In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

PETER ANTHONY STEER of Great Ormond Street Hospital for Children Foundation Trust, Great Ormond St, London WC1N 3JH, United Kingdom, Chief Executive, states on oath:

1. I have been provided with a Requirement to Give Information in a Written Statement dated 6 October 2015. **Exhibit A** to this affidavit is a copy of this notice.

Professional Background

2. I am currently employed as the Chief Executive for the Great Ormond Street Hospital for Children Foundation Trust. My current curriculum vitae outlines my full qualifications and employment history. **Exhibit B** to this affidavit is a copy of my current curriculum vitae.
3. Between July 2012 and December 2014 I held the role of Chief Executive of Children's Health Queensland Hospital and Health Service.
4. **Exhibit C** to this affidavit is the position description for the position I held between July 2012 and December 2014, as well as a copy of my employment contract. The position description describes my key responsibilities in the position of Chief Executive

Deponent ~~A J.P., C.Dec.~~, Solicitor

AFFIDAVIT

On behalf of the State of Queensland

Crown Solicitor
11th Floor, State Law Building
50 Ann Street
BRISBANE QLD 4000
TEL:
Email:

Nishcon de Reya LLP
Africa House
70 Kingsway
London WC2B 6AH

of Children's Health Queensland Hospital and Health Service ('*Children's Health Queensland*').

5. For the purpose of preparing this Affidavit I have been provided with copies of documents to which I would have had access while in my role at Children's Health Queensland.

Role and Involvement with the Barrett Adolescent Centre

6. My responsibility with respect to the Barrett Adolescent Centre was that, as Chief Executive of Children's Health Queensland, I was the executive sponsor for the planning, transition and implementation of clinical services to replace those services previously provided by the Barrett Adolescent Centre.

7. The responsibilities for governance of the Barrett Adolescent Centre closure and transition were split between Ms Lesley Dwyer as Chief Executive of West Moreton Health and Hospital Service ('*West Moreton HHS*') and I as follows:

   (a) Ms Dwyer was responsible for the closure of the Barrett Adolescent Centre and the management of patients and staff throughout that closure process; and

   (b) I was sponsoring, and as Chief Executive of Children's Health Queensland was accountable for, the development and provision of replacement services. The development and provision of these services was to be through the Child and Youth Mental Health Service of Children's Health Queensland.

8. Ultimately, the governance of those services provided by West Moreton HHS prior to the closure of the Barrett Adolescent Centre was transferred to Children's Health Queensland.

9. Children's Health Queensland worked with West Moreton HHS in relation to the Barrett Adolescent Centre transition formally through the Chief Executive and

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Department of Health Oversight Committee ('*Oversight Committee*'). The Oversight Committee was formed with representatives for Children's Health Queensland and West Moreton HHS, as well as representatives for the other Hospital and Health Services and the Department of Health. **Exhibit D** to this affidavit is a copy of the Terms of Reference, including membership, of the Oversight Committee and the agendas and minutes of meetings.

10. Communication between the Department of Health, Children's Health Queensland and West Moreton HHS was ensured by:

(a) mutual committee membership by practitioners, managers and leaders;

(b) informal input received on the drafting and development of key materials;

(c) informal sharing of documentation;

(d) regular and formal updates from the working committees to the Oversight Committee; and

(e) formal monthly reporting from the Clinical Care Transitional Panel to the Oversight Committee.

11. The project officers for the Oversight Committee worked closely to ensure planning and execution was comprehensive and timely in the transition from services offered by the Barrett Adolescent Centre to the new model that involved Queensland-wide services. This work included:

(a) a report every month to Children's Health Queensland's governing board about the progress of transition of the Barrett Adolescent Centre patients, including a summary update of West Moreton HHS' activities. This update was to ensure Children's Health Queensland was aware of the likely timing of transfer and the geographic placement of the existing Barrett Adolescent Centre patients before it took over governance of the new service; and

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(b) monthly updates about service transition plans to Children's Health Queensland from responsible project officers.

Closure of the Barrett Adolescent Centre

12. I cannot recall when or how or from whom I first became aware that the Barrett Adolescent Centre was to be closed.

13. Due to my engagement as Chief Executive of Children's Health Queensland, and meetings attended in that role, I was generally aware of the failed effort to relocate the Barrett Adolescent Centre to Redlands, and that there were decisions being made about The Park Centre for (Adult) Mental Health that would make it impossible for the Barrett Adolescent Centre to continue to operate at its current location. Based on my awareness of these issues, together with the change in contemporary practice for treatment of adolescents with severe mental health issues, I considered it logical and inevitable that the Barrett Adolescent Centre would close.

14. I know that Lesley Dwyer informed me of the formal decision to close the Barrett Adolescent Centre before the media announcement about the closure was made, but I am not sure of when or how I received the information, other than to say it was not by way of formal correspondence. I certainly recall that I was attending monthly meetings with Lesley Dwyer and believe it is likely that Ms Dwyer told me of the decision at one of those meetings.

15. I do not recall being formally consulted by Queensland Health in relation to the closure of the Barrett Adolescent Centre. I was not party to any formal decision-making around the issue of closure of the Barrett Adolescent Centre. The leadership, clinical expertise and mental health management implications of the planning process for replacement services for Barrett Centre were provided by Dr Stephen Stathis and Judi Krause, senior

Mishcon de Reya LLP
Africa House
70 Kingsway
London WC2B 6AH

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~~A J.P., C.D.C.~~, Solicitor

leaders within Children's Health Queensland. In regular meetings with Dr Stathis and Ms Krause I was informed and supportive of their proposals. Through informal and more formal communication (eg Oversight Committee) with the Department of Health, the leadership of Queensland Health and the Mental Health Branch would have been aware at all times of my support for the thoughtful transition plans undertaken by West Moreton HHS and the planning process for replacement services for this adolescent cohort.

16. With respect to the Barrett Adolescent Centre, I was aware that:

(a) West Moreton HHS was undertaking a review or consultation about the future of the Barrett Adolescent Centre, particularly with respect to two major issues namely:

(i) should West Moreton HHS be governor of a State-wide service for children; and

(ii) whether the model of care at the Barrett Adolescent Centre was still appropriate contemporary care for a cohort of adolescents with severe mental health issues; and

(b) West Moreton HHS reported back to its governing board, and that report precipitated a broader engagement with Dr Stathis to look at future plans.

17. I am aware of the matters referred to in paragraph 16 above because Dr Stathis kept me informed of such matters.

18. I am aware, again from contemporaneous discussions with Dr Stathis, that as things evolved, Dr Stathis was taking a lead role in shaping the plan for subsequent services that would be offered after the closure of the Barrett Adolescent Centre. I was informed, and supportive, of the planning process that Dr Stathis was undertaking. I consider Dr

Stathis to be a considered, thoughtful and skilled clinician. At all times, I was permissive and supportive of his work.

State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee

19. SWAETRIS is the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee.

20. I was "Project Sponsor" for the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy ('*Strategy*'). I nominated Dr Stathis and Ms Judi Krause to be clinical representatives for the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee ('*Steering Committee*'). I considered them to be sensible and appropriate appointees for the Steering Committee and appropriate Co-Chairs.

21. The purpose and role of the Steering Committee are best summarised in the Terms of Reference for the Steering Committee provided at **Exhibit D** of this affidavit. Pages 47 to 73 of the exhibit bundle (contained within **Exhibit D)** to this affidavit is a copy of the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy presented at the first meeting of the Oversight Committee.

22. The Steering Committee had no involvement in decision making relating to the Barrett Adolescent Centre closure or patient transition, although it was kept aware of the progress of the transition process.

23. I note that the Terms of Reference and Project Plan record that Dr Stathis and Ms Krause acted as Co-Chairs on the Committee. I was not Chair nor did I attend these Committee meetings. The Steering Committee membership included a carer representative and consumer representative. Details as to the manner in which the input of carers, families

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Document No: 6273725

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Mishcon de Reya LLP
Africa House
70 Kingsway
London WC2B 6AH

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and consumers were considered by this committee are best addressed by the committee members.

24. The Steering Committee did facilitate a presentation from the patients and their families. I recall attending this meeting but I did not make a file note of the proceedings.

25. In terms of the consultation with the families, it is my understanding that one of the families was a '*lightning rod*' on social media and gathered the broader family views of other Barrett consumers, which were incorporated into the presentation to the Steering Committee.

26. At all stages of the planning process, patient and family centric care was a core consideration. Along with "representation" and voice within working groups and committees, the extraordinary detailed engagement with families as a consequence of the closure of the Barrett Centre and the engagement with other providers, ensured that the very practical issues and concerns of consumers and families were shared, considered and at all times informed discussion and decision of all Committees and decision makers.

27. The family dynamic weighed into the plans for the future model of care. There was thoughtful consideration of the challenge presented by family input. The Barrett Adolescent Centre model of care involved complete dislocation of adolescents from their family, often for a lengthy period. The new model of care was to involve greater contact with families and treatment options for the adolescents closer to home, so as to allow them to return to their families and communities. In this sense, family relationships were always a key consideration.

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Oversight Committee

28. I was the Chair of the Chief Executive and Department of Health Oversight Committee. The Terms of Reference and minutes of meetings are provided at **Exhibit D** of this affidavit.

29. The Terms of Reference explain the purpose and role of the Oversight Committee.

30. The overall responsibility of the Oversight Committee was to confirm the new model of care to address the State-wide needs for a particular cohort of patients, namely a cohort of patients with various combinations of developmental trauma, major psychiatric disorders with comorbidities, high and fluctuating risk to self, major pervasive functional disabilities, unstable accommodation options, learning disabilities and drug and alcohol misuse. The model of care was to address the needs for future patients with these diagnoses.

31. The Oversight Committee was not engaged in the management of the closure of the Barrett Centre or the planning of the transition of Barrett Adolescent Centre patients. The Committee was however kept informed of the progress of the transition plans.

32. The State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy was to submit any proposed amendments of the Project Plan to the Oversight Committee for approval, report on project risk management and risk mitigation strategies and escalate concerns where appropriate, and to provide a communications plan to the Oversight Committee for endorsement.

33. The project manager and I were the common link between the Steering Committee and the Oversight Committee.

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Discussions with families

34. The consultations, meetings and contact that I had with families of Barrett Adolescent Centre patients were all before closure of the Barrett Adolescent Centre. They are limited to those meetings outlined above in terms of my involvement in the Steering Committee. There were meetings on 4 November 2013 and a subsequent meeting I held on 7 November 2013.

35. The meeting with families was about the multi-tiered plan for the new model of care, of which Tier 3 – inpatient services - was just one layer. At no stage did I have discussions with families, or other stakeholders, that related only to the Tier 3 – inpatient services. The replacement services were multi-tiered, and of all of the levels, Tier 3 Services were the least complex to manage and have contingency plans for at the time of the Barrett Centre closure. I have previously addressed my individual and the governance approach to the inclusion and consideration of parent and consumer feedback.

36. While I had no direct engagement or accountability for the care of Barrett Adolescent Centre patients, at the meeting with families I listened to the concerns expressed by the parents in relation to their child and their child's current situation and the challenges of the transition planning process.

37. I had no contact with the families after closure of the Barrett Adolescent Centre.

38. Other than the consultations, meetings and contact that I had with families, I also attended at least one, and possibly two, workshops with senior clinicians and service leaders to critique and engage around the emerging new model of care.

39. With respect to the Tier 3 inpatient services, I also recall two other stakeholder engagements, namely:

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(a) an engagement with Metro South Hospital and Health Service about the possibility of the provision of a Tier 3 facility in the Logan area. This option was not feasible because of difficulties with the timing of the availability of the proposed site and because the capital expenditure required was prohibitive; and

(b) a successful negotiation with Mater Health Service and in particular with John O'Donnell, the service's Chief Executive, and Mr Sean Hubbard Executive Director of Adults, Women's and Children's at the Mater, who agreed that Mater Health Service would host a number of Tier 3 beds until the opening of the new Lady Cilento Children's Hospital at which time the transfer of this service would occur.

Transition plans

40. But for one occasion, I had no involvement in developing, managing or implementing the transition plans for the Barrett Adolescent Centre patients. I had no involvement in identifying, assessing and planning for care, support, service quality or safety risks. The single occasion was to confirm recommendations regarding the interim placement of the final patient from the Barrett Adolescent Centre. **Exhibit F** to this affidavit is a File/Meeting Note which records my involvement in planning for care for this final patient from the Barrett Adolescent Centre. I did not author this File/Meeting Note.

41. I did communicate with Dr Anne Brennan occasionally to support her. Dr Brennan carried an enormous load in relation to the transition of the patients and, having approached her to consider this difficult role, I would make an occasional supportive phone call.

42. I had knowledge of the educational needs of the Barrett Adolescent Centre patients as I had to be kept up to date with the progress of the plans for transition of the patient

because there was a prospect that some of the patients may be transferred to Children's Health Queensland's service. I also needed to be kept informed in terms of timing issues, as it was necessary to understand the likely timing of a formal governance handover at which point Children's Health Queensland would be formally responsible for any further referrals that would previously have met the Barrett Adolescent Centre criteria.

43. However, I had no other involvement in ensuring that the educational needs of the Barrett Adolescent Centre patients were considered in the development, management and implementation of the clinical transition plans.

44. I have no direct knowledge of the arrangements that were made for adolescents on the waiting list for the Barrett Adolescent Centre who may otherwise eventually have been admitted to the Centre. My knowledge is that, for the first time, under Dr Anne Brennan's leadership, attention was being paid to those on the waiting list and there was engagement by Dr Brennan and her colleagues across the state in the appropriate care planning for those on the waiting list.

Barrett Adolescent Centre closure dates

45. I don't recall being aware of initial closure dates of either 26 January 2014 or 2 February 2014. It is my recollection that there was always a target for the end of January 2014, but from the time of the announcement there was equally a recognition that the Barrett Adolescent Centre would not close until the transition plans for every adolescent had been finalised. The priority and commitment was to ensure that transition plans were in place for all patients prior to the closure. In that sense, the closure date was flexible. There was discussion as the end of January approached, that it would be an inappropriate and unhealthy environment to keep the Barrett Centre opened for a

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[redacted] A J.P., C.Dec., Solicitor

[redacted] de Reya LLP
Africa House
70 Kingsway
London WC2B 6AH

hypothetical case of one remaining patient. I was involved in a teleconference with a number of colleagues where concern was expressed regarding an individual patient returning post Christmas leave to be the sole patient at the Centre. I concurred with the recommendations of the attending clinician and supported the plan for an interim placement in Logan until the Townsville transition plan was in place. The record of this meeting is contained in **Exhibit F** above.

46. It was necessary to have a closure date or target – without a date, planning becomes impossible.

47. I was not involved in making decisions in relation to the closure date of the Barrett Adolescent Centre, nor do I know who was formally involved.

48. The communicated closure date did not affect the transition planning process. Children's Health Queensland was always working broadly towards closure at the end of January 2014.

49. There was constant communications about the planning for the closure, but I recall that it was always made clear that, if it was necessary for clinical reasons, the closure date would be extended or re-negotiated.

50. I do not recall any stakeholder specifically seeking to re-negotiate the closure date. However, it was always clear from the Project Manager, clinicians and managers that their prime concern was always the existing Barrett Adolescent Centre patients and their clinical needs rather than any particular date for closure.

Responsibility for patients

51. I had no responsibilities in relation to patients of the Barrett Adolescent Centre once they were discharged from the Barrett Adolescent Centre. The primary care

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…on de Reya LLP
Africa House
70 Kingsway
…ndon WC2B 6AH

responsibility for the Barrett Adolescent Centre patients was handed to clinicians in health services other than Children's Health Queensland.

52. My recollection is that Dr Anne Brennan stayed on in her role for a period of months to co-ordinate, support (through the regional care providers) and monitor the progress of these adolescents once they were transferred to their new care providers.

53. I had no engagement, accountability or responsibility with respect to the staff of the Barrett Adolescent Centre – that was a matter for West Moreton HHS.

54. I have no knowledge of when West Moreton HHS ceased monitoring and/or responding to queries in relation to the Barrett Adolescent Centre.

55. Children's Health Queensland did not formally assume responsibility for managing the care of patients from the Barrett Adolescent Centre at any time. The patients were transferred from the clinical care of West Moreton HHS to clinicians and Hospital and Health Services other than Children's Health Queensland.

56. Children's Health Queensland assumed responsibility for the new model of care and its implementation in that it was responsible for:

(a) negotiating and contracting with Mater Health Service for Tier 3 beds;

(b) negotiating and contracting with a not-for-profit organisation for the provision of supportive rehabilitative residential accommodation;

(c) establishing and recruiting emergency support teams across the State; and

(d) the acceptance and management of referrals to these new services

Replacement services

57. Services that are very similar to the Victorian Youth Prevention and Recovery Care (Y-PARC) services were established in Greenslopes Queensland in February 2014 and accepted the first patients in March 2014. This Residential Rehabilitation Centre (the

[redacted] [redacted]

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A.J.P., C.D. Mission de Reya LLP Solicitor Africa House 70 Kingsway London WC2B 6AH

Y-PARC equivalent service) was one option of a suite of alternative care options available for patients who would previously have been referred to the Barrett Adolescent Centre. I am unaware of whether any Barrett Centre patient was admitted to this service.

