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CABINET DECISION

Brisbane, 13 March 2000

Decision No. 1553 (Submission No. 1248)

TITLE: Information Submission - Progress Report on the Waiting List Reduction Strategy, Medical Workforce Issues and Queensland Health's Budget Status.

CABINET decided:

1. That following consideration, the contents of the submission be noted.

2. To note that the Premier and the Minister for Health are to consider a number of associated reports and that the Minister for Health is to table those reports pertinent to the submission at the Cabinet Meeting of 20 March 2000.

CIRCULATION:

Implementation Responsibility
Nil.
Departmental Records
Department of the Premier and Cabinet.
Department of Health and copy to the Minister.
Perusal and Return
All other Ministers.

Cabinet Secretary

CABINET SECRETARIAT QUEENSLAND

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CAB.0007.0001.00072

SECURITY CLASSIFICATION "A"

INFORMATION SUBMISSION

COVER SHEET

TITLE

Progress Report on the Waiting List Reduction Strategy, medical workforce issues and Queensland Health's budget status

MINISTER

Minister for Health

OBJECTIVE

To inform Cabinet of the progress of the Waiting List Reduction Strategy, medical workforce issues and Queensland Health's budget status.

SUMMARY

The Waiting List Reduction Strategy is a major commitment of the Government. Waiting list census information details data as at 1 January 2000 and which was published on 31 January 2000. Comparison of waiting list information is provided for the period 1 July 1998 to 1 January 2000.

Medical workforce issues impact on access to services in emergency departments, specialist outpatients clinics and surgical services in public hospitals. The submission updates the number of vacancies in Queensland public hospitals and highlights a range of employment incentive initiatives aimed at reducing the overall numbers of specialist vacancies and in placing specialists in rural areas where long term vacancies have occurred.

RESULTS OF CONSULTATION

- **Is there agreement? YES. See paragraph 59 of body of submission.**

RECOMMENDATION

That, following consideration, the contents of the submission be noted.

WENDY EDMOND MLA
MINISTER FOR HEALTH
4 / 3 /2000

BODY OF SUBMISSION

OBJECTIVE

1. To inform Cabinet of the progress of the Waiting List Reduction Strategy, medical workforce issues and Queensland Health's budget status.

BACKGROUND

- **Context**

2. In July 1998, the Government gave a commitment to significantly expand previous strategies to reduce waiting lists in public hospitals in Queensland. The Waiting List Reduction Strategy involves an eight-point plan to cut waiting lists and includes a commitment to:
   - publish the waiting list for each hospital every three months so that money can be channelled to where the real need is;
   - supply general practitioners with quarterly briefings on waiting lists to help them when referring people for surgery;
   - even out waiting lists by moving people in appropriate cases to a hospital where their procedure can be performed more speedily;
   - provide additional funding of $6.8M per year to finance extra surgery for complex procedures;
   - work with the specialist colleges to expand training places for new specialists to meet the demand of the next century;
   - use holiday times to keep operating theatres working for the benefit of those waiting for surgery;
   - benchmark waiting times for accident and emergency departments to reduce excessive waits; and
   - increase levels of day surgery across the state to reduce the length of waiting times for elective surgery.

3. A further element was added to the eight-point plan. This element is the collection of waiting times for specialist outpatient appointments to assist in clinical prioritisation for surgery and appointments.

- **Previous consideration by Cabinet**

4. Cabinet (Decision No.681) on 12 April 1999, noted that the Minister for Health would provide quarterly reports on progress of the Waiting List Reduction Strategy and Queensland Health's budget status.

5. Cabinet (Decision No. 1152) on 20 September 1999 noted that the Minister for Health would continue to report quarterly on the Waiting List Reduction Strategy.

ISSUES

Waiting List Reduction Strategy

Project Update

Publication of the quarterly Elective Surgery Waiting List Report

6. The aim of the publication has been to provide public information regarding the status of elective surgery waiting lists of 33 hospitals around the state. This provides general practitioners with timely information on the relative size of waiting lists in public hospitals by surgical specialty.

7. Six reports have been published containing information on the waiting lists as at 1 July 1998, 1 October 1998, 1 April 1999, 1 January 1999, 1 July 1999 and 1 October 1999. The report is published on the Queensland Health intranet and Internet sites and a hard copy is produced and distributed.

8. The report containing data as at 1 January 2000 was published on 31 January 2000.

Quarterly briefings of general practitioners

9. The aim of the briefings is to improve communication between general practitioners and their local public hospital.

10. Briefings have been provided for inclusion in the Divisions of General Practice newsletters. The briefings include elective surgery waiting list information for the hospitals relevant to each division.

11. Meetings have been held with a number of Divisions throughout Queensland to further develop communication links between Divisions, hospitals and Surgical Access Team.

Transfer of patients to even out waiting lists

12. The aim of the initiative is to relieve pressure on hospitals with long waiting lists by transferring patients to those facilities with spare capacity in certain specialties.

13. In December 1999, funding was allocated to hospitals to retain surgeons to provide surgical services in specialities with extensive waiting lists or where there was identified need. This has lead to the provision of funds for orthopaedic surgery at Bundaberg Hospital and The Prince Charles Hospital and ENT surgery at Cairns Hospital and Toowoomba Hospital.

14. It is anticipated that the provision of these funds will prevent the need to transfer patients to other facilities and will ensure that patients access services near their place of residence.

Better use of operating theatres during holidays

15. Surgical sessions during holiday periods continue to be monitored by the General Manager, Health Services.

Emergency Services Strategy

16. The aim of this strategy is to improve access to services in emergency departments and to an inpatient bed if the patient requires admission.

17. In 1999/2000, as well as providing funding for emergency medicine specialists ($2.44M) and emergency department nursing positions ($506,000) funding has been allocated:

- to trial a Level 3 Nurse Educator – Critical Care based at Mt Isa Hospital ($91,000);
- to provided for capital projects including minor works to improve the efficiency of department layouts at Mt Isa and Gold Coast Hospitals and for equipment purchases at Mater Children's, Townsville and Bundaberg Hospitals ($90,500);
- to hospitals to conduct local service enhancement projects. The projects are intended to develop and establish improved service delivery and patient management processes and will be completed prior to July 2000. Projects will be undertaken at Townsville, Bundaberg, Mt Isa, Hervey Bay, Royal Children's, Princess Alexandra, QEII, Ipswich and Toowoomba Hospitals ($232,900).

18. Funding of $170,00 has been reprovided in 1999/2000 for an additional two medical officers attached to the Royal Flying Doctor Service based at the Rockhampton Hospital. The appointment of these staff has significantly reduced the overtime demands on medical staff at the Rockhampton Hospital Emergency Department.

19. All 20 hospitals with a emergency department role delineation of 4 or greater are participating in the benchmarking programme and are supplying performance data on a monthly basis. Quarterly performance reports are distributed to the participating hospitals. The third report (December 1999 Quarter) will be distributed shortly.

20. There has been significant improvement in the waiting times in Queensland public hospital emergency departments over the period of January to December 1999 (Attachment 1). As a result of these improvements approximately 3,500 additional patients were seen within the recommended times.

21. Comparison with other States indicates that emergency department waiting times in Queensland during recent months are comparable to other States (Attachment 2). (It should be noted that the better performance by Victoria is due in part to a different waiting time calculation methodology that measures waiting time from presentation to being seen by a doctor or a nurse. The calculation used in Queensland measures waiting time to being seen by a doctor.)

22. The decline in performance during the winter months is a recognised seasonal effect. The Surgical Access Team, in conjunction with emergency department staff, is developing strategies to minimise this effect.

23. Access block data (waiting time from presentation to admission to an inpatient bed) indicates that Queensland is performing well compared to other states (Attachment 3).

Day surgery targets

24. The day surgery target for all elective surgery in Queensland public hospitals in 1998/99 was 50%.

25. This target was achieved with 51.0% of elective surgery undertaken as day surgery. This is an increase from the 44.6% result achieved in 1997/98.

26. Strategies to be introduced in 1999/2000 to achieve further increases in the rate of day surgery further include:

- the identification and categorisation of the major procedures performed as day surgery to establish a day-surgery 'basket of procedures'. This will allow direct comparison of day surgery rates of individual procedures between hospitals and result in the benchmarking of day surgery rates between Queensland hospitals and at a national level;
- the development of theatre utilisation reporting within Queensland Health will provide comparative information that will lead to increased surgical throughput and improved operating room management. Improved day surgery rates is a key component of increased operating room efficiency;
- the completion and commissioning of new and refurbished facilities will also improve the efficiency of operating theatres in Queensland public hospitals and subsequently improve day surgery rates.

Specialist outpatient services

27. The Government has indicated its commitment to review the demand for specialist outpatient services.

28. In order to ensure a consistent approach to the delivery of specialist outpatient services the Surgical Access Team has developed the *Guidelines for the*

Management of Specialist Outpatient Clinic Waiting Lists that have been distributed to hospitals and general practitioners throughout Queensland.

29. A monthly collection of specialist outpatient waiting times at the 33 reporting hospitals, including waiting time until next available appointments and the total number of patients awaiting their initial appointment, is continuing.

30. The number of patients awaiting an initial specialist outpatient appointment has remained steady throughout 1999 (Attachment 4). As at 1 December 1999 there were approximately 47,607 patients awaiting an initial specialist outpatient appointment as compared to 48,097 as at 1 March 1999.

31. 28,809 patients were awaiting a surgical appointment at 1 December compared to 29,380 at 1 March 1999.

32. Waiting time until the next available appointment varies throughout the state between hospitals and specialities. The longest waits are for orthopaedic, ophthalmology and ENT appointments.

33. Failure of patients to attend scheduled outpatient clinic appointments has been identified as a significant problem that reduces the efficiency of outpatient clinics resulting in increased delays for services. The Surgical Access Team has coordinated a project run by the Mater Hospital and the Department of Social and Preventive Medicine, University of Queensland to examine factors contributing to non-attendance and to identify strategies to reduce the problem. This issue will be progressed by the Surgical Access Team in 2000.

34. The Surgical Access Team is reviewing the information systems used in specialist outpatient departments to identify processes and reports that will reduce the labour required to provide monthly data and optimise the consistency of data collection between sites.

<u>Elective Surgery Funding 1999/2000</u>

35. Total elective surgery funding provided in 1998/99 was $87.91 million compared with $79.535 million in 1999/2000. The current funding includes provisions for Emergency Services Strategy ($5.0 million), Publication of Waiting List Information ($0.2 million) and Transfer of Patients ($0.9 million).

36. Targeted funding of $20.073 million has been provided to health service districts for elective surgery services in 1999/2000. Included in the total funding package are specific funds have been provided for complex procedures ($6.0 million) and increasing day surgery rates ($1.5 million) Activity against targets is monitored quarterly.

37. With the finalisation of the *Elective Surgery Drawback Funds*, an additional $2.52M has been allocated for additional elective surgery activity in 1999/2000 (Attachment 5).

Performance Report

Comparison of waiting list information 1 July 1998/1 January 2000

38. Attachment 6 shows in percentage terms a comparison of waiting list information of the 33 reporting hospitals by category for the period 1 July 1998 to 1 January 2000.

Category 1 Patients

39. As at 1 January, 2000, 4.0% of Category 1 patients on the waiting lists of the 33 reporting hospitals had waited longer than the recommended time (30 days) for surgery. This is below the State target of 5% and compares with 2.4% as at 1 December 1999 and 2.3% as at 1 January 1999.

40. In the 33 reporting hospitals there were, on average, 2,612 Category 1 elective surgery patients treated per month for the period of 1 July 1998 to 1 January 2000. This compares with an average of 2,438 Category 1 elective surgery patients treated per month for the period of 1 July 1997 to 1 July 1998.

Category 2 Patients

41. At 1 January, 2000, 9.9% of Category 2 patients on the waiting lists of the 33 reporting hospitals had waited longer than the recommended time (90 days) for surgery. This is above the State target of 5% and compares with 8.7% as at 1 December 1999 and 18.4% as at 1 January 1999

42. In the 33 reporting hospitals there were, on average, 4,392 Category 2 elective surgery patients treated per month for the period of 1 July 1998 to 1 January 2000. This compares with an average of 4,072 Category 2 elective surgery patients treated per month for the period 1 July 1997 to 1 July 1998.

43. In Category 2, orthopaedics is an ongoing issue. At 1 January 2000, orthopaedic patients represented approximately 27.9 per cent of all Category 2 patients and 38.0 per cent of those Category 2 patients waiting longer than 90 days for surgery. This has improved since 1 July 1999 where orthopaedic patients represented 52.9 per cent of the 'long wait' category two patients.

Category 3 Patients

44. At 1 January, 2000, 29.6% of Category 3 patients on the waiting lists of the 33 reporting hospitals had waited longer than one year for surgery. This compares with 29.6% as at 1 December 1999 and 28.1% as at 1 January 1999.

45. In the 33 reporting hospitals there were, on average, 2,789 Category 3 elective surgery patients treated per month for the period of 1 July 1998 to 1 January 2000. This compares with an average of 2,950 Category 3 elective surgery patients treated per month for the period 1 July 1997 to 1 July 1998.

A comparison of Elective Surgery Throughput 1998/1999 – 1999/2000

46. A comparison of the throughput for the 33 reporting hospitals has been undertaken to provide an indication of the increase in elective surgical activity since 1997/98. The total number of elective surgery admissions in these hospitals for the first six months of the financial years 1998/99 and 1999/2000 was 3,788 (6.7%) and 2,121 (3.7%) cases higher respectively than that reported for 1997/98. For the year to date 1999/2000, elective surgery throughput has decreased by some 1,667 (-2.8%) elective surgery admissions compared with that reported for the same period in 1998/99.

Specialist Shortages

47. Medical workforce issues impact on access to services in emergency departments, specialist outpatients clinics and surgical services in hospitals.

48. The following statistics provide an update of vacancies in Queensland public hospitals and reflect a range of employment incentive initiatives:

<u>full-time specialist vacancies</u>

June 1995	125	
November 1995	93	
March 1996	82	
July 1996	62	
March 1997	61	
March 1999	32	(six unfilled new positions included)
July 1999	45	(seven unfilled new positions included)
December 1999	30	(eight unfilled new positions included)

<u>visiting medical officer (VMO) vacancies</u>

March 1999	6
July 1999	7
December 1999	16.

49. Thirty-four new specialist positions have been created since July 1998. Eighteen of these positions have been filled. Eight of the positions are currently vacant and included in the total number of vacancies for full-time specialists. Eight VMO specialist positions have been created since July 1998.

50. Queensland Health has also created additional positions in rural areas through the Medical Workforce Summit and the Rural Registrar Program. It is likely that many of these doctors will remain at their current locations when they have completed their training.

51. The strategies detailed below have been successful in reducing the overall numbers of vacancies and in placing specialists in rural areas where long term vacancies have occurred:

- incentives to attract full-time specialists to remote Queensland including, country specialists receiving 45% of base salary compared to 35% for metropolitan specialists; free accommodation; and private use of motor vehicle;
- Queensland Health now notifies colleges of vacancies for inclusion in their journals ;
- changes in the way specialist positions are advertised (eg. Total remuneration packages of $200,000 per annum rather than stating basic salary);
- access to salary sacrificing and higher commencement pay rates for visiting specialists in rural areas;
- consultation with the various medical colleges and the Commonwealth to extend the number of specialist training places in accordance with the Australian Medical Workforce Advisory Committee reports;
- improvements to enhance the retention of doctors eg. Provision of access to appropriate computer services, provision of increased levels of support staff, increased participation by specialist staff in resource allocation and administrative decision-making, increased professional autonomy and development opportunities for specialists in rural areas are being addressed at health service district level;
- the introduction of four year scholarships to ensure longer bonded periods will result in 30 medical scholarship holders graduating each year. Benefits include a living allowance of $7,000 per academic year, a tertiary grant of $3,500 and an annual travel allowance of $500. Some of these doctors may enter a specialty and return to the bush.

Budget Status

52. The department's overall year to date position is reported to Queensland Treasury through the Tridata system. Although figures are preliminary at the time of preparing this submission, it is expected that the Tridata position at 31 December 1999 will reflect a small surplus of $4.7 million. However, the State funded

component of the budget is significantly over expended as at 31 December 1999. Steps are being taken to contain this over expenditure. It should be noted that there could be some difficulty in providing the 'smoothing' funding to Queensland Treasury at the end of the financial year.

53. The year to date position of Commonwealth programs is under expended. However, it is expected that the programs will be fully spent at 30 June 2000.

54. Year to date revenues indicate a continuing decline in chargeable patient fees, which is being offset by a favourable increase in Department of Veteran's Affairs payments. As a result, the revenue forecast indicates a balanced revenue position.

CONSULTATION

55. Formal consultation on the Waiting List Reduction Strategy has been through existing mechanisms within Queensland Health. These mechanisms include the Clinical Advisory Committee, the Medical Superintendents Advisory Committee, the Elective Surgery Coordinators, Emergency Services Specialist Advisory Panel, the Operating Room Management Information System (ORMIS) Strategic Management Group, the Nursing Workforce Committee and the Medical Workforce Committee.

56. Consultation has occurred with the Australasian College for Emergency Medicine, the Queensland Emergency Nurses Association and the Divisions of General Practice.

57. Consultation has also occurred through the establishment of the Specialist Outpatients Best Practice Working Party and the convening of the Emergency Department Workshop and the Outpatient Failure to Attend Workshop.

58. Consultation has occurred with Zonal staff, district managers and key medical and nursing personnel from the participating hospitals on the approach to enhancing emergency, outpatient and surgical services including theatre utilisation. Such consultation has included feedback in the form of a monthly report to hospitals. In addition, visits to the participating hospitals have been conducted.

RESULTS OF CONSULTATION

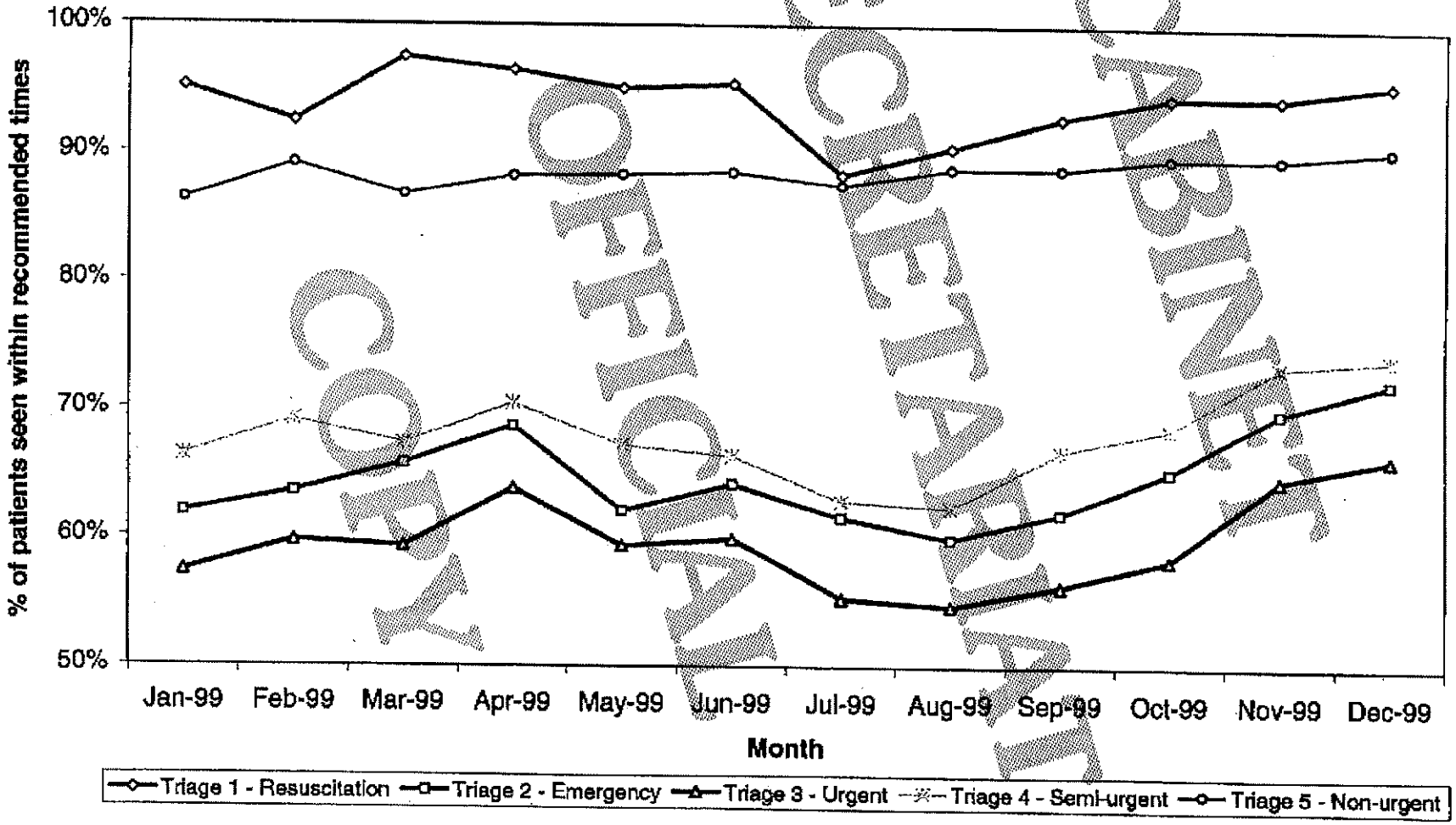
59. Internal consultation mechanisms within Queensland Health have been effective in providing timely indicators of performance in relation to these issues (Refer Attachment 7).

60. Consultation remains a major part of the Waiting List Reduction Strategy and mechanisms as outlined above continue to provide a major support role to the project.

PUBLIC PRESENTATION

61. Not proposed.

Queensland Emergency Department Performance - Patients Seen Within Recommended Times - 1999



Attachment 1

Waiting Time Report December 1999 Quarter

Princess Alexandra	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	66	100	484	66	1595	69	1074	71	490	86	3709
November 99	62	100	427	73	1492	73	1078	76	501	91	3558
December 99	78	100	435	71	1564	71	1016	75	447	88	3540
December Quarter	206	100	1346	70	4651	71	3168	74	1438	88	10607
Principal Referral - December Qu	*445*	*100*	*3168*	*76*	*12250*	*72*	*12008*	*75*	*6163*	*90*	*34034*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Royal Brisbane	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	57	100	556	77	2135	71	1354	78	1047	96	5149
November 99	66	100	527	80	2193	70	1150	78	1098	89	5034
December 99	72	100	516	82	2172	73	1245	80	921	98	4926
December Quarter	195	100	1599	80	6500	71	3749	79	3066	94	15109
Principal Referral - December Qu	*445*	*100*	*3168*	*76*	*12250*	*72*	*12008*	*75*	*6163*	*90*	*34034*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Townsville	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	17	100	71	87	353	75	1704	68	589	82	2734
November 99	12	100	76	88	368	79	1607	76	507	87	2572
December 99	15	100	74	86	378	82	1782	71	563	82	2812
December Quarter	44	100	223	87	1099	78	5093	72	1659	84	8118
Principal Referral - December Qu	*445*	*100*	*3168*	*76*	*12250*	*72*	*12008*	*75*	*6163*	*90*	*34034*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Attachment 1

Waiting Time Report December 1999 Quarter

Mater Children's	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen Immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	3	100	44	91	357	78	1871	71	154	97	2409
November 99	1	100	37	86	303	85	1426	84	165	99	1932
December 99	11	91	27	81	282	88	1278	87	240	96	1838
December Quarter	15	93	108	87	922	84	4575	80	559	96	6179
Paediatric - Decemebr Quarter	*67*	*99*	*445*	*95*	*3277*	*71*	*5805*	*79*	*922*	*97*	*10516*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Royal Children's	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen Immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	17	100	120	94	875	60	468	68	149	96	1629
November 99	24	100	106	100	742	65	397	77	131	97	1400
December 99	11	100	111	100	738	77	365	89	83	95	1306
December Quarter	52	100	337	96	2355	67	1230	77	363	96	4337
Paediatric - Decemebr Quarter	*67*	*99*	*445*	*95*	*3277*	*71*	*5805*	*79*	*922*	*97*	*10516*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Gold Coast	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen Immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	32	94	312	37	2285	32	1217	37	83	53	3929
November 99	29	97	319	71	2212	64	919	68	81	86	3560
December 99	39	97	343	64	2089	57	1211	61	133	66	3815
December Quarter	100	96	974	57	6586	50	3347	54	297	68	11304
Metropolitan - December Quarter	*270*	*95*	*3056*	*56*	*19624*	*51*	*20284*	*64*	*2688*	*80*	*45952*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Attachment 1

Waiting Time Report December 1999 Quarter

Ipswich	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	15	100	187	63	987	66	1871	69	482	84	3322
November 99	11	91	150	64	958	66	1818	70	390	83	3127
December 99	22	100	140	64	967	72	1514	79	448	82	3091
December Quarter	48	96	457	64	2912	68	4803	73	1320	83	9540
Metropolitan - December Quarter	*270*	*95*	*3086*	*56*	*19624*	*51*	*20284*	*64*	*2688*	*80*	*45952*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Logan	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	30	100	319	44	1836	33	1773	43	66	56	3924
November 99	17	100	316	39	1527	36	1852	44	94	58	3806
December 99	15	100	247	47	1564	41	1785	49	77	62	3686
December Quarter	62	100	882	43	4727	36	5210	46	237	58	11118
Metropolitan - December Quarter	*270*	*95*	*3086*	*56*	*19624*	*51*	*20284*	*64*	*2688*	*80*	*45952*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Mater Adult's	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	5	100	146	74	525	85	1434	84	207	92	2317
November 99	11	100	106	75	508	79	1360	82	218	88	2203
December 99	12	100	117	67	523	80	1416	80	194	78	2262
December Quarter	28	100	369	72	1556	81	4210	82	619	86	6782
Metropolitan - December Quarter	*270*	*95*	*3086*	*56*	*19624*	*51*	*20284*	*64*	*2688*	*80*	*45952*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Attachment 1

Waiting Time Report December 1999 Quarter

QE II Jubilee	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	13	69	148	57	1315	40	895	57	63	70	2434
November 99	8	63	128	47	1287	44	827	66	69	80	2319
December 99	11	91	126	71	1241	55	992	73	83	88	2455
December Quarter	32	75	404	58	3843	46	2714	65	215	80	7208
Metropolitan - December Quarter	*270*	*95*	*3068*	*56*	*19624*	*51*	*20284*	*64*	*2689*	*80*	*45952*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Cairns	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	36	83	189	53	556	66	1179	67	272	91	2232
November 99	48	73	155	62	559	73	1111	64	227	80	2100
December 99	38	66	161	60	584	72	1265	63	258	83	2306
December Quarter	122	75	505	59	1699	70	3555	64	757	85	6838
Major Regional - December Quar	*368*	*88*	*2548*	*70*	*11838*	*65*	*16609*	*72*	*2445*	*85*	*33806*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Nambour	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	37	81	202	58	1105	59	895	63	111	95	2350
November 99	27	96	181	62	942	66	868	67	148	88	2166
December 99	24	100	151	66	967	69	1020	69	127	95	2289
December Quarter	88	91	534	61	3014	65	2783	67	386	93	6805
Major Regional - December Quar	*368*	*88*	*2548*	*70*	*11838*	*65*	*16609*	*72*	*2445*	*85*	*33806*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Attachment 1

Waiting Time Report December 1999 Quarter

Redcliffe	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	26	100	265	83	919	79	1241	71	152	84	2503
November 99	11	100	231	78	910	75	1258	78	177	89	2487
December 99	19	100	231	92	765	86	1247	86	144	90	2406
December Quarter	56	100	727	84	2394	80	3746	78	473	88	7396
Major Regional - December Quar	*366*	*88*	*2548*	*70*	*11838*	*68*	*16609*	*72*	*2445*	*85*	*33806*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Rockhampton	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	28	100	170	80	1285	46	963	52	142	49	2588
November 99	25	100	161	89	1191	50	870	48	144	57	2391
December 99	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0
December Quarter	53	100	331	85	2476	48	1833	50	286	53	4979
Major Regional - December Quar	*366*	*88*	*2548*	*70*	*11838*	*68*	*16609*	*72*	*2445*	*85*	*33806*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Toowoomba	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	21	95	174	84	757	76	1540	82	180	94	2672
November 99	14	79	150	65	760	79	1503	84	185	92	2612
December 99	12	92	127	65	738	80	1649	85	178	93	2704
December Quarter	47	89	451	58	2255	78	4692	83	543	93	7988
Major Regional - December Quar	*366*	*88*	*2548*	*70*	*11838*	*68*	*16609*	*72*	*2445*	*85*	*33806*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Attachment 1

Waiting Time Report December 1999 Quarter

Bundaberg	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	11	100	115	71	321	82	1247	79	613	93	2317
November 99	12	100	107	72	271	79	1263	76	662	91	2315
December 99	11	100	100	72	321	82	1211	73	776	93	2419
December Quarter	34	100	322	72	923	81	3721	76	2051	93	7051
Regional - December Quarter	*125*	*93*	*1963*	*71*	*6685*	*73*	*18527*	*79*	*9785*	*94*	*37085*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Caboolture	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	15	87	274	63	772	57	892	57	147	79	2100
November 99	13	100	257	87	679	70	943	82	108	84	2000
December 99	12	92	227	81	757	71	973	74	153	92	2122
December Quarter	40	93	758	70	2208	66	2808	71	408	85	6222
Regional - December Quarter	*125*	*93*	*1963*	*71*	*6685*	*73*	*18527*	*79*	*9785*	*94*	*37085*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Hervey Bay	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	10	100	93	82	205	91	726	90	902	97	1936
November 99	7	86	97	77	195	89	626	93	814	98	1739
December 99	9	89	91	84	235	88	672	91	1061	95	2068
December Quarter	26	92	281	81	635	89	2024	91	2777	96	5743
Regional - December Quarter	*125*	*93*	*1963*	*71*	*6685*	*73*	*18527*	*79*	*9785*	*94*	*37085*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Attachment 1

Waiting Time Report December 1999 Quarter

Mackay	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen Immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	7	43	122	54	577	68	1546	73	533	86	2787
November 99	9	100	143	61	535	74	1382	78	559	86	2628
December 99	5	100	121	68	525	79	1480	78	608	91	2739
December Quarter	21	81	386	61	1637	74	4410	76	1700	88	8154
Regional - December Quarter	*125*	*93*	*1963*	*71*	*6685*	*73*	*18527*	*79*	*9785*	*94*	*37085*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

Mt Isa	Triage 1 - Resuscitation		Triage 2 - Emergency		Triage 3 - Urgent		Triage 4 - Semi-urgent		Triage 5 - Non-urgent		Total Attendances
	Attendances	% seen Immediately	Attendances	% seen within 10 minutes	Attendances	% seen within 30 minutes	Attendances	% seen within 60 minutes	Attendances	% seen within 120 minutes	
October 99	1	100	71	76	512	70	1930	82	837	97	3351
November 99	2	100	81	75	405	69	1734	81	1015	97	3237
December 99	1	100	64	78	365	74	1900	86	997	98	3327
December Quarter	4	100	216	76	1282	71	5564	83	2849	98	9915
Regional - December Quarter	*125*	*93*	*1963*	*71*	*6685*	*73*	*18527*	*79*	*9785*	*94*	*37085*
State - December Quarter	1273	95	11210	69	53674	64	73233	72	22003	90	161393
TARGET		100		80		75		70		70	

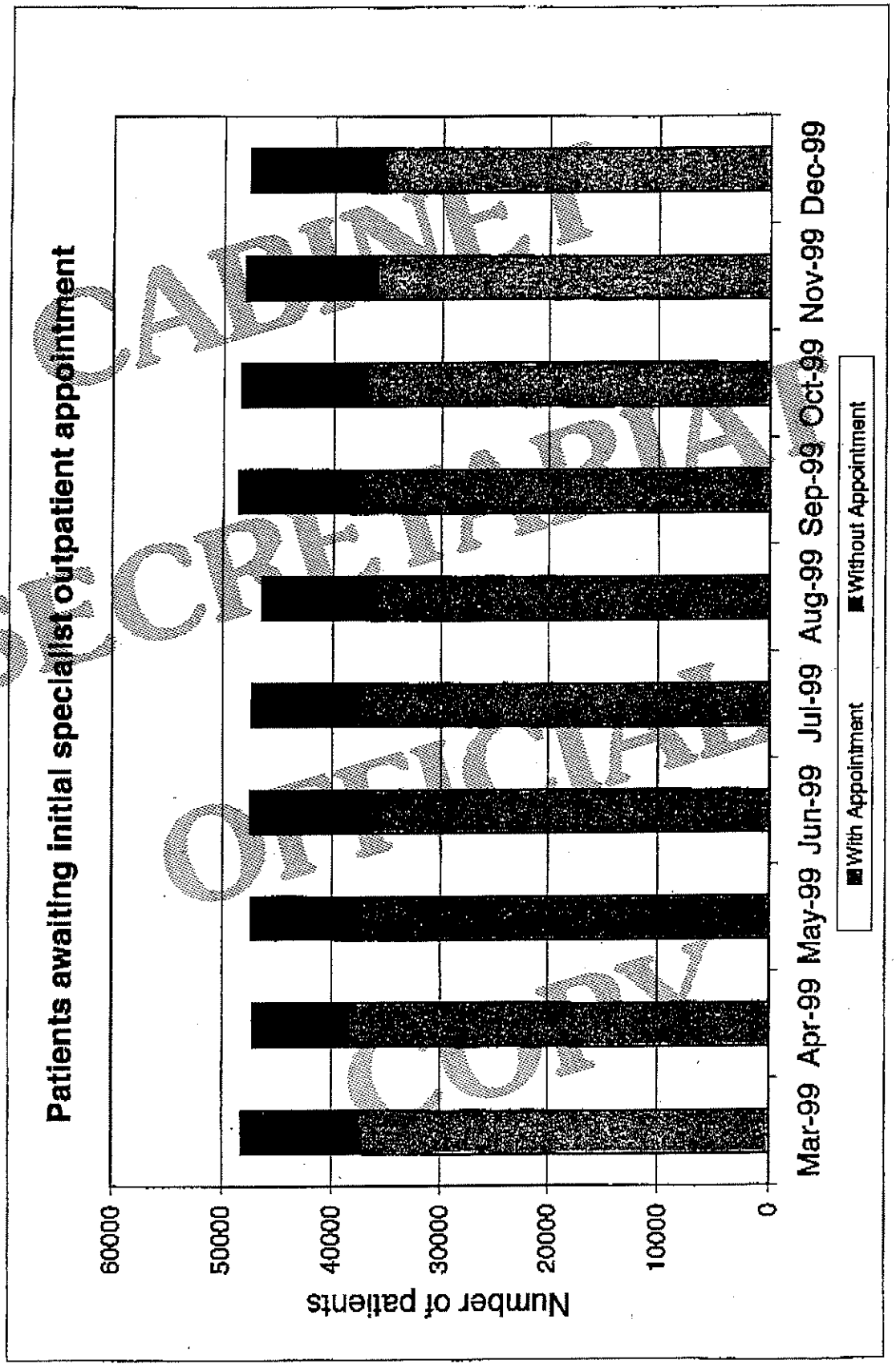
Attachment 1

Proportion of patients seen within recommended times

NTS Category	Queensland December Quarter 1999	NSW December Quarter 1998	Victoria December Quarter 1998
Cat 1	95%	98%	100%
Cat 2	69%	77%	84%
Cat 3	64%	63%	77%
Cat 4	72%	67%	n/a
Cat 5	90%	88%	n/a

