Hospital and Health Boards Regulation 2023

Explanatory notes for SL 2023 No. 100

made under the

Hospital and Health Boards Act 2011
Public Sector Act 2022
State Development and Public Works Organisation Act 1971

General Outline

Short title

Hospital and Health Boards Regulation 2023

Authorising law

Section 282 of the *Hospital and Health Boards Act 2011*
Section 287 of the *Public Sector Act 2022*
Section 173 of the *State Development and Public Works Organisation Act 1971*

Policy objectives and the reasons for them

The objective of the *Hospital and Health Boards Act 2011* (Act) is to establish a public sector health system that delivers high quality hospital and other health services to people in Queensland having regard to the principles and objectives of the national health system. This objective is mainly achieved by:

- strengthening local decision-making and accountability, local consumer and community engagement and local clinical engagement;
- providing for Statewide health system management including health system planning, coordination and standard setting; and
- balancing the benefits of the local and system-wide approaches.

The *Hospital and Health Boards Regulation 2012* (Existing Regulation) prescribes various matters to support the operation of the Act. The Existing Regulation was due to expire on 31 August 2022. The *Statutory Instruments Regulation 2022* exempted the Existing Regulation from expiry until 31 August 2023.

The *Hospital and Health Boards Regulation 2023* (Regulation) has been prepared to replace the Existing Regulation. The Regulation is necessary for the continued effective operation of the Act. The Regulation supports the Act by prescribing various matters including:

- the name of each Hospital and Health Service (HHS) and geographical area covered by each HHS, other than Children's Health Queensland which functions in various areas across Queensland;
- employment matters including arrangements for the movement of staff between health system employers;
- prescribed requirements for health equity strategies, clinician engagement strategies and consumer and community engagement strategies;
- matters relating to the functioning of Hospital and Health Boards (HHBs) such as the requirement for a HHB to have a safety and quality committee, finance committee and audit committee;
- procedures for HHB committees, such as requirements to keep minutes and the conduct of meetings;
- setting requirements for minimum nurse-to-patient and midwife-to-patient staffing in hospitals and minimum nurse and registered nurse percentages and minimum average daily resident care hours in State aged care facilities;
- defining a *reportable event* for which a root cause analysis may be conducted;
- listing of prescribed information sharing agreements under which Queensland Health may disclose confidential information to prescribed entities which evaluate, manage, monitor or plan health services; and
- prescribing certain health professionals who may access confidential patient information through an information system, known as 'The Viewer'.

The Regulation also amends the *Public Sector Regulation 2023* and *State Development and Public Works Organisation Regulation 2020* to update references from the Existing Regulation to the Regulation.

Achievement of policy objectives

The Regulation is largely consistent with the Existing Regulation, with minor changes to improve the operation of the Regulation, reflect contemporary drafting practices and improve clarity and readability.

The key changes in the Regulation include:

- updating the version number of the *Financial and Performance Management Standard* from 2009 to 2019, which outlines the requirements for each HHB's audit committee;
- updating examples of national and State strategies, policies, agreements and standards that are relevant to promoting consultation with health professionals working in a HHS;
- updating the names of certain prescribed government departments and entities such as Medicare Australia to Services Australia;
- expanding the functions of each HHB's safety and quality committee by requiring the committee to monitor how the workplace culture is contributing to the safety and quality of health services;
- updating the names of certain aged care facilities such as Cooinda House to Cooinda House, Kippa-Ring;
- prescribing a number of updated agreements between the Commonwealth, another State, or Commonwealth or State entities that allow for the disclosure of confidential information; and
- removing redundant transitional provisions.

Consistency with policy objectives of authorising law

The Regulation is consistent with the policy objectives of the Act.

Inconsistency with policy objectives of other legislation

No inconsistencies with the policy objectives of other legislation have been identified.

Alternative ways of achieving policy objectives

The Regulation is the only effective means of achieving the policy objectives.

Maintaining the status quo would result in the expiration of the existing Regulation and the Act operating without supporting subordinate legislation. This would lead to significant gaps in the regulatory framework and prevent the objectives of the Act from being achieved.

Benefits and costs of implementation

The Regulation supports the objectives of the Act such as strengthening local decision-making and local consumer and community engagement. The Regulation has been modernised to reflect contemporary drafting practice.

There are no direct costs associated with the making and implementation of the Regulation to replace the Existing Regulation. Any costs will be met within existing budget allocations.

Consistency with fundamental legislative principles

The Regulation is generally consistent with the fundamental legislative principles in section 4 of the *Legislative Standards Act 1992*, except for the following matters outlined below.

Rights and liberties of individuals

Does the legislation make rights and liberties, or obligations, dependent on administrative power only if the power is sufficiently defined and subject to appropriate review?

Required movement of health service employees and HHS chief executives

Section 4(3)(a) of the Legislative Standards Act states that whether legislation has sufficient regard to the rights and liberties of individuals depends on whether the legislation makes rights or liberties, or obligations, dependent on administrative power only if the power is sufficiently defined and subject to appropriate review. Depending on the seriousness of a decision made in the exercise of administrative power and the consequences that follow, it is generally inappropriate to provide for administrative decision-making in legislation without providing criteria for making the decision.

Clause 7(2)(b) of the Regulation enables the chief executive of Queensland Health (that is, the Director-General) to give a written direction to a health service employee that the employee is to be moved from one health system employer to another. Clause 7(3) of the Regulation provides that the Director-General may only give the direction if they consider the movement is necessary to mitigate a significant risk to the public sector health system.

Similarly, clause 8(2) of the Regulation provides that a Health Service Chief Executive may be moved from a HHS to the department or between HHSs, with approval of the Minister for Health, Mental Health and Ambulance Services and Minister for Women (Health Minister). Clauses 8(2)(a) and (b) provides for such movements with the agreement of the Director-General and HHB chair, or relevant HHB chairs. Clause 8(3) provides that a Health Service Chief Executive may be moved between health system employers by a written direction from the Health Minister on the recommendation of the Director-General. Clause 8(4) of the Regulation provides the criteria to be considered when making the written direction is that the movement is necessary to mitigate a significant risk to the public sector health system.

The delegations of administrative power to the Director-General and Health Minister respectively are sufficiently defined because the Regulation sets out clear criteria in clauses 7(3) and 8(4) of the Regulation – that is, the movement must be necessary to mitigate significant risk to the public sector health system. The delegation of administrative power is subject to appropriate safeguards and review rights. For example, the individual concerned must be allowed a reasonable time to establish reasonable grounds for refusing the movement under clauses 11(2) and 12(2) of the Regulation. If such grounds are established, the proposed movement is cancelled and the refusal must not be used to prejudice the employee's prospects for future promotion or advancement.

The length of time provided to employees to establish reasonable grounds will vary depending on the circumstances. For example, clause 11(2) may be used where an employee is moved on medical grounds where, due to a medical condition, the employee is not able to perform their substantive role at their HHS but could perform another role available at a different HHS. This employee may need to investigate the health care options to treat their condition at the new location. In this case, they may require a longer period to establish reasonable grounds to refuse the movement.

