Barrett Allied Health Services (BAC)

Barrett Adolescent Centre (BAC) is a level 6 unit in the Clinical Services Capability Framework, providing highly specialised interventions. BAC is viewed by staff in the unit as the 'last chance' resort for adolescents and their families who have been unable to either engage with, or respond to, therapy services in acute and community settings, due to the complexity, severity and persistency of the young person's mental illness. BAC provides an extremely unique service to the state, through a multidisciplinary team of highly skilled health practitioners. BAC allied health staff acquire specialised knowledge and experience, specific to the extended and intensive care of adolescence with severe and complex mental health issues. Barrett has a 4.5 FTE of Allied health professionals for 25 clients (15 inpatient beds).

The unit's management believe they are understaffed by national and international comparisons;

- The Walker Centre in Sydney, NSW; For 12 inpatients, they have 1 psychologist, 1 social worker/family therapist, 1 occupational therapist, 1 half time art therapist, 1 half time music therapist and a part time speech pathologist. 4.5 FTE allied health for 12 patients.
- The Mater day program has 1 psychologist, 1 social worker/family therapist, 1.2 occupational therapists, 1 part time art therapist, 1 part time music therapist and a part time speech pathologist for 10 to 12 patients. Again about 4.5 FTE for 10 to 12 patients.

There is a 0.5 specialist clinical supervisor (SCS) among those providing interventions. The primary role is supervision, in particular of nursing staff. The service has no CNC. The position also provides training, and supports interventions provided by Allied Health in the unit. The unit has 2 OTs. There was originally 1 OT however a second position was created out of a former nursing position at the suggestion of a former NUM, and the Clinical Director. The unit's management strongly believe that they have the most advanced and well articulated rehabilitation program in the state and this is attributed to the decision a decade ago to strengthen the rehabilitation component of the service by having a second OT. The other positions are 0.5 FTE HP6 Speech Therapist, 1x HP5 Social Worker and 2x 0.5 Psychologists.

Although BAC currently has 15 inpatient beds, occupied beds can be as low as 10. There is however an additional 7-8 day patients who receive the same level of care from allied health services. Staff at BAU suggested that day patients require even more intensive and regular support, as they are learning to begin managing their illness in complex home and community settings, rather than being contained in a ward setting. Day patients are often being supported to reintegrate back to mainstream schooling, to use public transport to access the unit and to care for themselves in the home environment (e.g cooking meals, managing time, and sleep hygiene).

The reviewer noted that the day programme adds a significant amount of workload to the staff at Barrett. The reviewer also noted that the current model of service delivery that has been adopted at Barrett is resource intensive and needs to be reviewed with the specific view of exploring whether this model is still contemporary.

Summary of findings and recommendations

Category of recommendations	Recommendations	Rationale
1. Integrated model of service delivery	1. The current separate allied health and rehabilitation structures should be restructured and reorganised under one management. (see attached proposed structure) 2. There is need for the multidisciplinary team to establish business rules for structured programme delivery. 3. The Park should set minimum core programmatic requirements that are monitored by each unit's director. At a minimum each unit should provide activities in the following core programme domains of: Recreational; Therapeutic; Educational and Vocational activities. 4. Allied health staff should take an active role, and collaborate with their nursing and medical counterparts and other members of the multidisciplinary team; in the designing and implementation of evidence based psychosocial rehabilitation interventions/ programmes at the Park	1. Financial savings will be made through reduced duplication of management structures. 2. One of the benefits of the proposed model is that the savings suggested are largely achieved through the abolition of vacant or temporary positions. This may alleviate some staff anxieties about job security. 3. Integration of services under a common leadership structure would support a common understanding and delivery of rehabilitation services. 4. Through improved coordination of all staff a greater level of responsiveness to emergent needs of individual consumers may be achieved while sharing the delivery of the structured program. 5. A greater coordination of allied health staff may contribute to establishing clearer priorities for interventions aimed at preparing consumers for discharge. 6. Localised coordination of programmes would enhance the chances of individual needs of consumers being met.
2. Integration and partnerships with the wider community services.	1. The Park should designate the role of community linkages to a senior clinician with specific expectations of maintaining liaison relationships with community services. The staff member designated with the role will actively seek to gain membership in interagency forums in the community and develop service agreements with key community services that	1. Firstly this will improve consumer access to community services provided by NGOs, private and other governmental agencies. 2. This will enhance exit pathways for consumers and lead to more options for those consumers ready for discharge.