Waiting time for Admission to an inpatient bed

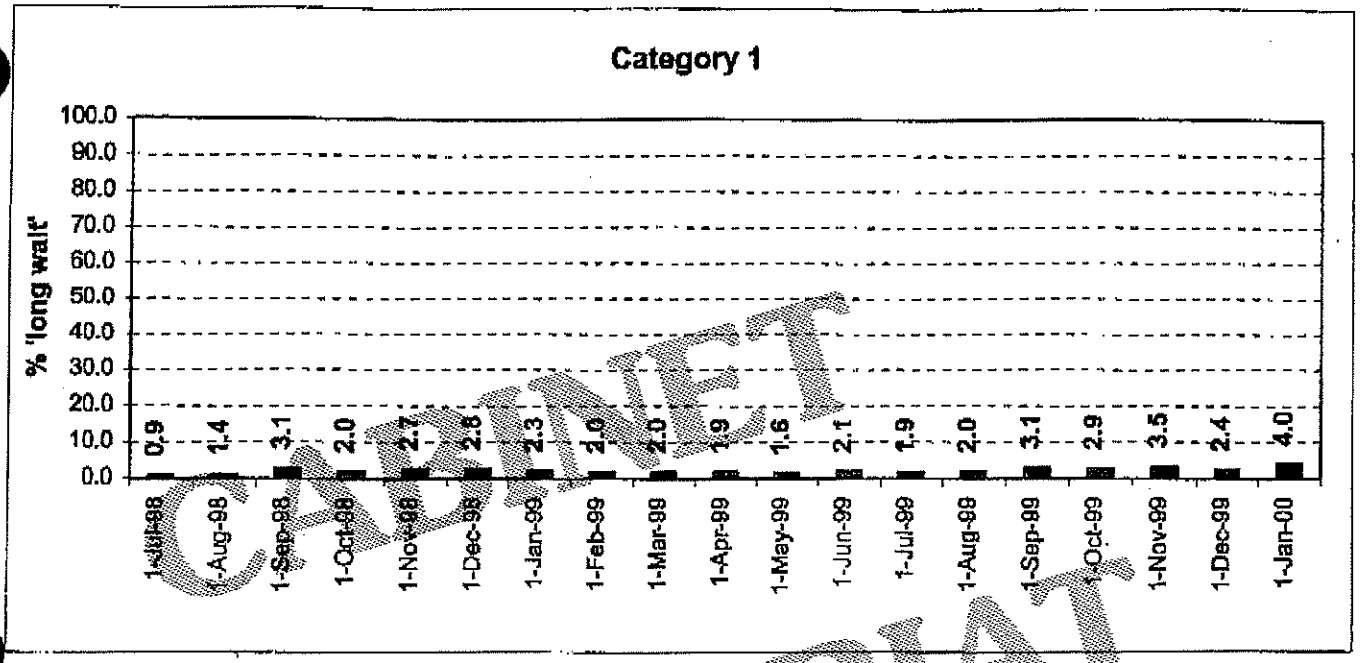
	Queensland September Quarter 1999	NSW December Quarter 1998	Victoria December Quarter 1998
% of patients admitted within 8 hours of seeing a doctor	95.1%	81.0%	----
% of patients admitted within 12 hours of presentation	98.3%	----	98.6%

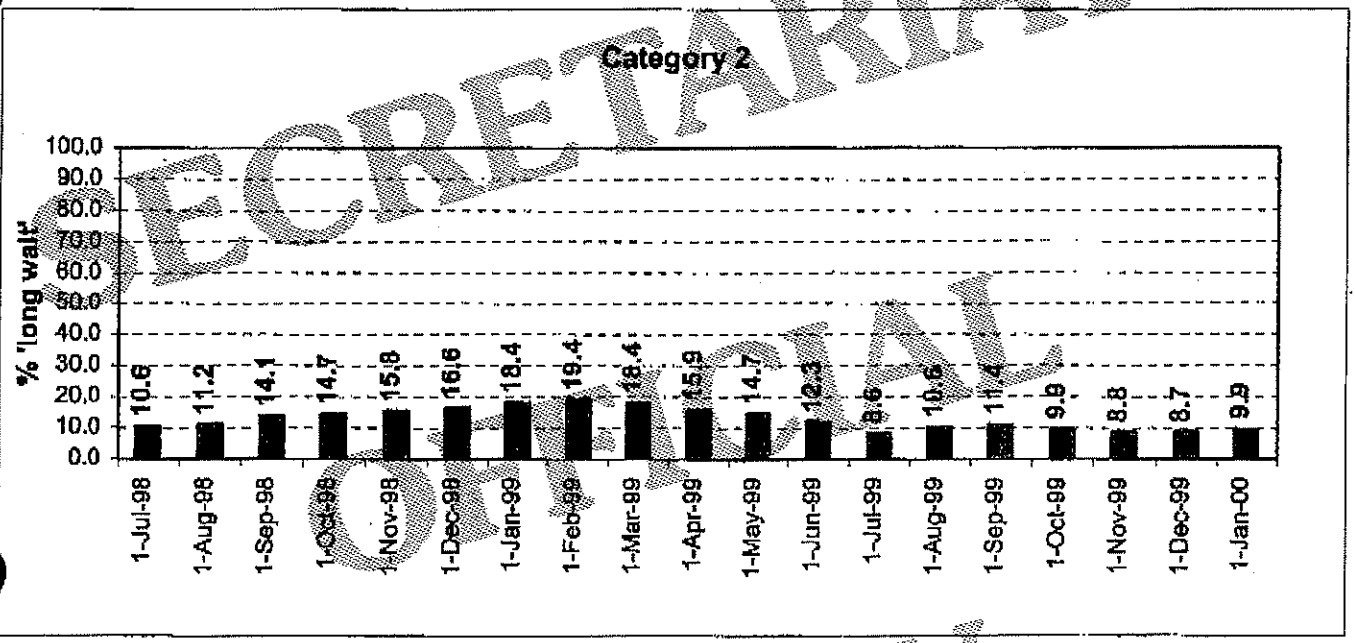


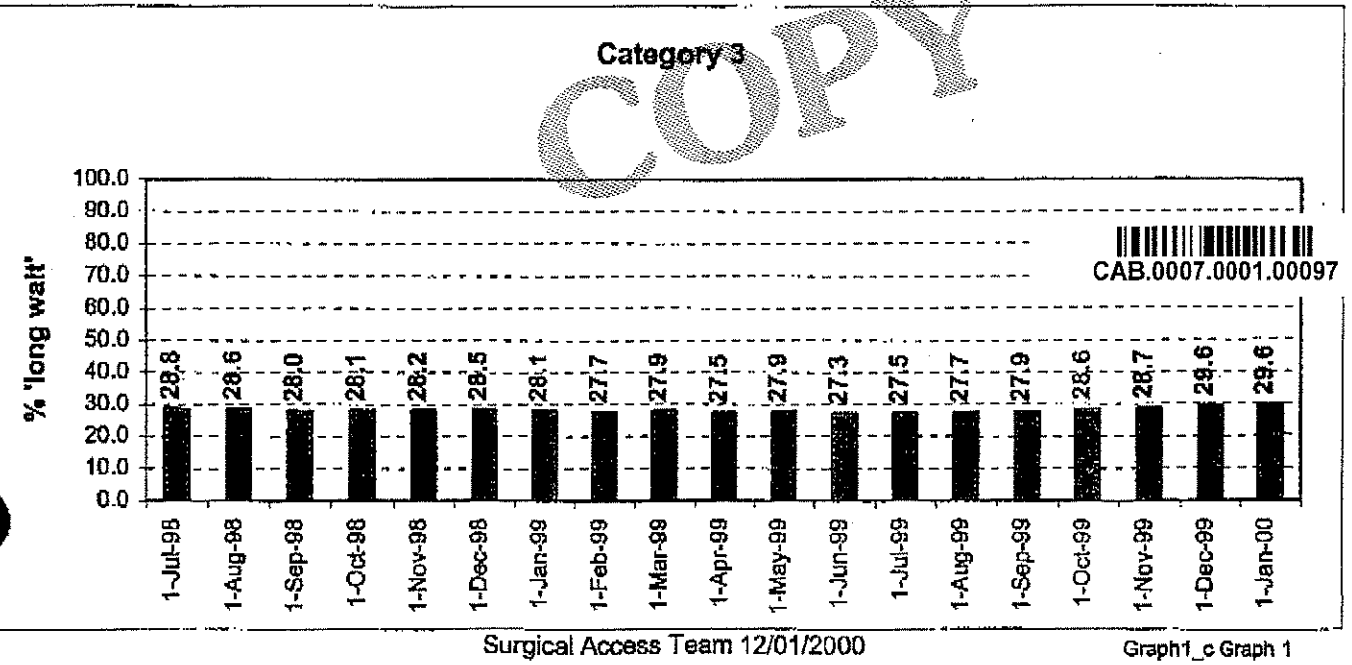
ADDITIONAL ELECTIVE SURGERY FUNDING BY DISTRICT

District	HOSPITAL	Surgical Incentives Fund	Additional Surgical Incentive Funds 1999/2000	Total 1999/2000
		$	$	$
Bundaberg	Bundaberg	425,000	250,000	675,000
Cairns	Cairns	300,000	310,000	610,000
Central Highlands		62,000		62,000
Fraser Coast	Hervey Bay		300,000	300,000
Gympie	Gympie	120,000		120,000
Gold Coast	Gold Coast	500,000		500,000
Logan/Beaudesert	Logan/beaudesert	500,000		500,000
Mackay	Mackay	725,000		725,000
Mater	Mater Adults	1,900,000		1,900,000
	Mater Children's	350,000		350,000
Princess Alexandra	Princess Alexandra	2,500,000	2,750,000	5,250,000
Queen Elizabeth II	Queen Elizabeth II	1,500,000	750,000	2,250,000
Redcliffe/Caboolture	Redcliffe	1,300,000	210,000	1,510,000
	Caboolture	700,000		700,000
Rockhampton	Rockhampton	431,000		431,000
Royal Brisbane	Royal Brisbane	0		0
Royal Children's	Royal Children's	110,000		110,000
Sunshine Coast	Nambour/Caloundra	500,000		500,000
The Prince Charles	The Prince Charles	2,000,000	350,000	2,350,000
Toowoomba	Toowoomba	500,000	100,000	600,000
Townsville	Townsville	2,700,000	500,000	3,200,000
	Kirwan	100,000		100,000
West Moreton	Ipswich	850,000	500,000	1,350,000
		18,073,000	**6,020,000**	**24,093,000**

ELECTIVE SURGERY REPORTING HOSPITALS: PERCENTAGE 'LONG WAITS' BY CATEGORY







ATTACHMENT TO SUBMISSION NO. 1248

QUEENSLAND HEALTH

A BRIEFING TO THE MINISTER

BRIEFING NOTE NO: BR010323

REQUESTED BY: Minister, Hon Wendy Edmond MLA

DATE: Tuesday 1 February 2000

PREPARED BY: June Lithgow, District Manager, Central West Health Service District (07 4658 3223)

CLEARED BY: Lindsay Pyne, Zonal Manager, Central Zone Management (07 3234 0825)

DEPARTMENTAL OFFICER ATTENDING:

Deadline: 20 January 2000

SUBJECT: ***Contentions Issues within Central West Health Service District, Particularly in the Winton and Longreach Areas.**
***Capital Works Projects, Maintenance Expenditure, New Equipment Costs**

MINISTER'S COMMENTS:

Wendy Edmond MLA
MINISTER FOR HEALTH
Date:

BACKGROUND:

CONTENTIOUS ISSUES:

1. Budget Position

Issue/Sensitivity:

- The Central West Health Service District's budget situation is tight. 1998/99 saw a budget surplus and subsequent rollover of approximately $122 000. With a $320 000 rise in WorkCover Premium (an increase of approximately 149%) as well as costs associated with Year 2000 compliance, the District's budgetary position is currently unfavourable. however, pending budget supplementation should alleviate the adverse position.

Status:

- The District continues to work towards maintaining budget integrity and a budget overrun of up to $200 000 had been anticipated. Some supplementation has been received to combat the WorkCover increase ($113 000) although it still leaves the District to find the remaining shortfall and this may mean foregoing repairs to facilities and replacement of minor equipment etc.

Issue/Sensitivity:

- The Winton Hospital is seen by the community and hospital executive as in need of replacement. Winton Hospital is, despite its condition, seen as the District's fourth building priority.

Status:

- The District acknowledges the need to improve facilities at Winton.

  There are three other facilities in much worse condition Isisford, Windorah and Alpha.

- These priorities were identified with Capital Works in the Asset Management Plan last year and again this year.

- These issues have been notified to the Zonal Unit and reinforced at every opportunity.

- Over the past two years a new Doctors Surgery has been built, the dental clinic has been upgraded and there have been improvements to the theater and aged care.

- No word on funding has been received by the District and the projects are beyond the scope of the local budget.

2. Staffing Issues

Issue/Sensitivity:

- The staff dentist in Winton has resigned and the position is currently vacant.

Status

- No applications have been received for the Senior Dental position. which has now closed.

- The District is negotiating the appointment of the private practitioner in Longreach as a part time Senior Dentist.

- Advertisements are now being placed for the Staff Dentist Winton.

- Discussions have been held with Dr Grundy (retired) regarding providing a service should the Staff Dentist position not be filled.

Issue/Sensitivity:

- The physiotherapy position remains vacant despite numerous recruitment strategies.

Status:

- Recruitment process for this position are ongoing by Education Queensland and Queensland Health. The position is shared by both departments in an attempt to enhance attractiveness.

- The District has applied for a graduate bonded student two years running and has been unsuccessful on both occasions.

Issue/Sensitivity:

- The Flying Surgeon is on extended sick leave and the anaesthetist has resigned. Recruitment to these positions are proving extremely difficult.

Status:

- The Flying Surgeon Service, Roma has been providing some services during times when locums have been unobtainable. Experienced locums have been organised from 7 February 2000 to 12 March 2000.

- The anaesthetist position has been advertised and a small pool of applicants has been achieved.

- The appointment cannot proceed until we have a return date for the surgeon.

Issue/Sensitivity:

- Staffing (both medical and nursing) continues to be difficult at Aramac hospital. Second or third year Medical Officers are rotated on a three monthly basis from Bundaberg hospital. Extensive advertising of the Director of Nursing position failed to identify a suitable applicant. The nursing division relies heavily on agency staff.

Status:

- It is anticipated that a Medical Superintendent will be recruited under the Doctors for the Bush Program. In lieu of a suitable applicant for the Director of Nursing position, a level three nurse has been appointed for six months with a view of upskilling under the supervision of the Director of Nursing, Longreach.

  This process has been working well and it is hoped that the level 3's skills will have improved to the level where she meets the key selection criteria at the next recruitment attempt (May 2000).

3. **Aboriginal Health**

Issue/Sensitivity:

- Due to the resignation of a Coordinator and death of a Health Worker this service is short staffed.

Status:

- The Senior Health Worker is acting as the Coordinator. The position cannot be advertised due to restructure of this service at a Corporate Office level.
- Advertisements were placed to recruit workers to Longreach and Boulia.

  There were no applicants for Boulia.

  Neither of the two applicants who applied for Longreach and were interviewed last week met the selection criteria.

  Support and training is being put in place for these applicants with a view to assisting them to meet the criteria when readvertised in March.

- There are two temporary Health Workers in place.

4. **Capital Works**

Issue/Sensitivity:

- Boulia air-conditioning has remained a constant problem. A new evaporative system was installed 2 ½ years ago. This system has experienced constant failures due to the quality of water at Boulia.

Status:

- Tenders for the refrigerative air-conditioner were called in line with Ergon Energy requirements. Cost is in excess of $61 000. The District has authorised half this financial year and will complete next financial year due to budget constraints.

- This issue has not been raised with Capital Works as it is within District responsibilities and budget.

  Q-Build (Rockhampton) has managed the process.

Issue/Sensitivity:

- The Central West Health Service District has capital equipment items that need replacing, some urgently (eg: new steriliser for Longreach hospital). The Districts financial position does not offer the scope to replace from within operating budget.

Status:

- The District has included the capital items in its Capital Investment Strategic Plan and are hopeful of receiving funding through the Capital Works Branch. Some of the items up for replacement are becoming critical, the steriliser at the Longreach Hospital has been deemed obsolete and no longer practical or economical to repair.

- This issue has been communicated to Capital Works over the past two years.

- The finance officer has been unofficially informed that the money would be forthcoming, no official word to the District as yet.

Issue/Sensitivity:

- Staff quarters Longreach have been an issue for a long time. The quarters are well below standard and there are too few rooms to meet needs. This hampers recruitment and retention and the ability to accept rural students from all disciplines.

Status:

- The District has been allocated $600 000 to provide new staff quarters. There have been delays in this project due to the difficulty of meeting stated priorities within budget.

  The priorities for the District are to provide a minimum of 21 rooms.

  The priorities for Capital Works are to provide ensuite bathroom facilities.

  The issue has been referred to the Zonal Unit.

Issue/Sensitivity:

- Currently the District pays $80 000 per annum in rental for the District Office and Community Health. Neither set of accommodation is suitable.

Status:

- The District over the past two years, in the Capital Investment Strategic Plan and in written submissions and notifications to the Zonal Unit proposed the redevelopment of the old staff quarters into a combined Community Health and District Office. This would result in financial savings from rentals and pooling of resources, appropriate facilities, enhance teamwork, supervision and communication. Staff are in general supportive and no community concerns have been raised.

  There has been no formal response to this proposal by Capital Works. Positive verbal comment on appropriateness has been received.

5. **Service Issues**

Issue/Sensitivity:

- Multipurpose Health Services. The District is attempting to implement these services at Barcaldine, Blackall and Alpha. Implementation raises community expectation regarding aged care facilities to the detriment of the broad spectrum of services achievable under this project.

Status:

- The District maintains commitment to the initiative. A full time project officer has been allocated. Barcaldine is progressing well and the plan will be submitted in January 2000. Alpha is progressing. Blackall process is problematic due to their focus on building a separate Nursing Home. This is made difficult by the allocations of high level and low level care places being held by the community.

  The community members recently met with representatives from the Ministers office and Capital Works. No communication has been forthcoming to the District. The

District remains convinced that all services can be provided under one roof and that a stand alone unit is not viable.

Issue/Sensitivity:

- Ambulance services in Alpha and Barcaldine have remained the responsibility of Queensland Health when other and sometimes smaller communities have fully staffed Queensland Ambulance Service centers. Vehicles supplied to Queensland Health by the Queensland Ambulance Service are old and the hospital staff lack necessary skills and training in Queensland Ambulance procedures.

Status:

- Negotiations are currently in progress to co-locate QAS services at Alpha and Barcaldine hospitals. This will result in a better standard of vehicle and skilled and fully trained staff providing services to Alpha and Barcaldine communities. The QAS will require additional funding to operationalise the service. The agreement is expected to be completed before 1 July 2000.

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

BRIEFING NOTE NO:

REQUESTED BY: Kylie Craig

DATE: 19/01/2000

PREPARED BY: Ms K Batchler, Team Leader
Southern Zone Management Unit
Ph: 41863

CLEARED BY: Mrs L Dawson, Acting Zonal Manager
Southern Zone
Ph: 40683

DEPARTMENTAL OFFICER ATTENDING:
Mrs L Dawson, Acting Zonal Manager
Southern Zone
Ph: 40683

Deadline: 19/01/2000

SUBJECT: **Briefing Meeting on the Southern Zone**

DIRECTOR-GENERAL'S COMMENTS:

(Dr) R L Stable
Director-General
/ /2000

PURPOSE: To provide background information to the Parliamentary Secretary on the Southern Zone and the Southern Zone Management Unit

PHILOSOPHY:

- Support Districts in their role as Service Providers
- Promote Good Practice
- Foster Clinical Leadership and Contribution
- Maintain budget integrity with an emphasis on Value for Money
- Promote Zonal Co-operation
- Make a Difference
- Be Transparent and Honest
- Work Co-operatively as a Team
- Do no harm

STRUCTURE: (see Attachment A)

PROFILE:

The Southern Zone covers 428,666 square kilometres, extending from the southern banks of the Brisbane River, down the east coast to the southern border of Queensland, and out to the western border of the state.

The Southern Zone has the largest population of the three zones – 1,478,556 persons, 44.5% of the Queensland population.

The 1998/99 budget for Southern Zone Health Service Districts was approximately $1.1billion. 200,000 staff (16,500 FTEs) are employed in the Districts.

The Southern Zone includes the following Health Service Districts:

- Bayside
- Logan-Beaudesert
- Princess Alexandra Hospital
- Southern Downs
- Charleville
- QEII Hospital
- Toowoomba
- Gold Coast
- Northern Downs
- Roma
- West Moreton
- *Mater Misericordiae Hospitals**

* Private provider of public hospital services, operated by the Corporation of the Trustee of the Order of the Sisters of Mercy

PRIORITIES IN SERVICE DELIVERY:

Service development priorities in the Southern Zone are:

- Cancer Services
- Renal Dialysis Services
- Cardiac Services
- Rural Services
- Palliative Care Services
- Paediatric Hospital Services
- Intensive Care Services
- Neonatal Services

By June 2000, plans will be developed for all these priority areas. These plans provide a broad strategic direction, within which Southern Zone managers, clinicians and planners can collaborate to develop strategies and structures which ensure: sufficient service capacity; appropriate location of services; high quality service delivery; effective service links and clinical networks; and adequate resources.

KEY CURRENT ISSUES:

FLOWS

- The key principles underpinning the Queensland Health Capital Works Redevelopment Program are:
  - the developments will result in efficiencies in management of capital and recurrent resources
  - health services will be responsive to changing community needs, devolved from the inner metropolitan area to where people live and co-ordinated across District boundaries.

- The success of this project will depend on achieving a shift or "flow" of patients back to the new "local" hospitals from the inner metropolitan hospitals they have historically attended. Funding appropriate to the level of activity flowing back will also be transferred.

- In the Southern Zone, the Districts involved are the Mater Hospitals, Princess Alexandra Hospital, QE11, Logan, Bayside, West Moreton, Gold Coast and Toowoomba Health Service Districts. Discussions between these Districts have occurred. Guidelines and strategies to facilitate the flow reversals have been developed and agreed.

- The current focus is on facilitation of flows from PAH, QE11 and Mater Hospitals to both Redland and Logan Hospitals. The services which are being targeted for flow reversals between these sites have been agreed as follows:

Orthopaedics	General Surgery
General Medicine	Obstetrics & Gynaecology
Neonatology	Intensive Care Services
Emergency Medicine	

- Co-ordination of the flow reversal strategies across the Zone is ongoing to ensure service distribution and reallocation is done in the most clinically appropriate and cost efficient manner.

- Districts have been required to quarantine the flow reversal allocations and to provide quarterly reports on progress. First quarter reports have been received.

MATER MISERICORDIAE HOSPITALS

- The redevelopment and reconfiguration of Queensland Health hospitals is likely to have a significant impact on the Mater Misericordiae Hospitals, in particular the long-term viability of the Mater Adults' Hospital.
- With activity transferring out of the metropolitan hospitals, an alternative role may need to be found for adult services at the Mater.
- The Minister has authorised Dr Steve Buckland, Zonal Manager, Southern Zone, to explore with the Mater Health Services Governing Board a mutually acceptable future role for the Mater Hospitals. This is still in progress.

COLLOCATION & BOOT (Build Own Operate Transfer) PROJECTS

BOOT PROJECT - ROBINA

- Queensland Health has entered into arrangements with two private hospital operators, Health Care of Australia and the Sisters of Charity to build hospitals at Noosa and Robina respectively.

- The Department will purchase public patient services from the two facilities as part of twenty year Service Agreements with each of the private hospital operators. At the end of the Service Agreement term, the ownership of each facility will transfer to the State.
- The Robina Hospital is planned to open in April 2000.

COLLOCATION PROJECTS

There are three collocation projects planned for the Southern Zone:

Logan Hospital

- The collocated Logan Private Hospital, operated by Health Care of Australia, will open in October 1999.
- The location of a private hospital on the Logan campus will provide further incentive for medical specialists to be attracted to the site. Furthermore, the opening of the Logan Private Hospital will provide additional private health services to the Logan community.

Redland Hospital

- Construction has commenced on the Mater Redland Private Hospital operated by the Sisters of Mercy. It is anticipated the collocated Mater Redland Private Hospital will open in September 2000.
- The opening of the Mater Redland Private Hospital will enhance the Redland Public Hospital's capacity to attract medical specialists and provide additional private health services to the Bayside community.

Princess Alexandra Hospital

- Negotiations are continuing with Ramsay Health Care (RHC) in relation to the collocated Princess Alexandra Hospital (PAH). RHC have confirmed their continued commitment to the PAH collocation project.
- Negotiations are continuing in relation to the timing of construction of the private hospital.

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

BRIEFING NOTE NO:

REQUESTED BY:

DATE: 05 January 2000

PREPARED BY: Graeme Kerridge
Senior Manager – Operations, Central Zone Management
323 40232

CLEARED BY: Lindsay Pyne
Zonal Manager, Central Zone Management
323 40825

DEADLINE:

SUBJECT: **Flow Reversal Strategies – Redcliffe Caboolture**

DIRECTOR- GENERAL'S COMMENTS:

(Dr) R L Stable
Director-General
/ / 2000

PURPOSE:

To advise the Office of the Director-General of current developments in service development at Redcliffe-Caboolture, in particular to facilitate reverse flows.

BACKGROUND:

The Capital Works Business Case for Redcliffe-Caboolture Health Service District is based on a significant reversal of current flows of patients out of the District. In total, these reversals were estimated to equate, by 2005/06, to almost 5,800 separations per annum, utilising approximately 15,500 occupied bed days. These are net figures as some transfer of activity from Redcliffe to Caboolture was anticipated as part of the service build-up at Caboolture. These figures do not include the Mental Health ramp-up in the District.

Funding to facilitate the initial flow reversal had been made in the 1999/2000 budget totalling $1.1 million. More detailed analysis of the Business Cases, however, has identified that "Flow Changes" funds were envisaged to disappear until 2004/05 and increase rapidly in 2005/06. The District was in fact envisaged to increase its outflows over the next few years, creating a serious anomaly, given the broad corporate strategy of increasing the level of services in Districts such as Redcliffe-Caboolture. Graphs identifying the funding changes were submitted to the December 1999 Procurement Council and are attached.

The District Executive have undertaken service development planning in consultation with the Zonal Management team to identify possible areas for viable flow reversal recognising the necessity to work within projected budgets.

KEY ISSUES:

- In developing a service ramp-up in accordance with expected resources, the Zonal Executive and District Manager are regarding the planned "Growth" funds and the "Flow Changes" funds as a merged pool to allow rational service development to proceed. It is recognised that some uncertainty about future funding levels inevitably exists.

- With completion of capital works at Caboolture, community interest in expanding services at that site is expected to increase. Accordingly, focus in service development is being balanced between service enhancement at that site and the specialised chronic services such as Renal and Medical Oncology, which are concentrated at the Redcliffe site.

- Approval has been given for enhancing Obstetrics and Neonatology services at Caboolture, with a planned operational date by early March 2000. This enhancement is planned to require approximately $400,000 on a full-year basis. While the level of outflow of secondary obstetric patients is not currently substantial, capacity limitations at Caboolture are threatening to create flows. Moreover, there appears to be considerable scope to reduce the level of outflow of neonatology patients by facilitating early return of infants from the Royal Women's Hospital.

- In line with the current proposal to develop Renal Dialysis services at Redcliffe as a networked service with the Renal services provided through Royal Brisbane Hospital, Redcliffe staff are currently assessing the minor capital works requirements and timeframes for establishing this service. It is envisaged that the capital costs to be undertaken in the current year would be funded from the "Flow Changes" funds and that recurrent funding for the service would be by transfer of resources from RBH using the Renal Dialysis funding model with some

supplementation from the Flow Changes funds. The funding transfer from RBH would reflect patients who would be transferred to a new incentre dialysis unit at Redcliffe from Keperra and Sandgate. It would not be envisaged that this service would, however, be operational until the 2000/2001 financial year. This recurrent funding proposal has been discussed with the District Manager of RBH and will be further progressed over the next month.

- In conjunction with Obstetrics, some increase in Gynaecology services at Caboolture is envisaged. Details of this enhancement are currently being developed. This would be aimed at further reduction in the outflow of patients for these services and would be funded through the Flow Change funds.

- Some expansion of General Surgery at Redcliffe-Caboolture is being undertaken through use of additional Surgical Access funds.

- In respect to other service development that may be resourced on the basis of flow changes, while ENT is considered as a high priority to develop, given the uncertainties as to development of a sustainable service, current attention is on expansion of the Medical Oncology service which is under capacity constraints and which is perceived as an area where there is still significant secondary outflow. Further enhancement of this service can be expected to assist relieve some of the pressure on the RBH Medical Oncology services.

BENEFITS AND COSTS:

ACTIONS TAKEN/ REQUIRED:

- As the Redcliffe-Caboolture Executive submit to the Zonal Manager business proposals for service development in accordance with the available resources in the current and future years, these will be considered and, if acceptable, approved. This development will need to recognise not only financial constraints and service sustainability but also facility constraints and cost-efficient sequencing of service development.

- The business proposals for enhancement of Gynaecology services and Medical Oncology are expected to be submitted during January 2000. Likewise, the full business proposal for Renal service development will be completed shortly in conjunction with Ms Sue Hinkins (Capital Works) and Ms Kate Mason (Keperra).

- The Office of the Director-General will be kept informed as service development planning continues. With commencement of the new District Manager and completion of preliminary service and resource planning, it is envisaged that a more comprehensive service ramp-up plan can be undertaken over coming months.

QUEENSLAND HEALTH

A BRIEFING TO THE MINISTER

REQUESTED BY: John Algate Office of the Minister for Health

DATE: 4/1/00

PREPARED BY: Ron Wynn, District Manager **Contact Number:** 41 206865
Fraser Coast Health Service District

CLEARED BY: Martin Jarman, Senior Manager - Operations **Contact Number:** ext 76861
Central Zone

SUBJECT: **MARYBOROUGH HOSPITAL – FAX DATED 31/12/99 FROM DR KINGSTON MLA TO PREMIER**

MINISTER'S COMMENTS:

Wendy Edmond MLA
MINISTER FOR HEALTH
Date:

PURPOSE:

To provide information for a response to Maryborough Hospital issues raised by Dr Kingston MLA in the Maryborough Chronicle newspaper of 1/1/00 and in his fax to the Premier on 31/12/99.

BACKGROUND:

Since the opening of the new Hervey Bay Hospital in June 97, the Fraser Coast District now operates two Level 4 hospitals within close proximity for a small population base.

A public protest in September 1999 stopped a proposal to merge the Intensive Care Units with higher risk patients to be treated at the Hervey Bay Hospital. Within the Maryborough Hospital a small group of Operating Theatre Nurses and Visiting Medical Officers became active with local politicians and media outlets. This group now see itself as a powerful lobby group with a responsibility to the Maryborough community.

The population of nearby Hervey Bay has grown rapidly in recent years and it is now the largest population centre in the Fraser Coast Health Service District. Maryborough has seen the loss of industry and public services to Hervey Bay. The tension between the two towns is largely based on socio-economic change and parochialism with the two hospitals taking on symbolic and economic significance.

The acute inpatient occupancy at Maryborough continues to decline to the point where it has functioned within the 70 beds available whilst the main accommodation block is under renovation as part of the redevelopment. The level of utilisation is an obvious concern for staff.

The Health Service is grappling with an unexpected WorkCover premium increase of $1.1m which has been partially supplemented ($345k) by Queensland Health. Staff were asked for savings suggestions by 6 December 1999 that would not compromise direct patient services. To date only minor straightforward suggestions have been implemented, as a consultation phase with Zonal Office, unions and staff will be undertaken in January.

The catalyst for the current media interest in Maryborough Hospital is the withdrawal of meals for the Operating Theatre staff.

KEY ISSUES:

Swimming Pool:
This is the staff swimming pool adjacent to the Nurses Quarters and should not be confused with the heated pool used for patient treatments. The swimming pool is 40 years old, leaks badly and is at the end of its useful life. It was closed and drained in November 1999.

To repair the pool would cost an estimated $17k and an estimated $35k to replace. The Health Service cannot afford either option.

Running costs of the existing pool were $5k per annum whilst it has been estimated that a modern pool would cost $2k per annum.

It is believed that nursing staff raised the funds for the construction of the pool and made contributions towards its upkeep until the mid 1980's, according to senior members of staff.

Cessation of free meals to Operating Theatre staff:
A savings suggestion by Maryborough Hospital staff notified management about this practice. Its implementation was not primarily to save money (savings approx $5k pa.) but because there is no entitlement for taxpayer funded meals for selected occupations. The issue is about equity for all staff and award entitlements. In relation to overtime, it appears that doctors and nurses have been paid meal allowances and have also received free meals.

Local management implemented the withdrawal of free meals. It is acknowledged that this could probably have been done better but this would not have changed the outcome.

It should be noted that staff do not receive free meals in any unit at the Hervey Bay Hospital.

Charges for visiting junior doctors:
There are no "visiting junior doctors". There was a savings suggestion from Maryborough Hospital staff to charge for accommodation for student doctors and nurses. No decision has been made in relation to this suggestion.

Job descriptions to elevate junior staff from 002 to 005:
There are no 005 positions (a hotel services management level position) at Maryborough Hospital. Staff and AWU have been consulted about upgrading the 004 positions in the New Year in line with similar classifications at the Hervey Bay Hospital where the 005 positions were recently filled on merit (but not by 002 staff).

I suspect that Dr Kingston's comment refers to a highly experienced staff member (classified at 002) being given the developmental opportunity to relieve as Manager Environmental Services (004) Maryborough Hospital for five weeks during November 1999.

Campaign to humiliate hardworking staff until they resign:
This is thought to refer to Dr David Cooke, a United Kingdom registered surgeon who is not recognised within Australia as a specialist. Therefore he can only practice in a public hospital setting as a lower paid Senior Medical Officer. Dr Cooke has been describing himself as a specialist surgeon to general practitioners and staff and using the unauthorised letterhead "Department of General and Vascular Surgery".

Dr Hanelt, Director of Medical Services for the District based at the Hervey Bay Hospital has instructed Dr Cooke to cease these actions as it exposes himself and Queensland Health to medico-legal consequences.

