Bundaberg Hospital *Commission of Inquiry*

STATEMENT OF SHAUN PATRICK COLIN DRUMMOND

I, Shaun Patrick Colin Drummond, Executive Director Operations of the Townville Health Services District, of an address known to the Commission makes oath and states:

1. I am currently the Executive Director Operations of the Townsville Health Services District.

2. Previously I have consulted to unions and employer groups in New Zealand predominantly in the health, manufacturing and constructions industries. I have worked in Human Resources and Corporate Services in Hospitals in New Zealand since 1996. I joined the Townsville Health Services District in 2003.

3. I am responsible for the day to day delivery of services across the Hospital. My role involves support for the institute in the resolution of clinical issues. The clinical and operational directors of the Institutes report to my position on operational matters.

4. My position involves monitoring performance, activity, finances and the co-ordination of resources across the Hospital. I have no direct responsibility for supervision of clinicians on clinical issues.

Hospital Structure

5. The Townsville Health Services District is divided into 7 Clinical Institutes. Those Institutes each have a Clinical Director and an Operational Director. The Clinical Directors are practicing clinicians whose clinical workload is usually about 50% of their workload. The Operational Directors, where they are also Nursing Directors, are responsible for the nursing side of the Institute

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and are nursing professionals, however their role is predominantly administrative and they will not routinely perform clinical duties. In partnership, the Clinical Director and Operational Director of each Institute are responsible for the operations of their respective Institutes.

6. The directors have financial delegations and responsibilities for delivering the services required within the allocated resources in a clinically safe and appropriate manner.

7. When I arrived at the Hospital six of the Institutes were already established. Each Institute had a Chair that had a full clinical workload. For example, the Chair for Institute of Surgery was Mr Reno Rossato who at the time was a VMO. He had a full time clinical workload with no time allocated for his administrative duties. This meant the Hospital had a VMO running a $40million service with a staff of 700 with no time allocated to properly administer and plan for the service.

8. At the time the Hospital was in financial crisis and had significantly exceeded its budget for the previous year. The initial goal was to turn around the financial crisis. In 2003/04 the primary goal was to fund the actual occupancy from within the existing budget. Then in 2004/05 the primary goal was to attempt to expand services within the existing budget to meet community need.

9. In order to do that it was necessary to look at service planning and also find ways of increasing efficiencies across the Hospital. The goal was to find a way to deliver the same level of services for a lower cost. To do that it was necessary to examine those areas of the Hospital were efficiencies could be gained. For example, the use of pathology services was improved. There was also significant alteration to staffing configurations across the Hospital to make the Hospital more cost effective.

10. Over the past 2 years the Hospital has managed to employ approximately an additional 100 medical and nursing staff within the existing budget.

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11. There was also a detailed examination of budgets and expenditure across the Institutes. That was necessary to ensure that budgets were realistic. For example, in the Institute of Women's and Children's Health it had been approximately $2million over budget in the previous few years. The Executive took a decision to take $2million from the Executive Services budget and transfer that money to the Institute of Women's and Children's Health. That meant that the Executive had to find efficiencies to make up the shortfall and also wear the overrun at the end of the financial year. However, this also enabled us to get the Institute to take more accountability for financial control within that department. In the past the Institute had been frustrated in attempting to achieve the budget as the staff seemed to feel that it was pointless attempting to meet the budget as the budget was unrealistic.

12. When I arrived at the Hospital a decision was taken to keep the Institutes in place and appoint full time Clinical Directors and additional staff to allow for proper management of the Institute. At first, this resulted in increased cost but, in the long term, it has allowed the Institutes to better plan service delivery and manage their clinical resources.

13. As part of that increase in administrative time the Hospital also increased the autonomy within the Institutes. The Directors have significant autonomy in the management of their budgets; however they are also accountable for their decisions. This allows the Clinical Directors to have a large say in the operations of their Institutes. The financial responsibility is effectively devolved to the clinicians running the Institutes.