	provide services needed by mental health consumers in hospital and those transitioning into community living.	3. *Evidence based practice denotes that skills training works best when conducted in real environments ie community. Consumers will gain skills they need to exit hospital quicker leading to faster discharge possibilities.*
3. *Professional and leadership development*	1. *The service should seek opportunities to grow current leaders. The service should invest in a leadership programme that motivates leaders and gives them skills and tools to provide strategic and visionary leadership.* 2. *Ongoing professional development needs to be available to all staff to ensure that they acquire the skills, knowledge and confidence required to practise in a recovery oriented way.* 3. *The Park leadership group should investigate current professional development opportunities eg MHPOD and collaborate with QCMHL for new avenues.* 4. *The Park should seek volunteers to take on the portfolio of recovery champion in each unit that would champion recovery oriented practices.*	1. *Better consumer experiences as recovery orientated practises are employed by staff.* 2. *Consumer focused programme development would be realised.* 3. *Better engagement and enhanced use of least restrictive practises leading to better safety, quality of care and consequently better consumer experience* 4. *Evidence from the literature suggests that leadership is a skill and can be learnt. Visionary and strategic leaders who are able to set priorities and lead the organisation forward would enhance consumer outcomes.* 5. *Professional development would give staff the skills, knowledge and confidence required to commit to an agreed model of service delivery.* 6. *Access to rehab interventions would be improved as all staff will now be confident in providing core rehab interventions. The current notion of "rehab happens when rehab staff are present" will no longer reign.* 7. *Financial savings will be realised from reduced overtime as rehab and allied health staff would no longer be required to come in after hours and on weekends.*
4. *Data collection and information management*	1. *Allied Health staff should use available information systems and adapt business rules as needed in order to ensure that data is routinely captured for clinical as well as service*	1. *Service evaluation, monitoring of outcomes and reporting would be improved* 2. *Communication would be improved as all client*

	delivery and evaluation purposes. *2. Utilise existing CIMHA committee to plan and implement changes.* *3. The service should consider the use of a single data collection system and the need to position the service for an electronic record system.*	*information would be easily available* ***3.*** *Patient safety would be enhanced*
5. Allied health governance	*1. The business unit structures should have allied health leaders as integral members of the clinical and leadership teams.* *2. The Director of Allied Health position should represent all allied health services in mental health reporting to the Executive Director of mental health.*	***1.*** *The risk of not having a strong allied health mental health workforce representation at all levels is that psychosocial interventions may not be maximised in the service leading to poorer outcomes for consumers.* ***2.*** *Representation of allied health at the business unit level could advocate for a greater adoption of practices to prepare consumers for the community*
6. Resourcing	*1. Targeted recruitment of staff with the skills and interest to provide programmes that utilise existing resources should be pursued.* *2. The Park leadership group should work together to support a greater participation and mobility of staff between clinical programs to ensure a greater sharing of expertise between these areas.* *3. The ATSI position should be refocused and realigned with other ATSI positions under one leadership.* *4. The exercise physiologist position should be refocused and realigned.*	*1. Improved consumer access to a range of expertise and programmes by more clients leading to better consumer experience and consumer outcomes.* *2. Better utilisation of existing facilities such as the gym and swimming pool.* *3. Better support for staff in solo specialist roles and less risk of these roles diverting from core business.*

Current Structure

The current structure of Rehab and Allied Health Services is attached in Appendix 2.

1.2 *Scope of Initiative*

The current model of Mental Health Rehabilitation and Allied Health Services within The Park Centre for Mental Health was identified as needing review (consultation Paper , Attachment 10 dated 27/07/12). Previous internal service reviews in 2002 and 2012 have highlighted that the current model of service delivery does not meet the client needs. An integrated approach where all staff report through one governance structure was identified as necessary to maintain cost effectiveness of the service and to facilitate a philosophy of rehabilitation and recovery.

The reviewer was specifically asked to;

- Review the current model and develop a contemporary model in line with a recovery philosophy.
- Review core skill requirements, roles and levels of rehab and allied health staff with a view of creating some efficiencies and realising some financial gains.
- Present and report recommendations to the Mental Health Executive

Allied health professions included in this review are; Nutrition and dietetics, occupational therapy, physiotherapy, psychology, social work, speech pathology, exercise physiology and complementary services; therapy aides and recreation officers.

Outside the scopes of this review and therefore excluded in this review are;

- Review of Allied Health Services in IMHS
- Review of BAU MOS
- Pharmacy
- Laboratory technology
- Information management officers
- Medical imaging
- Orthotics and prosthetics

1.3 *Deliverables*

Change	Deliverables	Timeline
Integration and partnerships with the wider community services.	• The role is assigned to a senior staff as in the proposed structure	January 2013- ongoing
Integrated model of service delivery	• The rehab and allied health staff are restructured and integrated.	January 2013-ongoing
Data collection and	• Allied health staff use	March 2013 -ongoing

information management	CIMHA for POS, progress notes and assessments.	
Allied health governance	• Allied health staff are in leadership positions reflected in the service's operational structure.	January 2013-ongoing
Professional and leadership development	• Consumers have access to a wide range of evidence based therapies and interventions • Staff have the skills, knowledge and confidence to deliver services that meet the needs and expectations of consumers, their families/ and carers.	March 2013 -ongoing
Resourcing	• Consumers have access to a wide range of evidence based therapies and interventions	January 2013-ongoing

Financial deliverables are presented in other parts of this document.