ACTIONS TAKEN/ REQUIRED:

It should be noted that the Health Service must make significant savings to ensure budget integrity in 99/00 and 00/01.

Please note also that Dr Kingston brought the media into the grounds of the hospital without seeking permission from local management.

QUEENSLAND HEALTH

SUBMISSION TO THE:

☑ **Director-General**
☒ **General Manager, Health Services**
☐ **Deputy Director-General (Policy and Outcomes)**

DATE: 23 December 1999

PREPARED BY: Sue Hinkins **Contact No:** 32252781

SUBMITTED THROUGH: Lindsay Pyne **Contact No:** 32340825

CONFIDENTIAL

Subject: **RBH/RWH East Block**

APPROVED/ NOT APPROVED

COMMENTS

(DR) R L Stable
Director-General
/ / 1999

PURPOSE:

To advise the Director General and the General Manger Health Services of the risks in the proposed new plans for East Block.

BACKGROUND:

As part of the Capital Works Audit certain parts of the RBH/RWH were reviewed in order to minimise future risk to Queensland Health. The revised plans for East Block have been submitted for approval.

ISSUES:

The new plans accommodate the changes in relation to the engineering throughout the block. However, there are still significant issues in relation to the following:

- The large amount of office space on the first floor allied health area.
- The outpatient area on the second floor appears excessive when specialist outpatients are attached to the inpatient units throughout Central Block.
- The minor procedure suite on the first floor duplicates the operating suites on the fifth floor of central block where economies of scale can be achieved.
- The thoracic unit on the third floor is excessively large for the services currently provided by RBH. The majority of these services are currently being undertaken at TPCH. A reduction in the size of the unit would potentially allow for the executive offices to be accommodated on that floor.
- The size of the intensive care unit on the fourth floor needs to be limited with space only provided for future use. The actual numbers of beds should be decided and the remainder of the unit closed off. Recommended commissioning of 20 beds only, including neurological beds.

A meeting has been arranged for Wednesday 5th January to review the plans and discuss the issue.

From: Michelle Jensen
To: Brennan, Cheryl
Date: 22/12/99 11:36:28
Subject: Meeting

Cheryl,

Could you please put in JY's diary the following.

Meet with DG, Lindsay Pyne and Sue Hinkins to discuss East Block at RBH. [redacted]
[redacted]

Regards
Michelle

Michelle - DDCS will be at bound Hosp - 4.50pm

DG not required to attend - JY to handle.
NG
24/12/99

Judith

HS
ExDG

RECEIVED
21 DEC 1999
5B009501

QUEENSLAND HEALTH

SUBMISSION TO THE MINISTER

Date: 17th December 1999

Prepared by: Sue Hinkins
Contact No: 3225 2781
0412241966

Submitted through: Lindsay Pyne
Zonal Manager Central Zone
Contact No: 32252678

supported.

Deadline: 17th December 1999

File Reference:

KM 21/12

Subject: **Renal Services at Sandgate**

RECOMMENDED/ ~~NOT RECOMMENDED~~

APPROVED/ NOT APPROVED

DIRECTOR-GENERAL'S COMMENTS

The unit from Sandgate needs to move in a reasonable time frame given its status

MINISTER'S COMMENTS

(Dr) R L Stable
Director-General
21.12.99

Date:

Wendy Edmond MLA
MINISTER FOR HEALTH

Date:

CAB.0007.0001.00117

- No further action is to be taken w.r.t. Redcliffe proposal until approval, if any, given
- Why has the previously discussed proposal for the service to relocate to the Nursing Home at Sandgate (Eventide) not been proposed?
- Please provide a breakdown of place of residence of users of the current facility at Sandgate.

PURPOSE:

To inform the Minister of impending changes to Renal Services at Sandgate, Redcliffe and Keperra.

BACKGROUND: Following the acceptance of the previous submission in relation to changes to the renal services in the Central Zone, detailed planning is now being undertaken for the development of a Renal Unit at Redcliffe Hospital.

ISSUES:

1. Once the unit at Redcliffe has been prepared the first move will be to relocate the services currently being provided at Sandgate.

2. The local member, Mr Nutall, has previously opposed any proposals to move this service from the current site. There are however, several reasons why this move should be supported. These are as follows:

The current renal unit is situated on the upper level of the Sandgate Health Clinic. The access is by a rusted iron staircase, which is especially dangerous when wet. The building and access do not comply with the building regulations and would not meet health and safety standards. Thus the venue is not a safe acceptable place for the delivery of clinical care.

Equipment and fixtures at Sandgate, in particular the water supply, require replacement, however, any work undertaken would require the building to comply with building regulations. This would be a very expensive exercise and would not be recommended by Capital Works. An alternative would be to build a separate unit at Sandgate however, this would not meet the needs of the wider population in relation to renal services.

It is proposed therefore, to move these services to a new unit at Redcliffe Hospital. A suitable area has been identified and detailed planning is under way.

Discussions have taken place between the Royal Brisbane District and the Redcliffe Caboolture District and tentative agreement as to the scope of the service has been reached. Both Districts are keen for the service to be developed at Redcliffe in order for the needs of the local population to be met. Discussions have been held in relation to funding and its believed that the funding required for this project is within that available to facilitate flows across districts.

Most of the patients currently receiving treatment at Sandgate do not live in the Sandgate area. Redcliffe is on a direct route from Sandgate and there is a good public transport service. The transport needs of individuals currently receiving treatment at Sandgate, will be addressed on an individual basis.

The development of a renal unit at Redcliffe will allow many patients who live in that area to receive treatment without the need to travel to Keperra or the Royal Brisbane Hospital.

BENEFITS AND COSTS:

The main benefit of this move is the opportunity to further develop services close to where the need is. The Redcliffe Caboolture Health Service District provides services for a growing population and as their services develop, particularly in relation to intensive care, their need for renal services will increase. The move will allow for not only the self-care unit to be rehoused more suitably but provide the basis for the treatment of a wider range of patients as the service develops.

RECOMMENDATION:

It is recommended that the Minister for Health discuss this issue with the member for Sandgate prior to detailed discussions with patients and staff at the site.

DRAFT MEDIA RELEASE:

There has been no media release prepared at this moment. However, this opportunity arises at the same time as the Corporate Media Campaign is being considered. It would provide an ideal opportunity to demonstrate that Queensland Health is committed to the process of providing services close to where patients live.

QUEENSLAND HEALTH

MEMORANDUM

To: Zonal Manager, Southern

Copies:

From: Acting Director-General

Contact No: (07) 323 41171
Fax No: (07) 323 41482

Subject: MONTHLY FINANCIAL REPORT AS AT 30 NOVEMBER 1999

File Ref: D66252/5

I note that the following districts are exceeding the pro-rata annual budget allocation by more than one percent.

- Charleville
- Gold Coast — legal costs
- QEII
- Roma

I would appreciate being provided with an explanation of why this is so and what is being considered/undertaken to address the situation, given the need for budget integrity.

(Dr) J G Youngman
Acting Director-General
15/12/1999

QUEENSLAND HEALTH

MEMORANDUM

To: (Dr) J G Youngman, Acting Director General

Copies to:

From: Mr D Bergin, Acting Zonal Manager, Southern Zone
Contact No: 323 40683
Fax No: 323 40790

Subject: **MONTHLY FINANCIAL REPORT AS AT 30 NOVEMBER 1999**

File Ref: **DG025215**

As at 30 November 1999, the following Districts in the Southern Zone are exceeding the pro-rata annual budget allocation by more than one percent:

- Charleville
- Gold Coast
- QE11
- Roma

Discussions have occurred with these Districts and the explanations for the YTD budget over runs and the budget management strategies being implemented to achieve budget integrity are outlined below.

Charleville District Health Service

As at the end of November 1999, Charleville has reported a YTD over run of $315,000. However the District failed to include a number of significant claims (eg unallocated funds and budget offsets) in their November snapshot report. When these are factored in, the YTD budget over run reduces to less than $100,000. This over run is due to specific non-labour one off expenses as follows:

- Upgrading of the Medical Superintendent's house
- Upgrade of two PABX systems
- Legal fees of $30,000
- Equipment Purchases ($40,000)

The over run was first noted at the end of October 1999. Since then budget management strategies have been implemented and the District has reduced the over run by $38,000 at the end of November 1999.

Further strategies to contain expenditure are currently being developed and implemented by the new District Manager.

Gold Coast District Health Service

As at the end of November 1999, the Gold Coast District has expended 43.26% of their State Budget. However, the District is reporting only an $8,000 over run from their planned YTD State Budget. Thus the District's cashflow is such that expenditure was expected to be greater in the first half of the financial year than the second half.

The principal contributing factor to this situation is that the District has expended $0.5M YTD on litigation with an amount of $0.27M being expended in November alone. Most of this expenditure relates to one case, Bloodworth, which went to trial in Sydney in November. A submission seeking reimbursement of these expenses is currently with the General Manager, Health Services.

The Gold Coast District is forecasting a balanced end of year position and has implemented significant strategies, specifically in their Surgical Division, to achieve budget integrity. However, reimbursement of the legal expenses is an important variable in whether budget integrity is achieved. Should this claim of $0.5M be disallowed service cuts will be the only alternative to achieve budget integrity.

QEII District Health Service

As at the end of November 1999, the District has reported a $1.309M budget over run. However the District states that when State and Commonwealth claims and sundry debtors are taken into consideration, the negative variance reduces to $275,000.

The District's analysis shows that the over expenditure is due to:

- Carry over deficit of $620,000
- Excessive acute activity
- Over expenditure on orthopaedic prostheses

QE 11 have submitted a number of detailed strategies to contain expenditure which total $534,154. A budget Management Plan is currently being developed.

Roma District Health Service

The District has reported a $751,000 budget over run as at the end of November, 1999. However, expenditure YTD is no greater than the same time last FY. Discussions with the District Manager reveal that the problems are more related to inappropriate cash flow rather than over expenditure. For example a Q-Build bill of $457,000 was received in November.

The District is currently undertaking a review of its budget allocations and cashflow and will be moving allocations sitting in 'pools' in June's budget. This will be completed by the December snapshot report and the District expects a much healthier YTD position to be evident by the end of December. The District Manager states that she is confident of achieving a balanced end of year position.

D Bergin

Mr Dan Bergin
Acting Zonal Manager
Southern Zone
/12 /1999

repared By: Joanne Meldrum, Team Leader
Southern Zone Management Unit
Phone: 323 41862
20/12/1999

Cleared By: Linda Dawson, Manager
Southern Zone Management Unit
Phone: 323 41524
20 /12/1999

QUEENSLAND HEALTH

SUBMISSION TO THE DIRECTOR-GENERAL

Date: 15 December 1999

Prepared by: Mark Davey
Director – Health Services
Central West Health Service District
Contact Number: 46583223

Cleared by: June Lithgow
District Manager
Central West Health Service District
Contact Number: 46583223

Submitted Through: Martin Jarman
Senior Manager, Operations
Central Zone Management
Contact Number: 32252678

RECOMMENDED/NOT RECOMMENDED BY:

☑ Zonal Manager, Central
☐ General Manager (Health Services)

[signature] Kevin Lofthouse [illegible]

Deadline: N/A **File Reference:** 32-01-01

Subject: Alternative Models of Health Service Delivery – Aramac

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RECOMMENDED/NOT RECOMMENDED
DIRECTOR-GENERAL'S COMMENTS

ZM Central
Unless there is sufficient [illegible] community, the matter cannot be progressed. Consideration [illegible] [illegible] [illegible] [illegible]

[signature]
(Dr) R L Stable
Director-General
21 . 12 . 99

Date:

APPROVED/ NOT APPROVED
MINISTER'S COMMENTS

Not to proceed
[signature]

Stable
DG
7. 1. 2000

Wendy Edmond MLA
MINISTER FOR HEALTH

Date:

1. PURPOSE

This submission outlines a proposal to begin discussions regarding an alternative model of health service delivery at Aramac.

2. BACKGROUND

- Aramac Hospital is a 10 bed acute care facility that employs approximately 15 staff.
- The hospital provides services to a population of 832 (1998 ABS Data) and is declining in numbers.
- Aramac is 66 kilometres from Barcaldine on a sealed road.
- Barcaldine has a new hospital with 18 beds and is serviced by 2 Medical Officers.
- The Queensland Ambulance Service has a fully staffed ambulance station with 2 vehicles in Aramac.
- Visiting services are no longer provided by the Flying Obstetrician or Surgeon due to reduced need in the community for the service and lack of trained and experienced staff.
- The position of Medical Superintendent, WRPP, Aramac, has been vacant for over 3 years, despite a number of extensive advertising campaigns. The position is currently filled by relievers on a 3 month rotational basis. These staff are generally first or second year Doctors, with limited rural experience.
- The Director of Nursing, Aramac, is a Level 5 Grade 1 position. This is the equivalent level to most of the Primary Health Centre DONs in the district. These positions also receive entitlement to the Remote/Rural Incentive Scheme for Nurses. As a result the applicant pool for the DON Aramac is comparatively very small.
- There have been 3 incumbents in the position of Director of Nursing, Aramac, in the last 3 years. The most recent selection process was unable to identify an applicant with suitable skills and abilities. A determination was made to appoint one of the applicants as a Level 3 nurse reporting to the Director of Nursing Longreach for 6 months with structured performance and development.
- There is generally one long stay patient and the occasional low level acute care patient at Aramac Hospital. Serious cases are transferred out as soon as practicable. Staff at the hospital are not able to utilise their skills. Those that wish to maintain their skills move on to busier hospitals.
- Staffing the hospital is becoming increasingly difficult. Half of the Nursing staff at the hospital are supplied by Agencies.
- A comparison of Aramac's expenditure, unweighted separations and outpatient presentations against two of the Primary Health Centres (PHC) in the district is illustrated in the table below.

1999/2000 Forecast

Facility	Expenditure	Separations (Unweighted)	Outpatients
Aramac Hospital	$848,000	280	1460
Tambo PHC	$228,000	276	5744
Boulia PHC	$260,000	128	5780

- The above figures indicate that Aramac provides a lower volume of services at almost four times the cost. This represents a considerable inequity between expenditure on resources and health outcomes for the community as a whole.

3. ISSUES

3.1 Service Alternatives

Option 1 – Primary Health Centre

- The current 10 bed hospital currently employing 15 staff be replaced with a Primary Health Centre employing one Director of Nursing and an Operational Services Officer. This is in line with other facilities providing services to similar sized communities.

Option 2 – Multi Purpose Health Service

- This is an option that is currently being promoted by certain members of the Aramac community, in the hope of acquiring an aged care facility. A MPHS would result in flexibility in relation to funding arrangements. However, as there would be no overall reduction in resource allocation to the Aramac community the arrangement would be operationally inefficient. In fact, it is anticipated that further capital investment would be required.

Option 3 – Doctor's Clinic

- A Doctor's clinic could be provided on an outreach basis from Barcaldine 1 to 2 times per week. The Medical Officer would provide services from a room in the hospital. The community would be reliant on the current QAS service for emergency care and evacuation. No other resources would be required.

Option 4 – No Service

- All clients requiring care in Aramac and the surrounding areas would be required to travel to Barcaldine Hospital for consultation and treatment. As above, the community would be reliant on the current QAS service for emergency care and evacuation. No Queensland Health resources would be allocated to Aramac.

3.2 Outcomes

- Options 1, 3 and 4 would result in current resources, including staff, being reassigned to areas of greater need. Voluntary Early Retirement packages would need to be examined for some staff, particularly in the Operational area.

3.3 Scope

- The project will have an impact on the population of Aramac and the surrounding areas - 832 (1998 ABS Data) and the operation of Muttaburra PHC, Aramac Hospital and Barcaldine Hospital.

4. BENEFITS AND COSTS FOR PREFERRED FOR OPTION 1 – Primary Health Centre

4.1 Resources

- Staffing for the proposed PHC would come from existing staff at Aramac Hospital. The infrastructure – equipment etc, would all come from present resources at the hospital.
- The Medical Officers at Barcaldine would be required to provide services to Aramac on an outreach basis. This would be included in the position descriptions for their positions. Services would be provided within the current remuneration packages for these positions.
- Medical services to Muttaburra PHC would no longer be available from Aramac. Services would need to be contracted from the Longreach Family Medical Practice.

4.2 Benefits

- This will result in a saving of over $600,000 per annum. The savings could be directed towards refurbishing/building the proposed PHC.
- Bundaberg Hospital would no longer be required to provide a relieving Medical Officer on a 3 monthly basis.
- Staff at the hospital could be utilised elsewhere in the district with Queensland Health.
- The community of Aramac and the surrounding area would receive Medical services from more experienced and skilled doctors.

4.3 Risks/Barriers

- The Community is politically active and have campaigned vigorously to maintain services at current levels.
- The hospital is a large employer in the town. There are several staff who are long term residents of Aramac.
- Extensive consultation and negotiation with all key stakeholders would be required.

5. PROJECT PLAN

5.1 Strategies/Activities

1-2 Months	3-4 Months	5-6 Months	7-8 Months	9-10 Months	11-12 Months
Meet with all key stakeholders.					
		Modify contract with Longreach Family Medical Practice to include service to Muttaburra. All inpatients moved to Barcaldine Hospital. Redeploy excess staff from Aramac and offer VERs. Redistribute all resources from Aramac and redesignate Aramac Hospital as a PHC.			
		Ongoing review of services and feedback from community and service providers.			

5.2 People

- The District Manager, Central West Health Service District, would be ultimately responsible for the implementation.
- The Director - Health Services, Central West District, would be responsible for operationalising the re-allocation of resources.

- The Manager, Central Zone, would be responsible for managing the corporate process.
- Support from the District Health Council, particularly the member for Aramac to be acquired.
- 13 staff will be surplus to requirements. However, several staff are temporary agency Nurses.
- Any patients will need to be transferred to Barcaldine Hospital.

5.3 **Consultation**

- Consultation and negotiation will need to take place with:- Minister for Health; Director General, Central Zone Management, District Health Council; Community and staff of Aramac and surrounding district; Medical Staff - Barcaldine; Longreach Family Medical Practice; local State and Federal politicians.
- At recent discussions with Queensland Commonwealth Officers, an indication of support for the directions being proposed in this business case was given. The Officers also agreed to join with QH in discussions with the community already planned for early next year.

5.4 **Communication**

- Personal approach to key stakeholders and community leaders. Newsletters, staff and community meetings and articles in local papers will provide the means for communication.

5.5 **Training**

- The DON Aramac will be required to enrol in the Isolated Practice Certificate course.
- Some retraining would be required for deployed personnel.

5.6 **Related Projects**

- Home and Community Care
- Public Health Project
- Mobile Women's Health
- Visiting Podiatrist
- Visiting Occupational Therapist
- Visiting Dentist

5.7 **Critical Success Factors**

- Effective communication and change management strategies.
- Political support.

5.8 **Policy/Legislative Issues**

- Queensland Health's Policy for Management of Organisational Change
- Obligations under Certified Agreement 1998

5.9 **Quality Assurance**

- Quality Standards under Primary Health Care Model.

5.10 Evaluation

- Regular and ongoing community feedback through client satisfaction surveys, and verbal feedback.
- Regular and ongoing verbal and survey feedback from service providers.

6. RECOMMENDATIONS

That a consultative process commence with the Aranac Community and relevant stakeholders for the purpose of establishing an alternative and more appropriate model of health service delivery for the local catchment area.

QUEENSLAND HEALTH

COPY

A BRIEFING TO THE DIRECTOR-GENERAL

BRIEFING NOTE NO:

REQUESTED BY:

DATE: 14 December 1999

PREPARED BY: Graeme Kerridge, Senior Manager – Operations, Central Zone Management

CLEARED BY: Lindsay Pyne, Zonal Manager, Central Zone Management

DEADLINE:

SUBJECT: **Security Services at Redcliffe/Caboolture Hospitals**

DIRECTOR-GENERAL'S COMMENTS:

(Dr) R L Stable
Director-General
/ / 1999

PURPOSE:

To provide an update on issues surrounding the proposal to contract in security services at Redcliffe and Caboolture Hospitals.

BACKGROUND:

1. As per earlier submission of 30 November 1999 Redcliffe and Caboolture Hospitals are currently provided with a security service on an external contract basis. The contracts are for limited coverage only, currently at Redcliffe Hospital 84 hours per week and at Caboolture Hospital 128 hours per week.

2. As previously noted there has been discussion over a lengthy period between the Redcliffe/Caboolture Executive and the AWU about trading a staffing reduction in the Nutrition Department for development of an in-house security service.

3. Tenders were called for a 24-hour service and a shortlist prepared of external tenders with quotes ranging from $347,454 per year to $398,762 per year. The internal service was costed locally at approximately $445,000 per year but several "corporate costs" such as superannuation had not been included. The cost was more comprehensively estimated at approximately $480,000 per year and thus very substantially above an outsourced service.

4. On the basis of that the advice on the costs from the District, the previous recommendation was made that Queensland Health seek to negotiate with the AWU on staffing economies not only in Food Services at Redcliffe/Caboolture District Health Service but also at The Prince Charles Hospital District Health Service.

KEY ISSUES:

1. The AWU has identified that the tender documents did not include a clause requiring contractors to pay as per the Hospital Employees Award and that this may alter costs significantly.

2. The Employment Relations and Strategies Unit has formally confirmed the requirement for contractors to pay as per the Hospital Employees Award although emphasised that contractors are not required to pay the Enterprise Bargaining increase that Queensland Health employees are entitled to.

3. In view of the likelihood with the above consideration that in-house service may be much more competitive, a more rigorous analysis of the cost comparison is necessary. The Support Service Reform Project staff are commencing a cost analysis using the agreed costing model and expect to be able to complete that by 24 December 1999 with additional information coming from the District.

4. Mr Bill Kelly has been consulted on appropriate management of the absence of the clause referring to use of the Award and has advised that Redcliffe/Caboolture should:
   - Seek advice from short listed tenders as to the Award used in their calculations but not seeking a new costing;
   - Undertake a tabletop conversion of bids on the basis of advice of Awards.

   This has been advised to Redcliffe/Caboolture who have been requested to proceed immediately.

5. The evaluation of in-house and outsourced tenders should then be evaluated by a panel separate from those involved in the development of an in-house bid. Dr Harvey (recently commenced District Manager) and a senior officer from another District could appropriately fulfil this role. Other factors may be considered in that evaluation but this process would be clearly a transparent one.

6. There is considerable industrial anxiety at Redcliffe/Caboolture regarding this matter given the understandings reached between the AWU and the Executive at Redcliffe/Caboolture and key staff. The AWU have indicated that they would withdraw support for staffing improvements in the Nutrition Department if progress towards the previous understanding has not been made by early January.

BENEFITS AND COSTS:

These will become available through the commenced evaluation process.

ACTIONS TAKEN/ REQUIRED:

That the above update be noted.

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

DATE: 10 December 1999

PREPARED BY: Colleen Conway, Senior Project Officer, Central Zone Management

THROUGH: Martin Jarman, Senior Manager – Operations, Central Zone

CLEARED BY: Lindsay Pyne, Zonal Manager, Central Zone

SUBJECT: **STORM DAMAGE AT BUNDABERG BASE HOSPITAL**

DIRECTOR- GENERAL'S COMMENTS:

(Dr) R L Stable
Director-General
/ / 1999

BACKGROUND:

Bundaberg Base Hospital sustained water damage to its operating theatre suite lift and to a laser image printer for CAT scan and ultrasound services as a result of a severe storm on 27 October 1999. The storm was considered a one in one hundred year event and several properties in Bundaberg were damaged.

Repairs to the lift have been carried out, the costs for which are expected to exceed $30,000 and damage to the laser image printer will incur costs of approximately $20,000.

The District Manager liased with the Corporate Emergency Health Services Coordinator who advised that funding may be available from the Department of Emergency Services (DES). However on application, the DES advised that the hospital was ineligible for financial compensation as the damage did not exceed $200,000.

Central Zone Management approached Capital Works, on behalf of the District, and were advised that no funding is available from the Capital Works Program and that the repair costs will have to be met from District resources or from the Bundaberg Hospital Redevelopment Project.

KEY ISSUES:

- The overall budgetary position of the Bundaberg District Health Service is extremely tight, with a projected 1999/2000 overrun of nearly $1 million. The District is instituting stringent controls in an attempt to reduce the projected deficit.
- The Redevelopment budget is under pressure due to issues such as:
    - A recent change in the policy on sale of assets means that the District will not retain funds from the disposal of a Child Health Building (approximately $270,000) which was previously signed off as being funding available for the redevelopment project; and
    - Builders and electrical contractors employed on the redevelopment project have submitted a claim for $1.2M which the Project Directors and District Manager believe is outside the parameters of their entitlement. Whilst such a large claim will not be approved it does limit the potential use of redevelopment funds. It is possible that this claim may become subject to litigation at a future date.

ACTIONS TAKEN/ REQUIRED:

The Director-General's assistance in providing an avenue through which the Bundaberg District Health Service can claim reimbursement of $50,000 for the cost of storm damage repairs would be appreciated.

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BR010020

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

BRIEFING NOTE NO: BR010020

REQUESTED BY: Dr R Stable, Director-General, Queensland Health

DATE: 7 December 1999

PREPARED BY: Mr G Kerridge, Senior Manager, Operational Central Zone
Phone: 3234 1297

CLEARED BY: Mr L Pyne, Zonal Manager, Central Zone
Phone: 3234 0825

DEPARTMENTAL OFFICER ATTENDING:

Deadline: 7 December 1999

SUBJECT: **Update on Radiotherapy Services at Royal Brisbane Hospital (RBH)**

DIRECTOR-GENERAL COMMENTS:

7-12-99

(Dr) R L Stable
Director-General
Date:

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

BRIEFING NOTE NO: BR010020

REQUESTED BY: Dr R Stable, Director-General, Queensland Health

DATE: 7 December 1999

PREPARED BY: Mr G Kerridge, Senior Manager, Operational Central Zone
Phone: 3234 1297

CLEARED BY: Mr L Pyne, Zonal Manager, Central Zone
Phone: 3234 0825

DEPARTMENTAL OFFICER ATTENDING:

Deadline: 7 December 1999

SUBJECT: **Update on Radiotherapy Services at Royal Brisbane Hospital (RBH)**

DIRECTOR-GENERAL COMMENTS:

(Dr) R L Stable
Director-General
Date:

PURPOSE: eg. For media event, to update on situation etc

To advise the Director-General on the proposal to temporarily increase radiation therapy services at RBH and to assist in addressing the growing waiting list for care.

BACKGROUND:

- Waiting times for radiation therapy from the Radiotherapy services based at RBH and the Mater have been rising substantially since June 1999.

- In May 1999, LA6 at the Mater broke down and is in the process of being replaced. It is expected that replacement and commissioning will be completed in the first half of 2000. This reduction in operating capacity substantially impacted on the ability to manage the growing demand.

- In August 1999 a temporary unfunded shift at RBH was ceased when staff attrition brought the staffing level back to that funded in the 1998/99 financial year. This shift cessation would also impact on ability to manage growing demand.

- Complexity of treatment has also been marginally increasing in recent years.

- Total activity has been rising over recent years although the above factors have stalled the growth in activity as follows:

  Monthly average treatments (RBH and Mater)

1996/97	5846
1997/98	6208
1998/99	6434
1999/00 (July-Oct)	6292

- On Tuesday 30 November 1999, there was a meeting between Zonal Managers in Southern and Central, District Manager, RBH, Directors of Radiation Oncology, Dr R Allison and Dr D Thomas and Zonal staff identified the merit of an additional temporary shift to address the growth in waiting list. Details were provided of costs and output on Monday 6 December 1999.

- Proposal is for a strategy involving four (4) additional Radiation Therapists to be employed for a 9 month period. Staff by then would be absorbed into funded establishment with expected normal staff turnover. It is proposed that RBH would be able to readily recruit four (4) graduating students who would be arranged with rosters with appropriate supervision. It is proposed to commence on 10 January 2000.

- Annual cost $210,805
  Pro-rate 1999/00 $101,348 (25 weeks)
  9 months $158,104

- It is expected that this strategy would bring the waiting period back to an acceptable timeframe of 10 days

- Overtime cover prior to commencement is not recommended as it is not expected that delay starting shift till 10 January 2000, will worsen waiting period.

KEY ISSUES:

- While this strategy can be expected to assist in overcoming the rise in waiting periods, longer-term strategies will be necessary to avoid embedding the additional shift at the end of the period.

- Securing a stable equipment framework over coming years pending transfer of services to a new centre at RBH will be critical. Means of replacing an additional aged linear accelerator at Mater are currently being considered.

- A longer-term service development planning process has commenced chaired by Zonal Managers, Mr L Pyne, Zonal Manager, Central and Dr S Buckland, Zonal Manager, Southern.

- Pressures exist in other clinical services at RBH. Caution must be exercised not to be seen as supporting one group rather than others who also have service resource pressures.

BENEFITS AND COSTS: (If applicable)

- Additional Cost

Annual	$210,805	
Pro-rate 1999/2000	$101,348	(25 weeks from 10 January 2000)
9 months	$158,104	

ACTIONS TAKEN/ REQUIRED: (If any)

- To approve allocation of additional funding to commence additional shift as from 10 January 2000.

Funds required:	1999/2000	$101,348
	2000/2001	$ 56,756 (balance)

DRAFT MEDIA RELEASE: ATTACHED/NOT ATTACHED

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

BRIEFING NOTE NO: BR009989

REQUESTED BY: Director-General

DATE: 02/12/99

PREPARED BY: Ms K Batchler, Team Leader, Southern Zone Management Unit
Ph: 41863

CLEARED BY: Dr S Buckland, Zonal Manager, Southern Zone
Ph: 40683

DEADLINE: 03/12/99

SUBJECT: OPTIONS FOR THE FUTURE ROLE AND DIRECTION FOR THE MATER MISERICORDIAE HOSPITALS

DIRECTOR- GENERAL'S COMMENTS:

(Dr) R L Stable
Director-General
/ / 1999

SOUTHERN ZONE MANAGEMENT UNIT
OPTIONS FOR THE FUTURE ROLE AND DIRECTIONS FOR THE MATER MISERICORDIAE HOSPITALS

1. BACKGROUND

HOSPITAL REDEVELOPMENTS. The key principles underpinning the Queensland Health Capital Works Redevelopment Program are:

- the developments will result in efficiencies in management of capital and recurrent resources
- health services will be responsive to changing community needs, devolved from the inner metropolitan area to where people live and co-ordinated across District boundaries.

EXCESS BED CAPACITY. The Capital Works Audit Team Preliminary Report identified that there will be a projected excess bed capacity of between 192 and 293 beds in facilities in the Metropolitan area of the Southern Zone in 2005/06. These projections exclude provision of any beds at the Mater Hospital Complex. If the beds proposed for the Mater Complex are included in these projections, it is suggested that the excess bed capacity could be greater than 450 beds by 2005/06.

The report identified the Mater Complex and QEII Hospitals as two critical issues in the Southern Zone that, if dealt with appropriately, would minimise the long term risk to Queensland Health of duplication of services:

- There needs to be a redefinition of the role of the Mater taking into account flows to Redland, PAH and Logan
- QEII needs to be given a viable future complementary with other facilities

2. OPTIONS. This paper proposes options to solve two significant strategic issues for public hospital service provision in the Southern Zone:

- Adult services (2 – 5 years)
- Location of women's and children's services (10 years)

The Mater has submitted a proposal to the Minister which proposes that the Mater:

- Assume management and service delivery of hospital/health service facilities in the Southern growth corridor (Logan and Redland Hospitals)
- Relocate tertiary women's and children's services to Logan

It appears that, for the Mater, the elements of this package cannot be separated.

However, from Queensland Health's point of view it would be possible, even desirable, to address the adults and women's/children's issues separately.

OPTIONS FOR ADULT SERVICES (Timeframe for implementation 2 – 5 years)

OPTION 1	ADVANTAGES	DISADVANTAGES
DO NOTHING Queensland Health continues to fund the Mater Adults Hospital (MAH) at South Brisbane		• Compromises QH capacity to meet the undertakings of the Business Cases, ie, to transfer funding and activity to provide services close to where people live • Mater will struggle financially, with diminishing funding in real terms and increasing need for subsidisation by the Sisters of Mercy. • Will continue the protracted debate with QH re Mater funding and expose QH to continuing political and community backlash

OPTION 2	ADVANTAGES	DISADVANTAGES
CLOSE MATER ADULTS Absorb activity into PAH, RBH, Redland, Logan, QEII	• Would alleviate excess inner city beds and allow more efficient utilisation of QH bed stock • Frees up recurrent funding of $75M to meet Business Case obligations • Maximise flows to Logan & Redland	• Loss of historical symbol for Mater public hospital services • Loss of clinical support services for MCH, MMH • Places Mater private investments at risk through adverse financial impact on Mater's private facilities (hospitals, medical suites) • Adverse HRM impact on Mater • Retention of staff for both public and private facilities • Cost (to both QH and Mater) of accrued staff liabilities

OPTION 3	ADVANTAGES	DISADVANTAGES
Offer alternative location/premises for the Mater Adults		• Requires that services unable to be provided by Mater on ethical grounds be addressed. (In reality, very few of these types of cases, eg, termination of pregnancy, occur in the public sector anyway)
OPTION 3(a)		
Relocate Mater Adults Hospital to QEII Hospital. (Management of QEII community services to remain with QH)	• Allows solution of Mater Adults independently of other services as QEII only offers adult services • Maximises utilisation of QEII facility • Addresses inner city bed excess • No private collocation partner in competition with Mater services • May avoid privatisation, competition, contracting issues though being marketed as a relocation rather than a privatisation or Mater "taking over" management • Available land for future expansion • Mater and QEII have same geographical catchment area: • Consolidation of services for the same community catchment • Mater could maintain existing linkages	• Staffing/industrial issues: • Existing QH staff may need to be redeployed or become Mater employees (as with the Child & Youth Mental Health Service) • Community perceptions of "privatisation" of public facilities. • The Mater health philosophy will require alternative management of those services the Mater is ethically unable to provide, eg, terminations, contraception, and euthanasia. • Problem remains of decrease of collocated infrastructure for MMH and MCH

OPTION 3(b)	ADVANTAGES	DISADVANTAGES
Mater to manage Redland Hospital	• Advantage for Mater in close linkage with Mater Redland Private Hospital	• Mater would assume management of all Redland services when we only want to solve the problem of adult services • Current Mater financial difficulties may be continued in Redland • Community perception of 'privatisation' of public hospitals • Community and political perceptions of Mater "takeover" of Redland. • Staff/industrial issues

OPTION 3 (c)	ADVANTAGES	DISADVANTAGES
Mater to manage Logan Hospital	• No advantage for adult services – already a hospital providing the service	• Mater would assume management of all Logan services when we only want to solve the problem of adult services • Potential competition with HCOA collocated hospital (20 year contract) • Current Mater financial difficulties may be continued in Logan • Community perception of 'privatisation' of public hospitals • Community and political perceptions of Mater "takeover" of Logan. • Staff/industrial issues

4. OPTIONS FOR WOMEN'S AND CHILDREN'S SERVICES (Timeframe - 10 years)

BACKGOUND: This is the area of most mutual benefit for QH and the Mater and negotiations need to be continued to enhance the services for women and children in the Southern Zone.

