Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-19

April 2004

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T		6	13	20	27
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May 2004

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June 2004

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March
WEEK 14

GLORIA WALLACE
24 — 9 — 2004

KEY ISSUES 7.30AM — 9.20 089/277 **Monday 29**

8.00 am
- Leadership
9.00
- Culture — where we go
- Collaboration = unique programme
10.00
- Budget

11.00
Directorship — Corrective bodge today Nationally & International
Noon
Look at a Statewide plan for Cardiac Services — Apparent that it is absolutely critical. Mtg = Dr Buckland 1/12 ago suggested to this. He agreed that it is appropriate to look at that.
1.00
We asked that Gloria meet = Statewide Planning Group — submission went to the Board of Management of the group
2.00
Pat Copeland has been involved.
Names of people to talk to have been given to her
3.00
She minute has endorsed this — to be completed after the renal plan
4.00
(Which mentioned the previous committee, statewide — which has been abandoned)
5.00 pm

090/276 **Tuesday 30**

8.00 am
(Con talked of the CSANZ plan. It has been fed into the committee. No official response from Old Health
9.00
apart from acknowledgement of receipt. Point that statewide issues relate to this hospital
10.00
(Cameron asked if the plan for Paed Cardiol statewide. Gloria says paediatrics should be part of the planning process. Cannot say that it is independent
11.00
(Rob asked about the time frame — Gloria does not have this
Noon
1.00
Hard fortune project — endorsed by this district. Has had to go through other administrators and is therefore slow.
2.00
Working on an implementation plan — starting next week
3.00
Two VMOs on that plan — looking to get George Jaworsky on board
4.00
5.00 pm

March - April

WEEK 14

January 2004						
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February 2004						
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March 2004						
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31 Wednesday 091/275

8.00 am
- Staffing is an issue
- difficult to plan around staffing
9.00 eg with Con on leave, not knowing what
long term intention is
10.00 Need to trust people and plan.
Has been told about people leaving from
11.00 our agency in South Africa

Noon
- Activity & Funding

1.00 (Barrer stated that the next pressures do not
relate heart failure - picking out zebras
2.00 from the programme.
Gloria says there is an enormous heart failure
3.00 load
(Deb Meyers says we are all interlinked
4.00 with both labs, surgery etc
(Cameron Ward - staffing has been stable
5.00 pm for 8-10 years with increasing need which
has been made clear

1 Thursday 092/274

June: We have had discussions about that a
8.00 am meeting has been arranged, cancelled and
is now rescheduled
9.00 (Con - Overseas graduates are unlikely to
come and stay for years. They go out
10.00 into private. We need to get our
Registrars into the system. Look around
11.00 the task as to long term people who stay back
- Issues of succession planning
Noon Feedback that Registrars are not enjoying
their experience
1.00 - exposed. Will set up meeting again
needs to finalised by end of October
2.00
(Rob - Need environment with attractions
3.00 such as research etc People will stay
if it is a pleasant environment
4.00
(Barrer - Clinicians feel that Administrators
5.00 pm contribute to that culture
Con - We are the only advocate for our

April 2004

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May 2004

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093/273 **Friday 2**

8.00 am — patients. We are bothered
C- perceptions of the cardiology programme are not good
9.00 — We have to be politically savvy
We have to present a cogent case showing that
10.00 — we cover all the facts + solutions
E-mails / letters create responses,
11.00 — (Darren — local issues create problems.
Noon — C- I have to act when E-mails go around I
1.00 — have to investigate.
2.00 — Darren — who is picked to enquire has relevance
C — JG is not easy to get people to come and investigate
3.00 — She would prefer not to have the responses in
the first place. Once exposed she has to
4.00 — investigate
— She does go to corporate office
5.00 pm

Deborah

094/272 **Saturday 3**

8.00 am — It is a problem that corporate office has a
perception of trouble making. How can
9.00 — we remedy this and move forward?
Jan Cameron
10.00 — important to maintain a critical mass of
quality. There are sustainability issues
11.00
C — There is a healing process to go through
Noon — We came out of Corporate office after 10 yrs
1.00 — We were initially a mess, hitching the system
learnt that to influence the system, we
must work within the system
2.00 — Need to work positively with clear transparent
reliable information. But we have not
3.00 — collected this information reliably.
4.00 Darren — Perception causes a problem
C — We have not had the systems in
5.00 pm — place to record the activity
approach the way Darren works on hand

095/271 **Sunday 4**

April
WEEK 15

February 2004						
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5 Monday 096/270

Ching Ming Festival (Hong Kong) Arbor Day (South Korea) Tomb-Sweeping Day (Taiwan)

8.00 am C — In recent weeks we have got better systems in place.

9.00 — It is not efficient to oversee cardiac beds & do late night rounds to clear beds

10.00 — We are doing many over activity than we funded ourselves

11.00

Rob — If we are over activity who does our activity (in beds)

Noon

Darren — Loss for Robotic — productivity of staff is high outcomes are excellent

1.00 — Criteria by which we are judged is that we do not cross budget level.

