Ex 427

ANSWERS OF DR GLENN PHILLIP CUFFE
TO SCHEDULE 2 QUESTIONS

1. **Question 1:**

(a) *What was Dr Cuffe's responsibility in relation to the Queensland Health measured quality program?*

My responsibility in relation to the Queensland Health was to provide the resources, administration and oversight of the Measured Quality Program ("**MQP**") and to ensure key milestones were achieved.

(b) *Did the Measured Quality Program Manager, Justin Collins, report to Dr Cuffe?*

Yes, the MQP Manager, Justin Collins reported directly to me on a day to day basis. Mr Collins also reported to the two sponsors of the MQP, the General Manager Health Services ("**GMHS**") and the Deputy Director General (Policies and Outcomes) (the "**DDG(P&O)**"). During the life of the MPQ Drs. Youngman, Buckland and Scott were at different times the GMHS and Dr Filby and Ms Deeth were the DDG(P&O). In addition the MQP Manager also reported to a Board for the Measured Quality Program Area. The Board's Terms of Reference were to have responsibility to:

- Influence the progress and direction of the MQP Area through assisting in the development of the consolidated business case, where possible;
- Review progress against performance indicators at major milestones; and
- Communicate with the Quality Council should the MQP Area Sponsors be considered to be managing the MQP Area contrary to the Board's advice.

Glenn Philip Cuffe
5 October 2005

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A copy of the Minutes of the first meeting of the Board is attachment **GPC 2** to these Answers.

2. **Question 2:**

(a) *Did Dr Cuffe attend a presentation on the development of the measured quality program on 13 August 2002?*

Yes.

(b) *Does Dr Cuffe recall at any stage prior to, during, or after that presentation, there being discussions in relation to the need for secrecy to attach to measured quality program date and reports? If so, what are the details of those recollections?*

No.

(c) *Does Dr Cuffe recall at any stage prior to, during, or after, that presentation there being discussions in relation to submitting the measured quality data and reports to Cabinet to exempt that material from Freedom of Information legislation? If so, what are the details of those recollections?*

I do not recall any discussion in relation to submitted measured quality data and reports to Cabinet to exempt that material from Freedom of Information legislation prior to the presentation. I recall that the draft media plan raised the issue of the potential for hospitals to be asked for the MPQ hospital reports which District Health Services could release without restriction or applications could have been made for the MQP reports to be released under FOI.

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During the presentation the Minister made the decision that the draft of the public MQP report and the individual hospital reports were to be submitted to Cabinet. I do not recall any discussion of FOI.

After the presentation I had a discussion with Justin Collins and Lisa Crawford about the Minister's decision to take the information to Cabinet and that the decision would mean that the FOI exemption could be invoked and any requests for information would need to go to Cabinet for a decision on release.

(d) *Justin Collins has said that he and Dr Cuffe shared the view, around the time of the 13 August 2002 presentation, that submitting the measured quality data and reports would effectively kill the measured quality program. Is this true?*

Yes.

(e) *What are the details of any disagreement Dr Cuffe has with respect to the said version?*

I have no disagreement with Mr Collins' version.

(f) *If Dr Cuffe did in fact share such a view with Mr Collins, what was the basis of that view?*

Some of the information contained in the hospital reports was sensitive. There was a range of potential decisions the Cabinet might make about the submission, from just "noting" the reports through to placing an embargo on release of the reports. This was Cabinet's choice. However if restrictions were placed on release of the reports, it would have been more difficult for MQP to deliver on its intended program of dissemination to clinicians and managers to effect clinical practice reforms, enhance quality

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and safety and make organisational improvements. It would also limit the sharing of the information with the Health Care Collaboratives and the Organisational Improvement Unit of Queensland Health.

(g) *What is Dr Cuffe's view in respect of same today?*

It is the same.

