities in order to prevent design related hazards.

It is recommended that:

RECOMMENDATIONS (Capital works and maintenance)

Nurses be always included in consultations for the initial design and ongoing commissioning phases of all new capital works and redevelopments to ensure that workplace designs are both patient and health worker friendly.

A consistently applied, equitable and transparent whole of agency approach to prioritising of the development of staff accommodation refurbishment and rebuilding projects and a fair process for determining access to accommodation be developed.

Funding be allocated to facilitate the development of minimum design guidelines for Queensland Health facilities.

Maintenance at Queensland Health facilities

The QNU has been concerned for some time now about the trend within Queensland Health to contract out maintenance services. We fear that this may not be a cost effective practice in the long term and are also concerned that there has not been adequate monitoring or review of the appropriateness of this action. It is especially important that close attention be paid to the adequate maintenance of assets, especially when such a significant amount has been expended on capital works in Queensland Health in recent years.

It is also of significant concern that Queensland Health appears to not be meeting its obligations with regard to the training of new tradespersons in recent years. It is extremely important that Queensland Health, as one of the largest if not the largest employer in Queensland, plays a role in the training and employment of new apprentices. Government agencies play a key role in this regard (especially in rural and remote communities) and have an essential part to play in helping to address the current and projected shortages of tradespeople in this state. The QNU was shocked and dismayed to discover recently that of the total Queensland Health workforce (head count as at December 2004) of **49,327** there were only **169** tradespeople employed by Queensland Health. This is, in our view, a disgrace. Queensland Health must urgently review the employment of tradespeople and proactively plan to contribute to addressing tradespeople skill shortages in Queensland by engaging more tradespeople to carry out asset maintenance "in house" which would in turn facilitate the agency playing a more active role in the training and employment of trades apprentices in this state. The state government has a key role to play in the training of tradespeople. State agencies (such as Queensland Health) have in recent times taken a short term view on training and development needs and the needs of the community as a whole in relation to skills shortages. By refusing to acknowledge they have an important role to play in this regard they have contributed to the current skill shortages.

RECOMMENDATION (Capital works and maintenance)

It is recommended that:

Queensland Health urgently review its policies regarding the contacting out of maintenance services in Queensland Health with a view to increasing the direct employment of tradespeople to undertake maintenance in house and be available to supervise apprentice tradespeople within the agency. Further to this that Queensland Health subsequently significantly increase the number of apprentices that it employs to assist the state to address the significant skill shortages that currently exist.

Information management

Lack of adequate information management by Queensland Health has been a long-standing source of frustration to the QNU. Some of our concerns regarding our inability to access meaningful information upon which to base decisions and our general concern about a culture of secrecy within Queensland Health have already been highlighted in this submission. This is a critically important issue to the QNU. A genuine partnership with Queensland Health is required to re-establish confidence of both staff and the community and this cannot occur until these issues are addressed. One clear example of the long term difficulty we have experienced in accessing information relates to a simple issue such as ascertaining the number of nurses employed by Queensland Health.

Despite being one of the largest Queensland public sector agencies (with the second largest budget allocation) Queensland Health cannot state with any degree of accuracy its actual number of employees at any given time (unless they do a manual head count). It is our understanding that Queensland Health

until very recently was the only government department required to report MOHRI (Minimum Obligatory Human Resource Information) data that could not do so. Even though they are reporting against MOHRI data in the 2003-2004 Annual Report (as is prescribed by the Ministerial Portfolio Statements) we have grave doubts that the data recorded is accurate as they cannot provide us with data on actual numbers of nurses employed and current vacancy levels. It is not uncommon for a number of different figures to be given to us by HSDs when we ask for nursing FTE numbers. We therefore have no confidence in the data Queensland Health provides us with in respect to nursing employees and we wonder whether it is convenient for the agency to not have accurate data available for public scrutiny as this would clearly demonstrate the efficiency gains in recent years by nurses and other health workers and the extent of excessive workloads in that agency.