58. Other new or replacement adolescent mental health services were established in Queensland around the time of closure of the Barrett Adolescent Centre. Those services included:

(a) the Y-PARC equivalent i.e. the "Resi" or Residential Rehabilitation Service;

(b) a day program in Townsville; and

(c) Tier 3 beds at the Mater Hospital.

59. Board briefing notes and Board Papers from Children's Health Queensland track and record the development of the different elements of the extended services. **Exhibit G** to this affidavit is a redacted copy of the Children's Health Queensland Board papers and briefing notes.

60. The Tier 3 beds were available at the Mater from February 2014, as was the Greenslopes "Resi" facility. While the Resi admitted patients from March, the Tier 3 beds at the Mater were only required for one patient from August to September, and the same patient readmitted in October 2014. These Tier 3 beds were transferred to the Lady Cilento Children's Hospital after this hospital opened in November 2014.

61. Service agreements for the AMYOS (Assertive Mobile Youth Outreach Services) were negotiated with the relevant Hospital and Health Services (Metro North, Metro South, Darling Downs and Gold Coast) through the first 6 months of 2014, with recruitment for these services proceeding through the second half of 2014.

62. To my knowledge no previous Barrett patient was referred to or cared for by these new services, prior to my departure in December 2014.

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63. I did not have any involvement in providing information to and/or addressing the concerns of the Barrett Adolescent Centre staff, or the education staff.

All the facts sworn to in this affidavit are true to my knowledge and belief except as stated otherwise.

Sworn by Peter Anthony Steer)
on 15th December 2015)
at 70 Kingsway, London WC2)
in the presence of:

[redacted]

~~A Justice of the Peace, C.Dec~~., Solicitor
R.T. PRESTON-JONES

Mishcon de Reya LLP
Africa House
70 Kingsway
London WC2B 6AH

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

CERTIFICATE OF EXHIBIT

Exhibit A to G to the Affidavit of Peter Anthony Steer sworn on December 2015.

[redacted] [redacted]

Deponent ~~A J.P., C.Dec.~~, Solicitor

Mishcon de Reya LLP
Africa House
70 Kingsway
London WC2B 6AH

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

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BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Commissions of Inquiry Act 1950
Section 5(d)

REQUIREMENT TO GIVE INFORMATION IN A WRITTEN STATEMENT

To: Dr Peter Steer

Of: c/- Crown Solicitor, by email to [redacted]

I, THE HONOURABLE MARGARET WILSON QC, Commissioner, appointed pursuant to Commissions of Inquiry Order (No. 4) 2015 to inquire into certain matters pertaining to the Barrett Adolescent Centre ("the Commission") require you to give a written statement to the Commission pursuant to section 5(1)(d) of the *Commissions of Inquiry Act 1950* in regard to your knowledge of the matters set out in the Schedule annexed hereto.

YOU MUST COMPLY WITH THIS REQUIREMENT BY:

Giving a written statement prepared either in affidavit form or verified as a statutory declaration under the *Oaths Act 1867* to the Commission on or before **Friday, 16 October 2015**, by delivering it to the Commission at Level 10, 179 North Quay, Brisbane.

A copy of the written statement must also be provided electronically either by: email at mail@barrettinquiry.qld.gov.au (in the subject line please include "Requirement for Written Statement"); or via the Commission's website at www.barrettinquiry.qld.gov.au (confidential information should be provided via the Commission's secure website).

If you believe that you have a reasonable excuse for not complying with this notice, for the purposes of section 5(2)(b) of the *Commissions of Inquiry Act 1950* you will need to provide evidence to the Commission in that regard by the due date specified above.

DATED this 6th **day of** October **2015**

[redacted]

The Hon Margaret Wilson QC
Commissioner
Barrett Adolescent Centre Commission of Inquiry

SCHEDULE

1. What are Dr Steer's current professional role/s qualifications and memberships? Please provide a copy of Dr Steer's most recent curriculum vitae.

2. We understand that Dr Steer held the role of Chief Executive of Children's Health Queensland Hospital and Health Service (**CQHHS**) (in its various forms) from July 2012 until December 2014.

    a. Explain what Dr Steer's key responsibilities are/ were in this position;

    b. Explain whether Dr Steer's key responsibilities in this position changed at any stage during the period of 2012 to 2014; and

    c. Provide copies of Dr Steer's job description and employment contract.

3. Explain Dr Steer's role and involvement with the Barrett Adolescent Centre (**BAC**).

4. Explain:

    a. How responsibilities for governance of the BAC closure and transition were split between Dr Steer and Ms Lesley Dwyer as Chief Executive of West Moreton Hospital and Health Service (**WMHHS**).

    b. How CHQHHS worked with WMHHS in relation to the BAC transition.

5. When, how and by whom, did Dr Steer first become aware that the BAC was to be closed?

6. We understand that the Department of Health consulted with Dr Steer a number of times in relation to the BAC.

    a. Explain when these consultations occurred, the content of these consultations, any recommendations Dr Steer made to the Department of Health during these consultations (particularly in relation to Tier 3 – inpatient services, continuity

of care and new services) and whether Dr Steer's recommendations were accepted or rejected by the Department of Health and why.

b. Please provide the details requested in section 6(a) above in relation to any other entity which consulted with Dr Steer in relation to the closure of the BAC.

7. How was Dr Steer involved in the announcement of the decision to close the BAC on 6 August 2013?

8. We understand that Dr Steer was the "Project Sponsor" for the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy (**SWAETRIS**) and sought clinical representatives for the SWAETRIS Steering Committee.

a. What was the SWAETRIS?

b. Explain the purpose and role of the SWAETRIS Steering Committee, and how this Committee was involved in decisions relating to the BAC.

c. We understand that Dr Steer was Chair of the SWAETRIS Steering Committee, however Dr Stephen Stathis and Judi Kraus acted as Co-Chairs on the Committee. Did Dr Steer formally delegate his functions, and if so, why?

9. We understand that the SWAETRIS Steering Committee invited the families of BAC patients to make submissions in relation to the development of service options.

a. Which families made submissions to the SWAETRIS Steering Committee?

b. How were these submissions considered, evaluated and incorporated in the SWAETRIS?

10. We understand that Dr Steer was the Chair of the Chief Executive and Department of Health Oversight Committee (**Oversight Committee**), which provided guidance in relation to the SWAETRIS.

a. Explain the purpose and role of the Oversight Committee, and how the Oversight Committee was involved in decisions relating to the BAC.

b. What was the relationship between the SWAETRIS Steering Committee and the Oversight Committee?

c. What guidance did the Oversight Committee provide in relation to the SWAETRIS?

11. What consultations, meetings or contact did Dr Steer have with the families of BAC patients before and after the closure of the BAC? How did Dr Steer take these views into account?

12. What discussions did Dr Steer have with families of BAC patients and other relevant stakeholders about the future model for adolescent mental health care in Queensland (particularly in relation to Tier 3 – inpatient services)? How did Dr Steer consider, evaluate and incorporate these stakeholder views in developing the future model of care?

13. What involvement did Dr Steer have in developing, managing and implementing the transition plans for the BAC patients (including, but not limited to identifying, assessing and planning for care, support, service quality and safety risks)?

a. Who was Dr Steer accountable to and responsible for when he was discharging these responsibilities?

b. What were the key challenges in the development, management and implementation of the BAC transition plans?

c. What involvement (if any) did Dr Steer have in ensuring that the educational needs of BAC patients were considered in the development, management and implementation of their clinical transition plans?

14. What arrangements were made for adolescents on the BAC waiting list who would otherwise have been admitted to the BAC?

15. We understand that initial BAC closure dates of 26 January 2014 and 2 February 2014 were communicated internally, but later changed to the end of January 2014.

a. Who was involved in making decisions in relation to the closure date of the BAC?

b. Did the communicated closure date affect the transition planning process, and if so, how?

c. What communications did Dr Steer receive about the closure date for the BAC and from whom did he receive these communications? Could this closure date be renegotiated according to clinical necessity?

d. Did any stakeholder seek to renegotiate this date on the basis of clinical necessity? If so, how were these concerns managed and addressed?

16. Did Dr Steer or CHQHHS have any responsibilities in relation to patients of the BAC once they were discharged from the BAC? If so, what were these responsibilities?

17. Were there any arrangements in place to monitor the adequacy of the transition processes for patients of BAC (and their families) and staff of the BAC?

a. If so, what were these monitoring arrangements?

b. When did WMHHS cease monitoring, and/or responding to queries in relation to, the BAC?

c. When did CHQHHS assume responsibility for managing the care of patients from the BAC?

18. We understand that the Department of Health was planning to establish Youth Prevention and Recovery Care (**Y-PARC**) services in Queensland by January 2014 and that this service was intended as one alternative care option for the BAC patients. Were any Y-PARC services established by January 2014? If so, did any BAC patients benefit from these services?

19. Were any other new or replacement adolescent mental health services established in Queensland immediately following/in the course of the closure of BAC? If so, did any BAC patients benefit from these new or replacement services and how?

20. What involvement (if any) did Dr Steer have in providing information to and/or addressing the concerns of BAC staff (including education staff)?

2. Outline and elaborate upon any other information and knowledge (and the source of that knowledge) Dr Steer has relevant to the Commission's Terms of Reference.

3. Identify and exhibit all documents in Dr Steer's custody or control that are referred to in his witness statement.

Dr Peter Steer

Summary of Qualifications (Primary & Postgraduate):

Qualification University / College Country Year

Qualification	University / College	Country	Year
MB BS	University of Queensland	Australia	1981
FRACP (Paediatrics)	Royal Australasian College of Physicians	Australia	1989
FRCPC (Paediatrics)	Royal College of Physicians & Surgeons of Canada	Canada	2003
FAAP	American Academy of Paediatrics	Canada	2005
GAICD	Australian Institute of Company Directors	Australia	2011

Current & Previous Medical Licensing Authorities:

Licensing Authority	*Country of Registration*
Ontario	Canada
Medical Council of New Zealand	New Zealand
Medical Board of Queensland	Australia

Achievements:

2011

- Irish National Paediatric Hospital Development Board Review Panel.
  The program's themes included presentations and discussions regarding health reform agendas and outcomes that can impact on children's hospitals, care of adolescents and the interface with adult healthcare.
  Healthcare implications and hospital design related to child health initiatives that would be beneficial to the new Queensland Children's Hospital.

- The purpose to attend this international conference was to understand the international perspective on these critical issues, learn from CEO peers regarding successful and not so successful innovations and compare our own planning process, especially with regard to hospital design and adolescent/adult transition healthcare planning with international peers.

Memberships / Committees / Leadership Positions:

2011 - 2012	Member, Queensland Mental Health Commission Transition Steering Committee
2011	Vice President, Children's Health Australasia
2011	Board Member, Children's Health Australia
2011	Board Member, Royal Children's Hospital
2009 – 2012	Member, Children's Healthcare Australasia
2011	Board Member, Children's Health Foundation Queensland
2011	Member Developing Business Excellence Program – Leadership Learning Development Unit
2010	Member, Children's Hospitals International Executive Forum

2009 – 2012	Children's Hospitals International Executive Forum [CHIEFS]
2008	Vice Chair, Chair Elect, Canadian Association of Paediatric Health Centres
2007 – 2009	Executive Member, Paediatric Chairs of Canada
2006 - 2009	Board Member Canadian Association of Paediatric Health Centres
2006 - 2009	Member Paediatric Council on Child Health (Ontario)
2005 - 2008	Member, Board Subcommittee – Canadian Committee on Decision Support, Canadian Association of Paediatric Health Centres
2003 - 2006	SPCC *(Specialized Paediatric Coordinating Council), Ontario, Ministry of Health and Long Term Care
2003 - 2009	Member of Canadian Association of Paediatric Health Centres
2003 - 2009	Paediatric Chairs of Canada
2003 - 2009	Chair, Provincial Alternate Funding Programs Branch (AFP) Paediatric Task Force *(involving MOHLTC, Planning, Hospital Branch and the Alternate Funding Programs Branch representatives)
2004 - 2005	Steering Committee for MOHLTC Information Management "Long Term Planning Scenario" for Paediatric Human Resources Planning as a Pilot Project *(Chair, Stainey Brown)
2005 - 2008	Ministry of Child & Youth Services "Best Start-18 month Strategy" Committee
2005 – 2008	Canadian Health Coalition Steering Committee for "Child Health Indicators"
1999 - 2001	National Commission, Catholic Health Australia
1992 - 1994	Director, State Committee Queensland Sudden Infant Death Association
1997 - 2001	Director, Radio Lollipop Australia Limited
2000 - 2001	Vice President – Children's Hospitals Australasia
1999 - 2000	Honorary Treasurer - Children's Hospitals Australasia
1995 - 2001	Director – Children's Hospitals Australasia
2000	Southern Clinical School, Implementation Committee, Faculty of Health Sciences, University of Queensland
1999 - 2001	Director – Operations Smile Australia Limited
1999	Invited Examiner – Royal Australian College of Physicians (Clinical Examinations)
1999 - 2003	Member of Steering Committee, Australian Centre for Paediatric, Pharmacokinetics (Research Centre for University of Queensland)
1996 – 2000	Chair, Neonatal Advisory Committee, Queensland Health Child Health Advisory Panel, Queensland Health Obstetric and Neonatal Advisory Group, Southern Zone, Queensland Health

Queensland Health Committees:

- 2012 Member, Program Reform Executive Committee
- 2011 Member of Risk Advisory Committee
- 2011 – 2012 National health and Hospital Reform Executive Committee
- 2009 Member of Resource Executive Committee
- 2009 – 2011 Member of Patient Safety and Quality Executive Committee

Memberships of Medical Colleges and Organisations:

- Member of Australian Institute of Company Directors 2011
- Fellow Royal Australian College of Physicians (Paediatrics)
- Society for Paediatric Anaesthesia in New Zealand and Australia [SPANZA]
- Australian and New Zealand Association of Paediatric Surgeons [ANZAPS]
- Australian College of Health Service Management, Australia
- Fellow of the Royal College of Physicians and Surgeons of Canada
- Fellow of the American Academy of Paediatrics
- Canadian Medical Protection Association 2003 - 2009
- College of Physicians and Surgeons of Ontario & Australia 2003 - 2009
- Perinatal Society of Australia and New Zealand, 1991 - 2003
- Paediatric Society of Queensland, 1991 - 2003
- Australian and New Zealand Intensive Care Society, 1991-2003

Hospital /University Committees – Educational Responsibilities:

- Price Waterhouse Coopers – Bending the Cost Curve, Emerging International Best Practice,
- Singapore 2011
- Council for the Michael G. DeGroote School of Medicine, McMaster University, 2003-2009
- Faculty Executive, McMaster University, 2003- 2009
- Executive Committee, Hamilton Health Sciences, 2003-2009
- Site Vision Master Planning Steering Committee, 2003-2009
- Chair, McMaster University Medical Centre Master Planning Steering Committee, 2005 - 2009
- Medical Advisory Committee, Hamilton Health Sciences, 2003-2009
- Medical Advisory Committee, St. Joseph's Healthcare Hamilton, 2003-2009
- Ethics Advisory Council, Mater Health Services, 1998-2003
- Human Resource Ethics Committee, Mater Health Services, 2001-2003
- Ethics Committee, Mater Children's Hospital, 1995–1998
- Scientific Sub-Committee of Hospital Ethics Committee, Mater Mother's Hospital, 1992-1995
- Pharmacy and Therapeutics Committee, Mater Hospitals, 1991-1994

Employment History:

Jan 2015 to Present	**Chief Executive – Great Ormond Street Hospital for Children NHS Foundation Trust, London, United Kingdom**
Jan 2009 to Dec 2014	**Chief Executive - Children's Health Queensland Hospital and Health Services, Queensland Health, Brisbane, Queensland, Australia** ▪ Manage operations of Children's Health Queensland ▪ Ensure optimal levels of patient care are delivered and current & future local ▪ health service needs are met ▪ Ensure procedures and systems are in place to meet governance and patient safety requirements. ▪ Development and implementation of strategic, operational and health ▪ service plans ▪ Responsibility for and management of annual budget ▪ Management of workforce ▪ Ensure effective community engagement strategies are in place ▪ Ensure cross district collaboration in the planning and delivery of integrated ▪ health services **Professor, School of Medicine, Faculty of Health Sciences University of Queensland, Brisbane, Australia**
Dec 2003 to Dec 2008	**Adjunct Professor, School of Public Health, Queensland University of Technology, Brisbane, Queensland, Australia**
Dec 2003 to Dec 2008	**President - McMaster Children's Hospital Hamilton, Ontario, Canada** **Professor and Chair, Department for Paediatrics McMaster University, Hamilton, Ontario, Canada** **Chief, Department Paediatrics, McMaster Children's Hospital Hamilton, Ontario, Canada** **Chief of Paediatrics, St Joseph's Healthcare Hamilton, Ontario, Canada**
2005 to December 2008	**Executive Lead - McMaster University Medical Centre, Hamilton Health Services, Hamilton, Ontario, Canada**
Jan 2002 to Dec 2003	**Neonatologist & Director, Centre for Clinical Studies – Women's & Children's Health – Mater Hospital, Brisbane, Queensland, Australia** **Associate Professor, Central Clinical School, Faculty of Health Sciences University of Queensland, Brisbane, Queensland, Australia**
July 2001 to Dec 2001	**Division Chief, Clinical Director & Academic Head, Division of Neonatology McMaster University, Hamilton, Ontario, Canada**
Jan 2001 to July 2001	**Neonatologist & Director, Centre for Clinical Studies – Women's & Children's Health (formerly the Mater Perinatal Epidemiology Unit), Mater Hospital Brisbane, Queensland, Australia**

