Curriculum Vitae of Dr. John Scott

Personal Details

Dr John Scott

[redacted]

Professional Details

Primary Degree

- M.B.B.S.
  University of QLD, 1976
- Bachelor of Economics
  University of New England, 1994

Post Graduate Qualifications

- Diploma of Obstetrics
  Royal Australian College of Obstetricians and Gynaecologists, 1980
- Master of Applied Epidemiology
  The Australian National University, 1994

Specialist Areas

- Public Health Medicine
- Tropical Medicine
- Health Administration
- General Practice
- Community Health and Community Development

Professional Colleges

- Royal Australian College of General Practitioners, 1989
  Fellowship of College
- Faculty of Public Health Medicine, Royal Australasian College of Physicians, 1994
  Fellowship of Faculty
- Australian College of Tropical Medicine, 1995
  Fellowship of College

Employment History

Senior Executive Director, Health Services (Acting)
November 2003 - Current
Queensland Health

Principal Responsibilities

- Accountability for the delivery of public sector health services including zones districts, public health, pathology, statewide health and community health services.

- Financial responsibility of capital and recurrent resources to the value of $3.3 Billion.

Major Achievements

- Provision of strong leadership in rebalancing the investment in public health services within Queensland
- Led the implementation of a Balanced Score Card methodology to optimize integrated strategic planning, policy development and performance management in the Health Services Directorate through the provision of strategic advice and ongoing support of the project.
- Led the review and the mainstreaming of the Elective Surgery Program which has resulted in a simplified methodology being introduced for the future management of the program and a move from Districts being funded marginally in some cases up to 86% for elective surgery to a model where funding has been integrated into the base budget.
- Led the development of Health Determinant Reports and their alignment to District and Zonal catchments
- Leadership in progressing recommendations at a whole of Government level with regard to 3 Aero-Medical Reviews through QEMSAC.
- Provision of leadship and management in the implementation and operational management of the Government's 2004 election commitments with a budget totaling $480 Million.
- Strategically managed the fiscal position of the Health Services Directorate.
- Maintained a sound and compliant position with all legislative policy and procedural requirements of the Queensland Government.
- Leadership in the whole of Government agenda in particular aligning and sequencing strategic initiatives to deliver on the Government's Health 2020 vision and the departments strategic plan.
- Provision of ongoing leadership in partnerships with Universities, Colleges, and Unions to ensure consultation, collaboration and the alignment of strategic agendas.

Employment History cont...

State Manager Public Health Services Services

October 1996 - November 2003

Queensland Health

(seconded from 22 January 1996 to 10 October 1996 to Acting Director, Public Health in Division of Public Health Services)

Principal Responsibilities:

Financial responsibility of capital and recurrent resources to the value of $250 Million.

Major Achievements:

Public Health Services in 1996 was a disparate group of professionals with different service focuses, with dispersed geographical locations with no strategic focus, no performance monitoring and with individualized budgets.

Achievements have been significant including:

- establishment of a Board of Management where disparate public health groups have come together and developed a shared vision for the delivery of public health services in Queensland
- implementation of a system for strategic planning based on outcome areas providing three year goal focused plans
- developed and implemented an approach to project management to track concepts to final rollout as part of a broader integrated, planning, monitoring and reporting process. The approach has now become the departmental standard.
- developed costing and budgeting methodologies and successfully zero based all Public Health Unit budgets.
- developed a new approach to managing for performance which linked back to strategic plans and projects. The implementation required refocusing disparate groups fighting to gain acceptance and demonstrate benefits and outcomes.
- developed a Joint Action Plan on a range of public health issues with Education Queensland
- National recognition as leaders in the areas of food safety reform, childhood obesity, nutrition, physical activity, health impact assessment, school based nurses, immunization programs and breast screening

Employment History contd...

Assistant Regional Director, Community and Clinical.
August 1995 to 22 January 1996
Brisbane North Regional Health Authority

Principal Responsibilities:

Line responsibility for the Division of Public Health including Community Health facilities and coordination of services across the range of clinical facilities in the Region.

Responsibility for service delivery valued in excess of $1Billion

Major Achievements:

- Establishment of a broad community plan with focus on integration of like services and linking with the private sector, in particular general practitioners.

Co-ordinator, Population Health Unit (PHU) Network
February 1995 - May 1995
Department of Health, Queensland

Major Achievements:

The co-ordinator position involved extensive consultation across all facets of Public Health. Achievements included:

- numerous presentations on the subject of Public Health and the Queensland "vision" of Population Health;
- the establishment of a communications network throughout the State based on Public Health Units;
- the development of a software programme for a state-wide vaccination system;
- a plan for the Population Health Units to be a focus for communicable diseases responses;
- the development of a vaccination recall system for use in conjunction with the VIVAS program;
- led the integration of Environmental Health and Health Promotion resources particularly in the area of infectious diseases prevention and control; and
- been involved with a degree of administration.

Employment History contd...

Director Communicable Diseases Branch (Acting)
1994 - August 1995

Principal Responsibilities:
The Acting Director's position involved mostly organisation of the Branch, promotion of the establishment of new positions to co-ordinate statewide programmes in immunisation and infection control, and promotion of collaborative links with other service providers.

Epidemiology Registrar
1992 - 1994
Queensland Health

Principal Responsibilities:
This period represents the coursework for the Masters of Applied Epidemiology as well as involvement in associated areas including an NH&MRC Panel on Zoonoses.

Locum Medical Officer
1991 – 1992
Royal Flying Doctor Service, Cairns

General Practice
1981 – 1991
Ingham Medical Centre, Ingham, North Queensland

Responsibilities:

During this period I acted as State Government Medical Officer for Hinchinbrook Shire, Shire Medical Officer of Health, Designated Medical Officer for the Civil Aviation Authority, Committee Member for the Queensland Ambulance Transport Brigade, Chairperson of the Ingham District Welfare Council, Committee Member of the North Queensland Sub-Faculty of the RACGP, as well as various other honorary positions such as medical officer for the boxing club, swimming club etc.

Employment History

contd...

General Practice Registrar
1979 – 1980
Toowoomba General Hospital, Toowoomba, Queensland

Resident Medical Officer
1977 – 1978
Royal Brisbane Hospital, Brisbane, Queensland

Publications

Scott J. (1992) Ross River Virus Disease: Nine Years' Experience In Queensland. Abstract, Australasian College of Tropical Medicine Conference, Townsvillle, November 20 - 21.

Scott J. (1993) Review of Pertussis in Queensland 1990 - 1993. Communicable Diseases. Intelligence, 17: 254 – 256

Scott J. (1993) Review of Notifications of Invasive *Haemophilus influenzae b* Infections in Queensland, 1990 to 1993. Communicable Diseases Intelligence, 17: 403 – 406

Scott J. (1993) The Effects Of Airborne *Thermoactinomyces Spp.* Spores On Raw Sugar Mill Workers In Queensland. Abstract, Australian Society of Microbiology Conf., Perth Sept 24 - 30.

Scott J. (1993) Epidemiology Of Notified Diarrhoeal Diseases In Queensland - For Whose Sake? Abstract, Australian Tropical Health and Nutrition Conference, Brisbane, October 21 - 23.

Scott J, Sheridan J. (1994) Review of Hepatitis A in Queensland, 1983 - 1993. Communicable Diseases Intelligence, 18: 86 – 90

Dick A, Beezley C, Scott J. (1994) Persisting Hepatitis A Infection in a Central Queensland Town. Communicable Diseases Intelligence, 18: 83 – 86

Scott J, Sheridan J. (1994) The Role Of Socioeconomic Status And Behaviour In Hepatitis A Transmission, Queensland, Australia. Abstract, Field Epidemiology Training Program's Fourth International Conf., Chiang Mai, Thailand, Jan. 23 - 28.

Scott J. (1995) Zoonoses Current Therapeutics, April 1995:42 – 45

Dawson M, Smythe L, Scott J. (1995) Recent Developments in Spore Detection Methods for *T sacchari* in sugar mills. Abstract, Australian Sugar Cane Technologists Conference, Bundaberg, May 2 - 5.

Scott J. (2000) Editorial: Australian bat lyssavirus: the public health response to an emerging infection The Medical Journal of Australia, 19 June 2000: 573 - 574

Publications Continued

Accepted / Submitted / In Preparation:

Dawson M, Scott J. (1995) The Medical and Epidemiological Effects on Workers of the Levels of Airborne Thermoactinomyces spp. Spores Present in Australian Raw Sugar Mills - accepted by the American Journal of Industrial Hygiene

Dont M, Smythe L, Scott J. (1996) Review of Notifications of Leptospirosis in Queensland 1992 - 1996 - accepted by Communicable Diseases Intelligence.

Reports

Dawson M, Scott J. (1993) The Medical and Epidemiological Effects on Workers of the Levels of Airborne *Thermoactinomyces spp.* Spores Present in Australian Raw Sugar Mills Report to Division of Workplace Health and Safety, Brisbane, Queensland

Scott J. (1994) Therapeutic Opioid Dependence - A Guide for Medical Practitioners Report to Therapeutic Opioid Drugs of Dependence Committee, Queensland Department of Health.

Westwood J, Scott J. (1994) Report on Hyperbaric Facilities Townsville Report to Chief Health Officer, Queensland Department of Health.

Committees / Working Groups

State Based

Queensland Health Board of Management

Finance Committee

Queensland Health Information Strategy and Investment Board

Steering Committee ISAP

Steering Committee Clinical Informatics Program

Audit and Risk Management Committee

Workforce Board

Safety and Quality Board

Queensland Public Health Forum

Queensland Emergency Medical System Advisory Committee Chair

Queensland Centre for Public Health Steering Committee

General Practice Advisory Council

Centre for E-Health Research

Committees / Working Groups Continued:

National

National Public Health Partnership (Past Chair)

Strategic Inter-governmental Nutrition Alliance, National Chair

Strategic Injury Prevention Partnership, National Chair

Australian Health Ministers Advisory Council, Advisor

Australia and New Zealand Food Ministers Council, Advisor

Food Regulation Standing Committee

Australian Fruit and Vegetable Coalition, National Chair

Secretary, Zoonoses Panel, National Health and Medical Research Council

Member, Therapeutic Opioid Committee, Queensland Health

Member, Health Act Review Working Groups, Queensland Health

Member, General Practice Liaison Council, Queensland Health

Chair, IM/IT Investment Board, Queensland Health

Member, Faculty of Public Health Advisory Committee, Queensland University of Technology

Member, Board, Faculty of Health Sciences, University of Queensland.

Chair, Foy Report of Drugs of Dependence Implementation Group, Queensland Health

Chair, Public Health Services, Board of Management.

Member, Health Promotion Queensland.

Member, Steering Committee, Queensland Alcohol and Drug Research and Education Centre

Member, Primary Health Care Outreach Network, Queensland Health

Member, Queensland Public Health Forum.

Lecturer, Anton Brienl Disease Control Course and James Cook University, 1994-2002.

Presenter, Summer School on Community Health, QUT, 1995-2003.

