Care Unit at Gailes, meant that staffing needs within WMHHS were in a state of change and it was appropriate to review staffing needs across the whole service.

(d) Inappropriate rostering and overtime practices had developed informally within The Park which were contributing to a significant overspend on staff costs.

(e) There was room for improvement in the nursing skills mix across many of the units, where staffing consisted solely or substantially of registered nurses but a mix of registered nurses and enrolled nurses would be as efficient.

12.5 I appointed Sharon Kelly to the position of Executive Director Mental Health and Specialised Services and one of her key responsibilities was the development of a plan for WMHHS which addressed these issues and delivered an on-budget result.

12.6 Ms Kelly was supported in this work by Chris Thorburn, Acting Director of Services Redesign, who had a background in mental health services. The outcome of that work as the Business Case for Change which was presented to the Minister for Health in December 2012. Attached and marked **LD-12** is a copy of the Business Case for Change.

12.7 Preparation of the Business Case for Change occurred over the second half of the 2012 calendar year. It was during that time that the Redlands project was cancelled and work was commenced in relation to considering other options. The Business Case for Change reflected that, stating that "an ECRG will provide advise to promote the development of a contemporary evidence based model of care to meet the needs of adolescent mental health consumers who require medium to longer term treatment and rehabilitation in Queensland' and "It is not possible at this stage to incorporate this into the Business Case".

12.8 As this reflects, the closure of BAC was not a result of the Turnaround Plan nor was it an initiative resulting from the Turnaround Plan.

12.9 WMHHS was block funded for BAC and closure of BAC simply meant that the block funding ceased. BAC was generally within budget and closure was financially neutral for WMHHS.

12.10 I was not involved in the day to day implementation of the turnaround plan for WMMHS. My role was to hold the Executive Director Mental Health and Specialised Services accountable for delivering on the turnaround plan.

13 What processes were put in place to communicate the closure of the BAC to BAC patients, their families and carers, and the BAC staff? How were these processes carried out?

13.1 A communications plan was developed by the Executive Director Mental Health and Specialised Services and her team, and approved by me.

13.2 Communication with patients took place through their usual clinical contacts and supports within BAC, ie the Clinical Director BAC and/or the psychiatric registrar, nursing staff, their case co-ordinator and allied health staff as relevant to the particular patient which included social worker, psychologist, occupational therapist and speech therapist.

13.3 The processes put in place to communicate with patients included the following:

(a) When a decision was made that the closure of BAC would formally be announced on 5 August 2013 (although subsequently delayed to 6 August 2013), arrangements were made for Dr Sadler, Dr Stedman and Ms Kelly to jointly telephone the parent/carer contact for each patient ahead of the announcement, to advise them in person.

(b) This was followed by a letter to each parent/carer contact confirming the position.

(c) An information sheet titled Fast Facts was developed which provided periodic updates to interested parties, particularly targeted to informing parents and carers of progress with considerations regarding BAC.

(d) The Fast Facts were also published on the WMHHS website.

13.4 The processes put in place for communication with BAC staff were that:

(a) Sharon Kelly and I met with all BAC staff on 9 November 2012, shortly after the public statement by Dr McDermott that 'BAC would be closing' to inform staff of the processes WMHHS would be following to consider the future of the BAC service.

(b) An information sheet titled BAC Staff Communiques was developed which

provided periodic updates to staff.

(c) Sharon Kelly and I also met with staff at the time of the Minister's announcement on 6 August 2013 to ensure they were personally advised before the public announcement was made. Ms Kelly followed this with an email to all staff.

14 Provide information relating to the decision to cease the on-site integrated education program located at the BAC including:

(a) Ms Dwyer's involvement with the education program including who her contact and liaison was with and the nature of her working relationship with Peter Blatch and Patrea Walton;

14.2 I had no involvement with the education program. The education program was delivered by the Department of Education through the Barrett School which was staffed by the Department of Education.

14.3 The interface between BAC and the Barrett School staff was managed at the unit level.

14.4 The interface between WMHHS and the Department of Education in relation to how closure of BAC would affect the Barrett School, was managed for WMHHS by Sharon Kelly in her role as Executive Director Mental Health and Specialised Services.

14.5 Apart from the meetings described in paragraph 14.6, to the best of my recollection I did not meet with any representative of the Department of Education and I did not have a 'working relationship' with either Mr Blatch or Ms Walton as those were my only contacts with them.

(b) Any meetings or correspondence Ms Dwyer had with the Department of Education and BAC school staff.

14.6 To the best of my recollection, I was involved in two meetings with Department of Education representatives regarding BAC. These were:

(a) On 2 August 2013, Sharon Kelly and I met with the Deputy Director-General of the Department of Education, Patrea Walton and other representatives of the Department of Education, who from recollection included Mr Blatch.

(b) On 2 December 2013, Dr Cleary, Dr Kingswell and I met with Assistant Deputy Director General Education, Margaret Pethiagoda and other representatives of the Department of Education.

14.7 The purpose of those meeting is set out in paragraph 11.10.

14.8 Barrett School staff were present at the meeting which Ms Kelly and I attended with BAC staff on 9 November 2012. In retrospect I formed the view that it would be preferable for Barrett School staff to receive information from the Department of Education, as WMHHS could not, for example, give them any information or advice about their future employment. For this reason, I requested that future meetings with BAC staff comprise WMHHS staff only, and Barrett School staff direct any queries regarding their future to the Department of Education.

15 Information about, and Ms Dwyer's involvement in, the Barrett Adolescent Strategy Project Plan (Planning Group) and the Expert Clinical Reference Group (ECRG) including:

(a) How was the composition of the Planning Group and the ECRG determined?

15.2 I was not a member of either the Planning Group or the ECRG.

15.3 I was involved in deciding who was invited to be a member of the ECRG. I sought advice and canvassed opinions from peers, the College and within WMHHS as to who would be appropriate. My requirements were that:

(a) The ECRG include clinicians in the field of adolescent mental health, with currency of practice and experience in the different service models being used in different services who could bring an evidence based approach to considering the matters within the ECRG's terms of reference.

(b) A regional perspective was to be represented, ie not just a group of clinicians from south-east Queensland.

(c) Interstate representation was to be sought, so that if there were models of care being used outside the State these could be represented by clinicians with actual experience in those models of care.

(d) Representation from a consumer perspective and a parent/carer perspective was to be included.

(e) Representation from an educational perspective was to be included.

(f) As the long-term and current director of BAC, Dr Sadler was to be a member.

15.4 For the Planning Group, similar considerations applied, however there was also a representative from MHAODB as the entity responsible for determining State-wide policy for mental health.

(b) Meetings of the Planning Group;

15.5 I was not a member of the Planning Group and did not attend the meetings of the Planning Group.

(c) ECRG recommendations and any consideration or implementation of these

recommendations by the Planning Group;

15.6 I received a copy of the ECRG and Planning Group recommendations. I reviewed and considered those recommendations and I would have discussed them with the Executive Director Mental Health and Specialised Services.

15.7 I reviewed the paper prepared by Ms Kelly in relation to those recommendations which was provided to the WMHHB in the Board Papers for the meeting of the Board on 24 May 2013 and I was present at the Board meeting where the ECRG and Planning Group recommendations and Ms Kelly paper were considered by the WMHHB.

(d) Who was responsible for the formation and composition of the State wide Adolescent Extended Treatment and Rehabilitation Initiative and what was its function?

15.8 My understanding is that after the Planning Group recommendations were considered by the WMHHB and the WMHHB resolved to support the closure of BAC, the State Wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee grew out of and replaced the Planning Group, to take responsibility for implementation of change.

15.9 I understand this is because at around this point in time it became consciously recognised that the development of alternative service models was a State-wide matter properly to be taken forward by CHQHHS not WMHHS.