2.00 — All criteria on LOS, patient outcome etc are good, but not judged.

3.00

4.00 Rob — We need to manage before Strathwide plan

C — Leave absence

5.00 pm Darren — Leave has exploded recently

6 Tuesday 097/269

Chakri Day (Thailand)

Why do you think it is? Does this reflect problems in the system?

8.00 am

9.00 C — It can also tell me that we have poor collaborative management

10.00

Darren — Personally, the environment has become unbearable

11.00

Noon Cameron — Beds has managed Reflects to Ward Earth Lab Investigations

1.00 C — Plan re CDT has been sent to you

2.00 — Come back with plan.

3.00 D — set time frames Lab stands 9.00 & 5.00

4.00 C — routine

5.00 pm It was agreed that there was over Level of activity. You were

May 2004

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July 2004

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April
WEEK 15

098/268 **Wednesday 7**

8.00 am — given a list of possibles and asked to discuss it with colleagues. There was a 52 week year with 57 allocated cases — To reschedule in regard to numbers

9.00

10.00 — Must have an early morning discharge round

11.00 — Ability to have registrars to work in the open of hours and not having formal clerks at 7.30

Noon — After the rescheduling of cath lab — It was all premised on physician feed-back

1.00 — Disagree that ward we need to be out by 5-00

2.00 — We need to predict start + finish times

3.00 — Cannot have all the add-ons at the end of the day

We have to define what is an emergency

Wanting a list of waits to define with PAH

4.00 — as we are still doing $300,000 worth of Sanitum Jane activity per month

5.00 pm — Agree Dental + Transplants come here

Maundy Thursday (Philippines) — 099/266 **Thursday 8**

Can work through a lot of that with PA

8.00 am — She is trying hard to work with us on this.

9.00

It is up to us to define which days it will finish early.

10.00

11.00 — In practice, this has impacts on the waiting list

We are to monitor the waiting list and

Noon — corporate office is monitoring this

1.00 D — Recently the waiting list 589 — PCH

105 — RBH

2.00 — negligible — PAH

3.00 C — Will negotiate with PAH

4.00 Can — be W/L at PAH.

Go in the physicians mind who does not adhere to Australian Guidelines

5.00 pm

April
WEEK 15

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9 Friday *100/266*

Good Friday Bataan Day (Philippines)

8.00 am — Clare Wright — In parts, we cannot transfer elsewhere
9.00 — She transferred a lot of cath work to MR1
But to now have a cut is bad
10.00
Gloria — There is a misunderstanding here
11.00 It was not the intention to cut bed lists
Annmarie —
Noon There is not plan to cut these lists
1.00 Chris — relates to lack of anaesthetists
2.00 Michael — Put up 6 slots per week for elective
Cleary
3.00 Camelon — The number of interventional cath as
a proportion has increased
4.00 Cleary — must think of planned leave,
Christmas etc
5.00 pm — make adjustments

10 Saturday *101/265*

Easter Saturday (Hong Kong)

8.00 am Darren — procedures
All ASDs are
9.00
Gloria Does not want to beg down into
10.00 specifics just
11.00 Jobs not received back on agreed
plan
Noon
Happy to negotiate at a higher level re
1.00 what patients need to go to Southern Zone
2.00
Peter Pohlner Why is PCH being presented with such a
3.00 large caseload compared to other hospitals
Doctors are getting a service here that
4.00 the patients need
The changes to which have occurred in
5.00 pm surgery — 34 5.00 pm/c are inhospital patients

11 Sunday *102/264*

8.00 am are capped
9.00 gone for the year
10.00 get
11.00
Noon
2.00
3.00
4.00

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April
WEEK 16

103/263 Monday 12

Easter Monday

8.00 am — (They are each on a ~~another~~ a lower W/L)
We are working on crisis mode

9.00

To go from 90 to 57 cases per week in COT,
that will impact on the surgical list
We will chew up hospital beds of patients
10.00 waiting Cognate office need to be aware
of this

11.00

Noon

C I have advised cognate office
1.00 We have to be seen to be managing
the 57 cases per week will end up > 70
2.00 per week with leave etc

3.00 D We have never closed down cath lab

4.00 C I am asking that you distribute the case load
We are each really progressing at this point
5.00 pm What would you like to do from here?

104/262 Tuesday 13

Songkran & Family Day (Thailand)

8.00 am — Should you have a meeting
- Work out how the group should be led
9.00 until the new director is appointed
- So we need to have a facilitated work shop

10.00

Chris The cath lab conflicts the hospital service
11.00 In cap the COT service is cutting ability
to service patients

Noon

Cameron The basic problem is that the budget is
1.00 inadequate

2.00 C If we cannot get to an agreed plan of
management otherwise management will
3.00 have impose a plan on us
Giving us a chance to manage it

4.00

5.00 pm D We are playing a game of whist the
patients outcomes are bad

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WEEK 16

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14 Wednesday *105/261*

Songkran & Family Day (Thailand)

8.00 am George – Concerns about losing Cert a Darren, we are really in trouble

9.00 Darren has been very efficient in moving patients through

10.00 The great stress in numerous phone calls of patients elsewhere awaiting investigation That is why the junior staff do not enjoy working here

Noon The Aust. guidelines published for management have changed the game

1.00 Waiting for plans is frustrating Not giving answers, but summarizing the findings

2.00

3.00 Chris Our jobs as administrators / clinicians all confused

4.00 There is a morale problem

5.00 pm G We can each around this.