14. The Directors have responsibility for the purchasing of equipment, hiring of staff and the general operation of their Institutes. The Executive becomes involved when there are issues of inadequate resources to provide the services or alternatively where there is a need to purchase something, or hire someone which will result in a significant ongoing cost to the Hospital. The Hospital recently applied to Queensland Health to increase the financial delegation of

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the Clinical Directors from $20,000.00 to $50,000.00 to enable them more autonomy. In my view, the Clinical Directors ought to have a financial delegation to spend between $50,000.00 and $100,000.00. However, the recent application to increase the financial delegation was not supported by the officers co-ordinating this for Queensland Health and subsequently rejected by Corporate Office.

15. The Structure is designed to have clinicians in charge of the operations of the delivery of clinical services. The Executive then takes on the role of advocating for increased resources, seeking additional efficiencies across the Institutes, and co-coordinating the delivery of services across the District. The Executive exists to empower and support clinicians and the key is that clinicians are directly involved in the decisions that affect clinical delivery of services.

16. This management structure is similar to that in many New Zealand Hospitals and, in my view, would operate in smaller Hospitals, albeit with some modifications. The process results in the balancing of decisions within the Hospital from a medical, nursing and management point of view. It combines good clinical governance with sound business practices to delivery clinical services to the community.

17. Under the old structure the Institutes were not given control of their capital budget and the Executive had to be involved in all purchasing decisions. Under this model purchasing decisions are left to clinicians who best understand the needs to deliver services. I don't think that it is necessary for the Executive to see every purchase order.

18. The structure of the Hospital is unique within Queensland Health, and possibly within Australia. It is not well understood within Queensland Health.

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Corporate Office

19. I have limited contact with Corporate Office as Mr Ken Whelan deals with Corporate Office on behalf of the Hospital. However, from my dealings with Corporate Office, it is clear that the structure of the Hospital in Townsville is not well understood.

20. In my opinion, Corporate Office doesn't have any role in assisting the efficient operation of the Townsville Hospital. The main interest of Corporate Office appears to be a bureaucracy for its own sake resulting in the collection of data for the sake of collecting data and the implementation of policy and systems without any attached resource. There is little feedback from Corporate Office on the data that is collected. This information may be useful in a global environment but has little relevance to clinicians at the patient contact point.

21. The constant requests for data are a burden on the Clinical Directors as much of the information is in the hands of the Institutes within our structure.

22. An example of this is the measured quality report that has a completion time of about 2 years. By the time the report is produced the data is so old it is irrelevant. In order to be of any use data must be current and relevant.

23. In the Townsville Hospital the principal decision makers are clinicians. In order to be of use to clinician's the data must be accurate, relevant and timely. In my opinionc the measured quality program meets none of these criteria. To effectively manage a Hospital the data must be timely.

24. The Townsville Hospital has a 5 day coding time. This means that the average time between a patient being discharged and the data being entered into the clinical information systems is 5 days. Most other Hospitals have an average coding time of 30-40 days. This allows the Townsville Hospital to provide a timely and accurate snapshot of what is going on in the Hospital now.

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25. The Hospital achieved that through managing resources and ensuring that the data coding section is staffed appropriately. The coding section has an establishment of 5 FTE, however currently we have one vacancy. If the coding time blows out then more resources are temporarily added to ensure that the 5 day timeframe is met. There has been significant interest from other Hospitals about how the Townsville Hospital has achieved this result.

Elective Surgery and Hospital Funding

26. The funding model used by Queensland Health is inherently flawed as it takes no account of activity and is based on a historical funding model. The only other source of funding is through the elective surgery program.

27. The elective surgery program is used by the Townsville Hospital as a means of sourcing funds across the other Institutes particularly medicine. It is important to remember that elective surgery is often lifesaving surgery. For example, a large proportion of life saving cardiac surgery falls within the meaning of "elective surgery".

28. The Townsville Hospital has looked at ways to increase surgical activity within the existing cost structure. For example, if the Hospital is currently doing three vascular surgery lists per week, by adding an additional session each week within the current staffing levels it is possible to increase the revenue within the current marginal costs. By maximizing the efficiency of operating theatres it is possible to increase total revenue for theH. This is only possible where there is already a pre-existing level of activity within a particular type of surgery.

29. The Hospital has been very aggressive in targeting elective surgery as it is an important source of revenue for the Hospital and is used as a means of increasing services across the Hospital. This has enabled the District to create additional medical appointments in Vascular, ENT, Urology, General Surgery, Orthopaedics and Neuro Surgery.