15.10 I was not responsible for nor was I involved in the formation of or determining the composition of this committee.

16 Which Relevant Stakeholders were consulted prior to the decision to close the BAC (and when) and what advice/views were given by the Relevant Stakeholders; state the nature of the consultation (i.e. meetings, submissions considered etc.).

16.1 As previously stated, the decision to close BAC was made prior to the time of my appointment as Health Service Chief Executive, on the basis that the services provided at BAC would be relocated to the Redlands facility which was to be built.

16.2 Following the cancellation of the Redlands project, in relation to service options going forward, consultation occurred within and by the ECRG and the Planning Group, MHAODB, WMHHB, the Director-General of Health and the Deputy-Director Health Services and Clinical Innovation and the Minister for Health.

16.3 To the extent that I was involved in those consultations, my involvement is set out above.

17 Any meetings and correspondence Ms Dwyer had with Save the Barrett and concerned families and friends of BAC patients.

17.1 [redacted]

17.2 WMHHS also received various emails from Ms Earl and a number of letters and emails from members of the public which at times included individual parents of current BAC patients. WMHHS provided responses to all of these.

17.3 [redacted]

17.4 [redacted]

17.5 [redacted]

18 Who made the decision and what were the reasons for the decision (10 September 2013) to stand down Dr Sadler from his position as Director of the BAC?

18.1 I made the decision to stand down Dr Sadler from his position as Clinical Director BAC.

18.2 [redacted]

18.3 [redacted]

18.4 [redacted]

19 Who made the decision to employ Dr Anne Brennan, when was this decision made, and what were the terms of Dr Brennan's engagement?

19.1 When Dr Sadler was stood down it was necessary to appoint an acting Clinical Director BAC.

19.2 I spoke to my counterpart at CHQHHS, Dr Peter Steer, who spoke to Dr Stephen Stathis as he was Clinical Director CYMHS at CHQHHS. Dr Steer advised me that Dr Stathis had recommended Dr Anne Brennan as a suitable Acting Clinical Director. She was highly experienced in the field and on that recommendation, she was offered the position.

19.3 I am unsure of the specific date, but from my recollection this would have been very shortly after Dr Sadler was stood down, most likely within a few days.

19.4 I cannot now recall the terms of Dr Brennan's engagement. She was not a Department of Health employee. She had a private practice and my recollection is that she was

retained on a part time basis, although this increased effectively to full time once the work of transitioning patients began.

20 All information relating to whether, in association with the Closure Decision, there was any consideration of alternatives for replacing the BAC.

20.1 I refer to paragraph 11.6.

20.2 I also considered Dr Sadler's suggestion that the planned hospital at Springfield should be investigated. In relation to that suggestion:

(a) As with the proposal to rebuild/refurbish at The Park:

(i) there was no capital funding available, and in the absence of support from MHAODB, none would be available.

(ii) This option would not address the lack of alignment with the QMPH and that BAC was not a contemporary model of care.

(iii) The recommendations of the ECRG and the Planning Group reflected that the development of alternative service models aligning with contemporary models of care would result in better services for this cohort of patients

(b) The hospital at Springfield was in the planning stages was a private partnership with Mater Health Services and would have required the agreement of Mater and very significant work would have been required to even ascertain whether it could be done.

(c) Mater Springfield did not have any other mental health services in its plan. It would not have been appropriate to relocate BAC to an inpatient hospital service which did not have associated mental health services such as an acute unit and a community mental health service necessary to create a 'step up, step down' service consistent with contemporary models of care.

21 All information relating to the support provided to the staff of the BAC in relation to the closure.

21.1 As noted above, Sharon Kelly and I met with staff on 9 November 2012 after Dr McDermott made a public statement about BAC closing, and again on 6 August 2013 ahead of the formal announcement by the Minister for Health that BAC would close.

21.2 Staff received BAC Staff Communiques providing periodic updates regarding the process which was being undertaken regarding BAC.

21.3 I was not involved with specific staff support measures but I understand that Ms Kelly tasked specific individuals in leadership positions as support contacts for staff within their discipline area, such as Lorraine Dowell in relation to allied health staff.

21.4 Staff from the Workforce Division of WMHHS were available to provide information to staff regarding issues such as redeployment and redundancies.

21.5 A State-wide Voluntary Early Retirement program was in place in 2013 consistent with the Department's efficiency initiatives. That program was to close prior to the closure of BAC, however I ensured arrangements remained open so that BAC staff could make use of it without having to make decisions prior to final decisions being made about the future of BAC.

21.6 Once closure was formally announced WMHHS Workforce Division undertook a formal process in compliance with the Department of Health and public service State-wide protocols to formally consider staff for redeployment within WMHHS or to the general employment pool within the Department or to seek a redundancy.

Transition Arrangements

22 Ms Dwyer's involvement in the Transition Arrangements. The term Transition Arrangements refers to how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure of the BAC. Including:

(a) Who was responsible for the arrangements for the Transition Arrangements once the decision to close the BAC had been made, including with respect to responding/addressing any concerns raised during the transition process?

(b) The information, material, advice, processes, considerations and recommendations that related to or informed the Transition Arrangements;

(c) What consultations, meetings, dealings did Ms Dwyer have with any of the Department of Health, Staff of BAC, any Health Service or Board, the Department of the Premier and Cabinet and any relevant Human Services Agency or Relevant Stakeholder regarding the Transition Arrangement and the adequacy of the care, support and services that were to be provided to the Transition Clients? The term Transition Clients refers to the BAC patients transitioned to alternative care arrangements in association with the closure of the BAC, whether before or after the closure announcement.

(d) How were care, support, service quality and safety risks identified, assessed, planned for, managed and implemented during the transition?

(e) Did Ms Dwyer have any input or make any recommendations regarding the Transition Arrangements? If so, what were they? Were they accepted or rejected?

(f) Explain Ms Dwyer's involvement in and contribution to the governance model put in place by the WMHHS to manage the oversight of the Transition Arrangements including information relating to:

(i) the principal features of the governance model;

(ii) when that model was put in place, and if it was varied, when it was varied and in what way;

(iii) how and who chose the members of the Clinical Transitional Panel and the respective roles of the Panel members;

22.2 I was not involved in the Transition Arrangements.

22.3 I was informed that a transition process was in place, managed by Dr Brennan and her team, which formally considered transition needs for each patient, identified appropriate services to provide for those needs, engaged with potential receiving services to accept patients with care arrangements having been first agreed, and facilitated and supported the transition.

22.4

22.5 I was not involved in nor did I contribute to the governance model put in place by WMHHS to manage the oversight of transition arrangements. This was a matter for Sharon Kelly in her role as Executive Director Mental Health and Specialised Services.

(i) the identities of the members of the Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee, how and why they were chosen, and their respective roles;

22.6 I did not have any involvement in the Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee .

(i) the identities of the members of the West Moreton Management Committee, how and why they were chosen and their respective roles;

22.7 I am not aware of an entity called the West Moreton Management Committee and therefore cannot comment on the identity of its members or how or why they were chosen.

(i) the identities of the members of the Chief Executive and Department of Health Oversight Committee and their respective roles.

22.8 The members of the Chief Executive and Department of Health Oversight Committee and their roles were:

(a) Dr Peter Steer, Hospital Service Chief Executive, CHQHHS.

(b) Myself, Hospital Service Chief Executive, WMHHS.

(c) Dr Richard Ashby, Hospital Service Chief Executive, Metro South HHS.

(d) Dr Bill Kingswell, Executive Director MHAODB.

(e) Ms Deb Miller, A/Executive Director, Office of Strategy Management CHQHHS.

(f) Dr Stephen Stathis, Clinical Director, CYMHS CHQHHS.

(g) Ms Ingrid Adamson, Project Manager, SW AETRS, CHQHHS.

(h) Ms Julia Squires, Hospital Service Chief Executive, Townsville HHS.

(i) Dr Leanne Geppert, Director of Strategy, WMHHS Mental Health Services.

