Response to the
Review of Department Governance, Organisational Structures and Capability
(the Hunter Review)

May, 2015
The Queensland Nurses’ Union (QNU) thanks Queensland Health (QH) for the opportunity to make a submission to the Review of departmental governance, organisational structures and capability (the Review).

Nurses and midwives for the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNU is the principal health union in Queensland covering all categories of workers that make up the nursing and midwifery workforce including registered nurses (RN), registered midwives, enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 52,000 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 vast majority of nurses in Queensland are members of the QNU.

The QNU agrees with the issues the review has already acknowledged\(^1\). However, we point out that the LNP government actively excluded us from any involvement in matters related to governance, structures or capability. Despite this, we remain committed to safe, quality health care and we are available for any further consultations on this matter.

In 2005, the QNU made a very detailed submission to the Queensland Health Systems Review (the Forster Review) yet ten years later many of the issues we raised at that time remain relevant. Our concern then, as it is now, is patient safety. In our view, the previous government’s focus on delivering budget surpluses and scaling back the patient safety unit are clear indicators that neo-liberal, market based principles have informed the operation of state-based health care. This is a precarious approach to governance, one that international experience clearly shows can have tragic outcomes. We refer here to the Francis Report of 2013\(^2\) that identified a serious failure on the part of a provider Trust Board in the United Kingdom (UK).

*It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust’s attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.*

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\(^1\) We refer here to the union briefing on 22 May, 2015.

\(^2\) See Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*
Governance

When the LNP government came to power in 2012, its aims comprised:

- reducing bureaucracy;
- reducing waiting times for admission to hospital, specialist consultation and routine surgery;
- ensuring patients were seen by medical specialists and received required surgery within reasonable timeframes; and
- a more efficient Queensland Health.

The methods for achieving this included decentralising the health system by creating autonomous health regions with their own boards of directors who had the power to control operations locally [Health and Hospital Services (HHS)]. Membership of these boards was by direct ministerial appointment, and the government expected them to use an efficient business model. Because Queensland Health (QH), as one of the biggest employers in Queensland, was notoriously cumbersome, the new boards were expected to cut staff and implement targets, the achievement of which became the driving force behind facilitation of many of the changes. All this was put in place between 2012 and 2015, the three years of the LNP government (Shields, 2015).

The changes wrought by the Newman government have had significant effects on the health system, and we welcome a full and formal evaluation to assess if there were indeed any real efficiencies achieved.

We concur with the themes arising from consultations to date that identify:

- Clarity of roles between the Department of Health and HHS is required;
- The authority of the Department needs to be clear, as do areas where HHSs have autonomy;
- Governance structures across the Department (and more broadly the system) require improvement;
- Linked to lack of role clarity, there is a need for a new governance structure that supports decisions that impact the health system as a whole.

A sound governance structure will require strong leadership to promote a significant cultural change. To this end, we welcome the prompt appointment of a Director-General who will put patient safety at the centre of activity. This will require clear strategic vision, one that draws the Department of Health and the HHSs together rather than pursue independent rivalries.
A key fallout of the lack of role clarity has been around effective implementation of industrial relations provisions affecting nursing and midwifery. The QNU is aware of repeated, inconsistent interpretation and application of the award, agreement and Human Resource Management (HRM) policies. This has not only caused confusion amongst nurses and midwives, but it has also led to some HHS staff receiving lesser access to entitlements than others. This is not acceptable industrial practice. Awards, agreements and policies are negotiated with unions, HRM, senior nurses and midwives in a particular context and with specific knowledge of professional and industrial practice.

**Recommendation**

The QNU recommends that the review considers delegating the authority to issue statements to all HHS on interpretations of industrial instruments be delegated to the Nursing and Midwifery Implementation Group (NaMIG) - a group of senior QH HRM staff, Office of the Chief Nurse and Midwifery Officer (OCNMO) and QNU representatives. This is a peak consultative group that has the expertise and knowledge to make such decisions. NaMIG is ideally placed to issue directions or statements regarding all matters on nursing and midwifery arising from their industrial instruments.

We recognise this forum only exists for nursing and midwifery. Other occupational groups may make a request for similar arrangements.

**Capability**

The LNP cuts to staffing have had a significant effect on workforce capability. Around 4,820 positions were removed from the QH workforce, and of those, more than 1,800 were nurses and midwives (QNU, 2015). Although the previous Minister assured the public that his government cut no ‘frontline’ jobs this was patently untrue, with many nursing and midwifery positions lost from wards and units.