3. **Question 3:**

Attachment A is a document entitled "A briefing to the Minister" dated 12 March 2003. Was Dr Cuffe responsible for the addition of the words, "to afford it the same consideration for FOI exemption" on the final page of that document? If so, what were the circumstances leading to the addition of those words in that document?

I do not recall adding the phrase or words "to afford it the same consideration for FOI exemption" on the final page of that document. I do recall that I suggested changes to the text to enhance the English expression, sentence construction and to economise on word usage. Due to the time since this was done I do not recall the specific changes that I suggested to the brief.

4. **Question 4:**

Does Dr Cuffe know the origins of the decision to send the measured quality data and reports to Cabinet? If so, what are the details of that knowledge?

I assume that this question refers to the phase 2 hospital reports. So far as I know the background to the decision it is as follows.

- On 26 February 2003 an email was sent by Justin Collins to Ms Helen Little, the Senior Departmental Liaison Officer (the "**SDLO**"). A copy of that email is attachment **GPC 3**. The email asked, inter alia, the SDLO to check to see if

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the Minister and Director-General would like to submit the phase 2 hospital reports to Cabinet and whether the Minister and DG wanted to be briefed on the strategy and results for phase 2, as had occurred for the phase 1 reports.

- On 7 March 2003 Justin Collins gave me a copy of his email, with hand-written notes on it.
- That same day, 7 March 2003, I received an "Issues Briefing Request Form" to prepare a brief for the Minister to address the nominated issues. A copy of the request form is attachment **GPC 4**.
- I passed on the request form to Justin Collins.
- Justin Collins prepared the brief "Measured Quality Hospital reports (phase 2)" dated 12 March 2003. A copy of the brief is exhibit JEC 13 to Mr Collins statement.
- I cleared the brief on 12 March 2003.

5. **Question 5:**

Was the effect of putting the measured quality data and reports before Cabinet, being to exempt them from Freedom of Information legislation, ever a consideration that was canvassed to Dr Cuffe's knowledge before those documents were put to Cabinet? If so, what are the details of that knowledge?

I do not recall the effect of putting the measured quality data and reports before Cabinet being canvassed before I received the copy of the email (GPC 3). After receiving the copy of the email, with the handwritten notes indicating the decision, I discussed with Justin Collins the fact that, because of the decision to take the hospital reports to Cabinet, the standard FOI restrictions would apply to them as they did to the phase 1 reports.

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"GPC 2"

Queensland Government
Queensland Health

QUALITY IMPROVEMENT AND ENHANCEMENT PROGRAM

MINUTES

Board Meeting of the Measured Quality Program Area

Held October 25, 2000 9am – 11am

3th Floor Conference Room, Queensland Health Building

The meeting was chaired by Dr Youngman for Dr Filby who was unavailable.

1. **Welcome and apologies**

Present:
Prof Bryan Campbell
Ms Sue Cornes
Dr Glenn Cuffe
Ms Elizabeth Garrigan
Mr David Jay
Dr Chris Kennedy (via video conference)
Ms Susan Mahon
Mr Paul Monaghan
Ms Jenny Pouwer
Ms Geri Taylor
Ms Jenny Thomas
Dr Youngman (chair)

Observers:
Dr Roger Brown
Mr Mike Edwards

Program Area staff:
Ellen Hawes (Program Area Manager)
Vanessa Cornell

Apologies:
Dr Filby
Dr Alan Isles
Dr Ian Scott

Dr Youngman welcomed Board members. Members had been nominated because of their expertise in areas being assessed in the Measured Quality Program Area or because of their association with related programs and projects (eg Patient Surveys Program Area). Dr Youngman noted that Mr Steve Buckland had declined membership and requested that a District Manager be asked in his stead. It was noted that the Board already has District Management representation through Dr Kennedy.