OPTION 1	ADVANTAGES	DISADVANTAGES
DO NOTHING Queensland Health continues to fund the Mater Mothers' Hospital (MAH) and Mater Children's Hospital at South Brisbane	• Current building program appropriately utilised • Service more central for southern and bayside suburbs	• Target population in growth areas are inappropriately serviced (access & equity) • Maintains inefficiencies inherent on proximity to RCH & RWH • Inhibits activity and funding in flow transfers • QH spends funding inappropriately on secondary services in the inner metropolitan area. • The growth corridor is missing out on both access to both tertiary services and viable secondary services • Mater tertiary services may become unviable through shrinking secondary base • Mater could lose tertiary role as demand for tertiary services develop in other population centres

OPTION 2	ADVANTAGES	DISADVANTAGES
Relocation of Mater Mothers' and Mater Children's	• Would meet major need in the Southern corridor • Reduces service duplication with RCH	• Capital cost • Current building program would be seen to have wasted public funds
To Logan	• As above	• Competition with HCOA collocated hospital • Mater unlikely to manage adult services at Logan
To QEII	• If MAH relocates to QEII site, a new women's and children's hospital could be built at QEII. This would be an integrated service • Major transport access to need areas, eg, Toowoomba, Ipswich, Logan • Minimises adverse impact on Mater private services – activity feeder options maintained and appeal to clinicians.	

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03 DEC 1999

QUEENSLAND HEALTH

SUBMISSION TO THE:

- [x] Director-General
- [ ] General Manager, Health Services
- [ ] Deputy Director-General (Planning & Systems)

DATE: 30 November 1999

PREPARED BY: Graeme Kerridge, Senior Manager of Operations **Contact No:** 07 3234 0232

CLEARED BY: Lindsay Pyne, Zonal Manager **Contact No:** 07 3234 0825

SUBMITTED THROUGH: Lindsay Pyne, Zonal Manager, Central Zone **Contact No:** 07 3234 0825

DEADLINE: **File Reference:**

Subject: **Security Services at Redcliffe / Caboolture Hospitals**

APPROVED/ NOT APPROVED

COMMENTS

Signature:
Date: 14-12-99

Records,
File please + away
copy forwarded to MCZ
HP 14/12/99

CAB.0007.0001.00146

PURPOSE:

To recommend a strategy with respect to the proposal to contract-in security services at Redcliffe and Caboolture Hospitals.

BACKGROUND:

1. Security services at Redcliffe and Caboolture Hospitals are currently provided by an external contract. They are limited coverage only, currently at Redcliffe Hospital 84 hours per week and at Caboolture Hospital 128 hours per week.

2. There has been growing concern on the very limited security coverage on both sites, particularly in view of the Draft Queensland Health Security policy and the requirements of the relevant Australian Standard.

3. Potential staffing economies have been identified in food services and waste management as a result of the substantial investment in capital works and equipment on both sites.

   This matter has been discussed with the AWU over a lengthy period who have indicated a preparedness to consider staff reductions in those areas as long as the membership numbers on site are maintained. The staff reductions in Food Services are approximately 5 x 002 positions and in Waste Management 2 x 002 positions. These have in fact been largely implemented already although 4 remaining Food Service position reductions remain to be implemented.

4. An understanding has been given over many months of discussion between local management and the AWU, that the AWU would consider not disputing staff reductions if in-house security services to provide full coverage were pursued. A 24-hour in-house security service is estimated to require 9.8 staff, 1 x 005 and 8.8 x 003. Discussions between the local management have been pursued in the spirit of EBIII section 3.2 "Contracting-in".

ISSUES:

1. The in-house 24-hour security service has been costed locally at approximately $445,000 per year. To this cost might be an added "corporate costs" not directly incurred by the cost centre, in particular superannuation. Additionally, the workers compensation cost suggested in the costing is less than currently being experienced at Redcliffe / Caboolture and thus a full cost of approximately of $480,000 per year would be an appropriate estimate. External contracts have been quoted by shortlisted offerers at between $347,454 per year to $398,762 per year. Thus a significant cost penalty applies to an internal service.

2. Redcliffe / Caboolture District Management see that their endeavours to achieve staffing economies in food services and waste management may be compromised unless the understanding reached with the AWU is pursued for security services to bought onto an

in-house basis. Indeed, their view is that the strength of the understanding is such that industrial disputation would occur and surplus positions in food services and waste management would continue to be funded.

3. Redcliffe / Caboolture District Management see some staff benefits from providing an in-house service and fostering positive industrial climate. It is noted that the AWU have referred to the proposed contract in their newsletter recently distributed to members highlighting their activities in Queensland Health facilities.

4. Central Zone Management have serious concerns as to whether the additional cost can be justified, albeit recognising that District Management have over many months negotiated in good will on an independent basis prior to the instruction that any proposal for contracting requires Director General sign off and prior to introduction of Zonal Management. Local District Management who pursued this over a lengthy period now view with some concern that the appropriateness of this proposal is being questioned.

5. Limited cover of less than a 24 hour service could be pursued, although it is questionable as to whether this would be sustainable from an OH & S perspective and movement to continuous coverage, either on an in-house or contracted basis would appear to be inevitable.

6. It is noted that there are other workforce issues in neighbouring District Health Services that require negotiations with the AWU e.g. food services at The Prince Charles Hospital. In that situation very substantial staffing economies are being sought.

BENEFITS AND COSTS: (if applicable)

1. The excess cost of an in-house service on a 24-hour basis compared with an externally contracted service appears to be in the range of $120,000 - $100,000 per annum. Timing would be critical to limit excess cost to that level – ie all staff would need to be redeployed out of the food services area prior to starting a new service.

2. This cost may be acceptable if it directly achieved very substantial economies throughout the rest of Queensland Health. For instance at The Prince Charles Hospital it is possible that, over a period, up to 30 positions may be able to be reduced from the catering department. Timing of such staffing reductions would have significant cost implications.

3. The linking of full implementation of the staffing reductions at Redcliffe / Caboolture and in the food services at The Prince Charles Hospital may be a means of expediting those reductions and justifying the additional cost at Redcliffe / Caboolture that would arise from implementation of a contracted-in security service. Such internal security services should however only be implemented once all staffing reductions in the other areas had been achieved.

4. Industrial concerns are likely to be raised through political channels should Queensland Health not endorse the earlier understanding arrived at at a local level.

CONSULTATION:

Consultation has not occurred at this point on this proposal with District Management at either site or with staff groups. As noted previously Management at Redcliffe / Caboolture have major concerns with any tampering with earlier discussions which they have pursued in good faith with the AWU. They are concerned that external "interference" in local industrial relations may be counter productive and create longer term difficulties and costs.

RECOMMENDATION(S):

It is recommended that the District Management and the AWU be advised that Queensland Health would only consider the additional cost of a contracted in security service at Redcliffe and Caboolture if full implementation of staffing reductions in the food service and waste management area at Redcliffe and Caboolture and the food service area at The Prince Charles Hospital are achieved.

It is also recommended that if a contracted-in approach is adopted, it be on the basis that the service would be expected to be competitive with an external service within a three year period, at which time open competitive tenders would be called.

SB004324

(4)

QUEENSLAND HEALTH

RECEIVED

23 NOV 1999

DG'S OFFICE

SUBMISSION TO THE MINISTER

Date:	22 November 1999		
Prepared by:	John Wylie, Director – Corporate Services, The Prince Charles Hospital and District Health Service	**Contact No:**	07 335 08216
Cleared by:	Phil Sheedy, District Manager, The Prince Charles Hospital and District Health Service	**Contact No:**	07 3350 8224
	Graeme Kerridge, Senior Manager – Operations, Central Zone	**Contact No:**	07 323 40232
Submitted through:	Martin Jarman, Acting Zonal Manager, Health Unit (Central Zone)	**Contact No:**	07 323 40825

22/11

RECOMMENDED/ NOT RECOMMENDED BY:

☐ General Manager, Health Services

☐ Deputy Director-General (Planning and Systems)

ESE KM 9/12

Deadline: **File Reference:**

Subject: **Food Service Reorganisation – The Prince Charles Hospital and District Health Service**

RECOMMENDED/ NOT RECOMMENDED

DIRECTOR-GENERAL'S COMMENTS

RECORDS TEAM
RECEIVED
14 DEC 1999
DEPT. OF HEALTH

(Dr) R L Stable
Director-General

Date: Discussed with A/DG. Please refer to comments by A/DG on SB009215. AE Ex04

APPROVED/ NOT APPROVED

MINISTER'S COMMENTS

Wendy Edmond MLA
MINISTER FOR HEALTH

Date: Records, Like to have a copy.

CAB.0007.0001.00150

PURPOSE:

To seek endorsement for the consultation with staff groups to commence the change process.

BACKGROUND:

Concern was raised in a previous Brief to the Minister regarding the options for redevelopment of supernumerary food services staff.

Reorganisation of food services at The Prince Charles Hospital may result in up to thirty operational services staff being supernumerary.

ISSUES:

Redeployment of a number of these staff will be achievable over a twelve to eighteen month period. The District has a total staff of 3,680 (permanent and part-time) of which 600 positions are operational and administrative staff at base level (002,AO2).

Within this group there has been an attrition rate of 5.5% for the twelve months to 31 October 1999 (33 positions), consequently there is reasonable certainty in placing a number of redeployees in real vacancies.

Some further redeployment should be achievable in adjoining Districts, more particularly Redcliffe/Caboolture, as there are some operational services staff who live in those areas and have expressed interest in transfer should positions be available.

There will of course be some staff who may be unable to take up redeployment and for whom a voluntary early retirement would be their preferred option.

Exploration of the potential take up of VERs within the District earlier this year identified the following categories and numbers:

The Prince Charles Hospital (Food Services)	14
The Prince Charles Hospital (Wardspersons)	8
The Prince Charles Hospital (Laundry)	9
The Prince Charles Hospital Total	31
Eventide and Community	10
District Total	41

Based upon this information and subsequent discussions with staff, projections for VER take up rates are:

The Prince Charles Hospital (Food Services)	15
The Prince Charles Hospital (all operational services staff)	30
District (across all services)	40

Management of supernumerary staff through utilisation of VER packages will assist in gaining savings at the earliest opportunity. However, realistically, a combination of redeployment and VER packages will be the most acceptable outcome to staff over the longer term.

Effective utilisation of some surplus staff can be achieved in the short term through using those staff to provide leave relief (particularly long service leave) in a concerted program to reduce leave accruals and thus reduce future expenditure.

Consultation with industrial groups and staff at The Prince Charles Hospital will commence as of 1 December 1999.

BENEFITS AND COSTS:

The current food services cost of $35.00 per occupied bed day for The Prince Charles Hospital significantly exceeds agreed Queensland Health benchmarks.

The reorganisation will provide an improved menu for patients and deliver savings of $1.3M per year.

CONSULTATION:

The reorganisation will progressively require redeployment of up to ten staff in each of the three stages which will take place over the next five months. The organisational change will be implemented within the principles of the Enterprise Bargaining Agreement and Queensland Health Change Management protocols with extensive consultation with staff and unions, commencing 1 December 1999.

RECOMMENDATION(S):

A District-wide approach (supported by other adjacent Districts in the Zone if necessary) be adopted to manage placement of The Prince Charles Hospital food service staff redeployees together with the option of VERs where appropriate, to ensure that the best outcome is achieved both for the organisation and each individual.

DRAFT MEDIA RELEASE: NOT ATTACHED

QUEENSLAND HEALTH

A BRIEFING TO THE MINISTER

MIN x2
SDLO x1
File

BRIEFING NOTE NO: ....

REQUESTED BY:

DATE: 22 October 1999

PREPARED BY: John Wylie, Director – Corporate Services
Phone: 3350 8216)

CLEARED BY: Philip Sheedy, District Manager [signature] 24/10/99
Phone: 3350 8224

DEPARTMENTAL OFFICER ATTENDING:

Deadline:

SUBJECT: FOOD SERVICE REORGANISATION – THE PRINCE CHARLES HOSPITAL

MINISTER'S COMMENTS:

D/W DG + Minister
2) Flanberry to discuss with GMHS. [initials] 15.11.99.

Any reservations with proceeding? c D/W CC

YES. – 30 staff in 5/12 is not on
– D/W Julie Carberry c CC
– ? redeployment in district.

Wendy Edmond MLA
MINISTER FOR HEALTH
Date: [signature]

PURPOSE:

Update on Food Services reorganisation at The Prince Charles Hospital

BACKGROUND:

The current food service cost of $35.00 per occupied bed day for The Prince Charles Hospital significantly exceeds agreed Queensland Health benchmarks.

A comprehensive review of food services has identified that with reorganisation of the food services, major savings can be achieved.

KEY ISSUES:

The reorganisation will progressively require redeployment of up to ten staff in each of the three stages which will take place over the next five months.

The organisational change will be implemented within the principles of the Enterprise Bargaining Agreement and Queensland Health Change Management protocols with extensive consultation with staff and unions.

BENEFITS AND COSTS:

- An improved menu will be provided for patients.
- Deliverable savings of $1.3 million per annum have been identified.

ACTIONS TAKEN/ REQUIRED:

Implementation of recommendations will take place in consultation with staff and unions and the report findings and recommendations will now be presented as the first step in the implementation process.

DRAFT MEDIA RELEASE: NOT ATTACHED

QUEENSLAND HEALTH

COPY

A BRIEFING TO THE MINISTER

BRIEFING NOTE NO: Refers to BR009803

REQUESTED BY: General Manager, Health Services (E-mail 16/11/99 to Dr Buckland)

DATE: 22 November 1999

PREPARED BY: Ms Kerry Batchler, Team Leader, Planning & Evaluation
Southern Zone Management Unit

CLEARED BY: Dr Steve Buckland, Zonal Manager
Southern Zone

DEPARTMENTAL OFFICER ATTENDING:
Dr Steve Buckland, Zonal Manager, Southern Zone
Ph: 40683

Deadline: 23/11/99

SUBJECT: **Mater Misericordae Hospital Future Directions & Roles Planning Meeting with the Minister 23/11/1999**

MINISTER'S COMMENTS:

Wendy Edmond MLA
MINISTER FOR HEALTH
Date:

PURPOSE:

- To provide background information for the Minister for a meeting on 23 November 1999 with a delegation from the Mater Misericordiae Hospitals (the Mater).

- The delegation comprises:
  Sr Pauline Burke, Congregational Leader, Sisters of Mercy (Brisbane)
  Professor Colin Apelt, Chair, Mater Health Services Governing Board
  Sr Anne Hetherington, member, Mater Health Services Governing Board
  Mr Mark Avery, Chief Executive Officer, Mater Misericordiae Hospitals
  Mr Wayne Goss, Consultant to Mater Health Services Governing Board

- The meeting was initiated by the Mater, to discuss the progress, next stages of development and in-principle agreements for the future direction and role options of the Mater Public Hospitals and Health Services.

BACKGROUND:

During 1998/99 Queensland Health and Mater Hospitals negotiated a formal contractual agreement for the 1998/99 financial year and commenced negotiations for a longer-term contractual framework. Because of the long and ambiguous position of the Mater as an integral part of Queensland Public Hospital service delivery, a number of long-standing issues need to be negotiated prior to finalisation of a long-term agreement.

On 26 May 1999, the Deputy Director-General (Planning & Systems) made a presentation to the Mater Health Services Governing Board. The aim of the presentation was to directly communicate to the Board the following:

- Queensland Health's investment framework
- The implications for the Mater Hospitals
- The necessity for setting the Queensland Health – Mater relationship on a proper contractual footing to provide certainty for both sides.

On 18 August the Minister wrote to the Mater Health Services Governing Board (Attachment 1) to formally invite the Board to put a proposal to Queensland Health addressing the future of the Mater Public Hospitals within the public health system. The Minister requested that Dr Steve Buckland, Zonal Manager, Southern Zone explore with the Board a mutually acceptable role for the Mater.

On 1 October 1999, Dr Steve Buckland and Dr John Youngman met with the Governing Board to initiate the planing process. The options canvassed by the Mater at that meeting were:

- management role at Logan Hospital
- management role at Redland Hospital
- significant role in a Southern Zone Mothers' and Children's Service Network.

It was agreed by Queensland Health (Attachment 2) that these options could be explored in more depth, with the aim of presenting a mutually acceptable, viable solution for Queensland Health consideration, with a view to making a submission to Cabinet around March 2000.

Queensland Health also:

- agreed to provide the planning information necessary to facilitate the planning process, with an understanding that access to this information would be restricted to senior executives and relevant planning staff within each organisation.

- proposed that a joint planning team be established to liaise on a regular basis, with leadership of the project remaining with the Mater team.

CURRENT STATUS

Southern Zone Management Unit Planning Team met with Mater planners to clarify the Mater's data requirements and provided the following within the short time frame requested:

- comprehensive zonal and metropolitan demographic, geographic, service and activity data
- direct access to the Health Information Centre

Southern Zone Management Unit expected that the draft Mater proposal would be presented to the Zonal Manager Southern Zone for preliminary appraisal in order to advise the Minister on the efficacy of the proposals.

To date, the Mater has forwarded no proposal to the Southern Zone Management Unit. As a result, the Unit is unable to advise the Minister on options for the Mater for the meeting on 23 November.

KEY ISSUES:

It appears from the brief submitted to Minister by the Mater (Attachment 3) that the main thrust of the Mater proposal will be for the Mater to "take over the management" of Logan and Redland Hospitals and that the Mater is seeking from the Minister:

- agreement that the Mater assumption of management of Logan and Redland Hospital will be the main focus of the Cabinet Submission in March 2000
- agreement that wider consultation can now occur with major stakeholders prior to development of the Cabinet submission.

While Dr Youngman and Dr Buckland agreed that the Mater should further explore the scenarios in relation to Logan, Redland and women's and children's services, no commitment could be given until the Mater had developed a proposal for consideration. The complexity of the issues requires extensive legal, clinical and health planning consideration.

ACTIONS REQUIRED: It is recommended that the Minister;

- reiterate her assurance already communicated to the Mater that the Queensland Government wishes to see the Mater continue its long tradition of health care in Queensland
- acknowledge the Mater's need to sustain its mission and viability in a complex and changing health service environment
- acknowledge the Mater's preparedness to embrace change and consider alternative to better match the needs of the population
- advise the Mater that she is unable to give in-principle agreement either to their proposal or to any consultation with major stakeholders without detailed consideration by Queensland Health of the proposal
- accept the proposal for consideration by the Department or request that a proposal be forwarded to the Zonal Manager, Southern Zone for consideration and preparation of advice to the Minister

QUEENSLAND GOVERNMENT

Minister for Health

cc DR STEVE BUCKLAND

18 AUG 1999

Professor C Apelt
Chairman
Mater Health Services Governing Board
Mater Misericordiae Hospitals
Raymond Terrace
SOUTH BRISBANE QLD 4101

Dear Professor Apelt

As you are aware, the commissioning of the new Redlands, Logan, and Princess Alexandra Hospitals will have a significant impact upon the demand for adult inpatient services at the Mater Public Hospitals in Brisbane. I am therefore formally inviting your Board to put a proposal to Queensland Health addressing the future of the Mater Public Hospitals within the public health system.

You have my assurance that the Queensland Government wishes to see the Mater continue its long tradition of offering high quality health care to the people of Queensland. Obviously that role will have to change in inner metropolitan Brisbane to match the actual demand for services. However, the Mater may wish to take advantage of other opportunities as they emerge.

In order to assist your Board to produce a proposal that would be acceptable to both Queensland Health and the Mater, I have asked the Director-General to arrange for the recently appointed Zonal Manager (Southern Zone), Dr Steve Buckland to exchange service planning data with your Board's staff and explore a mutually acceptable role for the Mater. Dr Buckland will contact you shortly to begin discussions.

As the views and opinions of your Board are vital in progressing these arrangements, I would be pleased if this matter could be given your urgent attention.

Yours sincerely

Wendy Edmond MLA
MINISTER FOR HEALTH

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SOUTHERN ZONE MANAGEMENT UNIT

Enquiries to: Dr Steve Buckland
Zonal Manager
Southern Zone
Telephone: (07) 3234 0683
Facsimile: (07) 323 40790
File Number: 1230-0345-003

Professor C Apelt
Chair
Mater Health Services Governing Board
Mater Misericordiae Hospitals
Raymond Terrace
SOUTH BRISBANE QLD 4101

Dear Professor Apelt

Thank you for the opportunity to meet with the Mater Health Services Governing Board on 1 October 1999. I am encouraged by the willingness of the Mater to collaborate to reach solutions of mutual benefit to Queensland Health and the Mater.

We have agreed that the options canvassed by the Mater could be explored in more depth, with the aim of presenting a mutually acceptable, viable proposal for Cabinet consideration around March next year. We have also agreed to provide information necessary to facilitate the planning process, with an understanding that access to this information will be restricted to senior executives and relevant planning staff within each organisation.

To formalise the mutual planning and information sharing, I would like to propose that a joint planning team be established to liaise on a regular basis. I would have no objection to leadership of the team remaining with the current Mater team. I would appreciate your consideration of this proposal and, if it is acceptable to your organisation, your advice as to how this formal planning interface might be managed to maintain the interests of both our organisations.

I would be happy to discuss this proposal further with you and I can be contacted by phone on 3234 0683 or 0419 686 826 (mobile).

Yours sincerely

Dr Steve Buckland
Zonal Manager
Southern Zone
07/10/1999

cc. Mr M Avery
CEO, Mater Hospitals

Queensland Health Briefing/Liaison Unit – Briefing Number: BR000803 – Mater Misericordiae Hospitals Future Directions and Roles Planning

Issue: "Please provide an update on ongoing discussion between Mater Hospital and Queensland Health".

- The Minister for Health is meeting with the Congregational Leader, Chairman and Members of the Mater Health Services Governing Board with their Adviser and Consultant on Tuesday, 23rd November, 1999 to discuss the progress, next stages of development and in-principle agreements for the future direction and role options of the Mater Public Hospitals and Health Services.

- On the 16th August, 1999 the Minister extended an invitation to the Chairman of the Mater Health Services Governing Board, for the Congregation of the Sisters of Mercy and the Mater Board to make proposals to Government about the future role for the Mater Health Services. These proposals would need to be agreed with Queensland Health.

- The Board Chairman, Professor Colin Apelt, formally accepted the Minister's invitation on the 22nd September, 1999 and a planning process involving the Mater Hospitals and Queensland Health commenced.

- The Sisters of Mercy Congregation and the Mater Health Services Governing Board have formed a Board Task Force to focus on this important task. Several senior Consultants (health planning, finance, major strategic development) have been appointed by the Mater to work on this initiative.

- On the 1st October, 1999 the Mater Task Force met with Dr John Youngman, General Manager, Health Services and Dr Steve Buckland, Zonal Manager Southern Zone (Queensland Health). A high level strategic direction was developed and agreed at that meeting. The Mater agreed that the planning towards these major goals would need to be undertaken with in the framework of Queensland Health's current service planning and the operational issues of 'zonal strategies'.

- The main focus of the proposal is for the Mater to take over the management and service delivery of hospital/health service facilities in the southern growth corridor – Logan and Redland Hospitals; with associated transfer and reduction of hospital beds and services away from South Brisbane. Over a period of time, this would provide tertiary level/zonal services in adult, paediatric and maternal services at Logan and services at Redland.

- The Mater has received very positive support from Queensland Health. The provision of high level strategy development at executive level of Queensland and the excellent support in provision of planning data from a number of Units in the Department is greatly appreciated by the Mater.

- There is a strong sense from the Sisters of Mercy and the Mater Board that this initiative is very real, supported and is being undertaken on a basis of mutual trust and clearly understood expectations of goals and the stated proposal. The Hospital feels that while the agenda and project is exceptionally large, there are best endeavours from Queensland Health and the Mater to achieve this direction.

- The purpose of the meeting with the Minister on November 23rd is to discuss the proposal; agree that the proposal will be the main focus of the recommendations to come to Queensland Health, the Minister and Cabinet (timetabled for March, 2000); agree with the Minister that wider consultation can now occur with major stakeholders in line with an agreed understanding between the Mater and Government about the planning objectives and the need to provide a detailed submission (currently the project is maintained in strict confidentiality).

- For further information contact: Mr M.J. Avery, Chief Executive Officer, Mater Misericordiae Hospitals. Telephone: 3840-8494 Facsimile: 3840-1595 E-mail: mavery@mater.org.au

18-11-99

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QUEENSLAND HEALTH

SUBMISSION TO THE:

☐ **Director-General**

☐ **General Manager, Health Services**

☐ **Deputy Director-General (Policy & Outcomes)**

DATE: 18 November 1999

PREPARED BY: Kate Copeland, Manager, CWB — **Contact No:** 323 41849
Graeme Kerridge, Senior Manager, Central Zone — 323 40232

CLEARED BY: David Jay, Director, CWB — **Contact No:** 323 41788

SUBMITTED THROUGH: Lindsay Pyne, Zonal Manager, Central Zone — **Contact No:** 323 40824

DEADLINE: **File Reference:** 0228-0034-392

Subject: **HERSTON HOSPITALS COMPLEX REDEVELOPMENT - HYPERBARIC MEDICINE – STATUS AND ISSUES**

APPROVED/ NOT APPROVED

COMMENTS

(Dr) R L Stable
Director-General

Date:

PURPOSE:

To advise current status and issues with respect to development of hyperbaric oxygen therapy (HBOT) at Royal Brisbane Hospital.

BACKGROUND:

A range of previous briefing notes and submissions refer. The most recent are BR009156 dated 20 August 1999 prepared by Capital Works Branch and Submission dated 27 September 1999 prepared by Central Zone.

Installation of the desired hyperbaric chamber into the planned location has a limited window of opportunity for installation due to the dimensions of the unit and constraints of the site. The window is between completion of Centre Block in September 2000 and the construction of East Block level 1 anticipated Jan/Feb 2001. After this time there will be insufficient space to manoeuvre the chamber into the required location.

Due to the long lead time for design, construction, testing, delivery and installation, a determination must be made regarding acquisition of the planned hyperbaric chamber by December 1999/January 2000 to utilise the identified window.

Capital equipment funding for the project (approx $1.8M) would be sourced from the Redevelopment Project FF&E budget. An amount of $1.7M is currently allowed for this purpose. A further amount estimated at $350,000 is allowed for the installation and fitout of this area. This amount has been deleted from the current contract and held for future works.

Royal Brisbane Hospital has recently completed a Business Plan for operating funds and this is attached. It is estimated that recurrent costs of approximately $600,000 per year would be required to undertake 2000 treatments, or $750,000 for 5000 treatments – commencing 2002/3.

ISSUES:

Timing

There are two significant constraints.

- Limited window of opportunity to install the desired chamber into the optimal location. As noted this is September 2000 to January 2001.
- Equally important. Due to the phased nature of the Herston Redevelopment, the commencement of the hyperbaric medicine service in conjunction with the relocated emergency department cannot commence until July/October 2002.

If the current plan is endorsed then following installation of the designed hyperbaric chamber would commence in late 2000, the equipment would be unused until late 2002. Consideration should be given to use of the identified location for this service, but consideration of alternative designs that could have installation deferred until 2002.

Demand for hyperbaric therapy is difficult to predict. The current contract with the Wesley Hyperbaric Medicine Group provides some information regarding demand for public services in South-East Queensland. During 98/99, referrals were received primarily from RBH, PAH, Ipswich, Gold Coast, and Nambour with occasional referrals from Redcliffe/Caboolture, Gladstone and QEII. Over twelve months, approximately 500 treatments were provided of which 15 % were emergencies.

It has been argued that the current utilisation of the Wesley service reflects only a portion of the demand due to limited clinician familiarity with the treatment modality, current authorisation processes, and the charging process which has been implemented whereby requesting Districts pay the Wesley unit for services provided. Hospitals have expressed concern regarding the current price charged by the Wesley ($350 to $400 per "dive"). Proponents of the service have argued that clinicians resist incurring this cost while not equating it to alternate costs incurred using other treatment modalities. The current activities within Queensland Health in rolling out clinical benchmarking software and the planned introduction of Pathology charging will facilitate sound clinical practices in this regard.

Wesley have advised that the provision of emergency treatment is uneconomic at this price and have proposed a revised price structure ranging from $1935 to $2781 for these cases. It should be noted that the vast majority of private cases are ambulatory elective treatments – emergency cases are all identified through the public hospital emergency system. Even at this higher charge, it is likely that the total cost to Queensland Health at current utilisation levels is well below the direct operational cost of providing the service internally, even without considering capital costs.

It has been stated that private sector demand for the Wesley service is exceeding planning parameters and that by 2002/3 this demand will saturate the centre's capacity with progressive exclusion of public patients. Thus, the interest by the Wesley group to continue service provision to the public sector is unknown.

Service Delivery Model

Location of a hyperbaric service in close proximity to the emergency department is considered optimal. Alternative locations would not have the same timing constraints but would generate additional capital and operational costs.

In addition to economies of scale for staffing, technical infrastructure and emergency response, there is existing medical and nursing hyperbaric expertise within the emergency department.

As this would be a new service, such a service could be established on a private practice basis for referred outpatients and private inpatients. Both Medicare Benefits Schedule and private hospital insurance rebates are available for HBOT.

At present, 15% of 500 QH referrals are emergencies. If one assumes that all non-emergency cases are outpatients (consistent with known utilisation at Wesley for private referrals), and

t... ...e annual utilisation is 2000 cases, then 1700 patients would be eligible for MBS rebate with a current rebate of $169 ($287,300). In addition, any privately insured patients who are inpatients may be eligible for a private insurance rebate. This level of utilisation does represent a significantly higher level than currently experienced. An appropriate private practice arrangement would need to be developed for sharing of any income from income generated.

It must be noted that such a model would be establishing a public hospital based hyperbaric medicine unit in direct competition to the Wesley Group.

An issue which would need further consideration is the management of internal charging to other Districts utilising the service. This would determine the extent of budget transfer that would be required from other Districts to Royal Brisbane Hospital to operate such a service. Continuation of a price mechanism such as that currently used would appear to be a useful means of ensuring that clinicians requesting such a service for individual patients considered the cost implications. Indeed such a mechanism is a critical element of the further pursuit of clinical management approaches.

Staffing Profiles

The staffing proposed for the service identifies staffing economies due to proximity with the emergency department, and some of the costs of providing out-of-hours and emergency care are therefore absorbed. It would be important to clearly identify these hidden costs to ensure accurate calculation for cost-recovery. The sustainability of this absorbed staffing element as activity increases is unknown.

Preliminary comparison with the Wesley Group indicates that staffing profiles are minimised by the integrated model proposed. Comparative information is not to hand for the Townsville service but it should be noted that the patient profile is significantly different, with a much higher emergency load. Raw operational costs of the Townsville service suggest a direct cost of approximately $706,000 per annum.

Further analysis of staffing in comparable centres is underway.

CONSULTATION:

Consultation has occurred with SHANGU, Capital Works Branch, Royal Brisbane Hospital and the Central Zone.

RECOMMENDATION(S):

Given the capital costs of $2.2 million and operating costs which for the foreseeable future would appear to be higher with a public facility than utilising a private facility, it is recommended that Queensland Health:

- investigate whether longer term use of the Wesley unit by Queensland Health is likely. If such is available, then it is recommended that a public installation not proceed at this time. This could be tested by seeking service provision for a longer period (eg. 5 years) than the 2 years that will be required at the end of the current contract which expires in June 2000.

- investigate whether alternate installation methods of alternate chambers may allow installation at a later time. If such approaches are available at reasonable cost, then it is recommended that acquisition and installation of a chamber not proceed until a later time when activity better justifies such investment.

- regardless of whether it is decided to seek extended service provision from the Wesley Group rather than pursue development of an inhouse service, it will be necessary to continue with contractual arrangements with the Wesley Group from 2000 to 2002, with regular review as an inhouse service would be unable to commence operations in the preferred site prior to 2002. Accordingly, it is recommended that contractual negotiations to maintain service provision after completion of the existing contract commence .

- reconsider the service delivery model and funding options closer to the likely time of the new service being initiated.

QUEENSLAND HEALTH

A BRIEFING TO THE MINISTER

BRIEFING NOTE NO:

REQUESTED BY: **Dr J Youngman**

DATE: **9 November 1999**

PREPARED BY: Dr John Menzies, District Manager, RBH. Phone: 3636 8201

CLEARED BY: Mr L Pyne, Manager, Central Zone Management Unit, Queensland Health.
Phone: 3234 0825

DEPARTMENTAL OFFICER ATTENDING:
Dr J Youngman, General Manager – Health Services, Queensland Health.
Phone: 3234 0858

Deadline:

SUBJECT: **KEPERRA HOSPITAL**

MINISTER'S COMMENTS:

Wendy Edmond MLA
~~MINISTER FOR HEALTH~~
Date:

PURPOSE: Minister and Dr Youngman meeting with Member for Ferny Grove on 12 November 1999.

BACKGROUND:

Keperra Hospital is a freestanding healthcare facility at Keperra. It provides an extensive array of dialysis services, predominantly haemodialysis for patients as well as 8 respite beds. For many years, the Keperra facility has been considered to be in a less than desirable geographic position, the key reason being the lack of public transport to the facility. Approximately 52 patients attend the centre in an ongoing capacity for haemodialysis services. Predominantly, these patients do not live in the immediate vicinity of the hospital. In addition, there are currently 63 peritoneal dialysis patients cared for in the community by nursing staff based at Keperra Hospital. Very few of these patients live near Keperra, yet they at times require access to clinical care at the hospital.

This type of distribution of patients treated at Keperra Hospital has been common for many years and plans had been considered last year to eventually close Keperra Hospital and provide the services in other centres that would have been closer to patients' homes. It was planned that some of the renal dialysis facilities would have been transferred to Royal Brisbane Hospital, many to The Prince Charles Hospital and some to the Redcliffe / Sandgate area, because this would have provided a better service to patients and would have been more cost effective.

In December 1998 the Government made a decision to continue renal services at Keperra Hospital.

However, clinicians still believe that to keep the services going at Keperra Hospital is inappropriate for the vast majority of patients, and that it would be preferable to move renal services closer to the majority of patients' homes. In short, they believe that to split the workload between Redcliffe Hospital, The Prince Charles Hospital and Royal Brisbane Hospital is clinically and economically the best way to go.

KEY ISSUES:

- The key intentions would be that:
  - Those patients who live in close proximity to Redcliffe Hospital would go to that hospital
  - Those patients who live in close proximity to The Prince Charles Hospital would go to that hospital, and
  - Those patients who live in close proximity to the Royal Brisbane Hospital would go to that hospital.
- Public transport at these three sites is substantially better for patients than the Keperra site. Although it is acknowledged that a small number of renal patients live close to Keperra Hospital, the majority of patients who utilise renal services at that hospital do not live in close proximity to that site.
- Further to this, the provision of a renal service at The Prince Charles Hospital would optimise dialysis services for cardiac and thoracic services. This would be an effective means of providing the infrastructure for intermittent acute dialysis at The Prince Charles Hospital.

