A

The cardiologists had argued strongly against this closure, as it was pure cost-cutting and would blow-out cath lab Category 1 and 2 patient waiting lists even further. Closure of the cardiac outpatients (already with 5-7 month waiting times) was also enforced at this time, which we had also argued against (the heart failure unit felt that patient care would be severely compromised and more lives would be placed at risk), and this closure also occurred.

First letter to the Premier and its aftermath

17 After we had received no withdrawal of these many "life-threatening" cutbacks in early December 2003, I wrote to the Premier and Health Minister on 16/12/03 (**CA5**).

18 I made the following points to the Premier:

- Cardiologists have been directed that they cannot proceed with immediate treatment of severe coronary lesions (stent angioplasty) except in emergencies, but must rebook patients for a second procedure, which may be three or months later.
- Cardiac booking staff have been directed not to schedule elective stent angioplasty cases from 1st January 2004, and Queensland patients have

been placed in a holding pattern for an indefinite period until funds become available.

- These changes are against best-practice, put patients at risk of death or heart attack, delay effective treatment, may require a second hospital admission and lead to increased costs! They are also in direct violation of the Queensland Health 20-20 document and the Health Outcomes Plan – Cardiovascular Health: Coronary Heart Disease 2000-2004.
- Plans are being made to reduce coronary angiography, stent-angioplasty and cardiac surgery numbers for Central Zone patients, despite increases in demand in all zones.

19 I also apprised him of three recent avoidable cardiac deaths (Pts 3-5).

20 After my letters to the Health Department and Premier did not lead to any withdrawal of the cutbacks, meetings of all the cardiologists at PCH from 3rd- 5th January 2004, discussed the prospects of the life-threatening cutbacks which were about to begin, and in desperation they asked that I, as the Chair of the Qld Branch of the CSANZ release details of the cutbacks and recent deaths to the media.

21 The Public Sector Ethics Act (1994) and Code of Conduct (Qld Health 2000) include:

- Employees should also ensure that any conflict between their personal interest and official duties is resolved in favour of the public interest
- Employees should disclose fraud, corruption and maladministration of which they are aware
- Employees should exercise diligence, care and attention and for high standards of administration and health care.

22 In my view, public disclosure of the unnecessary causation of deaths by ill-informed and intransigent budget control was in the circumstances fully justified and even required by the Act and the Code of Conduct. After repeated attempts to be heard through line management, through letters to the Premier, through direct face to face waylaying of the Minister, and senior QH bureaucrats, the need to stem this rising rate of unnecessary deaths was without doubt the higher public interest. As Chair of the Qld Branch of the CSANZ, I therefore issued a press release on January 5 2004 to the Courier Mail.

23 On January 8, 2004, I was contacted by Qld Health bureaucrat Dr John Scott by telephone who requested an urgent meeting to discuss the problems I had raised (in my press release), and I immediately accepted his request, anticipating that progress might at last be made. I met with Dr Scott and Mr. Dan Bergin from Qld Health on the evening of Jan 8, and I invited another cardiologist Dr Andrew Galbraith to also attend. The

meeting began with what would be best described as a vicious verbal assault which was I felt was clearly intended to reprimand and intimidate me from ever raising these issues again. Dr Scott even stated to me "You come after us with more shots, and we'll come after you". Dr Scott refused to comment on my statement that cutbacks would lead to increased deaths and rejected my suggestion of developing an expert cardiac committee to directly advise the department. Herewith are excerpts of minutes of the meeting (**CA6**) which were made after the meeting by myself and Dr Galbraith.

Excerpts of the Meeting 5.15pm Jan 8th 2004: Lvl 3, Holy Spirit Northside Medical Centre.

Dr Constantine Aroney (Cardiac Society)

Dr Andrew Galbraith (Invited by Cardiac Society, and Cardiac Society Member)

Dr John Scott (Queensland Health)

Mr. Dan Bergin (Queensland Health)

JS: "Your letter to the Premier was offensive to Queensland Health and personally offensive to me" "You made a lot of cheap shots"

CA "I don't consider unnecessary deaths as cheap shots – you might"

JS - "We're going to investigate the 3 deaths you mentioned"

B

review, which I supported, recommended that in future patients are transferred as soon as they are stable. The clinical call as to whether this patient was stable after the first or second operation would be difficult, as the patient was very shocked, so I was not alert to issues about Dr Patel's initial post-surgical judgment needing further examination; the problems with the boy's health emerged after Dr Patel went on leave. As to subsequent care, I agreed with the recommendations that major vascular injuries should be transferred as soon as possible, so again I did not see a need to get Dr Patel's views on that.

18.4 I agree that the severity of the patient's condition as described in the 5 January briefing report is difficult to reconcile with the descriptions received by the Commission from e.g. Dr Rashford. At the time the issue I saw was that the initial surgery was appropriate, but the post-surgical care was not. Reports from the RBH may have given me a different, more damning picture of the post-surgical care at Bundaberg. This would not have led me to enquire about Dr Patel because, as explained he was on leave before the boy's condition worsened. Even had I received reports from RBH I doubt I would have investigated further as to their (too lengthy) retention of the patient with Bundaberg because that hospital had accepted that they should transfer such patients at the earliest stage possible – i.e., the hospital had put in place a policy to prevent repetition of like occurrences and the Zone Manager was working with RBH to ensure the policy worked, as that hospital would be the receiving hospital.

19. Dr Aroney in his evidence (see the statement and the transcripts for 10 August and 24 August 2005) makes a number of comments about Dr Scott. Does Dr Scott dispute the accuracy of those comments?

19.1 I dispute the accuracy of Dr Aroney's comments. Prior to my commencing the role of SEDHS, work had been started to develop separate cardiac services at TPCH, RBWH, and PAH, to establish services at Gold Coast and to enhance services at Townsville/Cairns. I believe this approach is appropriate given that Queensland is a decentralised state and treating patients close to where they live is the ideal both in terms of patient convenience (thereby ensuring that patients are likely to attend for treatment), and also to provide equity of access.

19.2 Dr Aroney makes reference to Queensland's coronary mortality rate. QH's approach was to address all facets of cardiac disease not just coronary artery disease. As well as coronary artery disease this requires an approach to heart failure management; rheumatic heart disease; and congenital conditions. To comprehensively address these matters it is also necessary to consider environmental, lifestyle and risk factors; access to primary treatment services; prevention approaches like diabetes and blood pressure management; access to secondary level diagnostic services to identify and treat conditions before serious outcomes develop, and access to tertiary level treatment. The responsibility of any health department is to ensure all of these factors are addressed. QH is required to allocate funding within its budget. The funds available to QH are not unlimited and must be used to address all aspects of public health management. To give a disproportionately high level of funding to tertiary treatment services using

percutaneous coronary interventions in one location is to condemn more people to developing what are often preventible conditions and probably to allow more preventable deaths than those to which Dr Aroney refers. Dr Aroney's view that QH's approach was simply to take services away from TPCH is deeply flawed.

19.3 I believe that the development of a properly organised cardiac service across the state was the appropriate direction to take in providing the best possible cardiac care in Queensland.

19.4 The first round of cuts to which Dr Aroney refers (Statement page 3), was not a cut in funding but a reallocation of funds from TPCH to the PAH after construction of cardiac catheter laboratory and other facilities at the PAH. After the construction of the cardiac catheter laboratory, the level of activity funded at TPCH and the PAH was determined based on population figures. Any perception that there was a cut in funding to TPCH was not real as patient treatment activity had moved, with funds, to PAH from TPCH i.e., patients who were historically treated at TPCH were now treated at PAH. QH was not reducing services across the state and TPCH was still receiving the same amount per patient treated. In fact QH put significant extra amounts of funding into cardiac services in the 2003/4 financial year - an extra $1.86 million into the RBWH; $4.5 million into TPCH; $1.44 million into PAH to build the extra catheter laboratory and other facilities and $1 million for ongoing work, $290,000 into Townsville, and $5.1 million into the Gold Coast. In addition approximately $1 million extra beyond the population-based estimate was put into TPCH budget based on work done by an independent external consultant Mr Jim Lowth (currently assisting Mr Peter Forster).

19.5 I was not involved in the issues Dr Aroney describes prior to November 2003 as I was not in the SEDHS position at that time. I was in fact State Manager of Public Health Services, working at the state and national levels to reduce smoking rates (a major cause of coronary artery disease); respond to some of the highest rates of childhood obesity in the world (a risk factor for heart disease); improve nutrition and physical activity (risk factors for heart disease) across the population, and to improve remote aboriginal community living conditions (risk factors for rheumatic heart disease). My budget to address these issues was about 1% of the total health budget, giving little chance of adequately responding to these major health determinants and making me very aware of the need for a balance in terms of how funds were allocated to respond to heart disease.

19.6 Dr Aroney refers to a cut in activity at TPCH in 2003 of "300 cardiac surgical cases, 500 angiograms, and 96 angioplasties/stents" (Statement page 3). This reduction in activity was part of the transfer of funds and activity to PAH referred to above which took effect on 1 July 2003. While the budgeted activity at TPCH reduced by these levels, the budgeted activity at PAH increased by 300 cardiac surgical cases, 560 angiograms, and 140 angioplasties/stents. As such there was no reduction across the two facilities, in fact there was an increase of 60 angiograms and 44 angioplasties/stents with cardiac surgical cases remaining static. Activity across the state in 2002/03 was 2720 cardiac surgical cases, 6238 angiograms, and 1427 angioplasties/stents whereas for 2003/04 it was 2706

cardiac surgical cases, 6394 angiograms, and 1724 angioplasties/stents. Again, there was no reduction. Rather there was an increase of 303 cases (and an increase from 2001/02 of 766 cases).

19.7 Dr Aroney suggests that there was a second cut in activity announced for 1 January 2004 (Statement page 4). There was in fact no cut in activity in January 2004. In November 2003 the district of which TPCH was a part, had provided figures indicating that they would be over budget for the financial year by approximately $2.2m. This was caused in a large part by the fact that cardiac interventions were being performed at a greater rate than was allowed for by the funding that had been provided to TPCH. Dr Aroney would have been aware of the level of activity that was funded and that he was exceeding this level of activity. TPCH was reminded by QH that they were obliged to limit themselves to the new level of activity which had been funded. It was not concerned that the procedures at TPCH were unnecessary, but to ensure equity across districts. These are obviously difficult matters. This is what Dr Aroney refers to as the second round of cuts. There was in fact no cut in activity at this time. In fact funding to TPCH in the 2003/04 financial year, for coronary related inventions, increased above the baseline budget by at least $1.45 million.

19.8 Dr Aroney talks of a third cutback in September 2004 (Statement page 6). I was not involved personally in this issue as I was on long service leave from July to October 2004. Again there was no cutback but a return to baseline activity after the one-off extra funding ($20 million to reduce elective surgery waiting lists) provided after the election of early 2004.

19.9 In fact, the available budget was sufficient to allow 57 procedures per week to be performed and that is the level to which activity was limited. When further funds were made available in January 2004 as part of the 2004/05 $20 million funding increases, further work was able to be undertaken. When this funding had been expended, activity level was reduced to the budget level of 57 procedures per week. There was no decrease in funding activity below the budgeted level.

19.10 Dr Aroney suggests that subsequently in January 2005 the hospital realised that they weren't doing enough to get funding, because funding is based on activity and these activity cuts were then withdrawn in January 2005 and the numbers were pushed up in order to obtain the appropriate funding for activity – t 3948. In fact in January 2005 extra funding became available. Some of this money went to TPCH, allowing activity to be increased from 57 to 65 procedures per week. Dr Aroney's suppositions about the reasons for the increase in activity in January 2005 are totally untrue.

19.11 The matter of what activity budget allows compared to what is needed due to clinical demand is a major problem across the world and creates hugely difficult decisions for politicians, administrators and clinicians. Available funds must be spread across services from the primary to the tertiary level, from prevention to treatment, from neurology to podiatry, from the north to the south of the state, from hospitals to the community. The administrator is uniquely placed to be aware of all of the impacts of non-availability of optimal resources, the deaths that occur, and the frustrations of not having enough

resources to respond comprehensively. The administrator is required to allocate the available budget appropriately, always knowing that not all people will get the services they need. This can often be a thankless task which results in criticism from people such as Dr Aroney, who only consider their particular area of interest.

19.12 Dr Aroney met with me, accompanied by Dr Andrew Galbraith and Mr Dan Bergin on 8 January 2004. He has made allegations of bullying against me at that meeting. I reject the allegations that I bullied Dr Aroney at that meeting or on any other occasion. Before the meeting Dr Aroney chose to go to the media, and to proclaim that Queensland Health administrators did not care if people died but was driven by budgets. He had not taken the time to meet with me to discuss his issues and concerns. I found the claim personally deeply offensive having worked in direct patient care and being at least as ethical and morally motivated as Dr Aroney. After fifteen years in direct patient care I had come to Public Health and to public sector management not to rest, but rather to do my best for patients and the people of Queensland at the statewide level. His claims were made without speaking to me and without making any attempt to ascertain my personal views and values. At that meeting I did say words to the effect that if Dr Aroney came after us we would come after him. This was never intended to convey that QH would take steps to go after Dr Aroney personally. What I intended to convey was that if Dr Aroney continued to criticise QH in the media, that we would respond directly to any allegations he made.

19.13 His recollection of the events of the meeting (as contained in his statement) is clearly intended to paint me as uncaring and insensitive. I am amazed that he chooses to suggest that I seriously tried to tell him how to treat acute coronary syndrome. For fifteen years as a GP I referred my patients to specialists in recognition of their expert knowledge in their particular field. I stated to Dr Aroney that I had difficulty getting a consensus view on management of cardiac issues from a range of expert clinicians in the area. I did not disagree with the views put to me by Drs Aroney and Galbraith regarding the management of acute coronary syndromes. What I said was that I had been provided with differing views regarding management. I do not accept that it follows that I do not have any idea about the central principles of modern management of such patients.

19.14 At the meeting I tried to talk through a range of issues with Dr Aroney. In particular I advised Dr Aroney of the variety of issues which were required to be managed by QH and in particular the breadth of the approach being taken. His responses appeared to indicate that he was only interested in TPCH and tertiary services. It became apparent to me in that meeting that Dr Aroney did not have the capacity to be objective in terms of what I said to him. My kindest interpretation is that he was passionate about the issues and this clouded his observations of my actions and views. I have spoken to Mr Bergin about this meeting. Dr Aroney's comment regarding Mr Bergin's memory of the conversation does not fit with Mr Bergin's recollection of the meeting. Mr Bergin's recollection, and my recollection, is that Mr Bergin did not speak to the media. Mr Bergin's recollection is that he did not state that he was in the bathroom during part of the meeting.

19.15 I later wrote twice to Dr Aroney saying I would appreciate the Cardiac Society's view on how they believed we should allocate funding in the south-east corner. He did not help us with this. He replied asking for staffing numbers, budgets, numbers of patients etc. At my initiative, Dr Buckland and I met with members of the Cardiac Society to address this and other issues.

19.16 Dr Buckland and I went to the meeting with the Cardiac Society on 15 February 2004 to hear what the Society had to say and to share information. From the first presentation we, and the QH position, were attacked. Steve Buckland said that we were happy to hear people's points of view but we weren't there to be personally attacked. I reject the allegation that we had an intention to intimidate speakers or to discourage open discussion of the problems being presented. Nor do I believe that there was such behaviour on our part. To the contrary, Dr Buckland and I remained after the formal meeting speaking with participants. I subsequently spoke further with one or two of the participants to follow-up themes presented.

19.17 The first speaker at that meeting, who is mentioned by Dr Aroney in his statement, Dr Darren Walters, has since been promoted to the position of Director of Cardiology at TPCH. Obviously this does not demonstrate malice, bullying or victimisation and I am happy to have on record my appreciation for Dr Walters' actions as Director.

19.18 Dr Aroney raises the issue of publication of waiting lists for coronary angiograms and cardiac defibrillators. These lists were not published because they did not form part of the national reporting requirements for elective surgery. This is however a decision for government and not QH. If the government decides that they wish to have additional waiting lists published, this will be done by QH. Data was collected and used within the department. Had the government wished to use it publicly it was available.

19.19 Dr Aroney refers to an inquiry into three deaths, completed in January/February 2004. He disparagingly refers to the two authors as QH bureaucrats although they were in fact the Deputy Medical Superintendent of the RBWH and the Deputy Director of the PAH Emergency Department. He says he feared that the internal enquiry would be a whitewash. In fact the report made three recommendations regarding inter-hospital referrals, bookings of procedures, and a review of the implantable defibrillator waiting lists at different facilities to ensure that there was consistency of categorisation and potential for referrals of patients between TPCH, RBWH and PAH depending on clinical urgency. It was not released publicly as it contained information on the deceased patients that was identifiable and the recommendations in the report were implemented.

19.20 Classification of patients as categories 1, 2 or 3 between PAH, RBWH and TPCH was problematic given that different criteria seemed to be used at each hospital. Dr Aroney in his evidence to the Commission labels this discrepancy as a devious excuse to transfer patients and cut services at TPCH yet the categorisation of patients at the PAH was done by clinicians and these same clinicians were prepared to accept patients transferred from TPCH. On 22 January 2004 the DG requested that further steps be taken to

ensure that patients referred for cardiac services could be efficiently managed across the three Brisbane facilities to ensure that patients were seen in whichever facility could ensure their treatment first. In particular the DG noted "Executive Management at PAH advise they have immediate capacity to address patients on the Prince Charles Hospital angiography waiting list".

19.21 At the same time work was being done to establish the Clinical Coordination Centre and to establish a contract (subsequently signed with Care Flight) to enhance our capacity to refer people, by air if required, to facilities for appropriate care and to ensure that the first available bed was used. Our response was to increase the numbers of interventions provided and the ability of people in peripheral areas to be transferred when they need it. This work around transfers was not just about cardiac care but also involved intensive care, general surgical and medical processes and other key emergencies.

19.22 As I have stated, an extra $11,250,000 was put into cardiac services across the state in 2004/05 and an extra $17,330,000 will be allocated in each year from 2005/06 onwards. Dr Aroney's statement that QH was either deliberately trying to precipitate a crisis by enforcing cutbacks or was guilty of culpable negligence as managers, is totally baseless and untrue. I absolutely reject Dr Aroney's comment that suggests cutbacks occurred as a punishment against the hospital for his stance on speaking out about deaths of people on waiting lists.

19.23 Dr Aroney accuses me of labelling him as dishonest on radio and television. I do not recall saying such things and do not expect that I would have done so. I did however disagree with the view he was putting forward in the media. Dr Aroney says that other clinicians were unwilling to go public. In fact I believe the clinical staff at TPCH were becoming tired of Dr Aroney's constant sniping. They told me in a meeting with them that they just wanted the issue to settle down. I believe that members of the clinical staff may have had a quiet word with Dr Aroney around this time to suggest that it was time for things to be allowed to settle.