15 Thursday *106/260*

Songkran & Family Day (Thailand)

8.00 am The only way is to set activities around our budget, monitor our work and numbers, then go on.

9.00 Darren To provide rationing criteria eg age of the patient

11.00 G There are 2 possibilities – we manage who come in the door then close the door or we can rationalise the work.

Noon

1.00 Peter Feldner Clinicians should accompany you to Aged Health to explain

2.00

3.00 G You as a group may need to plan how budget is used.

4.00 I have asked for more

5.00 pm The department says there is a lot of money but on,

107/259 Friday 16

8.00 am — Con — Obvious a simple solution is to put an age limit on

9.00 — Now that Old Health made a cutoff of 70 years

10.00

11.00 — G — go away and discuss how we move forward then have a meeting & Michael in the next 2 weeks

Noon

1.00

2.00 — Attendees

3.00 — Gloria Wallace
Michael Cleary

4.00 — Jan Roberts
Cheryl Burns

5.00 pm — Jenny Walsh

108/258 Saturday 17

8.00 am — Logan Einstein
Margaret Dahlia

9.00 — Darren Walters

10.00 — Dorothy Rochford
James Cameron

11.00 — Peter Pohlmer

Noon — Peter Desar

1.00 — Deborah Meyers
George Donnelly

2.00 — Liza Walters

3.00 — Chris Wright
Rob Justo

4.00 — Cameron Ward

5.00 pm — Ronel Denman
(not to leave)
Mark Bell (")

109/257 Sunday 18

8.00 am

9.00

10.00

11.00

Noon

1.00

2.00

3.00

4.00 — Con Arney

5.00 pm — Eric Bonsant

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-20

MINUTES OF MEETING
between
Dr Con Aroney & Ms Gloria Wallace, District Manager, The Prince Charles Hospital
On Wednesday 3rd November 2004 at 1030am – 1130am
Venue: District Managers Office, The Prince Charles Hospital

Attendees:
Ms Gloria Wallace, District Manager
Dr Michael Cleary, Executive Director Medical Services
Dr Con Aroney, Cardiologist
Dr Peter Tesar, Cardiac Surgeon

GW indicated that she wished to discuss Dr Con Aroneys leave application.

CA indicated that until he saw the hospital running smoothly he would not wish to return to work.

He also indicated that he was unhappy with the current Capitation system in place within the Catheter Laboratory.

GW requested that Dr Aroney reconsidered his position given that there was a high level of demand within the Cardiology Service and that further leave would impact on this.

Dr Aroney was advised that should he wish to take leave that the District would approve this. It would prove difficult for the District to replace Dr Aroney and this may impact on patient care. Gloria Wallace asked Dr Aroney how his position should be filled.

CA responded indicating that if the catheter lab activity was capped at 57 cases per week that this could be done from within 1 laboratory and by the existing specialist staff being Dr Walters, Dr Bett and Dr Cameron.

He indicated that he still had a commitment to the hospital if the laboratory was quote "fully funded".

GW advised that Dr Walters had provided her with information indicating that 65 cases per week was required to service the needs of the Central Zone.

CA responded by saying that "this should have been considered before this mess occurred".

GW Stated that "if you are working in the public interest and given your comments would it not be appropriate to return to work at this stage and not take further leave".

CA responded "not if I am not able to work in a laboratory working at capacity".

He indicated he was happy to hear that growth had occurred in the infrastructure of both the Royal Brisbane and Princess Alexandra hospitals but suggested they were not serving their community appropriately at the current point in time.

It was the view that "transfer of cases to the PAH was illogical".
He indicated that "Royal Brisbane and Women's Hospital are understaffed and demoralised".

GW indicated that the advise from the Royal Brisbane & Women's Hospital and Princess Alexandra Hospital was that they are able to assist the Prince Charles Hospital in addressing the waiting list and that the Cardiology Departments there were not under resourced.

MC explained the process by which patients are being reviewed and transferred to the RB&WH and the PAH. He also indicated that more than 20 cases had been booked for procedures at those hospitals and this had reduced the number of patients on the category 1 waiting list at TPCH.

GW indicated that she was not aware of the specific funding and case / activity that had been approved at the PAH and RBWH but that this was under discussion at the moment. There is capacity for the two hospitals to take on some additional work.

CA further commented that transfer of any activity to the PAH was not appropriate as they are not able to currently support patients within the Southern Zone.

CA requested to be advised of the status of the current Statewide review.