23 Were there any arrangements in place to monitor the adequacy of the Transition Arrangements for Transition Clients of the BAC? In particular, once the BAC closed, did Ms Dwyer make any checks to ensure that the Transition Arrangements were appropriate and effective, and, if so, what were those checks and when and how did they occur?

23.1 Responsibility for monitoring the adequacy of transition arrangements rested with Sharon Kelly as Executive Director Mental Health and Specialised Services.

23.2 I checked to ensure arrangements were appropriate and effective by receiving regular reports from Ms Kelly as to the progress of the transitions.

24 All information relating to the care, support and services that were provided to the families and carers of the Transition Clients.

24.1 This is detailed earlier in my statement.

25 All information relating to the support provided to the staff of the BAC in relation to the Transition Arrangements.

EXHIBIT 49

25.1 This has been previously detailed in my statement.

Other Matters

26	**Outline and elaborate upon any other information and knowledge (and the sources of that knowledge) Ms Dwyer has relevant to the Commission's Terms of Reference.**

26.1 Nil.

27	**Identify and exhibit all documents in Ms Dwyer's custody or control that relate to her evidence in respect of the matters above.**

27.1 All documents referred to in my witness statement are exhibited.

And I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

Taken and declared before me by)
Lesley Dwyer at Brisbane in the State of)
Queensland this 6th day of)
NOVEMBER 2015)
Before me:)

[redacted]

....
Signature of authorised witness Signature of declarant

A Justice of the Peace/
~~Commissioner for Declarations~~

EXHIBIT 49

STATUTORY DECLARATION OF LESLEY DWYER

INDEX OF EXHIBITS

No	Document Description	Document number	Page
LD-1	Curriculum Vitae	WMS.5000.0024.00021	1 - 10
LD-2	Queensland Health, West Moreton Hospital and Health Service position description for Health Service Chief Executive, dated 24 July 2012	WMS.5000.0024.00001	11 - 16
LD-3	Contract of employment between Queensland Government and Lesley Dwyer dated 10 August 2012	WMS.5000.0024.00007	17 - 30
LD-4	Email from MD09-WestMoreton-HSD to Lesley Dwyer and Sharon Kelly dated 29 August 2012 attaching: • Email from HIO-Correspondence to MD09-WestMoreton-HSD dated 29 August 2012, attaching: o Queensland Health Memorandum – Cancellation of Capital Delivery Project dated 28 August 2012	WMS.0014.0003.00093 WMS.0014.0003.00094 WMS.0014.0003.00095	31 - 33
LD-5	Email from Trevor Sadler to Lesley Dwyer dated 12 September 2012	WMS.0017.0001.09749	34 - 35
LD-6	Email from Ray Chandler to Lesley Dwyer and Sharon Kelly dated 4 October 2012, attaching: • Email from Robert Wood to Ray Chandler dated 21 September 2012, attaching: o West Moreton Hospital and Health Service, Report on the Condition of the Barrett Adolescent School and Accommodation dated 21 September 2012 o West Moreton Hospital and Health Service, Report on the Condition of the Barrett Adolescent School and Accommodation dated 21 September 2012	WMS.0012.0001.08161 WMS.0012.0001.08162 WMS.0012.0001.08163 WMS.0012.0001.08167	36 - 46

[redacted] .... [redacted]

Lesley Dwyer **Witness**

EXHIBIT 49

LD-7	Email from Sharon Kelly to Bill Kingswell, Jagmohan Gilhotra and Leanne Geppert, copied to Lesley Dwyer and Chris Thorburn dated 26 October 2012	WMS.0011.0001.19338	47-48
LD-8	West Moreton Hospital and Health Service Project Plan – Barrett Adolescent Strategy	WMS.0012.0001.14639	49-63
LD-9	West Moreton Hospital and Health Service, Health Service Chief Executive Report for the Board dated 23 November 2012	WMB.1000.0001.00090 at .00091	64-65
LD-10	Briefing Note for Noting to Director-General dated 11 December 2012	WMS.0012.0001.24306	66-67
LD-11	Briefing Note for Noting to Director-General dated 12 July 2013	WMS.1000.0005.00167	68-71
LD-12	West Moreton Hospital and Health Service, Integrated Mental Health Services, The Park – Centre for Mental Health and Offender Health Services Service Changes dated 15 January 2013	WMS.0012.0001.15789	72-90

[redacted] .... [redacted]

Lesley Dwyer **Witness**

Lesley Dwyer | Resume

Address

Telephone

Email

Professional Profile

An experienced chief executive with more than 30 years' experience across the public health system at senior leadership, strategic, operational and capital planning levels.

A pragmatic leader who is comfortable with planning and leading change, with a demonstrated track record of delivering on financial turnaround, service innovation and cultural change

Demonstrated ability to build strong, mutually respectful partnerships with staff, patients, other service providers and key stakeholders, in addition to effective engagement with the community

A flexible and dynamic leader who understands the relationships between the various components of the health system and uses these interdependencies to make sound business and system related decisions

A deep understanding of both corporate and clinical governance and the imperative to develop the necessary assurance frameworks to increase the focus of attention on the quality of the services provided.

A resilient person who copes with the competing demands of the Chief Executive and leadership role without a diminution in performance. Brings a comprehensive understanding and experience of public sector accountabilities, effective governance and performance frameworks that ensured the effectiveness and quality of services delivered.

Recognised by peers as a person who 'does what she says', most importantly putting patients at the centre of all decisions whilst delivering on service targets and budgets

Education

2000	Monash University - Mt Eliza Executive Development Programs attended towards Master of Business Administration
1992	Bachelor of Applied Science , Australian Catholic University
1986	Diploma in Midwifery
1981	Diploma in General Nursing

Lesley Dwyer | Curriculum Vitae

Employment

July 2012 – current | **Inaugural Chief Executive**
West Moreton Hospital and Health Service

In July 2012, Queensland Health, through the establishment of the *Hospital and Health Boards Act 2011*, established new statutory bodies known as Hospital and Health Services.

Boards of Governance were established and Health Service Chief Executives appointed to establish the necessary governance frameworks to fulfil the legislative requirements as described in the Act. The Health Service Chief Executive is accountable for ensuring a high quality of care through effective leadership and management of all services and staff.

West Moreton, with an annual budget of $440M and through 2,600 staff, provides services over a large diverse geographical area, encompassing both metropolitan and rural populations. The population is expected to increase by 82% from 245,000 to 475,000 by 2026. This is the largest increase in Queensland and the demographic is one of diverse ethnicity, social disadvantage and has the lowest percentage of health care need met.

Achievements

- Led the turnaround of a poorly performing heath service into one of the highest performing hospital and health services in Queensland and in many areas nationally.
- Winner of the 2014 Premier's award for outstanding innovation in the Public Sector
- Achieved financial turnaround of $24M in first twelve months to deliver a surplus of $7.4M. For the second year delivered a substantial surplus which is invested in the provision of better services for the community.
- Comprehensive reviews across all services identified achievable savings and opportunity for redesign to better meet the needs of the changing local community.
- Initiated Integrated Care demonstration pilot incorporating social care, health and local government to provide "joined-up" care for chronic disease.
- In addition to reducing long wait elective surgery lists, enhancing maternity, cardiac and paediatric services, and undertaking building improvement works, the surplus was reinvested into service delivery which enabled:
    - Achievement of national emergency department wait time targets. Recognised nationally as 2nd best performer and first in peer group to reach the 90% target.
    - All national elective surgery targets met. 25% reduction in the total number of patients waiting for elective surgery with a 92% reduction in patients waiting longer than recommended time frames and

100% of all urgency category patients being treated within clinically recommended times.

- Reduction of dental waiting lists from 3,521 patients waiting for more than two years for treatment to zero in less than 10 months.

