CONF

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Minister's Office RecFind No:	11004731
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

PT 15

Briefing Note
Director-General

NFA

Next steps to be further considered post 24/3/

Requested by: Chief Executive Officer, Townsville Health Service District

Date requested:

Action required by:

Action required
- ☐ For approval
- ☐ For meeting
- ☐ With correspondence
- ☒ For information

Other attachments for Ministerial consideration
- ☐ Speaking points
- ☐ Draft media release
- ☐ Ministerial Statement
- ☐ Question on Notice
- ☐ Cabinet related document

SUBJECT: Restructure of management in the Institute of Mental Health Services, Townsville Health Service District

Proposal
That the Director-General:

Note the process for the planned reform and restructure of the Institute of Mental Health Services (IMHS), Townsville Health Service District (THSD). Management downsizing and reallocation of potentially released resources to enhance service delivery in the service have been delayed due to ongoing consultation processes with unions, in particular Together Queensland.

Provide this brief to the Minister for information.

Urgency

1. Routine

Background

2. Initial review and planned restructure of the Institute of Mental Health Services (IMHS), Townsville Health Service District undertaken by the Institute, commenced in 2009.
3. Significant concerns were raised by numerous stakeholders, especially the Unions to District Executive, in mid 2010.
4. District Executive ceased review in June 2010 and requested assistance from People & Culture Strategic Services (PACSS) to formally review the IMHS 2009 findings.
5. The PACSS report was released in August 2010.
6. Key findings presented to District Executive were of significant concern and therefore placed as a high priority to implement recommendations and resolve issues outlined in the PACSS report.
7. The District CEO appointed an Executive Director Mental Health Reform in December 2010.
8. The two key focus areas were the restructuring of the current Institute and management structures.

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Key issues

9. The management and service reform process which commenced in December 2010 is still anticipated to be implemented in the first quarter of 2012. There will be a requirement of ongoing monitoring and a review at the end of 12 months.

10. It is envisaged that the restructure will result in:

    a. a reduction in the number of managerial positions This can be further justified based on the Mental Health Directorate figures for the numbers of "Leaders & Safety and Quality" Community full time equivalent (FTE) staff. In 2009, Townsville Mental Health Services was already at 130% of the required number for 2017; and

    b. a proposed increase in the number of lower level positions, which will improve services and increase access for clients, as a result of financial savings made from the realignment of management positions.

11. The reform process and consequent restructure will build the foundations for increased accountability, trust, transparency in decisions, respect for each other, equity and fairness across the Institute, and acknowledgement of diversity in the Institute.

12. A set of principles/guidelines for the management restructure was developed and discussed with unions, prior to their endorsement at the local District Consultative Forum (DCF) on the 16 August 2011.

13. Operational and professional management responsibilities will be merged and this will be identified in relevant role descriptions.

14. With regard to the restructure's impact upon patients:

    a. during the reform process, there are no foreseeable implications for 'patient experience'. No negative impact on patient delivery is anticipated during the restructure; however, it is envisaged that there will be a positive impact on service delivery post review. To date there have been no reported negative impacts on service delivery and it is still too early to report on concrete positive impacts.

    b. the proposed resource savings from the reduction in management positions will be utilised for the provision of increased services and increases in frontline staff for direct patient care.

15. Expected benefits of the restructure include:

    a. proposals from the iMHS Strategic Reform Project:

        i. recovery focused and responsive:

        refocusing on recovery principles and practice, in collaboration with consumers and carers and with other service providers;

    b. accessible, appropriate and sustainable service delivery:

        i. establishing a rural and remote mental health stream, responsible for current community services of THSD Institute of Rural Health and Ingham Community Mental Health Service (MHS);

        ii. establishing an Indigenous mental health stream, as part of the Rural and Remote mental health stream, including Palm Island MHS (an Indigenous team in the Townsville area), the Townsville Aboriginal and Islander Health Service, and in conjunction with the Mount Isa MHS (the lower Gulf outreach service);

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iii. expanding e-mental health services for Rural and Remote MHS delivery, including from Townsville based specific clinics where possible;

iv. initiating a MHS for young adults in the Townsville area;

c. continuous, safe care:

i. improving discharge and transfer of care for consumers within IMHS and to extended partners;

d. capable, evidence-based practice:

i. consistent use of standardised clinical information practices, including the statewide documentation suite the Consumer Integrated Mental Health Application (CIMHA);

e. effective and efficient practice:

i. continued focus on outcomes of care;

ii. establish expectations of service components to measure and evaluate Queensland Health performance; and

iii. comparing performance on outcomes, resources and costs, internally and externally, identifying areas for improvement and making appropriate changes.

16. As at 13 October 2011:

a. the final draft of the proposed structure has been presented to Mental Health staff at various forums;

b. as agreed with the Queensland Public Sector Union (QPSU) on 5 October 2011, the QPSU planned to hold staff consultations in the week commencing 10 October 2011;

c. as the QPSU Organiser was ill, a union official contacted the Executive Director, Mental Health Reform via telephone on 12 October 2011 to express concern that a final draft had been be released with no consultation with the unions. The union official was assured that significant consultation had occurred and that the District understood that the union, Together, was going to undertake its consultations with relevant staff that week;

d. the official was notified that a letter had been sent to all relevant union State Secretaries on 5 October 2011, providing an overview and relevant documentation. The THSD awaits their responses regarding any feedback or concerns they may have in relation to the information provided to them; and from Oct 12

e. Schedule 3 (7) legal professional privilege

17. As at 12 December 2011

a. As the TSHD received no response from Together Queensland to its letter dated 5 October 2011, a follow up letter was sent on 24 October 2011. A response to the first letter was received on 24 October 2011; however, the only feedback provided in relation to the proposed structure was "with respect to the Mental Health Reform proposal, members have considered this and have overwhelmingly rejected it".

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b. Further follow up letters were sent on 2 November 2011 and 17 November 2011 to request feedback and clarify what the concerns entailed.

c. On 28 November 2011, a letter was received from Together Queensland where it stated that if Queensland Health wished to have meaningful consultation some of Together Queensland's delegates were prepared to meet and further discuss the proposal and alternatives. At no stage has the union put forward any alternative suggestions. The letter goes on to state that if Queensland Health does not continue to consult further on the proposed changes, then it will be in dispute and the union will escalate the matter to the Queensland Industrial Relations Commission to seek an enforcement of its members' rights to meaningful consultation.

d. A further letter has been sent to Together Queensland requesting a meeting between the local organiser and the District Chief Operating Officer (who is also the Chair of Mental Health Reform Steering Committee) to ascertain what the issues are. The THSD is still working to try and facilitate a mutually agreeable time for this meeting to take place.

e. The reform process is now moving at a much slower pace than was expected, whilst awaiting outcomes of attempts to actively engage with the local organiser. The reform team has therefore been extended to early March 2012.

f. At the Mental Health Reform Steering Committee meeting held on Monday, 12 December 2011 a direction was given to the reform team to continue to progress the restructure as there was a view that adequate consultation had occurred.

18. As at 24 January 2012

a. Together Queensland raised its disquiet about the proposed Institute and Management Structure, to the Chair of the Mental Health Reform (MHR) Executive Steering Committee.

b. As a result of these concerns a meeting was held on 16 December 2011 with Together Queensland (TQ); four TQ delegates; the Manager Human Resources, and the Chair of the Mental Health Reform Executive Steering Committee who was also the A/District CEO (Mr John Burns). TQ put forward their concerns and tabled an alternative structure on behalf of the delegates.

c. This alternative structure had already been previously tabled by a few individuals and was considered and analysed in detail, discussed at both MHR Steering Committee and Executive Management Team (EMT) meetings. It was found in this analysis it failed to meet the majority of the criteria in the Guiding Principles for Management Restructure.

d. After the lengthy discussions at the 16 December 2011 meeting, Mr Burns advised that he would review the alternate proposal that was tabled, utilising the Guiding Principles for Management Restructure (which were endorsed at DCF on 16 August 2011, of which a TQ Organiser was present). Mr Burns gave an undertaking that he would provide a response of the outcomes of these deliberations, prior to Christmas.

e. A response was provided to TQ on 21 December 2011, advising that the alternate proposal failed to meet the majority of the criteria outlined in the Guiding Principles for Management Restructure and therefore would not be supported.

f. TQ responded by email advising their disappointment on 22 December 2011.

g. A *Business Case Request to Apply for Specified Advertising* was sent to relevant Unions (outlined below) on 22 December 2011, to seek endorsement:

   i. Australian Services Union, Queensland Branch (ASU Qld Branch);

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ii. Together Queensland (TQ);

iii. Australian Workers' Union (AWU); and

iv. Queensland Nurses' Union (QNU).

h. Initial letters were sent to impacted staff on 5 January 2012 advising of the process.

i. Follow up emails were sent to TQ, AWU and QNU on 12 January 2012, in regards to the *Business Case Request to Apply for Specified Advertising* to once again seek their endorsement.

j. We still await responses from TQ, AWU and QNU.

k. Delegates at the MHR Steering Committee meeting on 10 January 2012 reiterated their direction to the MH Reform Team, to continue to progress the Institute and Management Structures, having considered the above information.

l. A forum with senior staff, including team leaders occurred on 12 January 2012 outlining anticipated timelines leading up to the 'go live' date and implementation of the new structure.

m. Regular teleconferences with the Senior Director, Workplace Relations Unit have continued to occur throughout this process to guide decision making at a local level.

n. The anticipated 'go live' date for implementation of the new structures is 5 March 2012.

o. <u>Key issues to be resolved</u>

i. Endorsement of *Business Case Request to Apply for Specified Advertising* by relevant Unions.

ii. Risk management process if a specified advertising (closed merit) process is not endorsed by the Unions, resulting in the need to move to an open merit process. This is definitely not the preferred option from the District; however, it is a District priority to implement these reforms.

iii. Outcome of brief for Voluntary Separation Packages (VSP's) for a limited group wishing to become surplus officers. This brief is currently with the Deputy Director-General Human Resource Services awaiting a determination.

iv. If VSP's are not available, the resulting implications for surplus officers under LHHN's.

Consultation

19. Consultation with stakeholders about the existing structure has been ongoing throughout 2011 via individual meetings with union organisers, the Steering Committee, the DCF and staff feedback processes. Feedback has been forthcoming from the QNU, ASU and AWU - which have stated their support and satisfaction with the consultation as part of the Mental Health Reform process to date.

20. The IMHS senior management meets weekly with the Executive Director, Mental Health Reform to guide the process.

21. Four Mental Health Reform workshops were conducted throughout 2011. All MHS managers were invited to participate. Attendance has averaged approximately 55 participants per workshop and has included members of the District Executive and members of the Mental Health Directorate.

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22. Information gathered has assisted with setting the direction for the reform process. The feedback that managers have provided has been valuable in the provision of strategic direction. In addition to this, there have been various group and individual meetings to provide updates on the reform process as well as an opportunity for input.

23. Extensive consultation with IMHS staff has occurred and has been ongoing through a variety of methods from group service forums to individual interviews.

24. Extensive consultation has been undertaken and discussions have occurred with local union organisers as detailed below:
    a. Ms Mary Louez, Organiser, Queensland Nurses' Union;
    b. Mr Joel Wilson, Organiser, Together Queensland;
    c. Ms Michelle Duggan, Organiser, Australian Workers' Union;
    d. Ms Chiara Lennox, Organiser, Australian Services Union North Queensland;
    e. members of the Reform Steering Committee; and
    f. participation in the Mental Health Local Consultative Forum and DCF.

25. Prior to the endorsement of the principles/guidelines for the management restructure, all union organisers met individually with the Executive Director, Mental Health Reform to discuss and make amendments to the proposed principles.

26. At the DCF meeting of 16 August 2011, attended by Organisers from the QNU and Together Queensland, these principles were endorsed for utilisation in developing the new structure.

27. The local union organisers have been very supportive of this restructure, as many issues that they have raised over a number of years are reflective of the issues noted in the PACSS report.

28. It is noted that on 3 September 2011 there was a change of tone from Together Queensland, with the union advising that it could not endorse the structure without further consultation with its members. This consultation was verbally agreed to by the Executive Director, Mental Health Reform and the Union Organiser, to occur in the week commencing 10 October 2011. In addition, it was agreed that the reform team would present the proposed structure to those staff most impacted, in small peer groups (for equity purposes), ensuring staff were receiving the same information at the same time. There were also open forums throughout the IMHS where the reform team presented the new structure to staff and there was opportunity for questions and clarifications if required.

29. Individual interviews and consultation with all managers and other staff, around their perceptions of the issues in the service and ways to improve the service, has occurred.

30. A discussion was held with Mr John Cairns, Deputy Director-General, Human Resource Services on 30 August 2011, to brief him on the reform process and the union consultation and explore the possibility of voluntary separation packages for relevant senior positions.

Financial implications

31. It is expected this will be a cost neutral exercise and that any potential resources released as part of the downsizing of the management structure will be redirected into service delivery positions.

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32. The objective of the reform is to provide improved and expanded clinical services within budget constraints.

Legal implications

33. There are no legal implications.

Elected representative

34. Ms Lindy Nelson-Carr MP, Member for Mundingburra

35. Ms Mandy Johnston MP, Member for Townsville

36. The Honourable Craig Wallace MP, Minister for Main Roads, Fisheries and Marine Infrastructure

37. Mr Ewen Jones MP, Member for Herbert

Remedial action

38. There has been extensive consultation with internal and external key stakeholders in developing a more effective management structure.

39. A gap analysis was conducted regarding service delivery with the Statewide Queensland Health Model of Service Delivery Framework documents to guide the mental health reform process.

40. A plan to implement a more sustainable service governance structure that meets the needs of the IMHS has been developed.

41. A reduction or downsizing of senior management positions will free resources that will be redirected to direct consumer care/service delivery positions

42. Following discussion with the Deputy Director-General, Human Resource Services on 30 August 2011, the District Chief Executive Officer requested a formal assessment of industrial awards and agreements.

43. The THSD will also engage with Human Resource Services to assess the eligibility of offering voluntary separation packages within the definition of "frontline staff".

Attachments

44. Nil

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Proposal
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Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

/ /

To Minister's Office **For Noting** ☒
For Approval ☐

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Val Tuckett	Dr Andrew Johnson	Dr Andrew Johnson
District Executive Director Mental Health Reform	District CEO	District CEO
Townsville HSD	Townsville HSD	Townsville HSD
4796 4146	4796 0931	4796 0931
30 August 2011 Updated 13 October 2011 Updated 12 December 2011 30 January 2012	1 September 2011 Updated 4 October 2011 John Burns Acting District CEO 14 December 2011	1 September 2011 Updated 4 October 2011 John Burns Acting District CEO 14 December 2011 Andrew Johnson District CEO 30 January 2012

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Briefing Note

The Honourable Geoff Wilson MP
Minister for Health

Requested by: **Date requested:** **Action required by:**

Action required
☐ For approval ☒ For Information
☐ For meeting ☐ With correspondence

Other attachments for Ministerial consideration
☐ Speaking points ☐ Ministerial Statement
☐ Draft media release

SUBJECT: Restructure of management in the Institute of Mental Health Services, Townsville Health Service District

Recommendation
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APPROVED/NOT APPROVED **NOTED** **NOTED**

GEOFF WILSON
Minister for Health

Principal Advisor

Senior Policy Advisor/
Policy Advisor

/ / / / / /

Minister's comments

2 FEB 2012

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Briefing Note
Director-General

Requested by: Chief Executive Officer, Townsville Health Service District

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f. At the Mental Health Reform Steering Committee meeting held on Monday, 12 December 2011 a direction was given to the reform team to continue to progress the restructure as there was a view that adequate consultation had occurred.

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j. We still await responses from TQ, AWU and QNU.

k. Direction at the MHR Steering Committee meeting on 10 January 2012, reiterated their direction to the MH Reform Team, to continue to progress the Institute and Management Structures, having considered the above information.

l. Forum with senior staff, including team leaders occurred on 12 January 2012 outlining anticipated timelines leading up to the 'go live' date and implementation of the new structure.

m. Regular teleconferences with the Senior Director, Workplace Relations Unit have continued to occur throughout this process to guide decision making at a local level.

n. The anticipated 'go live' date for implementation of the new structures is 5 March 2012.

o. Key issues to be resolved

i. Endorsement of *Business Case Request to Apply for Specified Advertising* by relevant Unions.

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    e. members of the Reform Steering Committee; and
    f. participation in the Mental Health Local Consultative Forum and DCF.

25. Prior to the endorsement of the principles/guidelines for the management restructure, all union organisers met individually with the Executive Director, Mental Health Reform to discuss and make amendments to the proposed principles.

26. At the DCF meeting of 16 August 2011, attended by Organisers from the QNU and Together Queensland, these principles were endorsed for utilisation in developing the new structure.

27. The local union organisers have been very supportive of this restructure, as many issues that they have raised over a number of years are reflective of the issues noted in the PACSS report.

28. It is noted that on 3 September 2011 there was a change of tone from Together Queensland, with the union advising that it could not endorse the structure without further consultation with its members. This consultation was verbally agreed to by the Executive Director, Mental Health Reform and the Union Organiser, to occur in the week commencing 10 October 2011. In addition, it was agreed that the reform team would present the proposed structure to those staff most impacted, in small peer groups (for equity purposes), ensuring staff were receiving the same information at the same time. There were also open forums throughout the IMHS where the reform team presented the new structure to staff and there was opportunity for questions and clarifications if required.

29. Individual interviews and consultation with all managers and other staff, around their perceptions of the issues in the service and ways to improve the service, has occurred.

30. A discussion was held with Mr John Cairns, Deputy Director-General, Human Resource Services on 30 August 2011, to brief him on the reform process and the union consultation and explore the possibility of voluntary separation packages for relevant senior positions.

Financial implications

31. It is expected this will be a cost neutral exercise and that any potential resources released as part of the downsizing of the management structure will be redirected into service delivery positions.

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32. The objective of the reform is to provide improved and expanded clinical services within budget constraints.

Legal implications

33. There are no legal implications.

Elected representative

34. Ms Lindy Nelson-Carr MP, Member for Mundingburra

35. Ms Mandy Johnston MP, Member for Townsville

36. The Honourable Craig Wallace MP, Minister for Main Roads, Fisheries and Marine Infrastructure

37. Mr Ewen Jones MP, Member for Herbert

Remedial action

38. There has been extensive consultation with internal and external key stakeholders in developing a more effective management structure.

39. A gap analysis was conducted regarding service delivery with the Statewide Queensland Health Model of Service Delivery Framework documents to guide the mental health reform process.

40. A plan to implement a more sustainable service governance structure that meets the needs of the IMHS has been developed.

41. A reduction or downsizing of senior management positions will free resources that will be redirected to direct consumer care/service delivery positions

42. Following discussion with the Deputy Director-General, Human Resource Services on 30 August 2011, the District Chief Executive Officer requested a formal assessment of industrial awards and agreements.

43. The THSD will also engage with Human Resource Services to assess the eligibility of offering voluntary separation packages within the definition of "frontline staff".

Attachments

44. Nil

Minister's Office RecFind No:	11004731
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

Proposal
That the Director-General:

Note the process for the planned reform and restructure of the Institute of Mental Health Services (IMHS), Townsville Health Service District (THSD). Management downsizing and reallocation of potentially released resources to enhance service delivery in the service have been delayed due to ongoing consultation processes with unions, in particular Together Queensland.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

/ /

To Minister's Office **For Noting** ☒
For Approval ☐

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Val Tuckett	Dr Andrew Johnson	Dr Andrew Johnson
District Executive Director Mental Health Reform	District CEO	District CEO
Townsville HSD	Townsville HSD	Townsville HSD
4796 4146	4796 0931	4796 0931
30 August 2011	1 September 2011	1 September 2011
Updated 13 October 2011	Updated 4 October 2011	Updated 4 October 2011
Updated 12 December 2011	John Burns	John Burns
30 January 2012	Acting District CEO	Acting District CEO
	14 December 2011	14 December 2011
		Andrew Johnson
		District CEO
		30 January 2012

Attn: Exec Support

Pls thank District for providing this brief – however, based on para 23(c-f) an updated brief should be prepared once outcomes of meeting are known.

Also perhaps we could summarise background + focus on current issues to be resolved.

12 JAN 2012

Thx

Allison

Minister's Office RecFind No:	11004731
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Division/District:	Townsville HSD
File Ref No:	

Briefing Note

Director-General

16 DEC 2011

Requested by: Chief Executive Officer, Townsville Health Service District

Date requested:

Action required by:

Action required
- ☐ For approval
- ☐ For meeting
- ☐ With correspondence
- ☒ For Information

Other attachments for Ministerial consideration
- ☐ Speaking points
- ☐ Draft media release
- ☐ Ministerial Statement
- ☐ Question on Notice
- ☐ Cabinet related document

SUBJECT: Restructure of management in the Institute of Mental Health Services, Townsville Health Service District

Proposal

That the Director-General:

Note the process for the planned reform and restructure of the Institute of Mental Health Services (IMHS), Townsville Health Service District (THSD). Management downsizing and reallocation of potentially released resources to enhance service delivery in the service have been delayed due to ongoing consultation processes with unions, in particular Together Queensland.

Provide this brief to the Minister for information.

Urgency

1. Routine

Background

2. In 2009, the IMHS, THSD commenced a process of restructuring the institute and reviewing models of service delivery across a range of services.

3. It was recognised that there was a need to improve clinical service delivery. There was a belief that the current management structure was absorbing funding that could, and should, be directed to frontline clinical services rather than to managerial positions. To explore this potential, the IMHS senior management embarked on an organisational reform process. This process was managed internally by the IMHS senior management staff.

4. Concerns were raised by numerous stakeholders that the consultation around the proposed restructure was insufficient.

5. Following consideration of these concerns, the THSD executive sought assistance from the People and Culture Branch in Corporate Office. As a result of these discussions, it was considered that a formal review of the reform process was required to determine whether the concerns that had been raised had merit and what improvements could be made to ensure the reform could progress.

6. The work on the IMHS-initiated restructure process was ceased in June 2010 pending a review by the then People and Culture Strategic Services (PACSS - now Human Resources Coordination). The review was conducted in July 2010 with the findings outlined in a PACCS report dated August 2010.

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7. As a result of the review, the THSD executive received a report in October 2010 known as the 'PACSS report'. This report made a number of observations and recommendations on how to progress the reform process. The report became the basis of the reform within the IMHS.

8. The report identified serious concerns expressed by some staff regarding the reform process, such as:
   a. a lack of transparency;
   b. poor processes; and
   c. a lack of agreed vision and goals.

9. However, there was recognition that there was a need for reform. It was also recognised that the services were top heavy in the management structure.

10. The THSD executive was of the opinion that the reform was a high priority within the District.

11. To progress the IMHS reform process, the District executive assigned the District Executive Director of Nursing (DEDON) to this project for a period of one year from December 2010, in the role of Executive Director, Mental Health Reform.

12. It was recognised that the operational staff within IMHS did not have the time to undertake this role while carrying out their operational duties.

13. The main themes identified during the PACSS review process were:
   a. a lack of role clarity in the Institute;
   b. a high proportion of managers/supervisors to employees (approximately 1:5);
   c. a complicated management structure;
   d. a top-heavy structure with multiple supervisory and managerial roles in each team;
   e. confusion on reporting lines within the current structures; and
   f. diminished accountability due to reporting line confusion, as a result of inconsistent leadership, with changes to the Operations and Clinical Director positions.

14. Other issues of concern raised by staff included but were not limited to:
   a. a lack of communication;
   b. nepotism;
   c. governance issues;
   d. a lack of standardised protocols and procedures;
   e. poor human resources processes; and
   f. a lack of agreed vision and goals.

Key issues

15. The management and service reform process which commenced in December 2010 is still anticipated to be implemented in the first quarter of 2012. There will be a requirement of ongoing monitoring and a review at the end of 12 months.

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16. It is envisaged that the restructure will result in:
    a. a reduction in the number of managerial positions, This can be further justified based on the Mental Health Directorate figures for the numbers of "Leaders & Safety and Quality" Community full time equivalent (FTE) staff. In 2009, Townsville Mental Health Services was already at 130% of the required number for 2017; and
    b. a proposed increase in the number of lower level positions, which will improve services and increase access for clients, as a result of financial savings made from the realignment of management positions.

17. The reform process and consequent restructure will build the foundations for increased accountability, trust, transparency in decisions, respect for each other, equity and fairness across the Institute, and acknowledgement of diversity in the Institute.

18. A set of principles/guidelines for the management restructure was developed and discussed with unions, prior to their endorsement at the local District Consultative Forum (DCF) on the 16 August 2011.

19. Operational and professional management responsibilities will be merged and this will be identified in relevant role descriptions.

20. With regard to the restructure's Impact upon patients:
    a. during the reform process, there are no foreseeable implications for 'patient experience'. No negative impact on patient delivery is anticipated during the restructure; however, it is envisaged that there will be a positive impact on service delivery post review. To date there have been no reported negative impacts on service delivery and it is still too early to report on concrete positive impacts.
    b. the proposed resource savings from the reduction in management positions will be utilised for the provision of increased services and increases in frontline staff for direct patient care.

21. Expected benefits of the restructure include:
    a. proposals from the IMHS Strategic Reform Project:
        i. recovery focused and responsive:
            - refocusing on recovery principles and practice, in collaboration with consumers and carers and with other service providers;
    b. accessible, appropriate and sustainable service delivery:
        i. establishing a rural and remote mental health stream, responsible for current community services of THSD Institute of Rural Health and Ingham Community Mental Health Service (MHS);
        ii. establishing an Indigenous mental health stream, as part of the Rural and Remote mental health stream, including Palm Island MHS (an Indigenous team in the Townsville area), the Townsville Aboriginal and Islander Health Service, and in conjunction with the Mount Isa MHS (the lower Gulf outreach service);
        iii. expanding e-mental health services for Rural and Remote MHS delivery, including from Townsville based specific clinics where possible;
        iv. initiating a MHS for young adults in the Townsville area;

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c. continuous, safe care:

   i. improving discharge and transfer of care for consumers within IMHS and to extended partners;

d. capable, evidence-based practice:

   i. consistent use of standardised clinical information practices, including the statewide documentation suite the Consumer Integrated Mental Health Application (CIMHA);

e. effective and efficient practice:

   i. continued focus on outcomes of care;

   ii. establish expectations of service components to measure and evaluate Queensland Health performance; and

   iii. comparing performance on outcomes, resources and costs, internally and externally, identifying areas for improvement and making appropriate changes.

22. As at 13 October 2011:

a. the final draft of the proposed structure has been presented to Mental Health staff at various forums;

b. as agreed with the Queensland Public Sector Union (QPSU) on 5 October 2011, the QPSU planned to hold staff consultations in the week commencing 10 October 2011;

c. as the QPSU Organiser was ill, a union official contacted the Executive Director, Mental Health Reform via telephone on 12 October 2011 to express concern that a final draft had been be released with no consultation with the unions. The union official was assured that significant consultation had occurred and that the District understood that the union, Together, was going to undertake its consultations with relevant staff that week;

d. the official was notified that a letter had been sent to all relevant union State Secretaries on 5 October 2011, providing an overview and relevant documentation. The THSD awaits their responses regarding any feedback or concerns they may have in relation to the information provided to them; and

e. Schedule 3 (7) legal professional privilege

23. As at 12 December 2011

a. As the TSHD received no response from Together Queensland to its letter dated 5 October 2011, a follow up letter was sent on 24 October 2011. A response to the first letter was received on 24 October 2011; however, the only feedback provided in relation to the proposed structure was "with respect to the Mental Health Reform proposal, members have considered this and have overwhelmingly rejected it".

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b. Further follow up letters were sent on 2 November 2011 and 17 November 2011 to request feedback and clarify what the concerns entailed.

c. On 28 November 2011, a letter was received from Together Queensland where it stated that if Queensland Health wished to have meaningful consultation some of Together Queensland's delegates were prepared to meet and further discuss the proposal and alternatives. At no stage has the union put forward any alternative suggestions. The letter goes on to state that if Queensland Health does not continue to consult further on the proposed changes, then it will be in dispute and the union will escalate the matter to the Queensland Industrial Relations Commission to seek an enforcement of its members' rights to meaningful consultation.

d. A further letter has been sent to Together Queensland requesting a meeting between the local Organiser and the District Chief Operating Officer (who is also the Chair of Mental Health Reform Steering Committee) to ascertain what the issues are. The THSD is still working to try and facilitate a mutually agreeable time for this meeting to take place.

e. The reform process is now moving at a much slower pace than was expected, whilst awaiting outcomes of attempts to actively engage with the local Organiser. The reform team has therefore been extended to early March 2012, although this now seems quite ambitious with the Christmas closure to soon occur.

f. At the Mental Health Reform Steering Committee meeting held on Monday, 12 December 2011 a direction was given to the reform team to continue to progress the restructure as there was a view that adequate consultation had occurred.

Consultation

24. Consultation with stakeholders about the existing structure has been ongoing throughout 2011 via individual meetings with union organisers, the steering committee, the DCF and staff feedback processes. Feedback has been forthcoming from the Queensland Nurses' Union, Australia Services' Union and the Australian Workers' Union—which have stated their support and satisfaction with the consultation as part of the Mental Health Reform process to date.

25. The IMHS senior management meets weekly with the Executive Director, Mental Health Reform to guide the process.

26. Four Mental Health Reform workshops were conducted throughout 2011. All MHS managers were invited to participate. Attendance has averaged approximately 55 participants per workshop and has included members of the District Executive and members of the Mental Health Directorate.

27. Information gathered has assisted with setting the direction for the reform process. The feedback that managers have provided has been valuable in the provision of strategic direction. In addition to this, there have been various group and individual meetings to provide updates on the reform process as well as an opportunity for input.

28. Extensive consultation with IMHS staff has occurred and has been ongoing through a variety of methods from group service forums to individual interviews.

29. Extensive consultation has been undertaken and discussions have occurred with local union organisers as detailed below:

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a. Ms Mary Louez, Organiser, Queensland Nurses' Union;
b. Mr Joel Wilson, Organiser, Together Queensland;
c. Ms Michelle Duggan, Organiser, Australian Workers' Union;
d. Ms Chiara Lennox, Organiser, Australian Services Union North Queensland;
e. members of the Reform Steering Committee; and
f. participation in the Mental Health Local Consultative Forum and DCF.

30. Prior to the endorsement of the principles/guidelines for the management restructure, all union organisers met individually with the Executive Director, Mental Health Reform to discuss and make amendments to the proposed principles.

31. At the DCF meeting of 16 August 2011, attended by Organisers from the QNU and Together Queensland, these principles were endorsed for utilisation in developing the new structure.

32. The local union organisers have been very supportive of this restructure, as many issues that they have raised over a number of years are reflective of the issues noted in the PACSS report.

33. It is noted that on 3 September 2011 there was a change of tone from Together Queensland, with the union advising that it could not endorse the structure without further consultation with its members. This consultation was verbally agreed to by the Executive Director, Mental Health Reform and the union Organiser, to occur in the week commencing 10 October 2011. In addition, it was agreed that the reform team would present the proposed structure to those staff most impacted, in small peer groups (for equity purposes), ensuring staff were receiving the same information at the same time. There were also open forums throughout the IMHS where the reform team presented the new structure to staff and there was opportunity for questions and clarifications if required.

34. Individual interviews and consultation with all managers and other staff, around their perceptions of the issues in the service and ways to improve the service, has occurred.

35. A discussion was held with Mr John Cairns, Deputy Director-General, Human Resource Services on 30 August 2011, to brief him on the reform process and the union consultation and explore the possibility of voluntary separation packages for relevant senior positions.

Financial implications

36. It is expected this will be a cost neutral exercise and that any potential resources released as part of the downsizing of the management structure will be redirected into service delivery positions.

37. The objective of the reform is to provide improved and expanded clinical services within budget constraints.

Legal implications

38. There are no legal implications.

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Elected representative

39. Ms Lindy Nelson-Carr MP, Member for Mundingburra

40. Ms Mandy Johnston MP, Member for Townsville

41. The Honourable Craig Wallace MP, Minister for Main Roads, Fisheries and Marine Infrastructure

42. Mr Ewen Jones MP, Member for Herbert

Remedial action

43. There has been extensive consultation with internal and external key stakeholders in developing a more effective management structure.

44. A gap analysis was conducted regarding service delivery with the Statewide Queensland Health Model of Service Delivery Framework documents to guide the mental health reform process.

45. A plan to implement a more sustainable service governance structure that meets the needs of the IMHS has been developed.

46. A reduction or downsizing of senior management positions will free resources that will be redirected to direct consumer care/service delivery positions

47. Following discussion with the Deputy Director-General, Human Resource Services on 30 August 2011, the District Chief Executive Officer requested a formal assessment of industrial awards and agreements.

48. The THSD will also engage with Human Resource Services to assess the eligibility of offering voluntary separation packages within the definition of "frontline staff".

Attachments

49. Nil

Minister's Office RecFind No:	11004731
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

Proposal
That the Director-General:

Note the process for the planned reform and restructure of the Institute of Mental Health Services (IMHS), Townsville Health Service District (THSD). Management downsizing and reallocation of potentially released resources to enhance service delivery in the service have been delayed due to ongoing consultation processes with unions, in particular Together Queensland.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

/ /

To Minister's Office For Noting ☒
For Approval ☐

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Val Tuckett	Dr Andrew Johnson	Dr Andrew Johnson
District Executive Director Mental Health Reform	District CEO	District CEO
Townsville HSD	Townsville HSD	Townsville HSD
4796 4146	4796 0931	4796 0931
30 August 2011	1 September 2011	1 September 2011
Updated 13 October 2011 Updated 12 December 2011	Updated 4 October 2011 John Burns Acting District CEO 14 December 2011	Updated 4 October 2011 John Burns Acting District CEO 14 December 2011

EXECSUPPORT - BR051437 MD25 - Returned for Update

From: EXECSUPPORT
To: MD25-Townsville-HSD
Date: 7/12/2011 11:33 AM
Subject: BR051437 MD25 - Returned for Update
Attachments: BR051437.pdf; BR051437 MD25 RESTRUCTURE OF MANAGEMENT INSTUTE MENTAL HEALTH - Cover Sheet.doc

Hi

Please find attached BR051437 which requires amendments as outlined in the attached PDF document as follows :

"Please provide update"

When making changes to the brief can you please use the attached Word document.
***** NB: Please do not amend the original version of the document prepared by your Unit.**

The updated brief is due back **by 14/12/11.**

Many thanks... Mary Delahenty
ESU 3234 1029.

Minister's Office RecFind No:	11004731
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

RECEIVED
DATE 25-10-11 BY CM

Briefing Note

The Honourable Geoff Wilson MP
Minister for Health

Requested by: **Date requested:** **Action required by:**

Action required
☐ For approval ☒ For Information
☐ For meeting ☐ With correspondence

Other attachments for Ministerial consideration
☐ Speaking points ☐ Ministerial Statement
☐ Draft media release

SUBJECT: Restructure of management in the Institute of Mental Health Services, Townsville Health Service District

Recommendation
That the Minister

Note the process for the planned reform and restructure of the Institute of Mental Health Services, Townsville Health Service District (THSD) and management downsizing and reallocation of potentially released resources to enhance service delivery in the Service.

APPROVED/NOT APPROVED **NOTED** **NOTED**

GEOFF WILSON
Minister for Health
/ /

Principal Advisor
/ /

Senior Policy Advisor/
Policy Advisor
/ /

Minister's comments

Please provide update

24 OCT 2011

Minister's Office RecFind No:	11004731
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

Briefing Note

Director-General

Requested by: Chief Executive Officer, Townsville Health Service District **Date requested:** **Action required by:**

Action required
☐ For approval ☐ With correspondence
☐ For meeting ☒ For Information

Other attachments for Ministerial consideration
☐ Speaking points ☐ Ministerial Statement
☐ Draft media release ☐ Question on Notice
☐ Cabinet related document

SUBJECT: Restructure of management in the Institute of Mental Health Services, Townsville Health Service District

Proposal

That the Director-General:

Note the process for the planned reform and restructure of the Institute of Mental Health Services (IMHS), Townsville Health Service District (THSD), management downsizing and reallocation that potentially may be released through the reform process, to enhance service delivery in the Service.

Provide this brief to the Minister for information.

Urgency

1. Routine

Background

2. In 2009, the IMHS, THSD commenced a process of restructuring the Institute and reviewing models of service delivery across a range of services.

3. It was recognised that there was a need to improve clinical service delivery as there was a belief that the current management structure was absorbing funding that could, and should, be directed to frontline clinical services rather than to managerial positions. To explore this potential, the IMHS senior management embarked on an organisational reform process. This process was managed internally by the IMHS senior management staff.

4. Concerns were raised by numerous stakeholders that the consultation around the proposed restructure was insufficient.

5. Following consideration of these concerns, the THSD executive sought assistance from the Queensland Health Corporate Office People and Culture Branch. As a result of these discussions, it was considered that a formal review of the reform process was required to determine whether the concerns that had been raised had merit and what improvements could be made to ensure the reform could progress.

6. The work on the Institute of Mental Health Services initiated restructure process ceased in June 2010 pending a review by People and Culture Strategic Services (PACSS - now HR Coordination). The review was conducted in July 2010 with the findings outlined in the PACCS report dated August 2010.

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7. As a result of the review, the THSD executive received a report in October 2010 known as the 'PACSS report'. This report made a number of observations and recommendations on how to progress the reform process. This became the basis of the reform with IMHS.

8. The report identified some serious concerns expressed by some staff regarding the reform process, such as:
   a. lack of transparency;
   b. poor processes; and
   c. lack of agreed vision and goals.

9. However, there was recognition that there was a need for reform. It was also recognised that the services were top heavy in the management structure.

10. The THSD executive was of the opinion that the reform was a high priority within the District.

11. To progress the IMHS reform process, the District Executive assigned the District Executive Director of Nursing (DEDON) to this project for a period of one year from December 2010, in the role of Executive Director, Mental Health Reform.

12. It was recognised that the operational staff within IMHS did not have the time to undertake this role while carrying out their operational duties.

13. The main themes identified during the PACSS review process were:
   a. lack of role clarity in the Institute;
   b. high proportion of managers/supervisors to employees (approximately 1:5);
   c. complicated management structure;
   d. top-heavy structure with multiple supervisory and managerial roles in each team;
   e. confusion on reporting lines within the current structures; and
   f. diminished accountability due to reporting line confusion, as a result of inconsistent leadership, with changes to the Operations and Clinical Director positions.

14. Other issues of concern raised by staff include but are not limited to:
   a. lack of communication;
   b. nepotism;
   c. governance issues;
   d. lack of standardised protocols and procedures;
   e. poor human resources processes; and
   f. lack of agreed vision and goals.

Key issues

15. The management and service reform process, which commenced in December 2010, is anticipated to be implemented in the first quarter 2012. There will be a requirement for ongoing monitoring and a review at the end of 12 months.

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16. It is envisaged the restructure will result in:
    a. a reduction in the number of managerial positions. This can be further justified based on the Mental Health Directorate figures for the number of "Leaders & Safety and Quality" Community full time equivalents (FTE). In 2009, the Townsville Mental Health Service was already at 130% of its required number for 2017; and
    b. a proposed increase in the number of lower level positions, which will improve services and increase access for clients, as a result of financial savings made from the realignment of management positions.

17. The reform process and consequent restructure will build the foundations for increased accountability, trust, transparency in decisions, respect for each other, equity and fairness across the Institute and acknowledgement of the diversity in the Institute.

18. A set of principles/guidelines for the management restructure, was developed and discussed with unions, prior to their endorsement at the local District Consultative Forum (DCF) on 16 August 2011.

19. Operational and professional management responsibilities will be merged and this will be identified in relevant role descriptions.

20. Impact upon patients:
    a. during the reform process, there are no foreseeable implications for 'patient experience'. No negative impact on patient delivery is anticipated during the restructure; however, it is envisaged that there will be a positive impact on service delivery post review; and
    b. the proposed resource savings from the reduction in management positions will be utilised for the provision of increased services and increases in frontline staff for direct patient care.

21. Expected benefits:
    a. proposals from IMHS Strategic Reform Project:
        i. recovery focused and responsive:
            - re-focusing on recovery principles and practice, in collaboration with consumers and carers and with other service providers;
    b. accessible, appropriate and sustainable service delivery:
        i. establishing a rural and remote mental health stream, responsible for current community services of THSD Institute of Rural Health and Ingham Community Mental Health Service (MHS);
        ii. establishing an Indigenous mental health stream, as part of the Rural and Remote mental health stream, including Palm Island MHS (an Indigenous team in the Townsville area), the Townsville Aboriginal and Islander Health Service, and in conjunction with the Mount Isa MHS (the lower Gulf outreach service);
        iii. expanding e-mental health services for Rural and Remote MHS delivery, including from Townsville based specific clinics where possible;
        iv. initiating a MHS for young adults in the Townsville area;
    c. continuous, safe care:
        i. improving discharge and transfer of care for consumers within IMHS and to extended partners;
    d. capable, evidence-based practice:

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i. consistent use of standardised clinical information practices, including the Statewide documentation suite - Consumer Integrated Mental Health Application (CIMHA);

e. effective and efficient practice:

i. continued focus on outcomes of care;

ii. establish expectations of service components to measure and evaluate Queensland Health performance; and

iii. comparing performance on outcomes, resources and costs, internally and externally, identifying areas for improvement and making appropriate changes.

22. As at 13 October 2011:

a. the final draft of the proposed structure has been presented to Mental Health staff at various forums;

b. as agreed with Together Queensland on 5 October 2011, the union planned to hold staff consultations in the week commencing 10 October 2011;

c. as the Together Queensland Organiser is currently off sick, another union official contacted the Executive Director, Mental Health Reform via telephone on 12 October 2011 to express concern that a final draft had been be released with no consultation with the unions. The union official was assured that significant consultation had occurred and that the District understood that the union was undertaking consultation with relevant staff in the week commencing 10 October 2011;

d. the union official was notified that on 5 October 2011 a letter had been sent to all relevant Union State Secretaries, providing an overview and relevant documentation. The District is awaiting their responses, regarding any feedback or concerns they may have in relation to the information provided to them; and

e. Schedule 3 (7) legal professional privilege

Consultation

23. Consultation with stakeholders about existing structure has been ongoing throughout 2011.

24. The IMHS senior management meets weekly with the Executive Director, Mental Health Reform to guide the process.

25. Three Mental Health Reform workshops have been conducted throughout 2011, with another workshop planned for November 2011. All MHS managers have been invited to participate. Attendance has averaged approximately 55 participants per workshop and has included members of the District executive and members of the Mental Health Directorate.

26. Information gathered has assisted with setting the direction for the reform process. The feedback that managers have provided has been valuable in the provision of strategic direction. In addition to this, there have been various group and individual meetings to provide updates on the reform process and well as an opportunity for input.

27. Extensive consultation with IMHS staff has occurred and has been ongoing through a variety of methods from group service forums to individual interviews.

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Department RecFind No:	BR051437
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File Ref No:	

28. Extensive consultation and discussions have occurred with local union organisers of the following unions:
    a. Mary Louez, Organiser, Queensland Nurses' Union;
    b. Joel Wilson, Organiser, Together Queensland;
    c. Michelle Duggan, Organiser, Australian Workers' Union;
    d. Chiara Lennox, Organiser, Australian Services Union North Queensland;
    e. Members of the Reform Steering Committee; and
    f. Participation in the Mental Health Local Consultative Forum and DCF.

29. Prior to the endorsement of the principles/guidelines for the management restructure all union organisers met individually with the Executive Director Mental Health Reform to discuss and make amendments to the proposed principles.

30. At the DCF meeting of 16 August 2011, attended by Organisers from the QNU and Together Queensland, these principles were endorsed to be utilised to develop the Structure.

31. The local union organisers have been very supportive of this restructure, as many issues that they have raised over a number of years are reflective of the issues noted in the PACSS report.

32. It is noted that on 3 September 2011 there was a change of advice from Together Queensland, with the union advising that they could not endorse the Structure without further consultation with its members. This consultation was verbally agreed to by the Executive Director, Mental Health Reform and the Together Queensland Union Organiser, to occur the week commencing 10 October 2011. In addition, it was agreed the reform team would present the proposed Structure to those staff most impacted, in small peer groups (for equity purposes), ensuring staff were receiving the same information at the same time. There were also open forums throughout the Institute where the reform team presented the new Structure to staff where there was opportunity for questions and clarifications if required.

33. Individual interviews and consultation with all managers and other staff, around their perceptions of the issues in the service and ways to improve the service, has occurred.

34. A discussion was held with Mr John Cairns, Deputy Director-General, Human Resource Services Division on 30 August 2011, to brief him on the reform process and the union consultation and explore the possibility of voluntary separation for relevant senior positions.

Financial implications

35. It is expected this will be a cost neutral exercise and that any potential resources released as part of the downsizing of the management structure will be redirected into service delivery positions.

36. The objective of the reform is to provide improved and expanded clinical services within budget constraints.

Legal implications

37. There are no legal implications.

Minister's Office RecFind No:	11004731
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

Elected representative

38. Ms Lindy Nelson-Carr MP, Member for Mundingburra

39. Ms Mandy Johnston MP, Member for Townsville

40. The Honourable Craig Wallace MP, Minister for Main Roads, Fisheries and Marine Infrastructure

41. Mr Ewen Jones MP, Member for Herbert

Remedial action

42. There has been extensive consultation with internal and external key stakeholders in developing a more effective management structure.

43. A gap analysis was conducted regarding service delivery with the Statewide Queensland Health Model of Service Delivery Framework documents to guide the mental health reform process.

44. A plan to implement a more sustainable service governance structure that meets the needs of the IMHS has been developed.

45. A reduction or downsizing of senior management positions will free up resources that will be redirected to direct consumer care/service delivery positions

46. Following discussion with the Deputy Director-General, Human Resource Services Division on 30 August 2011, the District Chief Executive Officer requested a formal assessment of industrial awards and agreements.

47. The District will also engage with Human Resource Services to assess the eligibility of offering voluntary separations within the definition of "frontline staff".

Attachments

48. Nil

Minister's Office RecFind No:	11004731
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

Proposal
That the Director-General:

Note the process for the planned reform and restructure of the Institute of Mental Health Services (IMHS), Townsville Health Service District (THSD), management downsizing and reallocation that potentially may be released through the reform process, to enhance service delivery in the Service.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

25 / 10 / 11

To Minister's Office **For Noting** ☒
For Approval ☐

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Val Tuckett	Dr Andrew Johnson	Dr Andrew Johnson
District Executive Director Mental Health Reform	District CEO	District CEO
Townsville HSD	Townsville HSD	Townsville HSD
4796 4146	4796 0931	4796 0931
30 August 2011	1 September 2011	1 September 2011
Updated 13 October 2011	Updated 4 October 2011 Updated 18 October 2011 John Burns, Acting/DCEO	Updated 4 October 2011 Updated 18 October 2011 John Burns, Acting/DCEO

EXECSUPPORT - Fwd: Attn Nikki: BR051437- Restructure of IMHS Townsville

From: EXECSUPPORT
To: MD25-Townsville-HSD
Date: 14/10/2011 11:10 AM
Subject: Fwd: Attn Nikki: BR051437- Restructure of IMHS Townsville
Attachments: 20111014103313876.pdf; BR051437 MD25 RESTRUCTURE OF MANAGEMENT INSTUTE MENTAL HEALTH.doc

Originals w/ Rhiannon

Hi Julie

As discussed earlier, BR051437 will need to be cleared before it can be progressed to the Director-General.

I spoke with Rhiannon Bowden, Senior Policy Advisor, Office of the Director-General to facilitate the return of the brief to Executive Support so that it could be updated with the new information. She advised that she had some questions that needed to be answered on the brief. Please see attached PDF document with her requests for update.

I have incorporated the new information provided by MD25 into the Word document, please ensure that all amendments are made to this Word version and not the version prepared by the District.

Please return to Executive Support by 18 October 2011 - please advise if you would like more time to complete this.

Kind regards

Nikki Joseph
Executive Support
3234 1102

>>> Rhiannon Boden 14/10/2011 10:47 am >>>
Hi Nikki,

As discussed, please find attached the scanned version of BR051437 with questions that need to be addressed by the District.

Most notably, the brief needs to identify timeframes that are associated with the reform process and provide a list of names and positions of all union reps / organisers that they have consulted with for attachment to the brief.

Can you please ask them to update the version that we have rather than the version that they sent to you as that would be very helpful....

Thank you!

Regards,
Rhiannon

Rhiannon Boden
A/Senior Policy Officer

Cabinet and Executive Services | Office of the Director-General | Queensland Health
T: 323 40168 | E: Rhiannon_Boden@health.qld.gov.au

Send back via Exec support 14/10/11.

10 OCT 2011

Minister's Office RecFind No:	11004731
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

Briefing Note

Director-General

Requested by: Chief Executive Officer, Townsville Health Service District

Date requested:

Action required by:

Action required
- ☐ For approval
- ☐ For meeting
- ☐ With correspondence
- ☒ For Information

Other attachments for Ministerial consideration
- ☐ Speaking points
- ☐ Draft media release
- ☐ Ministerial Statement
- ☐ Question on Notice
- ☐ Cabinet related document

SUBJECT: Restructure of management in the Institute of Mental Health Services, Townsville Health Service District

What are the timeframes associated with the planned reform + restructure?

Proposal

That the Director-General:

Note the process for the planned reform and restructure of the Institute of Mental Health Services (IMHS), Townsville Health Service District (THSD), management downsizing and reallocation of potentially released resources to enhance service delivery in the Service.

Provide this brief to the Minister for information.

please outline in key issues section.

Urgency

1. Routine

Background

2. In 2009, the IMHS, THSD commenced a process of restructuring the Institute and reviewing models of service delivery across a range of services.

3. It was recognised that there was a need to improve clinical service delivery. There was a belief that the current management structure was absorbing funding that could, and should, be directed to frontline clinical services rather than to managerial positions. To explore this potential, the IMHS senior management embarked on an organisational reform process. This process was managed internally by the IMHS senior management staff.

4. Concerns were raised by numerous stakeholders that the consultation around the proposed restructure was insufficient.

5. Following consideration of these concerns, the THSD executive sought assistance from the Queensland Health Corporate Office People and Culture Branch. As a result of these discussions, it was considered that a formal review of the reform process was required to determine whether the concerns that had been raised had merit and what improvements could be made to ensure the reform could progress.

6. The work on the restructure process was ceased pending a review by People and Culture Strategic Services (PACSS - now HR Coordination).

when? 2009?

conducted in ...? X

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File Ref No:	

→ when was this completed

7. As a result of the review, the THSD executive received a report known as the 'PACSS report'. This report made a number of observations and recommendations on how to progress the reform process. This became the basis of the reform with IMHS.

8. The report identified some serious concerns expressed by some staff regarding the reform process, such as:
   a. lack of transparency;
   b. poor processes; and
   c. lack of agreed vision and goals.

9. However, there was recognition that there was a need for reform. It was also recognised that the services were top heavy in the management structure.

10. The THSD executive was of the opinion that the reform was a high priority within the District.

11. To progress the IMHS reform process, the District Executive assigned the District Executive Director of Nursing (DEDON) to this project for a period of one year, in the role of Executive Director, Mental Health Reform.

→ commencing when?

12. It was recognised that the operational staff within IMHS did not have the time to undertake this role while carrying out their operational duties.

13. The main themes identified during the PACSS review process were:
   a. lack of role clarity in the Institute;
   b. high proportion of managers/supervisors to employees (approximately 1:5);
   c. complicated management structure;
   d. top-heavy structure with multiple supervisory and managerial roles in each team;
   e. confusion on reporting lines within the current structures; and
   f. diminished accountability due to reporting line confusion, as a result of inconsistent leadership, with changes to the Operations and Clinical Director positions.

14. Other issues of concern raised by staff include but are not limited to:
   a. lack of communication;
   b. nepotism;
   c. governance issues;
   d. lack of standardised protocols and procedures;
   e. poor human resources processes; and
   f. lack of agreed vision and goals.

Key issues → Please identify timeframes envisaged for reform process.

15. The reform process envisages the restructure will result in:
   a. a reduction in the number of managerial positions; and
   b. an increase in the number of lower level positions, which will increase resources to deliver client services.

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16. The reform process and consequent restructure will build the foundations for increased accountability, trust, transparency in decisions, respect for each other, equity and fairness across the Institute and acknowledgement of the diversity in the Institute.

17. Operational and professional management responsibilities will be merged and this will be identified in relevant role descriptions.

18. Impact upon patients: → hasn't the review occurred? or are you referring to the reform process?

    a. during the review process, there are no foreseeable implications for 'patient experience'. No negative impact on patient delivery is anticipated during the restructure; however, it is envisaged that there will be a positive impact on service delivery post review; and

    b. the proposed resource savings from the reduction in management positions will be utilised for the provision of increased services and increases in frontline staff for direct patient care.

19. Expected benefits:

    a. proposals from IMHS Strategic Reform Project:

        i. recovery focused and responsive:

            - re-focusing on recovery principles and practice, in collaboration with consumers and carers and with other service providers;

    b. accessible, appropriate and sustainable service delivery:

        i. establishing a rural and remote mental health stream, responsible for current community services of THSD Institute of Rural Health and Ingham Community Mental Health Service (MHS);

        ii. establishing an Indigenous mental health stream, as part of the Rural and Remote mental health stream, including Palm Island MHS (an Indigenous team in the Townsville area), the Townsville Aboriginal and Islander Health Service, and in conjunction with the Mount Isa MHS (the lower Gulf outreach service);

        iii. expanding e-mental health services for Rural and Remote MHS delivery, including from Townsville based specific clinics where possible;

        iv. initiating a MHS for young adults in the Townsville area;

    c. continuous, safe care:

        i. improving discharge and transfer of care for consumers within IMHS and to extended partners;

    d. capable, evidence-based practice:

        i. consistent use of standardised clinical information practices, including the Statewide documentation suite - Consumer Integrated Mental Health Application (CIMHA);

    e. effective and efficient practice:

        i. continued focus on outcomes of care;

        ii. establish expectations of service components to measure and evaluate Queensland Health performance; and

        iii. comparing performance on outcomes, resources and costs, internally and externally, identifying areas for improvement and making appropriate changes.

Minister's Office RecFind No:	11004731
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File Ref No:	

Consultation

20. Consultation with stakeholders about existing structure has been ongoing throughout 2011.

21. The IMHS senior management meets weekly with the Executive Director, Mental Health Reform to guide the process.

22. Three Mental Health Reform workshops have been conducted throughout 2011, with another workshop planned for November 2011. All MHS managers have been invited to participate. Attendance has averaged approximately 55 participants per workshop and has included members of the District executive and members of the Mental Health Directorate.

23. Information gathered has assisted with setting the direction for the reform process. The feedback that managers have provided has been valuable in the provision of strategic direction. In addition to this, there have been various group and individual meetings to provide updates on the reform process and well as an opportunity for input.

24. Extensive consultation with IMHS staff has occurred and has been ongoing through a variety of methods from group service forums to individual interviews.

25. Extensive consultation and discussions have occurred with local union organisers of the following unions:

    a. the Queensland Nurses' Union;
    b. Together Queensland;
    c. the Australian Workers' Union;
    d. the Australian Services Union North Queensland;
    e. members of the Reform Steering Committee; and
    f. participation in the Mental Health Local Consultative Forum and THSD District Consultative Forum.

Please provide list of names + positions of union reps. consulted with – an attachment would be ideal.

26. All local union organisers are very supportive of this restructure. The many issues that they have raised over a number of years are reflective of the issues noted in the PACSS report.

27. Individual interviews and consultation with all managers and other staff, around their perceptions of the issues in the service and ways to improve the service, has occurred.

28. A discussion was held with Mr John Cairns, Deputy Director-General, Human Resource Services on 30 August 2011, to brief him on the reform process and the union consultation and explore the possibility of voluntary separation for relevant senior positions.

Financial implications

29. It is expected this will be a cost neutral exercise and that any potential resources released as part of the downsizing of the management structure will be redirected into service delivery positions.

30. The objective of the reform is to provide improved and expanded clinical services within budget constraints.

Legal implications

31. There are no legal implications.

Minister's Office RecFind No:	11004731
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

Elected representative

32. Ms Lindy Nelson-Carr MP, Member for Mundingburra

33. Ms Mandy Johnston MP, Member for Townsville

34. The Honourable Craig Wallace MP, Minister for Main Roads, Fisheries and Marine Infrastructure

35. Mr Ewen Jones MP, Member for Herbert

Remedial action

36. There has been extensive consultation with internal and external key stakeholders in developing a more effective management structure.

37. A gap analysis was conducted regarding service delivery with the Statewide Queensland Health Model of Service Delivery Framework documents to guide the mental health reform process.

38. A plan to implement a more sustainable service governance structure that meets the needs of the IMHS has been developed.

39. A reduction or downsizing of senior management positions will free up resources that will be redirected to direct consumer care/service delivery positions

40. Following discussion with the Deputy Director-General, Human Resource Services on 30 August 2011, the District Chief Executive Officer requested a formal assessment of industrial awards and agreements.

41. The District will also engage with Human Resource Services to assess the eligibility of offering voluntary separations within the definition of "frontline staff".

Attachments

42. Nil

Minister's Office RecFind No:	11004731
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

Proposal
That the Director-General:

Note the process for the planned reform and restructure of the Institute of Mental Health Services (IMHS), Townsville Health Service District (THSD), management downsizing and reallocation of potentially released resources to enhance service delivery in the Service.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

/ /

To Minister's Office **For Noting** ☒
For Approval ☐

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Val Tuckett	Dr Andrew Johnson	Dr Andrew Johnson
District Executive Director Mental Health Reform	District CEO	District CEO
Townsville HSD	Townsville HSD	Townsville HSD
4796 4146	4796 0931	4796 0931
30 August 2011	1 September 2011 Updated 4 October 2011	1 September 2011 Updated 4 October 2011

Minister's Office RecFind No:	11004731
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

Briefing Note

The Honourable Geoff Wilson MP
Minister for Health

Requested by: Chief Executive Officer, Townsville Health Service District **Date requested:** **Action required by:**

Action required
☐ For approval ☒ For Information
☐ For meeting ☐ With correspondence

Other attachments for Ministerial consideration
☐ Speaking points ☐ Ministerial Statement
☐ Draft media release

SUBJECT: Restructure of management in the Institute of Mental Health Services, Townsville Health Service District

Recommendation
That the Minister

Note the process for the planned reform and restructure of the Institute of Mental Health Services, Townsville Health Service District (THSD), management downsizing and reallocation of potentially released resources to enhance service delivery in the Service.

APPROVED/NOT APPROVED **NOTED** **NOTED**

GEOFF WILSON
Minister for Health

Principal Advisor

Senior Policy Advisor/
Policy Advisor

/ / / / / /

Minister's comments

EXECSUPPORT - BR051437 MD25 - Returned for Update

From: EXECSUPPORT
To: MD25-Townsville-HSD
Date: 29/09/2011 10:58 AM
Subject: BR051437 MD25 - Returned for Update
Attachments: BR051437.pdf; BR051437 MD25 RESTRUCTURE OF MANAGEMENT INSTUTE MENTAL HEALTH - cover.doc

Hi

Please find attached BR051437 which requires amendments as outlined in the attached PDF document as follows :

"Please update brief to provide advice on any forseeable implications for patient experience whilst review is conducted - i.e. will there by any impact on service delivery?
Provide some clearer advice on the expected benefit to patients of THSD. Policy Advisor"

When making changes to the brief can you please use the attached Word document.
***** NB: Please do not amend the original version of the document prepared by your Unit.**

The updated brief is due back **by Thursday, 6/10/11.**

Many thanks... Mary Delahenty
ESU 3234 1029.

Minister's Office RecFind No:	11004731
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

RECEIVED JB
6 SEP 2011

Briefing Note

The Honourable Geoff Wilson MP
Minister for Health

5 SEP 2011

Requested by: **Date requested:** **Action required by:**

Action required
☐ For approval ☒ For information
☐ For meeting ☐ With correspondence

Other attachments for Ministerial consideration
☐ Speaking points ☐ Ministerial Statement
☐ Draft media release

SUBJECT: Restructure of management in the Institute of Mental Health Services, Townsville Health Service District

Recommendation
That the Minister

Note the process for the planned reform and restructure of the Institute of Mental Health Services, Townsville Health Service District (THSD) and management downsizing and reallocation of potentially released resources to enhance service delivery in the Service.

APPROVED/NOT APPROVED **NOTED** NOTED

GEOFF WILSON
Minister for Health

/ /

Principal Advisor

/ /

Senior Policy Advisor/
Policy Advisor

26 9 / 11

Minister's comments

Please update SV & provide advice on any foreseeable implementation issues for Parker experience whilst review is conducted — i.e. will there be any impact on service delivery. Would some clear advice on the expected benefit to patients of THSD.

Minister's Office RecFind No:	
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

Briefing Note

Director-General

- 5 SEP 2011

Requested by: Chief Executive Officer, Townsville Health Service District

Date requested:

Action required by:

Action required
- ☐ For approval
- ☐ For meeting
- ☐ With correspondence
- ☒ For information

Other attachments for Ministerial consideration
- ☐ Speaking points
- ☐ Draft media release
- ☐ Ministerial Statement
- ☐ Question on Notice
- ☐ Cabinet related document

SUBJECT: Restructure of management in the Institute of Mental Health Services, Townsville Health Service District.

Proposal

That the Director-General:

Note the process for the planned reform and restructure of the Institute of Mental Health Services, Townsville Health Service District (THSD) and management downsizing and reallocation of potentially released resources to enhance service delivery in the Service.

Provide this brief to the Minister for information.

Urgency

1. Routine

Background

2. In 2009, the Institute of Mental Health Services (IMHS), THSD commenced a process of restructuring the Institute and reviewing models of service delivery across a range of services.

3. It was recognised that there was a need to improve clinical service delivery. There was a belief that the current management structure was absorbing funding that could, and should, be directed to frontline clinical services rather than to managerial positions. To explore this potential, the IMHS senior management embarked on an organisational reform process. This process was managed internally by the IMHS senior management staff.

4. Concerns were raised by numerous stakeholders that the consultation around the proposed restructure was insufficient.

5. Following consideration of these concerns, the THSD Executive sought assistance from Queensland Health People and Culture Branch. As a result of these discussions it was considered that a formal review of the reform process was required to determine whether the concerns that had been raised had merit, and what improvements could be made to ensure the reform could progress.

6. The work on the restructure process was ceased pending a review by People and Culture Strategic Services (PACSS - now HR Coordination).

Minister's Office RecFind No:	
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

7. As a result of the review, the THSD Executive received a report known as the 'PACSS report'. This report made a number of observations and recommendations on how to progress the reform process. This became the basis of the reform with IMHS.

8. The report identified some serious concerns expressed by some staff regarding the reform process, such as:
    a. lack of transparency;
    b. poor processes;
    c. lack of agreed vision and goals.

9. However, there was recognition that there was a need for reform. It was also recognised that the services were top heavy in the management structure.

10. The THSD Executive was of the opinion that the reform was a high priority within the District.

11. To progress the IMHS reform process the District Executive assigned the District Executive Director of Nursing (DEDON) to this project for a period of one year, in the role of Executive Director, Mental Health Reform.

12. It was recognised that the operational staff within IMHS did not have the time to undertake this role while carrying out the operational duties.

13. The main themes identified during the PACSS review process were:
    a. lack of role clarity in the Institute;
    b. high proportion of managers/supervisors to employees (approximately 1:5);
    c. complicated management structure;
    d. top-heavy structure with multiple supervisory and managerial roles in each team;
    e. confusion on reporting lines within the current structures; and
    f. diminished accountability due to reporting line confusion. Inconsistent leadership with changes to the Operations and Clinical Director positions.

14. Other issues of concern raised by staff include but are not limited to:
    a. lack of communication;
    b. nepotism;
    c. governance issues;
    d. lack of standardised protocols and procedures;
    e. poor human resources processes; and
    f. lack of agreed vision and goals.

Key issues

15. The reform process is envisaging the restructure will result in:
    a. a reduction in the number of managerial positions;

Minister's Office RecFind No:	
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

b. an increase in the number of lower-level positions, which will increase resources to deliver client services.

16. The reform process and consequent restructure will build the foundations for increased accountability, trust, transparency in decisions, respect for each other, equity and fairness across the Institute and acknowledgement of the diversity in the Institute.

17. Operational and professional management responsibilities will be merged and this will be identified in relevant role descriptions.

Consultation

18. Consultation with stakeholders about existing structure has been ongoing throughout this year.

19. The IMHS senior management meets weekly with the Executive Director, Mental Health Reform to guide the process.

20. Three Mental Health Reform workshops have been conducted throughout the year with another workshop planned for November. All mental health service managers have been invited to participate. Attendance has averaged approximately 55 participants per workshop and has included members of the District Executive and members of the Mental Health Directorate.

21. Information gathered has assisted with setting the direction for the reform process. The feedback that managers have provided has been valuable in the provision of strategic direction. In addition to this, there have been various group and individual meetings to provide updates on the reform process and well as an opportunity for input.

22. Extensive consultation with IMHS staff has occurred and has been ongoing through a variety of methods from group service forums to individual interviews.

23. Extensive consultation and discussions have occurred with local union organisers of the following unions:

    a. Queensland Nurses' Union;
    b. Together Queensland;
    c. Australian Workers' Union;
    d. Australian Services Union North Queensland;
    e. members of the Reform Steering Committee; and
    f. participation in the Mental Health Local Consultative Forum and THSD District Consultative Forum.

24. All of the local union organisers are very supportive of this restructure. The many issues that they have raised over a number of years are reflective of the issues noted in the PACSS report.

25. Individual interviews and consultation with all managers and other staff, around their perceptions of the issues in the service and ways to improve the service, has occurred.

Minister's Office RecFind No:	
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

26. A discussion was held with Mr John Cairns, Deputy Director-General, Human Resource Services on 30 August 2011 to brief him on the reform process, the union consultation and explore the possibility of voluntary separation for relevant senior positions.

Financial implications

27. It is expected this is a cost neutral exercise and that any potential resources released as part of the downsizing of the management structure will be redirected into service delivery positions.

28. The objective of the reform is to provide improved and expanded clinical services within budget constraints.

Legal implications

29. There are no legal implications.

Elected representative

30. Ms Lindy Nelson-Carr MP, Member for Mundingburra.

31. Ms Mandy Johnston MP, Member for Townsville.

32. The Honourable Craig Wallace MP, Minister for Main Roads, Fisheries and Marine Infrastructure.

33. Mr Ewen Jones MP, Member for Herbert.

Remedial action

34. There has been extensive consultation with internal and external key stakeholders in developing a more effective management structure.

35. A gap analysis was conducted regarding service delivery with the statewide Queensland Health Model of Service Delivery Framework documents to guide the mental health reform process.

36. A plan to implement a more sustainable service governance structure that meets the needs of the IMHS has been developed.

37. A reduction or downsizing of senior management positions will free up resources that will be redirected to direct consumer care/service delivery positions

38. Following discussion with the Deputy Director-General, Human Resource Services on 30 August 2011, the District Chief Executive Officer requested a formal assessment of industrial awards and agreements.

39. The District will also engage with Human Resource Services to assess the eligibility of offering voluntary separations within the definition of "frontline staff".

Attachments

40. Nil

Minister's Office RecFind No:	
Department RecFind No:	BR051437
Division/District:	Townsville HSD
File Ref No:	

Proposal
That the Director-General:

Note the process for the planned reform and restructure of the Institute Mental Health Services, Townsville Health Service District (THSD), and management downsizing and reallocation of potentially released resources to enhance service delivery in the Service.

Provide this briefing to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

5 / 9 / 11

To Minister's Office **For Noting** ☒
For Approval ☐

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Val Tuckett	Dr Andrew Johnson	Dr Andrew Johnson
District Executive Director Mental Health Reform	District CEO	District CEO
Townsville HSD	Townsville HSD	Townsville HSD
4796 4146	4796 0931	4796 0931
30 August 2011	1 September 2011	1 September 2011

CONF

18/4/12. QCOS/018278

Minister's Office RecFind No:	
Department RecFind No:	**BR053822**
Division/District:	**Townsville HSD**
File Ref No:	

1D

RECORDS TEAM
RECEIVED 2 JUN 2012 QLD HEALTH

Briefing Note

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED DATE 23.4.12 BY CH

Requested by: Acting Chief Executive Officer, Townsville Health Service District **Date requested:** **Action required by:**

Action required
x For approval
☐ For meeting
☐ With correspondence
x For Information

Other attachments for Ministerial consideration
☐ Speaking points
☐ Draft media release
☐ Ministerial Statement
☐ Question on Notice
☐ Cabinet related document

SUBJECT: Restructure of management in the Institute of Mental Health Services, Townsville Health Service District

Recommendation
That the Minister:

Note the content of this updated brief regarding the process for the planned reform and restructure of the Institute of Mental Health Services (IMHS), Townsville Health Service District (THSD). Management downsizing and reallocation of released resources, to enhance service delivery in the service, encountered some delays, however, it went live on 9 April 2012.

Note that as a result of the restructure there are six identified surplus officers who will need to be provided with meaningful duties. We await the outcome of the brief regarding possible Voluntary Separation Packages (VSP) for identified surplus officers.

Note the District is awaiting the outcome of the Deputy Director-General, Human Resource Services, deliberations' regarding possible VSPs for identified surplus officers.

APPROVED/NOT APPROVED **NOTED** **NOTED**

LAWRENCE SPRINGBORG
Minister for Health
15/5/12.

JAKE SMITH.
Chief of Staff
04/05/2012

Minister's comments

URGENT

17 APR 2012

Minister's Office RecFind No:	
Department RecFind No:	BR053822
Division/District:	Townsville HSD
File Ref No:	

Briefing Note

Director-General

Requested by: Acting Chief Executive Officer, Townsville Health Service District **Date requested:** **Action required by: 17 April 2012**

Action required
☒ For approval ☐ With correspondence
☐ For meeting ☐ For Information

Other attachments for Ministerial consideration
☐ Speaking points ☐ Ministerial Statement
☐ Draft media release ☐ Question on Notice
☐ Cabinet related document

SUBJECT: Restructure of management in the Institute of Mental Health Services, Townsville Health Service District

Proposal

That the Director-General:

Note the content of this updated brief regarding the process for the planned reform and restructure of the Institute of Mental Health Services (IMHS), Townsville Health Service District (THSD). Management downsizing and reallocation of released resources to enhance service delivery encountered some delays, however it went live on 9 April 2012.

Approve the recruitment process for the positions in the new reduced management structure and the increase in clinical and support positions in line with released resources.

Note that as a result of the restructure there are six identified surplus officers who will need to be provided with meaningful duties. We await the outcome of the brief regarding possible Voluntary Separation Packages (VSP) for identified surplus officers.

Note the District is awaiting the outcome of the Deputy Director-General, Human Resource Services, deliberations' regarding possible VSPs for identified surplus officers.

Provide this brief to the Minister for information.

Urgency

1. Urgent – the interviews are scheduled for 17, 18 and 19 April 2012.

Background

2. Initial review and planned restructure of the Institute of Mental Health Services (IMHS), THSD, undertaken by the Institute, commenced in 2009.