GW advised that Qld Health's approach at this time was that Qld Health funds Cardiac Services and that Qld Health has a responsibility to transfer cases from long waiting lists to shorter waiting lists where this was practically possible. This was even more important where hospitals had been resourced or had the resources to be able to take on additional patient loads.

CA Indicated that the transfer of activity would not work because patients would still be referred to TPCH because cardiologists believe that TPCH provided more appropriate level of service.

PT indicated some support for Dr Aroney in that patients tend to be referred to TPCH because Cardiologists within Brisbane are aware that there is better access to AICD Implantation Services at TPCHHSD.

PT described the changes in his Cardiac Surgical Practice where he was performing more complex and redo surgery.

GW asked Dr Aroney why there was a problem in transferring the cases given the principles under which Qld Health operates.

PT responded by indicating that the funding did not necessarily match the cost of certain procedures because of the complex nature of the procedures performed at some sites such as TPCH vs the less complex procedures performed at other sites.

GW advised that this was addressed through the funding model and should not be the subject of discussion and that the more important thing to discuss was the clinical distribution of services.

PT agreed that the distribution of services was a critical element of discussion and that what was needed at TPCH was a sustainable infrastructure to support services. He particularly did not wish to be working with "hassled Cardiologists".

PT agreed that everybody supports growth in activity at both the PAH and RBWH but that also there needs to be a growth in the critical mass and services at TPCH.

CA stated that "if this place goes down then state services will be affected". This included ASD closure therapies where TPCH is the leader and had performed more than 90 of these procedures: Valvuloplasty, where again TPCH is the leader and he personally had performed more than 300 cases and Septal ablations where there had been approximately 30 cases performed at TPCH. He further indicated that staff that perform these procedures may move from TPCH if the environment was not appropriate.

GW clarified her comments at a previous meeting that locum cardiologist perhaps were available from overseas but that it would be a difficult process in bringing these staff into the hospital.

PT indicated that we should not discuss the operational issues further but that we needed to focus on the overarching services and how these services would be supported.

PT indicated he wished to discuss service delivery for example the model of care in paediatric cardiac surgery which was very robust and appropriate when people worked across both adult and paediatric services.

PT indicated that we needed to recognise the critical mass required for some services and that some of the staff working at the hospital is unbelievably skilled.

GW noted Dr Tesar's comments, advised that there had been significant funding provided to the hospital and that this included:

- ASD closures
- ICD would be increased and that there had been discussions between the Acting SEDHS and Dr Denman.
- Stenting activity had been increased with the provision of $850,000.00 in addition to base funding.

CA Indicated that "funding may be available but you may not have staff".

GW requested clarification as to whether Dr Aroney was still planning to take leave given that there had been a clear commitment to increase funding and resources within TPCH as well as other hospitals within Queensland.

CA advised that "he should be careful and that he had spoken to his union representatives in relation to this".
- He would have to consider it in the context of coming to a hostile environment where he maybe victimised.
- He also indicated that he believed Dr Darren Walters be made the Director of Cardiology because he was an extremely competent Cardiologist.
- Dr Aroney further advised that the union had advised him of potential hostile environments when people return to work after speaking out in a public arena.
- Dr Aroney said that "I am taking my leave and will see what happens, and that staff within the hospital should be able to cope with the demands of the services".

GW asked Dr Aroney if given the above comments he planned to return to work at all.

CA advised "I have not made a decision; I will continue to take leave until there has been a turn around".

Dr Aroney indicated that he had previously been given unanimous support from the Cardiologists and was prepared to continue to advocate for patients.
He also indicated that he had been prepared to return if he was offered the position of Director of Cardiology.

PT Expressed the view that Darren Walters was an excellent cardiologist but was still maturing. He had improved many aspects of his approach to work.
PT asked if there was a way of easing Dr Aroneys return to work.

GW indicated that she was not aware of the reason for Dr Aroney's concern, however, she would expect that he as all employees of Qld Health would comply with the Code of Conduct. Ms Wallace also indicated that Dr Aroney would be in breach of this document if he were currently working at TPCH and not on leave. For example releasing into the public arena details of the hospitals waiting lists without approval.

GW "The ball is in Dr Aroneys court". In that the expectations of the organisation are that he would comply with the Code of Conduct.
PT stated that this is a very emotional time for all of the staff involved.

PT indicated there is a perception that exists and that we need to minimise distress to staff because it can waste a lot of energy.

CA indicated that he was doing what he was doing because he believed in the need for appropriate service provision.

GW indicated there was a Code of Conduct and that all staff have to comply with this and work within the Code of Conduct.

CA Indicated that it would be difficult for him to be quiet when he saw people dying on waiting lists

CA indicated that at the Medical Staff meeting the previous evening, there was general support for him from staff. At the meeting there was a strong feeling that to move forward there would need to be appropriate funding for beds, activity such as AICD's and angioplasty's.

CA indicated that if appropriate funding was made available that he would no longer go public.

CA advised that at The Cardiac Society meeting earlier in the year, he was asked by the Cardiologists to speak out on their behalf.

CA indicated that he was "not willing to be gagged and would not stop speaking out until major improvements were made".