July 1995 to Dec 2000	**Executive Director - Mater Children's Public & Private Hospitals Brisbane, Queensland, Australia** **Adjunct Associate Professor, Department of Paediatrics & Child Health University of Queensland, Brisbane, Queensland, Australia** **Neonatologist - Mater Mother's Hospital, Brisbane, Qld Australia**
Jan 1995 to July 1995	**Acting Medical Superintendent – Mater Children's Hospital Brisbane, Queensland, Australia**
July 1991 to Dec 1994	**Staff Neonatologist & Director Post-Graduate Education Mater Mother's Hospital & Mater Children's Hospital, Brisbane, Qld, Australia**
July 1989 to June 1991	**Neonatal Fellowship, McMaster University, Hamilton, Ontario, Canada**
Dec 1988 to June 1989	**Acting Staff Neonatologist, National Women's Hospital, Auckland, New Zealand**
1988	**Senior Registrar / Neonatology, National Women's Hospital Auckland, New Zealand**
1985 to 1987	**Paediatric Registrar Mater Children's Hospital Brisbane, Queensland, Australia**
1984	**Senior Medical Officer/ Medical Registrar Mater Adult Hospital Brisbane, Queensland, Australia**
1983	**Junior Resident Medical Officer Mater Adult Hospital Brisbane, Queensland, Australia**
1982	**Intern Mater Adult Hospital Brisbane, Queensland, Australia**

Additional Information:

Courses Taken:

2011	Australian Institute of Company Directors Course, Brisbane, Australia
2008	Rotman School of Business University of Toronto Advanced Health Care Leadership Program
2007	Niagara Institute – Conference Board of Canada Executive Leadership Program
2006	Executive Health Program Rotman School of Management
1998	General Manager Program Australian Graduate School of Management University of Sydney and University of New South Wales
1989 - 1991	Courses within the Design Measurement and Evaluation Programme, Department of Epidemiology, McMaster University ▪ MS 721 Introduction to Clinical Epidemiology ▪ MS 730 Study Design and Measurement ▪ MS 702 Introduction to Biostatistics ▪ MS 723 Applied Regression Analysis

Reviews Hosted:

July 2011	Review for Minister of Health Republic of Ireland Clinical review of Planning for National Paediatrics Hospital, Ireland Co-Reviewers: Jane Collins Chief Executive, Great Ormond Street Hospital for Children's NHS Trust, London Jim Schmerling CEO, Children's Hospital, Colorado, USA James Mandell CEO, Boston Children's Hospital, USA

Speaking Engagements & Presentations at Forums:

March 2014	Health Facilities Design and Development Conference "Australian Healthcare Week", *Partnerships in Healthcare Design and Delivery*, Sydney.
October 2013	ACHSM Breakfast *"Queensland Children's Hospital looks different and is different – Why?"* (Co-presenter with Bruce Wolfe, Conrad Gargett Riddell).
October 2013	Darling Downs Medicare Local AGM, *"Statewide Children's Healthcare Solutions".*
July 2013	Annual Design and Health World Congress, Symposium. *"Healthcare Design".*
March 2013	AbiGroup Bi-Annual Breakfast, Brisbane. *"The Queensland Children's Hospital.*
November 2012	UQ Faculty Board Meeting (Guest Speaker) *"Vision for Children's Healthcare and Research*

September 2012 Combined Special Interest Group Meeting, Royal College of Anaesthetists, Gold Coast "*Clinical Leadership"*

May 2012 Royal Australasian College of Physicians Annual Scientific Meeting, " *Child Health Networks"* Brisbane

April 2012 Children's Hospitals International Executive Forum [CHIEFS] , Hawaii

March 2012 Cystic Fibrosis Queensland Conference & AGM, Brisbane "Queensland Children's Hospital Update"

February 2012 Child & Adolescent Health, Perth WA - Launch of Medical Leadership Program - Keynote speaker at Launch "Medical Leadership Learnings"

November 2011 Women's & Children's Hospitals Australasia [WCHA] Annual Conference, Adelaide (Keynote Speaker)

October 2011 Society for Paediatric Anaesthetists in New Zealand and Australia (SPANZA)/Australia and New Zealand Association of Paediatric Surgeons (ANZAPS) Scientific Meeting, Coolum "Scoping the Challenge"

July 2011 Central and Southern Qld Training Consortium (CSQTC) Leadership Seminar, Mooloolaba "Queensland Children's Hospital Update"

May 2011 Children's Hospitals International Executive Forum [CHIEFS] in Ireland

February 2011 Nationally Funded Centre, Clinician Meeting at Royal Brisbane & Women's Hospital, Brisbane "Challenge of volume quality relationship in child health care"

October 2010 Neurosurgical Society of Queensland Annual Meeting, Brisbane "Planning for Neurosciences for Tertiary Paediatrics within Queensland"

September 2010 University of Queensland Centenary Event, Brisbane

August 2010 QUT Health Leadership Forum, Brisbane "Queensland Children's Hospital Development Update"

August 2010 Australian College of Health Service Management (ACHSM) Breakfast, Royal on the Park, Brisbane "Little Queenslanders, Big Issues, Giant Steps"

August 2010 Queensland Royal Australian College of Surgeons – Annual Scientific Meeting Gold Coast, Queensland "The planning challenges for paediatric surgery and subspecialty surgery in Queensland"

June 2010 GP Interface Group Meeting "Queensland Children's Hospital Development Update"

May 2010 Research Reference Group, Brisbane "QCH Academic & Research Facility Update"

September 2009 Australian College of Health Service Management (ACHSE) Breakfast Forum, Brisbane "Health Services for Queensland and Young People"

Awards – Honours:

1991 Percy Williams Memorial Award
Annual Postgraduate Paediatric Research Award
McMaster University, Ontario, Canada
"Pulmonary Function Assessment with Neonatal Volume Monitor"

1990	Percy Williams Memorial Award Annual Postgraduate Paediatric Research Award McMaster University, Ontario, Canada *"Enteral Feeding of the Low Birthweight Infant - A Meta-analysis of Randomised Trials"*
1989	Riker Young Presenter of the Year Award Annual Scientific Meeting, New Zealand Paediatric Meeting *"Severe Birth Asphyxia"*

Formal Teaching Responsibilities:

2005 -2009	Tutor, Professional Competencies Curriculum, MD Program, McMaster University
2003 - 2009	Graduate Medical Program, McMaster University. Teaching within the Obstetric, Paediatric and Evidence Based Medicine themes of the Graduate Program.
2002	Lecturer, Indigenous Health Program – University of Queensland, Australia
1993 - 2003	Lecturer, Tutor – University of Queensland Undergraduate Medical Program

Publications:

1. Sinclair, J., **Steer, P.A.**. Neonatal hypoglycaemia and subsequent neurodevelopment: A critique of follow-up studies. Ciba Foundation Discussion Meeting. *Hypoglycaemia in Infancy: the need for a rational definition*. London, 17 October 1989

2. Lucas, A., **Steer, P.A.**, Sinclair, J.. Enteral feeding of the low birthweight infant Chapter in *Effective Care of the Newborn*. Editor, J C Sinclair Oxford University Press 1990.

3. Sidhu, J.S., Charles, B.G., Triggs, E.J., Tudehope, D.I., Gray, P.H., **Steer, P.A.**. Assessment of bioelectrical impedance for individualising Gentamicin therapy in neonates. *Eur J Clin Pharmacol*, 1993;44:253-258.

4. Charles, B.G., Schild, P.N., **Steer, P.A.**, Cartwright, D., Donovan, T. Pharmacokinetics of Dexamethasone following single-dose intravenous administration to extremely low birth weight infants. *Dev Pharmacol Ther*, 1994;20:205-210.

5. Lee, T.C, Charles, B.G., **Steer, P.A.,** Flenady,V.. Salivary is a valid alternative to serum monitoring of caffeine after intravenous treatment for apnoea of prematurity. *Ther Drug Monit.* 1996;18:288-293.

6. Lee, T.C, Charles, B.G., **Steer, P.A.**, Flenady,V., Grant, T. Theophylline population pharmacokinetics from routine monitoring data in very low birthweight infants with apnoea of prematurity. *Br J Clin Pharmacol*. 1996;41:191-200.

7. Tudehope, D.I., **Steer, P.A.**. Which milk for the preterm Infant? Editorial. *J Paed Child Health*. 1996; 32:275-277.

8. Lee, T.C, **Steer, P.A.**, Charles, B.G., Flenady,V.. Population pharmacokinetics of caffeine in premature neonates with apnoea of prematurity. *Clin Ther Pharmacol* 1997: 61 (6): 628-40.

9. Nourse, C.N., **Steer, P.A.**. Perinatal outcome following conservative management of mid trimester preterm rupture of membranes. *Jnl Paed Child Health* 1997:33 (2): 125-30.

10. Lee, T.C, Harte, G., Gray, P.H., **Steer, P.A.,** Charles, B.G.. Haemodynamic responses and population pharmacokinetics of Midazolam administration to ventilated preterm infants. *Jnl Paed Child Health*. 1997; 33 (4): 335-8.

11. **Steer, P.A.**, Henderson-Smart, D.J.. Caffeine vs theophylline treatment for apnoea in preterm infants. In Sinclair, J., Bracken, M., Soll,R.F., Hobar, J.D. (eds.) Neonatal Module of *The Cochrane Database of Systematic Reviews* [updated Feb 1998]. Available in *The Cochrane Library* [database on disk and CDROM]. The Cochrane Collaboration; Issue 3. Oxford: Update Software; 1996. Updated quarterly. Available from: BMJ Publishing Group, London.

12. Henderson-Smart, D.J., **Steer, P.A.**. Prophylactic caffeine to prevent postoperative apnea following general anaesthesia in preterm infants. In Sinclair, J., Bracken, M., Soll,R.F., Hobar, J.D. (eds.) Neonatal Module of *The Cochrane Database of Systematic Reviews* [updated July 2001]. Available in *The Cochrane Library* [database on disk and CDROM]. The Cochrane Collaboration; Issue 3. Oxford: Update Software; 1996. Updated quarterly. Available from: BMJ Publishing Group, London.

13. Henderson-Smart, D.J., **Steer, P.A.**. Prophylactic methylxanthine in preterm infants. In Sinclair, J., Bracken, M., Soll,R.F., Hobar, J.D. (eds.) Neonatal Module of *The Cochrane Database of Systematic Reviews* [updated April 2001]. Available in *The Cochrane Library* [database on disk and CDROM]. The Cochrane Collaboration; Issue 3. Oxford: Update Software; 1996. Updated quarterly. Available from: BMJ Publishing Group, London.

14. Henderson-Smart, D.J., **Steer, P.A.**. Doxapram treatment for apnea in preterm infants. In

Sinclair, J., Bracken, M., Soll,R.F., Hobar, J.D. (eds.) Neonatal Module of *The Cochrane Database of Systematic Reviews* [updated July 2001]. Available in *The Cochrane Library* [database on disk and CDROM]. The Cochrane Collaboration; Issue 3. Oxford: Update Software; 1996. Updated quarterly. Available from: BMJ Publishing Group, London.

15. Charles, B.G., Lee, T.C, **Steer, P.A.**, Flenady,V., Population pharmacokinetics of intravenous Amoxycillin in very low birthweight infants. Jnl Pharm Sci 1997; 86, (ii) 1288 - 92.

16. Lee, T.C, Charles, B.G.. Harte, G., Gray, P.H., **Steer, P.A.**, Flenady,V. Population pharmacokinetic modelling in extremely preterm infants receiving midozolam during ventilation. *Anaesthesiology* 1999; 90; 451-457.

17. Henderson-Smart, D.J., **Steer, P.A.**. Doxapram versus Methylxanthine for apnea in preterm infants. In Sinclair, J., Bracken, M., Soll,R.F., Hobar, J.D. (eds.) Neonatal Module of *The Cochrane Database of Systematic Reviews* [updated April 2001]. Available in *The Cochrane Library* [database on disk and CDROM]. The Cochrane Collaboration; Issue 3. Oxford: Update Software; 2000. Updated quarterly. Available from: BMJ Publishing Group, London.

18. Henderson-Smart, D.J., **Steer, P.A.**. Methylxanthine treatment for apnea in preterm infants. In Sinclair, J., Bracken, M., Soll,R.F., Hobar, J.D. (eds.) Neonatal Module of *The Cochrane Database of Systematic Reviews* [updated July 2001]. Available in *The Cochrane Library* [database on disk and CDROM]. The Cochrane Collaboration; Issue 3. Oxford: Update Software; 2000. Updated quarterly. Available from: BMJ Publishing Group, London.

19. Woodgate, P., **Steer, P.A.,** Flenady, V. Intramuscular Penicillin in newborns for early onset Group B Streptococcal Infections - Protocol Published. In Sinclair, J., Bracken, M., Soll,R.F., Hobar, J.D. (eds.) Neonatal Module of *The Cochrane Database of Systematic Reviews* [updated April 2001]. Available in *The Cochrane Library* [database on disk and CDROM]. The Cochrane Collaboration; Issue 3. Oxford: Update Software; 2002. Updated quarterly. Available from: BMJ Publishing Group, London.

20. Cooke, L., **Steer, P.A.,** Woodgate, P. Indomethacin in low birthweight infants with asymptomatic patent ductus arteriosus. – Protocol Published. In Sinclair, J., Bracken, M., Soll,R.F., Hobar, J.D. (eds.) Neonatal Module of *The Cochrane Database of Systematic Reviews*]. Available in *The Cochrane Library* [database on disk and CDROM]. The Cochrane Collaboration; Issue 2. Oxford: Update Software; 2003. Updated quarterly. Available from: BMJ Publishing Group, London.

21. **Steer PA**, Flenady VJ, Shearman A, Lee TC, Tudehope DI, Charles BG. Periextubation caffeine in preterm neonates: a randomized dose response trial. Journal of Paediatrics and Child Health – Jan 2003,Vol 39, Issue 7, page 511-515.

22. Cooke L, **Steer P**, Woodgate P. Indomethacin for asymptomatic patent ductus arteriosus in preterm infants. Cochrane Database Syst Rev. 2003;(2):CD003745.

23. Henderson-Smart, DJ, **Steer, PA**. Doxapram treatment for apnea in preterm infants. The Cochrane Database of Systematic Reviews 2004, Issue 4. Art. No.: CD000074.pub2. DOI: 10.1002/14651858.CD000074.pub2.

24. **Steer, P**., Flenady, V., Shearman, A. Charles, B., Gray, PH, Henderson-Smart, D., Bury, G., Fraser, S., Hegarty, J., Rogers, Y., Reid, S., Horton, L., Charlton, M., Jacklin, R., Walsh, A.; Caffeine Collaborative Study Group Steering Group. High dose caffeine citrate for extubation of preterm infants; a randomized controlled trial. Arch Dis Child Fetal Neonatal Ed. 2004 Nov;89(6):F499-503. PMID: 15499141 [PubMed-indexed for MEDLINE]

25. Woodgate, P., Flenady, V., **Steer, P.** Intramuscular penicillin for the prevention of early onset group B streptococcal infection in newborn infants. The Cochrane Database of

Systematic Reviews 2004, Issue 2. Art No.: CD003667. pub2. DOI: 10.1002/14651858.CD003667.pub2.

26. Charles B, Townsend S, **Steer P A**, Flenady V, Gray P, Shearman A. Caffeine Citrate Treatment for Extremely Premature Infants with Apnoea: Population Pharmacokinetics, Absolute Bioavailability and Implications for Therapeutic Drug Monitoring; Ther Drug Monit 2008;30:709–716.

27. Gray, PH, Flenady VJ, Charles GB, Steer PA, Caffeine Collaborative Study Group. Caffeine Citrate for very premature infants: Effects on development, temperament and behaviour. J Paediatr. Child Health 2011, (47(4), 167-72

Collaborations:

28. Schmidt B, Davis P, Moddemann D, Ohlsson A, Roberts RS, Saigal S, *et al.* Long-term effects of indomethacin prophylaxis in extremely-low-birth-weight infants. N Engl J Med 2001;344(26):1966-72. (Local Coordinator at Mater Health Services, Brisbane)

Presentations:

29. **Steer, P.A.** Severe Birth Asphyxia. Annual Scientific Meeting, Australian Paediatric Society and Paediatric Research Society of Australia May 1989. Abstracts in *Australian Paediatric Journal* 1989;25:310.

30. **Steer, P.A.**. Outcome of Severe Birth Asphyxia. Annual Scientific Meeting New Zealand Paediatric Society August 1988. Proceedings in *The New Zealand Medical Journal*. 1989;102:195.

31. **Steer, P.A.**. Chronic neonatal lung disease. Current Issues in Newborn Medicine. Paediatric Regional Meeting, Hamilton Ontario. 1991.

32. Sinclair, J.C., **Steer, P.A.**. Neonatal hypoglycaemia critical evaluations of follow-up studies. Ciba Foundation Meeting. Tokyo. December 1994.