1.4 *Potential Dependencies*

The success or lack of, in the implementation of the recommendations of this review depends on a number of internal and external factors. Some of the internal factors include support from other senior managers, changes to the management structure, support from other departments eg HR, outcomes of other reviews taking place concurrently. External factors include change in policy from government, change in legislation, changes to other services that provide community services needed and used by consumers at the Park.

1.5 *Potential Impact of Initiative*

Change	Impacts on	Potential impact
Membership in interagency forums and service agreements with key community services.	Consumers Staff Community	• Better outcomes would be achieved through improved partnerships with other community services

	Quality & safety	• Reduced reliance on internal resources, freeing up of internal resources • Better staff and consumer satisfaction
Data collection and information management	• Improved data quality & safety • Staff • Service	• Increased pressure on resources such as computers
7. *Allied health governance*	• Consumer outcomes • Consumer satisfaction • Staff morale • Service outcomes	• Staff will feel more supported within the new structure • Consumers will get a better service and better outcomes • Families and Carers will be much more satisfied • Offers a greater capacity for drawing flexibly from the skill mix of the larger group • Financial savings will be realised from decreased duplication of roles.
Localised development and coordination of rehabilitation programmes with an overarching set of minimum core programmatic requirements.	Consumers Carers Families Staff Quality & safety	• Individual consumer needs would be met • A wider range of programmes would be accessible to consumers at The Park. • Clients will get better engagement from clinicians
Representation and active participation of allied health at all levels including the business unit level .	Staff Clients Carers Families	• Enhanced multidisciplinary approach at all levels leading to better consumer outcomes eg greater adoption of practices that prepare consumers for community living

	Quality & safety	• Better satisfaction from consumers, carers and families
The realignment of the ATSI and exercise physiology positions And the; Targeted recruitment of staff to provide programmes that utilise existing resources.	Staff Consumers Carers Families Service	• Redundancies maybe needed which impacts on staff and their families income • Consumers will get better services and will be more satisfied • Families and Carers will be more satisfied • Service will realise some financial savings
recovery champions in each unit that would champion recovery oriented practices	Staff Consumers Carers Families Service Regulatory/legislative compliance	• Improved knowledge, skills and confidence of all staff on recovery • Improved autonomy and self determination from consumers in care • Recovery oriented practice and national mental health standards can be met

Proposed Structure

The proposed structure of Rehab and Allied Health Services is attached in Appendix 3.

The reviewer recommends that the service adopts an Integrated Decentralisation Model also known as the Matrix Model (Boyce, 2001). This model supports individual professional discipline identities and also promotes responsiveness to the needs of clinical units through team based service delivery design. The model creates an internal allied health matrix which recognises the value of professionally managed services to sustain professional identity, service management and development whilst focusing on outcomes for consumers. Successful implementation of this model requires high levels of inter –professional trust and a collective allied health philosophy. The professional structure i.e. discipline seniors, lead service management and development of an organisational and clinical nature whereas the operational structure is concerned with service delivery. In this model allied health teams are organised to mirror the internal structure of the organisation. This model integrates the complexity of delivering services to a range of clinical units with greater expectations for collaboration, accountability and service outcomes.

Boyce (2001) recommends that in the first instance the roles of discipline seniors are reformulated to include responsibility of leading an Allied Health Team in order to minimise managerial overheads. It is also recommended to move members of a team into one

location and discipline seniors offices into a shared open plan office. The main advantage of this model is that it delivers flexibility ie professional resources can be moved between teams to respond to unexpected service demands or staff absence because staff are not "owned" by the clinical units.

The reviewer recommends a transitional period where the Director of Allied Health position operationally manages the discipline senior and coordinator positions for the first six months to support the roles develop a collaborative approach. The coordinator positions will take responsibility for group programme coordination for their respective business units whilst also carrying service wide portfolios on therapies and community linkages. The Directors of Allied Health, Nursing and Psychiatry will set agreed targets and expectations (through a collaborative process and in consultation with the unit directors), for the business units to deliver on each year under the leadership of each unit director. This team of directors will also take responsibility for monitoring the achievement or lack of, of these targets.

2. Business Benefits

2.1 Business Benefits and Outcomes

This new clinical governance and operational management structure integrates treatment and rehabilitation services to ensure that a seamless service underpinned by a recovery philosophy can be realised. The advantage of the proposed structure is that it clearly identifies the responsibility for the coordination of a structured program. The new structure mobilises a greater number of staff to assist in the development and delivery of the programme thereby sharing the responsibility for the work more equitably. Financial savings will be realised from decreased duplication of roles.