3. Significant concerns were raised by numerous stakeholders especially the Unions to the District Executive Management Team in mid 2010.

4. The District Executive Management Team ceased review in June 2010, and requested assistance from People and Culture Strategic Services (PACSS) to formally review the IMHS findings of the 2009 PACSS report released in August 2010.

5. Key findings presented to the District Executive Management Team were of significant concern and therefore, placed a high priority to implement recommendations and resolve issues outlined in the PACSS report.

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6. The Chief Executive Officer (CEO), THSD, appointed an Executive Director, Mental Health Reform, in December 2010.

7. The two key focus areas were the restructuring of the current Institute and management structures.

Key issues

8. The management and service reform process which commenced in December 2010, is still anticipated to be implemented in the first quarter of 2012. There will be a requirement of ongoing monitoring and a review at the end of 12 months.

9. It is envisaged that the restructure will result in:

   a. a reduction in the number of managerial positions. This can be further justified based on the Mental Health Directorate figures for the numbers of "Leaders and Safety and Quality" Community full-time equivalent (FTE) staff. In 2009, Townsville Mental Health Services were already at 130% of the required number for 2017; and

   b. a proposed increase in the number of lower level positions, which will improve services and increase access for clients, as a result of financial savings made from the realignment of management positions.

10. The Reform process and consequent restructure will build the foundations for increased accountability, trust, transparency in decisions, respect for each other, equity and fairness across the Institute, and acknowledgement of diversity in the Institute.

11. A set of principles/guidelines for the management restructure was developed and discussed with unions, prior to their endorsement at the local District Consultative Forum (DCF) on 16 August 2011.

12. Operational and professional management responsibilities will be merged and this will be identified in relevant role descriptions.

13. With regard to the restructure's impact upon patients:

   a. during the reform process, there are no foreseeable implications for 'patient experience'. No negative impact on patient delivery is anticipated during the restructure, however, it is envisaged that there will be a positive impact on service delivery post review. To date there have been no reported negative impacts on service delivery and it is still too early to report on concrete positive impacts; and

   b. the proposed resource savings from the reduction in management positions will be utilised for the provision of increased services and increases in frontline staff for direct patient care.

14. Expected benefits of the restructure include:

   a. proposals from the IMHS Strategic Reform Project:

      i. recovery focused and responsive:

         - refocusing on recovery principles and practice, in collaboration with consumers and carers and with other service providers;

   b. accessible, appropriate and sustainable service delivery:

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i. establishing a rural and remote mental health stream, responsible for current community services of the THSD Institute of Rural Health and Ingham Community Mental Health Service (MHS);

ii. establishing an Indigenous mental health stream, as part of the Rural and Remote mental health stream, including Palm Island MHS (an Indigenous team in the Townsville area), the Townsville Aboriginal and Islander Health Service, and in conjunction with the Mount Isa MHS (the lower Gulf outreach service);

iii. expanding e-mental health services for Rural and Remote MHS delivery, including from Townsville based specific clinics where possible;

iv. initiating a MHS for young adults in the Townsville area;

c. continuous, safe care:

i. improving discharge and transfer of care for consumers within IMHS and to extended partners,

d. capable, evidence-based practice:

i. consistent use of standardised clinical information practices, including the Statewide documentation suite the Consumer Integrated Mental Health Application (CIMHA);

e. effective and efficient practice:

i. continued focus on outcomes of care;

ii. establish expectations of service components to measure and evaluate Queensland Health performance; and

iii. comparing performance on outcomes, resources and costs, internally and externally, identifying areas for improvement and making appropriate changes.

15. As at 13 October 2011:

a. the final draft of the proposed structure has been presented to Mental Health staff at various forums;

b. as agreed with the Queensland Public Sector Union (QPSU) on 5 October 2011, the QPSU planned to hold staff consultations in the week commencing 10 October 2011;

c. as the QPSU Organiser was ill, a union official contacted the Executive Director, Mental Health Reform, via telephone on 12 October 2011, to express concern that a final draft had been be released with no consultation with the unions. The Union official was assured that significant consultation had occurred and that the District understood that the Together Union, was going to undertake its consultations with relevant staff that week;

d. the official was notified that a letter had been sent to all relevant union state secretaries on 5 October 2011, providing an overview and relevant documentation. The THSD awaits their responses regarding any feedback or concerns they may have in relation to the information provided to them; and

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e. Schedule 3 (7) legal professional privilege

16. As at 12 December 2011:

a. as the TSHD received no response from Together Queensland (TQ) to its letter dated 5 October 2011, a follow up letter was sent on 24 October 2011. A response to the first letter was received on 24 October 2011, however, the only feedback provided in relation to the proposed structure was *"with respect to the Mental Health Reform proposal, members have considered this and have overwhelmingly rejected it";*

b. further follow up letters were sent on 2 November 2011 and 17 November 2011, to request feedback and clarify what the concerns entailed;

c. on 28 November 2011, a letter was received from TQ where it stated that if Queensland Health wished to have meaningful consultation, some of TQ's delegates were prepared to meet and further discuss the proposal and alternatives. At no stage has the Union put forward any alternative suggestions. The letter goes on to state that if Queensland Health does not continue to consult further on the proposed changes, then it will be in dispute and the Union will escalate the matter to the Queensland Industrial Relations Commission to seek an enforcement of its members' rights to meaningful consultation;

d. a further letter has been sent to TQ requesting a meeting between the local organiser and the District Chief Operating Officer (who is also the Chair, Mental Health Reform Steering Committee) to ascertain what the issues are. The THSD is still working to try and facilitate a mutually agreeable time for this meeting to take place;

e. the reform process is now moving at a much slower pace than was expected, whilst awaiting outcomes of attempts to actively engage with the local organiser. The reform team was extended to early March 2012.

f. at the Mental Health Reform (MHR) Steering Committee meeting held on Monday, 12 December 2011, a direction was given to the reform team to continue to progress the restructure as there was a view that adequate consultation had occurred.

17. As at 24 January 2012:

a. TQ raised their disquiet about the proposed Institute and Management Structure, to the Chair, MHR Executive Steering Committee.

b. As a result of these concerns, a meeting was held on 16 December 2011, with TQ; four TQ delegates; the Manager, Human Resources, and the Chair, MHR Executive Steering Committee who was also the Acting CEO, THSD (Mr John Burns). TQ put forward their concerns and tabled an alternative structure on behalf of the delegates.

c. This alternative structure had already been previously tabled by a few individuals and was considered and analysed in detail, discussed at both the MHR Steering Committee and the Executive Management Team (EMT) meetings. It was found in this analysis it failed to meet the majority of the criteria in the Guiding Principles for Management Restructure.

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d. After the lengthy discussions at the 16 December 2011 meeting, Mr Burns advised that he would review the alternate proposal that was tabled, utilising the Guiding Principles for Management Restructure (which were endorsed at DCF on 16 August 2011, of which a TQ Organiser was present). Mr Burns gave an undertaking that he would provide a response of the outcomes of these deliberations, prior to Christmas 2011.

e. A response was provided to TQ on 21 December 2011, advising that the alternate proposal failed to meet the majority of the criteria outlined in the Guiding Principles for Management Restructure and therefore would not be supported.

f. TQ responded by email advising their disappointment on 22 December 2011.

g. A Business Case Request to Apply for Specified Advertising was sent to the relevant Unions (outlined below) on 22 December 2011, to seek endorsement:

   i. Australian Services Union, Queensland Branch (ASU Qld Branch);

   ii. TQ;

   iii. Australian Workers' Union (AWU); and

   iv. Queensland Nurses' Union (QNU).

h. Initial letters were sent to impacted staff on 5 January 2012, advising them of the process.

i. Follow up emails were sent to TQ, AWU and the QNU on 12 January 2012, in regards to the Business Case Request to Apply for Specified Advertising to once again seek their endorsement.

j. We still await responses from TQ, AWU and the QNU.

k. Direction at the MHR Steering Committee meeting on 10 January 2012, reiterated their direction to the MHR Team, to continue to progress the Institute and Management Structures, having considered the above information.

l. A forum with senior staff, including team leaders occurred on 12 January 2012, outlining anticipated timelines leading up to the 'go live' date and implementation of the new structure.

m. Regular teleconferences with the Senior Director, Workplace Relations Unit, have continued to occur throughout this process to guide decision making at a local level.

n. The anticipated 'go live' date for implementation of the new structures was identified as 5 March 2012.

<u>Key issues to be resolved</u>

o. Endorsement of Business Case Request to Apply for Specified Advertising by relevant Unions.

p. Risk management process if a specified advertising (closed merit) process is not endorsed by the Unions, resulting in the need to move to an open merit process. This is definitely not the preferred option from the District, however, it is a District priority to implement these reforms.

q. Determination on whether VSPs can be approved for a limited group wishing to become surplus officers.

r. If VSPs are not supported, the resulting implications for surplus officers.

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18. As at 10 April 2012:

a. on 10 February 2012, TQ signed off on the Business Case Request to Apply for Specified Advertising;

b. as a result of this, the first round Specified Advertising (closed merit) process has been finalised;

c. the second round Specified Advertising (closed merit) process has occurred for the Institute's identified relinquished officers;

d. external advertising has been progressed for most positions with the anticipation of interviewing in the week of 16 April 2012. This is subject to approval to continue this process and fill positions as per HR Policy B1;

e. the 'go live' date for implementation of new structures was 9 April 2012;

f. new positions will only come online once the resources have been released to fund these positions. All positions currently being advertised are as a result of either resignations, vacancies or through a change in the Model of Care to a Secure Rehabilitation model in the Secure Mental Health Unit;

g. the new structure which underpins the whole Reform process has been guided by extensive consultation with staff, unions, Mental Health Directorate, QH Workplace Services and District Executive. This new structure which streamlines communication flows, increases accountability and reduces senior management FTEs is essential to finalising the Reform and without this the latter will be unsustainable;

h. the position of Operations Director has been in a temporary capacity intermittently for a number of years. Particularly throughout the Reform process, that is over the last 16 months. This has been as a result of extended sick leave of incumbent who can no longer return to the role for health reasons on the advice of her external consultant and treating physician; and

i. on 10 April 2012, Dr Andrew Johnson, CEO, THSD, discussed the MHR process with the Director-General, with an aim to progressing the recruitment process required as a result of the reforms.

<u>Key issues still to be resolved</u>

j. In light of the most recent directive received on 4 April 2012, the District is now seeking approval to continue the implementation and recruitment process to fill the new positions created as a result of the Reform; and

k. a determination on the District's request for consideration to approve VSPs for a limited group wishing to become surplus officers. If VSPs are not available, the resulting implications for the Service will be to find meaningful duties for six identified surplus officers. At the level of these officers, because of the specific nature of their expertise, opportunities are few and this could result in a stressful time for the staff involved.

Consultation

19. Consultation with stakeholders about the existing structure has been ongoing throughout 2011 via individual meetings with union organisers, the MHR Steering Committee, the DCF and staff feedback processes. Feedback has been forthcoming from the QNU, ASU and the AWU—which have stated their support and satisfaction with the consultation as part of the MHR process to date.

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20. The IMHS senior management meets weekly with the Executive Director, MHR, to guide the process.

21. Four MHR workshops were conducted throughout 2011. All MHS managers were invited to participate. Attendance has averaged approximately 55 participants per workshop and has included members of the District Executive and members of the Mental Health Directorate.

22. Information gathered has assisted with setting the direction for the Reform process. The feedback that managers have provided has been valuable in the provision of strategic direction. In addition to this, there have been various group and individual meetings to provide updates on the Reform process as well as an opportunity for input.

23. Extensive consultation with the IMHS staff has occurred and has been ongoing through a variety of methods from group service forums to individual interviews.

24. Extensive consultation has been undertaken and discussions have occurred with local union organisers as detailed below:

    a. Ms Mary Louez, Organiser, QNU;

    b. Mr Joel Wilson, Organiser, TQ;

    c. Ms Michelle Duggan, Organiser, AWU;

    d. Ms Chiara Lennox, Organiser, ASU North Queensland;

    e. members of the MHR Steering Committee; and

    f. participation in the Mental Health Local Consultative Forum and DCF.

25. Prior to the endorsement of the principles/guidelines for the management restructure, all union organisers met individually with the Executive Director, MHR, to discuss and make amendments to the proposed principles.

26. At the DCF meeting on 16 August 2011, attended by organisers from the QNU and TQ, these principles were endorsed for utilisation in developing the new structure.

27. The local union organisers have been very supportive of this restructure, as many issues that they have raised over a number of years are reflective of the issues noted in the PACSS report.

28. It is noted that on 3 September 2011, there was a change of tone from TQ, with the Union advising that it could not endorse the structure without further consultation with its members. This consultation was verbally agreed to by the Executive Director, MHR, and the Union Organiser, to occur in the week commencing 10 October 2011. In addition, it was agreed that the Reform Team would present the proposed structure to those staff most impacted, in small peer groups (for equity purposes), ensuring staff were receiving the same information at the same time. There were also open forums throughout the IMHS where the Reform Team presented the new structure to staff and there was opportunity for questions and clarifications if required.

29. Individual interviews and consultation with all managers and other staff, around their perceptions of the issues in the service and ways to improve the service, has occurred.

30. A discussion was held with Mr John Cairns, Deputy Director-General, Human Resource Services, on 30 August 2011, to brief him on the Reform process and the union consultation and explore the possibility of VSPs for relevant senior positions.

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Remedial action

34. There has been extensive consultation with internal and external key stakeholders in developing a more effective management structure.

35. A gap analysis was conducted regarding service delivery with the Statewide Queensland Health Model of Service Delivery Framework documents to guide the MHR process.

36. A plan to implement a more sustainable service governance structure that meets the needs of the IMHS has been developed.

37. A reduction or downsizing of senior management positions will free resources that will be redirected to direct consumer care/service delivery positions.

38. Following discussions with the Deputy Director-General, Human Resource Services, on 30 August 2011, the District CEO requested a formal assessment of industrial awards and agreements.

39. The THSD will also engage with Human Resource Services to assess the eligibility of offering VSPs within the definition of "frontline staff".

Attachments

40. Nil

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Proposal
That the Director-General:

Note the content of this updated brief regarding the process for the planned reform and restructure of the Institute of Mental Health Services (IMHS), Townsville Health Service District (THSD). Management downsizing and reallocation of released resources to enhance service delivery encountered some delays, however it went live on 9 April 2012.

Approve the recruitment process for the positions in the new reduced management structure and the increase in clinical and support positions in line with released resources.

Note that as a result of the restructure there are six identified surplus officers who will need to be provided with meaningful duties. We await the outcome of the brief regarding possible Voluntary Separation Packages (VSP) for identified surplus officers.

Note the District is awaiting the outcome of the Deputy Director-General, Human Resource Services, deliberations' regarding possible VSPs for identified surplus officers.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

18/4/12

To Minister's Office For Noting ☑
For Approval ☐

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Val Tuckett	Dr Andrew Johnson	Dr Andrew Johnson
District Executive Director Mental Health Reform	District CEO	District CEO
Townsville HSD	Townsville HSD	Townsville HSD
4796 4146	4796 0931	4796 0931
30 August 2011 Updated 13 October 2011 Updated 12 December 2011 Updated 30 January 2012 Updated 10 April 2012	1 September 2011 Updated 4 October 2011	1 September 2011 Updated 4 October 2011 Updated 11 April 2012 Mr John Burns Acting District CEO Townsville HSD Updated 14 December 2011

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Q005/017863

22

Minister's Office RecFind No:	
Department RecFind No:	**BR054138**
Division/District:	**ODG**
File Ref No:	

Briefing Note for Approval

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED
DATE 18 MAY 2012

Requested by: Director-General **Date requested: 15 May 2012** **Action required by: 22 May 2012**

SUBJECT: Business Case for restructure of Queensland Health 'corporate office'

RECORDS TEAM
07 MAY 2013
QLD HEALTH

Recommendation
That the Minister:

Approve release of the *Business Case for Change* (Attachment 1) to commence staff consultation in relation to the proposed new organisational structure.

Note *Queensland Health Framework Award – State 2012* requires consultation with staff and unions prior to any significant organisational change.

Note the attached Business Case, Transition Plan and Communications Strategy seek to meet industrial requirements to allow Queensland Health 'Corporate Office' to transition to new System Manager role from 1 July 2012.

Note proposals set out in Business Case align with Government's policy during recent election that there be a 'single' System Manager and to devolve functions to Hospital and Health Services (HHSs) wherever practicable.

APPROVED/NOT APPROVED **NOTED**

LAWRENCE SPRINGBORG
Minister for Health
4 / 6 / 12

NOTED

JANE SMITH

Chief of Staff
20th May 12012

Minister's comments

VP.

Minister's Office RecFind No:	
Department RecFind No:	BR054138
Division/District:	ODG
File Ref No:	

Briefing Note for Approval

Director-General

Requested by: Director-General **Date requested: 15 May 2012** **Action required by: 22 May 2012**

SUBJECT: Business Case for restructure of Queensland Health 'corporate office'

Proposal

That the Director-General:

Provide this brief to the Minister for approval to release the *Business Case for Change* (Attachment 1) to commence staff consultation in relation to the proposed new organisational structure.

Urgency

1. Critical – in order to formalise the Department's new structure prior to the 1 July 2012 commencement of national health reforms.

Headline Issues

2. The top three issues are:
   - *Queensland Health Framework Award – State 2012* requires consultation with staff and unions prior to any significant organisational change
   - The attached Business Case, Transition Plan and Communications Strategy seek to meet industrial requirements to allow Queensland Health 'Corporate Office' to transition to new System Manager role from 1 July 2012
   - Proposals set out in Business Case align with Government's policy during recent election that there be a 'single' System Manager and to devolve functions to Hospital and Health Services (HHSs) wherever practicable

Key Values

3. The key values that apply are the following:

☒ Valuing Queensland Health employees and empowering its frontline staff

☒ Empowering local communities with a greater say over their hospital and local health services

☒ Value for money for taxpayers

Key issues

4. The Business Case proposes a smaller organisational structure with a reduced role for the proposed System Manager, compared to the current 'Corporate Office' arrangements.

5. In order to transition to the System Manager role by 1 July 2012, consideration of the Business Case and its release for consultation is imperative.

6. The Business Case proposes a consultation period from the week of 21 May 2012 through to the week of 4 June 2012.

7. The Business Case is in draft and has not yet been formatted for publication. Following approval (and subject to any amendments), it can be available for release within 24 hours.

8. Given current Award requirements, Government is unable to 'approve' the structure until consultation has occurred. Following the consultation period and subject to any amendments, a Cabinet submission will be prepared for Government approval of the new structure.

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9. The Business Case proposes the reduction of the current nine corporate Divisions to three, and creation of two Commercialised Business Units to deliver functions which lend themselves to improved efficiency by allowing future outsourcing or market contestability.

10. The Business Case proposes commencement of the new structure from 1 July 2012, with a 'stepped' process to devolve current corporate functions to HHSs along a timeline of:
    - 1 July 2012 where work is either already underway or devolution may be achieved without significant risk or major technical changes;
    - a 12 month period after 1 July 2012 where a staged process that is dependent on HHS capacity is required;
    - a longer period, in limited circumstances, where system upgrades are required.

11. The Business Case provides for a 'single' System Manager function – in accordance with the policy position announced by the Government during the election campaign. It proposes devolution of the functions of the Queensland Health Shared Services provider to HHSs over the coming twelve months, rather than the creation of a centralised Health Corporate Services Authority which was proposed by the former Government.

12. In order to realise savings and maintain consistency with the Government's intention, the transition to the new structure will link with whole-of-government 'streamlining' initiatives that are already underway: the Commission of Audit; the Public Sector Renewal Program; and the Public Service Commission's agency reviews of Human Resource issues.

Background

13. From 1 July 2012, current Queensland Health 'Corporate Office' is to transition to the role of System Manager under the *Health and Hospitals Network Act 2011.*

14. The System Manager will develop system-wide policy and standards, undertake state-wide planning, enter Service Level Agreements with HHSs to fund the delivery of clinical services, and maintain responsibility for functions that benefit from whole-of-system approaches (such as negotiation of Enterprise Bargaining Agreements, coordination of disaster-response activities and delivery of Information, Communication and Technology services)

15. The Business Case draws on work undertaken internally by Queensland Health in the first half of 2011, by PricewaterhouseCoopers in the second half of 2011, by Shane Solomon of KPMG in early 2012 and internal work by Queensland Health following the March 2012 election.

Financial implications

16. The actual costs associated with the restructure will be borne within existing resources. Savings will be achieved as a result of the restructure, as the size of the current 'Corporate Office' reduces over the phased period of devolution.

Legal implications

17. Queensland Health has a legal obligation under the *Queensland Health Framework Award – State 2012* to consult with staff and unions about any 'significant' organisational change.

18. Failure to adequately consult provides the opportunity for the Queensland Industrial Relations Commission to direct Queensland Health to cease any implementation of a new organisational structure and to undertake additional consultation.

19. Scheudle 3 (7) legal professional privilege

20. It is still possible that unions will raise concern about the proposed structure and will seek to use the Queensland Industrial Relations Commission to intervene in the process.

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Attachments

21. Attachment 1 – *Business Case for Change: Restructuring Queensland Health's Corporate Office to become System Manager from 1 July 2012*
    - Appendix 1 – Glossary
    - Appendix 2 – table setting out proposed movement of current branches/units within the new organisational structure
    - Appendix 3 – table setting out proposed devolved functions to Hospital and Health Services from 1 July 2012 onwards
    - Appendix 4 – System Manager Transition Plan

22. Attachment 2 – Communications Strategy
    - Appendix 1 – Draft Media Statement
    - Appendix 2 – Draft DG Special Broadcast

Recommendation

That the Director-General:

Provide this brief to the Minister for approval to release the *Business Case for Change* (Attachment 1) to commence staff consultation processes in relation to the new organisational structure, as required by the *Queensland Health Framework Award – State 2012*

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

18/5/12

To Minister's Office for Approval ☑

Director-General's comments

Minister: I am very keen for you to approve this significant rationalization of Corporate Office structure/function which aligns well with your Government's priorities.

Author	Author
Dan Harradine	Rebecca Wells
Executive Director	Deputy Executive Director
Office of the Director-General	Human Resource Services
3234 0536	
12 May 2012	12 May 2012

Business Case for Change: Restructuring Queensland Health's Corporate Office to become System Manager from 1 July 2012

Prepared by: Office of the Director-General, Queensland Health

Table of Contents (pages to be updated as part of final formatting)

Part A: Executive Summary

In April 2010, the Australian Government announced its intention to undertake significant reform of the Australian healthcare system. In August 2011, Queensland, as a member of the Council of Australian Governments (COAG), signed the National Health Reform Agreement (NHRA), committing to major changes in the way that health services in Australia are funded and governed. These changes take effect from 1 July 2012 and include:

- moving to a purchaser-provider model, with health service delivery to be purchased from legally independent Hospital Networks (to be known as Hospital and Health Services [HHSs] in Queensland)
- introducing national funding models and a national efficient price for services, with the majority of services to be funded on an activity unit basis into the future[1]
- defining a refocused role for state governments in managing the health system, including:
  - the use of purchasing arrangements and other levers to drive access and clinical service improvements within and across the HHSs
  - a responsibility to intervene to remediate poor performance, either at the state's initiative or in response to prompting by the National Health Performance Authority (NHPA), which will publicly report on performance of the HHSs and healthcare facilities.

The *Health and Hospitals Network Act 2011* (HHNA), enabling the establishment of the new health service entities and the System Manager role for the health department in Queensland, was passed by the Queensland Parliament in October 2011.

Under the new arrangements, the role of Queensland Health's current corporate office will change. Corporate office will transition to the System Manager and will purchase services from the proposed HHS under service level agreements negotiated between the two entities. The System Manager will not be involved in the day-to-day functioning of health services, and will devolve responsibility for frontline service delivery to the HHSs unless there is a significant economic or similar benefit to maintaining a state-wide function.

Given the devolution of functions to the HHSs, the System Manager will have responsibility for:

- developing system-wide strategy, policy and standards
- focusing the direction of activities of the health system in Queensland by interpreting wider public health objectives, understanding the needs of Queensland's health consumers, and setting system-wide objectives and targets in line with government policy direction
- planning and forecasting the delivery of health services required by the Queensland population, guided by policy and strategy objectives
- integrating workforce, infrastructure, health technology and finance needs to ensure aligned planning across the HHSs, which will deliver services under a contractual, service level agreement arrangement
- acting as the purchaser and contract manager on behalf of the state managing the relationship with the national funding body and Independent Hospital Pricing Authority (IHPA)
- managing enterprise bargaining arrangements at a state-wide level, while devolving other day-to-day decisions in relation to human resource management to the HHSs based on their performance
- monitoring the system's attainment of targets and identifying activities and processes which can assist HHSs to improve performance
- providing guidance and performing regulatory functions relating to public health and private

[1] This efficient price will incorporate service delivery overheads and be set by the Independent Hospital Pricing Authority (IHPA).

health licensing as required under relevant legislation, as well as health protection programs and emergency preparedness activities
- implementing programs relating to health promotion and disease prevention
- statewide crisis co-ordination
- supporting Queensland Government strategy and policy.

Following the March 2012 election, the new government has strengthened Queensland's commitment to the devolution of front-line service delivery within the healthcare setting to further empower health professionals working in HHSs.

The new government has also confirmed its desire for a single, streamlined and more responsive System Manager role for the current corporate office. It is proposed that the new structure set out in this business case will functionally commence from 1 July 2012, in support of the new HHS arrangements where possible, with devolution to continue over a 12-month period as the capacity of HHSs to take on additional functions grows. Transition to the new structure will link with similar "best-practice" initiatives underway across Government wherever possible, including the Public Sector Renewal Program, the Commission of Audit and the Public Service Commission's reviews of Human Resource issues.

This business case meets Queensland Health's obligations within section 4.2 of the *Queensland Health Framework Award – State 2012* to establish the benefits of the significant organisational change described therein. During the process of change, there will be consultation with key stakeholders including staff and unions for the purpose of seeking their input and to identify any issues which Queensland Health may need to consider further in its transition to the System Manager role.

Part B: Introduction

1.0 Background

In April 2010, the Australian Government announced its intention to undertake significant reform of the Australian healthcare system. In August 2011, Queensland, as a member of the Council of Australian Governments (COAG), signed the National Health Reform Agreement (NHRA), committing to major changes in the way that health services in Australia are funded and governed.

1.1. National Health Reform Agenda

Changes under the National Health Reform, to take effect from 1 July 2012, will facilitate the devolution of management in the healthcare setting to more localised models of decision-making. They include:

- moving to a purchaser-provider model, with health service delivery to be purchased from legally independent hospital networks (to be known as Hospital and Health Services [HHSs] in Queensland)
- introducing national funding models and a national efficient price for services, with the majority of services to be funded on an activity unit basis into the future[2];
- defining a refocused role for state governments in managing the health system, including:
  - the use of purchasing arrangements and other levers to drive access and clinical service improvements within and across the HHSs
  - a responsibility to intervene to remediate poor performance, either at the state's initiative or in response to prompting by the National Health Performance Authority (NHPA), which will publicly report on performance of the HHSs and healthcare facilities.

1.2. Drivers for change in Queensland

Queensland Health's reform agenda has been driven by a number of critical factors:

The State Government believes the best health service outcomes are achieved by devolving management, responsibility and accountability for the delivery of services to local decision-makers.

Similarly, the public's confidence in Queensland Health's current organisational approach needs to be rebuilt. The current arrangements with corporate office overseeing both the total system and intervening in the delivery of health services is not sustainable, and this lack of role separation (between system manager and health services provider) departs from industry best practice, which recognises the disparate capabilities in performing true strategic direction-setting and frontline service delivery roles.

As the department's corporate office function has grown, its structure, frameworks and processes and have not adequately adapted to increasing responsibilities. This has resulted in a lack of focus in some areas and outcomes that have increased exposure for the department.

Concerns have been raised about the culture of Queensland Health. Broadly, there is a lack of trust and confidence with a perceived reluctance of the corporate office to trust in the capability of local

[2] This efficient price is to incorporate service delivery overheads and is to be set by the Independent Hospital Pricing Authority (IHPA).

management, and conversely, a lack of confidence in the ability of corporate office to deliver on its core responsibilities. It is likely that this culture is a symptom of a range of issues, including lack of role clarity for corporate office and inefficiencies created by a large centralised bureaucratic corporate office function.

The current structure and functionality of Queensland Health's corporate office is not consistent with the National Health Reform agenda or the State Government's view that large, centralised arrangements create inefficiencies and do not provide the flexibility to respond to local interests.

1.3. Instrument for change

In support of the National Health Reform and the Queensland Government's drivers for change, in October 2011, the Queensland Parliament passed the *Health and Hospitals Network Act 2011* (HHNA) to provide for the creation of:

- new Local Health and Hospital Networks, which will have responsibility and accountability for the delivery of front-line healthcare services and
- a System Manager function to replace the current Department of Health.

Following the March 2012 election, the new government strengthened Queensland's commitment to the devolution of accountability for front-line service delivery within the healthcare setting to health professionals working in proposed Hospital and Health Services (to replace the Local Health and Hospital Networks). Similarly, the new government has confirmed its desire for a single, more streamlined and more responsive System Manager to replace the current corporate office.

2.0 Purpose of the business case

This business case sets out the proposed transition of Queensland Health's current corporate office to that of a System Manager.

It outlines the guiding principles supporting National Health Reform and confirms the State's commitment to empower the proposed HHSs to deliver front-line services through provision of clear strategic direction, targeted funding and efficient administration.

The approach outlined has been informed by extensive consultation undertaken in relation to various System Manager model propositions, including internal consultation throughout the first half of 2011, work by PricewaterhouseCoopers in December 2011 and the subsequent Solomon Report prepared by KPMG in January 2012. Significant work in relation to individual elements of the National Health Reform program has already been completed. The implementation of a new structure and devolution of functions to HHSs is the final element to supporting the new operating environment for health services from 1 July 2012.

No steps to implement the proposed structure have been undertaken, and the business case fulfills Queensland Health's obligations under section 4.2 of the *Queensland Health Framework Award – State 2012* to consult with staff and unions in relation to proposed significant organisational changes. Feedback from that process will be incorporated into the final model to be considered by government.

2.1 Scope of the business case

This business case identifies the proposed approach that Queensland Health's corporate office will take during transition to satisfy its key responsibilities agreed by COAG. It summarises the:

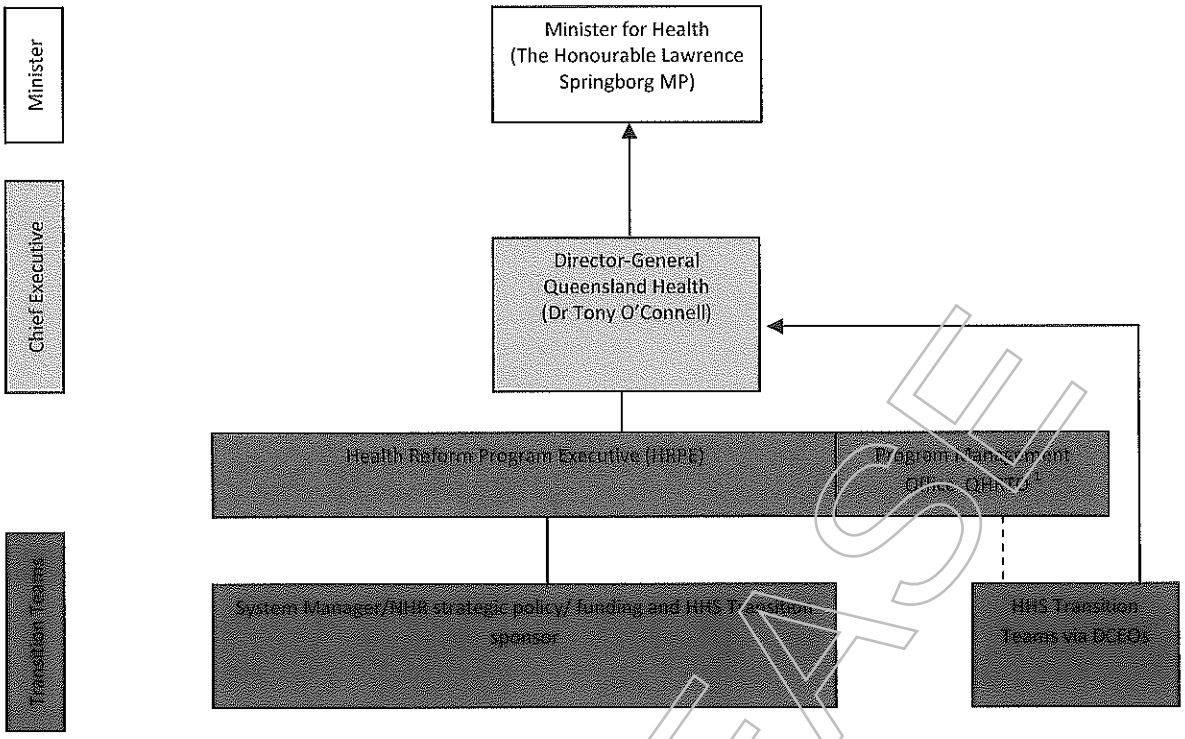
- role of the System Manager in Queensland's Health System
- delineation of functions, roles and responsibilities within the System Manager
- governance arrangements to support decision making for the transition of corporate office to System Manager
- human resources and industrial relations considerations of the transition process.

This business case does not identify activities, risks or implications of any other component of the National Health Reform arrangements, which are being managed through alternate projects by each of the relevant health service districts transitioning to HHSs.

3.0 Governance

The governance structure supporting the implementation of the National Health Reform program, as illustrated below, will continue to be used for the purposes of transitioning the current corporate office to the new role of System Manager. Significant work in relation to individual elements of the National Health Reform program has already been completed, and the implementation of a new structure and devolution of functions to HHSs is a final element to support the new operating environment for health services from 1 July 2012. Therefore, it is appropriate that the existing governance arrangements continue with reporting to the Health Reform Program Executive (HRPE) and Queensland Audit Office (QAO), as currently occurs, to continue.

Figure 1: Program Governance Structure



[1] Responsible for coordination of program and project management consistency

4.0 Acknowledgements

This business case draws on a range of sources, including:

- a detailed process facilitated by the Queensland Health Reform Transition Office (QHRTO) across both corporate divisions and health service districts during the first half of 2011
- work undertaken by PricewaterhouseCoopers for Queensland Health in late 2011
- a report prepared by Mr Shane Solomon (Partner KPMG), who was engaged from mid-December 2011 to mid-January 2012 to provide advice about corporate office reform opportunities.

The final business case draws on various elements of work prepared for and by Queensland Health to date in preparation for the implementation of National Health Reforms from 1 July 2012.

Part C: Methods and assumptions

5.0 Design approach

The organisational design proposed in this business case aligns with:

- a number of key principles designed to align Queensland Health's restructure with the National Health Reform agenda
- the role of the System Manager (see section 7)
- people and change management principles.

5.1 Assumptions

- The System Manager will be leaner, more flexible and provide greater support to the 17 HHSs than the current corporate office model.
- Restructure is targeted for 1 July 2012, however this is subject to consultation with affected staff and unions, in accordance with Queensland Health's industrial obligations, and any future directions stemming from complementary processes underway at a whole-of-government level, such as the Public Sector Renewal Program, the Commission of Audit and the Public Service Commission's reviews of Human Resource issues.
- Empowerment of the HHSs will be a staged process, with devolution of key corporate services dependent on:
  - system capability/readiness
  - capability and performance of the individual HHSs
  - establishment of agreed protocols with reference to accountability/responsibility of legacy issues.
- The Director-General will have the support of the HRPE to:
  - scope and appoint the System Manager's executive management team (EMT)
  - redeploy current remaining executives to alternative positions within the System Manager, as required.
- HRPE will endorse the proposed business model and three-phased implementation process described in this plan.
- Access to expert advice/resources to facilitate the implementation is available, subject to approval of the Director-General.
- Any cost associated with the System Manager restructure will be funded by Queensland Health and savings identified from the process will be realised.

5.2 National Health Reform design principles

The Queensland Government has adopted the following broad principles to guide design of the new System Manager:

- The System Manager will be focused on strategic, whole-of-system functions with frontline service delivery to be devolved as far as practicable.
- Accountability for health services will be held at a local level wherever possible.
- Frontline services should be devolved to HHSs unless there are demonstrable advantages of statewide / regional operation.

- Service level agreements underpinning service delivery requirements will be developed between the System Manager and HHSs.
- Staff should not experience a reduction in their terms and conditions.
- A governance system is essential to maintain connections between all the agencies in the health system.

5.3 Key principles

The System Manager transition proposes to follow a number of key principles,[3] to which transition leaders will refer when assessing competing priorities and options throughout the process.

Key principles	
	People Principles[4]
1	Queensland Health is committed to maximum employment security for permanent public sector employees. Where changes to employment arrangements are necessary, there will be active pursuit of retraining and deployment opportunities in accordance with the Queensland Government's policy on employment security.
2	Staff and health unions will be informed, consulted and involved throughout the transition and will play a key role in shaping the new health system.
3	Queensland Health employees will continue their employment under the same terms, conditions and entitlements.
4	Staff will have up-to-date information on health reform.
5	Transition leads will facilitate transformation activities at the local level.
6	Queensland Health staff will be supported and treated with respect.
	Change Principles
1	People have a shared understanding of the vision for an improved and sustainable health system.
2	Adopt an approach that is consultative, participative and inclusive of all stakeholders.
3	Leaders act and implement changes locally that are consistent with the vision.
4	People are supported to manage and implement the change.
5	The process of transition will be sufficiently flexible to ensure local innovation and service improvement will continue to be enhanced.
6	Communication is open and transparent.
	Transition Principles
1	Devolution of responsibility and accountability for the delivery of health services to

[3] Approved by the previous Queensland Government

[4] Transition Principles included in Health Reform Queensland *Change Strategy November 2011 Version 1.1*

	HHSs is paramount.
2	The health and safety of Queenslanders remains our first priority.
3	Creation of value for patients is a clear focus.
4	Program governance structure is transparent and outcome focused.
5	Decision-making is evidence-based.
6	The final business model allocates clear accountabilities and responsibilities.
7	Transition and improvement efforts will be efficient, effective and prioritised to deliver maximum benefits to the health care system.

5.4 Organisational design principles

The organisational design approach used to deliver the draft structure proposed in this business case is based on five design principles. It considers the importance of a nationally consistent system focused on local delivery, accountability and decision-making

The principles reflect the government's desire to improve the efficiency of health expenditure by streamlining and reducing the size of central control features evident in the current system, and re-directing funding, functions, accountability and responsibility for healthcare services to local decision-makers. This approach will ensure a higher proportion of the health budget is spent on providing front-line health services. The approach seeks to achieve these objectives through ensuring greater clarity of roles, reducing the size of the System Manager relative to the current corporate office, simplifying structures and better aligning functions and processes.

Principle	Rationale	Implication for System Manager structure
1. Understanding the greater context	Organisational design must consider the role of the System Manager in context of both the state's healthcare model and the broader national system.	The organisational model must enable effective relationships between 1. the System Manager and the HHSs 2. the System Manager and the national health system. It must enable the System Manager to interact effectively with internal and external stakeholders in order to deliver agreed outcomes (e.g. funding).
2. Role clarity	The System Manager has two distinct high level functions: 1. System Manager, as specified in the HHNA 2. Service provider (where there is benefit in standardisation or economy of scale)	Separation of accountabilities will facilitate far greater role clarity and enable efforts to be focused. Greater ability for the organisation to support and empower the HHSs in their delivery of frontline services. Greater transparency in goal setting, including a more performance focused approach to the functions of the System Manager. Efficient decision making processes will lead to greater trust in the organisation to support the needs of the health system, leading to an improved culture over time.

3. Simplification wherever possible	A simplified, more streamlined structure should reflect the devolution of relevant functions as part of the National Health Reform agenda. It should eliminate the duplication of functions and facilitate improved role clarity (as per design principle 2)	A more streamlined structure will result in greater financial efficiency and the direction of a larger proportion of Queensland Health's budget to the delivery of front-line services. Elimination of duplicated functions will further clarify roles within the state's system and effectively empower the HHSs to deliver agreed outcomes. This 'handing over of the reins' will improve the relationship between frontline service providers and the System Manager, resulting in an improved culture over time.
4. Functional alignment to promote effective teams	End-to-end processes grouped under one executive will facilitate: • greater functional alignment and improved workflow efficiencies • improved communication, co-operation and collaboration between teams engaged in related functions • reduced complexity of management.	This reflects best-practice arrangements in other jurisdictions and other portfolios. Functional alignment will allow individual managers to focus on their area of expertise and deliver outcomes that will benefit the greater health system, and will ensure the improved delivery of common goals. This approach also facilitates a greater focus on leadership and team dynamics, and will assist in improving organisational culture within the System Manager. Finally, this approach also facilitates improved stakeholder engagement strategies because of clarity in purpose (e.g. internal service delivery functions versus outward-facing customer focus)
5. Alignment of structure and processes	A simplified structure facilitates streamlined processes	This opportunity has allowed for a review of process design in the context of National and State Health Reform (structure, accountabilities, outcomes) to further provide efficiencies within the System Manager's functions which will deliver further devolution to frontline service delivery entities. The new structure will reduce red-tape and bureaucratic complexities, facilitate greater empowerment in the delivery of health services and significantly reduce corporate costs and overheads.

5.5 Proposed organisational design

In support of the organisational design principles outlined above, it is envisaged that the functional structure of the System Manager will be divided into two components, made up of the core System Manager functions (as described at point one below) and entities that will seek to transition to commercialised business units (as described at point two below):

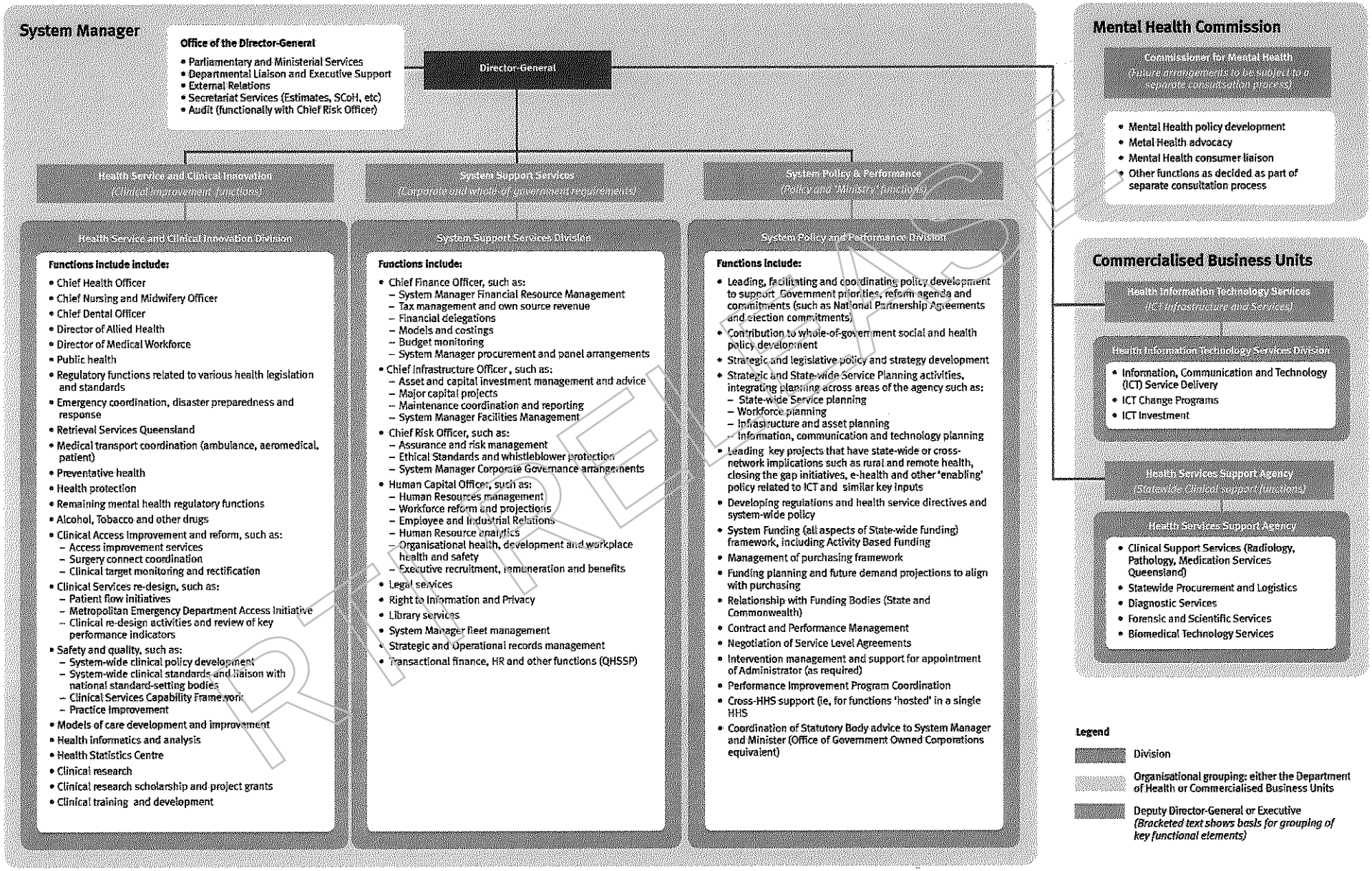
1. functions supporting the role of the System Manager, such as:
    - Strategy and Performance (system strategy and governance, state policy and ministry functions);
    - System Support Services (key strategic corporate functions to support the state in its delivery of health services (e.g. finance, internal governance, human resources, risk, assurance and legal services)
    - Health Service and Clinical Innovation (clinical functions).

2. commercial and/or customer focused services provided to the HHSs (e.g. supply chain services, ICT, radiology and pathology support services, transactional services delivered by the Queensland Health Shared Service Partner).

This separation of function will enable the System Manager to clarify its roles and accountabilities and focus on clear outcomes, both for the health system as a whole and for the individual needs of the HHSs. It is also intended to:

- illustrate the devolved nature of responsibility and accountability of health services to HHSs
- demonstrate the fundamental change in approach to healthcare delivery in Queensland
- facilitate increased trust in the public health system by adding value through clear leadership and efficient provision of services, rather than a complex system of bureaucracy.

Draft Structure—System Manager



5.6 Structure of the System Manager

The proposed structure will provide a streamlined, more efficient System Manager function rather than those provided under the current corporate office arrangement.

The total number of divisions will be reduced from nine to three, improving the span of control of the Executive Management Team (EMT). It also reduces the current practice of multiple areas of Queensland Health corporate office being responsible for similar tasks. While some integration of work must occur across divisions, the reduced number will mean clear responsibility and greater accountability where it occurs.

Similarly, the Queensland Government's commitment to devolve decisions about healthcare services to local boards, as far as practicable, means a reduction in the number of functions in the System Manager.

In the proposed organisational structure, the three divisions will each have a broad area of responsibility. Branch structures within divisions will be determined by EMT members following their appointment. The broad movement of current units to new System Manager entities is set out in Appendix 2.

In the proposed new structure, service delivery responsibilities will be devolved to HHSs wherever practicable, leaving the System Manager accountable for system-wide policy, strategy and performance management.

It is therefore appropriate to establish a smaller EMT whose responsibility will be predominately to support the chief executive in system-wide policy, strategy, risk and performance management. The reduced operational functions in the re-shaped System Manager will be performed by the next level in the management structure that would have the delegations of authority necessary to resolve any operational issues arising within the System Manager's span of control—which would be reduced given the devolution of functions to HHS.

This smaller EMT will consist of the chief executive officer, three direct reports (Deputy Directors-General) and the officers responsible for the Commercialised Business Units, each of whom will be individually responsible for health service improvement, system performance management and services essential to support the efficient operation of the system.

The three key Deputy Directors-General will be responsible for the following divisions:

- Health Service and Clinical Innovation
- System Policy and Performance
- System Support Services.

The intent of this delineation is to provide clarity of focus on the particular knowledge required to manage the system, acknowledging the different skills required to deliver health services, policy and strategy functions and corporate service arrangements.

6.0 Scope of the change

6.1 Role of the System Manager

Under the proposed arrangements, the System Manager will purchase services from HHSs under service level agreements negotiated with the various HHSs. It will have responsibility for:

- developing system-wide strategy, policy and standards
- focusing the direction of activities of the health system in Queensland by interpreting wider public health objectives, understanding the needs of Queensland's health consumers, and setting system-wide objectives and targets in line with government policy direction
- planning and forecasting the delivery of health services required by the Queensland population, guided by policy and strategy objectives
- integrating workforce, infrastructure, health technology and finance needs to ensure aligned planning across the HHSs, which will deliver services under a contractual, service level agreement arrangement
- acting as the purchaser and contract manager on behalf of the state managing the relationship with the national funding body and Independent Hospital Pricing Authority (IHPA)
- managing enterprise bargaining arrangements at a state-wide level, while devolving other day-to-day decisions in relation to human resource management to the HHSs
- monitoring the system's attainment of targets and identifying activities and processes which can assist HHSs to improve performance
- providing guidance and performing regulatory functions relating to public health and private health licensing as required under relevant legislation, as well as health protection programs and emergency preparedness activities
- implementing programs relating to health promotion and disease prevention
- statewide crisis co-ordination
- supporting Queensland Government strategy and policy.

In addition, the System Manager will also support and empower the HHS through the provision of services for which:

- state-wide economies of scale or other demonstrable reasons for a state-wide approach exist
- there are demonstrable advantages, such as cost-savings, in the standardisation of systems.

These services will be provided within an approach that is commercial in nature (that is, in order to deliver the most efficient and cost-effective arrangements as possible by generating competitive tensions) through the gradual separation of these functions into commercialised business units. Functions to be delivered in this manner include:

- managing, developing and implementing system-wide information, communication and technology (ICT) systems (and establishing governance protocols for the implementation of localised ICT systems)
- administering state-wide technology programs such as e-health
- delivering clinical support services such as pathology services and radiology services
- establishing and implementing a supply chain strategy across the state.

It is envisaged that these functions will be gradually separated into commercialised business units to further build the culture of customer focus and service provision within a commercial environment.

6.2 *System Manager divisions*

The three broad areas are described below:

Health Service and Clinical Innovation Division

The Health Service and Clinical Innovation Division will comprise the state-wide clinical support and coordination functions within the System Manager. This division recognises that the core business of the health system is delivery of patient care and, while it will not be directly involved in the delivery of services, it will assist HHSs with interdependencies between direct health service delivery performed in the HHSs. It will also provide coordination functions for matters that have whole-of-system implications, such as emergency coordination and response, aeromedical and other clinical transport coordination which may cross HHSs boundaries and public health functions.

An important component of the division will be the management of quantitative and qualitative clinical information, to inform standards and regulations around clinical safety and quality to ensure Queenslanders continue to receive standardised, world-class healthcare irrespective of the HHSs in which they receive healthcare services.

The offices of the Chief Health Officer, Chief Nursing Officer and Chief Dental Officer will fall within this division. The Chief Health Officer will continue a defined role as the key advisor on medical matters to the Director-General and Minister, in addition to being the organisation's key point of contact in responding to crisis situations. There will also be a focus on clinical process improvement to help resolve issue with patient access to care across Queensland.

The division will also provide guidance and perform regulatory functions relating to public health and private health licensing as required under relevant legislation. It is also proposed that the division be responsible for state-wide health protection and disease prevention programs, and the coordination of mental health and alcohol, tobacco and drugs programs.

System Policy and Performance Division

The System Policy and Performance Division consists of those functions that fulfil the System Manager role as specified in the HHNA. The division will provide coordination and strategic functions:

- to ensure performance goals are met
- to determine future purchasing decisions of the System Manager based on state-wide demand for health services
- to act as the contract manager in negotiating service level agreements with HHSs (and in doing so to ensure integrated planning on a system-wide basis)
- to provide direction to HHS in relation to government policy.

In situations where the performance of an HHSs performance falls below the required standards, the System Policy and Performance Division will also engage with the HHSs to ensure they are enabled to deliver the range of services detailed in their service agreements, and provide guidance when necessary.

The division will incorporate strategic policy and strategy functions to develop and maintain system-wide arrangements for health and other services. The division will inform service planning, which in turn will be integrated with other state-wide planning requirements such as workforce, infrastructure, health technology and financial plans, drawing input from experts across the health system.

These arrangements will, logically, be key inputs into service level agreements negotiated between the System Manager and HHSs, which will be overseen by a health services contracts management function. The service contracts will inform funding allocations and financial planning activities. Finally,

the performance improvement function will ensure that appropriate initiatives are taken to address any part of the system that is unable to meet targets or where remedial action is required.

System Support Services Division

The System Support Services Division will provide functions that are necessary to support both the System Manager and the broader health system to enable it to function effectively, but are not directly involved in health service delivery. It will comprise what are considered to be key corporate services functions, including financial services, risk, assurance and legal functions, capital program delivery and human capital areas.

Within this division, the human capital and capital program delivery functions will be outward looking and primarily concerned with providing system-wide support, although the nature of that support will vary. For example, the human capital function will undertake statewide enterprise bargaining and industrial relations functions, to provide system wide oversight, coordination, capability building and reform to address workforce issues.

Capital program delivery will be responsible for capital program and project management for major projects (unless otherwise agreed), and support to HHSs in relation to minor projects wherever the need arises. This function will necessarily have strong links to the integrated planning function in the System Policy and Performance Division, since capital works are strongly linked to state-wide service and capital planning and the purchase of services through negotiations with HHSs.

Links to the workforce planning function in human capital will also be required to ensure the pipeline of future staff reflects services to be delivered from planned new facilities.

The financial services function within System Support Services will provide support to the System Manager, including budgeting and accounting expertise. It will also need to provide high-level assessment and interaction with Queensland Treasury in the management of system-wide funding and financial issues.

Additionally, the risk, assurance and legal services function will provide services as required to the other functional areas in the System Manager, including a significantly increased emphasis on audit, fraud prevention and risk identification, management and mitigation. The HHSs will be separate legal entities and as such will require independent legal services.

6.3 Commercialised Business Units

It is also proposed that two separate entities—Health Information Technology Services and the Health Services Support Agency—be established.

The intent of separating these entities from the three divisions of the System Manager is to distinguish their clear service delivery objectives in assisting HHSs in the direct delivery of front-line services. Additionally, given the nature of the functions grouped within these entities, it is clear that efficiencies will be able to be gained by pursuing structures that reflect best practice in a corporate environment, by seeking to transition each of them to commercialised business units.

A table setting out the movement of current units within Queensland Health into the new organisational structure is provided at Appendix 2.

Health Information Technology Services

Health Information Technology Services (HITS) will report directly to the Director-General and provide ICT support for the HHS and the System Manager as well as administering important technology

programs such as e-health. This entity will operate on a fee-for-service basis with commercial pressures being an attempt to ensure prices and volumes for services reflect industry best practice. Functions within the current Information Division which do not relate specifically to service delivery, such as parts of Information Management and e-health teams, will move to better align with other key areas of the System Manager.

Over time, individual HHSs will be able to procure discretionary services from this entity according to their needs and based on an ICT services catalogue endorsed by the System Manager. It is intended that 'tied arrangements' will be in place in the initial period, while transition to the new organisational arrangement occurs.

Health Services Support Agency

The Health Services Support Agency (HSSA) will also report to the Director-General and will similarly seek to transition to a commercialised business unit, given the nature of the functions it provides to HHSs.

The HSSA will work closely with HHSs to provide support services directly related to clinical care, such as pathology services and the provision of clinical consumables, in instance where economies of scale and thus cost savings are achieved by undertaking a coordinated, whole-of-system approach to functions.

It will similarly seek, over time, to allow individual HHSs to procure services from it according to the needs of the HHSs and based on a services catalogue endorsed by the System Manager. It is also intended that 'tied arrangements' be used in the initial period, while transition to the new organisational arrangement occurs.

The intention of transitioning both HITS and the HSSA to commercialised business units will deliver greater efficiencies by introducing a competitive tension in the delivery of their services and the prices that they charge HHSs. While contestability will be introduced in a phased approach over coming years, its introduction will provide the opportunity for HHSs to purchase services from alternate providers and thus generate greater economic benefits if possible. Similarly, the two commercialised business units will need to ensure cost structures are maintained at a competitive level if with are to continue to function in a contestable market.

6.4 Mental Health Commission

As noted in the proposed organisational structure, the Government's commitment to further examine a proposed Mental Health Commission will also have an impact on those staff who currently work within the Mental Health Directorate of Queensland Health. The organisational structure acknowledges the future role of the Mental Health Commission, which will be the subject of further specific consultation undertaken by Government.

6.5 Implementation of restructure

It is proposed that the new structure will functionally commence from 1 July 2012, with additional reform planned in a phased approach. Implementation of the System Manager changes under National Health Reform have been detailed in the *System Manager Transition Plan*, attached as *Appendix* 4

Part D: Benefits to the community and service delivery

7.0 Benefits

The Queensland Government is resolved to return decision-making on frontline health services to local communities, by devolving management, responsibility and accountability for the delivery of health services to local communities.

Queensland Health's current organisational structure has become confused, with corporate office both overseeing the total system and intervening in the delivery of health services. This lack of role separation (between system manager and health services provider) departs from industry best practice, which recognises the disparate capabilities in performing true strategic direction-setting and frontline service delivery roles. It also disempowers local staff and communities who are unable to influence decisions in relation to local health care arrangements. The devolution of functions and the streamlining of the current corporate office into the new System Manger entity will provide real benefits in this regard. Where local communities require swift decisive action in relation to a local healthcare issue, local decision-makers will be empowered to make such determinations.

Similarly, as Queensland Health's current corporate office function has grown its structure, frameworks and processes have not adequately adapted to the increasing responsibilities. This has resulted in a lack of focus in some areas and outcomes that evidence increased exposure for the department.

The new structure will remove the perceived and sometimes real silos that exist within the current corporate office structure by reducing the total number of senior executives and broadening the span of control of the EMT. This will have the benefit of ensuring greater emphasis on similar areas of operation within the System Manager entity, with increased accountability for those functions and the better realisation of synergies within the System Manager.

In this regard, the more streamlined and flexible System Manager entity will mean reduced corporate overheads for the public health system and will see the maximisation of health expenditure at front-line service delivery areas.

In relation to the broader culture of Queensland Health, it is widely acknowledged that various events within the organisation over the previous five years have impacted on the culture of the organisation and the perception of the entity itself. This is despite the significant results that have been achieved against key national benchmarks. Broadly, there is a lack of trust and confidence—a perceived reluctance of the corporate office to trust in the capability of local management, and conversely, a lack of confidence in the ability of corporate office to deliver on its core responsibilities. It is likely that this culture is a symptom of a range of issues, including lack of role clarity for corporate office and inefficiencies created by a large centralised bureaucratic corporate office function. The revised structure will over time, and aligned with internal change management strategies, seek to restore the organisational culture within the System Manager entity.

7.1 Enhanced service delivery to the organisation

The proposed re-structure of Queensland Health's current corporate office to that of a System Manager will deliver a number of improved efficiencies and deliver greater effectiveness to the organisation, and therefore the community, through:

- increasing clarity regarding the role of the System Manager, which in turn empowers the System Manager to add value to the health system in Queensland

- organisational structure (of the System Manager), designed to support its purpose and allow the members of the EMT to focus on functions relevant to their individual capabilities
- empowering the HHS to deliver agreed health care services and standards of service, without the interference of a centralised bureaucratic corporate office
- clear focus, increased functional alignment and improved processes within the System Manager will reduce its financial and other risk (e.g. reputational risk)
- functional alignment will allow individual managers to focus on their area of expertise, create greater synergies and deliver outcomes that will benefit the health system
- functionally aligned divisions within the System Manager will facilitate a performance based culture through common goals and appropriate leadership
- increased trust in the System Manager to add value, rather than a complex layer of bureaucracy
- performance mechanisms within the health system (e.g. service delivery contracts) will affirm positive performance and therefore confidence in the HHSs to deliver agreed health care outcomes
- clarity in purpose and organisational structure creates a platform for a targeted change management program, aimed at improving organisational culture
- reciprocal trust and confidence between the HHSs and the System Manager will facilitate a cultural change in Queensland Health
- re-branding exercise of the System Manager that incorporates clear communication of purpose and common goals will build on improved internal culture.

7.2 Enhanced service delivery to the community

The proposed structural changes have been formulated for the purpose of enhancing service delivery to the community by:

- meeting the requirements of National Health Reform and therefore securing funding from the Australian Government as well as the State Government
- placing accountability and responsibility for decision making in health service delivery as close to the front line as possible, thereby reducing bureaucratic and costly delays and optimising health service outcomes (as indicated by industry best practice)
- re-branding the System Manager and communicating the department's purpose and goals that results in improved public perception of Queensland Health
- separating system manager versus service focused functions to enable clarity of purpose for teams and facilitate better outcomes for the HHSs. More efficient outcomes for the HHSs empowers them to deliver improved health care services
- increasing the proportion of the state's healthcare budget that is spent on front-line service delivery, thereby enabling better health care outcomes for Queensland's population.

7.3 Improved efficiency and effectiveness

The re-structured corporate office will result in improved direct improvements linked to the Queensland Government's desire to demonstrate:

- a culture of performance through the implementation of service delivery contracts
- clarity in purpose and structure that allows process improvement to increase efficiencies throughout the system and result in better health outcomes for the communities

- role of the System Manager that facilitates economies of scale wherever possible, thereby creating cost and other efficiencies
- a streamlined, more flexible System Manager that results in reduced corporate overheads for the public health system and maximised expenditure in frontline service delivery areas
- delegation of financial performance to local boards that creates a more customer focused environment for the HHSs and results in improved financial performance of the system as a whole. This will enable the allocation of more funds to the delivery of frontline services.

Part E: Sensitivities and risks

8.0 Risk and mitigation

Critical risks to the successful implementation of the System Manager re-structure on 1 July 2012, together with appropriate mitigation strategies, are summarised below. The mitigation strategies have been and continue to be adopted in the preparation and subsequent release of this Business Case

Risk	Mitigation strategy
Appointment of the new EMT may be delayed thereby impacting on finalising divisional organisational designs.	Plan in place to appoint new EMT in acting capacity to allow commencement of implementation following consultation feedback.
Delay in communicating new organisational structure to affected employees will deplete morale and contribute to additional staff turnover and subsequent loss of knowledge.	Ensure detailed communications strategy is in place to avoid all possible delays and facilitate clear communication of changes and direct impacts on staff. Maintain channels of communication for staff through cascade briefings
Some or all of the HHSs will not have capability to take on functions being fully devolved by the System Manager on 1 July 2012.	System Manager structure designed to incorporate transitional/ongoing service provision for health service districts requiring support, with 'gradual' devolution of more complex functions that may need to provide 'support'.
Business continuity will be affected if the appropriate health service directives and service level agreements are not in place by 1 July 2012.	Dedicate appropriate resources to ensure completion of task within specified timeframe.
Key business systems will not be ready to support the restructure, particularly finance and payroll.	Engage early with system owners to identify all potential business continuity issues. Ensure that appropriate 'work around' solutions are in place to prevent business continuity impacts.
Key stakeholder expectations of the timing for the devolution of current 'corporate' functions (eg shared services) will not be aligned with the capacity of systems and capability of HHSs to allow actual transfer.	Business case and transition plan approved by government and distributed to all key stakeholders as soon as possible for their review. Key messages from business case and transition plan communicated as early as possible.

Part F: Appendices

Appendix 1: Glossary of terms

CASS	Clinical and Statewide Services
CBU	Commercialised Business Units
CHI	Centre for Healthcare Improvement
CHO	Chief Health Officer
CHS	Children's Health Services
CIO	Chief Information Officer
CMH	Commissioner for Mental Health
COAG	Council of Australian Governments
DDG	Deputy Director-General
EMT	Executive Management Team
FPLS	Finance, Procurement and Legal Services
HHNA	Health and Hospitals Network Act 2011
HPA	Hospital Pricing Authority
HHS	Hospital and Health Services
HPID	Health Planning and Infrastructure
HRPE	Health Reform Program Executive
HRS	Human Resource Services
HSD	Health Service District
HSSA	Health Services Support Agency
HTIS	Health Information Technology Services
IHPA	Independent Hospital Pricing Authority
NHPA	National Health Performance Authority
NHRA	National Health Reform Agreement

ODG	Office of the Director-General
P&A	Performance and Accountability
PSR	Policy, Strategy and Resourcing
QAO	Queensland Audit Office
QHSSP	Queensland Health Shared Services Partner

Appendix 2: Proposed movement of current branches/units within the new System Manager structure

Note 1 - Appendix 2 represents the current state of branches and/or units and where they will move as part of the System Manager restructure. Where there are over-allocations of certain skills or officers with specific expertise, case-by-case assessment with managers will be required. Names and staffing profiles of branches/units ***will change (ie, further than identified below),*** *regardless of whether they are designated to be split and/or moved or where there is no change in their organisational location identified. These proposed changes will occur as detailed structures of the new divisions are finalised.*

Note 2 – Appendix 2 represents change ***within the System Manager only*** *and* ***does not*** *seek to identify functions being devolved to HHS. Devolution of functions to HHS is set out in Appendix 3. Devolution of resources as part of that process will be managed on a unit-by-unit basis.*

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
	Policy, Strategy and Resourcing Division (PSR)					
1	Office of the Deputy Director-General	PSR	System Policy and Performance	To merge with Office of the Deputy Director-General, Performance and Accountability	Nil	1 July 2012
2	Strategic Policy, Funding and Intergovernmental Relations	PSR	System Policy and Performance	Additional generic policy resources to be co-located into this branch from across a number of areas of the System Manager	Whole-of-system coordination functions, for Standing Committee on Health, Estimates, etc to move to Office of the Director-General	1 July 2012
3	Clinical Workforce Planning and Development	PSR	Split between System Policy and Performance, System Support Services and Health Service and Clinical Innovation	Nil	The functions of this unit will move: ➢ Aboriginal and Torres Strait Islander Workforce Team moves to System Support Services ➢ Clinical Workforce Development Team moves to Health Service and	1 July 2012

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
					Clinical Innovation ➢ Workforce Planning Team remains as part of System Policy and Performance ➢ ClinEdQ moves to Health Service and Clinical Innovation	
4	Primary, Community and Extended Care	PSR	Split between System Policy and Performance and Health Service and Clinical Innovation	Nil	The functions of this unit will move: ➢ Cancer Control Team moves to Health Service and Clinical Innovation ➢ Older Person's Health and Extended Care remains part of System Policy and Performance ➢ Child Health and Maternity Units remain part of System Policy and Performance ➢ Primary and Community Care Team remains part of System Policy and Performance	1 July 2012
5	Office of Rural and Remote Health	PSR	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
6	Aboriginal and Torres Strait Islander Health	PSR	System Policy and Performance	Nil	Nil	1 July 2012
7	Office of the Chief Nursing and	PSR	Health Service and	Nil	Nil	1 July 2012

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
	Midwifery Officer		Clinical Innovation			
8	Office of the Chief Dental Officer	PSR	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
	Performance and Accountability Division (P&A)					
9	Office of the Deputy Director-General	P&A	System Policy and Performance	To merge with Office of the Deputy Director-General, Policy, Strategy and Resourcing	Nil	1 July 2012
10	Portfolio Management Office	P&A	System Policy and Performance	Nil	The functions of this unit will move to System Policy and Performance	1 July 2012
11	Health Statistics Centre	P&A	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
12	Information Integrity and Policy Services	P&A	System Support Services	Nil	Nil.	1 July 2012
13	Healthcare Purchasing and Activity Based Funding	P&A	System Policy and Performance	Nil	Nil	1 July 2012
14	Performance	P&A	System Policy and	Nil	The functions of this unit will move	1 July 2012

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
	Management Branch		Performance		to System Policy and Performance	
15	Library Services	P&A	System Support Services	Nil	Nil	1 July 2012
	Finance, Procurement and Legal Services Division (FPL)					
16	Office of the Deputy Director-General	FPL	System Support Services	To merge with Office of the Deputy Director-General, Health Planning and Infrastructure and Deputy Director-General, Human Resource Services	Nil	1 July 2012
17	Finance	FPL	System Support Services	Nil	Nil	1 July 2012
18	Legal Services	FPL	System Support Services	Nil	Nil	1 July 2012
19	Health Services Purchasing and Logistics	FPL	Health Services Support Agency	Nil	Nil	1 July 2012

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
20	Activity Based Funding Technical Team	FPL	System Policy and Performance	Nil	The functions of this unit will move to System Policy and Performance	1 July 2012
21	Models and Costings	FPL	System Support Services	Nil	Nil	1 July 2012
22	Mental Health Court Registry	FPL	System Support Services	Nil	Nil	Consideration to be given to movement of Registry to Mental Health Commission in timeframe aligned to commencement
23	Professional Conduct Review Panels	FPL	System Support Services	Nil	Nil	1 July 2012
	Human Resource Services Division (HRS)					
24	Office of the Deputy Director-General	HRS	System Support Services	To merge with Office of the Deputy Director-General, Health Planning and Infrastructure and Deputy Director-General, Finance, Procurement and Legal Services	Nil	1 July 2012
25	People and Culture Strategic Services	HRS	System Support Services	Nil	Nil	1 July 2012

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
26	Business Performance and Improvement	HRS	System Support Services	Nil	Nil	1 July 2012
27	Business Capability	HRS	System Support Services	Nil	Nil	1 July 2012
28	Payroll Improvement Program	HRS	System Support Services	Nil	Nil	1 July 2012
29	Workplace Relations	HRS	System Support Services	Nil	Nil	1 July 2012
30	Safety and Wellbeing	HRS	System Support Services	Nil	Nil	1July 2012
31	Leadership, Learning and Development	HRS	System Support Services	Nil	Nil	1 July 2012
32	Queensland Health Shared Services Partner	HRS	System Support Services	Nil	Nil	Resources relating to Health Services to be devolved to HHS as system upgrades allow

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
	Health Planning and Infrastructure Division (HPID)					
33	Office of the Deputy Director-General, HPID	HPID	System Support Services	To merge with Office of the Deputy Director-General, Finance, Procurement and Legal Services and Deputy Director-General, Human Resource Services	Nil	1 July 2012
34	Program Management Office	HPID	System Support Services	Nil	Nil	1 July 2012
35	Planning	HPID	System Policy and Performance	Additional generic planning resources to be co-located into this branch from across a number of areas of the System Manager	Nil	1 July 2012
36	Asset and Property Services	HPID	System Support Services	Nil	Operational Records Management to be relocated from this unit to align it with Strategic Records Management functions, but remaining within System Support Services	1 July 2012
37	Capital Delivery Program	HPID	System Support Services	Nil	Nil	Responsibility for specific large projects to be devolved to HHS

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
						following negotiation
	Division of the Chief Health Officer (CHO)					
38	Office of the Chief Health Officer	CHO	Health Service and Clinical Innovation	To merge with Office of the CEO, Centre for Healthcare Improvement	Nil	1 July 2012
39	Preventative Health	CHO	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
40	Health Protection	CHO	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
41	Offender Health Services	CHO	Health Service and Clinical Innovation	Nil	Nil.	All resources to be devolved to HHS by 1 July
42	Health Coordination Services	CHO	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
43	Retrieval Services Queensland	CHO	Health Service and Clinical Innovation	Nil	Nil	1 July 2012

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
44	Mental Health, Alcohol, Tobacco and Other Drugs	CHO	Split between Mental Health Commission and Health Service and Clinical Innovation	Nil	The functions of this unit will move: ➢ Mental Health functions other than those related to regulatory functions to move to the Mental Health Commission *(subject to final consultation outcomes)* ➢ Alcohol, Tobacco and Other Drugs functions to remain as part of Health Service and Clinical Innovation	Subject to timing of Mental Health Commission commencement, but with anticipation that changes will occur from 1 July 2012 and then any further machinery-of-government changes will occur in line with decisions of government
45	Organ and Transplant Services	CHO	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
46	Governance and Capability	CHO	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
47	Tropical Regional Services	CHO	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
48	Southern Regional Services	CHO	Health Service and Clinical Innovation	Nil	Nil	1 July 2012

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
49	Central Regional Services	CHO	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
	Centre for Healthcare Improvement (CHI)					
50	Office of the Chief Executive Officer	CHI	Health Service and Clinical Innovation	To merge with Office of the Chief Health Officer	Nil	1 July 2012
51	Access Improvement	CHI	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
52	Clinical Skills Development	CHI	Health Service and Clinical Innovation Division	Nil	Nil	1 July 2012
53	Healthcare Culture and Leadership	CHI	Health Service and Clinical Innovation Division	Nil	Nil	1 July 2012
54	Office of Health and Medical Research	CHI	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
55	Patient Safety and Quality	CHI	Health Service and Clinical Innovation	Nil	Nil	1 July 2012

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
	Improvement					
56	Clinical Services Redesign	CHI	Health Service and Clinical Innovation	Nil	Nil	1 July 2012
	Information Division (ID)					
57	Office of the Chief Information Officer	ID	Health Information Technology Services	Nil	Nil	1 July 2012
58	ICT Service Delivery	ID	Health Information Technology Services	Nil	Nil	1 July 2012
59	ICT Infrastructure	ID	Health Information Technology Services	Nil	Nil	1 July 2012
60	Finance and Business Services	ID	Health Information Technology Services	Nil	Nil	1 July 2012
61	e-Health	ID	System Policy and Performance	Nil	These functions move to System Policy and Performance	1 July 2012
62	Clinical and Corporate Business Solutions	ID	Health Information Technology Services	Nil	Nil	1 July 2012

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
63	Strategy, Planning, Governance and Architecture	ID	Split between Health Information Technology Services and System Policy and Performance	Nil	ICT planning functions move to System Policy and Performance, with the remainder continuing within Health Information Technology Services	1 July 2012
64	Information Management	ID	Splits between Health Information Technology Services and Office of the Director-General	Nil	Online information management functions (other than those which provide technical infrastructure support for intranet and internet services) move to the Office of the Director-General, with the remainder continuing within Health Information Technology Services	1 July 2012
	Clinical and State-wide Services (CaSS)					
65	Office of the Chief Executive Officer	CaSS	Health Services Support Agency	Nil	Nil	1 July 2012
66	State-wide Health Services	CaSS	Health Services Support Agency	Nil	Nil	1 July 2012
67	Biomedical Technology	CaSS	Health Services	Nil	Nil	1 July 2012

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
	Services		Support Agency			
68	Forensic and Scientific Services	CaSS	Health Services Support Agency	Nil	Nil	1 July 2012
69	Pathology Queensland	CaSS	Health Services Support Agency	Nil	Nil	1 July 2012
70	Medications Services Queensland	CaSS	Health Services Support Agency	Nil	Nil	1 July 2012
71	Radiology Support	CaSS	Health Services Support Agency	Nil	Nil	1 July 2012
72	Health Contact Centre	CaSS	Health Services Support Agency	Nil	Nil	1 July 2012 – Staff continue to be physically located within Metro South
73	Information and Communication Technology (AusLab)	CaSS	Health Services Support Agency	Nil	Nil	1 July 2012

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
74	Telehealth	CaSS	Health Services Support Agency	Nil	Nil	1 July 2012
75	Blood Management Program	CaSS	Health Services Support Agency	Nil	Nil	Functions to be moved to System Policy and Performance in the 12 months after 1 July 2012
76	Finance and Business Services	CaSS	Health Services Support Agency	Nil	Nil	1 July 2012
	Office of the Director-General (ODG)					
77	Cabinet and Executive Services	ODG	ODG	Nil	These functions will move to Departmental Liaison and this unit will cease to exist.	1 July 2012
78	Integrated Communications	ODG	ODG	Nil	These functions will move to External Relations and Marketing and Communication and this unit will cease to exist.	1 July 2012
79	Parliamentary and Ministerial Services	ODG	ODG	Nil	Nil	1 July 2012
80	Departmental Liaison	ODG	ODG	This unit becomes responsible for executive support functions	Nil	1 July 2012

#	Branch/Unit	Current location	Future location of remaining functions	Functional gains	Functional relocations	Notes and/or timeframes
81	Executive Support	ODG	ODG	Nil	The function of this unit will merge with the Departmental Liaison Unit and this unit will cease to exist.	1 July 2012
82	Media	ODG	ODG	Nil	Functions of this unit will merge with External Relations.	1 July 2012
83	Strategic Marketing	ODG	ODG	Nil	Functions of this unit will merge with External Relations.	1 July 2012
84	Organisational Engagement	ODG	ODG	Nil	Functions of this unit will merge with External Relations and this unit will cease to exist.	1 July 2012
85	Ethical Standards	ODG	System Support Services Division	Nil	This unit moves to System Support Services	1 July 2012
86	Assurance and Risk Advisory Services	ODG	Split between: ODG and System Support Services Division	Nil	The functions of this unit move to System Support Services. For the purposes of functional alignment, internal audit functions will continue to be organisationally aligned to ODG, with day-to-day management by the Chief Risk Officer within System Support Services	1 July 2012

Appendix 3: Functions proposed to be devolved to Hospital and Health Services (HHS) post 1 July 2012

Note 1 - Appendix 3 is prepared from the perspective of HHSs. While some functions may be devolved to HHSs, many functions will continue to be required of the System Manager and will be replicated by the System Manager for its internal purposes. For example, Right to Information (RTI) responsibility is devolved, but the System Manager will also need to service RTI requirements; internal audit responsibility is devolved, but the System Manager will also need to service internal audit requirements.