2. Background of Program and purpose of meeting – Dr Youngman

Dr Youngman indicated that a risk to Queensland Health was the large number of groups currently existing to which Queensland Health provides data and the lack of co-ordination among these groups. He noted that the National Health Performance Committee, chaired by Dr Filby, had identified this risk (relevant to all jurisdictions) and was working towards a coordinated approach to performance monitoring. The agenda for the National Health Performance Committee is to gain consensus of the performance measures for quality health services. Dr Youngman noted that the Measured Quality Program Area was directly relevant to this agenda.

Dr Youngman noted the importance of scoping the agenda of the Measured Quality Program Area so that it did not increase the number of performance measures but rather focuses on a core set of indicators which can be collected from current information systems.

Dr Youngman opened the floor for discussion on the agenda/aim of the Measured Quality Program Area.

Ms Taylor noted that the Program Area was only approved at this point for 6 months and that the work to be completed was significant. She indicated that the manner in which the cells of the National Health Performance Framework were populated was the most important issue rather than ensuring an exhaustive process.

Prof Campbell endorsed the Measured Quality Program Area as being important for the overall co-ordination of the QIEP Program and that it was a key Program Area in the QIEP Program.

Mr Monaghan sought clarification on the involvement of external agencies (including Treasury). Dr Youngman responded that this would depend on the audience for the performance report. He noted that a key issue in reporting on performance will be the presentation of the data ie. the use of rates, percentages or numbers. He also noted that a major use of the data would be on analysing variability in performance rather than producing league tables (ie listing the "best" to "worst" hospital on various criteria).

Dr Cuffe noted that for the Measured Quality Program Area to have significant impact, it was important that it was linked to change processes (eg other QIEP Program Areas including the Change Management Program Area).

Ms Thomas indicated that the Measured Quality Program Area should focus on identifying the criteria for selecting core indicators and that the data for these indicators should be analysed in an environment in which potentially confounding variables are taken into account.

Summary: There was strong support among members for the Measured Quality Program Area to proceed in identifying a set of performance indicators through which the performance of Queensland health services can be assessed. There was also strong support that this occur in a manner that focuses on existing data collections, the synthesis and co-ordination of performance measures, analysis of the data in terms of variability and understanding what the factors which underpin favourable performance vs less favourable performance. Links to change processes must also be established.

Purpose of the meeting

Dr Youngman described the purpose of the meeting as being to seek:

- agreement on Terms of Reference for the Board (as per QIEP Governance document)
- endorsement of decisions made to date
- advice on planned progress over the approved 6 months and on planning for next 2 ½ years

Prof Campbell requested clarification on the Terms of Reference. The Terms of Reference were stated in the letter of invitation and are taken directly from the QIEP Governance document ie. :

1. A Program Area Board will be established for each Program Area.
2. Program Area Boards have the responsibility to:
   a. Influence the progress and direction of the Program Area through assisting in the development of the consolidated business case, where possible;
   b. Review progress against performance indicators at major milestones.
   c. Communicate with the Quality Council should the Program Area Sponsor be considered to be managing the Program Area contrary to the Board's advice.

3. Report on progress to date – Ellen Hawes (Program Area Manager)

Ms Hawes provided an overview of the Program Area aims, progress to date and planned progress over the 6 month project approved timeframe (powerpoint presentation attached). A list of decisions for which endorsement was being sought was provided to members and discussion was held for each project area in the Measured Quality Program.

3.1 Framework for performance assessment and Program Area Structure

Presented information on the aim of the Program Area, status of the Program Area (ie approved for 6 months) and current staffing. Performance reporting in Queensland Health was overviewed and a comparison between current reporting requirements and the domains in the National Health Performance Framework was discussed to highlight discrepancies and the need to review international and national indicators in addition to current Queensland indicators (ie. To identify measures that more comprehensively reflected the definition of the domains of the National Health Performance Framework) (refer Slide 9).

Members endorsed the National Health Performance Framework as the performance framework for the Measured Quality Program Area. Prof Campbell noted that the definition of the "Efficiency" domain in the Framework needs to be reviewed to ensure that financial efficiency is not the major focus.