19.24 Dr Aroney refers to my comments on the ABC Stateline programme and implies that I lied when asked if cardiac catheter laboratory work was planned to be reduced to 57 procedures per week. The baseline of activity in the laboratory was always 57 and I stand by my comments.

19.25 The Maher Report was released in late February 2005, though Dr Aroney says that the Report was not released until April 2005. In discussing the Mahar Report, Dr Aroney accuses QH management of media bullying and making a thinly veiled attack on the two dedicated cardiologists at TPCH (Denman and Walters) who perform these life-saving procedures, as well as a vindictive attack on the hospital itself. I have nothing but respect from these two doctors and have spoken to both of them and indicated my support for their work.

19.26 In discussing his resignation, Dr Aroney talks of QH's cavalier attitude to unnecessary deaths and says that QH's stated intention of establishing more

cardiac committees without increasing activity was totally inadequate. He also says that he felt QH's continued failure to consult the CSANZ on important issues and QH's dismissal of the advice provided in CSANZ's submission meant that progress appeared unlikely. Dr Aroney was however invited in April 2005 to participate in a meeting on 5 May 2005 to develop a strategic approach to cardiac services in Queensland. He also spoke in early 2004 of the need to have an expert cardiac committee for Queensland.

19.27 Dr Aroney says that I threatened to punish TPCH and made him fear for his job. These allegations are untrue. So is his allegation that TPCH "cuts" were as a punishment for his speaking out.

20 The Commission website contains a number of discussion papers. What comments, if any, does Dr Scott wish to make about those papers?

20.1 I have not had time to prepare a response to this question and I rely on the Morris Commission's letter of 30 August 2005 in this regard. I am happy to deal with any specific questions in my evidence.

C

CA 6

Meeting 5.15pm Jan 8th 2004: Lvl 3. Holy Spirit Northside Medical Centre.

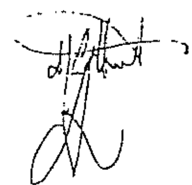
Dr Constantine Aroney (Cardiac Society)
Dr Andrew Galbraith (Invited by Cardiac Society, and Cardiac Society Member)
Dr John Scott (Queensland Health)
Mr Dan Bergin (Queensland Health)

CA: "Thankyou for coming to hear our concerns"
JS: "Your letter to the Premier was offensive to Queensland Health and personally offensive to me" "You made a lot of cheap shots"
CA "I don't consider unnecessary deaths as cheap shots – you might"

JS - "We're going to investigate the 3 deaths you mentioned"
CA - "Investigate the deaths, but remember the Cardiac Society is an advocate for our patients, and we will continue to monitor all deaths and report them."

JS - "You come after us with more shots, and we'll come after you"

JS - Stated that there was increased funding in cardiac risk prevention strategies, planned cath lab at Gold Coast Hospital, increased surgery at PAH.
AG: Stated that the committee formed to facilitate an increase in referrals to PAH to increase the size of the cardiac surgical unit, had not taken into account a new cath lab at the Gold Coast Hospital. That forward planning was deficient.
JS: Agreed that forward that the addition of referrals from the Gold Coast Hospital had not been factored into the equation.
Would not put a moratorium on reducing angiography, angioplasty or surgery numbers at PCH.
Stated that a cardiac surgeon he spoke too, felt differently about managing high risk acute coronary syndromes, and that surgeons should manage these patients and treat them with surgery and not stents.
CA: Stated that he was totally incorrect. Pointed out the lack of communication between expert cardiologists and Qld Health, and recommended the re-formation of an expert advisory committee.
JS: Would not agree to formation of an expert committee to assist in cardiac services. Stated that previous committees had disagreed on too many issues.
AG: We have shown 30% reduction in readmissions with community nurses trained in managing heart failure patients. We need a statewide strategy for managing cardiac failure.
JS: We agree with increasing community nursing strategies in heart failure.
CA: "The planned reduction in cardiac services at PCH will lead to increased deaths in the Central Region." JS did not comment.



been restricted-----

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COMMISSIONER: You did nothing?-- I felt that we should wait until the outcome of the clinical audit.

All right.

MR FREEBURN: So, you basically awaiting an independent investigation?-- Yes.

Thank you.

10

COMMISSIONER: Thank you.

MR BODDICE: I understand Ms Dalton-----

COMMISSIONER: That was a long 20 minutes.

MR BODDICE: I understand Ms Dalton has a couple of questions - she's indicated-----

20

MS DALTON: I promise I will be five minutes, Commissioner.

COMMISSIONER: I don't think you should promise. Go on.

CROSS-EXAMINATION:

30

MS DALTON: Mr Bergin, I am Joan Dalton. I act for John Scott. I would like to take you to one topic and that is the meeting that occurred on the 8th of January 2004 between yourself, Dr Constantine Aroney, John Scott and Andrew Galbraith. I think you were asked some questions about that earlier today?-- Yes.

Dr Aroney says that at that meeting John Scott bullied him; that is, bullied Dr Aroney. Can you comment on that for me, please?-- That wouldn't be my assessment of what occurred. I believe that there was a very robust discussion of equals standing toe to toe, so to speak, and having that robust discussion.

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When you say "equals", you mean Dr Aroney and Dr Scott as equals-----?-- Yes.

-----having a robust discussion?-- Yes.

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All right. Was there - to your observation was there any intimidation of Dr Aroney by Dr Scott at that meeting?-- Well, look, I'm not an expert. I can only give a layman's view, but my impression of Dr Aroney was that he was not intimidated in any way-----

And-----?-- -----by anything that Dr Scott said.

He gave as good as he got, didn't he?-- That would be my view, yes. 1

Now, Dr Aroney says that after that meeting there was a press conference. Are you aware he says that?-- I have - I understand he has made that statement, yes.

Did you go to that press conference?-- No.

Did you speak to the press at all after that conference?-- No. 10

Were you ever asked whether at that conference Dr Scott bullied Dr Aroney and did you ever give an answer, "I don't know, I must have been at the bathroom at that time."?-- Certainly not.

How would you describe that allegation?-- Bizarre.

Do you recall yourself being on the receiving end of allegations from Dr Aroney that you didn't care if people died on Queensland Health waiting lists?-- I understand that Dr Aroney made that in relation to the meeting that - where I addressed the doctors out at Prince Charles Hospital----- 20

Yes?-- -----the 60 doctors. I can't - I can't recall that particular set of comments or statements by Dr Aroney, I must admit.

You don't recall him making that allegation about you?-- At the time at that meeting? 30

Yes. Well, at any time?-- I can't recall that, no.

You'd agree with me, I think, that any sincere person working in Queensland Health would be angered by such an allegation?-- Well, it's very offensive. It's - people might have concerns about the way in which things are done, but to sort of impute those sort of motives is pretty offensive, in my view.

40

Thanks, Mr Bergin. Thank you, Commissioner.

COMMISSIONER: Thank you. Mr Boddice?

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In Australia, the Public Health Association of Australia Inc (PHAA) provide for the exchange of ideas, knowledge and information on public health. Tl Association is also involved in advocacy for public health policy, developn research and training.

Membership is open to any person who is supportive of the objects of the These are:

- to encourage research and promote knowledge relating to the problem and development of public health;
- to promote and provide a forum for the regular exchange of views and
- to promote the development and education of public health workers;
- to promote, maintain and extend the interests of PHAA's Branches, Sp Interest Groups and any affiliated organisations;
- to promote excellence in public health practice; and
- to advocate the objects and policies of the Association.

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health news and events in Australia.

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public health workforce and training and knowledge development in healtl
and reports on these topics and many other are available from the nationa
secretariat.

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Sydney Sax Public Health Medal Winners

The Public Health Association of Australia, in 2000, initiated the first Public Healt
This Medal was designed to be the Associations pre-eminent prize. The Medal is
every year. To be eligible a nominee must:

· Have a proven track record in the advancement of public health in Australia;
· Be an Australian citizen or resident; and,
· Have undertaken his/her activities in Australia.

The criteria for the Medal are that nominees will have actively engaged in work o
Australia designed to achieve one or more of the following:

· Protect and promote public health in Australia;
· Promote multi-disciplinary approaches to designing public health solutions and
public health problems;
· Advance community awareness of public health measures and outcomes and tl
of inadequate public health responses; and,
· Advance the ideals and practice of equity in provision of health care (equity defi
equal care for equal need).

In 2001 the Public Health Medal was re-named the Sidney Sax Medal in honour
Dr Sidney Sax. For further information about the Sidney Sax Medal click on XX.

Winners of the Medal are:

Dr Neal Blewitt - The inaugural Public Health Medal, later renamed the Sidney S
was awarded to Dr Neal Blewitt in 2000 for his record of advancement of public h
Australia.

Professor Mary Sheehan - Was awarded the Sidney Sax Medal 2001, in recogr
involvement in teaching, education, research and service in promotion of public h
the past twenty years.

Professor Judith Lumley - Was awarded the Sidney Sax Medal in 2002, for her
two decades of work dedicated to the promotion of public health and for her effor
improving maternal care in Australia.

Professor Annette Dobson - Was awarded the Sidney Sax Medal in 2003, for h
dedication to public health education and commitment to developing integrative a
disciplinary approaches to solving public health problems in Australia and overse

Associate Professor David Legge - Was awarded the Sidney Sax Medal in 20(
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Health Council's Program.

Dr John Scott
Nominee for the Sidney Sax Public Health Medal
2005

Biography

Dr John Scott graduated from the University of Queensland with a MBBS in 1976, and completed a Bachelor of Economics at the University of New England in 1994. He holds a postgraduate Diploma of Obstetrics (1980) and a Master of Applied Epidemiology from the Australian National University (1994). He is a fellow of several professional colleges, the Royal Australian College of General Practitioners (1989), the Faculty of Public Health Medicine, Royal Australasian College of Physicians (1994) and the Australian College of Tropical Medicine (1995).

After completing his Resident Medical Officer training at the Royal Brisbane Hospital (1977-1978), Dr Scott finished his training as a General Practice Registrar at the Toowoomba General Hospital (1979-1980). He then spent over ten years in general practice at the Ingham Medical Centre in North Queensland (1981-1991). During this period, he acted as State Government Medical Officer for Hinchinbrook Shire, and Shire Medical Officer of Health and Designated Medical Officer for the Civil Aviation Authority. He also chaired the Ingham District Welfare Council and was a committee member for the Queensland Ambulance Transport Brigade and the North Queensland Sub-Faculty of the RACGP. In addition, he held various other honorary positions, including Medical Officer for the boxing and swimming clubs. Dr Scott also spent some time as a locum Medical Officer with the Royal Flying Doctor Service in Cairns (1991-1992).

Dr Scott then went on to undertake postgraduate studies in epidemiology and completed his training as an Epidemiology Registrar with Queensland Health (1992-1994). Over the last twelve years he has held a number of senior management positions responsible for various and then all aspects of public health throughout the organisation, namely:

- Acting Director of Communicable Diseases Branch (1994-August 1995)
- Co-ordinator, Public Health Unit (PHU) Network – responsible for establishing Queensland's first network of 5 public health units (February-May 1995)
- Assistant Regional Director, Community and Clinical, at the Brisbane North Regional Health Authority (August 1995-January 1996)
- Acting Director, Public Health in the Division of Public Health Services (January–October 1996)
- State Manager, Public Health Services, (October 1996-November 2003)
- Seconded to the position of Acting General Manager, Health Services (November 2003)
- Senior Executive Director, Health Services Directorate, following an organisational realignment (from July 2004)

Personal Attributes

Dr Scott is highly respected professionally and personally within the field of public health in Queensland and nationally, the Queensland health sector more broadly, and by key partners of Queensland Health.

His leadership skills, including key strategic, analytical, advocacy, problem solving, decision making and communication skills, have been instrumental in shaping public health practice statewide in Queensland over the past 10+ years. This has included raising the profile and importance of public health within the broader health system and with other government departments, securing significant additional investment in key and emerging public health programs, and ensuring that its place within a contemporary health system has become well understood and well respected.

This has been achieved, in large part, through a strong commitment to partnerships with a wide range of health and intersectoral partners throughout his career, and through the trust he has gained through two Directors-General and three Ministers, to be able to clearly define the problem and the solution, and with their agreement, to go away and deliver on that solution. This has been instrumental in the growing confidence in, and investment in the public health function in Queensland.

A great strength of Dr Scott's is his personal values and his management and leadership style, which clearly supports the development of strong, capable public health leaders, fosters managers and staff who are excited by the opportunities offered by strategic thinking and sound business cases for service improvement, and where he communicates his confidence and trust in the abilities of his unit and network Directors and their staff. In return, he has enjoyed the confidence and support of staff in his ability to lead and deliver on the shared vision for public health services within Queensland. In addition, Dr Scott has shown amazing capacity to maintain the energy required to address obstacles, and resilience and good humour in the face of a daunting workload, ever-present political pressure and diverse public health challenges on a regular basis, all in the context of broader health care system challenges and demands.

Key achievements and supporting testimonials

Since Dr Scott commenced his career in public health, his unwavering vision, leadership, ethical approach, professionalism and strong advocacy have inspired and motivated a broad cross section of people, as a true transformational leader in public health. He has been responsible for, or a key player in, a broad range of significant achievements within Queensland and across Australia, spanning a diverse range of public health challenges from communicable disease issues to nutrition, injury, environmental health and social determinants of health.

In his relatively short time in the role of Senior Executive Director, Health Services, a role in which he has been responsible for all aspects of health service delivery provided or funded by Queensland Health, he has also brought a clear public health perspective to the key challenges for clinical service delivery. In doing so, he has provided a strong population based focus on key reform areas, including action on avoidable hospital admissions, a strengthened primary health care capacity, action on Indigenous health, the interface between public health and clinical service delivery, and equity and accessibility in the provision of health care. A summary of the some of the key achievements in relation to the criteria is provided below.

1. Protect and promote public health within Australia

Dr Scott has demonstrated strong and consistent leadership at both state and national levels to enable the following key achievements:

Public health leadership

- Establishment of Public Health Services as a statewide service of public health functions, consisting of statewide units with policy/program coordination functions and regional-based public health unit networks. Dr Scott's leadership brought together a disparate group of

professions and business units into a strategically focused service, encompassing policy development, regulation, surveillance and service delivery - with a shared vision and clear priorities, with an appropriate balance in relation to delivering on major national and state priorities, strengthening consistency and quality practice across the state, while at the same time being responsive to local needs and acknowledging local capacity and opportunities.

This has been achieved through the implementation of a system for strategic planning, monitoring and reporting, based on key outcome areas providing three year, outcome focused plans which are directly linked to resource allocation processes through a Board of Management and implementation of a quality improvement agenda based on the Australian Business Excellence Framework, now part of Standards Australia. The statewide model for delivery of public health services has involved a level of integration not seen to the same extent in other jurisdictions and is now well respected by public health professionals and administrators within Australia.

- Provision of a strong public health focus to the development of Queensland Health's vision for the future, *Smart State: Health 2020*, the development of its implementation process *Integrating Strategy and Performance (ISAP)* and the reworking of the organisation's mission, vision and strategic intents. It was no accident that four of the seven key sections of Health 2020 clearly acknowledge the importance of disease prevention and health promotion, a whole of government approach addressing the underlying determinants of health and illness, and the role of the health system as a 'leader for health' as well as provider of health services.

Increased investment in public health

- Strong leadership in securing significant additional investment in public health services within Queensland has included:
  - growth in core public health capacity (ie. statewide units and public health unit networks) from approximately 400 positions when Public Health Services came together in 1996 to approximately 750 at the time of this nomination in 2005. During that time, the budget has also doubled.
  - Investment enhancements have extended across a broad range of areas including needle and syringe availability, drug courts, Indigenous public health and primary health care workforce, nutrition and physical activity, tobacco control including environmental health workforce enhancement to support tobacco legislation enforcement, food regulation reform, school based youth health nurses and enhanced communicable disease preparedness and response capacity
  - advocacy for the collaborative state/federal funding for the establishment of three new public health units in western Queensland (Mt Isa, Longreach, Roma and Charleville). Prior to this, there had been no offices beyond the eastern seaboard and Toowoomba.
  - most recently, as part of the 2005/06 budget, substantial additional resources in public health and related primary health care capacity in key public health issues have been secured in relation to:
    - chronic disease prevention (nutrition, physical activity, alcohol and other drugs) totalling $37.7M as part of a $151M chronic disease package over four years and culminating in an additional recurrent investment of $13.3M per annum from 2008/09
    - tobacco control (an additional $4.5M per annum recurrently); and
    - Indigenous health ($89M over four years) for the priority areas of chronic disease prevention and early intervention, cervical screening, sexual and reproductive health, alcohol and drug misuse, environmental health and children and young people's health, again culminating in an additional recurrent investment of over $26M per annum from 2008/09.

Public health legislation

- Leading the substantial reform of Queensland's public health legislation in the areas of pool fencing, safer housing (thermostatic mixing valves to reduce the risk of scalds from hot water to children aged 0 to 5 years, Child Safe Housing guidelines for public housing, building standards), public health, food safety and tobacco control.

A national leader

- Leading activity where Queensland has been a national leader in a number of fields, through the development of new areas like programs for nutrition, physical activity and school-based youth health nurses, development of statewide information systems including NOCS (notifiable conditions) and VIVAS (vaccination information and vaccine administration – ahead of the national ACIR), and in achieving significant performance improvements in areas like immunisation and breast cancer screening in a state with the geographic, Indigenous, GP access and other challenges.
- Longest serving member on the National Public Health Partnership – past Chair, Chair of SIGNAL (nutrition), Co-Chair of SIPP (injury) and a key advocate for collaborative national action on a broad range of public health issues, for example, food reform, the role of general practice in population health, public health surveillance, and food supply and access in rural and remote Indigenous communities.

2. Promote multi-disciplinary approaches to designing public health solutions and solving public health problems

From his broad-ranging training and experience in multiple aspects of public health, combined with his high level understanding of public health problems, Dr Scott brings a clear vision about innovative solutions required to solve public health problems and is a strong advocate for multidisciplinary approaches. This operates at multiple levels, both within the public health workforce itself, practitioners across the health continuum and intersectorally. His strong commitment to working in partnership both within the health sector and intersectorally, combined with his strong and sustained advocacy at multiple levels, has enabled significant progress towards achieving a shared vision. This is well demonstrated through:

- creation of the network of multidisciplinary public health units across Queensland in the early 1990s. This brought together small numbers of existing health promotion and environmental health staff and added public health medical officers, public health nurses and data managers, and over time public health nutritionists, immunisation nurses, epidemiologists, entomologists and vector control officers and additional staff in all existing disciplines.
- promoting the importance of drawing on the value of different perspectives in planning and priority setting through the establishment of a statewide mechanism for strategic and operational planning which brings together multidisciplinary teams from across relevant statewide and public health unit networks into outcome areas teams which are responsible for leading annual planning and review for each program area (eg. environmental health, injury).
- refocusing Queensland Health's vision for the future to clearly acknowledge the integral role of disease prevention and health promotion and whole of government role in addressing underlying determinants of health and illness, as outlined in *Smart State: Health 2020*
- establishment of the Queensland Public Health Forum, consisting of18 member organisations (including commonwealth, state and local government, key professional associations, other state government departments and non government organisations, the

university sector, Queensland Division of General Practice, Inc. and Indigenous health) with a commitment to improve public health outcomes through a partnering approach. The Forum has continued to grow in importance as an effective mechanism for joined up action across the diverse health and related sectors in Queensland.