Note 2 – It should be noted that one of the guiding princples of health reform is the better utilization of existing resources, not the creation of additional resource demands. Therefore, while there may be opportunities for resource re-allocation over time following case-by-case discussions with affected staff and as natural attrition occurs, only in circumstances where discussions are already underway will devolution mean that staff reporting relationships change.

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
	Clinical and operational functions					
1	Frontline health service delivery	HSD	HHS	Yes	No change	N/A
2	Mental health services (note regulatory functions will remain with System Manager)	Chief Health Officer	MHC	Yes, but to MHC not HHS	Exact functions subject to consultation process	Timing subject to outcomes of consultation process regarding what specific functions will move
3	Offender health services	CHO	HHSs	Yes	Frontline service to be transitioned to HHSs from CHO	1 July 2012
4	Refugee health services	CHO	HHSs	Yes	Frontline service to be transitioned to HHSs from CHO	1 July 2012
5	Cancer screening services	CHO	HHSs	Yes	Frontline service to be transitioned to HHSs from CHO	1 July 2012
6	Delivery of clinical teaching functions	HSD	HHSs	Yes	No change	N/A

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
7	Undertaking local research functions	HSD	HHSs	Yes	No change	N/A
8	Ownership of dental vans and servicing arrangements	PSR	HHSs	Yes	To be undertaken by a host HHS who will provide assistance on behalf of other HHSs	1 July 2012
9	13Health	CaSS	HSSA	Yes	Staff will continue to be physically located at Metro South	1 July 2012
10	Medical Aids Subsidy Scheme	Metro South	Metro South	Yes	Continue to be undertaken by a single HHS (Metro South) on behalf of all HHSs	Continuing from 1 July 2012
11	Queensland Amputee Limb Service (QALS)	Metro South	Metro South	Yes	Continue to be undertaken by a single HHS (Metro South) on behalf of all HHSs	Continuing from 1 July 2012
12	Consulting with health consumers and members of the community about the provision of health services within the Health Service, including Medicare Local	HSD	HHSs	Yes	HHSs are required to develop and publish a consumer and community engagement strategy	1 July 2012
13	Development of local clinical guidelines	HSD	HHSs	Yes	No change	Continuing from 1 July 2012
14	Clinical Safety and Quality	CHI and HSD	System Manager (Health Service and Clinical Innovation) and HHSs	Shared	Incident reporting, whole-of-system learning and improvement, state-wide standards and similar functions to be maintained at a System Manager level, while individual clinical	Continuing from 1 July 2012

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
					safety arrangements in relation to frontline service delivery to be maintained at HHS level	
15	Delivery of public health functions (communicable diseases, environmental health, regulatory functions and public health)	CHO	System Manager (Health Service and Clinical Innovation)	No	Given critical need to mobilise staff in response to issues with cross-health service implications, this function will be directly managed by the Chief Health Officer except for those services agreed in service level agreements	N/A
16	Preventative health (sun safety, nutrition, physical activity, etc)	CHO	System Manager (Health Service and Clinical Innovation)	No	Consideration may be given within the System Manager to movement of this function over time	N/A
17	Retrieval Services	CHO	System Manager (Health Service and Clinical Innovation)	No	This function occurs across multiple HHS, therefore System Manager will continue to coordinate	N/A
18	Disaster response (State Health Emergency Coordination Centre) and related emergency coordination functions	CHO	System Manager (Health Service and Clinical Innovation)	No	This function occurs across multiple HHSs therefore System Manager will continue to coordinate	N/A
19	Patient transport services (including ambulance services)	CHO	System Manager (Health Service and Clinical	No	Ambulance services may only be purchased from Queensland Ambulance	N/A

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
			Innovation)		Service – a central agreement between QAS and System Manager will be maintained, with budgets allocated to HHSs	
20	Alcohol, tobacco and drugs functions	CHO	System Manager (Health Service and Clinical Innovation)	No	Current central arrangements to be reduced over time	N/A
21	Coordinating whole-of-system medical research and commercialisation opportunities (viz, Office of Health and Medical Research functions)	CHI	System Manager (Health Service and Clinical Innovation)	No	This function occurs across multiple HHSs therefore System Manager will continue to coordinate	N/A
22	Private health regulatory services	CHO	System Manager (Health Service and Clinical Innovation)	No	Regulatory functions to be maintained by System Manager	N/A
23	Transplant and organ donation	CHO	System Manager (Health Service and Clinical Innovation)	No	Current state-wide approach to be continued in the immediate future	N/A
24	Coronial recommendation coordination	CHI	System Manager (Health Service and Clinical Innovation)	No	This functions occurs across multiple HHSs therefore System Manager will continue to coordinate	N/A
25	Development of state-wide clinical guidelines	CHI	System Manager (Health Service and Clinical	No	State-wide function to be continued	N/A

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
			Innovation)			
26	Forensic and scientific services	CaSS	HSSA	No	State-wide function to be continued	N/A
27	Coronial counselling	CaSS	HSSA	No	State-wide function to be continued	N/A
28	Biomedical technology services	CaSS	HSSA	No	State-wide function to be continued	N/A
29	Telehealth coordination	CaSS	HSSA	No	State-wide function to be continued	N/A
30	Central pharmacy arrangements, including safe medications, pharmacy practitioner development and medications management and support (HHS continue to manage local operations)	CaSS		No	State-wide function to be continued	N/A
31	Locum arrangement services	PSR	HSSA	No	State-wide function to be continued	N/A
32	Blood Management Program	CaSS	HSSA	No	State-wide program linked to national policy arrangements.	To be transitioned from HSSA to System Manager (Policy Division) in 12 months following 1 July 2012
33	Radiology support functions (Health Services continue to manage local operations)	CaSS	HSSA	No	Economy of scale exists for a State-wide support service to generate savings	Not applicable
34	Pathology support functions	CaSS	HSSA	No	Economy of scale exists for a State-wide support service to generate savings	Not applicable

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
	Human resource functions					
35	Employment of staff – CEO and HES staff	HRS	HHSs	Yes	To be managed by HHSs in accordance with HHNA	1 July 2012
36	Employment of staff – all other staff	HRS	Health Service, subject to performance	Yes, subject to performance	To be managed by HHSs in accordance with HHNA	Transitioned over 12 months following 1 July 2012, subject to performance
37	Consulting with health professionals and other staff within the network in relation to emergent human capital issues	HRS	HHSs	Yes	HHS are required to develop and publish a clinician engagement strategy to promote consultation with health professionals.	1 July 2012
38	Orientation program for international medical graduates endorsed by the Australian Medical Council	CHI and HSD	HHSs	Yes	No change	Continuing from 1 July 2012
39	Nurse on Q	PSR	HSSA	No	State-wide function to be continued.	
40	Queensland Country Relieving Doctors program	PSR	HSSA	No	State-wide function to be continued.	
41	Credentialing and definition of scope of practice for medical officers, allied health professionals nurse practitioners, midwives and others	HSD	HHSs	Yes	No change	Continuing from 1 July 2012
42	Professional development of staff	HRS	HHSs	Yes	To be managed by HHSs in accordance with HHNA	Transitioned over 12 months following 1 July 2012, subject to performance
43	Clinical training functions	CHI and PSR	HHSs	Yes	Specific clinical training arrangements (such as the Skills Development Centre	Transitioned over 12 months following 1 July 2012

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
					and Cunningham Centre) to be devolved to relevant single HHS, subject to access arrangements being finalised	
44	Shared service provider transactional human resource functions, including recruitment services	HRS (via QHSSP)	HHSs	Yes	Transition to occur subject to system upgrades providing functionality	Transitioned over 12 months following 1 July 2012
45	WorkCover arrangements	HRS and HSD	HRS and HHSs	Yes	No change to present arrangements until devolution of employment functions occurs	Current arrangements continuing with any additional requirements to be transitioned over 12 months following 1 July 2012 in line with employment functions
46	Indemnity arrangements	HRS	HHSs	Yes	No change to present arrangements until devolution of employment functions occurs	Likely to be transitioned over 12 months following 1 July 2012 in line with employment functions
47	Occupational health and safety arrangements	HRS	HHSs	Yes	No change to present arrangements until devolution of employment functions occurs	Likely to be transitioned over 12 months following 1 July 2012 in line with employment functions
48	Management of annual leave and long service leave obligations	HRS	HHSs	Yes	No change to present arrangements until devolution of employment functions occurs	Likely to be transitioned over 12 months following 1 July 2012 in line with employment functions
49	State-wide intern recruitment campaign	HRS	System Manager (System Support Services)	No	This function occurs across multiple HHSs, therefore System Manager will	N/A

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
					continue to coordinate	
50	State-wide Resident Medical Officer recruitment campaign	HRS	System Manager (System Support Services)	No	This function occurs across multiple HHSs, therefore System Manager will continue to coordinate	N/A
51	Graduate Nurse Online Recruitment placement process	PSR/HRS	System Manager (System Support Services)	No	This function occurs across multiple HHSs, therefore System Manager will continue to coordinate	N/A
52	Work For Us program	PSR	System Manager (System Support Services)	No	Size of Work For Us program to be reduced over time	N/A
53	Negotiating enterprise bargaining agreements	HRS	System Manager (System Support Services)	No	This function occurs across multiple HHSs, therefore System Manager will continue to coordinate	N/A
	Financial and finance-related functions					
54	Ensure operations are carried out efficiently, effectively and economically	FPL	HHSs	Yes	Increased level of accountability as HHSs are statutory bodies from 1 July 2012	1 July 2012
55	Allocation of health service budget to meet requirements and service needs	FPL and HSD	HHSs	Yes	HHSs will have discretion to allocate funds to budget programs and priorities	1 July 2012
56	Managing performance of the health service against the performance measures stated in the service agreement	HSD	HHSs	Yes	No change	Continuing from 1 July 2012, noting new service level agreements

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
57	Local procurement and contracting	FPL	HHSs	Yes	Local purchasing decisions continue to be able to be made	Continuing from 1 July 2012
58	Enter into contracts and agreements	FPL	HHSs	Yes	New arrangements mean statutory bodies may enter contracts and agreements	1 July 2012
59	Engage consultants and contractors	HSD	HHSs	Yes	New arrangements mean statutory bodies may enter contracts and agreements	Continuing from 1 July 2012 but with increased delegation
60	Appoint agents and attorneys	FPL	HHSs	Yes	New arrangements mean statutory bodies may appoint agents and attorneys	1 July 2012
61	Manage own bank account and cash position	FPL	HHSs	Yes	New arrangements mean Statutory Bodies may manage their own financial arrangements	1 July 2012
62	Internal audit functions	ODG	HHSs	Yes	New arrangements mean statutory bodies must undertake necessary internal audit functions	1 July 2012
63	TriData input to Treasury	FPL	HHSs	Yes	Queensland Treasury has agreed for the first 12 months System Manager will manage TriData entry in accordance with whole-of-government standards, with devolution occurring as HHSs readiness is confirmed	Transitioning over 12 months following 1 July 2012

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
64	Travel arrangements (excludes international travel which is subject to whole-of-government policy)	HSD	HHSs	Yes	Only some HHSs use the corporate travel hub. System Manager will continue to use a central travel process and assist HHS while they build capacity	1 July 2012
65	Shared service provider transactional finance functions	FPL (via QHSSP)	HHSs	Yes	Transition to occur subject to system upgrades providing functionality	Transitioned over 12 months following 1 July 2012
66	Insurance arrangements	FPL	HHSs	Yes	Given changes to arrangements regarding ownership of land and buildings, work being finalised on what impact this will have on previously proposed arrangements.	Likely to be transitioned over 12 months following 1 July 2012 in line with arrangements for ownership of land and buildings.
67	Setting of total health service budget	FPL	System Manager (System Support Services)	No	System Manager will compile total budget from State and Commonwealth funds and then determine purchasing arrangements to establish total budget for each HHS	N/A
68	Taxation arrangements	FPL	System Manager (System Support Services)	No	Central Taxation Unit will prepare a single business activity statement for System Manager and HHSs given status of payroll and finance systems	N/A
69	Annual budget bids	PSR	System Manager (System Support	No	System Manager will submit all budget bids to	N/A

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
			Services)		government in accordance with whole-of-government arrangements	
70	Grants arrangements	FPL	System Manager (System Support Services)	No	Grants arrangements to be maintained centrally in the short-term while future role of such funding mechanisms is considered	N/A
71	State-wide procurement and contracting	FPL	HSSA	No	Economy of scale exists for a state-wide support service to generate savings	N/A
72	Manage system-wide aeromedical and transport contracts	CHO	System Manager (Health Services and Clinical Innovation)	No	Funds for aeromedical transfers (inter-facility and primary retrieval) will be allocated to HHSs but the contracts for the various service providers (given they service cross-service) will be managed centrally	N/A
	Capital/infrastructure functions					
73	Acquire, hold, deal with real property	HPID	HHSs	Yes	To be managed by HHSs in accordance with HHNA	1 July 2012
74	Ownership of land and buildings	HPID	HHSs	Yes	To be managed by HHSs in accordance with HHNA	Transitioned over 12 months from 1 July 2012
75	Delivery of capital projects – minor projects	HPID	HHSs	Yes	To be managed by HHSs in accordance with HHNA	1 July 2012
76	Asset management	HPID	HHSs	Yes	Manage maintenance of building and equipment, including sub-leases.	1 July 2012

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
					System Manager will continue to provide limited assistance with emergent works	
77	Ownership of equipment	HPID	HHSs	Yes	To be managed by HHSs in accordance with HHNA	1 July 2012
78	Delivery of capital projects – major projects	HPID	HPID or HHSs	Yes, subject to performance	In the same way as currently occurs, the System Manager will be accountable for planning and delivery of major capital projects, unless delegated to HHS based on its capacity	Continuing from 1 July 2012
	Policy development, performance management and planning functions					
79	Development of local health service policies	HSD	HHSs	Yes	No change	Continuing from 1 July 2012
80	Development of local health service planning tools deemed necessary to align with state-wide plans	HSD	HHSs	Yes	No change	Continuing from 1 July 2012
81	Development of state-wide policy, planning and strategy initiatives – plans an/or strategies for workforce, ICT, e-health, assets, investment, strategic plan, capital, future services, etc.	Various parts of Corporate Office	System Manager (System Policy and Performance)	No	Integrated planning functions at a state-wide level are key levers to implement government policy and will be co-located in a single area of the System Manager	N/A
82	Performance management - develop and manage the Performance Management Framework	P&A	System Manager (System Policy and	No	NHRA sets out that System Manager will be responsible for overall system	Continuing from 1 July 2012

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
			Performance)		performance and for remediating poor performance if it arises	
83	Reporting on implementation of government commitments	PSR	System Manager (System Policy and Performance)	No	No change	N/A
84	Food standards policy and regulatory functions	CHO	System Manager (Health Service and Clinical Innovation)	No	No change	N/A
	Executive services type functions					
85	Manage public relations including responding to media enquiries	ODG	HHSs	Yes	Devolved to HHSs from 1 July 2012	Continuing from 1 July 2012
86	Respond to correspondence about local issues	ODG	HHSs	Yes	Devolved to HHSs from 1 July 2012	Continuing from 1 July 2012
87	Deal with RTI and privacy applications	P&A	HHSs	Yes	Continuing current arrangements from 1 July 2012, without central coordination	Continuing from 1 July 2012
88	Annual reporting	P&A	HHSs	Yes	Each HHSs will be required to develop its own annual report	1 July 2012
89	Ownership and management of clinical and administrative records	P&A/HPID	HHSs	Yes	State archivist has agreed to effect the transfer as a machinery-of-government change over the course of the 2012-13 financial year	Transitioned over 12 months following 1 July 2012

#	Function/accountability	Current	Future	Devolved?	Notes	Timeframe
90	Maintenance of local websites and intranet sites	HSD	HHSs	Yes	Continuing current arrangements from 1 July 2012	Continuing from 1 July 2012
91	Library services	P&A	System Manager (System Support Services)	Yes	Currently delivered by hub-spoke model, with central arrangements to be devolved over time	Transitioned over 12 months following 1 July 2012
	Audit, legal, risk, ethical standards					
92	Reporting of suspected official misconduct to the CMC and management of investigations in this regard	ODG	HHSs	Yes	System Manager will maintain a smaller Ethical Standards Unit to perform these duties for the System Manager entity and also to enable the DG to appoint investigators (as per the HHNA) in situations where serious allegations warrant higher-level intervention	1 July 2012
93	Reporting of PID to the PSC and management of whilstleblowers	ODG	HHSs	Yes	System Manager will maintain a smaller function to manage and support PIDs/whilstleblowers within the System Manager entity	1 July 2012
94	General audit functions	ODG	HHSs	Yes	To be managed by HHSs in accordance with HHNA	1 July 2012
95	Legal services	FPL	HHSs	Yes	To be managed by HHSs in accordance with HHNA	1 July 2012

Appendix 4: System Manager Transition Plan

Prepared by: Office of the Director-General, Queensland Health

Table of Contents (pages to be updated as part of final formatting)

Introduction

In April 2010, the Australian Government announced its intention to undertake significant reform of the Australian healthcare system. In August 2011, Queensland, as a member of the Council of Australian Governments (COAG), signed the National Health Reform Agreement (NHRA), committing to major changes in the way that health services in Australia are funded and governed. These changes take effect from 1 July 2012 and include:

- moving to a purchaser-provider model, with health service delivery to be purchased from legally independent Hospital Networks (to be known as Hospital and Health Services [HHSs] in Queensland)
- introducing national funding models and a national efficient price for services, with the majority of services to be funded on an activity unit basis into the future[5]
- defining a refocused role for state governments in managing the health system, including:
  - the use of purchasing arrangements and other levers to drive access and clinical service improvements within and across the HHSs
  - a responsibility to intervene to remediate poor performance, either at the state's initiative or in response to prompting by the National Health Performance Authority (NHPA), which will publicly report on performance of the HHSs and healthcare facilities.

The *Health and Hospitals Network Act 2011* (HHNA), enabling the establishment of the new health service entities and the System Manager role for the health department in Queensland, was passed by the Queensland Parliament in October 2011.

Purpose of the System Manager

The purpose of the System Manager is to:

"Provide strategic focus on system-wide policy, planning and funding arrangements to ensure value for money in the delivery of public health care in Queensland and support Hospital and Health Services to deliver the highest standard of care to patients."

The System Manager has responsibility for:

- developing system-wide strategy, policy and standards
- focusing the direction of activities of the health system in Queensland by interpreting wider public health objectives, understanding the needs of Queensland's health consumers, and setting system-wide objectives and targets in line with government policy direction
- planning and forecasting the delivery of health services required by the Queensland population, guided by policy and strategy objectives
- integrating workforce, infrastructure, health technology and finance needs to ensure aligned planning across the HHSs, which will deliver services under a contractual, service level agreement arrangement
- acting as the purchaser and contract manager on behalf of the state managing the relationship with the national funding body and Independent Hospital Pricing Authority (IHPA)
- managing enterprise bargaining arrangements at a state-wide level, while devolving

[5] This efficient price will incorporate service delivery overheads and be set by the Independent Hospital Pricing Authority (IHPA).

other day-to-day decisions in relation to human resource management to the HHSs
- monitoring the system's attainment of targets and identifying activities and processes which can assist HHSs to improve performance
- providing guidance and performing regulatory functions relating to public health and private health licensing as required under relevant legislation, as well as health protection programs and emergency preparedness activities
- implementing programs relating to health promotion and disease prevention
- statewide crisis co-ordination
- supporting Queensland Government strategy and policy.

Figure 1.1 illustrates the new functions within Australia's public health system, including local, state and national levels. These changes will be implemented from 1 July 2012.

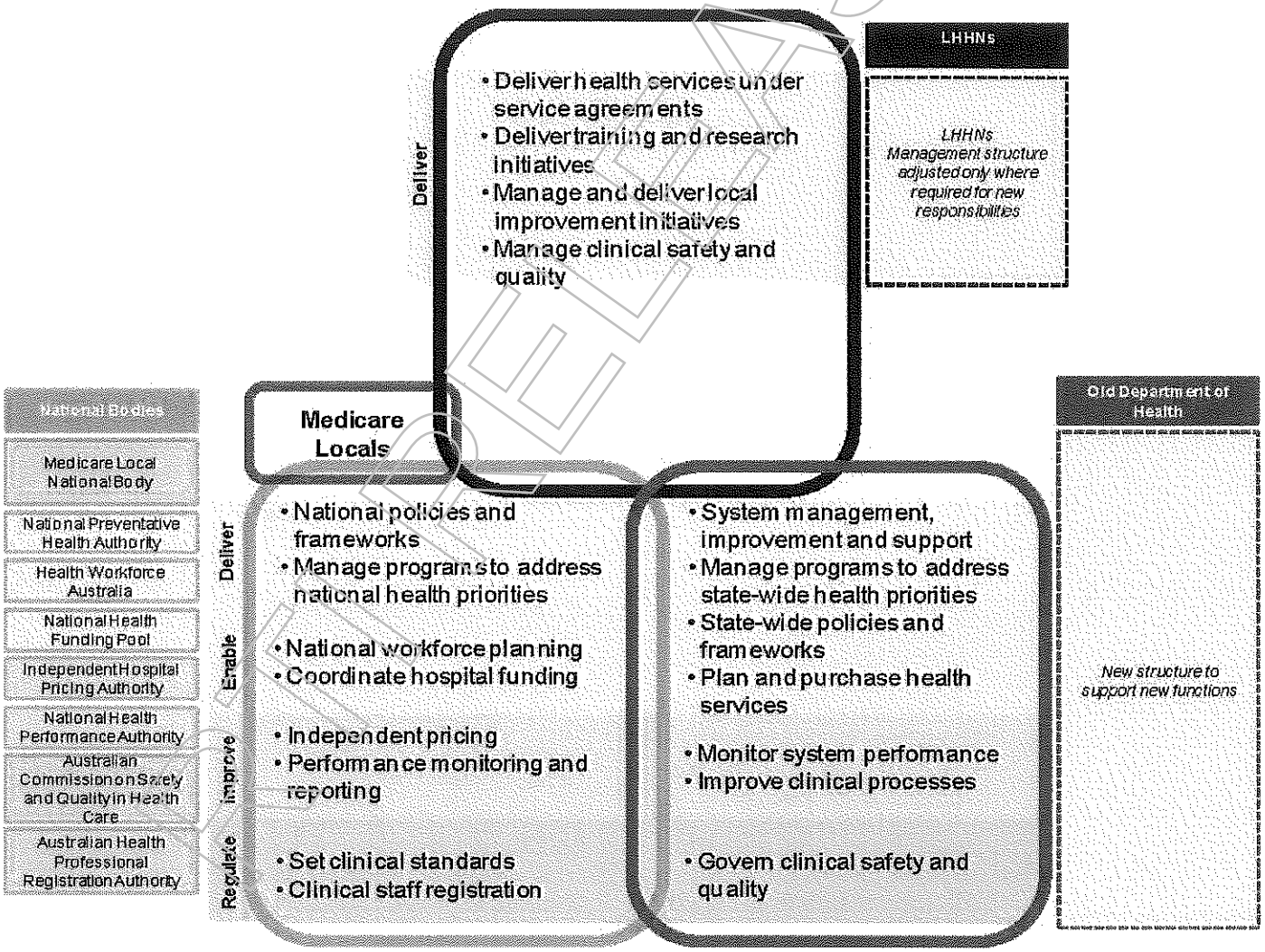


Figure 1.1: Australian Public Health System

Scope

Transition from corporate office to System Manager

In addition to 'business as usual' functions, Queensland Health will, by 1 July 2012:

- plan for a 1 July 2012 change in role from corporate office to System Manager
- commence developing the vision and high level strategic plan for the System Manager (in consultation with the Executive Management Team - EMT)
- document leadership and core capability requirements of the System Manager
- identify and mitigate transition risks to business continuity
- oversee the legislative changes required to establish the System Manager
- review key policies and processes to support System Manager outcomes
- liaise and collaborate with the various restructure stakeholders
- communicate the status of the restructure process, particularly any impacts on employees to staff, unions and other stakeholders
- provide timely and accurate information to the Health Reform Program Executive (HRPE) and government as requested
- plan, monitor and control activity to ensure the System Manager is operational on 1 July 2012 and those functions that are to devolve from 1 July 2012 are positioned to do so
- plan, monitor and control activity beyond 1 July 2012 to accommodate the future devolution of key corporate functions as HHSs' readiness allows
- liaise and collaborate with HHSs that will be administered from 1 July 2012.

National Health Reform design principles

The Queensland Government has adopted the following broad principles to guide design of the new System Manager:

- The System Manager will be focused on strategic, whole-of-system functions with frontline service delivery to be devolved as far as practicable.
- Accountability for health services will be held at a local level wherever possible.
- Frontline services should be devolved to HHS unless there are demonstrable advantages of statewide / regional operation.
- Service level agreements underpinning service delivery requirements will be developed between the System Manager and HHS.
- Staff should not experience a reduction in their terms and conditions.
- A governance system is essential to maintain connections between all the agencies in the health system.

Assumptions

- The System Manager will be streamlined, more flexible and provide greater support to the 17 HHS than the current corporate office model.
- Restructure is targeted for 1 July 2012, however this is subject to consultation with affected staff and unions, in accordance with Queensland Health's industrial obligations, and any future directions that the Queensland Government provides.
- Empowerment of HHS will be a staged process, with devolution of key corporate services dependent on:
  - system capability/readiness
  - capability of the individual HHS
  - establishment of agreed protocols with reference to accountability/responsibility of legacy issues.
- The Director-General will have the support of the HRPE to:
  - scope and appoint the System Manager's EMT
  - redeploy current remaining executives to alternative positions within the System Manager, as required.
- HRPE will endorse the proposed business model and three-phased implementation process described in this plan.
- Access to expert advice/resources to facilitate the implementation is available, subject to approval of the Director-General.
- Any cost associated with the System Manager restructure will be funded by Queensland Health.

Principles

The System Manager transition proposes to follow a number of key principles [6], to which transition leaders will refer when assessing competing priorities and options throughout the process.

	Key principles
	People Principles[7]
1	Queensland Health is committed to maximum employment security for permanent public sector employees. Where changes to employment arrangements are necessary, there will be active pursuit of retraining and deployment opportunities in accordance with the Queensland Government's policy on employment security.
2	Staff and health unions will be informed, consulted and involved throughout the transition and will play a key role in shaping the new health system.
3	Queensland Health employees will continue their employment under the same terms, conditions and entitlements.
4	Staff will have up-to-date information on health reform.
5	Transition leads will facilitate transformation activities at the local level.
6	Queensland Health staff will be supported and treated with respect.
	Change Principles
1	People have a shared understanding of the vision for an improved and sustainable health system.
2	Adopt an approach that is consultative, participative and inclusive of all stakeholders.
3	Leaders act and implement changes locally that are consistent with the vision.
4	People are supported to manage and implement the change.
5	The process of transition will be sufficiently flexible to ensure local innovation and service improvement will continue to be enhanced.
6	Communication is open and transparent.
	Transition Principles
1	Devolution of responsibility and accountability for the delivery of health services to HHSs is paramount.
2	The health and safety of Queenslanders remains our priority.
3	Creation of value for patients is a clear focus.
4	Program governance structure is transparent and outcome focused.
5	Decision-making is evidence-based.
6	The final business model allocates clear accountabilities and responsibilities.
7	Transition and improvement efforts will be efficient, effective and prioritised to deliver maximum benefits to the health care system.

[6] Approved by the previous Queensland Government

[7] Transition Principles included in Health Reform Queensland *Change Strategy November 2011 Version 1.1*

Exclusions

This System Manager transition process will not seek to ensure readiness of HHS or to deliver business improvements outside the scope of National Health Reform. However, any improvement opportunities identified will be documented, prioritised according to risk and benefit and recommended for future action.

Dependencies

The transition plan and subsequent implementation is dependent on:

- feedback from the staff and union consultation process
- government confirmation of proposed outcomes
- successful transition of HHS
- legislative changes and administrative orders ready for restructure
- finance and payroll systems in place to support the business needs of the HHS and System Manager.

Critical risks

Internal controls provide reasonable assurance regarding achieving the System Manager's objectives. Critical risks to successful implementation of the restructure can be mitigated by:

- clarification of the business model, with clear accountabilities across the restructured entities – System Manager and the 17 HHS
- broad support for the proposed restructure by key industrial relations stakeholders
- sufficient due diligence to ensure all business critical impacts are identified (eg employee liabilities, system deficiencies, impacts of voluntary separation packages)
- stakeholder buy-in on high level vision and strategic plan for the System Manager
- compliance sign-off
- business continuity:
  - Health Service Directives and service level agreements are in place
  - key staff are retained during a period of low morale
  - information and knowledge is retained and transferred
  - key business systems are ready to support the restructure, particularly finance and payroll
- key stakeholder expectations of the timing of devolution of current corporate functions (eg shared services, capital maintenance delivery) to the HHS are aligned with the capacity of systems and capability to allow actual transfer
- operating protocols relating to post-transition issues are established.

Constraints

The restructure will be subject to confirmation that the proposed business model and transition plan meet the HHS business needs and health outcomes for patients are maintained.

Implementation

Role of the System Manager

Transformation of the Queensland Health corporate office to System Manager will require a number of fundamental changes to organisational purpose and functional design.

These changes will support a cultural shift to enable the System Manager to perform its role and drive improved health outcomes through:

- devolution of responsibility and accountability for health services to HHS
- provision of strategic direction for Queensland's health system
- planning and coordination of statewide health services
- implementation of mechanisms to support a culture of accountability and performance across the state
- provision of customer-focused key corporate services, that add value (either through an interim transition period or on an ongoing basis).

Structure of the System Manager

The proposed structure will provide a streamlined, more efficient System Manager function rather than those provided under the current corporate office arrangement.

The total number of divisions will be reduced from nine to three, improving the span of control of the Executive Management Team (EMT). It also reduces the current practice of multiple areas of Queensland Health corporate office being responsible for similar tasks. While some integration of work must occur across divisions, the reduced number will mean clear responsibility and greater accountability where it occurs.

Similarly, the Queensland Government's commitment to devolve decisions about healthcare services to local boards, as far as practicable, means a reduction in the number of functions in the System Manager.

In the proposed organisational structure, the three divisions will each have a broad area of responsibility. Branch structures within divisions will be determined by EMT members following their appointment. The broad movement of current units to new System Manager entities is set out in Appendix 2.

In the proposed new structure, service delivery responsibilities will be devolved to HHSs wherever practicable, leaving the System Manager accountable for system-wide policy, strategy and performance management.

It is therefore appropriate to establish a smaller EMT whose responsibility will be predominately to support the chief executive in system-wide policy, strategy, risk and performance management. The reduced operational functions in the re-shaped System Manager will be performed by the next level in the management structure that would have the delegations of authority necessary to resolve any operational issues arising within the System Manager's span of control—which would be reduced given the devolution of functions to HHS.

This smaller EMT will consist of the chief executive officer, three direct reports (Deputy Directors-General) and the officers responsible for the Commercialised Business Units, each of whom will be individually responsible for health service improvement, system performance management and services essential to support the efficient operation of the system.

The three key Deputy Directors-General will be responsible for the following divisions:

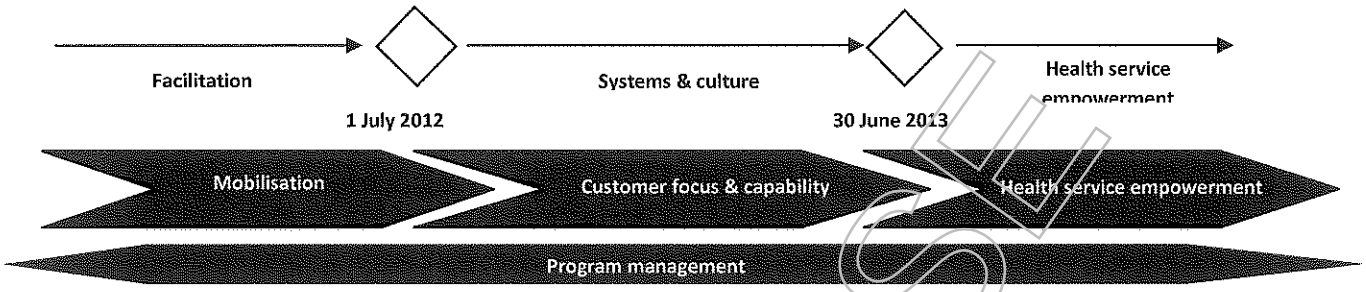
- Health Service and Clinical Innovation
- System Policy and Performance
- System Support Services.

The intent of this delineation is to provide clarity of focus on the particular knowledge required to manage the system, acknowledging the different skills required to deliver health services, policy and strategy functions and corporate service arrangements.

A high-level, draft organisational structure for the System Manager is included in the business case.

Roadmap for creation of the System Manager

The implementation timeline for establishing the System Manager is illustrated below:



Activities associated with each stage of implementation are:

Mobilisation

- determine System Manager organisation structure
- determine executive management and core capability requirements for the System Manager
- appointment of EMT
- develop name and brand for System Manager
- establish System Manager governance arrangements
- identify functions, resources and timeframe for devolution, focusing on those items to be devolved 1 July 2012
- confirm critical risks/issues
- confirm business continuity impacts and mitigation strategies of health reform.
- confirm service level agreement arrangements.

Customer focus & capability

- develop high level strategic vision/direction for System Manager document
- develop high level purpose, vision and strategic pillars for System Manager.

Execute Strategic Planning and change management activities to:

- foster cultural change to support renewed customer focus for System Manager
- progress devolution of longer-term functions as system capacity is rectified
- increase commerciality of statewide support functions by progressing to, and implementing, commercialised business units
- build performance management framework for commercial/transitional service components of System Manager
- continue change management activities with all key stakeholders (including employees and HHS)
- upgrade key systems
- devolve functions that may require system support/disinvestment.

Devolution & empowerment

- reach agreement on operational protocols for management of legacy issues as part of devolution of final functions.
- devolve all service delivery functions and transactional functions (either to HHS or commercialised business units), unless there is an economic or other case for statewide coordination.

Functions to be devolved

Functions for which the individual HHS will become accountable on 1 July 2012 have been summarised and are attached at Appendix 3.

Key milestones

COAG has provided guidance on the implementation pathway for states/territories in relation to structures for central entities. It is recognised that reducing uncertainty to staff is an important consideration along with adequate consultation with staff and unions. The key milestones for this process are:

Deliverable	***Due date***
Identify key functions to be retained by System Manager or devolved to HHS	April 2012
Draft System Manager organisational structure, based on functions identified	April 2012
Draft Business Case for Change to meet industrial obligations to consult staff and unions	April 2012
Ministerial endorsement of draft organisational structure and Business Case for Change	May 2012
Commence both corporate consultation process and direct consultation with affected staff	Week of 21 May 2012
Specifically consult with directly affected staff and identify options for: • movement to HHS/commercialised business unit environment • movement to alternative role within System Manager • re-skilling or deployment.	Week of 21 May 2012
Complete consultation process	Week of 4 June 2012
Finalise arrangements for devolution of functions and final System Manager organisational culture	June 2012
Government endorsement of final System Manager organisational structure	June 2012
Announce Executive Management Team	Mid-June 2012
Confirmation of final System Manager organisational structure to staff	Mid- June 2012
Finalise System Manager governance arrangements for commencement 1 July 2012	Mid-June 2012
System Manager entity commences operation	1 July 2012

Stakeholders

Key stakeholders

Stakeholder	Involvement / Expectation
Employees of the System Manager	• expect clarity in reporting lines, that conditions of their employment will be maintained and that any future impacts on them are identified and communicated early. • require clarity re impact on end-to-end processes, eg accountability, process re-engineering
Managers within the System Manager	• need to be positioned to 'manage / lead' staff directly impacted by the re-structure
Unions	• have obligation to consult re national health reform • have relationship with members directly impacted by re-structure
Sponsors of HHS Transition Teams	• are directly impacted by end business model (building accountability and capability for their respective HHS, process re-engineering as required) • act as agents for future 'customers' of transitional services (eg, clinical services, supply chain, capital project delivery, ICT, payroll, transactional finance). Expect consultation re System Manager Service Support Agreement, and standards of service
Program Management Office	• provides platform for consistency across the System Manager and HHS transition teams • monitors interdependencies (across teams), coordinates program reporting and expects efficiency and timeliness
Health Reform Program Executive [*Queensland Health*]	• has overall health reform program governance. • expects full and timely disclosure of significant transition issues, including interdependencies
Queensland Government	• provides the highest level of governance. • expects national health reform program to be successfully delivered on schedule
System Manager Executive Management Team	• provides critical input into organisational design, performance frameworks, systems and processes to ensure the success of the System Manager
HHS – senior executives, Governing Councils, CEOs and service provision contacts (i.e. client contacts)	• act as service providers to the System Manager and can negotiate directly re health service delivery outcomes and monitor ongoing performance against contractual deliverables • customers of transitional services provided by the System Manager. • expect consultation re System Manager Service Support Agreements and standards of service
Suppliers	• provide materials and services to existing entity, either through contractual arrangement or ad hoc agreement

	• expect that transition to System Manager will not impact on continuity of payment. • assume that current supply arrangements will be maintained
External agencies (various - eg Australian Medical Association Queensland, Queensland Aboriginal & Island Health Council, Aged Care Queensland, Medicare locals etc	• expect clarity re model of health services delivery in Queensland

Stakeholder management and communication plan

A detailed stakeholder management and communication plan will ensure transition activities focus on:

- identifying information needs of all key stakeholders
- developing communication strategies for each key stakeholder group throughout the mobilisation and customer focus and capability phases.

Communication priorities include the following:

- defining and preparing primary communication channels and resources including progress updates, communication protocols and planning for improvements
- communicating the recommended business model (for the health system) and providing clarification for employees before information is leaked to the media
- communicating to key stakeholders the strategic direction of the System Manager (purpose, vision and high level strategic plan)
- developing key messages for employees updating them on transition activities as the transition progresses (from System Manager, Director-General).

Queensland Health

Queensland Health Corporate Restructure

Communications Strategy

May 2012

Introduction

On 14 October 2011, the Queensland Parliament passed the *Health and Hospitals Network Act 2011* which will give effect to major reform of the State's health system from 1 July 2012.

The reforms will be significant, with the commencement of seventeen new Hospital and Health Services (HHSs) from 1 July 2012 as statutory bodies managed by governing boards. These new statutory bodies will be responsible for the current range of community health services provided by Districts, in addition to a number of functions that were previously performed by Queensland Health's corporate Divisions. These new entities will have far greater flexibility to respond to local priorities and demands and make decisions based on local needs.

There will also be significant reform to the current operation of Queensland Health's 'corporate office'. Under the new arrangements, the role of Queensland Health's current 'corporate office' will change. Corporate Office will become the 'System Manager' and will purchase services from HHSs under Service Level Agreements. The System Manager will not be involved in the day-to-day functioning of health services, and will devolve responsibility for those frontline service delivery functions it has provided previously to HHSs, unless there is a significant economic or similar benefit to maintaining a state-wide function. This will require significant organisational change to the current structure of Queensland Health's 'corporate office'.

In order to commence the transition to the role of System Manager, a proposed new structure and complementary *Business Case for Change* for the current 'corporate office' have been developed for the purposes of consulting staff and unions.

The proposed model

Following the March 2012 election, the Government has strengthened Queensland's commitment to the devolution of front-line service delivery within the healthcare setting to further empower health professionals working in HHSs. Similarly, the new Government has confirmed its desire for a single, leaner and more responsive System Manager role for the current 'corporate office', and committed to even greater devolution of decision-making to local communities than was previously proposed through the creation of governing boards.

It is proposed that the new structure set out in the business case will functionally commence from 1 July 2012, in support of these new arrangements. The physical transition of functions and the devolution of additional functions to HHSs will be treated as a second phase of the reform with the further transition of functions to HHSs over the coming twelve months.

The proposed new structure takes into consideration the impact of agreed reforms to the health system by acknowledging the service delivery responsibilities that are clearly devolved to the new HHSs, leaving the System Manager with accountability for system-wide policy,

strategy and performance management. Accordingly, the new structure proposes a smaller executive leadership team whose responsibility would be predominately to support the chief executive in system-wide policy, strategy and performance.

This lean executive leadership team would consist of the chief executive and three direct reports, with an additional two senior executives heading up entities progressing to Commercialised Business Unit status, each of whom would be jointly responsible for health service improvement, system performance management and improvement, and services essential to support the efficient operation of the System Manager.

These three key functional roles, together with system-wide enabling functions in the Commercialised Business Units, can be categorised into three board Divisions, relating to pure policy and performance management functions, corporate services type functions and clinical functions.

The intent of this delineation is to provide clarity of focus on the particular skills and knowledge required to manage the system, acknowledging the different skills and knowledge required to deliver health services, and the strong interdependencies of each.

Objectives of this Communications Strategy

The objectives of this strategy are to:

1. Determine the views of staff, unions and other key stakeholders on the proposed new structure, in accordance with industrial obligations and requirements associated with major organisational change;
2. Engage staff, unions and other key stakeholders on the transition from the existing 'corporate office' structure to the proposed new structure (subject to any refinements that may arise as a result of the consultation process specified at point one, above);
3. Manage staff, union and other stakeholder expectations associated with health reform to the extent that there will be a smaller, facilitative System Manager role when Hospital and Health Services come into existence on 1 July 2012, requiring a smaller workforce and potentially resulting in the adopting of change management strategies for certain cohorts of staff whose functions move to HHSs or cease to be required.

Key messages

The broad key messages associated with the communications strategy are set out as individual dot points below.

- Government's commitment to reform of Queensland Health's system necessitates a transition of 'corporate office' to the role of System Manager from 1 July 2012.
- That transition process will be planned and managed and ensure that there is no impact on the delivery of health services to the community.
- Given the greater autonomy of HHSs, the role of the System Manager is different to the current role of 'corporate office' and therefore there is a need for a new organisational structure and culture.
- The process to agree upon and transition to the new organisational structure will be consultative, with staff and unions provided with the opportunity to discuss the proposals.
- The new structure will result in a smaller organisation compared to the current 'corporate office', including a leaner Executive Management Team with greater integration of functions. This approach is consistent with Government's commitment to ensure decision-making in relation to health services is returned to local communities.
- The re-alignment of functions under three direct reports to the Chief Executive Officer (and two Commercialised Business Units) will give greater emphasis to the core

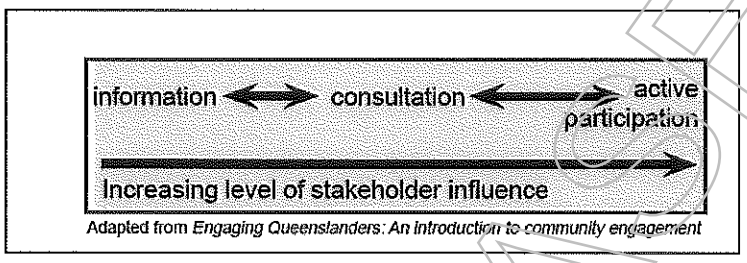
functions of a System Manager, being health service improvement, system performance management and improvement and corporate support functions.

- The organisation realises that the proposed changes will generate uncertainty for staff and will ensure consultation occurs and information is freely available..

Stakeholders

Queensland Health's engagement framework identifies increasing levels of stakeholder influence and the need to recognise these levels of influence to ensure key stakeholders are appropriately involved in any consultation and (where necessary) decision making process.

An excerpt of the framework, which has been used to categorise the stakeholders as part of this process, is set out below.



Adapted from *Engaging Queenslanders: An introduction to community engagement*

Interested stakeholders (Information):	One-way relationship, where information is provided to stakeholders or other bodies
Influencing stakeholders (Consultation):	Two-way relationship, where views are sought and there is an opportunity to influence the final outcome
Approval stakeholders (active participation):	Stakeholders are actively involved in project decisions; can help manage the process of developing solutions; there are opportunities for shared agenda setting and deliberation on issues and solutions.

Approval stakeholders	Influencing stakeholders	Interested stakeholders
• Minister for Health and/or Cabinet • Director-General of Queensland Health • Queensland Health union groups *(to the extent required by industrial obligations)*	• Public Service Commission • Department of the Premier and Cabinet • Queensland Health union groups • Directly affected staff members	• AMAQ and other stakeholder groups • Clinical Senate • General public • Health Reform Strategic Advisory Committee • Indirectly affected staff members

Communication tools and milestones

Development of a proposed organisational structure for the System Manager and subsequent transition to that structure is one element of the implementation of national health reforms in Queensland. A 'blueprinting' exercise was undertaken between June 2011 and November 2011 to seek staff and union feedback as part of the reform process.

Queensland Health has in place a Reform Stakeholder Community and Engagement Plan, which has been developed by Integrated Communications Branch and the Queensland Health Reform Transition Office. This approach builds upon the existing communication channels that have been in place for some time.

To that end, specific communication tools and milestones associated with consultation, finalisation and transition to the new organisational structure fit within and are aligned to health reform timeframes and objectives.

Regular updates to staff, unions, senior executives and other stakeholders have taken place through established consultation and information-sharing mechanisms such as District Chief Executive Officer forums, regular Queensland health reform union meetings, staff broadcasts, and through the established Queensland Health Reform intranet site for all Queensland Health staff. It is intended that such mechanisms would continue to be used, with a short-term emphasis on the proposed new structure and transition to the role of System Manager.

It is acknowledged that the caretaker period, coupled with the different approaches adopted by the various major political parties, provided a level of uncertainty in relation to the reform process. However, specific messages associated with preparation for, consultation and release of, and transition to the new structure were undertaken well prior to the election, and this communication strategy will now provide for the commencement of consultation on the final arrangements to be implemented.

Date	Mechanism and target	Message
16 June 2011	Special Broadcast / All staff	Key step in health reform with introduction of Bill means changes to way we operate are progressing – specific mention of transition to System Manager
14 October 2011	Special Broadcast / All staff	Key step in passage of Bill means changes to way we operate will be required – specific mention of transition to System Manager and acknowledgement of staff uncertainty and QH commitment to industrial relations principles
20 October 2011	Special Broadcast / All staff	Extension of Voluntary Separation Packages for staff considering future with Queensland Health – specific mention of transition to System Manager and acknowledgement of staff uncertainty and QH commitment to industrial relations principles
31 October 2011	EMT meeting / Executive Management Team members	Provision of preliminary draft of proposed new structure to EMT members for consultation – specific advice that DG would value EMT members' feedback to PricewaterhouseCoopers in relation to their specific views.
14 November 2011	Special Broadcast / All staff	Announces work on proposed new structure has commenced and notes that unions will be consulted – specific mention of need to transition to System Manager and acknowledgement of staff uncertainty and QH commitment to industrial relations principles.
14 November 2011	Health Reform Union meeting / DG briefs unions	DG has developed proposed structure and would like union consideration of transition to the new model. Acknowledges staff movements will be necessary and significant organisational change, but commits to working with unions to ensure transition is planned and well managed. Seeks any specific concerns or comment
15 November 2011	DCEO forum / District Chief Executives	DG has developed proposed structure and has discussed with unions, as per Special Broadcast to all staff yesterday. Given impact on EMT members, has consulted with them directly. Impact on DCEOs will be indirect, but key decisions about acting arrangements and market process being finalised.
16 November 2011	Stream Leaders meeting / DG briefs transition stream leaders	DG has developed proposed structure and has discussed with unions, as per Special Broadcast to all staff yesterday. Given impact on EMT members, has consulted with them directly. Impact on DCEOs will be indirect, but key decisions about acting arrangements and market process being finalised.
16 November 2011	Special Broadcast / All staff	Extension of Voluntary Separation Program until mid-December 2011 (12 December 2011) to allow staff one final opportunity to consider future plans. All need to be in by no later than 31 December (therefore scope to extend date further if necessary) with a view to existing organisation by early 2012 (March).
17-23 November 2011	Individual meetings / EMT members	DG met individually with EMT members to discuss future roles and potential transition of functional elements
25 November 2011	Reform Matters / All staff	Launch/convergence of planned Health Reform updates relating to workforce/corporate office/other health reform messages
Early December 2011	Former Government	Former Government announces intention to split Queensland Health's Corporate Office into two entities if it is re-elected following the March 2012 election
Early December 2011	Then Opposition (current Government)	Then Opposition publicly confirms it does not support such an approach and sees significant value in reducing complexity by maintaining a single 'corporate' entity.
Early December	Work on structures	In light of the partisan nature of commitments and the

Date	Mechanism and target	Message
2011	ceases	impending election, consultation on potential structural options ceases until such a time as direction is able to be provided.

Staff/union communication and consultation

Special Broadcast about the proposed new structure has been prepared for release pending Government's consideration of the Business Case for Change and endorsement of the draft structure for consultation with staff and unions.

Unions are to be briefed directly by Director-General at Health Reform union meeting, concurrent with the release of the proposed structure.

Queensland Health's Health Reform intranet site will be updated to reflect proposed draft structure and a copy of the Special Broadcast on the day of the release.

It is proposed the consultation period commence in the week of 21 May 2012 through to the week of 4 June 2012.

External communication/media and consultation

A holding statement to be released to media, upon request, has been prepared (see next page).

The statement confirms that Queensland Health has indicated for some time the need to transition 'corporate office' to a new structure that aligns with the role of System Manager given the Queensland Government's adoption of national health reforms.

The statement confirms Queensland Health is consulting with staff and unions and will be taking an open, transparent process in the finalisation of and transition to the new structure.

Queensland Health
media statement

Queensland Government

XX May 2012

Major changes proposed to Queensland Health's 'corporate office'

Sweeping changes to Queensland Health's corporate structure are proposed as reforms to the State's public health system continue, XXXX announced today.

Releasing a new corporate structure for consultation, XXXX confirmed Queensland Health's 'corporate office' would become leaner as part of the biggest reform of the State's health system in a generation.

If issued by DG: "Following my appointment to the role of Director-General in October, I indicated that there were a number of key changes to the organisation that I considered necessary. One of the fundamental changes was transition to a more efficient organisational as we approach the implementation of national health reforms on 1 July 2012.

As part of the announcement, XXX confirmed that there would be a significant reduction in corporate divisions and major changes to the agency's Executive Management Team.

"Under the proposed structure, the current nine corporate Divisions of Queensland Health's head office would be reduced to three, with two Commercialised Business Units being created to deliver those functions that provide support to Hospital and Health Services," he said.

The proposed changes that will occur at the executive level follow the reduction in back-office staff through the previous Voluntary Separation Program, where more than 900 positions were removed.

XXXX said over recent months Queensland Health had been working hard to prepare for the transition of Health Service Districts to Hospital and Health Services, and for 'corporate office' to take up the role of System Manager.

"While the department has an important part to play, it needs to step back from day-to-day operations and focus on its core roles," he said.

"These core roles will focus on policy, legislation, and governance arrangements, and planning for future capacity (such as beds, technology, specialised services) and will play a supporting role to the Hospital and Health Services.

The System Manager will set standards such as those related to patient safety and to maintain compliance with legislative requirements, and will provide a number of state-wide services such as disaster response, emergency coordination and state-wide preventative health campaigns.

"This is about giving control of health services back to the community – local boards will manage the operations of the services and have the flexibility to respond to local priorities, and corporate office will have a reduced role.

"We know different communities have different needs.

"That's why these reforms are so important – we want local health services to be driven by the people who use them every day."

For more information visit our website at XXX.

ENDS

Special Broadcast – DRAFT

Topic: Proposed structure for role of System Manager

Dear colleagues,

As you are aware, over recent months Queensland Health has been continuing its preparations for the transition of Districts to Hospital and Health Services and for Corporate Office to take up the role of System Manager from 1 July 2012.

Since mid-2011, an extensive consultation process has occurred, and during recent months a number of proposed organisational structures for the System Manager have been publicly released.

Following the March 2012 election, in line with the commitment of the Government for more localised ownership of healthcare decisions and the establishment of a single System Manager entity, I am today releasing the proposed organisational structure for the System Manager for consultation with staff and unions.

You may find the *Business Case* for the new structure, and a copy of the proposed organisational arrangements, at the following link: XXXX.

This approach to reduce the size of Queensland Health's current head office is consistent with Government's current commitment to achieve savings. Once feedback has been received and a decision made in relation to the proposed structure, work will continue with whole-of-government initiatives such as the current Commission of Audit and the Public Sector Renewal Program to ensure alignment with the new Government's savings strategies.

The process of transitioning to the new structure will continue to be open, transparent and consultative.

I realise many staff will have questions about the proposed new structure and the reasons for the need to transition to the role of System Manager. I would encourage you to look at the Frequently Asked Questions page on the Queensland Health Reform intranet site on QHEPS, located at http://qheps.health.qld.gov.au/health-reform/home.htm, or to discuss the proposed reforms with your manager.

Yours sincerely

Dr Tony O'Connell
Director-General

19/6/12. 2005/018282 Pt. (3A)

AM

Minister's Office RecFind No:	
Department RecFind No:	BR054336
Division/District:	Darling Downs HSD
File Ref No:	

RECEIVED DATE 19/6/12 BY CM

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

RECORDS TEAM RECEIVED 17 SEP 2012 QLD HEALTH

Requested by: Chief Executive Officer, Darling Downs Health Service District

Date requested:

Action required by:

SUBJECT: **Increase in establishment as a result of new funding for specialised Mental Health programs Darling Downs Health Service District Mental Health Service**

Recommendation
That the Minister:

Note increase in establishment as a result of new funding for specialised Mental Health programs 2010-2011, 2011-2012 and 2012-2013.

Note the increase in full time equivalent (FTE) establishment of 25.1 FTE as a result of new funding over 2010-2011 and 2011-2012.

Note that 11.5 FTE are permanent FTE – to establish Evolve Therapeutic Service.

Note that 10.5 FTE are temporary FTE until 30 June 2013 at this stage to establish the Resilience and Recovery Team.

Note that 3.1 FTE are permanent FTE establishment in preparation for operationalisation of enhancement to the Child and Youth Mental Health Program.

Note that a further 26.3 FTE are under recruitment during 2012-2013 to open and operate eight bed Adolescent Unit and 14 place Adolescent Day Program.

Note all positions are frontline clinical and clinical support positions.

Trust. Lm

APPROVED/NOT APPROVED **NOTED** **NOTED**

LAWRENCE SPRINGBORG
Minister for Health

Chief of Staff
13/9/12

Minister's comments

Grant pertains
Noted.

15 JUN 2012

Minister's Office RecFind No:	
Department RecFind No:	BR054336
Division/District:	Darling Downs HSD
File Ref No:	

Briefing Note for Noting
Director-General

Requested by: Chief Executive Officer, Darling Downs Health Service District **Date requested:** **Action required by:**

SUBJECT: Increase in establishment as a result of new funding for specialised Mental Health programs Darling Downs Health Service District Mental Health Service

Proposal
That the Director-General:

Note the increase in establishment as a result of new funding for specialised Mental Health programs.

Provide this brief to the Minister for information.

Urgency
1. Routine – so that the Director-General is aware of an increase in establishment within the Darling Downs Mental Health Service, 25.1 full time equivalent (FTE) 2010-2011 and 2011-2012 and a further 26.3 FTE clinical frontline positions under recruitment 2012-2013, to operationalise the new Adolescent Unit/Day Program

Headline Issues
2. The top issues are:
   - an increase in FTE establishment of 25.1 FTE as a result of new funding over 2010-2011 and 2011-2012;
   - 11.5 FTE are permanent FTE – to establish Evolve Therapeutic Service;
   - 10.5 FTE are temporary FTE until 30 June 2013 at this stage to establish the Resilience and Recovery Team; and
   - 3.1 FTE are permanent clinical FTE in preparation for operationalisation of enhancement to Child and Youth Mental Health Program with a further 26.3 under recruitment during 2012-2013.

Key issues
3. There has been an increase in establishment for clinical services (25.1 FTE) for the Darling Downs Mental Health Service. All positions provide frontline services.

4. The Department of Child Safety funded the District by a Grant which provides for 11.5 FTE to establish Evolve Therapeutic Services. This follows a recommendation from the Forde enquiry. These have been established as permanent positions. This team is fully operational and has 3 FTE (multidisciplinary) vacant, which are currently under recruitment.

5. Post floods of January 2011, 10.5 FTE was established in the Resilience and Recovery Team. This team is funded by Regional Disaster Funding and is operational and funded until June 2013, at this stage.

6. As necessary to operationalise the newly constructed $10.6 million Adolescent Inpatient Unit and Day Program that is to be officially opened by the Minister for Health on 19 July 2012, 29.4 FTE have been funded and agreed to.

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7. The increase in FTE will be reflected in reporting.

Background

8. Since 2010, there has been significant increase in clinical FTE into specialised Mental Health Programs namely:
   - establishment of Evolve Therapeutic Services;
   - establishment of Resilience and Recovery Team in response to the natural disaster of 2011;
   - establishment of Adolescent Inpatient Unit (eight beds) and Day Program (14 places); and
   - all positions are frontline clinical and clinical support positions.

Attachments

9. Nil

Minister's Office RecFind No:	
Department RecFind No:	BR054336
Division/District:	Darling Downs HSD
File Ref No:	

Recommendation
That the Director-General:

Note the increase in establishment as a result of new funding for specialised Mental Health programs.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General
19 / 6 / 12

To Minister's Office For Noting ☑

Director-General's comments

Author Shirley Wigan	Cleared by: (SD/Dir) Dr Peter Bristow	Content verified by: (CEO/DDG/Div Head) Dr Peter Bristow
Executive Director	A/District Chief Executive Officer	A/District Chief Executive Officer
Division of Mental Health Darling Downs Health Service District	Darling Downs Health Service District	Darling Downs Health Service District
4616 5200	4616 4936	4616 4936
22 May 2012 13 June 2012	29 May 2012 13 June 2012	31 May 2012 13 June 2012

SDLO

EXECSUPPORT - BR054326 and BR054336 - due 13/6

BR054336

From: Sdlo
To: MD08-DarlingDowns-HSD
Date: 07/06/2012 9:37 AM
Subject: BR054326 and BR054336 - due 13/6
CC: EXECSUPPORT
Attachments: BR054326 MD08 - ATTACH 1.doc; BR054326 MD08 INCREASE ESTABLISHMENT ADOLESCENT INPATIENT PROGRAM.doc; BR054336 MD08 INCREASE ESTABLISHMENT MENTAL HEALTH PROGRAMS.doc

Hi Dianne,

We have received two brief BR054326 and BR054336 which both talks about Mental Health increases in staff. Would it be possible to combine the two briefs together?

If it is possible can you please resubmit via ESU by 13 June 2012.

Many thanks
Simone

Simone Ryder
A/Senior Departmental Liaison Officer
Office of the Director-General
Ph: 3234 0826
Mob:

* Originals w/ SDLO

- 4 JUN 2012

Minister's Office RecFind No:	
Department RecFind No:	BR054336
Division/District:	Darling Downs HSD
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: Chief Executive Officer, Darling Downs Health Service District **Date requested: 16 May 202012** **Action required by:**

SUBJECT: Increase in establishment as a result of new funding for specialised Mental Health programs

Proposal

That the Director-General:

Note increase in establishment as a result of new funding for specialised Mental Health programs.

Provide this brief to the Minister for information.

Urgency

1. Routine – so that the Director-General is aware of an increase in establishment within the Darling Downs Mental Health Service, 22 full time equivalent (FTE) 2010-2011 and 2011-2012.

Headline Issues

2. The top issues are:
   - increase in FTE establishment of 22 FTE as a result of new funding over 2010-2011 and 2011-2012;
   - 11.5 FTE are permanent FTE – to establish Evolve Therapeutic Service; and
   - 10.5 FTE are temporary FTE until 30 June 2013 at this stage to establish the Resilience and Recovery Team.

Key issues

3. There has been an increase in establishment for clinical services (22 FTE) for Darling Downs Mental Health Service. All positions provide frontline services.

4. The Department of Child Safety funded by a Grant for 11.5 FTE to establish Evolve Therapeutic Services, following a recommendation from the Forde enquiry. These have been established as permanent positions. This team is fully operational and has 3 FTE (multidisciplinary) vacant, which are currently under recruitment.

5. Post floods of January 2011, 10.5 FTE was established in the Resilience and Recovery Team. This team is funded by Regional Disaster Funding and is operational and funded until June 2013, at this stage.

6. The increase in FTE will reflect in reporting.

Background

7. Nil

Attachments

8. Nil

Minister's Office RecFind No:	
Department RecFind No:	BR054336
Division/District:	Darling Downs HSD
File Ref No:	

Recommendation
That the Director-General:

Note increase in establishment as a result of new funding for specialised Mental Health programs.

Provide this brief to the Minister for information.

Combining the 2 briefs together

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

/ /

To Minister's Office For Noting ☐

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Shirley Wigan	Dr Peter Bristow	Dr Peter Bristow
Executive Director	A/District Chief Executive Officer	A/District Chief Executive Officer
Division of Mental Health Darling Downs Health Service District	Darling Downs Health Service District	Darling Downs Health Service District
4616 5200	4616 4936	4616 4936
22 May 2012	29 May 2012	31 May 2012

We didn't discuss Item 2?

one brief

Minister's Office RecFind No:	
Department RecFind No:	BR054336
Division/District:	Darling Downs HSD
File Ref No:	

Briefing Note

The Honourable Lawrence Springborg MP
Minister for Health

Requested by: Chief Executive Officer, Darling Downs Health Service District | Date requested: | Action required by:

SUBJECT: Increase in establishment as a result of new funding for specialised Mental Health programs

Recommendation
That the Minister:

Note increase in establishment as a result of new funding for specialised Mental Health programs.

Note the increase in FTE establishment of 22 FTE as a result of new funding over 2010-2011 and 2011-2012.

Note that 11.5 FTE are permanent FTE – to establish Evolve Therapeutic Service.

Note that 10.5 FTE are temporary FTE until 30 June 2013 at this stage to establish the Resilience and Recovery Team.

APPROVED/NOT APPROVED NOTED NOTED

LAWRENCE SPRINGBORG
Minister for Health

Chief of Staff

/ / / /

Minister's comments

21/9/12. COS/019296 20A

Minister's Office RecFind No:	
Department RecFind No:	BR055246
Division/District:	South West HHS
File Ref No:	

BR055246

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED DATE 21 SEP 2012 BY

Requested by: South West Hospital & Health Service Board **Date requested:** 27 August 2012 **Action required by:** 12 October 2012

SUBJECT: Effect of Minimum Obligatory Human Resource Information (MOHRI) targets and non-frontline definition on South West Hospital and Health Service

Recommendation
That the Minister:

Note the impacts of the non-frontline definitions on South West Hospital and Health Service.

Note the contradiction between Minimum Obligatory Human Resource Information (MOHRI) targets and budget targets for South West Hospital and Health Service (SWHHS) and probable inability for SWHHS to meet the MOHRI target.

Note the difficulties for the South West Hospital and Health Board to meet the MOHRI and non-frontline targets.

Note the South West Hospital and Health Board has requested their concerns about non-frontline positions and MOHRI staffing targets be escalated to the Minister.

Note that most designated non-frontline positions provide critical service for SWHHS as a rural and remote health service and outsourcing of functions is not an option at most of the SWHHS facilities.

Note the MOHRI targets are unreachable for SWHHS, as would impact on the ability of the service to operate and there are opposing factors impacting on reaching the MOHRI target versus balancing the budget.

APPROVED/NOT APPROVED **NOTED** **NOTED**

RECORDS TEAM 12 DEC 2012

LAWRENCE SPRINGBORG
Minister for Health

Chief of Staff
17/12/12

Minister's comments

Minister's Office RecFind No:	
Department RecFind No:	**BR055246**
Division/District:	**South West HHS**
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: South West Hospital & Health Service Board **Date requested: 27 August 2012** **Action required by: 12 October 2012**

SUBJECT: Effect of Minimum Obligatory Human Resource Information (MOHRI) targets and non-frontline definition on South West Hospital and Health Service

Proposal

That the Director-General:

Note the impacts of the non-frontline definitions on South West Hospital and Health Service.

Note the contradiction between Minimum Obligatory Human Resource Information (MOHRI) targets and budget targets for South West Hospital and Health Service (SWHHS) and probable inability for SWHHS to meet the MOHRI target.

Provide this brief to the Minister for the Minister to note the difficulties for the South West Hospital and Health Board to meet the MOHRI and non-frontline targets.

Urgency

1. Routine

Headline Issues

2. The top issues are:
   - South West Hospital and Health Board has requested their concerns about non-frontline positions and MOHRI staffing targets be escalated to the Minister.
   - Most designated non-frontline positions provide critical service for SWHHS as a rural and remote health service and outsourcing of functions is not an option at most of the SWHHS facilities.
   - The MOHRI targets are unreachable for SWHHS, as would impact on the ability of the service to operate and there are opposing factors impacting on reaching the MOHRI target versus balancing the budget.