Referees

Queensland Health utilises 360 feedback as part of the Success Program. I would encourage the Selection Panel to contact any of the following referees to assist in assessing my suitability for this position:

Direct Reports:

[redacted]
Executive Director,
Statewide Health and Community Health Services [redacted]

[redacted]
A/Executive Director
Public Health Services [redacted]

Peers:

[redacted]
Acting Senior Executive Director
Innovation and Workforce Reform [redacted]

[redacted]
Senior Executive Director
Resource Management [redacted]

External:

[redacted]
Executive Dean
Faculty of Health Sciences
University of Queensland [redacted]

[redacted]
Vice-Chancellor
Bond University [redacted]

Reporting to:

Dr Stephen Buckland

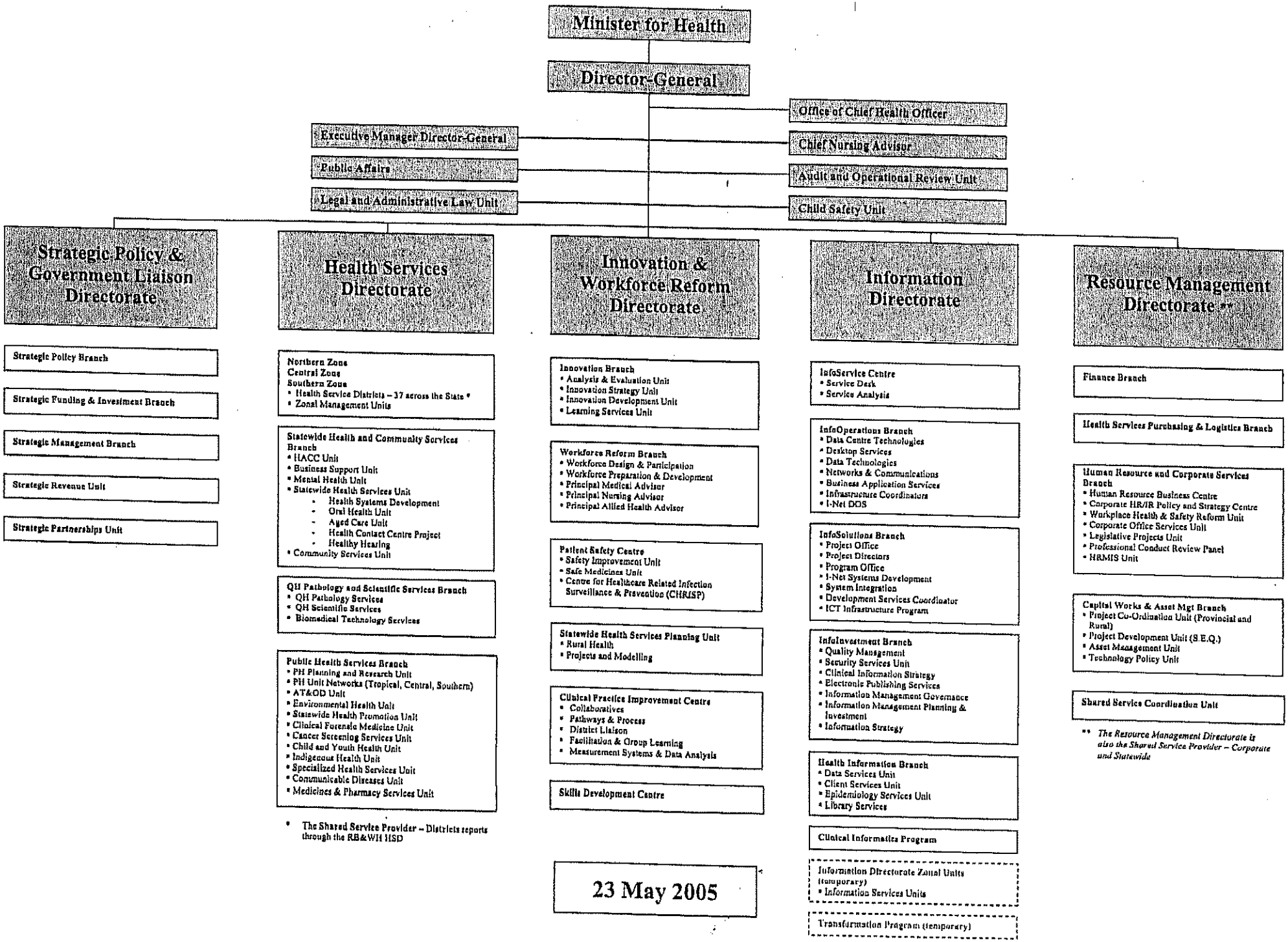
Director General

[redacted]

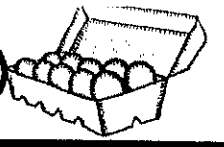
Hon Gordon Nutall MP

Minister for Health

[redacted]


Minister for Health
Director-General
Executive Manager Director-General
Public Affairs
Legal and Administrative Law Unit
Office of Chief Health Officer
Chief Nursing Advisor
Audit and Operational Review Unit
Child Safety Unit
Strategic Policy & Government Liaison Directorate
Strategic Policy Branch
Strategic Funding & Investment Branch
Strategic Management Branch
Strategic Revenue Unit
Strategic Partnerships Unit
Health Services Directorate
Northern Zone
Central Zone
Southern Zone
• Health Service Districts – 37 across the State *
• Zonal Management Units
Statewide Health and Community Services Branch
• HACC Unit
• Business Support Unit
• Mental Health Unit
• Statewide Health Services Unit
- Health Systems Development
- Oral Health Unit
- Aged Care Unit
- Health Contact Centre Project
- Healthy Hearing
• Community Services Unit
QH Pathology and Scientific Services Branch
• QH Pathology Services
• QH Scientific Services
• Biomedical Technology Services
Public Health Services Branch
• PH Planning and Research Unit
• PH Unit Networks (Tropical, Central, Southern)
• AT&OD Unit
• Environmental Health Unit
• Statewide Health Promotion Unit
• Clinical Forensic Medicine Unit
• Cancer Screening Services Unit
• Child and Youth Health Unit
• Indigenous Health Unit
• Specialized Health Services Unit
• Communicable Diseases Unit
• Medicines & Pharmacy Services Unit
* The Shared Service Provider – Districts reports through the RB&WH HSD
Innovation & Workforce Reform Directorate
Innovation Branch
• Analysis & Evaluation Unit
• Innovation Strategy Unit
• Innovation Development Unit
• Learning Services Unit
Workforce Reform Branch
• Workforce Design & Participation
• Workforce Preparation & Development
• Principal Medical Advisor
• Principal Nursing Advisor
• Principal Allied Health Advisor
Patient Safety Centre
• Safety Improvement Unit
• Safe Medicines Unit
• Centre for Healthcare Related Infection Surveillance & Prevention (CHRISP)
Statewide Health Services Planning Unit
• Rural Health
• Projects and Modelling
Clinical Practice Improvement Centre
• Collaboratives
• Pathways & Process
• District Liaison
• Facilitation & Group Learning
• Measurement Systems & Data Analysis
Skills Development Centre
23 May 2005
Information Directorate
InfoService Centre
• Service Desk
• Service Analysis
InfoOperations Branch
• Data Centre Technologies
• Desktop Services
• Data Technologies
• Networks & Communications
• Business Application Services
• Infrastructure Coordinators
• I-Net DDS
InfoSolutions Branch
• Project Office
• Project Directors
• Program Office
• I-Net Systems Development
• System Integration
• Development Services Coordinator
• ICT Infrastructure Program
InfoInvestment Branch
• Quality Management
• Security Services Unit
• Clinical Information Strategy
• Electronic Publishing Services
• Information Management Governance
• Information Management Planning & Investment
• Information Strategy
Health Information Branch
• Data Services Unit
• Client Services Unit
• Epidemiology Services Unit
• Library Services
Clinical Informatics Program
Information Directorate Zonal Units (temporary)
• Information Services Units
Transformation Program (temporary)
Resource Management Directorate **
Finance Branch
Health Services Purchasing & Logistics Branch
Human Resource and Corporate Services Branch
• Human Resource Business Centre
• Corporate HR/IR Policy and Strategy Centre
• Workplace Health & Safety Reform Unit
• Corporate Office Services Unit
• Legislative Projects Unit
• Professional Conduct Review Panel
• HRMIS Unit
Capital Works & Asset Mgt Branch
• Project Co-Ordination Unit (Provincial and Rural)
• Project Development Unit (S.E.Q.)
• Asset Management Unit
• Technology Policy Unit
Shared Service Coordination Unit
** The Resource Management Directorate is also the Shared Service Provider – Corporate and Statewide

Health Services Directorate - Dozen Indicators (District Alignment)



	Measure Name	Measures	Obj	District Measure	Perspective	District	Zone
1	Quality of Advice: - DG, Minister - Briefings - Ministerial	% late Average days late by dept % rework by reason	IP9	Chart availability	Internal Processes	Royal Brisbane & Womens	Central
			WF4	Number of days taken to provide an Executive Summary and analysis of decision making data to Executive	Shaping our Workforce	Logan-Beaudesert	Southern
			WF4	Number of Managers who receive the appropriate suite of reports each month to make decisions	Shaping our Workforce	Redcliffe Caboolture	Central
2	Election Promises	Status Report summary by project highlighting variance from plan					
3	Elective Surgery	% long wait by month Patients waiting per specialty	C8	The number of patients waiting longer than the recommended time for their category of elective surgery	Consumer	Charleville	Southern
			C6	Elective surgery waiting times report	Consumer	Cairns	Northern
			C6	The proportion of patients waiting longer than the recommended time for their category of elective surgery in Cat 1, 2, 3 (Cat 3 eye and hip data only)	Consumer	Sunshine Coast	Central
4	Key Government Initiatives (Currently: Child Safety)	% Staff trained Resources consumed by Zone					
			P1	Overall budget position (accural)	Paying for Health	Charleville	Southern
			P1	Balanced budget	Paying for Health	PA & QEII	Southern
			P1	Variance between Actual and Budget expenditure and revenue for District controlled funds	Paying for Health	Toowoomba	Southern
			P2	Budget Vs Variance (expressed YTD)	Paying for Health	Logan-Beaudesert	Southern
			P1	Revenue and expenses equal (or are in suplus) as reported in the Operating Statement in Annual Financial Statement	Paying for Health	QEII	Southern
			P1	Revenue and expenses equal (or are in suplus) as reported in the Operating Statement in Annual Financial Statement	Paying for Health	Bayside	Southern
			P1	Expenses equal (or are in surplus) to revenue and funding received	Paying for Health	Northern Downs	Southern

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			P1	Revenue and expenses equal (or are in suplus) as reported in the Operating Statement in Annual Financial Statement	Paying for Health	Southern Downs	South
			P1	Actual Vs Budget by facility and major program areas	Paying for Health	Southern Downs	Southern
			P1	Recurrent budget is on target, every unit every month (average daily cost & recurrent/ non-recurrent spending)	Paying for Health	Roma	Southern
			P1	Expenditure over actual	Paying for Health	West Moreton	Southern
			P1	Cost/ weighted separation compared with like facilities (Towoomba, Redcliffe, Logan, Gold Coast, Rockhampton)	Paying for Health	West Moreton	Southern
			P1	Year to date monthly budget position	Paying for Health	Central West	Central
			P1	Actual Vs budget position vs activity. Report evaluated	Paying for Health	Banana	Central
			P1	% Budget reallocated to service priority areas	Paying for Health	Prince Charles	Central
			P1	Overall budget position - accrual	Paying for Health	Prince Charles	Central
5	Budget Integrity	Budget % variance YTD and forecase	P1	Overall budget position by facility	Paying for Health	Rockhampton	Central
			P1	Overall budget position (accural)	Paying for Health	Royal Brisbane & Womens	Central
			P1	Expenditure meets budget allocation; Number of services delivered	Paying for Health	Central Highlands	Central
			P1	GHSD manages service delivery within allocated budgets (monthly)	Paying for Health	Gympie	Central
			P1	Balanced recurrent and overall budget	Paying for Health	Royal Childrens	Central
			P1	Monthly actual budget position. Budget Vs Actual	Paying for Health	South Burnett	Central
			P1	Revenue and expenses equal (or are in suplus) as reported in the Operating Statement in Annual Financial Statement	Paying for Health	Sunshine Coast	Central
			P1	Expenditure Vs Budget	Paying for Health	Redcliffe Caboolture	Central
			P1	Variance between Actual and Budget expenditure and revenue for District controlled funds	Paying for Health	North Burnett	Central
			P1	Overall budget position (accural)	Paying for Health	Cairns	Northern
			P1	Approved Vs Allocated positions (FTE)	Paying for Health	Cairns	Northern