- Undertook significant workforce reform that resulted in a comprehensive organisational restructure, made appointments to key positions which has increased the capability of the organisation and ensuring high calibre clinical leadership across all service areas
- Established Clinical Governance, Education and Research Division to ensure services are evidence-based, safe and effective.
- Strengthened the quality of care through the development of the Highly Reliable Care strategy – with over 1000 staff undertaking the "fundamentals of care" training.
- Delivered on the inaugural Strategic Plan under the theme of 'Your Partner in Healthcare Excellence.'
- Personally led the development of organisational values that set the expectations of behaviours for each and every staff member. The values are:
  - Really Care
  - You Matter
  - We Deliver
  - Be the Best
- Developed a Health Service Plan to provide a roadmap for growth of services until 2026 focussing on increasing the level of service provision to meet 90% of the local community's health needs. Includes an investment and divestment plan which outlines services to be done independently or in partnership.
- Established strong governance frameworks, outlined within legislation that included an established board process regarding audit and risk, safety and quality and finance subcommittees.
- Built a Community Engagement Framework which saw the establishment of six reference groups across the geographic area, culminating in a Community Advisory Council that provides advice to the West Moreton HHS Board.
- Developed a Clinical Engagement Strategy that includes a Lead Clinician Group that provides 'think tank' styled advice to the executive and the board.
- Invested in development leadership skills of clinicians in

management positions drawing on learning from the US based Vanderbilt University Health System.

- Personally established a Strategic Partnership Group encompassing private providers, local council, not-for-profit organisations and education to share planning information and reduce duplication of services across the region.
- Increased commercial and corporate capability through establishment of a financial compliance framework, introduced contestability capability within the organisation, built a strong legal team with a focus on compliance and contract management, and developed a strategic asset plan.

August 2011 – June 2013	**Healthcare Consultant**

Undertook health related consultancies providing content expertise across a range of areas including strategic planning, specialised service redesign and workforce planning.

June 2010 – August 2011	**Acting Chief Executive / Chief Operating Officer Adelaide Health Service**

The role managed of a range of health services for defined population groups in metropolitan South Australia. The position was accountable for the efficient and effective operational delivery of all health and corporate services as well as delivering on system reform and service reconfiguration.

Adelaide Health Service provided services to more than 1 million people in the metropolitan area, as well as state-wide services to consumers across South Australia and has an operating budget in excess of $2.5 billion and more than 23,000 staff.

From March 2011, I was the Acting Chief Executive Officer and was accountable for the devolution of Adelaide Health Service into three Local Health Networks in line with the National Health Reforms.

Achievements

- Provided leadership across the Region as the Acting Chief Executive Officer. During this period of change and uncertainty, I put in place an interim and transitional organisational structure and provided the required leadership to keep the organisation focused on delivering key outcomes.
- Established a high level Financial Turnaround Team and expanded the role to include both the planning and performance functions.
- Established a Financial Sustainability Plan with an agreed three year 'break even' timeframe.
- Established a tiered performance monitoring framework to oversee the operations within the three area health services.
- Established local and system Activity Plans relating to Emergency Department targets.

- Met all Commonwealth Government targets relating to elective surgery outcomes.
- As the Chief Operating Officer, I established and implemented an organisational and management structure based on clinical streams that support the integration of services across the continuum of care.
- Led the implementation of a whole of system Outpatient Reform with targeted reduction in expenditure of 10%.
- Assisted in leading the process for the integration of Biomedical Services, Pharmacy Services and Medical Imaging Services at a State Level.
- Provided leadership and representation for State Government in industrial matters.

April – July 2010 | **Acting Chief Executive Officer**
Southern Adelaide Health Service

Reporting directly to the Chief Executive SA Health, the role was responsible for the day to day running of health services across southern metropolitan Adelaide by ensuring alignment of corporate goals to support the strategic objectives of the SA Health Care Plan agenda.

Southern Adelaide Health Service provides services to 450,000 people in the southern region, has a budget of $850 million and staff of 7,500.

The position was a short term appointment with a key priority to merge the administration and management with another health region. This required skills in effective negotiation and leading change whilst maintaining a business as usual leadership focus.

Achievements

- Established an interim structure to provide the necessary governance to merge with another region.
- Established a Financial Turnaround Team to support the organisation with high level and detailed analysis and monitoring to ensure focus on achieving a sustained financial platform.
- Australian Council on Healthcare Standards Corporate Accreditation Survey undertaken with full 4 year accreditation achieved
- Instrumental in determining the new merged regional structure by aligning priorities across both regions with clinical streams to support clinical outcomes and clarity of accountability for all staff.

May 2008 – April 2010 | **Executive Director – Operations, Acute and Specialist Services**
Central Northern Adelaide Health Service

Accountable to the Chief Executive Officer, the role was provided the strategic leadership of acute, specialised (Rehabilitation) and acute state-wide services. The position had responsibility for acute health care policy implementation across the Health Service to support the strategic objectives of the Region and the SA Health Care Plan agenda.

The role monitored the day-to-day operations across service delivery sites as providing the effective leadership of service, programs and facility redevelopments

The Directorate had an annual budget of $1.2B and 12,000 staff across four acute sites, two subacute sites, Statewide Retrieval services, Pregnancy Advisory Services, Statewide Burns services.

Achievements

- Developed operational frameworks to ensure that the Directorate delivered on the multiple reform agendas inherent within the SA Health Care Plan
- ACHS Organisational Wide surveys undertaken across all services and sites in 2009 resulting in full accreditation
- Developed a priority access plan that delivered 100% achievements of all State and Commonwealth Elective Surgery targets
- Developed a KPI reporting framework that enabled real time monitoring and remediation of access targets.
- Created a building capacity and capability framework with the establishment of an Organisational Performance and Improvement Unit to support service change.
- In conjunction with key clinical staff, developed a regionalisation framework which continues to support and direct the development of services and clinical collaboration across multiple sites.
- Provided the leadership for the integration of renal services across the region. The first service to implement the SA Health Care Plan model of care for service delivery.
- In partnership with the Department of Health established the state-wide retrieval service - MedSTAR. This service is responsible for the Adult, Paediatric and Neonatal retrieval services as well as the coordination of ICU bed capacity.

April 2006 – April 2008	**Executive Director – Continuing Care** **Southern Health, Victoria**

Southern Health is the largest health service in Melbourne (Victoria) and provides comprehensive integrated services to over 750,000 people.

The Continuing Care Sector of Southern Health consists of Victoria's largest Rehabilitation, Aged Care, Dental, Community and Primary Care services and Aged Care Services. Continuing Care provided a defined point of access to services for both internal and external service provides and patients of Southern Health and creates a seamless system of patient and client flow.

With a budget of $120M and 1,200 staff, I was accountable and responsible for the effective management of all services and in addition hold the Executive Portfolio for Allied Health Professional Governance across Southern Health and the Executive Sponsor roles for the Community Advisory Committee, Multicultural and Diversity Committee and Southern Health, Health Promotion Committee.

Achievements

- Development and implementation of an appropriate organisational structure for Continuing Care which ensures effective operational management as well as professional governance model.
- Developed resource and budget processes to deliver budget surplus in two financial years by improving business systems.
- Provided executive sponsorship for the overall cost reduction strategies achieving a better than forecast result in 2006/07 to take Southern Health from significant financial deficit to one of break even.
- Using a risk management framework, identified urgent quality issues and initiated remedial achieved which resulted in an overall improvement in clinical standards which is evidenced by the achievement of full Commonwealth Aged Care Standards accreditation for five residential facilities.
- Created a vision for a future state of subacute service delivery by commissioning an "Opportunity Scan of Care of the Elderly across Southern Health" by Monash University resulting in a strategic redesign of subacute services under the aegis of the Subacute 2020 project hallmarked by patient centred, interdisciplinary care.
- Increased capacity to relieve demand pressures within the acute services by introducing flexible models of care in the subacute services resulting in models such as the Medihostel and Orthogeriatric care.