33. Masters, I.B., **Steer, P.A.**, Wales, P., Stretton, M.A. The effects of subnasal flow and changing low flow oxygen rates on oxygen saturation stability during sleep on infants with chronic neonatal lung disease. Australasian Thoracic Society Meeting. March 1995.

34. Shearman, A., **Steer, P.A.**. Comparison of oxygen saturation recordings measured with and without ECG synchronisation. Australian Perinatal Society Meeting, Auckland. April 1995.

35. Lee, T.C, **Steer, P.A.**, Charles, B.G.. Population pharmacokinetics of theophylline in extremely low birthweight infants. Australian Perinatal Society Meeting, Auckland. April 1995.

36. Harte, G., Lee, T.C, **Steer, P.A.**, Charles, B.G.. Pharmacokinetics and pharmacodynamics of Midazolam on VLBW infants. Australian Perinatal Society Meeting, Auckland. April 1995.

37. **Steer, P.A..** Outreach Perinatal Education. Australian Perinatal Society Conference, Brisbane. May 1995.

38. Lee, T.C, Gray, P.H., Harte, G., Charles, B.G., **Steer, P.A.**, Flenady,V.. Concentration targeting of Midazolam in very low birth weight neonates based on a population pharmacokinetic approach. Australian Perinatal Society. Adelaide S.A. March 1996.

39. Lee, T.C, Charles, B.G., **Steer, P.A.**, Flenady,V.. Methylxanthine concentration targeting using a population approach: a valuable tool in neonatal therapeutics. Australian Perinatal Society. Adelaide S.A. March 1996.

40. Bradbury, J., **Steer, P.A.**, Burns, Y. Effects of respiratory physiotherapy on oxygenation of neonate: a randomised crossover trial. Australian Perinatal Society. March 1996.

41. **Steer, P.A.**, Shearman, A., Flenady,V., Lee, T., Charles, B.G.. Effect of different caffeine dosing regimes on hypoxemia and heart rate in preterm infants post extubation. Accepted for platform presentation Australian Perinatal Society, Perth. March 1997.

42. **Steer, P.A.**. Harassing Opinion Leaders – Getting research into practice. Perinatal Society of Australia and New Zealand, Evidence Based Health Care. September 1997.

43. **Steer, P.A.** Targeting specific groups – Paediatric populations – Special needs. Surgery on time – Cutting new ground, Queensland Health Seminar, Brisbane. October 1997.

44. **Steer, P.A.** Caffeine vs Theophylline for apnea in preterm infants. Royal Women's Hospital 60th Anniversary Academic Meeting, Brisbane. 1998.

45. **Steer, P.A.** Four Walls and A Door – A Clinicians Perspective (on capital health developments). Australian Institute of Architects Annual Meeting, Cairns. October 1998.

46. **Steer, P.A.** Paediatric Workforce Issues in Australia Children's Hospital Australasia, Annual Meeting, Melbourne. November 1999.

47. **Steer, P.A.** Paediatric Specialist Training – Impact on Hospitals. National Conference, Children's Hospitals Australasia, "Working Together in the 21st Century", Melbourne. February 2000.

48. **Steer, P.A.**, for the Caffeine Collaborative Group. Periextubation Caffeine for Neonates born less than 30 weeks gestation: A randomised trial of two dosing regimes. Perinatal Society of Australia and New Zealand, Brisbane. March 2000.

49. Shearman, A.D, **Steer, P.A.,** Flenady,V.J, Gray, P.H., Charles, B.G., The effect of two different caffeine doses on measures of SpO_2 and Heart Rate in preterm infants who have successfully extubated from mechanical ventilation. Perinatal Society of Australia and New Zealand, Brisbane. March 2000.

50. Hurrion, E., Gray, P.H., Shearman, A., Flenady,V., **Steer P.A.** The effect on cerebral blood flow velocity in a subgroup of preterm infants enrolled in a randomised trial of two caffeine dosing regimens. Perinatal Society of Australia and New Zealand, Brisbane. March 2000.

51. Davis, P., Roberts, R, **Steer P.A.,** Vohr, B., Wright, L., Zupancic, J., and The TIPP Investigators. Inter-Country Differences in Long-Term Neurosensory Outcomes of Extremely Low Birth Weight [ELBW] Infants. Presented at the Paediatric Academic Societies' 2001 Annual Meeting, Baltimore. April-May 2001, and Presented at the Perinatal Society of Australia and New Zealand, Canberra, March 2001.

52. **Steer, P.A.,** Flenady, V. Increasing Cochrane Systematic Reviews through a local support service. Perinatal Society of Australia and New Zealand, Christchurch, New Zealand., March 2002.

53. Woodgate, P., **Steer, P.A.** Comparison of Inborn versus Outborn infants at the Mater Mothers Hospital 1996-2000. . Perinatal Society of Australia and New Zealand, Christchurch, New Zealand., March 2002.

54. Flenady, V., **Steer, P**., Woodgate, P., Davies, M., Welsh, K. Expectations across Cochrane Review Groups: experiences of a unique Cochrane support service. 7th Annual Conference of Perinatal Society of Australia and New Zealand Hobart, Tasmania, Australia, March 2003.

55. Flenady, V., Lewis, L., Jenkins-Manning, S., Welsh, K., **Steer, P**., Woodgate, P., King, J., Coory, M. Survey of reported compliance with guidelines on two common perinatal problems. 7th Annual Conference of Perinatal Society of Australia and New Zealand Hobart, Tasmania, Australia, March 2003.

56. Flenady, V., Lewis, L., Jenkins-Manning, S., Welsh, K., **Steer, P.**, Woodgate, P., King, J., Coory, M. Survey of reported compliance with guidelines on two common perinatal problems. 7th Annual Conference of Perinatal Society of Australia and New Zealand Hobart, Tasmania, Australia, March 2003.

57. **Steer, PA**. Lessons Learned – A Children's Hospital within a Hospital. McGill University, May 2006.

58. Liley H, Dean M, Lopez g, Jenkins- Manning S, **Steer PA** et al. Mannose Binding Lectin and Hospital Acquired Infections in Very Low Birthweight Infants. Paediatric Academic Society Meeting, May 2006, Toronto Canada.

59. **Steer PA**. Meeting the needs of Children and Youth using Canadian Data to determine capacity. Canadian Association of Paediatric Health Centres Annual Meeting, Vancouver, October 2006.

60. **Steer, PA**. Qld Royal Australasian College of Surgeons, Gold Coast

Grants Obtained:

1990 McMaster University Study Fund, March 1990, $5,200
"*Pulmonary Function Assessment with Neonatal Volume Monitor*"

1990 Regional Medical Associates Scholarship Ontario, Canada, October 1990, $5,000
"*Pulmonary Function Assessment with Neonatal Volume Monitor*"

1992 JP Kelly Research Foundation; Masters, B., **Steer, P.A.**, Stretton, M., 1992, $15,000
"*The effects of nasal gas flow on oxygen saturation stability in infants with chronic neonatal lung disease*"

1994/5 JP Kelly Research Foundation; **Steer, P.A.**, Charles, B.G.; 1994/95, $8,000
"*Population pharmacokinetics of Amoxycillin and Gentamicin in preterm infants*"

1993/5 Mayne Bequest, University of Queensland; **Steer, P.A.**, Charles, B.G.; 1993/95, $35,000
"*Dose response trial of caffeine in VLBW infants*"

1994 Ramaciotti Foundation; Charles, B.G., **Steer, P.A.**; 1994, $8,000
"*Dexamethasone pharmacokinetics in ELBW infants*"

1995 National Health and Medical Research Council; **Steer, P.A.**, Charles, B.G.; 1995, $120,000;
"*Caffeine Treatment of Apnoea in VLBW Infants; is there a therapeutic window?*"

2001 JP Kelly Research Foundation; Flenady,V., Woodgate, P, **Steer, P.A.**, 2001, $22,100
"*Improving perinatal health care through the promotion of Cochrane Systematic Reviews at the Mater Hospital* "

2002 JP Kelly Research Foundation; **Steer, P.A.,** Flenady, V., Woodgate, P., 2002, $8,000
"Cochrane Collaboration and Evidence Based Medicine Outreach Education for North Queensland".

2002 Hockey, R., Flenady, V., Woodgate, P., **Steer, P.A.**
"Review of Indigenous cause specific infant mortality in Queensland".

Queensland Government
Queensland Health

Schedule 2

Children's Health Services Hospital and Health Service

Job ad reference:	
Role title:	Health Service Chief Executive, Children's Health Services Hospital and Health Service
Status:	
Unit/Branch:	Children's Health Services Hospital and Health Service
Health Service District:	
Location:	
Classification level:	
Salary level:	
Closing date:	
Contact:	
Telephone:	
Online applications:	www.health.qld.gov.au/workforus or www.smartjobs.qld.gov.au
Fax application:	
Post application:	
Deliver application:	

About our organisation

Queensland Health's purpose is to provide safe, sustainable, efficient, quality and responsive health services for all Queenslanders. Our behaviour is guided by Queensland Health's commitment to high levels of ethics and integrity and the following **five core values**:

- **Caring for People:** We will show due regard for the contribution and diversity of all staff and treat all patients and consumers, carers and their families with professionalism and respect.
- **Leadership:** We will exercise leadership in the delivery of health services and in the broader health system by communicating vision, aligning strategy with delivering outcomes, taking responsibility, supporting appropriate governance and demonstrating commitment and consideration for people.
- **Partnership:** Working collaboratively and respectfully with other service providers and partners is fundamental to our success.
- **Accountability, efficiency and effectiveness:** We will measure and communicate our performance to the community and governments. We will use this information to inform ways to improve our services and manage public resources effectively, efficiently and economically.
- **Innovation:** We value creativity. We are open to new ideas and different approaches and seek to continually improve our services through our contributions to, and support of, evidence, innovation and research.

Purpose of role

The Health Service Chief Executive (HSCE) is appointed by, and reports to, the Hospital and Health Service Hospital and Health Board (effectively the Hospital and Health Board of the organisation), and is the single point of accountability for ensuring patient safety through the effective executive leadership and management of all hospitals and health services, as well as associated support functions within the Children's Health Services Hospital and Health Service ('HHS', 'the Hospital and Health Service'). The HHS is an independent statutory body which will be a specialist statewide HHS providing care for children from across Queensland and beyond, including Northern New South Wales and overseas. The position is accountable to the Hospital and Health Board for ensuring that the HHS achieves a balance between efficient service delivery and high quality health outcomes.

Key accountabilities

Key result area	Key accountabilities	Performance measures
Strategy Development	Support the Hospital and Health Board in the development and implementation of the HHSs vision and strategy, ensuring alignment to the HHSs user and community needs and Qld Health's priorities. Implement state-wide service priorities and plans as determined by the Chief Executive / Director General and Minister for Health.	Adherence to HHSs service agreement (to be revised every 3 years), strategy, and relevant legislation and Queensland Health policy.
Healthcare Performance	Establish and lead a high quality HHS Executive Team, operating model and committee structures and provide leadership and direction for all of the HHSs facilities and services in order to deliver effective, efficient and economical healthcare to the HHSs community. Collaborate with private healthcare providers to facilitate alignment and utilise available synergies in service provision.	Leadership and management skills of HHS Executive Team. Effectiveness of healthcare service delivery: • Patient flow (e.g. Emergency department wait times) • Patient safety and quality (e.g. Hospital Standardised Mortality Ratio) • Chronic disease management • Closing the gap (e.g. A&TSI birth weights)
Healthcare Improvement	Ensure the ongoing development of organisation, service and workforce capability to leverage the HHSs organisational capacity to deliver improved and sustainable healthcare outcomes. Promote a culture of learning, innovation and research and development across the organisation.	Efficiency of service delivery and financial performance (e.g. YTD operating position). Workforce effectiveness (e.g. Hours lost via WorkCover vs Occupied FTE). Provision of regular performance reports to other HHSs and Queensland Health.
Risk and Compliance Management	Ensure a strong culture of, and commitment to, safety and quality that pervades the whole organisation and underpins health service delivery. Ensure risk, compliance and clinical governance frameworks operate across the HHS and are linked to	Adherence to quality expectations of the Hospital and Health Board and demand for high quality healthcare within the HHS. Safety and quality outcomes for patients as well as clinical and non-clinical workforces.

Key result area	Key accountabilities	Performance measures
	continuous improvements in health service delivery.	Adherence to all relevant legislation (e.g. *Hospital and Health Boards Act 2011*; *Work Health and Safety Act 2011*).
Expert Advice	Provide strategic advice and high level counsel to the Hospital and Health Board to enhance decision making regarding the management and improvement of health care services across the HHS.	Quality and appropriateness of advice provided with respect to healthcare service delivery across the HHS.
Resource Efficiency	Ensure resources are planned, allocated and evaluated to meet health service agreements and related financial requirements and targets.	Adherence to expenditure budgets (e.g. YTD Operating position & forecast operating position) and successful management of multiple funding models (e.g. Activity Based Funding, blocked funding, Own Source Revenue). Monitoring and reporting on performance against workforce plans, asset management plans and financial plans. Return on investment for operational and capital expenditure.
Workforce Management	Establish a workforce vision, strategies (including engagement strategy) and management plan that reflects the needs of the HHS's users and community. Create a positive working environment free from bullying and harassment which encourages respect and embraces diversity.	Development of workforce vision, strategies (including engagement strategy) and management plan to support the delivery of the HHS's Service Agreement. A&TSI proportion of HHS workforce.
Relationships and Engagement	Ensure the HHSs engagement with the community, practitioner groups, other HHSs and relevant stakeholders within the HHS (e.g. the Hospital and Health Board, particularly the Chair) and Queensland Health. Ensure that the needs, interests and expectations of clinicians, the community and other stakeholders are included in health service planning and evaluation. Encourage and foster the development of strategies to support collaboration among HHSs. Communicate in a transparent way with the community regarding HHS clinical and financial performance, service priorities and decision making	Engagement strategies (to be reviewed every three years) developed in accordance with relevant stakeholders as stipulated in the *Hospital and Health Boards Act 2011*, including: • Consumer and community engagement strategy to promote consultation with health consumers and community members. • Clinician engagement strategy to promote consultation with health professionals working in the HHS. • Inter-HHS engagement strategy to promote engagement and collaboration with other HHSs. • Protocols with Local Primary

Key result area	Key accountabilities	Performance measures
	processes. Ensure openness to complaints from HHS healthcare users.	Healthcare Organisations (Medicare Locals) – a HHS must use its best endeavours to agree on a protocol to promote cooperation between the HHS and the primary healthcare organisation in the planning and delivery of health services. Timeliness and effectiveness of response to user complaints.

Staffing and budget responsibilities
The HSCE will carry accountability for the HHS which comprises 1,828 FTE staff. The position is accountable for an annual operating budget in the order of $281 million.

Delegations
In accordance with the Hospital and Health Boards Act, the HSCE may delegate any of its functions to an appropriately qualified (i.e. deemed to possess the necessary qualifications, experience and standing) Health Service Executive or employee, except for the authorisation to disclose confidential information in the public interest.

About the HHS
This role is located in the Children Health Services HHS, which provides care for children from across Queensland and beyond. The HHS will also be responsible for the successful delivery of the Queensland Children's Hospital Project by 2014, in collaboration with the Queensland Health Planning and Infrastructure Division. The HHS is responsible for providing paediatric services, Child and Youth Mental Health Services, Outreach children specialist services, paediatric education and research and advocacy of children's health service needs.

The HHS includes the Royal Children's Hospital (RCH), which is the major specialist paediatric hospital in Queensland and is a centre for paediatric treatment, care, teaching and research. Additionally, the HHS provides a range of outreach clinics and telemedicine in order to improve access to services throughout the State, as well as an integrated Child and Youth Family Health Service which brings together community health services previously run by the Metro South and Metro Health Service Districts into a single service. A new $1.4b facility, the Queensland Children's Hospital (QCH), is currently under construction (due to open in late 2014), and will replace both the Royal Children's Hospital and the Mater Children's Hospital (a private facility) as the state's major specialist children's hospital.

Key challenges
The establishment of the HHSs is a significant reform to the public health system in Queensland and involves adopting a new legislation and the establishment of local independent statutory bodies. The HSCE will face significant challenges in developing a collaborative working relationship with the Hospital and Health Board; negotiating and agreeing the HHSs Service Level Agreement; taking accountability for the HHSs own corporate and clinical governance; driving cultural change to achieve performance; and engaging with the community to ensure alignment of service delivery to community needs.

Many of the Children Health Services HHSs most significant challenges are associated with the Queensland Children's hospital. In particular, the HSCE will lead a significant organisational change project in unifying two distinct cultures in the Royal Children's Hospital and Mater Children's Hospital. The HSCE must also ensure the merit-based transfer of staff from State and Federal awards to new industrial arrangements, the seamless service delivery transition from the RCH to the QCH, and timely recruitment of additional health professionals.. Subsequently, the

HHS will be challenged to ensure the delivery of specialised and complex paediatric services and research consistent with world best practice.
The HSCE is expected to overcome these challenges to deliver cost-effective, high quality services across the HHS in a timely manner within the context of the HHSs Service Agreement.