			budget (accrual basis)	Paying for Health	Torres	Northern
		P2	Expenditure Vs budget allocation	Paying for Health	Moranbah	Northern
		P1	Overall budget position	Paying for Health	Charters Towers	Northern
		P1	Actual expenditure equals budget alllocation	Paying for Health	Bowen	Northern
		P1	Budget allocation = actual expenditure	Paying for Health	Tablelands	Northern
		P1	Revenue and expenses equal (or are in suplus) as reported in the Operating Statement in Annual Financial Statement	Paying for Health	Mt Isa	Northern
		P1	Budget status	Paying for Health	Mackay	Northern
		P1	Overall budget position (accrual). Revenue and expenses equal (or are in surplus)	Paying for Health	Innisfail	Northern
		P1	Overall budget position (accrual) (monthly)	Paying for Health	Cape York	Northern
Risk Management	Risk Registers / top 5 Complaints Amount of litigation	C4	Proportion of new programs that are risk managed	Consumer	Moranbah	Northern
		IP8	(i) % of extreme and very high risks resolved and mitigated for the previous month	Internal Processes	Bayside	Southern
		IP8	(ii) % of extreme and very high risks resolved and mitigated for the year to date	Internal Processes	Bayside	Southern
		IP5	Patients screened prior to surgery for risk factors and action taken	Internal Processes	Charleville	Southern
		IP8	Number of corrective measures implemented as part of risk management plan	Internal Processes	Northern Downs	Southern
		IP8	Risk register evaluated and outcomes measured	Internal Processes	Royal Brisbane & Womens	Central
		IP5	Total District risk rating	Internal Processes	Rockhampton	Central
		IP6	(i) Number of consumers identified as 'falls risk', (ii) Number of notified alerts and allergies	Internal Processes	Sunshine Coast	Central
		IP8	Number of actions completed from risk register/ Total number of actions identified from risk register/ Total number of risks on risk register	Internal Processes	Redcliffe Caboolture	Central
		IP6	Proportion of patients who have been assessed using the District admission risk assessment tool	Internal Processes	Tablelands	Northern
		C3	Incidence of consumer complaints per facility and the category of complaint	Consumer	Roma	Southern

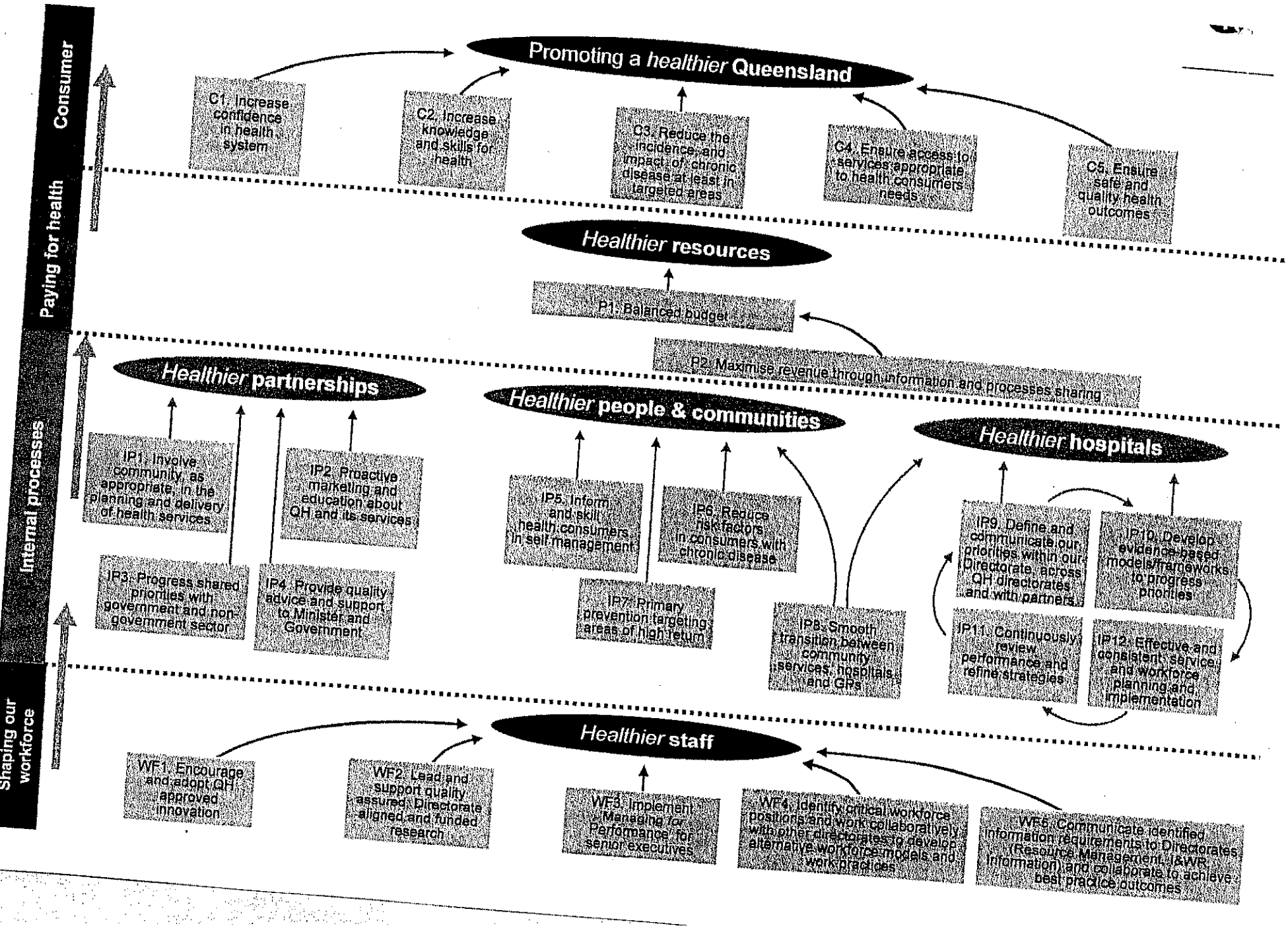
			complaints that identify communication as an issue	Consumer	Logan-Beaudesert	Southern
		C3	Proportion of client complaints managed and resolved in line with the QH complaints management policy and complaints management guidelines	Consumer		
		C7	Trends in patient complaints		Torres	Northern
		C1	Proportion of negative feedback (complaints)	Consumer	Innisfail	Northern
		C6	Number of consumer complaints regarding PTS and specialist type services	Consumer	Rockhampton	Central
		C4	Complaints by category by work unit	Consumer	Central West	Central
		IP6	Incidence of consumer complaints per facility and the category of complaint	Internal Processes	Gympie	Central
Investment Mix/ Population Demand	$ per population				Roma	Southern
Management Performance/ Communication	Issue resolved/ unresolved					
Services	Day Saurgery Basket Avoidable Admissions Relative Stay Index Day Surgery and DOSA NHTP in acute Access block ED ED Waiting Time	C4	Rate of hospital separations for selective avoidable admissions (hypertension, diabetes etc)	Consumer	Charters Towers	Northern
		C3	Rate of avoidable hospital admissions related to cardiovascular disease and diabetes	Consumer	Bowen	Northern
		C5	Median age at admission for complications of diabetes for indigenous people vs non indigenous people	Consumer	Tablelands	Northern
		C4	Rate of avoidable hospital admissions related to cardiovascular disease and diabetes	Consumer	Mt Isa	Northern
		C3	Rate of preventable presentations (admissions) relating to chronic disease inc. mental health (inc private hospitals)	Consumer	Mackay	Northern
		C6	Decrease in preventable admissions related to primary health care programs offered	Consumer	Central Highlands	Central
		C2	Number of category 4 and 5 presentations out of hours (before 7.30am, after 5pm)	Consumer	Bowen	Northern
		C2	No. of category 4 & 5 presentations	Consumer	Tablelands	Northern
		C2	Total of cat 4 & 5 presentations to the emergency department after hours, without referrals from GP's and where the patient is not subsequently admitted	Consumer	Mt Isa	Northern

		IP5	...risk assessment - high risk patients/ Number of patients assessed as high risk who present to ED (first presentation)	Internal Processes	West Moreton	Southern
		C3	Achieve benchmark for ED waiting times, all triage categories	Consumer	PA & QEII	Southern
Relationships/ Partnerships	Identify 'key relationships' and those that are causing problems	C1	% of people seen in the Emergency Department within benchmark times for triage category 2 & 3 Emergency Department Triage times.	Consumer	Bayside Sunshine Coast	Southern Central
		WF1	(i) Proportion of emergent/ planned leave filled by casual staff (ii) Proportion of shifts filled by casual staff by unit	Shaping our Workforce	Gympie	Central
		WF1	Number of unapproved leave days (SR=231-AB) taken per full-time equivalent staff	Shaping our Workforce	Torres	Northern
		IP4	The overtime costs per full-time equivalent for nursing staff stratified by Thursday Island/ Bamaga and the Oute Islands and medical staff	Paying for Health	Torres	Northern
		WF2	Sick leave	Shaping our Workforce	Rockhampton	Central
		WF2	Number of days taken for sick leave	Shaping our Workforce	Mackay	Northern
		WF5	Rate of absenteeism (scheduled and unscheduled leave), number of grievances, number of industrial disputes, turnover (terminations as a proportion of total staff)	Shaping our Workforce	Gympie	Central
		IP8	Measure nursing staff turnover and reasoning for exiting	Internal Processes	Central West	Central
		WF3	Audit of exit interviews	Shaping our Workforce	Southern Downs	Southern
Our People/ Staff	Overtime Sick Leave Workcover Terminations Leave Liability Violence	WF3	Staff turnover matched against results of exit interviews, Report on the number of staff who indicate that workplace culture contributed to exit	Shaping our Workforce	Rockhampton	Central
		WF3	Exit survey results - Service that you/ your department provide, how your career/ development was care for and how you were treated within the organisation	Shaping our Workforce	Royal Childrens	Central

			Exit rates and exit interview surveys	Shaping our Workforce	**South Burnett**	Central
		WF4	Terminations as a proportion of total staff	Shaping our Workforce	**Roma**	Southern
		WF3	Exit Rates	Shaping our Workforce	**Charleville**	Southern
		WF3	# of staff separations in month per total number of staff	Shaping our Workforce	**Redcliffe Caboolture**	Central
		WF3	Staff turnover matched against results of exit interviews	Shaping our Workforce	**Rockhampton**	Central
		WF4	Exit rates and exit interview surveys	Shaping our Workforce	**South Burnett**	Central
		WF3	Cost per weighted separation	Shaping our Workforce	**Charleville**	Southern
		WF2	Percentage of leavers who have exit interviews conducted and identified issues actioned	Shaping our Workforce	**Sunshine Coast**	Central
		WF2	Number of people who leave with Exit Interviews over total number of people who leave	Shaping our Workforce	**Gympie**	Central
		WF4	Monitor episodes and data on: violence, absenteeism, workcover rates	Shaping our Workforce	**QEII**	Southern
No Surprises	Misconduct Sentinel Events	C7	Number of Workcover claims	Shaping our Workforce	**Royal Brisbane & Womens**	Central
		C7	Rates of sentinel events	Consumer	**Charleville**	Southern
		C7	Rate of sentinel events	Consumer	**Gold Coast**	Southern
		C7	% of actions completed per investigated sentinel and critial event categorised as extreme and very high risk	Consumer	**Bayside**	Southern
		C7	Number of actions completed per reported and investigated sentinel event/ Numebr of actions identified	Consumer	**West Moreton**	Southern
		C5	Sentinel events and incident reporting	Consumer	**Cairns**	Northern
		C7	Number of actions completed per reported and investigated sentinel event	Consumer	**Redcliffe Caboolture**	Central
		C4	Rates of sentinel events / clinical incidents	Consumer	**Sunshine Coast**	Central
		C5	The number of sentinel events	Consumer	**Prince Charles**	Central