January 2005 – April 2006	**Executive Director – Patient Access and Demand Strategies Southern Health**

Reporting to the Chief Executive, I was responsible for the development and leadership of strategies to improve access for patients by engendering a culture of solution focus to demand pressures across Southern Health.

The skills necessary for the role were those of negotiation, influence and the ability to stimulate constructive debate and support colleagues in the achievement of organisational objectives. I brought, to the role, an expert knowledge of the interdependencies of systems and patient flow strategies as well as the knowledge and understanding of funding structures and extensive skills in management of clinical services.

2004 – 2005	**Deputy Director, Metropolitan Health Service Performance and Relations and Manager, Hospital Demand Management Strategy**

Department of Human Services, Victoria

During my time with the Department of Human Services, governance structures for Health Services were significantly reformed and improved accountability mechanisms were established between Health Service Boards and the Minister for Health.

The role of the Branch was to standardise these accountability requirements to support an environment which will support collaboration, innovation and performance management.

A key achievement during this time was the development and implementation of a Performance Monitoring Framework for Metropolitan Health Services and the review of the demand management strategy which is a series of linked programs that aim to improve patient access to hospital emergency and elective services.

The Auditor General's review of the emergency component of the strategy in 2004 found that the strategy and has been substantially effective in reducing presentations to emergency departments and had made significant improvements in processes to reduce time spent in the emergency department.

2003 – 2004 | **Executive Director, Strategic Developments**
Melbourne Health

Melbourne Health is affiliated with the University of Melbourne and provides specialised tertiary and quaternary services and is one of two trauma services for the State of Victoria. It has an annual budget of $500 million per year and has the busiest emergency department in the State with presentations of 52,000 per annum.

This role reported to the Chief Executive and was responsible for the development of strategic and clinical service planning as well as capital development on site

2001 – 2003 | **Director, Division of Emergency and Perioperative Services**
Melbourne Health

With a budget of $127M, this division was the largest of the clinical divisions which had been established. During this time a prime focus was on the establishment of a Patient Management Taskforce to established effective consultative mechanisms to engage key stakeholders to work with us in developing innovative and sustainable programs designed to improve performance and access to services.

1996 – 2000 | **Divisional Director, Specialist Women's Health**
Women's and Children's Health Care Network (Melbourne)

The Royal Women's Hospital is the largest specialist women's hospital in Australia offering a range of tertiary and quaternary services.

In 1996, the Royal Women's Hospital and the Royal Children's Hospital formed a network of specialist services. The Specialist Women's Health Division, which encompassed, not only specialty and subspecialty non obstetric units, but also support departments such as allied health, pharmacy and biomedical engineering, was established across the network to ensure efficiencies were gained and rationalisation of services.

Committee Membership and Representative Roles

Queensland

2012- current	Board Member - Australian Hospital and Healthcare Association
	Board Member – Queensland Heath Reform. The Board provides advice and oversees changes to governance across Queensland and is chaired by the Minister for Health
	Member Queensland Health System Management Team
	Board Member – Information Technology Reform. Queensland Health
	Queensland Clinical Senate – Advisory Member
	University of Queensland School of Health Science Advisory Committee – Member
	Regional Heath Alliance, West Moreton – Founding Member
	Regional Leaders Forum, Ipswich City Council - Member

South Australia

2008 – 2011	Australian Commission on Safety and Quality – Recognition of the Deteriorating Patient Advisory Committee
	Executive Member New Royal Adelaide Development Committees • Executive Steering Committee • Clinical Steering Committee • Chair HR Transition Steering Committee
	SA Health Enterprise Patient Administration System Board
	Chair SA Health Emergency Taskforce
	Chair Burns SA Advisory Committee
	Management Committee of Biogrid Australia
	Board Member – Flinders Reproduction Medicine
	Board Member – Health Round Table

Victoria

2007- 2008	Executive Member of the "Care in Your Community" Department of Human Services Southern Region Planning Trial.
2006 -2007	Executive Member of the South East Healthy Communities Partnership.
2005-2009	Judge/Chair of Panel for "Excellence in Service Delivery" and "Innovation in Access" for Victorian Health Service Awards
2005	Member Expert Advisory Panel on Perioperative Services for Patient Flow Collaborative
2004 – 2006	Member of Gateway Review Panel

2004 – 2005	Chair – Clinical Advisory Committee on Development of State-wide Elective Services
2003 – 2005	Member Ministerial Advisory Committee on Access to Elective Surgery
2003 - 2004	Expert Advisor on Auditor General's Review of Management of Emergency Services
2003 - 2005	Department Of Human Services Steering Committee member for Patient Flow Victorian initiative.
2004 - 2005	Department of Human Services Representative on Commonwealth Committee advising on General Practitioner/Acute interface

Professional Membership

- Australian Institute of Company Directors, Member
- Monash Mt Eliza Alumni Association
- Executive Management Learning Set – Hardy Group International

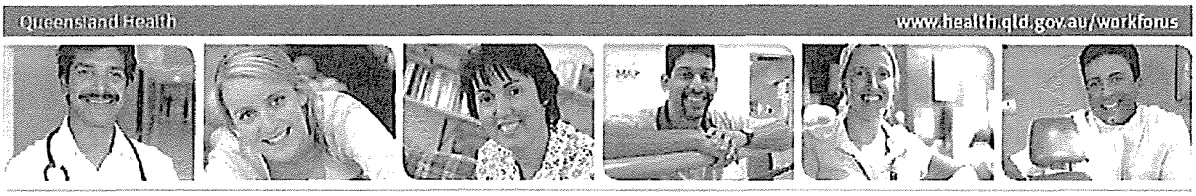
References

Available on request.

Queensland Government
Queensland Health

Schedule 2

West Moreton Hospital and Health Service



Job ad reference:	
Role title:	Health Service Chief Executive, West Moreton Hospital and Health Service
Status:	
Unit/Branch:	West Moreton 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 West Moreton Hospital and Health Service ('HHS', 'the Hospital and Health Service'). The HHS is an independent statutory body which covers the area around and west of Ipswich. 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 2,610 FTE staff. The position is accountable for an annual operating budget in the order of $352 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 West Moreton HHS, which covers the area between Esk in the north, Boonah in the south, Ipswich in the east and Gatton in the west. The HHS services a population of approximately 220,000 people, which is forecast to grow by 55% to over 330,000 by 2021, making it Queensland's fastest growing HHS. The HHS is demographically diverse, with 13.4% of its population born overseas, 3.6% of A&TSI Australian heritage and 5% speaking a language other than English at home. The HHS includes one metropolitan area (Ipswich) and a number of small regional towns (e.g. Gatton, Laidley, Esk, Boonah).

The HHS includes one major referral hospital (Ipswich Hospital, 341 beds) and four small facilities (Boonah Health Service, 23 beds; Esk Health service, 15 beds; Gatton Hospital, 22 beds; and Laidley Health Service, 15 beds). The HHS also includes The Park Centre for Mental Health, which provides high security forensic mental health care (61 beds) and other specialised Mental Health services. The combination of facilities in the West Moreton HHS allows the majority of the HHS's residents to be treated locally, though some patients require referrals to Brisbane hospitals for some specialist services.

The Queensland Government has committed $122 million for the re-development of Ipswich hospital to provide an additional 84 beds between 2011 and 2016, as well as a further $6.7 million to expand the emergency department to cater specifically for children.

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.

The West Moreton HHSs primary challenge will be meeting service demands associated with its rapidly growing population. This will be particularly challenging given that a large proportion of the HHSs workforce is currently approaching retirement age. The HHS must also provide health

services to a demographically diverse patient group, including considerable proportions of overseas-born and A&TSI residents, and residents of low socio-economic status.