- establishment of formal partnership agreements and work programs with local government and Education Queensland
- supporting, advocating and securing resources to develop a stronger role for health impact assessment in policy, major infrastructure projects, land-use planning and program development, which involves harnessing the skills of diverse disciplines including such as scientists, urban, town and social planners, social workers, etc.
- establishment of a statewide health surveillance network to more effectively work with and support multidisciplinary public health practitioners with a broad-based focus across the communicable disease, chronic disease and underlying risk and broader social determinants.

3. Advance community awareness of public health measures and outcomes and the real cost of inadequate public health responses

Dr Scott has made a significant contribution to increasing community awareness of public health issues, measures and outcomes by initiating the development and accessibility of improved information on health status and health determinants at zonal and district, local government, general practice and community organisation levels. *Health Indicators for Queensland* (2001) clearly brought together and identified for the first time the significant contribution to ill health by common risk factors, and the burden of ill-health experienced predominantly by the socially and economically disadvantaged. *Health Determinants Queensland* (2004) clearly pulled together for the first time the impact of these factors and the ways we could intervene to address the inequity. Dr Scott's commitment to progressing a system wide understanding of the social determinants of health and the role that the health system has to play in relation to these issues has been critical in moving this agenda forward. These reports have been instrumental in progressing a shared understanding of the social determinants of health as a platform for intersectoral action and have been widely used in planning, priority setting, and partnership development by these stakeholders.

He has been a strong and consistent advocate within Queensland Health, with General Practice through his long term active participation in GPAC, the General Practice Advisory Council, and across government more broadly in increasing broader awareness of the risks of failing to invest adequately in public health responses. This has been demonstrated by significant increases in investment across a broader range of program areas as mentioned above, as well as additional investments in other portfolios such as education, transport (active transport), local government and planning (Indigenous environmental health) and emergency services (safe communities).

4. Advance the ideals and practice of equity in the provision of health care (equity defined as equal care for equal need)

Over an extended time period, Dr Scott was responsible for raising awareness of the social determinants of health across the health sector and the need for ameliorating the effects of social disadvantage and exclusion in reducing health inequalities. His success in this area is demonstrated by ensuring that the strategic agenda for Queensland Health, as articulated in *Smart State Health 2020: Directions Statement*, clearly reflects the social determinants of health.

Dr Scott has also championed the need to improve Indigenous health. In the late 1990s, he established a core of dedicated Indigenous positions within public health unit networks to address environmental health, nutrition and communicable disease prevention and control. More recently, his ongoing advocacy in this area has been instrumental in achieving the significant new investment referred to above in both public health unit and primary health care settings. He has also strongly advocated for sharper focus on Indigenous health challenges via the National Public Health Partnership.

In planning and resource allocation processes, he has consistently challenged and asked the hard questions of PHS managers and staff and the broader department in terms of the focus and investment going beyond 'neat solutions for neat people' and fundamentally addressing the needs of those most in need. In taking a statewide and epidemiological perspective, he has driven a focus on better use of data to understand equity, service and access gaps, to develop different solutions to address these gaps and to evaluate their impact.

Supporting Testimonials

Dr Scott's contribution to the field of public health programs and intervention and his impact across the four inter-related criteria addressed above is best evidenced by the testimonials of colleagues and staff. While too many to include in this nomination, Appendix 1 includes a snapshot of Dr Scott's impact from a small selection of colleagues on his contribution to the field of public health nationally and within Queensland.

Appendix 1: Supporting Testimonials

Reform of Queensland tobacco legislation

In 2001, smoking bans were introduced in many public places and workplaces, and point-of-sale tobacco advertising prohibited. During 2004, Dr Scott successfully led and supported further legislative reforms which built on those introduced in 2001.

The new tobacco legislation represents the toughest and most comprehensive smoking bans in Australia which will make a significant contribution to reducing the public's exposure to environmental tobacco smoke. This has included banning smoking at outdoor areas (including patrolled beaches, children's playgrounds entrances to non-residential buildings and at major sporting stadiums) from 1 January 2005. In addition, the smoking ban for indoor areas of liquor licensed premises is being implemented progressively in three phases so that by 1 July 2006, smoking will be banned in all indoor areas of liquor licensed premises. From 1 July 2006, outdoor areas where food or drink is provided as part of a business will also be no smoking. The new legislation also contributes to a culture that supports smokers trying to quit and discourages young people from taking up the habit.

Research shows that since the commencement of the tobacco legislative amendments in January 2005, 58% of smokers report smoking less in public areas, 26% of smokers report an overall decrease in the number of cigarettes they smoke, and 19% of smokers have made a quit smoking attempt.

(Mark West, Program Manager, Alcohol, Tobacco and Other Drugs Unit, Public Health Services Branch (PHSB)).

National and state nutrition agenda and enhanced public health nutrition capacity in Queensland

Dr Scott has been a particularly active and effective champion for public health nutrition over the last 5 years. Nationally, he has been Chair of SIGNAL, the nutrition arm of the NPHP from 2002 to present. In this role he steered implementation of Eat Well Australia and the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP). With practical flair, he led effective action in three priority areas: Indigenous nutrition (particularly workforce and food supply initiatives); capacity building (especially around national nutrition monitoring and surveillance essential for acquiring reliable and timely data to inform national chronic disease and food standard policy setting); and fruit and vegetable promotion. To support the latter work, he took on the role of Chair of the Australian Fruit and Vegetable Coalition which was pivotal in instigating the recent national social marketing campaign based on the successful Go for 2 fruit and 5 veg developed in WA.

In Queensland Health, Dr Scott together with Director-General Dr Steve Buckland, presided over a huge corporate change agenda to reform public health care in Queensland, including reorientating and building service capacity towards primary prevention and health promotion. As a specific example, the significantly increased funding in nutrition and physical activity since 2002 would not have been possible without Dr Scott as a key driver of this agenda within Queensland. New initiatives announced in the 2005-06 state budget will result in an additional recurrent Queensland Government investment in nutrition and physical activity from 2002 to 2010 to over $16M per annum. These initiatives include enhanced nutrition promotion programs, many with a focus on equity issues particularly amongst Indigenous groups, and increased support for environmental change to help make healthy choices easier choices. All of these initiatives are guided by the evidence-based approaches outlined in *Eat Well Queensland*, the Queensland food and nutrition strategy developed by the inter-sectoral Queensland Public Health Forum, another of Dr Scott's legacies.

Dr Scott's vision, ethical approach, professionalism, knowledge and skills have inspired and motivated a broad cross section of people, as a true transformational leader in public health. In public health nutrition, an often under-appreciated field, Dr Scott has left an inspiring legacy that illustrates clearly the significant health gains which may be achieved by tackling this complex issue.

Dr Scott's track record is notable against all four of the criteria for the Sidney Sax Public Health Medal, and on behalf of the broader public health nutrition community in Queensland and Australia, we urge the selection committee to recognise his achievements by bestowing this honour on Dr Scott.

(Dr Amanda Lee, Principal Public Health Nutritionist, Health Promotion Unit and on behalf of the public health nutrition staff across the state, PHSB).

Increased focus and capacity of health promotion workforce

Dr Scott has shown an ongoing commitment to health promotion action through overseeing the building of a strong health promotion workforce and bringing about significant achievements in the areas of smoking, nutrition, physical activity, alcohol, injury, skin cancer and mental health promotion. His commitment to quality and his willingness to 'ask the hard questions' that build that quality, have been directly responsible for a strengthening of the health promotion capacity of Queensland Health. Under Dr Scott's leadership, increased resources have been committed to health promotion and led to improved outcomes in this area.

This commitment has also extended to increasing the health promotion capacity of the broader Queensland Health workforce. Dr Scott championed the expansion of the range of duties performed by dental therapists in Queensland Health to include prevention and health promotion duties.

(Michael Tilse, Director, Health Promotion Unit, PHSB).

Immunisation

The immunisation program in Queensland has made considerable gains under Dr Scott's leadership and continued strong advocacy for immunisation as a fundamental component of public health.

Dr Scott was responsible for the establishment and development of Queensland Health's vaccine register and state of the art vaccine distribution system, Vaccine Information and Vaccination Administration System (VIVAS). This system was established well ahead of the national system. He also advocated for the establishment of Public Health Nurse (Immunisation) positions in Public Health Units across Queensland. These positions are integral to delivery of the immunisation program across the state and provide critical support to vaccine service providers and the community.

In 1996, an Australian Bureau of Statistics (ABS) survey estimated national immunisation coverage at 53%, and a similar level of coverage in Queensland. Currently, vaccination coverage for children in Queensland at 12 months and 2 years of age is comparable to, or better than, the national average and is over 90%. This is a significant achievement given Queensland's dispersed population distribution, the significantly lower rates of bulk billing by GPs and GP access is rural areas. In recent years, Queensland has led the way in managing quality issues in immunisation, including vaccine management (or cold chain).

Dr Scott also advocated strongly for provision of the Japanese Encephalitis vaccine to the TPHUN in 1995, which enabled an effective response to the outbreak.

(Ms Karen Peterson, Immunisation Coordinator, Communicable Diseases Unit and Dr Ross Spark, Director, Tropical Public Health Unit Network, PHSB).

Indigenous environmental health

Over an extended time period, Dr Scott has advocated in a range of intersectoral forums for increased investment in Indigenous environmental health. This laid the foundations for the recent success in securing significant new recurrent state government investment in this area for the employment of Indigenous Environmental Health Workers by local councils in all Deed of Grant in Trust (DOGIT) communities and Cape York (34 councils in all), and the establishment of Animal Management Workers to focus on issues of domestic and feral animal management. This infrastructure represents a major development in effectively and sustainably addressing what continue to be significant public health issues in these communities. This investment will enable delivery on relatively short term, measurable improvements in the living conditions and selected health conditions of people in these communities.

(Sophie Dwyer, Director, Environmental Health Unit, PHSB)

Communicable Diseases

Through the development of the public health unit networks in the early/mid 1990s, Dr Scott oversaw a tremendous increase in the capacity to respond to communicable diseases of public health importance across the state. There are now eight public health medical officer positions and a significant public health nurse workforce across Queensland who are involved in communicable disease surveillance and control. Their inclusion within the public health unit networks reporting, through the Network Director, to the Executive Director, Public Health Services Branch, as does the Director, Communicable Diseases Unit, greatly enhances the ability to coordinate and standardise their activities throughout the state.

Queensland is now in the enviable position of being well-resourced and efficiently organised from a communicable disease control perspective. This has enabled us to undertake enhanced surveillance for a range of conditions, to be able to respond well to urgent matters such as outbreaks, and to work together, support each other and quickly marshall the necessary resources in urgent situations.

When he was State Manager, Public Health Services, Dr Scott supported the development of the Notifiable Conditions Information System (NOCS), which pioneered electronic disease notification in Australia. This system has greatly enhanced the timeliness and ability to respond to notifiable diseases across the state.

He was also instrumental in driving significant policy reform in relation to the role of nurses and other health practitioners in the areas of immunisation and sexual health service delivery and isolated practice more generally.

(Dr Linda Selvey, Director, Communicable Diseases Unit, PHSB)

Dr Scott secured critical resources to establish the Dengue Action and Response Team (DART) in the Tropical Public Health Unit Network, following an outbreak of dengue fever in 1998 with further enhancements in 2004. The DART has been highly successful, the key to the success being the early recognition and notification of a dengue case, followed up by thorough, effective mosquito control. This level of infrastructure has proved critical in managing the 2005 outbreak in the Torres Strait.

(Dr Ross Spark, Director, Tropical Public Health Unit Network, PHSB).

Dr Scott supported a whole of government approach to HIV/AIDS, Hepatitis C and Sexually Transmissible Infections through the development and Cabinet endorsement of the

Queensland *HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005 – 2011*. This whole of government endorsed strategy is a first for any state or territory government.

Dr Scott has also provided sponsorship of the Queensland Health and Papua New Guinea (PNG) HIV/AIDS and Sexual Health Collaboration Project to develop a joint work plan with PNG colleagues to address the unique public health challenges within the Torres Strait Treaty Zone.

He was also responsible for securing recurrent state funding for the zonal sexual health medical officer in the Tropical Public Health Unit network, which has had a direct and positive impact on the unique challenges related to sexual health service delivery to the large Indigenous population of North Queensland.

(Mr Mark Counter, A/Manager, HIV/AIDS, Hepatitis C and Sexual Health, Communicable Diseases Unit, and Dr Ross Spark, Director, Tropical Public Health Unit Network, PHSB).

Cancer Screening

Dr Scott recognised the importance of the population based cancer screening programs of BreastScreen Queensland and the Queensland Cervical Screening Program in the early stages of forming Public Health Services. He became a strong advocate and corporate supporter of these public health interventions and assisted greatly in their ongoing establishment and growth in Queensland. He also provided key advocacy at the national level by raising key issues, particularly about the level of resourcing to continue to grow these programs in line with population growth and aging and through his negotiations for the Public Health Outcomes Funding Agreements over the last eight years.

A key part of his leadership is evidenced by his support and advocacy for the development and implementation of the software application for the Registry databases that underpin these programs, in the face of many challenges in information management and technology.

The achievements of these programs in Queensland have been facilitated by Dr Scott's supportive and visionary leadership.

(Ms Jennifer Muller, Director, Cancer Screening Services Unit, PHSB).

Establishment of a health surveillance network with a broader focus on social determinants

When Public Health Services was formed in 1996, the health surveillance workforce was very limited and professionally aligned with communicable diseases only. Dr Scott recognised that in order to make significant gains in improving the health of Queenslanders, health surveillance across the range of health outcomes and broader social determinants was required, in order to provide information for decision making through monitoring and evaluation within public health as well as advocacy for public health across the health sector.

Public Health Services Branch now has a coordinated workforce of epidemiologists and other health surveillance staff who work collaboratively with public health managers, practitioners, policy officers to provide, collect, analyse and communicate information across the breadth of diseases and determinants amenable to public health intervention within PHSB, but more importantly beyond PHSB. The lighthouse was always clear, and Dr Scott was responsible for keeping it shining.

(Ms Catherine Harper, Coordinating Epidemiologist, Planning and Research Unit, Public Health Services Branch).

Reflections from a colleague and fellow advisory board member

Dr John Scott was one of the original members of the Advisory Board for the Centre for Public Health Law. His contribution was always thoughtful, practical and grounded in a sophisticated understanding of how the law might support solutions to public health problems. One example I recall was a conversation about the obesity issue and a problem where local councils were charging fees for use of playing grounds, affecting the ability of small, local sporting clubs to use the grounds. Comments were being made about the short sighted approach of the Council. Dr Scott said that he thought it was appropriate for councils to charge for use of the playing grounds. He said that, in deciding what to charge sporting clubs, consideration should be given to the contribution made to the community in fostering activity, community involvement, etc. The value of the community contribution made by sporting clubs would reduce the amount they should pay to a nominal amount. This was an elegant solution which saw council by laws pursuing cost recovery, but not at the expense of a public health approach.

In addition to his contribution to conceptual thinking, he was supportive on a personal level and agreed to be a mentor of one of the Centre's Legal Interns.

(Genevieve Howse, Director (Programs), Centre for Public Health Law)

Social determinants of health

Dr Scott has been instrumental in raising awareness of the social determinants of health across the health sector and in embedding action to address these determinants of health within the work practices of Public Health Services in Queensland. Work in this area was in its infancy in Australia when Public Health Services, under the leadership of Dr Scott, undertook the challenge to determine Public Health Services' role in addressing social determinants. Dr Scott has demonstrated the importance of ameliorating the effects of social disadvantage and exclusion in reducing health inequalities. As a consequence the organisation now has a clear charter to address equity issues.

Dr Scott's leadership in addressing the social determinants of health has significantly influenced the policy and practices of Queensland Health. Examples include:

- Increased organisational capacity to redress health inequalities, through promoting integration of public health practices, further research to increase our understanding of the causal pathways and intervention points and investing in community engagement functions.
- Strengthening community action, including sponsoring multiyear projects such as the Community Public Health Planning in Rural and Remote Areas Project, a community development project undertaken in remote disadvantaged communities. This approach has now been embedded as a core aspect of the practice of the Western public health units.
- Building supportive physical and social environments and healthy public policy through greater investment in public health planning and health impact assessment functions
- And ensuring the social determinants of health are embedded in the policies of the broader department including the *Smart State Health 2020: Directions Statement*

Whilst Dr Scott's leadership in addressing the social determinants of health has significantly influenced Queensland Health's policy and practices, he has also personally undertaken the role of champion for these issues across the health sector and with other government departments. Whether he was among colleagues, addressing public forums or conferences or meeting with the CEOs of other government departments, Dr Scott was able to raise awareness of the social determinants of health and mobilise action accordingly.

(Paul Harris, Natalie Baig & Garth Henniker, Senior Project Officers, Health Promotion Unit, Public Health Services Branch)

Contribution to the National Public Health Partnership

Dr Scott has been the Queensland member of the NPHP since February 1999. From October 2001 to September 2002, he served as Chair of the NPHP. As Chair, Dr Scott presented the future priority agenda of the NPHP which was endorsed by CEOs of Health (Australian Health Ministers Advisory Council - AHMAC) and oversighted work across a range of key public health issues including environmental health, health information development, public health genetics, communicable disease control, child and youth health, legislative reform, General Practice and population health, and mental health prevention and promotion.

Dr Scott was instrumental in the establishment of the Aboriginal and Torres Strait Islander Working Group of the NPHP and was a key player in the development of the Smoking, Nutrition and Physical Activity (SNAP) framework which has been developed as a resource for general practice.

Since 2002, Dr Scott has chaired the Strategic Inter-governmental Nutrition Alliance (SIGNAL), with responsibility for oversight of *Eat Well Australia*. He led work to progress implementation of the *National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010*; to facilitate nationally consistent health promotion messages on the consumption of fruit and vegetables; and engagement of the food industry through the establishment of the Australian Fruit and Vegetable Coalition. He also represented SIGNAL on the National Obesity Task Force (NOTF) addressing healthy weight issues for children, adults and older Australians.