The powers in clauses 7 and 8 of the Regulation to require movement of a health service employee or Health Service Chief Executive are reasonable because they may only be used in circumstances where the movement is necessary to mitigate significant risk to the public sector health system and where the individual concerned has not demonstrated reasonable grounds for refusing the movement. This use of administrative power is reasonable as protecting the public sector health system and the community from the significant risk identified outweighs the potential detriment to an individual created by the movement.

Fundamental legislative principles not contained in Legislative Standards Act

Right to privacy

The right to privacy, the disclosure of private or confidential information, doctor-patient confidentiality, and privacy and confidentiality issues have generally been identified by the former Scrutiny of Legislation Committee as relevant to the consideration of whether legislation has sufficient regard to individuals' rights and liberties.

Disclosure of information between health service employers

Clause 15 of the Regulation allows a health system employer to transfer or disclose particular personal information of an individual to another health service employer. The information permitted to be disclosed is restricted to information that was collected or held by the first health system employer in relation to the person's employment or appointment with the employer. The information may only be disclosed to the second health system employer where the person who the information is about is being considered for appointment or is appointed by a second health system employer.

This could be considered to breach the right to privacy because it will allow personal information of an employee to be disclosed from one health service employer to another. However, this disclosure is justified because it helps to ensure the appropriateness of those appointed within the public sector health system. This in turn supports the health and safety of the community.

Quality Assurance Committees

Section 82 of the Act provides for the establishment of Quality Assurance Committees by the chief executive, HHSs and private health facilities. The role of a Quality Assurance Committee is to assess and evaluate the quality of health services, report and make recommendations concerning those services and monitor the implementation of its recommendations.

Part 5 of the Regulation prescribes a number of matters relating to the procedures of Quality Assurance Committees. Clause 33 requires a committee to make certain information available to the public, including the full name and qualifications of each committee member, their office or position in the committee and a summary of their experience as relevant to the committee.

This may be considered an infringement of the right to privacy of the committee members as it will result in their personal information, including their full names and relevant experience, being made public. The infringement on the Committee members' privacy is considered minor, as the information being shared relates to their professional capacity and is information that the individual may already make publicly available in different contexts.

Quality Assurance Committees are established for the purpose of improving and promoting safe and effective care for patients and enhancing health outcomes. They play an important and trusted role in the health system. Making the Committee members' details, including their qualifications and experience relevant to the Committee's functions, available to the public helps to enhance transparency and instil public confidence in the Committee's decisions. For these reasons, any breach of privacy is considered justified.

Prescribed entities

Part 7 of the Act imposes a general duty of confidentiality in relation to information that could identify a person who is receiving or has received a public sector health service (confidential information).

Section 142 of the Act provides that a designated person, which includes public service employees of the department and health service employees, must not directly or indirectly disclose confidential information to another person unless the disclosure is required or permitted under the Act. The maximum penalty for non-compliance is 100 penalty units.

Part 7 of the Act sets out exceptions to the general of duty of confidentiality, including that a designated person may disclose confidential information to an entity prescribed under a regulation for evaluating, managing, monitoring or planning health services (section 150 of the Act).

Clause 51(1) of the Regulation prescribes a number of entities who are entitled to access to confidential information for particular purposes. This includes, for example:

- Services Australia for maintaining the Australian Immunisation Register;
- Australian Orthopaedic Association for collecting data about joint replacement surgery for use in the Australian Orthopaedic Association National Joint Replacement Registry; and
- Florey Institute of Neuroscience and Mental Health for collecting data about eligible stroke and transient ischaemic attack patients for use in the Australian Stroke Clinical Registry and for community-based follow-up.

Clause 51(2) lists the National Disability Insurance Agency and certain Queensland Government agencies as prescribed entities for evaluating, managing, monitoring or planning health services relating to the implementation and management of the National Disability Insurance Scheme.

Prescribing entities under section 150(b) of the Act may be seen to infringe upon the privacy of individuals because it will allow personal information about individuals who have received public sector health services to be disclosed to the entities. The information disclosed may include sensitive health information.

However, the Act contains safeguards to ensure that any infringement of privacy is as limited as possible. This includes the requirement in section 150 of the Act that the disclosure must be for the specific purpose of evaluating, managing, monitoring or planning health services as stated in the regulation.

Any infringement of privacy is considered justified given the limited recipients and uses, and the important role the prescribed entities play in evaluating, managing, monitoring or planning health services. These entities support the provision of high-quality health services and provide tangible health benefits to both individuals and the community.

Prescribed agreements

Section 151(1)(a) of the Act provides a further exception to the general duty of confidentiality in part 7 of the Act. This section allows a designated person to disclose confidential information to the Commonwealth or another State, or an entity of the Commonwealth or another State if the disclosure is required or allowed under a prescribed agreement and considered by the relevant chief executive to be in the public interest. Section 151(1)(b) applies a similar exception in relation to Queensland entities.

Clause 52 of the Regulation provides that schedule 8 prescribes agreements for the purposes of section 151 of the Act. Part 1 of schedule 8 contains the names of the prescribed agreements between Queensland and other jurisdictions including, for example, bilateral agreements relating to funding of admitted patient services provided to each other's residents, an intergovernmental agreement relating to the Electronic Donor Record and an agreement between the Queensland and Commonwealth government regarding the Rheumatic Fever Strategy. Similarly, part 2 of schedule 8 prescribes particular agreements and memorandums of understanding between Queensland Health and other Queensland Government entities.

Prescribing particular agreements that allow information sharing may be seen to infringe upon the privacy of individuals because it will allow personal information about individuals who have received public sector health services to be disclosed to the entities. The information disclosed may include sensitive health information.

However, the Act contains a number of safeguards to ensure that any infringement of privacy is as limited as possible, and to prevent further disclosure. This includes the requirement in section 151 of the Act that the relevant chief executive must also consider the disclosure is in the public interest. Section 151(2) also restricts how the recipient of the confidential information may deal with it – the recipient must not give it to anyone else unless allowed to do so by the agreement or in writing by the relevant chief executive. The recipient must also ensure the confidential information is used only for the purpose for which it was given under the agreement. Additionally, the prescribed agreements contain confidentiality protocols that restrict the use of the information to only the prescribed entity for the prescribed purpose.

The potential infringement of privacy is considered reasonable and justified given the limited scope of the disclosure and the safeguards contained within the Act.

Prescribed information system

Section 161C of the Act provides that a prescribed health professional may access a prescribed information system.

Clause 48 and schedule 7 of the Regulation replicate section 34A and schedule 2C of the Existing Regulation by prescribing the health professionals that may access a prescribed information system under section 161C of the Act. This includes health professionals registered under the Health Practitioner Regulation National Law (National Law), from Aboriginal and Torres Strait Islander health practice, dental practice, medical practice, midwifery and nursing, occupational therapy, optometry, pharmacy, and psychology practices. It also includes a range of other health professions that are not registered under the National Law, but are accredited by other professional bodies, such as dieticians, social workers and speech pathologists.