2.2 Non-Financial Benefits

- The advantage of the proposed structure is that it clearly identifies the responsibility for the coordination of a structured program. The new structure mobilises a greater number of staff to assist in the development and delivery of the programme thereby sharing the responsibility for the work more equitably.
- This new clinical governance and operational management structure integrates treatment and rehabilitation services to ensure that a seamless service underpinned by a recovery philosophy can be realised.
- Enhanced multidisciplinary approach at all levels leading to better consumer outcomes eg greater adoption of practices that prepare consumers for community living
- Better satisfaction from consumers, carers and families
- Better outcomes would be achieved through improved partnerships with other community services
- Reduced reliance on internal resources, freeing up of internal resources
- Savings are achieved largely through abolition of vacant positions which minimises impact on existing staff
- Staff will feel more supported within the new structure
- Consumers will get a better service and better outcomes
- Families and Carers will be much more satisfied
- Offers a greater capacity for drawing flexibly from the skill mix of the larger group
- Financial savings will be realised from decreased duplication of roles.
- Improved knowledge, skills and confidence of all staff on recovery
- Improved autonomy and self determination from consumers in care
- Recovery oriented practice and national mental health standards can be met

2.3 *Financial Benefits*

A total financial saving of **$1,018,505** (mostly recurrent) will be realized through this proposed restructure. A detailed breakdown on financial savings is under the "Savings Worksheet" section of this document and also detailed further in the appendix.

3. Evaluation

Change	Key Performance Indicator/ measures	Timeline
Integration and partnerships with the wider community services.	• Membership in interagency forums • Service agreements with key community services. • Number of consumers accessing services from other agencies • Number of agencies providing services at the Park • Consumer, carer, staff and NGO satisfaction	• June2013- ongoing
Integrated model of service delivery	• Financial indicator 1: Savings • Financial indicator 2: reduction in MOHRI FTEs • Staff will feel more supported within the new structure • Reduction in average length of stay • Consumer, Families and Carers will be much more satisfied	January 2013-ongoing
Data collection and information management	• Number of complaints/incidences relating to communication • Number of staff using CIMHA • Staff satisfaction	March 2013 -ongoing
Allied health governance	• Number of allied health leadership positions reflected in the service's operational structure.	January 2013-ongoing

Professional and leadership development	• Number and category of programmes accessible to consumers • Consumer satisfaction • Staff satisfaction • Families/ carers satisfaction	March 2013 -ongoing
Resourcing	• Consumer satisfaction • Staff satisfaction • Financial savings	January 2013-ongoing

4. Risk Management

Having considered the risks identified in the risk matrix and the current political and economic climate the reviewer considers the overall risk rating as high. Early communication and engagement in the consultation process will reduce this risk significantly. All clinical leaders and managers in the district will need to be briefed as they are key roles that will need to respond to questions and concerns from staff.

5. Communication and Consultation

The purpose, scope and intent of this review and implications of any subsequent recommendations has been communicated to all staff at The Park by the reviewer and the working group put together by the reviewer. Rehabilitation and Allied Health Staff from the service and other stakeholders were invited to participate in the review and were offered group and individual sessions with the reviewer. The aim was to ensure that all stakeholders were provided the opportunity to participate. A consumer survey was conducted during the review period to gather the views of consumers. The Park management will now need to engage specific staff that may be directly affected by the review and their unions and support the staff through the change process. All other stakeholders will then need to be informed.

Communication will be available through a range of modalities however face to face will be the preferred mode wherever appropriate and possible.

Other key staff consulted during this review includes but is not limited to the following;
Paul Clare, Rehab Coordinator, High Secure Unit
Lorraine Dowell, OT Senior, The Park
Scott Nacho, Psychology Senior, The Park
Robin Young, Social Work Senior, The Park
Daniel Volk, Rehab Coordinator, Medium Secure Unit
Dominic Mitchell, Rehab Coordinator, ET&R
William Brennan, Director of Nursing
Sharon Kelley, Executive Director Mental Health
Kathy Green, Executive Director Allied Health
Dr Terry Stedman, Director Clinical Services, The Park
Dr Daniel Nielle, Director Clinical Services, High Secure
Dr Trevor Sadler, Director Clinical Services, BAU
Padraig McGrath, Nursing Director, High Secure Unit
Sue Cardy, Nursing Director, Medium Secure and ET&R

6. Recommendation

This review recommends the following broad changes; an integrated model of service delivery, an identified person who leads community linkages, ongoing professional development for staff and their managers, a consistent approach to data collection, an improved representation of allied health at all levels of the business and better utilisation of existing resources.