Perspective	Objective Number	Strategic Objective	Strategic Objective Definition
Consumer	C1	Increase confidence in health system	The Queensland community will have a greater confidence in the services that Queensland Health provide. They will feel assured that when they need to access a Queensland Health service it will be of a high quality.
	C2	Increase knowledge and skills for health	Queenslanders will have the knowledge and confidence in their ability to successfully manage their own health and to participate optimally in their own health care management. Queenslanders will also know the most appropriate service to access, and how to access it when they need to.
	C3	Reduce the incidence and impact of chronic disease at least in targeted areas	Through the services provided by Queensland Health the incidence and impact of chronic disease on Queenslanders will be minimised in at least: (1) the targeted conditions of heart failure and diabetes; (2) the priority populations that are most at risk, Indigenous peoples and the socioeconomically disadvantaged. Outcomes will include reductions in acute care presentations for Aboriginal and Torres Strait Islander peoples with chronic disease, socioeconomically disadvantaged people with chronic disease, and those with heart failure and diabetes. It is anticipated that this will minimise unnecessary demand for health care services through improved preventative and self management strategies.
	C4	Ensure access to services appropriate to health consumers needs	Equitable access to reasonable and appropriate multidisciplinary health care services will be available for Queensland Health consumers. These include services: (1) provided in the community setting that are responsive to local health needs and address care of common health problems, illness prevention, health promotion and protection; and (2) requiring specialist diagnostic or interventional services, regardless of the consumer's geographical location. Consumers will be provided an appropriate level of safe and sustainable specialist care provided directly by Queensland Health or in partnership with the private sector.
	C5	Ensure safe and quality health outcomes	Through utilising evidenced-based (clinical and business) models and frameworks, Health Services Directorate will provide services that are safe, effective and responsive, that will optimise the health outcomes for QH consumers. NB: refer to Safety & Quality strategy map and scorecard
Paying for health	P1	Balanced budget	The Health Services Directorate supports health service delivery to be provided and managed within fiscal allocations.
	P2	Maximise revenue through information and processes sharing	Support health service districts ability to maximise revenue for services provided to clients who are ineligible for public services, not Queensland residents or who choose to receive private services, through information and processes dissemination within the Health Services Directorate.
Internal processes	IP1	Involve community, as appropriate, in the planning and delivery of health services	Community members will participate in the planning and delivery of health services at times and at a level that is suitable for the situation.
	IP2	Proactive marketing and education about QH and its services	Health Services Directorate will guide and support health services to increasingly use proactive approaches to marketing and education principles to promote Queensland Health and the services that Queensland Health provides. This will be achieved through using a planned and coordinated approach across the Directorate and in collaboration with other Queensland Health directorates and Public Affairs, to increase awareness of the services Queensland Health provides and the public confidence in them.
	IP3	Progress shared priorities with government and non-government sector	Health Services Directorate will build appropriate partnerships with all tiers of government and non-government sector to facilitate intersectoral action and development of supportive public policies. By actively engaging, the Directorate can build on and strengthen Queensland Health initiatives and better integrate services so collectively Queenslanders receive better health services.
	IP4	Provide quality advice and support to Minister and Government	Through interdirectorate collaboration, the Health Services Directorate will provide quality advice and support to the Minister for Health, State and Commonwealth Governments.
	IP5	Inform and skill health consumers in self management	Consumers of Queensland Health services will be provided with information, resources and other support regarding the management of their condition and general health post service.
	IP6	Reduce risk factors in consumers with chronic disease	Health Services Directorate will systematically identify QH consumers already in contact with our services who are at greatest risk of developing illness or injury, with a particular focus on preventing avoidable episodes of illness or injury (including admissions or re-admissions) and to reduce the impact of these existing conditions. Queensland Health services will provide these consumers and their carers/advisers with cost effective interventions (according to standard protocols) to address identified needs. The aim of the interventions is to reduce common risk factors associated with chronic disease and improve the individuals' overall quality of life.

Perspective	Objective Number	Strategic Objective	Strategic Objective Definition
Internal processes continued	IP7	Primary prevention targeting areas of high return	Health Services Directorate will support the development and implementation of strategies in the community that promote healthy behaviours and health environments. Using a targeted multi-strategic approach to reduce the burden of disease, Queensland Health services will choose those complementary strategies that have been proven to show the greatest health gain for the population.
	IP8	Smooth transition between community services, hospitals and GPs	Health Services Directorate in collaboration with other directorates will build strong linkages at all levels of the health system along with coordination mechanisms and supportive management processes that result in integrated, user friendly, patient focussed services. Health consumers will be able to move through the continuum of care, in particular between community services, hospitals and general practitioners, in an efficient patient centred way with minimal barriers.
	IP9	Define and communicate our priorities within our Directorate, across QH directorates and with partners	The Health Services Directorate will improve interdirectorate communication, decision making and prioritisation, and through enhanced communication and collaboration will advance its priorities with other directorates and external partners.
	IP10	Develop evidenced-based models/frameworks to progress priorities	Consistently develop and apply best available evidence to develop models and frameworks to progress Health Services Directorate priorities. This may include collaboration with other directorates within Queensland Health.
	IP11	Continuously review performance and refine strategies	The Health Services Directorate will continuously review and improve performance. This will include evaluation and refinement of clinical and business processes, frameworks and models associated with health service delivery.
	IP12	Effective and consistent service and workforce planning and implementation	The Health Services Directorate will develop in collaboration with other directorates (Resource Management, Innovation & Workforce Reform, Information, Strategic Policy & Government Liaison) integrated service planning mechanisms that support the implementation of strategic priorities. The service planning will encompass effective workforce planning and resource planning. It will also address emerging technology implications and future demand pressures.
Shaping our workforce	WF1	Encourage and adopt QH approved innovation	Health Services Directorate will foster and support an innovative workforce and create a work environment that demonstrates to staff the value of their experience and positive ideas. They will promote a culture and support mechanisms for staff to share ideas on how to improve and streamline service delivery, enhancing quality and safety outcomes, reduce red-tape and save costs. The Directorate will actively support the adoption of Queensland Health approved innovation.
	WF2	Lead and support quality assured, Directorate aligned and funded research	The Health Services Directorate will lead the process and framework to support quality assured, Directorate aligned and specifically funded health services research.
	WF3	Implement 'Managing *for* Performance' for senior executives	Senior Executives of the Health Services Directorate will benefit from effective performance management through the implementation of 'Managing *for* Performance' (M*f*P). Effectively managing *for* performance will be a routine part of the way the Directorate does business. It means that all executives will have and work to performance partnership plans which articulate their contribution to delivering on their branch/unit//zone's strategy and business plan and their development needs. This will include but not be limited to: leadership/management responsibilities being clearly identified, acknowledged and undertaken, and the branch/unit/zone's contribution to the Health Services Directorate outcome areas and quality management plans.
	WF4	Identify critical workforce positions and work collaboratively with other directorates to develop alternative workforce models and work practices	In collaboration with other Queensland Health directorates (Resource Management, Innovation & Workforce Reform, Information, Strategic Policy & Government Liaison) the Health Services Directorate will identify critical workforce positions and work collaboratively to develop and adopt alternative workforce models and work practices.
	WF5	Communicate identified information requirements to Directorates (Resource Management, Innovation & Workforce Reform, Information, Strategic Policy & Government Liaison) and collaborate to achieve best practice outcomes	Queensland Health will establish, maintain and refine information and knowledge management systems to: support our staff, health service providers, clients and partners to ensure appropriate and timely access (i.e.. at the point of intervention) to evidence and health information; and enable effective policy development, priority setting, resource allocation and evaluation.


Consumer
Paying for health
Internal processes
Shaping our workforce
Promoting a healthier Queensland
C1. Increase confidence in health system
C2. Increase knowledge and skills for health
C3. Reduce the incidence, and impact of, chronic disease at least in targeted areas
C4. Ensure access to services appropriate to health consumers needs
C5. Ensure safe and quality health outcomes
Healthier resources
P1. Balanced budget
P2. Maximise revenue through information and processes sharing
Healthier partnerships
IP1. Involve community, as appropriate, in the planning and delivery of health services
IP2. Proactive marketing and education about QH and its services
IP3. Progress shared priorities with government and non-government sector
IP4. Provide quality advice and support to Minister and Government
Healthier people & communities
IP5. Inform and skill health consumers in self management
IP6. Reduce risk factors in consumers with chronic disease
IP7. Primary prevention targeting areas of high return
IP8. Smooth transition between community services, hospitals and GPs
Healthier hospitals
IP9. Define and communicate our priorities within our Directorate, across QH directorates and with partners
IP10. Develop evidence-based models/frameworks to progress priorities
IP11. Continuously review performance and refine strategies
IP12. Effective and consistent service and workforce planning and implementation
Healthier staff
WF1. Encourage and adopt QH approved innovation
WF2. Lead and support quality assured, Directorate aligned and funded research
WF3. Implement 'Managing for Performance' for senior executives
WF4. Identify critical workforce positions and work collaboratively with other directorates to develop alternative workforce models and work practices
WF5. Communicate identified information requirements to Directorates (Resource Management, I&WR, Information) and collaborate to achieve best practice outcomes

August 2004

Queensland Health Strategy Map

our mission **Promoting a *healthier* Queensland**

our vision **Leaders in health — partners for life**

Queensland Government
Queensland Health

Promoting a *healthier* Queensland

rovided by Queensland Health the incidence and impact of chronic disease on Queenslanders will be minimised in at least:

- C1. Achieve whole-of-government approach to quality of life
- C2. Increase confidence in health system
- C3. Increase knowledge and skills for health
- C4. Improve access to primary health care
- C5. Reduce impact of chronic disease including on Indigenous peoples
- C6. Smooth transition between community services, hospitals and GPs
- C7. Ensure safe and quality health outcomes
- C8. Appropriate access to specialist services across Queensland

isonable and appropriate multidisciplinary health care services will be available for Queensland Health consumers. These include services:

munity setting that are re… care of common health problems, illness prevention, health promotion and protection; and

diagnostic or inter… …ical location. Consumers will be provided an appropriate level of safe and sustainable
l directly by Queensland Health or in partnership with the private sector.

Healthier resources

nced-based (clinical and business) models and frameworks, Health Service Directorate will provide services that are safe, effective and responsive, that will optimise the
l co… P1. Balanced budget
uali…

rectorate supports health service delivery to be provided and managed within fiscal allocations.

P2. Leverage other sectors

…r services provided to clie… …within the Health Services …

P3. Maximise revenue

…vices, not Queensland residents or who choose to receive private

ill participate in the planning and delivery of health services at times and at a level that is suitable for the situation.

Healthier partnerships

- IP1. Improve community participation in the planning and delivery of health services
- IP2. Proactive marketing and education about QH services
- IP3. Progress shared priorities with government and non-government sector

Healthier people & communities

…rate will guide and support health services to increasingly use proactive approaches to marketing and education principles to promote Queensland Health and the
nd Health provides. This will be achieved through using a planned and coordinated approach across the Directorate and in collaboration with other Queensland Health
Affairs, to increase awareness of the services Queensland Health provides and the public confidence in them.

- IP4. Inform and skill health consumers
- IP5. Reduce risk factors in high risk consumers
- IP6. Primary prevention targeting areas of high return

…rate will build app… …gaging, the Direc… …government sector to fac… …atives and better integrate

…a collaboration, the Health Services Directorate will provide quality advice and support to the Minister for Health, State and Commonwealth Governments.

…and Health services will be provi… …rces and other support regarding the management of their condition and general health post service.