Clause 49 of the Regulation replicates 34B of the Existing Regulation by prescribing 'The Viewer' as a prescribed information system. The Viewer is a read-only web-based application that displays a consolidated view of patients' clinical and demographic information from a variety of Queensland Health clinical and administrative systems. Providing health professionals with access to The Viewer provides these health professionals with a greater ability to understand the care that has been provided to a patient and assess their future care requirements, which improves the health outcomes for patients.

Replicating the provisions of the Existing Regulation by prescribing certain health professionals and prescribing The Viewer may be considered a breach of privacy as it will allow those health professionals to continue to access The Viewer and the personal information contained within.

However, there are legislative and operational safeguards in place that protect personal information from being inappropriately accessed. For example, each person is required to prove their identity to obtain system access to The Viewer and a person must provide their credentials on each log in to The Viewer. Every user's access to and activity on The Viewer is recorded in audit files, allowing for regular usage checks by Queensland Health. Health practitioners can only access The Viewer through a read-only secure access portal known as the Health Provider Portal. Health practitioners must go through a stringent registration process to register for the Health Provider Portal. This includes confirmation of personal identity information, qualifications, and professional registrations. Patient searches can only be undertaken in The Viewer based on a set of unique patient identifiers, ensuring the patient is known to the health practitioner in a healthcare context, before their information can be accessed. Importantly, a patient can opt out of having their information shared with health professionals through The Viewer.

Under the Act, it is an offence for a health professional to inappropriately access information in The Viewer that is not directly related to the provision of care or treatment to the person. The maximum penalty for breaching this requirement is 600 penalty units. Queensland Health conducts audits to ensure patient information is being used appropriately and investigates and acts on any inappropriate use of information. Any privacy breaches would also be dealt with under the *Information Privacy Act 2009*.

The potential breach of fundamental legislative principles is considered justified as access to The Viewer is for the purpose of providing appropriate treatment to an individual. This objective is balanced with the safeguards outlined above that prevent any instances of inappropriate access or inadvertent disclosure of confidential information.

Reasonable and fair treatment

Legislation should be reasonable and fair in its treatment of individuals. It should not be discriminatory. The reasonableness and fairness of treatment of individuals is relevant in deciding whether legislation has sufficient regard to the rights and liberties of individuals.

As outlined above, clause 7 of the Regulation provides for the movement of health service employees (other than chief executives) by agreement between relevant chief executives, or by written direction given by the Director-General. Clause 8 of the Regulation provides for the movement of Health Service Chief Executives between health system employers with the approval or written direction of the Health Minister. A Health Service Chief Executive moved under clause 8 may, as a result of the movement, be employed in a position other than Health Service Chief Executive. Clause 9(3) of the Regulation provides that, for an employee appointed on a contract who is moved under clauses 7 or 8, if a provision in a health employee's contract is inconsistent with a movement under this part, the movement takes effect despite the inconsistency. This requires consideration of whether the provision is reasonable and fair in its treatment of the employee.

Clause 9(3) is considered justified as section 66 of the Act provides the conditions of employment for health service employees which include: provisions of the Act; the *Industrial Relations Act 2016*; the *Public Sector Act 2022* including any directive under that Act that applies to the employee; an industrial instrument that applies to the employee; health employment directives and the employee's contract. The employee's contract is not the only consideration when determining the employee's rights and obligations as a health service employee – a number of other considerations, laws and instruments also apply. It is appropriate to designate which conditions are to prevail in circumstances of inconsistency between the employment conditions.

Any potential unfairness resulting from clauses 7, 8 and 9 are mitigated by clauses 11 and 12 of the Regulation, which provide that an employee must be given reasonable time to establish grounds for refusing a movement, and that a movement will be cancelled if the employee establishes reasonable grounds for refusing the movement. Clauses 11 and 12 also provide that where an individual establishes reasonable grounds for refusing a movement, that refusal must not be used to prejudice the employee's prospects for future promotion or advancement.

Consultation

In April 2023, a consultation draft of the Regulation and consultation paper were sent to stakeholders including the Australian Medical Association Queensland, Australian Workers' Union (QLD) (AWU), Health Consumers Queensland, Health Services Union Queensland Branch, Pharmaceutical Society of Australia, Pharmacy Guild of Australia (Qld), Private Hospitals Association of Queensland, Queensland Aboriginal and Islander Health Council, Queensland Nurses and Midwives' Union, Royal Australian College of General Practitioners (Qld), Rural Doctors Association of Queensland, Together Union and United Workers Union. The consultation paper and draft Regulation were also provided to all HHSs and HHBs.

Stakeholders who provided feedback were generally supportive of the Regulation. A small number of stakeholders proposed amendments that were outside the scope of the Regulation, as they would require changes to the Act.

The AWU supported the new function for Safety and Quality Committees to monitor how workplace culture is contributing to the safety and quality of health services. The AWU proposed that further detail be included in the Regulation including references to relevant work health and safety legislation and a definition of the term *workplace culture*. These changes are not considered necessary as it is intended that the Committees interpret the reference to workplace culture broadly. Including references to work health and safety legislation may unintentionally limit the matters a Safety and Quality Committee considers.

The AWU also submitted the Regulation should provide each Safety and Quality Committee must include union representation and require the Committee to report regularly to unions on workplace culture. It is open to HHBs to appoint a union representative to a Safety and Quality Committee. However, as conduct and membership of the Safety and Quality Committee is provided in the schedule 1 of the Act, rather than the Regulation, it is not possible to include these requirements in the Regulation.

A sunset review of the Existing Regulation was undertaken in accordance with *The Queensland Government Guide to Better Regulation*. The Office of Best Practice Regulation, Queensland Treasury was consulted on the sunset review and advised that Queensland Health satisfactorily met the objectives for sunset reviews as set out in the Guidelines.

Notes on provisions

Part 1 Preliminary

Short title

Clause 1 states the short title is the *Hospital and Health Boards Regulation 2023* (Regulation).

Commencement

Clause 2 states that the regulation will commence on 1 September 2023.

Definitions

Clause 3 states the dictionary in schedule 9 defines particular words used in the regulation.

Part 2 Hospital and Health Services

Continuation of Hospital and Health Services—Act, s 17

Clause 4 provides for the continuation of the Hospital and Health Services (HHS) under section 17 of the *Hospital and Health Boards Act 2011* (Act) (Establishment of Services). Section 17 of the Act provides that a regulation may establish a HHS for the health service area, assign a name to the HHS and declare any one or more of the following to be a health service area for a HHS:

- a part of the State;
- a public sector hospital;
- a public sector health service facility; or
- a public sector health service.

The *expired regulation* means the expired *Hospital and Health Boards Regulation 2012*.