Key Values

The key values that apply are the following:

☒ Better service for patients
☒ Better healthcare in the community
☒ Valuing our employees and empowering its frontline staff
☒ Empowering local communities with a greater say over their hospital and local health services
☒ Value for money for taxpayers
☒ Openness

Key issues

3. The MOHRI target set for SWHHS, is a reduction of approximately 21 MOHRI Full Time Equivalent (FTE).

4. MOHRI staffing figures do not count vacant positions, nor are locum staff counted in MOHRI figures. SWHHS currently has approximately 32 FTE agency locums in the nursing and medical stream.

Minister's Office RecFind No:	
Department RecFind No:	**BR055246**
Division/District:	**South West HHS**
File Ref No:	

5. Locum salary costs are a significant budget risk for the SWHHS. Year to date (31 August 2012), locum costs for SWHHS are in excess of $2.01 million. Annual locum projection if permanent staff cannot be recruited is $12 million. Despite these risks, SWHHS is currently projecting a balanced budget position as at 30 June 2013, with savings strategies in place.

6. SWHHS is undertaking a positive and targeted recruitment campaign in an attempt to attract permanent doctors and nurses to essential frontline positions, however, every locum position converted to a permanent position, whilst being a significant cost saving to the service, will increase the MOHRI head count, rather than reduce it.

Background

7. The ability to outsource services for non-frontline staff is severely limited in rural and remote areas and many non-frontline staff provide multiple roles and essential clinical support. For example, many Operational Officers (for example, Gardeners and Wardspersons) are ambulance drivers for Hospital Based Ambulances; Licensed X-Ray operators, or trained Plaster Technicians. The small rural hospitals could not function without these positions being filled.

8. In addition, the impact of the Coal Seam Gas industry across much of the SWHHS is impacting on small business, service companies and staffing. For example, SWHHS attempted to source a cleaning contractor to provide a between tenant clean for a staff flat – the only quotation able to be sourced for this work (which would have taken less than three hours) was for a massive $3,980.00, proving that contracting out of cleaning services would impact drastically to the negative on the SWHHS budget position.

9. Whilst cooks are on the non-frontline list, in our small rural facilities, we are often the only supplier of meals in the town, and provide Meals on Wheels services to the elderly in the community as well as meals for hospital residents. There are no companies in these towns to provide alternate services, and in fact, some towns, such as Dirranbandi, do not even have a grocery store.

Consultation

10. South West Hospital and Health Board
11. Chief Finance Officer, SWHHS

Financial implications

12. Ability for SWHHS to reach balanced budget position.

Legal implications

13. There are no legal implications.

Attachments

14. Nil

Minister's Office RecFind No:	
Department RecFind No:	**BR055246**
Division/District:	**South West HHS**
File Ref No:	

Recommendation
That the Director-General:

Noted – **Note** the impacts of the non-frontline definitions on South West Hospital and Health Service.

Reserve judgement – **Note** the contradiction between Minimum Obligatory Human Resource Information (MOHRI) targets and budget targets for South West Hospital and Health Service (SWHHS) and probable inability for SWHHS to meet the MOHRI target.

OK – **Provide** this brief to the Minister for the Minister to note the difficulties for the South West Hospital and Health Board to meet the MOHRI and non-frontline targets.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

21 / 9 / 12

To Minister's Office for Approval ☐
for Noting ☑

Director-General's comments

Minister, we will speak to the new CEO (Graem Kelly) after he assesses practicability of the targets.

Author	Content verified by: (CEO/DDG/Div Head)
Meryl Brumpton	Meryl Brumpton
Interim Health Service Chief Executive	Interim Health Service Chief Executive
South West Hospital and Health Service	South West Hospital and Health Service
4624 2853	4624 2853
14 September 2012	14 September 2012

NITTLINGR - FH11/43

Q605/015400

(5)

BR055248

Minister's Office RecFind No:	
Department RecFind No:	BR055248
Division/District:	CHRO/SSS
File Ref No:	HRS05524

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED
DATE 21 SEP 2012

Requested by: Deputy Director-General, System Support Services Division **Date requested:** 17 September 2012 **Action required by:** 18 September 2012

SUBJECT: Withdrawal of Labour by Aboriginal and Torres Strait Islander health workers in Torres Strait – Northern Peninsula Hospital and Health Service.

Recommendation
That the Minister:

Note the referral of the progressed unlawful industrial action which was taken by the Aboriginal and Torres Strait Islander (ATSI) health workers in Torres Strait – Northern Peninsula Hospital and Health Service (TS-NP HHS) to the Queensland Industrial Relations Commission (QIRC). The action was scheduled to occur 12:30pm–5pm on 18 September 2012, and 8am–5pm on 19 September 2012.

Note Commissioner Thompson of the QIRC issued orders to prevent the unlawful industrial action.

Note any unlawful industrial action by ATSI health workers would cease primary care services in rural and remote areas of Torres Strait.

Note withdrawal of labour could risk safety of other Queensland Health employees in provision of services.

APPROVED/NOT APPROVED

LAWRENCE SPRINGBORG
Minister for Health

/ /

NOTED

RECORDS TEAM
RECEIVED 11 DEC 2012 QLD HEALTH

NOTED

Chief of Staff

11/11/12

Minister's comments

URGENT

Minister's Office RecFind No:	
Department RecFind No:	BR055248
Division/District:	CHRO/SSS
File Ref No:	HRS05524

Briefing Note for Noting
Director-General

Requested by: Deputy Director-General, System Support Services Division **Date requested:** 17 September 2012 **Action required by:** 18 September 2012

SUBJECT: Withdrawal of Labour by Aboriginal and Torres Strait Islander health workers in Torres Strait – Northern Peninsula Hospital and Health Service.

Proposal
That the Director-General:

Note the referral of the progressed unlawful industrial action which was taken by the Aboriginal and Torres Strait Islander (ATSI) health workers in Torres Strait – Northern Peninsula Hospital and Health Service (TS-NP HHS) to the Queensland Industrial Relations Commission (QIRC). The action was scheduled to occur 12:30pm–5pm on 18 September 2012, and 8am–5pm on 19 September 2012.

Note Commissioner Thompson of the QIRC issued orders to prevent the unlawful industrial action.

Provide this brief to the Minister for information.

Urgency
1. **Urgent** – Unlawful industrial action was scheduled to begin 12:30pm on 18 September 2012.

Headline Issues
2. The top issues are:
   - any unlawful industrial action by ATSI health workers would cease primary care services in rural and remote areas of Torres Strait.
   - withdrawal of labour could risk safety of other Queensland Health employees in provision of services.

Key issues
3. ATSI health workers are covered by *Queensland Public Health Sector Certified Agreement (No.8) 2011* with a nominal expiry date of 31 August 2014. Any action taken outside the bargaining period for this agreement is unlawful.

4. At 11:55am on 17 September 2012, Mr Stephen Christian, Australian Workers Union (AWU), representative and Manager of Northern Peninsula Area Primary Health Care Services sent an email (Attachment 1) describing the intent for the entire ATSI health worker workforce to withdraw labour which was to occur 12:30pm–5pm on 18 September 2012, and 8am–5pm on 19 September 2012.

5. Queensland Health lodged a notice of dispute in the QIRC and sought an urgent conference to resolve the issue.

6. Conference convened at 3:30pm by Commissioner Thompson of QIRC to seek resolution.

7. Queensland Health sought orders which were issued by Commissioner Thompson of QIRC.

Minister's Office RecFind No:	
Department RecFind No:	**BR055248**
Division/District:	**CHRO/SSS**
File Ref No:	**HRS05524**

8. Simone Kolaric, Health Service Chief Executive (Interim), TS-NP HHS has issued a copy of the orders to all staff in accordance with the orders issued by Commissioner Thompson of the QIRC.

9. Staff were further informed that as the proposed industrial action was unlawful and they would not be paid for any time taken due to the action.

10. The proposed withdrawal of labour by the ATSI health workers would cease primary care services in rural and remote areas of Torres Strait.

11. Financial risks would include increase in need to medivac non-critical emergencies to hospital and requirement to engage agency staff to meet service requirements.

12. Risk of community anger from decreased services, which could include risk of personal attack on Queensland Health employees.

13. After failed conciliation with AWU, Commissioner Thompson of QIRC issued orders (Attachment 2) deeming the withdrawal of labour as unlawful industrial action and failure to comply with the orders would be subject to penalty.

Attachments

14. Attachment 1: Mr Stephen Christian Email
    Attachment 2: Orders issued by Commissioner Thompson of QIRC

Minister's Office RecFind No:	
Department RecFind No:	**BR055248**
Division/District:	**CHRO/SSS**
File Ref No:	**HRS05524**

Recommendation
That the Director-General:

Note the referral of the progressed unlawful industrial action which was taken by the Aboriginal and Torres Strait Islander (ATSI) health workers in Torres Strait – Northern Peninsula Hospital and Health Service (TS-NP HHS) to the Queensland Industrial Relations Commission (QIRC). The action was scheduled to occur 12:30pm–5pm on 18 September 2012, and 8am–5pm on 19 September 2012.

Note Commissioner Thompson of the QIRC issued orders to prevent the unlawful industrial action.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

20 / 9 / 12

To Minister's Office For Noting ☑

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)	Content verified by: (CEO/DDG/Div Head)
Georges Khoury	Mark Brady	Lyn Rowland	Susan Middleditch
A/Principal Advisor	Senior Director	Chief Human Resources Officer	Deputy Director-General
Employee Relations, System Support Services	Employee Relations, System Support Services	System Support Services	System Support Services
3234 1371	3234 0350	3234 1685	3234 0622
18 September 2012	18 September 2012	18 September 2012	18 September 2012

s.47(3)(b) - **Discriminant Slashing, Cutting and Burning of Indigenous Health Worker workforce / positions [Frozen] to save cost, impacts on service delivery / Indigenous Workforce - No transparency. NO PROFESSIONAL RECOGNITION - DEEMED AS NOT CRITICAL FRONT LINE SERVICE PROVIDERS - unless you are a Doctor, Nurse or Allied Health Professional, Organisational Restructure BREACHING OF THE COMMONWEALTH / STATE INITIATIVE Closing the Gap 2033,**

From: Stephen Christian
To: s.47(3)(b)
Date: 17/09/2012 11:55 AM
Subject: Discriminant Slashing, Cutting and Burning of Indigenous Health Worker workforce / positions [Frozen] to save cost, impacts on service delivery / Indigenous Workforce - No transparency. NO PROFESSIONAL RECOGNITION - DEEMED AS NOT CRITICAL FRONT LINE SERVICE PROVIDERS - unless you are a Doctor, Nurse or Allied Health Professional, Organisational Restructure BREACHING OF THE COMMONWEALTH / STATE INITIATIVE Closing the Gap 2033,
CC:
Attachments: Stephen Christian4.vcf

Discriminant Slashing, Cutting and Burning of Indigenous Health Worker workforce / positions [Frozen] to save cost, impacts on service delivery / Indigenous Workforce - No transparency. NO PROFESSIONAL RECOGNITION - DEEMED AS NOT CRITICAL FRONT LINE SERVICE PROVIDERS - unless you are a Doctor, Nurse or Allied Health Professional, Organisational Restructure BREACHING OF THE COMMONWEALTH / STATE INITIATIVE Closing the Gap 2033,

Biomedical Model / Structure not cost effective
[Returning to colonial Structures] DNA Department Native Affairs.]

AS INSTRUCTED MY THE ABORIGINAL TORRES STRAIT ISLANDER WORKFORCE, TORRES STRAIT NORTHERN PENINSULA AREA - TOP WESTERN, NEAR WESTERN, EASTERN AND CENTRAL CLUSTERS, NPA - SENIOR HEALTH WORKERS, PROGRAM COORDINATORS, CLUSTER COORDINATORS,GENERALIST HEALTH WORKERS,ADVANCED HEALTH WORKERS.

I ADVISE that the entire Aboriginal Torres Strait Islander Health Worker Workforce of the Torres Strait Northern Peninsula Area, will be taking Industrial Action - [**WITHDRAWING OF LABOUR**] effective Tuesday 12:30 pm to 5:00 pm / 18th September 2012, and including Wednesday 19th September 2012 / 8:00 am to 5:00 pm.

INSTRUCTIONS To the Aboriginal Torres Strait Islander Workforce;

- **In the case of a medical emergency or critical medical emergency Health Workers MUST ATTEND and PROVIDE medical care.**
- **On call Health Workers will NOT BE ATTENDING / PROVIDE HEALTH CARE as we are not considered Critical front line service providers.**

Stephen
AWU Health Worker Representative TSNPA

Stephen Christian
Manager
NPA Primary Health Care Services
PH: 07 40693200
Fax: 07 40693332
email: Stephen_Christian@health.qld.gov.au

QUEENSLAND INDUSTRIAL RELATIONS COMMISSION

Industrial Relations Act 1999 - s. 230 - action on industrial dispute

The State of Queensland (Queensland Health) v The Australian Workers' Union of Employees, Queensland AND Aboriginal and Torres Strait Islander Health Workers employed by the State of Queensland (Queensland Health) in the Torres Strait Northern Peninsula Hospital and Health Service

Matter No. D/2012/210

COMMISSIONER THOMPSON 17 September 2012

ORDER

THIS Commission, after hearing the parties in the above matter at Brisbane on 17 September 2012 does, pursuant to s. 230(4) of the *Industrial Relations Act 1999,* Order that:

[1] This Order shall come into effect at 8.00 a.m. on 18 September 2012 and shall remain in effect for 90 days thereafter, or until otherwise decided by this Commission

[2] The Australian Workers' Union of Employees, Queensland (AWU) and its officers, agents, employees and members are not to organise or take any industrial action for 90 days.

[3] Aboriginal and Torres Strait Islander Health Workers employed by State of Queensland (Queensland Health) in the Torres Strait Northern Peninsula Area Hospital and Health Service are not to organise or take any industrial action for 90 days.

[4] Service of this Order by facsimile to the Secretary of the AWU shall be deemed sufficient service on the said officers, agents, employees and members of the AWU.

[5] Service of this Order by email to all employees of the Torres Strait Northern Peninsula Area Hospital and Health Service and to all Aboriginal and Torres Strait Islander Health Workers employed by State of Queensland (Queensland Health) in the Torres Strait Northern Peninsula Area Hospital and Health Service from the Chief Executive of the Torres Strait Northern Peninsula Area Hospital and Health Service, shall be deemed sufficient service on the said Aboriginal and Torres Strait Islander Health Workers for the Torres Strait Northern Peninsula Area Hospital and Health Service.

[6] Stephen Christian and Yancy Laifoo will use their best endeavours to contact all Aboriginal and Torres Strait Islander Health Workers employed by State of Queensland (Queensland Health) in the Torres Strait Northern Peninsula Area Hospital and Health Service and say the following:

"The Queensland Industrial Relations Commission has ordered that the withdrawal of labour planned for tomorrow, 18 September 2012 and Wednesday, 19 September 2012 not take place. You should view your emails to obtain a copy of the Order.".

[7] For the purposes of this Order:

a. "Industrial action" means any of the following actions taken in relation to industrial issues which relate to work performed by the employees:

i. A ban, limitation or restriction on the performance of work, or an acceptance of or offering for work;

ii. A failure or refusal by an employee to attend for work and/or to perform work as required by their contract of employment;

iii. The performance of work by an employee in a manner different from that in which it is customarily performed or the adoption of a practice in relation to work, the result of which is a restriction or limitation on, or delay in, the performance of work; and

iv. A failure or refusal by an employee to attend for work and/or to perform work as required by their contract of employment in order to attend a stop work meeting; and

b. In respect of employees "industrial action" also means a failure or refusal by an employee to attend for work and/or to perform work as required by their contract of employment in order to attend a stop work meeting, whether this action is taken in relation to industrial issues which relate to their work as required by their contract of employment or otherwise,

but shall not include:

i. action by an employee that is protected action;

ii. action by an employee that is authorised or agreed to by State of Queensland (Queensland Health); or

iii. action by an employee if:

1. the action was based on a reasonable concern by an employee about an imminent risk to their health or safety; and

2. the employee did not unreasonably fail to comply with a direction of State of Queensland (Queensland Health) to perform other work whether at the same or other workplace, that was safe and appropriate for the employee to perform.

c. In respect of the AWU, "industrial action" means to authorise, direct, organise, encourage or incite any of the members of the AWU to engage or participate in any conduct set out in paragraphs 7(a) or (b) of this Order.

[8] State of Queensland (Queensland Health), the AWU, Stephen Christian and Yancy Laifoo file respective affidavits with the Industrial Registrar by 4.30 p.m. on 20 September 2012 as to whether there has been compliance with the Order, and if default of the compliance, what steps (if any) have been taken to comply with the Order.

[9] In the event that any Aboriginal and Torres Strait Islander Health Workers employed by State of Queensland (Queensland Health) in the Torres Strait Northern Peninsula Area Hospital and Health Service fails to comply with any or all of the provisions detailed in this Order, the Industrial Registrar will, in accordance with s. 233(7) of the *Industrial Relations Act 1999* (the Act), issue a notice calling on those parties to show cause to the Full Bench why the parties should not be dealt with under s. 234 of the Act.

Dated 17 September 2012.

OFFICIAL SEAL

J.M. THOMPSON,
Commissioner.

Operative Date: 17 September 2012
Released: 17 September 2012

BUCHHOLZK - 11/11

EC05/003940

(1)

BR055666

Department RecFind No:	BR055666
Division/District:	SSS Division
File Ref No:	HRS05767

RECEIVED
DATE 26 NOV 2012

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

Requested by: Deputy Director-General, System Support Services Division

Date requested:

Action required by:

SUBJECT: **Queensland Health Guidelines for the process to be adopted when introducing change regarding restructures and/or redundancies**

Recommendation
That the Minister:

Note the contents of the brief regarding Queensland Health (QH) guidelines for the process to be adopted when introducing change regarding restructures and/or redundancies.

Note Queensland Health (QH) has issued guidelines for the process to be adopted when introducing change regarding restructures and/or redundancies (Attachment 1).

Note the guidelines are based on the principles outlined by Deputy President (DP) Bloomfield of the Queensland Industrial Relations Commission (QIRC) (Attachment 2).

Note the guidelines should be provided to the Queensland Nurses' Union in direct response to concerns raised with the Minister and to other health unions in response to their document, "Union Principles – Queensland Health Restructures/Redundancies".

APPROVED/NOT APPROVED **NOTED** **NOTED**

LAWRENCE SPRINGBORG
Minister for Health

/ /

RECORDS TEAM
RECEIVED 03 DEC 2012 QLD HEALTH

Chief of Staff

30 / 11 / 12

Minister's comments

Department RecFind No:	BR055666
Division/District:	SSS Division
File Ref No:	HRS05767

Briefing Note for Noting

Director-General

Requested by: Deputy Director-General, System Support Services Division **Date requested:** **Action required by:**

SUBJECT: Queensland Health Guidelines for the process to be adopted when introducing change regarding restructures and/or redundancies

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Proposal

That the Director-General:

Note the contents of the brief regarding Queensland Health (QH) guidelines for the process to be adopted when introducing change regarding restructures and/or redundancies.

Provide this brief to the Minister for information.

Urgency

1. Routine

Headline Issues

2. The top issues are:
   - Queensland Health (QH) has issued guidelines for the process to be adopted when introducing change regarding restructures and/or redundancies (Attachment 1);
   - the guidelines are based on the principles outlined by Deputy President (DP) Bloomfield of the Queensland Industrial Relations Commission (QIRC) (Attachment 2); and
   - the guidelines should be provided to the Queensland Nurses' Union in direct response to concerns raised with the Minister and to other health unions in response to their document, "Union Principles – Queensland Health Restructures/Redundancies".

Key issues

3. QH is currently undergoing significant organisational change which includes staff redundancies.

4. Unions are rigorously opposing this and have lodged a number of disputes with the QIRC regarding the organisational change.

5. As a result of the disputation with QH and other Government Departments, DP Bloomfield has outlined the principles of how such organisational change should be managed.

6. DP Bloomfield has issued injunctions to stop the process where the principles have not been adhered to.

Background

7. Following the Minister's address on 7 September 2012, QH has been implementing significant organisational change.

8. Unions are opposing the implementation of the change in QH and across the Queensland public sector which has resulted in disputes being lodged in the QIRC.

9. In an attempt to prevent disputation, DP Bloomfield held a compulsory conference on 16 October 2012 where senior human resources staff from the System Manager and Hospital and Health Services, health unions and the Public Service Commission attended.

Department RecFind No:	**BR055666**
Division/District:	**SSS Division**
File Ref No:	**HRS05767**

10. DP Bloomfield outlined principles and processes for managing organisational change at this conference and also other dispute conferences.

11. QH has developed guidelines that reflect these principals and will be attached in a letter (Attachment 3) from the Chief Human Resources Officer to unions outlining QH's approach to organisational change.

Attachments

12. Attachment 1: QH guidelines for the process to be adopted when introducing change regarding restructures and/or redundancies
    Attachment 2: Union Principles – Queensland Health Restructures/Redundancies.
    Attachment 3: Letter from the Chief Human Resources Officer to all health unions attaching the Queensland Health guidelines

Department RecFind No:	**BR055666**
Division/District:	**SSS Division**
File Ref No:	**HRS05767**

Recommendation
That the Director-General:

Note the contents of the brief regarding Queensland Health (QH) guidelines for the process to be adopted when introducing change regarding restructures and/or redundancies.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

Richard Lday

DR TONY O'CONNELL
Director-General

23 / 11 / 2012

To Minister's Office For Noting ☐

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Mark Brady	Lyn Rowland	Susan Middleditch
Senior Director	Chief Human Resources Officer	Deputy Director-General
Employee Relations	Human Resource Services	System Support Services
3234 0350 8 November 2012	3234 1685 13 November 2012	3234 1725 20 November 2012

Enquiries to: Mark Brady
Senior Director
Employee Relations
Telephone: 3234 0350
Facsimile: 3234 0314
File Ref:

Union Secretary

Dear ……..

Following the compulsory conference convened by Deputy President Bloomfield on 16 October 2012 and subsequent dispute conferences regarding the management of organisational change, Queensland Health has produced and distributed a document, "Process to be adopted when introducing change regarding restructures and/or redundancies."

This document is based on the principles arising out of proceedings convened by the Queensland Industrial Relations Commission. A copy is attached for your information.

Queensland Health has also considered the document tabled at the compulsory conference "Union Principles – Queensland Health Restructures/Redundancies".

As outlined at the Reform Consultative Group, Queensland Health is obliged to manage change in accordance with our industrial and legislative commitments which are reflected in the document produced and distributed by Queensland Health as attached.

Yours sincerely

Lyn Rowland
Chief Human Resources Officer
November 2012

Office
Queensland Health
Insert Office Street Address 1
Insert Office Street Address 2

Postal
Insert Postal Address 1
Insert Postal Address 2

Phone
Insert Phone No.

Fax
Insert Fax No.

Prepared by: Mark Brady
Senior Director
Employee Relations
3234 0350
8 November 2012

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Fax
Insert Fax No.

CONF

3/12/12. Q(OS/O/8272

Department RecFind No:	BR055715
Division/District:	Gold Coast HHS
File Ref No:	

BR055715

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED DATE 9 DEC 2012 BY

Requested by: Chief Executive, Gold Coast Hospital and Health Service **Date requested:** 29 November 2012 **Action required by:**

SUBJECT: Impact of Revised Budget on Gold Coast Hospital and Health Service

Recommendation
That the Minister:

Note actions proposed by the Gold Coast Hospital and Health Service Board and Executive regarding the reduced budget for 2012-2013.

Note that the Board of the Gold Coast Hospital and Health Service (GCHHS) has determined it necessary to activate a program of voluntary separations, in response to the recent budgetary reduction of $9.2 million. This action is taken on the basis of advice that Queensland Treasury will fully fund the cost of the separation package, and that there will not be reduction in recurrent budget in future years. The GCHHS Board have endorsed this action via a flying minute on 30 November 2012.

Note that the Chief Executive, GCHHS will issue an announcement on 3 December 2012, to call for expressions of interest for voluntary redundancies from interested employees, with a closing date of 11 January 2013.

Note that unions will be formally notified on 3 December 2012, and be briefed at the District Consultative Forum on 4 December 2012. It will be necessary for implement significant workforce redesign pursuant to the loss of positions.

APPROVED/NOT APPROVED

LAWRENCE SPRINGBORG
Minister for Health

/ /

NOTED RDS TEAM RECEIVED 13 DEC 2012 QLD HEALTH

NOTED

Jake Summ

Chief of Staff

9 / 12 / 12.

Minister's comments

No Need for Minister to sign as HC is now HOC.

URGENT

Department RecFind No:	BR055715
Division/District:	Gold Coast HHS
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: Chief Executive, Gold Coast Hospital and Health Service **Date requested:** 29 November 2012 **Action required by:**

SUBJECT: Impact of Revised Budget on Gold Coast Hospital and Health Service

Proposal

That the Director-General:

Note actions proposed by the Gold Coast Hospital and Health Service Board and Executive regarding the reduced budget for 2012-2013.

Provide this brief to the Minister for information.

Urgency

1. **Critical** - given the need for Gold Coast Hospital and Health Service to take immediate steps, commencing 3 December 2012, to address the reduction of $9.2 million in its 2012-2013 budget, and the timeframes available to mobilise a major program of this type.

Headline Issues

2. The top issues are:
   - The Board of the Gold Coast Hospital and Health Service (GCHHS) has determined it necessary to activate a program of voluntary separations, in response to the recent budgetary reduction of $9.2 million. This action is taken on the basis of advice that Queensland Treasury will fully fund the cost of the separation package, and that there will not be reduction in recurrent budget in future years. The GCHHS Board have endorsed this action via a flying minute on 30 November 2012.
   - The Chief Executive, GCHHS will issue an announcement on 3 December 2012, to call for expressions of interest for voluntary redundancies from interested employees, with a closing date of 11 January 2013.
   - Unions will be formally notified on 3 December 2012, and be briefed at the District Consultative Forum on 4 December 2012. It will be necessary for implement significant workforce redesign pursuant to the loss of positions.

Key issues

3. GCHHS is currently on budget, but given the recent reduction of $9.2 million, will not sustain financial integrity without additional significant measures such as a voluntary redundancy program. The reduction of positions arising from this program will necessarily involve further workforce redesign and efficiencies.

4. It will be necessary for GCHHS Executive to carefully consider which positions are removed, so that commissioning of Gold Coast University Hospital is not impacted. GCHHS is also currently considering options for expanded public private partnerships. It is therefore probable that the program of voluntary redundancies will be followed by some targeted programs of involuntary redundancies.

Background

5. On 27 November 2012, GCHHS received advice from the Director-General, Queensland Health, that its budget for 2012-2013 would be reduced by $9.2 million and that this change would be reflected in the November 2012 Service Agreement variation. This reduction related to the Commonwealth Government's review of population growth for Queensland.

Department RecFind No:	**BR055715**
Division/District:	**Gold Coast HHS**
File Ref No:	

6. The reduction of $9.2 million follows the earlier productivity dividend of $13.6 million which was removed from the Health Service early in the financial year. On a year to date basis, GCHHS is achieving budget integrity, due to the implementation of a comprehensive suite of labour and non-labour efficiencies. This has included job reduction via natural attrition, reduction in casual and temporary use, and a small number of voluntary separation package. A detailed change plan has been developed to support the implementation of this program. Support from the System manager will be required to facilitate the offers to approved employees and payment of packages.

7. Given the recent notification of the $9.2 million, and the remaining period on the financial year, GCHHS will need to quickly adopt significant additional measures to achieve 2012-2013 budget integrity. On 30 November 2012, the Board of the GCHHS approved the implementation of a program of Voluntary Redundancies, which will be followed by further consideration of organisational review and possible involuntary redundancies.

8. Given the timeframes, it is necessary for an announcement to be made to call for expressions of interest for voluntary redundancies on 3 December 2012. Verbal advice has been received form the Acting Chief Finance Officer that the fill cost of voluntary separation packages will be met by Queensland Treasury, and that there will be no recurrent impact on outer year budgets for the GCHHS. This advice is also confirmed that there is no upper limit on the number of Voluntary redundancy Packages that may be offered by a Health Service.

Attachments

9. Nil

Department RecFind No:	**BR055715**
Division/District:	**Gold Coast HHS**
File Ref No:	

Recommendation
That the Director-General:

Note actions proposed by the Gold Coast Hospital and Health Service Board and Executive regarding the reduced budget for 2012-2013.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

3 / 12 / 12

To Minister's Office For Noting ☑

Director-General's comments

Author
Naomi Dwyer

Chief Operations Officer

Gold Coast Hospital and Health Service

5519 7470

29 November 2012

Content verified by: (CEO/DDG/Div Head)
Ron Calvert

Chief Executive

Gold Coast Hospital and Health Service

5519 8305

30 November 2012

QCOS/010658 (4)

BR055904

Department RecFind No:	BR055904
Division/District:	Townsville HHS
File Ref No:	

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED
DATE 3 JAN 2013 BY

Requested by: Chief Executive Date requested: 21 December 2012 Action required by:

SUBJECT: Townsville Hospital and Health Service realignment

Recommendation
That the Minister:

Note the status of the full-time equivalent (FTE) reductions through realignment and the further up to 145 FTE reductions to be progressed in January 2013.

Note any advice provided by the Director-General to Townsville Hospital and Health Service (THHS) as a result of the first two proposals.

Note that to meet the Service Agreement targets of a balanced budget and FTE, the Board of the THHS announced in September 2012, that up to 200 FTE positions needed to be removed through a process of realignment. These 200 included occupied positions and vacancies.

Note that on 17 December 2012, the Board were provided with an update of the realignment process that identified 44 staff have accepted offers of voluntary redundancies and that a further 55 vacant positions have been abolished.

Note that the Board has approved a targeted program identifying up to 145 further occupied positions for removal in January 2013. This will allow the THHS to meet its Service Agreement targets, address the impact of the Commonwealth funding reduction of $7.8 million, and deliver changes for full year financial impact in 2013-2014.

Note that this means that 200 occupied positions will be disestablished.

APPROVED/NOT APPROVED **NOTED** **NOTED**

LAWRENCE SPRINGBORG
Minister for Health

/ /

RECORDS TEAM
RECEIVED - 5 APR 2013 OLD HEALTH

Chief of Staff
23 / 3 / 13

Minister's comments

Department RecFind No:	BR055904
Division/District:	Townsville HHS
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: Chief Executive Office **Date requested: 21 December 2012** **Action required by:**

SUBJECT: Townsville Hospital and Health Service Realignment

Proposal

That the Director-General:

Note the status of the full-time equivalent (FTE) reductions through realignment and up to 145 FTE further reductions to be progressed in January.

Provide this brief to the Minister for information.

Provide any advice felt necessary to Townsville Hospital and Health Service (THHS) as a result of the first two proposals.

Urgency

Critical: Affected staff and unions will be advised of the ongoing FTE reductions from 14 January 2013, in order to effect the change in a timely way which will deliver an improved financial position for 2013-2014 and minimum obligatory human resource information (MOHRI) targets.

Headline Issues

1. The top issues are:
   - To meet the Service Agreement targets of a balanced budget and FTE the Board of the THHS announced in September 2012 that up to 200 FTE positions needed to be removed through a process of realignment. These 200 included occupied positions and vacancies.
   - On 17 December 2012, the Board were provided with an update of the realignment process that identified 44 staff have accepted offers of voluntary redundancies and that a further 55 vacant positions have been abolished.
   - The Board has approved a targeted program identifying up to 145 further occupied positions for removal in January 2013. This will allow the THHS to meet its Service Agreement targets, address the impact of the Commonwealth funding reduction of $7.8 million, and deliver changes for full year financial impact in 2013-2014.
   - This means that 200 occupied positions will be disestablished.

Key issues

2. The THHS has concentrated on non-frontline positions in this realignment, and of the 145 positions identified for removal, 24% or 34.4 FTE are non-frontline, whereas non-frontline positions are only 16% of the total FTE of the Health Service.
3. The positions identified for removal include 29 administration and 15 operational roles. Frontline clinical staff are also included in the realignment program and include 62 nursing roles, 21 health practitioner/nursing and just under 10 medical positions. This is 76% of the 145 compared with 84% frontline positions in the organisation as a whole
4. The THHS Operating Position is currently $5.6 million favourable to budget and is currently favourable to the year to date (YTD) MOHRI target. This realignment program is necessary to allow the THHS to absorb the forecast growth in positions funded in the Service Agreement, position the Health Service to meet its anticipated funding in 2013-2014 and deliver appropriate establishment.

Department RecFind No:	BR055904
Division/District:	Townsville HHS
File Ref No:	

5. The THHS favourable in year financial position has been delivered in most part by holding a very high number of vacancies in year. The THHS also had a high number of long standing vacancies above this. The vacancy control process has been effective financially, but has also been largely opportunistic. To date it has been handled safely, but it is not sustainable as a management tool and if continued will impact on safety, performance and reputation. For these reasons the Board has decided to realign its establishment in a planned way.

Background

6. The number of FTE vacancies is five times higher than the 2011-2012 average at 250 by December 2012 compared to 50 in 2011-2012.
7. The THHS holds establishments within service areas that are historical, do not reflect workload and incorporate very long term vacancies which have never been filled and have not therefore attracted a run rate. The 55 vacancies abolished to date are in that category and do not therefore help with either MOHRI or financial targets. This is a significant contributor to the need to realign occupied positions not vacancies.
8. The 145 positions now identified have been worked up by the institutes themselves, quality assured and costed by a 'challenge and confirm' process run by the executive clinicians for nursing, allied health and medicine, the acting and substantive chief operating officer (COO), finance and people and culture. The Board is assured that these are both necessary and deliverable within the required safety, performance , financial and MOHRI standards.
9. Of the 145 posts up to 100 can be redeployed into funded occupied vacancies which are backfilled currently by temporary arrangements.
10. The realignment will enable the MOHRI growth planned for the Townsville Hospital redevelopment and further devolved Queensland Health services to be delivered inside the MOHRI target for June 2013.
11. It is planned that in order to deliver the timetabled separations and voluntary redundancy (VR) process, IR arrangements and reissue establishments and budgets for Q4 2012-2013, announcements are made on 14 January 2013. There will still be some separations into July 2013 with this date.
12. It should be noted that the Board intends to deliver its Queensland Health breakeven target (after savings including $23 million and $7.8 million new Commonwealth clawback). These measures are predominantly realignment with some productivity gains. For future efficiencies on current assumptions, the Board wishes to focus efforts on non pay costs and service redesign and minimise the need for further large realignments/VRs.
13. It should also be noted that the new Chief Executive and COO are undertaking a management review which may result in some senior changes and VRs during this year. The Board will consider these in January 2013.
14. **Attachments**
    Nil

Department RecFind No:	BR055904
Division/District:	Townsville HHS
File Ref No:	

Recommendation
That the Director-General:

Note the status of the full-time equivalent (FTE) reductions through realignment and the further up to 145 FTE reductions to be progressed in January 2013.

Provide this brief to the Minister for information.

Provide any advice felt necessary to Townsville Hospital and Health Service (THHS) as a result of the first two proposals.

APPROVED/NOT APPROVED NOTED

DR TONY O'CONNELL
Director-General

21 / 1 / 12

To Minister's Office For Noting ☑

Director-General's comments

DDG-SSS to rvw brief & provide any advice (as requested).

Author	Cleared by: (SD/Dir)
Kieran Keyes	Julia Squire
Chief Operating Officer>	Health Service Chief Executive
Townsville HHS	Townsville HHS
4433 0074	4433 0072
21 December 2012	21 December 2012

AQNF

11/1/13

Qcos/021180 (1)

BR055978

Department RecFind No:	BR055978
Division/District:	Central Queensland HHS
File Ref No:	

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED DATE 11 JAN 2013 BY

Requested by: Chief Executive, Central Queensland Hospital & Health System **Date requested:** 3 January 2012 **Action required by:** A/MES

RECORDS TEAM RECEIVED 30 JAN 2013 QLD HEALTH

SUBJECT: Moura Hospital closure

Recommendation

That the Minister:

Note the Central Queensland Hospital and Health Service (CQHHS) has postponed the release of the paper on *Future Directions of Health Services to Moura in Central Queensland* and new model of care from Wednesday, 9 January 2013 to Thursday, 17 January 2013.

Note that the new model of care will result in the closure of Moura Hospital with admissions to cease from 28 January 2013.

Note the intention to meet with Moura Hospital Staff and inform external stakeholders including (but not limited to) relevant unions, the Banana Shire Mayor, mining companies, Capricorn Helicopter Rescue Service and Aerial Ambulance, the Moura aged care facility, Bluecare and the Moura pharmacist on Thursday, 17 January 2013, to inform them of the proposal.

Note the intention to host a Moura community forum at the Kianga Memorial Hall on 17 January 2013, where the *Future Directions* paper will be presented and the community will be asked to form a committee and provide feedback to CQHHS at a meeting on Thursday, 24 January 2014.

Note the CQHHS had planned to announce the closure of Moura Hospital on 9 January 2013. The community became aware of a meeting with staff on this day and a Facebook campaign by Moura residents had more than 100 people attending the Moura Hospital to link arms and form a human chain to prevent entry to the meeting.

Note the The announcement was postponed to consider further community input and ensure the Future Directions Paper could be presented to the community for feedback. The staff, stakeholder and community meetings, including the release of the Future Directions Paper, are now scheduled for 17 January 2013.

APPROVED/NOT APPROVED **NOTED** **NOTED**

LAWRENCE SPRINGBORG
Minister for Health

/ /

Chief of Staff

30/1/13

Minister's comments

11 JAN 2013

Department RecFind No:	**BR055978**
Division/District:	**Central Queensland HHS**
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: Chief Executive, Central Queensland Hospital & Health System **Date requested: 3 January 2012** **Action required by: A/MES**

SUBJECT: Moura Hospital closure

Proposal

That the Director-General:

Note the Central Queensland Hospital and Health Service (CQHHS) has postponed the release of the paper on *Future Directions of Health Services to Moura in Central Queensland* and new model of care from Wednesday, 9 January 2013 to Thursday, 17 January 2013.

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Note the intention to host a Moura community forum at the Kianga Memorial Hall on 17 January 2013, where the *Future Directions* paper will be presented and the community will be asked to form a committee and provide feedback to CQHHS at a meeting on Thursday, 24 January 2014.

Urgency

1. **Critical**

Headline Issues

2. The top issues are:
   - CQHHS had planned to announce the closure of Moura Hospital on 9 January 2013. The community became aware of a meeting with staff on this day and a Facebook campaign by Moura residents had more than 100 people attending the Moura Hospital to link arms and form a human chain to prevent entry to the meeting.
   - The announcement was postponed to consider further community input and ensure the Future Directions Paper could be presented to the community for feedback. The staff, stakeholder and community meetings, including the release of the Future Directions Paper, are now scheduled for 17 January 2013.

Key Values

3. The key values that apply are the following:

☐ Better service for patients
☐ Better healthcare in the community
☒ Valuing our employees and empowering frontline staff
☒ Empowering local communities with a greater say over their hospital and local health services
☒ Value for money for taxpayers
☒ Openness

Key issues

4. Moura Hospital is in the electorate of Callide represented by the Deputy Premier the Honourable Jeff Seeney MP.
5. Under the model of care outlined in the Future Directions Paper, the Moura Hospital building will close but services currently offered from that structure will continue to be offered from the collocated Medical Clinic (to be redesignated as a primary care centre).

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File Ref No:	

6. There will no longer be a 24 hour Emergency Department in Moura, but a casualty response service will be implemented (details below). The Moura community will have access to quality health care from the Moura Medical Centre, purpose built in 2008 and opened in 2009 on the Moura Hospital precinct.
7. Moura Hospital staff, 18.64 full time equivalent (FTE), will be offered Voluntary Redundancies or placed in current vacancies with appropriate skill requirements.
8. A casualty response service will be developed in Moura which will encompass limited after hours casualty care provided by a Nurse Practitioner or Rural and Isolated Practice Registered Nurse (RIPRN) in conjunction with other Emergency Services and located within the current modern Moura Medical Centre.
9. As is currently the case, higher level emergency presentations (Category 1, 2 and 3) will be triaged and transferred to an appropriate hospital for further investigations and/or admissions for example Biloela, Rockhampton or a metropolitan hospital.
10. Community based programs will operate during normal business hours and will focus on chronic disease management with some diagnostic services located within the Medical Centre. Ambulatory/Outpatient type services will cease in the hospital and will be directed to the Medical Centre.
11. There are no planned changes to the model of practice of GPs at the Moura Medical Centre.
12. Occupancy at Moura Hospital has been steadily declining. It is not viable to continue to operate Moura Hospital in its current model of care:
    - Moura Hospital's budget for 2012-2013 is $3.04 million, or an equivalent to $8,000 per day;
    - In 2011-2012 the facility had an average of 75 patients a month – or just over two a day – attend the Emergency Department; and
    - In the same period there was an average of less than one inpatient a night in the hospital. There were 336 inpatients for the 2011-2012 financial year.

Background

13. Declining patient numbers means it is no longer viable to operate inpatient services at Moura Hospital with the purpose-built Moura Medical Centre meeting the majority of the town's daily needs.
14. The CQHHS Board has made the decision to close inpatient services at Moura Hospital and transfer other ambulatory services to the Moura Medical Centre, which will be designated as the Moura Primary Care Centre.
15. The decision is based on the demographics of the Moura community and their usage of health services. The community has access to comprehensive GP services and as a result the use of emergency, ambulatory and inpatient services has declined to a point where inpatient services at the Hospital are no longer financially viable.
16. 24 hour health care in Moura will be maintained through the Moura Primary Care Centre. It will include 24/7 emergency response together with a rapid evacuation service in conjunction with Queensland Ambulance Service to Biloela, Rockhampton or a metropolitan hospital.
17. The Board deeply regrets the impact on our staff and the concern in our community and are doing everything possible to manage the impacts of the decision.
18. The Primary Care Centre will have two GPs and four nurses, including two Rural and Isolated Practice Registered Nurses (RIPRN).
19. The RIPRN will work in the Centre, from the daily closure of GP services until midnight, to respond to emergency presentations by community members. The RIPERN will provide an on-call service from midnight until GP opening hours and contribute to a round-the-clock casualty response service developed in conjunction with the GP practice and Queensland Ambulance Service.
20. The RIPRN will triage and observe a patient in a 'holding' bed while determining if admission to another facility is necessary. The RIPRN will be assisted in the observation process through tele- or video-linkages to the Emergency Department at Rockhampton Hospital. The observation capacity will not extend beyond midnight so the patient will be either discharged home or transferred out by that time.
21. New x-ray services and facilities will be provided in the Centre. The Centre already has the capacity to undertake minor procedures.

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Division/District:	Central Queensland HHS
File Ref No:	

22. Outreach allied health, mental health and social work/counselling services will continue to be provided from Biloela Health Service. Telehealth facilities will be expanded with the aim of improving the range of allied health and specialist medical services provided to the community. CQHHS will work closely with the Primary Care Centre, CQ Medicare Local and the Rural Division of General Practice to achieve the service enhancements.
23. A community, in-home palliative care service will be developed with Bluecare through a specific funding arrangement. There will be no inpatient capacity in Moura.
24. Meals on Wheels services will continue to be provided by Bluecare, which will find an alternative source to prepare the meals.
25. Patients requiring respite care will be admitted to Biloela Hospital or to Theodore or Baralaba Multi-purpose Health Services. There will no longer be respite care provided in Moura.
26. In the event of a disaster, the existing CQHHS Disaster Management Planning Response, which has been developed in conjunction with QAS, other Government and non-government agencies and local industry groups, will be implemented.
27. As is currently the case in the event of a major emergency, patients would be airlifted to appropriate facilities such as Rockhampton Hospital or a metropolitan hospital.
28. All mine sites have their own emergency evacuation and disaster management plans, which would involve CQHHS, QAS and the Primary Care Centre in responding to critical events.
29. Services will transition from the hospital to the Moura Primary Care Centre by February, 2013 (Date TBC).
30. The CQHHS is doing everything possible to reduce the impact on staff and the community:
    - Staffing will be reduced from the present 19 FTE positions (positions currently filled by 34 people given many work on a part-time basis) to nine full-time roles at the Primary Health Centre;
    - There will be no loss of doctors in the community;
    - The numbers of nurses will change from 10.1 FTE to 4.4 FTE, with a significant focus on the RIPRN function;
    - Up to 18 people may be impacted by the change including nurses, administration officers and operational services staff;
    - Meetings will be held with staff individually and, for those wishing to remain with CQHHS, appropriate vacancies will be identified in local facilities in Biloela, Theodore and Baralaba;
    - If suitable positions are not available staff will be offered voluntary redundancies;
    - Free counselling will be offered via the confidential Employee Assistance Service; and
    - All staff directly or indirectly impacted will be encouraged to speak to the Human Resources (HR) team via phone, email or during Moura visits.
31. CQHHS will work with the community as it comes to terms with this change and will involve the community in every possible manner during the transition of services.
32. Regular information updates will be provided.
33. There will be opportunities for staff and the community to meet with CQHHS staff in the weeks to come.

Consultation

34. Initial consultation has been held with the Mayor, Deputy Mayor, representatives of the Moura Health Action Group, Queensland Ambulance Service and other community members.
35. There will be further consultation on Thursday, 17 January 2013, with mining and gas companies, MP Ken O'Dowd, the local Pharmacist, Unions, Capricorn Helicopter Rescue Service, RFDS, Chamber of Commerce, Queensland Rural Doctors Association and representatives of the (non-Government) Moura aged care facility.

Financial implications

36. Recurrent operational savings of between $1.5 million and $2 million would be realised through the model changes. These would be in base and ancillary staff levels that would no longer be required in addition to routine consumable and maintenance costs.
37. Once off maintenance and capital improvement costs would be saved. Routine maintenance costs (approximately $80,000 spent in 2011-2012 year) would be saved.

Attachments

38. Nil

Department RecFind No:	**BR055978**
Division/District:	**Central Queensland HHS**
File Ref No:	

Recommendation
That the Director-General:

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APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

11 / 1 / 13

To Minister's Office For Noting ☑

Director-General's comments

- Dept of Health media team to work with HHS on comms
- Telehealth alternatives/expansion to be maximally explored (para 20 noted)

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Michael Rutherford		Maree Geraghty
A/Manager Executive Services CQHHS		Chief Executive CQHHS
4920 5778 Updated 9 January 2013		4920 6331 9 January 2012

AM

BR056092

1/2/13

Department RecFind No:	BR056092
Division/HHS:	Cairns & Hinterland HHS
File Ref No:	

RECEIVED
DATE 1 FEB BY 2013

Briefing Note for Approval

The Honourable Lawrence Springborg MP
Minister for Health

Requested by: Chief Executive, Cairns & Hinterland Hospital & Health Service **Date requested:** **Action required by:**

SUBJECT: Cairns and Hinterland Hospital and Health Service Financial Realignment Plan

Recommendation
That the Minister:

Approve the Cairns and Hinterland Hospital and Health Service Financial Realignment Plan, Ernst & Young, 30 January 2013.

Note that to balance the revised MOHRI actual FTE target, the Cairns and Hinterland Hospital and Health Service must have a reduction of 50 positions.

Note that to balance the year end average MOHRI FTE target the Cairns and Hinterland Hospital and Health Service must have a reduction of 230 positions.

Note that to balance the Cairns and Hinterland Hospital and Health Services financial position, as a result of the $6.5 million reduction in Commonwealth funding, innovative changes and difficult decisions are necessary.

Note that the Cairns and Hinterland Hospital and Health Service are currently are projecting a $9.5 million deficit which the Financial Realignment Plan will enable the Hospital and Health Service to deliver a balanced financial position at June 2013.

APPROVED/NOT APPROVED **NOTED** **NOTED**

RECORDS TEAM
RECEIVED 7 MAR 2013 QLD HEALTH

LAWRENCE SPRINGBORG
Minister for Health

Chief of Staff

Minister's comments

NFA

4/3/13

31 JAN 2013

URGENT

Department RecFind No:	BR056092
Division/HHS:	Cairns & Hinterland HHS
File Ref No:	

Briefing Note for Approval

Director-General

Requested by: Chief Executive, Cairns & Hinterland Hospital & Health Service **Date requested:** **Action required by:**

SUBJECT: Cairns and Hinterland Hospital and Health Service Financial Realignment Plan

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Proposal

That the Director-General:

Provide this brief to the Minister for approval of the Cairns and Hinterland Hospital and Health Service Financial Realignment Plan, Ernst & Young, 30 January 2013.

Urgency

1. **Urgent** - In correspondence dated 18 January 2013, from the Minister for Health addressed to the Board Chair, it stipulates that advice should be provided to the Minister by 1 February 2013 in regards to specific cuts to programs, reductions in services and/or other strategies that are currently being considered to cater for the reduction in funding from the Commonwealth.

Headline Issues

2. The top issues are:
   - To balance the revised MOHRI actual FTE target, the Cairns and Hinterland Hospital and Health Service must have a reduction of 50 positions
   - To balance the year end average MOHRI FTE target the Cairns and Hinterland Hospital and Health Service must have a reduction of 230 positions.
   - To balance the Cairns and Hinterland Hospital and Health Services financial position, as a result of the $6.5 million reduction in Commonwealth funding, innovative changes and difficult decisions are necessary.
   - We currently are projecting a $9.5 million deficit which the Financial Realignment Plan will enable the Hospital and Health Service to deliver a balanced financial position at June 2013.

Key Values

3. The key values that apply are the following:

☒ Better service for patients
☒ Better healthcare in the community
☒ Valuing our employees and empowering frontline staff
☒ Empowering local communities with a greater say over their hospital and local health services
☒ Value for money for taxpayers
☒ Openness

Key issues

4. The Cairns and Hinterland Hospital and Health Service (CHHHS) is committed to a balanced 2012-2013 Financial Year.
5. On 30 January 2013, the Board approved:
   - The new Integrated Organisation Structure and Executive Management Team structure;
   - The list of opportunities deliverable in Financial Year 2013 as described and detailed in the Ernst & Young, Financial Realignment Plan (Cairns and Hinterland Hospital and Health Service) and any and all actions associated with achieving these opportunities;
   - That vacant positions as determined by the Executive Management Team be disestablished;
   - The removal of 44 Temporary FTE;
   - The reduction of 190 permanent FTE;
   - An expression of interest for a Voluntary Separation Program. Delegated authority to the Chief Executive of CHHHS to assess and action;

- In principle, the list of opportunities deliverable in Financial Year 2014 as described and detailed in the Ernst & Young, Financial Realignment Plan (Cairns and Hinterland Hospital and Health Service) and any and all actions associated with achieving these opportunities;
- That any amendments or inclusions to the Financial Year 2014 opportunities be presented to the Board for approval.

6. There are no facility closures as a result of the strategies or restructure and an impact assessment of front-line services is being conducted.
7. Staff of the CHHHS will be informed of the restructure on 11 February 2013. Simultaneously, a communication will be prepared for the Media. A communication strategy, including consultation with the Union is currently being progressed.
8. It is imperative that the initial implementation of the Plan commence by at least 14 February 2013 to ensure that the cost benefits of FTE reductions and financial strategies are realised in the current financial year.

Background

9. The CHHHS has adopted a robust and balanced approach to responding to the challenges that we are now facing. The CHHHS is seeking to generate a range of opportunities across the short, medium and longer term to ensure the CHHHS is exhausting every available opportunity.
10. The CHHHS has extensively engaged the organisation primarily through the 'Redesigning from the Inside Out' Program. Thirty-two Change Leaders from the Service were drawn from current staff on the ground in September 2012 (for a period of four weeks) to work on improving efficiencies, reducing costs and improving patient services across the whole of the CHHHS. This work has continued to date with a number of change leaders progressing the initial recommendations.
11. Pursuant to a resolution made by the Board on 18 December 2012, the CHHHS engaged Ernst & Young to support the HHS in the development of an integrated financial realignment plan. Ernst & Young were engaged to complete a rapid diagnostic of the operations of the CHHHS; 'Reviewing from the Outside In.' One of the elements of this approach is incorporating a detailed Rostering Assessment utilising the Allocate software (EY Alliance Partner).
12. Since December 2012, the Executive Management Team has been conducting a review of the organisation's structure to ensure that it functions effectively and efficiently as an autonomous HHS; 'Review from top down'.
13. The Executive Management Team also tasked the Service Directors of the CHHHS to perform a 'Review from the bottom up,' of the Service to determine opportunities for redesigning our services.
14. As previously advised, Ernst & Young were tasked to validate all identified initiatives (including alignment of positions to FTE targets) prior to the Plan being provided to the Board on 30 January 2013.
15. The Financial Realignment Plan incorporates the strategies from the Redesigning from the Inside Out Project, Executive Management Team 'Review from top down,' the Service Director 'Review from the bottom up,' and initiatives from Ernst and Young 'Review from the Outside in.

Consultation

16. Cairns and Hinterland Hospital and Health Board
17. Cairns and Hinterland Hospital and Health Service Executive Management Team
18. Service Directors of Cairns and Hinterland Hospital and Health Service
19. Ernst & Young

Financial implications

20. Potential cost savings of $9.45 million in the 2013 Financial Year.
21. Potential cost savings of $20 million+ in the 2014 Financial Year and beyond.

Department RecFind No:	**BR056092**
Division/HHS:	**Cairns & Hinterland HHS**
File Ref No:	

Legal implications

22. *Industrial Relations Act 1999* – Please note that appropriate Placement Process for Staff will be managed by our Human Resource Team.

Attachments

23. Attachment 1: The Cairns and Hinterland Hospital and Health Service Financial Realignment Plan, Ernst & Young, 30 January 2013.

Department RecFind No:	**BR056092**
Division/HHS:	**Cairns & Hinterland HHS**
File Ref No:	

Recommendation
That the Director-General:

Provide this brief to the Minister for approval of the Cairns and Hinterland Hospital and Health Service Financial Realignment Plan, Ernst & Young, 30 January 2013.

APPROVED/NOT APPROVED **NOTED**

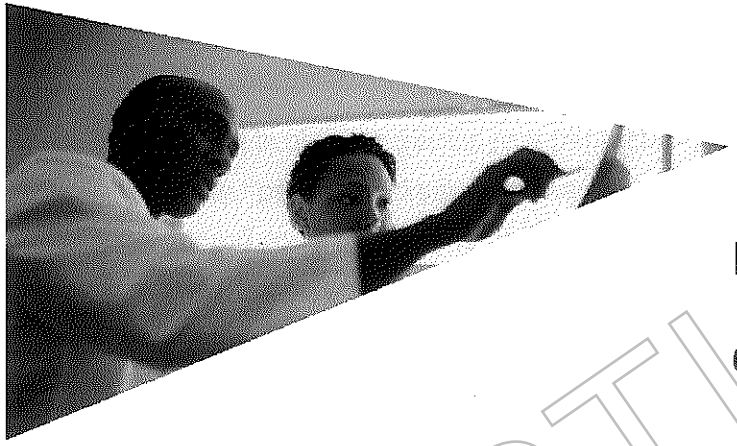
DR TONY O'CONNELL
Director-General
1 / 2 / 13

To Minister's Office for Approval ☐
for Noting ☑

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Jodie-Lee Johnson	Julie Hartley-Jones	Robert Norman
Board Secretary	Chief Executive	Chair
CHHHS	CHHHS	CHHHB
4226 5204 30.01.2013	4226 5205	

EY WORKING PAPER
CHHHS BOARD IN CONFIDENCE
NOT FOR CIRCULATION



Financial realignment plan

Cairns & Hinterland Hospital and Health Service

SUMMARY

30th January 2013

ERNST & YOUNG
Quality In Everything We Do

CHHHS context and size of the challenge

- Significant reform and financial pressure across the Queensland health system
- Establishment of HHS - HHS Readiness assessment and ongoing transition and development (governance mechanisms etc)
- Devolution agenda and new relationships with the system manager
- HHS continuing to experience growth - activity, expenditure, FTE and OSR

Size of the challenge

The figures reported the to the system manager on the 16 January 2013 outline the size of the challenge for the HHS:

1. Balancing to MOHRI actual FTE - target 50 positions
2. However, balancing year end average MOHRI target - 230 positions
3. Reducing projected deficit to a balanced position - $9.5m.

Objectives of this work

1. To deliver a balanced budget in FY13 ie, opportunities that will increase revenue or reduce expenditure in the next 5 months
2. To achieve both the average and actual Minimal Obligatory Human Resource Indicators (MOHRI) ie, reduce FTE across the HHS in the next 5 months.
3. To identify a pipeline aimed at delivering a more longer term, financially sustainable position for the HHS in FY14 and beyond.

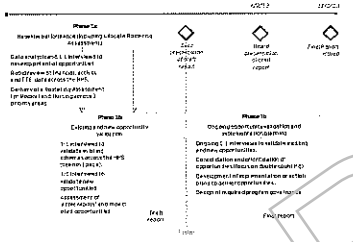
Responding to the challenge – an integrated approach

Redesigning from the Inside out (RIO) program

Short-term financial and FTE realignment analysis

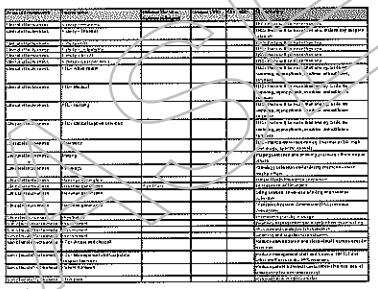
Organisational redesign work

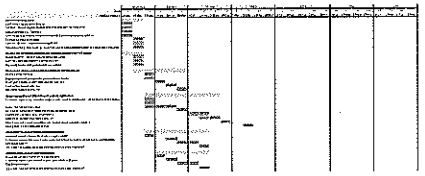
Ernst & Young Diagnostic (inc Rostering Assessment), Implementation Planning and Program design



Delivers:

1. Single consolidated log of opportunities across clinical, non-clinical and service effectiveness areas(see framework overleaf)
2. Single program governance structure for implementation
3. Single set of implementation/action s plans





Implementation

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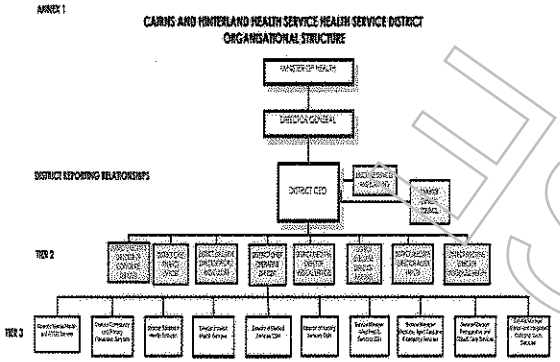
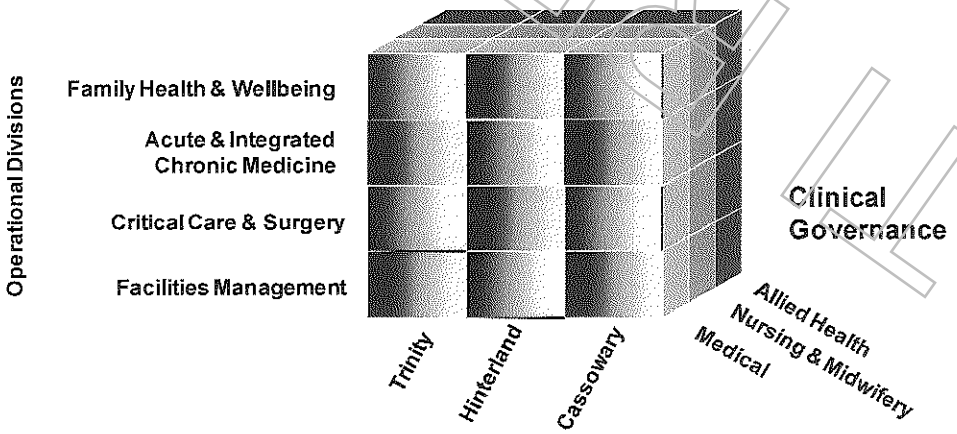
Organisational restructure – a key lever



Built from the following clinical and operational principles (not exhaustive):

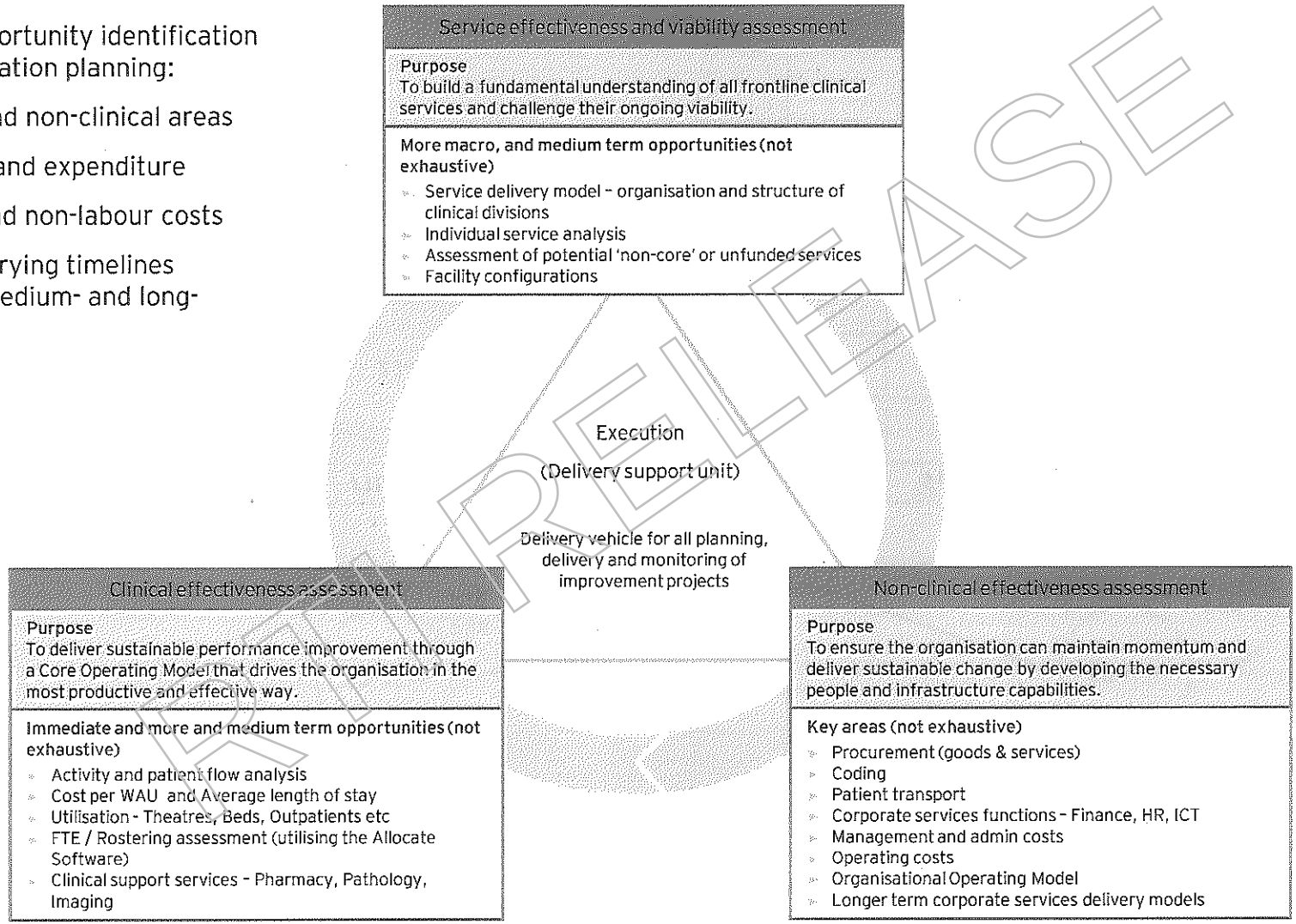
- Focus on patient journey and frontline services
- Establish common clinical standards across the HHS
- Ensure professional leadership based on "three-legged stool" model
- Encourage multidisciplinary functioning
- Support timely discharge and prevention of admissions
- Increase focus on chronic disease
- Reduce administration
- Provide clear accountability and single point responsibility for KPIs across whole HHS
- Streamline performance reporting
- Devolve and speed up decision making.



Ernst & Young framework for developing opportunities

Balance to opportunity identification and implementation planning:

- Clinical and non-clinical areas
- Revenue and expenditure
- Labour and non-labour costs
- Across varying timelines (short-, medium- and long-term).



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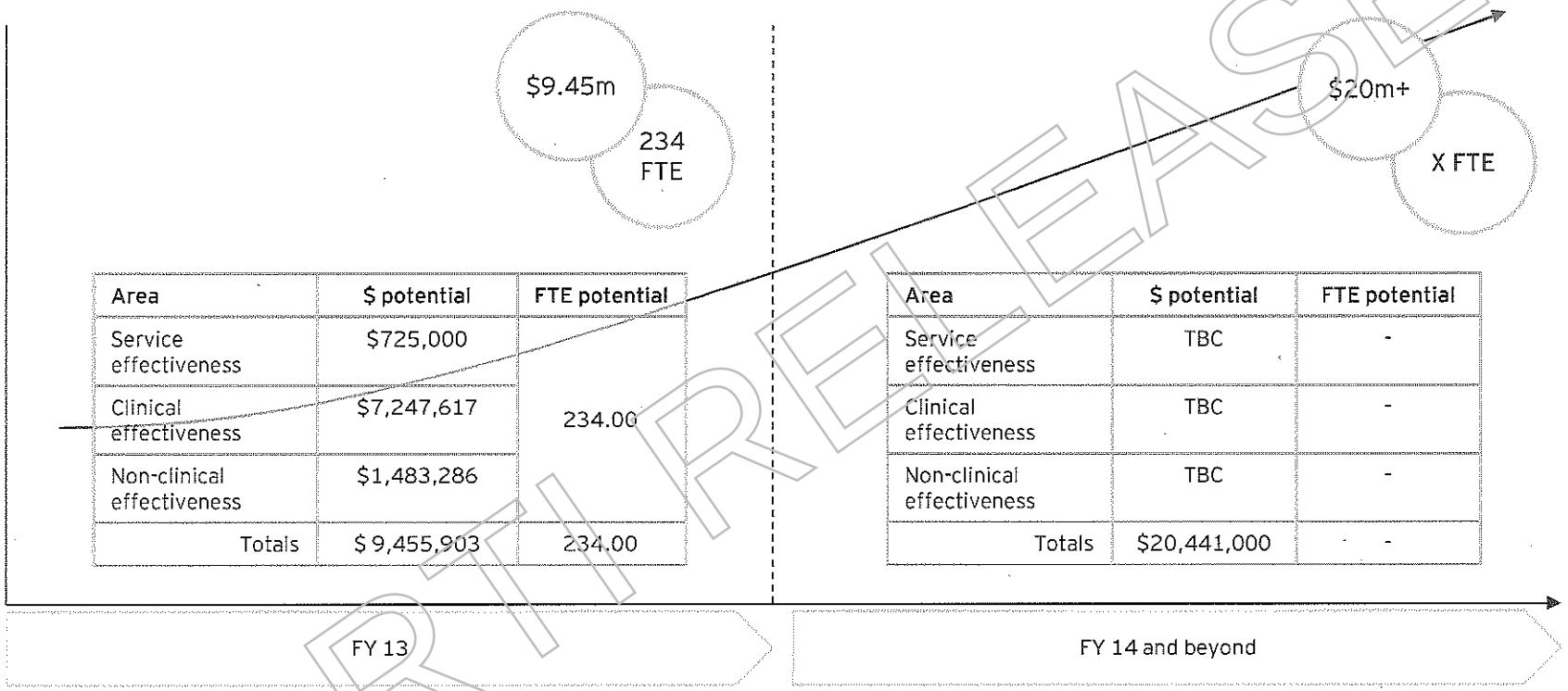
Overview

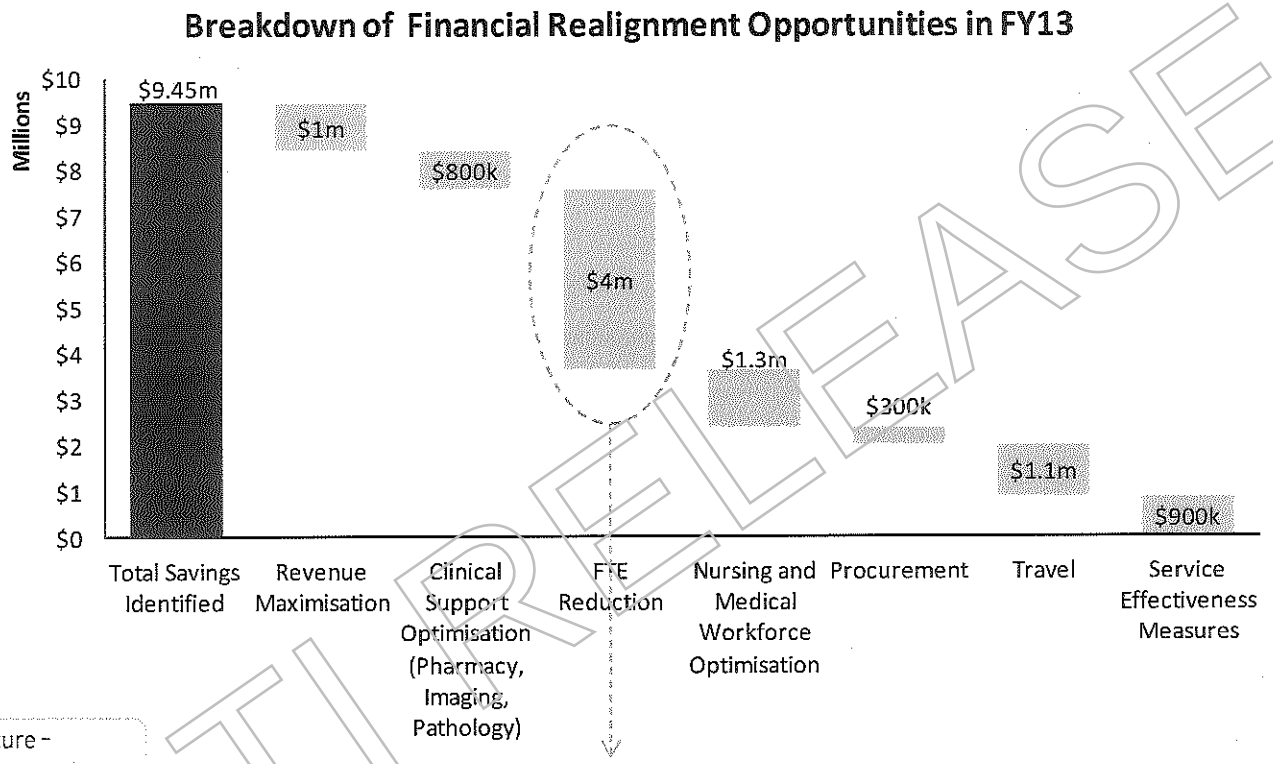


Area	$ potential	FTE potential
Service effectiveness	$725,000	234.00
Clinical effectiveness	$7,247,617	
Non-clinical effectiveness	$1,483,286	
Totals	$ 9,455,903	234.00

Area	$ potential	FTE potential
Service effectiveness	TBC	-
Clinical effectiveness	TBC	-
Non-clinical effectiveness	TBC	-
Totals	$20,441,000	-

Overview of areas of FY13 opportunities

Figures have been rounded



Including org restructure -
17.8 Mgt FTE (1.2 Exec level FTE

	Admin	Medical	Nursing	Operat's	Trades	VMO's	Prof	Health Pract's	Tech	TOTAL
Total FTE (Current)	611	393	1,668	689	22	6	28	413	1	3,832
Proposed Staffing reductions	-116	0	-33	-16	0	0	0	-25		-190
% of Stream staff affected	-18.99%	0.00%	-1.98%	-2.32%	0.00%	0.00%	0.00%	-6.05%	0.00%	-4.96%
Proposed Temp Reductions	-20	-4	-11	-2				-7		-44
Total Reductions	-136	-4	-44	-18	0	0	0	-32	0	-234
Grand Total of % of Stream staff affected	-22.27%	-1.02%	-2.64%	-2.61%	0.00%	0.00%	0.00%	-7.74%	0.00%	-6.11%

List of opportunities deliverable in FY13

Area of framework	Specific focus	ID	Opportunity	$ potential	FTE	Implementation complexity
Clinical effectiveness	Revenue generation	EY001	Optimisation of Private Health Insurance conversion rates	650,000	-	Medium
Clinical effectiveness	Revenue generation	EY002	Optimisation of ROPP Option A billing processes	350,000	-	Medium
Clinical effectiveness	Revenue generation	EY003	Optimisation of Aged Care Funding Instrument revenue	55,000	-	High
Clinical effectiveness	Pharmacy	EY004	Pharmacy cost control measures including controls of high costs tests and controls around waste avoidance for high-cost infusions	353,000	-	Medium
Clinical effectiveness	Pharmacy	EY005	Ordering from the PBS	47,000	-	Low
Clinical effectiveness	Pharmacy	EY006	Pharmacy cost control measures including implementing ward pharmacist in surgical and W&C, demand management, accessing cheaper alternatives and increasing mechanisation of pharmacy.	211,000	-	High
Clinical effectiveness	Imaging	EY007	Maximise Imaging utilisation and revise ordering practices	50,000	-	Medium
Clinical effectiveness	Imaging	EY008	Move to 7 days per week roster for Imaging	50,000	-	Medium
Clinical effectiveness	Pathology	EY009	Maximise Pathology utilisation and ordering practices	100,000	-	Medium
Clinical effectiveness	FTE - All	EY010	Reduction in temporary positions	749,713	44	Medium
Clinical effectiveness	FTE - All	EY011	FTE reductions	1,905,900	190	High
Clinical effectiveness	FTE - All clinical	EY012	Freeze in clinical educators positions	643,077	-	High
Clinical effectiveness	FTE - Medical	EY013	Medical workforce optimisation	187,274	-	High
Clinical effectiveness	FTE - Medical	EY014	Medical workforce optimisation (annual leave and use of Locums)	300,000	-	Medium
Clinical effectiveness	FTE - Nursing	EY015	Regain 2 hour hours each day removing shift overlap	134,138	-	Medium

List of opportunities deliverable in FY13 continued

Area of framework	Specific focus	ID	Opportunity	$ potential	FTE	Implementation complexity
Clinical effectiveness	FTE - Nursing	EY016	Reduce Casual Usage	764,712	-	Medium
Clinical effectiveness	FTE - Nursing	EY017	Improve rostering practices	168,384	-	Medium
				-		High
Clinical effectiveness	Activity - Inpatients	EY019	Close Flex Beds (Coral Sea)	125,000	-	Medium
Clinical effectiveness	Activity - Inpatients	EY020	Ward closures	400,000	-	Medium
Non-clinical effectiveness	Procurement	EY021	Limit availability of lymphodeama service garments	12,500	-	High
Non-clinical effectiveness	Procurement	EY022	Reduce orthopaedic consumables	143,500	-	Low
Non clinical effectiveness	Patient transport	EY023	Record, capture and report PTSS claims	547,286	-	Low
Non clinical effectiveness	Patient transport	EY024	Reduce patient transport costs	420,000	-	High
Non clinical effectiveness	Staff catering	EY025	Cease staff catering	50,000	-	Low
Non clinical effectiveness	Fleet rationalisation	EY026	Reduce vehicle leasing costs	150,000	-	Low
Non clinical effectiveness	Staff travel	EY027	Staff Travel - No fly months March and June	160,000	-	High
Service effectiveness	MH Team Leader Review	EY028	Restructuring the Team Leader roles to reduce by 4 FTE at HP5	125,000	-	Medium
Service effectiveness	Maternity services	EY029	Review staffing levels, birthing roster and maternity new: review ratios levels in out-patients	250,000	-	Medium
Service effectiveness	Nursing support	EY030	Enforce nursing support unit controls	200,000	-	High
Service effectiveness	Plastic Service	EY031	Review service model for plastic service	-	-	High
Service effectiveness	Oral health redesign	EY032	Oral Health Review complete by 31 Jan	150,000	-	Medium
Totals				$9,455,903	234.00	

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Further details on opportunities deliverable in FY13

ID	Opportunity	Detail	Assumptions	$m	FTE	Complexity	Timeline*	Page**
EY001	Optimisation of Private Health Insurance conversion rates	Current PHI Conversion Budget is approx. $17m for FY13. Opportunity represents an increase of PHI conversions by 5% (from currently level of 66%)	Opportunity represents a 10% increase in PHI conversions based on FY13 budget ($17m).	650,000	-	Medium	Feb-13	55
EY002	Optimisation of ROPP Option A billing processes	ROPP Option A is an scheme that provides clinicians with a fixed percentage of their salary in 'bonuses' in return for the revenue generated from PHI patients. An opportunity exists to optimise ROPP Option A billing as there is revenue leakage due to private patients being seen by 'non-provider number' consultants and potential for additional revenue from coding optimisation of PHI episodes.	Opportunity represents the difference between FY13 projected and FY13 budget targets.	350,000	-	Medium	Mar-13	56
EY003	Optimisation of Aged Care Funding Instrument revenue	Babinda is currently receiving $800,000 from the commonwealth as part of ACFI funding. This equates to $125 per patient bed day, which is below state and national benchmarks of $160 per patient bed day	Opportunity represents the difference between Babinda's ACFI revenue to state and national benchmarks, multiplied by current activity levels	55,000	-	High	Apr-13	57
EY004	Pharmacy cost control measures including controls of high costs tests and controls around waste avoidance for high-cost infusions	This includes reducing the volume of discharge medications and controls on high cost drug prescription.	Bring 89 DRGs currently above the national average within 80% of the national average Pharmacy cost per case by reducing outliers and implementing controls on high-cost tests.	353,000	-	Medium	May-13	65
EY005	Ordering from the PBS	Reduce usage of drugs that do not appear on the PBS (therefore not funded) by 20%	FY2012 spend for non-PBS medications was $940,000 - reduce this by 20% annually.	47,000	-	Low	Apr-13	65

*Timeline to realising the opportunity.