The QNU receives mixed messages about Queensland Health's capacity to provide accurate workforce data. We are frequently advised by some when we request information from Corporate Office HR/IR Policy and Strategy Centre about nursing numbers (head count and FTE) and nursing vacancies across the state that this information cannot be provided. And then when we attend meetings with other Queensland Health officials we are provided with information on employment numbers. An example of this was that a document was tabled at a meeting of the Queensland Health Workplace Harassment Project Meeting on 8 June 2005 that detailed the number of Queensland Health employees who had attended training about this issue. This document also provided a total "head count" of employees by occupational category for each HSD as at 31 December 2004. We totalled the numbers provided in this document to reveal the following total headcount of employees of Queensland Health by occupational group:

Occupational Category	QH Total Number by Occupation
Professional	5009
Medical	4353
Operational	9555
Administrative	7872
Nursing	21039
Technical	862
Trades	169
Dental	468
TOTAL	49327

Note: It appears from data provided that Northern Downs HSD provided FTE data rather than head count.

Our question is: if one part of the agency can gather and supply this sort of information why can't all areas? It is difficult to determine with accuracy whether it genuinely is the case that Queensland Health's IT and HR systems do not allow them to provide unions with meaningful data or whether they use systems inadequacies as an excuse for not releasing the information to us. For the purposes of this submission we will assume system deficiencies.

How can accurate workforce planning and reporting (e.g. legislated Equal Employment Opportunity reporting against set government objectives) or proper budgeting take place in such an information vacuum? In our view immediately addressing Queensland Health's information deficiencies, especially in relation to human resources, should be a top level priority for the Queensland government.

The current situation represents a critical and ongoing risk for government and until it is addressed a fundamental accountability flaw will continue. Surely this is of great concern to central government agencies. The community of Queensland is entitled to expect that such a significant government agency has accurate and efficient systems for data gathering. Given the IT systems that are now available it is hard to comprehend why this issue has not been addressed by now, unless it is the case that the agency somehow benefits from maintaining the status quo of information ignorance.

Associated with the lack of HR information is the lack of organisational will to address standardised HR and IR practices and policies across Queensland Health. We have been advised for some years now that a standardised HR/IR policy and procedure framework is proposed but have seen little progress towards achievement of this objective. Until this issue is addressed the QNU and other unions will continue to experience extreme difficulty in obtaining compliance with industrial instrument provisions. This is not only a source of frustration for health unions but also their members - the employees of Queensland Health - who are tired of the continual buck shifting between facility/district/zone and corporate office levels. They simply want to cut through the bureaucracy and achieve their rightful entitlements. The current situation destroys relationships and good faith between the agency and unions and the agency and its employees. Surprisingly one Queensland Health official advised us that we should have included our request for the implementation of a standardised HR/IR policy and procedure framework in our last EB claim. This is not a bargaining issue - it represents standard (not even best) HR/IR practice.

The government needs to exercise extreme caution when they state they have employed "extra" nursing positions in recent years. Not only is Queensland Health HR data notoriously unreliable, it should also be noted that it has been estimated by Queensland Health that demand for nursing services will increase by 30% between 2000 and 2010.[30] The number of nurses per 100,000 population in Queensland has decreased in recent years and Queensland Health has also significantly expanded services in some areas of particular population growth or demand growth due to other factors. Given these factors and based on available information we believe it is safe to assume that the number of nurses employed by Queensland Health has been decreasing (or in a best case scenario has remained static), be this in number of full time equivalents (FTE) employed or actual head count of nursing employees. Evidence provided earlier in this submission clearly demonstrates that Queensland Health public hospitals employ far less nurses per 1000 population than the rest of Australia.

There is broad nursing workforce data highlighting the increasing shift to part time work by nurses – over 50% of nurses are now working part time. We also have access to significant Queensland anecdotal evidence on the causes of this major shift through USQ research undertaken in 2001 and 2004. National and Queensland evidence highlights that a significant contributing factor to this change in working patterns is work intensification. Nurses are decreasing the hours they work per week so they can better cope with excessive workloads. When nursing vacancies are not filled those left in the system are expected to cope as management refuses to cut services provided in order to match supply of nursing services with demand. Addressing the causes of decreasing nursing workforce attachment will be central to finding sustainable solutions to the growing demand for services evidenced by indicators such as lengthening waiting lists for elective surgery.