A health service area for a HHS under the expired regulation continues to be a health service area for the HHS. A HHS established under the expired regulation continues as the HHS for the health service area. The name of the HHS that was assigned under the expired regulation continues as the name assigned to the HHS.

Power to grant or take lease without Minister's and Treasurer's approval—Act, s 20A

Clause 5 prescribes for section 20A of the Act (Limitation on Service's dealing with land or buildings) the circumstances when a HHS may grant or take a lease over land or a building without the prior written approval of the Health Minister or Treasurer. This enables the HHS to make local decisions that best suit their community's leasing needs for matters that are considered lower risk, for example, a lease or sublease where the term of the lease is 10 years

or less, or the lease or sublease is used or intended for use as office accommodation and the annual rent payable is not more than $100,000.

A lease of a type mentioned in schedule 2, part 1, column 1 for a HHS mentioned in column 2 opposite the lease may be granted by the HHS without the prior written approval of the Treasurer. A lease of a type mentioned in schedule 2, part 2, column 1, for a HHS mentioned in column 2 opposite the lease, may be taken by the HHS without the prior written approval of the Health Minister and Treasurer.

Part 3 Employment matters

Definitions for part

Clause 6 provides definitions for *health system employer* and *relevant chief executive* for the purposes of part 3.

Movement of health service employees, other than health service chief executives, between health system employers

Clause 7 provides health service employees, other than Health Service Chief Executives, may be moved from one health system employer to another health system employer in the following ways by:

- agreement between the relevant chief executives of the employers; or
- the chief executive of the department (that is, the Director-General of Queensland Health) giving a written direction to the employee and either:
  - the Health Service Chief Executive, if the movement is between the department and a HHS; or
  - the relevant Health Service Chief Executives, if the movement is between HHSs.

The Director-General may only give a written direction for an employee to move from the department to a HHS or between HHSs if the movement is necessary to mitigate a significant risk to the public sector health system. Prior to giving the written direction to move an employee, the Director-General must consult with the Health Service Chief Executive of any HHS where the employee is and will be employed.

A health service employee who is moved from one health system employer to another health system employer, is employed by the other health system employer, on either the date stated in the agreement between relevant chief executives for the move or the date stated in the written direction.

Movement of health service chief executives between health system employers

Clause 8 provides Health Service Chief Executives may, with the approval of the Health Minister, be moved:

- from a HHS to the department by agreement between the chair of the HHS's Hospital and Health Board (HHB) and the Director-General; or
- between HHSs by agreement between the chairs of the relevant HHBs.

A Health Service Chief Executive may also be moved by the Health Minister, on the Director-General's recommendation, by written direction given by the Minister to the Health Service Chief Executive and either:

- if the movement is from the HHS to the department, the chair of the HHB for the HHS; or
- if the movement is between HHSs, the chairs of the relevant HHBs.

The Director-General can only make a recommendation to the Minister to move a Health Service Chief Executive if the Director-General considers the movement is necessary to mitigate a significant risk to the public health sector.

Prior to giving the written direction, the Health Minister must consult with the chair of the HHB of the relevant HHS that the Health Service Chief Executive is and will be employed.

A Health Service Chief Executive moved from a health system employer to another health system employer is employed by the other health system employer on either the date stated in the agreement, or the date stated in the written direction. Also, a Health Service Chief Executive moved under this clause may, as a result of the movement, be employed in a position other than Health Service Chief Executive.

Movement of health service employees employed on a contract

Clause 9 applies to the movement of a health service employee to another health service employer under:

- clause 7 if, immediately before the movement, the employee was appointed under a contract; or
- under clause 8.

The health system employee is taken to be employed by the health system employer under the contract under which the employee was employed before the movement. If a provision in the employee's contract is inconsistent with a movement under part 3 of the Regulation, the movement takes effect despite the inconsistency.

If the direction given under clauses 7 or 8 is to an employee on a contract for a fixed term, the employee is appointed for the period stated in the agreement or written direction for the movement. If no period is stated in the agreement or written direction to move health system employer, then the period remaining on the term of the employee's contract is the term of the contract at the new health system employer.

The period stated in the agreement or written direction cannot be for a period longer than the term of the employee's contract.

Movement between classification levels

Clause 10 provides that a health service employee can be moved between health service employers at the same or a different classification level. The health service employee may only

be moved at a lower classification level if the employee consents to the movement. However, this does not prevent movement to a lower classification level as the result of disciplinary action against the employee.

Effect of movement of health service employees other than health service chief executives

Clause 11 provides a process for a health service employee to refuse a movement proposed under clause 7 of the Regulation. The movement under clause 7 has effect unless the employee establishes reasonable grounds for refusing the movement to the satisfaction of:

- for a movement by agreement under clause 7(2)(a) – the chief executive of the health system employer from which the employee is moved; or
- for a movement by written direction under clause 7(2)(b) – the Director-General.

A health service employee must be given a reasonable time to establish reasonable grounds for refusing the movement.

If the health service employee fails to establish reasonable grounds for refusing the movement and refuses the movement then:

- if the movement was by agreement, the employee's employment may be ended by the relevant chief executive of the health service employer giving a signed notice to the employee;
- if the movement was by written direction, the employee's employment must be ended by a signed written notice given to the employee.

If the employee establishes reasonable grounds for refusing the movement, the movement is cancelled and the refusal must not be used to prejudice the employee's prospects for future promotion or advancement.

Effect of movement of health service chief executives

Clause 12 provides that if a Health Service Chief Executive is moved by agreement under clause 8 of the Regulation, the movement has effect unless the Health Service Chief Executive establishes reasonable grounds for refusing the movement to the satisfaction of the chair of the HHB from which the Health Service Chief Executive is proposed to be moved. If the movement is by written direction under clause 8 of the Regulation, the movement has effect unless the Health Service Chief Executive establishes reasonable grounds for refusing the movement to the satisfaction of the Health Minister.

A Health Service Chief Executive must be given a reasonable time to establish reasonable grounds for refusing the movement.

If the Health Service Chief Executive fails to establish reasonable grounds for refusing the movement, and the Health Service Chief Executive refuses the movement then:

- if the movement is by agreement, the chair of the Health Service Chief Executive's HHB may end the Health Service Chief Executive's employment by signed notice; or
- if the movement is by written direction, the chair of the Health Service Chief Executive's HHB must end the Health Service Chief Executive's employment by a signed notice.

If the Health Service Chief Executive establishes reasonable grounds for refusing the movement, the movement is cancelled and the refusal must not be used to prejudice the Health Service Chief Executive's prospects for future promotion or advancement.

Continuation of entitlements of health service employees

Clause 13 provides for the continuation of entitlements for a health service employee if the employee is appointed to another health system employer without a break of service, including as a result of a movement under part 3. The employee is entitled to all leave entitlements and superannuation that have accrued to the employee because of the employee's employment with their employer prior to the movement. The employee's continuity of service is not interrupted, including for the purposes of accruing leave entitlements and superannuation, except the employee is not entitled to claim the benefit of a right or entitlement more than once in relation to the same period of service.