…rate will systematically identify … …contact with our services who are at greatest risk of develop… …particular focus on
…isodes of illness or injury (including admissions or re-admissions) and to reduce the impact of these existing conditio… …vices will provide these
…rers/advisers with cost effective inter… …on standard protocols) to address identified needs. The aim of the interventions is to reduce common risk
…chronic dise…

Healthier hospitals

- IP7. Increase use of clinical evidence-based decision making
- IP8. Continuously improve key business processes
- IP9. Effective service and workforce planning

Healthier staff

- WF1. Encourage innovation and targeted research
- WF2. Develop values-based organisation
- WF3. Recruit, develop and retain an appropriately skilled workforce
- WF4. Right information at the right time at the right place in the right medium

Consumer

Paying for health

Internal processes

Shaping our workforce

GMHS Dirty Dozen

Measures	Reasons	Ongoing	Responsibility
1. Quality of Advice – DG - Minister • Briefings • Ministerials	• Incorrect info/recorded content • Rework/Rejects – Process Standards • Process Discipline • Weekly/Monthly Reporting	• Incorrect/Unsound/Missing Factual / Frank / Fearless / Confusing / Sufficient Rework / # Reason / -Volume of Briefs / -Volume of Ministerials GM / Zone? / District? Minister..... / D.G..... Zones + State wide And Others (Deb M) • Timelines — Late/Passed on Requests — Brief Allocation / -Original Time Allocation • Error Free/Structure Change	Graham Kerridge Sean Conway
2. Election Promises = Project Plant Met		Health Services Accountabilities Project Plans/Milestones...Progress Update (Monthly) Gary Walker (Draft Template and Trial Date) – Roadblocks (Immediate) On Time/Milestones – outcomes achieved – Projects/Total Projects??	Andrew McAuliffe
3. Elective Surgery • Cat 1-2 Benchmarking • Cat 3? (Agree better process and compliance)		Existing Monthly Reports Cat 1-2 - Progress Against Target (Monthly) - Roadblocks/Failures [Just Cat 1-2 Focus] Cat 3? - Excellent Performances - Outpatient Waiting Lists????	Andrew McAuliffe Deb Miller
4. Child Safety?? (Start-up)		Initiatives – Progress?? - Roadblocks?? Critical Relationships - Performance - Liaison/Cooperation	
5. Budget Integrity Forecasting – one off – current - trend - Future impact • Productivity • Roster Cost Template • Commitment Register		Budget – Variance / - Forecasting ← Key Indicators — Monthly — Zones Draft Indicators Performance – Effectiveness – Measure of Quality Services / Community and Client Focus Measured – Hospitals [DEA] – Efficiency Quality District Zones	Sean Conway Paula Bowman Justin Collins John O'Brien Anitra Matisusi
6. Risk Management • Sentinel Events • Media • Credentialing • Compliments	• Clinical • Financial • Systems • Business • Political/Tech • Social/Economic • Over Horizon	Talk to Dorothy (MS) AClinical / Non Clinical / Patients/Clients / Employees "PROCTIVE" / *Sentinal Events / Informed Consent / Credentialy DISTRICT / Risk Mgmt Planning / Commencement / Commintary Dorothy Medico/Legal (LAG) / -Litigation Claims per 100 beds / -Estimated Exposure / -Categories Health Rights commission Complaints	Justin Collins
7. Investment Mix / Pop Demand • Acute • Primary • Utilization/Availability	• Admissions – Acute/Chronic Avoidable(to inform) • Demographics – Mortality/Morbidity	POPn ~~~ NEEDS ~~~ SERVICES --- ACUTE ← Bed / AMB Relative Resource Allocation Model 1. Look at for this purpose NOW District Profile 2. Profile 2nd Zones / Public Health Partnership -Prevention / -Protection / -Chronic / -Acute Public Health Interventions -Primary RELATIONSHIP PROFILE	Neil Gardiner Graham Kerridge John O'Brien Clair Runciman Public Health

Measures	Reasons	Ongoing	Responsibility
8. Management Performance/Communication Process • Emergent Issues Outstanding – Upset – dealing with • Issues Resolved	• Communication System to Escalate - District - Zone - G.M. • And Feedback System	Issues – Register "Work in Progress" ⟵ Deb M and Zones ELEVATE	Claire Runciman ZM Units
9. Any Service Access Block) Variation Waiting Time) Beyond Parameters Services/Locations		FRONT END 12 Keys -Variation/Roadblocks Zone Statewide Public Health T.S. Outside Standards Parameters One-Off Events or Trends Clusters of One-Offs	Clinical Outcomes
10. Relationships/Partnerships # Quality Value Add/Difficulty Productivity – Efficiency and Effectiveness - eg. Cost/Wtd Seps (Acute) - Procedural Rates		QUALITY OF Claire/Deb 8.9% - Service Delivery Partnerships - Community Engagement - Inter Departmental Engagement Initiatives Interventions Roadblocks G.Ps L.C.As Prin. Providers Other Govt. Agencies -Admissions -Nursing Homes -Shared Care • **Active** • **Indicator** • **New Initiatives**	
11. Our People Staff Beyond Parameters Time - Critical Gaps/Demands - Safety & Wellbeing (hours, risk, roster) - Work Cover **Time Is of Essence** - Grievances/Morals - all staff * # Type Trend Sustained–all staff *Absentee Turnover *Code of Conduct/Performance Issues – IR Union/Public On Suspension ⟶ time on	TRENDS Reliable Data Any Issue?? • Forward Estimates • Capability / No. Mix • Work Environment Standards • Longer Term	• Critical Gaps/Demand – Now and Forecast • Threats and Violence – Internal - External TRIAL REPORT	Paula Bowman
12. Link to Info Last Rule – No Surprises, except pleasant ones	1. Reporting, timing, Who 2. Parameters / Escalation	1. Good News – Our People - Our Performance - Our Clients/Patients 2. Left Field Issues - Debrief	

Objective and Measure Definitions (approved 30 July 2004)

...ent/ ...rspective	Obj No	Strategic Objective	Objective Definition	Obj Sponsor	Meas No	Measure Name/Frequency	Measure Definition	Measure Owner	Frequency	Notes
Consumer/Promoting a Healthier Queensland	C1	Achieve whole-of-government approach to quality of life	Other government agencies whose functions impact on and can improve the health, well being and quality of life of individuals and communities, work together with Queensland Health to achieve these goals. No government agencies have activities or policies that impact negatively on the health, well being and quality of life of Queenslanders.	SED Strategic Policy & Gov Liaison	C1.1	Other sectors implementing their commitments in whole of government strategies.	Number and proportion of other government agencies/sectors implementing their commitments in whole-of-government strategies that impact on health. Strategies measured are: - Eat Well Queensland - Alcohol Action Plan - Tobacco Action Plan - Meeting Challenges, Making Choices - Queensland Suicide Prevention Strategy.	SED Strategic Policy & Gov Liaison	Six monthly	
	C2	Increase confidence in health system	The Queensland community will have a greater certainty of the services that Queensland Health will and will not provide. They will feel assured that when they need to access a Queensland Health service it will be of a high quality.	SED Health Services	C2.1	Community Confidence	Proportion of the population surveyed who indicate confidence in Queensland Health services (will require development).	SED Health Services	Quarterly	Survey to be developed.
	C3	Increase knowledge and skills for health	Queenslanders will have the knowledge and confidence in their ability to successfully manage their own health and to participate optimally in their own health care management. Queenslanders will also know the most appropriate service to access, and how to access it when they need to.	SED Health Services	C3.1	Self efficacy - i) on exit from QH ii) in community	i) Proportion of patients on exit from QH who report knowing what to do, how to do it and confident in their ability to adopt their role in management of their condition ii) Proportion of population in the community who report an understanding of risk factors, their health condition and what they need to do to improve their health.	State Manager, Public Health Services	Quarterly	i) The survey, which needs to be developed, will provide data for measures C3.1, C6.1 and IP4.1. ii) The Omnibus survey can provide some information, but further development is required.
	C4	Improve access to primary health care	Consumers have ready access to multidisciplinary health care services encompassing care of common health problems, illness prevention, health promotion and protection. These primary health care services are provided in the community and are responsive to local health needs.	SED Health Services	C4.1	Category 4/5 to Emergency Department	Total of Cat 4 & 5 patients in ED, where referrals are not from GP's and where the patient is not subsequently admitted.	Zonal Manager	Quarterly	
					C4.2	Cervical Cancer screening	The proportion of women aged 20 - 69 who had a pap smear within the past two years.	State Manager, Public Health Services	Annually	
					C4.3	Consumer perception of access to primary health care services provided in the community	Proportion of population surveyed who perceive that they have access to primary health care services provided in their community (note will need further definition of access etc).	SED Health Services	Quarterly	Survey tool to be developed - could be done via the OMNIBUS survey.
	C5	Reduce impact of chronic disease including on Indigenous people	Through the services provided by Queensland Health, the impact of chronic disease on Queenslanders will be minimised. Outcomes will include reductions in acute care presentations for those with chronic illness and minimising unnecessary demand for health care services through improved preventative and self management strategies. Priority will be given to the population most at risk, the Indigenous population, reducing the gap in health inequality.	SED Health Services	C5.1	Admissions for acute episodes of chronic conditions	Admitted patient episodes of care for angina, COPD and diabetes.	Zonal Manager	Quarterly	
	C6	Smooth transition between community services, hospitals and GP's	Consumers will be able to move through the continuum of care in an efficient patient centred way with minimal barriers. Strong linkages built at all levels of the health system along with coordination mechanisms and supportive management processes result in integrated, user friendly, patient focussed services.	SED Health Services	C6.1	Patient satisfaction with admission and discharge procedures	Proportion of hospital patients surveyed who report satisfaction with the admission and discharge processes.	SED Health Services	Quarterly	The survey, which needs to be developed, will provide data for measures C3.1, C6.1 and IP4.1.
	C7	Ensure safe and quality health outcomes	Through providing services that are safe, effective and responsive, Queensland Health will optimise the health outcomes for our consumers.	SED Innovation & Workforce Reform	C7.1	Rates of sentinel events		Ex Director, Innovation Branch	Quarterly	
	C8	Appropriate access to specialist services across Queensland	Consumers requiring specialist diagnostic or interventional services, regardless of their geographical location, will have reasonable access to an appropriate level of safe and sustainable specialist care provided directly by Queensland Health or in partnership with the private sector	SED Health Services	C8.1	Elective surgery access	The proportion of patients waiting longer than the recommended time for their category of elective surgery in Cat 1, 2, 3 (Cat 3 eye & hip data only).	Zonal Manager	Quarterly	

Objective and Measure Definitions (approved 30 July 2004)

Intent/ Perspective	Obj No	Strategic Objective	Objective Definition	Obj Sponsor	Meas No	Measure Name/Frequency	Measure Definition	Measure Owner	Frequency	Notes
Healthier Resources/Paying for Health	P1	Balanced budget	Health service delivery is provided and managed within fiscal allocations.	SED Resources Mgt	P1.1	Overall budget position (accrual)	Revenue and Expenses equal (or are in surplus) as reported in the Operating Statement as part of Queensland Health's Annual Financial Statements.	Ex Director, Finance	Monthly	
	P2	Leverage other sectors	Health plus non-health sectors invest to improve health outcomes.	SED Strategic Policy & Gov Liaison	P2.1	Uptake of chronic care planning by GP's	Diabetes Annual Cycle of Care Patient participation: MBS item nos charged divided by estimated population by Zone GP participation: MBS item nos charged divided by total GP consultations.	Ex Director, HSFB	Quarterly	
	P3	Maximise revenue	Maximise revenue for services provided to clients who are ineligible for public services, not Queensland residents or who choose to receive private services.	SED Strategic Policy & Gov Liaison	P3.1	Patient revenue	Ratio of non-public revenue collected compared to potential revenue. This measure aims to establish the cost recovery of services provided to clients who are eligible for non-public services (MAIC, Q-Comp, DVA and patients using their private health insurance) by comparing the revenue collected for all eligible non-public patients against the revenue that could have been secured if all eligible non-public presented as fee-paying patients.	Ex Director, HSFB	Quarterly	
	P4	Optimise asset use	The asset base is aligned to service delivery and consumer and community needs. Wastage, duplication and inefficient/ineffective use of assets is avoided where possible through effective management and maintenance.	SED Resources Mgt	P4.1	To be determined				