Specifically, the reviewer recommends that integration of services under a common leadership structure would support a common understanding and delivery of rehabilitation services. Consumers should be adequately prepared for community living through adequate engagement, person orientation and a multidisciplinary approach to service provision. The reviewer recommends a number of actions to improve consumer experience at the Park such as; recovery champions, unit based management of programmes, minimum programme elements, and ongoing professional development for staff. A leadership programme for middle level managers and clinical leaders to enhance outcomes and assist in turning around service provision, the West Moreton way, is also recommended.

RISK ANALYSIS

Risk Analysis
*Describe the risks in the table below, noting that risks with a rating of high and above should be fully considered and included. Please refer to the Integrated Queensland Health Risk Management Framework and Policy:*http://qheps.health.qld.gov.au/audit/IRM_Stream/policies.htm An analysis of the proposal risk exposure against the Integrated Risk Management Framework identifies the following risk profile for the proposal.

No	Risk Event *(what could go wrong)*	Inherent Risk Rating	Mitigating Action *(what are you going to do about it)*	Owner
1	Resistance to change from staff directly affected by change ie, AH & Rehab staff	medium	• Design and deliver key messages about the change using various communication methods such as face to face, email and letters.	The Park Senior Management
2	Limited uptake of the multidisciplinary team ie nurses and doctors	high	• Design and deliver specific key messages for this group • Deliver multidisciplinary-cross functional workshops on the changes.	The Park Senior Management
	Required consultation is not undertaken appropriately increasing resistance to change	high	• Engage stakeholders in consultation process early • Monitor progression of implementation and consultation activities	ED, HR and Senior Management
3	Decreased motivation from staff who may already be change weary leading to increased absenteeism/stress claims	high	• Most of the positions demolished are vacant • Open respectful communication with all staff • Use data/evidence as platform for initiating change	All leaders and managers
The Park staff are heavily unionised therefore it will be imperative to adequately consult with unions before any changes are implemented. The reviewer has involved a wide range of staff and this has significantly reduced the likelihood of unions being a major impediment.				

LIKELIHOOD		CONSEQUENCES				
		Negligible	Minor	Moderate	Major	Extreme
	Rare	Low	Low	Low	Medium	High
	Unlikely	Low	Medium	Medium	High	Very High
	Possible	Low	Medium	High	Very High	Very High
	Likely	Medium	High	Very High	Very High	Extreme
	Almost Certain	Medium	Very High	Very High	Extreme	Extreme

COMMUNICATION

Stakeholder Engagement
State the Primary or Key stakeholders consulted and their commitment to the proposal.

Name of Group/Person and Position	Consultation and communication method	Date	Comments on the proposal and key messages
Allied Health Seniors, & MH Rehab Team Leaders The Park	• Face to face meetings • Weekly meetings from 17/09/12 till 25/10/12	Various meetings between 17/09/12 and 25/10/12.	Generally supportive some concerns raised by AH seniors concerning risk of AH losing autonomy if managed by other disciplines/ leaders.
Terry Stedman, Director of Clinical Services, The Park	•Individually- face to face •Written feedback received	Various meetings between 17/09/12 and 25/10/12.	supportive
Dr Trevor Sadler, Director Clinical Services, BAU	• Individually- face to face • Written feedback received	Various meetings between 17/09/12 and 25/10/12.	Concerned about impact of any reduction of FTEs on BAU consumer outcomes and staff
William Brennan, Director of Nursing	•Individually- face to face	Various meetings between 17/09/12 and 25/10/12.	supportive
Kathy Green, Executive Director Allied Health	•Individually- face to face	Various meetings between 17/09/12 and 25/10/12.	supportive
Sharon Kelley, Executive Director Mental Health	•Individually- face to face	Various meetings between 17/09/12 and 25/10/12.	supportive
Dr Daniel Nielle, Director Clinical Services, High Secure	•Individually- face to face	Various meetings between 17/09/12 and 25/10/12.	supportive
Psychologists	• Face to face, attendance at the Park Psychologists Meeting • SWOT Analysis	Various meetings between 17/09/12 and 25/10/12.	Supportive, some concerns raised around risk of losing autonomy
Occupational Therapists	• Face to face, Attendance at the Park OT Meeting • SWOT Analysis • Individually with some OTs	Various meetings between 17/09/12 and 25/10/12.	supportive
Social Workers	• Individually –face to face • SWOT analysis • Individually with some SWs.	Various meetings between 17/09/12 and 25/10/12.	Supportive
All other staff	• Individually- face to face • SWOT analysis • MDT meetings	Various meetings between 17/09/12 and 25/10/12.	supportive