30 Queensland Health Workforce Planning Discussion Paper (2002), *Towards a sustainable supply for Queensland Health's nursing workforce: Recruitment and planning issues for 2000-2010, page 12.*

As stated above, extreme care needs to be taken when interpreting nursing workforce data. For example, the government has stated that they have exceeded their 2001 election promise to employ an additional 1500 new nursing graduates over three years. (A similar promise was again made in the lead up to the 2004 state election.) Yes, it was the case that just over 1500 new graduates were employed in the three year period since 2001 and another 500 are expected to be employed in early 2005. (As of December 2004, 520 new graduates have been employed by Queensland Health during 2004.) However these new graduates have only been employed into existing nursing vacancies and should not be interpreted as the government employing **additional** nurses. This simply has not occurred and has been acknowledged by Queensland Health officials as having not occurred. An examination of the available data demonstrates that these "additional" nurses have not been employed. Queensland Health has admitted for example that it is routine for nursing vacancies in the second half of the year not to be filled so that positions will be available for new graduates in the New Year.

The information we have access to about the number of nurses employed by Queensland Health is based on the actual number of nurses balloted in various EB ballots and Queensland Health Annual Reports and other materials:

Enterprise Agreement	Number of nursing employees Balloted
No 2 – 1996	19,429 (RN, EN and AIN)
No 3 – 1998	23,000 (RN, EN and AIN)
No 4 – 2000	21,062 (RN, EN and AIN)
Qld Health Est for No 5*	19,338
As at Dec 2004**	21039

* If ballot had been conducted
** Based on information tabled at Queensland Health Workplace Harassment Project meeting on 8 June 2005)

Qld Health Annual Report Year	No of FTE Nursing Staff Employed[31]
1998/99	17,048 (RN, EN and AIN)
1999/2000	16,141 (RN, EN and AIN)
2000/2001	16,171 (RN, EN and AIN)
2001/2002	16,280
2002/2003	over 16,000 – no precise figure given
2003/2004	16,831[32]

The QNU strongly believes that this ridiculous situation regarding the lack of availability of meaningful data within Queensland Health must be addressed as a matter of urgency. This is simply an embarrassment for government for this to continue and it must be a particular concern to them given the significant resources previously allocated to Queensland Health for IT systems and staff. We have already provided a recommendation about this issue in an earlier section of this submission.

31 Queensland Health Annual Reports 1998/99 page 8, 1999/2000 page 29, 2000/2001 page 35, 2001/2002 page 28 and 2002/2003 page 37.
32 Queensland Health Annual Reports – Note: 2003-2004 Annual Report FTE figure uses MOHRI data that they say excludes contract/agency staff data.

Monitoring health system outcomes

The issue of national reporting frameworks for public hospitals (and the deficiencies we see regarding lack of development of indicators of equity and effectiveness) has already been discussed previously in our submission. Queensland Health contributes to a number of other health system outcome reporting processes to organisations such as Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics, the Commonwealth Department of Health and the Productivity Commission (for the *Report on Government Services*). It is our understanding that work is under way to achieve better standardisation of data required and provided.

The QNU would support the development of a standardised comprehensive reporting framework for health given that this would help decrease duplication of effort with regards to reporting requirements. The critical point for the QNU are that any performance indicator framework/s for health must be balanced and include robust indicators of equity and effectiveness. Community needs and expectations about health care must always underpin the development of such indicators. To date, undue emphasis has been placed on the development of efficiency indicators and now a concerted effort must be made to develop comprehensive and robust indicators of equity and effectiveness. We also strongly believe that much more can and should be done on the development of tools to promote "evidence based practice" so that informed decisions can be made by consumers and clinicians alike about available treatment options. The work of the international Cochrane Collaboration provides an invaluable starting point for this. To date this resource is largely utilised by clinicians. Much more work is required to further develop the application of evidence based practice by clinicians and increase community awareness of the need to base decisions about treatments on the best available evidence.

The current Queensland Health Strategic Plan provides details (at page 20) of their proposed performance measures. A mixture of measures of health status indicators and health systems performance measures are listed. The health status measures are relatively straightforward and represent a good starting point to reportage on health status and the vast majority of these are already broadly reported on. (No doubt more health status performance indicators will be developed over time. There must however be a rational number of such indicators so that we do not end up reporting for the sake of it, hence the importance of reaching agreement at the national level about what constitute appropriate measures for inclusion.) The measures of health system performance could prove to be more problematic in our view. For example, how can factors such as "Community confidence in Queensland Health" and "Whole of government action that supports health" be accurately measured? We believe that further careful consideration of the "systems performance measures" is required. Why is it not possible, for example, to measure and report upon the perceptions of the performance of Queensland Health by key stakeholders including unions? Also, why aren't measures of the success of Queensland Health's broader role of regulating all health services (including private health and aged care facilities) included? This is a significant deficiency in our view.

