West Moreton Hospital and Health Service

Board Meeting

Board Meeting - 23 November 2012

Nov 23, 2012 at 09:00 AM - 05:00 PM

Boonah Hospital

Leonard Street

Boonah, QLD 4310

HEALTH SERVICE CHIEF EXECUTIVE REPORT FOR THE BOARD

Board Meeting Date:	23 November 2012

1. Current Significant Issues

1.1 Financial integrity and budget is the major focus for the Executive and management teams of the Hospital and Health Services (HHS). Further discussion and reporting is contained within the monthly finance report.

- The Executive Director Finance and Corporate Services has been transferred at level to the HHS. Finalisation of the position description and role, currently being reviewed by Mercer's for classification, is ongoing.
- **Paxton Partner's reports**. The Board are aware that Paxton Partners have been retained by the General Manager Finance – Queensland Health to review the work with the HHS to develop/refine a coherent set of financial management strategies for 2012/13 which targets a balanced position. The Paxton Partner's work has been in two areas:
    - **Review of West Moreton HHS 2012/13 Budget and Financial Turnaround Strategy**. It is currently proposed that the final report will be delivered to the System Manager prior to 30 November 2012, however this is subject to a final visit by Paxton Partner's to review the HHS non-FTE saving strategies and further develop initiatives for contestability. Executive have continued to work closely with Paxton's to ensure that both our issues and progress in developing the Turnaround Plan are accurately reflected in the final report.
    - **Review of West Moreton HHS Financial Management Capability**. As a separate request within the Paxton Partner's engagement, a review of the HHS financial management capability has been undertaken. This review is to report directly to the HHS and a draft final report has been received on 16 November 2012. It has been left in draft to provide an option for the Chair or Board to provide some input prior to finalisation if required. The report has a number of recommendations for the Finance Department which the Executive Director Finance and Corporate Services has commenced implementing.
- The Commonwealth's Mid-year Economic and Fiscal Outlook proposes a reduction of $63M to the Queensland National Health Reform Funding for 2012/13. This is in addition to the retrospective reduction of $40M to payments already received in the 2011/12 National Healthcare Specific Purpose Payment, which is due to be clawed back in 2012/13. Based on West Moreton's share of the total Queensland Health budget, an indicative reduction of around $4.3M has been communicated to the HHS by the Director General. Confirmation of this funding reduction is yet to be received following the meeting of the Standing Council on Health on 9 November 2012. If confirmed, it would represent a significantly detrimental factor in the likelihood of West Moreton achieving a balanced budget.

1.2 Other Items

1.2.1 Potential Closure of the Barrett Adolescent Unit

- The Barrett Adolescent Centre is a service that has been provided at The Park – Centre for Mental Health facility for over 30 years for adolescents suffering significant mental health illness as both an inpatient and a day service inclusive of an Education Queensland school on site.
- In accordance with the Statewide Mental Health Plan, The Park - Centre for Mental Health is to become an adult forensic centre, anticipating July 2013. It will no longer be appropriate to have young teenagers on a campus for adults in a medium to high security setting. In August 2012 the Health Minister endorsed that the capital build funding would no longer be made available for the Adolescent Extended Treatment Unit - Redlands and these funds were reallocated within the health portfolio.

- In light of the new centre that was to be built at Redlands no longer being an option and the current condition of the Barrett Adolescent Centre building at The Park - Centre for Mental Health being no longer fit for purpose and the plans for the adult forensic centre we had commenced high level discussions with the System Manager and senior Park staff some weeks ago.
- Information was provided to the media via an external source that has raised the issues within the community and broader sector prior to us being able to implement a planned approach to the consultation and decision making.
- Actions to progress this review:
    - Staff have been briefed on potential issues and advised that no formal decision has been made by the WMHH Board.
    - A meeting was held on Thursday, 15 November 2012 with key Child and Youth Psychiatrists, WMHHS Chief Executive and Executive Director Mental Health and Specialised Service and System Manager with agreement reached that a Planning Group be formed to lead the planning, consultation and development of options and final recommendation for decision. This Planning Group will be supported by a clear communication strategy, a consumer consultation strategy and an expert clinical reference group with appointed membership from representative groups as well as interstate and national experts.
    - An action plan will be developed with the Planning Group by Wednesday, 21 November 2012 and provided to the Board for endorsement.

1.2.2 Suspension of Limited Community Treatment Orders (LCT) following Leave Without Permission of two Consumers at The Park

- Following the most recent consumer not returning from unescorted leave the Queensland Health Director of Mental Health (DMH) issued the following directive:
    - "The MHA Section 309a sets out the DMH's powers in relation to issuing policy in relation to Forensic patients.
    - All unescorted leave for patients detained on Forensic Orders to The Park – Centre for Mental Health must cease immediately until further notice.
    - All unescorted leave for patients detained on Forensic orders and designated Special Notification Forensic Patients (SNFP) must cease immediately until further notice"
- A blanket ban on LCT is counterproductive to the rehabilitation of individual patients and it is the HHS's recommended that an individual assessment approach be instituted.
- Following the establishment of such an approval process within the WMHHS, the Minister has been advised that LCT has been reinstated for most patients at The Park.
- We were also asked to look at the feasibility of ankle bracelets for patients accessing unescorted leave from the High Security Inpatient Service for the first time.
- For the Board's information, I have included a memorandum written by the Director of Clinical Services at The Park.
- At this stage we have not been asked to progress the use of anklet bracelets.

1.2.3 Processing Voluntary Redundancies

- We have recently been advised of the cut-off dates advised by the System Manager in relation to processing of voluntary separation packages and exit dates.
- This has occurred due to the large number of requests – to date 1103 - across the system to be processed.

West Moreton Hospital and Health Board MINUTES

Committee: West Moreton Hospital and Health Board					
Date:	Friday, 23 November 2012	**Time:**	9am to 5.10pm	**Location:**	Conference Room Boonah Hospital

Members
Dr Mary Corbett, Chair
Timothy Eltham, Deputy Chair
Dr Robert McGregor, Board Member
Paul Casos, Board Member
Melinda Parcell, Board Member
Professor Julie Cotter, Board Member
Alan Fry OBE QPM, Board Member
Ex Officio Standing Invitees
Lesley Dwyer, Health Service Chief Executive (CE)
Ian Wright, Executive Director Finance and Corporate (EDFC)
Shannon Ryall Secretariat
Invitees
Linda Hardy, Executive Director Performance Strategy and Planning (EDPSP)

STAFF AND STAKEHOLDER MEETING

The Board toured Boonah Hospital and met with Boonah Hospital staff from 9.30am to 10am.

The Board met with Boonah Hospital stakeholders from 10am to 10.30am. Attendees included Jon Krause MP, Member for Beaudesert, Scenic Rim Regional Councillor Rick Stanfield and President of the Boonah Hospital Auxiliary, Mrs Doreen Nason. The group discussed key issues including the reduction in Oral Health services at Boonah hospital and also acknowledged the strong community network and the support the auxiliary receives from the community.

BOARD IN CAMERA

The Board held an in-camera session from 10.40am to 11.15am.

The Board approved the attendance of the Chair and CE at a Media Training session on the 7th Dec in Brisbane, at a cost of $1150 + GST each.

1.0 MEETING OPENING

1.1 Attendance

All Members were in attendance.

1.2 Adoption of Agenda

The agenda was adopted with no alterations.

1.3 Register of Director's Interests

1.4 No amendments or declarations were made.

1.5 Confirmation of Minutes

The minutes of the meeting held on 26 October 2012 were confirmed as a true and accurate record of proceedings. The summary minutes for publication were also approved. The Board discussed the creation of a list of stakeholders who should be sent the Board Summary.

1.6 Actions Arising

The Board noted the actions that had been actioned and included in the agenda papers.

2.0 STRATEGIC MATTERS

2.1 WMHHS Clinician Engagement Framework

The Board noted the draft Clinician and Workforce Engagement Strategy, Implementation Plan and Expression of Interest for the WMHHS Lead Clinician Group. Members acknowledged the

importance of clinician engagement and requested a revision of the strategy be undertaken to separate clinician and workforce engagement. Discussion followed regarding the development of an overarching Workforce Strategy, with two separate Engagement Strategies, one for Clinicians and one for non-Clinicians.

ACTION: Revised Clinician Engagement Strategy to be provided next meeting for endorsement.

ACTION: Overarching Workforce Strategy to be developed.

DECISION: The Board endorsed the expression of interest for the WMHHS Lead Clinician Group with proposed amendments and requested a status update to the February Board meeting.

2.2 Mater Springfield Proposal

The Board noted the actions to date and were provided with an overview of the progress of the Mater/Springfield proposal due to the Minister on 12 December 2012. The briefing will aim to identify unresolved issues requiring further work and to allow for a considered collective view around community needs. The Board discussed the engagement of Carramar Consulting to assist with proposal development.

ACTION: The Board to endorse the Mater Springfield briefing to the Minister out of session

2.3 Draft Medicare Local Protocol

The Board discussed the draft Medicare Local protocol (Wide Bay example) and agreed to its completion by early December.

ACTION: CE to develop protocol in conjunction with Medicare Local CEO and Deputy Board Chair for endorsement at the December Board meeting.

3.0 GENERAL MATTERS

3.1 For Decision

3.1.1 Audit and Risk Committee Charter

The board noted the Audit and Risk Charter and proposed amendments were discussed.

ACTION: For amendment and further discussion at next Audit and Risk Committee early 2013.

3.2 For Discussion

3.2.1 Occupational Health and Safety Report

The Board noted the content of the Occupational Health and Safety Reports provided. The Board discussed the strategies to address occupational violence and ergonomics incidents.

3.2.2 Safety and Quality Report

The Board noted the Safety and Quality Report and discussed RCA and complaint response timeframes. The CE advised a review of the complaints process has been undertaken.

3.2.3 Health Service Chief Executive Report

The CE spoke to the items addressed in the HSCE report and discussion ensued on the following items:

a) Barrett Adolescent strategy
b) Gifts & Benefits framework for HHSs
c) Executive Director Medical Services coaching and support
d) Esk Working Party
e) Australia Day Awards

3.2.4 Financial Performance Report

The Board noted the Business and Finance Report and acknowledged the updated format and information. The Board noted a handout provided by the EDFC. Discussion followed regarding;

a) MOHRI FTE reductions and Turnaround Plan
b) ABF model changes
c) Governance budget

d) Commonwealth funding reduction and non FTE strategies
e) Underlying budget deficit
f) Operating position adjustments

ACTION: EDFC to draft detailed governance budget for comment at 14 December Board meeting.

ACTION: EDFC to negotiate expenditure and revenue in Service Level Agreements to transfer across at the same time

3.2.5 HHS Performance Report
The Board noted the HHS Performance report and acknowledged the sustained positive achievement of NEAT targets since September and compliance with the no bypass directive. NEST performance and booking strategies with the orthopaedic team have been agreed upon.

3.2.6 Turnaround Plan Update
The Board noted the monthly summary progress report and the final version of the WMHHS Turnaround Plan. MOHRI FTE data was discussed.

4.0 CORPORATE GOVERNANCE AND COMMITTEES

4.1 Board Committees

4.1.1 Executive Committee
The Board noted the confirmed minutes from 19 October 2012. The Committee Chair gave a brief overview of the meeting held on 2 November including;

a) West Moreton Health Alliance
b) Patient Opinion Survey
c) Mater Springfield

4.1.2 Audit and Risk Committee
The Board noted the confirmed minutes from 23 October 2012. The Board noted the Ernst & Young draft Risk Management and Internal Engagement report and discussed the recommendations from the 20 November Audit and Risk meeting.

ACTION: CE to report at a later Board meeting on the Committee's suggestion that an Executive be given overall responsibility for risk management.

DECISION: The Board endorsed Section 1 of the Ernst &Young report.

DECISION: The Board endorsed the appointment of Ernst & Young to undertake the first 5 initiatives for setting up the foundations for risk management.

DECISION: The Board endorsed adoption of the first year of the three year Internal Audit Plan 2012-15.

DECISION: The Board approved in principle the co-source model for internal audit.

4.1.3 Finance Committee
The Board noted the confirmed minutes from 23 October 2012. The Finance Committee Chair provided a brief overview of the meeting held 20 November 2012 highlighting;

a) Commonwealth funding reduction
b) Investment policy
c) Assets report
d) Outstanding repairs and maintenance

4.1.4 Safety and Quality Committee
The Board noted the next meeting will be held on 4 December 2012 where John Hodge from the Australian Council on Healthcare Standards will provide an overview of the national standards and the 5 additional EQuIP standards.