SAVINGS WORKSHEET

The Park AH Position Occupancy and Savings

All Disciplines/ All units

Discipline	Appt FTE	Apprvd FTE	12/13 Budget Productive FTE (V13)	12/13 Budget $ (V13)	Proposed FTE	MOHRI FTE Inc/Dec	Savings FY - $
Occupational Therapy	9.26	13.53	11.2	$1,293,298	8.2	-3	-$284,739
Social Work/Social Work Associate	10.01	13	11	$1,360,380	9.51	-1.49	-$202,081
Recreation Officers, ATSI Officers & Therapy Aides	8.5	12.5	9.5	$686,484	7.5	-1	-$76,280
Psychology	8	10	8.5	$1,129,460	8.5	0	$0
Exercise Physiology, Speech Pathology & Podiatry, Dietetics & Food Nutrition	3.13	3.63	3.6	$445,016	3.1	-0.5	-$94,026
Nursing	2	5	4	$540,676	1	-3	-$361,379
Totals	**40.9**	**57.66**	**47.8**	**$5,455,314**	**37.81**	**-8.99**	**-$1,018,505**

NEW UNIT - EFTRU (additional positions)

Discipline	Appt FTE	Apprvd FTE	12/13 Budget Productive FTE (V13)	12/13 Budget $ (V13)	Proposed FTE	MOHRI FTE Inc/Dec	Savings FY - $
Occupational Therapy	0	0	0	$0	1	1	$0
Social Work/Social Work Associate	0	0	0	$0	1	1	$0
Recreation Officers, ATSI Officers & Therapy Aides							
Psychology	0	0	0	$0	0.8	0.8	$0
Exercise Physiology, Speech Pathology & Podiatry, Dietetics & Food Nutrition							
Nursing							
Totals	**0**	**0**	**0**	**$0**	**2.8**	**2.8**	**$0**

Summary -	Appt FTE	Apprvd FTE	12/13 Budget Productive FTE (V13)	12/13 Budget $ (V13)	Proposed FTE	MOHRI FTE Inc/Dec	Savings FY - $
Existing services	40.9	57.66	47.8	$5,455,314	37.81	-8.99	-$1,018,505
New Unit EFTRU	0	0	0	$0	2.8	2.8	$0
Totals	**40.9**	**57.66**	**47.8**	**$5,455,314**	**40.61**	**-6.19**	**-$1,018,505**

Individual Impact analysis

Most positions are unoccupied. The occupied positions are the ones with change management plans described on the impact analysis below.

Cost Centre	Position ID	Position Title	Position Level	Incumbent	Change Management Plan
996203	30469736	Exercise Physiologist	HP3	Tegan Archibald	Position to be reclassified to OO4 when incumbent leaves. Incumbent wanting to go and study medicine.
996240	30469617	Occupational Therapist	HP3	Kim Hoang	Incumbent can undergo a suitability assessment for other vacant OT positions within the HHS.
996123	30469729	Occupational Therapist	HP3	unoccupied	Position vacant
996123	30469729	Occupational Therapist	HP3	Karen Miles	Incumbent on extended sick leave and wants redundancy
996140	30469738	Social Worker	HP3	Colleen Freeman	Incumbent is on a temporary contract and can be moved to position number 304697730 in the same unit.
996123	30469676	Therapy Aide	OO3	n/a	Incumbents have already been moved. Positions can be closed.
996200	30469586	Psychology Senior	HP5	Scott Natho	Suitability assessment for the redeveloped position
996160	30469611	Social Work Senior	HP5	Robin Young	Suitability assessment for the redeveloped position
996200 996540	30473828	Occupational Therapy Senior	HP5	Lorraine Dowell	Suitability assessment for the redeveloped position
996203	30469677	Rehab Coordinator	HP5	Paul Clare	Suitability assessment for the redeveloped position
996123	30469676	Rehab Coordinator	HP5	Dominic Mitchell	Suitability assessment for the redeveloped position
996143	30469675	Rehab Coordinator	HP5/NG7	Daniel Volk	Temporary employee. Incumbent to be assessed for other nursing positions within the HHS.

996544	30469596	ATSI	AO5	Bobby Haggan	This position needs to be realigned in a team of other ATSI workers or consumer advocates.
996123	30469728	Nurse	NG6	Vacant	Vacant position
996203	30469733	Nurse	NG6	1xFTE Vacant Annette Clifford	Incumbent to be assessed for suitability to other nursing positions within the service.
various	various	All rehab and Allied Health staff at The Park	HP2-HP6	All	Changes to operational manager and work units. Role descriptions to be rewritten to reflect changes.

ENDORSEMENT AND VALIDATION

Endorsement
Endorsement confirms the workload impact and saving/ cost estimates are appropriate to the proposal given its scope and risk profile, and the benefits are realistic and can be delivered as outlined.