- The Keperra Hospital will require capital expenditure to improve the physical fabric of the building if it is to continue as a renal dialysis facility. Because of the decision to stay at Keperra Hospital, the district now has need for additional recurrent monies which were not included in our forward planning. At the moment there is a need to undertake the undermentioned works in the immediate future, which are crucial to the continuing operations of Keperra:-
  - Reverse osmosis system - approximately $160,000
  - PABX system – approximately $13,000
  - Pan sanitiser – approximately $6,300
- At Dr Youngman's request, the district has investigated other possible uses for Keperra Hospital but because of extremely poor public transport, we have not been able to find any Queensland Health facilities or activities that would benefit by a move to the Keperra site.
- Whilst Queensland Health does not have any alternative activities that could reasonably use the building, it may be of potential interest to private purchasers, eg. for a hostel or nursing home.

QUEENSLAND HEALTH

SUBMISSION TO THE:

☐ **Director-General**
☐ **General Manager, Health Services**
☐ **Zonal Manager (Southern Zone)**

DATE: 9 November 1999

PREPARED BY: (Amar Sharan, Project Officer) **Contact No:** < 323 41779 >

CLEARED BY: (Name, Position) **Contact No:** < >

SUBMITTED THROUGH: (Name, Position) **Contact No:** < >

DEADLINE: < > **File Reference:**

Subject: **Public Liver Transplants – 1999/2000 Indicative Allocations**

APPROVED/ NOT APPROVED

COMMENTS

Signature:
Date:

PURPOSE: To seek approval to allocate liver transplant funds to Royal Childrens and Princess Alexandra Hospitals.

BACKGROUND:

- The 1998/99 allocation and activity for public liver transplant is summarised in the table below.

Hospital	No of Transplants	Price/Transplant	Total
PAH (Adults)	19	$131,888	$2,506,000
PAH Adults – additional adults	11	$106,363	$1,170,000
RCH	5	$131,888	$689,572
Nationally Funded Centres (eligible Children)	4	$131,888	$642,000
Additional	2	$81,786	$163,572
Total	41		$5,171,144

- In 1998/99, $4.2 M was provided from Departmental Specials for adult liver transplants. This pool has also supplemented paediatric transplants at Royal Chdilren's Hospital (RCH). The Royal Children's Hospital received $642,000 from Commonwealth (Nationally Funded Centre) and $689,572 from Departmental Specials for paediatric liver transplants. However, late last year, the Commonwealth Government decided to broadband the Nationally Funded Centres (NFC) and advised Queensland Health that no funds will be available for paediatric liver procedures in 1999/2000.

ISSUES:

- There is considerable variation in liver transplant prices in various pricing systems (see table below).

Prices paid for transplants	Price per Transplant
Princess Alexandra Hospital Price (Group A Hospital -CFM)	$140,381
Royal Children' Hospital (Group P Hospital CFM)	$109,364
National Public Price (V4 NHCDC)	$118,615
Queensland Public Price (V4 NHCDC)	$112,923
Nationally Funded Centre Price	$131,888
Proposed Queensland Price for Public liver transplants	$120,000

- For 1999/2000, Queensland Health has to fund both paediatric and adult liver transplants from a fund of $4.2 M (Departmental Specials). The NFC unit price has historically used as the basis for calculation of funding. The variation in prices offered for liver transplants indicates that the current base unit base may be over-generous. There may be some potential to price transplants more accurately, and possibly less expensively. For 1999/2000, it was decided that the Districts will be funded at the National Public Price of approximately $120,000 per transplant.

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

BRIEFING NOTE NO:

REQUESTED BY:

DATE: 28 September 1999

PREPARED BY: Peter Murphy
Acting District Manager, Fraser Coast District Health Service
07 41206865

CLEARED BY: Tony Williams
Manager, Operations, Central Zone Management Unit
3234 1514

DEADLINE: 28 September 1999

SUBJECT: Maryborough Visit on 1 October 1999

DIRECTOR- GENERAL'S COMMENTS:

(Dr) R L Stable
Director-General
/ / 1999

Capita. Works – Maryborough Redevelopment:

After some delay, major work to install air-conditioning and refurbish the interior of Block B – the main inpatient accommodation block - is due to commence on 7 October 1999. It will take 6-7 months but despite the obvious disruption, all public services will be maintained without decanting to Hervey Bay. All inpatients will be housed in (existing) air-conditioned accommodation.

The current plan is to leave the ICU as is for as long as possible but if it is required to move due to intrusion from construction noise or dust etc, it will be relocated temporarily into the Theatre Recovery area. Recovery will then be done in the second theatre. Paediatrics will be scaled down and moved into another area.

A minimum of 70 beds will be available which exceeds the statistical average of 60 inpatients. However some smoothing of the mid-week peaks could well be required and some elective surgery may have to be restricted, according to priority, during the building phase. The number of available beds will be the determinate for the theatre throughput, but a review of past statistics indicates that there may not be much impact on the theatres particularly if there is a positive increase in the percentage of day cases as against overnight stays.

Some discussion has been held with VMOs about the transfer of private surgery to St Stephens, which should reduce the pressure on the operating theatres. There is some opposition to this as it would probably result in a loss of income for some of the VMOs whose patients can't or won't pay the increase in cost of private hospitalisation.

In November, upgrading of the acute kitchen will start and meals will be supplied from the existing Nursing Home kitchen. Upon completion of the new kitchen the Nursing Home kitchen will close.

Maryborough Hospital will operate in a near-optimal configuration for its actual workload during the building phase. Should circumstances dictate that the ICU needs to be relocated and a theatre closed to accommodate this, fewer staff will be needed. The cessation of temporary employees and the redeployment of staff to other units such as the Wards and the Nursing Home will cause discontent.

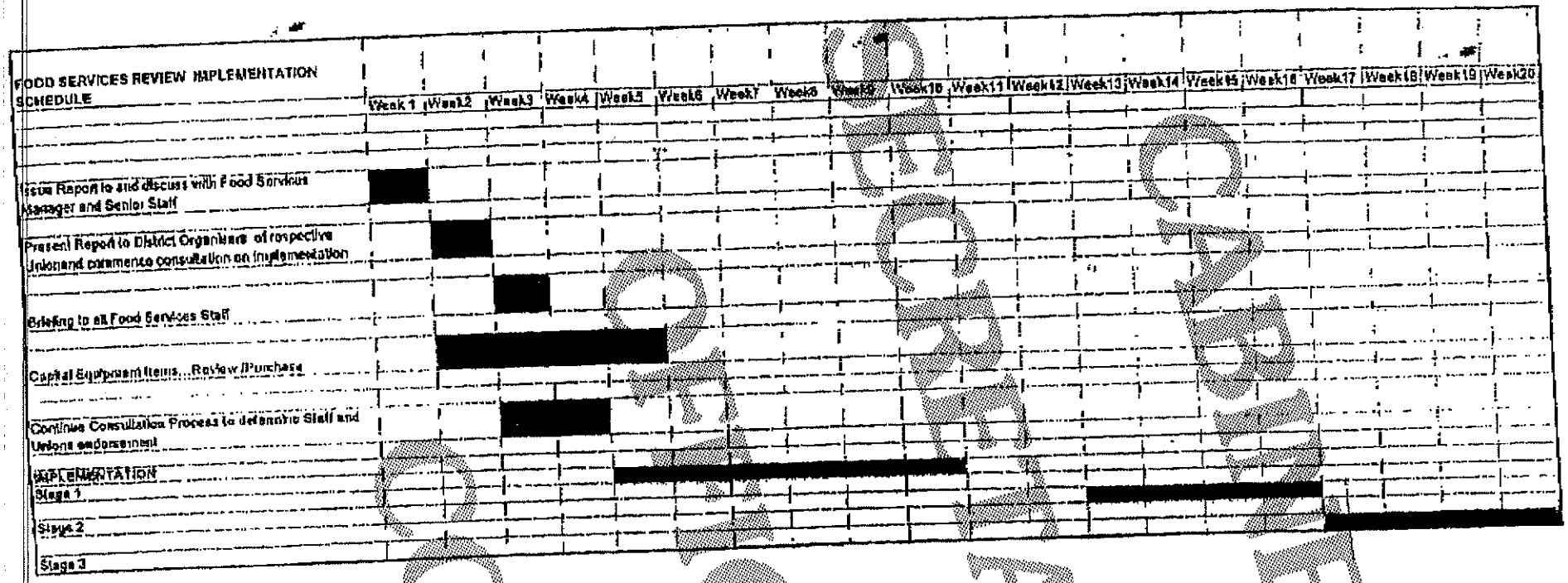
The staff consultation phase commenced on 17 September 1999. Staff feedback/suggestions on how we could best accommodate the implications of the building program were requested by close of business 22 September 1999 and following review of all options, the Executive will brief the staff and VMOs on the management plan on the afternoon of 28 September 1999. There will obviously be some discontent with whatever plan is implemented, as some staff will not like their daily routines being disrupted. The redevelopment is delivering what the staff demanded and the management plan will be as least disruptive as possible

The final phase is the renovation of Block A – operating theatres, allied health, morgue and administration.

Concerns remain over the high proportion of project fee payments and advice is awaited to confirm remaining funding will meet scope of works.

1. **Budget:**

Cost estimates for the additional funds for full duplicated hospitals in 1998/99 were 6^{+}M and for a minimalist approach ranged from $3.5M to $5M. Queensland Health allocated $3.5M, withdrew $3M in September 1998 and did not reallocate the remaining $0.5M in 1999/2000. A claim to



CONSULTATION:

The change will be organised on a fully consultative basis. District organisers of the respective unions were briefed at the time of the commencement of the review and it is planned to release the review and recommendations to the district organisers in the first instance prior to presentation and consultation with all food services staff. The implementation plan will then be developed in consultation with staff and unions.

Some staff deployment will be accommodated through attrition and staff placement within other Queensland Health services. For those staff seeking redeployment any necessary training will be provided. However, it is expected that there will be a need for some voluntary early retirements to be offered to accommodate the surplus staff over the longer term.

The district has a large number of staff, consequently it would expect to achieve acceptance of a number of voluntary retirements if offered across the district and thus allow those anxious to retire to do so and ensure continued employment of any displaced food services staff.

RECOMMENDATION(S):

Endorsement is sought of this organisational change to achieve efficiencies that are now deliverable as an outcome of the Capital Works Program.

DRAFT MEDIA RELEASE: NOT ATTACHED

ISSUES:

A recent food services review has now confirmed that further efficiencies can be implemented A part of that efficiency is the implementation of a new menu. The introduction of new Standing Offer Arrangements for the provision of frozen food as from January 2000 from additional suppliers will also assist in providing an improved menu. Significant savings will be achieved through revised staff requirements.

The review has identified changes that will deliver efficiencies within the food service, namely; the distribution of meals, production of meals and the meals management and menu monitoring functions. The implementation of recommendations amounts to a significant organisational change and it is proposed to implement this change on a three stage basis.

At each stage up to ten staff would be available for redeployment. The redeployment of staff will be managed in terms of Queensland Health's Change Management Principles and specifically the terms of the Enterprise Bargaining Agreement.

The review proposes a food service similar to food services being delivered at other facilities and as part of the consultation and implementation, it is expected that unions would visit those sites in conjunction with relevant Prince Charles Hospital food services staff.

The changes would be introduced over approximately a five month period as outlined in the *attached* program.

A risk to the implementation would be if the unions perceived major difficulties, however, this risk will be minimised by ensuring that the unions are involved at all stages of the implementation.

BENEFITS AND COSTS:

Significant improvement can be achieved for the patient's menu. Deliverable savings of up to $1.3 million per annum for a full year after completed implementation, have been identified. This projection is consistent with varied bed numbers and the reduction in occupied bed days that have been achieved within the new facilities provided through the Capital Works Program.

A saving of this scope will also assist the hospital reduce the significant deficit it is currently accruing.

PURPOSE:

To seek Ministerial endorsement of organisational change for The Prince Charles Hospital food services.

BACKGROUND:

An underlying principle of all Capital Works Programs is that efficiencies were to be achieved as a consequence of providing new facilities. This principle was espoused in the initial Prince Charles Hospital Redevelopment business case in keeping with government policy.

Throughout the redevelopment continuing efficiencies have progressively been implemented. Changes in service provision have been achieved including the relocation of resources to the Redcliffe-Caboolture Health Service District following the establishment of the Mental Health facilities at Caboolture. The new Mental Health Unit at The Prince Charles Hospital site was opened with reduced beds (sixty beds). In the latter part of 1998. Together with the opening of the ninety-six bed Extended Care Unit, planned efficiencies were achieved.

The opening of the new Main Acute Block in August this year has enabled further improvements to be pursued and in particular within Food Services.

However, significant changes to Food Services could not be considered until occupation of the new kitchen facilities with the new Main Acute Block The method of providing food services (while the work was being undertaken adequately at the time) can now allow significant efficiencies to be achieved with the new systems. Further, as part of the Capital Works Program, the planned bed reductions have now been implemented and though throughput has been maintained, a reduction in occupied bed days has been achieved.

The following table details the variation in bed numbers.

Beds	Current – 1999	Actual – 1996	Variation
Overnight	450	592	(142)
Day only	30	10	20
Total	480	602	(122)

With current Food Services infrastructure and reduced bed days, benchmark prices for food services are being exceeded.

During the course of the redevelopment program, some reduction in staffing resources has been managed where possible through attrition, staff transfer and a small number of voluntary early retirements.

3

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QUEENSLAND HEALTH

SUBMISSION TO THE MINISTER

CABINET SECRETARIAT OFFICIAL COPY

Date: 2 November 1999

Prepared by: John Wylie, Director – Corporate Services, The Prince Charles Hospital **Contact No:** 3350 8216

Cleared by: Philip Sheedy, District Manager, The Prince Charles Hospital & District Health Service **Contact No:** 3350 8224

Submitted through: **Contact No:**

RECOMMENDED/ NOT RECOMMENDED BY:

☑ Central Zonal Manager M. Assen 2/11/99

Deadline: **File Reference:**

Subject: **FOOD SERVICES REVIEW – THE PRINCE CHARLES HOSPITAL**

RECOMMENDED/ NOT RECOMMENDED

DIRECTOR-GENERAL'S COMMENTS

APPROVED/ NOT APPROVED

MINISTER'S COMMENTS

Minister requires Mgmt plan + Communication strategy in order for it to be considered.
Instruction given to D/m on 6/11/99 9/11/99

(Dr) R L Stable
Director-General

Date:

Wendy Edmond MLA
MINISTER FOR HEALTH

Date:

Faxed to Director, TPCH. 10/12/99.

Records, file pls & away

CAB.0007.0001.00177

up to ten regions). This would need to be over and above current option A and B payments for private practice in the Hospital's time.

Images transmitted throughout the day could be stored on disk, reported that evening, typed the next morning, and transmitted back to Nambour by midday the next working day, at a charge of $10 per region ($8 professional fee, $2 for "typing and handling" the latter allowing a small profit margin for the department). I think it would be impractical to have a digital duration line to Nambour for reporting purposes, as the report would then have to be transmitted back to us for checking which would be altogether too messy

A digitiser would also be needed by Nambour to digitise plain films onto a 2,500 x 2,000 matrix. A 1,250 x 1,000 matrix would involve some loss of definition, but the images could be digitised and transmitted four times as fast. We would be prepared to report these images

Any other examinations apart from plain films – CT, IVP, brain studies performed by the radiographer etc, would be charged at a flat rate on $50 per examination, for up to 50 transmitted images (including previous images transmitted for comparison) plus $1 for each additional transmitted image.

We do not think it would be productive for us to report on ultrasound examinations which we have not performed.

Note that CT images would need to be transmitted individually, on a 500 x 500 matrix, by direct link to the digital outpatient of the CT scanner. Re-digitising the hard copy output of the CT would be an inferior option.

3) Reporting hard copy couriered back and forth from Nambour. Costs as above. Nambour would be responsible for transporting the films.

4) A combination of options (1), and (2) or (3), would be possible.

We will consider these issues at our next staff meeting on Tuesday, 26th October.

Dr Paul Mowar
Director of Medical Imaging

...ND HEALTH
ROYAL BRISBANE HOSPITAL & DISTRICT HEALTH SERVICE

Memorandum

Date 22 October 1999

To: Dr Richard Ashby, A/Director of Medical Services

From: Dr Paul Mowat, Director of Medical Imaging File Ref:

Subject: *Short term relief for Nambour Hospital*

1) In regard to an onsite presence at Nambour, this is problematical with our present staff situation, as we have discussed. We have no spare capacity here, and would therefore need to provide the service in our own time.

The only way I can see to do this would be to go onto a variation of the "special deal" in place at PA for radiologists, and at PA and RBH for intensive care physicians. Some or all of the full time staff would need to agree to work five ten hour days per week, including one at Nambour which would include travelling time. We would receive our normal salary and benefits for the four days worked at RBH, and the VMO rate plus a 25% loading for the time spent at Nambour, including travelling.

I believe we need to warn Nambour in advance that we will not be able to provide a comprehensive service for them in the limited time available. I think everyone agrees that the workload there was requires two full time equivalent radiologists and can not be done adequately by one person.

In view of what they may think is an extravagant payment for not doing the whole job, a more transparent method of payment, in terms of everyone getting value for money, might be for us (as individuals) to bill Nambour Hospital 40% of the medicare rebate fee for anything that we perform/report. That way, they could decide where their priorities lie for reporting, although we would need a guaranteed minimum payment for the day to make the travelling worthwhile (say $1,200). If we had less than five volunteers, we could offer the on site service for less than five days per week.

2) Teleradiology reporting

If a teleradiology link were put in place, we would be prepared to report cases in our own time (ie after 5pm in the evenings; our working day in the department extends from 7.30am to 5.00pm including registrar teaching from 7.30am to 8.30am), for a consideration of $8 per plain film examination (that is per region eg chest including PA and lateral views; a skeletal survey however may involve

iology consultants at Nambour, a teleradiology link for consultation or after-hours reading or specialised reporting would be most appropriate.

It may be possible to direct some staff from Royal Brisbane Hospital. However, given the desire to encourage development of appropriate and acceptable outreach and teleradiology support, a directive approach may not be appropriate.

BENEFITS AND COSTS:

ACTIONS TAKEN/ REQUIRED:

That there can be convened, through the Procurement Council, a meeting of appropriate staff from relevant sections of Queensland Health to identify acceptable remuneration arrangements for teleradiology support prior to negotiation with staff groups.

RPOSE:

To highlight the need to resolve medical staff remuneration arrangements that might apply for a teleradiology service.

BACKGROUND:

Staff turnover in radiology at Nambour General Hospital has created an urgent need for interim arrangements while recruitment to vacant positions occurs. With the Central Zone Management, Nambour Hospital staff have explored possible cover from private practices to maintain services during this period. Exploration of possible cover by the Royal Brisbane Hospital Radiology Department has also been explored.

A proposal for short-term relief has been submitted by Dr Paul Mowat, Director of Medical Imaging at Royal Brisbane Hospital (copy attached). Several alternate arrangements were proposed by Dr Mowat including:

1. A "special deal" similar to arrangements for a number of staff groups.
2. Alternatively, a modified fee-for-service arrangement has been proposed.
3. In respect to teleradiology, a per-item proposal has also been proposed.

Comments on this proposal are being sought from the Executive of the Royal Brisbane Hospital and Nambour General Hospital.

Given the internal priorities for budget maintenance and given concerns within Royal Brisbane Hospital about maintenance of an adequate internal service, development of an outreach service such as that being proposed may not be seen as an immediate priority for Royal Brisbane Hospital. Nonetheless, it would constitute an appropriate longer-term role for any significant tertiary centre. Alternate arrangements are available from private sector providers which are likely to be only slightly more expensive in cost.

Since submitting the proposal, it is understood radiology staff at Royal Brisbane Hospital have advised that they would not be prepared to undertake an on-site role at Nambour.

KEY ISSUES:

Given the need to avoid industrial precedence, a private sector interim arrangement is currently being persued. Arrangements such as that proposed with fee-for-service or per-item payments to staff specialists would set a very dangerous precedent and should be avoided. Teleradiology services, possibly with some outreach component, are an appropriate service development for Royal Brisbane Hospital, however, must be in an industrially acceptable form and with a customer focus.

Reference was made in the submission by Dr Mowat to arrangements for other staff groups and it is critical that no arrangement be made for an individual major hospital without recognising the system implications from further roll-out.

Means of promoting and recognising work provided by teleradiology need to be explored urgently within Queensland Health prior to negotiation with staff groups so that, as opportunities arise for teleradiology service at Nambour and elsewhere, they may be implemented. Even with staff

QUEENSLAND HEALTH

Central Zone Management
10 NOV 1999
Document No 3206

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43

A BRIEFING TO THE DIRECTOR-GENERAL

DG: x1 file

BRIEFING NOTE NO:

REQUESTED BY:

DATE: 3 November 1999

Records file + away 15.11.99

PREPARED BY: Graeme Kerridge, Senior Manager, Operations
Central Zone Management

CLEARED BY: Lindsay Pyne, Zonal Manager
Central Zone Management

DEADLINE:

SUBJECT: **Radiology Link possibility from Royal Brisbane Hospital to Nambour General Hospital**

DIRECTOR-GENERAL'S COMMENTS:

QH is one organisation and these sort of arrangements perhaps are not to be considered - no special deals, no fee for service.

Question: Is there any spare capacity at RBH or other facilities to be involved in Teleradiology?

Is it possible to recruit staff to participate in Teleradiology at a Brisbane Hospital?

My preferred position would be to use recent [illegible] procedures [illegible] Nambour & recruit staff to a Brisbane hospital to undertake Teleradiology or if this is not possible to go to tender to contract [illegible] [illegible] [illegible] [illegible]

(Dr) R L Stable
Director-General
/ / 1999

Hospital	Projected Number of liver Transplants	Year-to-date Activity	Price per Liver Transplant	1999/2000 Allocation
Princess Alexandra Hospital (Adults)	21	7	$120,000	$2,520,000
Royal Children' Hospital (Paediatric liver transplant)	10	4	$120,000	$1,200,000
Total	31	11		$3,720,000

- The above table outlines the indicative allocation and performance targets for RCH and PAH. Historically, both Districts initially received an indicative allocation based on projected activity. The performance/activity for both districts was monitored and additional funding provided if the districts exceeded the target. It is proposed that the same process be followed this year.

RECOMMENDATION :

- That 1999/2000 indicative allocation and activity targets for PAH and RCH be endorsed and funds released as soon as possible. The balance of the State allocation ($480,000) be held in Corporate Office, for any additional activity.
- That Health Systems Strategy Branch seek additional funding from Queensland Treasury for paediatric liver transplants (State Replacement of Commonwealth Funds - Nationally Funded Centres).
- That Queensland Health clarify the price and activity projections for liver transplant as soon as possible. This will enable funding to be accurately and directly linked to performance/activity.
- That the relevant District Managers be advised accordingly.

Treasury for $5M to honour funding promises by the Premier saw $2.7M allocated in February 1999.

Estimated actual cost in 1998/99 was $4.2M offset by the additional funds of $3.2M ($2.7M + $0.5M), opportunist delays in recruitment of additional positions created by the Minister and for the Mental Health Unit (one-off effect). Management action to attrition excess staffing at Maryborough Hospital also contributed with the resultant underlying minor overrun of just -$145K in 98/99.

Estimated shortfall in 1999/00 is $1.4M:

1. $0.75M full year cost of the additional unfunded Maryborough Hospital positions created by the Minister in late 1998
2. $0.5M withdrawal of Queensland Health growth funds
3. $0.2M Transition implementation and recurrent costs (probably $0.15M in 1999/00)

The $1.4M excludes a $1.2M rise in workers' compensation premium (may be partly or fully offset by Treasury/Queensland Health).

There are some unquantified offsets – the continuing attrition of excess staff at Maryborough Hospital (scope now greatly limited by Union influence) and the savings from the amalgamation of units at the Maryborough Hospital during the building phase of the redevelopment (a one-off saving for 1999/2000). Actual cost in 1999/2000 will be lower than $1.4M but due to one-off effects and the underlying problem will resurface in 2000/2001.

Opportunities exist for management action to reduce costs without reducing services particularly at Maryborough Hospital, but local politically sensitivities make this difficult without strong support. In the past successful resistance to change by staff has resulted in more expensive outcomes than if no attempt had been made. Management actions without support may lead to questioning about the Premiers funding promise.

The budget situation is currently under negotiation with Central Zone Management Unit. As the situation stands, the District is not able to guarantee that it will meet its current budget allocation on the basis that many of the changes lie outside its control. The District has made a successful effort under difficult conditions to minimise the problem with savings capping the duplicated hospital shortfall.

3. Hervey Bay - Methadone Service:

On 1 March 1999 the Premier announced an expanded Methadone Program as part of the State's strategy to combat illegal drugs. Hervey Bay was to receive its own Methadone Service. On 1 July 1999 $132,660 was allocated to Fraser Coast District for the establishment of the Methadone Service comprising 0.5 medical officer, 0.5 administrative support and 1.0 clinical nurse.

On 15 September 1999 Lyn Biggs (QH Alcohol and Drug Unit) in conjunction with local staff inspected available sites. Consensus was that the Allied Health wing of the old Point Vernon Hospital was the best and most economical site especially as part of the area was already under renovation to house the Public Health Unit. The Alcohol and Drug Unit would be collocated with the new methadone service.

Local residents around the old hospital site have held two protest meetings (about ten at the first meeting and about thirty at the second meeting on 24 September 1999) to gain support to have the service located elsewhere. A meeting was held today (27 September) with a representative group of

the residents to discuss their concerns. The outcome of the meeting is that the residents now have an accurate understanding of the service and how it operates and they are very supportive of such a program. However, they don't want it located in their neighbourhood. There is also a strong feeling that the clients of the methadone program will be constantly breaking into the nearby Nursing Home for drugs etc and/or discarding used syringes onto adjacent properties.

Of the five neighbourhood representatives at the meeting four remained adamant that they didn't want the service in their neighbourhood and would continue a campaign to have it stopped.

Contentious Issues:

Aged Care reform – QNU have stalled the process over a sustained period, the latest excuse being to await the corporate decision over AWU v QNU coverage of the unregulated worker.

Maryborough Hospital Redevelopment Issues

Hervey Bay - Methadone Service.

Management action over budget and cultural reform – some restructuring of management positions along District lines is needed for effective management, work practice changes and cost savings. Lack of management flexibility to resolve local issues, which are operational but politically sensitive due to geographic location, hinder progress on many fronts.

QUEENSLAND HEALTH

COPY

SUBMISSION TO THE:

☐ **Director-General**
☐ **General Manager, Health Services**
☐ **Deputy Director-General (Planning & Systems)**

DATE: 27 September 1999

PREPARED BY: Graeme Kerridge
Senior Manager
Operations Central Zone
Contact No: 07-3234 0232

CLEARED BY: Lindsay Pyne
Zonal Manager
Central Zone
Contact No: 07-3234 0824

SUBMITTED THROUGH: Lindsay Pyne
Zonal Manager
Central Zone
Contact No: 07-32340824.

DEADLINE: < > **File Reference:**

Subject: Current Status and Issues re RBH Hyperbaric Medicine Development

APPROVED/ NOT APPROVED

COMMENTS

(Dr) R L Stable
Director-General
/ /1999

PURPOSE:

To advise current status and issues with respect to development of hyperbaric oxygen therapy (HBOT) at Royal Brisbane Hospital.

BACKGROUND:

- Attached Background Paper outlines history of project and available activity and cost data.
- Building works issues are driving final decision to proceed with equipment purchase in view of the limited window period for installation in the planned location. Substantial building expenditure has already been incurred preparing physical environment.
- Capital equipment funding for project (approximately $1.8M) would be sourced from FF and E budget for Royal Brisbane Hospital redevelopment. This would require the deleting of some items previously planned for purchase.
- Royal Brisbane Hospital have not at this stage completed a Business Plan for operating funds. No corporate funds have been allocated at this point to support this new service. It is expected that the Business Plan will be completed in the near future.
- The current contract with Wesley Hyperbaric Medicine Group is proving an insight into demand for public services in South east Queensland. Currently, under existing referral and charging arrangements, public demand is for about 500 "dives" per year - about 14% of which is for urgent services.

ISSUES:

- While current levels of public demand would have difficulty justifying development of a public unit separate from the private unit at Wesley, considerable investment has already occurred preparing a physical environment in what is generally considered an optimal location. An alternate location would not have the same equipment installation timing issues but would probably involve considerably higher capital and operational costs. Accordingly, alternate locations to avoid time constraints are probably not practical.
- While clinical profile of current public demand is very different from that experienced at Townsville General Hospital there would appear little merit considering a mono rather than a multi-place unit as there would be limited capital and operating economies but significant disadvantages in cost-efficiency and operational and strategic flexibility. Additionally, mono-place units have limited clinical application, particularly for emergency patients.

- While the Business Plan has not been prepared at this stage by Royal Brisbane Hospital, the justification for this treatment modality rests largely on it providing a more cost-effective treatment option than alternative regimes (e.g. reducing drug and length-of-stay costs). Accordingly, scope exists to require an internal changing approach to provide a substantial component of operational funds rather than necessarily seeking additional external funds.

- Assuming a decision is made to purchase and install a chamber where currently planned, any service commencement could be scheduled carefully in accordance with trend in public demand upon the Wesley unit and the costs thereof compared with the costs of providing an in-house service. While expectation management is difficult, equipment installation should not be interpreted as approved for immediate service commencement.

- Any pricing structure which requires critical assessment of cost-effectiveness in individual cases (such as current scheme) is valuable. It does, however, operate optimally when all aspects of treatment regimes (e.g. pathology, drugs, bed days, and clinical efficiency) are also assessed. It has been suggested that demand for HBOT would be higher were clinical units required to fund alternate treatment regimes in the same way that they are required to fund purchases of hyperbaric services for the Wesley.

RECOMMENDATION(S):

1. That no decision be made to proceed with tender for chamber until Business Case has been prepared and reviewed.

2. That, in reviewing Business Case, scope to fund by internal charging and external revenue raising be optimised.

3. That, if decision to proceed with service development is made following review of Business Case, the time constraints for cost-efficient equipment installation be recognised.

4. That, if decision to proceed with service development is made following review of Business Case, flexibility be maintained as to when in-house service provision commences in place of purchased external services.

Background Paper
Central Zone Hyperbaric Medical Services

1. Background

Hyperbaric oxygen therapy (HBOT) is the process by which pure oxygen is administered to a patient under pressure of more that 1 atmosphere. It is well established that hyperbaric therapy is effective for the treatment of decompression sickness, CO poisoning and air embolism. Currently, 14% of services purchased by Queensland Health from the Wesley Hyperbaric Medical Unit are to treat these critical conditions.

There is some emerging evidence that hyperbaric therapy is useful in the treatment of a broader range of medical conditions. With the projected increase in the incidence of chronic diseases, which generate conditions effectively treated with decompression, it is likely that this demand will increase. Additionally, the application of this technology has been expanding over the last few years and may continue to expand, resulting in further increases in demand.

The amount of HBOT required varies across patients and conditions, but generally requirements can range from 10 to 30 treatments, or dives, each of which may range from 1 to 2 hours duration.

2. Mono-place and Multi-place chambers

HBOT takes place in either a mono-place chamber or a multi-place chamber. A multi-place chamber can accommodate between 2 and 18 patients, depending on the size of the chamber and the requirements of the individual patients. In a multi-place chamber oxygen is administered to patients via a mask or hood. The multi-place chamber allows for a nurse or doctor in attendance and can accommodate ventilators and monitoring equipment.

A mono-place chamber accommodates only one patient at a time. It cannot accommodate an attendant or medical equipment. Therefore, a mono-place chamber is not suitable for treating seriously ill patients who need continuous medical or nursing care during decompression sessions. Additionally, as mono-place chambers operate at lower levels of pressurisation than multi-place chambers, their clinical application is relatively limited.

It is likely that in the immediate term and short term there would be insufficient demand to support two multi-place, comprehensive hyperbaric units in the Brisbane metropolitan area. (ie; one at the Wesley and one at the Royal Brisbane Hospital).

However, assuming that growth in demand occurs over the next few years, concern about viability of the two units in south-east Queensland may be unnecessary by the time a new Royal Brisbane Hospital HBOT unit is fully commissioned.

3. History

In the past, prior to the opening of the Wesley Hyperbaric Medical Unit, patients in Queensland who required decompression treatment were referred to either the unit in Townsville or Sydney.

1995 – Ministerial endorsement was given to the establishment of a comprehensive hyperbaric unit at the Royal Brisbane Hospital

1996 Planning continued at the Royal Brisbane Hospital campus to build a comprehensive hyperbaric unit, to be completed in 2000 and commissioned in 2002.

1997 A number of significant events occurred:

1. A private hyperbaric unit was planned at the Wesley and construction commenced
2. The Technology Assessment Team undertook a review and recommended that Queensland Health develop a contractual arrangement to purchase hyperbaric services from the Wesley unit
3. Performance Management Branch conducted a cost-effectiveness study and concluded that Queensland Health should purchase hyperbaric services from the private sector and should monitor the use and effectiveness of this option
4. The Herston Redevelopment Team noted that the 1995 submission from the Royal Brisbane Hospital to establish a comprehensive hyperbaric unit had grossly underestimated capital costs.

On the basis of these events and reports the Director General endorsed the following actions:

1. Allow space for the installation of a hyperbaric chamber within the Central Block of the redeveloped Royal Brisbane Hospital/Royal Women's Hospital.
2. Proceed with negotiations with the Wesley Hyperbaric Medical Group for the provision of hyperbaric medicine services as an interim measure.
3. Commission a consultancy for a revised Economic Evaluation and Business Plan for the proposed Royal Brisbane Hospital hyperbaric unit. Decisions regarding the timing and funding of a public hyperbaric unit should made on the basis of this evaluation. (This evaluation has not been undertaken.)

1998 District Managers in the Southern and Central Zones were advised that a Standing Offer Arrangement had been established with the Wesley Hyperbaric Medical Group and patients from these Zones requiring HBOT should be referred to the Wesley Hyperbaric Medical Unit.

A consultancy report was commissioned by Queensland Health from Dr Ian Miller in two phases:

Phase 1 – March 1988
Phase 1 of this report examined the potential demand for hyperbaric medicine services at the new Royal Brisbane Hospitals Campus site, as well as the practicability of installing a hyperbaric chamber into the Royal Brisbane Hospital building which is presently under construction. Recommendations were made regarding the type and size of hyperbaric chamber that would be most suitable. The time periods when installation could be most optimally achieved were identified.