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 HHS's 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
- State and Federal Government agencies
- State and Federal Members of Parliament
- Medicare locals
- Primary Health Care Organisations
- Aged care services
- Industry bodies
- Regulators
- Union bodies
- Leaders of other HHSs
- Local councils
- Local business and commercial associations

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

MS LESLEY DWYER

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)	Ms Lesley Dwyer
2.	Commencement Date (clause 1.1)	30 July 2012
3.	Expiry Date (clause 1.1) (must not be longer than 5 years from the Commencement Date)	29 July 2017
4.	Hospital and Health Service (clause 1.1)	West Moreton
5.	Total Remuneration Package (clause 1.1)	$300,000 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: Ipswich Hospital Chelmsford Avenue IPSWICH QLD 4305 Residential Address:
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)

10 / 8 / 12

(date)

[redacted]

(signature of witness)

Alice Gaston

(name of witness)

SIGNED by the Health Service CE in the presence of:

[redacted]

(signature of Health Service CE)

10 / 08 / 2012

(date)

[redacted]

(signature of witness)

Catherine Franks

(name of witness)

From: MD09-WestMoreton-HSD
Sent: 29 Aug 2012 13:57:44 +1000
To: Dwyer, Lesley;Kelly, Sharon
Subject: Re: CHIO APPROVED MEMO: SSS000097_HPID02770 - Deferral Cancellation of Capital Delivery Project
Attachments: CHIO APPROVED MEMO: SSS000097_HPID02770 - Deferral Cancellation of Capital Delivery Project.txt

Hi Lesley and Sharon

Please see attached

thanks
Shireen

From: HIO-Correspondence
Sent: 29 Aug 2012 09:25:56 +1000
To: MD09-WestMoreton-HSD
Cc: Flenley, Jason;
Subject: CHIO APPROVED MEMO: SSS000097_HPID02770 - Deferral Cancellation of Capital Delivery Project
Attachments: SSS000097 - CHIO CLEARED MD09.pdf

Morning Lesley

Please find attached CHIO APPROVED memorandum from Chief Health Infrastructure Officer regarding Cancellation of Capital Delivery Project.

For further information, [:ease contact Jason Flenley, A/Executive Director, Capital Delivery Program on email

Thanks

Health Infrastructure Correspondence Team | **Health Infrastructure Branch**
System Support Services | Queensland Health

Level 5, Anzac Square Building
200 Adelaide Street BRISBANE Q 4000
E

Alan Costin, Correspondence Coordinator,
Alana Scheikowski, Correspondence Officer,
Angelica Patu, Correspondence Officer,

Please email all correspondence related requests to the email account - Thank you

Queensland Government

Queensland Health

MEMORANDUM

To: Lesley Dwyer, Chief Executive Officer, West Moreton Hospital and Health Service

Dr Richard Ashby, Chief Executive Officer, Metro South Hospital and Health Service

Copies to: Jason Flenley, A/Executive Director, Capital Delivery Program, Health Infrastructure Office

From: Glenn Rashleigh, Chief Health Infrastructure Office, System Support Services

Contact No: [redacted]
Fax No:

Subject: Cancellation of Capital Delivery Project

File Ref: ~~Ref Number~~ SSS000097 HPI002770

The purpose of this memo is to advise of a decision by government to cancel or defer a small number of capital delivery projects.

This includes the cancellation of the replacement Adolescent Mental Health Unit at Redlands from the current location at Wacol.

For further information, please contact Jason Flenley, A/Executive Director, Capital Delivery Program on email [redacted]

Yours sincerely

[redacted]

Glenn Rashleigh
Chief Health Infrastructure Office
System Support Services
Director – Capital Delivery Program
28 / 08 /2012

From: Trevor Sadler
Sent: 12 Sep 2012 13:00:08 +1000
To: Dwyer, Lesley
Subject: Some BAC background
Attachments: Site Options Paper for the Redevelopment of the Barrett Ad.Centre Oct 2008 final, Proposal for limited BAC redevelopment.doc

Hello Lesley,

It was good to meet you yesterday. I really appreciated your taking the time to visit the unit.

I'm following up with some background and some suggestions (if we are to continue to exist).

A site redevelopment panel (which I was part of) surveyed a number of sites in 2008. The findings are contained in the attached report. Of significance is

- the current site was one of two potential sites
- at the time the site of the planned Springfield Hospital was not considered. (It may still be a fair way off, but the Minister has recently encouraged the Mater to commence discussions, as you would be aware.) It does not have the environmental concerns of Redlands.
- there are no other sites.

If there was to any rebuilding in the future, it would appear that here are Springfield are the only options.

I wrote to Dr Bill Kingswell in April asking him to consider an alternative plan should Redlands not be able to go ahead. (Apart from the environmental constraints which may have scuttled it, it had gotten to the stage where the constraints on the building due to the environmental concerns meant that it could not have adequately served the population.) I suggested the above two options if there was any money for any redevelopment.

However, rather than a total rebuild on the current site, I suggested just a rebuild of the patient accommodation. This is outlined in the attached Word document. This may be a way to secure improved accommodation for the adolescent in times of budgetary constraint.

I wrote to Bill after yesterday's meeting. When I discussed step down accommodation, I anticipated that we would be seeking private sponsorship if we had the ground. Staff have some thoughts and links on how to approach this.

Of course this is all relevant if the decide to close the unit. I hope we don't have to go down another consultation path about this again. In the past we had strong endorsement from CYMHS services across the state, from child psychiatrists, from parents and adolescents. I know the majority of the current group of adolescents feel passionate that this has been important in their lives so that they are either still alive or able to function or both. Prof Graham Martin of RCH (originally Director of Southern CAMHS in Adelaide) and A/Prof Brett McDermott of Mater CYMHS (originally from WA) both said this was one gap in their services. I could always go into private practice, and there are a lot of quality staff who would have no problem finding a job, but we would all have grave concerns for the adolescents we treat. Have to wait and see, I guess.

Kind regards,

Trevor

Dr Trevor Sadler
Director
Barrett Adolescent Centre
Clinical Leader CYMHS Collaborative
The Park _ Centre for Mental Health
Locked Bag 500
Sumner Park BC
Queensland 4074

From: Ray Chandler
Sent: 4 Oct 2012 05:32:58 +1000
To: Lesley Dwyer;Sharon Kelly
Subject: Fwd: Barrett Adolescent condition summary
Attachments: Barrett Adolescent condition summary.txt

Good morning

I asked BEMS to pull together a high level estimate of what would be involved in bringing BAC back to good condition if it is to be used for an elongated period. The report is attached for your information

Ray

Ray Chandler
Executive Director Infrastructure & Ipswich Hospital Expansion

West Moreton Hospital and Health Service
T:
M:
E:
Chelmsford Ave, Ipswich, QLD 4305
PO Box 73, Ipswich, QLD 4305
www.health.qld.gov.au

From: Robert Wood
Sent: 21 Sep 2012 17:05:44 +1000
To: Ray Chandler
Cc: Wayne Plummer;Logan Steele
Subject: Barrett Adolescent condition summary
Attachments: Barrett Adolescent Condition Report.doc, Barrett Adolescent Condition Report2.doc

Hi Ray,

Attached are two versions of the Barrett Adolescent maintenance challenges.

My Estimate is $400,000 to bring it back to good condition in the same layout etc that it is now. This includes some asbestos removal but there is a lot in the building - it remains safe if it is maintained.

One report has a few pictures and the other one doesn't.

Hopefully it's enough to get the ball rolling with MH Capital Delivery people.

See Ya,
Robert

Robert Wood
A/Building, Engineering and Maintenance Manager
Ipswich Hospital
West Moreton Hospital and Health Service
T:
E:
Chelmsford Avenue, Ipswich, QLD 4305
PO Box 73, Ipswich, QLD 4305
www.health.qld.gov.au

West Moreton Hospital and Health Service

Report on the Condition of the Barrett Adolescent School and Accommodation

EXECUTIVE SUMMARY

This report has been prepared due to the expectation that the Adolescent School and Accommodation in Barrett C (school) & D (accommodation) is to remain on The Park site for the foreseeable future.