Since 2002, Dr Scott has co-chaired the Strategic Injury Prevention Partnership (SIPP). During this time he assisted in oversight of implementation of the *National Injury Prevention Plan* and development of a suite of new national strategies for injury prevention and safety promotion, consisting of the *National Injury Prevention and Safety Promotion Plan 2004-2014* and the *National Aboriginal and Torres Strait Islander Safety Promotion Strategy*.

On behalf of the NPHP, Dr Scott led the work on development of a Public Health Action Plan for an Ageing Australia to contribute to the *National Strategy on Healthy Ageing*. The Plan was endorsed by Health and Community Services Ministers. Implementation commenced under the auspice of the NPHP in 2005 and with the support of the Positive Ageing Taskforce of the Community Services Ministers Advisory Council.

On behalf of NPHP, Dr Scott has raised issues for AHMAC related to refugee health, and has championed state and territory and Australian Government contribution to a project for improving access to healthy foods in remote Indigenous communities in Australia.

(Ms Karen Roger, Secretariat, NPHP).

Reflections on local and national public health capacity-building from a former Public Health Unit Network and NPHP colleague

John Scott followed on from the vision of Diana Lange and Gerry Murphy to become the driving force in implementation and coordination of a newly established public health unit network across Queensland - a network that grew remarkably rapidly to provide a consistent and coherent public health protection and promotion service that remained responsive to local needs.

The National Public Health Partnership has benefited not only from Dr Scott's chairing, but also from his drive and leadership in a number of its output areas – particularly in areas such as SIGNAL and SIPP. Systems changes in such areas require time, and the benefits of this work will continue to be realised for some time to come.

There have been several keys to Dr Scott's success in public health. One is his commitment to multi-disciplinary approaches to solve public health problems, as exemplified by the management and professional leadership structures put in place in Queensland's Public Health Services. Many of the excellent achievements described above obviously were not the result of a single person's effort: what is important to note is that Dr Scott provided an enabling and supportive environment for work colleagues to collectively and effectively progress mutual goals. Another success factor has been an ability to extrapolate from the local to the national, to bring about systemic responses to address public health issues such as Indigenous nutrition. He had the ability to provide, in appropriate circumstances when support was required from key decision-makers, a brief narrative based on local knowledge and experience to illustrate the need for and benefits of a public health intervention. This helped bring about a sense of the practical importance of public health and build strategic alliances. These attributes, combined with a pointed sense of humour and irony, have made John Scott a highly effective public health practitioner well-deserving and worthy of the honour of the Sidney Sax award.

(Dr Roscoe Taylor, public health physician in Central Queensland Public Health Unit 1994 – 2002; Director of Public Health and Director of Population Health, Tasmania and NPHP member since 2002).

Reflections from a NPHP colleague

I would like to contribute to the nomination of Dr John Scott for the Sidney Sax Public Health Medal 2005. I am sure there are many public health professionals who would welcome the opportunity to advocate for Dr Scott as an outstanding public health professional for this nomination and I am but one of those.

I have known Dr Scott for approximately ten years. My association with John has been through national committees concerned with public health in Australia, particularly the National Public Health Partnership (NPHP), SIGNAL and SIGPAH.

Dr Scott is an eminent public health professional in Australia, particularly in view of his experience, his good character, his broad knowledge and ability to translate that knowledge articulately, his sound counsel in balancing the political dimension, industrial and community issues we deal with and his ability to take a leadership role.

Dr Scott has employed all of these attributes within his role in the NPHP and other national committees and has promoted public health at the highest level within the national context.

His aims have always been the protection of public health and safety of the community and he has always acted impeccably.

Of particular significance has been his leadership in the nutrition area in chairing the SIGNAL group and in so doing bringing nutritional issues to the highest level of government. This has been demonstrated through the NPHP and the Australia New Zealand Food Standards Ministerial Council.

Dr Scott has recently promoted the 2 Fruit & 5 Veg Campaign in the national arena by enlisting the support of the food industry, particularly the horticultural industry, supermarket chains and marketing companies in the promotion of fruit and vegetables. This together with his work in the promotion of other lifestyle issues such as physical activity are key determinants in many of the chronic diseases affecting the Australia and New Zealand public which have a profound impact on the health costs of the Australian health system.

I believe that Dr Scott more than satisfies the criteria for this medal in that he has protected and promoted public health within Australia in particular, but has throughout his career addressed all of the criteria for this medal.

It is without hesitation that I highly recommend Dr Scott as an eminent public health professional and one who is eminently appropriate for the award of the Sidney Sax Public Health Medal 2005

(Michael P Jackson, Executive Director, Population Health, Western Australia Department of Health)

A former peer's and academic perspective

Over a period of more than 10 years, Dr Scott has bought a practical reality to the public health agenda in Australia, bringing his disciplinary backgrounds in economics and general practice to a commitment to population health. Perhaps more than any of the other government based leaders of public health in Australia, he has been able to articulate a vision of population health as the public health-clinical interface in a way that resonated to Director-Generals of Health. Through his leadership, Queensland government has adopted this as can be clearly seen in the *Health 2020 Strategic Directions Statement*.

(Professor Andrew Wilson, University of Queensland)

ATTACHMENT "F"

1.	Exhibit 301C, paragraphs 28 – 33, 109 – 110	1 – 2
2.	Attachment MIC-7 to exhibit 301C	3 – 8
3.	Exhibit 263, attachment CA4	9 – 15
4.	Transcript 6269 – 6270	16 – 17
5.	Exhibit 301C, MIC - 21	18 - 27

February 2003. The Director General, subsequently requested the issue be progressed.

22 Discussions took place between the Director General, General Manager Health Services and Zonal Managers, who provided 'in principle' support to the transfer of activity and resources.

23. Following these discussions, Queensland Health made a decision in early 2003, to expand cardiac services at PAH through the transfer of services from TPCH.

24 The Cardiac Surgery Services Working Party was commissioned and a project officer appointed to provide a detailed assessment of the recurrent and capital requirements of the service expansion.

25. A copy of the Cardiac Surgery Services Working Party Terms of Reference are attached and marked **MIC-3**.

26. In April and May 2003, both TPCH and PAH prepared Impact Analysis Reports based upon the transfer of 300 cardiac surgical procedures, 700 coronary angiograms and 233 coronary angioplasty procedures. Copies of those impact reports are attached and marked **MIC-4**.

27. Due to some disparities in the two reports, it was agreed at the May 2003 Cardiac Surgery Services Working Party meeting, that an external consultant would be appointed to review both business cases to determine the reasonableness of the assumptions and projections Mr Jim Lowth, was appointed to undertake this process. Copies of the minutes of that meeting are attached and marked **MIC-5.**

28 On 30 July 2003, a meeting was held between myself, Mr Lowth, Graeme Kerridge, Manager Central Zone Management Unit and Dr Paul Garrahy, Director of Cardiology, PAH to finalise the cardiac services activity transfer.

29. It was agreed at that meeting that the final transfer numbers would be 300 cardiac surgical procedures, 500 coronary angiograms and 96 coronary angioplasty/stent procedures.

30 The transfer in cardiology activity was to commence in April 2004. The transfer in cardiac surgical activity was to commence in July 2004. Attached as a bundle and marked **MIC-6** is copies of memorandums from me to department heads regarding this transfer.

31. Despite the transfer of activity from TPCH to PAH, demand for cardiology and cardiac surgery continued to increase.

32. Submissions were made for additional funding for cardiac surgery by TPCH to Dr John Scott, Acting General Manager Health Services on 24 May 2004. Attached and marked **MIC-7** is a copy of that submission.

33. Additional funding in the sum of $2.4M was provided in the 2004-2005 financial year to undertake additional cardiac surgery at TPCH.

109. On 12 October 2004, I prepared a briefing to Dr Scott, Acting Senior Executive Director Health Services in relation to these issues. A copy of that briefing is attached and marked **MIC-21**.

110. In response to this briefing, Queensland Health provided additional funding as follows:

- October 2004 $1.07M (used for additional angiography and ICD activity);
- December 2004 $1.4M (allocated to ICD, ASD closures and angiography);
- April 2005 $3M (used to support ICU, transplants - heart and lung, and oncology).

111. The cumulative effect of the additional funding allocations referred to above has been that, since February 2005 (the date from which reliable data on this topic is available to me):

- The angiography waiting list reduced from 192 to 99 cases;
- The angioplasty waiting list reduced from 52 to 48 cases;
- Currently only 7% of Category 1 angioplasty cases are waiting longer than their recommended 30 days compared to January 2005 when 30% of such cases waited longer than 30 days;
- The waiting list for defibrillators has reduced from 68 (February 2005) to 55 (current). Of these current cases, over 70% are facing a wait longer than their recommended 30 days. However, only last week I submitted a funding request for an additional $2.1M to address their wait. I am optimistic of a favourable outcome to my funding request;
- Currently the cardiac waiting list for new patients is 575 cases compared to 745 such cases in October 2004.

112. Attached and marked **MIC-21A** are true copies of the statistical data on average waiting times for cardiology services (other than out-patients)

Resignation of Aroney and credentialing/privileging issues

113. By letter dated 9 March 2005 addressed to Ms Wallace, Dr Aroney gave written notice of his resignation from TPCH. In that correspondence, Dr Aroney requested ongoing privileges at TPCH. By letter dated 21 March 2005, I advised Dr Aroney that *'if the need arises, the process for considering and awarding privileges will be awarded through Medical Administration'*. A copy of that correspondence is attached and marked **MIC-22**.

114. I note in paragraph 58 of his statement, Dr Aroney states that his offer to provide services was *'effectively refused'* and that it was treated *'as a request for privileges rather than an offer of voluntary service'*.

115. I refer to my previous statement to the Commission of Inquiry, regarding the role of the EDMS signed 23 August 2005. In paragraph 6 (e) and (f) I have provided information regarding the way in which clinical privileges are awarded. For any person who is not a member of staff at TPCH, privileges are granted on a case-by-case basis for each procedure undertaken. This is a very simple process and is approved by the EDMS or the EDMS on-call.

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-7

EMAILED
MCZ 4/6/04

02-03.3.

Queensland Government
Queensland Health

SUBMISSION TO THE A/GENERAL MANAGER HEALTH SERVICES

DATE:	24 May 2004		
PREPARED BY:	Paul Winton – Program Business Manager, Cardio-Thoracic Surgery, Orthopaedic Surgery & Critical Care, TPCHHSD	**Contact No:**	(07) 3350 8802
	Dr Greg Stafford – Program Medical Director, Cardio-Thoracic Surgery, TPCHHSD	**Contact No:**	(07) 3350 8696
	Mary Wheeldon – Nursing Director, Cardio-Thoracic Surgery, Orthopaedic Surgery & Critical Care, TPCHHSD	**Contact No:**	(07) 3350 8215
	Jon Roberts – Executive Director of Finance & Information Services, TPCHHSD	**Contact No:**	(07) 3350 8418
	Dr Michael Cleary – Executive Director Medical Services, TPCHHSD	**Contact No:**	(07) 3350 8226
CLEARED BY:	Gloria Wallace - District Manager, TPCHHSD (signed G Wallace 3/6/04)	**Contact No:**	(07) 3350 8224
SUBMITTED THROUGH:	Mr Dan Bergin – Zonal Manager, Central Zone Management Unit	**Contact No:**	(07) 3234 0825
DEADLINE:	District Initiated	**File Ref:**	02.03.3

SUBJECT: Funding Submission – Extra Activity Cardio-Thoracic Surgery

APPROVED/ NOT APPROVED

COMMENTS

Dr John Scott
A/General Manager Health Services

PURPOSE:

To seek additional funding to allow The Prince Charles Hospital to increase elective Cardiac Surgery throughput.

BACKGROUND:

The potential exists for The Prince Charles Hospital (TPCH) to increase elective Cardio-Thoracic surgery for the 2004/2005 financial year.

TPCH supports the largest Cardio-Thoracic Surgical Service in Australia.

TPCH redevelopment included 2 x 30 bed Cardio-Thoracic Surgical wards and an expanded operating theatre complex. The planned capacity in the redevelopment allowed for significant workload increases in cardiac and thoracic services.

Currently the Cardio-Thoracic service utilises 44 of the 60 beds allocated to Cardio-Thoracic Surgery. An average of 38 half day operating sessions per week are currently used to achieve funded activity levels.

As a result of the transfer of 300 cardiac surgery cases to the Princess Alexandra Hospital (PAH), there will be vacant theatre sessions available to facilitate additional Cardio-Thoracic Surgical activity.

ISSUES:

Queensland Health is in the process of expanding the cardiac service infrastructure at the PAH through the allocation of growth funds to PAH and the transfer of funding from TPCH to PAH. Planned activity transfer included transfer of both surgical and interventional cardiology.

To a large degree interventional cardiology activity from the Southern Zone has shifted to the PAH during the past 18 months.

- As at 1 April 2004, TPCH had 380 patients on the Cardio-Thoracic Surgical Waiting List, in the following categories:
  - Category 1 – 65
  - Category 2 – 243
  - Category 3 – 72

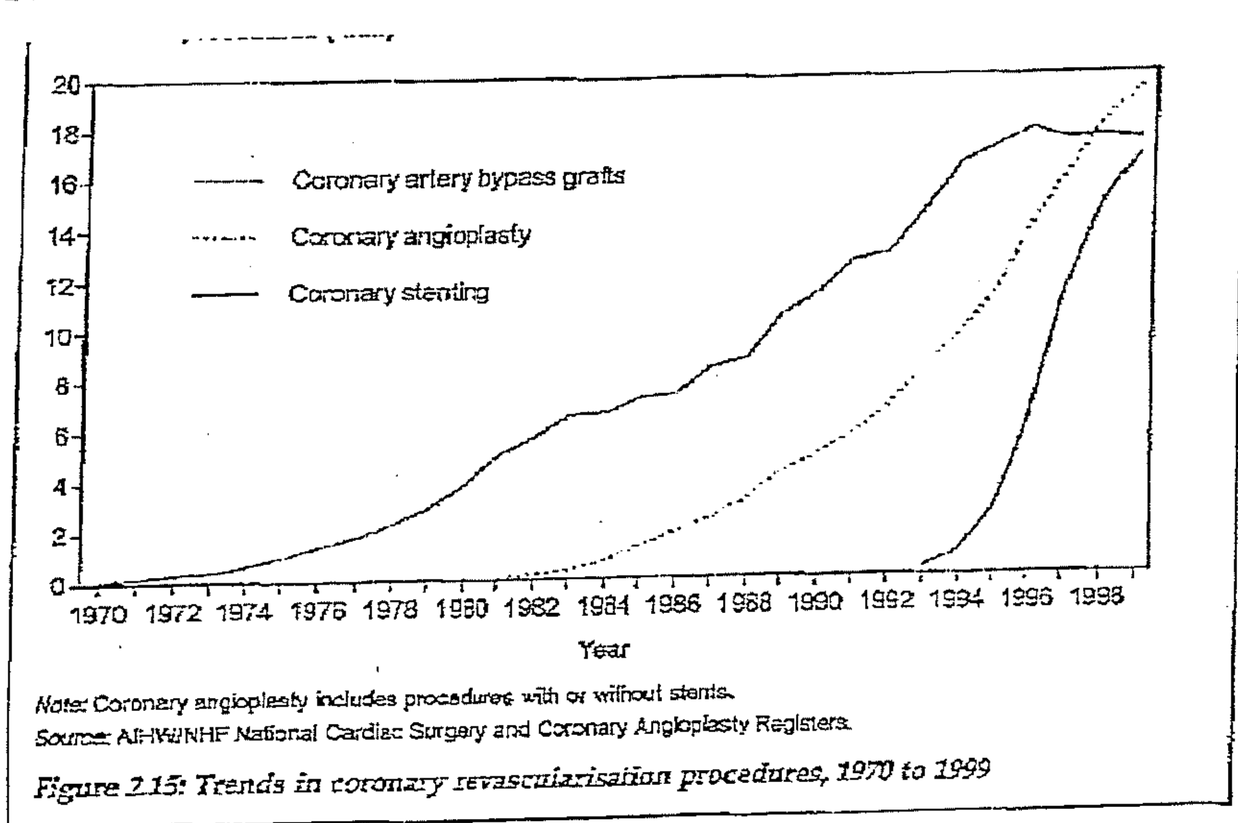
- As at 1 April 2004, TPCH had 79 new patients waiting to be seen in Cardio-Thoracic Surgical Outpatients.
- The average waiting time for a new patient appointment for a Cardio-Thoracic Surgical Outpatient Clinic is 5 weeks.
- New surgical referrals from the Cardiology Department to the Cardiac Surgical Department have increased over the previous 12 months from approximately 15 cases per week to over 20 cases per week.
- Ten to fifteen percent of cardiac surgical activity undertaken at TPCH relates to patients from the Southern Zone who require specialist services eg. Congenital Heart Surgery for children, transplantation, etc.
- Given the success of donor rates, transplantation procedures are likely to increase.

- Additional funding to support interventional cardiology totalling $2.0M has been approved for the 2004/05 financial year. This will result in an increase in the number of angiograms being performed within Queensland. Given that 30% of patients having angiograms are referred for surgery, this increase in cardiological activity will result in additional patients being referred for surgery.
- In Australia revascularisation (coronary angiogram and stenting procedures) rates vary across all states. Queensland rates are significantly lower than the national rates (see table 1 and figure 1).
- Clinical practice changes related to the treatment of acute coronary have resulted in, and will continue to result in, an increase in patients requiring acute cardiac surgery.
- As the population ages there will be an increasing need for cardiac valve surgery.
- Adults who as children had cardiac surgery to treat congenital heart conditions are increasingly requiring further corrective surgery. This is an emerging area of cardiac surgery demand.

TABLE 1:Percutaneous coronary intervention rates per million of population by region, 2000

	National Rate	Queensland Rate	Variance	Victorian Rate	West Australian Rate	SA & NT Rate	Tasmanian Rate
PCI	1125	944	-181	1370	1065	1155	1203

FIGURE 1:



Note: Coronary angioplasty includes procedures with or without stents.

Source: AIHW/NHF National Cardiac Surgery and Coronary Angioplasty Registers.

Figure 2.15: Trends in coronary revascularisation procedures, 1970 to 1999

BENEFITS AND COSTS:

Increasing the level of cardiac surgical activity at TPCH will provide the following benefits:

- Assist with the reduction of Category 2 long wait patients at TPCH.
- Improved community access to elective cardiac surgery.
- Increase the utilisation of the spare physical capacity at TPCH.
- Maintain service at TPCH in line with the Hospital Redevelopment Business Case.
- Reduce the average cost per weighted separation at TPCH.
- TPCH current activity target is 42,000 weighted separations under Phase 8 Cost Weights.
- The provision of an additional $2,432,500 in funding would allow an increase in net activity of 973 weighted separations under the Phase 8 Cost Weights.