Communication – key stakeholders
The HSCE role will be required to engage, liaise or negotiate with the following key stakeholders on the HHSs behalf:

- HHS Hospital and Health Board
- Director-General
- Local Community and Consumers
- HHS Executive Team
- Other HHS employees
- Other System Entities
- Universities
- Key vendors
- Peers at major children's hospitals around Australia
- National Children's Healthcare HHS
- Medicare locals
- Primary Health Care Organisations
- Aged care services
- Industry bodies
- Regulators
- Union bodies
- Leaders of other HHSs
- The Queensland Children's Hospital Foundation

Knowledge, qualifications/professional registration, experience
- Possession of tertiary qualifications in administration/management is highly desirable.
- Prior experience in health service leadership is highly desirable

Key skill requirements/competencies
- Demonstrated achievement at a senior level in delivering high quality services and progressing a reform agenda in a large and complex organisation including:
  - Leading change through people
  - Holding others to account and being held to account for agreed targets
  - Empowering and influencing others
  - Developing collaborative working relationships
  - Ability to identify with the patient experience and factor into all decision making processes
- Demonstrated ability to provide strategic, analytical and innovative skills in management and delivery, particularly in a healthcare environment
- Demonstrated understanding of the commonwealth, state and local contexts and drivers for health reform
- Demonstrated ability to effectively develop, implement and manage a substantial budget
- Demonstrated ability to lead, manage and take responsibility for a strong safety culture
- Demonstrated ability to lead and manage a significant workforce and lead the development of people and culture at a whole of organisation level
- Demonstrated ability to lead and develop an Executive team
- Demonstrated high level negotiation, consultative, communication and interpersonal skills including the ability to deal with the competing needs of various government, non-government and community stakeholders
- High level of political acumen and demonstrated performance in a politically sensitive environment
- Possession of outstanding personal qualities consistent with the Queensland Health values, Code of Conduct (or like documents in other organisations) and leadership framework including self belief, self awareness, self management, drive for improvement and personal integrity.

Pre-Employment screening
Pre-employment screening, including a criminal history check, may be undertaken on persons recommended for employment. Please refer to the Information Package for Applicants for details of employment screening and other employment requirements.

Queensland Government

HEALTH SERVICE CHIEF EXECUTIVE CONTRACT OF EMPLOYMENT

DR PETER ANTHONY STEER

Hospital and Health Boards Act 2011

Crown Solicitor
State Law Building
50 Ann Street
BRISBANE QLD 4000

Queensland Health
147-163 Charlotte Street
BRISBANE QLD 4000

THIS CONTRACT is made

BETWEEN: The **Authority**.

AND: The **Health Service CE** specified in Item 1 of Schedule 1.

BACKGROUND

A. The Authority appoints the Health Service CE under the Act to be the Chief Executive of the Service.

B. Section 74(1) of the Act requires the Health Service CE to enter into a written Contract of Employment with the Authority.

C. Section 74(2)(a) of the Act requires that the term of the Health Service CE's appointment can not be more than 5 years.

AGREED TERMS

1. DEFINITIONS & INTERPRETATION

1.1 In this Contract, unless a contrary intention appears:

Act means the *Hospital and Health Boards Act 2011;*

Applied Public Service Law has the same meaning as in the Act;

Approved Superannuation Scheme means a superannuation scheme approved by the QSuper Minister under section 15(2) of the *Superannuation (State Public Sector) Notice 2010*;

Authority means the chair of the board for the Service;

Basic Accumulation Category has the same meaning as in the QSuper Deed;

Chief Executive means the Chief Executive of the Department;

Commencement Date means the date specified in Item 2 of Schedule 1, on which this Contract commences;

Comprehensive Accumulation Category has the same meaning as in the QSuper Deed;

Confidential Information includes all oral, written and electronic information, comments, conversations, observations, documents, notes, letters, emails, reports, specifications, policies, data, research or any other type of information that is not in the public domain and is acquired by the Health Service CE in the course of employment with the Authority, the Service or the Department;

Contract includes this document and any schedules to it;

Department means the department administering the Act;

Election Amount has the same meaning as in the QSuper Deed;

End Date means the date on which this Contract ends, being whichever is the earliest of the following:

(a) the Expiry Date;

(b) the effective date of termination in accordance with clause 7.5;

(c) the date of termination contained in a notice given by the Health Service CE under clause 8; or

(d) another date of termination prescribed by the Act;

Expiry Date means the date specified in Item 3 of Schedule 1, on which this Contract will expire;

Government Entity has the same meaning as in the *Public Service Act 2008*;

Government Entity Employment means employment for a cumulative period of more than twenty (20) working days in a Government Entity and includes:

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

(b) engagement as a contractor if the contract is wholly or principally for the labour of the Health Service CE, unless the Health Service CE does not have any financial interest in the entity engaged to provide the services;

Health Service Executives Service Terms and Conditions of Employment means the terms and conditions of employment applicable to the Health Service CE and contained in the document entitled "Health Service Chief Executive Terms and Conditions of Employment", as amended from time to time;

Health Service Directive has the same meaning as in the Act;

Minister means the Minister with portfolio responsibility for the Act;

Payback Period means a period of twenty-six (26) weeks commencing on the End Date;

Performance Agreement means an agreement which states the criteria against which the performance of the Health Service CE is to be assessed;

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

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

QSuper Minister means the Minister responsible for administering the QSuper Act;

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

Separation Payment means an amount equal to six (6) months Total Remuneration Package, calculated on the Total Remuneration Package applicable on the End Date;

Service means the Hospital and Health Service specified in Item 4 of Schedule 1;

Service Agreement has the same meaning as in the Act;

Total Remuneration Package means the amount specified in Item 5 of Schedule 1 as varied in accordance with this Contract.

1.2 In this Contract:

(a) words importing a gender include any other gender and words in the singular include the plural and vice versa;

(b) all dollar amounts refer to Australian currency;

(c) a reference to legislation includes subordinate legislation made under it and legislation amending, consolidating or replacing it;

(d) a reference to an individual or person includes a corporation or other legal entity;

(e) a reference to a clause or schedule means a clause or schedule to this Contract;

(f) headings are included for convenience of reference only and are not intended to affect the meaning or interpretation of this Contract;

(g) if an expression is defined, other grammatical forms of that expression will have corresponding meanings; and

(h) a reference to a number of days, weeks or months means calendar days, weeks or months.

2. APPOINTMENT & CONDITIONS OF EMPLOYMENT

2.1 The Health Service CE accepts appointment under this Contract as Health Service CE and health executive, from the Commencement Date until the End Date.

2.2 The appointment of the Health Service CE is not effective until it has been approved by the Minister in accordance with the Act.

2.3 The Health Service CE's conditions of employment are governed by the Act, the Applied Public Service Law, Health Service Directives, this Contract and the Health Service Chief Executive Terms and Conditions.

2.4 If there is an inconsistency between this Contract and the Act or the Applied Public Service Law, the Act or Applied Public Service Law prevails to the extent of the inconsistency.

2.5 If the Health Service CE's employment as a health executive continues to the Expiry Date, in accordance with the Act a further contract may be entered into.

3. TERM OF EMPLOYMENT

3.1 This Contract, and the employment of the Health Service CE, starts on the Commencement Date and ends on the End Date.

3.2 If the Health Service CE wishes to be considered for reemployment as a Health Service CE and health executive after the Expiry Date, the Health Service CE must give notice of that to the Authority at least six (6) months prior to the Expiry Date.

3.3 If the Authority receives a notice under clause 3.2, the Authority may give notice to the Health Service CE at least three (3) months, but not less than one (1) month, prior to the Expiry Date whether or not the Health Service CE will be reemployed.

3.4 A failure by the Authority to give notice under clause 3.3 is not a breach of this Contract.

3.5 If the Health Service CE does not give a notice under clause 3.2, the Health Service CE will be taken to have elected not to be reemployed as a Health Service CE and health executive.

4. DISCHARGE OF THE HEALTH SERVICE CE'S RESPONSIBILITIES

4.1 The Health Service CE must:

(a) discharge the responsibilities and functions of a Health Service CE as stated in:

(i) the role description contained in Schedule 2; and

(ii) the Act;

(b) devote substantially the whole of the Health Service CE's time and attention during work hours to discharging the responsibilities of a Health Service CE;

(c) conform to the hours of work and other work arrangements reasonably required by the Authority and the Chief Executive, having regard to:

(i) the Health Service CE's leave entitlements; and

(ii) the Department's policies about work/life balance and family friendly flexible working arrangements;

(d) comply with all laws, including the Act and the Applied Public Service Law, that are relevant to the Health Service CE's employment;

(e) comply with the principles of health executive service employment as set out in the Act;

(f) become familiar with the Health Service Chief Executive Terms and Conditions of Employment;

(g) ensure that the Service complies with the Service Agreement;

(h) comply with the Health Service CE's Performance Agreement and meet the performance criteria contained in the Performance Agreement; and

(i) comply with the Code of Conduct for the Queensland Public Service.

4.2 The Health Service CE must enter into a performance agreement with the Authority within three (3) months after the Commencement Date. The Health Service CE's performance against the performance agreement will be assessed from time to time, as determined by the Authority.

4.3 The Health Service CE may be required to travel within Australia or overseas to discharge the responsibilities of a Health Service CE.

4.4 The Health Service CE must notify the Authority immediately after any of the following events occur:

(a) the Health Service CE is or becomes bankrupt;

(b) the Health Service CE is charged with an indictable offence;

(c) the Health Service CE is convicted of an indictable offence; or

(d) the Health Service CE is or becomes the subject of an investigation under the *Crime and Misconduct Act 2001*.

5. REMUNERATION & BENEFITS

5.1 The Health Service CE is entitled to receive the Total Remuneration Package.

5.2 The Health Service CE may be entitled to other benefits prescribed by the Act, the Applied Public Service Law or a Health Service Directive.

5.3 The Total Remuneration Package may be determined and varied from time to time by the Chief Executive in accordance with the Act.

6. SUPERANNUATION

6.1 If, at the Commencement Date, the Health Service CE is:

(a) a member of the QSuper Scheme – the Authority will continue to comply with the requirements of the QSuper Act in respect of the Health Service CE's membership;

(b) on leave from other employment and continues to be a member of an approved fund operated for that employment – the Authority:

(i) will contribute the standard employer contribution required under the approved fund for up to a maximum of three (3) years; and

(ii) after three (3) years, will contribute an amount that, if the Health Service CE was a member of the Comprehensive Accumulation Category, would be required under the QSuper Act; or

(c) not already a member of the QSuper Scheme and not on leave from other employment – then the Health Service CE can elect to be a member of the Comprehensive Accumulation Category or Basic Accumulation Category.

6.2 If the Health Service CE elects to receive the Election Amount into an approved fund, the Health Service CE will become a member of the Basic Accumulation Category.

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

7. TERMINATION BY AUTHORITY

7.1 The Health Service CE's appointment and this Contract may be terminated by notice signed by the Authority, which must specify a proposed termination date that is at least one (1) month after the date on which the notice is given to the Health Service CE. The notice does not need to provide reasons for the termination.

7.2 The termination of the Health Service CE's appointment and this Contract is not effective until it is approved by the Minister.

7.3 The Health Service CE may, within seven (7) days after receiving a notice under clause 7.1, provide a written submission to the Authority explaining why this Contract should not be terminated.

7.4 The Authority must ensure that any written submission received from the Health Service CE under clause 7.3 is included in any submission to the Minister seeking approval to terminate the Health Service CE's appointment and this Contract.

7.5 If, after consideration of any submission received from the Health Service CE under clause 7.3, the Minister approves termination of the Health Service CE's appointment and this Contract, the effective date of termination will be whichever of the following dates is the later:

(a) the proposed termination date specified in the notice given under clause 7.1; or

(b) the date on which the Minister gives approval.

7.6 The Authority may direct the Health Service CE to take special leave on full pay and without debit to any of the Health Service CE's leave accounts during the notice period.

7.7 The Authority may revoke a notice under clause 7.1 before it takes effect.

8. TERMINATION BY HEALTH SERVICE CE

8.1 The Health Service CE may resign or retire by giving at least one (1) months notice to the Authority.

8.2 The Authority may consent to a shorter notice period after the Health Service CE's notice of resignation or retirement is received.

8.3 A consent by the Authority to a shorter notice period is not a termination under clause 7.

8.4 If the Health Service CE does not give at least the minimum period of notice required under clause 8.1, the Authority must pay to the Authority, as a liquidated debt and realistic estimate of any detriment that the Authority may suffer because of the termination of this Contract by the Health Service CE, an amount of the Total Remuneration Package that is equivalent to the period of notice not given by the Health Service CE.

9. PAYMENT AT THE END OF EMPLOYMENT

9.1 The Health Service CE is entitled to be paid the Separation Payment as soon as practicable after the End Date, unless clause 9.2 applies.

9.2 The Health Service CE will not be entitled to be paid the Separation Payment if:

(a) the Contract expires on the Expiry Date (whether or not the Health Service CE has given a notice under clause 3.2);

(b) the Health Service CE is on leave from a public sector entity of another jurisdiction and the Health Service CE resumes duty with that public sector entity after the End Date;

(c) before the End Date, the Health Service CE is appointed to, or employed by, the Department, a Service or a Government Entity such that the Health Service CE has continuity of employment;

(d) termination of this Contract occurs as a result of:

(i) resignation or retirement of the Health Service CE under clause 8;

(ii) disciplinary action in respect of the Health Service CE under the Applied Public Service Law or otherwise;

(iii) retirement of the Health Service CE for mental or physical incapacity under the Applied Public Service Law or otherwise;

(iv) the Health Service CE being or becoming bankrupt;

(v) the Health Service CE being convicted of an indictable offence;

(vi) the Health Service CE being found guilty of official misconduct under the *Crime and Misconduct Act 2001*; or

(vii) death of the Health Service CE.

10. PAYMENT TO BE FINAL

10.1 If this Contract is terminated:

(a) the Separation Payment, if any, made to the Health Service CE under clause 9 constitutes the only entitlement of the Health Service CE (subject to clause 10.1(d));

(b) the Health Service CE must not institute proceedings for compensation for loss of office, injunctive relief, reinstatement or appeals unless the Health Service CE has an express statutory right to do so;

(c) the Separation Payment is deemed to be liquidated damages that each party acknowledges are a realistic assessment of any detriment the Health Service CE may suffer because of termination of this Contract; and

(d) any statutory entitlements of the Health Service CE are to be calculated by reference to the Total Remuneration Package payable as at the End Date.

10.2 If a court or tribunal determines that termination of this Contract is unlawful, the Health Service CE's entitlements are limited to the amount that would be payable under clause 9 if the termination had been lawful.

10.3 Nothing in this clause may be deemed or construed as a release in respect of any action, personal injury or death of the Health Service CE that the Health Service CE or anyone claiming by, through or under the Health Service CE, may have.

11. REPAYMENT OF SEPARATION PAYMENT IF HEALTH SERVICE CE COMMENCES GOVERNMENT ENTITY EMPLOYMENT DURING THE PAYBACK PERIOD

11.1 If the Health Service CE receives a Separation Payment under clause 9 but commences Government Entity Employment during the Payback Period, the Health Service CE must repay to the Authority a percentage of the Separation Payment equivalent to the number of weeks during which the Health Service CE is in Government Entity Employment.

Examples:

If the Health Service CE is re-employed one (1) week after the End Date - the Health Service CE would have to repay a proportion equivalent to twenty-five (25) weeks Total Remuneration Package.

If the Health Service CE is re-employed thirteen (13) weeks after the End Date - the Health Service CE would have to repay 50% of the Separation Payment.

11.2 The Health Service CE must repay the amount specified by clause 11.1:

(a) Within twenty-eight (28) days after commencing employment with a Government Entity; or

(b) by another reasonable date agreed to by the Authority.

11.3 If the Health Service CE subsequently ceases employment with a Government Entity before the end of the Payback Period, the Health Service CE is not entitled to a refund of any repayment made under clause 11.1.

12. CONFIDENTIAL INFORMATION

12.1 The Health Service CE must not, without the written consent of the Authority, use or disclose Confidential Information, other than for the purpose of proper discharge of the responsibilities of a Health Service CE under the Act.

12.2 The Health Service CE must deliver all Confidential Information in the Health Service CE's power, possession or control to the Authority:

(a) on demand by the Authority; and

(b) on or before the End Date.

12.3 Clause 12.1 does not apply to the extent that:

(a) the Health Service CE is required by law to disclose Confidential Information; or

(b) Confidential Information is publicly available, other than because of the Health Service CE's breach of this Contract.

12.4 The obligations of the Health Service CE under this clause continue after the End Date.

13. NOTICES

13.1 Any notice, notification, direction, consent or approval required to be given under this Contract must be in writing and may be delivered by hand, sent by prepaid post, faxed or emailed to the respective addresses specified in Items 6 and 7 of Schedule 1 or such other addresses as a party may notify to the other from time to time.

13.2 A notice may be delivered by hand to the addressee personally at any place.

13.3 Subject to clause 13.4, a notice will be deemed to have been given:

(a) if delivered by hand – on the date of delivery; or

(b) if mailed – the day which is two business days after the notice was posted; or

(c) if faxed – on the date on which the sender's fax machine records an apparently successful transmission; or

(d) if emailed – on the date of the email.

13.4 A fax or email sent after 5.00pm will be deemed to have been given at 9.00am on the next business day.

14. GENERAL PROVISIONS

14.1 This Contract supersedes and replaces all other Contracts, understandings or arrangements between the parties.

14.2 Subject to clauses 14.3, 14.4 and 14.5, the Authority can waive the benefit of any clause of this Contract.

14.3 A failure by the Authority at any time to enforce a clause of this Contract, or a forbearance, delay or indulgence granted by the Authority to the Health Service CE, does not constitute a waiver of the Authority's rights.