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30. Other steps that have been taken have been to look at bottlenecks in activity and see if there are specific areas were efficiency can be improved. For example, in ENT surgery there was a long waiting list. In order to address that waiting list the Hospital created another Staff Specialist.

31. The current funding model does not reflect increases in activity. For example, the Townsville Hospital has had a 13% increase in renal services over the past few years and this reflects and increased cost of approximately an additional $1million per annum. Over a two year period this has resulted in a need to fund within internal budgets an additional $2million per annum to maintain the services to our community.

32. Even though the Hospital has aggressively pursued efficiencies in the elective surgery program, the decisions on the surgery to be performed is always based on clinical need. In the last financial year the Hospital did not meet its elective surgery program by about 200 weighted separations. The Hospital had to return about $500,000 to Corporate Office.

33. In my view, population based funding models, while not perfect, have some advantages over the current funding model. Those models can take into account issues such as population growth, ethnicity, age, and remoteness of service delivery, and can lead to a fairer funding model.

Difficulties in Recruitment of Doctors

34. I am not heavily involved in the recruitment of Doctors to the Hospital generally. However, in my view, one of the difficulties is that the remuneration system for Staff Specialists is inflexible and makes it difficult to effectively tailor salary packages to individual doctors. For example, Staff Specialists are provided with a motor vehicle. The total cost per annum of operating a motor vehicle is about $20,000.00. If the doctor wished to cash out that benefit then the Hospital can only pay $6,000.00 instead.

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35. Another area of inflexibility is annual leave. It is not possible for an employee to "purchase" additional leave as the remuneration system is too rigid.

36. In my view, there needs to be increased flexibility in how salary packages can be structured. The total cost to the Hospital would be the same but the package could be structured to suit the individual which would make working in Queensland Health more attractive.

Use of VMO's at the Townsville Hospital

37. The Townsville Hospital has a number of VMO's working across most of the Institutes. There are some Institutes that are staffed extensively with VMO's.

38. The Townsville Hospital has no specific policy about recruiting VMO's, rather the Hospital recognises the need to provide health services and attempts to do so using what ever doctors are available VMO or Staff Specialist.

39. As far as cost is concerned I believe that VMO's and Staff Specialist are very comparable as far as the total cost to the Hospital. For example, when you include superannuation, holidays and conference leave and the other costs involved in employing and consider that on an hourly rate the cost to the Hospital of a Staff Specialist the cost is comparable to the cost of a VMO.

Neurosurgery in Townsville

40. The Townsville Hospital has been actively seeking a third neurosurgeon for some time. The Hospital currently has two neurosurgeons, Dr Rossato as Staff Specialist, and Dr Guazzo as VMO neurosurgeon. However, Townsville is the acute tertiary referral centre for the Northern Zone. The Hospital also takes referrals from the Central Zone. This makes the acute call for the service demanding and leads to the need for at least a 1 in 3 call for each clinician.

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41. In the circumstances, a third neurosurgeon is necessary to sustain the practice in the long term.

42. The Hospital has not been allocated any funding for an additional neurosurgeon. The Hospital has managed to fund the position from within its own budget.

43. As a result of this the Hospital has recently employed Dr Donald Myers as a locum neurosurgeon with a view to attempting a more permanent appointment in the future. I was not involved in the recruitment process until the decision had been made by the Institutes. I became involved in negotiations about the financial arrangements to bring Dr Myers from Townsville.

44. I recall that Mr Rossato and Ms Jackie Hanson had interviewed Dr Myers and considered him to be a good applicant. Mr Rossato and Ms Hanson did state that Dr Myers may need to refresh some of his skills as his practice in the Virgin Islands would have a different scope, however they had confidence in has clinical skills.

45. Ideally the neurosciences unit at the Hospital should have three neurosurgeons and at least one additional neurologist in order to be sustainable in the long term.

All the facts and circumstances above stated are within my own knowledge and belief save such as are from information only and my means of knowledge and sources of information appear on the face of this my statement.

SWORN on 2nd day of August 2005 at Townsville in the presence of:

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