CONSULTATION:

N/A

ATTACHMENTS:

N/A

RECOMMENDATION(S):

The Acting General Manager Health Services approve the allocation of an additional $2,432,500 in funding for elective cardiac surgery in the 2004/2005 financial year.

CA 4

SUBMISSION TO THE
A/GENERAL MANAGER HEALTH SERVICES

DATE:	24 November, 2003		
PREPARED BY:	Dr Andrew Galbraith, Program Medical Director, Cardiology, TPCHHSD	Contact No:	3350 5566
	Tony Shields, Acting Program Nursing Director, Cardiology, TPCHHSD		3350 5884
	Hayley Middleton, Program Business Manager, Cardiology, TPCHHSD		3350 8913
CLEARED BY:	Jon Roberts, Executive Director Finance and Information, TPCHHSD	Contact No:	3350 8418
	Cheryl Burns, Executive Director Nursing Services and Sponsor for Cardiology		3350 8214
	Dr Michael Cleary, Acting District Manager, TPCHHSD		3350 8224
SUBMITTED THROUGH:	Dan Bergin, Central Zone Manager	Contact No:	3234 0825
DEADLINE:	URGENT	File Ref:	CPMT03-001

SUBJECT: Emergency and Unplanned Activity Demand for patients presenting with Acute Coronary Syndrome and existing resource availability for treatment

APPROVED/ NOT APPROVED

COMMENTS

Dr John Scott
A/General Manager Health Services
/ /

PURPOSE:

To inform Queensland Health and confirm Zonal support of demand management strategies being put into place to provide treatment to adult patients presenting with Acute Coronary Syndrome to Queensland Public Hospitals and subsequent referral options to The Prince Charles Hospital Catheter Laboratory.

To seek additional funding within Central Zone to address the increasing ratio of emergency/ unplanned activity that is compromising capacity to undertake elective revascularisational procedures at The Prince Charles Hospital.

BACKGROUND:

Despite a decline in Cardiovascular deaths, mortality reduction has not been achieved equally amongst the population. Gains continue to be linked to higher socioeconomic groups who are more likely to be managed in the private HealthCare system. Thus the major burden in terms of funding and demand remain on the public health system.

Queensland's tyranny of distance results in mortality increasing with distance from large population centres. Queensland Health Information Centre confirms that mortality rates are statistically higher in remote areas (25%) and socioeconomically disadvantaged areas (10%).

The challenge facing Catheter Laboratories is managing the increasing demand, both metropolitan and rural/remote. Increased demand for access by regional public hospitals to transfer at-risk patients to tertiary centres has occurred as clinical management shifts to adopt and reflect Acute Coronary Syndrome Guidelines. These guidelines are aligned to both European and American clinical management.

Unplanned Demand

The Inter-hospital transfer rates for non-surgical cardiac DRGs has exponentially grown over the last 2 years. Inter-hospital transfers now accounts for over 50% of the PCI activity at TPCH. The current budget is set for an average of 13 PCI's per week. Over the preceding 12 months there has been a significant increase in the number of Inter-hospital transfers requiring interventional activity from 33% of PCI activity in 2002 to 50.5% in 2003. In terms of absolute numbers, this has grown from 46 patients in the September 2002 Quarter to 93 in the September 2003 Quarter. The full year growth in PCI activity from Inter-hospital transfers is projected at an additional 188 patients.

Elective Demand

Categorisation used for Elective patients is similar to that used for elective surgery.

Current Elective Waiting List

[illegible]	Waiting Time [illegible]	[illegible]	[illegible]	[illegible] PCI [illegible]
Angio Cat 1 (30 days)	155	34	67	15
Angio Cat 2 (90 days)	[illegible]	[illegible]	[illegible]	[illegible]
Angio Cat 3 (365 days)	5	1		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PCI	12	12	8	8
Total	[illegible]	[illegible]	[illegible]	[illegible]

This data is not reported with the elective surgery data.

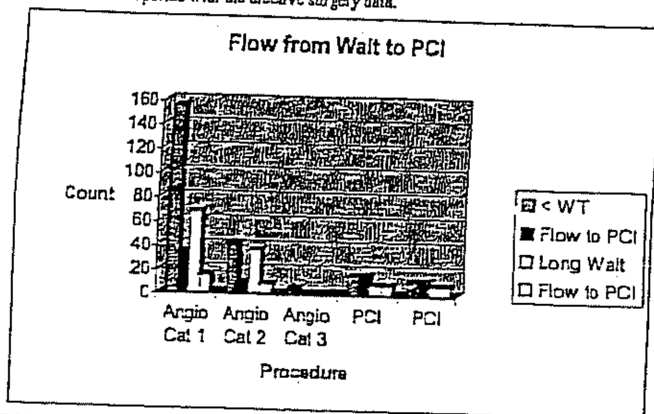


Table 1: Elective Waiting list and flows to PCI (Stents)

Improving Treatment Options

Patients presenting to Emergency Departments throughout Queensland with the following indications constitute the demand for access to the TPCH Catheter laboratory:

- Myocardial infarct
- Unstable angina
- At risk patient groups:
  - Pain or ischaemia refractory to medical therapy
  - ECG changes (depression or inversion)
  - Positive serum markers, eg Troponin levels
  - Associated heart failure or haemodynamic instability
  - High risk on stress testing
  - Recent MI or revascularisation

All patients are risk stratified through the TIMI score to prioritise patients in terms of clinical need to determine appropriate timeframes for transfers.

High Risk Patients

Early invasive revascularisation is recommended for high-risk patients with an ACS to reduce the six-month relative risk of death, infarct or re-hospitalisation for ACS. These patients are the most at risk of having a subsequent coronary event and therefore have the most to gain from early treatment.

Whilst the current average ratio of patient:stent is resourced at 1:1.38 – there is significant risk in this ratio increasing over time as the complexity of patients grows and scope of the procedures expand. Given the significant financial implications of changes within this ratio, it will require monitoring and planning in terms of numbers of stents and numbers of patients resourced.

Timing of Therapy is shifting – evidenced- based medicine and medicine-based evidence

The Cardiac Catheterisation Laboratory has experienced increased demand over the preceding years and the change in ratio between elective and emergency / unplanned transfers is now placing significant pressures on the service to continue to function within current resource allocations. Demand management strategies have revolved around capacity within the elective waiting lists to absorb the increased demand from inter-hospital activity. However, the elective lists now include a number of patients outside the best-practice waiting time to access service. There is also increased waiting times for inter-hospital transfers and these are being managed based on clinical priority.

The CHI Cardiac Collaborative activities focus has had an emphasis on the secondary prevention activities to deliver improved outcomes. There is anecdotal evidence that needs to be further reviewed, that would suggest a significant decrease in the practise of lysing in regional public health facilities. This would reflect improved awareness of the ACS guidelines and a desire to improve patients' outcome, reduce disability of patients by fast-tracking access to revascularisation.

Technology Impacts – the issue around substitution

The scope of revascularisation within the Catheter Laboratory environment does have some impact on the number of procedures undertaken surgically. This change in scope of procedures within a laboratory environment will continue to escalate as new technology (viz drug eluting stents) becomes available. The impact of substitution needs to be assessed in conjunction with revascularisation demand projections based on the ageing population and underlying burden of disease in Australia.

Unplanned Admissions

The ratio of unplanned admissions impacts on service delivery planning and has an impact on the efficient utilisation of resources. Elective patients are often not scheduled given the risks of outlier patient bed management from inter-hospital transfers waiting in regional hospitals. There are inherent difficulties in planning for what is in its very nature – an unplanned event.

To address this, the Catheter Laboratory is building a model to predict the daily number of admissions in the short to medium term. An important aspect of this model will be to quantify daily risk that the actual number of admissions will be within this prediction. Development of this model has identified a likely further impact on capacity for local elective activities.

<u>ISSUES:</u>

- The cardiac catheterisation intervention rate has been regulated at TPCH in an attempt to contain activity within available funding for the District.
- The level of intervention for a public patient in Queensland verses the rest of Australia is 351.5/million (Qld) population compared to 565.3/ million (Aust.) population (data from the 2001/2002 National Hospital Cost Data Collection). This confirms that public intervention rates in Queensland are significantly below the Australian average. (Refer to Table 2)

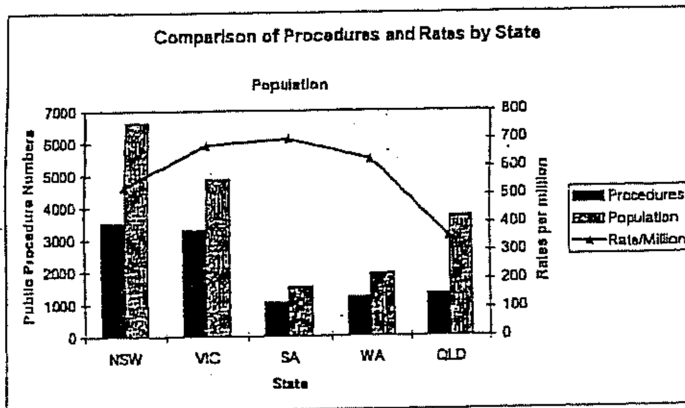


Table 2: Queensland has the lowest rate per million for major states.

- There has been a significant increase in the number of Urgent Inter-hospital Transfer's to TPCH. (Refer to Table 3)

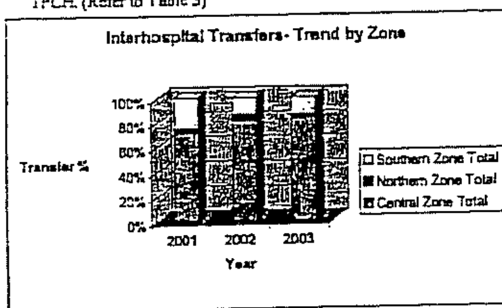


Table 3: Inter-hospital Transfers

- Intervention rates at RBWH appear to be static and therefore have not contributed to the increased demand at TPCH.
- Patients from the Southern Zone are actively redirected to the PAH. There are currently no Southern Zone patients on the Inter-hospital transfer list at TPCH. This is supported by an analysis of all cardiac related DRG's for the last 3 years
- Patients from the Northern Zone are actively redirected to Townsville. Reduction in actual numbers at TPCH has been offset by the commencement of TPCH Cardiologists travelling to Townsville monthly to undertake procedures at that centre. There is an agreement in place to recover marginal costs associated with PCI activity for the Northern Zone.

- The potential for diagnostic procedures to progress to percutaneous revascularisation is approximately 22 - 25%. Meeting these elective requirements is difficult to accommodate within the current resources.

- The District is progressing integration between RB&WHHSD and TPCHHSD Cardiac Services. There is preliminary commitment to developing a single coordination for both Catheter Laboratories. The first phase of this includes exploring how single point coordination and logistics can be operationalised in terms of emergency and requests for inter-hospital and urgent unplanned admissions. This model is in alignment with strategies being employed in Metropolitan Sydney and Melbourne with coordination across Cardiac services to address emergency and unplanned urgent cases. The Working group across TPCH and RB&WHHSD will be reviewing and exploring this model as progress is made toward integration.

BENEFITS AND COSTS:

Management of Acute Coronary Syndrome is hospital based and resource intensive. The centralisation within Metropolitan areas of public cardiac catheter laboratories supports improved outcomes through volume, but also adds to demand in trying to respond to planned and unplanned activity from many referring sources and populations with varying community and social determinants and risk factors.

The *Health 2020* documents identify the need for more locally accessible and community based services in terms of access to health services. It also identifies that Acute Hospitals will become more specialised with higher volumes of complex care. There is significant work already underway in terms of health promotion and secondary prevention for managing cardiovascular disease. There remains a need for decision and appropriate investment regarding the model of care for management of acute coronary syndrome within public hospitals.

Strategies identified in the Queensland Health Outcomes Plan - Cardiovascular Health: Coronary Heart Disease 2000-2004 for Clinical management identify the following key areas relative to Acute tertiary services targeted to improve service response to Queenslanders.

- The adoption of evidence based practice for the clinical management of acute myocardial infarction (AMI), unstable angina and post cardiac surgery patients by service providers.
- A coordinated response by emergency services to acute coronary events.
- Early identification and resuscitation of people who suffer from AMI.

Costs of care are shifting and will now be front-loaded within initial acute presentation for Acute Coronary Syndrome. The District request a Health Technology Assessment be undertaken regarding the health outcomes and economics of investing in initial acute presentation and treatment for Acute Coronary Syndrome and identification of the flow on savings that would support the significant growth required for Queenslanders to access this therapy.

Based on the current demand for urgent care directly resulting from Inter-hospital Transfers, the District estimates the need to perform an additional 188 procedures per annum to address the current demand for Urgent Inter-hospital Transfer's and a further 38 procedures per annum to address the long wait elective cases.

There is limited capacity to further reduce elective activity without further impact on the waiting list and waiting times for the population to access further treatment.

patients should not be exposed to multiple procedures when in most cases this can be achieved in the primary episode of care.

The marginal cost implications of this level of activity are estimated to be approximately $600,000 – $700,000.

The capacity of the District to manage within current resources for Cardiology has previously been flagged as a budget risk. This concern has now been confirmed.

CONSULTATION:

TPCH
Jon Roberts, Executive Director Finance and Information Services
Dr Sue Phillips, Acting Executive Director Medical Services
Cardiology Program Management
Dr Darren Walters, Clinical Director Catheter Laboratory Services
Margaret Dahl, Clinical Nurse Manager, Catheter Laboratory Services

ATTACHMENTS:

1. National Acute Coronary Syndrome Guidelines
2. District Manager Memo regarding Catheter Laboratory Activity
3. Cardiology Protocol for Inter-hospital Transfers of Cardiology patients
4. Proposed tools for Registrars to assist in understanding Zonal patient flows for Catheter activity
5. Presentation from Dr Walters "Changing Management of Acute Coronary Syndrome"
6. Health Outcome Plan (Note Page 8: ACS clinical management strategies)

RECOMMENDATION(S):

1. That Queensland Health Zonal Management review the issues relating to the resourcing difficulties being experienced in managing demand resulting from increasing Inter-hospital Transfers for acute coronary syndrome patients presenting at Queensland Public Hospitals.
2. That Central Zone review the resourcing applied to the demand for emergency and unplanned revascularisational activity within Central Zone and increase resource allocation by $650,000 to address the projected demand for unplanned and urgent transfers during 2003/2004 and assist to reduce the resulting long wait patients for elective procedures.
3. Central Zone support planning and resourcing relating to the development and implementation of a coordinated emergency revascularisational cardiology service across Brisbane North Catheter laboratories (TPCH and RB&WHHSD) in line with the strategy : Queensland Health Outcomes Plan - Cardiovascular Health: Coronary Heart Disease 2000-2004.
4. That Northern Zone continue to reimburse TPCH for Northern Zone activity based on agreed patient acceptance and transfer protocols and marginal cost recovery mechanisms.
5. A statewide plan based on a Health Technology Assessment for acute revascularisation (including cardiac surgery) as recommended in the Queensland Health Outcomes Plan - Cardiovascular Health: Coronary Heart Disease 2000-2004 is developed and funded to support the cardiovascular burden of disease for Queenslanders.
6. That Southern Zone Management unit supports these demand management strategies and Southern Zone Catheter Laboratories provide access to emergency and unplanned revascularisational cardiology for Southern Zone patients.

MS DALTON: I want to discuss these - the cutbacks with the witness. 1

COMMISSIONER: I thought you had, but all right.

MS DALTON: No, I want to discuss them individually. Look, I don't know. I might be another 30 minutes.

COMMISSIONER: All right.

10

MS DALTON: Dr Aroney, you know that as part of that extra $20 million elective surgery funding, you got extra money to be doing work in the cath lab at Prince Charles, don't you?-- Yes, we did.

And the extra money meant you increased the number of procedures you did?-- Yes. As I said, this happened during an election campaign - or after the election, after our public disclosures of the second cutbacks. These were then announced, promised by the government, and went ahead after 20 the election. I don't think that none of this would have gone ahead if we hadn't made our public disclosures.

And that meant that the cath lab procedures increased to 80 a week?-- Yes, back to where they should have been, where they have been for the past four or five or more years.

Well, they'd never been that high, have they?-- Yes, they have. I tendered that information this morning.

30

Well, you didn't tender it. You gave some oral information. Where did you get those figures from?-- I've had access to the activity at the cath lab continually, as my work in the cath lab and as Director of the Coronary Care Unit.

Do you just remember them off the top of your head?-- I keep the information, and I've got it here.

In what form is that information?-- I write it down and I have - I have the exact numbers, and you can get them from 40 Queensland Health directly.

So it's your personal, handwritten records, is it?-- Yes.

And the cutback to 57 per week, Dr Aroney, was when that funding money was lost in about June - that extra $20 million funding money was lost in June 2004?-- As I stated, the activity for the past four years has been between 77 and 80 per week. So cutting this back suddenly to 57 per week in November 2004 can't be due to a loss of extra funding. 50 It's a direct cutback. There's no other explanation, and someone should be held accountable for this, and for the reasons for it. The tendered explanation is incorrect. What you're just saying now is incorrect.

Well, you say that, and you say that the reason it was cut back to 57 per week is in September 2004-----?-- The decision was made then. The cutback didn't apply until November.

1

Okay. The decision was made in 2004 - September 2004, was it?-- Mmm.

And that was John Scott punishing you?-- My view is it was either John Scott or Steve Buckland punishing the hospital and the people of Queensland for our public disclosures. That is my view.

Dr Aroney, you have no basis to suggest that at all, do you?-- I do have. I do have basis for that. 10

In fact even in your statement you say that the action was either due to "punishment" for bringing these deficiencies to light or to negligent mismanagement. You don't know what it was about?-- I believe it was punishment. There's - certainly Scott and Buckland aren't going to come directly out and tell me, "You are being punished and the hospital is being punished", but Ms Wallace told us at the meeting - and it is minuted at that meeting - when I asked her, "Why is the hospital being bullied about this 57 cutback", and her answer, and I quote, is that the cardiologists were not "politically savvy". Now, there's no other explanation for her to say that. 20

That's what Ms Wallace told you?-- That's what he told us, and she also told us she was the meat in a sandwich. It wasn't her decision, the decision-----

Where are these meetings?-- In the minutes of the July meeting. It's been tendered here as evidence previously. 30

The July meeting? The decision was made in September?-- September meeting.

MR FITZPATRICK: I think it's MIC19 to Mr Cleary's statement.

COMMISSIONER: Thank you, Mr Fitzpatrick.

MS DALTON: See, it's just - John Scott was on long service leave from July until October 2004?-- Yes. 40

It's a scandalous thing to say that-----?-- In his evidence - in his evidence that he's tendered he says that he was well aware of this 57 cutback, and in full knowledge that it occurred, in full knowledge. He says that in his documentary evidence.