** Page reference for further analysis where applicable and in full report.

Further details on opportunities deliverable in FY13

ID	Opportunity	Detail	Assumptions	$m	FTE	Complexity	Timeline*	Page**
EY006	Pharmacy cost control measures including implementing ward pharmacist in surgical and W&C, demand management, accessing cheaper alternatives and increasing mechanisation of pharmacy.	Replicating the successful ED ward pharmacist model in surgical and W&C, reducing the volume of discharge medications, eliminating unpaid inpatient prescriptions, accelerating the shift to generic drug usage, extending 'Antimicrobial stewardship' program to other overprescribed drugs and capitalising on the Off patent top 10 Blockbuster drug. In emergency department the ward pharmacist has been able to reduce inappropriate and incorrect drug ordering by $47k per month	This figures assumes a saving of $40k per month minus $120k for salary	47,000	-	High	May-13	65
EY007	Maximise Imaging utilisation and revise ordering practices	Placing approval controls over ordering high cost tests and reduction in order duplication/unnecessary orders.	Bring 178 DRGs currently above the national average within 50% of the national average Pharmacy cost per case.	211,000	-	Medium	May-13	63
EY008	Move to 7 days per week roster for Imaging	Controls over out of hours ordering	FY2012 spend for after-hours/weekend coverage of $415k; reduce this expense by $50,000 by FY13 year end via 7 day/week roster.	50,000	-	Medium	May-13	63
EY009	Maximise Pathology utilisation and ordering practices	Controls on high cost tests and implementation of standardised order sets for focus DRGs.	Bring 162 DRGs currently above national average within 80% of the national average Pathology cost per case.	50,000	-	Medium	Apr-13	64
EY010	Reduction in temporary positions	Temp Positions - Phase 1 - Finalised Friday 22 Jan for EY Needs to align with Linda Bailey work		749,713	44.41	Medium	May-13	N/A

*Timeline to realising the opportunity.

** Page reference for further analysis where applicable and in full report.

Further details on opportunities deliverable in FY13

ID	Opportunity	Detail	Assumptions	$m	FTE	Complexity	Timeline*	Page**
EY011	FTE reductions	FTE Savings - Phase 2 See tab - FY13 CHHHS FTE (needs to align)		1,905,900	190.59	High	May-13	N/A
EY012	Freeze in clinical educators positions	Educators (Nursing, Allied Health and Drs to return to Clinical Positions for remainder of financial year: limit or eliminate training for remainder of financial year.		643,077	-	High	Mar-13	N/A
EY013	Medical workforce optimisation	Includes specific schemes around Reduce FTE in ED through automating the rostering process, Improve Management of contracted hours for VMOs, Reduction in training for Junior doctors, Reduction in training for Registrars, Reduce Medical Administration FTE in relation to rostering, Reduce SMO FTE, and Improve Productivity Orthopaedics Consultants	Range of assumptions relating to each scheme as derived by Allocate.	187,274	-	High	TBC	Allocate
EY014	Medical workforce optimisation	Delaying Medical Annual leave for those clinicians whose positions are to be backfilled by locums would reduce locum spend from 490k per month to 415k per month	Medical leave would not o be backfilled by locums in FY13 for the final quarter	300,000	-	Medium	Mar-13	N/A
EY015	Regain 2 hour hours each day removing shift overlap	Additional two hour training and break time per day 7 days per week	Based on 21 employees on an early shift at $35.00 per hour, 365 days per year	134,138	-	Medium	TBC	Allocate
EY016	Reduce Casual Usage	Casual usage is rostered above demand	Based on the 3 units analysed in the RA and multiplied across the nursing workforce at a rate of $43 per hour	764,712	-	Medium	TBC	Allocate
EY017	Improve rostering practices	Improve rostering practices and reduce FTE in ED through automating the rostering process	Improve the management of leave, skill mix (eg EN: RN ratios to 70:30 guidelines) and additional duties. Additional scheme includes a CN that is dedicated to rostering 3 days per month	171,804	-	Medium	TBC	Allocate
E								

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Further details on opportunities deliverable in FY13

ID	Opportunity	Detail	Assumptions	$m	FTE	Complexity	Timeline*	Page**
EY019	Close Flex Beds (Coral Sea)	Short stay unit closure		125,000	-	High	May-13	N/A
EY020	Ward closures	Painting / Maintenance (Annual cost Gen Bed $423k pa using March 2011 Statewide Bed Estimates for a 14 medical bed o/n template)	Cost of Medical Bed Annually is $423,990; 14 bed ward closed for 30 days and paint cost of $20,000 is savings of $467k	400,000	-	High	Mar-13	N/A
EY021	Limit availability of lymphodeama service garments	Cease the supply of high-cost lymphodaema garments to outpatients	Indicative FY13 reduction based on $50 estimated annual spend	12,500	-	High	Apr-13	N/A
EY022	Reduce orthopaedic consumables (prosthetics)	Rationalise supplies and products for prosthetics and establish clinician incentive program	Total annual spend for prosthetics is $8.2m. The opportunity represents a 7% annual saving (benchmark from our experience). Potential size equates to savings that could be made within 1 qtr	143,500	-	Medium	Jun-13	N/A
EY023	Record, capture and report PTSS claims	Dedicate resource(s) to record, capture and report PTSS claims and data to QH System Manager in order to receive the additional $547,286 in PTSS funding	The $547,286 is based on the 25% PTSS funding vested by the system manager pending adequate PTSS data is received	547,286	-	Medium	Jun-13	89
EY024	Reduce patient transport costs	Elevate all approvals to Service Directors - including patient escorts above policy Focus on inter-HHS site and use of emergency for non-emergency Reduce patient transport costs to PTSS levels with target for a zero net cost service	Current spending on patient travel is 12% above the PTSS funded level. This represents the annual target for cost reduction based on patient travel.	420,000	-	Medium	Jun-13	89
EY025	Cease staff catering			50,000	-	Medium	Apr-13	N/A
EY026	Reduce vehicle leasing costs	Cessation of three vehicle operating leases and running costs	Leasing and other operating costs per vehicle estimated to be $50k for 5 months	150,000	-	High	Apr-13	N/A

Further details on opportunities deliverable in FY13

ID	Opportunity	Detail	Assumptions	$m	FTE	Complexity	Timeline*	Page**
EY027	Staff Travel - No fly months March and June	Opportunity exists to reduce patient travel. Based on a $380,000 per month indicative staff travel (domestic flight spend only, excluding accommodation + incidentals) for 2 'no flight months".	The savings figure is based on x2 the average monthly spend on domestic flights in FY13 of $380,000	160,000	-	High	Mar-13	N/A
EY028	Restructuring the Team Leader roles to reduce by 4 FTE at HP5	Reduce number of Team Leader roles in mental health from 8 to 4 by merging like teams such as Children's and Youth and Evolve, First response team and Case Management teams, Acute unit and Acute care teams	Four HP4 FTEs reduced by final quarter	125,000	-	Medium	May-12	N/A
EY029	Review staffing levels, birthing roster and maternity new: review ratios levels in out-patients	Review BPF and patient acuity to ensure staffing numbers and EN:RN ratios are appropriate in inpatient and outpatient staffing levels in maternity	This figures assumes a 25% reduction in overspend as a result of staffing levels both in number and in level. Requires Allocate rostering check	250,000	-	Medium	Apr-13	N/A
EY030	Enforce nursing support unit controls	Tighten the controls for how the Nursing Support Unit is used	Assumes reduction in requirement for Nursing Support Unit use due to right sizing of the establishment and reduction in temporary and backfilled roles across the organisations	200,000	-	High	May-13	N/A
EY031	Review service model for plastic service	Consider alternatives for the provision of single consultant plastic service including discussions to share additional consultants with Townsville.	Recruitment is currently underway for second consultant	-	-	High	May-13	N/A
EY032	Oral Health Review complete by 31 Jan	Oral Health Review complete by 31 Jan		150,000	-	Medium	Mar-13	N/A

*Timeline to realising the opportunity.

** Page reference for further analysis where applicable and in full report.

Likely contentious issues – FY13 opportunities

Contentious – impacting program delivery

No	Opportunity	Amount at Risk	FTEs at Risk
EY012	Reallocating clinical educator positions	$643,077	N/A
EY014	Revising annual leave practices for Medical workforce and locum usage	$300,000	N/A
EY019, EY020	Medical ward closures (multiple)	$525,000	N/A
EY021	Lyphodaema Service - changes to supply of garments	$12,500	N/A
EY001	Optimisation of PHI Rates	$650,000	N/A
EY008	7 day/week Rostering for Imaging Services	$50,000	N/A
EY013, EY014, EY018, EY028, EY029	Workforce Optimisation (multiple opportunities)	$737,500	
EY010, EY011	Reduction in FTEs (NB – see further analysis overleaf)	$2,655,613	234

Services based on analysis	$ p.a.	FTE
School Based Youth Health Nurses	$420k	5.1
Reduction in health promotion positions in oral health, sexual health breastscreen	$480k	5
Reduction in bowel cancer health promotion positions	$150k	2
Closed merit process affecting admin FTE as per the Administration Review	$1,270k	190
Mental Health service FTE reductions incl executive, health promotion, ATODS and community teams	$5, 481k	60.9
Local management structures affected in Innisfail and Tablelands	$990k	11

Likely contentious issues - FY14 Opportunities

Contentious - impacting program delivery

No	Opportunity	Amount at Risk	FTEs at Risk
EY033 and EY034	Clinical services realignment (patient flow, ALOS etc)	TBC	TBC
EY035	Theatres optimisation across HHS	TBC	TBC
EY036	Outpatients optimisation.	TBC	TBC
EY037	Increased deployment of Advance Allied Health Practitioners	TBC	TBC
EY035	8th Surgical Theatre - revisiting board decision	TBC	TBC
EY037	Increased deployment of Advance Allied Health Practitioners	TBC	TBC
EY040	Revisions to Orthopaedic Medical Staff VMO contracts	$276,300	TBC

Program risks

No.	Risk
1	Change management and the need for change
2	Clinical leadership
3	Staff engagement and Employee Relations
4	Maintaining momentum and rapid delivery
5	Capability and capacity to deliver (balancing with BAU)
6	Media and political interest
7	Data and information availability

Summary recommendations / next steps

No	Recommendation	Timeline
1	CHHHS submits this report to both the CHHHS Board for approval and to the Minister for Health in Queensland.	31st January 2013
2	CHHHS adopts the opportunities in this report as a holistic financial realignment plan for the HHS for both FY13 and FY14. Continue to develop a build a pipeline of opportunities going forward and continue to consider the balance of financial sustainability with the impact on the patient and the quality agenda.	31st January 2013
3	CHHHS aligns the FTE targets with occupied positions and submits this data to Queensland Health as per the recently issued memo outlining required timelines. In doing so CHHHS should consider the Employee Relations environment and implications.	15th February 2013
4	CHHHS and Ernst & Young continue to develop action and implementation plans for all opportunities and integrate these into a final report.	8th February 2013
5	CHHHS considers and agrees on the Allocate Rostering Software business case	8th February 2013
6	CHHHS establishes the required program governance and delivery support unit to ensure the ongoing focus on this program of work and the execution of the opportunities detailed in the plan.	8th February 2013
7	CHHHS develops and delivers robust communications, change and stakeholder engagement strategy and plan across the program of work	11st February 2013
8	Clinical leadership and engagement required to implement the program of work	11th February 2013
9	Establishment of a Long-term financial model and embed this a key operational decision-making tool	April 2013
10	Analyse and improve focus on financial/HR management and controls	March/April 2013

Appendix
FY14 Opportunities (detail), Implementation approach and governance

List of opportunities deliverable in FY14 and beyond

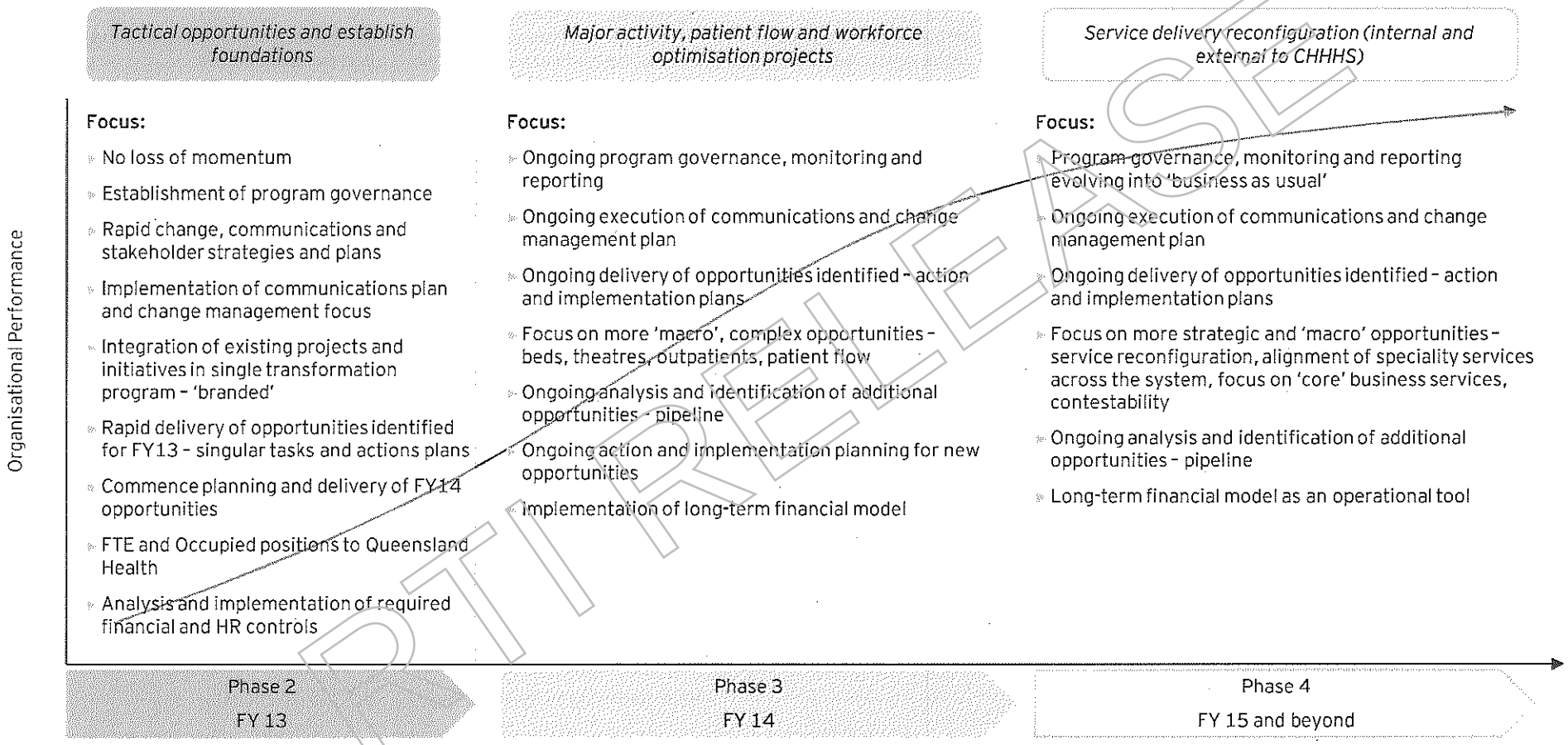
The following table provides an overview of opportunities which will deliver benefits in FY14 and beyond and support the achievement of the third objective for this work. These have been sourced from data analysis, 1:1 interviews as well as from the initiatives completed by CHHHS.

Area of framework	Specific focus	ID	Opportunity	$ potential	FTE	Implementation complexity
Clinical effectiveness	Activity - Inpatients	EY033	Ongoing Clinical services realignment to meet WAU targets	TBC	TBC	Medium
Clinical effectiveness	Activity - ALOS	EY034	Active ALOS management across focused DRGs.	TBC	TBC	High
Clinical effectiveness	Activity - Theatres	EY035	Ongoing Theatres optimisation across HHS	TBC	TBC	Medium
Clinical effectiveness	Activity - Outpatients	EY036	Ongoing outpatients optimisation.	TBC	TBC	Medium
Clinical effectiveness	Activity - Outpatients	EY037	Increase proportion of advanced health practitioner lead clinics	TBC	TBC	High
Clinical effectiveness	Activity Management	EY038	Maximise activity management and coding practices	TBC	TBC	Low
Clinical effectiveness	FTE - All	EY039	Implement new organisational restructure	TBC	TBC	High
Clinical effectiveness	FTE - Medical	EY040	Ongoing Medical workforce optimisation	TBC	TBC	High
Clinical effectiveness	FTE - Nursing	EY041	Ongoing Nursing workforce optimisation	TBC	TBC	High
Clinical effectiveness	Pharmacy	EY042	Introduce Robotic dispensary system	500,000	-	High
Clinical effectiveness	Pharmacy	EY043	Pharmacy cost control measures including controls of high costs tests and controls around waste avoidance for high-cost infusions	1,150,000	-	Medium
Clinical effectiveness	Pharmacy	EY044	Ordering from the PBS	1,880,000	-	Low
Clinical effectiveness	Pharmacy	EY045	Pharmacy cost control measures including implementing ward pharmacist in surgical and W&C, demand management, accessing cheaper alternatives and increasing mechanisation of pharmacy.	1,531,000	-	High
Clinical effectiveness	Pharmacy	EY046	Vigorously pursue local and international drug trials especially in HIV/chemo	500,000	-	High
Clinical effectiveness	Imaging	EY047	Ongoing maximise Imaging utilisation and revise ordering practices	TBC	TBC	Medium
Clinical effectiveness	Imaging	EY048	Review Imaging outsourcing models	TBC	TBC	Medium
Clinical effectiveness	Imaging	EY049	Implementation of transcription services	TBC	TBC	Medium

List of opportunities deliverable in FY14 and beyond continued

Area of framework	Specific focus	ID	Opportunity	$ potential	FTE	Implementation complexity
Clinical effectiveness	Pathology	EY050	Review Pathology outsourcing models	TBC	TBC	Medium
Clinical effectiveness	Pathology	EY051	Ongoing pathology utilisation and ordering practices	TBC	TBC	Medium
Clinical effectiveness	Revenue generation	EY052	Ongoing ACFI maximisation	1,700,000	-	High
Clinical effectiveness	Revenue generation	EY053	Ongoing optimisation of Private Health Insurance conversion rates	1,300,000	-	Medium
Clinical effectiveness	Revenue generation	EY054	Ongoing optimisation of ROPP Option A billing processes	1,400,000	-	Medium
Clinical effectiveness	FTE - Admin and clerical	EY055	Reduce number of medical typists through pooling, outsourcing and available technologies	TBC	TBC	High
Clinical effectiveness	Indigenous Health	EY056	Indigenous Health Worker productivity review	180,000	-	High
Non clinical effectiveness	Procurement	EY057	Ongoing Procurement transformation	8,460,000	-	High
Non-clinical effectiveness	Core delivery model	EY058	Feasibility and development of shared services arrangement across Far North Queensland (CH, Cape York and Torres)	TBC	-	High
Non-clinical effectiveness	Patient Transport	EY059	Ongoing patient transport cost reduction	1,680,000	-	High
Non-clinical effectiveness	Staff Travel	EY060	Ongoing staff transport cost reduction	160,000	-	High
Service effectiveness	Service delivery model	EY061	Feasibility into future service reconfiguration work across Far North Queensland (CH, CY and Torres) across Primary, Community, Secondary and Tertiary care	TBC	TBC	High
Service effectiveness	Service analysis and Core Business Review	EY062	Reduction in unfunded and/or 'pet' services and consideration of outsourcing of non-core services (to private or primary)	TBC	TBC	High
Service effectiveness	Service analysis and Core Business Review	EY063	Review of specialty services for ongoing viability (finance, operations, quality) and consideration of future service delivery models eg, with Townsville	TBC	TBC	High
Service effectiveness	Urology	EY064	Undertake sustainability review of single Consultant/VMO led services e.g. Urology	TBC	TBC	High
Totals				$20,441,000		

Implementation program approach



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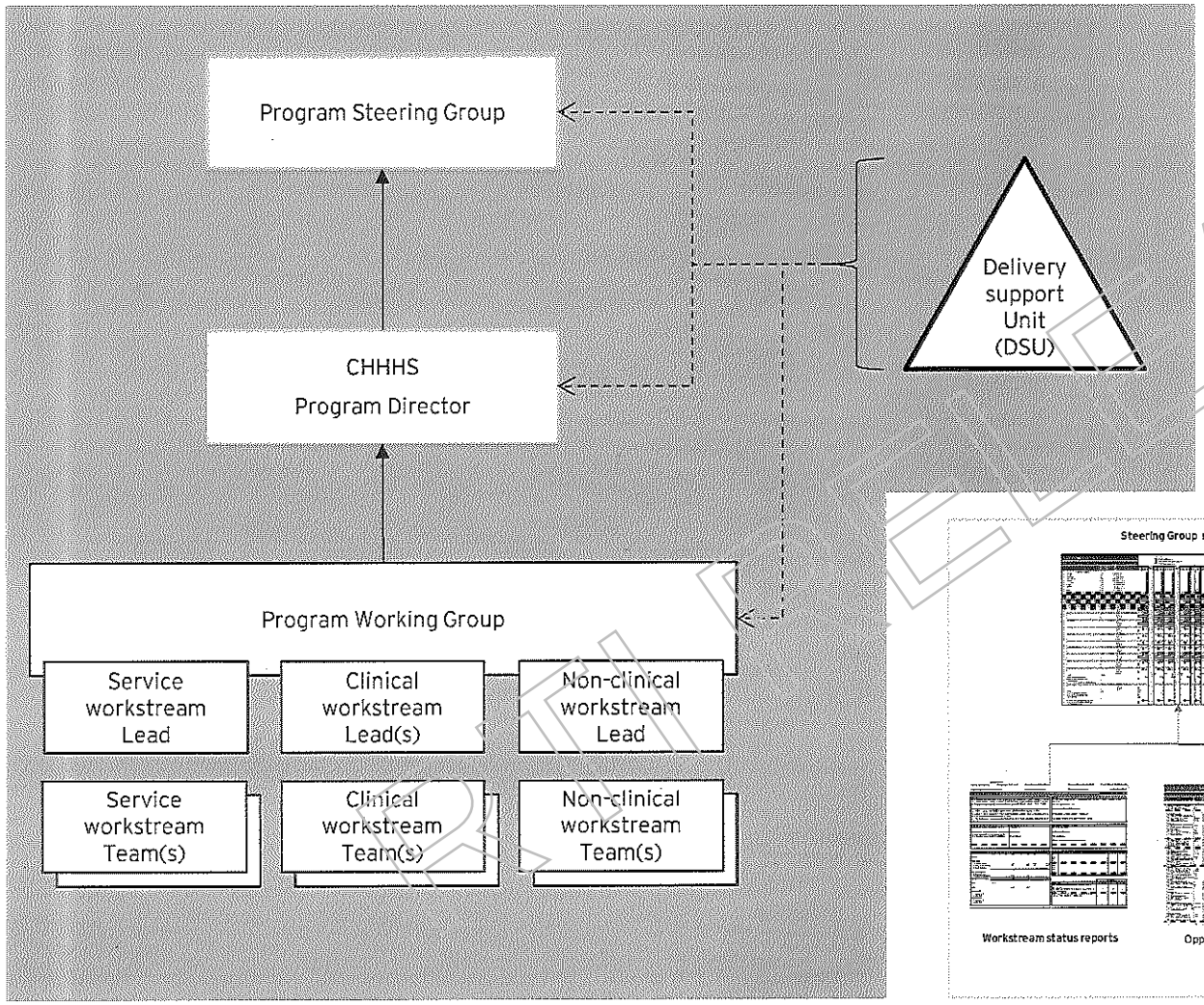
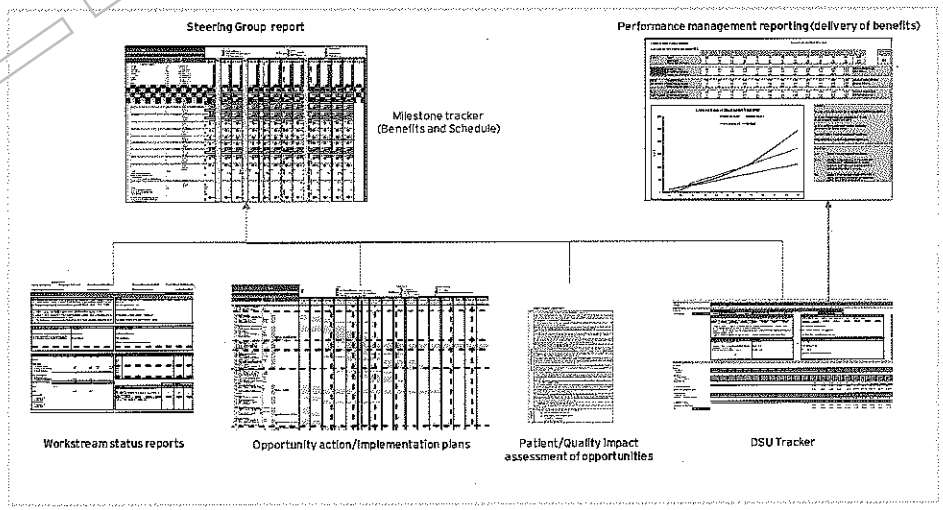
Establishing robust program governance and planning/monitoring tools





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Quality In Everything We Do

DG Dg correspondence - BR056237 FINAL - Note DG comments

From: DG Dg correspondence
To: SPP-Corro
Date: 3/4/2013 11:55 AM
Subject: BR056237 FINAL - Note DG comments
Attachments: BR056237 FINAL.pdf

Good morning

Please find attached **BR056237 FINAL** which was approved by the DG on 4/3/2013, forwarded for your information and action as required.

* Please note DG comments:

"Minister, as discussed this morning (March 4): current situation. Opportunity to modify "drawback" exists".

* Please note a copy of this brief has been sent to the Minister's office for noting (at the request of the DG).

Thank you
Kind regards
Axele

Office of the Director-General / Executive Services
Queensland Health
Axele 3234 1553
Amanda 3234 1554
Email: DG_Correspondence@health.qld.gov.au

Department RecFind No:	BR056242
Division/District:	Townsville HHS
File Ref No:	

(2)

RECEIVED
DATE 4 MAR 2013

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

Requested by: Chief Executive, Townsville Hospital & Health Service **Date requested: 1 March 2013** **Action required by:**

SUBJECT: Townsville Hospital and Health Service Realignment - Executive

Proposal
That the Minister:

Note the organisational changes being implemented as approved by the Townsville Hospital and Health Service Board (TTHSB).

Note that the staff affected and their representatives will be informed about the changes on Tuesday, 5 March 2913.

Note that informal discussions have been held with the senior clinical and operational leaders already.

APPROVED/NOT APPROVED **NOTED** **NOTED**

LAWRENCE SPRINGBORG
Minister for Health

Chief of Staff

4 3 13

Minister's comments

RECEIVED
RECORDS TEAM
15 MAR 2013

Department RecFind No:	BR056242
Division/HHS:	Townsville HHS
File Ref No:	

Briefing Note for Noting
Director-General

URGENT COPY

Requested by: Chief Executive, Townsville Hospital & Health Service **Date requested: 1 March 2013** **Action required by:**

SUBJECT: Townsville Hospital and Health Service Realignment - Executive

Proposal
That the Director-General:

Note the organisational changes being implemented as approved by the Townsville Hospital and Health Service Board (TTHSB).

Note that the staff affected and their representatives will be informed about the changes on Tuesday, 5 March 2913.

Note that informal discussions have been held with the senior clinical and operational leaders already.

Urgency
1. **Urgent** - Affected staff and unions will be advised of the organisational changes on the 5 March 2013.

Headline Issues
2. The top issues are:
   - This is the final stage of the realignment first announced by THHB in September 2012 and clarified as affecting 220 Full Time Equivalents (FTEs) in January 2013 rather than the 200 announced September 2012.
   - The Townsville Hospital and Health Service (THHS) is reducing the number of Institutes from seven to five, and renaming them Service Groups.
   - The effect of these changes will be an overall reduction in FTE in line with the 220 aim overall, a saving to the organisation of $0.5 million as part of the savings identified through the realignment process to date, clear accountabilities and leadership development and succession planning.

Key issues
3. Each Service Group will have a single leader, a Service Group Director, accountable to the Chief Operating Officer, at a standardised classification to ensure accountabilities are clear and performance agreements are delivered.
4. The Chief Finance Officer role will expand to include responsibility for a Commercial Services function, which will ensure our non-clinical support services demonstrate value for money and the Board's expectation is that a suitably qualified appointment will be made.
5. An Executive Director for Planning and Performance post will be created to provide dedicated strategic, operational planning, performance management and reporting and coordinate Service Agreement negotiations within the THHS.
6. The full time Executive Director posts for Allied Health and Indigenous Health as they are currently configured with no operational responsibilities will be ceased, with the roles reconfigured as part time advisors and part time operational.
7. For Allied Health the role will integrate into a full time Director for Allied Health with the advisory and operational functions integrated. The Executive Director Indigenous Health EDIH role will become the Director for Palm Island's services and lead the to be established dedicated Palm Island Project Team to lead implementation of the Palm Island Health Service review being finalised by Barbara Schmidt associates. Both roles will sit on the new Senior

Department RecFind No:	BR056242
Division/HHS:	Townsville HHS
File Ref No:	

Management team which will include Executive Directors, Service Group Directors and the advisors for Indigenous and Allied Health.

8. The Director of Audit role will cease and be subsumed into the Finance structure.
9. Each Service Group will have a Director, Medical Director, Director(s) of Nursing/Allied Health and general management/business support. The resource will be streamlined.

Background

10. The purpose is to create a clear and accountable structure preparing the THHS for sustained delivery, viability and capability to pick up devolved responsibilities as outlined in the Act.
11. Management structures within each Service Group will be organised according to the requirements of the service, but will include a Medical Director and Nursing Directors reporting directly to the Service Group Director.
12. Classification of positions affected by this change is underway, with Mercer engaged to undertake the Service Group Director, Chief Financial Officer and Executive Director Planning and Performance posts. The organisational change is not contingent on a particular classification outcome for the Service Group Director post.
13. In addition, clarification of Executive roles is occurring with some changes: The Tropical Public Health Unit has been aligned under the Executive Director of Nursing post, along with responsibility for Infection Control.
14. Clinical governance, changing clinical practice, safety and mortality, business and disaster planning and medical/dental leadership/links to Primary care are consolidated under Executive Director Medical Services.
15. Clinical risk management and responsibility for health care standards have been consolidated under the Executive Director of Nursing Services.
16. Legal services, public affairs, strategic and business planning, performance management and headquarters management has been aligned under the Executive Director Planning and Performance.
17. A single team covering process for credentialing and scope of practice, supported by advice from professional leads, has been established under the Executive Director of People and Culture.

Attachments

18. Attachment 1: set out the current and new organisational structures – Direct Reports
    Attachment 2: set out the current and new organisational structures – Institute Structure

Department RecFind No:	BR056242
Division/HHS:	Townsville HHS
File Ref No:	

Recommendation
That the Director-General:

Note the organisational changes being implemented as approved by the Townsville Hospital and Health Service Board (TTHSB).

Note that the staff affected and their representatives will be informed about the changes on Tuesday, 5 March 2913.

Note that informal discussions have been held with the senior clinical and operational leaders already.

APPROVED/NOT APPROVED NOTED

DR TONY O'CONNELL
Director-General

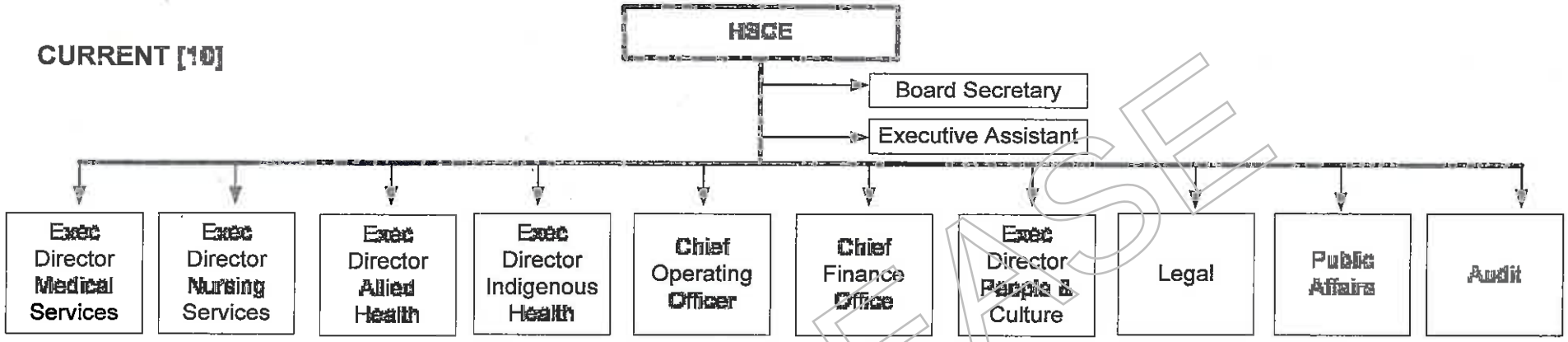
4 / 3 / 13

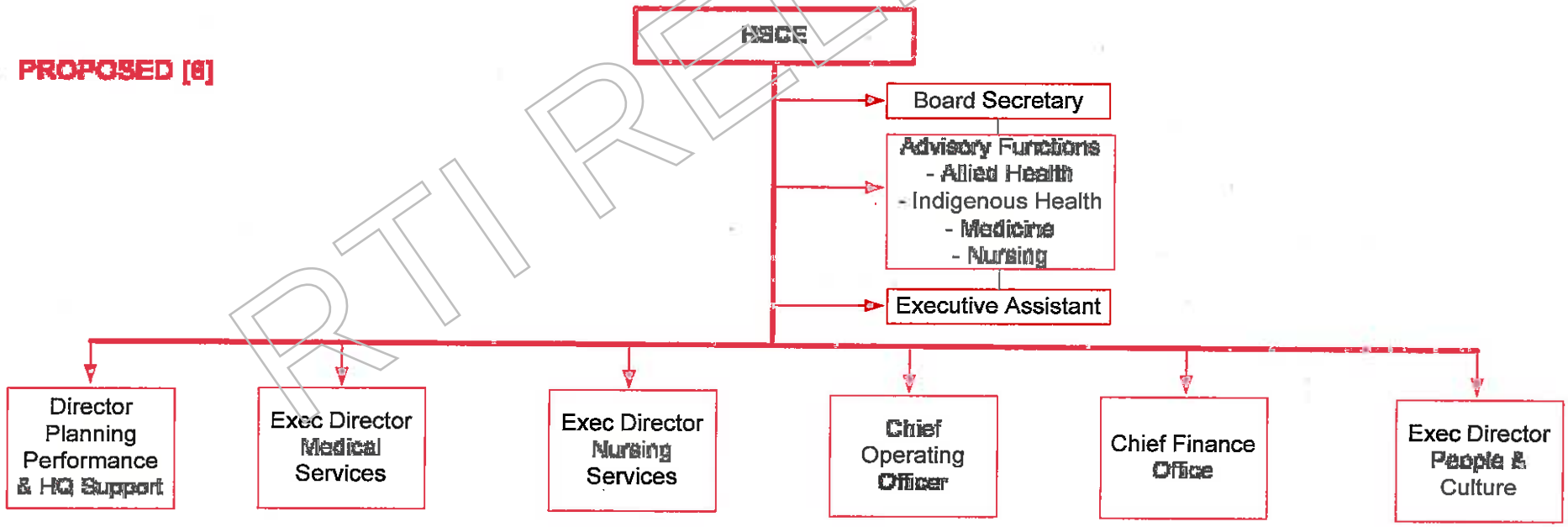
To Minister's Office For Noting ☑

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Kieran Keyes		Julia Squire
Chief Operating Officer		Health Service Chief Executive
Townsville HHS		Townsville HHS
4433 0074		4433 0072
27 February 2013		1 March 2013

HSCE DIRECT REPORTS





INSTITUTE STRUCTURE

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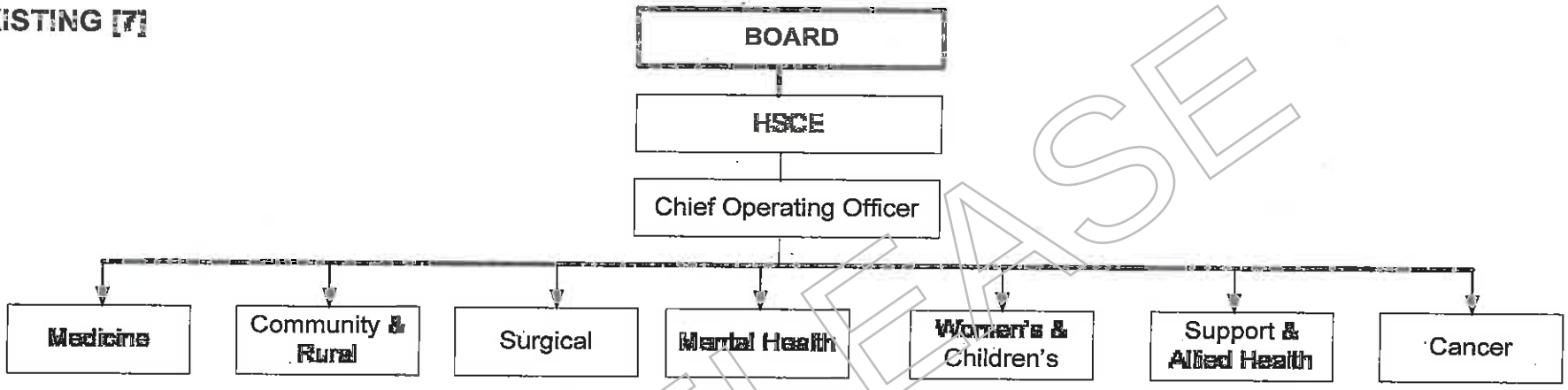

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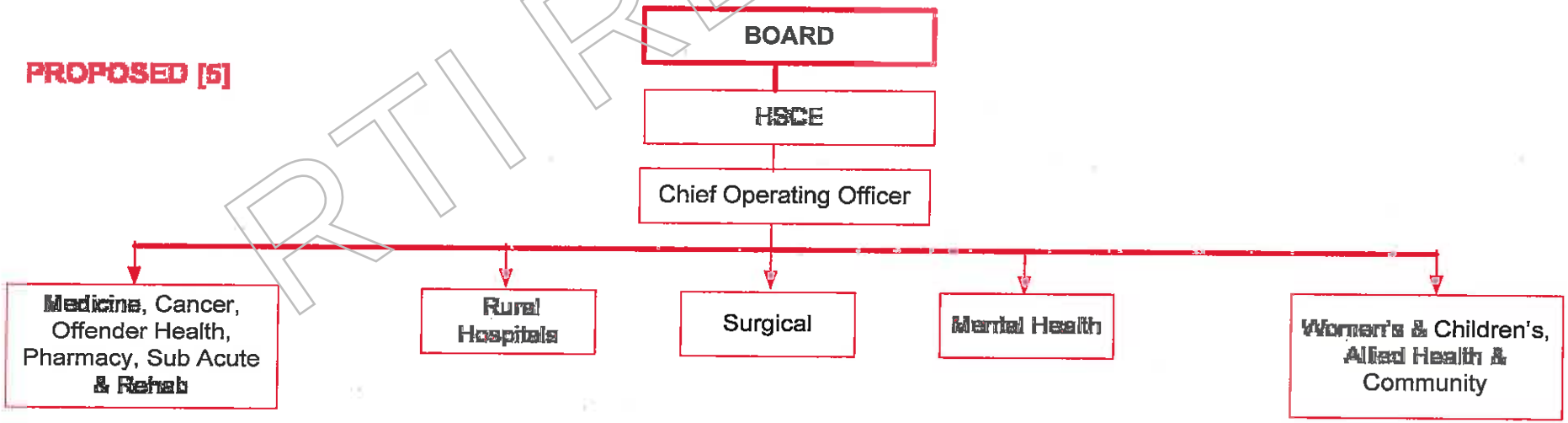

BR056295

13/3/13

Department RecFind No:	BR056295
Division/HHS:	Cape York HHS
File Ref No:	

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

URGENT

REC'D MAR 2013
DATE | BY

Requested by: Acting Chair, Cape York Hospital and Health Service **Date requested:** **Action required by:**

SUBJECT: Cape York Hospital and Health Service – Business Case for Change Update

RECORDS TEAM
DEPUTY DIRECTOR-GENERAL
QLD HEALTH
3 APR 2013

Recommendation
That the Minister:

Note the update and issues of the implementation of the Cape York Hospital and Health Service (CYHHS) Business Case for Change; and

Note the announcement was made by Ms Louise Pearce, Acting Chair, CYHHS and Ms Susan Turner, Health Service Chief Executive, CYHHS, on 12 March 2013.

APPROVED/NOT APPROVED **NOTED** **NOTED**

LAWRENCE SPRINGBORG
Minister for Health

/ /

Chief of Staff

28 / 3 / 13

Minister's comments

Email scanned copy to me please

17 MAR 2013

URGENT

Department RecFind No:	BR056295
Division/HHS:	Cape York HHS
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: Acting Chair, Cape York Hospital and Health Service **Date requested:** **Action required by:**

SUBJECT: Cape York Hospital and Health Service – Business Case for Change Update

Proposal

That the Director-General:

Note the implementation of the Cape York Hospital and Health Service (CYHHS) Business Case for Change.

Note the announcement was made by Ms Louise Pearce, Acting Chair, CYHHS and Ms Susan Turner, Health Service Chief Executive, CYHHS, on 12 March 2013.

Provide this brief to the Minister for noting.

1. **Urgent** - Cape York Hospital and Health Service's (CYHHS) announced the Full Time Equivalent (FTE) reductions on Tuesday, 12 March 2013.

Headline Issues

2. The top issues are:
   - CYHHS announced the reduction of 71 FTE of both occupied and unoccupied positions on 12 March 2013.
   - CYHHS through the redesign intends to establish 43.5 new positions within the HHS and may be able to redeploy affected staff.
   - The net FTE reduction is 27.5 FTE, of which the HHS intends to accept 20 Expressions of Interest (EOI) for Voluntary Redundancies.

Key Values

3. The key values that apply are the following:

☒ Better service for patients
☒ Better healthcare in the community
☒ Valuing our employees and empowering frontline staff
☐ Empowering local communities with a greater say over their hospital and local health services
☒ Value for money for taxpayers
☐ Openness

Key issues

4. CYHHS intends to disestablish 71 FTE positions of which 49 are occupied and 22 are vacant. The CYHHS Business Case for Change and the further service redesign through the EOI applications will result in the establishment of 43.5 FTE's.

5. The effective FTE reduction would be 28.5 FTE's and CYHHS intends to accept 20 EOI for Voluntary Redundancies.

6. Attachment 1 provides a Summary of the effects of the FTE changes.

7. There are three clinical areas that will experience a reduction in FTE, however, this has enabled our HHS to improve the access, and equity of services in Cape York. These clinical changes and their impacts are summarised in Attachment 2 - Clinical Areas Impacted by FTE Reductions.

Department RecFind No:	BR056295
Division/HHS:	Cape York HHS
File Ref No:	

Background

8. In 2012 Cape York HHS proactively engaged Ernst & Young, Australia to undertake an independent review of the organisation, to understand the breadth and size of the opportunities available to meet immediate and medium term (three years) fiscal demands. Completed in February 2013, the Organisational Review has identified the key opportunities for change, which have now informed the development of this Business Case for Change. Attachment 3 CYHHS Business Case for Change.

9. The Organisational Review provides the HHS with a an opportunity to effect changes that have not previously been available and a blueprint to move forward to further develop, retract or redesign a new service delivery model including the key steps for the HHS to develop a detailed implementation plan, track and monitor progress.

10. CYHHS subsequently completed an Expressions of Interest (EOI) process for voluntary redundancies. This process occurred between 18 February 2013 and 4 March 2013. This has provided the opportunity to undertake further redesign of services to improve access in Cape York communities. 54 Applications were received and 20 of these applications are intended to be accepted by CYHHS.

11. Following the Ernest Young Review and the EOI Process, CYHHS will undertake substantial organisation change which will achieve fiscal savings, reduce MOHRI FTE's; improve access and equity to services within Cape York. Attachment 4 Current CYHHS Organisation Structure and Attachment 5 New Organisation Structure.

12. In terms of a further savings potential as a result of the EOI process a significant opportunity exists to outsource the Alcohol, Drug and Tobacco Services (ATODS) to a Non-Government Organisation (NGO) was identified. This service in CYHHS provides counselling and early intervention services and these same services are provided by other NGO Service Providers. CYHHS estimates that a savings of between $300,000 to $400,000 and a reduction of 6 FTE could be realised. CYHHS has engaged the Contestability Branch to undertake the analysis and due diligence of this business opportunity. This savings could be implemented and realised by 30 June 2013. The Minister will be advised of this outcome once the work has been completed.

Consultation

13. Queensland Health Workplace Services
14. CYHHS Board and Executive Team
15. Ernest Young Organisation Review Final Report

Financial implications

16. CYHHS estimates that the organisation restructure will result in a $2.5 million budget savings. CYHHS is already under the agreed Occupied MORHI Target of 394 and is tracking consistently under the target level each month of this financial year.

Legal implications

17. There are no legal implications.

Attachments

18. Attachment 1: Summary of the effects of the FTE changes
    Attachment 2: Summary of Impacted Clinical Areas
    Attachment 3: Business Case for Change
    Attachment 4: CYHHS Current Structure
    Attachment 5: CYHHS New Structure

Department RecFind No:	**BR056295**
Division/HHS:	**Cape York HHS**
File Ref No:	

Recommendation
That the Director-General:

Note the implementation of the Cape York Hospital and Health Service (CYHHS) Business Case for Change.

Note the announcement was made by Ms Louise Pearce, Acting Chair, CYHHS and Ms Susan Turner, Health Service Chief Executive, CYHHS, on 12 March 2013.

Provide this brief to the Minister for noting.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

13/ 3 / 13

To Minister's Office for Approval ☐
for Noting ☑

Director-General's comments

Author Susan Turner	Content verified by: (CEO/DDG/Div Head) Louise Pearce
HHS Chief Executive	Acting Chair
Cape York Hospital and Health Service	Cape York HHS
4082 3600	4082 3600
11 March 2013	11 March 2013

ATTACHMENT 1 – SUMMARY OF THE EFFECTED FTE CHANGES

Stream	Organisational Unit	Reductions in FTE	Occupancy Status	Total FTE Reduction	New Roles	Net Reduction in FTE
Administrative	CYHHS	34	Occupied	26	27.5	(6.5)
			Vacant	8		
Building, Engineering & Maintenance	CYHHS	0	Occupied	0	0	0
			Vacant	0		
Dental	CYHHS	0	Occupied	0	0	0
			Vacant	0		
Health Practitioner	CYHHS	9	Occupied	8	7	(2)
			Vacant	1		
Medical	CYHHS	0	Occupied	0	0	0
			Vacant	0		
Nursing	CYHHS	8	Occupied	8	5	(3)
			Vacant	0		
Operational	CYHHS	19	Occupied	7	3	(16)
			Vacant	12		
Professional	CYHHS	0	Occupied	0	0	0
			Vacant	0		
Technical	CYHHS	0	Occupied	0	0	0
			Vacant	0		
Senior Officer/ District Senior Officer	CYHHS	1	Occupied	0	1	0
			Vacant	1		
Senior Executive/ Health Service Executive	CYHHS	0	Occupied	0	0	0
			Vacant	0		
	Total	**71**	**Occupied**	**49**	**43.5**	**(27.5)**
			Vacant	**22**		

ATTACHMENT 2 – SUMMARY OF IMPACTED CLINICAL AREAS IN CYHHS

SERVICE	FTE REDUCTION	IMPACT
Sexual Health and Mens and Womens Health Team	1	Clinical Nurse Consultant has submitted an expression of interest for voluntary redundancy; and there were 2 Health Worker vacancies. There is no Mens Health Services in Cooktown, Wujal Wujal, Hopevale, and Laura. Sexual Health Services not equitably available across the Cape. 3 Nursing roles included 1 FTE Sexual Health, 1 FTE Womens Health, 1 FTE Womens and Sexual Health and 1 FTE Health Worker Mens Health. **Solution** Redesign Nursing and Health Worker roles so that each Nurse does both Womens and Sexual Health. These roles would provide clinical support to a Male Health Worker to provide Mens Health Services. Each community would have the same access to these services. All Health Worker roles in this team would be male.
Directors of Nursing in the Remote Primary Healthcare Facilities	3	The Ernest Young Organisation Review highlighted that the Directors of Nursing in the Remote Primary Healthcare Facilities were primarily undertaking management activities rather than clinical activities. The report proposed that the service clusters the PHCC's and therefore Cluster the DON's together which would achieve savings. There are three DON's that have opted for redundancy. **Solution** CYHHS will deploy the solution of three clusters and merge the management and clinical leadership under fewer DON's. A new DON position will be established to provide the Clinical Leadership of all 10 Remote PHCC's and the further establishment of a Business Manager position to manage the business function of these facilities. CYHHS will be able to more effectively manage the performance of these PHHCC's in both clinical and business performance through this solution.

SERVICE	FTE REDUCTION	IMPACT
Mental Health & ATODS Service – Counselling Service	1	A Clinical Nurse ATODS has submitted an EOI for voluntary redundancy. The Clinical Nurse had been employed in another role within CYHHS and the Department of Communities has advised that there will be no funding for this service in 2013/14. This role will cease 31 March 2013. The Clinical Nurse has a substantiative position in the MH&ATODS Team but this role has been vacant for 18 months and has not been backfilled for 2 years. **Solution** CYHHS has initiated a review of the ATODS service to potentially outsource to an NGO. This role is within this team. The substantiative role has not been filled for 2 years so there is no impact on current service provision by disestablishing this role.

Attachment 3

Business Case for Change

Cape York Hospital and Health Service

Contents

Contents

Executive Summary

This Business Case for Change details a proposal to implement a revised organisational structure within the Cape York Hospital and Health Service (the HHS), to enable the HHS to better meet its service priorities and obligations.

Recognising current barriers to achieving its service goals, the HHS commenced a modernisation project in 2010[i]. The Transformation Project aims to improve the appropriateness of the HHS's model of care, improve service coordination issues with partner groups and introduce key enablers of coordinated care including a new information technology solution.

In response to the devolution of accountability for service delivery to the HHS, and in alignment with government priorities and objectives[ii] —the HHS initiated an Organisational Review [iii] in November 2012. Undertaken by Ernst &Young Australia, the Organisational Review recommended significant change including:

- health services and business functions be realigned and managed—ensuring consistency in assigned responsibilities and accountabilities
- improved clinical supervision and reduced administrative burden on clinical staff associated with time-consuming paper-based work practices
- a reduction in the number of Executive Management staff, and realignment of responsibilities to improve service cohesiveness and accountability
- reduced duplication and competition between service partners, and improved coordination of service delivery
- improved business service functions that support and enable the new organisational structure, performance management and governance arrangements
- the ability to provide accurate, complete and actionable information derived from aggregated operational and clinical data
- enhanced career structures, professional development and leadership for the workforce.

This Business Case for Change proposes how the HHS will implement the Organisational Review's key recommendations. Once approved, the benefits of the proposed changes are expected to be partially implemented in 2013 and fully realised by 2015, enabling Cape York HHS to maintain its position as the leading performing remote HHS in Queensland.

1. Introduction

1.1 Background

Cape York HHS has responsibility[iv] for ensuring the effective delivery of safe, high quality and locally responsive public health services within the Cape York region. Through the Cape York HHS Service Agreement[v], the HHS has responsibility to deliver primary health, non acute and sub-acute care services through its facilities and to support outreach teams, including visiting specialist services from other HHS, and non-government providers such as Apunipima-Cape York Health Council and the Royal Flying Doctors Service.

In 2012 Cape York HHS proactively engaged Ernst & Young, Australia to undertake an independent review of the organisation, to understand the breadth and size of the opportunities available to meet immediate and medium term (three years) fiscal demands. Completed in February 2013, the Organisational Review has identified the key opportunities for change, which have now informed the development of this Business Case for Change.

1.2 Purpose of the business case

The purpose of this Business Case is to present the proposed change process the HHS will undertake to meet its Service Agreement KPIs and fiscal targets, and achieve the identified service realignments to address recently expanded HHS functions.

The Business Case presents the intended blueprint forward for implementing the Organisational Review recommendations and managing the change processes in alignment with current endorsed government processes.

1.3 Governance

The Cape York Health Services Board is the overarching governing body for the Organisational Change. Additionally each of the following groups is accountable for management and implementation of the change processes, being:

- **Sponsor**: Oversight the implementation, and provide guidance and direction to the Change Steering Committee:
  - Health Service Chief Executive (HSCE)
- **Change Steering Committee**: Leads the change process within their allocated portfolio and makes recommendations to the sponsor on options, models and systems for consideration. Includes:
  - Chief Operating Officer
  - Chief Finance Officer
  - Executive Director Medical Services
  - Director Primary Health Care
  - District Director of Nursing
  - Director- Human Resources (advisory only).
- **The Change Team:** Facilitates the change process, and ensure that the project advances in a timely and effective manner. Report on the progress towards the outcomes of the project. Includes:
  - Chief Operating Officer
  - Chief Finance Officer
  - Director- Human Resources
  - Board Secretariat
  - Program Director- Transformation Project.

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- **The Organisational Review Advisory Group:** This group consists of staff, and staff representative groups including Union representation. This group has been active during consultation, planning and review phases of the Organisational Review, and will play an advisory and consultative role during implementation of the change.
- **Additional Working Groups** will be established as needed.
- **District Consultative Forum:** Subject to Unions' agreement, this Forum will provide a formal mechanism to proactively engage and consult with Unions.

1.4 Methods and Assumptions

The HSCE initiated the proposal and achieved Board approval to undertake an Organisational Review process. The Organisational Review has progressed through the conceptualisation and planning phase to determine the most likely re-alignments of services. The review process encompassed:

- key leaders and clinicians workshops (two)
- interviews with 60 key stakeholders
- review of 300 documents
- service and functional mapping
- site visits
- financial and other key metrics reviews, including human resources, internal business processes.

Assumptions of the review were that the outcomes would enable the HHS to:

- better deliver government priorities
- improve health service provision
- realign services identified as duplicates, or opportunities for partner groups
- meet its Service Agreement KPIs and targets
- address known service and process inefficiencies
- maintain or improve its current HHS level of independence.

Additionally the assumptions of the review process itself included:

- a transparent process aligning with current government standards and processes for review
- an active workforce, and workforce representative groups participation across the entire process.

1.5 Key findings

Key findings from the final Organisational Review report undertaken by Ernst & Young included:

- the HHS model of service delivery was predominantly acute primary health care focused and largely episodic in nature, rather than a comprehensive 'family centred' primary health service model
- historical and no longer always 'fit for purpose' organisational and team structures, processes and systems ; variable approaches to recruitment and retentions, complex HR issues and limited adherence to policies and controls, and performance management

- a need to build more business management and financial support for PHCCs services; improve data collections and collation, and accountability for services delivery
- improve expenditure controls including travel, overtime, drugs and staffing
- review widespread staff and clinical accommodation for all visiting services, including partner groups for revenue opportunities.

Grouped into four categories, the Review proposes four categories overarching 20 key opportunities with a potential value of $4.05M and with a reduction of 25.5 FTE. The categories are:

1. Organisational structural reviews:
    a. refocus the role and structure of the Executive
    b. adopt a clustered approach to managing health service facilities
    c. outsource learning and development functions
    d. consolidate staff travel hub back into the HHS
2. Service assessments:
    a. integrate Men's and Women's Health, Healthy Lifestyle and Cervical Screening outreach teams
    b. enhance the service coordination process to better assess clinical service effectiveness and efficiencies
    c. centralise the responsibility of Patient Safety and Quality roles and transition towards more defined 'hub and spoke' model
    d. transition of Napranum site to Apunipima as a pilot towards a community control model
    e. remove dental prosthetics' role and outsource service
3. Cost reductions:
    a. reduce patient travel by 15 per cent and staff travel by 10 per cent
    b. remove 25 per cent of surplus long term vacancies from establishment
    c. reduce nursing overtime and medical overtime
    d. proactively manage complex long term sick leave
    e. reduce overlap with other providers in diabetes educator and nutrition roles
    f. reduce overlap with Apunipima and Medicare Local in community engagement function
    g. strengthen contact management processes

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    g. strengthen contact management processes

4. Revenue optimisation:

    a. optimise Medicare and pathology billing opportunities.

1.6 Analysis of alternatives

During the Organisational Change review process, alternative solutions were explored as part of the conceptualisation and planning phase, being:

Alternative 1 – do nothing

- This alternative is likely to result in a fiscal deficit and unchanged end of year HHS position.

Alternative 2 – Implement Organisational Review recommendations

- Approve the Organisational Review recommendations for change to enable the HHS to restructure its functions, services and workforce to meet its service and fiscal obligations.

Alternative 3 – Increase HHS operating budget to meet projected expenditure for 2012-13

- This option would enable the HHS more time to continue to adjust workforce (through natural attrition) and services over time without risk to the HHS capability level or fiscal deficit.

It was considered by the Board and the Executive Leadership Team that alternative two was the most suitable alternative.

1.7 Proposed structure

The new structure incorporates the recommendations of the Organisational Review recommendations, and reallocates a number of functions and work areas to ensure better strategic alignment, and clearer accountability to the revised Executive structure. There is not expected to be an impact on front line clinical service delivery from the proposed changes, and the HHS is expected to remain within its current approved MOHRI target for 2012-13.

1.8 Scope of the change

The Organisational Review provides the HHS with a blueprint to move forward to further develop, retract or redesign a new service delivery model including the key steps for the HHS to develop a detailed implementation plan, track and monitor progress.

The new structure will place an increased focus on accountability for service performance rather than professional service representation. It is considered that no clinical services or staff will be unduly impacted by the changes recommended. There will be a realignment of business functionality at all service sites which should result in a 'freeing' of more direct clinical time. This will impact on the level of site managers at some facilities, but is not expected to affect the overall clinical FTE number at each site.

Revision of position levels and responsibilities will be necessary to ensure consistency and equity in allocation of duties. This is to address inconsistency with historical establishments transferred into the HHS and to ensure business services are streamlined, coordinated and function as delegated.

It is possible that some positions may be subject to review and redesign. The vast majority of staff will have changed supervisory arrangements. To a degree, all business services staff will be affected by the migration to the new Executive structure and management framework.

Significant relocation of staff is not expected, although minor movement within existing buildings is likely to ensure appropriate support is provided in the right location to address the needs of the new structure. If this is to occur we will consult with affected staff. With approval to progress this Business Case for Change, consultation with staff and key stakeholders will be progressed in line with Queensland Health's Enterprise Bargaining obligations.

1.9 Staffing Impacts

The proposed reduction in the number of Executive positions and work teams is aimed at improving the span of control of the Executive Leadership Team. Integration of work streams and a reduced number of Executives will mean clear responsibility and greater accountability within the HHS. This reduced number of Executives is likely to cascade and have a similar impact on the number of middle management positions in the new structure.

Re-profiling positions will ensure the relative mix of classification levels is given appropriate consideration as well as whether adequate positions will exist to support career development and succession planning.

Positional changes across the HHS will require the matching of eligible permanent staff in some work areas to new or changed roles in other work areas within the HHS.

To minimise further impacts on existing permanent staff it is proposed that all long standing vacancies will be reviewed to determine whether positions could be utilised to offset the impact of the Organisational Review targets. Other strategies that will also be considered include:

- introduction of flexible work arrangements where operationally convenient including job share, and part time work
- exploring revenue enhancement opportunities including Own Source Revenue.

1.10 Process for matching staff to positions in new structure

The following matching process has been developed by the System Manager in consultation with staff and their union delegates, and is consistent with the HHS's industrial obligations and whole of government requirements.

An eligible permanent employee will be considered suitable for a role at level if they have the skills and abilities necessary to meet the requirements of the role to a satisfactory level, given a reasonable period of training and on-the-job experience and are fit to undertake the role with reasonable adjustment, if required.

Reasonable periods of training may differ between roles. Some positions may require a shorter development period than others due to current Government priorities or a critical shortage of skill sets within teams. Suitability assessments will involve obtaining referee statements to support placement decisions. Employees will have the opportunity to respond to any adverse statements from referees. Where more than one permanent employee is assessed as suitable, appointment shall be on the basis of relative merit between the eligible employees. Staff eligible for consideration in the HHS matching process will include permanent or contracted staff substantively attached to the HSS.

The HHS may approve the inclusion of a permanent employee in the HHS matching pool where satisfied that extenuating circumstances apply. Such applications will be considered on a case by case basis. The continuation of temporary and higher duties roles approved through the EMP process is dependent upon ongoing business requirements within the new structure. Staff will be advised as soon as possible if an outcome from the HHS process affects them continuing in their current role.

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Re-profiling positions will ensure the relative mix of classification levels is given appropriate consideration as well as whether adequate positions will exist to support career development and succession planning.

Positional changes across the HHS will require the matching of eligible permanent staff in some work areas to new or changed roles in other work areas within the HHS.

To minimise further impacts on existing permanent staff it is proposed that all long standing vacancies will be reviewed to determine whether positions could be utilised to offset the impact of the Organisational Review targets. Other strategies that will also be considered include:

- introduction of flexible work arrangements where operationally convenient including job share, and part time work
- exploring revenue enhancement opportunities including Own Source Revenue.

1.10 Process for matching staff to positions in new structure

The following matching process has been developed by the System Manager in consultation with staff and their union delegates, and is consistent with the HHS's industrial obligations and whole of government requirements.

An eligible permanent employee will be considered suitable for a role at level if they have the skills and abilities necessary to meet the requirements of the role to a satisfactory level, given a reasonable period of training and on-the-job experience and are fit to undertake the role with reasonable adjustment, if required.

Reasonable periods of training may differ between roles. Some positions may require a shorter development period than others due to current Government priorities or a critical shortage of skill sets within teams. Suitability assessments will involve obtaining referee statements to support placement decisions. Employees will have the opportunity to respond to any adverse statements from referees. Where more than one permanent employee is assessed as suitable, appointment shall be on the basis of relative merit between the eligible employees. Staff eligible for consideration in the HHS matching process will include permanent or contracted staff substantively attached to the HSS.

The HHS may approve the inclusion of a permanent employee in the HHS matching pool where satisfied that extenuating circumstances apply. Such applications will be considered on a case by case basis. The continuation of temporary and higher duties roles approved through the EMP process is dependent upon ongoing business requirements within the new structure. Staff will be advised as soon as possible if an outcome from the HHS process affects them continuing in their current role.

1.11 Evaluation

The Board, HHS and System Manager will undertake evaluation of the change through a matrix of evaluation processes, including:

- The Board will evaluate:
  - HHS performance against Service Agreement KPIs and targets
  - Change management outcomes as they impact on HHS future strategic opportunities
- The System Manager will evaluate:
  - HHS performance against Service Agreement KPIs and targets
- The HHS Executive Leadership Team will evaluate:
  - Internal change management processes
  - Evaluation of revised work models and workforce processes.

1.12 Cost-benefit analysis

The cost of the change will be met from within the allocated budget for the HHS. The allocated FTE will remain to be affordable and reflect projections of funding that is available to the HHS. There are no additional resources being allocated to the change process. Work priorities have been reassessed to enable existing staff to work on the Project Team.

2. Risks and sensitivities

The proposed changes associated risks and sensitivities have been considered during the planning phases of change. Below is a summary of the risks (Table 1) and sensitivities (Table 2), with potential contingent strategies for implementation to mitigate associated risks.

Table 1: *Risk issues and mitigating strategies*

Risk	Mitigating strategy
Challenge of establishing an effective communication mechanism across a diverse service operating from 12 different facilities	• Web page information and referral resources • Email communications • Additional communication systems being explored • Regular HSCE updates at staff forums
Staff change "burnout"	• Recognition of previous organisational changes • Frequent communication and consultation • Engagement of staff in change process • Promotion of Employee Assistance Services • Change Management training for Change Champions to enable them to effectively support staff through the change process
Inadequate engagement	• Engagement of staff in the consultation process • Engage HR/IR support to assist with engagement and consultative processes
Maintaining project time frames	• A change plan outlining the change projects, proposed timeframes and detailed communication plan is being developed.

