QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF DR MICHAEL IAN CLEARY

1. I, **DR MICHAEL IAN CLEARY,** Acting District Manager and Executive Director of Medical Services of The Prince Charles Hospital Health Service District ('TPCHHSD') of c/-Building 14, The Prince Charles Hospital, Rode Road, Chermside in the State of Queensland, acknowledge that this written statement by me is true to the best of my knowledge and belief.

2. This statement is made without prior knowledge of any evidence or information held by the Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me

Role of Executive Director of Medical Services

3. I have been the Executive Director of Medical Services of TPCHHSD ('EDMS') since April 2000. On 2 August 2005, I was also appointed as the Acting District Manager of TPCHHSD.

4. Attached and marked **MIC-1** is a copy of my curriculum vitae. Pages 4 and 5 of my curriculum vitae sets out some of the duties I have undertaken as EDMS.

5 The position description for the position of EDMS is attached and marked **MIC-2**.

6. My role as EDMS includes:

   a. Coordinating the administrative activities and staff within Medical Administration;

   b. Responsibility for the management and oversighting of a broad range of clinical governance activities including:
      - Medical Advisory Committee ('MAC')
      - Medical Credentials and Clinical Privileges Committee
      - Selection, Appointment and Clinical Privileges Committee

- Postgraduate Medical Education Committee
- Patient Safety Committee

7. The MAC was established to provide a formal mechanism through which clinicians were able to have input into the planning and management of services at TPCHHSD. The Terms of Reference of the MAC are attached and marked **MIC-3** The MAC has a key role in TPCHHSD decision making processes. It also acts as a 'clearing house' for matters where different clinical groups have divergent views on the same subject and where no consensus position can be reached. In this manner clinicians can debate and resolve challenging issues. The MAC is chaired by a senior clinician and includes senior clinical staff as well as young leaders who will over time take up senior leadership roles. The Chair of the Committee is also a member of TPCHHSD's Executive Committee, the peak decision making group in TPCHHSD.

8. The Medical Credentialing and Clinical Privileges Committee considers all applications for clinical privileges at TPCHHSD (attached and marked **MIC-4** is an Application for Clinical Privileges form). The Chair of this committee is also the Chair of the MAC. The majority of the Committee's work is conducted 'out of session' that is, by circulating the relevant documentation among Committee members Privileging of International Medical Graduates is managed through the same process once the regulatory arrangements relating to appointment and ongoing employment are complied with.

9. When complex issues arise, a Specialist Advisory Committee may be established to make recommendations. For example, in early 2004, a Specialist Advisory Committee was established to advise in relation to two issues; carotid artery stenting and endovascular aortic stenting (attached and marked **MIC-5**).

10. TPCHHSD also has procedures and policies in place that govern the overall management of medical staff. The Chair of the MAC and I have developed, reviewed and endorsed the following procedures:

    a. The Appointment of Consultant Staff and Initial Granting of Clinical Privileges (attached and marked **MIC-6**).

    b. The Management of Medical Staff within TPCHHSD (attached and marked **MIC-7**).

    c. The Medical Credentials and Clinical Privileges (attached and marked **MIC-8**).

11 As EDMS, I also:

    a. Advise the District Manager about applications for the use of new technology or procedures. These applications are first considered by the MAC and the

Specialist Advisory Committee, a sub-group of the Credentialing and Privileging Committee. Both committees obtain advice from relevant specialists before making a recommendation about any application.

b. Oversee all matters relating to the research activities undertaken at TPCHHSD through membership of the Human Research Ethics Committee and through the Office of Research and Ethics at TPCHHSD. The Human Research Ethics Committee considers applications to undertake research and deals with any issues that arise during research projects

c. Oversee medical education provided within TPCHHSD. The Post Graduate Medical Education Committee together with the Directors of Clinical Training manage this process.

d. Oversee patient safety and clinical risk management by chairing the Patient Safety Committee. This Committee, which is made up of a cardiac surgeon, Cardiologist, Intensive Care Specialist, Anaesthetist, Anamatomical Pathologist, Psychiatrist, Quality Manager, Medical Officer – Clinical Audit, Executive Director Nursing Services, Deputy Director Medical Services and EDMS, has a key role in assuring patient safety within the TPCHHSD. The Terms of Reference of that Committee are attached and marked **MIC-9** The Patient Safety Committee:

- Monitors, investigates, reports on and oversights action in relation to adverse and sentinel events.
- Reviews Root Cause Analyses of adverse and sentinel events and makes recommendations on further action to the District Manager.
- Considers concerns raised by medical practitioners and independent reviews about the health services provided by TPCHHSD.
- Oversees audit processes at TPCHHSD. Most recently, the Committee established a review process for all deaths that occur within TPCHHSD
- Recommends changes to practice or procedure within TPCHHSD arising as a result of its activities.

The Patient Safety Committee has been functioning in its current form for 12 months and during this time its have evolved. Attached and marked **MIC-10** is a copy of the Lessons Learned newsletter.

12. I am a member of the Queensland Health Safety and Quality Board and the Commonwealth Medical Services Advisory Committee. The Commonwealth Medical Services Advisory Committee oversights the use of new technology and procedures for the Commonwealth Department of Health.

13. I have been trained in the United State's Veteran's Health Administration Root Cause Analysis model. I have also had the opportunity to represent Queensland at a number of national and international forums relating to this area From my experience, I have formed the view that clinical governance needs to be based at the clinical unit level. This means that clinical units should be responsible for the development of clinical pathways. It is at this level that evidence based clinical practice guidelines should be implemented.

Elective Surgery and Classification Systems

14. From March 1993 to mid 2003, I was a member of the Australian Casemix Clinical Committee, the national committee tasked with the development and implementation of the casemix classification coding systems (both inpatient and outpatient) nation wide. Between about mid 1999 and mid 2003, I was also either the deputy chair or chair of that Committee.