I'm sure he knew it occurred, but it is a scandalous thing to say that it was done as a punishment to you. 50

COMMISSIONER: He didn't say a punishment to him. He said as a punishment to the hospital and the people of Queensland for the statements - public statements he had made.

MS DALTON: That's a scandalous thing to say about an individual when you don't even know that they're at work or not?-- I didn't see - wasn't sure it was Scott or Buckland or

F

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-21

01-01-A

13

Queensland Government
Queensland Health

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

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

BRIEFING NOTE NO:	District Initiated
REQUESTED BY:	District Initiated
DATE:	12 October 2004
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SUBJECT:	**Cardiology Program – The Prince Charles Hospital**

COMMENTS A/SED HEALTH SERVICES:

FILE
BRIEFING FILE
7/4/05

DR JOHN SCOTT
A/Senior Executive Director
Health Services Directorate

/ /

PURPOSE:

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

BACKGROUND:

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

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

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

Higher than usual demand for clinical services

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

Emergency Department referrals

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

Figure 1 – Emergency Admission

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

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

CARDIAC INVESTIGATION UNIT

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

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

Figure 2 – Cardiac Investigation Unit activity

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

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

Figure 3 – Analysis of activity and funding

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

*This table identifies changes to base funding and activity.

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

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

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

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

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

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

PROGRAM MANAGEMENT

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

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

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

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

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

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

Discussions at the meeting included:

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

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

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

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

Cardiology Inter-hospital transfer waiting list

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

- The number of patients waiting for transfer to TPCH as at 27 September 2004 was 17. Five of these cases were noted to be of a high priority.

- Three of the high priority patients were transferred to TPCH for further care.

- Following discussions with the Executive Director of Medical Services at the Royal Brisbane and Women's Hospital (RBWH)the remaining two high priority patients were accepted by RBWH for care.

- The Princess Alexandra Hospital Executive Director of Medical Services advised that they had five patients on the inter-hospital transfer waiting list and could not accept additional patients at this time.

Deaths on the Waiting List

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

Surgical Activity

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

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

- increased paediatric cardiac surgical activity prolonged ICU stays for post transplant patients The net effect of this increase in urgent referrals for surgery has been a

reduction in elective surgical activity, some of which relates to increased occupancy in the cardiology wards.

Cardiologist Leave

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

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

KEY ISSUES:

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

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

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

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

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

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

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

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

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

RELATED ISSUES:

N/A

BENEFITS AND COSTS:

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

ACTIONS TAKEN/ REQUIRED:

Corporate endorsement is sought of:

- Limiting activity as described above, at TPCH and

- a proposed strategy in accordance with this brief.

ATTACHMENTS:

Attachment 1 – Activity Profile

ATTACHMENT 1

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

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

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

Activity Profile (Acute and elective)

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

Year Profile (Acute and Elective)

PCI	612
CORS	2032
Paeds	192

long time because doctors in the bush came in, I think was the first in Australia of that proposal, it was about 2000. 1

Or even earlier than that perhaps?-- It might have. I mean, the discussions et cetera started not long after I became Minister and the work-up for the proposal, and but I think it was in 2000, January 2000 we signed up the first ones. I'm sorry, please don't hold me to that date.

No, no, that's all right. But you don't recall him anyway from that context apparently. Do you recall that he had quite an interest in rural health work?-- He certainly had a wide interest in rural health and certainly particularly in getting programs such as breast screening to rural, you know, the small rural communities, all of that, those programs, make the public health programs - he was particularly committed to making sure they were available to people in no matter how remote a community. 10

And you were aware, no doubt, that he'd spent long years working in hospitals or as a GP in rural hospitals himself?-- Yes, I was. 20

One of the things somebody's passed comment in giving their evidence here that he was more a bureaucrat, I think the words were "He wasn't a real doctor"?-- I have to say it was considered rather amusing when I met Administerial Health Councils that I used to have more doctors on my side of the table than the rest of the Council put together because so many of the senior bureaucrats in Queensland did have long and extensive experience as clinicians. 30

Mmm, and in Dr Scott's case, as a rural clinician for many years?-- Yes.

Now, you explain in your statement the process I think when you - and you've given evidence here about how you would go to Cabinet and that Cabinet Budget Review Committee to fight your hardest for your department?-- Mmm-hmm.

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And you didn't always get what you wanted?-- I think that's a fair comment.

The process, I suppose, preceding that is that the districts would each year, each budget cycle put in what they called their bids for the money that they wanted each year?-- Yes.

So-----?-- It goes up the chain. I think everybody has a say. I think the units, the various units in a hospital and in the community et cetera would put their bids into the District Manager who would collate those and put - and do any extra work that needed to be done with them and prioritise them and put those bids into the - into the zonal manager. 50

Yep?-- And yes, it did work up the chain but it also meant that people right down at the grass roots in many cases had input into that process in identifying what the needs were.

Yes. And that input would be people acting in their own interests so if you're a cardiologist at Prince Charles?-- Yes. 1

You're going to be bidding your level best for cardiology at Prince Charles and that will feed into the system which ends up does it not with the department coming to you prior to you going to the Cabinet Budget Review Committee?-- Mmm.

So that all of the bids and submissions from Queensland Health end up with the senior bureaucrats in health-----?-- Yes. 10

-----coming to you and saying this is what the department wants?-- Yes.

And I suppose when you come back from Budget Review Committee, they don't get what they want either?-- Yes, and there's an important - but there's an important second part of that, I'm Minister for Health in Queensland right across Queensland.

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Yes?-- And the health department has a responsibility as do - did I at the time to ensure that services were provided as far as possible equitably across the State.

Yes?-- It's not about looking after - while the submissions may be, I guess being pushed, you know, various people obviously pushed their barrow they see that as most important.

Yes?-- But you have to balance the needs right across the State, you can't sort of say we're only going to look after North Brisbane or we're only going to look after Cape York, it has to be across the board and doing the best you can with the budget you've got in the fairest possible way to meet the needs of people in Queensland and to meet the greatest needs first. 30

And when town or Charlotte Street goes back to the districts after the budget process and says, "Well, you asked for X but you've got X minus Y"?-- Mmm.

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"Sorry about that"?-- Yes,.

It's not because the bureaucrats in town don't recognise that the bids were legitimate and don't recognise that the clinicians who have put them in sincerely want or need what they've asked for, it's because of that process, there's a limited pie to cut up, isn't there?-- There's a limited pie at State level and there's a limited pie at the department at level.

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Mmm?-- Yes.

Were you able to observe Dr Scott interacting with other staff while you were Minister in either of the two roles he held? Were you-----?-- Oh quite, I did a lot of work with Dr Scott in both of his roles.

Mmm. See, there's some evidence before the Commission that

his manner is bullying, attacking, overbearing and intransigent; can you comment on that so far as you've seen him?-- Am I allowed to say that the staff in my office fell about laughing when they read that in the paper because he is such a gentle person, that he is one of the people that staff in my office, if they had a health issue, often went to for advice, but-----

You mean a personal health issue?-- Yes, I'm just sort of saying he was one of the persons who as he very approachable.

Mmm?-- The idea of him bullying actually was something that caused something of amusement to people in my office.

I think one of the people he is supposed to have bullied, or a person in a group he is supposed to have bullied is a fellow called Darren Walters, who is the Director of Cardiology at Prince Charles. Have you come across him in your travels?-- I am not sure I know - is that Dr Walters?

Dr Walters, yes?-- I don't think I know Dr Walters.

That's all right. I will ask you also, in your dealings with him while you were Minister, was there ever an occasion when you were seeking information from him and it wasn't provided to you promptly and fully that you are aware of?-- I think the only occasion we had some issues about the tobacco action plan when I think - but that was when he was in the position of Director of Public Health - about - I guess there was a difference of opinion from some of the people in his - in that area and myself, and the briefs I kept getting kept saying the same thing, and I kept saying, "No, that is not where we're going. That is not what the government wishes to do." And there was some difficulties, but that's the only time I can actually recall that.

That was-----?-- That wasn't Dr Scott, that was more people in a particular unit within the public health area.

And by the sounds of it, it wasn't a request from you to provide factual information, such as some discussion this morning as to waiting list numbers, or that sort of thing, it was a difference of opinion as to where the policy should go, by the sounds of it?-- Yes, about how something should be done, yes.

I was concerned to ask you that because it was suggested to you this morning that senior bureaucrats within the Charlotte Street office might have tried to impede your access as minister to information about, well, in particular, waiting lists and the numbers of people on waiting lists?-- I don't think I had a reputation for being easily bowled over or swamped. If I didn't get the information I wanted, I would perhaps more rigorously ask for it.

And I suppose specifically, so far as Dr Scott was concerned, did you have any difficulties getting information from him when you requested it?-- No.

And I think the other suggestion that was put to you this morning was that there might have been some advice coming to you from senior bureaucrats in Charlotte Street that you ought not to be talking about waiting lists, and, again, asking you about Dr Scott. Was there that sort of comment coming to you from him?-- No, there was a lot of advice that I couldn't be talking about waiting lists, that was a daft idea, et cetera, when I first put the proposal up.

That's back in 19-----?-- In opposition. That was back when I was in opposition.

senior bureaucrats, doctors Buckland and Scott, during the course of your ministry of health was to ensure that you were never placed in possession of unpalatable news?-- No, I disagree with that. That's incorrect. 1

All right. You're aware, are you, that Dr Scott has attached to his statement - have you read his statement incidentally?-- No.

Are you aware then that yesterday Dr Scott was taken to JG3, which is an attachment to his statement, in which it was indicated that the no surprises rule in relation to advice to you meant no surprises except pleasant ones?-- No, I disagree with that. 10

Were you unaware that within the documentation, which Dr Scott put in yesterday, reference was made to there being a no surprises rule, which meant no surprises except pleasant ones?-- No, I wasn't.

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You weren't aware of that?-- No. And on numerous occasions my department - my department's job is to give me information whether it's good or bad, and they did that.

Well, should they adopt a policy of only giving you pleasant news-----?-- No, not at all.

Let me finish the question. Should they adopt the policy of giving you only pleasant news. That would be a breach of your expectation?-- That's right. 30

And that would be a breach of their duty to fully and frankly keep you informed?-- I - I expect - I believe the department did keep me fully informed of all - of events whether they be good or bad.

See, I suggest to you that - well, are you aware of the classic, the famous approach by Peter Reith to irrefutable evidence; that is, if the video shows that, we should not see the video. Are you familiar with the incident to which I refer?-- No. Yes. 40

The children overboard incident?-- Yes.

Are you referring that you didn't have such a policy in your office?-- That's right.

"If the news was bad, make sure I don't see it"?-- No.

"Or, if necessary, bury those who are exposing it"?-- No, I couldn't disagree with you more on that. 50

You see, I suggest to you, Mr Nuttall, that you had a particular reason to be very concerned to ensure that bullying didn't take place on your watch?-- I don't support the concept of bullying full stop. And as IR Minister, that was quite clear because I was the Minister responsible for working on that policy for the government.

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So were you to come across evidence of such bullying, you would be deeply concerned and asked for your officers to implement a process whereby it could be stamped out; is that right?-- That's - that's correct, yes.

All right. Are you satisfied that occurred?-- I'm satisfied that we did the best we possibly could to try and eliminate bullying in the workplace.

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Heart Response

Broadcast: 15/10/2004

DR JOHN SCOTT, QLD HEALTH: Thanks.

KIRRIN MCKECHNIE: Dr Con Aroney is predicting a crisis in cardiac care. He says by international standards Queensland has only one third of the number of cardiologist that it should have, is that true?

DR JOHN SCOTT: We don't believe that it's true to the level that he's describing it. We certainly would be prepared to accept that we have issues to address with staffing but really that's and issue for Australia generally. So we don't see that we are behind any other states in Australia.

KIRRIN MCKECHNIE: How behind are you though in international standards?

DR JOHN SCOTT: I suppose we would say that we are behind but we really feel that the services that we are delivering at the moment are not putting any Queensland lives in jeopardy.

KIRRIN MCKECHNIE: Well the cardiac society says there are only the equivalent of 25 full time public cardiologists in Queensland and there should actually be 75. Is Queensland health actually reducing the number of cardiology procedures then at Prince Charles Hospital?

DR JOHN SCOTT: No, I think that, and this is the disappointing aspect of this debate is that we seem to be accused of cost cutting of reducing services and I can't see why we would want to do that. In fact what we're doing is looking to increase services across Queensland and of course what that means is that services and resources are going to hospitals other than Prince Charles and perhaps that's part of the reason why we're having this debate.

KIRRIN MCKECHNIE: Have you reduced the number of services cardiology procedures at the Prince Charles Hospital from 80 to 57?

DR JOHN SCOTT: No, what we've done is we've said lets go ahead and enhance services and that was happening in fact we've put something in the order of $5 million extra dollars into cardiac services in Queensland this year. And that $5 million will be there each year from here on. But what has happened is there has been an increase in services above what that increase budget will allow situation and we've asked the cardiologists to review the situation with a view to at least staying within the resources that are available to us but we have not in anyway respects reduced services.

KIRRIN MCKECHNIE: Dr Aroney says, well he's given us some examples of patients having heart attacks in regional areas and instead of waiting the recommended 48 hours to get help in a big city hospital that there are many other cases waiting over a week. Is that right?

DR JOHN SCOTT: We don't believe it is and of course as I've said before we're looking to services to enhance services for north Queenslanders so they've got better facilities to be transferred to. We've recently done work and are continuing to do work on clinical co-ordination and on aero-medical retrievals. So we're looking to provide people with the ability to transfer from their small service that they might have to attend if they have problems to larger services and we're ensuring that those larger services are more appropriately placed to take those transfers.

KIRRIN MCKECHNIE: Well it seems that you have a stand off then between our leading cardiologists in this state and Queensland health. How do you hope to fix this problem?

DR JOHN SCOTT: I'd say we have a stand off between certainly me and our leading cardiologists if you wish to call Dr Aroney that. In time I hope that we can show the cardiac society and Dr Aroney that we are here for the long term.

an issue could arise which the Minister may need to know about or, in fact, any of the members of the senior executive, then it was preferential to advise people of those issues rather than to not advise them. So, essentially issues that people thought might become problematic or which they felt were worthy of attention would be escalated up the chain and would go to certainly to myself and to the Director-General and usually on the basis that it was better to tell the Minister or the Minister's media advisor. They would be advised as well.

All right. Now, was it part of that no surprises rule that the rider was attached that the surprises, if any, be pleasant ones?-- Oh, I think that wasn't other than in a document that we were developing around indicators for the health services directorate and that was thrown in almost as a throw-away line, that if we are going to get surprises let's make them pleasant ones rather than unpleasant ones.

JG3 I think might be the document to which you refer. Have you got your statement in front of you?-- Yes.

Turn to JG3?-- Yes, that's right, yes.

Some perhaps 10 pages in?-- Yes.

"No surprises, except pleasant ones." Is that the one to which you refer?-- Yes. Tthat was very much a throw-away line.

So the throw-away line then, in effect, meant that the Minister didn't wish to be acquainted with any information introduced to him by the media or the public of which he wasn't already aware unless it was pleasant news?-- No.

Is that right?-- No. No, the throw-away line came at the level of myself and my executive and it was purely if we're going to get surprises, let's make them pleasant ones.

What were you to do with unpleasant surprises?-- Make sure that no-one got any unpleasant surprises.

What were you to do with unpleasant news?-- Make sure that the Minister was advised so that he wasn't surprised by the unpleasant news.

Was it part of your task as a senior - I don't like to use the pejorative term, what's become a pejorative term, bureaurocrat, but if you can accept I'm using-----

COMMISSIONER: It's not a pejorative term in the Inquiry.

MS KELLY: Thank you, Commissioner. That's what I wish to have made clear. As a senior bureaurocrat in Queensland Health, was it part of your task to manage those issues which might, quote, "blow-up", unquote, so that there was no need to acquaint the Minister with any such news?-- No. No, it was my job to acquaint the Minister and then to

manage them and if the Minister directed they should be managed in a certain way, then that was the way that we managed them. 1

Did you then acquaint the Minister with the public - the potential for public disquiet at disclosures being made by Dr Aroney in the course of November 2003 to the cessation of your tenure at Queensland Health?-- Yes, yes, as appropriate.

You did. On what occasions did you brief the Minister on Dr Aroney's disclosures?-- Oh, on numerous occasions and I briefed two ministers when Dr Aroney first raised the issues in, I think, November of 2003 or December. I was briefing the previous - the - at that time - sorry, Minister Edmond. 10

Yes?-- And then subsequent to that I was briefing Minister Nuttall.

Yes. And did you advise the Minister that essentially Dr Aroney's allegations being publicly made were in essence false?-- I think what we briefed the Minister was that there were issues around what Dr Aroney was claiming, that there were some elements of what he was claiming which were related to shifts in resourcing from Prince Charles to PA, which were part of established policy and had been part of established policy since probably 2002. So there were no cuts going on there. At the same time we also acquainted the Minister with other aspects of what Dr Aroney was saying around people on waiting lists, but at that point in time and subsequently as we have discussed this morning there are waiting lists which will always exist until we get sufficient funding to take them away. So, it's not a matter of these are terrible things that we can address now, but there will be waiting lists that will exist into the future until we have got sufficient funding. 20 30

So Dr Scott, were there any matters which you briefed the Minister - any matters raised by Dr Aroney which you briefed the Minister which were in essence false?-- Yes.

What were they specifically?-- I think Dr Aroney spoke about cuts in funding, which I think he referred to in the 2002/2003 financial year, and then he spoke about another two rounds of cuts to funding which were not cuts to funding. 40

Now, were these briefings committed to writing?-- I am sure that they would have been.

And do you have possession of those writings?-- No, I don't.

Do they remain in the possession of Queensland Health?-- I would expect that they are, yes. They would be on the formal system. 50

Thank you. Now, you have said that you advised the Minister that the allegation of funding cuts were wrong?-- Yes.

The essence of Dr Aroney's public disclosures, I suggest to you, was to the effect that people were dying and would die if

these limitations in procedures, if I can use that neutral term, were not addressed. Did you advise the Minister that that was true or false?-- We advised the Minister that particularly there were two elements to this. There was one element which was a list of specific cases that Dr Aroney raised, and we subsequently had those investigated and advised the Minister in relation to the substance of those claims, and then there was a broader claim in relation to waiting lists and people dying on waiting lists which we also advised him about. We found in the investigation of the first group that out of the, I think, probably eight or nine cases that were investigated we could only find one or two where perhaps we could have improved the management of those people. But on the broader issue of waiting times for people and people dying on waiting lists, I think that the advice would have been that while there were waiting lists there would be inevitably deaths, particularly in the area of implantable defibrillators, and this is taken up in the Maher Johnson report that was done, where until we - I think the funding estimate was about $60 million to address all of the people who could potentially be waiting and there was a potential for people to die on those waiting lists.