Objective and Measure Definitions (approved 30 July 2004)

ient/ erspective	Obj No	Strategic Objective	Objective Definition	Obj Sponsor	Meas No	Measure Name/Frequency	Measure Definition	Measure Owner	Frequency	Notes
Healthier Partnerships/Internal Processes	IP1	Improve community participation in the planning and delivery of health services	The Community participates in the planning and delivery of health services at a level that is appropriate for the situation.	SED Health Services	IP1.1	District Health Council satisfaction	Level of satisfaction by District Health Council members with their level of participation in the planning and delivery of health services.	Zonal Manager	Six monthly	DHC satisfaction survey to be developed.
	IP2	Proactive marketing and education about QH services	Queensland Health will apply marketing and education principles to promote the services that Queensland Health provides. This will be achieved through a planned and coordinated approach, to increase awareness of the services Queensland Health provides and the public confidence in them. Queensland Health will increasingly use a proactive approach to the media to support the marketing and education initiatives.	Director Media & Comms	IP2.1	To be determined	To be determined.	Director Media & Comms	Quarterly	
	IP3	Progress shared priorities with government and non-government sector	Build partnerships with all tiers of government and non-government sector to facilitate intersect oral action and development of supportive public policies. By actively engaging, Queensland Health can build on and strengthen initiatives and better integrate services so collectively Queenslanders receive better health services.	SED Strategic Policy & Gov Liaison	IP3.1	Partnership appraisal	Appraisal, by QH's partners, on QH's performance in achieving agreed partnership outcomes. Assess partnerships with: - Dept of Housing - Disability Services QLD - Education - Local Gov Association of QLD, Dept of Local Gov Planning - Emergency Services (QAS - QLD Division of GP - Commonwealth Dept of Health - Dept of Communities - Dept of Child Safety - Mainland Aboriginal Partnership - Torres Strait Islander Partnership - Police Dept - Dept of Sport & Recreation - Environmental Protection Authority - Universities (Nursing Sector).	Ex Director, HSFB	Six monthly	Survey to be developed. Examples are available from other organisations.
Healthier People and Communities/ Internal Processes	IP4	Inform and skill health consumers	Consumers of Queensland Health services will be provided with information, resources and other support regarding the management of their condition and general health post service.	SED Health Services	IP4.1	Proportion of patients provided with information about managing their condition	To be developed.	Zonal Manager	Quarterly	The survey, which needs to be developed, will provide data for measures C3.1, C8.1 and IP4.1.
	IP5	Reduce risk factors in high risk consumers	Queensland Health will systematically identify consumers already in contact with our services who are at greatest risk of developing illness or injury, or of further illness or injury, with a particular focus on preventing avoidable episodes of illness or injury (including admissions or re-admissions) and to reduce the impact of these existing conditions. Queensland Health will provide these consumers and their carers/advisers with cost effective interventions (according to standard protocols) to address identified needs. The aim of the interventions is to reduce common risk factors and improve the individuals' overall quality of life.	SED Health Services	IP5.1	Patients screened prior to surgery for risk factors and action taken	Proportion of patients, prior to surgery, screened for risk factors and referred to Quit Smoking programs.	Zonal Manager	Quarterly	
	IP6	Primary prevention targeting areas of high return	Queensland Health will develop and implement strategies in the community that promote healthy behaviours and health environments. Using a targeted multi-strategic approach to reduce the burden of disease, Queensland Health will choose those complementary strategies that have been proven to show the greatest health gain for the population.	SED Health Services	IP6.1	The number and proportion of Health Service District's providing population health initiatives	The number and proportion of Health Service Districts providing: - Smokecheck (quit smoking intervention guide for indigenous clients) - Lighten Up and/or Healthy Weight (healthy weight/lifestyle group-based programs) - Early intervention and parenting support programs - Falls assessments of Home Care clients using "Staying on - Stay Active and Independent in your Home" client questionnaire.	State Manager, Public Health Services	Six Monthly	
	IP7	Build capability for primary health care	Queensland Health will work with its primary health care sector partners (government and non-Government) to develop solutions to build the responsiveness of the primary health care sector. This will involve investing in infrastructure to support the delivery of a primary health care model of care and the development of a workforce capable of delivering effective primary health care service.	SED Health Services	IP7.1	Primary health care availability in rural districts	The percentage of small rural facilities providing primary health care programs.	Zonal Manager	Six monthly	
					IP7.2	Primary health care planning	Proportion of districts engaged in community health planning addressing primary health care needs.	Zonal Manager	Six monthly	

Objective and Measure Definitions (approved 30 July 2004)

ent/ rspective	Obj No	Strategic Objective	Objective Definition	Obj Sponsor	Meas No	Measure Name/Frequency	Measure Definition	Measure Owner	Frequency	Notes
Healthier Hospitals/Internal Processes	IP8	Increase use of clinical evidence-based decision making	Queensland Health will consistently apply best available evidence to inform policy and program design and in making decisions about the care of patients. While Queensland Health will institute processes that are shown to be effective based on evidence, we will also discontinue processes that have been shown to be ineffective.	SED Innovation & Workforce Reform	IP8.1	Evidence based management of congestive heart failure (CHF)	The proportion of eligible patients with CHF who receive beta-blocker at discharge.	Ex Director, Innovation Branch	Annually	
	IP9	Continuously improve key business processes	Queensland Health will identify those key business processes that require improvement and systematically progress our capacity in the priority areas of: integrated risk management; management of pathology testing; admission and discharge processes; and shared care mechanisms.	SED Health Services	IP9.1	Continuity of care framework	The proportion of districts that have commenced implementation of the Continuity of Care Framework.	Zonal Manager	Annually	Need to develop a more frequent and useful measure. In the interim, use Measured Quality report.
					IP9.2	Shared care arrangements	The proportion of districts that have a policy for ante and postnatal care to be shared with GP's.	Zonal Manager	Annually	Need to develop a more frequent and useful measure. In the interim, use Measured Quality report.
					IP9.3	Bed management	The proportion of patients whose length of stay (for specified DRG's) exceeds that recommended by a clinical pathway for that condition.	Zonal Manager	Quarterly	
					IP9.4	Operational measures	The number and proportion of key operational measures outside agreed parameters.	SED Health Services	Quarterly	The key operational measures need to be identified for BOM level.
	IP10	Effective service and workforce planning	Queensland Health will develop integrated service planning mechanisms that support the implementation of strategic priorities. The service planning will encompass effective workforce planning and resource planning. It will also address emerging technology implications and future demand pressures.	SED Innovation & Workforce Reform	IP10.1	Districts with valid workforce data	The proportion of districts with valid workforce data.	Ex Director Workforce Reform Branch	Quarterly	

Objective and Measure Definitions (approved 30 July 2004)

ent/ rspective	Obj No	Strategic Objective	Objective Definition	Obj Sponsor	Meas No	Measure Name/Frequency	Measure Definition	Measure Owner	Frequency	Notes
Healthier Staff/Shaping Our Workforce	WF1	Encourage innovation and targeted research	Queensland Health will encourage value and reward innovation and research that is targeted to improving health outcomes for Queenslanders.	SED Innovation & Workforce Reform	WF1.1	Number of innovations registered	The number of new innovations generated for organisational improvement.	Ex Director, Innovation Branch	Quarterly	
	WF2	Develop values based organisation	Queensland Health staff, systems and processes will demonstrate our values (listed below) in our workplace: Quality and recognition - we strive to excel in everything we do and are proud of our achievements; Professionalism - we are professional in what we do in that we treat all people with dignity and respect and we look for opportunities for improvement; Teamwork - we work together in an open, honest and supportive way to achieve collective goals; and Performance accountability - we accept accountability for our performance, our actions and our learning.	SED Innovation & Workforce Reform	WF2.1	Organisational climate	The response to survey questions related to the stated values of the organisation, and implementation of any subsequent interventions.	Ex Director, Innovation branch	Bi-annually	Survey has been identified and survey is being developed.
	WF3	Recruit, develop and retain an appropriately skilled workforce	In order to achieve Queensland Health's organisational goals and key health outcomes we will: conscientiously seek to recruit and retain quality staff; ensure that staff, throughout their career in Queensland Health, are provided with the appropriate skills, knowledge and experience to meet client, individual, service and organisational needs; develop and support leaders in order to meet the challenges of the current and future health environment; develop a supportive HRM infrastructure and flexible working conditions; develop employment frameworks that allow innovation in health service delivery; and revise skill mix of staff to respond to changes in demand.	SED Innovation & Workforce Reform	WF3.1	Utilisation performance appraisal and development process	The percentage of staff who utilise the Queensland Health Individual performance Planning and Appraisal Process.	Ex Director, Innovation Branch	Six monthly	
					WF3.2	Vacancy rates within employment group specialties	Percentage of long term vacant specialty positions within employment categories (?medical officers only).	Ex Director, Workforce Reform	Quarterly	
	WF4	Right information at the right time at the right place on the right medium	Queensland Health will establish, maintain and refine information and knowledge management systems to: support our staff, health service providers, clients and partners to ensure appropriate and timely access (i.e., at the point of intervention) to evidence and health information; and enable effective policy development, priority setting, resource allocation and evaluation.	SED Information	WF4.1	Accessibility, usage of information systems	Client satisfaction that the information they receive is fit for purpose.	Ex Director, Information Mgt	Six monthly	Survey being developed by the Information Management Unit

JGS - 4

Senior Executive Director Health Services
2004/05 Correspondence

Ministerial Correspondence		
	MIN Brief	479
	MIN Unrequested Brief	334
	MIN Correspondence	2,629
	MIN MLA	1,776
	MIN Premiers	113
	MIN Submission	616
	MIN Unrequested Brief	296
Sub total		6,243
Department Correspondence		
	HS Correspondence	288
	HS Brief	86
	HS Submission	1,019
	HS Unrequested Brief	296
Sub total		1,689
Total Correspondence		**7,932**

JGS - 5

21 JUN 2005

Queensland Government

Queensland Health

Enquiries
Telephone
Facsimile
File Ref: J.G S6.

Dr R Stitz
President
Royal Australasian College of Surgeons
College of Surgeons Gardens
240 Spring Street
Melbourne VIC 3000

Dear Dr Stitz

I write regarding the Royal Australasian College of Surgeons participation in Queensland Health Credentialling and Clinical Privileges Committees.

Queensland Health is committed to ensuring that all medical practitioners using a health care facility practise safe, high quality care. As you would be aware, Credentials and Clinical Privileges Committees are convened to assess the credentials and delineate the clinical privileges of senior medical practitioners with a clinical role in Queensland public hospitals and other health care facilities. Such committees are peer committees which consider applications from potential medical employees, existing medical employees and other practitioners seeking endorsement to practice within the public health facility but not defined as employees of Queensland Health.

While the actual composition of these committees varies depending on the discipline of the applicants under consideration, Queensland Health considers it is important that each committee has a representative from the relevant professional college. I am advised District Coordinators for Credentials and Clinical Privileges are having difficulties in engaging the participation of Royal Australasian College of Surgeons Fellows in this process. I am seeking your support for the Credentials and Clinical Privileges Committees and ask that your college assists Queensland Health by ensuring due and timely consideration of requests to your college for nominations for these committees.

Should you have any questions in relation to my advice, Dr John Scott, Senior Executive, Director, Health Services would be happy to assist and can be contacted on (07) 3234 1078.

Yours sincerely

Dr Steve Buckland
Director General
14/06/2005

Office
19th Floor
Queensland Health Building
147 - 163 Charlotte Street
BRISBANE QLD 4000

Postal
GPO Box 48
BRISBANE QLD 4001

Phone
3234 1171

Fax
3234 1482

0055-3539-003

(87)

Patron: H.R.H. The Prince of Wales

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

A.B.N. 29 004 167 766

OFFICE OF THE PRESIDENT
Dr Russell Stitz

College of Surgeons' Gardens, Spring Street, Melbourne Vic 3000
Telephone +61 3 9276 7404 Facsimile +61 3 9249 1217
E-Mail: college.president@surgeons.org

23 June 2005

RECORDS TEAM
RECEIVED
- 8 JUL 2005
QLD HEALTH

06/07/05

Dr Steve Buckland
Director General
Queensland Government
GPO Box 48
Brisbane QLD 4001

Dear Steve

Thank you for your letter dated 14 June 2005.