The employee's appointment is not a termination of employment, retrenchment or redundancy. The employee is not entitled to a payment or other benefit because they are no longer employed by their first employer.

Senior health service employees—Act, s 74A

Clause 14 prescribes for section 74A(1) of the Act (Meaning of senior health service employee) senior health service employee positions. These positions are listed in schedule 3, parts 1 and 2 of the Regulation.

Disclosure of personal information of health service employees and departmental public service employees in particular circumstances

Clause 15 provides a health system employer may transfer or disclose to another health system employer the personal information of a person who is or was a health service employee or departmental public service employee, or a person who is being, or was, considered for appointment to either of those two roles.

Personal information is defined by reference to section 12 of the *Information Privacy Act 2009*. Disclosure of personal information is permitted when the information was collected or held by a health system employer in relation to the person's employment or appointment with the employer and the person transfers or moves to, or is appointed by, a second health system employer. The disclosure is also permitted when a person was considered for appointment as a health service employee, but their suitability was not finally assessed by one health system employer and then the person is being considered for appointment or is appointed by a second health system employer.

Clause 15 applies to personal information held by a health system employer before or after the commencement and to matters not dealt with in section 274 of the Act (Disclosure of personal information of health service employees and health professionals). These matters relate to the disclosure of a person's personal information to another health agency (that is, the department

or a HHS) if the information is relevant to the person's suitability for employment or engagement with another health agency.

A person is considered for appointment as a health service employee or departmental public service employee if the person applied or otherwise expressed an interest in being appointed and the person's suitability for employment has not been finally assessed.

Part 4 Engagement strategies and protocols

Definitions for part

Clause 16 defines *Aboriginal and Torres Strait Islander community-controlled health organisation, Chief First Nations Health Officer, community, consumer, implementation stakeholders* and *service-delivery stakeholders* for part 4 of the Regulation.

Prescribed persons—developing health equity strategies

Clause 17 prescribes, for section 40(2)(c) of the Act (Engagement strategies), the persons that a HHS must consult with in developing the HHS's health equity strategy.

Prescribed requirements for clinician engagement strategies

Clause 18 prescribes, for section 40(3)(a) of the Act (Engagement strategies), the elements that must be included in each HHS's clinician engagement strategy. Section 40(3)(a) provides a clinician engagement strategy, consumer and community engagement strategy or health equity strategy developed by a HHS must include any requirement prescribed by regulation.

The list of prescribed elements that must be included in each HHS's clinician engagement strategy include:

- the objectives of the strategy;
- how the strategy will contribute to the achievement of the HHS's organisational objectives;
- the methods to be used for carrying out consultation with health professionals working in the HHS, including how the consultation will involve health professionals with a diverse range of skills and experience;
- the key issues on which consultation with health professionals working in the HHS will be carried out;
- how the HHS will use information obtained from implementing the strategy to continuously improve consultation with health professionals under the strategy; and
- how the effectiveness of consultation with health professionals under the strategy will be measured and publicly reported.

A clinician engagement strategy must have regard to national and State strategies, policies, agreements and standards relevant to promoting consultation with health professionals working in the HHS. The strategy must outline the relationship between the HHS's clinician engagement strategy and its consumer and community engagement strategy, health equity strategy and protocol with local primary healthcare organisations. The strategy must require a summary of the key issues discussed and decisions made in each of the HHS's board meetings to be made available to health professionals working in the HHS, subject to the HHB's obligations relating to confidentiality and privacy.

Prescribed requirements for consumer and community engagement strategies

Clause 19 prescribes, for section 40(3)(a) of the Act (Engagement strategies), the elements that must be included in each HHS's consumer and community engagement strategy. This strategy must include:

- the objectives of the strategy;
- how the strategy will contribute to the achievement of the HHS's organisational objectives;
- the methods to be used for carrying out consultation with consumers and members of the community, including at individual, service and HHS level, and with any ancillary board established by the HHB;
- the key issues on which consultation with consumers, members of the community and any ancillary board established for the HHS's board will be carried out;
- how the HHS will actively identify and consult with particular consumers and members of the community who are at risk of experiencing poor health outcomes or who may have difficulty accessing health services;
- how the HHS will use information obtained from implementing the strategy to continuously improve consultation with consumers and the community under the strategy; and
- how the effectiveness of the strategy will be measured and publicly reported.

A consumer and community engagement strategy must have regard to national and State strategies, policies, agreements and standards relevant to promoting consultation with health consumers and members of the community about the provision of health services by the HHS. The strategy must outline the relationship between the HHS's consumer and community engagement strategy and its clinician engagement strategy, health equity strategy and protocol with local primary healthcare organisations. The strategy must also require a summary of the key issues discussed and decisions made in each of the HHS's board meetings to be made available to consumers and the community, subject to the HHB's obligations relating to confidentiality and privacy.

Prescribed requirements for health equity strategies

Clause 20 prescribes, for section 40(3)(a) of the Act (Engagement strategies), the elements that must be included in each HHS's health equity strategy. The health equity strategy must include:

- the HHS's key performance measures, as agreed by the HHS and the Chief First Nations Health Officer, that relate to improving health and wellbeing outcomes for Aboriginal people and Torres Strait Islander people;
- the actions the HHS will take to:
  - achieve key performance measures;
  - work with the implementation stakeholders for the health equity strategy to ensure greater collaboration, shared ownership and decision-making and the implementation of the strategy;
  - improve integration of health service delivery between the HHS and the service-delivery stakeholders;
  - provide inclusive mechanisms to support Aboriginal people and Torres Strait Islander people of all needs and abilities to give feedback to the HHS; and
  - increase workforce representation of Aboriginal people and Torres Strait Islander people across all levels of health professions and employment streams to levels at least

commensurate with the health service area's Aboriginal and Torres Strait Islander population; and

- how the strategy aligns with:
  - the HHS's strategic and operational objectives;
  - other strategies, policies, guidelines or directives made by, or applying to, the HHS under the Act or another Act;
  - other HHSs' health equity strategies; and
  - other national, state and local government strategies, policies, agreements and standards relevant to promoting shared decision-making, shared ownership and working in partnership with Aboriginal people and Torres Strait Islander people.

Prescribed persons—giving effect to health equity strategies

Clause 21 prescribes, for section 40(5) of the Act (Engagement strategies), the *implementation stakeholders* a HHS must consult when giving effect to their health equity strategy. These are:

- the service-delivery stakeholders for the health equity strategy (*service delivery stakeholders* is defined in clause 16 of the Regulation);
- the Chief First Nations Health Officer;
- Queensland Aboriginal and Islander Health Council; and
- Health and Wellbeing Queensland.