Name:	**Signature:**
Position: Executive Director Mental Health & Specialised Services	**Date: / /**
Division: Division of Mental Health & Specialised Services	**Contact No:**
Comment:	

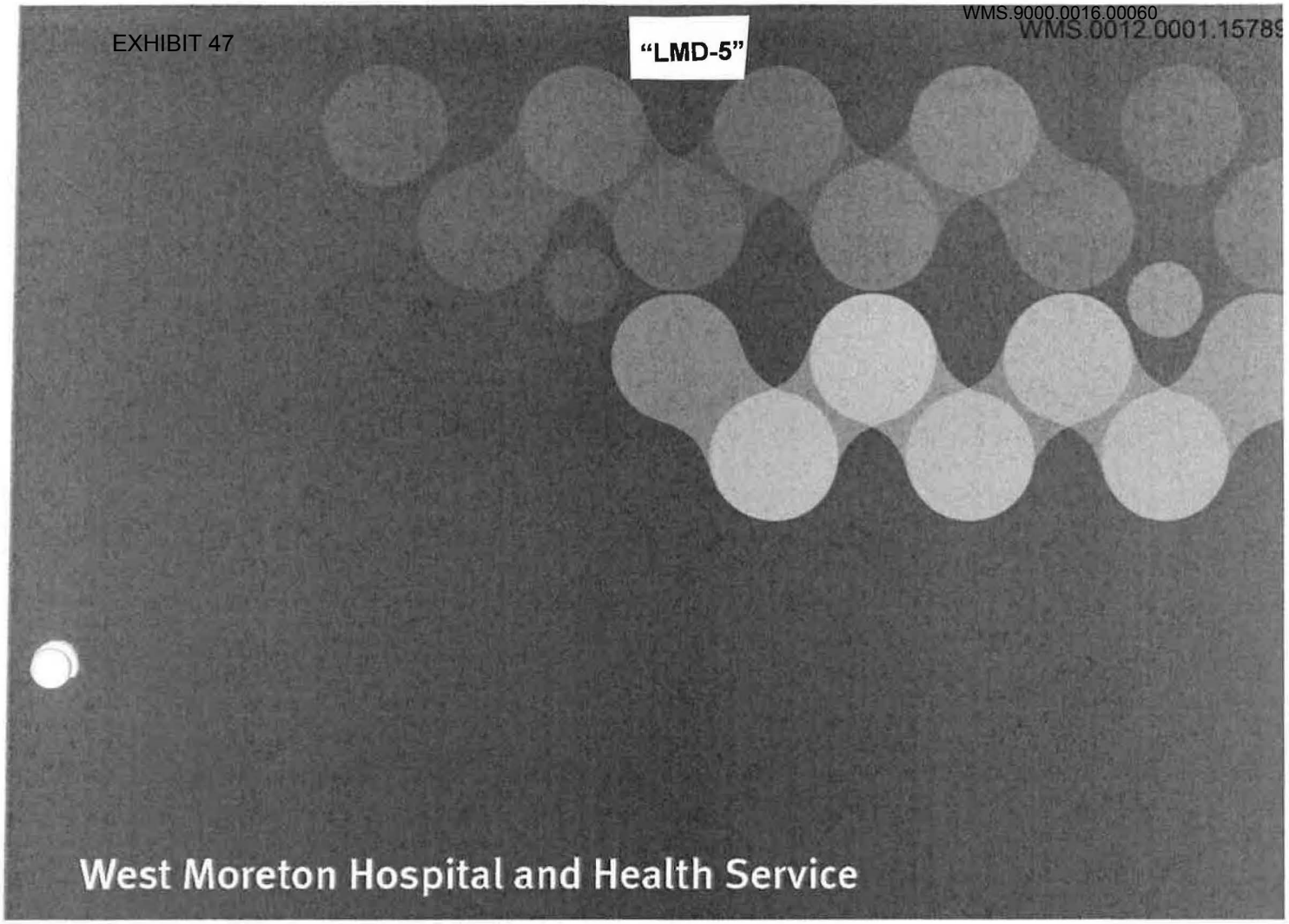
Validation
Validation Stage confirms the robustness of the Business Proposal.

Chief Finance Officer- West Moreton Hospital and Health Service	
Name:	**Date: / /**
Contact No:	**Signature:**
Endorsed	**Not Endorsed**
Comments:	

Approval	
Chief Executive	
Name:	**West Moreton Hospital and Health Service**
Date: / /	**Contact No:**
Approved	**Not Approved**
Signature:	
Comments:	

SUPORTING DOCUMENTS AND ATTACHMENTS

The following documents support this business change proposal and assist in reducing proposal risk	
Document Number/ Version	**Document Title**
Appendix one	Review Scoping Action Plan
Appendix two	Rehab and Allied Health Current Structure
Appendix three	Proposed structure of Rehab and Allied Health Services
Appendix four	Financial Savings by Position number and discipline



Integrated Mental Health Service, The Park – Centre for Mental Health and Offender Health Services Service Changes

Information for staff and stakeholders

15 January 2013

Prepared by:
Executive Director Mental Health and Specialised Services

Executive Summary

Background

On 1 July 2012 Queensland Health (QH) has, through the *Hospital and Health Boards Act 2011*, established 17 new statutory bodies known as Hospital and Health Services (HHSs).