Many employees had to apply for their own jobs, setting them up in competition with their co-workers, and staff cuts were so extensive that entire important services such as primary health care disappeared across Queensland.\(^3\) These widespread job losses

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\(^3\) The previous government made it very clear that it was not in the business of primary health care. This was purely a short-term, response to its preference for privatisation of state government services. In our view, there must be a focus on primary care. The long-term sustainability of our health care
caused a significant shortfall in knowledge and experience as staff relocated to other Australian states or left health professions entirely.

With the diminished workforce, there are now not enough staff to safely and appropriately care for patients. Consequently, continuity of care has been compromised, meaning that patients/clients of the health system do not receive the seamless ongoing efficiency needed for effective clinical care (Shields, 2015).

Therefore we are pleased to see that key consultation themes are service quality and the patient safety. The feedback identified patient safety responsibilities are unclear, functions are not aligned and significant simplification is required. This aligns with our consistent calls for nurse/midwife to patient ratios.

For some time, the QNU has expressed concern about the lack of resourcing to monitor patient safety as well as proper organisational coordination of patient safety activities. QH introduced Root Cause Analysis procedures to meet key recommendations of the Queensland Health Systems Review (Forster, 2005) that related to safety, quality and clinical governance with specific emphasis on incident monitoring and analysis. The following are some of the major actions from the review:

- appropriate training in incident investigation, clinical audit, benchmarking and clinical pathway variance analysis;
- review and implement of the incident management policy;
- analyse serious and sentinel events at local and state level (and contribute to national reporting) with a focus on preventing and minimising harm;
- develop and implement state-wide safety initiatives using clinician led networks based on incident analysis;
- provide an annual public report on sentinel events;
- development of legislation encouraging and protecting good quality and safety assurance analysis (Forster, 2005).

As a result of the Forster review, the QH Patient Safety Centre was established and directed to manage, coordinate and implement the above recommendations in order to improve the safety and quality across the state. Implementation of the recommendations was staged and embedded across the public sector over a number of years. This sent a clear message that incident management was integral to quality and safety for patients and staff. The annual public report *Patient Safety From* system will be determined in large part by strategies that shift the emphasis on to health promotion and disease prevention.
Learning to Action commenced in 2006, however, there have been no further reports since 2011 data was published in 2012.

The role of the central Patient Safety Unit (PSU) as it is now called is to provide support services to HHSs and the Department to maximise patient safety outcomes and the experience of QH patients. The PSU has three key priorities which include:

- supporting HHS to meet NSQHSS;
- measurement and reporting; and
- providing advice to HHS, the Department and national patient and safety bodies.

The PSU also has the overall governance and compliance role on behalf of the DG for Quality Assurance Committees (QAC). Unfortunately, there have been significant job losses in the area of patient safety at both the central agency and facility levels and we are aware of several HHS that have not established QACs or have incorporated their functions into the work of other committees.

Clinical quality and patient safety are core priorities of the Department and HHSs yet there remains ambiguity in the roles each perform. The QNU concurs with the Review’s proposal that the Department needs to establish a single area responsible for patient safety.

**Recommendation**

The QNU recommends the establishment of one single area responsible for monitoring, enforcing and reporting on patient safety.

In addition, the QNU seeks compliance with Part 6, Division 1 s82 of the Health and Hospital Boards Act 2011 in establishing QACs.

**Organisational Structures**

While the staff cuts have been the most visible changes to QH, another staffing trend has been the appointment of staff from the National Health Service (NHS) in the UK to many senior management positions. While new ideas from other countries and systems can be invigorating, the preference to appoint previous NHS staff to senior positions has been concerning. The NHS has its own major problems, one of which has
been the promotion of target driven health care as we have already highlighted (British Medical Association, 2005; Mason, Nicholl & Locker, 2010).

Overlaying these types of business principles on to public health systems may appease a government’s need for immediate change, but in the long term they create other difficulties as staff are forced to adopt a target driven approach to clinical care at the expense of safe outcomes.

Public health care is not a business. Queensland Health is not a corporation, despite the previous government’s philosophy that all matters can simply be reduced to cost. Governments have a responsibility to taxpayers which could conceptually equate with shareholders, but public health does not operate for profit. An effective health system that provides equal care for all is a right. Ethically then, it is important that this review revives the true purpose of public health services and encourages an organisational culture that does not place ‘the bottom line’ above all else. Responsible, cost efficient government is possible without forgoing the core professional values of compassion, caring and regard for the human condition both in its role as employer and provider of services.

**Recommendation**

The QNU recommends proper recognition of the nursing and midwifery classification structure by re-establishing senior nursing and midwifery positions and ensuring nurses and midwives report to their professional peers, not other management positions.

We are asking for no more than the previous arrangements that operated effectively.

**References**