Prescribed requirements for protocol with local primary healthcare organisations

Clause 22 prescribes, for section 42(2)(a) of the Act (Protocol with primary healthcare organisations), the elements that must be included in each HHS's protocol agreed upon with local primary healthcare organisations. These include:

- the objectives of the protocol;
- how the protocol will contribute to the achievement of the organisational objectives of the HHS;
- the key issues on which the HHS and the local primary healthcare organisations are to cooperate;
- how the HHS and local primary healthcare organisations will support the implementation of the protocol;
- arrangements for sharing information between the HHS and the local primary healthcare organisations to improve service delivery and health outcomes;
- how the protocol aligns with the HHS's cooperative arrangements with other entities delivering services in the health, aged care and disability sectors to improve service delivery and health outcomes;
- how the HHS will use the information obtained from implementing the protocol to continuously improve cooperation with local primary healthcare organisations under the protocol; and
- how the effectiveness of the protocol will be measured and publicly reported.

A HHS's protocol with local primary healthcare organisations must:

- have regard to national and State strategies, policies, agreements and standards;
- outline the relationship between the HHS's protocol and its consumer and community engagement strategy, clinician engagement strategy and health equity strategy; and

- require a summary of the key issues discussed and decisions made in each of the HHS's board meetings to be made available to the HHS's local primary healthcare organisations, subject to the HHB's obligations relating to confidentiality and privacy.

Part 5 Quality assurance committees

Division 1 Preliminary

Definitions for part

Clause 23 defines *committee, member, privacy policy* and *specified information* for part 5 of the Regulation.

Division 2 Procedures of committees

Chairperson

Clause 24 provides the process for appointing a chairperson for the committee if the entity that established the committee did not appoint a chairperson. This process involves the members of the committee electing a chairperson. The committee may elect a member as chairperson at any time.

The member elected by the committee to be chairperson is appointed as chairperson when the entity establishing the committee approves the appointment. If the committee was established by an entity other than the Director-General, the committee must give the Director-General a written notice containing the member's full name and the date the member was appointed as chairperson as soon as practicable after the appointment.

Times and places of meetings

Clause 25 provides the chairperson determines the times and places when quality assurance committee meetings are to be held. The chairperson must call a meeting if requested in writing to do so by at least the number of committee members that form a quorum for the committee. A committee must hold its first meeting within three months of the committee being established.

Quorum

Clause 26 provides a quorum for a quality assurance committee is the number equal to one-half of the number of its members. If one-half is not a whole number, a quorum is the next highest whole number.

Presiding at meetings

Clause 27 provides the chairperson is to preside at all meetings of the quality assurance committee at which the chairperson is present. If the chairperson is not present at a meeting or the office of the chairperson is vacant, the members present at the meeting are to choose a member to chair the meeting.

Conduct of meetings

Clause 28 provides a question at a committee meeting is decided by a majority of the votes of members present at the meeting. If the votes on the question are equal, the member presiding as chair also has a casting vote.

Minutes

Clause 29 requires a committee to keep the minutes of a committee meeting for 10 years after the meeting. This requirement does not apply to the extent the minutes are a public record under the *Public Records Act 2002*.

Other procedures

Clause 30 provides a committee must conduct its business, including its meetings, under the procedures, if any, decided for the committee by the entity that established the committee. If the entity that established the committee does not create any procedures, the committee may conduct its business, including its meetings, under procedures decided by the committee.

Division 3 Privacy policies

A committee must adopt a privacy policy

Clause 31 requires a committee to adopt, by resolution, a written privacy policy (privacy policy).

Content of privacy policy

Clause 32 provides a committee's privacy policy must state how the committee, or a member of the committee, may:

- acquire and compile relevant information;
- securely store relevant information;
- disclose relevant information; and
- ask an individual for consent to disclose the individual's identity under section 83(2) of the Act.

The privacy policy must state the circumstances when a record containing relevant information may be copied or destroyed. *Relevant information* is defined as information acquired or compiled by the committee in the performance of its functions. Nothing in the clause affects the operation of the *Information Privacy Act 2009* and the *Privacy Act 1988* (Cwlth).

Division 4 Information to be made available by committees

Specified information to be made available to the public

Clause 33 requires a committee to make specified information available to the public. *Specified information* is defined as:

- a statement of the committee's functions;

- for each committee member, their full name, qualifications, office or position and experience relevant to the committee's function;
- a summary of the activities and outcomes of the exercise of the committee's functions; and
- a summary of the committee's privacy policy.

The committee must give the specified information to the entity that established the committee before the committee makes the information available to the public. The committee may make the specified information available in a form the committee considers appropriate, for example, by including it in its annual report.

Division 5 Review and reporting obligations

Review of functions

Clause 34 requires a committee to carry out a review of its functions within three years after the committee is established and a subsequent review within three years after each previous review.

After each review is completed, the committee must give a report about the review to the entity that established the committee. If the committee was established by an entity other than the Director-General, a copy of the review report must also be provided to the Director-General.

Annual activity statement

Clause 35 requires a committee to prepare an annual activity statement and prescribes the elements the annual activity statement must include, such as the full names of the chairperson, all members and the dates of each meeting held during the reporting period. The annual activity statement must, either on or before each anniversary of the day the committee was established, be given to the entity that established the committee. If the committee was established by an entity other than the Director-General, a copy of the annual activity statement of the committee must also be provided to the Director-General.

Division 6 Miscellaneous

Prescribed patient safety entities and authorised purposes

Clause 36 prescribes, for section 85(3) of the Act (Giving of reports and documents to patient safety entity), the entities that are a *prescribed patient safety entity*.

Section 85 of the Act provides a quality assurance committee may give a report or other document to a prescribed patient safety entity for an authorised purpose for the entity. Clause 36 provides that, for the definition of *authorised purpose* for section 85(3) of the Act, the authorised purposes are stated in schedule 4, part 1 of the Regulation.

Part 6 Root cause analyses

Reportable events

Clause 37 prescribes, for section 94 of the Act (Definitions for div 2), the events that are a *reportable event*. Section 95 of the Act defines root cause analysis of a reportable event as a

systematic process of analysis under which factors that contributed to the happening of an event may be identified and remedial measures that could be implemented to prevent a recurrence of a similar event may be identified. Root cause analysis does not include investigating the professional competence of a person in relation to the event or finding out who is to blame for the happening of the event.

Clause 37 defines for this clause *acute psychiatric unit or ward*, *ABO incompatibility*, *invasive procedure*, *mechanical restraint*, *mental illness*, *serious harm*, *stillbirth* and *unauthorised person*.

Prescribed patient safety entities and authorised purposes

Clause 38 prescribes, for section 112(7) of the Act (Giving a copy of RCA report—patient safety entity), the entities that are *prescribed patient safety entities*. Section 112 provides that if an administrative unit of the department responsible for coordinating improvements in the safety and quality of health services commissions a root cause analysis, a person who performs functions for this administrative unit may provide a copy of the root cause analysis report, or information contained in the report, to a prescribed patient safety entity for an authorised purpose.

Clause 38 also provides that *authorised purpose* is defined, for section 112(7) of the Act, as the purposes prescribed in schedule 4, part 2 of the Regulation.