Action: Ms Hawes to follow up with Prof Campbell on broader definition of Efficiency domain

Discussion ensued on the Program Structure and the work breakdown by Phases. The Program Area comprises three broad programs – hospital performance, community health performance and population reporting (refer Slide 12). Progress in each program has been categorised into two phase with Phase 1 being the approved of the Program Area and until June2001[1], and Phase 2 being after July 2001 (to be further defined in Project Plan). The focus of Phase 1 work is on Hospital Performance. The rationale for this focus is that (a) hospitals are the most

[1] These timeframes assume that the Program Area will be approved to continue at the Quality Council's deliberation of the Project Plan in February 2001.

significant users of resources and (b) data is more likely to be available for assessing performance.

Members endorsed the Program Structure. The categorisation of Programs into the Phases was broadly endorsed. Prof Campbell noted his concern that population reporting was not being progressed in Phase 1. Ms Hawes clarified that work on population reporting was being progressed by conducting meetings with key stakeholders to investigate the feasibility of population reporting in Phase 1 but that current resources were not sufficient to progress actual reporting by population for all indicators in Phase 1.

Summary: Framework for performance assessment and Program Area Structure broadly endorsed.

3.2 Progress to date and planned – Hospital Clinical Assessment Project

Progress was detailed in Slides 14 -18. Discussion ensued on the document compiling clinical indicators to be pursued. This document was briefly presented at the meeting (Slide 15). A sample extract of the document for one indicator is attached as Attachment A. This document is the first draft of the technical specifications for the clinical indicators to be used in the performance assessment.

Prof Campbell noted that the document needs to include existing benchmarks internationally and nationally as the existence of a benchmark may be an important criterion in prioritising the indicators for inclusion in the performance assessment.

Prof Campbell further noted that the development of the document and planned progress is of assistance to the Clinical Audit Program Area and that he will revise the Clinical Audit Program Area to be structured around following up on the results of the indicator analysis.

Action: Ms Hawes to ensure consideration of the availability of benchmarks in the development of prioritsation criteria.

Summary: Progress to date and planned progress broadly endorsed.

3.3 Progress to date and planned – Hospital Patient Satisfaction/Responsiveness Project

Progress was detailed in Slides 19 -21. Discussion ensued on the potential for duplication across the Patient Surveys Program Area and the Measured Quality Program Area. Prof Campbell indicated that the Patient Surveys Program Area had responsibility for developing and implementing a system for measuring patient satisfaction. Ms Hawes noted that discussions with the Program Area Manager of the Patient Surveys Program Area indicated that the initial focus of that Program Area would be on the development of a complaints system. This poses a problem for the Measured Quality Program Area as one of the aims of the Program Area is to conduct a baseline assessment of hospital performance as part of the evaluation of the QIEP Program and a key element to be assessed is patient satisfaction. An assessment of patient satisfaction is therefore required prior to the implementation of major activities of the QIEP program (ie before May – June 2001).

Suggestions on progressing this project included establishing a working group comprising members of both the Patient Surveys Program Area and the Measured Quality Program Area.

It was agreed that clarification is required on the relationship between the two Program Areas. A briefing paper will be developed and circulated out of session.

Action: Ms Hawes to develop briefing paper and circulate out of session

Summary: The relationship between the Patient Surveys Program Area and the Measured Quality Program Area to be clarified.

3.4 Progress to date and planned – Hospital Financial Indicator Project

Progress was detailed in Slides 22 -23. Prof Campbell noted that the indicators for efficiency should not focus only on financial efficiency. This issue is to be considered by the project working team.

Action: Project working team to consider efficiency measures wider than financial measures.

Summary: Progress to date and planned progress broadly endorsed.