I have forwarded your correspondence to Mr Hugh Bartholomeusz, Chairman Queensland State Committee for his information the College is supportive of the credentialing and privileging process but surgeons in this process are engaged and identified by Queensland health. That is they do not represent the College.

I shall ask Hugh to communicate with you directly.

Yours sincerely

Dr Russell Stitz
President

emailed to DMs 11/7.

CC: Mr Hugh Bartholomeusz, Chairman Queensland State Committee
Ms Meg Milne, Manager, Queensland State Committee

DG 041207
DATE REC 5/7/05
ACKNOWLEDGEMENT ☐
ACTION OFFICER SEDHS
COPY TO DG FYI
REPLY TO DG'S SIGNATURE ☐
DUE BY:
ACTION DIRECT ☑
BRIEF ALSO REQD ☐
REFERS
NFR - FOR INFORMATION ONLY ☐
SCANNED: DM 7/7/05

0055-3539-003

88

Patron: H.R.H. The Prince of Wales

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E-Mail: college.president@surgeons.org

22 July 2005

Dr Steve Buckland
Director-General
Queensland Health
GPO Box 48
BRISBANE QLD 4001

Dear Dr Buckland

Basic Surgical Trainees

Further to my most recent correspondence about surgical training, I need to highlight again that the capacity block to surgical training is the availability of specialist surgical training posts. The most direct way to increase the surgical workforce is to fund more specialist surgical posts in your hospitals. The College will accredit them when the appropriate posts are identified.

The College has over 100 eligible applicants in Australia awaiting the creation of these posts. They are basic surgical trainees, transitional surgical trainees and international medical graduates who have already completed the educational requirements for commencement of specialist training.

More specialist surgical training posts will let them complete their training as surgeons!

The College has an issue of moral integrity and natural justice that can only be met by ensuring that all basic surgical trainees who currently have met, or will meet, their educational requirements progress through training. Without more specialist surgical training posts being funded by your government, we are currently unable to increase the intake to basic surgical training. Consequently the Council of College resolved that any increase in the number of basic surgical trainees for 2006 would come from the demonstrated increase in accredited specialist surgical trainee positions for 2006. Without this demonstrated increase of specialist surgical training posts, the intake for basic surgical training will remain at 45 for New Zealand and 220 for Australia.

The College and AHWOC had tried to develop a number of models for selection of surgical trainees and the employment of junior medical staff that brought the processes together. Despite the best efforts of a number of people, including College Councillors, the final models were not acceptable to the Chief Executives of the jurisdictions.

As the employer, the jurisdictions obviously have the right to select their staff. As the surgical training body, the College has been authorised to select the best surgical trainees.

Consequently the College will select the successful applicants for basic surgical training. However, to be successful in becoming a basic surgical trainee they must obtain employment in a hospital recognised for training. If they are not able to obtain employment the applicant will not be able to progress as a trainee. It is the trainees' right to seek employment in any hospital and consequently the College will only select the best trainees based on merit. We will not influence their geographical distribution.

The College looks forward to ensuring that a sustainable skilled surgical workforce is developed in Australia. The clear steps are having an increased number of specialist surgical

training posts, ensuring the current one hundred eligible trainees are placed as soon as possible and then increasing the Basic Surgical Training intake.

I emphasise again the College is prepared and ready to train our workforce. The capacity issue is specialist surgical training posts.

Yours sincerely

Dr Russell Stitz
President

cc. Executive Committee of Council, RACS
Chairs of Specialist Training Boards, RACS
Chair, State Committee, RACS
Dr David Hillis, Chief Executive Officer, RACS
Regional Manager, Regional Office, RACS
Mr Graeme Samuel AO, Commissioner, ACCC
Mr John Ramsay, Chair, AHWOC

From: John Scott
To: Dan Bergin
Date: 4/01/2005 11:57:58 am
Subject: Fwd: Sentinel Case

Dan
Could you follow this up and provide me with a brief?
Thanks
John

From: Steve Rashford
To: Dan Bergin; Darren Keating; Peter Leck
Date: 4/01/2005 11:54:46 am
Subject: Sentinel Case

Dear Dan, Darren and Peter,

Re: P26 16/07/1989

I would just like to touch base regarding this young man. It might be prudent to examine his Bundaberg chart and management.

He is a 15 YO male who was retrieved from Woodgate to Bundaberg by rescue helicopter on the 23/12. He suffered a motor cycle accident. He was shocked at the scene from a left femoral A bleed - BP 80/- PR 150/min! (QCC coordinated the case - Dr Peter Thomas)

I understand he underwent emergency surgery at Bundaberg (saphenous vein ligated) and was admitted to the ICU post operatively.

I was contacted on 1/1 for an urgent transfer for vascular opinion at RBH - his left leg was ischaemic and he was septic++.

Bundaberg 23/12 to 1/1:
During the subsequent 8 days his left leg had become extremely swollen and he had fasciotomies performed. It was discovered the femoral artery was injured and a prosthetic graft was inserted. I understand from the Bundaberg duty registrar on the 1/1 that he had just started back to discover the overtly ischaemic lower limb.

A paramedic staffed helicopter was the closest available resource and we dispatched it. I spent a lot of time giving the paramedic advice in flight re fluid/blood management.

I wandered up to RBH on the day. On arrival he was mildly acidotic with an ischaemic left leg - blue, cold and blistered. All the wounds were purulent. He had spiked fevers to 40C and had a HR of 140/min in flight.

I believe he had a debridement Day 1 and a thru Knee amputation Day 2. I think he may have had or be heading for a hind quarter amputation.

I guess the role of earlier transfer needs to be assessed. Peter Thomas - the coordinator on the 23/12 - thought he would have received a call for secondary transfer. There is no doubt Bundy hospital saved his life day 1. Peter and I have had long discussions about our (QCC) role in a case such as this. It is quite dangerous ground to ring in and ask why the transfer is not being done but we do it with smaller hospitals. Unfortunately our current workload - often with non essential minutiae - precludes this type of intervention. We would hope that given the chance we might improve morbidity and mortality.

We will be urgently examining our role in this type of case.

Thank you for looking at this case.

Regards

Steve

Dr Stephen Rashford
Director
Clinical Coordination and Patient Retrieval Services
Queensland Health

Mobile:0438 398 000
Pager: 1300 555 555 #90163

CC: John Scott; Peter Dr. Thomas

From: John Scott
To: Steve Rashford
Date: 4/01/2005 11:58:15 am
Subject: Re: Sentinel Case

Thanks Steve - will follow this up.
John

>>> Steve Rashford 01/04/05 11:54am >>>
Dear Dan, Darren and Peter,

Re: P26 16/07/1989

I would just like to touch base regarding this young man. It might be prudent to examine his Bundaberg chart and management.

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Thank you for looking at this case.

Regards

Steve

Dr Stephen Rashford

Director
Clinical Coordination and Patient Retrieval Services
Queensland Health

Mobile:0438 398 000
Pager: 1300 555 555 #90163

JGS - 7

From: Dan Bergin
To: John Scott
Date: 6/01/2005 3:14:52 pm
Subject: Fwd: Brief re Patient Issue raised by Dr Steve Rashford

John,
brief as requested. I have discussed with Steve Rashford. I will get Bundaberg and RBWH to liaise to ensure that in future patients in such circumstances requiring specialist vascular and related care are transferred asap following stabilisation. It is important that, in addition to Bundaberg having such a policy, that there are no obstacles to the transfer at the RBWH end.
Dan

Dan Bergin
Zonal Manager
Central Zone

Phone : (07) 3234 0825
Fax : (07) 3235 4384

From: Peter Leck
To: Bergin, Dan
Date: 5/01/2005 1:33:03 pm
Subject: Brief re Patient Issue raised by Dr Steve Rashford

Hi Dan,

Please find attached Brief and background material prepared by Darren Keating in relation to this matter.

Darren is not sure in the circumstances that an external review is warranted.

Would welcome your further advice re same.

Thanks

Peter

Queensland Government
Queensland Health

A BRIEFING TO THE ZONAL MANAGER

BRIEFING NOTE NO:	Click, enter Briefing Note Number, if known
REQUESTED BY:	Dan Bergin, Zonal Manager
DATE:	5 January 2005
PREPARED BY:	Dr Darren Keating, DMS BHSD, 4150 2210
CONSULTATION WITH:	Dr James Gaffield - Staff Surgeon BHSD, Dr Martin Carter – Director of Anaesthetics & ICU BHSD.
CLEARED BY:	Peter Leck, DM BHSD, 4150 2020
DEADLINE:	7 January 2005
SUBMITTED THROUGH:	N/A
SUBJECT:	**MANAGEMENT OF** P 26

COMMENTS ZONAL MANAGER:

DAN BERGIN
Zonal Manager
Central Zone

/ /

PURPOSE:

Provide brief on clinical management of P26 at Bundaberg Base Hospital (BBH).

BACKGROUND:

Dr Steve Rashford, Director of Clinical Coordination and Patient Retrieval Services raised concerns in an email dated 4 Jan 05 about possible delay in transfer of above patient to a tertiary centre from BBH, after he sustained critical injury to vascular structures of left groin plus associated pelvic fractures and possible sciatic nerve damage.

15 y.o. male patient sustained deep laceration to left groin in MBA on 23 Dec 04 and was noted by QAS to be profoundly shocked at injury site. Transported by helicopter to BBH and immediately transferred to OT at BBH on arrival due to shocked state.

Patient underwent three operations by general surgeon (as no vascular surgeon available) in next 12 hours. Initial operation repaired 1cm laceration of femoral vein, while at second operation 3 fasciotomies were performed to relieve compartment syndrome and third operation (for acute ischaemic limb) required bypass of occluded femoral artery. Patient was admitted to ICU after initial operation.

Patient's condition improved/stabilised and he was transferred to general surgical ward on 27 Dec 04. He was regularly reviewed by treating surgeons (as care handed over between surgeons on 26 Dec 04 due to planned leave). Patient's general condition and left leg continued to gradually improve with respect to size, colour and sensation while pulses were maintained. Daily wound checks revealed a small area of superficial muscle necrosis in 1 fasciotomy wound on 30 Dec 04 and no evidence of overt infection.

An antibiotic were begun at time of initial operation and another antibiotic added on 31Dec 04 after patient became intermittently febrile from 27 Dec 04 and white cell count began to rise on 30 Dec 04.

Patient transferred to RBWH on 1 Jan 05 because treating surgeon was concerned that leg had failed to improve as quickly as expected, muscles remained grossly swollen and distal foot colour had changed in last 12-24 hrs with some reduction in pulses. Treating surgeon had no sense of impending problems as outlined in Dr Rashford's email.

KEY ISSUES:

- Life threatening/critical injuries to left groin vascular structures/pelvis of 15 y.o. male.
- Emergency surgery by general surgeon saved patient's life and attempted to save limb. No vascular surgeon available in Bundaberg region.
- Multiple operations maintained limb viability for period after operation.
- Limited improvement in limb observations from 23 Dec 04 until 1 Jan 05.
- Early evidence of infection from 27 Dec and increasing infection from 30 Dec 04 despite investigation and antibiotic cover.

- Transfer on 1 Jan 05 to RBWH – In retrospect transfer was delayed by a number of days as condition of patient's leg failed to improve as quickly as expected combined with evidence of infection. Transfer was possibly affected by handover of care from initial treating staff surgeon to other staff surgeon. Ideally patient should have been transferred to RBWH when stable on or about 25-26 Dec 04.