14.4 No provision of this Contract may be waived unless the waiver is in writing.

14.5 A waiver by the Authority of a breach of any provision of this Contract will not operate as a waiver of any subsequent breach of the same provision or as a waiver of any other provision.

14.6 This Contract is governed by the laws of Queensland and each party submits to the jurisdiction of the courts of Queensland.

14.7 If any part of this Contract is determined to be invalid, unlawful or unenforceable for any reason then that part, to the extent of the invalidity, unlawfulness or unenforceability, will be severed from the rest of the Contract and the remaining terms and conditions will continue to be valid and enforceable to the fullest extent permitted by law.

14.8 Subject to clause 14.9, any variation to this Contract must be in writing and signed by both parties.

14.9 The following matters do not constitute a variation:

(a) the location at which the Health Service CE is based; and

(b) a determination permitted to be made under this Contract or the Act from time to time, including a change to the Total Remuneration Package by the Chief Executive under the Act.

15. SPECIAL CONDITIONS

15.1 This Contract includes the special conditions, if any, set out in Item 8 of Schedule 1.

15.2 If there is a conflict between a special condition and:

(a) the Act - the Act prevails;

(b) the Applied Public Service Law - the Applied Public Service Law prevails; or

(c) another provision in this Contract - the special condition prevails.

SCHEDULE 1 - CONTRACT PARTICULARS

Item no.	Topic	Details
1.	Health Service CE (clause 1.1)	Dr Peter Anthony Steer
2.	Commencement Date (clause 1.1)	1 July 2012
3.	Expiry Date (clause 1.1) (must not be longer than 5 years from the Commencement Date)	30 June 2017
4.	Hospital and Health Service (clause 1.1)	Children's Health Queensland
5.	Total Remuneration Package (clause 1.1)	$500,000 per annum
6.	Address for service of notices for the Authority (clause 13.1)	
7.	Addresses for service of notices for the Health Service CE (clause 13.1)	Business Address: Royal Children's Hospital Herston Road HERSTON QLD 4006 Residential Address: 3 Othaki Road ASHGROVE QLD 4060
8.	Special Conditions (clause 15.1)	Not Applicable

Signed by the parties on the dates stated below

SIGNED by the chair of the board for the Hospital and Health Service in the presence of:

[redacted]
(signature of chair of the board)

23 / 8 / 12
(date)

[redacted]
(signature of witness)

Taresa Rosten
(name of witness)

SIGNED by the Health Service CE in the presence of:

[redacted]
(signature of Health Service CE)

20 / 8 / 12
(date)

[redacted]
(signature of witness)

Dianne Feige
(name of witness)

Terms of Reference

Chief Executive and Department of Health Oversight Committee

1. Purpose

The purpose of the Chief Executive and Department of Health Oversight Committee (CE DoH OC) is to provide strategic leadership and governance for the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy.

2. Guiding principles

- The *Health Services Act 1991*
- *Fourth National Mental Health Plan*
- *Queensland Plan for Mental Health 2007-2017*
- *Mental Health Act 2000*

3. Functions

The functions and objectives of the Oversight Committee include:

- Provision of executive leadership, strategic advice and advocacy in the implementation of Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) service options.
- To identify the priorities and objectives associated with the development and implementation of SW AETR services, and to endorse plans and actions to achieve these objectives.
- To oversight the development of a contemporary model of care for SW AETR services within the allocated budget.
- To provide a strategic forum to drive a focus on outcomes and achievement of the transition of SW AETR services to CHQ HHS.
- To facilitate expert discussion from key executive around planning, development, and implementation of SW AETR services.
- To oversee the management of strategic risks.
- To monitor overall financial management of the transition of AETR services from West Moreton HHS to CHQ HHS.
- Provision of guidance and oversight for communication and stakeholder planning.
- Provide an escalation point for the resolution of issues and barriers associated with implementation of the SW AETR services.

4. Authority

Members are individually accountable for their delegated responsibility and collectively responsible to contribute to advice provided by the Committee to the Chair in the interests of a whole-of-service position.

Decision Making:

- Decisions made by the Steering Committee will be by majority.
- Where group consensus cannot be reached in relation to critical decisions, the Chair takes the final position

5. Frequency of meetings

Meetings will be held monthly, following the Chief Executive Forums, or as required. The Chair may call additional meetings as necessary to address any matters referred to the Committee or in respect of matters the Committee wishes to pursue within the Term of Reference.

Attendance can be in-person or via teleconference mediums.

The Committee is life limited for the duration of development, implementation and evaluation of transition to CHQ HHS. The Chair will advise the Committee members approximately one month prior to the dissolution of the Oversight Committee.

6. Membership

Dr Peter Steer (Chair)	Health Service Chief Executive, CHQ HHS
Dr Michael Cleary	Deputy Director General, Health Service and Clinical Innovation Division
Mrs Lesley Dwyer	Health Service Chief Executive, West Moreton HHS
Dr Richard Ashby	Health Service Chief Executive, Metro South HHS
Mrs Julia Squire	Health Service Chief Executive, Townsville HHS
Dr Bill Kingswell	Executive Director, Mental Health Alcohol & Other Drugs Directorate
Ms Deb Miller	A/Executive Director, Office of Strategy Management, CHQ HHS
Mr Stephen Stathis	Clinical Director, CYMHS CHQ HHS
Ms Ingrid Adamson (Secretariat)	Project Manager, SW AETRS, CHQ HHS

Chair:
The Steering Committee will be chaired by the Health Service Chief Executive, CHQ, or his delegate. The delegate must be suitably briefed prior to the meeting and have the authority to make decisions on behalf of the Chair.

Secretariat:
Secretariat support will be provided by the Project Manager, SW AETRS or an alternate officer nominated by the Chair.

Proxies:
Proxies are not accepted for this Oversight Committee, unless special circumstances apply and specific approval is given for each occasion by the Chair.

Other Participants:
The Chair may request external parties to attend a meeting of the committee. However, such persons do not assume membership or participate in any decision-making processes of the committee.

7. Quorum

A quorum will comprise half of the voting members, including the Chair, plus one.

8. Performance and Reporting

The Secretariat is to circulate an action register to Committee members within three business days of each Committee meeting.

The Secretariat will coordinate the endorsement of status reports and other related advice to be provided, as required, to the Children's Health Queensland Hospital and Health Service Board. Members are expected to respond to out of session invitations to comment on reports and other advice within the timeframes outlined by the Secretariat. If no comment is received from a member, it will be assumed that the member has no concerns with the report/advice and it will be taken as endorsed.

9. Confidentiality

Members must acknowledge and act accordingly in their responsibility to maintain confidentiality of all information that is not in the public domain.

10. Risk Management

A proactive approach to risk management will underpin the business of this Committee. The Committee will:

- Identify risks and mitigation strategies associated with the implementation of the SW AETR services; and
- Implement processes to enable the Committee to identify, monitor and manage critical risks as they relate to the functions of the Committee.

Meeting Agenda

Chief Executive and Department of Health Oversight Committee

Date:	17th October 2013
Time:	12.30pm to 2pm
Venue:	Boardroom, Level 5, Woolworths Building, RCH, Herston
Teleconference Details:	Phone: Participant passcode: Moderator passcode: ***** Please advise secretariat if you are using T/C*****

A/Chair:	Dr Peter Steer	Health Service Chief Executive, Children's Hospital Queensland HHS
Secretariat:	Ingrid Adamson	Project Manager, SW AETRS, CHQ HHS
Attendees:	Mr Michael Cleary Mrs Lesley Dwyer Dr Richard Ashby Ms Deb Miller Mr Stephen Stathis Mrs Leanne Geppert	Deputy Director General, Health Service and Clinical Innovation Division Health Service Chief Executive, West Moreton HHS Health Service Chief Executive, Metro South HHS A/Executive Director, Office of Strategy Management, CHQ HHS Clinical Director, CYMHS CHQ HHS A/Director of Strategy, Mental Health and Specialised Services, West Moreton, HHS
Apologies:	Dr Bill Kingswell	Executive Director, Mental Health Alcohol & Other Drugs Directorate
Observers / Guests:		

1.	**Presentations**	
Item no	**Item**	**Action Officer**
1.0	Nil	

2.	**Meeting Opening**	
Item no	**Item**	**Action Officer**
2.1	Welcome and Apologies	Chair
2.2	Statement of Conflict/Interest	Chair
2.3	Confirmation of the minutes from the previous	Chair
2.4	Statement of achievements	Chair

3.	**Business Arising from previous minutes**	
Item no	**Item**	**Action Officer**
3.1	Nil	

4.	Matters for Decision	
Item no	**Item**	**Action Officer**
4.1	Oversight Committee Terms of Reference	Chair
4.2	SW AETRS Project Plan (endorsing amendments to timeframes)	Chair
4.3	Communication Strategy	Chair

5.	Matters for Discussion	
Item no	**Item**	**Action Officer**
5.1	SW AETR Service Options Update Brief	SS
5.2	Previous proposal regarding Logan Hospital site as an interim bed-base option	SS

6.	Standard Agenda Items	
Item no	**Item**	**Action Officer**
6.1		
6.2	**Risk Management**	
6.3	**Progress of key milestones and deliverables**	
6.4	**Other business**	

7.	Matters for Noting	
Item no	**Item**	**Action Officer**
7.1	**Major correspondence**	

8.	For Information (papers only)	
Item no	**Item**	**Action Officer**
8.1		

	Next Meeting
Date:	
Time:	
Venue:	

Statewide Adolescent Extended Treatment and Rehabilitation Initiative Update Brief

Barrett Adolescent Centre Consumer Status

There are currently less than twelve inpatients at the Barrett Adolescent Centre (BAC) and eight young people on the waitlist. The number of inpatients varies based on consumers who have returned to their family for holidays and as West Moreton Hospital and Health Service (WM HHS) progresses the discharge of consumers. There are also a number of day patients that access the BAC service and school.

The demographic of current admitted consumers is:

The average age of BAC consumers is 17 years old, The majority of current admitted BAC consumers will turn 18 in the coming six months and thus would be planned for discharge into alternate services given the age for admission to the BAC is only up to 18 years old. The average age of wait list consumers is 16 years old, with the youngest consumer at 13 years of age and the oldest being 17 years of age.

The average length of inpatient stay is currently 17 months, with the shortest stay being

Of the current inpatients at the BAC, the (top 3) primary diagnosis include:

- Social Phobias
- Post-Traumatic Stress Disorder
- Mixed Anxiety Disorder

Clinical Care Transition Panels have been planned for each individual young person (including those on the waitlist) at BAC, to review their individual care needs and support transition to alternative service options when they are available and as is relevant to individual care needs. The panel will consider all service options for the young people including wrap around (intensive and time limited) services.

The weekly Panels will be chaired by Dr Anne Brennan, A/Clinical Director BAC and will consist of a core group of BAC clinicians and a BAC school representative. Other key stakeholders (Hospital and Health Services, government departments and NGOs) will be invited to join the Panel as is appropriate to the particular needs of the individual consumer case that is being discussed at the time.

It is believed that the large majority of current BAC consumers will be discharged prior to January 2013. It is anticipated that whose discharge planning is more complex and whose needs may not be fully met through existing services, and particularly special attention will be required for their transition process. All options are being explored to ensure uninterrupted support and care for these individuals. Treatment options and transition plans currently include:

- Transfer back into the community with support from local CYMHS
- Admission into a Day Program Unit
- Transfer to an acute unit (where there are ongoing acute care needs)
- Support packages delivered through Department of Communities, Child Safety and Disabilities
- Non-Government Organisation mental health services/programs
- Primary care service support, e.g. headspace
- Housing support
- Transfer to adult mental health services/programs

The West Moreton Hospital and Health Board is committed to ensuring that all young people in BAC have alternative service options in place before the closure of the BAC building at the end of January 2014. The closure date is flexible and will be responsive to the needs of the consumer group.

Adolescent Mental Health Extended Treatment and Rehabilitation Service Options

The target group for adolescent extended treatment and rehabilitation (AETR) services has been defined as:

- 13 - 17 years youths, with flexibility in upper age limit depending on presenting issue and developmental (as opposed to chronological) age.
- Severe and persistent mental health problems that may include co-morbid alcohol and other drug problems, which significantly interfere with social, emotional, behavioural and psychological functioning and development.
- Mental illness is persistent and the consumer is a risk to themselves and/or others.
- Medium to high level of acuity requiring extended treatment and rehabilitation.

On 1st October, a forum was convened to explore current service options available and future opportunities. A range of representatives from across the state and Hospital and Health Service Districts attended this forum, including mental health clinicians across nursing, allied health and medical professions, a carer representative, and a non-government organisation representative.

Contributions at the forum identified the need for:

- More efficient utilisation of existing mental health (MH) services and resources
- Greater education and awareness regarding the MH services available, especially for primary care providers, carer representatives, and families
- Greater family support and involvement in MH care plans and interventions
- Inclusion of dual-diagnosis services for co-morbid alcohol and other drug problems
- Stronger linkages to adult MH services in so far as to ensure smooth transition from adolescent MH services
- Redirection of current resources into future service enhancements (i.e. move operational funds from BAC into a bed-based facility and additional day programs)
- More assertive outreach and mobile service options over extended hours
- Need for a multi-disciplinary clinical care review team to assess consumer needs and refer to the most appropriate service options to meet those needs

An issue identified during the forum, and out of scope of this initiative, is the need for services for 18 to 25 year olds, with MH problems not deemed appropriate for adult MH services.

Whilst work is continuing on reviewing the full spectrum of AETR service options, some common elements are emerging. These include:

1. A Statewide Multi-disciplinary Complex Care Panel (involving CYMHS Service Integration Coordinators (SIC)), with oversight of admissions to:
   a. Bed-based Non-Acute Inpatient Facility (located in SE Qld)
2. Additional Day Programs (potential locations could include Metro North and Gold Coast)
3. Enhanced Community MH Positions (such as Intensive Youth Mobile Services (IMYOS))
4. Residential Rehabilitation for each MH Cluster

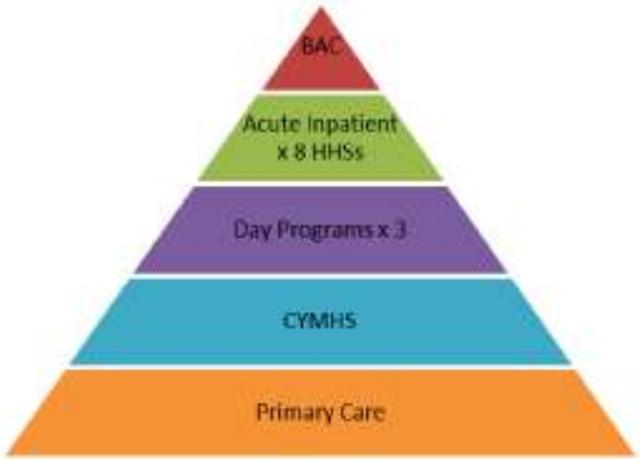
It is important to note that the bed-based non-acute inpatient facility proposed is not a replication of the existing BAC service approach. Specific differences include:

- 8 – 10 beds (down from 15 beds at BAC)
- Maximum 3 month stay, with extension based only on clinical requirements (down from 32 months at BAC)
- Assessment and referral to this facility by a multidisciplinary Statewide Clinical Care Panel (as opposed to a local clinical team)
- Discharge planning on entry with HHS undertaking to accept consumer on discharge, to ensure consumers are returned to their families and communities in an optimal timeframe to meet their clinical and care needs

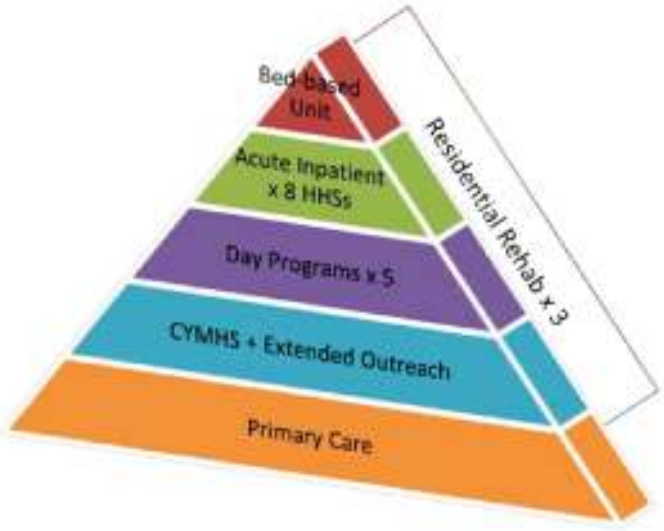
Figure 1 below depicts the current state of service options and a proposed future state of service options (pending further scoping), including the elements mentioned above.

Underpinning this model is a fundamental assumption that the consumer, family and community are central to the services and treatment outcomes.

Figure 1



Current State



Proposed Future State (pending further scoping)

Next Steps:

- Collate population data and supporting evidence to confirm service options required and their location (underway).
- Site visit to NSW to inspect their bed-based facility (23 October)
- Identification of the financial and workforce requirements for future service options
- Development of governance arrangements for future service options
- Refinement of service options into an AETR Service Model for endorsement by end November 2013
- Continuing communication regarding service options development with stakeholders, specifically consumers and families (CHQ HHS Communication Strategy under development).
- WM HHS continues to maintain open communication with current and past families and consumers of the BAC and BAC staff.