Part 7 Nurse-to-patient and midwife-to-patient ratios

References to shifts

Clause 39 defines *morning shift*, *afternoon shift* and *night shift* for part 7.

Nurse-to-patient and midwife-to-patient ratios applying to particular acute adult wards—Act, s 138B

Clause 40 applies in relation to particular acute adult wards in public sector health service facilities, as specified in clause 40 and schedule 5 of the Regulation. An acute adult ward covered by this clause must comply with the minimum number of nurses or midwives who must be engaged in delivering health services to the patients in the ward for the morning, afternoon and night shifts.

An *acute adult ward* is an acute ward in which health services are provided to adult patients.

Part 8 State aged care facilities

State aged care facilities—Act, ss 138H and 138I

Clause 41 provides that, for sections 138H (Prescription of minimum nurse and registered nurse percentages) and 138I (Prescription of minimum average daily resident care hours) of the Act, the State aged care facilities mentioned in schedule 6 of the Regulation are prescribed.

Section 138H of the Act relates to the minimum percentage of nurses or registered nurses providing residential care at a State aged care facility during each 24-hour period to the total

number of nurses and support workers providing residential care at the facility during the period. Section 138I of the Act relates to the minimum average daily resident care hours at a Stage aged care facility.

Minimum nurse and registered nurse percentages—Act, s 138H

Clause 42 prescribes, for section 138H of the Act (Prescription of minimum nurse and registered nurse percentages), the minimum percentage of nurses or registered nurses providing residential care at a relevant State aged care facility during each 24-hour period to the total number of care staff (that is, nurses and support workers) providing residential care at the facility during the period.

Clause 42 provides that at least 50 per cent of the care staff must be nurses and at least 30 per cent of the care staff must be registered nurses.

Minimum average daily resident care hours—Act, s 138I

Clause 43 provides for section 138I of the Act (Prescription of minimum average daily resident care hours) the minimum average daily resident care hours at a State aged care facility prescribed under clause 41 of the Regulation is 3.65 hours.

Part 9 Committees of boards

Prescribed committees

Clause 44 prescribes, for schedule 1, section 8(1)(b) of the Act (Committees), the following committees:

- a safety and quality committee;
- a finance committee; and
- an audit committee.

A HHB establishing the committee may assign the committee with a different name if the name is appropriate to the committee's functions.

Functions of a safety and quality committee

Clause 45 provides the functions of a safety and quality committee established by a HHS's board. These functions include:

- advising the HHB on matters relating to the safety and quality of health services provided by the HHS;
- monitoring the HHS's governance arrangements relating to the safety and quality of health services, including monitoring compliance with the HHS's policies and plans about safety and quality;
- promoting improvements in the safety and quality of health services provided by the HHS;
- monitoring the safety and quality of health services being provided by the HHS using appropriate indicators developed by the HHS;
- monitoring the workplace culture of the HHS in relation to the safety and quality of health services provided by the HHS;

- collaborating with other safety and quality committees, the department and State-wide quality assurance committees in relation to the safety and quality of health services; and
- any other function given to the committee by the HHB, if the function is not inconsistent with one of the other functions of the committee.

Functions of a finance committee

Clause 46 provides the functions of a finance committee established by a HHS's board. These functions include:

- advising the HHB about any of the functions of the committee;
- assessing the HHS's budgets and ensuring the budgets are consistent with the organisational objectives of the HHS and appropriate having regard to the HHS's funding;
- monitoring the HHS's case flow, having regard to the revenue and expenditure of the HHS;
- monitoring the HHS's financial and operating performance;
- monitoring the adequacy of the HHS's financial systems, having regard to its operational requirements and obligations under the *Financial Accountability Act 2009*;
- assessing financial risks or concerns that impact, or may impact, on the HHS's financial performance and reporting obligations and how the HHS is managing the risks or concerns;
- assessing the HHS's complex or unusual financial transactions; and
- any other functions given to the committee by the HHB, if the function is not inconsistent with one of the other prescribed functions of the committee.

Functions of an audit committee

Clause 47 provides the functions of an audit committee established by a HHS's board. These functions include:

- advising the HHB about any of the functions of the committee;
- assessing the adequacy of the HHS's financial statements;
- monitoring the HHS's compliance with its obligation to establish and maintain an internal control structure and systems of risk management under the *Financial Accountability Act 2009*, including whether the HHS has appropriate policies and procedures in place and whether the HHS is complying with the policies and procedures;
- monitoring and advising the HHB about its internal audit functions, if an internal audit function is established for the HHS under part 2, division 5 of the *Financial and Performance Management Standard 2019*;
- overseeing the HHS's liaison with the Queensland Audit Office in relation to the HHS's proposed audit strategies and plans;
- assessing external audit reports for the HHS's management of legal and compliance risks and internal compliance systems, including the effectiveness of the systems in monitoring compliance by the HHS with relevant laws and government policies;
- assessing the HHS's complex or unusual transactions or series of transactions, or any material deviation from the HHS's budget;
- any other functions given to the committee by the HHS, if the function is not inconsistent with one of its other functions.

Clause 47 also defines *external audit* and *Queensland Audit Office* for this clause.

Part 10 Confidentiality

Prescribed health professionals—Act, s 139

Clause 48 prescribes, for section 139 of the Act (Definitions for pt 7), health professionals who are a *prescribed health professional*.

Prescribed information system—Act, s 139

Clause 49 prescribes, for section 139 of the Act (Definitions for pt 7), 'The Viewer' as a *prescribed information system*. The Viewer is a read-only web-based application that displays a consolidated view of patients' clinical and demographic information from a variety of Queensland Health clinical and administrative systems. Providing health professionals with access to The Viewer gives relevant health professionals greater ability to understand the care that has been provided to a patient and assess their future care requirements, which improves the health outcomes for patients.

Prescribed designated person—Act, s 139A

Clause 50 prescribes, for section 139A(1)(m) of the Act (Meaning of designated person), the following persons as a *designated person*:

- the commissioner of the Queensland Ambulance Service appointed under section 4 of the *Ambulance Service Act 1991*; and
- a person employed under section 13 of the Ambulance Service Act.

Designated persons are subject to the general prohibition on the disclosure of confidential information in part 7 of the Act.

Disclosure of confidential information for purposes relating to health services—Act, s 150

Clause 51 provides, for section 150(b) of the Act (Disclosure of purposes relating to health services), the entities prescribed for evaluating, managing, monitoring or planning health services. Section 150 of the Act provides that a designated person may disclose confidential information if the disclosure is to one of these prescribed entities for the purposes of evaluating, managing, monitoring or planning health services.

Clause 51 also defines *injury severity score*, *National Disability Insurance Scheme*, *relevant asplenic patient* and *relevant trauma patient* for this clause.