5.0 MATTERS FOR NOTING

5.1 Correspondence
The Board noted correspondence.

5.2 Board Calendar and Work Plan
The calendar was noted and amendments discussed.

ACTION: Committee Chairs to provide Secretariat with meeting dates for next year.

5.3 Key Stakeholder List
The Board noted the Key Stakeholder List.

5.4 Overpayments Summary
The Board noted the Overpayments Summary.

6.0 MEETING FINALISATION
6.1 Review Actions
6.2 Meeting Evaluation
6.3 Next Meeting
6.4 Meeting Close
The meeting closed at 5.10pm

The Board undertook a meeting evaluation.

Minutes authorised by Chair as an accurate record of proceedings

	14/12/12
Dr Mary Corbett **Chair, West Moreton Hospital and Health Board**	**Date**

West Moreton Hospital and Health Service

Board Meeting

Board Meeting - 14 December 2012

Dec 05, 2012 at 11:00 AM - 05:00 PM

Queensland Health Building

Level 3 Videoconferencing Room

147-163 Charlotte Street

Brisbane,

West Moreton Hospital and Health Board

BOARD COMMITTEE AGENDA PAPER

Committee:			
Meeting Date:	**14 December 2012**	**Agenda Item Number:**	**2.3**
Agenda Subject:	**Mental Health Strategy**		
Action required:	☐ For Approval	☐ For Discussion	X For Noting

Proposal

That the West Moreton Hospital and Health Board:

Note The meeting date and proposed content of meeting with the Minister for Health

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Background

1. A meeting between the Minister and the Chair of West Moreton Hospital and Health Board, Chief Executive West Moreton Hospital and Health Service (WMHHS) and Executive Director, Mental Health and Specialised Services (MH&SS) is scheduled for 14 December 2012.

Key Issues or Risks

2. It is intended to brief the Minister on the proposed changes to and current significant issues in MH&SS ie
   a. A Business Case for Change has been developed and identifies a revised overarching organisational structure to promote the delivery of contemporary mental health and offender health services in WMHHS.
   b. In realising the efficient use of affordable resources, there will be an impact on some existing roles and responsibilities and some current systems and processes across the whole of the MH&SS.
   c. In additional to the impact of the Business Case for Change, there are a number of concurrent issues impacting on the MH&SS, such as the future model of care to replace services provided by Barrett Adolescent Centre, revised processes for Limited Community Treatment, the future commissioning of Extended Forensic Treatment and Rehabilitation beds and increasing Own Source Revenue for WMHHS through accommodation fees.
3. Attachment 1 contains the proposed speaking points to be covered in the meeting with the Minister for Health.

Consultation

4. Relevant stakeholders are being consulted in accordance with their respective engagement levels (ie information, consultation and active participation) and their level of influence/impact on specific areas.

Financial and Other Implications

5. 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.
6. The Business Case for Change has been developed outlining the scope of change, processes for communicating and managing staff, managing sensitivities and risks and the transition to the new organisational structure.
7. Any change to staffing, cultural practice or models of care will have a significant resultant industrial focus, in particular at The Park – Centre for Mental Health.

Strategic and Operational Alignment

8. The proposed changes and directions in MH&SS are consistent with the elements of West Moreton HHS's strategy map.
9. The proposed change is aiming to achieve the future vision to provide high quality, safe and responsive mental health and specialised services, reflecting contemporary models of care. This will require a range of organisational redesign, staffing changes, cultural levers and operational efficiencies.

Recommendation

10. That the West Moreton Hospital and Health Board:

Note The meeting date and proposed content of meeting with the Minister for Health.

West Moreton Hospital and Health Board

BOARD COMMITTEE AGENDA PAPER

APPROVED	NOT APPROVED	NOTED
Chair, West Moreton Hospital and Health Board		/ /

- ☐ Recommendation/s are consistent with Strategic Plan
- ☐ Funding impacts are included within approved budget
- ☐ Risks are identified and mitigation/management strategies included
- ☐ Implications for patient and/or staff care and well-being have been identified

Meeting with Minister for Health - 14 December 2012

In attendance from West Moreton Hospital and Health Service:
- Dr Mary Corbett, Chair, West Moreton Hospital and Health Board,
- Lesley Dwyer, Chief Executive, West Moreton Hospital and Health Service and
- Sharon Kelly, Executive Director, Mental Health and Specialised Services.

Proposed Talking Points for Executive Director Mental Health and Specialised Services

Introduction

Historically, the mental health services within West Moreton Hospital and Health Service (WMHHS) has functioned, been managed and resourced as distinct separate services which includes a range of statewide responsibilities such as forensic medicine. This has led to a disconnect between services that has not had strong integrated leadership, and reduced opportunities for efficiency with significant cultural barriers to any proposed changes.

The future vision to provide high quality, safe and responsive services, reflecting contemporary models of care and ensuring highly specialised components of The Park are safe and meeting community expectations, requires a range of organisational redesign, staffing changes, cultural levers and operational efficiencies. Barriers and behaviours within the Mental Health Services must be addressed for future success.

In West Moreton Hospital and Health Service (WMHHS), the newly created division of Mental Health & Specialised Services currently consists of:
- Integrated Mental Health Services (IMHS),
    - acute inpatient and older person unit 44 beds
    - Range of community based programs
- The Park- Centre for Mental Health (The Park)
    - High Secure Inpatient Services 70 + 20 new Beds
    - Secure rehabilitation services 34 beds
    - Extended Treatment and Rehabilitation 43 beds
    - Barratt Adolescent Centre 15 beds
- Queensland Centre for Mental Health Research
- Queensland Centre for Mental Health Learning
- Offender Health Services (OHS)
    - 1467 beds across Brisbane Correctional, Wolston Prison and Brisbane Women's Prison
- The Drug Court Program (which will cease by 30 June 2013).

Current challenges and opportunities

1.Service Redesign

Rationale
- It is proposed to develop a revised single integrated organisational structure for MH&SS, WMHHS. Integration will allow consistency of effort, efficiencies of resources increased quality and governance focus and opportunities to challenge cultural norms.

Major Changes

- Acknowledging and enforcing a patient focused service will result in reporting structure changes that will see the patient advocate and safety and quality roles report directly to the Executive Director.
- Leadership and senior organisational structural changes will be made that will result in changes to senior medical, nursing and Allied Health structures and staffing reductions.
- Addressing current staffing inefficiencies and duplication of effort will result in reductions to no longer required positions.
- Challenging current effort and clinical practices across a range of inpatient areas to ensure quality, contemporary care will result in practice and cultural changes and potential reduction in staffing.
- Changes to current overtime and rostering practices have already commenced but will need strong ongoing multi level support to make lasting changes to poor cultural practice. Changing practice has resulted in changes to individual's income.
- Introduction of nursing skill mix changes in 2013 will see a reduction in registered nurses across The Park with commensurate increase in Enrolled Nurses.
- Security of the facility has been reviewed and potential models are yet to be finalised. One option that would ensure efficiency, patient staff and community safety and best practice security for The Park is for contracting out of the service.
- It is proposed major redesign to structures and staffing within the Offender Health Services will result in improved primary health care focus and care for prisoners. Any change within the Correctional centres will have a significant industrial focus and require close partnership and consultation between Corrections and Health.

Risks/actions moving forward

- 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.
- A detailed Business Case for Change has been developed outlining the scope of change, processes for communicating and managing staff, managing sensitivities and risks and the transition to the new organisational structure.
- Any change to staffing, cultural practice or models of care will have a significant resultant industrial focus, in particular at The Park.

2. Leave for special notification forensic patients (SNFP)

Rationale

- Post the recent absconding of two SNFP from The Park the leave entitlements of particular patients received a great deal of attention subsequently resulting in a range of new processes being implemented or enhanced.

Major changes

- A review panel under the delegation of the CE WMHHS has assessed all indicated patients and been provided a new risk assessment with recommendations from the panel for re-establishing leave.
- Protocols and processes for security and searches of patients has been audited and improved practices in place.

- An ongoing process for patient leave and transfer is being established

Risks/actions moving forward
- Further actions may take place on understanding the intent and finalisation of current proposed changes to legislation.
- Forms of patient monitoring have been investigated.

3. Incident/issues Communications

Rationale
- With the establishment of the Hospital and Health Services governing Boards, a revised communication process was required. Particular significant event issues highlighted the need to ensure all stakeholders remain connected and informed in a timely manner.

Major changes
- Notification process of patient absences (particularly SNFPs) have been reviewed Initial meeting held with Deputy Commissioner Police and MHAOD branch to formulate shared response and information sharing requirements

Risks/actions moving forward
- A working party will develop communication/ information sharing pathway that are reflective of proposed MH Act changes

4. Barratt Adolescent Centre (BAC)

Rationale
- As the Redlands Unit Project has ceased and there is no longer a capital allocation to relocate BAC, an alternative contemporary, statewide model(s) of care must be developed to replace the services currently provided by BAC.

Major changes
- An expert Clinical Reference Group consisting of experienced multidisciplinary child and youth mental health clinicians has been formed to recommend alternative model(s).
- The West Moreton Hospital and Health Service Board has approved the governance of this process which will occur in partnership with Mental Health Alcohol and Other Drugs Branch.
- While there has been significant media interest and stakeholder angst, this is being managed through a communication and stakeholder engagement plan.

Risks/actions moving forward
- With the development of alternative models(s), a number of assumptions exist:
    - services currently provided by BAC will not remain on the campus of The Park post June 2013.
    - endorsed model(s) of care will be incorporated into forward planning for the implementation of components of the remainder of the *Queensland Plan for Mental Health 2007-2017.*
    - there will be robust evaluation criteria applied to determine the quality and effectiveness of the endorsed model(s) of care.

  - existing recurrent funding for BAC and the additional future funding earmarked for the former Redlands Unit will be utilised to fund the endorsed model(s) of care for this adolescent consumer group.
  - the endorsed model of care will be implemented in a two staged process, ie it will initially be applied to meet the needs of the current consumers in BAC and then implemented more widely across the state as per the parameters of the endorsed model of care.
- It is possible that the project may be constrained by a number of factors including:
  - resistance to change by internal and external stakeholders
  - insufficient recurrent resources available to support a preferred model of care
  - insufficient infrastructure across parts of the State to support a changed model (eg skilled workforce, partnerships with other agencies and accommodation requirements)
  - a delay in achieving an endorsed model of care.

5. Extended Forensic Treatment and Rehabilitation Service (EFTRU) opening early 2013- new 20 bed unit

Rationale

- The EFTRU has been designed to meet the needs of High Secure Inpatient Service (HSIS) consumers who no longer require the physical/procedural security of high security.
- There are a number of HSIS consumers who can be managed in less restrictive settings however remain within the HSIS perimeter due to the slow rate of Limited Community Treatment (LCT) progression.
- These consumers routinely access approved unescorted grounds and community leave.

Major changes

- The Model of Service Delivery in EFTRU will be about supporting skills development which can be generalised to community settings such as supported/independent living arrangements and community care units.
- EFTRU will be a part of The Park's Authorised Mental Health Service and not HSIS.
- As it is an open setting ie no external security fence (other than a domestic residential type fence) there will be the ability to transfer consumers back to HSIS should they become unwell. Consumers in EFTRU will be well engaged with the clinical team and their risk profile will be well understood and monitored.

Risks/actions moving forward

- EFTRU is situated outside of the HSIS campus and so will not have the same level of physical and procedural security as HSIS.
- The clinical team has developed a very comprehensive risk assessment process that will involve the Director of Mental Health who will give the final approval for the transfer of a consumer's Forensic Order from HSIS to The Park.
- Thomas Embley have introduced a similar service and lessons learnt from their processes will be considered in the opening of this service.

6. Accommodation fees for consumers at The Park-Centre for Mental Health

Rationale

- In 2011/2012, West Moreton Health Service District wrote off $2.3 M in total of accumulated bad debt. Previous years averaged $350,000 in write offs.
- Total accommodation fees invoiced for 2011/2012 was $1.3M. Previous years averaged $1.4M.
- Since 1 July 2012, accommodation fees for patients at The Park-Centre for Mental Health (The Park) are charged as per *Health Service Directive – Own Source Revenue* (Directive #QH-HSD-2012).
- Prior to 1 July 2012, fees and charges were charged in accordance with the previous Administration of Part 4 – Health Services Regulation. These guidelines outline that 66.67% of a patient's Centrelink payment should be charged for patients receiving extended treatment and rehabilitation. The guidelines also outline the process for approval of waivers and the writing off of bad debt.
- It is not uncommon for an involuntary patient to refuse to pay for accommodation. At The Park there are currently 136 involuntary inpatients, which equates to 92% of the total 148 inpatients.