RELATED ISSUES:

Initial treating surgeon unable to make comment as he is on leave.

Medico-legal issues – Dependant upon information provided to family of patient by staff at RBWH, civil proceedings under PIPA/CLA may occur.

Public Affairs – Increased risk of negative publicity related to delay in transfer to tertiary facility.

BENEFITS AND COSTS:

N/A

ACTIONS TAKEN/ REQUIRED:

BHSD will institute policy of transfer to tertiary facilities of patients with emergency vascular conditions when condition is stable (i.e. life and limb are safe).

Note information provided plus proposed policy change.

ATTACHMENTS:

Clinical summary – P26

Clinical Summary - P26
D.O.B. –

15 y.o. male sustained deep laceration to left groin in MBA on 23 Dec 04. At scene showed signs of shock with reduced conscious state, hypotension and tachycardia.

Arrived at BBH via helo and taken straight to theatre due to ongoing evidence of shock with extensive bleeding from wound, hypotension and peripheral shutdown. Resuscitated with blood, FFPs and fluids.

Initial Operation – 1215h

Operation findings – 1 cm laceration of femoral vein at saphenofemoral junction, femoral artery and nerve intact. Rectus femoris transected and incomplete laceration of adductors with associated muscle contusion.

Femoral vein repaired, wound debrided and washed out, muscles approximated with primary wound closure.
Transferred to ICU via Medical Imaging.

CT Head/Thorax – NAD. CT Abdomen – Free peritoneal fluid, pneumoperitoneum and surgical emphysema of the lower half of abdomen and pelvis with evidence of air tracking in muscles of anterior abdominal wall. Multiple fractures of pelvis and roof of left acetabulum.

Second Operation – 1700h

Operation findings – Pulseless left leg with left leg compartment syndrome.

Upper and lower leg fasciotomies performed with all compartments decompressed.

Returned to ICU.

Third Operation – 2100h

Returned to theatre due to acute left leg ischaemia despite fasciotomies. Bedside USS showed no flow distal to CFA.

Operation findings – 5cm thrombus in femoral artery due to intimal injury.

Arteriorotomy with Gortex bypass graft inserted. Good PT pulse. Femoral vein appeared patent with no evidence of thrombus.

Returned to ICU.

Total blood products – 12 U RBCs and 6 U FFP.

Remained in ICU until 27 Dec 04, when transferred to general ward area. Care handed over from Dir of Surgery to Staff Surgeon on 26 Dec 04 due to planned leave.

During period until 1 Jan 05 regularly reviewed by surgical team. Patient appeared to be improving with increasing appetite, improving urine output and passing flatus.

Left leg showed some improvement in size, colour, sensation and pulses, although no movement noted. Inguinal wound continued to drain serous fluid.

Wounds reviewed and dressings changed daily. No evidence of overt wound infection in any wounds. Superficial muscle necrosis in one fasciotomy wound noted on 30 Dec 04.

Became intermittently febrile from 27 Dec 04 with increasing WCC from 30 Dec 04.
CXR – RLL collapse, blood cultures negative, urine MCS – negative, CVC tip – negative.
Wound swabs fm 30 Dec 04 – gram positive bacilli and gram positive cocci – 1+. Identification pending (probable enteric and skin flora).
Begun on cephalothin on 23 Dec 04 and timentin added on 31 Dec 04.

1 Jan 05

Febrile, tachycardia (upto 110-120bpm) and increasing WCC with neutrophilia (23.1x 10^9/L).
Blood pressure WNL.
Left foot was cool from midfoot distally with very mottled appearance (with some worsening in last 12-24hrs). Treating specialist noted that colour had improved over previous week with only distal foot being very mottled.
Pulses
Popliteal – palpable
PT – weakly palpable
DP – not palpable and no evidence on Doppler.
Transferred to RBWH on 1 Jan 05 by helo because leg had failed to improve as quickly as expected, muscles remained grossly swollen, distal foot colour had changed in last 12-24 hrs with some reduction in pulses. Treating specialist had no sense of impending problems as per Dr Rashford's email.

Summary

Life threatening/critical injuries to left groin vascular structures/pelvis of 15 y.o. male.
Emergency surgery by general surgeon (no vascular surgeon in Bundaberg area) saved patient's life and attempted to save limb.
Multiple operations maintained limb viability for period after operation.
Limited improvement in limb observations.
Early evidence of infection from 27 Dec and increasing evidence from 30 Dec 04 despite investigation and antibiotic cover.
Transfer on 1 Jan 05 to RBWH.

In retrospect transfer was delayed by a number of days as condition of patient's leg failed to improve as quickly as expected combined with evidence of infection. Transfer was possibly affected by handover of care from initial treating staff surgeon to other staff surgeon. Ideally patient should have been transferred to RBWH when stable on or about 25-26 Dec 04.

Recommendation

Transfer of patients with major vascular injury from BBH to vascular service should occur as soon as possible after patient's condition is stable (i.e. life and limb are safe).

Dr Darren Keating
DMS BHSD

5 Jan 05

From: John Scott
To: Dan Bergin
Date: 9/01/2005 12:46:33 pm
Subject: Re: Fwd: Brief re Patient Issue raised by Dr Steve Rashford

Thanks Dan - that all seems appropriate.
John

>>> Dan Bergin 01/06/05 03:14pm >>>

John,
brief as requested. I have discussed with Steve Rashford. I will get Bundaberg and RBWH to liaise to ensure that in future patients in such circumstances requiring specialist vascular and related care are transferred asap following stabilisation. It is important that, in addition to Bundaberg having such a policy, that there are no obstacles to the transfer at the RBWH end.
Dan

Dan Bergin
Zonal Manager
Central Zone

Phone : (07) 3234 0825
Fax : (07) 3235 4384

Attachment JGS-8 JGS-8

From: Judith Woods
To: Peter Leck
Date: 10/01/2005 10:00:10
Caller: john scott
Company: corporate office
Phone: see message

[*] Telephoned
[ ] Will call again
[ ] Wants to see you
[ ] Urgent

[ ] Please call
[ ] Returned your call
[ ] Came to see you

Peter, John said if you were calling about the issue of Steve Brashford, as far as he is concerned it is all fine.

if it was another matter, please call him back.

JGS-9

From: Peter Leck
To: Scott, John
Date: 13/01/2005 10:39:27 am
Subject: Bundaberg Director of Surgery - Dr Jay Patel

Hi John,

Sorry we have missed each other over the last week.

I was really trying to catch up about Dr Patel, our Director of Surgery, who undertook the procedure on the 15 yo male who had initial surgery in Bundaberg and subsequently transferred to Brisbane where he had a leg amputation. You will recall that Steve Rashford raised some concerns.

I was just wanting to flag, that I actually do have some concerns about the outcomes of some of Dr Patel's surgery. Late last year I received some correspondence from a member of the nursing staff outlining a number of concerns about outcomes for patients (including some deaths). This is coloured by interpersonal conflict between Dr Patel and nursing staff - particularly in ICU.

Until the last week, my Medical Superintendent did not believe the complaints were justified and were completely driven by the personality conflict - however he has now expressed some concern although he still believes most of the issues are personality driven.

Late last year I made contact with Mark Mattiuissi for advice about who could conduct a review of the concerns - and particularly of elective surgical ICU cases. My Med Super is keen not to have a professorial "boffin" from a tertiary hospital undertake such a review for fear that they might not relate to the "real" world demands of surgery in regional areas.

Mark suggested Alan Mahoney from Redcliffe. I flagged this also with Audit and Operational Review seeking some assistance for the review. They have referred me to Gerry Fitzgerald.

Unfortunately Gerry has been away (back next week) - I was really ringing to flag this with you as I'm becoming increasingly anxious about the need for a swift review process and wasn't sure I could wait until next week to get something going (now I think that this is okay - sorry!).

A few of the nursing staff have advised that they reported the matter to the QNU before coming to management (thankfully the QNU advised them to report to us).

Peter

JGS-10

From: John Scott
To: Peter Leck
Date: 20/01/2005 8:03:58 am
Subject: Re: Bundaberg Director of Surgery - Dr Jay Patel

Hi Peter
Only just got to this now - sorry.
In the new environment of QH I would suggest you make contact with Mark Waters or John Wakefield if Gerry Fitzgerald is not able to help quickly.
If you can't get assistance from any of them (and I'd be surprised if you couldn't) then could you please contact me again - give me a call on 0411478453.
Thanks
John

>>> Peter Leck 01/13/05 10:39am >>>

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Peter

JGS 11

From: John Scott
To: Peter Leck
Date: 20/01/2005 8:41:38 am
Subject: Re: Bundaberg Director of Surgery - Dr Jay Patel

Thanks Peter - good luck

>>> Peter Leck 01/20/05 08:41am >>>
Thanks John - have discussed matter with Gerry Fitzgerald and progress is being made.

Peter

>>> John Scott 20/01/2005 8:03:58 >>>

Hi Peter
Only just got to this now - sorry.
In the new environment of QH I would suggest you make contact with Mark Waters or John Wakefield if Gerry Fitzgerald is not able to help quickly.
If you can't get assistance from any of them (and I'd be surprised if you couldn't) then could you please contact me again - give me a call on 0411478453.
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Peter

JGS - 12

From: John Scott
To: Peter Leck
Date: 12/04/2005 8:52:39 am
Subject: Re: Dr Patel

Thanks for this Peter - I will advise DG and Minister
John

>>> Peter Leck 04/11/05 07:09pm >>>

Hi John,

I tried to contact you this evening but seemed to have missed you.

Two issues which I think you need to be aware of:

1. Although it doesn't relate to Dr Patel, it is an issue of some concern. In some press clippings sent to me by Paul Michaels last week, was a small part about a caller to ABC radio Brisbane, who said that a relative had been sexually assaulted at Bundaberg Hospital and said that nothing was done. This would seem to relate to a pakistani doctor (Dr Patel is Indian) whom we sacked some 12 or 18 months ago. Whilst no official complaint was made, 3 female patients had raised concern that their physical examination was inappropriate. The doctor was subject to a Police enquiry and fled overseas prior to a scheduled arrest. We dismissed him for failing to be present at work - as the matter was still under investigation.

Whilst this matter doesn't directly relate to Dr Patel - I thought it may be something the Minister would want to know about.

2) Some months before ICU NUM Toni Hoffman, lodged her written complaint about Dr Patel, she came and saw me and complained about his attitude and personality conflict. She provided me a note but said she didn't want me to take the matter any further. I destroyed the note and advised her that if she wanted me to do anything about it then she would need to come and see me, lodge a formal complaint and let the matter be progressed through the appropriate processes. Ultimately this is the action that Ms Hoffman took - via her letter of 22 October 2004. I can't remember all the details in the note. It was largely about personality conflict and I think specifically around the transfer of an ICU patient to Brisbane.

Peter

From: John Scott
To: Peter Leck
Date: 12/04/2005 12:12:34 pm
Subject: Re: Dr Patel - Today's Courier Mail

Thanks Peter

>>> Peter Leck 04/12/05 09:42am >>>
Hi John and Dan,

Just wanting to let you know that (of course) no bonus has been paid to Dr Patel or to any employee for any reason.

We have two local District reward systems in use.

At a monthly forum I announce an "Employee of the month" who has been recognised by their colleagues for outstanding work performance or for role modelling organisational values. The recipient is given a certificate.

Following the tilt train crash we gave 9 employees an "Employee of the month" certificate. These were for employees who played a key role in the response. Dr Patel was one of these as he effectively coordinated the Emergency Department at that time.

The other reward system we have is based on teams/departments.

It is an annual award where we reward winners for quality improvement aligned with the ACHS functions (Leadership & Management, Continuum of Care, Safe Practice & Environment....etc). There are six awards.

The recipient dept/team wins a certificate and $500 to spend in their department pretty much as they like providing it is publicly supportable. Dr Patel has not been a winner or part of a winning team for these rewards.

Peter