Phase 2 – June 1999
Phase 2 involved an architectural, engineering and technical analysis leading recommendations for technical specifications for both the proposed hyperbaric chamber and its interfaces with the hospital. This information provided a resource for the technical specifications section of any tender/s that may arise for supply of a hyperbaric chamber and associated works.

4. Current Usage of the Wesley Hyperbaric Medical Unit by Queensland Health

The Wesley Hyperbaric Medical Unit was opened in March 1998. The chamber comprises one large unit with a small bulkhead at one end. The main section can accommodate a maximum of six people (including attendants) seated. This capacity is reduced if any patients require a stretcher. The chamber can accommodate two patients on stretchers. The bulkhead accommodates 2 people, that is one patient and one attendant. It is primarily used for patients with decompression sickness. The large chamber operates at a lower pressure, while the bulkhead operates at 5 bars.

Queensland Health entered into an agreement to purchase hyperbaric medical services from the Wesley Hyperbaric Medical Unit on July 1, 1998. Under this arrangement the cost per dive varies with the number of public patients in the chamber at one time, irrespective of the duration of the individual dive. Costs are identified in Table 1 below.

Table 1: Sliding scale of costs for services from the Wesley Hyperbaric Medical Unit

Number of public patients in the chamber	Cost per patient treated per dive
1- 2	$400
3-5	$375
>5	$350

Patients referred from Queensland Health to the Wesley Hyperbaric Medical Unit are treated as outpatients. If a patients requires hospitalisation in Brisbane due to travel or treatment requirements this is negotiated by the referring hospital with the appropriate public hospital in Brisbane.

Any District Health Service in the Southern or Central Zone may refer patients to the Wesley Hyperbaric Medical Unit for the treatment of decompression sickness, carbon monoxide poisoning or arterial air embolism. Patients requiring treatment for other medical conditions including, osteoradionecrosis, necrotising infections, traumatic ischaemia, non-healing wounds, thermal burns, sudden onset deafness, osteomyelitis and Bells palsy must be referred by a clinical specialist at a Level 5 or 6 hospital.

From October 1998 to June 1999 Queensland Health purchased 369 dives from the Wesley Hyperbaric Medical Unit at a cost of $182,350. Fourteen per cent of dives purchased were for treatment of decompression sickness, carbon monoxide poisoning or arterial air embolism.

In the three quarters from July 1, 1998, 78% of referrals were from the Brisbane metropolitan area, with 60% being from the Royal Brisbane Hospital. See table 2.

Table 2: Origin of referral from District Health Services to the Wesley Hyperbaric Medical Unit (3 quarters from July 1, 1998)

District Health Service	Number of dives purchased
Royal Brisbane Hospital	205
Princess Alexandra Hospital	61
QEII	1
Nambour	16
Ipswich	31
Redcliffe/Caboolture	4
Gold Coast	20
Murwillumbah	2
Gladstone	3

On a full year basis, under the current referral and charging arrangements, Queensland Health purchases approximately 500 dives per year from the Wesley Hyperbaric Medical Group.

It is understood from SHANGU that the Wesley Hyperbaric Medical Group claims that the current arrangement does not provide an economically viable price for emergency decompression services and that some revision of the charging arrangements is being sought.

5. Current situation regarding physical construction

To date the redevelopment project at the Royal Brisbane Hospital campus has been progressing with the plan to leave space for a comprehensive multi-place hyperbaric unit. Space has been reserved in the plans for "a triple lock multi-place rectangular steel chamber with wheel/walk through doorways and at least two compartments being capable of 500 kPa pressurisation. At least one compartment should have a capacity for 8 – 10 patients with several of these being recumbent. Both treatment compartments should be fitted for intensive care and at least one and preferably both treatment compartments should have doors of sufficient width to allow entry of an intensive care bed."

The Townsville General Hospital is planning to install a new chamber, in a new "greenfield" site based on the same specifications as provided by the Royal Brisbane Hospital consultancy. That is, a 15 seat, triple lock chamber with facilities to manage intensive care patients. Such a chamber has a life expectancy of 25 to 30 years.

The Townsville General Hospital has been quoted $1,757,328.00 for the cost of the new chamber and installation.

Based on the provision of 2,500 dives per year, the Townsville General Hospital has estimated annual recurrent costs of $1,054,313.59.

The location selected at the Royal Brisbane Hospital is in the new Central Block, close to the Emergency Department. This site allows good clinical service links for both urgent and non-urgent patients and allows flexible, co-operative staffing arrangements which potentially reduce operational costs. This location was identified by Dr Ian Miller in the consultancy report as the optimal location.

However, if the chamber is to be installed in this location, installation must be completed by February 2001 as convenient access would not be possible after this date. Access after this date might be achieved only at a very substantial cost penalty. These access problems will face the hospital should it be required to update the equipment at a later time. (In view of the past life-span of such units, this has not been seen as a major problem. However, the past may not provide a sound guide for the future with respect to medical technology.)

On the basis of these plans substantial investment has already occurred by Queensland Health in the new physical environment even though tenders have not been prepared for the equipment.

6. Options

a) **No chamber at the Royal Brisbane Hospital in either the medium or longer term– continue to purchase all hyperbaric services from the Wesley Hyperbaric Medical Unit.**

- The Wesley Hyperbaric Medical Unit has the only chamber south-east Queensland and therefore holds a monopoly position in the provision of these services.
- The Wesley claims that under the current contract (which is under review) the provision of emergency decompression is not economically viable. If the Wesley were to withdraw emergency hyperbaric services, Queensland Health would have no option in the immediate term but to transfer patients to either Townsville or Sydney, as was previously the case.
- A decision not to build a hyperbaric chamber at the Royal Brisbane Hospital at any stage would over turn previous Ministerial approval and a directive from the Office of the Director General to allow space for a chamber and plan installation on the basis of findings of thorough evaluation.

- While location of such a facility at an alternative public hospital could be pursued, it would be preferable for such a unit to be located at a major tertiary and oncology centre. Duplication of costs already expended would result.

b) **Allow space as currently planned in the current redevelopment to build and install a facility later with new initiative funding.**

- If as planned a 15 place, triple lock chamber is to be installed, this is not really an option, as fit out of this site after February 2001 will not be possible. As a 12-month lead-time to fit out is required, planning for fit out would need to commence by February 2000, at the latest.

c) **Build and install hyperbaric chamber in current planned position, but do not operate immediately.**

- While this would avoid operating costs in the immediate term, it would represent 'sunk" costs of capital expenditure which would not be in use.

d) **Build and install hyperbaric chamber, as part of current redevelopment and operate on completion.**

- There may not be sufficient demand in the public sector at this stage to justify operating the chamber immediately. However, current usage may not reflect current demand and is unlikely to be a good estimate of future demand. If usage were to increase substantially, this would have significant resource implications.

e) **Discard current planned location and identify a suitable location for future development.**

- Although substantial replanning and associated expense would result, this option would avoid pressure on Queensland Health to commit equipment capital (and possible operating) funds earlier than demand warrants.
- Alternate locations do not offer similar scope for supervisory and operational efficiency. These factors may rapidly exceed any immediate saving through delaying equipment expenditure.

BR004482.

retrs DG024130

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

BRIEFING NOTE NO:

REQUESTED BY: Dr R Stable

DATE: 16 September, 1999

PREPARED BY: Dr J Menzies, District Manager, Royal Brisbane Hospital and Health Service District. Phone: 3253 8201

CLEARED BY: Mr L Pyne, Zonal Manager, Central Zone, Queensland Health
Phone: 3234 0825

24/5/99

DEADLINE:

SUBJECT: **Radiological Advisory Council**

DIRECTOR- GENERAL'S COMMENTS:

NOTED

28 SEP 1999

DR. R L STABLE
DIRECTOR GENERAL

(Dr) R L Stable
Director-General
/ / 1999

PURPOSE: Update on Situation

BACKGROUND:

On 31 August 1999 the Acting Chairman of the Radiological Advisory Council wrote to you regarding the disposal of Radon from the Royal Brisbane Hospital. Council recommended that once a formal proposal had been prepared by Royal Brisbane Hospital – Division of Oncology, that it should be assessed by an independent consultant.

The relevant background to this situation is as follows. Radon, for medical use, was produced in the Radon Laboratory at the University of Queensland from 1938 to 1955 at George Street, and from 1955 to 1976 at St Lucia. The Radon plant was moved to Royal Brisbane Hospital in June 1976 where it was used until the late 1980's and consideration of the decommissioning of the plant commenced. It was not until the State Government facility at Esk became available, that decommissioning became feasible and planning could commence.

Over the last couple of years, considerable time and effort has been spent in developing a protocol to safely dispose of the Radon. A container suitable for transport of the radium from RBH to Esk, and the longterm storage thereafter, had to be designed, constructed, tested and approved. This process is ongoing with certification of the container due within a month. The protocol for precipitating the radium from solution, filtering and drying it, and sealing it in the container was developed using information from the University of Queensland transfer and plant decommissionings in Sydney and Adelaide, along with substantial original work from Physicists. Various draft documents have been submitted to Radiation Health over the last 12 to 18 months, discussions arising from these have resulted in a draft compilation of all aspects of the project, submitted to Radiation Health on 1/9/99.

Given the sensitivities of disposing of radioactive substances, it has been necessary to ensure that all procedures have been methodically developed. Funding for the project has had to come from the Division of Oncology's operational budget, occasionally resulting in lengthy approval processes and some restriction on the availability of funds. Expenditure to date by the Division is $20,018 and there are committed orders for $19,013 and future expenses estimated at $10,000 – $12,000. It is expected that the final protocol for the safe disposal of the radon will be submitted to Radiation Health - Queensland Health within the next 2 weeks.

ACTIONS TAKEN/ REQUIRED:

CURRENT SITUATION

The protocol that has been developed has been prepared by perhaps the most technically capable people within Australia, certainly within Queensland. Senior Oncologists and Physicists at Royal Brisbane Hospital believe that the use of an external consultant to verify that the proposed protocol is safe, is perhaps somewhat of an "overkill" given the reputation and competence of the experts who have prepared the document. Nevertheless, to reassure the broader community that the process has been approved not only by the best experts in Queensland, but also by an independent expert from interstate could be justifiable.

The RBH & HSD strongly recommends that the proposal for the safe disposal of the Radon be approved by the relevant authorities at Queensland Health, either with or without scrutiny by an

Block 10 at RBH which is to be demolished over the next month or so, following which major construction work will commence on the new QIMR Comprehensive Cancer Research Centre. Ideally, the radioactive substance should be removed prior to demolition and construction work commencing.

3018

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

BRIEFING NOTE NO:

REQUESTED BY:

DATE: 30 August 1999

PREPARED BY: Martin Jarman, Manager Operations Central Zone, 322 76861

CLEARED BY: Lindsay Pyne, Manager Central Zone Management Unit, 323 40825

DEADLINE:

SUBJECT: **Bundaberg Health Service District Budget 1999/00**

DIRECTOR- GENERAL'S COMMENTS:

(Dr) R L Stable
Director-General
/ / 1999

BACKGROUND:

- In 1998/99 the District received a Base Budget of $32,709,689 and expended $33,074,102. This represented an expenditure overrun of $364,413.

- The total District budget for 1998/99 (including Base, Specials and Commonwealth allocations) was $42,465,905 with expenditure for the year totalling $42,810,318. This represented a total expenditure overrun of $344,413.

KEY ISSUES:

- The Base Budget for the District for 1999/00 has been set at $33,374,546. This represents an increase of $1,734,376 per annum (approximately 5.5%) over the budget awarded in 1998/99.

- The total District budget for 1999/00 (including Base, Specials and Commonwealth allocations) is as follows.

	1998/99	1999/00	
Base	31,640,170	33,374,546	
Specials	8,335,877	5,331,607	(includes absorption of the 1998/99 expenditure overrun)
Commonwealth	2,489,858	1,610,137	
	$42,465,905	$40,316,290	

- The following funds are still to be allocated in 1999/00:

		1998/99 Allocation $
Specials	• Freedom of Information Application Fees.	1,152
	• Credit to Vote	312,080
	• Post Acute Program	135,000 (1)
	• Nursing Workforce Management Project	7,200
	• Oral Health Transfer	67,207
	• Cross District Services	
	• Frozen Food Penalty	5,602
	• Statewide ICU Program	10,000
	• ATSI Health Initiatives	65,000
	• Surgical Incentives Funds	200,000
Commonwealth		
	• Breast Cancer Screening	806,000
		$1,643,639
		- 5,602 (2)
		$1,638,037

(1) The District has advised that it does not expect to receive the same level of ıding for the Post Acute Program in 1999/00.

(2) This amount was deducted in 1998/99 for the Frozen Food Penalty.

- If the Specials and Commonwealth allocations (yet to be rolled out) remain the same as for 1998/99 the District would receive a total Budget of $41,954,337.

- The difference in the Specials Budgets as indicated above is largely due to the non recurring status of various items funded in 1998/99 (refer to attached documentation).

Fund_2	(All)
Entity	(All)
District	BUNDABERG
Fund_3	(All)

Fund_1	Group	Ref	Item	Note	Funding	Data 1998/99 Budget	1999/20 Budget
A. State - Operating F	1. Operating Budget	1-001	Opening Balance	N/A	recurrent	27,411,547	31,640,170
	1. Operating Budget Total					27,411,547	31,640,170
	2. Awards added to Operating Budget	2-001	Visiting Medical Officers	N/A	recurrent	243,800	0
		2-002	EB 2 - Stage 2 (State - Excl Pathology)	N/A	recurrent	606,959	0
		2-003	EB 2 - Stage 2 (State - Pathology)	N/A	recurrent	11,036	0
		2-004	Nurses 36 Hour Week	N/A	recurrent	450,971	0
		2-005	ATSI Health Worker Career Structure	N/A	recurrent	5,224	0
		7-001	EB 2 - Stage 3 (State - Excl Pathology	N/A	recurrent	0	746,436
		7-002	EB 2 - Stage 3 (State - Pathology)	N/A	recurrent	0	13,574
		7-003	EB 3 - First Increase	N/A	recurrent	0	804,600
		7-004	Level 3 Nurses	N/A	recurrent	0	5,566
		7-005	Oral Health Career Structure	N/A	TBA	0	0
	2. Awards added to Operating Budget Total					1,315,990	1,570,168
	3. Variation to Operating Budget	3-004	MH Community Enhancement	N/A	recurrent	111,000	0
		3-005	MH Community Based Clinical Staff	N/A	recurrent	340,400	0
		3-006	Elective Surgery Maintenance Fund	N/A	recurrent	419,000	0
		3-007	Elective Surgery Maintenance Fund -	N/A	recurrent	208,496	0
		3-015	Bundaberg Anaesthetics	N/A	recurrent	180,000	0
		3-022	Supplementation - 1994/95	N/A	recurrent	200,000	0
		3-023	Supplementation - 1995/97	N/A	recurrent	70,600	0
		3-041	Renal Services	N/A	recurrent	150,000	0
		3-044	Methadone Access	N/A	recurrent	109,500	0
		3-046	School Dental Scrn	N/A	recurrent	16,000	0
		3-047	Non Labour Escalation	N/A	recurrent	82,295	0
		3-060	Productivity Dividend	N/A	recurrent	-98,529	0
		3-064	Cashable Savings - Funding Supplem	N/A	recurrent	324,786	0
		3-065	Cashable Savings - 1995/97	N/A	recurrent	-324,786	0
		3-056	Round 2 Savings - Community Health	N/A	recurrent	-22,234	0
		3-057	Round 2 Savings - Hospitals	N/A	recurrent	-449,351	0
		3-058	ATSI Health Initiatives	N/A	recurrent	40,500	0
		3-062	EB 2 Productivity Savings	N/A	recurrent	-123,823	0
		3-063	Public Drunkenness	N/A	recurrent	85,000	0
		3-073	MH Commonwealth Replacement	N/A	recurrent	148,200	0
		3-098	Oral Health Funding	N/A	recurrent	1,478,900	0
		5.2-003	Extn Oral Health Services - Secondary	N/A	recurrent	0	0
		5.2-005	Activity Growth - 1998/99	N/A	recurrent	0	400,000
		7.1-001	Round 2 Savings - Hospitals	N/A	recurrent	0	-224,875
		7.1-002	Round 2 Savings - Community Health	N/A	recurrent	0	-11,117
	3. Variation to Operating Budget Total					2,912,753	164,208
A. State - Operating Funds Total						31,640,170	33,374,846
B. State - Special Fun	4.1 Treasury Specials	4.1-001	Equity	N/A	recurrent	122,286	122,286
		4.1-002	Provision for Superannuation	N/A	recurrent	2,437,639	2,437,639
		4.1-003	27 Pays	N/A	non-recurrent	1,088,364	0
		4.1-020	Freedom of Information Application Fe	N/A	TBA	1,182	0
		4.1-027	Credit to Vote	N/A	TBA	312,060	0
	4.1 Treasury Specials Total					3,912,481	2,559,905
	4.2 Treasury New Initiatives	4.2-001	Post Acute Program	N/A	TBA	135,000	0
		4.2-005	Illicit Drug Ministerial Task Force	N/A	recurrent	55,000	54,990
		4.2-006	MH Youth Suicide Prevention Strategy	N/A	recurrent	44,557	44,557
		4.2-015	School Based Youth Health Nurse pro	N/A	recurrent	22,500	109,000
		4.2-017	Emergency Department Strategy	N/A	recurrent	97,000	247,000
		4.2-018	Drug and Alcohol Strategies	N/A	recurrent	8,000	49,891
		4.2-019	Community Health - Child Care Centre	N/A	recurrent	24,361	48,722
		4.2-022	Hearing for ATSI Children	N/A	recurrent	15,000	0
		4.2-025	Triple P-Prog (Early Intervention)	N/A	recurrent	19,895	35,584
		4.2-026	MH 10 YR Strategy Funding Program	N/A	recurrent	360,683	644,760
		4.2-027	MH 10 YR Strategy Funding Program	N/A	recurrent	277,189	484,224
	4.2 Treasury New Initiatives Total					1,073,525	1,718,628
	4.3 Treasury Specials - Rollover	4.3-001	Rollover - State Base	N/A	non-recurrent	-34,144	-364,413
		4.3-014	Rollover - Oral Health Funds	N/A	non-recurrent	-12,738	0
	4.3 Treasury Specials - Rollover Total					-46,882	-364,413
	5.1 Departmental Specials	5.1-001	Paid Maternity Leave	N/A	recurrent	68,569	68,569
		5.1-021	ATSI Health Worker Career Structure	N/A	non-recurrent	2,976	0
		5.1-022	State Supplementation Commonwealt	N/A	recurrent	707,922	0
		5.1-024	Litigation	N/A	non-recurrent	26,250	0
		5.1-040	Special Allocation	N/A	non-recurrent	20,000	0
		5.1-042	Nursing Workforce Management Proje	N/A	TBA	7,200	0
		5.1-047	Transfer of funds to Human Resource	N/A	non-recurrent	-1,755	0
		5.1-052	Oral Health Transfer	N/A	TBA	67,207	0
		5.1-060	Quality Enhancement Programs	N/A	non-recurrent	500,000	0
		5.1-065	Cross District Services	N/A	TBA	40,000	0
		5.1-069	Frozen Food Penalty	N/A	TBA	-5,602	0
		5.1-071	Dental Services - Childers Hospital	N/A	non-recurrent	90,000	0
		5.1-094	PTSS Transfer from Districts	N/A	recurrent	-240	-480
		5.1-095	PTSS Transfer to Host Districts	N/A	recurrent	6,784	13,568
		5.1-099	Levy - MIS Project (LATTICE)	N/A	TBA	0	0

		5.1-100	Levy Adjustment - MIS Project (LATTI)	N/A	TBA		
	5.1 Departmental Specials Total					0	0
	5.2 Departmental New Initiatives					1,529,311	81,657
		5.2-003	Extn.Oral Health Services - Secondary	see OB 99/2	recurrent	6,800	0
		5.2-004	Statewide ICU Program - Critical Care	N/A	TBA	10,000	0
		5.2-005	Activity Growth - 1998/99	see OB 99/2	recurrent	400,000	0
		5.2-008	ATSI Health Initiatives	N/A	TBA	65,000	0
		5.2-021	Surgical Incentives Funds	N/A	TBA	200,000	0
		5.2-024	Rheumatology Services	N/A	non-recurrent	16,000	0
		5.2-028	MH - Growth	N/A	recurrent	101,113	0
		5.2-029	Activity Growth - 99/2000	N/A	recurrent	0	800,000
	5.2 Departmental New Initiatives Total					797,913	800,000
	7. Awards - Part Year	7-001	EB 2 - Stage 3 (State - Excl Pathology	see OB 99/2	recurrent	746,436	0
		7-002	EB 2 - Stage 3 (State - Pathology)	see OB 99/2	recurrent	13,574	0
		7-003	EB 3 - First Increase	see OB 99/2	recurrent	532,565	0
		7-004	Level 3 Nurses	see OB 99/2	recurrent	1,495	0
		7-005	Oral Health Career Structure	see OB 99/2	recurrent	11,247	0
		7-006	EB 3 - Second Increase	see OB 99/2	recurrent	0	535,930
	7. Awards - Part Year Total					1,305,311	535,930
	7.1 Awards - Cashable Savings	7.1-001	Round 2 Savings - Hospitals	see OB 99/2	recurrent	-224,675	0
		7.1-002	Round 2 Savings - Community Health	see OB 99/2	recurrent	-11,117	0
	7.1 Awards - Cashable Savings Total					-235,792	0
B. State - Special Funds Total						6,336,877	5,331,607
C. Commonwealth Fu	8. Commonwealth Programs	8-002	High Cost Drugs	N/A	recurrent	534,099	548,240
		8-011	Home and Community Care	N/A	recurrent	881,222	881,222
		8-014	Breast Cancer Screening	N/A	TBA	806,000	0
		8-018	National Drug Strategy	N/A	recurrent	50,000	50,000
		8-023	MH Reform & Incentive Program	N/A	recurrent	20,000	0
		8-031	Palliative Care Program	N/A	non-recurrent	[illegible]	130,675
		8-034	National Mental Health Plan	N/A	non-recurrent	[illegible]	0
		8-037	Enhanced Measles Control Campaign	N/A	non-recurrent	[illegible]	0
	8. Commonwealth Programs Total					[illegible]	1,610,137
C. Commonwealth Funds Total						2,489,858	1,610,137
Grand Total						42,465,905	40,316,290

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QUEENSLAND HEALTH

A BRIEFING FOR THE MINISTER

Min 2
Solicitor
file

BRIEFING NOTE NO:

REQUESTED BY:

DATE: 23 August 1999

PREPARED BY: Peter Leck,
District Manager, Bundaberg Health Service District

CLEARED BY: Lindsay Pyne,
Manager, Central Zone Management

Dr John Youngman,
General Manager, Health Services

DEPARTMENTAL OFFICER ATTENDING:

Lindsay Pyne,
Manager, Central Zone Management

Deadline: 24 August 1999

SUBJECT: **A BRIEFING FOR THE PREMIER AND MINISTER FOR HEALTH RELATING TO ISSUES CONCERNING THE BUNDABERG HEALTH SERVICE DISTRICT AND THE DISTRICT BUDGET**

MINISTER'S COMMENTS:

Wendy Edmond MLA
MINISTER FOR HEALTH

Date:

PURPOSE: To brief the Premier for his meeting with Ms Nita Cunningham, MLA, on issues relating to the Bundaberg Health Service District budget and health services.

BACKGROUND: The Bundaberg Health Service District has been the subject of considerable media speculation in recent months. Much of the publicity relates to the District's budget position. There has also been media attention concerning the closure of a general practice clinic, the review of operational services, dental waiting lists, orthopaedic surgery waiting lists, waste management and a reduction of bed numbers at the Childers Hospital.

ISSUES/SENSITIVITIES:

Budget Issues

The District's 1999/2000 budget will not be finalised until the State budget is brought down in September 1999. An interim budget has been determined with some Commonwealth funding and special purpose funding still to be allocated.

The District exceeded its 1998/99 budget allocation by $344,000. A number of strategies were put in place during that financial year to contain over expenditure. These included a reduction in temporary and casual administrative and operational employees, and a reduction in expenditure on new and replacement equipment. Elective surgery activity was also reduced.

The Minister for Health announced a financial assistance package for the District in February 1999. This consisted of a "one-off" allocation of $500,000. An additional $200,000 was also made available if elective surgery targets could be met.

During June 1999, specific purpose elective surgery funding of $700,000 was returned to Corporate Office of Queensland Health, as the District was unable to achieve its elective surgery targets. The District Health Council have been angered by this action, as they believe the Minister for Health had made a commitment during a meeting with the Council on 25 February 1999, that no elective surgery funds would need to be returned.

$800,000 in growth funding is anticipated to be provided to the District in 1999/2000. However there is a potential over-expenditure risk of $900,000 due to:

- an increase in the Workers Compensation premium
- new corporate systems costs
- increased Patient Transit Assistance Scheme costs
- an unfunded increase in the number of doctors 2-3 years ago, who are now providing additional services
- the employment of locum orthopaedic surgeons during the unanticipated absence of the hospital's one (1) orthopaedic surgeon on extended sick leave
- the carry over of the budget deficit of $344,000 from 1998/99

Mental Health

There has been some media speculation about the utilisation of Mental Health funding during 1998/99. Nearly $200,000 allocated to new mental health services was allocated to a capital works programme for Child & Youth Mental Health Services. This funding became available owing to difficulties in recruitment of several mental health positions during 1998/99. There are currently two (2) positions vacant but recruitment action is still progressing.

Surgical Waiting Lists

The District's category 2 and category 3 surgical waiting lists increased slightly during 1998/99. At the end of June 1999 there were no patients waiting for category 1 surgery. 18% of category 2 patients were waiting longer than ninety (90) days for surgery, and 20% of category 3 patients were waiting longer than 365 days.

Patients waiting for orthopaedic surgery have been increasing rapidly owing to the absence of the hospital's only orthopaedic surgeon on sick leave.

There are currently in excess of 500 patients waiting for a clinic appointment with an orthopaedic surgeon for assessment for surgery.

General surgery waiting lists are also increasing.

Dental Services

The waiting time for routine dental treatment at the Bundaberg Base Hospital has been steadily increasing over the past two (2) years.

The waiting period is now 48 months.

Emergency dental treatment is provided for all patients requiring such treatment five (5) days per week.

Recruitment of dental staff has been difficult and this has contributed to the increasing waiting times.

The District Health Council and Australian Dental Association have been critical of the waiting times being experienced by the local community.

Waste Management

Considerable media attention focussed on the disposal of waste from the hospital at local council landfill. Other health services such as private hospitals, and doctors' surgeries also utilise the council's facilities.

The Bundaberg City Council is licensed for the disposal of this waste in an appropriate manner.

The Health Service is exploring options for the incineration of waste, should this be required at a future date.

Childers/Gin Gin Hospitals

Bed numbers at Childers Hospital were recently reduced from twenty-two (22) to eighteen (18). This action received some publicity.

The occupancy rate at the Childers hospital is less than 60%.

The District Health Council and Gin Gin community have been actively lobbying for a new hospital for a number of years. The existing facilities were constructed in 1912.

The redevelopment of the Gin Gin hospital has not been included in the current capital works program and a more suitable approach, if funding was available, would be the development of a Multi-Purpose Health Centre.

STRATEGIES:

- District management will work closely with the newly appointed Central Zone Manager, Mr Lindsay Pyne and his staff, in reviewing the structure of hospital and health service delivery in Bundaberg and the District.
- The new structure being developed will reflect the particular needs of the District and will involve wide staff consultation and input into its development.
- Financial management is to be progressively devolved to clinical managers to improve their responsibility and accountability for services and their costs.
- The Zone Manager is to explore opportunities for addressing the difficulties in attracting suitable medical relief staff, particularly in the areas of orthopaedic and dental services.
- The Zone Manager will be closely monitoring the District's expenditure so as to address quickly any trends which could lead to budget overruns.
- Alternative methods of waste disposal are to be explored including the possibility of a whole-of-Zone approach.

RECOMMENDATIONS:

- That the strategies be noted.
- That the District's budget situation will be closely monitored by the Central Zone Management Team.

PREPARED BY: Peter Leck,
District Manager, Bundaberg Health Service District

CLEARED BY: Lindsay Pyne,
Manager, Central Zone Management

Dr John Youngman,
General Manager, Health Services

DATE: 23/08/99

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

BRIEFING NOTE NO: (If known

REQUESTED BY: Dr Robert Stable

DATE: 30 July 1999

PREPARED BY: Amar Sharau, A/Senior Project Officer, 323 41779

CLEARED BY: Clare Besly, Manager, 323 41516

DEADLINE: 2 August 1999

SUBJECT: Gold Coast Planning Information

DIRECTOR-GENERAL'S COMMENTS:

(Dr) R L Stable
Director-General
/ / 1999

PURPOSE: (eg for update on situation)

To provide information on Gold Coast planning data used in preparation of Business Cases, Tweed Head Hospital Redevelopment, Queensland Health Care Research Group, Robina Health Care Complex and health service plans.

BACKGROUND:

Gold Coast Hospital Redevelopment Business Case – Performance Management Branch (14 August 1997). The redevelopment of the Gold Coast Hospital was planned on the basis of the Gold Coast Hospital Functional Plan that provided an ambulatory and sub-acute health care facility at the Southern end of the South Coast (Robina) and redevelopment at the Gold Cost Hospital.

The proposed configuration for Gold Coast Hospital for the year 2006 is:

- Total of 475 overnight beds
- 368 acute beds in the Tower Block at the Gold Coast Hospital. Approximately $34M was directed towards upgrading the Tower Block and ancillary projects on the Hospital Campus.
- Significant upgrading and expansion of specialised services, in the Tower Block, including 24 ICU, 9CCU beds, 21 telemetry beds, 16 intensive care cots, growth in pathology and radiology, creation of doctors rooms
- 150 beds in addition to those in the Tower Block (90 acute, 40 rehabilitation, 20 low dependency ward), best accomodated through the building of new facility given major weakness of available facility for these services. The rehabilitation development will cost $21M.
- an ambulatory care building on the Gold Coast site, providing outpatient clinics, day procedures, endoscopy services, chemotherapy, renal dialysis, allied health services and a day hospital.
- A new Ambulatory Care Centre servicing the Southern end of the South Coast, at Robina, and formally networked to the Gold Coast Hospital, providing outpatient services, day procedures, endoscopy services, satellite renal dialysis, allied health, diagnostic services, rehabilitation inpatient unit (20 beds) and extended secure psychiatric unit (24 beds).

Business Case Model

The Business Case Model was analysed and updated by PMB in late 1998. 1997/98 actual data and the most recent supply projections for 2005/06 (based on 1996/97 actuals) were incorporated in the model. The revision resulted in updated performance indicators with the number of overnight beds required ranging from 440 to 475 which allowed bed occupancy to swing between 80 –85%.

It is important to note that the model adjusts the 2005/06 projections to take into account planned changes in services resulting from the hospital redevelopments. For Gold Coast Hospital these adjustments included recapture of activity from the private sector and inflows into Gold Coast Hospital.

Planning data & documents:

Queensland Health Care Research Group - South Coast Supply by SRG for 1993/1994 and projected for 2006.

d numbers: Based on John Bissett Model

pulation data: estimates based from data available from the South Coast Health Region (SCHR). Projections for the Gold Coast District are based on population data available for the Gold Coast City and Albert Shire Part B. Queensland Department of Housing, Local Government and Planning, 1994.

Gold Coast Hospital Functional Plan – Clinical Services. Shane Solomon & Associates for Conrad & Gargett Pty Ltd, June 1996,
Supplementary Report to Gold Coast Hospital Functional Plan – Robina Health Care Complex – Shane Solomon & Associates, December 1996,
Gold Coast Hospital – Rehabilitation Unit Redevelopment – Conrad & Gargett Pty Limited Architects and Health Facility Planners – May 1999.

Robina Health Care Complex

The Gold Coast Hospital Functional Plan (p 58) endorsed the establishment of a health facility at Robina. A Supplementary Report to the Gold Coast Hospital Functional Report on the Robina Health Care Complex (Shane Solomon & Associates Dec. 1996) was commissioned .

The supplementary report provided a service mix for the Robina Hospital comprising a 30 bed inpatient rehabilitation unit, day hospital and community support; 59 bed extended care mental health ward; 24 hour medical clinic providing outpatient services; 2 day surgery theatres and 1 procedure room; chemotherapy and renal dialysis services; 12 bed palliative care unit; pharmacy, pathology and radiology services. Robina Hospital was a initiative of the previous government. Queensland Health and Sisters of Charity are committed to making Robina work effectively.

The Supplementary Report also recommended a model of private sector financing whereby a private company would finance, build and operate a facility from which Queensland Health would purchase public services. The role of Robina has been expanded to include overnight acute services. The need to expand services was the consequence of advice from consultants that the original profile would not attract private providers.

Tweed Heads Hospital

Over 35% of Tweed Heads Hospital's inpatient activity are Gold Coast residents. In May 1997, the NSW Health Minister announced a $25 million redevelopment plan for the hospital expected to be completed in 2000/2001. Queensland Health has a cooperative relationship with Northern Rivers Health Service.

Regional Health Service Planning

Regional planning for the Brisbane South Region (that included Logan Hospital) was carried out in isolation of the planning for the South Coast Region. The roles of the Gold Coast Hospital and public services to be purchased from the Robina Private Hospital were planned in the context of the health care needs of residents of the South Coast Region. The Region included an area that is now part of Logan-Beaudesert District.

ACTIONS TAKEN/ REQUIRED: (If any)

For information

QUEENSLAND HEALTH

5.0002676

RECEIVED

Submission To:

☑ **Director-General** DG'S OFFICE

☐ **General Manager (Health Services)**

☐ **Deputy Director-General (Planning & Systems)**

Date: 26 July 1999

Prepared by: James Thiedeman, Principal Project Officer, Collocation & Development Projects, Procurement Strategy Unit — **Contact No:** 07 323 40352

Cleared by: Martin Jarman, Manager, Collocation & Development Projects, Procurement Strategy Unit 26/7 — **Contact No:** 07 322 76168

Deadline: 26 July 1999 — **File Reference:** 1230-0173-003

Subject: **1999/2000 Noosa and Robina Hospital Budget Allocations**

APPROVED/ ~~NOT APPROVED~~

COMMENTS

Signature:

Date: 16.8.99

PURPOSE:

To seek approval to release surplus funds (for 1999/2000) allocated to the Noosa and Robina Hospital for other Departmental priorities.