PT summarised the meeting on the previous evening with medical staff, indicating there was global support for Dr Aroney and that it might not be appropriate to continue to speak out in relation to the matters that have been raised but that it was a time to work together towards a sustainable solution.

CA indicated that he was hopeful that things go forward.
CA if they didn't go forward he stated that "I will continue to speak out and I will not go away".
CA indicated that he felt he had "universal support".
CA indicated that he was seeking a 5th term as The Chair of the Cardiac Society in Queensland.

PT Indicated that the medical staff as a group wanted to go forward and that they were hopeful of meeting with the Director General later today.

CA Indicated that he had never criticised the District and didn't plan to do so.

GW indicated that she had enormous commitment to the public sector and had for most of her life worked as a clinician. Her role now is ensuring the needs of the community are met. As opposed to the needs of individuals or groups.

The meeting closed at 11am.

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-21

01-01-A

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Queensland Government
Queensland Health

EXECUTIVE SERVICES STAFF
MIN / DG / GMHS / DDGP&O / FILE
EMAIL:- MIN SDLO DLO EXDG
EMMC MCM

A BRIEFING TO THE A/SENIOR EXECUTIVE DIRECTOR HEALTH SERVICES DIRECTORATE

BRIEFING NOTE NO:	District Initiated
REQUESTED BY:	District Initiated
DATE:	12 October 2004
PREPARED BY:	Michael Cleary, Executive Director Medical Services, The Prince Charles Hospital Health Service District (TPCHHSD), contact 3350 8220
CONSULTATION WITH:	N/A
CLEARED BY:	Gloria Wallace, District Manager, TPCHHSD, contact 3350 8223
DEADLINE:	N/A
SUBMITTED THROUGH:	Dan Bergin, Zonal Manager, Central Zone, contact 3234 0825
SUBJECT:	**Cardiology Program – The Prince Charles Hospital**

COMMENTS A/SED HEALTH SERVICES:

FILE BRIEFINGS FILE
7/4/05

DR JOHN SCOTT
A/Senior Executive Director
Health Services Directorate

/ /

PURPOSE:

To brief the A/Senior Executive Director Health Services on issues currently impacting on the Cardiology Program at The Prince Charles Hospital.

BACKGROUND:

The Cardiology Program at The Prince Charles Hospital provides comprehensive care to cardiac patients in Queensland. This includes a number of statewide services including:

- Heart Failure and Heart Transplantation
- Paediatric Cardiology
- Specialists support for electrophysiology services (shared with the Princess Alexandra Hospital)

The District is currently actively managing a number of issues in relation to the Program. These include:

Higher than usual demand for clinical services

- The District is currently experiencing an increase in demand for inpatient services. This has in part, been driven by increased referrals to the hospital.

Emergency Department referrals

- The Emergency Department has increased as outlined in Figure 1. The increase in admissions principally relates to Cardiology activity.

Figure 1 – Emergency Admission

	Admissions per week
2002/03	83
2003/04	85
2003/04	95
4 weeks to 28/09/04	112-120

The admission rate overall in the emergency Department has increased from 39% of attendances in 2003/04 to 46% in 2004/05. This increase has been related to Category 3 attendances.

CARDIAC INVESTIGATION UNIT

An area of contention within the Cardiology area is the level of planned activity that will be performed in the 2004/2005 financial year with the Cardiac Investigations Unit. The Unit performs Angiograms, Percutaneous Cardiac Interventions (PCI) such as acute coronary stents a well as the implantation of pacemakers and defibrillators.

The activity levels in the area are being redefined, based on the impact of activity transfer to the Princess Alexandra Hospital that occurred in July 2004 as well as growth funds received in the 2004/05 financial year and "one all" funding in 2003/04. The past two years activity and the funded activity for the current financial year, taking into account these factors, is outlined in figure 2 and figure 3.

Figure 2 – Cardiac Investigation Unit activity

	2002/03 Actual	2003/04 Actual	*2004/05 Estimated	Changed from 2003/04 to 2004/05
Angiogram	2526	2491	2117	-374
PCI	550	700 (includes 23 patients funded by Townsville Hospital)	538	-162
ICD Implants	120	179	143	-36
ASD Closures	15	57	15	-42

*2004/05 activity is after adjusting for the PAH transfers and including the indicative funding allocation for 2004/05 Election Commitments.

Figure 3 – Analysis of activity and funding

	Funding changes	Change in level of activity
Service transfer to PAH	- $1.2m	Activity Production at TPCH includes and transferred to PAH includes: - 500 Angiograms - 95 PCI's
Growth funds as part of 2004/05 election commitments Note: This has yet to be confirmed by Central Zone	+ $0.845m(interventional cardiology) + $0.25m (ICD activity)	Activity increase at TPCH includes: - 90 Angiograms - 78 PCI's - 10 ICD's
Funding of drug eluting stent	+ $0.7m	No change in activity, but provides ability to use drug eluting stents in patients having PCI'S

*This table identifies changes to base funding and activity.