15. Casemix is a generic term describing any system which groups patients by predetermined factors into clinically meaningful and resource homogenous groups to describe the services provided by a health care facility. For example, a group may be knee procedures or cardiac valve procedures.

16. Diagnosis Related Groups ('DRG') is the classification system that is used in Australia and in most countries around the world, to describe the acute inpatient casemix of a hospital by categorising patients into similar groups which:

- Are clinically similar;
- Require similar levels of resource consumption for treatment;
- Represent a manageable number of categories;
- Comprise of class definitions based on information routinely collected by hospitals.

17. Casemix enables us to relate service outputs to resources, develop prices which the provider is willing to 'pay' for the various services provided by Districts and to determine and monitor activity levels ie. weighted separation targets.

18. Through the Service Agreement, Districts negotiate activity targets which relate to the treatment of acute inpatients. The targets are expressed in weighted separation as measured by the Hospital Funding Model.

19. A 'separation' is another word for discharge. A 'weight' indicates the costliness relative to all other DRGs. An acute episode of care is determined by the 'Admission Type' field in HBSCIS. A 'weighted separation' is an acute episode discharge that has had a weight allocated to it depending on the type of treatment provided

20 I have authored a number of articles in relation to the Casemix classification coding system for both inpatient and ambulatory, that is, inpatient, care. Attached and marked :

a. **MIC-11** is an article that was published in the 5 September 1994 edition of the Medical Journal of Australia titled *"The future of casemix in emergency medicine and ambulatory care"*. The article details a classification system for emergency departments that has subsequently been implemented nationally and is used for reporting and benchmarking

b **MIC-12** is an article published in the 19 October 1998 edition of the Medical Journal of Australia titled *"Outpatient costing and classification: are we any closer to a national standard for ambulatory classification systems?"* The article details a major research initiative that concluded that a clinic based classification represented the optimal classification to describe outpatient services and that it was imperative to establish a method of measuring outpatient activity. A clinic based classification system is now in place, however, reporting and benchmarking is limited.

c. **MIC-13** is an article published in the Annals Academy of Medicine in July 2001 titled *"Getting Clinicians Involved. The Australian Experience"*. The article details how the Australian Casemix Clinical Committee operated and the importance of clinical leadership.

Current Elective Surgery Program

21 The manner in which the current elective surgery program operates is not significantly different to the original set up. The key changes are:

a. The amount of funds available for additional elective has increased.

b. The bonus pool has ceased. In the initial phases of the project it was desirable to stimulate the system to a greater level of activity. However, for the maintenance phase of the elective surgery program, it was not desirable to have overstimulated elective surgery activity and the bonus pool was ceased.

c. The Casemix weights for some DRGs have changed over time as the classification and costing systems have been further refined.

d. Targets for additional elective surgery are now set for Health Service Districts as a result of discussions with their Zonal Management Unit and the Senior Executive Director of Health Services. This reflects the increased understanding of the systems in place to manage surgical activity

e. The policy framework for elective surgery services has been regularly reviewed and revised. The current policy is the *"Policy Framework for Elective Surgery Services"*. A copy of that policy is attached and marked **MIC-14**.

f. The initial Elective Surgery Project was designed to set up a coordinated Elective Surgery Program. The implementation process required the centralisation of a great deal of the infrastructure associated with elective surgery. Much of that infrastructure has now been transferred to the Zones and other business units. For example, the Zones now track activity.

Problems with the Current Elective Surgery Program

22. The key problems with the current elective surgery program are:

a. That Health Service Districts are potentially penalised if at they fail to meet their elective surgery targets, that is, they have to pay back funds.

b. Although a sophisticated system for elective surgery funding has been developed, there are no comparable systems for the non-elective surgery interventions such as medical interventions (for example, endoscopies), surgical substation procedures (for example, implantable pacemakers, atrial septal defect closure devices, laser surgery on lung cancer and coronary stenting procedures) or for medical services in general. In my opinion, further refinement of the funding and monitoring systems should occur so that medical and surgical substation procedures are included in the elective surgery program. To not do so unfairly distorts the system and leads to preferential access to treatment of patients who have recognised elective surgical conditions.

c. In my opinion it would be appropriate to publish in the public arena the emergency department performance measures and outpatient and other ambulatory activity waiting times. Clear guidelines on definitions and for waiting time benchmarks will be required. I note that the major hospitals in Brisbane are not consistent in terms of some areas of waiting list management for non-elective surgery cases.

Integrating Strategy and Performance ('ISAP')

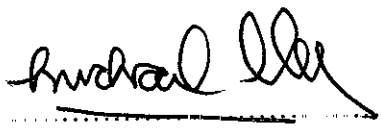
23. ISAP is a process that enables us to break down the strategic intents of Queensland Health into manageable steps or objectives. ISAP also enables us to measure our progress in becoming a strategy focussed organisation

24. Through the process Queensland Health will:

- Ensure that all employees are driving the same strategy forward and helping to create a sustainable health system;
- Communicate our strategy widely and engage staff and the broader community;
- Identify and prioritise health issues and put in place activities or processes to manage them;
- Align our finite resources to the direction we intend to take;
- Continually measure and review our progress towards achieving the strategy;
- Review our strategy to take into account future trends and potential issues.

25 TPCHHSD was one of the 4 pilot sites for the ISAP process. I was Acting District Manager for part of this time and lead the implementation locally. ISAP provided a strong focus on linking strategy and performance which is one of the many planning frameworks which Districts have to consider. Attached and marked **MIC-15** is a summary of the TPCHHSD's involvement with ISAP.

Signed at **Brisbane in the State of Queensland** on **23 August 2005**.



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