Major Changes

- Significant collaboration and effort has been made this financial year to promote the payment of patient fees. A number of patients who were previously not paying fees are now making part payments.
- Currently:
    - 21 patients are on full waivers
    - 15 patients are refusing to pay
    - 38 patients have committed to part payments
    - 74 patients have committed to paying in full

Risks/actions moving forward

- West Moreton HHS is continuing to examine ways of increasing its own source revenue through increasing compliance with the payment of accommodation charges at The Park.
- The previous guidelines and the current Directive are silent on whether involuntary patients (under the *Mental Health Act 2000*) can be forced to pay for accommodation.
- As per the *Mental Health Act 2000*, an involuntary patient's right to make decisions about other health care issues (non mental health treatment) and financial and personal matters is not affected by being an involuntary mental health patient.

- In addition, support from a Corporate Mentor is to provide the Board with a report in relation to the HHS progress and suitability to request re-evaluation. West Moreton did not formally appoint a Corporate Mentor and I would suggest that the Paxton Partner's financial integrity report be provided.
- It is intended that a workshop in late January be undertaken by the Executive, facilitated by Ernst and Young to complete the re-assessment. An extension will be sought from the system manager. Initially discussions indicate that this will be granted.

6. Matters For Noting

6.1. Events and Media

- There have been no events held since the last Board Report.
- The Hospital and Health Service has a communications and engagement plan to guide the current review and public interest in Barrett Adolescent Centre. This plan will be reviewed and updated accordingly as the working groups for Barrett continue to meet.
- Alice Gaston officially finishes Friday, 14 December 2012. Alice has been with the organisation for six years heading communications and media. Whilst we will not be replacing the three media and communications jobs straight away a plan is in place to realign the functions to the Board Support Officer and the new Senior Executive Support Officer.
- Media interest continues in the Barrett Adolescent Centre, at a local, state and national level with the most recent interviews occurring with The Project.
- Media regarding changes at West Moreton continue to be of local interest and so does the Model of Care Review for Esk Health Service.

6.2 New Mobile Breast Cancer Screening Service Commencing in New Year

- Women in the Ipswich region will have access to a new mobile breast cancer screening service in the New Year. The mobile van will be at Riverlink on 16 January 2013 and will operate until 13 February 2013.
- This service will offer a convenient choice for women and the Ipswich BreastScreen Service hopes it will encourage new women to attend as well as reminding women to continue having regular screening mammograms after their first breastscreen, as early detection has been proven to save lives.
- Women aged 50-69 are particularly encouraged to attend, however the service is also available for women aged 40-49 and women over 70.

West Moreton Hospital and Health Board
MINUTES

Committee: West Moreton Hospital and Health Board					
Date:	Friday, 14 December 2012	**Time:**	11am to 5.20pm	**Location:**	QHB Lvl 3 VC Room

Members
Dr Mary Corbett, Chair
Timothy Eltham, Deputy Chair
Dr Robert McGregor, Board Member
Paul Casos, Board Member
Melinda Parcell, Board Member
Professor Julie Cotter, Board Member
Alan Fry OBE QPM, Board Member
Ex Officio Standing Invitees
Lesley Dwyer, Health Service Chief Executive (CE)
Ian Wright, Executive Director Finance and Corporate (EDFC)
Shannon Ryall Secretariat
Invitees
Hon Lawrence Springborg MP, Minister for Health
Dr Tony O'Connell, Director-General
Dr Peter Osborne, Director Oral Health
Sharon Kelly, Executive Director Mental Health and Specialised Services

BOARD IN CAMERA

The Board held an in-camera session from 11.15am to 11.50am with the Hon Lawrence Springborg, Dr Tony O'Connell and Neil Hamilton-Smith.

1.0 MEETING OPENING

1.1 Attendance

All Members were in attendance.

1.2 Adoption of Agenda

The agenda was adopted with no alterations.

1.3 Register of Director's Interests

A potential conflict of interest was declared by Melinda Parcell in regard to discussion of HACC Services in the CE report. No further amendments or declarations were made.

1.4 Confirmation of Minutes

The minutes of the meeting held on 23 November 2012 were confirmed as a true and accurate record of proceedings. The summary minutes for publication were also approved.

1.5 Actions Arising

The Board noted the action register and the items that had been actioned and included in the agenda papers.

1.5.1 Board out of session – Mater Springfield Brief.

The paper was initially intended to be endorsed by the Board prior to submission to the Minister, however due to time constraints, was provided to the Minister as a draft.

DECISION: The Board endorsed the proposed way forward as outlined in the Mater Springfield Brief provided to the Minister.

2.0 STRATEGIC MATTERS

2.1 Medicare Local Protocol

The Board noted the Draft Medicare Local Partnership Protocol. Amendments were discussed regarding intellectual property, the inclusion of the West Moreton HHS logo, deletion of the requirement for the parties to *ensure* third parties were respectful (not as a principle, but as a requirement), and to amend the duplication in the Table in the Appendix .

ACTION: Content and formatting amendments to be made.

DECISION: The Board approved the Chair and CE to sign the Medicare Local Partnership Protocol with the proposed amendments and to publish by the 31 December 2012.

2.2 Clinician Engagement Strategy

The Board noted the revised draft Clinician Engagement Strategy and Implementation Plan and noted the further development of the overarching Workforce Strategy.

ACTION: Revised Workforce Strategy to be provided at February Board meeting for endorsement.

DECISION: The Board endorsed Clinician Engagement Part A of the Workforce Engagement Strategy for publication by 31 December 2012.

2.3 Mental Health Strategy

The Board noted the paper provided regarding the briefing to the Minister and the outcomes of the meeting with the Minister were discussed. The EDMHSS gave an overview of the issues within Mental Health Services and the strategies to address the workplace culture at The Park including service redesign efficiencies and principles. The Board discussed the excellent work done on this strategy and thanked the EDMHSS. The EDMHSS highlighted the efforts of the Queensland Centre for Mental Health Research and their input into the research papers for the Global Burden of Disease Study 2010 being presented in London 14 December 2012.

2.4 Oral Health Services

The Board were presented with an overview of West Moreton Oral Health Services and discussed the waiting times and the implementation of the strategies to address these. It was noted that at the November stakeholders meeting in Boonah, the reduction in dental clinic days was a concern. The Board was advised that given the short wait list in Boonah, the service was temporarily reduced by one clinic day and allocated to Esk to allow for reduction in the extended waiting times and also given the Esk community have limited access to private dental care.

ACTION: CE and DOHS to draft correspondence to President of Boonah Hospital Auxiliary to offer explanation of the temporary reduction in oral health services at Boonah.

ACTION: The Board requested a briefing note in the Board papers for future strategic presentations

2.5 Commonwealth Funding Reduction

The Board noted the initial proposals to mitigate the Service Agreement reduction of $4.3M and requested the Executive continue to seek all opportunities for cost savings.

3.0 GENERAL MATTERS

3.1 For Decision

3.1.1 Policies

The board noted the draft Occupational Health and Safety Board Policy and discussed the importance of the Board knowing the workplace is safe and the employees are operating safely. The Board noted the Queensland Health Occupational Health and Safety Policy Statement and discussed the addition of the West Moreton logo.

DECISION: The Board endorsed the draft Occupational Health and Safety Board Policy.

DECISION: The Board endorsed the Chair co-sign the Occupational Health and Safety Policy Statement with the Director General following addition of West Moreton logo.

3.2 For Discussion

3.2.1 Occupational Health and Safety Report

The Board noted the content of the Occupational Health and Safety Reports provided. The Board noted there were no notifiable incidents.

3.2.2 Safety and Quality Report

The Board noted the Safety and Quality Report and discussed the medication incidents. The Board discussed hospital acquired infection rates and the information the HHS provides to consumers.

ACTION: Hospital acquired infection rates report to be included in Board report for January meeting.

ACTION: Patient Information brochure to be provided next Board meeting.

3.2.3 Health Service Chief Executive Report

The CE spoke to the items addressed in the HSCE report and discussion ensued on the following items:

a) Future of HACC Services.
   In this topic, the Board agreed as no decision was required, that there was no conflict with Melinda Parcell remaining during the discussion.
b) Public Health transfer agreement.
   The document has come back from corporate for the Chair and CE to sign.
c) Health Atlas Workshop
d) Esk Working Party update
e) Patient Opinion Survey
f) Readiness assessment
g) Communications and Engagement resources

3.2.4 Financial Performance Report

The Board noted the Business and Finance Report and acknowledged the inclusion of the Board and Corporate Governance figures. Discussion followed regarding;

a) MOHRI FTE reductions and Turnaround Plan
b) ABF model changes
c) Governance budget
d) Underlying budget deficit
e) Operating position adjustments
f) Paxton reports

ACTION: EDFC to provide breakdown of interstate expenses to the Board next meeting.

ACTION: EDFC to identify governance budget in overall income statement, and to add the full year budget to the Income Statement

3.2.5 HHS Performance Report

The Board noted the HHS Performance report and acknowledged the sustained positive achievement of NEAT targets since September and compliance with the MEDAI no bypass directive. NEST continues to be a concern, with WMHHS currently the lowest performing in the State, with only 11% of patients treated in turn.

3.2.6 Turnaround Plan Update

The Board noted the monthly summary progress report and the final version of the WMHHS Turnaround Plan. MOHRI FTE data was discussed.

4.0 CORPORATE GOVERNANCE AND COMMITTEES

4.1 Board Committees

4.1.1 Executive Committee

No meeting this month.

4.1.2 Audit and Risk Committee
No meeting this month.
4.1.3 Finance Committee
No Meeting this month.
4.1.4 Safety and Quality Committee
Draft minutes circulated for comment to Committee members.

5.0 MATTERS FOR NOTING

5.1 Correspondence
The Board noted no further correspondence as per previously published on Board portal.

5.2 Board Calendar and Work Plan
The calendar was noted and amendments discussed.

ACTION: Secretariat to update for next Board meeting.

5.3 Chairs Meeting
The Chair provided a brief overview of the recent Chairs meeting and the Industry Briefing during the In-Camera session.

5.4 Queensland Clinical Senate
The Board noted the paper provided by Melinda Parcell on the recent Clinical Senate.

6.0 MEETING FINALISATION

6.1 Review Actions
6.2 Meeting Evaluation
6.3 Next Meeting – Jan 25th at the Park Centre for Mental Health.
The Opposition Leader to be invited to the In-Camera for a briefing on the Mental Health strategy.
6.4 Meeting Close
The meeting closed at 5.20pm

The Board undertook a meeting evaluation.

Minutes authorised by Chair as an accurate record of proceedings

25/1/13.

Dr Mary Corbett **Date**
Chair, West Moreton Hospital and Health Board

HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr TJ Ruthenberg MP (Chair)
Mrs JR Miller MP (Deputy Chair)
Mr SW Davies MP
Mr JD Hathaway MP
Mr DE Shuttleworth MP

Staff present:

Ms S Cawcutt (Research Director)
Ms K Dalladay (Principal Research Officer)

BRIEFING—QUEENSLAND MENTAL HEALTH COMMISSION BILL AND HEALTH PRACTITIONERS REGISTRATION AND OTHER LEGISLATION AMENDMENT BILL

TRANSCRIPT OF PROCEEDINGS

MONDAY, 17 DECEMBER 2012

Brisbane

MONDAY, 17 DECEMBER 2012

Committee met at 11.04 am

CHAIR: I declare this public briefing of the Health and Community Services Committee open. Officials from Queensland Health will brief the committee about the Queensland Mental Health Commission Bill 2012 and the Health Practitioners Registration and Other Legislation Amendment Bill 2012.

I will introduce the members of the committee. I am Trevor Ruthenberg, the member for Kallangur. The deputy chair of the committee is Mrs Jo-Ann Miller MP, member for Bundamba. Mr Steve Davies MP is the member for Capalaba. Mr Dale Shuttleworth MP is the member for Ferny Grove. Mrs Desley Scott MP, the member for Woodridge, is an apology. Mr John Hathaway MP, member for Townsville, is joining us via teleconference. I have apologies from Mr Scott Driscoll MP, member for Redcliffe, and Mr Vaughan Johnson MP, member for Gregory.