Table 2: *Sensitivity issues and mitigating strategies*

Sensitivity	Mitigating strategy
Managing staff morale and uncertainty	• Engagement of staff in the consultation process • Frequent communication and consultation • Engagement of staff in change process • Promotion of Employee Assistance Services
Ensuring effective engagement, representation and consultation	• Consultation and feedback strategies utilised during Organisational Review to be continued • Mobilisation of working groups if required • Implementation of communication plan
Sensitivity to people's uncertainty regarding the proposed changes	• Regular communiqués to staff • Access to a variety of feedback mechanisms • Implementation of the consultative framework and communication plan
Employee dissatisfaction with changes to roles	• Establish consultation forums with specific unit/area • Individual meetings with affected employees • Engage HR/IR support at point of identification

3. Recommendation

This Business Case for Change contains a summary of the HHS change drivers, recommends that the HHS adopts the Organisational Review's 20 key opportunities and provides a recommended approach to managing the organisational change processes, including redesign of services and changes to staff resources.

It is recommended that this Business Case for Change be supported and approved for implementation.

Table 2: *Sensitivity issues and mitigating strategies*

Sensitivity	Mitigating strategy
Managing staff morale and uncertainty	• Engagement of staff in the consultation process • Frequent communication and consultation • Engagement of staff in change process • Promotion of Employee Assistance Services
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3. Recommendation

This Business Case for Change contains a summary of the HHS change drivers, recommends that the HHS adopts the Organisational Review's 20 key opportunities and provides a recommended approach to managing the organisational change processes, including redesign of services and changes to staff resources.

It is recommended that this Business Case for Change be supported and approved for implementation.

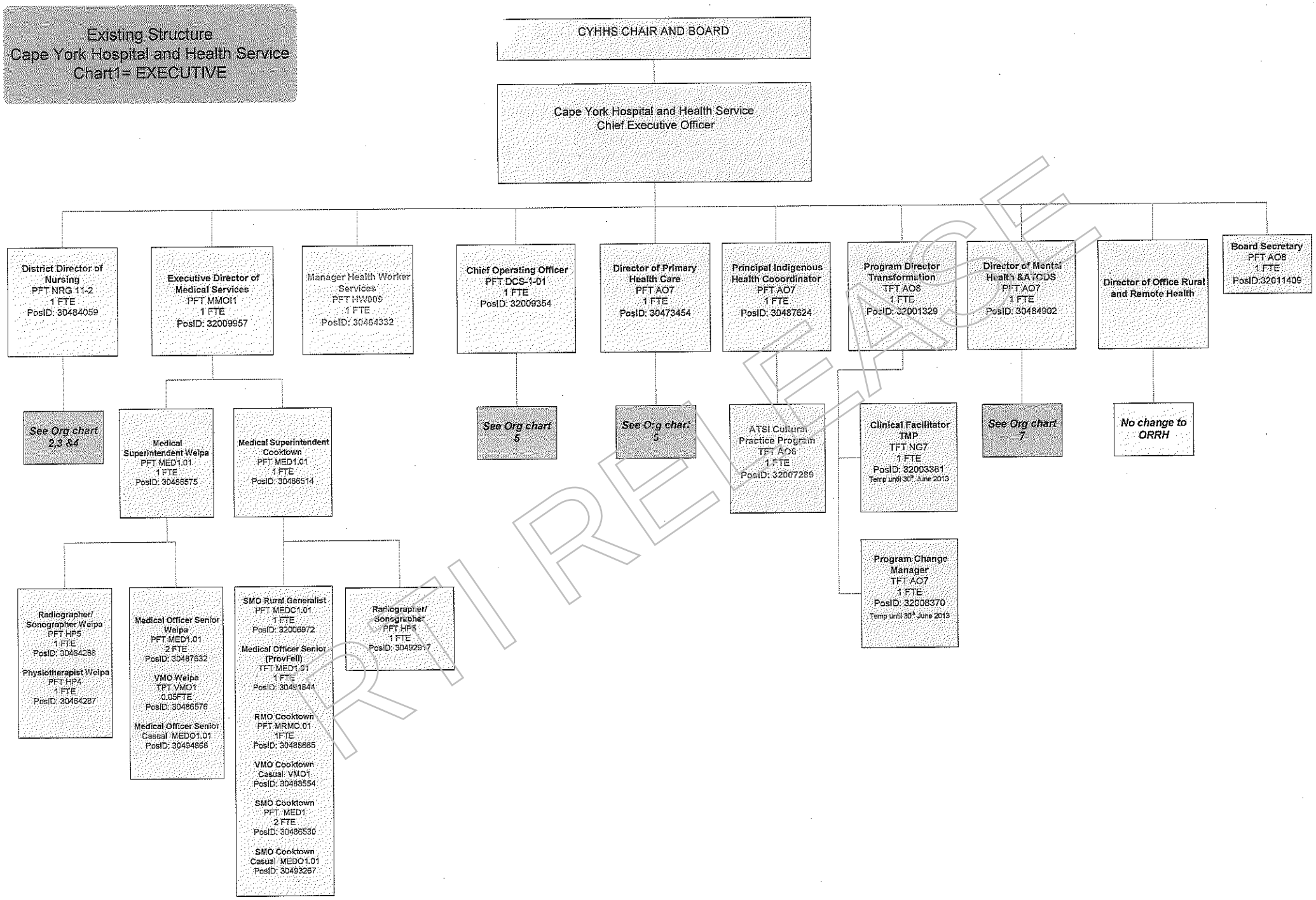
4. Appendix

High level Organisational Review opportunities
Opportunity
1. Refocus the role and structure of the Executive
2. Adopt a clustered approach to managing health service facilities
3. Outsource learning and development resources
4. Consolidate travel hub back into the HHS
5. Integrate Men's and Women's Health, Healthy Lifestyle and Cervical Screening outreach teams
6. Enhance the service coordination process to better assess clinical service effectiveness and efficiencies
7. Centralise the responsibility of Patient Safety and Quality roles and transition towards more defined 'hub and spoke' model
8. Transition of Napranum site to Apunipima as a pilot towards a community control model
9. Reduce patient travel by 15 per cent
10. Reduce staff travel by 10 per cent
11. Remove 25 per cent of surplus long term vacancies from establishment
12. Reduce nursing overtime to 1.5 per cent of total salaries and wages for MPHSs, and five per cent for PHCs
13. Proactively manage complex long term sick leave
14. Optimise Medicare billing opportunities
15. Remove dental prosthetics' role and outsource service
16. Reduce overlap with other providers in diabetes educator and nutrition roles
17. Reduce overlap with Apunipima and Medicare Local in community engagement function
18. Reduce medical overtime
19. Maximise pathology billing
20. Strengthen contact management processes

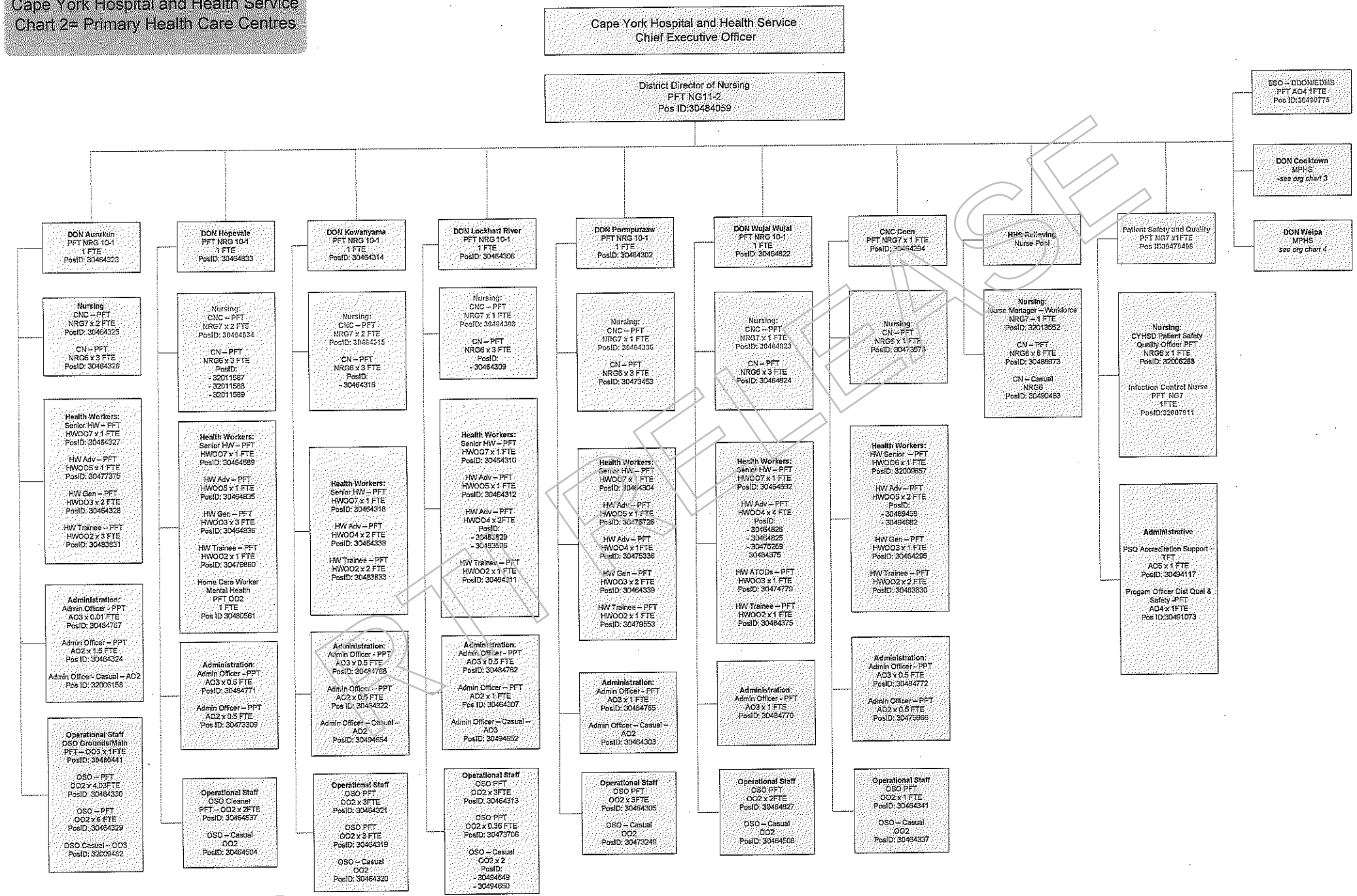
Source: Cape York HHS Organisational Review 2013, Ernst &Young, Australia.

References

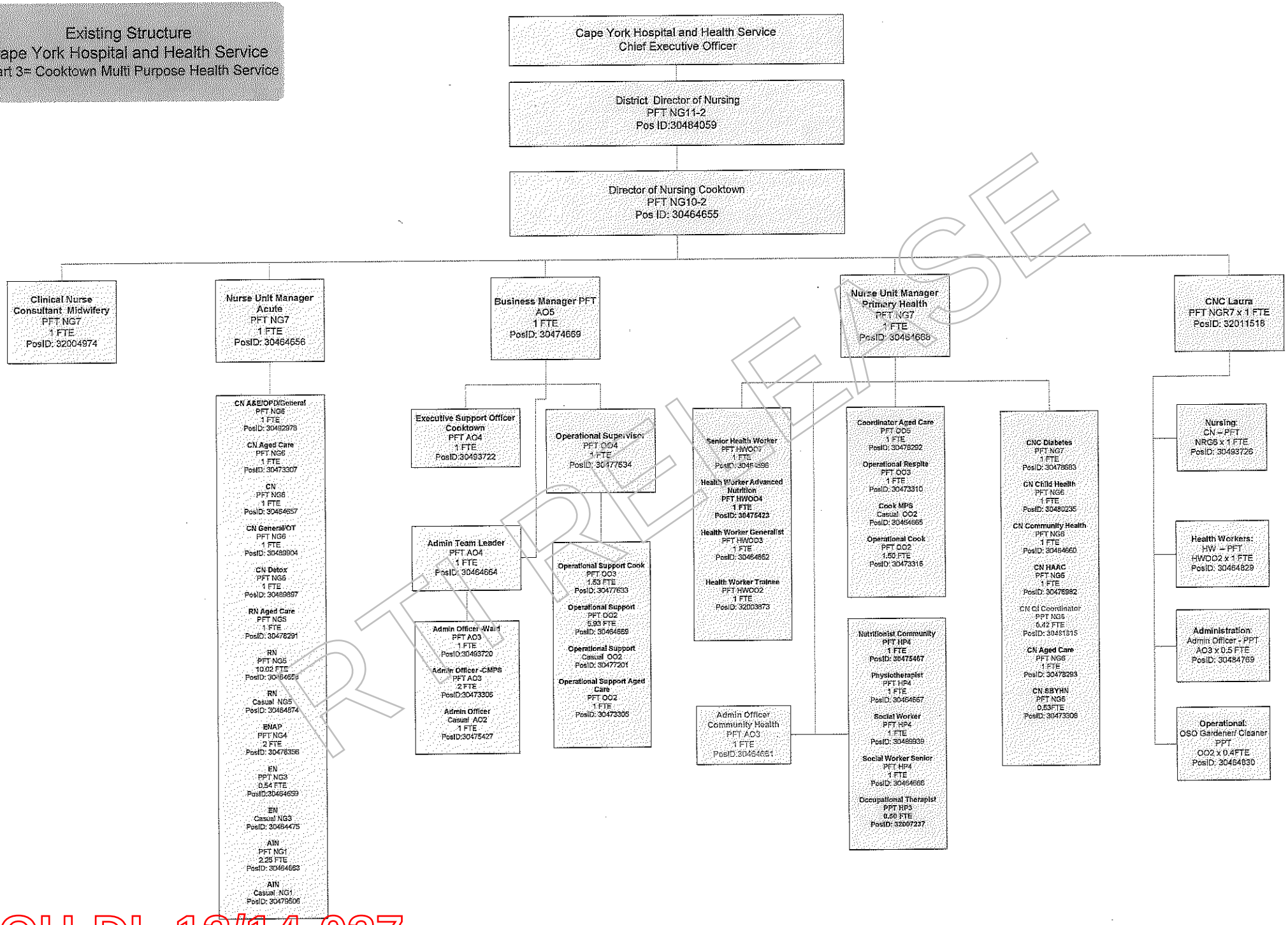
[i] Cape York Health Service District. *Transformation Project Initiation Proposal, 2010*
[ii] Queensland Government. *Statement of Government Health Priorities 2012*
[iii] Ernst & Young Australia. *Cape York Hospital and Health Service Organisational Review 2013*
[iv] Queensland Health 2012. *The Cape York Hospital and Health Service Agreement 2012-2013.*

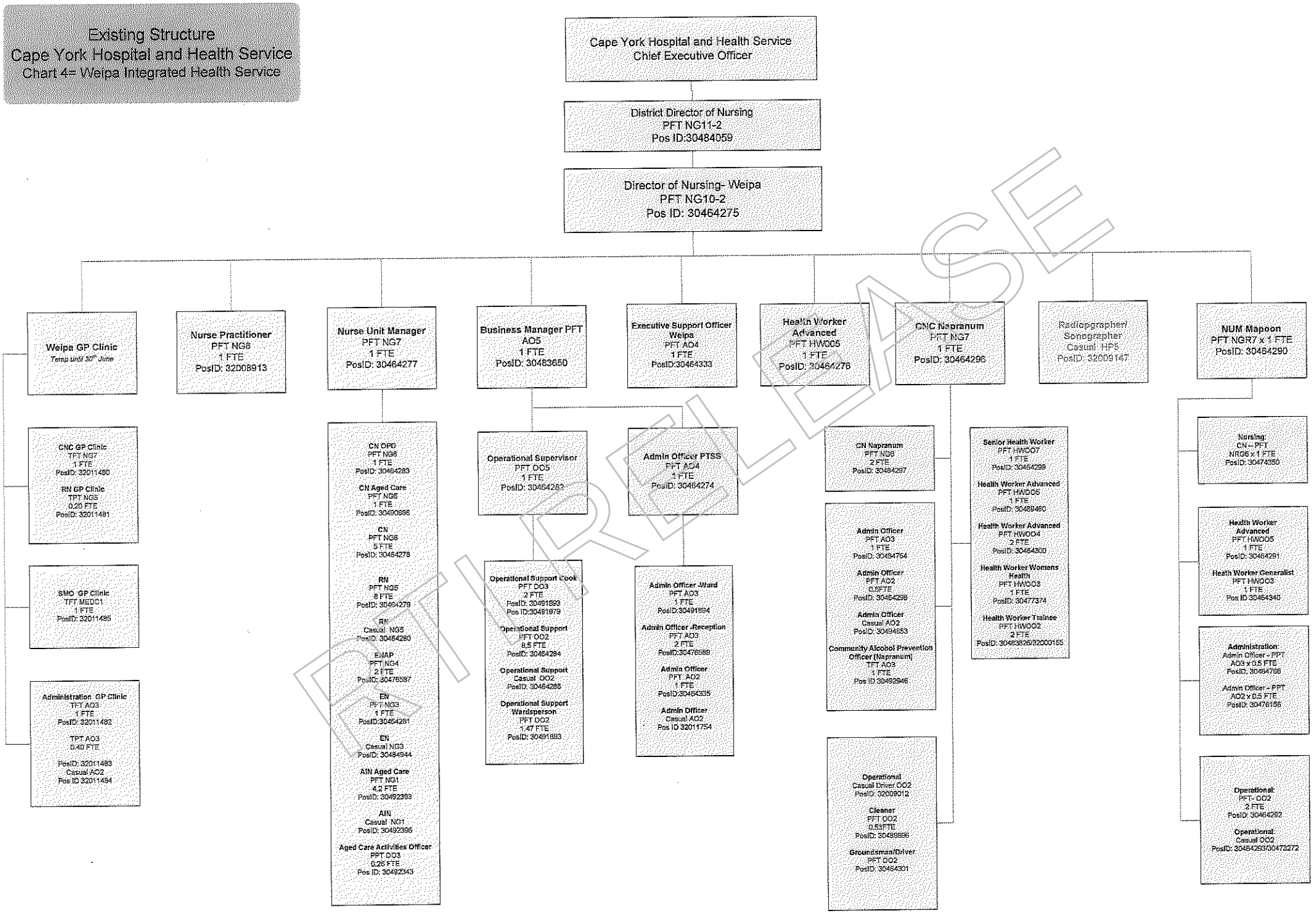


Existing Structure
Cape York Hospital and Health Service
Chart 2= Primary Health Care Centres

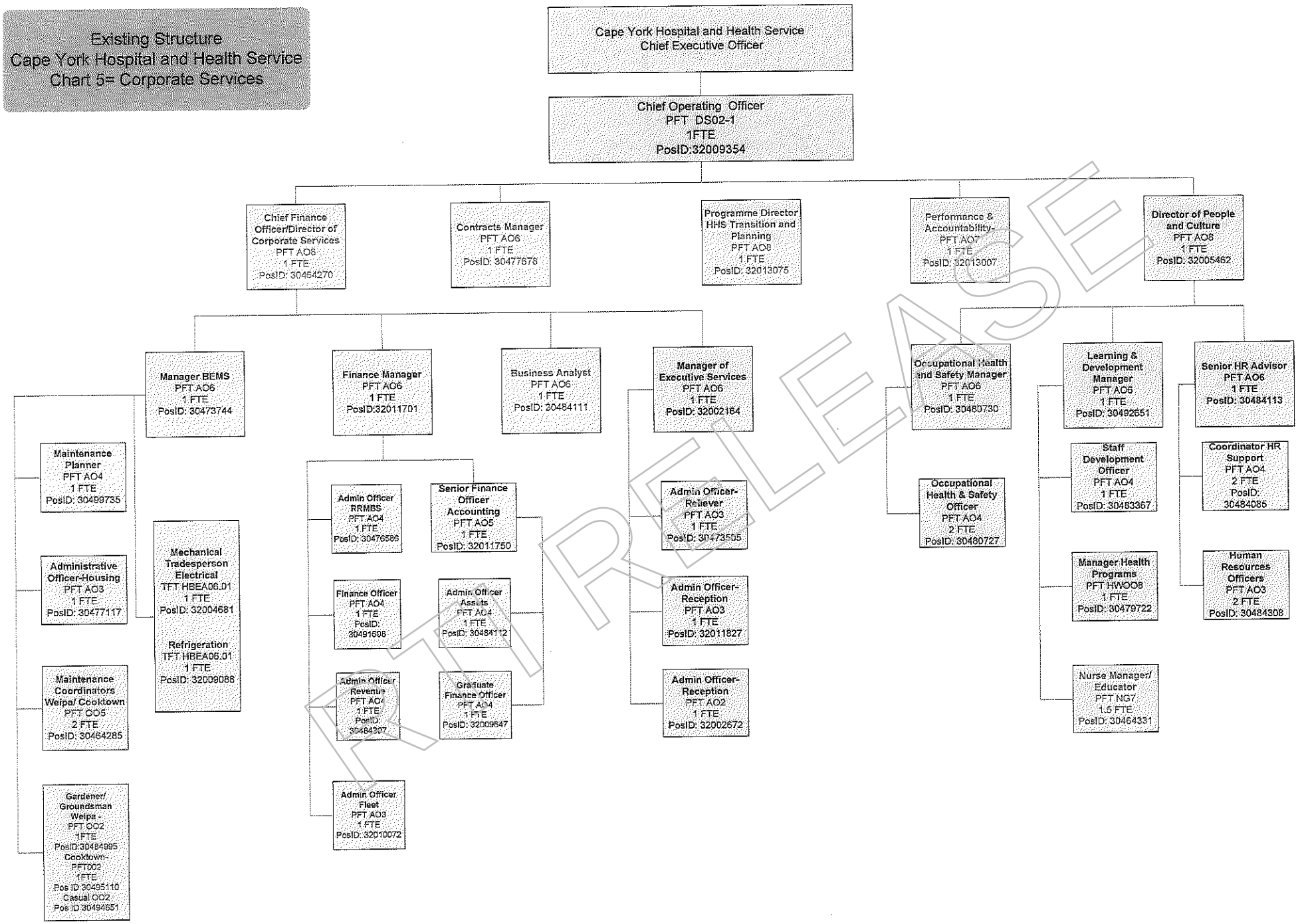


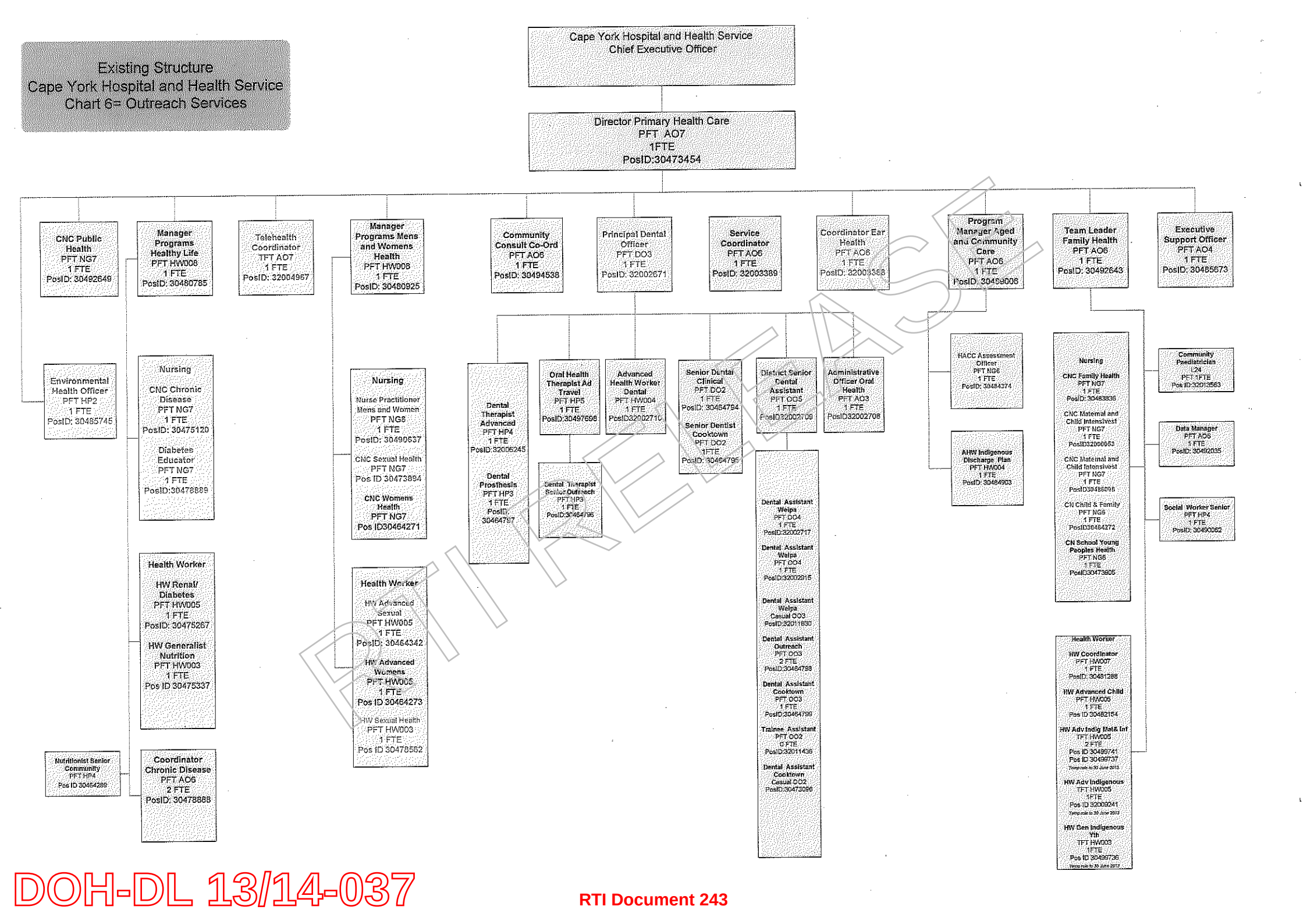
Existing Structure
Cape York Hospital and Health Service
Chart 3= Cooktown Multi Purpose Health Service



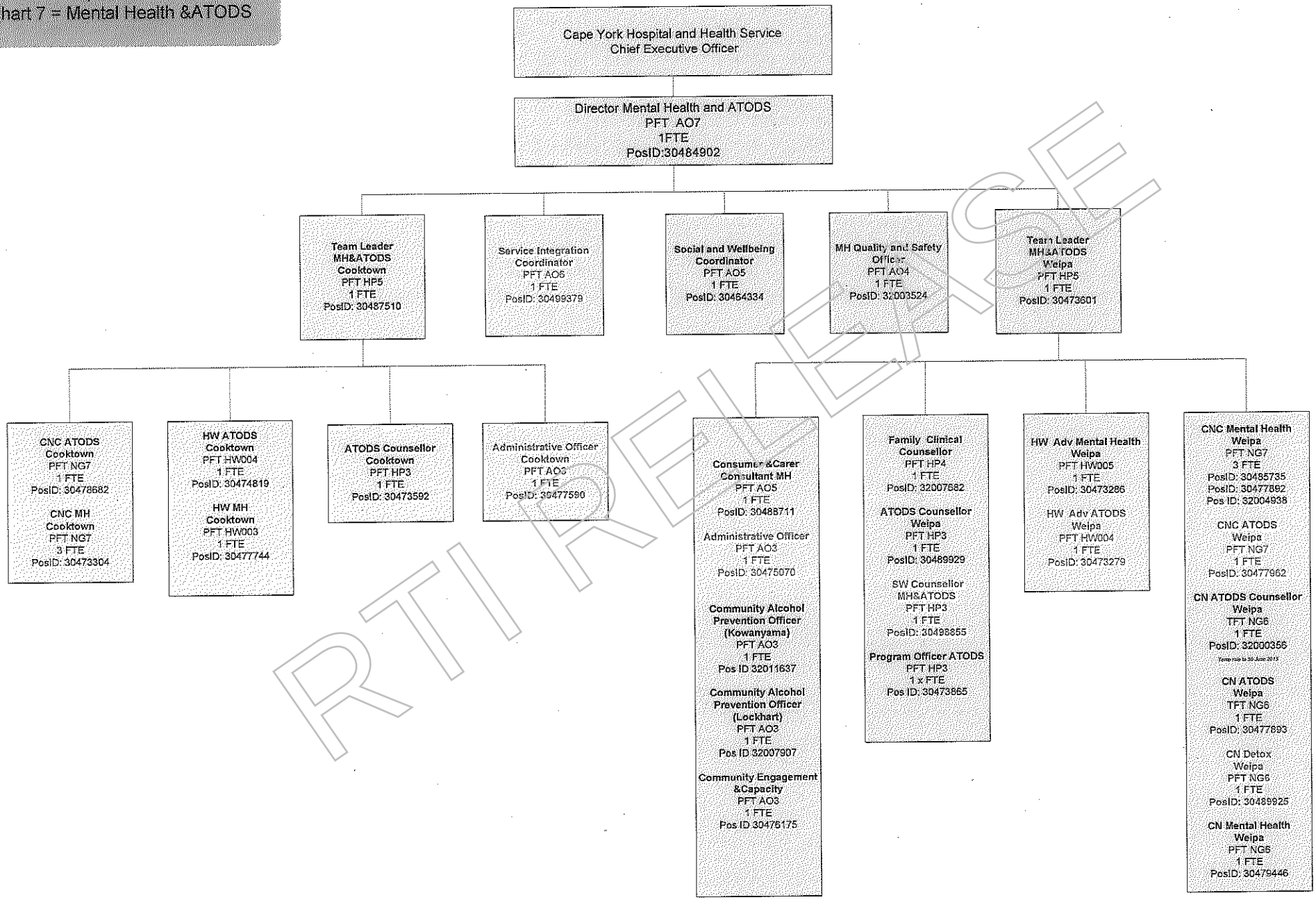


Existing Structure
Cape York Hospital and Health Service
Chart 5= Corporate Services

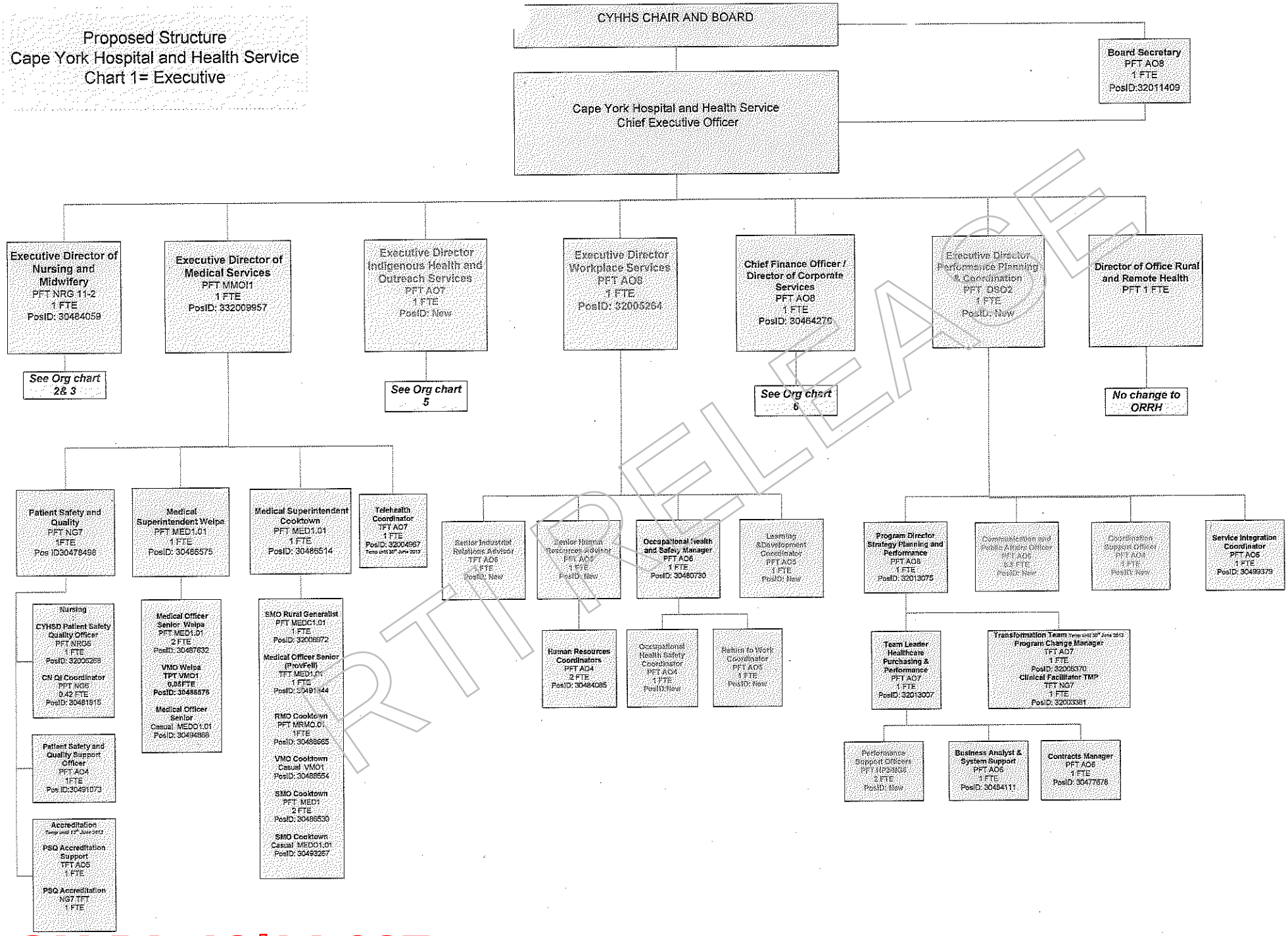




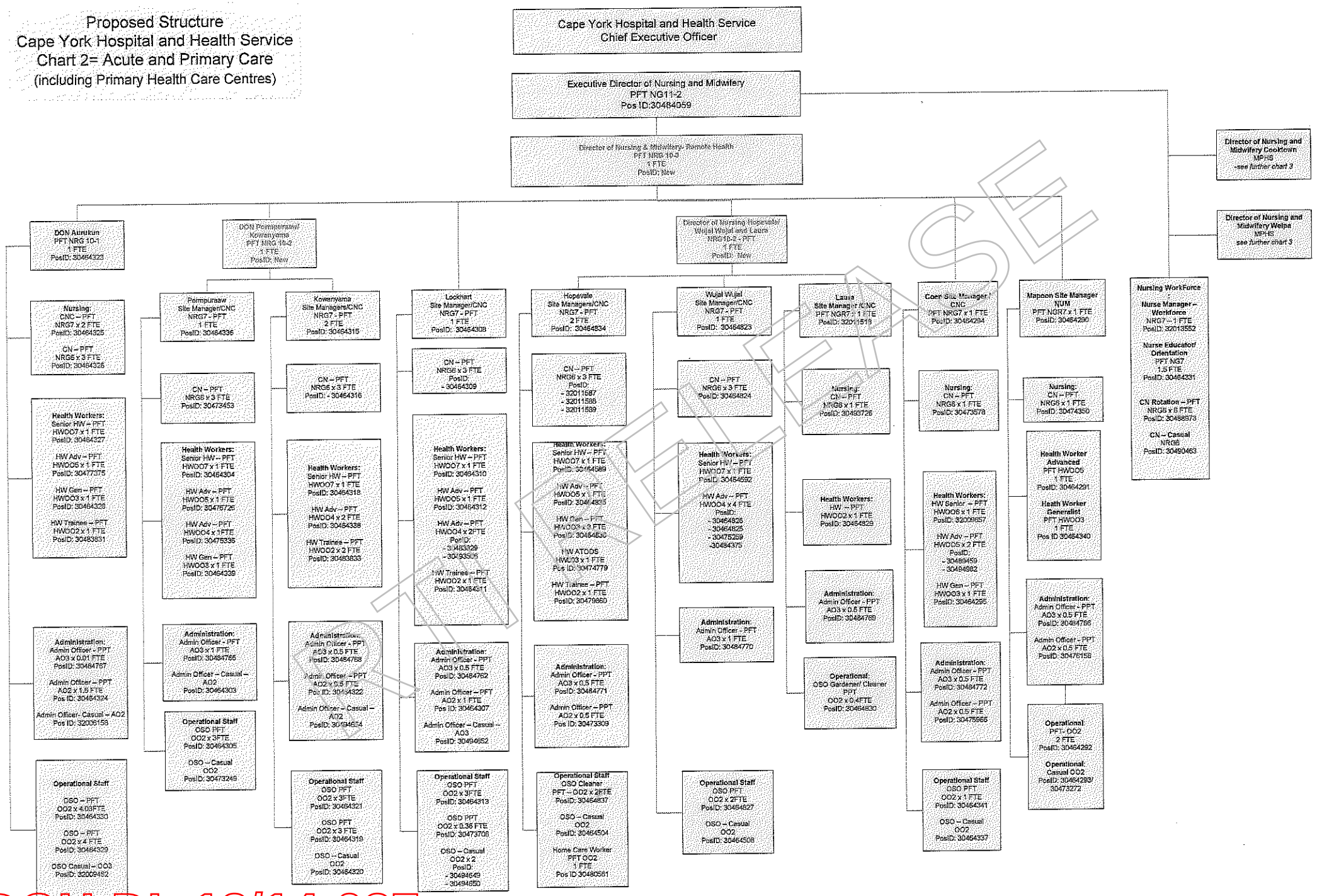
Existing Structure
Cape York Hospital and Health Service
Chart 7 = Mental Health &ATODS



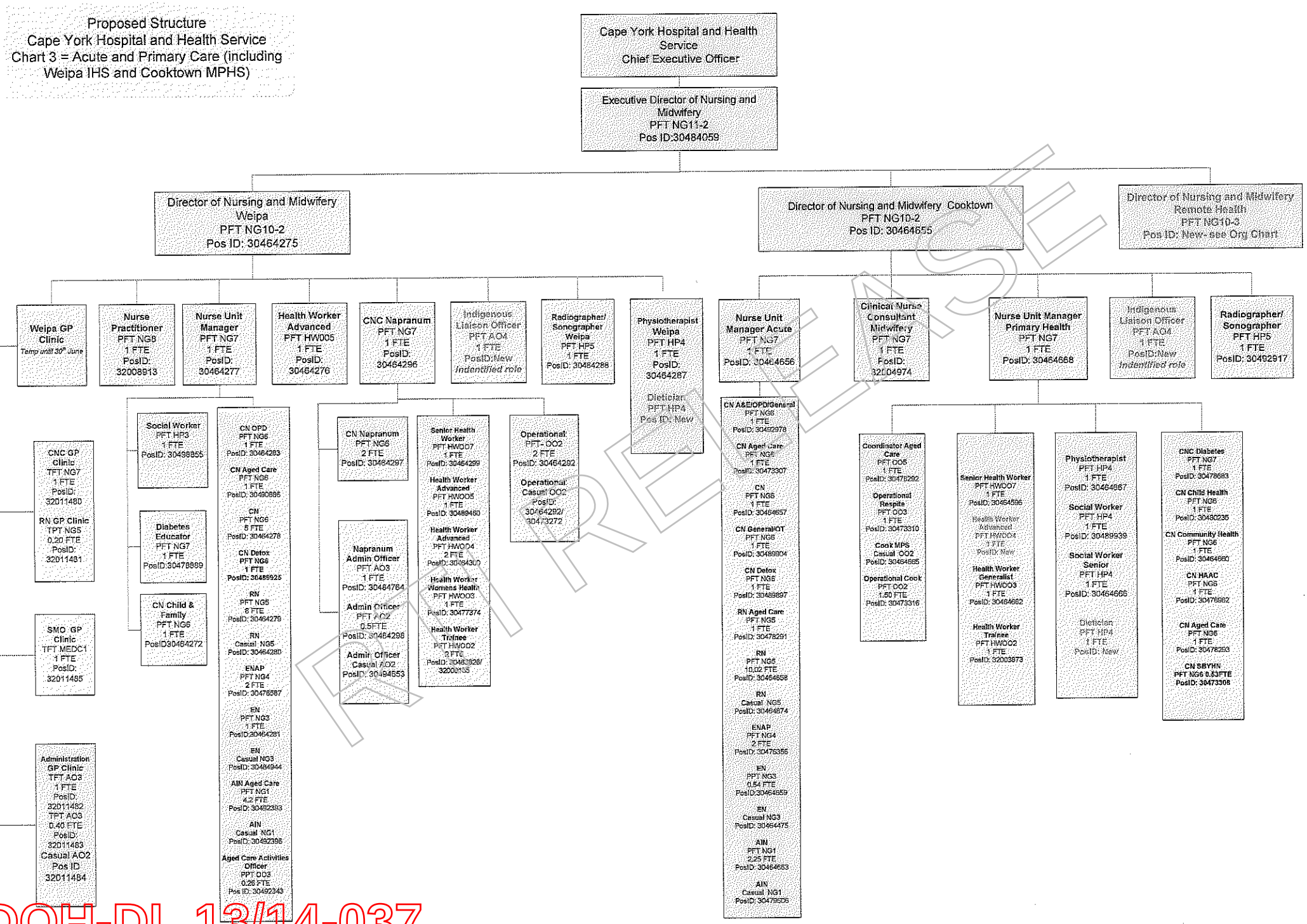
Proposed Structure
Cape York Hospital and Health Service
Chart 1= Executive



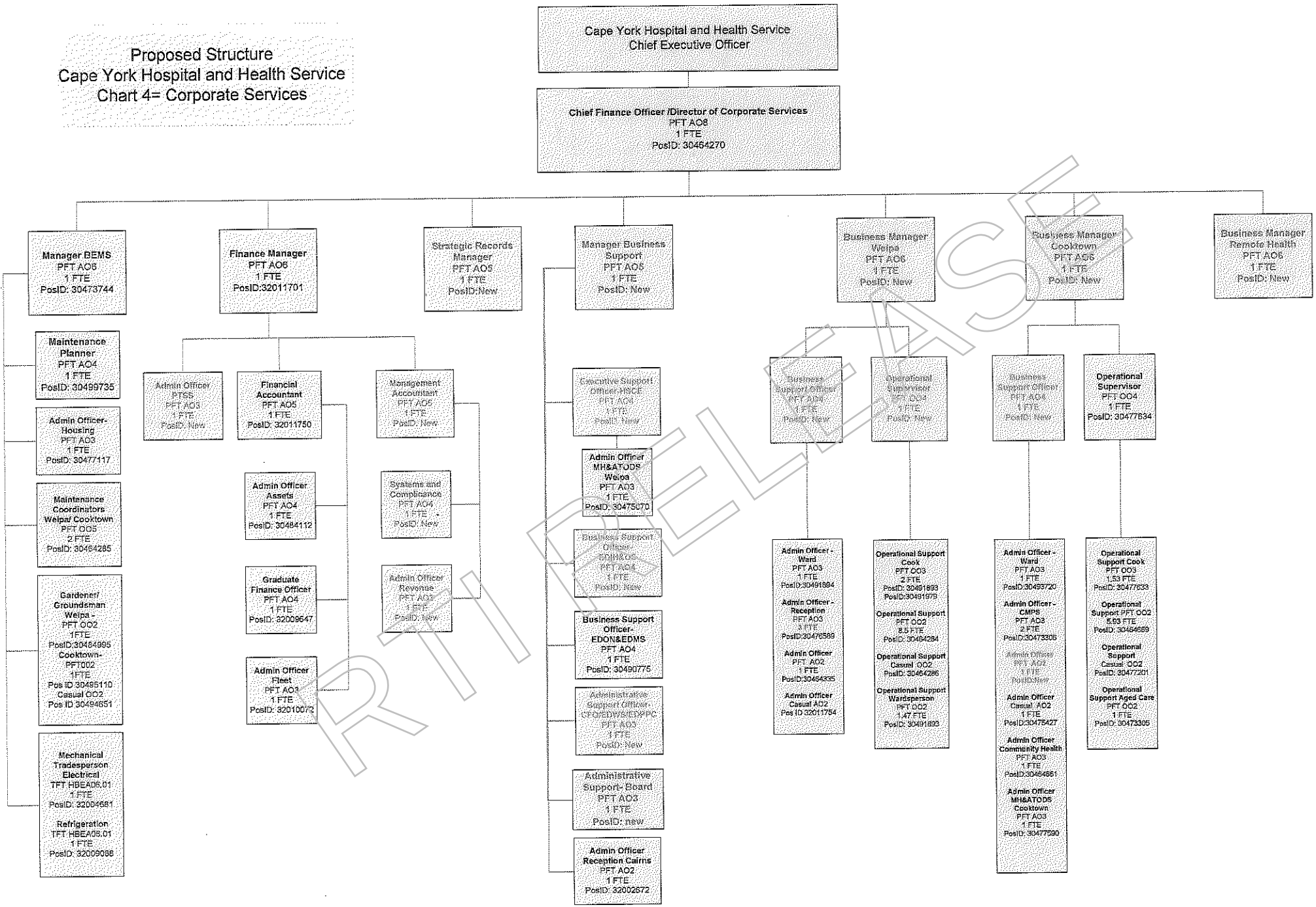
Proposed Structure
Cape York Hospital and Health Service
Chart 2= Acute and Primary Care
(including Primary Health Care Centres)



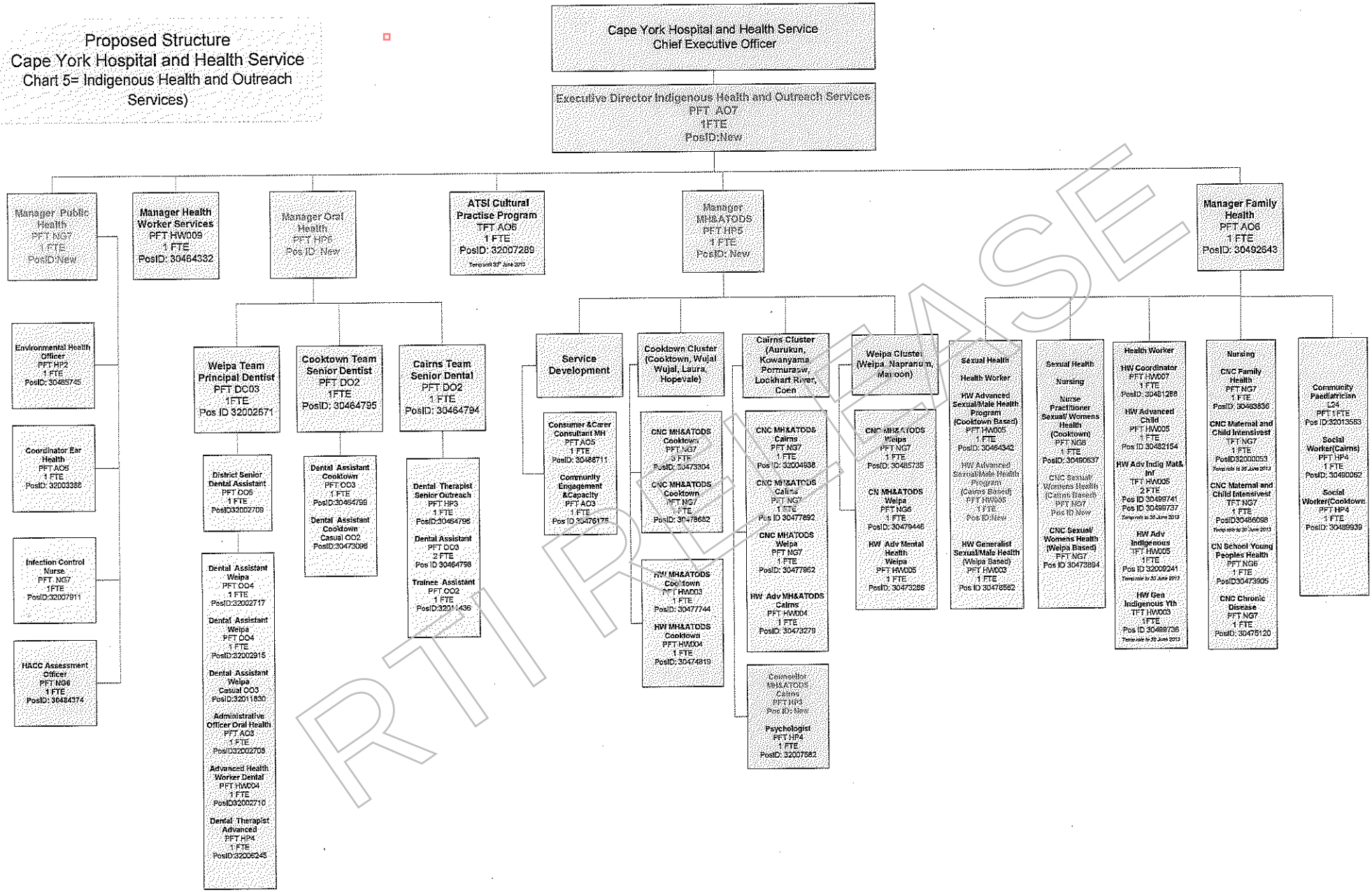
Proposed Structure
Cape York Hospital and Health Service
Chart 3 = Acute and Primary Care (including Weipa IHS and Cooktown MPHS)



Proposed Structure
Cape York Hospital and Health Service
Chart 4= Corporate Services



Proposed Structure
Cape York Hospital and Health Service
Chart 5= Indigenous Health and Outreach Services)



Department RecFind No:	BR056309
Division/HHS:	North West
File Ref No:	

BR056309

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED
DATE 15 MAR 2013 BY
RECORDS TEAM
RECEIVED 27 MAR 2013 QLD HEALTH

Requested by: Chief Executive, North West Hospital & Health Service

Date requested: 6 March 2013

Action required by: 27 MAR 2013

SUBJECT: Quality and Safety Review North West Hospital and Health Service

Recommendation

That the Minister:

Note the North West Hospital and Health Service (HHS) is undertaking a review of Quality and Safety which will potentially impact on staff and their current roles.

Note that no staff or Unions have been notified. The HHS plans to notify staff and Unions once Minister has been made aware of this Brief.

Note that following an evaluation process which included timeframes, relevant experience, understanding of issues and problems and value for money, Australian Healthcare Association has been selected to undertake the review.

Note that it is anticipated that the review process will commence as soon as notification communicated that this brief has been received.

Note the resultant report will be used to assist the North West HHS Executive and Board to develop and implement an appropriately robust Quality, Safety & Risk framework

APPROVED/NOT APPROVED **NOTED** NOTED

LAWRENCE SPRINGBORG
Minister for Health

/ /

PEA
Chief of Staff
22 / 3 / 13

Minister's comments

Department RecFind No:	BR056309
Division/HHS:	North West
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: Chief Executive, North West Hospital & Health Service **Date requested: 6 March 2013** **Action required by:**

SUBJECT: Quality and Safety Review North West Hospital and Health Service

Proposal

That the Director-General:

Note the North West Hospital and Health Service (HHS) is undertaking a review of Quality and Safety which will potentially impact on staff and their current roles.

Note that no staff or Unions have been notified. The HHS plans to notify staff and Unions once Minister has been made aware of this Brief.

Provide this brief to the Minister for information.

Urgency

1. **Urgent** - as requirement to inform staff that review is to commence.

Headline Issues

2. The top issues are:
   - The North West HHS will undertake a quality and safety review to achieve improved patient outcomes with a more effective service.

Key issues

3. The North West HHS Is committed to its vision of becoming a leading HHS in Queensland.
4. Current fragmented processes do not lend to a good governance process oversighting this critical area of HHS business.

Background

5. Transition to a Hospital and Health Service required a review of all current governance.
6. Transition to accreditation under National guidelines revealed a need for a more collaborative and effective quality and safety governance process.
7. Discussions with the Chair of the Quality and Safety Board committee identified a need to review current situation and recommend improved way forward.
8. A competitive process was offered to four panel firms procured through the 160 panel arrangement, of which three responded to our brief.
9. Following an evaluation process which included timeframes, relevant experience, understanding of issues and problems and value for money, Australian Healthcare Association has been selected to undertake the review.
10. It is anticipated that the review process will commence as soon as notification communicated that this brief has been received.
11. Resultant report will be used to assist the North West HHS Executive and Board to develop and implement an appropriately robust Quality, Safety & Risk framework.

Attachments

12. Nil

Department RecFind No:	BR056309
Division/HHS:	North West
File Ref No:	

Recommendation
That the Director-General:

Note the North West Hospital and Health Service (HHS) is undertaking a review of Quality and Safety which will potentially impact on staff and their current roles.

Note that no staff or Unions have been notified. The HHS plans to notify staff and Unions once Minister has been made aware of this Brief.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General
13/3/13

To Minister's Office For Noting ☑

Director-General's comments

Author
Barbara Davis

Executive Director Corporate Services

North West Hospital and Health Service

4764 0210

11 March 2013

Content verified by: (CEO/DDG/Div Head)
Sue Belsham

Chief Executive

North West HHS

4764 0210

11 March 2013

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

URGENT

Requested by: Chief Executive, North West Hospital & Health Service

Date requested: 8 March 2013

Action required by:

SUBJECT: Proposed Voluntary Redundancies for the North West Hospital and Health Service

Recommendation
That the Minister:

- **Note** the North West Hospital and Health Service (HHS) target Full Time Equivalent (FTE) is 609 currently and this has already been achieved but with the knowledge that there are a number of critical positions which still require recruitment.

  Note that ongoing weekly monitoring of MOHRI, plus intensive review of all positions across the HHS, has identified a number of occupied positions which are classified as surplus to requirements given changed models of care.

  Note proposed positions to make redundant has the support of the North West HHS Board.

  Note that no staff or Unions have been notified. North West HHS plans to notify staff and Unions once Minister has been made aware of this Brief.

APPROVED/NOT APPROVED **NOTED** **NOTED**

LAWRENCE SPRINGBORG
Minister for Health

/ /

Chief of Staff

/ /

Minister's comments

12 MAR 2013

URGENT

Department RecFind No:	BR056311
Division/HHS:	North West HHS
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: Chief Executive, North West Hospital & Health Service **Date requested:** 8 March 2013 **Action required by:**

SUBJECT: Proposed Voluntary Redundancies for the North West Hospital and Health Service

Proposal

That the Director-General:

Note the North West Hospital and Health Service (HHS) target Full Time Equivalent (FTE) is 609 currently and this has already been achieved but with the knowledge that there are a number of critical positions which still require recruitment.

Note that ongoing weekly monitoring of MOHRI, plus intensive review of all positions across the HHS, has identified a number of occupied positions which are classified as surplus to requirements given changed models of care.

Note proposed positions to make redundant has the support of the North West HHS Board.

Note that no staff or Unions have been notified. North West HHS plans to notify staff and Unions once Minister has been made aware of this Brief.

Provide this brief to the Minister for information.

Urgency

1. **Critical** - in order for the HHS to achieve payment of redundancy (some persons allocated to proposed redundancy have worked for Queensland Government for many years) from Treasury, a decision to support the offer of voluntary redundancy is required.

Headline Issues

2. The top issues are:
   - Voluntary redundancies to be offered to four staff based at the Mount Isa Hospital.
   - Chair of the North West HHS Board, Mr Paul Woodhouse, has consistently communicated to staff that there would be no forced redundancies.
   - The identified positions are considered surplus to requirements and the intent is to offer a voluntary redundancy.

Key issues

3. The North West HHS has always been challenged in recruiting to permanent positions and subsequently has a high level of locum and agency staff. To note, staffing levels are considered reasonable, particularly when level of service delivery is higher for the North West compared to other rural and remote HHSs.

4. Whilst MOHRI targets and trajectory are being met, the North West HHS was aware of need to still recruit to critical vacancies therefore a review of all positions identified four surplus to requirement.

5. Risks in the offer of voluntary redundancies include refusal of offer and potential poor media for the HHS.

Department RecFind No:	**BR056311**
Division/HHS:	**North West HHS**
File Ref No:	

Background

6. In late 2012, the current State Government directed that all Government Departments must decrease their workforce (MOHRI FTE) to meet a target by 31 March 2013. The decrease in FTE aligned with decreased budget allocation for the 2013-2014 financial year to move the State of Queensland back to a more positive credit rating.

7. A review of all positions resulted in the submission of possible offers of voluntary redundancies to the North West HHS Board who supported the progress of these offers.

Attachments

8. Attachment 1: List of positions to be offered voluntary redundancy

Department RecFind No:	BR056311
Division/HHS:	North West HHS
File Ref No:	

Recommendation
That the Director-General:

Note the North West Hospital and Health Service (HHS) target Full Time Equivalent (FTE) is 609 currently and this has already been achieved but with the knowledge that there are a number of critical positions which still require recruitment.

Note that ongoing weekly monitoring of MOHRI, plus intensive review of all positions across the HHS, has identified a number of occupied positions which are classified as surplus to requirements given changed models of care.

Note proposed positions to make redundant has the support of the North West HHS Board.

Note that no staff or Unions have been notified. North West HHS plans to notify staff and Unions once Minister has been made aware of this Brief.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

13/3/13

To Minister's Office For Noting ☑

Director-General's comments

Author	Content verified by: (CEO/DDG/Div Head)
Barbara Davis	Sue Belsham
Executive Director Corporate Services	Chief Executive
North West Hospital and Health Service	North West HHS
4764 0210	4764 0210
11 March 2013	11 March 2013

Position ID	MOHRI FTE	Position Name	Classification Level
30477379	1.0	Prevention Officer (Outreach)	AO4
30474034	1.0	Manager Health Worker Services	OO8
30468674	0.59	Administrative Officer	AO2
[redacted]			
32004063	1.0	Manager Learning and Development	AO6
Total	**4.09**		

s.47(3)(b)

BR056313

Department RecFind No:	BR056313
Division/HHS:	North West HHS
File Ref No:	

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED
DATE 15 MAR 2013 BY

Requested by: Chief Executive, North West Hospital & Health Service

Date requested:

Action required by:

RECORDS TEAM
QLD HEALTH
15 APR 2013

SUBJECT: Mental Health and ATODS Workforce Realignment

Recommendation

That the Minister:

Note the need to restructure and implement a realigned model of service delivery within Mental Health and Alcohol, Tobacco and Other Drugs Services (ATODS) to address the community demand for crisis presentations, suicidality and substance misuse in the North West Hospital and Health Service (HHS).

Note the impact of the change of model of service delivery will potentially attract a cost saving when fully implemented.

Note the impact of realignment on staffing as whilst will occur within current staffing levels, a number of staff will be affected by the realignment.

Note realignment will result in the loss of one currently occupied position.

Note change in model of service delivery will result in extended operational hours for mental health, including alcohol and drug support impacting positively for community, hospital staff and follow up consumer support.

Note that no staff or Unions have been notified. The North West HHS plans to notify staff and Unions once Minister has been made aware of this Brief.

APPROVED/NOT APPROVED **NOTED** **NOTED**

LAWRENCE SPRINGBORG
Minister for Health

/ /

Chief of Staff

PPA
28 / 3 / 13

Minister's comments

13 MAR 2013

Department RecFind No:	BR056313
Division/HHS:	North West HHS
File Ref No:	

URGENT

Briefing Note for Noting

Director-General

Requested by: Chief Executive, North West Hospital & Health Service **Date requested:** **Action required by:**

SUBJECT: Mental Health and ATODS Workforce Realignment

Proposal

That the Director-General:

Provide this brief to the Minister for approval to progress.

Note the need to restructure and implement a realigned model of service delivery within Mental Health and Alcohol, Tobacco and Other Drugs Services (ATODS) to address the community demand for crisis presentations, suicidality and substance misuse in the North West Hospital and Health Service (HHS).

Note the impact of the change of model of service delivery will potentially attract a cost saving when fully implemented.

Note the impact of realignment on staffing as whilst will occur within current staffing levels, a number of staff will be affected by the realignment.

Note realignment will result in the loss of one currently occupied position.

Note change in model of service delivery will result in extended operational hours for mental health, including alcohol and drug support impacting positively for community, hospital staff and follow up consumer support.

Note that no staff or Unions have been notified. The North West HHS plans to notify staff and Unions once Minister has been made aware of this Brief.

Urgency

1. **Urgent** - to improve support to community for crisis including potential to decrease the incidence of suicide in the North West HHS.

Headline Issues

2. The top issues are:
   - Extended hours for mental health, alcohol and drug support at Mount Isa hospital.
   - Improved consumer support and follow up.
   - Meets National Mental Health Priority areas for prevention and early intervention.

Key Issues

3. Currently, operational hours for adult mental health and drug and alcohol services are 8.30am to 4.30pm Monday to Friday. New model of service would extend operating hours from 6am to 11pm seven days per week with psychiatric on call between 11pm and 6am.

4. NWHHS needs to embark on sustainable service modelling for mental health that forms a basis for growth that meets increasing community demand.

5. Current model of service does not meet the need for continuum of care between existing services (internal and external) or provide for necessary short term support and follow up for crisis presentations.

6. Significant continued suicide completion rates and presentations of suicidality in the NWHHS.

Department RecFind No:	BR056313
Division/HHS:	North West HHS
File Ref No:	

Background

7. Review of the current models of service and integration of the four program areas occurred as a result of five significant factors.
   - Sentinel Event November 2010 – Root Cause Analysis (RCA) recommendations released September 2012 – AMHS review commenced mid 2011 including identifying evidence based models of service delivery and current internal practice/s.
   - Clinical Audit completed 2011.
   - ACHS recommendations 2011 to provide dedicated mental health staff to the Emergency Department Mount Isa.
   - Financial analysis and service demands review including Health Services Plan 2012-2027 and financial audit over 2010-2011 and 2011-2012
   - Withdrawal of Townsville Psychiatric service support and outreach service for NWHHS as at 1 July 2012.

8. In addition:
   - Review - no clear or defined acceptance or exclusion criteria for the adult mental health service documented;
   - Consumers have historically been assessed as to presence of 'treatable mental illness' and accepted dependent on clinical capacity with little or no structure in place for follow up and support; and
   - Given this historical practice and clinical capacity including fatigue management of staff, it is a concern that integrity of the community mental health services is impacted and at times limited access pathways for short term management and support.

Attachments

9. Attachment 1: Proposed Model of service Business Case for Change

Department RecFind No:	BR056313
Division/HHS:	North West HHS
File Ref No:	

Recommendation
That the Director-General:

Provide this brief to the Minister for approval to progress.

Note the need to restructure and implement a realigned model of service delivery within Mental Health and Alcohol, Tobacco and Other Drugs Services (ATODS) to address the community demand for crisis presentations, suicidality and substance misuse in the North West Hospital and Health Service (HHS).

Note the impact of the change of model of service delivery will potentially attract a cost saving when fully implemented.

Note the impact of realignment on staffing as whilst will occur within current staffing levels, a number of staff will be affected by the realignment.

Note realignment will result in the loss of one currently occupied position.

Note change in model of service delivery will result in extended operational hours for mental health, including alcohol and drug support impacting positively for community, hospital staff and follow up consumer support.

Note that no staff or Unions have been notified. The North West HHS plans to notify staff and Unions once Minister has been made aware of this Brief.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General
14/3/13

To Minister's Office For Noting ☑

Director-General's comments

Author	Content verified by: (CEO/DDG/Div Head)
Sandra Kennedy	Sue Belsham
ED Mental Health ATODS	Chief Executive
North West Hospital and Health Service	North West HHS
4744 7103	4764 0210
11 March 2013	11 March 2013

BUSINESS CASE
Model of Care Change Mental Health Services NWHHS

1. Current Situation

Mental Health & ATODS services provides community mental health and drug and alcohol services under 4 program areas

1. Adult Mental Health Service (AMHS)
2. Child & Youth Mental Health Services (CYMHS)
3. Alcohol, Tobacco & Other Drug Services (ATODS)
4. Homeless Health Outreach Services (HHOT)

Mental Health & ATODS services are provided in a hub and spoke model of service with Adult Mental Health and ATODS services being provided to all communities in the NWHHS with permanent staff in Normanton, Doomadgee and Mornington Island

Currently AMHS provides 24hr/7 days per week on-call services out of Mount Isa. This model evolved over time and historically has not been included in base funding. On-call has been managed with the utilisation of fatigue leave. In 2010/11 approximately $150,000.00 was spent on overtime alone – this financial analysis did not factor in fatigue leave.

Current clinical staff profile (please note this is clinical service delivery staff only - 8 AMHS are available to be rostered to on-call duties):

AMHS Mental Health	CYMHS
Clinical Director Mental Health Services	Team Leader CYMHS
Mental Health PHO	EdLinQ Coordinator – HP4 Social Worker (temp)
Team Leader	Psychologist Senior CYMHS – HP4
Psychologist Senior	Mental Health Professional – HP3
Senior Social Worker	Psychologist Child & Youth – HP3
Social Worker	
CNC Mount Isa	
CNC Doomadgee	
CNC Hospital Liaison	
CNC Mornington Island	
CNC MH Intervention /Court Liaison	
Clinical Nurse	
Clinical Nurse	
RN 1st Year Practitioner	
Health Worker Advanced	
Senior Health Worker	

Models of care

Meeting individual & community needs through workforce redesign

ATODS	HHOT
ATODS Manager	Team Leader HHOT
Senior Psychologist HP4	Clinical Health Practitioner
Clinical Treatment Officer – HP3	Clinical Health Practitioner
Clinical Treatment Officer – HP3	Clinical Health Practitioner
Clinical Nurse – Mount Isa	CNC HHOT
Clinical Nurse Doomadgee	Clinical Nurse
Clinical Nurse Mornington Island	Clinical Nurse
Nurse Manager – Mount Isa	Clinical Nurse
CNC - Dual Diagnosis Normanton	Senior Health Worker
Clinical Treatment Officer – HP4 outreach MI	Advanced Health Worker
Clinical Treatment Officer– HP4 outreach Normanton	Generalist Health Worker
Clinical Treatment Officer – HP4 outreach Doomadgee	
Advanced Health Worker – Mt Isa	
Community Support Worker (D'gee) x 2 FTE	
Community Support Worker (MI) x 2 FTE	
Community Support Worker (Norm) x 2 FTE	

SNAPSHOT Occasions of Service

Service contacts	2009/10	2010/2011	2011/2012 (to July)
AMHS Mount Isa	2143	4248	5160
CYMHS	710	1700	2112
ATODS	3903	3407	5553
HHOT	n/a	4038	1634

Mental Health related Emergency Department presentations 2011 = 999

Analysis of EDIS data for 2011 Mount Isa Emergency Department only as follows – please note it has not been determined the number of at risk of homelessness or homeless population included in data

Time frame	Alcohol related	Mental health
5pm – 11pm	120	169
11pm – 6am	102	138
Week end 6pm – 10am	73	104

SNAPSHOT Risk presentation to ED: 183 presentations of suicide ideation/self harm, 31 emotional crisis were captured in EDIS data in 2011 Mount Isa Emergency Department.

Queensland Government

Models of care

Meeting individual & community needs through workforce redesign

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Total Suicidal behaviour data 2011
Completed suicide – 16 (3 of which were youth 14-16 yoa)

	Self Harm	Ideation	Attempt	Completion
Adults	70	71	61	6
Youth	20	36	7	4
M.Isld	2	10	10	3
DGE	1	5	2	1
NTON	0	3	0	1
BKTWN	0	0	0	1
Total	**93**	**125**	**80**	**16**

Suicidal Behaviour data 2012 to date:
Completed suicide to date - 9

	Self Harm	Ideation	Attempt	Completion
Adults	22	63	40	6
Youth	14	27	7	0
M.Isld	0	4	6	0
DGE	2	3	6	1
NTON	0	1	1	1
J CK	0	0	0	1
Total	**38**	**98**	**60**	**9**

Currently the Adult Mental Health Model of Service includes intake, assessment and case-management. Intake meetings occur daily, case allocation and case review of scheduled consumers occurs weekly. At present there is no clear or defined acceptance or exclusion criteria for the adult mental health service documented. Consumers are assessed as to presence of 'treatable mental illness' and dependent on clinical capacity and consumer wishes is either accepted, referred or not accepted to service. While there are work instructions in place for the management of at risk presentations, if not accepted to the AMHS for 'treatment' and either referred or not accepted as a client, there is little or no follow up support from the service to assist in transition to another team/service provider or short term support through emotional crisis.