BACKGROUND:

- The Deputy Director-General (Planning and Systems) advised the Collocation and Development Projects Unit the Phase 6 Hospital Funding Model (HFM) should be used to determine the operating budget for the Noosa and Robina Hospitals when they begin operating in 1999/2000.
- The Phase 6 HFM has now been finalised and the full year budgets (including the capital recovery component and the discounts offered by the private operators) for the Noosa and Robina Hospitals are $12.030M and $22.700M respectively.
- The Noosa Hospital will begin operating on 1 September 1999. Accordingly the 1999/2000 full year budget will be adjusted pro rata to $9.987M (as per the conditions in the Service Agreement).
- The Sisters of Charity (SoC) have advised the Robina Hospital will be commissioned in April 2000. Accordingly the 1999/2000 full year budget will be adjusted pro rata to $5.659M (as per the conditions in the Service Agreement).
- In Submission SB008347 dated 28 June 1999 (refer to Attachment 1) the Collocation and Development Projects Unit advised the Deputy Director-General (Planning and Systems) an allocation of approximately $17M would be required in 1999/2000 for the Noosa and Robina Hospitals. This includes a pro rata allocation of $4.6M in recurrent annual funding to be transferred from the Wolston Park Hospital to the Robina Hospital (i.e. $1.147M based on an April 2000 commissioning date).
- $19.9M in new funding has been allocated in Queensland Health's 1999/2000 budget for the Noosa and Robina Hospitals.

ISSUES

Noosa Hospital

- Additional resources will be required to cover the costs of a number of initiatives outside the scope of the Noosa Hospital Service Agreement (these initiatives are outlined in the attached Submission).

Robina Hospital

- As Queensland Health and the SoC have taken a decision not to provide emergency medical services initially when the Robina Hospital opens in April 2000, an appropriate reduction will need to be made to the operating budget for the first year. The quantum of this adjustment is yet to be negotiated.
- The Sisters of Charity (SoC) have advised Queensland Health that the Robina Hospital is to be commissioned in April 2000. However the SoC have indicated there may be an opportunity to commission the mental health service facilities prior to April 2000. An allowance has been made in the hospital's 1999/2000 budget to provide for this contingency.
- In addition, it is likely resources will be required to cover the cost of information systems interfacing between Robina Hospital and Gold Coast Hospital. The interfacing will be designed to maintain the integrity of Queensland Health's corporate network environment.

As approved by the Deputy Director-General (Planning and Systems) and General Manager (Health Services) in Submission SB008347 dated 28 June 1999 (refer to Attachment 1), budgets for the Noosa and Robina Hospitals will be quarantined within the Sunshine Coast and Gold Coast District Health Services' budgets to ensure the budget integrity of the two facilities is maintained. Additional funds earmarked for expenses associated with the Noosa and Robina Hospitals will be retained by the Collocation and Development Projects Unit to meet the cost of contingencies outside the scope of the negotiated Service Agreements (e.g. the purchase of a vehicle to transport patients between the Noosa, Caboolture and Nambour General Hospitals for non-urgent up and down transfers - previously endorsed by the ODG on 3 December 1998).

- Expenditure of these funds will require approval from the Manager, Collocation and Development Projects Unit following application from the respective District Health Service. Unexpended funds will be returned to the unallocated fund pool.

- Funds to be transferred from Wolston Park to the Robina Hospital include a nominal annual allocation of $0.379M for superannuation costs which will need to be appropriated from Treasury at the end of the 1999/2000 financial year. This figure will be pro rated on the basis of the Robina Hospital's commissioning date.

	1999/2000 Budget Allocation ($ million)	1999/2000 Budget Requirement ($ million)	Funds earmarked for associated expenses ($ million)	1999/2000 Surplus Funds available for reallocation ($ million)
Noosa	12.200	9.987	0.213	2.000
Robina	7.500	5.659[1,2]	TBA	2.988[1]
Total	**19.900**	**15.646**	**TBA**	**4.988**

RECOMMENDATION(S):

It is recommended:

- The Director-General approve the release of surplus funds ($4.988M) allocated to the Noosa and Robina Hospitals (for 1999/2000) for other Departmental priorities.

[1] Assumes $1.147M in funds is available from Wolston Park Hospital.

[2] As this figure includes an allocation for emergency medical services, funds will be available from within this budget for associated expenses (e.g. information systems interfacing) once an appropriate emergency medical services budget reduction has been negotiated with the SoC.

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

REQUESTED BY: **Director-General**

DATE: 26 July 1999

PREPARED BY: Colleen Conway, Senior Project Officer, Central Health Unit ext 40876

CLEARED BY: Tony Williams, A/Manager, Central Health Unit, ext 41514

SUBJECT: Mental Health Funding to Bundaberg Health Service District

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DIRECTOR- GENERAL'S COMMENTS:

(Dr) R L Stable
Director-General
/ / 1999

PURPOSE: The Director-General has requested a briefing in relation to an article published in the Newsmail, Bundaberg, dated 19 July 1999, regarding the Bundaberg Health Service District budget position.

BACKGROUND:

In February 1999, the Director-General approved the resourcing of the Bundaberg Health Service District as follows:

- $500,000 budget relief package for quality enhancement programs funded from uncommitted health promotion funds
- $200,000 for extra Orthopaedic elective surgery activity funded from uncommitted Transitional Care funds.

An annual increase in funding of over $1.3M was made to the Bundaberg Health Service District in 1998/99. Eleven (11) new mental health positions were created.

The local media has reported extensively on the issue of the District's budget and financial position.

KEY ISSUES:

Mental Health funding was not part of the rescue package announced by the Minister.

Seven of the eleven new mental health positions are filled at present. Three positions are being readvertised due to lack of response to the original advertisements.

The remaining position, a Child and Youth Psychiatrist position, a difficult position to recruit, was not advertised previously as the Bundaberg mental health team were hopeful of receiving an application from a Queensland trained Psychiatrist working in Canada. This position is also currently being advertised and arrangements have been made with the Visiting Child Psychiatrist to increase attendance until such time as the position is filled.

There was no deliberate postponement of filling of mental health positions to assist the District's budgetary position. However, unspent funds that occurred as a result of not filling the positions were utilised to assist the District meet its budget targets. The District Manager commented to that effect in the Finance and Activity Executive Summary, April 1999, "....improvement in the budget situation had been gained from vacancies in Mental Health Funds".

The Bundaberg Health Service District will receive $1.270M for mental health services for 1999/2000. The variation in funding between 1998/99 and 1999/2000 is due to two adult mental health positions being located at North Burnett. The 1.270M does not include one-off set up costs allocated in 1999/2000.

ACTIONS TAKEN/ REQUIRED:

That the Director-General note the information contained in this brief.

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

BRIEFING NOTE NO:

REQUESTED BY: **Deputy Director-General (Planning & Systems)**

DATE: 15/07/1999

PREPARED BY: Ms K Batchler, Team Leader, Health Unit (Southern Zone)
Ph: 41863

CLEARED BY: Ms C Besly, Manager, Health Unit Southern Zone
Ph: 41516

Deadline: 16/07/1999

SUBJECT: **Mater Hospitals – Issues for Discussion**
Director-General Meeting with Mater Chief Executive Officer
2.30 pm, Monday, 19/07/1999

DIRECTOR-GENERAL'S COMMENTS:

(Dr) R L Stable
Director-General
Date:

PURPOSE:

- To provide background information for a meeting at 2.30 pm, Monday, 19/07/1999 between the Director-General and Mr Mark Avery, Chief Executive Office, Mater Misericordiae Hospitals.

BACKGROUND:

- The meeting on 19 July 1999 between the Director-General and Mr Mark Avery, Chief Executive Officer, Mater Misericordiae Hospitals follows a presentation by the Deputy Director-General (Planning & Systems) to the Mater Health Services Governing Board.

- The aim of the presentation by DDG(PS) was to directly communicate to the Board the following:
  - Queensland Health's investment framework
  - The implications for the Mater Hospitals
  - The necessity for setting the Queensland Health – Mater relationship on a proper contractual footing to provide certainty for both sides.

- The future of the Mater Adults was the most contentious issue raised in the presentation. The impact on the Mater of the redevelopment and reconfiguration of Queensland Health hospitals was discussed:

- Mr Pitt proposed that:
  - Queensland Health and the Mater should begin an immediate dialogue focussed on the role of the Mater, balancing the viability of the Mater with the long-term strategic objectives of the Queensland Health Redevelopment Program.
  - The Board should authorise the Chief Executive Officer to actively participate in resolution of this issue
  - The contractual issues should be resolved by mid-July 1999
  - An alternative role for the Mater Adults could be considered, with the following conditions:
    - Replacement services should not be at the expense of zonal self-sufficiency
    - Replacement services should conform to logical tertiary and quaternary planning
    - Queensland Health does not have the capacity to fund duplication of services
    - Services provided by the Mater should be geographically appropriate
    - The Mater should not compete for business which legitimately belongs to another service, in order to maintain funding.

- The Board indicated that:
  - The Mater recognises that, in order to maintain long-term viability, they may need to develop activities "off the Hill" and identify functions within the Southern Zone and other Zones in which they could be involved.
  - The continuation of tertiary service provision by the Mater Children's and the Mater Mothers' Hospitals require viable related services to be maintained
  - The Mater needs an indication from Queensland Health about what is mutually acceptable.

KEY ISSUES:

1. MATER-QUEENSLAND HEALTH CONTRACTUAL ISSUES

Status:

- Queensland Health and the Mater successfully negotiated a formal Service Agreement for the first time in 1998/99. This discharges key accountability issues flagged by the Auditor-General since 1993/94.
- Mater has been advised that Queensland Health intends to secure a long-term agreement (up to 10 years) from 1 July 2000. The terms and conditions of this agreement will be negotiated during 1999/2000.
- The form of the 1999/2000 Agreement has been negotiated. Budget and activity issues have yet to be finally negotiated and may pose an impediment to expedient sign-off by the Mater.
- The length of the long-term contract with the Mater may be subject to the outcome of Queensland Health's request for a specific term exemption from the open competition required by the State Purchasing Policy.

Suggested Approach:

- That the Mater's co-operation and collaboration in achieving a 1998/98 signed service agreement be acknowledged.
- That the Mater be encouraged to expedite execution of the 1999/2000 Agreement.
- That the Mater be assured that the achievement of a long-term contract will be in the interests of both Mater Misericordiae Hospitals and Queensland Health and that complex issues will be fully explored in the negotiation process during 1999/2000.
- That the Mater be advised that Queensland Health is subject to Government purchasing and financial administration policies in its dealings with private service providers and that Queensland Health is required to construct the future relationship with the Mater within this context.

2. FUTURE PLANNING FOR THE ROLE OF THE MATER

Status: Planning

- This issue is a key concern for both the Mater and Queensland Health. It is contingent on the outcomes of a number of planning/service development initiatives:
  - Hospital redevelopments, especially Redland, Logan, Princess Alexandra, Royal Children's, Royal Women's
  - Business Cases
  - Southern Zone Flow Reversals Project
  - Statewide Cancer Services Plan – in development by Procurement Strategy Unit

- Because the Mater Hospitals are not officially "Business Case" hospitals, the capacity purchased from them has not been subject to the Business Case planning process. This leads to inconsistency in the approach to the Mater Hospitals. "Mock" Business Cases have been developed for the Mater Hospitals, but are incomplete because the final position in 2005/06 is not developed and therefore cannot be factored into the equation.

- The Mater has been assessing these impacts and its future direction over the past year. The Mater Clinical Services Plan will be presented to the Mater Board in late July/August.

- To assist in this planning process, the Mater requested an indication of the Queensland Health position but this has not been communicated as it was felt to be contingent on the Queensland Health planning processes listed above.

- The clearest Queensland Health indications communicated to the Mater have been:

- the Deputy Director-General proposed that the Mater Adults Hospital will experience significant impacts from the transfer of activity to Redland and Logan Hospitals and that a collaborative planing process needs to be instituted to address this.
- the Southern Zone Flow Reversal Project has advised that activity will be transferred to the developing hospitals at Redland and Logan. The negotiation of the volume and pace of this transfer is the key task of the Flow Reversal Project. Unfortunately, the Mater has not fully participated in this process

- Resolution of this issue is urgent, because:
  - A negotiated, efficient and appropriate role for the Mater is integral to the success of the Southern Zone redevelopments
  - Both Queensland Health and the Mater require clarity about the Mater role to ensure efficient and effective service planning and delivery
  - Viability of the Mater Mothers' Hospital and the Mater Children's Hospitals, which have a key role in the provision of tertiary and some quaternary services for women and children rests in part on support services provided by the Mater Adults. The consequences of Mater Hospitals ceasing, or substantially changing services provision in these areas has not been adequately addressed by Queensland Health.

- Sufficient progress has been made on key planning initiatives, such as the Flows Reversals Project, to inform a considered Queensland Health position on the future role of the Mater Hospitals.

- The Health Unit (Southern Zone) is able to manage a dedicated project from 16 August to mid-November 1999 to produce a position delineating the long-term (5 – 10 year) profile of services to be purchased from the Mater Hospitals.

Status: Communication/Negotiation

- Many Queensland Health stakeholders have been involved in conversations and negotiations with Mater representatives on a range of issues. This has resulted in an inconsistent approach by Queensland Health, confusion and frustration on the part of the Mater, and has allowed the Mater to "play both ends against the middle".

- For example, Mater representatives assert that they cannot participate in the Southern Zone Flows Reversal Project because:
  - they have already agreed an activity flows figure with senior Queensland Health officers
  - a submission on flows forwarded to Performance Management Branch has not been formally responded to. This document was referred for consideration by the Flows Reversal Project.

- The adjusted structure of Health Services Division and the appointment of a Zonal Manager will provide a more identifiable point of negotiation on all issues.

Suggested Approach:

That the Director-General:

- endorse the offer by the Governing Board, through Mr Avery to participate fully in resolution of these issues
- endorse the Health Unit (Southern Zone) project and advise the Mater of this project
- inform the Mater of the changes to the structure of Health Services Division and emphasise that the Zonal Manager will be the first point of accountability and negotiation for Mater Senior Executives

- emphasise that Mater collaboration in the key planning processes is essential if considered and achievable outcomes are to be achieved for hospital service provision in the Southern Zone
- advise that, in particular, the Mater should involve itself fully in the weekly Flows Reversal Project meetings, as the recommendations of this project will be considered carefully by the Office of the Director-General.

3. 1999/2000 BUDGET/ACTIVITY ISSUES

Status: An indicative budget and activity schedule was presented to Mr David Kelly on 07/07/1999 by Health Unit (Southern Zone). No further discussions have taken place.

Activity. Initial activity targets were inconsistent with the requirements for activity transfers (and consequent budget adjustments) from the Mater in 1999/2000 and revised activity targets were developed. These are subject to the outcomes of the Southern Zone Flow Reversals Project.

Budget.

- Mater protests the deduction of $2M for flow reversals on the following grounds:
  - The flow estimates on which the $2M budget adjustment is based were not formally negotiated with the Mater
  - The flow estimates are not final.
  - The flow estimates vary from those informally agreed with Queensland Health
  - The volume of flows to be transferred is unrealistic, eg, the Mater asserts that the flow of obstetric patients to Redland Hospital is slower than expected.
- The Mater is unaware that an additional adjustment may be required for activity which flows to Logan Hospital in 1999/2000 (estimated to be approximately $0.68M).
- The Mater also objects to the drawback in the 1998/99 financial year of Elective Surgery Funds, pending finalisation of the 98/99 actual activity.

Suggested Approach:

That the Director-General advises the Mater that:

- The indicative activity targets are subject to ongoing negotiation, pending the outcomes of the Southern Zone Flow Reversal Project.
- Final recommendations of the Flow Reversal Project will consider service viability in the relinquishing hospitals.
- The activity targets will reflect the $2M reduction for flow reversals.
- The flow transfer process will be closely monitored by Health Services Division to ensure that the flows are facilitated by both relinquishing and receiving hospitals.
- The $2M flow deduction will stand, unless impediments beyond the Mater's control prevent the transfer of activity.

QUEENSLAND HEALTH

MEMORANDUM

To: Director-General

Copies to: Manager, Finance Unit
District Manager, Gold Coast Health Service District

From: Zonal Manager, Southern Zone

Contact No: 07 323 40683
Fax No: 07 323 40790

Subject: **Funding for the Robina Hospital**

File Ref: 1230-0173-002

I write in relation to the 1999/2000 budget allocation for the Robina Hospital.

Following discussions with Finance Unit, Corporate Office it has been determined that the budget allocation for the Robina Hospital will appear as a separate line item in the Gold Coast Health Service District's 1999/2000 budget.

Funds will be rolled out to the District on a monthly basis following District approval of invoices received from the St Vincent's Hospital and Health Service - Robina.

Please do not hesitate to contact Mr James Thiedeman, Principal Project Officer, Southern Zone Management Unit on 07 3234 0988 if you have any queries in relation to this matter.

Dr Steve Buckland
Zonal Manager
Southern Zone
/ /1999

QUEENSLAND HEALTH

A BRIEFING TO THE DIRECTOR-GENERAL

DG 01
File

BRIEFING NOTE NO:

REQUESTED BY: Director-General

DATE: 7 June 1999

PREPARED BY: Martin Jarman, Manager Collocation & Development Projects 7/6/99
Contact No. 323 76861

CLEARED BY: Glenn Cuffe, Manager Procurement Strategy Unit
Contact No. 322 52361
Ross Lee 7/7 7/7/99

SUBJECT: 24 - Hour Medical Service - Robina

DIRECTOR-GENERAL'S COMMENTS:

In reference to letter from
Mr Spring, agree that the service
be considered further

13.7.99

(Dr) R L Stable
Director-General
15 / 7 / 1999

PURPOSE:

To advise the Director - General of the current position in relation to the development of a twenty-four hour medical service at St Vincent's Hospital Robina.

BACKGROUND:

- Queensland Health and Sisters of Charity (SOC) representatives have been pursuing the development of an emergency medical service to be delivered from the Robina Hospital following its commencement in March / April 2000.

- There has been considerable comment about the need for an emergency medical service at Robina with specialists at the Gold Coast Hospital Accident and Emergency Department being critical about the various service models proposed.

- The Gold Coast Hospital specialists and more recently the Gold Coast Division of General Practice in correspondence to the Minister for Health dated 2 June 1999 commented that if an Accident and Emergency Service is to be developed at the Robina Hospital it should be one of high quality.

- The Request for proposal document issued by Queensland Health suggested there should be a 24 hour Medical Service on site utilising the resources of local General Practitioners. The document also stated it was envisaged a level 2 Emergency Service would be available to cope with minor ambulatory injuries and ailments with limited stabilisation capacity.

- The Gold Coast Hospital specialists have previously stated that if the Robina service is to be developed it should be staffed with an emergency specialist and the hospital should be capable of providing the critical care services required for seriously injured or ill patients.

KEY ISSUES:

- The attached correspondence from the Sisters of Charity reflects the difficulty and uncertainty surrounding this matter.

- The suggestion that this matter be put on hold pending further discussion and analysis is supported. With the area around the hospital still largely undeveloped it may be prudent to wait for a period of time to better establish the needs of the surrounding community.

- Verbal advice from our legal advisers on the Robina Services Agreement indicates that there should not be any problem in a reassessment of the need for emergency services on the hospital campus provided both Queensland Health and Sisters of Charity are in agreement with the position to be adopted and that position is properly documented.

HOLY SPIRIT NORTHSIDE

Project Office
259 Wickham Terrace
Brisbane QLD 4000

Telephone: (07) 3834 6224
Facsimile: (07) 3834 6122

Facsimile

To: MARTIN JARMAN **From:** Dr Maureen Corrigan

Re: LETTER TO ROSS PITT **Phone:**

Date: 7/7/99 **No of pages:** 3

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MARTIN

PLS FIND A COPY OF LETTER TO ROSS PITT ATTACHED. I HAVE POSTED LETTER TODAY. I HAVE DISCUSSED WITH STUART & HE WAS HAPPY FOR ME TO SIGN FOR HIM

REGARDS

Maureen.

Sisters of Charity Health Service

NATIONAL OFFICE

7 July 1999

QUEENSLAND
St. Vincent's Hospital, Toowoomba
Mount [illegible] Community Services, Brisbane
[illegible] Oliver Hospital,
[illegible] Nursing Home,
[illegible] Retirement Centre and Lynch House

NEW SOUTH WALES

DARLINGHURST
St Vincent's Hospital, Sydney
St Vincent's Private Hospital, Sydney
Sacred Heart Hospice
St Vincent's Clinic

ALBURY
St Joseph's Hospital
St Joseph's Village

VICTORIA
St Vincent's Hospital, Melbourne
St Vincent's Private Hospital, Melbourne
Caroline Chisholm Hospice
Caritas Christi Order of Malta
Hospice House Care Service
Penguin Homes

TAS[illegible]
St Vi[illegible]pital, Launceston

RESEARCH
Garvan Institute of Medical Research, Sydney
Victor Chang Cardiac Research Institute, Sydney
St Vincent's Institute of Medical Research, Melbourne

WORKING TOGETHER

Mr Ross Pitt
Deputy Director General, Planning Services
Queensland Health Department
GPO Box 48
BRISBANE QLD 4001

Dear Ross

I write in relation to the St Vincent's Hospital and Health Service Robina project and the issue of an Emergency Service at the site. There is still some concern amongst several parties as to how a 24 hour primary medical service might operate at Robina. I think it would be sensible to delay further work on this until we have an opportunity to discuss matters more fully with Queensland Health.

The project brief issued by Queensland Health asked for the provision of a level 2 emergency service. In our submission we responded by proposing two alternatives, one being a salaried 16 hour a day service, the other to facilitate a service provided on a contract basis by local practitioners.

This service has been the subject of some controversy and after considerable discussion with Queensland Health and other interested parties, it was recognised that further options had to be canvassed to ensure that, as well as meeting our contractual obligation, the services that we provide at Robina meet the community needs and complement existing services.

Representatives from the Sisters of Charity Health Service have held some discussions with the local Division of General Practice on primary care service provision over the last few months. The division was supportive but asked us to organise matters directly with General Practitioners.

continued....2

We recognise that there still may be some opposition to a 24 hour medical service on site at Robina. Also, the area is not yet fully developed and community expectations may change as the area grows. I think a sensible plan is to delay progress on this issue and rethink matters together with Queensland Health, whilst at the same time monitoring the need to provide such services.

Yours sincerely

FOR

Stuart Spring
National Chief Executive Officer
Sisters of Charity Health Service

QUEENSLAND HEALTH

A BRIEFING TO THE DEPUTY DIRECTOR-GENERAL (PLANNING AND SYSTEMS)

BRIEFING NOTE NO:

REQUESTED BY:

DATE: 17 June 1999

PREPARED BY: Martin Jarman, Manager, Collocation & Development Projects
Contact: (07) 3227 6861

17/6/99

CLEARED BY: Judith Robson, Director, Performance Management Branch
Contact: (07) 3234 0825

DEADLINE:

SUBJECT: **24-HOUR MEDICAL SERVICE - ROBINA**

DEPUTY DIRECTOR- GENERAL'S (PLANNING AND SYSTEM) COMMENTS:

DG
Why don't we say to DC

don't bother

DDGPS
Discussed with DG. The following needs to be provided before any further action is taken:- letter of instruction/clarification
- legal advice on the contract
- a briefing note for DG to discuss with the Minister.

DDG PS
15.6.99

Ross Pitt (Mr)
Deputy Director-General (Planning and Systems)
19/6/1999

PURPOSE:

To inform the Deputy Director-General (Planning and Systems) of the current position in relation to the development of a 24-hour medical service at St Vincent's Hospital, Robina.

BACKGROUND:

- Queensland Health and Sisters of Charity (SoC) representatives met with Gold Coast General Practitioners on 30 March 1999 to discuss the proposed establishment of a 24-hour medical service at the Robina Hospital.
- At that meeting the GPs decided to create a small representative group to meet with the SoC to discuss in greater detail the establishment of the service and the potential involvement of local GPs.
- After several attempts a meeting was held on 10 June 1999 which resulted in the GPs agreeing to consider their involvement in the establishment of the proposed service.
- The following day SoC management was advised by the GPs that they did not wish to be come involved in delivering services from the Robina Hospital.
- SoC representatives advised that reasons given by the GPs for the non-participation related to the impersonal approach that large medical centres create between doctor and patient and that delivering medical services from a hospital campus may create indemnity insurance issues for them. The latter issue was not explained in any detail.
- The GPs have been informed by SoC that other options will be considered for developing an on campus 24-hour medical centre.

KEY ISSUES:

- SoC management has advised that it is looking at two options for developing a 24-hour medical centre on the Robina Hospital Campus.
  - (i) In the first instance they intend to advertise for expressions of interest from GP practices willing to relocate to the hospital campus or to establish a medical service on site.
  - (ii) If the first approach does not produce a viable outcome the SoC will examine the feasibility of establishing their own Emergency Medical Centre on site.
- SoC management has been advised that once a preferred model has been adopted discussions will need to take place concerning adjustments to the agreed Accident and Emergency budget.

Atherton Draft Report

Prepared by: Organisational Improvement Unit

Executive Summary

Staff from the Organisational Improvement Unit were requested by the Director-General to undertake a review of the services of the Atherton Hospital with the view to ascertaining if there was the opportunity to improve clinical services particularly in the context of addressing their efficiency.

In particular, the review team was requested to examine the high level of outpatient/primary care activity, to consult with community leaders, to identify opportunities for improvement and efficiency gain, and to make recommendations to the General Manager, Health Services on changes to be implemented within the health service.

The review team visited the District from 6 to 10 September 1999, and carried out a series of interviews of hospital staff and community leaders. Information about the Service was collected at the time of the visit and from sources within Corporate Office.

The following report outlines the recommendations formulated by the review team.

In summary, the District provides level 2/3 services to the community of Atherton and surrounding areas. The level of acuity of services over the last 2 financial years has remained relatively static.

There was no one major area of inefficiency identified that would enable significant savings to be realised. However, there are a large number of areas where smaller savings, efficiencies and improvements could be made that would contribute substantially to the achievement of budget integrity.

In particular, these areas are:

- provision of an organisational structure that enables single point accountability for the day to day management of the hospital
- education and involvement of staff and the community in the planning for the future of the health services
- introduction of evidence based, multidisciplinary clinical pathways and variance analysis
- reduction in admissions and length of stay through clinical process control and discharge planning
- reduction in utilisation of radiology services
- improved co-ordination of community health services
- scheduling of theatre and endoscopy services and the better utilisation of staff to perform and assist with these procedures
- the consolidation of sterilising and laundry services to one service for the District
- the implementation of rostering arrangements that reduce overtime costs and improve employee's quality of life
- review of positions within the nursing structure to provide the appropriate number of positions for the level of responsibility
- the multiskilling of operational staff to enable better utilisation of support services
- reduction in the cost of support services

- a reduction in the use of consumables used in clinical areas
- implementation of the Hospital Reporting System
- implementation of devolved cost centre management
- improvement in training and development opportunities for staff
- strengthening of agreements and relationships between the hospital and General Practitioners
- encouragement of the patients in the use of community General Practitioners.

1.0 Introduction

This report provides recommendations for the improvement of how services are provided by the Atherton Hospital. When implemented, these recommendations should assist Atherton Hospital in achieving budget integrity and improved service delivery to the Tablelands community.

2.0 Sources of Information

The information contained in this report was obtained from personal interview of staff mainly in the Atherton Hospital, and from the examination of reports and information available in the District and Corporate Office. Staff from each of the services in the hospital and Community Health Centre were interviewed. In addition, consultation with community members was also undertaken. Analysis and cross-reference of responses matched with available data formed the basis for the recommendations of this report.

3.0 Scope of the Report

This report focuses mainly on the Atherton Hospital. Other services within the District are included in the report where it could be identified that their current function is impacting on Atherton Hospital or where efficiencies due to shared resources were identified.

4.0 Organisational Structure

A recent review of the functions of the Tablelands Health District Executive has led to the realignment of the reporting relationships and decision making process (Attachment 1). This realignment is intended to improve the day to day management of each of the facilities through the joint decision making of a Facility Executive. Discussions with the executive members of Atherton Hospital indicated that decision making continues to occur on a discipline by discipline basis. It appears that this realignment has not improved decision-making processes. Single point accountability is required to ensure day to day management decision making occurs.

1. **Appoint an Executive Officer at the Atherton Hospital to manage day to day operations of the facility. This role should be incorporated into the role of one of the current executive positions. Additional support may be necessary for an executive member to carry out this role.**

5.0 Organisational Culture

Many staff indicated that they feel disempowered and not included by the Hospital Executive in decision-making processes. They state that this has resulted in low morale amongst many of the staff. Recently, workshops involving senior clinical and executive staff were held to develop the District Operational Plan for the current year (Attachment 2). Minimal progress towards the achievement of the plan has occurred.

There appears to be a perception amongst staff that the hospital has been and continues to be under resourced, even with the extra budgetary allocation

2. **Commence two way consultative communication between the staff and the executive by use of monthly open staff forums, frequent newsletters, frequent executive visits to wards and staff work areas, and the establishment of collaborative decision making and consultative committees. Communicate and demonstrate to staff the values and goals of the organisation using the above strategies.**
3. **Progress the actions of the District Operational Plan through the involvement of the facility staff.**

6.0 Consultation with Community Leaders

The President of the Atherton Chamber of Commerce indicated that the community is generally very satisfied with the hospital services. The major issues of concern for the Chamber were maintenance of current hospital services, and building and asset maintenance - in particular the condition of the morgue and the external walls of the hospital.

Communication between the hospital executive and the Atherton Community occurs mostly on an ad hoc basis. Good news stories are provided to the local press as a mechanism for informing the community and improving the community's opinion of the service. A more pro-active strategy for managing the print media and for communicating to the community should be implemented. The District Executive has been provided with a copy of the Toowoomba District Health Service Media Plan as a guide to improving their management of community communications and consultation.

4. **Provide information to the District Health Council to emphasise the need to provide appropriate quality services, of a critical mass through the appointment of skilled staff.**
5. **Ensure ongoing maintenance of the facility is provided.**
6. **Implement an active media strategy that informs the community of the positive developments at the Atherton Hospital and the future global and community issues that will effect health services.**

7.0 Clinical Services

The Atherton Hospital provides level 2/3 medical, surgical, and midwifery services and a 5 bed high dependency unit. Services are provided by two visiting medical officers, full time senior medical officers and principal house officers. There are 65 beds available in the hospital – 26 surgical, 24 medical, 10 maternity and 5 high dependency.

Two theatres are utilised by the hospital and are situated in separate wings of the main building. The main theatre is situated in the surgical ward and provides all the surgical and sterilising services of the hospital. The other theatre is situated outside the Emergency Department and is used for endoscopy services.

The Community Health Centre is situated in the grounds of the hospital. The Centre provides physiotherapy, occupational therapy, community nursing services, social work services, mental health services, dietetics, and child health services. The Centre has an expansive floor area and has been developed to enable the introduction of GP services should this become possible in the future. Dental services are situated in a separate building within the hospital grounds.

Inpatient services are provided to both public and private patients. The percentage of private patients treated is 28.2%. The average acute case weight for 1998/99 financial year was 0.632. This was an increase of 0.032 in comparison to the previous financial year. The average case weight of the SNAP is 0.823 and has increased by 0.099 over a twelve month period. This data was collected and analysed using the casemix reporter at Atherton Hospital. This acute case weight is 0.109 less than the predicted acute case weight indicated in the Notional 10-Year Plan – 1996 –2006 – Activity and Costs (Attachment 3).

Clinical pathways are restricted to surgical procedures and have been developed through multidisciplinary consultation. They have been developed based on clinician preference rather than evidence and are utilised by the nursing staff only. No mechanism for the collection of variance has been implemented.

7. **Provide training to clinical staff on the development and use of evidence based, multidisciplinary clinical pathways and variance monitoring.**
8. **Involve key clinical staff in inter-district clinical communication mechanisms to enable them to learn from districts that have already developed clinical pathways eg Statewide Clinical Innovations Network.**
9. **Provide clinicians with access to the clinical pathway database on QHiN and examples of pathways developed at other Districts.**
10. **Provide access to computer resources for key clinical staff to enable the localisation/development of clinical pathways.**

7.1 Bed Utilisation and Length of Stay

Atherton Hospital provides pre-admission clinic services. In 1998/99 an average of 42 patients were seen in the pre-admission clinic per month with an average of 142 procedures provided by the hospital. The staff report that discharge planning is not done well, although meetings to discuss discharge issues occur on a regular basis. Length of stay for 8 out of 10 top DRG's by weighted separation is greater than the state average. Limited detail of the process for discharge planning is outlined on clinical pathways and nursing care plans.

11. **Increase the utilisation of the pre-admission clinic to ensure that all patients that are suitable can be admitted on the day of surgery and that appropriate cases are treated as day only.**
12. **Increase the focus on discharge planning through the development and implementation of clinical pathways.**
13. **Encourage active participation and decision making by clinical staff at discharge planning meetings.**

7.2 Medical Ward and High Dependency Unit

The High Dependency Unit is situated within the 24 bed Medical Ward. This Unit provides a service to the Atherton Community that reduces the need for transfer of most cardiac and medical conditions. Selection for admission is based on clinical preference. There was no evidence of documented protocols for the admission, discharge or transfer of patients.

The Unit is positioned such that full utilisation of nursing staff during low levels of occupancy is difficult, as the Unit cannot be viewed from the main desk of the Medical Ward. Therefore sharing of staff between HDU and the Medical Ward is restricted.

General medical patients are admitted to the medical ward. The length of stay of the top 5 DRG's by weighted separation exceeds the state average by a range of 0.57 to 7.1 days based on 1998/99 data.

14. Implement an admission and discharge protocol for the HDU.
15. Implement clinical pathways for the top 5 DRG's in the medical ward.
16. Move the HDU to the four bed cubicle opposite the Medical Ward main desk. Reduce the number of beds available in the HDU to three to ensure full utilisation.

7.2.1 Exercise Stress Testing

There is one Exercise Stress Test session a week. This is attended by the Physician VMO, a RN and an EN and is carried out in a room in the Medical Ward. Two nursing staff are provided to decrease the time spent at the clinic by the VMO.

17. Reduce the number of nursing staff involved in Exercise Stress Testing to one EN and ensure that appropriate training is provided to enable competent running of the clinic.
18. Utilise the PHO position to attend Stress Testing Clinics instead of the VMO. Same day reporting to the VMO should be maintained. This is in line with staffing arrangements of other Exercise Stress Testing clinics in other Queensland Health facilities.

7.3 Surgical Ward and Services

Surgery performed at the Atherton Hospital is general surgery. According to reports provided by the Surgical Access Team, 62% of elective surgery is provided to private patients. There are no long waiting times in any surgical category and last year's activity exceeded the Service Agreement target by 80 weighted separations.

The surgical ward has 26 beds, a dialysis unit funded and run by Cairns Health Service District and a day surgery recovery unit that is used for chemotherapy treatment and endoscopy recovery. Day surgery cases are recovered in the ward beds. The rate of day only procedures is 39% for public patients and 46% for private patients. Overall this equates to 41%. This includes all patients admitted as day only.

The oncology service provided at the Atherton Hospital is a continuation of treatment that has been prescribed and initiated at Townsville or Cairns Hospitals. There is one cytotoxic session a week in the hospital, conducted by an SMO.