As statutory authorities, the role of the Queensland Health's former corporate office has changed to a system manager and is no longer involved in the day-to-day functioning of health services. Consequently a higher level of accountability and responsibility rests with HHSs.

The executive structure of West Moreton HHS (WMHHS) has been realigned to effectively deliver on the organisations' key priorities, functions and objectives. The Chief Executive, West Moreton HHS has tasked each Executive Director with implementing changes within their respective Divisions to support these key priorities, functions and objectives.

Mental Health and Specialised Services

The Mental Health and Specialised Services (MH&SS) Division will support the WMHHS Chief Executive and Board to discharge its obligations and accountabilities through a revised organisational structure.

The revised organisational structure will promote the delivery of contemporary mental health and specialised services as well as achieving the efficient use of affordable resources (human and financial). Revised systems and processes will also be implemented as part of the organisational change for the Division.

1.0 Introduction

In WMHHS, MH&SS currently consists of:

- Integrated Mental Health Services (IMHS),
- The Park- Centre for Mental Health (The Park)
- Offender Health Services (OHS) and
- The Drug Court Program (which will cease by 30 June 2013).

Historically, the mental health services within WMHHS have functioned and been managed and resourced as distinct separate services including a range of statewide responsibilities. Since 1 July 2012, Offender Health Services have been devolved to Hospital and Health Services and it has been determined for this service to be aligned into the Division.

It is planned that into the future the program areas of Brisbane Youth Detention Centre (BYDC) and Alcohol, Tobacco and Other Drug Services (ATODs) will also be aligned into the Division.

It is proposed to develop a revised single organisational structure for MH&SS, WMHHS. Underpinning this organisational structural change, staffing efficiencies and consideration of no longer required positions will be a range of resource and operational changes to focus on a future efficient Division.

Any proposed organisational changes or efficiencies have been assessed against the current West Moreton 2012/13 Service Agreement with the System Manager and will ensure the intent of schedule 9 (Mental Health and Alcohol and Other Drugs Treatment Services) remains intact.

2.0 Purpose of the Business Case

This business case has been prepared to comply with Queensland Health's consultation obligations and sets out the details of implementation and benefits of the restructure of the MH&SS.

With respect to the development of a revised single organisational structure for MH&SS WMHHS, all service components will be examined (both clinical and non clinical) across Integrated Mental Health Services, The Park- Centre for Mental Health and Offender Health Services.

3.0 Governance of the Change Process

Governance of the implementation will be the responsibility of the Executive Director MH&SS. The consultation obligations will be managed through the WMHHS Executive Meetings, MH&SS Executive Meetings, relevant industrial Forums and individual and team meetings.

4.0 Acknowledgements/Credits

Wide ranging suggestions have been received from a cross section of staff and stakeholders. It is acknowledged that this input has assisted in the identification of ways to improve the quality and efficiency of services within MH&SS.

5.0 Proposed Structure and Functions

5.1 Key Principles

Key principles to achieve the proposed structure include:

- staff and stakeholders will be communicated with regarding this business case
- staff will be supported and informed regarding changes arising from the implementation of this business case
- implementation of this business case will increase value for money and the streamlining of services
- implementation will ensure the integrity of the intent of schedule 9 WMHHS Service agreement 2012/13.
- the revised organisational structure will:
  - consider the new health context (ie WMHHS and the System Manager)
  - promote role clarity and reflect a simplified more streamlined structure across MH&SS
  - improve functional alignment across MH&SS to promote effective teams, improve communication and reduce complexity of management
  - promote facilitation of streamlined processes across MH&SS and
  - consider known planned future mental health service initiatives

5.2 Proposed High Level Organisational Design – Tier 3

Executive Director Mental Health & Specialised Services:
In support of the key principles above, the following positions will report to the Executive Director MH&SS:

- Director of Clinical Services, Mental Health and Specialised Services
- Director of Nursing, Mental Health and Specialised Services
- Director of Allied Health and Community Mental Health Programs
- Director Queensland Centre of Mental Health Learning
- Director Queensland Centre for Mental Health Research
- Mental Health Business Manager (NB this is dotted reporting line as this position reports to the Chief Financial Officer, WMHHS)
- Coordinator, Quality, Safety & Governance
- Consumer Advocate, West Moreton Mental Health