Project Plan

Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy

Children's Health Queensland Hospital and Health Service

September 2013

V 0.4

A DOCUMENT PURPOSE

The Project Plan is used to guide the project implementation and the process for project control. It defines:

- project approach and strategy
- responsibilities and accountabilities for project strategies/ tasks
- project schedule, including key milestone points and the delivery of identified outputs
- dependencies within the project and with other projects
- resources required (financial, human and material), and financial management processes
- risk management strategies
- communication management strategy
- human resource management strategies

The project plan is also used to facilitate communication among the stakeholders.

B DOCUMENT CONTROL

Version	Date	Prepared by	Comments
V0.1	30/07/13	A/Director of Strategy, MH&SS, WM HHS	Initial draft for consideration with key stakeholders.
V0.2	01/08/13	A/Director of Strategy, MH&SS, WM HHS	Revisions made following meeting with Sharon Kelly, Stephen Stathis and Judi Krause 01/08/13.
V0.3	16/08/13	A/Director of Strategy, MH&SS, WM HHS	Revisions made following meeting with Stephen Stathis and Judi Krause on 15/08/13 and based on CE teleconference 16/08/13.
V0.4	19/09/13	Project Manager, SW AETRS	Revised for CHQ HHS format

**Drafts should use format vX.1 (e.g. start at v0.1). Final versions should use format vX.0 (e.g. v1.0).*

Distribution

Name	Title	Function*
	Chief Executive and Department of Health Oversight Committee	Approve
	SW AETR Steering Committee	Review
Sharon Kelly	Executive Director Mental Health & Specialised Services	Feedback
Deborah Miller	A/Executive Director, Office of Strategy Management, CHQ HHS	Feedback
Judi Krause	Divisional Director CYMHS CHQ HHS	Feedback
Stephen Stathis	Clinical Director, CYMHS CHQ HHS	Feedback
Leanne Geppert	A/Director of Strategy, MHSS WM HHS	Feedback

**Functions include: Approve, Review, Feedback*

Document Storage and Archive

During conduct of the project, documentation will be stored electronically under: \\Qldhealth\.qhb-cl3_data13.qhb.co.sth.health\CHQ\District - Office of Strategy Management\Projects\SW AETR.

A standard directory structure and file naming convention will be developed for use by the Project Manager.

C GLOSSARY

Abbreviation	Meaning
BAC	Barrett Adolescent Centre
CE	Health Service Chief Executive
CE DoH Oversight Committee	Chief Executive and Department of Health Oversight Committee
CHQ EMT	Children's Hospital Queensland Executive Management Team
CHQ HHS	Children's Hospital Queensland Hospital and Health Service
CYMHS	Child and Youth Mental Health Services
DETE	Department of Education Training and Employment
ECRG	Expert Clinical Reference Group
HHSs	Hospital and Health Services
MH	Mental Health
MHAODB	Mental Health Alcohol and Other Drugs Branch
MHSS	Mental Health and Specialised Services
NGO	Non-Government Organisation
QPMH	Queensland Plan for Mental Health
SW AETR	Statewide Adolescent Extended Treatment and Rehabilitation
SW AETRS	Statewide Adolescent Extended Treatment and Rehabilitation Strategy
The Park	The Park Centre for Mental Health
WM HHS	West Moreton Hospital and Health Service

TABLE OF CONTENTS

1 Project Description

1.1 Background

Queensland's public mental health system has undergone significant reform over the past ten years. The reform agenda includes a shift from institution-based service models, including extended treatment and rehabilitation, to more contemporary models of care that align with state and national policy. The impact of these important reforms has seen the care of consumers move primarily into community-based settings, where they are supported to engage in their own local neighbourhoods and facilities. This has been particularly vital for consumers requiring medium to longer-term care.

In alignment with the Queensland Plan for Mental Health 2007-17 (QPMH), a key area for reform within Mental Health and Specialised Services (MHSS) in the West Moreton Hospital and Health Service (WM HHS) is the development of The Park Centre for Mental Health (The Park) as an adult-only forensic and secure mental health campus. The high secure services have been expanded and, in July 2013, a new service option was established on campus, the Extended Forensic Treatment and Rehabilitation Unit.

In light of these significant changes, it is no longer safe or contemporary to provide long-term inpatient care for adolescents at the Barrett Adolescent Centre (BAC) on The Park campus. Compounding these changes at a service provision level, the existing infrastructure of the BAC is unable to be refurbished and the building will be decommissioned.

Through Stage 1 of the QPMH, an adolescent extended treatment unit was funded to replace the existing 15-bed BAC. The replacement service was to be located at Redlands within Metro South HHS, and had an indicative commissioning date of November 2013. Upon operation of the replacement 15-bed unit, the existing BAC would be decommissioned.

The Redlands adolescent extended treatment capital program encountered multiple delays and a significant budget over-run. There were unresolvable environmental barriers associated with the site, and the Department of Health ceased the development and redirected the capital funds toward other high priority health initiatives. Operational funding for the Redlands Facility, of approximately $2 million for 2013/14, has been retained and approved by the Department of Health to fund new adolescent mental health extended treatment and rehabilitation service options.

In December 2012, WM HHS initiated the Barrett Adolescent Strategy to identify new service options for adolescents requiring mental health extended treatment and rehabilitation in Queensland. An Expert Clinical Reference Group (ECRG) was convened, consisting of a consumer representative, a carer representative, an interstate Child and Youth Psychiatrist, multi-disciplinary Child and Youth clinician representation (including north Queensland), a representative of BAC, a representative of the BAC School, and a Non-Government Organisation (NGO) representative. The ECRG was chaired by the Director of Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch (MHAODB). The ECRG reported up to the WM HHS via a Planning Group, which was chaired by the Executive Director of Mental Health & Specialised Services, WM HHS.

In May 2013, a preamble and seven recommendations were submitted by the ECRG and considered by the WM HHS Board (Attachment 1). This was followed by comprehensive consultation with the Minister for Health, the Queensland Mental Health Commissioner, CHQ HHS,

Department of Education Training and Employment (DETE), and the Department of Health. The seven recommendations were accepted by the WM HHS Board.

On 6 August, 2013, the Minister for Health, the Honourable Lawrence Springborg MP made an announcement that adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Young people receiving care from the Barrett Adolescent Centre at that time will be supported through their transition to other contemporary care options that best meet their individual needs.

1.2 Business Need

To deliver on the Minister's commitment, a new statewide mental health service model for adolescent extended treatment and rehabilitation (AETR) is required by early 2014.

The foundation work for this initiative has now concluded and approval is sought to move into the implementation phase, of which this Project Plan forms the basis.

1.3 Purpose / Objective

- Develop service options within a statewide mental health model of service for adolescent extended treatment and rehabilitation, within a defined timeline.
- Develop an Implementation Plan to achieve the alternative model of service for adolescent mental health extended treatment and rehabilitation, within a defined timeline (noting mobilisation of implementation activities will occur as a separate project phase).
- Ensure continuity of care for adolescents currently admitted to BAC, and on the wait list, through a supported discharge / transition process to the most appropriate care option/s that suit individual consumer needs, and that are located in (or as near to) their local community.
- Within the context of a changing service model in early 2014, review the admission criteria to BAC for all new consumers post 5 August 2013.
- Oversee the redistribution of BAC operational funds, and other identified funding, to adolescent mental health service models to support the identified target group.
- Develop a consistent and transparent Communication Plan regarding the implementation of the new service options.
- Consider in all decision-making the key principles and recommendations as defined through the ECRG and Planning Group of the Barrett Adolescent Strategy (Attachment 1).
- Discharge all adolescents from the BAC facility by 31 January 2014, to enable finalisation of The Park campus as an adult-only forensic and secure mental health service facility.

1.4 Outcome and Benefits

Achievement of the project purpose will create a range of benefits including:

- High quality, effective extended treatment and rehabilitation mental health service options available to consumers that are based on contemporary models of care and take into account the wide geographical spread of Queensland.
- Increased access for adolescent consumers to their families, community and social networks by having greater access to more local mental health services.
- Improved, strengthened inter-sectoral partnerships in delivering adolescent mental health care.
- Value for money in the delivery of care for adolescents requiring extended treatment and rehabilitation mental health care.

1.5 Assumptions

- Key stakeholders will work in partnership to implement this phase of the initiative. The lead governing body for the project will be CHQ HHS, in partnership with WM HHS and the Department of Health.
- Identified funding sources will remain available to the identified adolescent target group and their mental health service needs. The identified funding sources include:
    - BAC operational funding (amount to be defined);
    - $2 million operational funding from the ceased Redlands Adolescent Extended Treatment and Rehabilitation Unit;
    - $1 million operational funding for NGO-delivered services (e.g. Residential Rehabilitation); and
    - Other potential Department of Health funding as defined by Mental Health Alcohol and Other Drugs Branch. This will include temporary 'bridging' funds to support the transition process from the current service model to the newly defined service options.
- The Mental Health Alcohol and Other Drugs Branch will provide project funding of $300,000 to support the temporary appointment of two project officers to CHQ HHS and one project officer to WM HHS.
- The stakeholders of this project will contribute resources (including staff time and content expertise) for the duration of the project.
- Timely approval will be received from the project stakeholders to enable major stages of the project to be implemented as planned.
- The Steering Committee and Working Groups will commit to action tasks both in and out of session to meet defined timelines, and thus support the timely completion of this project and the achievement of outcomes for the consumer group.
- Timeframes associated with this project will align with the timeframes for procurement processes to engage NGO services.

- The transfer of consumers to alternative care options will be underpinned by individual consumer choice and health care needs, and will be supported by the relevant 'home' Hospital and Health Service (HHS).
- Workforce management strategies, to support BAC staff, will be developed and managed by WM HHS.
- The governance of the new service options will be held by CHQ HHS and a model will be defined as a priority.
- The site/s for delivery of any potential bed-based service option will be identified and governance arrangements will be defined as a priority.
- Consideration will be given to all recommendations for service needs that were defined by the ECRG. This will also include consideration of alternative contemporary service options including Intensive Mobile Youth Outreach Services, Day Programs, residential rehabilitation services, and bed-based services.
- Service options identified will be modified (as required) to suit the needs of the target group within a Queensland setting, and will take into account the wide geographical spread of Queensland.
- Service options will broadly align with the draft National Mental Health Service Planning Framework.
- Not all service options within the statewide model that will be proposed will be available by early 2014. However, there is a commitment to ensure there is no gap to service delivery for the adolescent target group.

1.6 Constraints

- There is no capital funding currently identified to build new infrastructure.
- Transfer processes and time frames of operational funding to new service providers and HHSs need to be defined and negotiated.
- Timeframes and imperatives associated with the procurement processes of NGO contracting may be restrictive to timely progress.
- Alternative service options for BAC consumers must be available by early 2014, when The Park transitions to an adult-only forensic and secure mental health facility.
- Service options will align with the following strategic and planning directions:
  1. *National Mental Health Service Planning Framework (under draft)*
  2. *The Blueprint for better healthcare in Queensland* (2013)
     a. Health services focused on patients and people;
     b. Providing Queenslanders with value in health services;
     c. Investing, innovating and planning for the future.
  3. *Queensland Plan for Mental Health (2007-17) (QPMH)*
     a. Integrating and improving the care system;
     b. Participating in the community;
     c. Coordinating care.
  4. *Business Planning Framework: A tool for nursing workload management – Mental Health Addendum*

- Service options will meet in-scope activity based funding classifications as defined by the Independent Hospital Pricing Authority (2013-14), which includes:
    - All admitted activity
    - Crisis assessment and treatment
    - Dual diagnosis
    - Home and community-based eating disorders
    - Mental health hospital avoidance programs
    - Mobile support and treatment
    - Perinatal
    - Step-up step-down
    - Telephone triage
- CYMHS non-admitted activity is currently deemed out-of-scope by Independent Hospital Pricing Authority (2013-14). It should be noted that this may have financial implications for the model of service developed. In the meantime, the Mental Health Alcohol and Other Drugs Branch (MHAODB) are advocating for CYMHS non-admitted activity to be 'in-scope' for Activity Based Funding.
- Queensland has early / developing experience in the delivery of some models being proposed (e.g. models like Y-PARC, Intensive Mobile Youth Outreach Service, residential rehabilitation for adolescent mental health consumers, and other partnership models between the public and non government sectors).

1.7 Dependencies

There are no identified project inter-dependencies identified.

1.8 Project Scope

1.8.1 In-Scope

- End-to-end recovery-oriented adolescent mental health extended treatment and rehabilitation services
- Linkages to other adolescent mental health services that do not meet the definition of mental health extended treatment and rehabilitation services (such as acute, forensic, and Community CYMHS)
- Linkages to Adult Mental Health Services in so far as to ensure smooth transition from Adolescent Mental Health Services
- Linkages to primary care service providers in so far as to ensure smooth transition to and from Adolescent Mental Health Services
- Governance and resource arrangements for the statewide adolescent mental health extended treatment and rehabilitation services, including, financial, workforce, and assets.
- The target consumer group is:
    - 13 - 17 years old, with flexibility in upper age limit depending on presenting issue and developmental age (as opposed to chronological age).
    - Severe and persistent mental health problems that may include co-morbid alcohol and other drug problems, which significantly interfere with social, emotional, behavioural and psychological functioning and development.
    - Mental illness is persistent and the consumer is a risk to themselves and/or others.
    - Medium to high level of acuity requiring extended treatment and rehabilitation.

1.8.2 Out of Scope

- Individual consumer clinical treatment plans
- Current BAC facility operations
- Decommissioning of the BAC building
- Any system requirements or enhancements for electronic consumers records
- Implementation of new service options (will occur as a separate project phase)
- Other adolescent mental health services that do not meet the definition of mental health extended treatment and rehabilitation services (such as acute, forensic, and Community CYMHS)
- Non-adolescent mental health services
- Primary care service providers and their processes

1.8.3 Scope Changes

Scope changes will be managed under the Project Control approach as per **Section 2.8**.

2 Project Planning

2.1 Project Overview

2.1.1 Related Projects/Activities

Service Planning in Queensland:

- Queensland Plan for Mental Health 2007-17
- CYMHS in Queensland
- CHQ Transition Strategy
- Service Planning Frameworks and Funding Models
- Clinical Services Capability Framework for Public and Licensed Private Health Facilities v3.1
- Business Planning Framework: A tool for nursing workload management – Mental Health Addendum

Service Planning in Australia:

- National Mental Health Service Planning Framework

Awaiting further input from Marie Kelly, Information and Planning Unit, MHAODB (re other MH projects/activities that might impact)

2.2 Key Deliverables

The table below details the key milestones / products / activities to be delivered by the project:

Key Milestone / Product / Task / Activity	Responsible Officer	Completion Date
Project Initiation	Ingrid Adamson	30 August 2013
Project Plan and Communications Strategy	Ingrid Adamson	22 October 2013
BAC Consumer and Staff Engagement Strategy	Leanne Geppert	22 October 2013
SW AETR Service Model	Stephen Stathis	30 November 2013
Governance Model (including financial and workforce requirements) for the SW AETR Service Model	Ingrid Adamson	30 November 2013
Interim consumer clinical care plans (for current BAC and wait list consumers)	Anne Brennan	31 December 2013
Implementation Plan for SW AETR Service Model	Ingrid Adamson	31 January 2014
Mobilisation of Phase Two: Service Options Implementation	Stephen Stathis / Ingrid Adamson	February 2014

2.3 Cost Management

2.3.1 Budget

Direct Labour	Stream/Level	FTEs	Total Cost
CHQ – HSS: Project Manager 09/09/13 to 30/06/14 (10 months) Clinical Director 14/10/13 to 13/12/13 (10 weeks)	 AO8.4 MO2.2	 1 0.4	 $ 120,000 $ 30,000
WM HHS: Project Officer 23/09/13 to 30/06/14 (10 months)	 AO7	 1	 $ 100,000
TOTAL			**$ 250,000**
Additional Requirements			**Total Cost**
Communication and media strategies to raise awareness of initiative and promote new service model Room hire and catering expenses for workshops and forums Travel expenses for clinical representation at workshops and forums Travel expenses for interstate MH site visits Other additional administrative overheads			**$ 50,000**
TOTAL PROJECT BUDGET			**$ 300,000**

Source of Funding

- MHAODB has committed to providing temporary project funding to CHQ HHS and WM HHS for 2013/2014.
- Secretariat and Chairing of Steering Committee is the responsibility of CHQ HHS.
- All matters related to the BAC closure is the responsibility of WM HHS

Ongoing Operational Funding:

Operational Funding for new/enhanced service options will be sourced from:

- BAC operational funding (to be defined);
- $2 million operational funding from the ceased Redlands Adolescent Extended Treatment and Rehabilitation Unit;
- $1 million operational funding for NGO-delivered services (e.g. Residential Rehabilitation); and
- Other potential Department of Health funding as defined by Mental Health Alcohol and Other Drugs Branch. This will include temporary 'bridging' funds to support the transition process from the current service model to the newly defined service options.