CLEARY, Dr Michael, Deputy Director-General, Health Service and Clinical Innovation, Queensland Health

KINGSWELL, Dr Bill, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Queensland Health

WELCH, Ms Rachel, Acting Director, Regulatory Instruments Unit, Queensland Health

CHAIR: I welcome the Health officials here today. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing orders and rules. Mobile phones should be turned off or switched to silent. Hansard is making a transcript of the proceedings. The committee intends to publish the transcript of today's proceedings unless there is good reason not to.

I invite Dr Cleary to give an overview of the policy intent of the Health Practitioner Registration and Other Legislation Amendment Bill, and Ms Rachel Welch will give a short technical brief on the bill. We will then open it up to questions from members of the committee. John, if you would like to ask a question after the briefing, simply state your name and I will acknowledge you.

Mr HATHAWAY: Thanks, Chair.

CHAIR: My intention is that we will move through to either the natural end of this briefing, or at about 11.30 we will move into the next briefing. Dr Cleary, would you please start your brief?

Dr Cleary: Thank you very much for the opportunity for us to present to the committee. This bill abolishes the state based regulation scheme for dental technicians and for speech pathologists. This will result in the abolition of three statutory bodies in Queensland—the dental technicians registration board, the speech pathologists registration board and the Office of Health Practitioner Registration Boards.

Dental technology and speech pathology are the two remaining professions registered under Queensland's original health practitioners registration scheme. All other professions have transitioned to the national registration scheme, and for the health professions this commenced in July 2010. The bill brings Queensland in line with all Australian jurisdictions which have never registered, or no longer register, these two professions. The professions have unsuccessfully sought approval for national registration, most recently in 2009.

The Australian Health Workforce Ministerial Council decided that the professions may not be approved for national registration. So far the ministerial council has determined that the professions do not meet the criteria for national registration. In particular, the professions have a very low or non-existent risk to the public. The abolition of the registration scheme does not prevent these professions from seeking to be considered for national registration in the future. However, the professions will need to demonstrate to the ministerial council that they meet the criteria for national registration.

The registration of these professions in Queensland is now inconsistent with the principles of national registration and with other jurisdictions. It also creates a regulatory barrier to professionals from other states wishing to practice in Queensland. Continuing registration of these professions in Queensland has progressively become financially unviable, as other professions have moved into the national scheme. The registration scheme is self-funded, and therefore the cost burden of registration is falling to these professions. The bill does not change the employment status of dental technicians or speech pathologists. Conditions of employment that currently rely upon registration would instead rely upon qualifications.

The abolition of the Office of Health Practitioner Registration Boards will occur approximately one month after the registration boards are abolished. This will allow the winding up activities to be conducted. I would now like to hand over to Rachel Welch.

Ms Welch: I will quickly go through the technical elements of the bill that achieve the policy outcome that Michael has spoken about. The main three things that the bill does is repeal the Dental Technicians Registration Act, the Speech Pathologists Registration Act and the Health Practitioner Registration Boards (Administration) Act. As Dr Cleary said, the Health Practitioner Registration Boards (Administration) Act will be repealed approximately one month after the other two acts to enable time for winding up. The bill provides for commencement on proclamation, so we can shorten or extend that time if needs be for winding up.

The bulk of the bill then deals with the consequential and transitional provisions needed to repeal those two registration acts. Principally the Health Practitioner (Professional Standards) Act will be amended by this bill quite substantially. The professional standards act deals with the disciplinary action that is taken once a board has investigated a complaint. It is the link between the boards, and for the national scheme the national boards, and the Queensland Civil and Administrative Tribunal processes. The professional standards act needs to be amended quite significantly to remove any reference to any remaining state registration systems and to clean it up and make it a little neater for its application to the national scheme. There are no policy changes in the amendments. They are all consequential to the repeal of the two state registration schemes.

Across Queensland's portfolio of legislation there are various references to health practitioners, registered health practitioners, speech pathologists and dental technicians so there are a lot of consequential amendments that are removing references to the state registration professions.

There are a number of transitional matters that are applied in this bill. The first is that it specifically provides for the transfer of assets, liabilities and property including the records of the two registration boards to the Office of Health Practitioner Registration Boards in the first instance and then, upon repeal of the Health Practitioner Registration Boards (Administration) Act, transfer to Queensland Health. Queensland Health will take responsibility for any records.

The other transitional provisions deal with existing complaints at the time of repeal. We do not anticipate there to be many, and most complaints for these two professions also fall within the scope of the Health Quality and Complaints Commission. So the bill provides that any complaints on foot are to be transferred to the Health Quality and Complaints Commission to be dealt with under its existing provisions.

Where there may be disciplinary proceedings that are not finalised upon the abolition of the scheme, the bill provides a mechanism for a registrant to continue these proceedings under the preamended Health Practitioner (Professional Standards) Act. The purpose of this transitional provision is to enable a registrant natural justice by having an opportunity to address allegations made against them. The bill does not provide a mechanism for the state to continue disciplinary proceedings other than referral to the Health Quality and Complaints Commission, as the mechanism for addressing disciplinary issues are conditional on registration—so conditions on registration or suspension or termination of registration. With the abolition of the registration scheme, those actions are no longer available.

The other significant transitional arrangement is for the issuing of blue cards by the Commissioner for Children and Young People and Child Guardian or the issuing of yellow cards by Disability Services Queensland. At present registered health practitioners are not required to have these criminal history checks and these cards. They are exempt because they are checked under their registration scheme. The bill provides a three-month transitional period for them to seek a blue or yellow card as needed. I think that is the gist of the bill. I can answer any questions you may have.

CHAIR: Dr Cleary, is there anything else you want to add before we throw this open?

Dr Cleary: No, thank you.

CHAIR: Steve, go ahead please.

Mr DAVIES: I had a young lady come into my office only about three weeks ago talking about this piece of legislation. She has a son who has a speech difficulty. They are working with a speech pathologist. Her concern going forward was quality control. If there is no registration and she has to find a new person, how does she know whether that person necessarily has the proper qualifications to work with her child?

Dr Cleary: There are a number of arrangements that are in place to safeguard the services provided by professionals. The first is that for those people employed within the public sector—and I am assuming that this person could be employed within the public sector—then qualification checks will be undertaken, as is the normal process, to ensure that a person who is acting as a speech pathologist holds the correct qualifications. Within the private sector, the speech pathologists have access to billing arrangements under Medicare, and the existing accreditation scheme that operates within Medicare will operate going forward. That means that they will be able to bill under Medicare but also in attending a speech pathologist privately and in seeking remuneration from Medicare you will be able to be quite confident that the person has the appropriate qualifications.

This also brings into relief the general discussions that have occurred at a national level around the regulation of unregistered health professionals. There are other health professionals that fall into this group. The ministerial council has been considering how that can best be undertaken going forward. It may be that within the next 12 or 18 months there will be further work done on that. But I think what that work will do is provide a mechanism by which we can ensure the safety of the community when they are attending an unregistered health professional of any kind.

Mr SHUTTLEWORTH: Rachel, if a complaint is made to the Health Quality and Complaints Commission and there was thought that there was cause for concern about a certain individual's capacity to continue to provide their service, either dental or speech pathology, could you explain what would happen after that? In a previous meeting we have had with the HQCC, they indicated that from a doctor's standpoint or a surgeon's standpoint it goes back to the overarching body. If we are now removing registration for those two professions, what would happen if there were cause for concern in that regard?

Ms Welch: The Health Quality and Complaints Commission currently deals with a wide range of health professionals that are not registered. So they would deal with dental technicians and speech pathologists in the same way that they deal with social workers or naturopaths or other health services that are provided by unregistered practitioners. So they can require engagement in conciliation and mediation. They can make a report that can be provided to the minister for tabling. Is that right? I am not fully across all the remedies that the HQCC have. But they will be able to use the same remedies for speech pathologists and dental techs that they use now for unregistered professions. As Dr Cleary says, there is consideration at a national level of a more sanctioned focused role for somebody in unregistered professions. But, yes, there is no registration body for them to refer people to.

Dr Cleary: Just to provide some further context to this, dental technicians do not operate as independent practitioners. They work as part of a practice and they are under the supervision of a dentist. They may provide work around dental prosthetics but the work is supervised by dentists. So, in terms of the dental technicians, there is a high degree of clinical supervision. Again, direct patient care does not occur except under the supervision of a registered health practitioner.

In terms of the speech pathologists, as was the case with dental technicians, there was an assessment done of the number of complaints that had been received prior to consideration of this change. In terms of the complaints, there have been a number that have been received over the last year—one or two—and I am advised that they do not relate to professional practice. They relate to other matters of perhaps professional standing.

Mr HATHAWAY: I might have missed this but how many Queensland registrants, dental techs and also speech pathologists, will be impacted? Also, under the national registration, for either of those professions do we expect the cost of registration to go up, stay the same or go down under the national board, aside from the cost which I assume is extra for blue and yellow cards?

Dr Cleary: In terms of speech pathologists, there are approximately 1,590 speech pathologists registered in Queensland as of December 2012. Approximately 376 speech pathologists work in Queensland Health and an estimated 146 are also employed in Education. There are approximately 6,500 to 7,000 speech pathologists practising across Australia.

In relation to dental technicians, there are 939 dental technicians registered in Queensland as of December 2012. Approximately 150 dental technicians work in Queensland Health. There are approximately 2,500 to 3,000 dental technicians practising in Australia. A lot of the dental technicians actually have registration under another section of the national registration scheme that allows them to practise as dental prosthetists. It will be of benefit to them that they will not have to hold a separate Queensland registration to the national registration under the provisions of the registration scheme. So, for the group of dental technicians that hold two sets of registrations, the benefit will be that they will only have to hold one and there will be a cost benefit that will flow to them.

In terms of the other registrants that we have been discussing, they will not be required to pay a national registration scheme because there is no national scheme in place that accommodates these professionals. So they will then have only to arrange to obtain a blue card or a yellow card depending on the environment in which they work.

CHAIR: John, did that answer your question?

Mr HATHAWAY: Yes, thank you.

CHAIR: I am assuming that the boards currently have a small staff; is that correct? Will they be absorbed? Where are those staff going?

Ms Welch: The boards themselves do not have a staff. The boards are provided administrative support through the Office of Health Practitioner Registration Boards. They have a staff of I think it is about seven and their employment is under the Public Service Act. So the direction is under the Public Service Act in relation to surplus, and redundancies will apply.

Mrs MILLER: So how many may be made redundant?

Ms Welch: I do not know.

Mrs MILLER: Well someone must know. Deputy Director-General?

Dr Cleary: As per the process that would be followed subject to the legislation being considered by parliament, these staff will be incorporated into the whole-of-government approach. We have done this previously with the previous registration boards and the Office of Health Practitioner Registration Boards, which had quite a large number of staff. The staff essentially transitioned to Queensland Health and then once within Queensland Health were managed in accordance with the provisions of the Public Service Commission.

Mrs MILLER: So do the staff understand that they may be made redundant when that transition occurs or has anyone spoken to them about it?

Dr Cleary: The staff are aware of the provisions. Certainly the executive director of the Office of Health Practitioner Registration Boards has been very clear in his discussions with us around the transition provisions.

Mrs MILLER: What do those discussions reveal? For example, how many of these staff may be made redundant?

Dr Cleary: In terms of the specifics of individuals, I would not be able to answer that today.

Mrs MILLER: Can you take that on notice then and get back to us?

Dr Cleary: We can provide some advice on how the transition arrangements will apply. It would be difficult to give a specific number in terms of the staff because it will depend on the matching process that is entered into.

Mrs MILLER: An approximate number will be fine.

Dr Cleary: We can take that question on notice.

CHAIR: It may be difficult without knowing what is going on.

Mrs MILLER: I am a former public servant. I know that they would have this in mind.

CHAIR: If you will take that on notice and do your best for us please, Dr Cleary. there being no further questions on this bill, I will move proceedings along, Dr Cleary, to enable you to brief the committee now on the Queensland Mental Health Commission Bill, and the same procedures that we have just run through will apply.

Dr Cleary: Thank you very much. The Queensland Mental Health Commission Bill has two major policy objectives. The first is to create a Queensland Mental Health Commission and the second is to amend the Mental Health Act 2000 to strengthen the powers of the Director of Mental Health to address incidents of high risk to patients and to the public. The Queensland Mental Health Commission Bill fulfils an election commitment of the government. There is a need in Queensland for a leader to promote better integration and high-quality and more targeted services for people with mental illnesses or people with substance abuse issues and their carers and their families.