In addition to the recurrent funding changes identified above, it should be noted that additional activity was undertaken in 2003/04 as part of the Government's election commitments to elective surgery. This activity is identified in Figure 4.

Figure 4 -Additional activity funded in 2003/04 (non recurrent) as part of election commitments.

Funding	Activity
$0.24m	100 PCI's
$0.7m	28 ICD's
$0.51m	42 ASD Closures

Recent meetings have been held with cardiologists in an attempt to contain interventional activity within existing funding limits. This is particularly important as the District's budget position for the first quarter of the financial year shows an operating deficit of $2.2M with a major contributor to this being in interventional cardiology.

Current funding allows a weekly schedule of 57 funded acute and elective catheter laboratory procedures (excluding ASDs and valvuloplasty) to be performed, however weekly activity for the first quarter has in some weeks exceeded 80 procedures.

Cardiologists have been asked to revise the activity schedule to the 57 weekly procedures and to schedule cardiac investigations unit hours of operation, around the revised activity schedule. They have also been asked to revise rosters to cater to the revised schedule (see attachment 1, agreed activities to be undertaken by the program to correct current activity/expenditure).

PROGRAM MANAGEMENT

The leadership within the Cardiology Program has been limited by the willingness of some clinical staff to engage in discussions and negotiations in relation to service models and activity planning.

Dr Galbraith, Program Medical Director for the Cardiology Program resigned his Directorship on 16 September 2004, the day before he was due to go on annual leave for three weeks, following a meeting with the Cardiac Investigations Unit (CIU) staff to discuss required changes. Dr Galbraith advised that he found the role too stressful.

The District Manager elected not to appoint Dr Darren Walters as the Acting Program Medical Director because of his high clinical workload, his need to finalise the activity plan for the CIU and because of a lack of confidence that Dr Walters would cooperate to lead the Program in a manner commensurate with District requirements.

Because the District was unable to identify a senior member of the medical staff to provide the appropriate leadership, and in consultation with Dr Keith McNeil (Chair, Medical Advisory Committee), the District elected to nominate Dr Michael Cleary (Executive Director Medical Services) and Dr McNeil to support the Program's management team during the period that Dr Galbraith was on leave. Program staff members were advised that the Program Nursing Director would undertake the business administration of the Program.

On 17 September, the District Manager received a petition from a number of cardiologists, demanding that Dr Darren Walters be appointed interim Director of Cardiology. The District Manager advised the petitioners that this was not possible due to Dr Walters' workload and advised Dr Walters of her reservations in relation to his suitability for the leadership role.

The District Manager, Executive Director Medical Services, Executive Director Nursing Services and Executive Director Corporate Services met with the Cardiology Program medical staff on Friday 24 September 2004 to discuss issues within the Cardiology Program. Cardiologists invited a range of other persons to the meeting, including Dr Con Aroney and numerous cardiac surgeons.

Discussions at the meeting included:

- the state-wide cardiac services planning proposal
- the status of the heart failure community support project
- budget and activity planning (including the need to revise activity to meet budget)
- staffing within the Cardiology Program, with specific reference to leave relief, succession planning and paediatric cardiology staffing issues
- leadership and management within the Cardiology Program, including advertising for a Director of Cardiology.

Dr Aroney attempted to put a formal motion that Queensland Health be advised that patients over 75 years of age would not be treated through interventional cardiology procedures at TPCH, until such time as funding issues were addressed. Other medical staff did not support this motion, which was lost.

Program staff were asked to consider the issues raised with them and to provide feedback on their views, including that of a suitable interim Director of Cardiology, to carry through to the appointment of a new Director. At the request of cardiologists, a follow up meeting was scheduled for Thursday 30 September 2004 to gain feedback on their considerations of the issues discussed.

In the absence of the District Manager on leave, Dr Michael Cleary as Acting District Manager was asked to conduct this meeting, however only two cardiologists attended (ie. those in the heart failure sub program). The District was later advised that there had been agreement among the cardiologists to boycott the meeting. The interim directorship issue remains unresolved.

Cardiology Inter-hospital transfer waiting list

There have been recent pressures on the cardiology inter-hospital transfer waiting list. For example:

- The number of patients waiting for transfer to TPCH as at 27 September 2004 was 17. Five of these cases were noted to be of a high priority.
- Three of the high priority patients were transferred to TPCH for further care.
- Following discussions with the Executive Director of Medical Services at the Royal Brisbane and Women's Hospital (RBWH)the remaining two high priority patients were accepted by RBWH for care.
- The Princess Alexandra Hospital Executive Director of Medical Services advised that they had five patients on the inter-hospital transfer waiting list and could not accept additional patients at this time.

Deaths on the Waiting List

Two patient deaths occurred in recent months that have been the subject of a previous brief. As a result of the issues raised in relation to these deaths by medical staff, Dr Leo Mahar from the Royal Adelaide Hospital and Dr Andrew Johnson from Townsville General Hospital were appointed to investigate both the deaths, and the allegations made by some cardiology staff in relation to waiting lists. The investigations are occurring this week, but preliminary verbal reporting from the investigating team is that the nominated patients had both received an appropriate standard of care.