2.3.2 Responsibilities

The table below shows details of the cost management/monitoring activity and who is responsible:

Cost Management Activity	Responsible	When and How
Project expenditure	Project Manager, SW AETRS	Existing cost centre management practice

2.4 Time Management

2.4.1 Schedule

The draft project schedule is shown as a high level Gantt chart at **Appendix A**.

2.4.2 Schedule Changes

Changes will be managed under the Project Controls Approach as per **Section 2.8**.

2.5 Human Resource Management

2.5.1 Resource Plan

The table below contains a list of the human resources required for the project.

Role	FTE	Employee/ Contractor	Name(s) (if known)	From	To
Project Manager	1	Employee	Ingrid Adamson	09/09/13	30/06/14
Project Officer	1	Employee	Laura Johnston	23/09/13	30/06/14
Clinical Director	0.4	Employee	Stephen Stathis	14/10/13	13/12/13

2.6 Risk Management

2.6.1 Overall Assessment of Project Risks

Significant key risks to the project are listed below:

Risk Event & Impact	Rating	Treatment	Owner
Project Performance			
Schedule compliance – timeframes are exceeded	High	• Active monitoring and reporting • Variances reported to SW AETR Steering Committee and escalated to CE DoH Oversight Committee, where required	Project Manager
Scope creep	Medium	• Active monitoring and reporting • Variance reported to SW AETR Steering Committee and escalated to CE DoH Oversight Committee, where required	Project Manager
Insufficient funding	Medium	• Active monitoring and reporting • Variance reported to CE DoH Oversight Committee, where required	Project Manager
Communication gaps between Working Groups, Committees, and other forums	Medium	• Project Manager to act as consistent conduit between all parties • Regular status updates to all parties	Project Manager with CHQ Media and Comms

Risk Event & Impact	Rating	Treatment	Owner
Current Health Service Delivery			
Loss of specialist BAC staff	Medium	• Recruitment of contractors, in the interim, to meet service needs • Enact communication strategies to keep staff, and other stakeholders informed • Develop recruitment strategy for future service options	WM HHS CHQ HHS
Union action in response to employees requiring placement	Medium	• Engage with union and keep informed of workforce strategies	WM HHS
BAC incident resulting from co-location of adult forensic consumers	Medium	• Timely discharge of consumers • Park Campus safety and security measures	WM HHS
Critical incident with an adolescent during transition from BAC facility	Medium	• Appropriate, detailed Consumer Clinical Care Transition Plans	WM HHS and Local HHS
Negative messages given to families and carers	High	• Regular, open, transparent communications with families, carers, and consumers	WM HHS
Future Health Service Delivery			
Poor quality of service options developed	Medium	• Undertake sufficient research to inform service option development, and to instil confidence in the service model • Manage timeframes to allow quality development of service options • Consult with stakeholders to test validity of service model • Pilot service options with current BAC and wait list consumers • Engage with other Departments and organisations to ensure comprehensive service model (e.g. DETE, Child Safety, Housing, headspace, etc.)	CHQ HHS
Low level of support for new service options/service model	High	• Clear communication strategies regarding impact of change and benefits • Training, education and support for staff	CHQ HHS
Absence of capital and growth funding to support services	High	• Utilise existing operational funds • Explore operational expenditure options versus capital intensive options • Advocate for additional funding to support service options	CHQ HHS
Critical incident with an adolescent prior to availability of new or enhanced service options	High	• Appropriate Consumer Clinical Care Plans • Clear communication strategies with service providers regarding the development and rollout of service options • Develop an escalation process for referral of consumers whose needs fall outside of existing service options	Local HHS CHQ HHS

Risk Event & Impact	Rating	Treatment	Owner
Reputational Risk			
Reputational and political implications from any adverse incidents or media	High	• Clear communication strategies regarding impact of change and benefits • Proactive workforce and community engagement • Regular communication to Premier, Minister, and CEs regarding initiative, to keep fully informed of progress and issues	WM HHS and CHQ HHS

Risk severity has been determined using the risk matrix (as per CHQ HHS Risk Management Process).

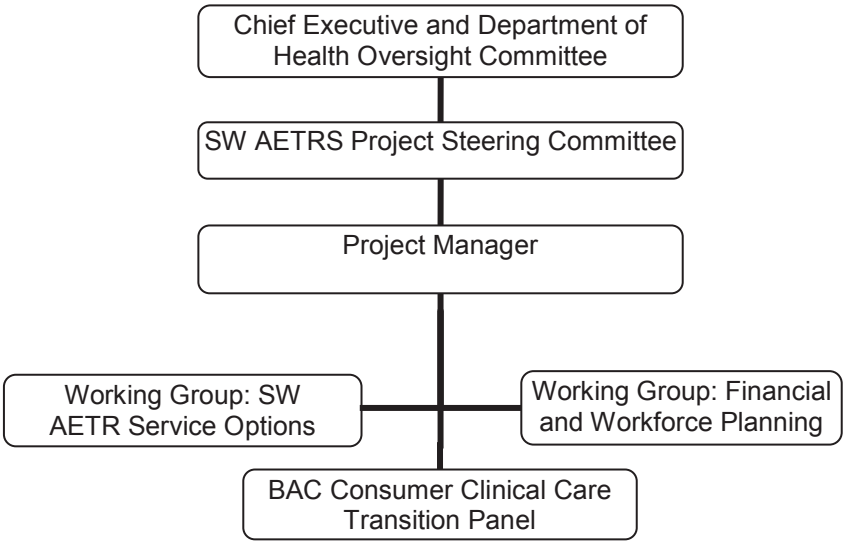
2.6.2 Risk Register

A Risk Register will be maintained to track the identified risks, their severity, and manage their treatment.

2.7 Project Governance and Control

2.7.1 Project Organisation

The diagram below identifies the Project Organisation and the reporting relationships of the Project team:



2.7.2 Roles and Responsibilities

Refer to **Appendix B** for details of the responsibilities of the project positions.

2.8 Project Controls

2.8.1 Reporting

The table below outlines the project reporting to be completed:

Report	Communication	Audience	Frequency
Update Briefs	Prepared by the Project Manager to provide a summary of progress	Project Sponsor Steering Committee CE DoH Oversight Committee CHQ EMT MH Clusters	Fortnightly
Status Report	Prepared by the Project Manager to provide a summary of progress, achievements, issues and risks	Project Sponsor Steering Committee CE DoH Oversight Committee	Monthly
Board Paper	Prepared by the Project Manager to provide a summary of progress, achievements, issues and risks	CHQ Board	Monthly
Project Issue and Change Request	Prepared by the Project Manager when Exception Planning or other action is determined by the key stakeholders	Project Sponsor Steering Committee	As required
Project Completion Report	Prepared by the Project Manager at the end of the project; to include follow-on action recommendations and lessons learned.	Project Sponsor Steering Committee	End of Project

2.8.2 Tolerance

The Project Manager is to report exceptions to the Project Sponsor and Steering Committee if at any time:

a) The forecast project milestone dates will not be met, or
b) The financial expenditure target is likely to vary by +/- 5%.

The following indicates the tolerances for this project as approved by the Project Sponsor:

Tolerances	Project Sponsor	Project Manager
Risk	One risk moves from High to Extreme	One risk moves from High to Extreme
Time	+ or – one week	+ or – one week
Cost	+ or – 5% change in $	+ or – 5% change in $

Tolerances	Project Sponsor	Project Manager
Quality	Less than 90% acceptance criteria met	Less than 90% acceptance criteria met
Customer Expectations	Less than 90% acceptance criteria met	Less than 90% acceptance criteria met

2.9 Communication Management

The Statewide Adolescent Extended Treatment and Rehabilitation Strategy Communications Plan will outline the detail regarding proactive engagement of all relevant stakeholders throughout this initiative. Below is a list of these key stakeholders and their information needs.

2.9.1 Key Internal Stakeholders

Group/Individual	Impact / Influence	Summary of Information Needs
Premier and Minister for Health	Strategic oversight	Progress updates and issue awareness • Briefs • Speaking notes
DDG Health Services and Clinical Innovation	Strategic oversight	Progress updates and issue awareness • Briefs • Status reports
Qld Mental Health Commissioner – Lesley van Schoubroeck	Strategic oversight	• Briefs
CHQ HHS: The Board CE – Peter Steer ED – Deb Miller	Project Sponsor Responsible for: • Governance of the project • Development of the future model of service • Provision of information and support to staff impacted by new service options • Communications and media regarding the future model of service • Achievement of project objectives	Complete visibility of initiative progress, including risks and issues • Project Documentation • Regular communiqués • Status Reports
WM HHS: The Board CE – Lesley Dwyer ED – Sharon Kelly	Project Partner Responsible for: • Clinical care for current BAC and wait list consumers • Transition of BAC operational funding • Provision of information and support to BAC staff	Complete visibility of initiative progress, including risks and issues • Project Documentation • Regular communiqués • Status Reports

Group/Individual	Impact / Influence	Summary of Information Needs
	• Communications and media regarding BAC • Achievement of project objectives	
Mental Health, Alcohol and Other Drugs Branch ED – Bill Kingswell	Project Partner Responsible for: • Funding for the project and identified service options • Provision of national and state information and data regarding policy and service planning as relevant to the project • Participate in statewide negotiations and decision-making	Visibility of initiative progress, including risks and issues • Project Documentation • Regular communiqués • Status Reports
Executive Director, CYMHS - Judi Krause	Steering Committee Co-Chair	Complete visibility of initiative progress, including risks and issues • Project Documentation • Regular communiqués • Status Reports
Clinical Director, CYMHS – Stephen Stathis	Steering Committee Co-Chair	Complete visibility of initiative progress, including risks and issues • Project Documentation • Regular communiqués • Status Reports
Other HHSs with acute inpatient units and MHSS	• Service provision to consumers • Participate in discussions and negotiations relevant to the service options being considered • Work collaboratively to support the transition of consumer care back to 'home' HHS as relevant to individual consumer needs	Awareness and understanding of interim service options during transition period and endorsed future service options, through: • Briefs • Regular communiqués
Mental Health Executive Directors, Clinicians and other staff	• Service provision to consumers • Participate in discussions and negotiations relevant to the service options being considered • Work collaboratively to support the transition of consumer care back to 'home' HHS as relevant to individual consumer needs	Awareness and understanding of interim service options during transition period and endorsed future service options, through: • Briefs • Regular communiqués
BAC Staff	• Service provision to BAC consumers	Implications of service changes to consumers and own employment • Regular communiqués

2.9.2 Key External Stakeholders

Group/Individual	Impact / Influence	Summary of Information Needs
Department of Employment, Training, and Education	Service provision to consumers Adapt current service delivery to suit new service options identified	Awareness and understanding of interim service options during transition period, and endorsed future service options
Mater Hospital	Service provision to consumers	Awareness and understanding of interim service options during transition period, and endorsed future service options
NGOs	Service provision to consumers Work collaboratively to support the transition of consumer care back to 'home' HHS as relevant to individual consumer needs	Awareness and understanding of interim service options during transition period, and endorsed future service options
Carer Representatives	Impact on the consumer/s they are representing	Enhanced service delivery options to meet increasing demands
Families	Direct impact on their family	Availability of enhanced mental health care options for their children
Existing and Potential Consumers	Direct personal impact	High quality mental health service options closer to home
Interstate Mental Health Counterparts	Participate in discussions regarding contemporary service options	Contribution sought for service model development Understanding of impact of Qld changes to their MH services, if any
SaveBarrett.org group	Influence on community perception of initiative	Provide clear, informative, transparent messages to reduce negative or speculative information
Media	Influence on community perception of initiative and public image of Qld Health	Provide clear, informative, transparent, positive messages to reduce negative or speculative information
Unions	Influence on QH workforce	Provide clear, informative, transparent, positive messages to reduce negative or speculative information
Opposition Parties	Influence on community perception of initiative and public image of current government	Provide clear, informative, transparent, positive messages to reduce negative or speculative information

Communication and engagement mechanisms include, but are not limited to:

- Committee & Working Group participation
- Information Fact Sheets
- Briefing Notes
- Speaking Notes
- Status Reports
- Face-to-face briefings and presentations
- Phone and email communication
- E-Alerts
- Intranet and Internet web pages
- Media releases and responses
- Community announcements

2.10 Quality Management

2.10.1 Applicable Standards

Standards which apply to deliverables produced by this project, or management of the project, are detailed in the table below:

Project Element	Applicable Standard
Project Management	Queensland Health / Children's Health Queensland (CHQ) Methodology
Risk Management	CHQ Risk Management Framework
Procurement	Qld Government's State Purchasing Policy – (refer to the latest version)

2.10.2 Quality Control Activities

The table below identifies the quality criteria for each major product and the technique for checking its quality:

Deliverable	Quality Criteria	How
Statewide adolescent mental health extended treatment and rehabilitation service model	Evidence-based Sustainable Statewide No gaps in service delivery Conforms with other national or international models	Stakeholder feedback on quality of model
Successful discharge and transition management of all current BAC and waitlist consumers	Individual needs are being met Mental health outcome measures Continuity of service	Consumer/family feedback and clinical outcomes
Service Implementation Plan	Clearly identified timeframes, activities, and stakeholders involved in the delivery of new or enhanced service options	Stakeholder feedback on comprehensiveness of plan
Communication Plan	Awareness of the project Understanding of the outcomes Engagement throughout delivery	Volume and nature of stakeholder feedback

2.10.3 Responsibilities

Responsibilities	Who
Define, implement, and control project quality Ensure that the project products, processes, and deliverables satisfy the requirements of this project plan Examine and escalate, as required, any reported deficiency	Project Manager
Ensure timeliness of each project task (as scheduled in Gantt Chart)	Project Manager
Ensure the quality of the products and deliverables	Project Sponsor Project Manager

Responsibilities	Who
Make critical decisions regarding the project and its product	Project Sponsor
Maintain the Deliverables Register, listing documents, their reviewers and recording that the review has occurred.	Project Manager

3 Project Evaluation

3.1.1 Project Evaluation Methodology (Process and Impact Evaluation)	Timely management of risks, issues, and deliverables Compliance with CHQ project management methodology
3.1.2 Post Implementation Review (PIR) (Outcome Evaluation)	Achievement of project objectives and outcomes: • Consumer, family, and carer feedback reflecting quality, effectiveness, and accessibility of extended treatment and rehabilitation mental health service options. • Service data demonstrating increased local access to extended treatment and rehabilitation mental health services, and demand management across Queensland. • Staff feedback demonstrating improved service provision across Queensland. • Feedback from service providers demonstrating improved, strengthened inter-sectoral partnerships in delivering adolescent mental health care. • Financial assessment demonstrating value for money in the delivery of care for adolescents requiring extended treatment and rehabilitation mental health care.

4 Recommendations (Project Manager)

Next Step	☒ Progress to Implementation* ☐ Cease Comments:		
	Prepared By	Name*:	Ingrid Adamson
		Title*:	Project Manager – SW AETRS
		Work Unit / Site*:	Office of Strategy Management
		Date*:	14/10/13
		Phone Number*:	
		Email*:	
	Prepared and Cleared By	Name*:	Judi Krause
		Title*:	Executive Director
		Work Unit/Site*:	CYMHS
		Phone Number*:	
		Email*:	
		Signed*:	
		Date*:	14/10/13
		Comments:	
	Prepared and Cleared By	Name*:	Stephen Stathis
		Title*:	Clinical Director
		Work Unit/Site*:	CYMHS
		Phone Number*:	
		Email*:	
		Signed*:	
		Date*:	14/10/13
		Comments:	

5 Approval by Executive Management Team Member

Name:	Dr Peter Steer
Title:	Health Service Chief Executive, CHQ HHS
Signature:	
Date:	
Comments:	

APPENDIX A: PROJECT GANTT CHART

Under development

APPENDIX B – ROLES AND RESPONSIBILITIES

Role	Responsibilities and Accountabilities
Project Sponsor	• Ultimately responsible and accountable for the delivery of project outcomes • Ensure the purpose of the project is clearly articulated to all stakeholders and aligns with the strategic direction of the organisation/s • Ensure the project's deliverables appropriately reflect the interests of stakeholders • Endorse the selection of a project manager with skills and experience commensurate with the project's strategic significance, cost, complexity and risk • Negotiate membership of and Chair the project Steering Committee to ensure that its composition adequately reflects the interests of key stakeholders • Ensure the project is appropriately and effectively governed • Receive status reports concerning the progress of the project and assist the project accordingly by resolving escalated issues; and • Advocate for the project to ensure the appropriate level of internal and external support and access to resources required to successfully complete it
Steering Committee	The Steering Committee monitors the conduct of the project and provides advice and guidance to the project team and the Project Sponsor. The general responsibilities of the Steering Committee include: • reviewing progress of project to plan and major project deliverables; • reviewing financial status of project (actual to budget) and monitoring the continued applicability of project benefits; • reviewing issues raised and agreeing action plans for their resolution; • understanding and advising the risks of the project raised with the Committee; • understanding and providing advice for the management of the dependencies of this project with other projects; Specific responsibilities of the Steering Committee are to: • Review key deliverables of the Working Group and Reference Group prior to approval by Project Sponsor. • Inform decision making regarding changes to the project and provide oversight to the change control process (e.g. system changes, schedule alterations, budget). • Provide expert advice to the Project Sponsor on the communication plan, training strategy and implementation timetable. • Facilitate communication to a wide variety of stakeholders in