3.4 Progress to date and planned – Hospital System Integration and Change Project

Progress was detailed in Slides 24 -25. Discussion ensued on the two suggested strategies to progress this project ie. To adapt and pilot the Ontario survey or to collaboratively review the Clinical Audit Tool with the Change Management Program Area. Ms Mahon indicated that a key barrier to using the Clinical Audit Tool in a survey to establish a baseline measure of "system integration and change" is the potential for low response rates. Prof Campbell suggested that a stratified sample may be a solution and Dr Youngman endorsed this suggestion.

It was agreed that the Change Management Program Area and the Measured Quality Program Area collaborate on developing a tool that is useful to both Program Areas.

Summary: Progress to date and planned progress broadly endorsed.

3.5 Progress to date and planned – QIEP Baseline Measures Project

Progress was detailed in Slides 26 -27.

Summary: Progress to date and planned progress broadly endorsed.

4. Terms of Reference and Board membership

Dr Youngman requested that any concerns relating to the Terms of Reference for the Board or the membership of the Board by relayed to Dr Filby or Ms Hawes out of session.

5. **Next meeting**

The next meeting of the Board will be to discuss the Project Plan for Measured Quality in 2001-2003. This meeting is planned for late January or February.

Attachment A. Sample extract from the Clinical Indicators Document (October 16 version).

- **Effectiveness Indicators**
  Avoidable Adverse Outcomes – Mortality

Indicator Topic	In-hospital mortality following common elective procedures in any procedure field: Hysterectomy; laminectomy/spinal fusion; cholecystectomy; transurethral prostatectomy; hip replacement; and knee replacement.
Quality Domain	Effectiveness
Indicator Intention	To identify hospitals where in-hospital mortality following common elective procedures is significantly higher or lower than that for other hospitals in the same peer group.
Rationale	High volume procedures.
Definition of terms	
Update Frequency	
Numerator	Deaths in hospital for specified procedures (Hysterectomy; laminectomy/spinal fusion; cholecystectomy; transurethral prostatectomy; hip replacement; and knee replacement)
Numerator source and details:	Hospital Morbidity Data Collection
Denominator:	Procedures with certain principal diagnoses relating to Hysterectomy; laminectomy/spinal fusion; cholecystectomy; transurethral prostatectomy; hip replacement; and knee replacement
Denominator source and details:	Hospital Morbidity Data Collection
Measurable:	Yes
Hospital level appropriate for:	
Available in other States:	Yes
Analysis issues:	Age-standardise Number of deaths per 100 patients receiving common elective procedures. (Outcome of interest, population at risk) * 100
Benchmark:	
Comment:	Investigate high death rates through Transition II intensive care use
Source:	USA MDS Definitions of Quality Indicators, Version 1.3, p2
Currently required for reporting:	TBD
Additional numerator details:	Nil

Additional denominator details:	All non-maternal/non-neonatal discharges age 18 years or older. Screen diagnoses and procedures (all fields) to limit risk population to uncomplicated cases: A. for hysterectomy (see page 34), exclude female genital cancer (see page 34) or pelvic trauma (see page 34), B. for laminectomy/spinal fusion (see page 34), include only simple intervertebral disc displacement (see page 35), C. for cholecystectomy (see page 35), include only non-acute, uncomplicated cholecystitis and/or cholelithiasis (see page 35), D. for transurethral prostatectomy (see page 35), include only prostatic hyperplasia (see page 35), E. for hip replacement (see page 35), include only osteoarthrosis of hip (see page 35), F. for knee replacement (see page 35), include only osteoarthrosis of knee (see page 35). Exclude cases transferred to another institution. Exclude MDC 14 (pregnancy, childbirth, and puerperium) and MDC 15 (newborns and other neonates). **Page 34 and 35: In-hospital mortality following common elective procedures** **Hysterectomy (Population at Risk):** ICD-9-CM Procedure Codes: 683 SUBTOT ABD HYSTERECTOMY 684 TOTAL ABD HYSTERECTOMY 685 VAGINAL HYSTERECTOMY 6851 LAP AST VAG HYSTERECTOMY# 6859 OTHER VAG HYSTERECTOMY# 686 RADICAL ABD HYSTERECTOMY 687 RADICAL VAG HYSTERECTOMY **Exclude female genital cancer (Population at Risk):** ICD-9-CM Diagnosis Codes: 179 MALIG NEOPL UTERUS NOS 1800 MALIG NEO ENDOCERVIX 1801 MALIG NEO EXOCERVIX 1808 MALIG NEO CERVIX NEC 1809 MAL NEO CERVIX UTERI NOS 181 MALIGNANT NEOPL PLACENTA 1820 MALIG NEO CORPUS UTERI 1821 MAL NEO UTERINE ISTHMUS 1828 MAL NEO BODY UTERUS NEC 1830 MALIGN NEOPL OVARY 1832 MAL NEO FALLOPIAN TUBE 1833 MAL NEO BROAD LIGAMENT 1834 MALIG NEO PARAMETRIUM 1835 MAL NEO ROUND LIGAMENT 1838 MAL NEO ADNEXA NEC