As the minister noted in his introductory speech to parliament, one in five Queenslanders experiences mental illness each year and 50 per cent of Queenslanders will experience mental illness during their lifetime. Treatment, clinical and human services provided to people with mental illness or substance misuse issues are sometimes difficult to navigate.

The key objective in creating the Queensland Mental Health Commission is that it will provide for better and more effective cooperation across government and the community sector; coordination and transparency in the delivery of clinical services; better evidence based policy development and practice; greater focus on outcomes of recovery, social inclusion and community wellbeing; improved focus on promotion, illness prevention and early intervention; and better understanding and targeting of vulnerable and disadvantaged groups by service providers.

The commission will be independent and will be able to provide a significant linkage between the community and government for the improvement of mental health services and for the improvement in substance misuse services. It will achieve these objectives through the development of a whole-of-government strategic plan, which will outline the key principles and requirements of an integrated service delivery system; monitor the adherence to the strategic plan by government entities and report on that compliance; work with agencies and the community to develop better and stronger partnerships; engage with the community to better understand the needs of people with mental illness and substance misuse issues and their families and carers. The commission will work in partnership with the Mental Health and Other Drug Advisory Council which will be a key mechanism through which stakeholder engagement will occur.

To move on, the second amendment relates to the Mental Health Act 2000. Two recent incidents involving patients on forensic orders absconding whilst on community or limited community treatment highlighted the limited authority the Director of Mental Health has to immediately take steps to safeguard patients and the community. One of the main objectives of the Mental Health Act is to achieve balance between the rights of patients with mental illness and whose care and treatment may involve treatment in an involuntary setting. To this end, the bill ensures that incidents that may take place can be managed appropriately.

The three policy outcomes of this part of the bill relate to the following areas. Firstly, the bill introduces a new power for the minister and the Director of Mental Health to identify a risk to a patient or to a community and take action on that risk. The Director of Mental Health will be able to suspend limited community treatment for a forensic, classified and section 273(1) (b) order patients. There are limitations to this power and there is a right of appeal.

Secondly, the bill introduces a new set of conditions called monitoring conditions that the Director of Mental Health may require on limited community treatment or forensic, classified or section 273(1) (b) patients in order that the service is able to identify the location of a particular patient while on limited community treatment.

Finally, the bill provides an exemption to a prohibition on the publishing of information about a person who has been the subject of a Mental Health Court hearing in certain circumstances. This will allow the Director of Mental Health or the police to provide the public with information about a person who has absconded while on limited community treatment.

I would just like to go on to identify for the committee the importance of limited community treatment. It is an essential mechanism for assisting people with mental illness to recover and integrate back into the community. Limited community treatment is a staged way and may include escorted excursions to the hospital's canteen, unescorted visits to the facility's gardens through to fully integrated unescorted leave into the community for extended periods to undertake employment or attend study. However, the use of limited community treatment must be done in such a way as to ensure the safety and the needs of the community are safeguarded. These amendments, as stated earlier, seek to reinforce the balance between providing safe and effective treatment models for patients and safeguarding the community. I might hand over to Rachel Welch to talk through some of the technicalities of the bill.

Ms Welch: I will quickly talk about the Queensland Mental Health Commission component of the bill first. The bill establishes the Queensland Mental Health Commission as a statutory body and it is bound by the Financial Accountability Act and the Statutory Bodies Financial Arrangements Act. The commission is established with a commissioner who is appointed by the Governor in Council for a term of three years. The commissioner is not a public servant but the staff of the commission are to be appointed as public servants under the Public Service Act.

The main function of the commission will be to develop a whole-of-government strategic plan, which is defined by the bill as a plan for the improvement of mental health and the limiting of harm associated with substance misuse. The bill then provides detailed guidance on what is the purpose of the plan and what is to be included in the plan.

The bill provides that government agencies involved in the provision of services to people with a mental illness or a substance misuse issue and their families or carers must apply the plan to their service planning. Such agencies include those agencies responsible for health, education, housing, disability services, police, corrective services, emergency services as examples.

The bill provides for the commission to monitor and to report on the compliance of those agencies with the plan, and it provides for the commission to generate two types of reports: ordinary reports, which are about general compliance with the plan, and special reports, which are on matters requested by the minister. The commission must provide the minister with both types of reports and the minister must in turn table any ordinary report that is provided and may table a special report.

The bill also establishes the Queensland Mental Health and Drug Advisory Council to support the commission's work. The council will be the primary mechanism for consultation with the community.

Most importantly, the bill embodies the guiding principles to which the commission must have regard when fulfilling its functions. These principles reflect the underlying best practice principles needed to establish a cooperative, fully integrated and community focused treatment, support and educational environment for people with a mental illness or a substance misuse issue. The bill includes fairly standard provisions around meetings and remuneration and is quite prescriptive in the principles that the strategic plan and the commission must embody.

I will now talk about the second component of the bill which is the amendments to the Mental Health Act. Firstly, the bill adds a new section 131A into the Mental Health Act to create monitoring conditions which the Director of Mental Health may require for certain patients when taking limited community treatment. These patients are limited to classified patients, forensic patients and patients for whom the Mental Health Court has made an order under section 273(1) (b). The director may require a monitoring condition if the director considers that a greater level of location monitoring is required for the patient.

The bill will insert examples of what a monitoring condition may include and these may be a detailed plan of the patient's location and movement during limited community treatment, a requirement that the patient call the relevant authorised mental health service whenever the patient intends to leave a place or the use of a location monitoring device. The bill clarifies that any information gathered through a monitoring condition is to be considered confidential information for the purposes of the duty of confidentiality in the Hospital and Health Boards Act which is the duty that currently applies to all health information about a patient in any public health service. The bill also includes consequential amendments to ensure that these monitoring conditions are dealt with the same way as other conditions for the purposes of reviews and appeals.

Secondly, the bill inserts a new division 1A into chapter 13, part 1 of the Mental Health Act to give the minister and the Director of Mental Health new powers under the act. If the minister considers that a significant matter arises in relation to one or more patients and there is a serious risk to the life, health or safety of a person or a serious risk to the public because of that matter, the minister may direct the director to review the matter and decide whether to take any action. The minister is not authorised under the amendments to direct the director to take action or to tell the director what action to take.

If the director is directed by the minister or if the director forms his or her own view as to a significant matter posing a risk, the director may initiate a number of actions including suspending limited community treatment of a patient or group of patients—for example, all patients at the park; order an administrator of an authorised mental health service to undertake an investigation into the matter; require reviews and

reports of treatment plans or the use of limited community treatment; and require the review and report of guidelines, policies and protocols on the use of limited community treatment. The bill includes the requirements the director must follow when initiating action and the officers that must be consulted or notified before action is taken. The bill increases the jurisdiction of the Mental Health Review Tribunal to enable a patient to appeal a decision to suspend limited community treatment.

The bill amends the power of delegation in the Mental Health Act to restrict to whom the director may delegate the power to suspend limited community treatment to senior officers within the department—that is, delegation cannot be to a health service administrator or a medical practitioner within a service.

The third set of amendments the bill makes are minor amendments to the Mental Health Act to include a defence to the offence of publication of information about a patient who has been the subject of a mental health hearing. This defence enables the publication of such information if the director has authorised the publication because the director believes the publication is necessary to assist in lessening or preventing a serious risk to the life, health or safety of a person or to public safety.

CHAIR: Dr Cleary, do you wish to add anything else?

Dr Cleary: No. If I could just introduce Dr Bill Kingswell, Executive Director of the Mental Health, Alcohol and Other Drugs Branch, who is with us here today.

CHAIR: Thank you. Dr Kingswell, is there anything else you would like to add or highlight?

Dr Kingswell: Not at this stage, no.

CHAIR: We will go to questions.

Mr DAVIES: Firstly, exactly how many patients would be under forensic orders? Secondly, of those who are under forensic orders, how many are on LCT?

Dr Cleary: There are approximately 740 patients who are under forensic orders within Queensland and approximately 140 who are special notification patients. We might have with us the data of those who are on LCT.

Dr Kingswell: I would need to find that. Essentially there are 70 high-secure beds in the state and so a proportion of people occupying those beds will not be accessing LCT, although a number will be. There will be a number of people on forensic orders in our medium-secure units and some of those will be unable to access LCT but a number will be. But the vast majority of those 740 will be accessing LCT because they are not in in-patient units.

Mr SHUTTLEWORTH: In relation to the appeals process, through the Mental Health Act or through the Mental Health Commission you mentioned that there was capacity to appeal decisions. Who has that capacity to appeal? If someone is severely impaired from a medical standpoint, who is able to appeal decisions on their behalf?

Ms Welch: I will just clarify that under the Mental Health Commission Bill there is no appeal as there are no decisions being made about individuals. The two sets of appeals or review rights under the Mental Health Act amendments are firstly seeking reviews of monitoring conditions on LCT, limited community treatment. They will be captured under the normal review mechanisms that a patient now has. They can go to the Mental Health Review Tribunal and the Mental Health Review Tribunal has general powers to review limited community treatment and review conditions placed on LCT.

A patient who is severely incapacitated would not be having limited community treatment. So a patient can seek a review of that condition. A patient has patient friends—under the act they have an allied person who can assist a patient in matters under the act, and the treating doctor of course, as part of the treating team, can make submissions to the Mental Health Review Tribunal as well.

With appeals on suspension of limited community treatment, again, it is only going to apply to patients who have limited community treatment. So there will be a degree of—I am not quite sure of the right term. They will not be people who are severely incapacitated because severely incapacitated people would not be having LCT. They can appeal again to the Mental Health Review Tribunal in their own right by themselves or with the support of an allied person or with the support of their treating team.

Mr SHUTTLEWORTH: I am just trying to understand. If there is an order placed for a position monitoring device—a GPS device—on a patient, is someone able to appeal that decision? What would be the process around that? If it were judged that from a community safety standpoint the department wanted to place a GPS device on someone, does that person have the capacity to appeal that or does someone have capacity to appeal that on their behalf?

Dr Kingswell: I can probably answer that. The Mental Health Review Tribunal has to review all involuntary patients every six months and then will at those hearings review the conditions of their leave, if any. The patient themselves can bring on a hearing at any time and the Mental Health Review Tribunal only has the capacity to refuse that if they consider that it is vexatious or unnecessary.

CHAIR: I will ask Mrs Miller if she has questions.

Mrs MILLER: I have quite a number of questions, so if you would like to bear with me. In accordance with the bill, I would like to take you to part 2, division 2, Functions and powers, section 11(1)(i) where it says 'to support and promote social inclusion and recovery of people with a mental illness' and also (j) where it says 'to promote community awareness and understanding about mental health' and it goes on and on. I would just like to ask you why this was included in the bill given that information was

released to a Brisbane newspaper only recently saying that the costs of care of a patient were over $1 million. That information was given to the media by a person or persons that we do not know at this point in time. How would that type of information assist in the social inclusion of a patient and also promote community understanding about mental health issues?

Dr Cleary: I do not think, given the nature of the meeting today or the committee's deliberations, I can comment on media outside the scope of the legislation. However—

Mrs MILLER: Except that someone gave that information to a media organisation and I would like to know under these amendments how that particular person is going to be dealt with. I understand that there is an investigation currently underway within Queensland Health in relation to this, but I would particularly like to know, given that these are the broad functions and powers of this new commission, if a person or persons gives that information to the media how will they be dealt with.

Dr Cleary: In terms of the public servants involved in the work of the commission, they will be covered under the Hospital and Health Boards Act and the provisions of confidentiality that apply within that act.

Mrs MILLER: What if they are not public servants?

Dr Cleary: All of the people who are working within the commission will be public servants. In terms of the arrangements that you have referred to in the act, they are built in so that we have an appropriate exposure to the broader community in terms of the issues that may need to be raised. If you look through the act, we recognise the need for consumers and carers. I think the strategic plan is going to provide that guidance. The commission's main role will be to create the strategic plan. That is going to be the important guiding document for government and a very important guiding document for the non-government sector.

Secondly, the commission will want to monitor that strategic plan and monitor the outcomes of the plan both within the government and non-government sector. The commission's role is really a very high level role to provide that overarching guidance to the minister and to the committee around the direction for mental health in Queensland. One of the areas that was extensively considered as part of the work-up for the legislation was the degree to which the committee should have an operational component. As a consequence of those considerations, the commission will not have an operational component in terms of oversighting health services from that operational perspective, but certainly from a strategic planning perspective they are going to be critically important. The operational planning will rest with the hospital and health services. The individual patient will probably not be an area that the commission would specifically look at. It would more be the care and treatment of, and support for, patients or individuals with drug misuse issues.