So, is the latter part of that answer you advised the Minister that the allegations of people dying on waiting lists was true?-- There are people who will die on waiting lists simply because - being something which is of a cardiac nature there is no way that you can avoid people waiting unless you put those defibrillators in, for instance, as soon as they come to the attention of the clinicians.

And the response of the Minister, if any? Was there any response of the Minister to acquire the defibrillators and put them in?-- Well, I think this comes back to my - I mean, the answer is yes but in a limited way compared to the $60 million worth of funding that was estimated to be required. But the question really comes back to the discussion that we had this morning around waiting lists, which is - and this is also the essence of the issue we took with Dr Aroney's concerns.

Sorry, Dr Scott, if can I just stop you.

COMMISSIONER: Now, let him finish. Let him finish his answer. Keep going, doctor?-- The difficulty is there will never be enough resources, so if we put resources of the amount of maybe $60 million into implantable defibrillators, I have already said that we probably need about $80 million a year to put in elective surgery waiting lists, and of course there's - Mr Douglas has shown us this morning there are a lot of people who are on waiting lists for oncology services. I have also spoken about some of the early interventions like colonoscopies that will prevent avoidable deaths. We just did not have the resources available, and it comes down to a decision as to where those resources are going to be put. That was the Minister's decision and I think the Minister took advice from the department as well as making his own calls on where those resources would be allocated. So, I'm sorry, but the short answer is some money was put towards addressing

people waiting for defibrillators and other cardiac interventions, but certainly not anywhere near the level that you would need to commit to stop avoidable deaths. 1

MS KELLY: Yes. Dr Scott, all I was asking you about is what was the Minister's response, not the defence or otherwise of that response?-- I was trying to explain how he'd come to that decision.

Okay. Thank you. So, Dr Scott, was it any part of your duty to make defence of the restrictive budget of Queensland Health and its impact on the provision of clinical services in the media?-- Put that way, no, it wouldn't be. 10

You appeared in the media on a number of occasions and I will take you to one in particular. On the 15th of October 2004 you made an appearance on Stateline, the ABC program?-- Mmm.

Do you recall that?-- Yes.

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It's CA13 to Dr Aroney's statement, the transcript of that interview. Now, did you tell the truth in that interview, Dr Scott?-- I believe I did.

All right. Can I just explain to you the context? I understand you had recently returned from long service leave on the 3rd of October; is that right?-- Thereabouts, yes.

You had previously in January of 2004 met with Dr Aroney and there had been some acrimony over Dr Aroney's disclosures. That's right, isn't it?-- Yes. 30

You and Dr Buckland attended a Cardiology Society - Cardiac Society-----?-- Cardiac Society.

-----meeting on the 15th of February 2004 where there was more acrimony. That's right, isn't it?-- I think at the start of the meeting. I felt by the end of the meeting that there wasn't a lot of acrimony at all.

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All right. And the Cardiac Society then prepared for and presented to you in the middle of 2004 a comprehensive submission, which is CA2 to Dr Aroney's statement, on the planning for and provision of clinical services for cardiology in Queensland. That's right, isn't it?-- I think it might have been to the Minister because I think the Minister responded to Dr Aroney. But-----

You were aware of that submission?-- Yes, definitely-----

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It was a comprehensive submission?-- Yes.

Of which Dr Aroney was the principal authority; that's right?-- I certainly recall that but it was - it went to the Minister.

Following that, at the Prince Charles Hospital there was what Dr Aroney has called a third round budget cuts?-- Mmm.

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Reducing the number of procedures from some 90 angiographies or some 90, 80 or 90, to 57?-- Mmm.

Over a fixed period?-- Mmm-hmm.

Do you recall that?-- Yes.

And in protest Dr Aroney made public comment about the impact of those cuts or that reduction on the cardiac patients serviced-----?-- Yes.

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-----by his zone?-- Yes.

You went on ABC television and said that you don't see that you were - "We are behind" - we, being Queensland - "being behind any other States in Australia in terms of the number of cardiologists per head of population." Is-----?-- Did I say this?

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All right. Let me be fair to you. The interviewer said to you, "Dr Con Aroney is predicting a crisis in cardiac care. He says by international standards Queensland has only one third of the number of cardiologists that it should have. Is that true?" Your response was, "We don't believe that it's true to the level that he's describing it." You go on to compare to Australia generally and say, "So we don't see that we are behind any other States in Australia." Now, was that true? Is that - does that truly represent your opinion?-- Yes. I think Dr Aroney - and I'm sorry but I can't recollect - but I think he said that we needed something like an extra 70 cardiologists in Queensland. Maybe I have got that wrong, but it was certainly of a quantum that we had no capacity at all to recruit to Queensland and we would never be in a position - even with very competitive wages we wouldn't be able to recruit the numbers that we were talking about to Queensland.

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Dr Scott, if I can just ask you, is it true that Queensland is not behind any other States in Australia in terms of cardiologists per head of population?-- No, I think I was saying not the level that Dr Aroney was talking about.

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COMMISSIONER: That's not the way it was read out, Dr Scott.

MS KELLY: Perhaps if I can put it up - ask for it possibly to be put up on the screen.

COMMISSIONER: Yes?-- Sure.

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MS KELLY: I have the only copy to hand.

COMMISSIONER: All right.

MS KELLY: And it's marked. The blue highlighted - the first blue highlight, Dr Scott, is what I've read out to you. I have read out all of it to that point?-- Yeah. Well, I think that's certainly what I said.

It's not true, is it?-- Well, I think when - we see that we would certainly be prepared to accept that we have issues to address with staffing, but really that's an issue for Australia generally, and so the question really is are we behind other States. We probably are in terms of numbers per head of population, but I think when we look at the other factors that we confront in terms of decentralised States, I think my point is we would be prepared to accept that we have issues to address with staffing. I think I go on to say, "I suppose we would say that we are behind but we're not putting lives at risk." I mean, essentially what I'm saying there is we are going ahead with further funding and I think if you look at the record we have done that.

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COMMISSIONER: You are saying you not behind in the statement, Dr Scott?-- Well, what I'm saying is I said, "We're not behind any other States in Australia." That sentence there - but the sentence prior to that I have said, "We would certainly be prepared to accept that we have issues to address with staffing."

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No, I know, but you still say and you seem to want to qualify that now that, "We are not behind other States of Australia." That's what you say?-- Well, in terms of that sentence, I guess, yes, that's a sentence that I would say is not correct.

So you accept that now that that's not true?-- That sentence is not correct. I guess I'm saying I would put it into the context of the two paragraphs that are there around it.

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Well, I can't see how the meaning of that sentence changes by reference to what's around it?-- No, well, I will have to accept that. I will have to accept that, Commissioner.

Yes.

MS KELLY: In relation to the second highlighted excerpt, "We really feel that the services we are delivering at the moment are not putting any Queensland lives in jeopardy.", now, that isn't what you really felt because you have told us following evidence you gave this morning that, "The services we", Quendland Health, "are delivering at the moment were, in fact, putting Queensland lives at jeopardy." That's right, isn't it, because people were dying on waiting lists?-- Yes, but again-----

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Thank you?-- I would probably stand by what I said about all other States in Australia as well.

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COMMISSIONER: No, no, but the point is whether, in fact, the services that Queensland is delivering at the time you made those statements are putting any Queensland lives in jeopardy and you just said here that they were?-- Yep. Okay. Well, look, I will accept again that as a basic sentence taken as it's written it's not correct.

Taken in context it's not correct, in the context of anything

else you have said there is not correct?-- Well, again, I guess I will have to take your view of that, Commissioner. 1

All right. Well, you don't have to. You can explain to me why I'm wrong?-- Well, as I have said before, I have tried to qualify in terms of the staffing issues and I think without getting into a great level of detail, as I have said, we also have to put this into the context of resources being scarce, allocation of those resources across a whole range of issues.

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You don't say that. You just make a royal statement there the services are not putting Queensland lives at risk and that's not correct?-- No, and I accept in the context of the print that's in in front of me that it is not correct, but I'm just saying to you in the context of what I knew I believe that there is a different picture which needs to be presented in the context of scarce resources in the context of decisions around implantable defibrillators that are not being made by any State in Australia as well. So if we are putting lives in jeopardy, then every other State in Australia was putting the lives of all of their populations in jeopardy as well. 20

MS KELLY: Well, you see, I want to suggest to you, Dr Scott, there was a concerted spin being placed on the lack of procedures or the cut in procedures available to Queenslanders and that was to suggest constantly that this was an Australia-wide problem and if you looked in any other State you will find exactly this same circumstance there, and this is the line that you have produced on Stateline-----?-- Well----- 30

-----to suggest that Queensland is the same as all the other States?-- Well, again, I would have to say I have said that we have got issues to address with staffing. I have also pointed out that there are other States in Australia where they don't have policies for implantable defibrillators and I have also spoken about resource allocation and scarce resources and they are issues for the other States in Australia as well.

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Well-----?-- Perhaps-----

Sorry, I want to suggest to you that they are not issues for the other States to the degree they are in Queensland. Is that true or not?-- They probably aren't, but again I'd have to say we have the most - probably the most decentralised State in Australia. We have a significant proportion of indigenous people in our State who are living in remote communities. We have got some of the highest rates of smoking and obesity in the country and we have been endeavouring to address those. So it's a multi-factorial issue and part of the argument that we were putting was the solution to this is not purely more angiograms and stents. 50

In fact-----?-- It-----

In fact, the Cardiac Society had told you as early as the 15th of February that Queensland had the worst coronary heart

disease outcomes of all the major States?-- Yes. 1

And that was attributable in large part to a lack of cardiologists?-- I absolutely disagree with that. I mean, I haev just said to you that it is not attributable in large part - it is attributable in large part, and I go back to the evidence of Dr Keith McNeill, that if-----

Sorry, we may be at cross-purpose?-- -----we were dealing with smoking we would not need to have the Prince Charles Hospital there. I absolutely reject that. 10

We may be at cross-purposes, Dr Scott. I'm not asking you whether you agree with me what the Cardiac Society told you. I'm asking you that is what they told you in February 2004?-- Again, I'd have to see what they have said because that's such a difficult proposition to put because as I said, Keith McNeill was recognised that the solution is not cardiologists.

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All right. Just before we leave, we will come to what you were told in February 2004. Just before we leave this, I want you to look at the last paragraph on the screen - sorry, where it says, "We seem to be accused of cost cutting." Do you see that blue highlight?-- Yes.

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Now, what you were asked by the interviewer was, "There are a reduction in the number of cardiology procedures at Prince Charles Hospital"?-- Yes. 1

And you said, "No"?-- And I still stand by that.

All right. All right, we'll come back to that. You said, "No", and then answered a question about cost cutting?-- Yes.

All right. Which isn't the same as procedure cutting. It's not the same thing, is it?-- No. 10

And you answered the point by saying, "We're transferring to other hospitals", in effect, and then ended up by saying, "And perhaps that's part of the reason why we're having this debate." Now, I suggest to you that that was clearly to implicate Dr Aroney as being Prince Charles-centric, if I can use that phrase, in protecting his own turf. Is that what you were intending to do when you answered that question?-- No, I think what I was endeavouring to do was to respond to an attack from Dr Aroney. 20

Yes?-- On me. So I didn't initiate an attack on Dr Aroney. I think what happened was Dr Aroney went out to the media first and took the issues to the media and I was responding to allegations like I was prepared to sit in Corporate Office and didn't care if people were dying. So what I'm saying here is we are not cost cutting. In fact, we have increased the investment that we've made in cardiac services significantly and we are not about cutting costs or cutting funding to Prince Charles; we're about expanding cardiac services across the state. Then when we come down to the issue of reducing cardiac procedures at the Prince Charles Hospital, I'm being accused of cost cutting because I've reduced the procedures, and what I was saying was, "No, the base budget has always been predicated upon 57 procedures." We increased the funding for procedures in 2004 as part of the increases in funding that came for elective procedures but the baseline always remained at 57. I hadn't cut the baseline funding. I hadn't cut the funding to Prince Charles, and in fact across the state, and I've highlighted this in my statement, we had increased services for cardiac care. 30 40

Dr Scott, I'm suggesting to you that you were indeed responding to what you perceived to be an attack by Dr Aroney on you?-- Mmm.

And you did that by identifying his concerns as being turf protection type concerns in protecting Prince Charles and at the expense of other districts; is that true?-- I was making the point that I didn't hear Dr Aroney talking about the increases in funding that were going to cardiac services at the PA, at the Gold Coast and Townsville or the increased number of procedures that we were doing across the state. All I heard about was what was happening at Prince Charles. 50

Dr Scott, nowhere in the interview is it indicated that

Dr Aroney had attacked you. So what is the basis on which you say you were responding to an attack by Dr Aroney on you?-- Well, again, I'm making the point that Dr Aroney has gone to the media and said, "Queensland Health administrators did not care if people died", that we're about protecting budgets, and I think----- 1

Did you identify that as an attack upon you personally?-- Well, as the person who was responsible for health care services in the health services directorate at that stage, as the person who Dr Aroney earlier in the year had accused of bullying, I thought it was----- 10

Sorry, can I get you to answer my question. Did you identify that as an attack upon you personally?-- Yes.

All right. Now, if I can come to the interviewer's next question it was a reduction, it was true, was it not, that Prince Charles had put in place a reduction in services from 80 to 57 per week or per fortnight?-- No. No, as I said before, the baseline activity was 57. The baseline activity had always been 57. For a period of time the activity increased with the funding that came in the elective surgery allocation and then - as with the previous round of costs, as Dr Aroney referred to them, people were being asked to come back to their baseline level of funded activity, which was 57 procedures per week. 20

COMMISSIONER: This is just playing with words, Dr Scott. They were reduced from 80 to 57. You have explained the reasons why they have been reduced from 80 to 57, but they were in fact reduced?-- Well, I guess that's----- 30

Isn't that right?-- Commissioner, I have got to accept your view of the words-----

No, no, don't accept my interpretation; just answer my question?-- They weren't - they weren't reduced. They had increased and they were coming back. Now, I'm sorry, if I sound like I'm playing with words. I apologise sincerely. 40

At one point in time there were 80 cardiac procedures performed at Prince Charles Hospital. At a later point of time there were 57?-- Yeah, I mean, without wanting to play with words, I would rather say-----

A lot of them transferred and brought back to baseline, you have said all that?-- For a period of time we increased the procedures that were being done.

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Yes, yes, but in the long term, they were reduced from 80 to 57?-- No, in the short-term they were increased from 57 to 80. I apologise.

All right. They were 80 at one point?-- Yes.

All right. They were reduced from that to 57?-- I can't argue with that interpretation but I guess the-----

1

All right?-- -----interpretation-----

But you say they had already been increased from 80 to 57 and they were brought back to baseline?-- Yes, and the interpretation I was trying to get across to Kieran McKechnie on Stateline was we are not about funding and cutting. We have for a period of time increased-----

But you didn't say that. You didn't say that?-- No, well, I'm sorry, I'm demonstrating today how on the media as well, sometimes I can't say exactly what I would like to say but the intent was very much we have not cut services. 10

All right.

MS KELLY: Well, I suggest to you, Dr Scott, that your intent was to identify Dr Aroney as the source of false information and the source of unfair criticism. What do you say?-- Well, I don't accept that. 20

Could the other document be put up, please? It's the document going on to the screen now, is CA8. That is the attachment CA8 to Dr Aroney's statement. Now, these were what passes for minutes of the meeting of the Cardiac Society on the 15th of February 2004 at which you attended with Dr Buckland. Do you recall the meeting?-- Yes.

Do you recall there was - you said initially there was some controversy but by the end it seemed to be rather less controversial; is that right?-- Yes. 30

I suggest to you that's not right but we'll come back to that. You were advised in the course of a meeting by numerous speakers that Queensland had the worst coronary heart disease outcomes of all the major states?-- Yes, yes.

Yes. And you were advised of inordinately high rates of death in northern and central Queensland centres?-- Yes.

Which have no staff cardiologists?-- Yes. 40

All right. And so, when you said earlier that you had not been so advised, you were wrong?-- I had not-----

I asked you earlier was it not the case that the Cardiac Society had advised you as early as February that not only did Queensland have the worst outcomes in Australia but that this was attributable to a lack of staff cardiologists?-- No, I - I absolutely reject the interpretation that what that says is that those deaths, inordinately high in northern and central Queensland centres have no staff cardiologists - that the cause of inordinately high deaths in those centres was no staff cardiologists. 50

COMMISSIONER: I agree with Dr Scott about that. I can't see that you can draw that inference at all.

MS KELLY: Thank you. Thank you, Commissioner. I take you to a further document. I'm going to take the witness to CA2, which is an attachment to Dr Aroney's statement. 1

COMMISSIONER: Can you put that up on the screen.

MS KELLY: Which is too large to put on the monitor.

COMMISSIONER: Right.

MS KELLY: But, Dr Scott, just let me ask you: do you recall having seen the cardiac submission which, as you mentioned earlier, was addressed to the Minister; it claims to also be addressed to you and to Dr Buckland and to the Premier?-- What was the date again? 10

29 July 2004?-- Well, as I say, I was on long service leave at that stage.

Oh, okay. So does that mean that as at the 15th of October 2004, when you were on Stateline responding to Dr Aroney's assertions, you hadn't read the Cardiac Society's submission?-- I can't recall. I mean, I don't know whether - I certainly wouldn't have received it when it was delivered because I wasn't there. Whether I read it after that, I don't know. I mean, I was aware of these sorts of interpretations before being told on the 15th of February 2004 but I don't know what that document says. 20

Have you read it now?-- If you could - oh, I have but not recently. If you would like to tell me what specifically you're referring to. 30

Well, there is no point me putting to you what it contained and what inference - what knowledge you had arising from it in October if, indeed, you hadn't read it?-- As I say, I may have read it.

MS DALTON: Commissioner, just in fairness, could the witness see that? It is a big document. It is Exhibit 2 to the affidavit which is Exhibit 263 in these proceedings. 40

MS KELLY: Sure.

COMMISSIONER: Yes. Exhibit what was it?

MS KELLY: CA2.

COMMISSIONER: CA2. What did you want him to see, Ms Dalton, the statement? 50

MS DALTON: CA2.

COMMISSIONER: Is a statement?

MS DALTON: It's Exhibit 2 to Dr Aroney's statement. Dr Aroney's statement is 263 in these proceedings.