Both Barrett B & C buildings are in approximately of 35 years old and were not originally designed or built to house a school or adolescents accommodation. Genuine redevelopment or capital investment in Barrett B & C had been avoided in the 2000 site redevelopment of The Park as the service was destined to be relocated. It has now been 12 years since the 2000 major site redevelopment and Capital Works Delivery Program has cancelled the build of an alternative site at Redland Bay.

In consideration of the relocation of the Adolescent Mental Health service the Barrett buildings have been maintained with a short term view and subsequently they now have a large number of infrastructure challenges to ensure they remain fit for purpose.

An estimated investment into Barrett C & D of approximately $400,000 is necessary to bring these buildings back to good condition.

INTRODUCTION

The purpose of this report is to identify capital or redevelopment level works which are necessary to allow the Adolescent Mental Health service to effectively operate from the Barrett Adolescent site for the foreseeable future.

A recent inspection and the tri-annual Building Condition Assessments are the basis for the comments below. Values may be increased to represent a longer term maintenance view as opposed to the previous view of meeting short term maintenance objectives.

STRUCTURE OF THE BUILDING (SBZZ)

The buildings are approximately 35 years old and generally the physical structure of the buildings appears in sound condition when considered against the mandatory Building Code of Australia standard for the period.

Roof General (RFZZ)

The cliplock roofing for each building is in fair condition for its age. Repairs were actioned approximately 15 years ago due to cliplock roof sheets rusting in areas.

Both buildings roofs require sections of replacement, sealing and/or painting to ridges, flashing and cliplock sheets in lieu of total replacement due to leaks and rust.
Barrett C requires a number of sections of insulation repaired.
Barrett D requires additional possum/vermin proofing.

Estimate for repairs is $60,000.

External Walls (EWZZ)

Both buildings have brick exteriors in sound condition.

External fascias of the buildings contain asbestos. The asbestos sheeting was repainted approximately five years ago. It is due for a clean and repaint by in lieu of removal to ensure the integrity of the encapsulation of the asbestos fibres.

Barrett D requires soffit repairs adjacent the visitors entrance.

Estimate for painting and repairs is $45,000.

Windows General (WWZZ)

A large number of window panels have been changed to perspex to avoid repeated breakages. Barrett D windows requires servicing, resealing and waterproofing of most windows.

Estimate for window maintenance/repairs is $20,000.

External Doors (DOZZ)

External doors and trims on both buildings require a level of servicing and painting to prolong their life.

Estimate for exterior door and trim work is $5,000.

Wall Finishes General (WFZZ)

The buildings appear to have been internally repainted around 2000. The internal painting of the school building walls is generally in sound condition. The accommodation building is in need of a repaint.

Estimate for Barrett D internal repaint is $20,000.

Floor Finishes (FFZZ)

Floor coverings, especially in the school building are in poor condition. In lieu of total replacement all floor coverings require cleaning and some areas require replacement.

Both buildings have asbestos backed vinyl.

Estimate for floor covering cleaning, repairs and necessary replacement (including some areas containing asbestos) is $60,000.

Ceiling Finishes (CFZZ)

Ceilings in both areas require replacement and/or repair.

The perforated ceiling tiles in the accommodation building have been identified as containing asbestos.

Estimate for ceiling repairs, insulation and replacement of asbestos ceiling tiles is $100,000.

Fitments (FTZZ)

Many cupboards throughout the buildings are original. In general they are in fair condition.

Cupboards associated with the adolescent bedrooms are due for replacement.

Estimate for bedroom cupboard replacement $10,000.

Air Conditioning (ACZZ)

Generally air conditioning systems are function correctly. Most are approximately 10 years old and due for replacement.

Fire Protection (FPZZ)

The fire sprinkler system throughout is 35 years old. Although the system is currently working it is foreseeable that the pipework is at the end of is expected lifespan and pipework failure can be expected.

The current fire protection panel is no longer supported by the manufacturer and requires replacement as currently only second hand spare parts can be sourced.

Estimate for replacement of existing fire panel and associated upgrade is $20,000

Lights and Power (LPZZ)

Although many bedroom light fittings have been upgraded to 'safe' fittings there is a large portion of the electrical infrastructure which requires upgrades/replacement. This includes:

- Light switches
- Power Points
- Light fittings
- Electrical switchboards
- Electrical circuit breakers
- Electrical earthing

Estimated light and power replacement / repairs is $50,000.

OVERALL CONDITION

In summary, the Barrett C & D buildings require the following minimum estimated expenditure to bring them back to sound condition:-

Roof	$60,000
External walls	$45,000
Windows	$20,000
External Doors	$5,000
Wall Finishes	$20,000
Floor Finishes	$60,000
Ceiling Finishes	$100,000
Fitments	$10,000
Fire Protection	$20,000
Light & Power	$50,000
TOTAL	$390,000

This estimate is to bring the buildings back to good condition in its current layout. Estimates are based on BEMS coordinating the works with current contractors.

This estimate excludes:

- items which have not failed yet (eg. Air Conditioning) but have a limited life.
- work to remove all asbestos containing materials
- changes to improve the living environment of the adolescents in care.

RECOMMENDATION

As the Barrett Adolescent School is to remain on the site the minimum investment to these buildings to bring them back to good order is $390,000.

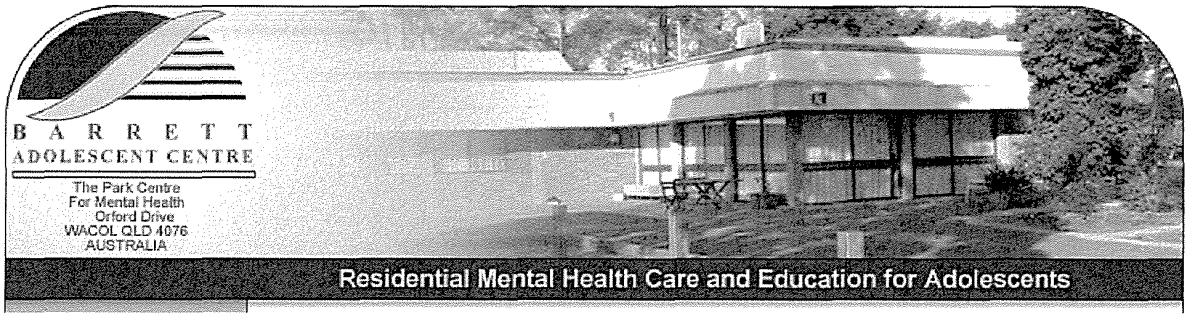
If the adolescent school is to remain for the long term investment in redesign and/or rebuilding should be considered to ensure the facility serves its purpose appropriately for the mental health treatment of adolescents

Robert Wood
A/ Manager BEMS
WMHHS

21/9/2012

West Moreton Hospital and Health Service

Report on the Condition of the Barrett Adolescent School and Accommodation



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An estimated investment into Barrett C & D of approximately $400,000 is necessary to bring these buildings back to good condition.