I do not know whether that has answered the question specifically except to say that the commission's role is really a high-level role which is going to focus on developing a strategic plan, getting that strategic plan operational, working with the government and non-government sector, and monitoring the outcomes to make sure that the goals that are required are achieved.

Mrs MILLER: Can you take on notice what happens if the person is not a technical public servant who gives that information to the media, please? I would like an answer on that. In relation to section 12—

CHAIR: Dr Cleary, are you clear about what you have been asked to take on notice? Because I am not sure myself.

Mrs MILLER: The answer referred to a public servant in terms of the public servants act. If information is given to the media that has not come from a public servant, what redress is available given—and I particularly quote—the circumstances that were recently in the Brisbane media? I think you understand that.

Dr Cleary: We can provide some advice about what actions can be taken where a non-public servant provides information, but it will be a general response because it is really a member of the community providing information to the media and that could come from many different sources. We can provide some advice around that general issue. I do not know that we will be able to provide a specific answer.

Mrs MILLER: I will move to proposed section 12(e) in relation to the commission's powers which states 'do anything else necessary or convenient to be done in the performance of its functions'. Would that include giving information to the Minister for Health's office?

Dr Cleary: I might ask Rachel Welch to provide some further detail, but there are a number of different mechanisms where the commission can provide advice. There is a requirement for the commission to report to parliament. There is an opportunity for the commission to provide specific reports to the minister, and then the minister can seek advice and they can be provided—

Mrs MILLER: Which is all in this bill, but I am asking outside of those specific instances that are in this bill would that include giving information to the minister or the ministerial office? I think it would.

Ms Welch: Yes, it would.

Mrs MILLER: Proposed section 19(1) (b) states—

... to make recommendations to the Minister about any matter that—

(i) relates to the performance or exercise of the commissioner's or commission's functions or powers ...

In relation to this and generally within the bill does the Minister for Health have any say by direction or consultation with the commission about specific mental health patients? For example, do you foresee in the future any political pressure being put on the commission or the council in relation to a particular patient or patients? Given that the $1 million cost of providing care to a particular patient, which has identified that person or has the capability of identifying that person, was in the media, I am trying to drill down to find out how far it goes in relation to the Minister for Health and a particular decision or political influence.

Ms Welch: Firstly, the Queensland Mental Health Commission will not have involvement with individual patients. It will not have patient information. It is a strategic body and it is not involved in the treatment of patients so it will not have the information to give the minister even if he asked for it. The expenditure on mental health services is dealt with at an institutional level. Again, the commission is not involved in how much it costs or what services are to be provided. Its role is to create a strategic plan that service providers use to develop their service plans. The commission will have a role in working with the DG of Health on service agreements with the hospital and health services, but it will not be down to a very specific, 'You must provide these services to these people at this cost.' It will not have that involvement.

Mrs MILLER: What if the commission wants to go along that path?

Dr Cleary: I do not believe that is the purpose of the commission, and that is certainly not what has been outlined in the legislation. The commission has a very specific and very important role in preparing, reviewing and monitoring that strategic plan, which I think is the key document that it is going to provide to us. It may advise on systemic issues, because as the commission it may become aware through its work of issues in some areas which it sees as ones which should be addressed. It will also have an important role in knowledge sharing, research and innovation. If we look forward, the commission's engagement with the community and the non-government sector as well as the government sector must surely provide the opportunity for those groups to work together in a collaborative arrangement.

Mrs MILLER: To follow up on that, if the commission wanted to make a recommendation or give some advice in relation to the Barrett Adolescent Centre, it would be outside its scope, I understand, if that is how you are narrowly defining the commission's powers and functions.

Dr Cleary: I do not want to speak specifically about circumstances that may or may not arise, but the minister can seek advice from the commissioner on these types of general issues. If in the fullness of time the minister was wishing to seek advice from the commission on a particular matter, it would be within the minister's purview to seek that advice. It could be the minister would wish advice on circumstances such as suicide prevention within Queensland, and I would think that would be an area that the commission would be well placed to respond to given that the issues are across multiple government portfolios including police, corrective services, education and the non-government and private sector. They are the sorts of areas that I would think the minister would be seeking advice on from the commission and would wish to identify opportunities for improvement going forward and how we can make the system work better.

Again, this is not a new instrumentality. It is one that is there to provide guidance and to provide reporting back to the minister and to the parliament on the activities that it undertakes. If you look at some of the strengths of the commission, which Dr Kingswell could talk about in terms of what we found from our consultation, it is really the opportunity to promote wellbeing, social inclusion, recovery and community awareness of mental health and alcohol and other drug issues within the community. From my perspective, I think that is a very important component of the work of the commission—to be outwardly focused and to provide those broader directions for the community. Certainly in our consultation process in relation to the development of the legislation we had quite positive feedback. I do not know whether it would be appropriate for Dr Kingswell to talk about some of that feedback.

Mr DAVIES: Chair—

Mrs MILLER: I would like to continue with the line of questioning.

CHAIR: Steve, I am going to allow this to continue but we need to keep it within the context of what the commission is.

Mrs MILLER: Well, we have to keep it within the context of the bill that we are examining. I have a technical question in relation to proposed section 53(3) and the meaning of the word 'official'. The minister is listed under (a). Does this include ministerial staff?

Ms Welch: I will have to come back to you on that.

Mrs MILLER: Okay, you can take that on notice. I have a follow-up question in relation to part 9, the amendment of the Mental Health Act 2000 and particularly the insertion of proposed section 131A. I think Dale spoke earlier about patients wearing devices. I would like to know whether these measures are in accordance with the United Nations conventions regarding persons with disabilities not being discriminated against on the basis of their mental illness. Will this prohibit their integration and rehabilitation back into the community? Furthermore, do you think it is fair that people will have to go around with monitoring devices perhaps around their ankles which are the same devices used for paedophiles in our community?

CHAIR: I am not sure that last part is—

Mrs MILLER: It is. Paedophiles do have to wear ankle—

CHAIR: But I am not sure asking for an opinion from the deputy director-general is where we need to be. We should be asking questions of clarification.

Mrs MILLER: Can you clarify that?

CHAIR: Could you answer from the perspective of providing clarification?

Mrs MILLER: I want to know about the monitoring devices. I am well aware of this. I have been a member of parliament for a long time. These anklet devices are monitoring devices that are used to protect the community. They are anklet devices. Will mental health patients have to wear similar anklet devices which paedophiles wear in our community? Is that the type of device that you are talking about?

Dr Cleary: Thank you very much for the question. The new provision provides for enhanced monitoring of patients and very specific classes of patients—forensic patients, classified patients and patients under section 273 orders. The monitoring provisions are there to provide safety and security for both the patients and the community. Monitoring can be undertaken in a range of mechanisms. One of those mechanisms could be for a telephone call to be made on a regular basis while a person is on leave or for a person to be at a predesignated spot at a particular time. It does not preclude the use of other monitoring devices. That is an area that will need some further exploration.

In terms of the monitoring devices that could be used, my understanding is that they have been used overseas and to very good effect and provide an ability for the patient—and these are forensic patients who are often patients of special notification who are perhaps on their first episode of unescorted leave on the grounds. In those circumstances, the technologies provide a range of benefits, one of which is being able to locate a patient if they do not return within a specified time frame. As I understand it, there is also the capacity for voice to be sent to be patients using the same technology to advise them that they may be out of the area that they are supposed to remain within. So it can be of benefit to the patients so that they know they have crossed a boundary or that they have entered an area that they are to be excluded from.

So, in terms of the types of technologies that are available, they will span from telephone with regular reporting in to being at a designated place or to other devices or other technologies that may be appropriate. I think it does provide both security for the patient and for the community. As we talked about earlier, it is about balance. That is what the Mental Health Act 2000 does. It is trying to balance the benefits of patients from care and the benefits to the community.

Mrs MILLER: So I assume from that that, yes, it will include anklet devices—that, yes, it could include that.

Dr Cleary: Yes, there is the possibility that monitoring devices could be used. The specific types of monitoring devices have not been explored.

Mrs MILLER: Can I go back to my earlier question in relation to the United Nations convention—

CHAIR: Just a second. How much more do you have, Jo?

Mrs MILLER: I have about another four questions and then I will be finished.

Mr DAVIES: Can I ask a question?

CHAIR: Just a second please. I am going to allow you to continue and finish. But I have some time frames to work within here and I would like to let some of the other members of the committee ask questions. So ask another couple of questions and then we will move on to someone else.

Mrs MILLER: I would like to ask about the United Nations conventions in relation to disabilities. For example, you talk about mental health patients—which are the subject of this act—and their particular concerns and protecting the community et cetera. But there are also United Nations conventions regarding persons with disabilities such as intellectual disabilities. So what I am asking is: in relation to the United Nations conventions, has the department or Parliamentary Counsel or whoever has devised this legislation taken into account those United Nations conventions and does this fall within that?

Dr Kingswell: There are probably two conventions that we would have had reference to—one is the UN Principles for the Protection of Persons with Mental Illness and the second is the Convention on the Rights of Persons with Disabilities. I would not think this legislation is contrary to either of those declarations in that it does not apply to a group of people with mental illness. It applies to an individual person undertaking limited community treatment usually for quite specific reasons, either the nature of the serious offending or the stage they are in their process through the mental health system.

Mrs MILLER: Thank you. In relation to the bracelet devices, would it be possible for a person to be able to take an action under the Anti-Discrimination Act if they believed they had an anklet device on them which would perhaps have the public thinking that they are either a very serious paedophile or a criminal, that the public would have that particular mindset, yet they are actually a mental health patient? How would that sit as far as the anti-discrimination legislation?

Dr Cleary: I will just make a couple of general comments. Firstly, I think the monitoring provisions are provisions that may in fact be of benefit to patients. If you are thinking about the care and treatment being supported by limited community treatment, early access to limited community treatment, I think, is a positive benefit to the patients because they are then able to become more mobile and move towards

integrating back into the community. So, from that perspective, monitoring to allow people to have earlier access to limited community treatment is a positive in that it benefits the patients. In terms of the specific provisions of the legislation, they allow for appeal, and I might ask Rachel Welch if she could comment on the general provisions around appealing a decision.

Ms Welch: Yes. They can be reviewed by the Mental Health Review Tribunal, as we previously discussed. A patient can cause an action to the Mental Health Review Tribunal to seek a review of that condition being placed on their limited community treatment. The tribunal would be reviewing it every six months anyway, and the tribunal could cease that condition if they felt it was appropriate to cease it.

Mrs MILLER: But it would not stop them taking an anti-discrimination action either, would it? It would not preclude them from doing that.

Ms Welch: I do not know if the Anti-Discrimination Act would be triggered by that action. That is something you would—

Mrs MILLER: Can you take that on notice then?

Ms Welch: We would need to get legal advice on that.

CHAIR: Mr Davies.

Mr DAVIES: My question is to Dr Kingswell. I am just trying to work out how the commission will work in the real world as far as the integration of early identification of issues and public awareness are concerned. It is a strategic body, but how will it actually influence the day-to-day running of mental health services as far as early intervention and so forth are concerned?

Dr Kingswell: At the moment responsibility for the whole-of-government mental health sector and the intersection of the Queensland government with the federal government all sits within my branch. This legislation will establish the commission as an independent statutory body reporting directly to the minister and it will take out of my directorate a lot of those functions that we are currently responsible for. So the whole-of-government strategic plan around preventing suicide, for instance, would be a function of this commission. Beyond just the six people and the commissioner that it is currently envisaged to constitute this commission, they will also take program budgets from our department to be administered, and that will include the early intervention prevention project.

Mr DAVIES: So where does drug and alcohol abuse sit or how will that work as far as awareness programs are concerned? Will the commission actually take that completely?

Dr Kingswell: There is a whole-of-government Queensland Drug Action Plan, which is currently in abeyance waiting the establishment of the commission. We would expect that the commission would pick up that function—chair the interdepartmental committee, review the Queensland Drug Action Plan, review the priorities within that plan and establish some actions around it.

CHAIR: Does the commission take any broad direction from a federal body or federal direction in any way? For example, are there any COAG arrangements or agreements with regard to the strategic focus of the commission or is there purely a Queensland-centric focus?

Dr Cleary: At this stage the commission is a Queensland entity and is established as a statutory body within Queensland. Having said that, there has been a significant amount of work done nationally in aligning mental health with alcohol and drug services and the policy oversight of those areas. We now have a national group that reports to the Australian Health Ministers Advisory Council which takes up both those portfolio issues. Previously they were separated and at a lower level within the national governance framework. Within each state and territory we are now seeing the emergence of mental health commissions, and they all have some variation so they are not a standard arrangement. But they are certainly being developed in each of our states and territories or larger states and territories. And of course we have the national commission, which recently released its report.