Disclosure to Commonwealth, another State or Commonwealth or State entity—Act, s 151

Clause 52 provides the list of agreements for section 151(1)(a)(i)(B) of the Act (Disclosure to Commonwealth, another State or Commonwealth or State entity) are prescribed in schedule 8, part 1 of the Regulation. Clause 52 also provides the list of agreements for section 151(1)(b)(i)(B) of the Act is prescribed in schedule 8, part 2 of the Regulation. Section 151 of the Act provides that a designated person may disclose confidential information to the

Commonwealth or another State if required or permitted under a prescribed agreement, and the relevant chief executive considers the disclosure is in the public interest.

Part 11 Miscellaneous

Major capital works

Clause 53 defines, for schedule 2 of the Act (Dictionary), *major capital works* as works that:

- are structural works for the construction of a building;
- involve alterations to the building envelope of an existing building; or
- consist of work, other than excluded work, that requires assessment, certification or approval under an Act and the estimated capital expenditure is $500,000 or more.

Excluded work is defined as work that only involves routine maintenance of, or repairs to, an existing building or other structure.

Part 12 Amendment of legislation

Division 1 Amendment of Public Sector Regulation 2023

Regulation amended

Clause 54 provides this division amends the *Public Sector Regulation 2023*.

Amendment of s 7 (Application of Act, ch 3, pt 10 and directives about appeals to movement of health service employees)

Clause 55 amends section 7 of the *Public Sector Regulation 2023* by removing the reference to *Hospital and Health Boards Regulation 2012* and replacing it with *Hospital and Health Boards Regulation 2023*.

Division 2 Amendment of State Development and Public Works Organisation Regulation 2020

Regulation amended

Clause 56 provides that this division amends the *State Development and Public Works Organisation Regulation 2020*.

Amendment of s 28D (Definitions for division)

Clause 57 amends the definition of *Cairns and Hinterland Hospital and Health Service* in section 28D by removing ‘established and named under the *Hospital and Health Boards Regulation 2012*, section 3 and schedule 1’ and replacing with ‘as continued under the *Hospital and Health Boards Regulation 2023*, section 4.’

Schedule 1 Hospital and Health Services

Schedule 1 provides, for clause 4 of the Regulation, the name and health service area for each HHS.

Schedule 2 Leases that may be granted or taken without Minister's and Treasurer's approval

Part 1 Leases that may be granted

Part 1 provides, for clause 5 of the Regulation, that a HHS may, without the Treasurer's approval, lease or sublease land or a building or part of a building if:

- the rent payable under the lease or sublease is at least market rent; and
- the term of the lease (including a further term arising under an option to extend the lease) is 10 years or less.

Section 20A(2) of the Act provides that a HHS cannot take or grant a lease of land or buildings without the prior written approval of the Health Minister or Treasurer, unless the lease is a type prescribed by regulation.

Part 2 Leases that may be taken

Part 2 prescribes, for clause 5 of the Regulation, types of leases that do not require the Minister and the Treasurer's approval. The types of leases are:

- for the following HHSs, a lease or sublease of land or a building, or part of a building, used or intended for use as office accommodation if the annual rent payable under the lease or sublease is not more than $100,000:
  - Cairns and Hinterland;
  - Central Queensland;
  - Central West;
  - Children's Health Queensland;
  - Darling Downs;
  - Mackay;
  - North West;
  - South West;
  - Torres and Cape;
  - Townsville;
  - West Moreton; and
  - Wide Bay;
- for the following HHSs, a lease or sublease of land or a building, or part of a building, used or intended for use as office accommodation if the annual rent payable under the lease or sublease is not more than $250,000:
  - Gold Coast;
  - Metro North;
  - Metro South; and
  - Sunshine Coast;

- a lease or sublease of land or a building, or part of a building, used or intended for use for a purpose other than office accommodation if the annual rent is not more than $100,000 but not including a lease or sublease of residential premises;
- a lease or sublease of residential premises, if the annual rent payable under the lease or sublease is not more than $100,000.

Schedule 3 Senior health service employee positions—Act, section 74A

Part 1 Positions prescribed by classification level

Part 1 prescribes, for clause 14 of the Regulation, certain classification levels for health service employees as senior health service employees.

Part 2 Other positions

Part 2 prescribes, for clause 14 of the Regulation, the position of visiting medical officer as a position in which a senior health service employee is employed if the employee is registered under the Health Practitioner Regulation National Law to practise in the medical profession and incurs ongoing private practice costs.

Schedule 4 Authorised purposes for prescribed patient safety entities

Part 1 Authorised purposes—Act, section 85

Part 1 prescribes, for clauses 36 and 38 of the Regulation, the authorised purposes for which a prescribed patient safety entity may receive a copy of a report or other document from a quality assurance committee for section 85 of the Act (Giving of reports and documents to patient safety entity).

Part 2 Authorised purposes—Act, section 112

Part 2 prescribes, for clauses 36 and 38 of the Regulation, the authorised purposes for which a prescribed patient safety entity may receive a copy of a root cause analysis report from a commissioning authority for section 112 of the Act (Giving a copy of RCA report—patient safety entity).

Schedule 5 Wards subject to minimum nurse-to-patient and midwife-to-patient ratios

Schedule 5 prescribes, for clause 40 of the Regulation, the public sector health service facilities and acute adult wards, which are either medical, surgical or mental health wards, that are subject to the legislated minimum nurse-to-patient and midwife-to-patient ratios.

Schedule 6 State aged care facilities subject to nurse and registered nurse percentages and minimum average daily resident care hours

Schedule 6 prescribes, for clause 41 of the Regulation, the state aged care facilities subject to nurse and registered nurse percentages and minimum average daily resident care hours for sections 138H (Prescription of minimum nurse and registered nurse percentages) and 138I (Prescription of minimum average daily resident care hours) of the Act.

Schedule 7 Prescribed health professionals

Part 1 Health professionals registered under the Health Practitioner Regulation National Law

Part 1 prescribes, for clause 48 of the Regulation, the prescribed health professionals registered under the Health Practitioner Regulation National Law for section 139 of the Act (Definitions for pt 7).

Part 2 Other health professionals

Part 2 prescribes, for clause 48 of the Regulation, the other prescribed health professionals, not registered under the Health Practitioner Regulation National Law, for section 139 of the Act (Definitions for pt 7).

Schedule 8 Agreements

Part 1 Agreements with Commonwealth, State or entity

Part 1 prescribes, for clause 52 of the Regulation, agreements with the Commonwealth, another State or Commonwealth or State entity for section 151 of the Act (Disclosure to Commonwealth, another State or Commonwealth or State entity). Under section 151, a designated person may disclose confidential information under these agreements, if the relevant chief executive considers the disclosure is in the public interest.

Part 2 Agreements with State entity

Part 2 prescribes, for clause 52 of the Regulation, agreements with State entities for section 151 of the Act (Disclosure to Commonwealth, another State or Commonwealth or State entity). Under section 151, a designated person may disclose confidential information under these agreements, if the relevant chief executive considers the disclosure is in the public interest.

Schedule 9 Dictionary

Schedule 9 defines terms used in the Regulation.