Review of the current models of service and integration of the 4 program areas occurred as a result of 5 significant factors:

1. Sentinel Event November 2010 – RCA recommendations released September 2012 – AMHS review commenced mid 2011 including identifying evidence based models of service delivery and current internal practice
2. Clinical Audit 2011
3. ACHS recommendations 2011 to provide dedicated mental health staff to the Emergency Department Mount Isa
4. Financial analysis and service demands review including Health Services Plan 2012-2027

5. Withdrawal of Townsville Psychiatric service support and outreach service for NWHHS as at 1 July 2012.

Review revealed the following

- While referral pathways exist between teams within the Mental Health & ATODS service, there is no consistent co-case management framework despite the presence of Dual Diagnosis Protocols for the service
- While additional local instructions implemented include a minimum of 1 follow up in the first 7 days post risk presentation, no clear support service for short term support and care exist for crisis management and/ referral and transition to external or internal service provision by other teams
- No clearly documented and defined entry and re-entry criteria to the AMHS
- No clearly documented and defined practice interventions according to scope of practice and skill mix
- Significant increase in presentations to mental health services within NWHHS
- Significant increase in community suicides and suicidal behaviour 2010-2012 – ongoing
- Need to review efficient service delivery to develop a reliable, sustainable service within the NWHHS to ensure
    - continuity of care across the continuum of care for those experiencing mental health concerns and/disorders
    - a recovery focused model of service based on best practice and in line with national frameworks and standards for Mental Health Service Delivery,
    - Improved capacity to respond to suicidality including prevention and management, and
    - Dual Diagnosis maintaining an 'every door is the right door' approach to service provision to improve consumer outcomes and community access to support, assistance and treatment.
    - Shift in organisational culture to provide a more 'inclusive' service that supports community mental health wellbeing

2. Future Profile

Directions for future service profile and objectives

A. Structure and implement an acute care model of service delivery that is based on state-wide evidence based framework that includes integration with ATODS and HHOT team with the inclusion of a clinician from each service on an acute care team
B. Extend adult mental health service operating hours to 6am – 11 pm 7 days per week to
    a. Increased capacity to respond to referrals and complete assessments and case reviews in a timely manner by increasing the hours of accessibility as per RCA recommendations and Clinical Audit 2011
    b. improve community access and capacity for follow up

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    b. improve community access and capacity for follow up

c. increase support to ED as per ACHS recommendations
d. provide increased capacity to manage short term acute presentations and support for suicidal behaviours and crisis management
e. improve the capacity to support consumers managed by other teams or services through crisis episodes
f. improve the capacity for after hours follow up for consumers managing employment/family commitments
g. improve capacity for drug and alcohol clinical governance, treatment capacity for Opioid Treatment Program and reduce risk in D&A population
h. Support ED staff with complicated drug and alcohol presentations and increase opportunistic intervention with this population

C. reduce fatigue leave by ceasing general mental health on call service with the exception of urgent psychiatric review
D. assist with capacity building with ED and ward staff to manage presentations for drug and alcohol and mild to moderate mental health disorders/presentations
E. Implement a Continued Care Model of Service for those consumers requiring ongoing treatment in a recovery based model of care and seamless transition to care
F. Provide increased access for hospital staff for consultation and liaison including capacity and skill building via flexible in service delivery capabilities after hours
G. Improving retention of staff through management of fatigue and structured shift work
H. Decrease costs associated with on call service
I. Increase recruitment and retention of Clinical Director by restructuring services to enable upgrade of PHO to Consultant Psychiatrist and enhance quality and safety of service provision including increased capacity to provide psychiatric outreach services

RESTRUCTURE OUTLINE REQUIREMENTS, METHOD AND RISKS

A. – See attached Acute Care Model Of Service
B. Required workforce profile : (Mount Isa Clinical Services only – does not include outlying service sites/support staff)

STAFF STRUCTURE AND COMPOSITION

WORKFORCE PROFILE – ACUTE CARE

Position Level	FTE	Team
CNC	1.5	AMHS
HP4	2.0	AMHS
CN	1.0	AMHS
CN	1.0	ATODS
HP3	1.0	HHOT
ALO	1.0	AMHS
Consultant Psychiatrist	1.0	AMHS

WORKFORCE PROFILE – CONTINUED CARE MENTAL HEALTH & ATODS

Position Level	FTE	Team
AMHS		
CNC	1.5	AMHS
HP4	1.0	AMHS
CN	1.0	AMHS
RN	1.0	AMHS
HW005	1.0	AMHS
Clinical Director	1.0	AMHS
CYMHS		
HP4	2.0	CYMHS (1 temp)
HP3	2.0	CYMHS
ALO	1.0	CYMHS
AO3	1.0	CYMHS
ATODS		
HP4	1.0	ATODS
HP3	2.0	ATODS
HP4	1.0	ATODS C&Y (temp)
HW004	1.0	ATODS
HHOT		
CNC	1.0	HHOT
CN	3.0	HHOT
HP4	1.0	HHOT
HP3	1.0	HHOT
HW006	1.0	HHOT
HW 004	1.0	HHOT

SAMPLE ROSTER PROFILE

	6am – 3pm	8am – 5pm	2pm – 11pm
Monday	2 FTE	1 FTE	1 FTE
Tuesday	1 FTE	1 FTE	1 FTE
Wednesday	1 FTE	1 FTE	1 FTE
Thursday	2 FTE	1 FTE	2 FTE
Friday	2 FTE	1 FTE	2 FTE
Saturday	1 FTE	0 FTE	1 FTE
Sunday	1 FTE	0 FTE	1 FTE
	CNC/shift coordinator & ALO	Mon-Fri	8-5

Models of care

Meeting individual & community needs through workforce redesign

WORKFORCE PROFILE – CONTINUED CARE MENTAL HEALTH & ATODS

Position Level	FTE	Team
AMHS		
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HP4	1.0	AMHS
CN	1.0	AMHS
RN	1.0	AMHS
HW005	1.0	AMHS
Clinical Director	1.0	AMHS
CYMHS		
HP4	2.0	CYMHS (1 temp)
HP3	2.0	CYMHS
ALO	1.0	CYMHS
AO3	1.0	CYMHS
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	CNC/shift coordinator & ALO	Mon-Fri	8-5

Models of care

Meeting individual & community needs through workforce redesign

Restructure 1a.

Upgrade PHO to Consultant Psychiatrist:

- approved by CE 5 November 2012
- accomplished by diverting the budget for the following funded positions (total budget allocation includes accommodation and Option A)
- currently maintaining Locum Psychiatrist for provision of services :

PHO upgrade to Specialist (outreach & D&A) - included in the MOS redesign AMHS				
Community Support Worker (M.I)	A03	vacant		66,021
Cultural Health Promotion Officer (HHOT)	AO3	vacant		66,021
[redacted]mmunity Support Worker (Doomadgee)	A03	vacant		66,021
[redacted]dministration Officer - Record Keeping	A02	vacant		26,501
Senior Health Worker (AMHS)	HW006	vacant	modify - 003	23,960
Mental Health PHO	Med L4	locum cover		140,909
ATODS CNC x 2 modify - CN (modification & budget completed 2012/13)	CNC		modify CN	23,280
				23,280
upgrade PHO to specialist (including Opt A & Accom)	Med L18-22	L22 costed	422,048	435,993

$13,945.00 SAVING

Restructure 1b.

- Restructure to extend Adult Mental Health operating hours from on-call service provision to 7 day/week, 6am – 11pm operating hours '
- Cease on call

Adult Mental Health Team Model Of Service Redesign

restructure MOS	2011	on call	17238.40	
		overtime	26018.34	
		recall	106664.95	
		total 2011 expenditure		149,921.08
Build in part yr 2012/13 budget	restructure to ACT	shift 6am - 11pm	cost =	73,866.26

$76,055.00 SAVING Potential annual saving

Queensland Government

Restructure 2.

Temporary trial period of 12 months required to develop and integrate teams
Need identified for HHOT due to majority of presentations being alcohol related and limited service provision for alcohol intervention provided currently. Re-orientation of team toward recovery based approach and drug and alcohol intervention
Further restructure may be necessary in 1-2 year period

Re-design ATODS & HHOT Model of Services -						
Team Leader HHOT	30492635	HP5	filled	PFT	suspend	131,808
Manager ATODS	30468731	HP5	vacant/backfill	PFT	modify ATODS&HHOT	131,808
Reinstate clinical coordinator ATODS	32006644	HP4/CN	reinstate	PFT	Pool Acute Care cover	116,640
Manager ATODS & HHOT Services	30468731	HP5	modify	PFT		131,808

$15,168 SAVING

Restructure 3.

- To maintain quality, training and development
- ensure implementation planning process for restructure is complete
- maintain and continue quality improvement ensuring all workplace instructions required are identified, developed, implemented and reviewed
- maintain development and focus on suicide prevention and integration both between internal program areas, NWHHS services, and key community stakeholders

AO6 Service integration	104,802.00
AO6 ATODS program coordinator	104,802.00
	209,604.00
AO4 Quality Officer	78,362.00
AO5/6 Business Planning & Development	104,802.71
	183,164.71

$26,440.00 SAVING

a. **Risk profile**
Extended hours of service for acute presentations with mental health will enable a more immediate response to community crisis and assistance in the emergency department with like presentations. With a more comprehensive and rapid response to crisis it is believed there will be a lower recurrence rate

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[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Pool Acute Care cover	[illegible]

$15,168 SAVING

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$26,440.00 SAVING

a. **Risk profile**
Extended hours of service for acute presentations with mental health will enable a more immediate response to community crisis and assistance in the emergency department with like presentations. With a more comprehensive and rapid response to crisis it is believed there will be a lower recurrence rate

of suicidal behaviour and improved pathways to care and recovery to assist those experiencing difficulties. In addition with acute care model of service comprising of members from 3 of the 4 program areas, it is determined to improve response to dual diagnosis, and improve internal co-case management and therapeutic models of care and recovery including re-access pathways in line with the national standards of 'every door is the right door' for accessibility and transition through appropriate services to meet consumer needs.

b. Service delivery model

The model of care differs in the following ways

- Extended hours of service and accessibility – 7 days/week 6am – 11 pm business hours as apposed to Monday to Friday 8.30am – 4.30pm
- Acute care will attend to all intake and referrals including assessment and crisis intervention/planning, longer term care will be provided by the continued care team and clinical treatment officers throughout the service according to skill. At present each team member is rostered to intake and carries a clinical case load of a mixture of continued care and short term clients. The capacity to provide for intense therapeutic intervention that is recovery orientated will be enhanced by this model
- see above for proposed staffing table and roster
- The NWHHS Health Services Plan – 2027 lists mental health as the third highest burden of disease for this health service which in effect will increase the need for further resources and demand on services. Research however has shown that successful early intervention is key to preventing long term mental illness and improving the well being of chronic mental illness in addition to preventing significant recurrence.

3. Policy Issues

- This restructure aligns with state and national policies
  - Queensland Plan for Mental Health 2007-2017 priorities:
    - Promotion, prevention and early intervention
    - Improving and integrating the care system
    - Participation in the community
    - Coordinating care
    - Workforce, information, quality, and safety
  - Fourth National Mental Health Plan 2009-2014
    - Social inclusion and recovery
    - Prevention and early intervention
    - 'service access, coordination and continuity of care

4. Budget and source of funds

This proposal works within current funding – see above costings and cost savings enabling further staged review and restructure

5. Recommendations

The Recommendation is to move toward staged implementation of an organisational change in line with HR management and guidance

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This proposal works within current funding – see above costings and cost savings enabling further staged review and restructure

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The Recommendation is to move toward staged implementation of an organisational change in line with HR management and guidance

Appendix 2: Risk Analysis

RISK ANALYSIS

Option 1: Current model of service delivery			
Risks	**Probability**	**Impact**	**Level of risk**
Untimely service provision	High	High	High
Inability to manage demand	High	High	High
Increasing absenteeism/inability to cover absen	Medium	Medium	Medium
Low job satisfaction	Medium	Medium	Medium
inability to meet state and national standards h	High	High	High

ONF

18/4/13

QCOS/019274

6A

Department RecFind No:	BR056530
Division/HHS:	North West HHS
File Ref No:	

Briefing Note for Approval

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED
19 APR 2013

BR056530

Requested by: Chief Executive, North West Hospital & Health Service

Date requested:

Action required by:

SUBJECT: Proposed Voluntary Redundancy to Clinical Nurse Consultant (CNC) Homeless Health Outreach Team (HHOT), North West Hospital and Health Service (HHS)

Recommendation
That the Minister:

Note the North West Hospital and Health Service (HHS) target FTE is 609 currently and this has already been achieved but with the knowledge that there are a number of critical positions which still require recruitment.

Note ongoing weekly monitoring of MOHRI plus intensive review of all positions across the HHS has identified a number of occupied positions which are classified as surplus to requirements given changed models of care.

Note the Clinical Nurse Consultant (CNC) Homeless Health Outreach Team (HHOT) position is to be made redundant and has the support of the North West HHS Board.

Note abolishing this position will have no significant impact on the community and management duties will be absorbed by existing staff.

Note no staff or Unions have been notified.

APPROVED/NOT APPROVED **NOTED** **NOTED**

LAWRENCE SPRINGBORG
Minister for Health

RECORDS TEAM
RECEIVED 16 MAY 2013 QLD HEALTH

Chief of Staff

17/5/13

Minister's comments

Department RecFind No:	BR056530
Division/HHS:	North West HHS
File Ref No:	

URGENT

Briefing Note for Noting

Director-General

Requested by: Chief Executive, North West Hospital & Health Service **Date requested:** **Action required by:**

SUBJECT: Proposed Voluntary Redundancy to Clinical Nurse Consultant (CNC) Homeless Health Outreach Team (HHOT), North West Hospital and Health Service (HHS)

Proposal

That the Director-General:

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Provide this brief to the Minister for information.

Urgency

1. **Critical** - the deadline for a submission of voluntary redundancies is 19 April 2013.

Headline Issues

2. The top issues are:
   - Voluntary redundancy to be offered to one permanent staff based at the Homeless Health Outreach Team off campus of Mount Isa hospital, after amalgamated service delivery.
   - The identified position is considered surplus to requirements and the intent is to offer a voluntary redundancy.

Key Values

The key values that apply are the following:

☐ Better service for patients
☒ Better healthcare in the community
☐ Valuing our employees and empowering frontline staff
☐ Empowering local communities with a greater say over their hospital and local health services
☒ Value for money for taxpayers
☒ Openness

Key issues

3. Whilst MOHRI targets and trajectory are being met, the North West HHS was aware of the need to still recruit to critical vacancies, therefore ongoing review of all positions identified an additional position surplus to requirement.

Department RecFind No:	BR056530
Division/HHS:	North West HHS
File Ref No:	

4. Amalgamation of service delivery of the North West Alcohol, Tobacco and Other Drugs Service (ATODS) and HHOT identified the CNC HHOT team role was surplus to needs and management duties could be absorbed by existing staff.
5. CNC HHOT incumbent approached North West HHS to advise they would be amenable to offer of voluntary redundancy.
6. The HHOT position will have no significant impact on the community and there is a low risk of poor media potential for the HHS.

Background

7. In late 2012, the current State Government directed that all Government Departments must decrease their workforce (MOHRI FTE) to meet a target by 31 March 2013. The decrease in FTE aligned with decreased budget allocation for the 2013-2014 financial year to move the State of Queensland back to a more positive credit rating.
8. A review of all positions resulted in the submission of possible offers of voluntary redundancies to the North West HHS Board who supported the progress of these offers.

Consultation

9. North West HHS Board has approved as has local Executive Management Group. Consultation will begin with staff and union as soon as possible.

Financial implications

10. Nil cost to HHS if Treasure time frames are met.

Legal implications

11. Providing consultation process with relevant staff is followed, risk of Industrial Relations Commission is minimal.

Attachments

12. Attachment 1: List of affected positions
    Attachment 2: Pre organisation chart
    Attachment 3: Post organisation chart

Department RecFind No:	BR056530
Division/HHS:	North West HHS
File Ref No:	

Recommendation
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APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

18 / 4 / 13

To Minister's Office for Approval ☐
for Noting ☑

Director-General's comments

Author
Narelle Anderson

A/EDCS

North West Hospital & Health Service

4764 0210
10 April 2013

Content verified by: (CEO/DDG/Div Head)
Sue Belsham

Chief Executive

NWHHS

4764 0210
10 April 2013

1.

Affected Positions spreadsheet: **North West Hospital and Health Service**

ABOLISHED POSITIONS

Organisational Unit	Position Title	Classification	Number of Positions	Comments
70068391	CNC Homeless Health Outreach Team	Nurse Grade 7	1.0	Proposed for DG & Minister Approval 11/4/13

DIRECT MATCH

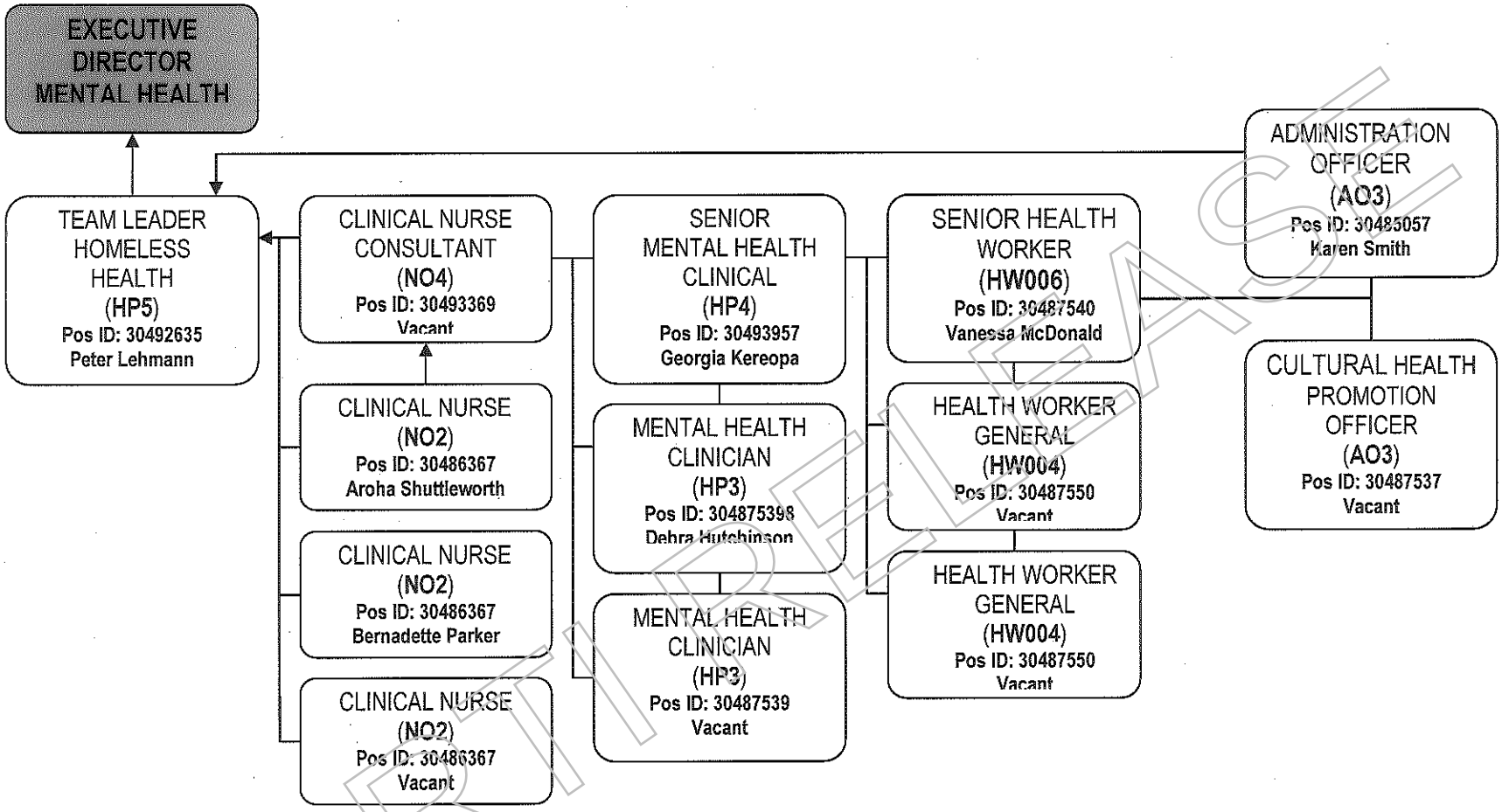
Organisational Unit	Position Title	Classification	Comments

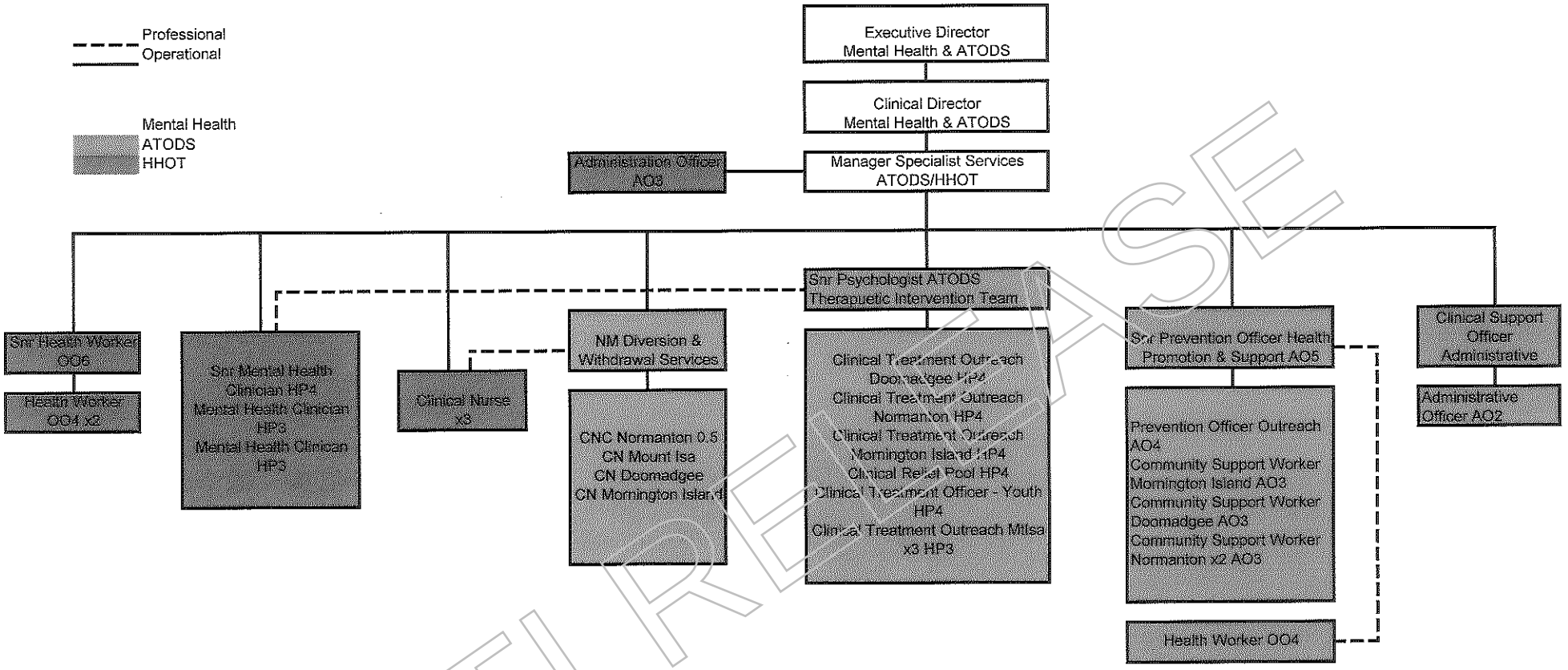
SUITABILITY ASSESSMENT (CLOSED MERIT)

Organisational Unit	Position Title	Classification	Closed Merit Strategy	Existing or New Position	Number of Positions	Applicant Pool	Comments

OPEN MERIT

Organisational Unit	Position Title	Classification	Recruitment Strategy	Existing or New Position	Number of Positions	Comments





CONF

16/5/13

Q05/018266

15

Department RecFind No:	BR056714
Division/HHS:	West Moreton HHS
File Ref No:	

Briefing Note for Noting

BR056714

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED
17 MAY 2013

Requested by: Senior Departmental Liaison Office **Date requested:** 8 May 2013 **Action required by:**

SUBJECT: Organisational Structure – West Moreton Hospital and Health Service

Recommendation
That the Minister:

Note that the West Moreton Hospital and Health Service (WMHHS) intends to introduce a new organisational structure across the Hospital and Health Service.

Note a new organisational structure that more closely aligns with the strategic intents of the WMHHS will promote the realisation of measures in the Strategic Plan.

Note a new organisational structure is required to better equip the WMHHS to function on an ongoing basis as a statutory body.

APPROVED/NOT APPROVED **NOTED** **NOTED**

RECORDS TEAM
RECEIVED 21 MAY 2013 DEPT. OF HEALTH

LAWRENCE SPRINGBORG
Minister for Health

1 1

Chief of Staff

15 1/5

Minister's comments

16 MAY 2013

Department RecFind No:	BR056714
Division/HHS:	West Moreton HHS
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: Senior Departmental Liaison Office **Date requested:** 8 May 2013 **Action required by:**

SUBJECT: Organisational Structure – West Moreton Hospital and Health Service

Proposal

That the Director-General:

Note that the West Moreton Hospital and Health Service (WMHHS) intends to introduce a new organisational structure across the Hospital and Health Service.

Provide this brief to the Minister for information.

Urgency

1. Routine

Headline Issues

2. The top issues are:
   - a new organisational structure that more closely aligns with the strategic intents of the WMHHS will promote the realisation of measures in the Strategic Plan; and
   - a new organisational structure is required to better equip the WMHHS to function on an ongoing basis as a statutory body.
   - The overall FTEs for WMHHS will not be significantly affected. There will be a slight increase to reflect new roles required to increase capability across business and finance services, the proposed new clinical streams and the increased focus on research and education. Professional Leadership roles will continue but will also have a revised focus for example, joint appointments with universities and expanded clinical governance accountabilities.

Key issues

3. The proposed changes to the organisational structure are consistent with the values of the Blueprint for better healthcare in Queensland.
4. The proposed change to the organisational structure demonstrates the ongoing commitment the WMHHS has in relation to achieving its mission – Providing better health, better care and better value.
5. Attachment 1 details the proposed executive structure consists of five Divisions and six direct reports to the Chief Executive (excluding the Office of the Chief Executive).
6. The proposed five Divisions are Clinical Operations (with two Executive Directors), Clinical Governance Education and Strategy, Corporate Governance Education and Strategy, Workforce, and Finance and Business Services.
7. The proposed new structure means there will be implications for four members of the Executive and these individuals will be managed appropriately.
8. As the next tier is developed, it is likely that new roles will be developed. For example, within the Clinical Operations Division, new roles called Director of Operations will be created to reflect the revised model of care for clinical streams.
9. It is also possible that the reorganisation of clinical streams away from the current business unit structure may result in some roles becoming redundant.

Department RecFind No:	BR056714
Division/HHS:	West Moreton HHS
File Ref No:	

10. As the organisational change will be an iterative process, the full implications of the final organisational structure to all levels within the WMHHS are not currently known.

Background

11. Since September 2012, an interim structure has been in place for the WMHHS.
12. This structure has eight Divisions and the Office of the Chief Executive.
13. This structure has served the WMHHS well and in a short space of time the WMHHS has grown from an organisation that was assessed prior to the commencement of Hospital and Health Services on 1 July 2012, as not being fully capable of meeting the finance, governance, people and quality requirements, to function as an independent statutory body.
14. The WMHHS is now an organisation that is demonstrating its capability to live within its financial means and it is demonstrating significant improvements in meeting criteria that are required function as an independent statutory body.
15. Despite these achievements, a new structure is required to promote the WMHHS to better function as a statutory body into the future.

Consultation

16. Limited confidential consultation has occurred to date with the West Moreton Hospital and Health Board and the current Executive staff.
17. The Director-General and the Senior Departmental Liaison Office were advised of the proposed organisational change on 6 May 2013 and provided with Attachment 2.
18. It is intended to commence broad consultation across the WMHHS from 20 May 2013.
19. A communication plan has been developed to support the organisational change process.
20. The WMHHS will meet its industrial obligations and follow all required steps associated with organisational change.

Attachments

21. Attachment 1: Proposed Organisational Structure West Moreton Hospital and Health Service
22. Attachment 2: Discussion Paper 6 May 2013 – Proposed Organisational Structure at West Moreton Hospital and Health Service

Department RecFind No:	**BR056714**
Division/HHS:	**West Moreton HHS**
File Ref No:	

Recommendation
That the Director-General:

Note that the West Moreton Hospital and Health Service (WMHHS) intends to introduce a new organisational structure across the Hospital and Health Service.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General
16 / 5 / 13

To Minister's Office For Noting ☑

Director-General's comments

Author:
Chris Thorburn

A/Executive Director Corporate Governance and Strategy

West Moreton Hospital & Health Service

3810 1388
13 May 2013
13 May 2013

Content verified by: (CEO/DDG/Div Head)
Lesley Dwyer

Chief Executive

WMHHS

38101226

13 May 2013
14 May 2013

Proposed Organisational Structure at West Moreton Hospital and Health Service

Introduction

Since September 2012 an interim structure has been in place for West Moreton Hospital and Health Service (WMHHS). This structure has served WMHHS well and in a short space of time WMHHS has grown from an organisation that was assessed prior to the commencement of Hospital and Health Services on 1 July 2012, as not being fully capable of meeting the finance, governance, people and quality requirements to function as an independent statutory body. WMHHS is now an organisation that is demonstrating its capability to live within its financial means and it is demonstrating significant improvements in meeting criteria that are required function as an independent statutory body. The interim structure has also promoted tighter financial controls and accountabilities and has promoted the ongoing ability to continually improve in aiming to meet activity and performance targets.

However it is now appropriate to consider the introduction of a new organisational structure that will better equip WMHHS to function on an ongoing basis as an statutory body, which is required to have an independent but collaborative relationship the Department of Health (the System Manager). In addition, a structure that more closely aligns with the strategic intents of WMHHS will promote the realisation of measures in the Strategic Plan.

Context for the introduction of a new organisational structure

The Blueprint for better healthcare in Queensland (February 2013) outlines that there are six key values that must be applied when assessing all new health initiatives. The proposed new structure for WMHHS does aim to reflect these six key values.

These key values are:
1. Better service for patients.
2. Better healthcare in the community.
3. Valuing our employees and empowering front line staff.
4. Empowering local communities with a greater say over their hospital and local health services.
5. Value for money for taxpayers.
6. Openness.

WMHHS has a vision - "Your partner in healthcare excellence" and six strategic directions. These strategic directions are:
1. Revitalise Services
2. Strengthen Safety and Quality
3. Drive Innovation and Research
4. Enable Our People
5. Plan for a Sustainable Future
6. Achieve Financial Health

Within the Strategic Plan, strategies have been developed which will promote the achievement of the strategic directions in WMHHS.

The proposed change to the organisational structure further demonstrates the ongoing commitment WMHHS has in relation to achieving it mission – "Providing better health, better care and better value."

Alignment of the proposed organisational structure with WMHHS Strategic Directions

1. Revitalise Services

Clinical Operations:
It is proposed to develop a Clinical Operations Division. Within this Division it is proposed that there will be four new clinical streams across WMHHS.

- Ambulatory Stream eg Specialist Outpatients, Clinical Measurements, Oral Health, Public Health, Screening Services, Pharmacy, Allied Health, Medical Imaging
- Acute Stream eg Emergency Department, Acute Assessment Unit, ICU, CCU, HDU, Anaesthetic, Central Patient Flow, Chest Pain Assessment, Medical Assessment Unit, Surgical Assessment
- Sub and Post Acute Stream eg Older person's care, Post Acute/Early Discharge Service, Rehabilitation, Palliative Care, Boonah Health Service and Esk Health Service.
- Coordinated Care Stream eg Maternity, Children and Family Health, Surgery, Surgi-Centre, Operating Theatres, CSSD, Gatton Health Service and Laidley Health Service.

The fifth clinical stream will be the existing Mental Health and Specialised Services (MH&SS). MH&SS have recently undergone significant organisational change consistent with the strategic directions of WMHHS.

The four new streams will replace the current clinical business units structure and will work across the health services provided by Ipswich Hospital, Community Health, Boonah, Esk, Laidley and Gatton Health Services. Each Stream will have a patient pathway directly from home or via the Emergency Department. The rural facilities are an integral part of the care team and will have pathways for direct admission or via the Ipswich Hub for ambulatory and sub acute programs.

he systems and processes to be introduced for the four new streams will improve equitable and timely access and reduce waiting times. The four new streams will also promote WMHHS to better meet the needs and choices of the community.

It is proposed to create a new role to manage and lead the four new streams. This role will be critical to ensure that activity and behaviours bring WMHHS strategy to life and provide a more integrated care system that is responsive, efficient, safe and effective. This role will be required to provide operational leadership and assume responsibility and accountability for the day to day delivery of all clinical services within the new streams to achieve strategic directions. In addition, this role will be responsible for reflecting WMHHS's strategic aspirations to deliver integrated care, in partnership with Primary Care organisations, as well as strengthen WMHHS's ability to operate integrated models of care, optimise resource allocation, remove structural boundaries that impede access and patient flow, and reduce patient waiting times.

Consultation is required to occur so as to determine the substructure to support the four new clinical streams. Engagement will occur with the clinical workforce, the community and other stakeholders to ensure that the new clinical streams do achieve revitalisation of services.

2. Strengthen Safety and Quality and 3. Drive Innovation and Research

Clinical Governance, Education and Research:
It is proposed to create a new Division that is accountable for leading a portfolio which encompasses Allied Health, Nursing and Midwifery and Medical Services. This Division will ensure a robust clinical governance framework is embedded across WMHHS. In cooperation with the streams within Clinical Operations, this Division will lead the design and delivery of strategies to respond to patient, carer and consumer input and needs, particularly in the context of developing an integrated care system.

Clinical Governance, Education and Research will be responsible for leading the creation of integrated governance systems that maintain and improve the reliability and quality of patient care as well as improve patient outcomes. In addition, there will be a focus on developing and leading the delivery of a research strategy aiming to improve the health outcomes of the community and building WMHHS's research capability. The Division will also lead the health outcomes of workforce planning, workforce re-design, and education and training for the clinical professions in collaboration with operational directors.

It is proposed to create a new role to lead clinical governance and bring education and research across WMHHS to a new level. A key focus for the role will be to develop a culture of performance and a focus on service excellence. Improved systems around clinical risk management, having the patient at the centre of all decisions in the clinical pathway and implementing and evaluating assurance frameworks will strengthen safety and quality of services in WMHHS. Another focus for the role will be to develop a

strong and vibrant research base which will create a culture of education, research and innovation across WMHHS.

The achievements of this new Division will also promote the strategic aim of WMHHS being an employer of choice.

4. Enable Our People

Workforce:
This Division is responsible for developing and implementing strategies relating to the workforce so that WMHHS has the necessary skills and capabilities to meet current and future health service needs, that the organisational culture and management of people issues contributes to optimal employee engagement and productivity and to ensure WMHHS complies with all statutory requirements relating to workforce issues.

In consultation with other Divisions, the Workforce Division will develop and implement a workforce strategy for WMHHS which draws upon WMHHS's strategic and related plans and initiatives to then position the management and organisational culture to achieve maximum employee engagement, safety and productivity. Ultimately this will maximise WMHHS's capacity to attract and retain the skilled human esources it needs.

This Division will ensure the necessary workforce structures, service models and skill sets are in place so that managers at all levels across WMHHS receive practical advice, guidance and coaching in the management of performance, disciplinary, absenteeism and other employee related issues. The Division will ensure the adoption of regular performance feedback and development planning within WMHHS as a mechanism for achieving optimal employee engagement and productivity. In addition, the Division will lead the application of Occupational Health and Safety legislation and policies so WMHHS is actively contributing to creating and maintaining a healthy, safe and secure environment for patients, visitors and staff.

An additional role for the recruitment component of the Workforce Division will be to lead the 'value add' components of the recruitment processes for speciality staff across the clinical streams.

5. Plan for a Sustainable Future

Corporate Governance and Strategy:
This Division is primarily responsible for overseeing and leading the effective program management and alignment of key strategic initiatives within WMHHS. The Division will provide leadership in the design, implementation and continuous improvement of the integrated planning, strategy management, performance monitoring and strategy communications frameworks and systems for WMHHS. The Division will ensure that WMHHS demonstrates autonomous capability in relation to governance, integrated risk management and stakeholder engagement.

The Division will be accountable for the development and deployment of organisational strategy to continuously build and enhance the performance of WMHHS into the future. In consultation with other Divisions, it will design and drive the implementation and ongoing review of strategy for health service planning and provide strategic and authoritative advice to the Chief Executive and Board.

Following the introduction of the proposed new clinical streams, they will need to be reviewed to ensure they are aligned with the strategic direction of the WMHHS. The Division will following consultation formulate strategies and coordinate service plans that will feed into workforce planning, priority setting for service gaps, future activity identification and training and development requirements.

This Division will lead and manage required future project teams by providing strategic leadership for identified projects, including engaged consultants to ensure that risks are effectively managed, key project milestones are achieved, the change process is managed and outputs are in accordance with endorsed plans for time, quality and cost.

It is proposed to create a new role to lead corporate governance and strategy. A key focus for the role will be to undertake the coordination of the integrated planning cycle, operational planning and periodic reviews of the organisational performance and capabilities, including using key performance measures, statistical reporting and analysis of those measures. In addition, the management of an effective governance framework to ensure that high levels of accountability are maintained across WMHHS and the execution of effective communications is also paramount.

6. Achieve Financial Health

Finance and Business Services:
The shift to an independent statutory authority has had significant implications for Finance and Business Services. In addition to the requirements associated with statutory reporting, the Division is responsible to the Board for the management of treasury functions, budget development and management and, indirectly, the internal audit function.

This Division is responsible for the development and administration of the annual budgets, fiscal analysis and planning, financial reporting and modelling, asset management, short/long-range forecasting, contract management and supply chain management. In addition, this Division leads the financial management function for WMHHS, as well as providing strategic advice to the Executive Team and Board to ensure that financial performance targets and imperatives are met. It also ensures that financial stewardship and governance arrangements are in place to meet financial performance targets and imperatives.

This Division has an end to end approach to the patients administrative journey though the HHS. It aims to streamline systems to achieve greater co-ordination between administrative, medical records and financial units, thereby maximising revenue generation opportunities and reducing inefficiencies. One focus is to enhance opportunities of greater co-ordination between financial, administrative and infrastructure services

In addition to incorporating the existing responsibilities of the Executive Director Finance and Corporate, this Division will assume a significant responsibility for leveraging the business development opportunities presented by the new statutory environment. To support this, it is proposed to create a Business Development and Contestability Unit. A more commercial orientation is necessary to enable WMHHS to effectively and efficiently operate in the new Activity Based Funding environment.

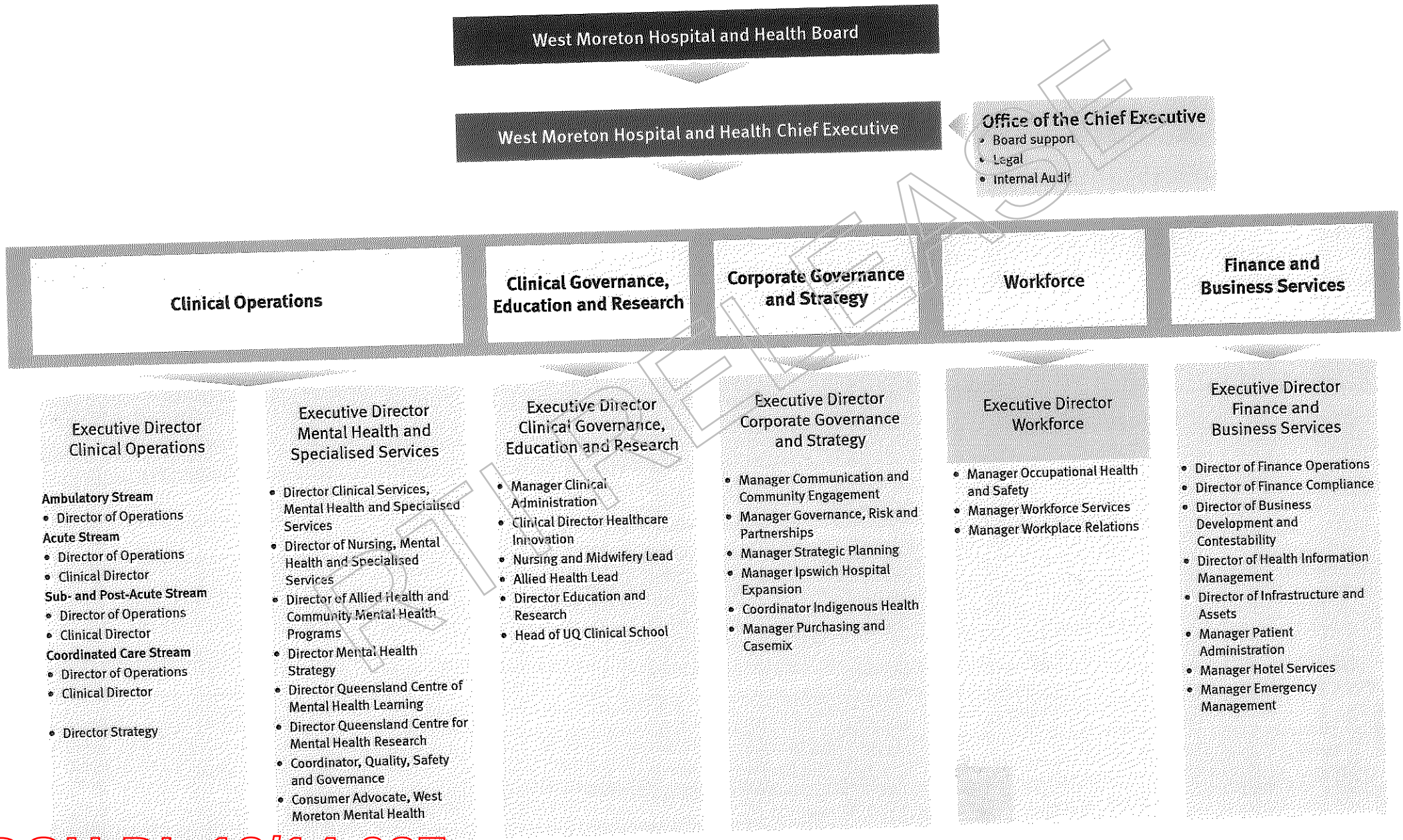
Current functions within the portfolio of and direct reports to the Executive Director Infrastructure and Ipswich Hospital Expansion will not change. It is proposed that they will however be within the Division of Finance and Business Services.

Proposed Process and Timetable to implement revised Organisational Structure for West Moreton Hospital and Health Service (WMHHS)

Process	Timeframe
1. Commence formal consultation with Board and Executive Directors	Commence 26 April 2013
2. Consider feedback from Board and Executive; finalise Executive Director structure, functional mapping to portfolios and finalise position descriptions	Commence 3 May 2013
3. Consult with SDLO regarding proposed organisational change.	Commence 6 May 2013
4. Commence communication with staff, unions and other stakeholders of WMHHS regarding revised organisational structure	Commence 20 May 2013
5. Consult with stakeholders on a proposed implementation strategy to achieve the revised organisational structure (including acting arrangements)	Commence 20 May 2013
6. Commence recruitment processes to new Executive positions	Commence 3 June 2013
7. Finalise recruitment processes to new Executive positions	Completed 30 June 2013

West Moreton Hospital and Health Service Organisational Structure (Proposed)

CONFIDENTIAL - Draft for consultation with WMHH Board 26 April 2013
Proposed reporting relationships / Position titles subject to change



EXECSUPPORT - BR056714 : Fwd: Notification_Proposed Organisational Structure for WMHHS - Due COB 13 May

From: EXECSUPPORT
To: MD09-WestMoretonSouthBurnett-HSD
Date: 13/05/2013 4:08 PM
Subject: BR056714 : Fwd: Notification_Proposed Organisational Structure for WMHHS - Due COB 13 May
CC: Sdlo
Attachments: Fwd: Notification_Proposed Organisational Structure for WMHHS - Due COB 13 May ; BR056714 MD09 ORGANISATION STRUCTURE WEST MORETON HHS.doc

Hi Anette

SDLO have forwarded me your brief regarding Organisational Structure - West Moreton Hospital & Health Service, which I have processed as BR056714.

I am sorry to have to do this to you, however, the brief requires a little updating. Under the **Proposal** heading I need a little more information. It needs to read **Note** .... and give a short run down of what the brief is about.

Also on the Minister's page, that also needs a little more information. It needs to have the most important paragraphs from the brief... rather like a one page mini-brief for the Minister's information.

When updating the brief, please use the brief I have processed in EXECSUPP and attached below, and NOT the original prepared by your Division.

If you have any queries at all regarding my advice, please do not hesitate to contact me.

The updated brief is due back to **SDLO and EXECSUPP by 10.0am tomorrow, 14/5/13.**

Cheers.. Mary Delahenty
ESU 3234 0816

>>> Sdlo 13/05/2013 3:47 pm >>>
>>> MD09-WestMoreton-HSD 5/13/2013 3:28 pm >>>
Hi Helen,

Please see attached briefing note as requested. This was approved by the CE, WMHHS today.

Can you please advise us of the BR number for tracking purposes.

Thanks
Annette

Office of the Chief Executive (MD09)
West Moreton Hospital &
Health Service

Ph: 07 3810 1126
Fax: 07 3810 1769

>>> Sdlo 8/05/2013 12:57 pm >>>
Hi Annette

Thanks for sending this through. I have provided the Ministers office with a copy of these documents and they have asked for a formal brief on the restructure.

Can you please provide this and include any advice on how the structure will impact on staff positions or numbers.

This is due COB 13 May.

Many thanks
Helen

Helen Langborne
Senior Departmental Liaison Officer
Office of the Director General
Level 19, QHB
Department of Health
Ph: 07 3239 0301
Mobile:
Fax: 07 3234 1482

>>> MD09-WestMoreton-HSD 5/6/2013 4:05 pm >>>
Good Afternoon,

Please find attached a discussion paper, communication plan (with time frames) and a proposed organisational structure for WMHHS.

Lesley Dwyer, CE WMHHS met with the Director-General today to discuss the proposed organisational structure in WMHHS. The WMHH Board supported this organisational structure at its meeting on 26 April 2013.

Kind Regards
Annette

Office of the Chief Executive (MD09)
West Moreton Hospital &
Health Service

Ph: 07 3810 1126
Fax: 07 3810 1769

CONF

22/7/13. Qcos/01128/

25B

Department RecFind No:	BR057040
Division/HHS:	SSS Division
File Ref No:	HRS06455

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

BR057040

RECEIVED
DATE 29 JUL 2013 BY

Requested by: Deputy Director-General, System Support Services

Date requested: 24 June 2013

Action required by: 28 June 2013

RECEIVED 09 SEP 2013 DEPT OF HEALTH

SUBJECT: Employees Requiring Placement / Voluntary Redundancies post 30 June 2013

Recommendation

That the Minister:

Note the forecasted number of expected Voluntary Redundancies (VR) offers for the period 1 July to 30 September 2013, provided by Hospital and Health Services (HHS)/Commercial Business Units (CBUs)/Department of Health (DoH) of 1,396 FTE (1,703 headcount) is significantly higher than previously forecast to Queensland Treasury and Trade (QTT) and the proposed process for offers of VR under Directive 6/12: Employees Requiring Placement.

Note QTT was provided with a forecast of 850 FTE based on data provided by the HHSs and the current number of forecast Employee's Requiring Placement (ERPs)/VRs is approximately 546 FTE higher than previously provided to QTT when continued funding support was sought by Finance Branch.

Note Finance Branch will need to seek confirmation regarding the funding of the additional 546 FTE VRs now forecast by the HHSs for the period 1 July to 30 September 2013, from QTT.

Note that QH set a date of 30 September 2013, as a completion date for processing VRs related to current work redesign and organisational restructure initiatives to adhere to QTT's extension of the VR funding arrangement into early 2013/2014 financial year.

Note based on current VR forecasts of 1,396 FTE all names must be submitted by 31 July 2013, or they will not be processed in the current round for separation by 30 September 2013.

Note the total number of ERPs/VRs for QH is now forecast to be 4,544 FTE, which is significantly higher than the 4,142 FTE figure contained in the 2012/2013 Service Delivery Statements/Budget papers.

APPROVED/NOT APPROVED **NOTED**

LAWRENCE SPRINGBORG
Minister for Health

/ /

NOTED

Chief of Staff

09 / 08 / 2013

Minister's comments

Briefing note rating

1 2 3 4 5

1 = (poorly written, little value, and unclear why brief was submitted). 5 = (concise, key points are explained well, makes sense)
Please Note: All ratings will be recorded and will be used to inform executive performance.

URGENT

Department RecFind No:	BR057040
Division/HHS:	SSS Division
File Ref No:	HRS06455

Briefing Note for Noting

Director-General

19 JUL 2013

Requested by: Deputy Director-General, System Support Services

Date requested: 17 July 2013

Action required by: 22 July 2013

SUBJECT: Employees Requiring Placement / Voluntary Redundancies post 30 June 2013

Proposal

That the Director-General:

Note the number of Employee's Requiring Placement (ERP)/Voluntary Redundancies (VRs) forecast for the period 1 July to 30 September 2013, and the proposed process for offers of voluntary redundancy under Directive 6/12: Employees Requiring Placement from 1 July 2013 to 30 September 2013.

Note Finance Branch will need to seek confirmation regarding the funding of the additional 546 FTE forecast number of VRs, which will bring the total forecast VRs for Queensland Health (QH) to 1,396 FTE for the period 1 July to 30 September 2013. A figure of 850 FTE VRs was the forecast previously provided to Queensland Treasury and Trade (QTT) when continued VR funding support was sought.

Provide this brief to the Minister for information.

Urgency

1. **Critical** – The processing of offers of VR for the 2013/2014 financial year is underway.

Headline Issues

2. The top issues are:
   - QTT will continue funding reductions through Voluntary redundancies.
   - QTT was provided with a forecast of 850 FTE based on data provided by the Hospital and Health Services (HHS) when continued support was sought by the Finance Branch.
   - QH set a date of 30 September 2013, as a completion date for processing VRs related to current work redesign and organisational restructure initiatives.
   - Any names submitted after 31 July 2013, will not be processed in the current round.
   - The forecasted number of expected VR offers provided by Hospital and Health Services (HHSs)/Commercialised Business Units (CBUs)/Divisions of 1,396 FTE (1,703 headcount) is significantly higher than previously forecast (Attachment 1).

Blueprint

3. How does this align with the *Blueprint for better healthcare in Queensland*?
   - The contents of this brief align with the workforce reform initiatives contained within the *Blueprint for better healthcare in Queensland*.

Key issues

4. HHSs have been advised that any names submitted after 31 July 2013, will not be processed in the current round, this is for separation by 30 September 2013.

5. The number of ERPs/VRs separated from 1 July 2012 to 30 June 2013, is 3,148 FTE (Attachment 1). The current number of forecast ERPs/VRs for the period 1 July to 30 September 2013, is approximately 1,396 FTE, which is approximately 546 FTE higher than the previously forecasted figure provided to QTT when continued funding support was approved.

Department RecFind No:	**BR057040**
Division/HHS:	**SSS Division**
File Ref No:	**HRS06455**

6. Based on the current VR payment costs, excluding accrued leave payments, the cost of 546 FTE VRs to QH would be approximately $40,000,000 should QTT not agree to fund these additional forecast VRs.

7. The total number of ERPs/VRs for QH is now forecast to be 4,544 FTE which is significantly higher than the 4,142 FTE figure contained in the 2012/2013 Service Delivery Statements/ Budget papers for QH.

Background

8. QTT has advised QH that they will continue the current VR funding arrangement to support the fiscal repair measures and Commonwealth funding reductions into early 2013/2014 to accommodate the funding issues associated with finalising VR processes.

9. To adhere to QTT's extension of the VR funding arrangement into early 2013/2014 financial year, the VR separation process QH has set a date of 30 September 2013, for completion of VR processing.

10. Based on current forecasts, processing may not be able to be completed until October/ November 2013.

11. Adjustment costs associated with contestability reforms would be subject to specific funding consideration by CBRC and are not part of the current VR funding arrangements.

12. Planning is now underway to manage the process for the period from 1 July to 30 September 2013.

13. The dates for separation from July to September 2013, are as follows:
    - 11 August 2013
    - 25 August 2013
    - 8 September 2013 and
    - 22 September 2013.

14. All names for processing are required to be submitted by 31 July 2013, to ensure all offers are finalised within the timeframe set by QTT. No names submitted after this date will be processed in this current VR round, this for separation by 30 September 2013.

15. A substantial number of names are already in the process and for planning purposes we will require forecasts for additional ERPs resulting from work redesign and organisational restructure by 31 July 2013.

Consultation

16. Finance Branch advised QH that QTT will extend VR funding arrangement into early 2013/2014 financial year.

17. Hospital and Health Services have provided VR forecasts related to current work redesign and organisation restructure initiatives and have been advised of the dates for separation from July to September 2013.

Attachments

18. Attachment 1: Updated forecast for post 30 June, as at 16 July 2013
    Attachment 2: Separated Voluntary Redundancies and Retrenchments 01 July 2012- 30 June 2013

Department RecFind No:	**BR057040**
Division/HHS:	**SSS Division**
File Ref No:	**HRS06455**

Recommendation
That the Director-General:

Note the number of Employee's Requiring Placement (ERP)/Voluntary Redundancies (VRs) forecast for the period 1 July to 30 September 2013, and the proposed process for offers of voluntary redundancy under Directive 6/12: Employees Requiring Placement from 1 July 2013 to 30 September 2013.

Note Finance Branch will need to seek confirmation regarding the funding of the additional 546 FTE forecast number of VRs, which will bring the total forecast VRs for Queensland Health (QH) to 1,396 FTE for the period 1 July to 30 September 2013. A figure of 850 FTE VRs was the forecast previously provided to Queensland Treasury and Trade (QTT) when continued VR funding support was sought.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

22/7/13

To Minister's Office For Noting ☑

Director-General's comments

Discussion with TSY should be at D-G level.

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)	Content verified by: (CEO/DDG/Div Head)
Margarita McCracken	Adam Williams	Annette McMullen	Susan Middleditch
Senior Director, Workplace Advisory and Remuneration	A/Chief Human Resources Officer	Acting Deputy Director General	Deputy Director General
Human Resources Services Branch	Human Resources Services Branch	System Support Services Division	System Support Services Division
32340108 25 June 2013 18 July 2013	32341685 28 June 2013 18 July 2013	32340622 28 June 2013	32340622 18 July 2013

	B - In Payroll Process	C - Forecast VRs - Headcount	C - Forecast VRs - FTE	Current Variance (Headcount)
ODG (Surplus)	1	1	1	0
HSCI		13	13	13
SPP		1	1	1
SSS	10	25	25	15
HSIA	1	3	3	2
HSSA	8	30	27	22
Cairns	7	39	30	32
Cape York	12	16	16	4
Central Qld	67	83	72	16
Central West	0	1	1	1
Childrens	1	52	52	51
Darling Downs	78	332	227	254
Gold Coast	7	17	16	10
Mackay	6	10	10	4
Metro North	278	655	556	377
Metro South	17	93	83	76
North West	2	2	2	0
South West	2	2	2	0
Sunshine Coast	37	66	57	29
Torres Strait		4	4	4
Townsville*	5	4	4	0
West Moreton	94	113.4	83	19.4
Wide Bay	79	144	115	65
Total	712	1706.4	1399.27	995.4

Pre 13 14 FY	Post 13 14 FY
1	
1	
8	2
	1
6	2
5	2
12	
66	2
1	
1	
80	2
7	
8	
255	33
14	4
1	1
2	
33	4
5	
93	2
81	
680	55

Total In Process	Do Not Offer	Total In Process Minus DNO
1		1
1	1	0
0		0
10		10
1		1
8		8
7		7
12		12
68	1	67
1	1	0
1		1
82	4	78
7		7
8	2	6
288	10	278
18	1	17
2		2
2		2
37		37
0		0
5		5
95	1	94
81	2	79
735	23	712

Pages 301 through 309 redacted for the following reasons:
- -
Schedule 4 - personal information

Headcount / FTE Separations from 21 April to 30 June 2013

Termination Date	Actual Offers	FTE	Actual Terms	FTE	Potential Offers / Headcount*	Potential FTE	Potential Terms**	
21-Apr	-	-	350	263.40	-	-	-	Includes retrenchment for term date 22/04/2013
5-May	-	-	363	310.58	-	-	-	Includes one termination for 06/05/2013
19-May	-	-	262	215.45	-	-	-	Includes 2 retrenchments for term date 19/05/2013
26-May	-	-	231	194.11	-	-	-	
2-Jun	-	-	296	226.67	-	-	-	
9-Jun	-	-	180	147.07	-	-	-	
16-Jun	-	-	116	98.24	-	-	-	Includes 1 retrenchment for term date 16/06/2013
30-Jun	-	-	1	1.00	-	-	-	retrenchment for term date 30/06/2013
Total	**0**	**0.0**	**1799**	**1456.52**	**0**	**0**	**0**	

Note:
* Potential offers reflect VR offers made based on forecasts provided by DoH and HHSs and names received
** Potential terminations are calculated by applying a 96% acceptance rate of all VR offers made

Actual FTE 01/07/2012 - 30/06/2013	3148.03
TOTAL FTE financial year 2013	**3148.03**
Actual Headcount 01/07/2012 - 30/06/2013	3717
TOTAL Headcount financial year 2013	**3717**

Separated Voluntary Redundancies and Retrenchments
01/07/2012 - 09/06/2013

Stream	FTE	Headcount	VR Payments	Leave Payments	Total
Managerial & Clerical	1,145.20	1,231	$ 72,464,447	$ 28,452,529	$ 100,916,976
Medical	28.35	32	$ 5,038,774	$ 2,624,261	$ 7,663,035
Nursing	681.25	839	$ 53,272,362	$ 18,496,841	$ 71,769,202
Operational	661.54	878	$ 28,548,921	$ 10,230,438	$ 38,779,359
Professional	35.42	41	$ 2,874,819	$ 1,116,452	$ 3,991,272
Professional & Technical	440.95	497	$ 35,677,307	$ 13,316,302	$ 48,993,610
Technical	3.52	4	$ 170,266	$ 77,770	$ 248,036
Trade & Artisans	50.68	51	$ 2,581,229	$ 1,122,575	$ 3,703,804
VMOs	5.90	27	$ 3,206,424	$ 1,431,781	$ 4,638,205
Total	3,052.81	3,600	$ 203,834,550	$ 76,868,950	$ 280,703,499

HES Summary	FTE	Headcount	VR Payments	Leave Payments	Total
Managerial & Clerical	23	23	$ 3,213,690	$ 1,882,977	$ 5,096,668

UPDATED FORECAST FOR POST 30 JUNE - 24 June 2013

	A -Offers made (as at 14 January)	B - In Payroll Process	C - Forecast VRs - Headcount	C - Forecast VRs - FTE	Current Variance (C-B)	Comment
ODG					0	
ODG (Surplus)		1	1	1	0	
HSCI***			15	13	15	
SPP					0	
SSS**		6	6	5	0	
HSIA			3	3	3	
HSSA		5	5	4	0	TBA
Sub Total (Department of Health)	***0***	***12***	***30***	***25.4***	***18***	***0***
Cairns		4	44	37	40	
Cape York		6	25	21	19	
Central Qld		55	91	30	36	
Central West		1	1	1	0	TBA
Childrens		1	51	43	50	
Darling Downs		76	329	280	253	
Gold Coast		6	56	41	50	
Mackay		1	11	10	10	
Metro North		245	910	774	665	
Metro South		9	209	178	200	
North West		2	2	2	0	TBA
South West		2	2	2	0	TBA
Sunshine Coast		32	73	60	41	
Torres Strait					0	TBA
Townsville*		5	5	4	0	Is checking with CE and COO
West Moreton		92	188	150	96	
Wide Bay*****		78	150	120	72	
Sub Total (HHSs)	***0***	***615***	***2147***	***1753***	***1532***	
Total	**0**	**627**	**2177**	**1778**	**1550**	
Accepted					**Total**	
Not Accepted						
Separated						

23/5 - Mackay - possibly 5 for 11/08/2013 and the other 5 after that.
11/6 - Cairns - Kitchen restructure - possible 40 (FTE to be advised)
12/6 - Wide Bay - 150 headcount including Yaralla

Qcos/00928 Pt 9

QUEENSLAND GOVERNMENT

Hon Lawrence Springborg MP
Minister for Health

MI183189

Level 19
147-163 Charlotte Street Brisbane 4000
GPO Box 48 Brisbane
Queensland 4001 Australia
Telephone +61 7 3234 1191
Facsimile +61 7 3229 4731
Email health@ministerial.qld.gov.au

Ms Beth Mohle
Secretary
Queensland Nurses' Union
GPO Box 1289
BRISBANE QLD 4001

25 SEP 2012

Dear Ms ~~Mohle~~ Beth

I refer to your facsimile dated 18 July 2012, in relation to optimising the employment of new graduate nurses and midwives within Queensland. I apologise for the delay in responding.

I acknowledge that the issue of graduate registered nurse (RN) employment raised in your letter is of critical importance, not only within Queensland, but for the nation as a whole. I tabled a paper at the 10 August 2012 Standing Council on Health (SCoH), regarding the underemployment of Australian RN graduates. This paper was prepared by the Nursing and Midwifery Office, Queensland, in consultation with the Chief Nursing and Midwifery Officers from across Australia.

The current underemployment of RN graduates in Australia will impact on future health service delivery capacity as RNs are the key workforce to deliver effective models of community and home based care and primary healthcare interventions. I agree that this issue requires discussion and consideration by Ministers of Health given the Health Workforce 2025 projections for nursing are 109,000 in deficit. This is the most significant shortfall of all health disciplines.

Queensland has the highest projected growth of health services in Australia and will require large volumes of RNs to open planned services this decade. I will be recommending to the Ministers that consideration is given to prioritising the next steps of the Health Workforce Australia work programme to seek to identify RN specialty gaps into the future. I will propose that this work be undertaken in collaboration with jurisdictions and major stakeholders to support modelling of new approaches for skilling the future RN workforce.

Should you require any further information in relation to this matter, I have arranged for Dr Frances Hughes, Chief Nursing and Midwifery Officer, Nursing and Midwifery Office, Queensland, Health Service and Clinical Innovation Division, Queensland Health, on telephone 3234 0910, to be available to assist you.

Yours sincerely

LAWRENCE SPRINGBORG MP
Minister for Health

Prepared by:

Cherie Egan
Principal Policy Officer - Nursing
Nursing and Midwifery Office, Queensland
32359039
8 August 2012

Submitted through:

Diana Schmalkuche
A/Chief Nursing and Midwifery Officer
Nursing and Midwifery Office, Queensland
32222915
9 August 2012

Cleared by:

Dr Michael Cleary
Deputy Director-General
Health Services and Clinical Innovation
3234 1524
Approved, 9 August 2012

ES 9 5/9/12

ES 3 5/9

DD 10/9

Executive Support Unit
MINISTERIAL CORRESPONDENCE – ACTION SHEET

Recfind Doc Type:

MIN	✓
MINPREM	
MINPREMD	
MINMP	
MINMPD	
MINAD	
MINNRR	
MINU	

Reg No: MI 183189

RCVD IN ESU: 23/7/12

DUE EXECUTIVE SUPPORT: 13/8/12

ACTION OFFICER: ~~DDG SSS~~ HSCI

COPIED TO: HSCI / HRS

Response required: Yes ✓ No ☐ Action Direct ☐

Response signatory: Minister for Health ✓ Assistant Minister ☐ Chief of Staff ☐

Closing contact details: Departmental ✓ N/A ☐

Response Template*: A (B) C G

Standard Letter: _____

ESU Option Letter Number: _____

Redirect to: _____

* Templates can be found on QHEPS by clicking on Corporate Templates under *I am looking for* or from the tool bar click on Business Support, and under Administration click on Templates. Alternatively, in Word, File / New and then click on Qld Health Templates (in the task panel on the right hand side of the page). It is important that you access the templates from the website *every time* (and not use a previous template) as the templates are updated regularly.

Briefing note required: YES / (NO)

Briefing note template*: A B C

COMMENTS: Please note comments over

ESU Contact: Dione Cochran

ACKNOWLEDGEMENT:

- ☐ Acknowledgement Letter
- ☐ Acknowledgement Email
- ☑ Acknowledgement **Not Required**

RESPONSE:

- ☑ Minister
- ☐ Assistant Minister
- ☐ Chief of Staff
- ☐ Board Chairs
- ☐ Refer to Department for Direct Reply
- ☐ No Response Required (Note and File)
- ☐ **BRIEFING NOTE REQUIRED**
- ☐ **BRIEFING NOTE NOT REQUIRED**

Department Ref #: _____

Policy Advisor: Marie

Re-Issue: Inc. both Marie

- Optimising the employment of new graduate nurses & midwives within Queensland

Previous Dept Ref #: _____

COMMENTS / REQUESTS:

Please send copy of this to Chief Nursing & Midwifery Officer x to Chief Nursing Officer also

Reviewed by: [signature] **Date:** 20/2/12

GPO Box 1289
BRISBANE Q 4001

Phone – 07 3840 1444
Fax - 07 3844 9387

QUEENSLAND NURSES' UNION

Fax

To: Hon Lawrence Springborg
Minister for Health

Fax: 3229 0444 **Pages: 4 in total**

Date 18 July 2012

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply**

Please see attached letter.

THE UNION FOR QNU NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

In association with the Australian Nursing Federation Queensland Branch

A.B.N. 84 382 908 052

www.qnu.org.au

18 July 2012

Hon Lawrence Springborg
Minister for Health
GPO Box 48
Brisbane Q 4001

Sent via Fax: 3229 0444

Dear Minister,

Re: Optimising the employment of new graduate nurses and midwives within Queensland

As you are aware, the Queensland Nurses' Union (QNU) has held grave concerns for some time now about the failure of Queensland Health and other health and aged care employers to employ all available new nursing and midwifery graduates in a timely manner. This represents a fundamental failure of appropriate nursing and midwifery workforce planning and represents an extreme and unacceptable risk to the future provision of high quality health services to the community of Queensland.

This issue has been highlighted in the recent QNU briefing document on key issues of concern for Queensland nurses and midwives. As this document highlights, this issue and the broader context of nursing and midwifery workforce planning has been of great concern to the QNU for some years, so much so that in October 2008 we launched the *Nurses. For you. For life.* campaign to highlight our concerns to the broader community.

We have also flagged our longstanding concerns with previous Queensland Health Ministers Paul Lucas and Geoff Wilson. We have also written to the current Commonwealth Health Minister Tanya Plibersek to outline our concerns and call upon governments to give urgent consideration to the need for a new model that will ensure the optimal employment of newly graduated registered nurses and midwives.

In recent years hundreds of nursing and midwifery graduates have failed to obtain timely employment with Queensland Health. This is despite the current and projected increased demand for health and aged care services in Queensland and the predicted retirement over coming years of a significant cohort of the existing nursing and midwifery workforce. We fear that the number that will not gain employment with Queensland Health at the end of 2012/beginning of 2013 may well exceed the number who do gain employment. This would be a disastrous situation in our view.

The failure to employ all available new graduates has caused much distress to the individual nurses affected by this lack of employment opportunities and is undermining the attractiveness of nursing and midwifery as a career. Word is spreading fast amongst existing and potential students about the current difficulties being experienced. We are also hearing reports from universities that they intend to decrease the course intake numbers significantly due to the current lack of gainful employment for all new graduates.

For more information please contact the QNU office indicated:

☐ **BRISBANE** GPO Box 1289 Brisbane Q 4001 P: (07) 3840 1444 F: (07) 3844 9387 E: qnu@qnu.org.au

☐ **BUNDABERG** PO Box 2949 Bundaberg Q 4670 P: (07) 4132 8411 F: (07) 4151 6066 E: qnubberg@qnu.org.au

☐ **CAIRNS** PO Box 846N Cairns North Q 4870 P: (07) 4031 4466 F: (07) 4051 6222 E: qnucairns@qnu.org.au

☐ **ROCKHAMPTON** PO Box 49 Rockhampton Q 4700 P: (07) 4922 5390 F: (07) 4922 3406 E: qnurocky@qnu.org.au

☐ **TOOWOOMBA** PO Box 3598 Village Fair Q 4350 P: (07) 4659 7200 F: (07) 4639 5052 E: qnutwmba@qnu.org.au

☐ **TOWNSVILLE** PO Box 3389 Hermit Park Q 4812 P: (07) 4772 5411 F: (07) 4721 1820 E: qnutsvle@qnu.org.au

The QNU appreciates the current low turnover and vacancy rates within Queensland Health's nursing and midwifery workforce. The QNU also appreciates the significant planned increase in health and aged care services in Queensland over the next three to five years, especially with the new Queensland Health (QH) facilities and expansion of existing services that are currently underway. In particular we note that thousands of additional nurses and midwives will be required for the new QH facilities at the Gold Coast, Sunshine Coast and new Children's Hospital and the significantly expanded hospital in Mackay. The anticipated time of peak demand nursing and midwifery workforce in for QH is in 2015/2016.

Many more nurses and midwives will also be required in the public and private non-acute care setting, especially in areas such as mental health, community health, aged care and primary health care settings such as Medicare Locals. There is a need for a new model of nursing and midwifery graduate employment, one that looks holistically at placement opportunities across sectors and settings, including addressing the particular needs of rural and remote communities.

We understand the current tension over the management of competing objectives within the health and aged care sectors – the need to ensure a safe and high quality health system, the need to maintain budget integrity and implement strategies to support ongoing sustainability and the need to plan for and invest upfront in matching future health workforce and service demands with supply. It is also a problem that is not confined to Queensland, though the needs of this state are in sharper relief given Queensland Health's planned service delivery enhancements linked to the significant service expansion that is occurring over the next few years.

The current situation is in urgent need of reframing. An investment now in nursing and midwifery workforce via the development of immediate strategies to support the optimal employment of new graduates is required. All too often a short term view is taken of the upfront costs incurred alone rather than assessing the costs associated with failing to act. Failing to act will result in greater costs in the long term in the form of adverse health outcomes resulting from poor skill mix and the substitution of qualified staff for unqualified personnel and the additional costs associated with attempting to take knee jerk corrective action when the crisis time is upon us.

The QNU is extremely concerned about the significant impact that a failure to appropriately manage this complex and pressing health workforce problem poses to our community and both the Queensland and Commonwealth governments. Our community that is reliant on having sufficient numbers of appropriately skilled health professionals to deliver high quality care when this is required. This is a major and known risk that must be addressed in a planned and proactive manner and must involve a number of key stakeholders. A large part of the difficulty in developing a strategy rests with the number of stakeholders that have a role to play in addressing the issue, with no one stakeholder being responsible for taking the lead role. This includes government at the state and national levels, employers in other sectors, the tertiary sector, Health Workforce Australia and health unions and their members.

The QH payroll disaster has highlighted to us all significant costs associated with failing to effectively manage risk. The QNU does not want to see a repeat of such a fundamental failure to manage risk, especially given that the scope of the impact is so broad, extending beyond the individual nurses and midwives who cannot find meaningful, timely employment in the community of Queensland. Modelling released this year by Health Workforce Australia on future nursing and midwifery workforce needs underscores the need for urgent action. No one can claim they were not warned of this impending workforce disaster.

The QNU believes that a new model is required for the employment of newly graduated nurses and midwives, one that is centrally coordinated and funded. The provision of central funding is critical for the next three to five years at least given the need to provide "seed funding" to ensure sufficient staffing is available for the planned significant expansion of QH services. More sophisticated and localised workforce planning tools are also needed to better match workforce supply with demand and a small investment in this now would pay dividends into the future.

In our view both State and Commonwealth governments must be involved in planning the health workforce of the future. It is a disgrace that the Commonwealth government is pouring hundreds of millions of dollars of additional funding into tertiary education courses for health professionals including nurses and midwives yet employment is not immediately available for new graduates on completion of the course.

The QNU wishes to place on record our willingness to work cooperatively with the Queensland and Commonwealth governments and other stakeholders to find solutions to this pressing problem. We have a long track record of working collaboratively to find solutions within an interest based problem solving framework as evidenced by our joint sponsorship (along with the Nursing and Midwifery Office of Queensland) of a Queensland Nursing and Midwifery Workforce Summit in April 2010. Strong foundation elements exist in Queensland upon which a plan to address this problem can be built given that we have already developed robust workforce planning and resource management tools. There also exist particular rural and remote workforce challenges in Queensland that require a fresh approach in our view.

It is imperative that the immediate development of a strategy to address the optimal employment of new nursing and midwifery graduates is discussed at the next meeting of Australian Health Ministers. The current crisis of new graduate under-employment must be viewed in the context of a long term nursing and midwifery workforce strategy. Your assistance in advancing this vitally important agenda at this forum would be greatly appreciated.

Thank you for your attention to this critical matter. Please do not hesitate to contact me on (07) 3840 1437 should you wish to discuss this matter further.

Yours sincerely,

BETH MOHLE
Secretary

EXECSUPPORT - Redirection Request: MI183189 (HRS05257)

From: HRSCorro
To: EXECSUPPORT.Corporate-Office-PO1.CORPORATE-OFFICE@health.qld.gov.au
Date: 7/24/2012 4:31 PM
Subject: Redirection Request: MI183189 (HRS05257)

Hi Exec Support

Kate Turner, A/Director, Work For Us, has advised that Work For Us do not deal with graduate recruitment of nurses. This is managed by the Nursing and Midwifery Office of Queensland, under the Chief Nursing and Midwifery Officer and this should be redirected to NMOQ for their action and response.

Kind regards,
Nichola.