Surgical Activity

The number of patients who are currently waiting in hospital for urgent cardiac surgery has fluctuated over recent weeks. This has been the result of increased referrals for surgery including some urgent cases eg:

- two patients on ventricular assist devices (VAD'S) who have had multiple returns to theatre

- increased paediatric cardiac surgical activity prolonged ICU stays for post transplant patients The net effect of this increase in urgent referrals for surgery has been a reduction in elective surgical activity, some of which relates to increased occupancy in the cardiology wards.

Cardiologist Leave

It is extremely difficult to plan suitable leave relief and to ensure adequate cover, with the lack of medical team cohesiveness in the Cardiology Program. Dr Con Aroney is currently on extended leave to 31 December, and has today requested to extend that leave further. Dr Darren Walters wished to take leave at the same time as the approved leave of Dr Nick Bett. This would have left TPCH with no interventionist cover other than 1 VMO session, so leave approvals have been given only where there is adequate cover.

Dr Walters has also requested a reduction of hours to half time, but has been advised that the District is unable to accommodate this while Dr Aroney is still on leave.

KEY ISSUES:

- It is proposed to contain cardiac diagnostic and intervention procedures within the 57 funded procedures limit as described above. This will take one month to implement, to manage the public perceptions, ie. to ensure that currently booked patients are not cancelled;

- This is creating political and media pressure, however for the TPCH Cardiology Program to achieve budget integrity, this is necessary;

- The preferred option for the distribution of PCI and diagnostic procedures has been established in consultation with cardiologists;

- Given the demand pressures, once this schedule is implemented, there will be waiting list growth;

- There are differing criteria for cardiac interventional procedures being applied across the metropolitan hospitals and there needs to be agreement on consistent standards, particularly for the categorising on wait lists.

- While TPCH functions at the more "liberal" end of the interventional scale in relation to AICD implantations, there is increasing collegial pressure for service expansion in the treatment of heart failure. It is proposed that this should be referred to MSAC to allow national intervention criteria for AICD utilisation in heart failure, to be agreed.

- While TPCH is moving to fill its Director of Cardiology position by national and international advertising, there appears to be no local solution to interim medical leadership, other than to place a non cardiologist in the role. It is proposed to either:

    - Appoint a non cardiologist from TPCH to the medical leadership role for the interim period; or

    - Seek Corporate assistance in the appointment of an interim Medical Director of Cardiology from another facility, to work through the issues of criteria standardisation, cross hospital workload and workforce distribution and management of medical issues within the program/s, and the appropriate distribution of any further funding investment.

RELATED ISSUES:

N/A

BENEFITS AND COSTS:

If actions are not taken within the next month, the forecast budget overrun full year effect in cardiology at TPCH will be $2.4M.

ACTIONS TAKEN/ REQUIRED:

Corporate endorsement is sought of:

- Limiting activity as described above, at TPCH and

- a proposed strategy in accordance with this brief.

ATTACHMENTS:

Attachment 1 – Activity Profile

ATTACHMENT 1

Based on weekly target of 4 paediatric cases/week however allowing for up to
6 scheduled spaces per week to accommodate operator availability and peak demands

Weekly acute target - 25 per week on a 35%/65% PCI/Cors split.

				Weekly target	Yearly spread	Annual Target
Acute	PCI	35%	9	25	52	1300
	DIAG	65%	16			
Elective	PCI	11%	3	28	48	1344
	DIAG	89%	25			
Paediatrics				4	48	192
% DISTRIBUTION	PCI	23%				
	DIAG	77%				
TOTAL				57		**2836**

Activity Profile (Acute and elective)

57 PCI and Angiograms per week
Excludes Valvuloplasty at 10/year
Embolisation at 32/year
ASD Closures at 15/year
(note that 8 have already been performed and the remaining 7 booked to be performed by December 2004)

Year Profile (Acute and Elective)

PCI	612
CORS	2032
Paeds	192

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-21A

CATEGORISED WAITING LIST and AVERAGE WAITING TIMES STATISTICS
as at 15 February 05

Definitions:

	Type of Procedure				
Category	Angio-Graphy	PTCA	PACE	ICD	R.H.C. Cardiac Biopsy
No. of Cat 1 </= 30 days	39	25	8	21	7
No of Cat 1 > 30 days	45	11	0	47	3
Sub-total	84	36	8	68	10
Av. Wait	**36**	**24**	**6**	**65**	**25**
No. of Cat 2 </= 90 days	82	13	2	0	11
No of Cat 2 > 90 days	23	3	0	0	12
Sub-total	105	16	2	0	23
Av. Wait	**60**	**57**	**37**	**0**	**112**
No of Cat 3 </= 120 days	2	0	0	0	8
No of Cat 3 > 120 days	1	0	0	0	2
Sub-total	3	0	0	0	10
Av. Wait	**49**	**0**			**77**
TOTAL NUMBER	192	52	10	68	43
Av. Wait					