When we were looking at establishing the legislation in Queensland, we had the benefit of being able to review the outcome of the policy and the legislative arrangements in each of the states and territories. We also looked overseas at Canada and New Zealand, which have had organisational arrangements that are considered to be world-class. So drawing on all of that information we then set about developing the policy framework and then the legislation for the Queensland commission. I believe—and I can say this with some independence not having been involved in the drafting—the framework we have has drawn on all the strengths from the overseas and interstate commissions.

We have also received very positive feedback from the community from carers, from patients and from advocacy groups around the proposed legislation. That has been very, very positive. So I think for Queensland we will have a very good framework to go forward. Nationally the report which was released recently was positive about Queensland in terms of it recognised that Queensland had provided the right framework for mental health services and was even reporting information to a higher level than some of the other states and territories around mental health services and their performance. I think the commission will further enhance that role because it will be able to access information from Queensland Health on service provision and again provide an independent view of the services provided not just in the public sector but also across government and in non-government sectors.

I am very positive about the commission. I think it will work very closely with the other commissions and with the national commission. But clearly it has a strong link to parliament and the minister.

CHAIR: Thank you. Our time is drawing very quickly to an end.

Mrs MILLER: I have a couple of questions—just simple ones.

CHAIR: They need to be really quick. We are just about finished.

Mrs MILLER: Yes.

CHAIR: Let's take one.

Mrs MILLER: I have questions in relation to section 42 and section 46. In section 42, which is about the business of the council, it does not say how often the council is going to meet. The bill is silent. It does not say how often the council is expected to meet. Also, section 46 talks about the minutes. What administrative support will the council have? Who is going to take the minutes? Who is going to supply the minutes?

Dr Cleary: In terms of the legislation, the legislation is drafted so that it is facilitatory legislation. Therefore, the specific details and frequency of meetings are not included in the legislation.

Mrs MILLER: But there normally is a minimum requirement in this sort of legislation, saying that councils or whatever will meet at least a couple of times a year. I am just wondering why that is not specified in this piece of legislation—or they could meet every week if they want to.

Dr Cleary: The information I have is that as they are not a decision-making body there is not a requirement for them to be mandated. However, again, I think it would be something we would be happy to look at and to examine.

In terms of the second question and the resource support, the planning that has commenced—and obviously it will be able to be enacted only after the legislation has passed parliament—is for a team to be transitioned from the existing branch to create the resource for the commission. That is going to mean that the commission will have a group of people that are able to commence work immediately it becomes active. The team that would transition are also the team that have been working on the legislation and on the transitional arrangements. So the team is a highly skilled team with an extensive background in this particular area and the operation of the commission as it is proposed.

CHAIR: Thank you. Our time for the public briefing has come to an end. Dr Cleary, I offer you a couple of minutes if you would like to give a summary. If you do not want to, that is fine.

Dr Cleary: Thank you. I would very gratefully accept the offer. Thank you very much to the committee for your time today in allowing us to brief you on two very important areas. In relation to the first bill and the change in the national registration scheme, I think this is the last step in a series of legislative changes that started some time ago and brings Queensland in line with the national framework for registration of health professionals. It is, I think, a very important step for us to take going forward.

The second piece of legislation in relation to the Queensland Mental Health Commission I believe is a key piece of legislation. As you would be aware, it is one of the areas the government has identified as a priority and the minister has identified as a personal priority. I believe that it is an appropriate structure going forward and that there has been an extensive amount of consultation and consideration of the framework that should be put in place. I would commend both pieces of draft legislation to you.

CHAIR: Thank you. With regard to answers to questions on notice, I am proposing that you have them back to us by 1 February, as public submissions are required back by 4 February, if that is acceptable.

Dr Cleary: Thank you.

CHAIR: Thank you. As I indicated earlier, the committee intends to publish the transcript of today's proceedings unless there is good reason not to. Dr Kingswell, Dr Cleary and Ms Welch, thank you for your attendance and your staff. I declare the briefing now closed.

Committee adjourned at 12.17 pm

West Moreton Hospital and Health Service

Board Meeting - 25 January 2013

Jan 25, 2013 at 10:00 AM

The Park Centre for Mental Health

Anderson House Boardroom

West Moreton Hospital and Health Board

BOARD COMMITTEE AGENDA PAPER

Committee: West Moreton Hospital and Health Board			
Meeting Date:	**25 January 2013**	**Agenda Item Number:**	**2.4**
Agenda Subject:	**Update on Barrett Adolescent Centre**		
Action required:	☐ For Approval	☐ For Discussion	☒ For Noting

Proposal

That the West Moreton Hospital and Health Board:

Note The update of the Barrett Adolescent Strategy

Background

1. A project plan titled Barrett Adolescent Strategy was tabled by the Chief Executive at the meeting of the West Moreton Hospital and Health Board on 23 November 2012.

Key Issues or Risks

2. The project plan identifies five areas of risk. With respect to each of the identified risk areas:
   a. Time frames in the gant chart are on track.
   b. The Expert Clinical Reference Group has not as yet agreed on a preferred model of care, as they have only met twice.
   c. Endorsement of the preferred model of care is not planned to occur until late February 2013.
   d. Communication of project objectives has occurred and the communication strategy within the project plan is being implemented.
   e. Endorsement of the implementation plan is not planned to occur until late March 2013.

Consultation

3. The Expert Clinical Reference Group (ECRG) has met twice and from 7 January 2013 it will meet on a weekly basis.
4. The ECRG has terms of reference and is seeking approval from the Planning Group to expand its membership to include consumer and carer representation.
5. The ECRG is using a structured approach to address service elements and is undertaking a service analysis across the adolescent mental health continuum.
6. The Planning Group has met on four occasions in 2012 and will meet fortnightly from 18 January 2013.
7. The Planning Group has oversighted the development of a stakeholder engagement plan, terms of reference for the ECRG, a media protocol and fact sheets (posted on the internet).
8. All correspondence from stakeholders (email, ministerials etc) and media enquiries have and are being responded to in a timely manner with consistent key messages being utilised.

Financial and Other Implications

9. It is not possible at this stage to indicate financial implications in the absence of a likely preferred model.
10. However, as noted in the Project Plan, It is assumed that the existing recurrent funding for BAC and the additional future funding earmarked for the former Redlands Unit will be utilised to fund the endorsed model(s) of care.

Strategic and Operational Alignment

11. Both the ECRG and the Planning Group are mindful that the final endorsed model(s) of care will
    a. need to clearly articulate a contemporary model(s) of care for extended treatment and rehabilitation for adolescents in Queensland.
    b. be evidenced based, sustainable and align with statewide mental health policy, service planning frameworks and funding models and
    c. replace the existing services provided by Barrett Adolescent Centre.

Recommendation

12. That the West Moreton Hospital and Health Board:

Note The update of the Barrett Adolescent Strategy

West Moreton Hospital and Health Board

BOARD COMMITTEE AGENDA PAPER

APPROVED	NOT APPROVED	NOTED
Chair, West Moreton Hospital and Health Board		/ /

- ☐ Recommendation/s are consistent with Strategic Plan
- ☐ Funding impacts are included within approved budget
- ☐ Risks are identified and mitigation/management strategies included
- ☐ Implications for patient and/or staff care and well-being have been identified

West Moreton Hospital and Health Board

BOARD COMMITTEE AGENDA PAPER

Committee: West Moreton Hospital and Health Board			
Meeting Date:	**25 January 2013**	**Agenda Item Number:**	**3.2.5**
Agenda Subject:	**Turnaround Plan Update**		
Action required:	☐ For Approval	☐ For Discussion	☒ For Noting

Proposal

That the West Moreton Hospital and Health Board:

Note the information contained within this paper in relation to the December 2012 Summary Turnaround Plan Progress Report.

Background

1. The Board endorsed the WMHHS Turnaround Plan on 26 October 2012. The Turnaround Plan continues to have multiple strategies undergoing diagnostics and solutions design to further contribute to the financial performance requirements of the WMHHS, including the revised $4.3M Commonwealth funding reduction.
2. A significant body of work has been implemented to deliver the target FTE position by mid December 2012, and further financial efficiency savings by March 2013, and in future months.
3. The service review process has several built-in 'tollgates' to ensure the strategies within the Turnaround Plan, or those undergoing diagnostics and solutions design, considered to be of a political or reputational risk in nature, and/or considered to result in a significant impact to service delivery, will be submitted to the Board for approval prior to implementation.

Key Issues or Risks

4. The value of strategies within the Turnaround Plan for the month of December has increased $44K to $12.156M total due to final costings of service reviews.
5. The additional commonwealth funding reduction of $4.3M is undergoing strategy development and inclusion into the Turnaround Plan to ensure a balanced end of year position.
6. It should be noted that included in the $12.156M is $592,639 which are part year savings in relation to a Mental Health Turnaround Plan Strategy (Barrett Adolescent Centre). It is noted this strategy has been rated as high risk. Should this strategy not be realised in full, alternate strategies are being developed to ensure confidence in the final end of year balanced position. Should this strategy be realised, full year savings in 2013/2014 would be $3,923,388.
7. **Turnaround Plan Progress Overview**

   - Target WMHHS MOHRI FTE = 2570. YTD December actual MOHRI FTE = 2608
   - WMHHS has a further 38 MOHRI FTE reduction required to realise the 174 target. (this is a decrease from 57 MOHRI FTE position required in the November report ie: 19 MOHRI FTE reduction from November to December reporting period)
   - Confirmation of a further 21 Voluntary Redundancies to be processed as part of the Turnaround Plan and will account for reductions in the coming January and February reporting cycles.
   - In total, a further 143.98 MOHRI FTE is still to be realised from within the Turnaround Plan strategies in out months.

   - ***Note***: Latest Payrun **06/01/2013** data identifies YTD actual MOHRI FTE = 2581.70 which equates to a remaining 11.7 FTE reduction required to realise the 174 target. Whilst there remains 134 MOHRI FTE reductions still to be realised from within the Turnaround Plan strategies in the out months, it is noted this figure is counter balanced to a degree due to necessary recruitments in the coming months. Analysis of final position is being undertaken as part of the development of the additional $4.3M saving strategy to ensure confidence around final figures and controls around agreed recruitment.

5.1 Readiness Assessment Re-evaluation Update

- We have confirmed the timeframes for submission of the readiness assessment re-evaluation:
  - 31 January – Executive workshop with Ernst and Young
  - 15 February – submission by HHS of Development Action Plan (DAP) and supporting documentation
  - 19 February – consideration of the submission by the Performance Management Executive Committee
  - 22 February – The decision of the PMEC confirmation is subject to Board endorsement

6. Matters For Noting

6.1. Events and Media

- There have been no events held since the last Board Report. However, Board should note the invitation to attend the Australia Day awards ceremony to be held on Thursday 24 January at 1000.
- We continue to have temporary arrangements in place pending finalisation of the Corporate Office structure.
- These arrangements are:
  - When responding to reactive media we are supported via the media office within the Department of Health and as previously advised we have appointed a communications consultant to support the review of the Barrett Adolescent Centre.
  - We have retained a website officer and our intranet has been recently updated.
- Media interest continues in the Barrett Adolescent Centre, as well as interest in Ambulance bypass – driven mainly by the commencement of an enterprise bargaining period for Queensland Ambulance Staff.
- The Board Chair and myself completed a Media training day in December.
- I have requested a communication and engagement strategy be developed in relation to the Ipswich Hospital Expansion project. This should be completed by end of February.
- An overall Communication strategy for both internal and external communications is currently being developed and will include Board communication internally to staff as well as externally.

6.2 Health Workforce Australia grants received

- UQ Health Care in partnership with WMHHS has received two Health Workforce Australia grants to establish and evaluate new models for clinical education. Together we will establish the Ipswich Primary Care Rehabilitation Clinical Training Placements and a Child and Youth Mental Health Student Assisted Clinic. The submissions were for $250 000 and $187 775.
- The clinical placement model will embed the student role in the clinical care pathway, providing an ongoing role for students in the delivery of services with the oversight of expert clinical staff. Both models will take an interdisciplinary approach to student learning.
- The clinics will offer student placements to most allied health disciplines.

7. Information for Board

7.1. Attached is information relating to:

- The Park summary of facilities and services
- Mental Health Centre for Research and Learning
- Bio of John McGrath

Consultation

8. Executive Directors have been consulted and signed off on allocated targets and Work Streams documented within the Turnaround Plan.