Queensland
Government

CONTRACT

OF

EMPLOYMENT

FOR

CONTRACTED HEALTH SERVICE EMPLOYEE

IN THE DISTRICT EXECUTIVE SERVICE

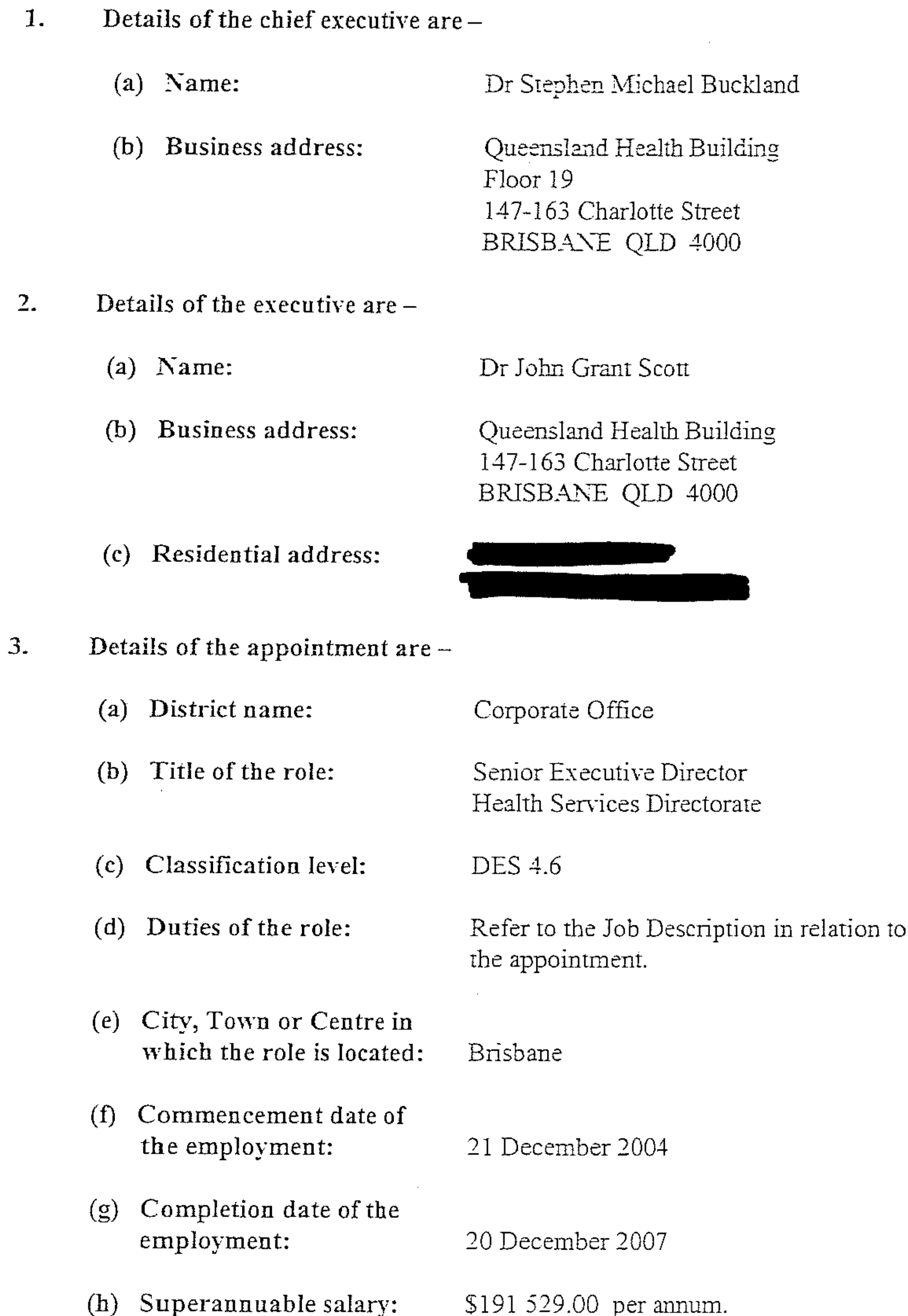
DR JOHN GRANT SCOTT

Health Services Act 1991

Crown Solicitor
State Law Building
50 Ann Street
BRISBANE QLD 4000

Office of the Public Service Commissioner
Level 3
61 Mary Street
BRISBANE QLD 4000

This contract of employment is made between the chief executive and the person appointed as a district executive ("the executive") under s.24(1) of the *Health Services Act 1991.*



PARTICULARS

1. Details of the chief executive are –

   (a) Name: Dr Stephen Michael Buckland

   (b) Business address: Queensland Health Building
Floor 19
147-163 Charlotte Street
BRISBANE QLD 4000

2. Details of the executive are –

   (a) Name: Dr John Grant Scott

   (b) Business address: Queensland Health Building
147-163 Charlotte Street
BRISBANE QLD 4000

   (c) Residential address:

3. Details of the appointment are –

   (a) District name: Corporate Office

   (b) Title of the role: Senior Executive Director
Health Services Directorate

   (c) Classification level: DES 4.6

   (d) Duties of the role: Refer to the Job Description in relation to the appointment.

   (e) City, Town or Centre in which the role is located: Brisbane

   (f) Commencement date of the employment: 21 December 2004

   (g) Completion date of the employment: 20 December 2007

   (h) Superannuable salary: $191 529.00 per annum.

PROVISIONS

1. Basis of Employment

The executive accepts appointment as a district executive on this contract from the commencement date until the termination date.

2. Location

(1) The executive will be located in the place specified in item 3(e) of the particulars.

(2) The executive acknowledges that travel throughout Australia and overseas may be required in the performance of the duties under this contract.

3. Responsibilities etc

The executive must –

(a) perform the duties specified in item 3(d) of the particulars or, where the duties are varied under clause 13(2), the varied duties;

(b) comply with the executive's annual performance agreement, and meet performance standards (if any) set by the chief executive;

(c) conform to such hours of work and other work arrangements as may from time to time be required of the executive by the chief executive;

(d) devote substantially the whole of the executive's time and attention during the hours determined in accordance with paragraph (c) to performing the duties under this contract; and

(e) be subject to those conditions of employment contained in section 28 of the Act.

4. Remuneration and Benefits

(1) The executive is entitled to –

- (a) the actual salary payable fortnightly in arrears;
- (b) remuneration benefits; and
- (c) any other entitlements in accordance with a ruling.

(2) The superannuable salary amount may be increased by such amount as may be determined by the chief executive from time to time.

(3) Except where the chief executive considers that special circumstances exist, where, for any reason, actual salary is not payable for a period, the executive is not entitled to receive any remuneration benefit during that period.

(4) The executive is not entitled to the payment of any overtime and allowances for working more hours than referred to in clause 3(d).

(5) The remuneration benefits under subclause (1)(b) must be –

(a) nominated by the executive;
(b) varied; and
(c) costed,

in accordance with a ruling.

5. Superannuation

(1) Where the executive is, at the commencement date -

(a) a member of a category of the QSuper Scheme, the executive must continue to comply with the requirements of the QSuper Act in respect of the executive's membership of the Scheme; or

(b) on leave from other employment and continues as a member of an approved fund operated for the other employment, the Crown -

(i) shall contribute the standard employer contribution required under that fund, provided that the maximum period of time, whether under this contract or any other contract, for which the Crown will pay such payments, is three (3) years; and

(ii) thereafter, must contribute an amount that, if the executive was a member of the comprehensive accumulation category, would be required under the QSuper Act; or

(c) (i) not a member of a category of the QSuper Scheme; and

(ii) not on leave from other employment

then the executive is a member of the comprehensive accumulation category with the option to elect to become a member of the standard defined benefit category instead of the comprehensive accumulation category.

If the executive elects to receive 'the election amount' into an approved fund, the member will become a member of the basic accumulation category.

(2) The superannuation contribution will be automatically adjusted in accordance with the rules of the applicable superannuation plan.

6. **Extension of Employment**

(1) Subject to subclause (6), the executive may be offered an extension of employment under this contract of up to an additional term of two (2) years from the completion date.

(2) The executive will be considered for continued employment as a district executive if the executive gives a notice to the chief executive, indicating a wish to continue employment, not less four (4) months before the completion date.

(3) If the chief executive receives a notice under subclause (2), the chief executive must give a notice to the executive, not less than two (2) months before the completion date:

(a) advising the executive that the executive will not be continued in employment as a district executive; or

(b) offering the executive continued employment as a district executive for up to an additional two (2) years after the completion date, to be given effect by variation of the term of this contract.

(4) The executive acknowledges that if the executive does not give a notice under subclause (2), the executive has elected not to continue employment as a district executive after the completion date.

(5) The term of this contract, including any extensions of the term, will not exceed five (5) years.

(6) If the executive's term of employment has been extended under subclause (1) and further extension of the term is prohibited by subclause (5), the executive will be considered for reappointment as a district executive if the executive gives a notice to the chief executive, indicating a wish to be reappointed, not less than four (4) months before the completion date.

(7) If the chief executive receives a notice under subclause (6), the chief executive must give a notice to the executive, not less than two (2) months before the completion date, advising whether the executive will or will not be reappointed as a district executive after the completion date.

(8) The executive acknowledges that if the executive does not give a notice under subclause (6), the executive has elected not to be reappointed as a district executive after the completion date.

(9) A failure by the chief executive to give a notice under subclause (3) or subclause (7) is not a breach of this contract.

7. **Termination**

(1) If the executive –

(a) receives a notice under clause 6(3) or clause 6(7) (as relevant to the circumstances) which advises that the executive will not be continued in employment or will not be reappointed as a district executive after the completion date; or

(b) does not receive a notice under clause 6(3) or clause 6(7),

the employment of the executive will terminate on the completion date, without requiring further notice from the chief executive.

(2) (a) The employment of the executive may be terminated by the chief executive prior to the completion date by a notice given to the executive not less than one (1) month before the termination date.

(b) A notice under paragraph (a) need not give any reason for the termination of the executive's employment.

(c) The chief executive may revoke a notice under paragraph (a) before it takes effect.

(3) (a) The executive may resign by a notice given to the chief executive not less than one (1) month before the termination date.

(b) A notice under paragraph (a) takes effect in accordance with its terms and without needing the chief executive's acceptance.

(4) This clause does not limit the chief executive's capacity to terminate or suspend the executive's employment pursuant to a disciplinary process under the determination referred to in the Act or any other relevant legislation.

8. **Service and Separation Payments**

(1) This clause does not apply to the executive if –

(a) the executive is on leave from a public entity of another jurisdiction and the executive resumes duty with the public entity following the termination of the contract on the termination date; or

(b) prior to settlement of the termination of the contract on the termination date, the executive is appointed to, or otherwise employed by, a government entity, such that the executive has continuity of employment; or

(c) the executive has not given a notice under clause 6(2) and the employment of the executive is terminated on the completion date; or

(d) termination of employment occurs as a result of –

(i) disciplinary action against the executive under the Act; or

(ii) retirement of the executive, by reason of mental or physical illness or disability under the Act; or

(iii) voluntary retirement by the executive under the Act; or

(iv) resignation by the executive; or

(v) death of the executive.

(2) If the executive's employment as a district executive and this contract expire on the completion date under clause 7(1), the executive must be paid on the completion date, in addition to other payments and benefits to which the executive is entitled, a payment equal to twelve (12) weeks' superannuable salary, calculated at the rate of the superannuable salary at the termination date.

(3) If the employment of the executive is terminated prior to the completion date under clause 7(2), the executive must be paid on the termination date, in addition to other payments and benefits to which the executive is entitled, a service payment and a separation payment.

9. Payments to be Final

(1) Where the employment of the executive is terminated in accordance with this contract –

(a) the provisions herein as to the payments to be made to the executive constitute the whole of the entitlements of the executive under this contract;

(b) the executive must not, except where the executive has an express statutory right to do so, institute any proceedings for compensation for loss of office, injunctive relief, reinstatement or appeals;

(c) payments paid under clause 8 are deemed to be liquidated damages which each party acknowledges are a realistic assessment of any detriment which the executive may suffer following a termination of this contract; and

(d) payments due by way of statutory entitlement are to be calculated, where relevant, by reference to the superannuable salary at the termination date.

(2) Should a termination of this contract be determined by a court or a tribunal to be unlawful, any entitlement the executive may have is limited to the amount of payments paid under clause 8 as liquidated damages, as if the termination had been lawful.

(3) Nothing in this clause shall be deemed or construed as a release in respect of any action, personal injury or death of the executive, that the executive or anyone claiming by, through or under the executive, may have.

10. Repayment

(1) Where the executive –

(a) receives a service payment or a separation payment under clause 8; but

(b) before the completion date recommences public sector employment,

the executive must, within twenty-eight (28) days after recommencing such employment, or within such period as otherwise directed by the chief executive, repay to the Crown the total of the amounts calculated in accordance with the following formulas –

(i) Service Payment

$$A = B - (W \times S)$$

AND

(ii) Separation Payment

$$A = Z - \frac{(W \times S)}{5}$$

Where –

A in respect of each formula, is the amount to be repaid. For service payment, where the formula produces a negative result, then A equals zero.

B is the service payment which the executive has received under clause 8.

W is the number of weeks between the termination date and the date on which the executive recommenced public sector employment.

S is the weekly superannuable salary of the executive as at the termination date.

Z is the separation payment which the executive has received under clause 8.

(2) The executive is not entitled to a refund of a service payment or a separation payment repaid to the Crown under subclause (1) if the executive subsequently ceases public sector employment.

11. Other Agreements Superseded

This contract supersedes and replaces all other contracts, understandings or arrangements prior to its execution.

12. Notice

Any notice required to be given under this contract is effectively given if made in writing and signed by the party giving such notice, and –

(a) in the case of the chief executive, sent to the address specified in item 1(b) of the particulars; or

(b) in the case of the executive, sent to the business or residential address specified in item 2 of the particulars; or

(c) sent to such other address as may be notified to the other party giving such notice.

13. Variation

(1) A variation to this contract, other than a variation under subclause (2), must be approved by the Chief Executive and accepted in writing by the parties before taking effect.

(2) A variation to the duties specified in item 3(d) of the particulars must be accepted in writing by the parties before taking effect.

(3) To remove any doubt, where this contract provides for a determination to be made by a person, a fresh determination made by that person is not a variation to this contract.

14. Governing Law

This contract is governed by, construed and interpreted in accordance with the laws of Queensland and the parties submit to the jurisdiction of the courts of that State.

15. Interpretation

(1) The dictionary in the schedule defines the terms used in this contract.

(2) Unless otherwise defined in this contract, terms used have the same meaning as in the Act.

(3) Clause headings are not to be used as an interpretation aid.

(4) A reference to a clause, the schedule or the particulars is a reference to a clause, the schedule or the particulars of this contract.

(5) A reference to a subclause, paragraph or subparagraph is a reference to a subclause, paragraph or subparagraph of the clause of this contract in which the reference is made.

(6) A reference to the Act or any other Act, includes that Act as amended from time to time or any Act which replaces that Act, and any statutory instrument made under that Act.

(7) A reference to a number of days is a reference to that number of calendar days.

(8) Words in the singular include the plural and words in the plural include the singular.

SCHEDULE

DICTIONARY

Act means the *Health Services Act 1991*;

actual salary means the remuneration package amount *less* the total cost of providing the remuneration benefits;

annual performance agreement means a performance agreement negotiated and developed by the executive with the chief executive, or the chief executive's delegate, in each year the contract is in force;

approved fund means a superannuation fund approved by the Executive Officer under the QSuper Act;

basic accumulation category means the category under Chapter 3 of the QSuper Deed;

commencement date means the date specified in item 3(f) of the particulars;

completion date means the date specified in item 3(g) of the particulars;

comprehensive accumulation category means the category under Chapter 3 of the QSuper Deed;

confidential information means information referred to in section 63 of the Act;

continuous service as a public sector employee - (1) means –

(a) the period of employment from the commencement date until the termination date, *less* any period of leave without salary which cannot be credited for service under a ruling;

(b) a period of service by the executive (unbroken by resignation, termination, retirement or redundancy) as a public sector employee on contract or on tenure, which continues up to immediately before the commencement date, *less* any period of leave without salary which cannot be credited for service under a ruling;

(c) any period of employment of the executive before the commencement date –

(i) which is capable of being recognised for the purpose of calculating an entitlement to long service leave under a ruling; or

(ii) which would, other than for the fact that the executive has taken long service leave or had an entitlement to long service leave paid as a cash equivalent, be capable of being recognised for the purpose of calculating an entitlement to long service leave under a ruling;

(2) does not include a period of employment which has already been used as the basis for calculating a payment received by the executive for an entitlement of the same or similar nature to a service payment;

Crown means the Crown in right of the State of Queensland;

department means the Department of Health established under the Public Service Act 1996, or any department which replaces that department;

district means the district specified in item 3(a) of the particulars;

election amount means an amount that, if the executive was a member of the comprehensive accumulation category, the Treasurer would require to be paid under the QSuper Act (including the contribution required to be made by or on behalf of the member) *less* any amount which is actually paid to the basic accumulation category.

party means a party to this contract;

public sector employment means employment for a cumulative period of more than twenty (20) working days in a government entity and includes –

(a) casual, part-time or full-time employment; and

(b) engagement as a contractor where the contract is wholly or principally for the labour of the executive, except where the executive does not have any financial interest in the company, partnership or similar entity engaged to provide the service;

QSuper Act means the *Superannuation (State Public Sector) Act 1990*;

QSuper Deed means the Deed of the State Public Sector Superannuation Scheme under the QSuper Act;

QSuper Scheme means the State Public Sector Superannuation Scheme under the QSuper Act;

remuneration benefit means a remuneration benefit referred to under clauses 4(1) and 4(3) and provided for under a ruling;

separation payment means a payment equal to twenty percent (20%) of the superannuable salary that would have been paid to the executive from the termination date to the completion date, had the employment of the executive not been terminated, calculated at the rate of the superannuable salary at the termination date;

service payment means a payment equal to two (2) weeks superannuable salary for each year of continuous service as a public sector employee, with a minimum of four (4) weeks superannuable salary and a maximum of fifty-two (52) weeks superannuable salary, calculated at the rate of the superannuable salary at the termination date;

standard defined benefit category means the category under Chapter 2 of the QSuper Deed;

statutory instrument has the same meaning as in the *Statutory Instruments Act 1992*;

superannuable salary means the amount specified in item 3(h) of the particulars or, where that amount is varied under clause 4(2), the varied amount;

termination date means the completion date or the date on and from which the employment of the executive under this contract is terminated.

The parties have executed this contract of employment as follows:

Signed by the chief executive or delegate

(signature of ~~chief executive or~~ delegate)

on the 27 day of January 2005

in the presence of

H E Kable
(signature of witness)

HAZEL ELIZABETH KABLE
(full name of witness - print)

AND

Signed by the executive

(signature of executive)

on the 19th day of January 2005

in the presence of

CE Brennan
(signature of witness)

CHERYL BRENNAN
(full name of witness - print)