CATEGORISED WAITING LIST and AVERAGE WAITING TIMES STATISTICS
as at 15 March 05

Definitions:

	Type of Procedure				
Category	Angio-Graphy	PTCA	PACE	ICD	R.H.C. Cardiac Biopsy
No. of Cat 1 </= 30 days	67	25	15	21	10
No. of Cat 1 > 30 days	10	2	1	50	1
Sub-total	77	27	16	71	11
Av. Wait	**19**	**16**	**15**	**62**	**20**
No. of Cat 2 </= 90 days	68	22	6	0	9
No. of Cat 2 > 90 days	25	4	0	0	12
Sub-total	93	26	6	0	21
Av. Wait	**65**	**52**	**22**	**0**	**103**
No. of Cat 3 </= 120 days	3	0	0	0	5
No. of Cat 3 > 120 days	0	0	0	0	2
Sub-total	3	0	0	0	7
Av. Wait	**26**	**0**			**73**
TOTAL NUMBER	173	53	22	71	39
Av. Wait					

CATEGORISED WAITING LIST and AVERAGE WAITING TIMES STATISTICS
as at 13 April 05

Definitions:

	Type of Procedure				
Category	Angio-Graphy	PTCA	PACE	ICD	R.H.C. Cardiac Biopsy
No of Cat 1 </= 30 days	30	21	8	15	10
No of Cat 1 > 30 days	15	5	1	58	1
Sub-total	45	26	9	73	11
Av. Wait	**25**	**21**	**15**	**72**	**15**
No of Cat 2 </= 90 days	67	19	5	0	9
No of Cat 2 > 90 days	22	2	0	0	12
Sub-total	89	21	5	0	21
Av. Wait	**60**	**54**	**40**	**0**	**101**
No of Cat 3 </= 120 days	4	1	0	0	5
No of Cat 3 > 120 days	0	0	0	0	1
Sub-total	4	1	0	0	6
Av. Wait	**47**	**20**			**100**
TOTAL NUMBER	138	48	14	73	38
Av. Wait					

CATEGORISED WAITING LIST and AVERAGE WAITING TIMES STATISTICS
as at 10 June 05

Definitions:

	Type of Procedure				
Category	Angio-Graphy	PTCA	PACE	ICD	R.H.C. Cardiac Biopsy
No. of Cat 1 </= 30 days	55	17	8	10	5
No. of Cat 1 > 30 days	11	11	3	49	2
Sub-total	66	28	11	59	7
Av. Wait	**15**	**17**	**12**	**80**	**32**
No. of Cat 2 </= 90 days	68	22	5	0	10
No. of Cat 2 > 90 days	6	5	1	0	7
Sub-total	74	27	6	0	17
Av. Wait	**44**	**50**	**42**	**0**	**102**
No. of Cat 3 </= 120 days	6	1	0	0	3
No. of Cat 3 > 120 days	1	0	0	0	4
Sub-total	7	1	0	0	7
Av. Wait	**66**	**78**			**89**
TOTAL NUMBER	147	56	17	59	31
Av. Wait					

CATEGORISED WAITING LIST and AVERAGE WAITING TIMES STATISTICS
as at 25 July 05

Definitions:

	Type of Procedure				
Category	Angio-Graphy	PTCA	PACE	ICD	R.H.C. Cardiac Biopsy
No of Cat 1 </= 30 days	44	26	9	15	7
No of Cat 1 > 30 days	4	2	1	39	4
Sub-total	48	28	10	54	11
Av. Wait	**17**	**15**	**13**	**69**	**33**
No of Cat 2 </= 90 days	47	19	2	0	19
No of Cat 2 > 90 days	1	0	1	0	3
Sub-total	48	19	3	0	22
Av. Wait	**37**	**44**	**46**	**0**	**58**
No of Cat 3 </= 120 days	2	0	0	1	6
No of Cat 3 > 120 days	1	1	0	0	1
Sub-total	3	1	0	1	7
Av. Wait	**102**	**123**		**18**	**64**
TOTAL NUMBER	99	48	13	55	40
Av. Wait					

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-22

The Prince Charles Hospital
Health Service District

Enquiries to: Dr Michael Cleary
Medical Administration
Telephone: 07 3350 8220
Facsimile: 07 3350 8867
File Number 04.03.21.4
Our Ref: MC:em 49-05

Dr Con Aroney
C/- Cardiology Program
IPCH

Dear Con

I received a copy of your letter dated 9 March 2005, advising of your resignation from the staff of The Prince Charles Hospital Health Service District. I hope that, for the most part, you have enjoyed your time within this District and hope that you have achieved both professional and personal satisfaction from your association with the Hospital.

I note your request for ongoing privileges. I can advise that the process for you gaining privileges will be considered on a case by case basis for individual patients. If such needs arise, the process for considering and awarding privileges will be through Medical Administration.

I would like to thank you for your personal commitment to the services provided by the Cardiology Program.

Kind Regards

Dr Michael Cleary
Executive Director Medical Services

~~09 August 2005~~
21/3/05