It is also of great concern to the QNU that there currently is no overall monitoring of coroner's cases in Queensland. Implementation of recommendations from coroner's cases are not monitored or coordinated effectively. This is a significant deficiency given that the coroner's court is a critically important safety and quality surveillance mechanism. The QNU only becomes aware of cases if our members are involved in them; however this does not capture all matters that may be of interest to us. When we recently contacted the coroner's court to attempt to ascertain how we could monitor cases coming up that may be of interest to the

QNU we were advised that these are publicised in the Law List in *The Courier Mail*. There are a number of problems with attempting to monitor the cases by the Law List in the Courier mail. Firstly, it is difficult to track cases given that they are not listed routinely. Also, very little information is readily available on the nature of the cases. Other deficiencies with regard to coroner's court processes will no doubt be highlighted by the Bundaberg Hospital Commission of Inquiry. We believe that it is vitally important that a simple and transparent monitoring mechanism for coroners' matters must be devised as a matter of urgency.

RECOMMENDATIONS (System performance)

It is recommended that:

In consultation with other key stakeholders there be further development of appropriate performance indicators within Queensland Health, especially indicators that relate to equity and effectiveness within Queensland Health.

As a matter of urgency an appropriate and comprehensive framework is developed for the monitoring and implementation of coroner's recommendations regarding deaths in public and private sector health and aged care facilities in Queensland.

Monitoring health systems outcomes in the private sector

Queensland Health's legislative responsibility to protect the health and wellbeing of Queenslanders includes responsibility for establishing standards and requirements to ensure high quality and safe health services for all Queenslanders. The Union believes there currently exist significant deficiencies regarding the monitoring of health outcomes in the private sector in Queensland. By way of example, the QNU wishes to provide comment about two specific issues of concern in relation to Queensland Health's monitoring of privately provided health care services in this State.

These issues are:

i) the current standards for staffing in private health facilities; and
ii) the proposed changes in Queensland Health policy in relation to administration of medications in residential aged care facilities.

i) Current standards for staffing in private health facilities

In July 2004 Queensland Health published the *Clinical Services Capability Framework for Public and Licensed Private Health Facilities* (SCF). The stated purpose of the document is to 'provide a standard set of capability requirements for most acute health facility services provided in Queensland by public and private health facilities'. The SCF, amongst other things, provides minimum levels of qualifications, skills and experience of medical, nursing and allied health staff required to ensure a safe service.

Of major concern to the QNU is that the SCF does not set minimum staffing levels for all services. For example, while the SCF requires that there is a minimum of two registered nurses on duty at all times when there is a patient in an intensive care unit, the SCF provides for staffing in an acute surgical unit to be determined at the local service/facility level. The QNU is constantly receiving reports from members in private hospitals that nursing staffing levels are inadequate, and in some cases, unsafe. Members, particularly from smaller acute care private hospitals, also regularly report concerns about inadequate access to medical officers in emergency situations.

RECOMMENDATION (System performance)

It is recommended that:

The *Clinical Services Capability Framework for Public and Licensed Private Health Facilities* (SCF) is reviewed as a matter of priority in consultation with the QNU and other stakeholders and amended to include minimum staffing levels and skills mix **required** to ensure safe practice in all service areas.

ii) Proposed changes in Queensland Health policy in relation to administration of medications in residential aged care facilities

The legislative framework that provides for administration of medications in all Queensland health services, along with other standards and controls for scheduled drugs and poisons, is established by the *Health (Drugs and Poisons) Regulation 1996*. The Regulation is made pursuant to the *Health Act 1937 (Qld)*. The Regulation is administered by Queensland Health and operational issues are managed by the Queensland Health Environmental Health Unit. The stated role of the Environmental Health Unit is to develop policies in relation to the management of medications that promote, safeguard and maintain the health and wellbeing of the people of Queensland.