INTRODUCTION

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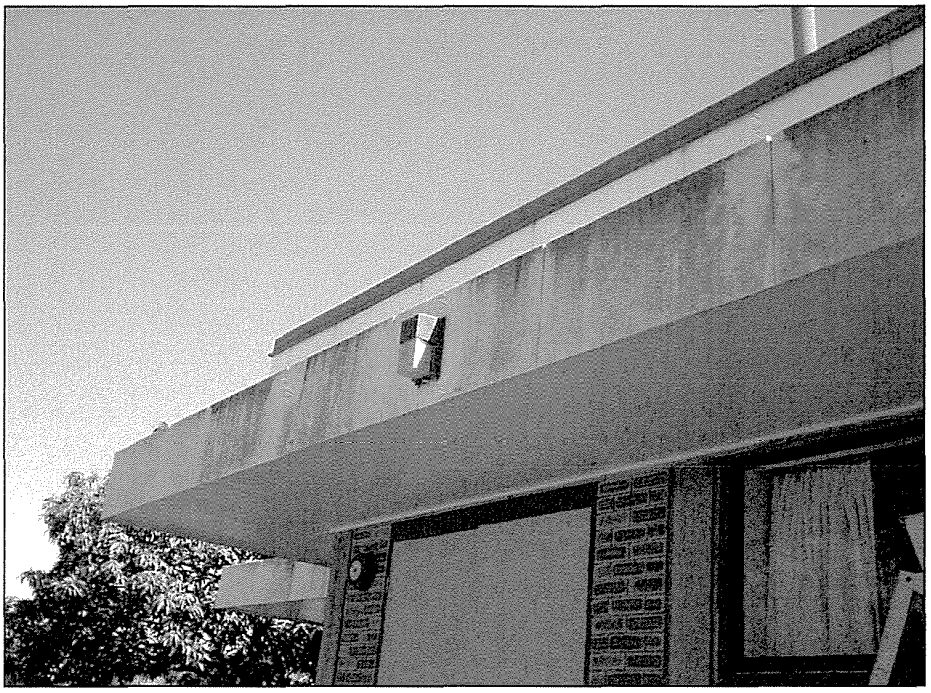

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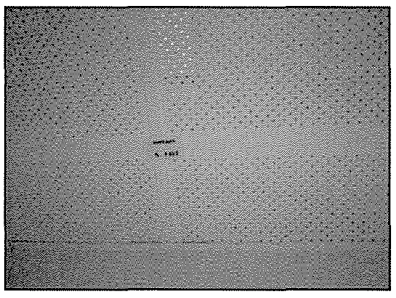

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Robert Wood
A/ Manager BEMS
WMHHS

21/9/2012

From: Sharon Kelly
Sent: 26 Oct 2012 14:46:22 +1000
To: Kingswell, Bill;Gilhotra, Jagmohan;Geppert, Leanne
Cc: Dwyer, Lesley;Thorburn, Chris
Subject: WMHHS and mental health plan

Bill, Leanne and Jagmohan,

thank you very much for my meeting yesterday afternoon with you to discuss the future mental health plan and the role West Moreton plays in this. I appreciated getting the up to date information and I trust we can move forward on a range of issues together.

if I can recap on some as I believe there were a few actions out of yesterday and it will help me get my thoughts in alignment and also allow me to provide the CE with an update at the same time:-

- The plan for The Park remains as a forensic unit and our current cohort of ETTR /DD patients will eventually be relocated to more suitable accommodation.
- I can confirm we have ceased admissions into the ETTR unit to achieve this, however a date for all to be transferred off site by June 2013 remains tenuous. I understand from our discussions that you are planning a conversation with the other units to attempt to expedite this process given the agreement of the State Mental health plan in this area. Please advise if you require any actions from us in this initial process.
- the funds that have currently been removed from WMHHS and reallocated to other HHS in anticipation of CCU movements will be formally support by yourselves with the system manager to reallocate those to us given we continue to have the consumers.
- [redacted] included in the next planned meeting to progress this.
- the development of the Goodna CCU has now been signed off by the Minister. I understand there is a significant amount of consultation etc moving forward so I look forward to progressing that together. If you have the signed brief back from the Minister's office we would appreciate a copy for our records as well.
- in regards to QCMHL I will ensure that the focus of QCMHL is aligned as we discussed to ensure they remain contemporary for the service requirements moving forward.
- opening of EFTRU - a number of consumers in other accommodation are awaiting the opening of EFTRU as you identified and we need to consider the opening time to relieve some congestion within the correctional facilities as well and ensure people are getting the most suitable treatment and care. I have indicated that the earliest EFTRU could open given the out of scope works etc would be March 2013 and this would rely on us being able to achieve this within our FTE etc. on that note I appreciate that besides us advising the System manager you will also advocate to the system manager regarding the omission of an increased MOHRI count into MH WMHHS for the EFTRU opening.
- Barrett Adolescent Centre- as we have all confirmed this is a somewhat sensitive issue as we define the future. I would like to confirm our discussions in regards to this however. I understand that a brief has gone to the Minister re BAC, a copy for our records would be appreciated. the content of the brief did not clearly articulate that closure was the only option, however from our discussion and opinions I have gleaned from others the model for BAC is not aligned into the future planning for The Park or for Queensland Mental Health Plan. as such the option is to close BAC as early as December 2012 given that all or most of the consumers all go home for the Christmas break. this would include the education program. an alternate would be to close the beds but keep the day program for a period of time. for any of this to occur I understand we need to commence discussions with other services that could provide the support for the young people once BAC does not exist.
  - the brief that was written to the Minister will be provided to WMHHS for noting

- I will need to brief Lesley, my CE on this early next week so our HHS board chair is made aware of this action and also the timing of our actions.
- a meeting planned for next Friday between myself, Terry and Dr Sadler will now be expanded to include Leanne in the absence of Bill and I would like to include Chris Thorburn who is working with me on redesigning mental health WM. - at this time we will advise that closure is not optional however needs to be planned
- a strategic stakeholder meeting is to be arranged by Bill the week after next in regards to meeting with the Mater services and others to map out what actions and requirements there are to ensure no young person is disadvantaged in this change. and is December achievable.
- prior to the Friday meeting a brief does need to be written that alerts appropriately as we are reasonable confident that the advice of closure will elicit community action for those families involved in BAC. thus a clear communication plan and strategy is required.

- I appreciated your advice that previous decisions with my predecessors has given commitment that once the services are removed at least 1/3 of the allocated funding would remain within WMHHS Mental Health budget. I do recognise that the funding horizon and arrangement are somewhat changed since that agreement was reached, however would be hopeful that this remains the intent.

once again I hope I have reflected our conversation and would appreciate any clarification of comment if this is not accurate.

Thank you very much for the meeting, looking forward to continuing our partnership into the future.

Regards
Sharon

Sharon Kelly
Executive Director
Mental Health and Specialised Services

West Moreton Hospital and Health Service
T:
E:
Chelmsford Avenue, Ipswich, QLD 4305
PO Box 878, Ipswich, QLD 4305
www.health.qld.gov.au

West Moreton Hospital and Health Servic
PROJECT PLAN

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Start Date:	16 November 2012	**Approval:**	☐ West Moreton Hospital and Health Board		
End Date:	TBD				

Description of Project: Barrett Adolescent Strategy

BACKGROUND of PROJECT	• Barrett Adolescent Centre (BAC) is located within The Park – Centre for Mental Health (The Park) and provides a state wide service of extended treatment and rehabilitation[1] for up to 15 adolescents with severe and complex mental health disorders.
	• As part of the *Queensland Plan for Mental Health 2007-2017* (QPMH), a capital allocation had been approved to rebuild BAC in a new location as:
	  o The capital fabric of BAC is no longer able to meet the requirements of a contemporary model of care for adolescent extended treatment and rehabilitation and
	  o The Park will become exclusively a High Secure and Secure Rehabilitation Mental Health Service for adults (by end of 2013).
	• Initial consultation with stakeholders (about a replacement service for BAC) commenced as part of the planning for Stage 1 of the QPMH (approximately 2005-06).
	• Planning associated with the QPMH incorporated in a new capital project to be delivered at Redlands, which would replace the BAC. The Adolescent Extended Treatment and Rehabilitation Unit was to be built adjacent to the Redlands Hospital. It was to be commissioned in 2014. Due to environmental and other issues, the project could not proceed and has now ceased.
	• The capital allocation previously attached to the rebuild of BAC has been redirected to other Queensland Health capital priorities; this capital funding is currently no longer available for a rebuild of BAC at an alternative site.

[1] While currently classified as an extended treatment and rehabilitation model of service, the replacement model of service for BAC will likely be classified as either a subacute rehabilitation or community residential program. The classification will need to align with national and state classification frameworks, and relevant funding models.

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