7.3.1 Theatre Utilisation and Waiting Lists

The main theatre generally has two elective surgery lists on Monday, one on Tuesday and one on Friday. Other lists are booked based on urgent and emergency needs. There are no regular theatre lists on Wednesday and Thursday and review of the last 6 months of theatre lists shows a low theatre utilisation rate on these two days. Theatre utilisation statistics are not available. On average, for the last financial year, there have been 5 major and 13 minor procedures in this theatre each week.

The one main theatre is staffed during the day shift 7 days per week. There are 3 to 5 nursing staff rostered each week day and one on each day shift on weekends. The theatre is covered by an on call registered nurse from 5pm to 7am each day. Nursing theatre staff also provide sterilising services for the hospital and undertake the cleaning of walls and floors in the theatre.

Operational services staff are provided one day per week for the cleaning of floors. In addition, two staff are provided to manage the endoscopy lists on Tuesday and Friday.

7.3.2 Endoscopy Services

There were 754 endoscopic procedures carried out at Atherton Hospital last financial year. On average 16 endoscopies are carried out each week in 3 endoscopy lists. These procedures are carried out in the operating theatre situated near the Emergency Department, with patients admitted and recovered in the Surgical Ward. Four extra nursing staff shifts per week are utilised to provide endoscopy services.

Booking to endoscopy lists occurs through the VMO's and SMO's, and GP's can book gastroscopies direct to the list without review by hospital staff. The Medical Superintendent reports that there are no waiting lists for endoscopy services and that lists are not fully utilised.

19. Utilise the staff from the main theatre for the Endoscopy Theatre
20. Use main Operating Theatre for Endoscopies. Utilise the current operating theatre staff to assist with these lists.
21. Reduce the total number of endoscopy lists to one to two per week to ensure full utilisation of these lists.
22. Cease GP access to Gastroscopy bookings. GP's to refer all patients that may require endoscopy services to SMO's or VMO's for review and booking if appropriate.
23. Continue to recover endoscopy patients in chairs in the day unit situated at the end of the Surgical Ward.
24. Cease rostering nursing staffing in the theatre on weekends. Nursing staff to be on call for the weekend.
25. Provide cleaning services for the theatre from the operational staff.

7.4 Maternity Services

The Maternity ward is situated some distance from the other wards in the hospital. It has 10 beds and an average daily occupancy of 3 patients. Due to the isolated position of the ward and the low occupancy, efficiency in terms of nursing resource use is not achievable.

The length of stay in the Maternity Ward only slightly exceeds the State average. Outreach maternity services are not provided in the District. The nursing staff of the Unit are very keen to commence an outreach service for maternity, medical and surgical patients as a mechanism for reducing length of stay and preventing admissions. This would also increase current nursing staff utilisation. An outreach service was provided by Atherton Hospital for general medical and surgical patients but was ceased last year when Commonwealth funding for the service was discontinued. The rescheduling of maternity ward clinic times would need to occur to provide time for outreach services.

There is an excellent range of antenatal services provided by the Maternity Ward. There appears to be some overlap and lack of co-ordination between the Midwife Antenatal Clinic and the Medical Antenatal Clinic. Information provided by the medical and nursing staff indicates considerable replication of services in this area. The opportunity for GP shared care is not generally utilised.

26. Move the Maternity Ward beds closer to main Hospital.
27. Assist the Maternity Ward staff to develop a business case for the delivery of outreach services and the introduction of an Early Discharge Program.
28. Reschedule maternity clinic times to allow for outreach services.
29. Examine work practices related to medical and nursing clinics provided in the Maternity service and remove areas of duplication.
30. Develop strategies to increase the GP shared care rate to 90%.

7.5 Outpatient Services and Emergency Department

A comprehensive OPD/GP service has existed at Atherton Hospital for some time. There are no bulk billing GP services in the town and therefore the hospital GP service has grown based on community demand. Over the last 2 years the Medical Superintendent reports that the number of scheduled OPD/GP sessions provided have been reduced. Medical and nursing staff encourage patients seen at these sessions to visit community GP's rather than utilise the hospital service. These sessions have been replaced by more critical primary care services such as cardiac, diabetes and trauma patients.

Waiting time data is not collected in the Emergency Department. Staff state that there are significantly fewer patients waiting long periods now than 5 years ago, due to the rostering of a doctor for day time duties in the Department. They claim there are no long waits for Category 1-3, with category 4 and 5 mostly receiving treatment within 2 hours.

There are no admission protocol established in the Emergency Department. Staff believe that this leads to inappropriate admissions to the hospital. In addition, there

are no protocols for the after hours management of common non-urgent primary care conditions, to prevent the call in of doctors after hours.

31.Develop admission criteria for the Emergency Department to reduce inappropriate admissions.
32. Develop nursing management protocol for the management of common non-urgent after hours primary care presentations.
33. Continue to encourage patients to utilise community GP services.

7.6 Medical Imaging

There are in total 6,000 medical imaging procedures carried out in Atherton Hospital each year. A full time radiographer is employed to carry out all radiological procedures. An office of Cairns Diagnostic Imaging (CDI) situated in Atherton reports films.

The Radiographer reports that approximately 40% of in-hours x rays produced by the Atherton Medical Imaging Department are ordered and self reported by the local GP's. Medicare guidelines stipulate that self-reporting can be carried out by the ordering doctor in the event that there is no private medical imaging service available within 30 km of the doctor's practice. However (CDI) provides a service during business hours in Atherton, with tele-radiology links to it's main office in Cairns. There is a 1 hour reporting time for urgent requests, with all other reports available within 24 hours. A number of the GP's do not use CDI.
Out of hours requests to the Atherton Hospital are mostly public. It was noted during the week of the review that some out of hour's radiology was non-urgent and could have been held over until normal working hours without effecting patient outcomes.

The radiographer in Atherton and Mareeba are both on call for urgent radiology requests. This costs approximately $2,800 per year for each radiographer in on call entitlements. In addition, the Radiographer in Atherton receives approximately $21,000 per year in overtime. The Radiographer in Mareeba receives around $11,000 per year in overtime payments.

The rostering of one radiographer for the District instead of two would reduce on call costs by only $2,800. This strategy in conjunction with the development of a protocol that differentiates between urgent and non-urgent requests would significantly reduce overtime payments. In addition, the medical superintendent should monitor the clinical appropriateness of all out of hour's radiology services to ensure that unnecessary overtime is not incurred.

34.Implement an after hour's radiology roster for the radiographers at Atherton and Mareeba - one radiographer to cover both sites for after hours call in.
35. Develop a protocol for the differentiation of urgent and non-urgent radiology requests to reduce the amount of after hour's call in and overtime for radiographers.
36. Medical Superintendent to implement a system of review of all after hour's radiology services to ensure clinical appropriateness.

37. Cease GP access to Hospital radiology services during business hours given that CDI provides a quality specialist service. After hours GP access to Hospital radiology should be restricted to emergencies only.

7.7 Pharmacy and Drug Dispensing

Although the focus of this report is Atherton Hospital, there has been a significant increase in outpatient drugs being dispensed at Mareeba Hospital. On investigation, this appears to be caused by a change in dispensing policy at Cairns Hospital. Mareeba staff report that until recently, Mareeba patients who attended Cairns Hospital for treatment were able to have their prescription dispensed by the Cairns Hospital Pharmacy. Mareeba patients are now instructed to return to Mareeba Hospital for the dispensing of these drugs. Mareeba staff predict that this change will add $70,000 to their drug expenditure this financial year.

38.Investigate the transfer of drug costs from Cairns to Mareeba. Design an appropriate strategy for dealing with this transfer from a Zonal perspective.

7.8 Community Services

The Community Health Centre is providing a wide range of services as outlined in a previous section of this report. As demonstrated in Attachment 1 the staff of the Centre report to their discipline senior or manager. The staff of the Centre report that at the time of the refurbishment of the Community Centre plans for the improvement of community services were developed. They report that these plans were not implemented.

There was no evidence of a program of integration of hospital-community services. The development of a structure that provides single point accountability for the provision of community services would provide improved services, co-ordination and integration.

39. Provide a community health structure that has single point accountability and co-ordination of community health services to increase integration with the hospital.

8.0 Medical Workforce

The full time medical Workforce consists of:

- The Medical Superintendent
- 3 Senior Medical Officers (SMO)
- 1 Principal House Officer (PHO) or General Practitioner (GP) Registrar (Rural GP Training Program).

The Visiting Medical Officer (VMO) workforce consists of:

- 1 Medical and 1 Surgical VMO's providing a total 8 sessions per week.

There are ongoing recruitment and retention issues for the full time Medical Workforce. The Medical Superintendent indicated that there has been a turnover of 15 SMO's in the last 5 years. Recruiting staff with general and procedural skills particularly Caesarean Section and anaesthetics has been difficult. There is currently only 1 SMO who can do either of these procedures. The Medical Superintendent can provide anaesthetics.

This situation of limited procedural skills amongst the hospital doctors could be resolved by recruiting SMO's with the generalist and procedural skills required. These doctors in the first instance could be sought within Australia or could be recruited from overseas. A South African doctor with the required skills has been recruited and will commence in January 2000.

In addition, appropriate accommodation should be provided for newly recruited doctors at the commencement of their employment. Caravan accommodation was provided for the current PHO on his arrival. This is not considered appropriate.

The use of PHO's should be reduced where possible. In the long term, if the role delineation of the District is adhered to, the use of the PHO position may be unnecessary.

Four GP's are participating in the GP Indemnity Scheme. These GP's have agreed to provide obstetric and emergency services where a hospital doctor is not available. In the event of this situation occurring, the nursing staff try to find one of the doctors to assist. The GP's have resisted the introduction of an on call roster system to co-ordinate this service. Recently, an incident where no GP's were available in the District led to significant concern and media attention by the Atherton community.

8.1 Medical Rosters and Overtime Arrangements

Each Doctor at the Atherton Hospital is rostered for duty from 8 am to 6 pm. Each evening, one of these doctors is on call, and usually works through to about 11 pm. The average number of times doctors are called in from 11pm to 8am is less than one each night. Rostering of every doctor during the daytime period, without set rosters for the evening shift has resulted in increased overtime in the after hours periods.

The weekends are split up into two 24-hour on call shifts. On Saturday morning, ward rounds are attended by both the Friday night on call doctor and the Saturday on call doctor. After this, both doctors attend the Emergency Department to attend to patients who have presented for treatment. This overlap occurs again on Sunday morning. As a result, there are three doctors involved in the weekend call, with two doctors working each morning. This results in doctors generally getting one full weekend off a month.

During the week of the review, a new medical roster and clinic timetable was developed in consultation with the Medical Superintendent. This reviewed arrangement provides:

- a rostered evening shift once a week for each full time medical officer
- two doctors for morning A&E sessions Monday to Friday
- three rostered administration sessions for the Medical Superintendent per week

- two long weekends (3 day) off per month for each doctor
- fatigue recovery time, by rostering the doctor on after hours call to the following evening shift
- a "buddy" system, to provide day time cover for patients in the absence of the attending doctor who is on the late shift.

These reviewed arrangements will substantially decrease overtime payments to full time medical staff. They have been discussed with the SMO's in Atherton, who have agreed in principle. This roster adheres to the arrangements that have been developed for the provision of Senior Medical cover for Emergency Departments in Queensland.

The medical VMO provides on call services 24 hours per day at an estimated cost of more than $50 000 per year. The Surgical VMO is also on call 24 hours per day with the exception of Thursday and Friday, at an estimated cost of more $40 000. Medical and nursing staff directly initiate call-ins of the VMO's. The Surgical VMO states that he is called to treat approximately one trauma case per month.

40. Implement the agreed reviewed arrangements for medical rosters and clinic times.
41. Implement a policy of all patients being seen by hospital doctors before the VMO.
42. Continue to negotiate with the GP's involved in the Indemnity Scheme to achieve an on call rostering system.
43. Cease VMO's on call arrangements.
44. Implement a policy of Medical Staff only to call in VMO's for Public Patients

8.2 Training and Development for Medical Staff

There was no formal orientation program for new doctors. Assessment of their level of skill and induction to the work environment is undertaken on an ad hoc basis. Medical and nursing staff report that some new medical staff require significant training to bring them to the expected level of competence in their new environment.

There is no strategy developed to address the limited procedural skills of the SMO's. They are not required to use their study/conference leave to upskill in areas of procedural weakness. No links have been established with Cairns or Townsville to enable this.

46. Develop a structured orientation program for new doctors that will quickly increase their level of competence in a new environment.
47. Co-ordinate links with Cairns or Townsville to enable SMO's to use Study/Conference to improve their skills in procedural areas.
48. The Medical Superintendent and the 2 VMO's to attend Clinicians taking the Lead to improve their understanding and facilitate the implementation of process control (clinical pathways), evidence based practice and resource management.

9.0 Nursing Issues

Selected staff in all ward areas are rotated from ward to ward to enable them to maintain a broad set of skills. The nursing staff expressed mixed feelings about this system. Some are very appreciative of the opportunity to maintain their skills, while others believe that this system reduces the level of skills available in a Unit at any one time. Nursing staff indicated that a core set of four staff should be maintained in each ward or service area to ensure that effective services are maintained.

The Director of Nursing is currently managing the day to day rostering of wards. This should be delegated to the level 3 nurses.

The Nursing Policy and Procedure manuals are out of date although the District is preparing for EQUIP Accreditation.

The nursing staff stated that they had received little or no education and training for the last 4 years as there has been no budget to enable this to occur. On investigation, it was identified that there is a part time level 2 providing inservice and orientation for the nursing staff. Ward and unit based inservice and journal clubs are not being provided by the level 2 and 3 nurses.

49. The Director of Nursing to delegate rostering to the level 3 nurses.
50. Review and update the nursing policy and procedure manual. Utilise documentation from other similar Districts.
51. Develop and deliver in house training and development programs utilising currently available resources.
52. Continue to prepare for third party accreditation in accordance with the District Operational Plan.

10.0 Management Information

There is a significant amount of detailed information being constructed by the Health Information Manager. Most of this information is not utilised for management decision making.

The District has developed a non-standard method of calculating the occupancy rate of the surgical ward at Atherton Hospital. The number of beds available is altered on a day to day basis depending on the number of nursing staff available in that area. This has resulted in a false high occupancy rate in this area.

Overall information is fragmented across the site and District. Co-ordination of reporting does not occur and therefore information provided to the hospital executive is not optimal. There is no evidence of a culture of regularly monitoring of performance.

53. Bed occupancy rates to be calculated utilising total number of beds permanently opened rather than total number of beds staffed. This will provide a constant platform to gauge occupancy. Beds no longer utilised should be closed.

54. **Implement the Queensland Health Hospital Reporting System to assist in the systematic analysis of hospital's performance on a monthly basis.**
55. **Provide monthly analysis to District Executive of the information contained in the Hospital Reporting System. This needs to include identifying significant trends, potential issues and causes, in addition to projections.**
56. **Hospital Report and analysis to be a standing agenda item at the monthly exccutive meetings.**
57. **Review the patient information services organisational structure and work practices to ensure they are appropriate for the size and level of services provided by Atherton Hospital.**

11.0 Corporate Services

11.1 Finance Department

Discussions with the Finance Manager indicated that traditionally the budget preparation for the District has been historically based. Zero-based budgeting is being introduced this year and budgets are currently being calculated by the Finance Manager. This task was not complete at the time of the review, therefore, in the interim the District is using last years expenditure increased by a factor of 3% as an indicative budget. This is causing significant variance in some areas where expenditure patterns have changed over the last year.

Nursing staff and corporate services managers have been informed that they are cost centre managers. Budget information, allocation, predictions, and appropriate cost centre reports are not provided to these managers. They expressed great concern about their ability to undertake this role without appropriate training, involvement and information.

Inaccuracy of payroll information is resulting in staff being costed to incorrect cost centres. The Finance Department is responsible for correcting the payroll errors using the Payman system. They subsequently advise the payroll department of all alterations. Cost centre managers are not provided with employee specific payroll expenditure information.

58. **Develop business rules including how the budgets are to be developed and the consequences and sanctions of under and over budget position.**
59. **Develop an integrated budgetary and financial information packages for cost centre managers. See attached package example.**
60. **Budgeting process needs to start in March to ensure that an indicative budget is available in July.**
61. **Provide cost centre management training in financial budgeting, variance analysis and resource management.**
62. **Devolve cost centres to the CNC, NPC level. Ward cost centres should include nursing salaries and wages, clinical and administrative consumables, meal costs, linen costs. Devolve medical salary and drug costs to Medical Superintendent.**
63. **Finance Department to develop a zero based budget in conjunction with cost centre managers to ensure ownership and greater accuracy.**

64. **Cost centre managers to provide an explanation of expenditure variances in relation to budget. This should include strategies of how the situation will be rectified.**

11.2 Human Resource Management

Human resource management services have been centralised in the District and are provided from Mareeba Hospital. There is evidence that some of the human resource management line functions have been delegated to the Directors of Nursing, Director of Corporate Services and the Medical Superintendents in the District. A human resource reference guide based on recruitment, selection and advertising is to be developed to help support this devolution. Training for these management functions has not been provided to the appropriate staff.

The Human Resource Manager confirmed that the District Manager "signs-off" on all new positions prior to them being advertised to ensure budget integrity. However, there is no ongoing process to ensure that part time staff provide only the contracted hours. In many areas part time staff are exceeding these set hours. Increases in budget have been negotiated with the District Manager to cover these increased costs.

The Payroll Department currently does not have access to the Payroll Decision Support System, Payman or the LATTICE quick query facility. In order for this department to respond to the current and future information needs it is important that they have access to these systems.

Given that the Human Resource Department has recently moved to a new system it is an ideal opportunity to introduce regular client surveys. The staff indicated that a client survey is currently being introduced through the District Consultative Forum. Once this is implemented the survey results should be discussed at the payroll meetings to provide constructive feedback and the opportunity to develop strategies to overcome any identified difficulties.

65. **Complete the recruitment, selection and advertising line management guide and training package and provide training to all cost centre managers.**
66. **Instigate a monthly review of the number of hours worked by part time staff in comparison to contract hours. This is a standard report available through LATTICE.**
67. **Maintenance of the Payman system to be moved from the Finance Department to the Payroll Department. Uploading of data from the Payman system to FAMMIS and DSS Payroll to remain with the Fiance Department.**
68. **Payroll Department to be given access to the Payroll Decision Support System and the LATTICE quick query facility.**
69. **Develop payroll information reports to support cost centre managers.**
70. **Develop a six monthly payroll audit process and policy to ensure staff and positions are mapped to the correct cost centres.**
71. **Develop a feedback mechanism for cost centre managers to advise the Human Resource Department of any incorrect salary costing and develop and undertake regular client surveys to ensure that the Department is meeting these client's needs.**

72. Monitor the levels of overtime through the Hospital Reporting System

12.0 Support Services

12.1 Cleaning

Cleaning services at Atherton Hospital are provided by 7.49 FTE's. They clean an area of 8,800 m^2, which includes the hospital and Community Health Centre. In addition to this the hospital Doctor's residence is also cleaned when a full time doctor does not occupy it. Cleaning staff, like the majority of operational staff at Atherton Hospital, are dedicated to one task and are not multi-skilled. While the operational staff are responsible for cleaning the outside of patient lockers, nurses clean the inside and also patient beds.

During 1998/9 a total of $373,000 was expended on cleaning services. $349,000 or 97% was labour costs and $24,000 or 7% was non-labour costs. In the same period there was a total of 7.91 FTE's including an average of 1.02 FTE's in casual staff and 2.39 FTE's in part time staff.

The average cleaning cost for last financial year was $42.40 per m^2 compared with the support services performance indicator of $42.50 per m^2. While this appears appropriate, the Community Health Centre is a large, underutilised building that has recently been refurbished. The Support Services Reform team confirmed that a performance indicator of $15 to $18 per m^2 for this type of area would be appropriate. This reduces the overall indicator to approximately $40.50 per m^2. The difference between current performance and this benchmark is $1.90 per m^2. Achieving this benchmark would save $16 700 per annum.

12.2 Catering

The Catering performance indicator utilised by the Support Services Reform Project is $25 to $30 per occupied bed day for Atherton Hospital. The actual cost of meals provided for 1998/9 was $31.40 per occupied bed day.

Analysis of the meal costs reveals that the labour component represents 85% of each meal. This is high in comparison to other facilities, but the food and other costs per meal was relatively low at $1.98. To achieve the $30 benchmark would require a reduction in expenditure of $23,000, for $25 to be achieved a reduction of $103,000 would need to be achieved.

There is currently a total of 12.76 FTE in the Catering Department including an average of 1.13 FTE's in casual staff. A reduction of 0.65 of an FTE would achieve $23,000 savings, a reduction of 2.9 FTE's would be required to achieve $103,000 of savings. A reduction in the use of casual staff should be explored with a strategy of multi-skilling operational staff in other areas to allow for backfilling or busy periods in the day.

The statistics that are currently being collected are adequate to debit the cost of meals to the wards and the medical cost centre for Doctors meals. This, together with collection on data regarding the number of waste meals in the ward, would encourage ward staff to be conscious of the cost of meals and the cost of waste.

There are no meals being provided to staff apart from Doctors who received 535 for the 1998/9-year and 516 for the previous year. This appears high and equates to a cost of $7,300 for the year at $13.63 per meal. The award states that a meal or payment of $7.00 should be provided after more than 10 hours of continuous work. Medical and catering staff need to be made aware of this policy.

12.3 Porterage

Porterage services within the Atherton Hospital are provided by a total of 4.6 FTE's. This comprises of approximately 3.9 full time staff, 0.4 part time and 0.3 casual. While there has not been a dedicated cost centre for this service until recently, it is likely that the cost of this service is approximately $180,000 per annum. The cost per occupied bed day for porterage services last financial year was $10.79. The Support Services Reform performance indicator range for this service is $9 to $12 per occupied bed day.

12.4 Linen

Atherton Hospital has a laundry service that provides all of the linen services for this site. However, the equipment in the laundry department is old, labour intensive and is continually breaking down. Occupational health and safety is compromised due to the equipment's functionality. This is particularly evident with the manual lifting of dirty linen into the washer and wet linen into the spin drier. Due to the heavy nature of the task the male member of staff in this area usually performs these lifting tasks.

Workflow difficulties and significant occupational health and safety risks are incurred by the staff of this area.

Information regarding the weight of linen washed is available for the period December 1998 to April 1999. Linen usage during this period was 7.13 kg's per occupied bed day excluding same day patients at an average cost of $1.58 per kg. This compares with Support Services Reform Project performance indicates of 6.5 kg per occupied bed day at a cost of $1.25. If usage was reduced to 6.5 kg per occupied bed day it would decrease the annual amount of dirty linen by 9,400 kg and would result in an $11,000 per annum saving on linen cost based on the current cost per kg.

Given that the cost of laundry services is $1.58 rather than $1.25 per kg due to the inefficient equipment recurrent costs could be reduced by moving linen services to Mareeba Hospital as has been previously suggested by the District. The annual laundry costs would be reduced by $35,000 if a cost of $1.25 were achieved.

Five staff are employed in the Atherton laundry. They do not provide any other support services for the facility. These staff did not appear to be fully utilised for laundry work.

73. Explore multi-skilling of operational staff between catering, cleaning, laundry and porterage to enable better utilisation of resources.

74. Reduce the use of casual operational staff through multi-skilling of staff.

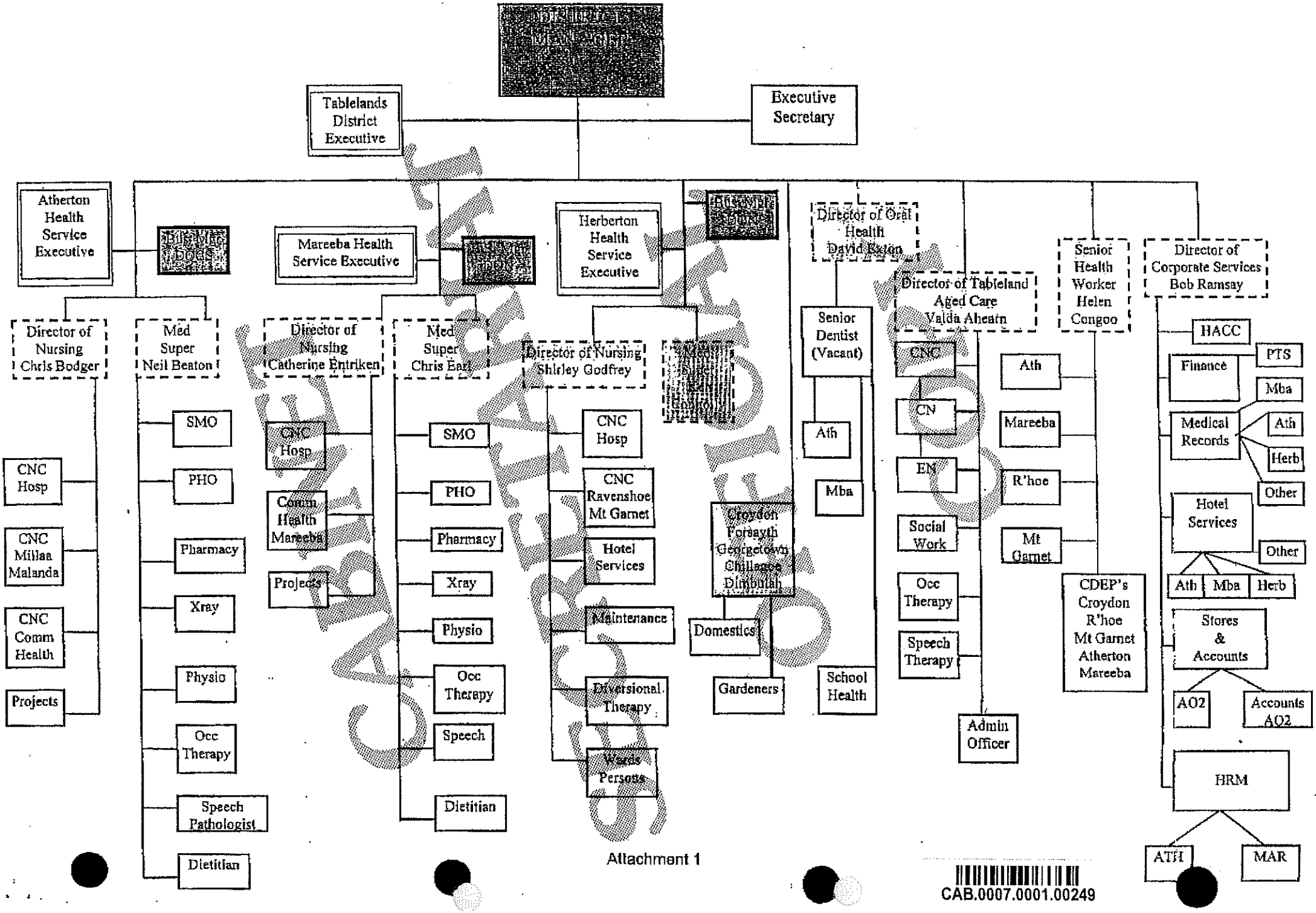
75. **Cleaning staff to commence cleaning duties currently undertaken by Nursing Staff (wall washing in theatre, bed washing, locker washing). Negotiate an appropriate reduction in nursing resources.**
76. **Provide costings of food services to ward areas to enable cost centre managers to monitor this expenditure.**
77. **Data on meal wastage to be collected, and examined at ward level.**
78. **Reduce unnecessary linen costs by reducing linen usage. Provide linen usage information to nursing staff to enable them to monitor reductions.**
79. **Pursue the business case for the construction of a new laundry to consolidate Atherton and Mareeba linen services and commence negotiations with the AWU on the consolidation of Laundry Services if the business case for the new laundry is approved.**
80. **Provide rotation of operational staff into the laundry to provide support and relief for the male employee who is currently providing all heavy lifting duties for the laundry.**

13.0 Supply

The main supply office for the District is situated at Mareeba Hospital. Discussions with the Supply Manager confirmed that there is a satisfactory policy and process in place when non-standard items and equipment are ordered. There are also appropriate delegations in place for the release of orders on the FAMMIS system.

Training in the use of the FAMMIS system has been provided to staff together with information on how to run reports. However, access to computers and the complexity of ordering reports is causing difficulties for some staff. When cost centre management is introduced in the District there will be an increased demand for a monthly report listing all items purchased for each cost centre. Due to the difficulties in the District, production of the report could be centralised and automated within the FAMMIS system.

81. **Provide information on supplies purchased, cost and quantity for each cost centre on a monthly basis. Production of this report can be automated within FAMMIS to occur over night. This information should form part of a package for each cost centre in conjunction with financial and payroll information.**



Attachment 1

DISTRICT OPERATIONAL PLAN
JUNE 1999

WHAT	WHO	WHEN
Objective 1.1		
a. Make management time available for line managers	a. Don's & District manager	a. September 1999
b. Develop organisational plans that identifies the cost centre managers, advisory committees including authority and responsibility	b. Executive	b. August – Facility September – District
c. Design cost centre report in collaboration with cost centre mangers including targets	c. DOCS	c. July & August
d. Meet with unit managers each month to discuss and educate	d. DOCS	d. Ongoing.
e. Budget work-up methodology with help from other districts and corporate office	e. DOCS and Unit Mangers	e. August
f. Business rules	f. Executive	f. September
g. Develop report on activity and quality initially at executive level	g. Manager Patient Information/A. HRM	g. By June 30th 2000
Objective 3 Transcribe Herberton Plan into District	a. DON Herberton	a. July 1999

Objective 4 a. Health workers to be involved in patient care from admission (policy) b. Examine state policy to ascertain currency	a. Senior Health Worker b. Atherton executive	a. 3 months Sept 99 b. 3 months Sept 99
Objective 5 a. Set up a District Quality committee (terms of reference members) – project plan regarding quality committee b. Achieve District accreditation – pt satisfaction and changes c. Clinical benchmarking partners	a. District manager b. Facility Executive with District Driver c. Corporate office with district Driver ? DM	a. July 1999 b. July 2001 c. September 1999
Objective 6 a. endorsement of more RN's for Immunisation Clinics	a. CNC OPD/A&E and DON	a. December 1999
Objective 7 a. Develop and distribute service profile and referral process	a. Team leader Mental Health	a. September 1999

Objective 8 a. Units to review care paths to achieve 2-3 multi-disciplinary entire episode care paths b. Review of post acute program c. Explore complex care paths based on health Care Agreement	a. Unit coordinators b. Executive c. Executive	a. June 200 b. End July c. June 2000
Objective 9 a. Alcohol Drug program developed b. Illicit Drug Strategy c. Develop Needle exchange program for Herberton d. Continue minimal intervention program	a. Jan Parr b. A.M.S. Executive c. DON Herberton d. Community Health	a. July 1999 b. Ongoing c. January 2000 d. Ongoing
Objective 10 a. IMB/Medical records committee to develop and drive IT Plan	a. DOCS & District Executive	a. September 1999

Objective 11 a. Develop District Training Plan (Workforce plan) • Training and development • Orientation • Recruitment • Retention • Workload • Code of practice • Credentialling	a. HR Manager, Clinical Nurse Educators & Medical Superintendents	a. Ongoing
Objective 12 a. Establish/reform District Scan Committee b. Continue to develop child health program (Submission)	a. Richard Heazlewood b. Lanor Tisson	

Objective 13 a. Rationalise surgical service – meeting with surgical unit staff from Atherton and Mareeba, Drs Green, Wu, Turner and Cairns to make maximum use of surgical service	a. DON DM & DOCS	a. End July
b. Reorganise endoscopies to one Tuesday list	b. Executive, Dr Brigden	b. End July
c. Communicate with cairns about referral problems	c. Dr Neil Beaton	c. August 1999
d. Inform all doctors that all patients will be required to attend pre-admission clinics	d. Margaret Beck	d. End July
e. CSSD to be done by Mareeba	e. DON Mareeba and CNC TO Atherton	e. End of august
f. Joint databases – Clinics • Physician • GP's • Multi-disciplinary	f. Dr .N Beaton and Margaret Hood	f. –
g. Joint cardiovascular clinics	g. –	g. –
h. Asthma rehabilitation program	h. Medical Unit	h. Ongoing
i. Develop submission for Pulmonary rehab Program	i. Medical Unit	i. June 2000
j. Develop submission to employ 2 pHO's	j. Medical Superintendents	j. September 1999
k. Review work practices	k. CNC East/West – P McLagan	k. July
l. Restructure GP Clinics – Chillagoe Mt Molloy	l. Dr C Hornischfeger	l. 3 months
m. Radiology review for reporting	m. District Manager	m. End August

n. Training program for Drs and Midwives ongoing professional development	n. Dr N Beaton	n. September 1999
o. Develop core group of staff to work in Maternity	o. Nursing Executive	o. Report by End of August

ATHERTON HOSPITAL

NOTIONAL 10 YEAR PLAN 1996 to 2006 - ACTIVITY AND COSTS

Year	95/96 Actual	96/97 Actual	97/98 Actual	Predicted 98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06			
Performance Levels														
Available beds	72	72	72	67	67	67	67	67	67	67	67			
Operational (staffed) beds	56	57	62	58	57	58	54	53	51	49	47			
Bed occupancy rate	58%	60%	55%	65%	64%	62%	61%	59%	57%	55%	52%	Demo area	New	Flows
Inpatient separations	4,895	4,978	5,167	5,386	5,670	5,762	5,934	6,117	6,299	6,481	6,663	6,663		
Same day separations	1,822	1,813	2,183	2,134	2,380	2,595	2,841	3,098	3,362	3,637	3,923	3,923		
Proportion of same day separations	37%	36%	42%	40%	42%	45%	48%	51%	53%	56%	59%	59%	#DIV/0!	#DIV/0!
Ave length of stay - non-same day separations	5.0	5.0	4.8	4.9	4.8	4.8	4.8	4.8	4.7	4.7	4.7	4.7	#DIV/0!	#DIV/0!
Occupied bed days	17,172	17,488	16,931	17,888	17,812	17,801	17,656	17,476	17,283	17,017	16,740	16,740		
Ave. DRG cost weight (V3Ph4)	0.6569	0.6797	0.6812	0.7408	0.7421	0.7435	0.7448	0.7461	0.7474	0.7487	0.7500			
Case weighted separations	3,215	3,383	3,520	3,992	4,134	4,277	4,420	4,563	4,708	4,852	4,997			
Non-inpatient occasions of service	42,793	52,168	51,000	51,686	53,433	55,180	56,928	58,675	60,422	62,169	63,917			
	13.3	15.4	14.5	12.9	12.9	12.9								
Financial Indicators (all $ at June 1997 values)														
	$	$	$	$	$	$	$	$	$	$	$			
Case weighted separation cost	1,537	1,539	1,668	1,462	1,452	1,423	1,395	1,367	1,340	1,313	1,270			
Inpatient bed day cost	268	298	385	328	336	342	348	357	365	374	378			
Non-inpatient occasion of service cost	46	46	51	47	46	45	44	43	42	41	40			
Annual Recurrent Expenditure ($M)	7.01	7.60	8.45	8.33	8.65	8.56	8.57	8.77	8.86	8.94	8.91			