In September 2004 Queensland Health released a draft Policy pursuant to the Health (Drugs and Poisons) Regulation 1996 *Guidelines for the Use of Carers in Helping with Medications (Residential Care Facilities)* for consultation. It is proposed that this document will replace the current Queensland Health policy (Circular No. 03/98). Currently only registered nurses and endorsed enrolled nurses may administer medications to residents who are unable to request assistance to take their medications. The proposed policy allows aged care providers to direct assistants in nursing/other unlicensed staff to give medications to *all* residents in residential aged care facilities.

The QNU opposes the introduction of the proposed Queensland Health policy. The union believes that implementation of the proposed policy would create serious risks to the health and safety of residents, and impose excessive and unreasonable responsibilities on unlicensed nursing staff in residential aged care facilities. The union also believes that the proposed policy does not reflect the legal requirements of the Health (Drugs and Poisons) Regulation 1996.

The carers' provisions in the Health (Drugs and Poisons) Regulation 1996 were introduced prior to changes in Commonwealth legislation that have resulted in dramatically increasing numbers of high care (nursing home) residents in low care aged care facilities (hostels). At the time the Regulation was introduced on 1 January 1997, all hostel residents in Queensland were classified as requiring low levels of care. In September 2000 approximately 29% of all hostel residents in Queensland were classified as high care residents. As at September 2004 approximately 40% of all residents in low care hostels in Queensland were nursing home type residents requiring high levels of care.

The majority of residents classified as requiring high levels of care do not have the capacity to ask for help to take their drugs and are not able to self manage their medications. These residents require their medications to be administered by a registered nurse, or an endorsed enrolled nurse under the supervision of a registered nurse.

The current Queensland Health policy stipulates that licensed nurses with endorsements under the Regulation must administer medications to residents in residential aged care facilities with only high care residents (nursing homes). Despite a statement excluding residential aged care facilities with only high care places from the proposed policy, Queensland Health has not confirmed that aged care providers could be prevented from directing assistants in nursing to give

drugs to residents in facilities/parts of facilities with only high care residents if the proposed policy is implemented.

A survey of QNU members working in aged care facilities has shown that licensed nurses currently administer medications in residential aged care facilities that care for at least 83% of all aged care residents in Queensland. The survey results also confirmed that the endorsed enrolled nurse role is under-utilised in low care facilities (hostels). The proposed policy confers authority on aged care providers to determine whether or not a licensed nurse will be 'available' to administer medications. The Union believes it is not appropriate for Queensland Health to permit aged care providers to decide who will administer drugs to residents in aged care facilities.

Ensuring that appropriate policies remain in place for medication management in residential aged care services is a matter of public interest as it affects some of the most vulnerable citizens of our community. The QNU believes that it is the responsibility of Queensland Health to ensure public safety in relation to the legal requirements for management of drugs and poisons in residential aged care facilities in this State. The proposed policy provides for persons without endorsements required under the Regulation to administer medications to totally dependent residents in aged care facilities. The proposed policy should not be implemented. A copy of the QNU submission to Queensland Health in response to the draft policy has been provided to this inquiry.

It is recommended that:

RECOMMENDATION (System performance)

Any Queensland Health policy related to medication management in residential aged care facilities reference the legislated requirements under the *Health (Drugs and Poisons) Regulation* that dispensed medications are administered by a registered nurse, or by an endorsed enrolled nurse under the supervision of a registered nurse, to any resident in residential aged care facilities who does not have capacity to request help from an assistant in nursing/carer to take their dispensed medication/s.

Conclusion

Thank you again for the opportunity to provide input into this important review. We view this process as a rare opportunity to bring about positive systemic change for health care in Queensland. We place on record again our eagerness to be involved in ongoing consultations during this review process. In particular, we would like to meet with the review team to discuss the contents of this submission, especially the USQ research provided with it, prior to the finalisation of your report.

The QNU is committed to a genuine partnership with government and our members to bring about the improvements needed to health service delivery in this state from both the perspective of nurses as workers in the system and citizens who hold legitimate concerns about current health policy and service delivery.

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Attachments

Attachment 1 – Confidential reports on Individual Health Service Districts and Corporate Office of Queensland Health

Attachment 2 – Case Studies of Queensland Health Culture and Behaviour

Attachment 3 – Background Materials on Best Practice Approach to Enterprise Bargaining in Health

Attachment 4 – Confidential Report on University of Southern Queensland Research conducted in 2004 into Nursing in Queensland