"GPC 3"

Brad Smith - Measured Quality Hospital reports (phase 2)

From: Justin Collins
To: Helen Little
Date: 26/02/2003 11:34 AM
Subject: Measured Quality Hospital reports (phase 2)
CC: Brad Smith; Jill Pfingst

Hi Helen

As you may recall, the Measured Quality Public & 60 Hospital reports (phase 1) were submitted to Cabinet on 11th Nov 2002.

The direction provided by cabinet was:

a) develop a communication strategy (for public report)
b) finalise changes (to the public report)
Both a & b are in the final stages of completion

c) finalise a strategy to manage the dissemination of the info in the 60 hospital reports.
The agreed stategy (with sponsors) involves the completion of a further 1 to 2 years data analysis and a round of visits to each HSD executive to highlight the outlier results and commence the process of further inquiry.

I would like to check to see if the Minister and DG would like to submit the Phase 2 Hospital reports to cabinet (as done for the phase 1 reports) prior to our planned visits commencing 31 March 03. If this is the case please let me know as quickly as possible as I will need to co-ordinate with Brad on the dates for submission and depending on how you would like to progress, arrange a time to 'brief' the Minister & DG on the strategy and results for phase 2 (as done for phase 1)?

Regards

Justin Collins
Program Area Manager
Measured Quality

Yes

7/3/03. Phase 2

Justin matched

Min
DG
Justin
Cliffe
Pickard.

Arrange suitable time
DG Meeting Room
Phase 1 - new writing
Where it is at?
being rewarded
Phase 2 - what is proposed

"GPC 4"

emailed to Maria Burns 7.3.03.

URGENT

Queensland Government
Queensland Health

Briefing Note Number: BR018109

ISSUES BRIEFING REQUEST FORM

12

DATE BRIEF IS DUE:	~~10~~ **MARCH 2003 – 3.00PM**
AREA/S RESPONSIBLE:	**MPS** **Note:** If input is required across branches every effort should be made to coordinate the information into one brief. The branch with the major input to the brief has the responsibility of coordinating the necessary information.
ISSUES THAT NEED TO BE ADDRESSED IN THE BRIEF:	**Please provide urgent brief regarding Measured Quality Hospital reports (Phase 2) addressing:** • **Phase 1 – Where it is at** • **Phase 2 – What is proposed.**
BACKGROUND MATERIAL ATTACHED:	**YES**
ADDITIONAL INSTRUCTIONS OR REQUIREMENTS:	**PLEASE EMAIL COMPLETED BRIEF TO CPCU BY 10 MARCH 2003**
WHO IS BRIEF FOR:	**MINISTERIAL**
BRIEF REQUESTED BY:	**ELIZABETH HEAD**
DATE BRIEF REQUESTED:	**7 MARCH 2003**

IF THIS REQUEST HAS BEEN ALLOCATED TO AN INCORRECT AREA - PLEASE NOTIFY ELIZABETH HEAD (323 41097) IMMEDIATELY