✓ Redirect to HSCI

Due 13/8

Nichola Byrne
Correspondence Coordinator
Office of the Chief Human Resources Officer
System Support Services
Queensland Health

Ph: 07 3234 1552
Level 15, 147-163 Charlotte St
GPO Box 48, Brisbane Qld 4001
Email: HRSCorro@health.qld.gov.au

Always download and use a Corporate template/s http://qheps.health.qld.gov.au/corro-templates/html/templates.htm

>>> EXECSUPPORT 23/07/2012 1:58 pm >>>
Good afternoon

Please find attached MI183189 for Ministerial Response due back to Executive Support by **13 August 2012**.

Please use Template B from QHEPS for the Ministerial Response for the signature of the Minister for Health.

Kind regards
Tyler
Executive Support Unit
323 41465

EXECSUPPORT - MI183189 - Update requested - due 24/8/2012

From: EXECSUPPORT
To: HSCI_Corro.Corporate-Office-PO6.CORPORATE-OFFICE@health.qld.gov.au
Date: 8/22/2012 11:32 AM
Subject: MI183189 - Update requested - due 24/8/2012
Attachments: MI183189.doc

Good morning Miranda

Can HSCI please update the attached response letter for **MI183189** with regard to the tabling of a paper on 10 August 2012 at the Standing Council on Health.

MI183189 is due back at ExecSupport on 24/8/2012.

Thank you
Kind regards
Axele
3234 1093

>>> HSCI_Corro 8/10/2012 12:11 pm >>>
Good morning,
Please find attached response cleared by the DDG HSCI

regards
Miranda

Office of the Deputy Director-General
Health Service and Clinical Innovation Division
Level 16 Queensland Health Building
147 - 163 Charlotte Street
Phone:
Karen 322 52465
Miranda 3227 6617
Mattina 3234 0260

>>> EXECSUPPORT 25/07/2012 8:57 am >>>
Good morning

Please find attached **MI183189** for Ministerial Response due back to Executive Support by **13 August 2012**.

MI183189 has been redirected from HRS as per the email below as it relates to recruitment of graduate nurses.

Please use **Template B** from QHEPS for the Ministerial Response for the **signature of the Minister for Health**.

Thank you
Kind regards
Diane
Executive Support
3234 0162

>>> HRSCorro 24/07/2012 4:31 pm >>>
Hi Exec Support

Kate Turner, A/Director, Work For Us, has advised that Work For Us do not deal with graduate recruitment of nurses. This is managed by the Nursing and Midwifery Office of Queensland, under the Chief Nursing and Midwifery Officer and this should be redirected to NMOQ for their action and response.

Kind regards,
Nichola.

Nichola Byrne
Correspondence Coordinator
Office of the Chief Human Resources Officer
System Support Services
Queensland Health

Ph: 07 3234 1552
Level 15, 147-163 Charlotte St
GPO Box 48, Brisbane Qld 4001
Email: HRSCorro@health.qld.gov.au

Always download and use a Corporate template/s http://qheps.health.qld.gov.au/corro-templates/html/templates.htm

>>> EXECSUPPORT 23/07/2012 1:58 pm >>>
Good afternoon

Please find attached MI183189 for Ministerial Response due back to Executive Support by **13 August 2012**.

Please use Template B from QHEPS for the Ministerial Response for the signature of the Minister for Health.

Kind regards
Tyler
Executive Support Unit
323 41465

CONF

6/5/13 Q05/02/1036

Department RecFind No:	BR056536
Division/HHS:	Mackay HHS
File Ref No:	

(3)

BR056536

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED DATE 7 MAY 2013

Requested by: Chief Executive, Mackay Hospital & Health Service

Date requested: 15 April 2013

Action required by: 16 April 2013

SUBJECT: Organisational Change within Mackay Hospital and Health Service

Recommendation
That the Minister:

Note that the Mackay Hospital and Health Service (MHHS) has determined to make organisational changes to services encompassing Clinical Governance, Child & Family Therapies and Alcohol, Tobacco and Other Drugs (ATOD) Services, which will result in the abolishment of 13.88 Full Time Equivalent (FTE) and creation of 4.28 FTE. (Total net reduction of 9.6 FTE).

Note the Clinical Governance Unit - Organisational changes determined so as to better align deployment of resources to meet service demand arising from National Quality & Safety Standards - total (net) reduction of 2.0 FTE.

Note the Child and Family Therapy Services – due to the introduction of services in the non-government sector, through the commencement of ATAPS for Kids, auspiced under the TMML, the services currently offered by MHHS are a duplication of services – total (net) reduction of 3.6 FTE.

Note the ATODS – Organisational changes determined to better align deployment of resources to meet projected service demand commensurate with anticipated budget capacity – total (net) reduction of 4 FTE.

APPROVED/NOT APPROVED

LAWRENCE SPRINGBORG
Minister for Health

/ /

NOTED

RECEIVED RECORDS TEAM 14 MAY 2013 DESPATCHED

NOTED

Chief of Staff

10/5/13

Minister's comments

6 MAY 2013

URGENT

Department RecFind No:	BR056536
Division/HHS:	Mackay HHS
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: Chief Executive, Mackay Hospital & Health Service **Date requested:** 15 April 2013 **Action required by:** 16 April 2013

SUBJECT: Organisational Change within Mackay Hospital and Health Service

Proposal

That the Director-General:

Note that the Mackay Hospital and Health Service (MHHS) has determined to make organisational changes to services encompassing Clinical Governance, Child & Family Therapies and Alcohol, Tobacco and Other Drugs (ATOD) Services, which will result in the abolishment of 13.88 Full Time Equivalent (FTE) and creation of 4.28 FTE. (Total net reduction of 9.6 FTE).

Provide this brief to the Minister for information.

Urgency

1. **Urgent** - MHHS announced the changes to affected staff and representative Union organisations on 17 April 2013.

Headline Issues

2. The top issues are:
   - Clinical Governance Unit - Organisational changes determined so as to better align deployment of resources to meet service demand arising from National Quality & Safety Standards - total (net) reduction of 2.0 FTE.
   - Child and Family Therapy Services – due to the introduction of services in the non-government sector, through the commencement of ATAPS for Kids, auspiced under the TMML, the services currently offered by MHHS are a duplication of services – total (net) reduction of 3.6 FTE.
   - ATODS – Organisational changes determined to better align deployment of resources to meet projected service demand commensurate with anticipated budget capacity – total (net) reduction of 4 FTE.

Key issues

3. Duplicate Services available in the Primary Care Sector:
   - There has been an introduction of services in the non-government sector, through the commencement of ATAPS for Kids, auspiced under the TMML.
   - The services offered through this service are a duplication of the services offered through the Child and Family Therapy Team.
   - The NGO service offers parents and children an initial 6 sessions, with no out of pocket expenses for families. A further six sessions may also be available after the initial course of treatment is
   - The service is geared to providing GPs and specialists with a therapeutic avenue for children (0-12 years) with mild to moderate behavioural or emotional presentations.
   - There is no similar service for Child Development Services, and as such this service will be maintained so that community has access to therapeutic services directly involved in Child Development.
4. Contribution of Service to Current Service Agreement and Priority Service Demands:
   - The Mackay HHS Service Agreement articulates the services that Mackay must provide for the funding allocated. There are no specific requirements for MHHS to maintain a primary care/first contact service offering counselling and support for parents and children.
   - Mackay HHS continues to make changes to services, so that the HHS can provide specified services, to required levels within the funding allocated.
   - This means that, from time to time, there will be a requirement to divest our investment in some services where there is no clear requirement within our contracted services.

Department RecFind No:	BR056536
Division/HHS:	Mackay HHS
File Ref No:	

- As part of the broader National reform agenda, the Federal Government are changing the way they fund healthcare. There is a reduction in funding coming to the States, and an increase in primary health care.
- MHHS will continue to experience changes to its future budget, and will be expected to change the service mix associated with this change, to respond to the efficiency targets applied by both National and State funding agendas.
- There are ambiguous KPIs and requirements in the MHHS Service Agreement related to ATODs.
- High level analysis of the current service indicates that these KPIs could be maintained and that there is opportunity to reallocate savings to other demands in addition to redirection of resources to other priority service demands.

5. Service Financial Viability:
   - Mackay Base Hospital, and all associated outpatient clinic services, are included under the ABF framework for funding.
   - With regard to Child & Family Therapy Services, based on an average of 1.8 occasions of service per FTE/Day (that is, less than two patients being seen per employee per day) – continuation of this service profile cannot be sustained.
   - Savings from the organisational change process will be redirected in to priority services such as ophthalmology wait lists.
   - This means that our service must show that we can maintain service costs for the price that is paid by the System Manager. The National Efficient Price for Healthcare is also driving our organisation to become more efficient.
   - Based on the client numbers and occasions of service provided within the Child and Family Therapy team, the MHHS cannot afford to maintain this service. The current ABF price paid for an outpatient psychology or social work intervention is $160.54/OOS for the M2 Peer Group.
   - When we apply this price to the OOS provided last financial year, and compare this to the cost of salaries to provide this service, there is a deficit of $170,000 pa. That is, the payments we generate for providing this service, is $170,000 short of paying for the salaries of the team.
6. National Safety and Quality Health Service Standards:
   - With the introduction of the aforementioned standards HHS are required to facilitate and enable resources and systems to be deployed to protect the public from harm and to improve the quality of health service provision.
   - MHHS former Clinical Governance Unit organisational structure was not reflective of required capacity and skill mix to provide a quality assurance mechanism and systems congruent with the national standards.

Background

7. MHHS in conjunction with the MHHS Board is continually monitoring and reviewing service demand and service capacity and capability to meet this demand.
8. As part of this process MHHS has identified required organisational change that will enhance service capacity and capability in the services.
9. The determination and implementation of the organisational change is in accordance with Queensland Public Service Commission Organisational Change process.

Consultation

10. MHHS Executive have been consulted on the organisational changes prior to determination by the Chief Executive.
11. MHHS Board has been consulted.
12. Staff and Union representatives will be provided with two weeks consultation from 17 April 2013 regarding the implementation process.

Attachments

13. Attachment 1: Proposed Implementation Plan for Organisational Change:
    - 13.1 Clinical Governance Unit;
    - 13.2 Child & Family Therapy Services; and
    - 13.3 ATODs.

Department RecFind No:	**BR056536**
Division/HHS:	**Mackay HHS**
File Ref No:	

Recommendation

Note that the Mackay Hospital and Health Service (MHHS) has determined to make organisational changes to services encompassing Clinical Governance, s.47(3)(b) Child & Family Therapies and Alcohol, Tobacco and Other Drugs (ATOD) Services, which will result in the abolishment of 13.88 Full Time Equivalent (FTE) and creation of 4.28 FTE. (Total net reduction of 9.6 FTE).

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General
6 / 5 / 13

To Minister's Office For Noting ☒

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Raelene Burke	Kerry McGovern	Kerry McGovern
Executive Director, People & Culture	Chief Executive	Chief Executive
People & Culture	Mackay Hospital & Health Service	MHHS
4885 6754	48856752	48856752
16 April 2013	16 April 2013	16 April 2013

Proposed Implementation Process - Clinical Governance Unit (CGU) Restructure, Mackay Hospital and Health Service

Purpose

This document aims to provide an overview of the restructure of the safety, quality and medical administration aspects of the Clinical Governance Unit. In addition it aims to provide a broad guide of the process and impacts on staff.

The document is intended to support consultation in relation to the way the Mackay Hospital and Health Service implements the change and invites input into ways in which the impacts of the change can be minimised.

Introduction

On the 28 March 2013, the Mackay HHS completed a review of the safety, quality and medical administration aspects of the Clinical Governance Unit and identified the need to change/realign some of the positions and functions within the unit. This will better support current work practices, improve service delivery and clinician support, and enable the Health Service to meet the new safety and quality governance requirements.

This document outlines how it is proposed that this change will be implemented. The Mackay Hospital and Health Service will undertake this change in accordance with government policy and industrial obligations.

Scope of the change

It is anticipated that up to 13.28 approved FTE of existing positions are likely to be affected by this change. The attached FTE changes table shows a summary of the effects of the changes (number and category of employees likely to be directly affected). The total (net) reduction of FTE will be 2.00 approved FTE.

Please refer to **Attachment 1**: Timeline - Proposed Implementation Plan – Clinical Governance Unit, Mackay Hospital and Health Service and **Attachment 2**: Proposed Implementation Process – FTE - Clinical Governance Unit, Mackay Hospital and Health Service, which shows a summary of the effects of the changes (number and category of employees likely to be directly affected).

Supporting staff through change

The Mackay HHS values and respects its staff and the contribution they make.

For employees identified as requiring placement the support offered will include:

- Individual discussion with the affected employees offering certainty about the impact of the changes as soon as is possible in the process
- Consultation will be conducted with staff and relevant unions as to ways to minimise the effects of the change
- Support and assistance through the process
- Employee Assistance Program (EAP) including face-to-face counselling and other strategies available through EAP; and

For employees generally the support will include:

- Offering detail about decisions and impacts as soon as possible in the process;
- EAP including face-to-face counselling and other strategies available through EAP

Minimising the effects of the change

The Mackay Hospital and Health Service wants to avoid or minimise the effects of the proposed change on existing staff. Input of staff in implementing the changes can help us minimise the impacts.

Where possible, displaced staff will be directly 'matched' to existing vacant positions at their substantive level dependent upon their suitability.

The proposed process to minimise effect on employees

- Where employees are substantially attached to the affected work unit and it is identified that the employee's role and ongoing duties can be transferred to another existing work unit then no further process need occur. This could be either a one to one match or multiple to multiple.

Employees Requiring Placement

Where the above strategies do not result in an affected staff member being substantively placed against a role in the new structure, the employee will be declared surplus and will be managed in accordance with Public Service Commission (PSC) Directive 6/12 'Employees Requiring Placement' and the relevant process will be followed.

Steps for consultation on implementation

1. Meeting with employees and unions to present restructure and consult upon proposed implementation – proposed implementation plan distributed.
2. Individual meetings with affected employees.
3. Period of consultation with employees and unions in relation to implementation.
4. Feedback received in relation to implementation considered.
5. Consultation finalised and implementation plan confirmed and commenced.

Timeframe and Proposed Changes

Attachment 1: Timeline - Proposed Implementation Plan – Clinical Governance Unit, Mackay Hospital and Health Service, outlines the timeframe for proposed implementation of the restructure.

Attachment 2: Proposed Implementation Process – FTE - Clinical Governance Unit, Mackay Hospital and Health Service.

Flowchart

Attachment 3: Proposed Implementation Process – Flowchart – Clinical Governance Unit, Mackay Hospital and Health Service.

Organisational Chart

Attachment 4: Current Organisational Structure – Clinical Governance Unit, Mackay Hospital and Health Service.
Attachment 5: Current Organisational Structure – Clinical Governance Unit, Mackay Hospital and Health Service

Providing feedback

Stakeholders are invited to provide feedback by close of business 1 May 2013 about the implementation process. Feedback may be provided by email: Kim.Timbs@health.qld.gov.au and DanielJ_Rowley@health.qld.gov.au.

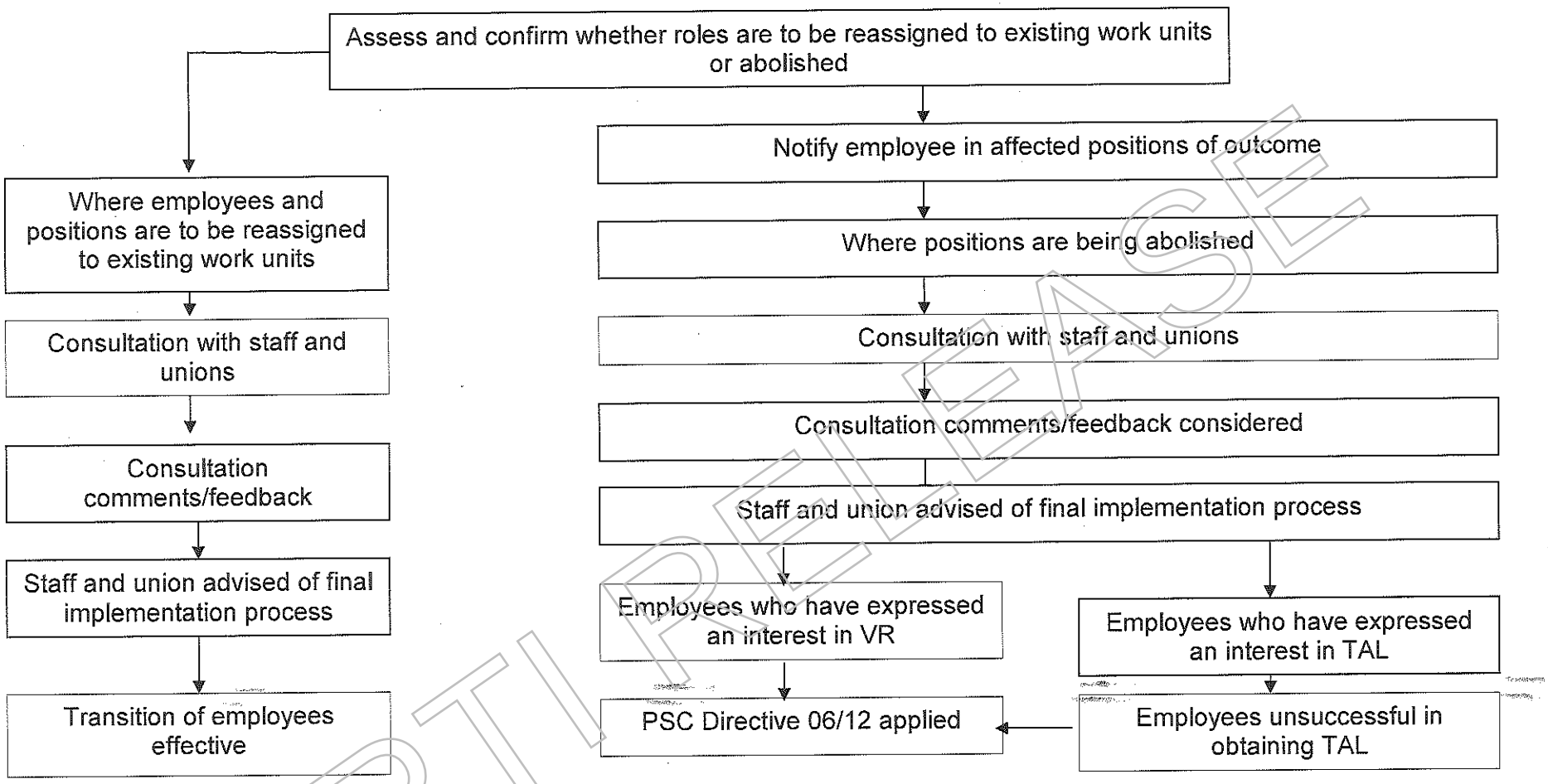
Regards

Kerry McGovern
Health Service Chief Executive
Mackay Hospital and Health Service
10 April 2013

Attachment 1: Timeline - Proposed Implementation Plan – Clinical Governance Unit, Mackay Hospital and Health Service

PROPOSED DATE	ACTION	RESPONSIBLE OFFICER
28/03/13	Changes approved by Chief Executive (HSCE)	HSCE
17/04/13	Consultation with Employees and Unions	Executive Director of Clinical Services Nursing Director Education and Research acting as Change Manager Manager Medical Workforce & Operations People & Culture Unit
17/04/13	Consultation period commences:	All stakeholders
17/4/13 to 01/5/13	One on one meetings held with employees and union representative	ND Education and Research acting as Change Manager Manager Medical Workforce & Operations People & Culture Unit
01/05/13	Consultation period concludes	All stakeholders
02/05/13	Feedback reviewed and implementation plan finalised	ND Education and Research acting as Change Manager Manager Medical Workforce & Operations People & Culture Unit
03/05/13	Implementation Plan approved	Executive Director of Clinical Services
03/05/13	Final Implementation Plan issued to employees and unions	Executive Director of Clinical Services
TBA	QH System Manager advised on Mackay HHS staff who are interested in a VR	People & Culture Unit
TBA	Positions and staff transferred to the new structure	Manager Medical Workforce & Operations
TBA	MHHS Executive advised on final outcome of VR Process and finalisation of restructure	HSCE
TBA	MHHS Board and Executive advised on final outcome	Executive Director of Clinical Services People & Culture Unit

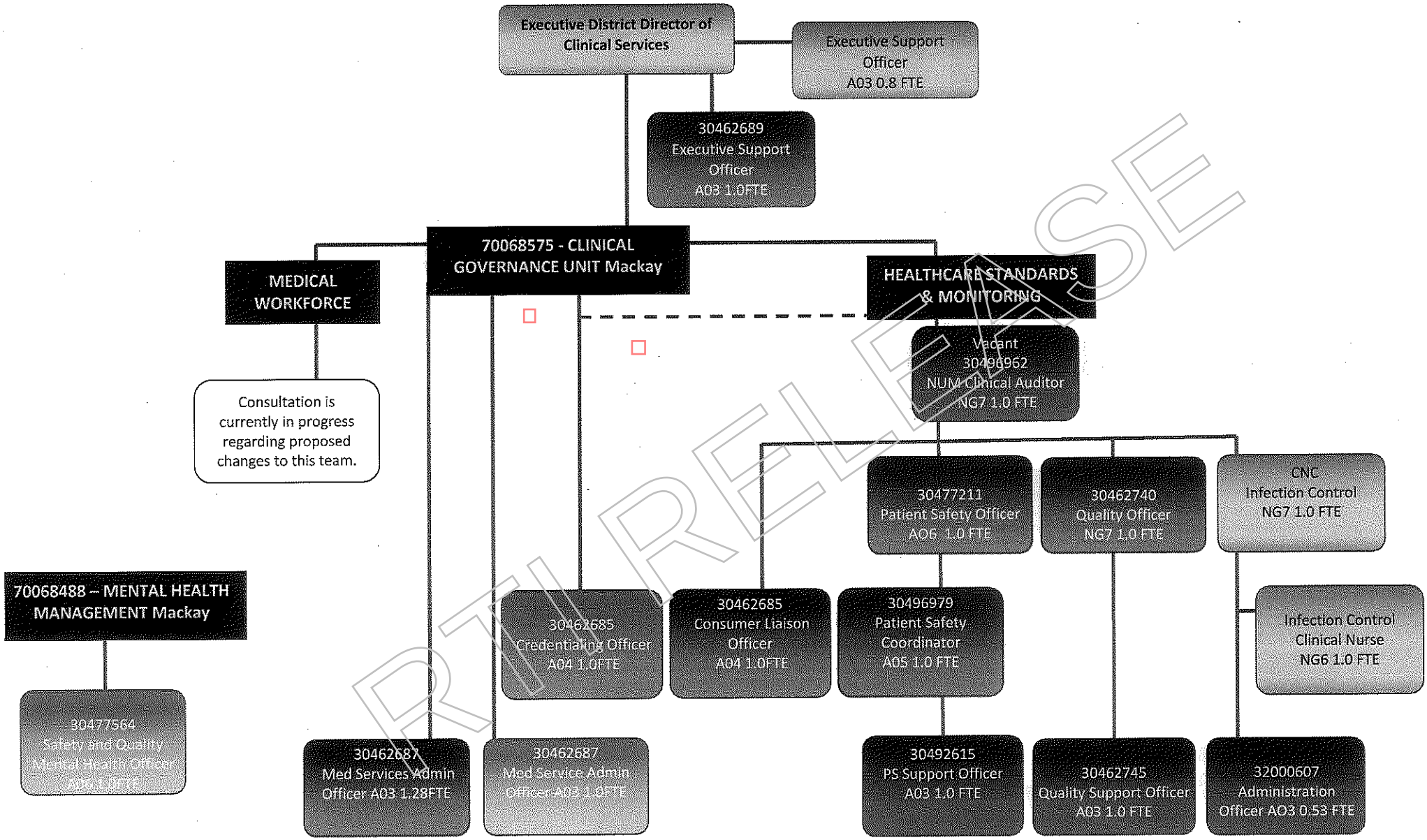
Attachment 3: Proposed Implementation Process – Flowchart – Clinical Governance Unit, Mackay Hospital and Health Service



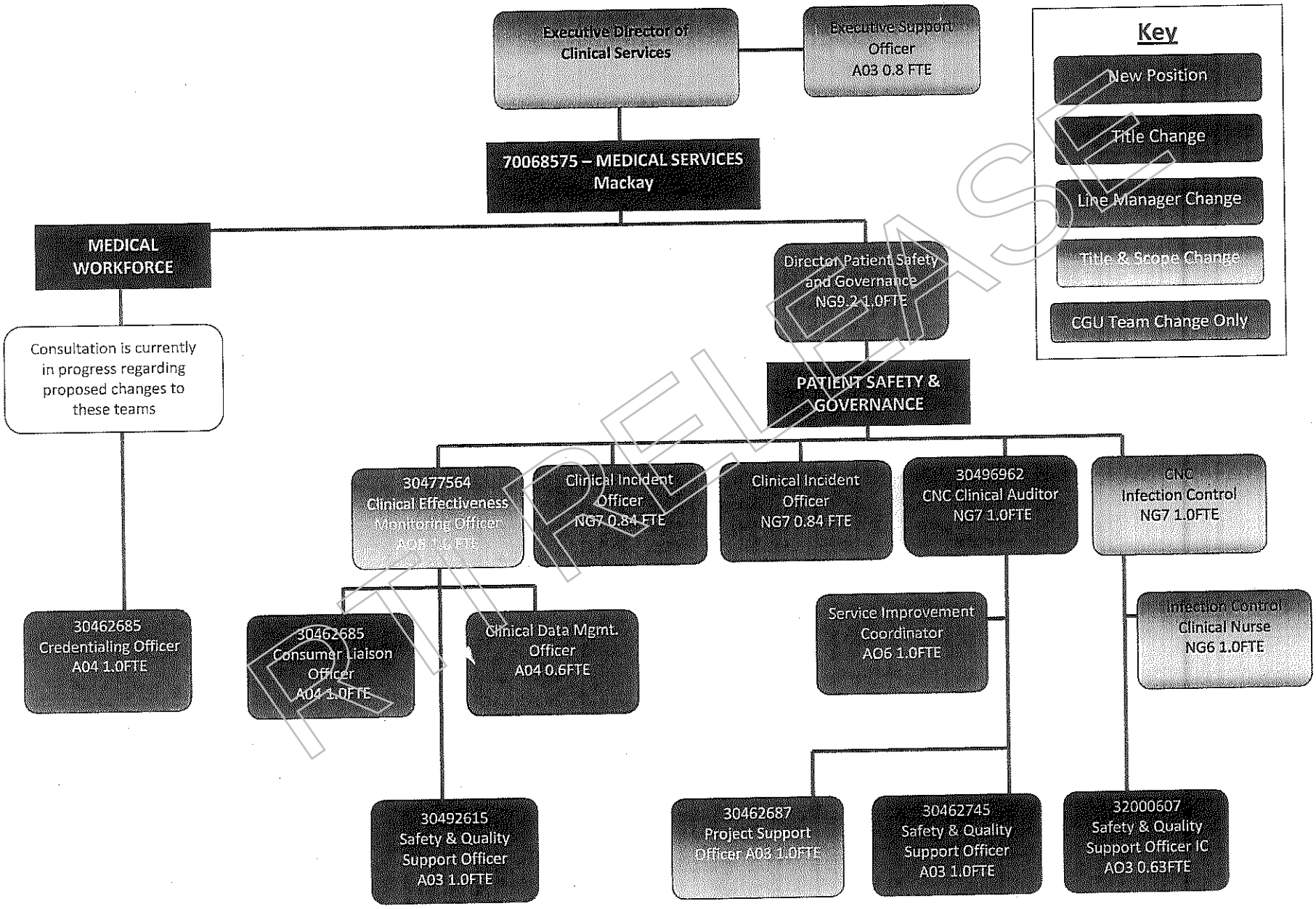
Attachment 2: Proposed Implementation Process – FTE - Clinica. ...ce Unit, Mackay Hospital and Health Service

Current				Approved Change		
Position ID	Current position	Approved FTE	Current Filled FTE	Change	Approved FTE	Comment
70068575 - Clinical Governance Unit Mackay						
30462740	COORD District Quality Management (NRG7)	1.00	1.00	Abolish	0.00	Abolish COORD District Quality Management role
30477211	Patient Safety OFF MK (AO6)	1.00	1.00	Abolish	0.00	Abolish Patient Safety Officer role
30496979	Coordinator Patient Safety MK (AO5)	1.00	0.00	Abolish	0.00	Abolish Coordinator Patient Safety role
New	Clinical Incident Officer (NO7)			Create	0.84	Create Clinical Incident Officer role
New	Clinical Incident Officer (NO7)			Create	0.84	Create Clinical Incident Officer role
New	Service Improvement Coordinator (AO6)			Create	1.00	Create Service Improvement Coordinator
New	Clinical Data Management Officer (AO4)			Create	0.60	Create Clinical Data Management Officer
30496962	NUM Clinical Auditor MK (NRG7)	1.00	0.00	Title change	1.00	Change title to Clinical Auditor CNC. Some functions to change
30462685	Consumer Liaison OFF (AO4)	1.00	1.00	Line Manager	1.00	Line Manager change, function retained
30479819	Credentialing Officer MK	1.00	1.00			Change to Medical Workforce team. No change to reporting line.
30462745	Quality Support OFF CGU MK (AO3)	1.00	1.00	Title	1.00	Some functions to change
30492615	Patient Safety Support OFF CGU MK (AO3)	1.00	1.00	Title	1.00	Some functions to change
32000607	Administration Officer (AO3) (Infection Control)	1.00	1.00	Title	1.00	Some functions to change
30462687	Medical Service Administration Officer (AO3)	2.28	0.00	Reduce FTE/title and function change	1.00	Reduce FTE by 1.28 - Medical Service Administration Officer role
New	Director Patient Safety and Governance (NRG 9.2)			Create	1.00	Create Director Patient Safety and Governance role
70068465 – Executive Support Officer Medical						
30462689	Executive Support Officer (AO3)	1.00	1.00	Abolish	0.00	Abolish Executive Support Officer role
70068488 - Mental Health Management Mackay						
30477564	Safety & Quality Officer Mental Health (AO6)	1.00	1.00	Reassign and Scope expanded	1.00	Title change to Clinical Effectiveness Monitoring Officer and position to be reassigned to CGU. Scope expanded.
Totals		13.28	9	2.0	11.28	

Attachment 4: Current Organisational Structure – Clinical Governance Unit, Mackay Hospital and Health Service



Attachment 5: Current Organisational Structure – Clinical Governance Unit, Mackay Hospital and Health Service



Proposed Implementation Process- Child and Family Therapy Service, Mackay Hospital and Health Service

Purpose

This document aims to provide an overview of the restructure of Child and Family Therapy Services within the Mackay Health and Hospital Service (MHHS). In addition it aims to provide a broad guide of the process and impacts on staff.

The document is intended to support consultation in relation to the way the Mackay Hospital and Health Service implements the change and invites input into ways in which the impacts of the change can be minimised.

Introduction

The Mackay Hospital and Health Service is implementing a restructure of Child and Family Therapy Services. The restructure will result in a reduction in the number of staff required.

This document outlines how it is proposed that this change will be implemented. The Mackay Hospital and Health Service will undertake this change in accordance with government policy and industrial obligations.

Scope of the change

It is anticipated that up to **3.60** approved FTE of existing positions are likely to be affected by this change. The attached FTE changes table shows a summary of the effects of the changes (number and category of employees likely to be directly affected).

Please refer to **Attachment 1**: Timeframe Proposed Implementation Process, Child and Family Therapy Services, MHHS and **Attachment 2**: Proposed Implementation Process – FTE – Child and Family Therapy Services, MHHS, which shows a summary of the effects of the changes (number and category of employees likely to be directly affected).

Supporting staff through change

The Mackay HHS values and respects its staff and the contribution they make.

For employees identified as requiring placement the support offered will include:

- Individual discussion with the affected employees offering certainty about the impact of the changes as soon as is possible in the process
- Consultation will be conducted with staff and relevant unions as to ways to minimise the effects of the change
- Support and assistance through the process
- Employee Assistance Program (EAP) including face-to-face counselling and other strategies available through EAP; and

For employees generally the support will include:

- Offering detail about decisions and impacts as soon as possible in the process;
- EAP including face-to-face counselling and other strategies available through EAP

Minimising the effects of the change

The Mackay Hospital and Health Service wants to avoid or minimise the effects of the proposed change on existing staff. Input of staff in implementing the changes can help us minimise the impacts.

The proposed process to minimise effect on employees

- Where possible, displaced staff will be directly 'matched' to existing vacant positions dependent upon their suitability.

Employees Requiring Placement

When the above strategies do not result in affected staff members being substantively placed against a role, the employee will be declared surplus and will be managed in accordance with Public Service Commission (PSC) Directive 6/12 'Employees Requiring Placement' and the relevant process will be followed.

Steps for consultation on implementation

1. Meeting with employees and unions to present restructure and consult upon proposed implementation – proposed implementation plan distributed.
2. Individual meetings with affected employees.
3. Period of consultation with employees and unions in relation to implementation.
4. Feedback received in relation to implementation considered.
5. Consultation finalised and implementation plan confirmed and commenced.

Timeframe and Proposed Changes

Attachment 1: Timeframe Proposed Implementation Process, Child and Family Therapy Services, MHHS outlines the timeframe for proposed implementation of the restructure.

Attachment 2: Proposed Implementation Process – FTE - Child and Family Therapy Services, MHHS.

Flowchart

Attachment 3: Proposed Implementation Process – Flowchart – Child and Family Therapy Services, MHHS.

Organisational Chart

Attachment 4: Current Organisational Chart, Child and Family Therapy Services, MHHS.

Attachment 5: Proposed Organisational Chart, Child and Family Therapy Services, MHHS.

Minimising the effects of the change

The Mackay Hospital and Health Service wants to avoid or minimise the effects of the proposed change on existing staff. Input of staff in implementing the changes can help us minimise the impacts.

The proposed process to minimise effect on employees

- Where possible, displaced staff will be directly 'matched' to existing vacant positions dependent upon their suitability.

Employees Requiring Placement

When the above strategies do not result in affected staff members being substantively placed against a role, the employee will be declared surplus and will be managed in accordance with Public Service Commission (PSC) Directive 6/12 'Employees Requiring Placement' and the relevant process will be followed.

Steps for consultation on implementation

1. Meeting with employees and unions to present restructure and consult upon proposed implementation – proposed implementation plan distributed.
2. Individual meetings with affected employees.
3. Period of consultation with employees and unions in relation to implementation.
4. Feedback received in relation to implementation considered.
5. Consultation finalised and implementation plan confirmed and commenced.

Timeframe and Proposed Changes

Attachment 1: Timeframe Proposed Implementation Process, Child and Family Therapy Services, MHHS outlines the timeframe for proposed implementation of the restructure.

Attachment 2: Proposed Implementation Process – FTE - Child and Family Therapy Services, MHHS.

Flowchart

Attachment 3: Proposed Implementation Process – Flowchart – Child and Family Therapy Services, MHHS.

Organisational Chart

Attachment 4: Current Organisational Chart, Child and Family Therapy Services, MHHS.

Attachment 5: Proposed Organisational Chart, Child and Family Therapy Services, MHHS.

Providing feedback

Stakeholders are invited to provide feedback by close of business 1 May 2013 about the implementation process. Feedback may be provided by email: Danielle_Hornsby@health.qld.gov.au and DanielJ_Rowley@health.qld.gov.au.

Regards,

Kerry McGovern
Health Service Chief Executive
Mackay Hospital and Health Service
12 April 2013

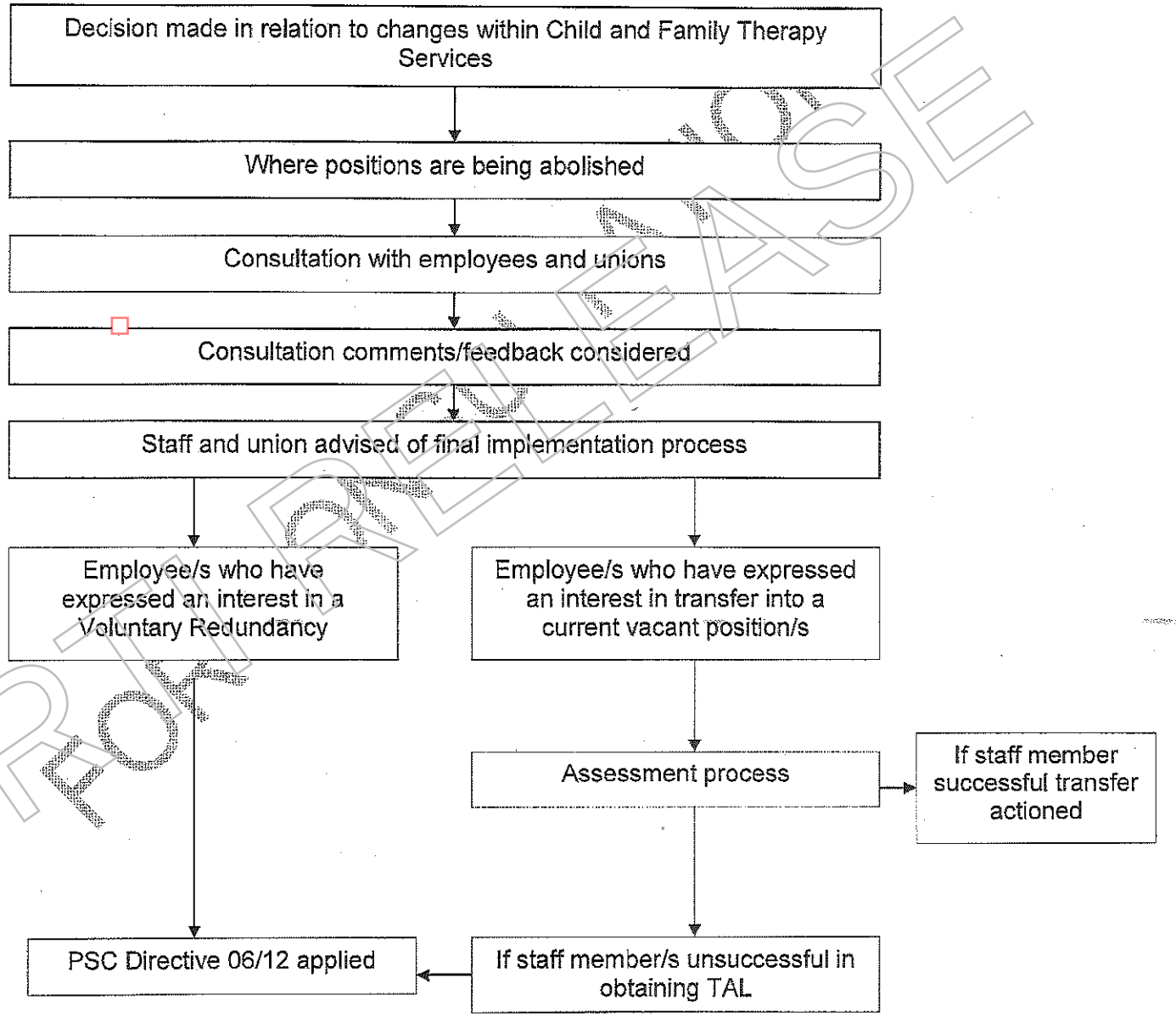
Attachment 1: Timeframe Proposed Implementation Process, Child and Family Therapy Services, MHHS

DATE	ACTION	RESPONSIBLE OFFICER
01/04/13	Changes approved by Chief Executive (HSCE)	HSCE
17/04/13	Consultation with Employees and Unions	Ex Director Allied Health Ex Director People & Culture People and Culture Unit
17/04/13	Consultation period commences	All stakeholders
17/04/13 to 01/05/13	One on one meetings held with employees and union representative	Ex Director Allied Health Ex Director People & Culture People and Culture Unit
01/05/13	Consultation period concludes	All stakeholders
02/05/13	Feedback reviewed and Implementation plan finalised	Ex Director Allied Health Ex Director People & Culture People & Culture Unit
03/05/13	Implementation Plan approved	Ex Director Allied Health
03/05/13	Final Implementation Plan issued to employees and unions	Ex Director Allied Health
TBA	QH System Manager advised of staff who are interested in a VR	People & Culture Unit
TBA	MHHS Executive advised on final outcome of VR Process and finalisation of restructure	Ex Director Allied Health
TBA	MHHS Board advised on final outcome	HSCE People & Culture Unit

Attachment 2: Proposed Implementation Process – FTE - Child and Family Therapy Services, MHHS

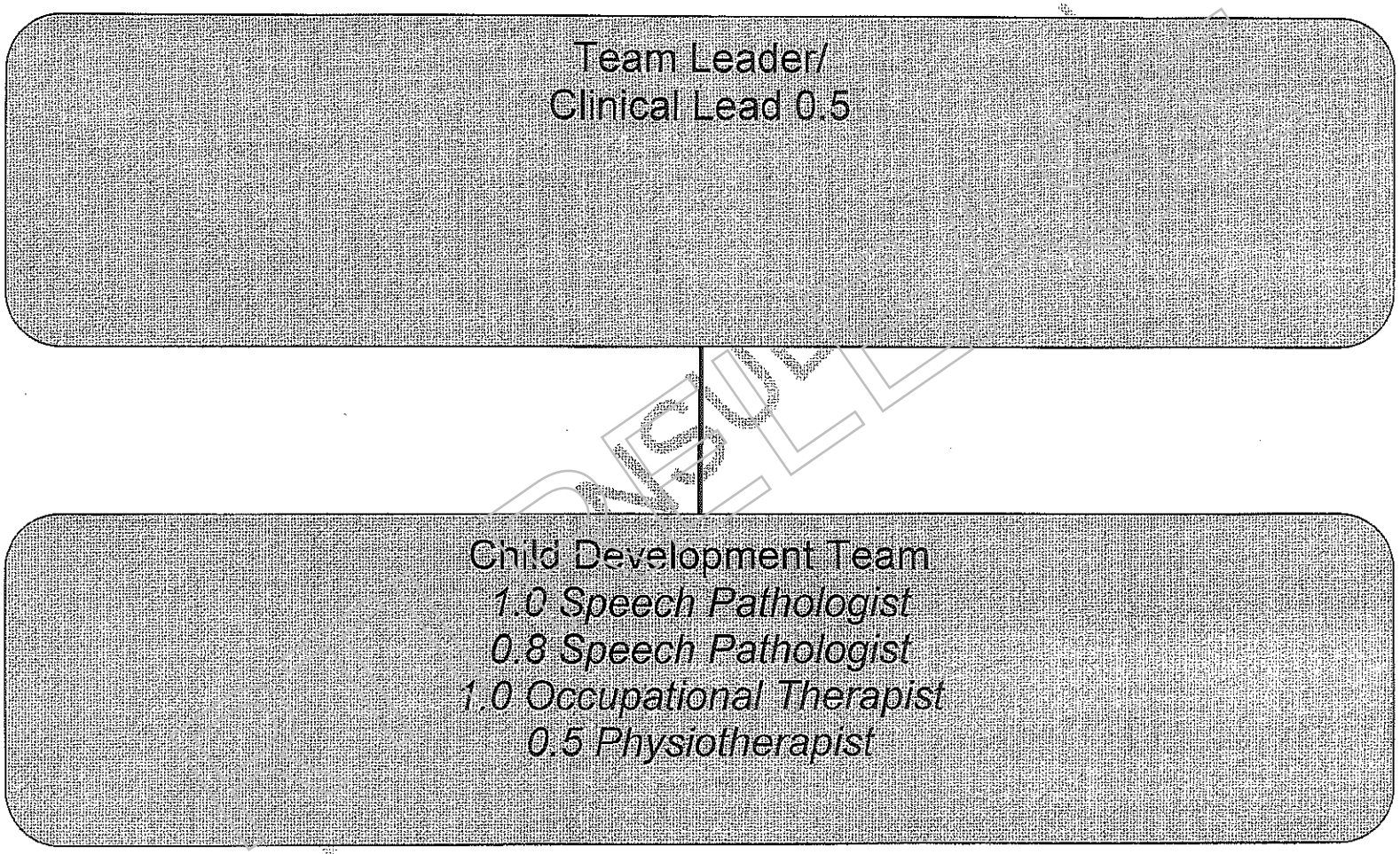
Current					Approved Change				
Position ID	Level	Title	Approved FTE	Currently Filled FTE	Change	Level	Approved FTE	Title	Comments
30462852	HP4	Psychologist Child and Family	1.00	1.00	Abolish				Abolish Position
30473459	HP4	Psychologist (Early intervention parenting)	1.00	1.00	Abolish				Abolish Position
30462854	HP3	Social Worker Child and Family	0.60	0.60	Abolish				Abolish Position
32009411	PO3	Family Therapist Counsellor	1.00	1.00	Abolish				Abolish Position
Total			3.60	3.60					

Attachment 3: Proposed Implementation Process – Flowchart – Child and Family Therapy Services, MHHS



Attachment 4: Current Organisational Chart, Child and Family Therapy Services, MHHS

Attachment 5: Proposed Organisational Chart, Child and Family Therapy Services, MHHS.



Proposed Implementation Process- Alcohol, Tobacco and Other Drugs Service (ATODS) Mackay Hospital and Health Service

Purpose

This document aims to provide an overview of the restructure of Alcohol, Tobacco and other Drugs Service (ATODS) within the Mackay Health and Hospital Service (MHHS). In addition it aims to provide a broad guide of the process and impacts on staff.

The document is intended to support consultation in relation to the way the MHHS implements the change and invites input into ways in which the impacts of the change can be minimised.

Introduction

The Mackay Hospital and Health Service is implementing a restructure of ATODS. The restructure will result in a reduction in the number of staff required.

This document outlines how it is proposed that this change will be implemented. The Mackay Hospital and Health Service will undertake this change in accordance with government policy and industrial obligations.

Scope of the change

It is anticipated that up to **5.00** approved FTE of existing positions are likely to be affected by this change. The attached FTE table changes shows a summary of the effects of the changes (number and category of employees likely to be directly affected). The total (net) reduction of FTE will be 4.00 approved FTE.

Please refer to **Attachment 1**: Timeframe Proposed Implementation Process, Alcohol, Tobacco and other Drugs Service (ATODS), MHHS and **Attachment 2**: Proposed Implementation Process – FTE – Alcohol, Tobacco and other Drugs Service (ATODS), MHHS which shows a summary of the effects of the changes (number and category of employees likely to be directly affected).

Supporting staff through change

The Mackay HHS values and respects its staff and the contribution they make.

For employees identified as requiring placement the support offered will include:

- Individual discussion with the affected employees offering certainty about the impact of the changes as soon as is possible in the process
- Consultation will be conducted with staff and relevant unions as to ways to minimise the effects of the change
- Support and assistance through the process
- Employee Assistance Program (EAP) including face-to-face counselling and other strategies available through EAP; and

For employees generally the support will include:

- Offering detail about decisions and impacts as soon as possible in the process;
- EAP including face-to-face counselling and other strategies available through EAP

Minimising the effects of the change

The Mackay Hospital and Health Service wants to avoid or minimise the effects of the proposed change on existing staff. Input of staff in implementing the changes can help us minimise the impacts.

The proposed process to minimise effect on employees

Where possible, displaced staff will be directly 'matched' to existing vacant positions dependent upon their suitability.

Employees Requiring Placement

When the above strategies do not result in affected staff members being substantively placed against a role, the employee will be declared surplus and will be managed in accordance with Public Service Commission (PSC) Directive 6/12 'Employees Requiring Placement' and the relevant process will be followed.

Steps for consultation on implementation

1. Meeting with employees and unions to present restructure and consult upon proposed implementation – proposed implementation plan distributed.
2. Individual meetings with affected employees.
3. Period of consultation with employees and unions in relation to implementation.
4. Feedback received in relation to implementation considered.
5. Consultation finalised and implementation plan confirmed and commenced.

Timeframe

Attachment 1: Timeframe Proposed Implementation Process, Alcohol, Tobacco and other Drugs Service (ATODS), MHHS. outlines the timeframe for proposed implementation of the restructure.

Attachment 2: Proposed Implementation Process – FTE – Alcohol, Tobacco and other Drugs Service (ATODS), MHHS.

Flowchart

Attachment 3: Proposed Implementation Process – Flowchart – Alcohol, Tobacco and other Drugs Service (ATODS), MHHS.

Organisational Chart

Attachment 4: Current Organisational Chart, Alcohol, Tobacco and other Drugs Service (ATODS), MHHS.

Attachment 5: Proposed Organisational Chart, Alcohol, Tobacco and other Drugs Service (ATODS), MHHS.

Providing feedback

Stakeholders are invited to provide feedback by close of business 1 May 2013 about the implementation process. Feedback may be provided by email: Tonya_Plumb@health.qld.gov.au and DanielJ_Rowley@health.qld.gov.au.

Regards,

Kerry McGovern
Health Service Chief Executive
Mackay Hospital and Health Service
April 2013

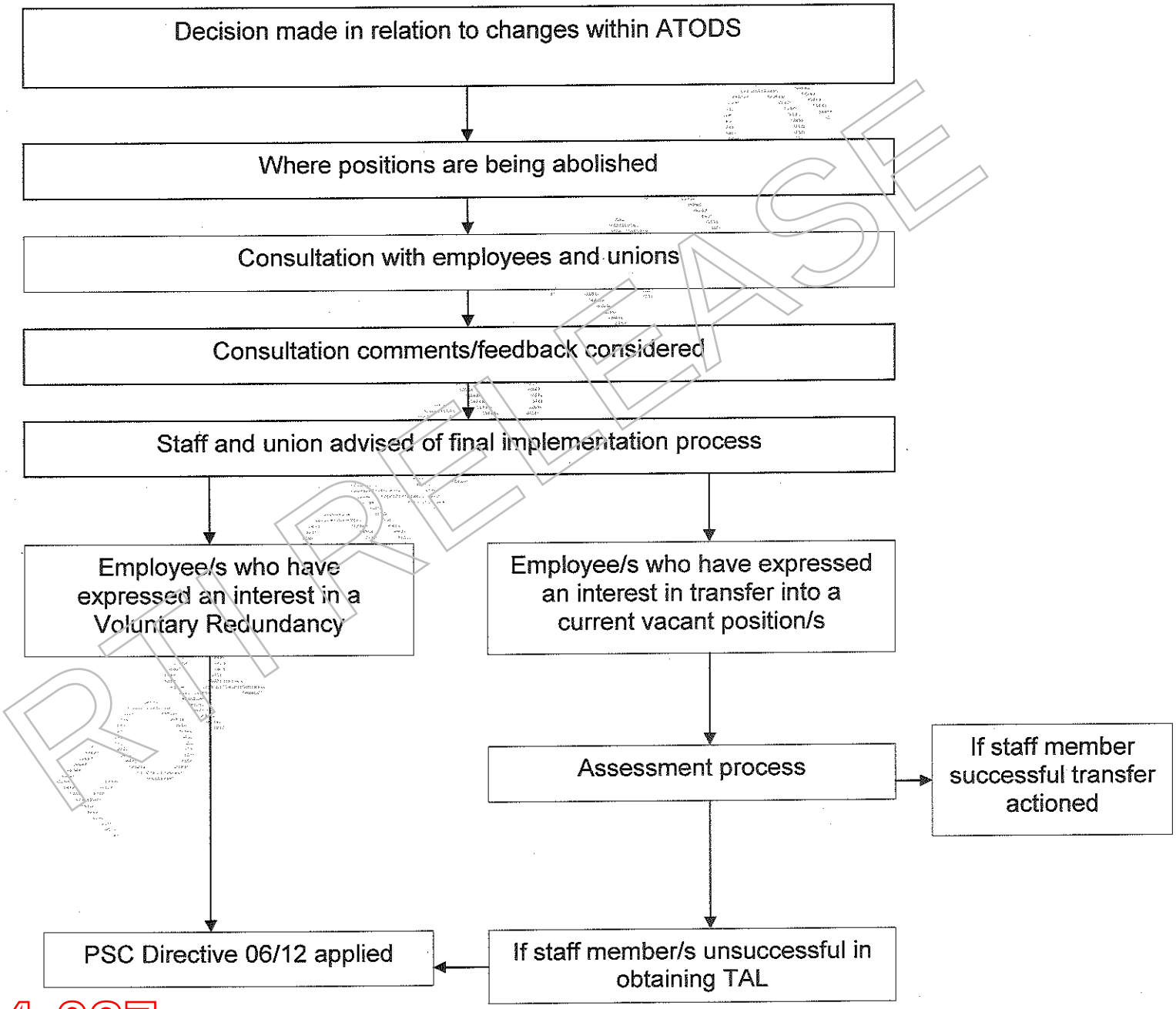
Attachment 1: Timeframe Proposed Implementation Process - Alcohol, Tobacco and other Drugs Service (ATODS), MHHS.

DATE	ACTION	RESPONSIBLE OFFICER
13/04/2013	Brief approved by Chief Executive Officer	HSCE
17/04/2013	Consultation with Employees and Unions	Operations Director, Mental Health & ATODS District Director of Nursing Chief Operations Officer Ex Director People & Culture People and Culture Unit
17/04/2013	Consultation period commences	All stakeholders
17/04/2013 to 01/05/2013	One on one meetings held with employees and union representative	Operations Director, Mental Health & ATODS District Director of Nursing Chief Operations Officer Ex Director People & Culture People and Culture Unit
01/05/2013	Consultation period concludes	All stakeholders
02/05/2013	Feedback reviewed and Implementation plan finalised	Operations Director, Mental Health & ATODS District Director of Nursing Chief Operations Officer Ex Director People & Culture People and Culture Unit
03/05/2013	Implementation Plan approved	District Director of Nursing
03/05/2013	Final Implementation Plan issued to employees and unions	District Director of Nursing
TBA	QH System Manager advised of staff who are interested in a VR	People & Culture Unit
TBA	MHHS Executive advised on final outcome of VR Process and finalisation of restructure	District Director of Nursing
TBA	MHHS Board advised on final outcome	HSCE

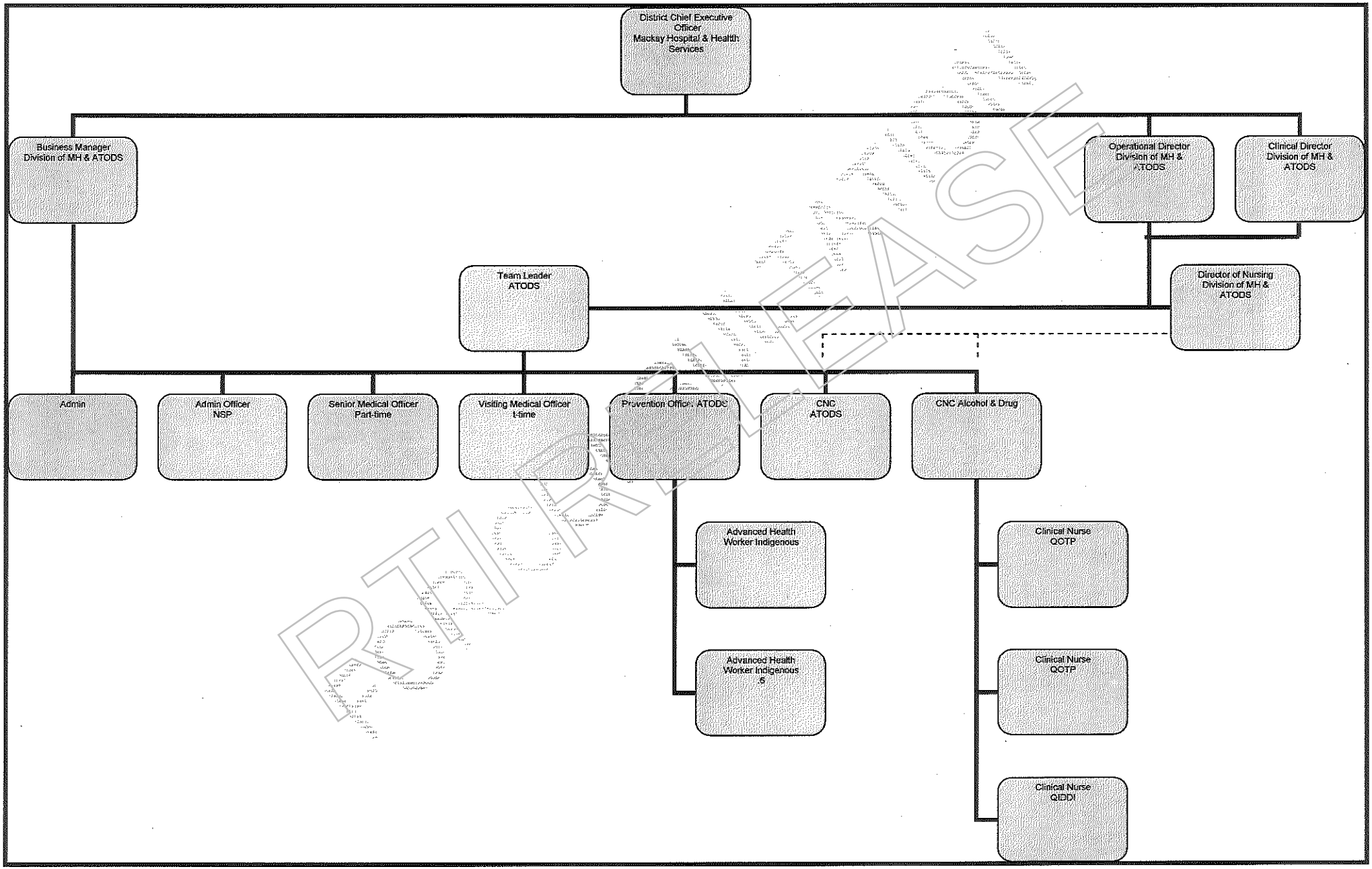
Attachment 2: Proposed Implementation Process – FTE - Alcohol, Tobacco and other Drugs Service (ATODS), MHHS.

Current					Approved Change				
Position ID	Level	Title	Approved FTE	Currently Filled FTE	Change	Level	Approved FTE	Title	Comments
30462799	NG7	Clinical Nurse Consultant ATODS	1.00	1.00	Abolish				Abolish
30462800	NG7	Clinical Nurse Consultant Alcohol & Drug	1.00	1.00	Abolish				Abolish
					New	CN6	1.00	Clinical Nurse ATODS	New
30497242	HP4	Prevention Officer, ATODS	1.00	0.79	Abolish				Abolish
30476887	AO3	Needle & Syringe Program Officer	1.00	1.00	Abolish				Abolish
30473329	AO2	Administrative Officer ATODS	1.00	1.00	Abolish				Abolish
Total			**5.00**	**4.79**			**1.00**		

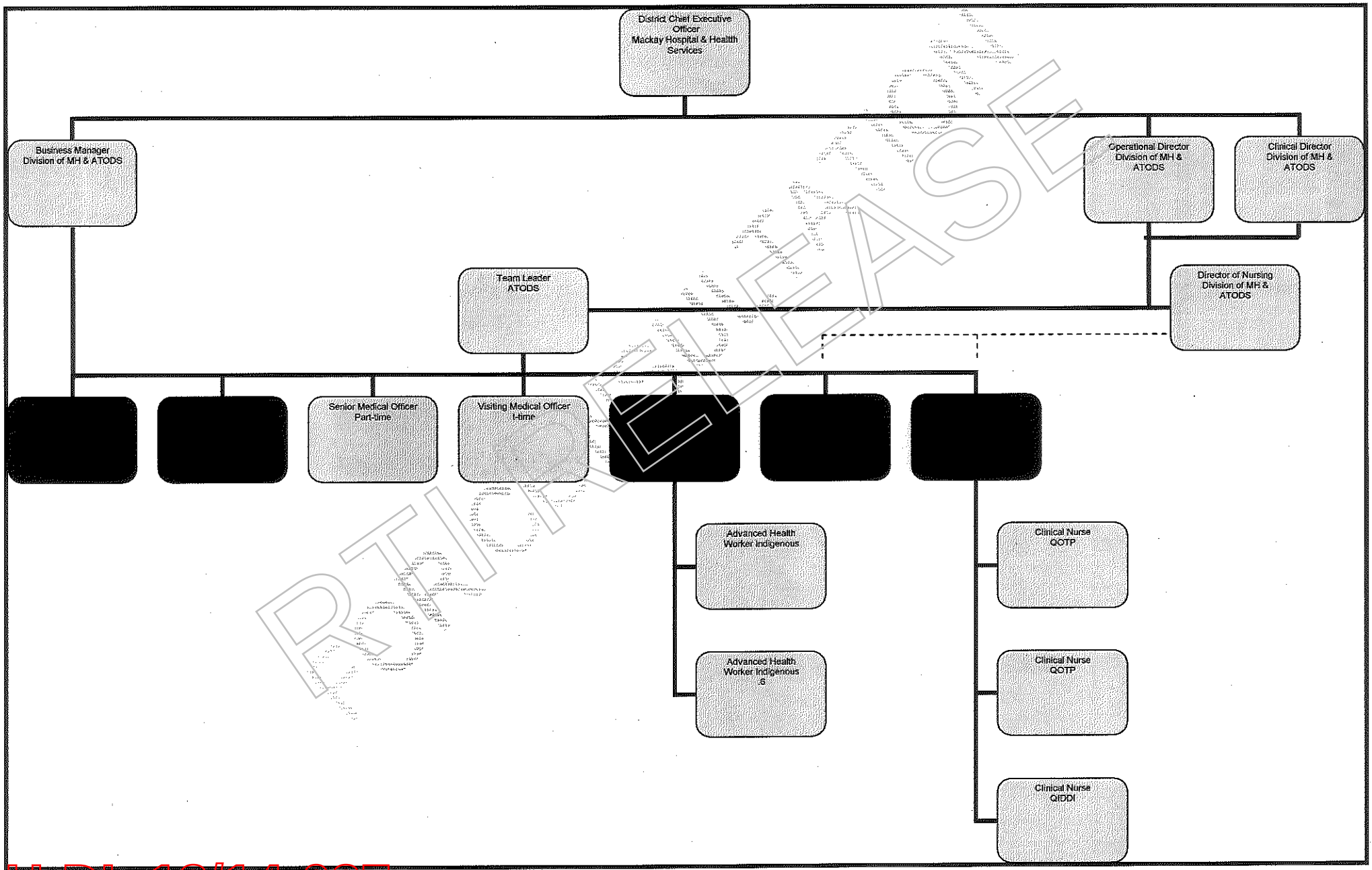
Attachment 3: Proposed Implementation Process – Flowchart – Alcohol, Tobacco and other Drugs Service (ATODS), MHHS.



Attachment 4: Current Organisational Chart, Alcohol, Tobacco and other Drugs Service (ATODS), MHHS.



Attachment 5: Proposed Organisational Chart, Alcohol, Tobacco and other Drugs Service (ATODS), MHHS.



EXECSUPPORT - BR056536 MD23 - Returned for Update

From: EXECSUPPORT
To: MD23-Mackay-HSD
Date: 2/05/2013 3:44 PM
Subject: BR056536 MD23 - Returned for Update
CC: Sdlo
Attachments: BR056536.pdf; BR056536 MD23 ORGANISATIONAL CHANGE MACKAY HHS.doc

Hi

Please find attached BR056536 which requires amendments as per the discussion between Neil Hamilton-Smith and Kerry McGovern.

When making changes to the brief can you please use the attached Word document.
***** NB: Please do not amend the original version of the document prepared by your Unit.**

The updated brief is due back **by COB Friday, 10 May 2013.**

Many thanks... Mary Delahenty
ESU 3234 0816.

16 APR 2013

URGENT

Department RecFind No:	BR056536
Division/HHS:	Mackay HHS
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: Chief Executive, Mackay Hospital & Health Service **Date requested:** 15 April 2013 **Action required by:** 16 April 2013

SUBJECT: Organisational Change within Mackay Hospital and Health Service

Proposal

That the Director-General:

Note that the Mackay Hospital and Health Service (MHHS) has determined to make organisational changes to services encompassing Clinical Governance, section 47(3)(b) , Child & Family Therapies and Alcohol, Tobacco and Other Drugs (ATOD) Services, which will result in the abolishment of 15.88 Full Time Equivalent (FTE) and creation of 4.28 FTE. (Total net reduction of 11.6 FTE).

Provide this brief to the Minister for information.

Urgency

1. **Urgent** - MHHS will announce the changes to affected staff and representative Union organisations on 17 April 2013.

Headline Issues

2. The top issues are:
   - Clinical Governance Unit - Organisational changes determined so as to better align deployment of resources to meet service demand arising from National Quality & Safety Standards - total (net) reduction of 2.0 FTE.
   - [redacted]
   - Child and Family Therapy Services – due to the introduction of services in the non-government sector, through the commencement of ATAPS for Kids, auspiced under the TMML, the services currently offered by MHHS are a duplication of services – total (net) reduction of 3.6 FTE.
   - ATODS – Organisational changes determined to better align deployment of resources to meet projected service demand commensurate with anticipated budget capacity – total (net) reduction of 4 FTE.

Key issues

3. Duplicate Services available in the Primary Care Sector:
   - There has been an introduction of services in the non-government sector, through the commencement of ATAPS for Kids, auspiced under the TMML.
   - The services offered through this service are a duplication of the services offered through the Child and Family Therapy Team.
   - The NGO service offers parents and children an initial 6 sessions, with no out of pocket expenses for families. A further six sessions may also be available after the initial course of treatment is
   - The service is geared to providing GPs and specialists with a therapeutic avenue for children (0-12 years) with mild to moderate behavioural or emotional presentations.
   - There is no similar service for Child Development Services, and as such this service will be maintained so that community has access to therapeutic services directly involved in Child Development.
4. Contribution of Service to Current Service Agreement and Priority Service Demands:
   - The Mackay HHS Service Agreement articulates the services that Mackay must provide for the funding allocated. There are no specific requirements for MHHS to maintain a primary care/first contact service offering counselling and support for parents and children.

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- Mackay HHS continues to make changes to services, so that the HHS can provide specified services, to required levels within the funding allocated.
- This means that, from time to time, there will be a requirement to divest our investment in some services, where there is no clear requirement within our contracted services.
- As part of the broader National reform agenda, the Federal Government are changing the way they fund healthcare. There is a reduction in funding coming to the States, and an increase in primary health care.
- MHHS will continue to experience changes to its future budget, and will be expected to change the service mix associated with this change, to respond to the efficiency targets applied by both National and State funding agendas.
- There are ambiguous KPIs and requirements in the MHHS Service Agreement related to ATODs.
- High level analysis of the current service indicates that these KPIs could be maintained and that there is opportunity to reallocate savings to other demands in addition to redirection of resources to other priority service demands.

5. Service Financial Viability:
   - Mackay Base Hospital, and all associated outpatient clinic services, are included under the ABF framework for funding.
   - With regard to Child & Family Therapy Services, based on an average of 1.8 occasions of service per FTE/Day (that is, less than two patients being seen per employee per day) – continuation of this service profile cannot be sustained.
   - Savings from the organisational change process will be redirected in to priority services such as ophthalmology wait lists.
   - This means that our service must show that we can maintain service costs for the price that is paid by the System Manager. The National Efficient Price for Healthcare is also driving our organisation to become more efficient.
   - Based on the client numbers and occasions of service provided within the Child and Family Therapy team, the MHHS cannot afford to maintain this service. The current ABF price paid for an outpatient psychology or social work intervention is $160.54/OOS for the M2 Peer Group.
   - When we apply this price to the OOS provided last financial year, and compare this to the cost of salaries to provide this service, there is a deficit of $170,000 pa. That is, the payments we generate for providing this service, is $170,000 short of paying for the salaries of the team.
6. National Safety and Quality Health Service Standards:
   - With the introduction of the aforementioned standards HHS are required to facilitate and enable resources and systems to be deployed to protect the public from harm and to improve the quality of health service provision.
   - MHHS former Clinical Governance Unit organisational structure was not reflective of required capacity and skill mix to provide a quality assurance mechanism and systems congruent with the national standards.

Background

7. MHHS in conjunction with the MHHS Board is continually monitoring and reviewing service demand and service capacity and capability to meet this demand.
8. As part of this process MHHS has identified required organisational change that will enhance service capacity and capability in the services
9. The determination and implementation of the organisational change is in accordance with Queensland Public Service Commission Organisational Change process.

Consultation

10. MHHS Executive have been consulted on the organisational changes prior to determination by the Chief Executive.
11. MHHS Board has been consulted.
12. Staff and Union representatives will be provided with two weeks consultation from 17 April 2013 regarding the implementation process.

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Attachments

13. Attachment 1: Proposed Implementation Plan for Organisational Change:
    - 12.1 Clinical Governance Unit;
    - 12.2 s.47(3)(b)
    - 12.3 Child & Family Therapy Services; and
    - 12.4 ATODs.

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Recommendation

Note that the Mackay Hospital and Health Service (MHHS) has determined to make organisational changes to services encompassing Clinical Governance, s.47(3)(b) s.47(3)(b) Child & Family Therapies and Alcohol, Tobacco and Other Drugs (ATOD) Services, which will result in the abolishment of 15.88 Full Time Equivalent (FTE) and creation of 4.28 FTE. (Total net reduction of 11.6 FTE).

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

/ /

To Minister's Office For Noting ☒

Director-General's comments

Author Raelene Burke	Cleared by: (SD/Dir) Kerry McGovern	Content verified by: (CEO/DDG/Div Head) Kerry McGovern
Executive Director, People & Culture	Chief Executive	Chief Executive
People & Culture	Mackay Hospital & Health Service	MHHS
4885 6754	48856752	48856752
16 April 2013	16 April 2013	16 April 2013

Department RecFind No:	BR056536
Division/HHS:	Mackay HHS
File Ref No:	

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health

Requested by: Chief Executive, Mackay Hospital & Health Service | **Date requested:** 15 April 2013 | **Action required by:** 16 April 2013

SUBJECT: Organisational Change within Mackay Hospital and Health Service

Recommendation

That the Minister:

Note that the Mackay Hospital and Health Service (MHHS) has determined to make organisational changes to services encompassing Clinical Governance, s.47(3)(b) Child & Family Therapies and Alcohol, Tobacco and Other Drugs (ATOD) Services, which will result in the abolishment of 15.88 Full Time Equivalent (FTE) and creation of 4.28 FTE. (Total net reduction of 11.6 FTE).

Note the Clinical Governance Unit - Organisational changes determined so as to better align deployment of resources to meet service demand arising from National Quality & Safety Standards - total (net) reduction of 2.0 FTE.

s.47(3)(b)

Note the Child and Family Therapy Services – due to the introduction of services in the non-government sector, through the commencement of ATAPS for Kids, auspiced under the TMML, the services currently offered by MHHS are a duplication of services – total (net) reduction of 3.6 FTE.

Note the ATODS – Organisational changes determined to better align deployment of resources to meet projected service demand commensurate with anticipated budget capacity – total (net) reduction of 4 FTE.

APPROVED/NOT APPROVED **NOTED**

Get updated as per discussion btwn Neil H-S and Kerry McGovern - Tx, J.

LAWRENCE SPRINGBORG
Minister for Health

/ /

Minister's comments

Pages 359 through 366 redacted for the following reasons:
- -
section 47(3)(b)

Attachment 5: Proposed Organisational Chart, Child and Family Therapy Services, MHHS.