Financial and Other Implications

9. The risks associated with not delivering the MOHRI FTE and financial savings within the required timeframes remain considerable due to organisational capacity and capability, and have been impacted by the additional $4.3M saving required within the current financial year. A rigorous reporting and governance framework has been implemented in conjunction with an enhanced Workforce Engagement Strategy and Performance and Accountability Framework to mitigate the risks associated with not delivering the required savings.

Strategic and Operational Alignment

10. Aligned to the achievement of a balanced budget position and ensuring the WMHHS attains financial health into the future.

Recommendation

Note the information contained within this paper in relation to the December 2012 Summary Turnaround Plan Progress Report.

APPROVED	NOT APPROVED	NOTED
Chair, West Moreton Hospital and Health Board		/ /

☐ Recommendation/s are consistent with Strategic Plan
☐ Funding impacts are included within approved budget
☐ Risks are identified and mitigation/management strategies included
☐ Implications for patient and/or staff care and well-being have been identified

WEST MORETON HOSPITAL & HEALTH SERVICE
Jan-13
TURNAROUND PLAN

Red	Tracking over Budget FTE /Not compliant
Amber	Moderate issues identified / Progress delayed / Partially compliant
Green	On track – In Progress/Compliant
Blue	Complete
White	Identification of Explicit PIDs - Work in Progress

Workstream Reference	Labour (FTE) Strategy	Due to Commence	2012-2013 Value	MOHRI FTE Reduction	MOHRI FTE Reduction Performance
1.1	Legal Advice Model	6-Jan-13	$61,937	1.00 FTE	Green
1.2	Communications & Engagement Team Structure & Model	25-Nov-12	$116,896	3.00 FTE	Amber
1.3	IH Foundation Position	23-Dec-12	$24,847	0.84 FTE	Green
2.1	Executive and Senior Management Restructure	9-Dec-12	$99,766	1.00 FTE	Green
2.2	Finance Branch structural review	10-Feb-13	$103,768	2.00 FTE	Green
2.3	Medical records review **PLUS HIM Service Review** (This will be broken out into it's own Service Review as it is awaiting the result of the Offender Health Business Case)	6-Jan-13	$131,107	4.00 FTE	Green
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2.5 / 2.6	Administration Vacancy Management & Growth (15)	6-Jan-13	$529,384	14.18 FTE	Green
2.7	The Park Switchboard	6-Jan-13	$41,539	1.00 FTE	Green
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3.2	Service Planning	9-Dec-12	$81,678	1.00 FTE	Green
4.1	Rural Social Worker HP5	6-Jan-13	$69,682	1.00 FTE	Red
4.2	Women's Health	05-Sep-2012	$113,522	2.80 FTE	Green
4.3	Re-evaluate HACC services to match funding allocation	6-Jan-13	$254,789	6.60 FTE	Green
4.4	Remove Backfill for Sick Leave & Annual Leave	11-Jul-2012	$108,508	1.24 FTE	Blue
4.5	Delay Recruitment for Principal Dentist	11-Jul-2012	$0	0.00 FTE	Blue
4.6	Delay Recruitment for 2 FTE senior dentist	11-Jul-2012	$0	0.00 FTE	Blue
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4.8	Removal of O03 Allied Health Assistant	11-Jul-2012	$59,772	1.00 FTE	Red
4.9	Coordinator Ethnic Health DCS	11-Jul-2012	$111,496	0.00 FTE	Blue
4.10	Service Agreement Notification - Reduced Funding Oct Performance Resource Committee	6-Jan-13	$323,454	8.98 FTE	Amber
4.11	Ipswich Hospital Social Work Review	11-Nov-12	$129,309	1.00 FTE	Red
4.12	Healthy Communities (Projects and Research Services) Review	6-Jan-13	$195,763	3.20 FTE	Green
5.1	Non-Clinical Model of Service Redesign and Realignment: Security at The Park	6-Jan-13	$181,737	4.20 FTE	Green
5.2	Non-Clinical Model of Service Redesign and Realignment: Ipswich Hospital Courtesy Bus	12-May-13	$14,728	1.50 FTE	Green
5.3	Explore opportunities for savings by rationalising BEMS management structure	6-Jan-13	$47,961	1.00 FTE	Green
5.4	Security at the Plaza	25-Nov-12	$62,609	1.63 FTE	Amber
5.5	Operational Services Restructure	25-Nov-12	$56,454	1.40 FTE	Blue
5.6	Review Hotel Services - inefficiency, utiliation of less demanding hours	11-Nov-12	$125,285	2.60 FTE	Blue
5.7	Corporate and Corporate Support Functions (including District Wide), including service manager at The Park	6-Jan-13	$108,091	2.00 FTE	Green
6.1	Review Service Model at The Park	11-Jul-2012	$2,953,009	28.44 FTE	Amber
6.2	Relocation of Patients within the Park to reduce staffing costs	1-Mar-13	$952,549	12.79 FTE	Amber
6.3	Non-Clinical Model of Service Redesign and Realignment: Mailroom at The Park	14-Oct-12	$47,578	1.00 FTE	Blue
6.4	Model of Care Redesign - Mental Health Rehab at The Park (Service Review due 02/11/2012)	1-Mar-13	$658,212	7.50 FTE	Amber
6.5	Mental Health (Corporate 3.1FTE /IMHS)	1-Mar-13	$260,376	4.63 FTE	Amber
6.6	Mental Health Nursing Structure	1-Mar-13	$146,077	3.80 FTE	Amber
6.7	CYMSH HPs	1-Mar-13	$34,063	1.00 FTE	Amber
6.8	Mental Health IMHS Clinical Support	1-Mar-13	$145,504	1.00 FTE	Amber
6.9	Mental Health Nursing Support; Mental Health Clinical Support; Mental Health Unit	28-Oct-12	$0	0.00 FTE	Amber
6.10	Administration (and data management) Review Mental Health & The Park	1-May-13	$85,289	3.50 FTE	Amber
6.11	Pharmacy Review Mental Health & Offender Health	28-Oct-12	$0	0.00 FTE	Amber
6.12	QCMHR	6-Jan-13	$58,962	1.00 FTE	Green
6.13	DSO Position - Remove from budget build from 31.12.12;	6-Jan-13	$0	0.00 FTE	Amber
6.14	ESO - 1FTE transferred to Offender Health 993398 from 24.09.2012	28-Oct-12	$2,838	1.00 FTE	Green
6.15	QCMHL	6-Jan-13	$950	0.20 FTE	Green
6.16	Drug Court - Service to cease from 01 July 2013	1-Jul-13	$0	0.00 FTE	Green
7.1	Demand Management (10 FTE to be found)	19-Sep-2012	$911,379	11.48 FTE	Green
7.2	Allied Health Efficiencies	08-Aug-2012	$191,240	1.90 FTE	Green
7.3	Medical Workforce Realignment with current purchasing agreement	08-Aug-2012	$230,047	0.80 FTE	Amber
7.4	Radiology - resource model	6-Jan-13	$102,113	2.00 FTE	Green
7.5	ED Medical Model and VMO/Medical Vacancy Management and Growth now known as RMOs (JHO/SHO)	6-Jan-13	$388,927	5.00 FTE	
7.6	Medical Imaging Administration Efficiencies	9-Dec-12	$122,171	3.00 FTE	Amber
7.7	Rational use of Pharmacy & Radiology	05-Sep-2012	$135,105	2.00 FTE	Amber
8.1	Nursing & Midwifery Review Work in Progress - Service Review Feedback 5 November; Numbers Locked Down	25-Nov-12	$332,582	9.60 FTE	Green
8.2	Safety & Quality	9-Dec-12	$129,886	2.00 FTE	Green

WEST MORETON HOSPITAL & HEALTH SERVICE
Jan-13
TURNAROUND PLAN

Red	Tracking over Budget FTE /Not compliant
Amber	Moderate issues identified / Progress delayed / Partially compliant
Green	On track – In Progress/Compliant
Blue	Complete
White	Identification of Explicit PIDs - Work in Progress

Workstream Reference	Labour (FTE) Strategy	Due to Commence	2012-2013 Value	MOHRI FTE Reduction	MOHRI FTE Reduction Performance
8.3	Rural FTE efficiencies / CSO Rationalisation and Redesign Service Review Feedback 5 November; Numbers Locked Down Rural FTE Efficiencies (Gatton .5FTE Medical, Esk 1FTE Nurse, Esk 05-00 Stream, Boonah 1FTE, Esk ?? 1 FTE Medical, ?? 0.5FTE - Boonah); Esk - 1 FTE Nurse dropped effective Nov; Esk 0.5 OO - dropped November) Gatton - 0.5 Medical dropped Nov	6-Jan-13	$389,485	5.11 FTE	Red
8.4	Education, Training & Development (inc Medical Admin Growth 2.9) Note: Could be 4.47FTE	6-Jan-13	$220,657	3.93 FTE	Green
9.1	Occupational Health & Safety/Safety & Quality	6-Jan-13	$80,000	2.00 FTE	White
9.2	Workforce	6-Jan-13	$100,000	2.50 FTE	White
9.3	Recruitment devolution back to HHS (efficiencies)	6-Jan-13	$0	0.00 FTE	White
			$12,156,108	**190.88 FTE**	

Please note red flags with an asterisk have been identified as possible delay in payroll processing applicable paperwork

Please note decrease in MOHRI FTE from 196.18 to 190.88 relates to the identification of Administrative staff being reviewed in Finance & Corporate Service Review Plans, but already accounted for under other Service Reviews

			Full year 2013/2014
$592,639 included in above savings figure is part year effect Barrett. FY effect would be $3,923,388 (30.94 FTE)	$	555,114	$ 3,679,055
	$	37,525	$ 244,333
	$	**592,639**	**$ 3,923,388**
			$ 363,556
Additional 9 FTE MH identified to take effect from July 2013 recurrent savings part of $4.3K strategy			$ 801,199
			$ 1,164,755

West Moreton Hospital and Health Board
MINUTES

Committee: West Moreton Hospital and Health Board					
Date:	Friday, 25 January 2013	**Time:**	10.00am to 5.20pm	**Location:**	The Park Centre for Mental Health Anderson House

Members
Dr Mary Corbett, Chair
Timothy Eltham, Deputy Chair
Dr Robert McGregor, Board Member
Paul Casos, Board Member
Melinda Parcell, Board Member
Professor Julie Cotter, Board Member
Alan Fry OBE QPM, Board Member
Ex Officio Standing Invitees
Lesley Dwyer, Health Service Chief Executive (CE)
Ian Wright, Executive Director Finance and Corporate (EDFC)
Melissa Fellows Secretariat
Invitees
Mr Greg Fowler, Senior Health Advisor to Annastacia Palaszczuk MP
Ms Sharon Kelly, Executive Director Mental Health & Specialised Services (EDMHSS)
Prof John McGrath, QCMHR

BOARD IN CAMERA

The Board held an in-camera session from 10.30am to 11.18am with Mr Greg Fowler, Senior Health Advisor to Annastacia Palaszczuk MP. Mr Fowler represented Ms Annastacia Palaszczuk, Member for Inala and Opposition Leader & Ms Jo-Ann Miller, Member for Bundamba and gave a brief overview of his background. EDMHSS gave an overview and update of The Park Centre for Mental Health and the Mental Health services at the Ipswich Hospital. EDMHSS discussed the long standing mental health plan for The Park. Greg Fowler's response to the Board was that mental health is important and the Office of the Opposition Leader would like to ensure that the whole of the system functions effectively. He was very supportive of the integration of ATODS into Integrated Mental Health services.

ACTION: WMHH Board Support Officer to forward Board Summary of Minutes to Ms Annastacia Palaszczuk's office when confirmed by WMHH Board.

1.0 MEETING OPENING

1.1 Attendance

Tim Eltham was an apology for the meeting.

1.2 Adoption of Agenda

The agenda was adopted with no alterations.

1.3 Register of Director's Interests

A potential conflict of interest was declared by Mr Paul Casos & Dr Bob McGregor in regards to discussion of Ipswich Hospital Foundation Car Park. Ms Melinda Parcell declared a potential conflict of interest with respect to any discussion of HACC services.

1.4 Confirmation of Minutes & Meeting Summary

The minutes of the meeting held on 14 December 2012 were confirmed as a true and accurate record of proceedings, with the inclusion of Neil Hamilton-Smith as an attendee at the In camera sessions. The Board approved the Board Meeting Summary.

1.5 Actions Arising

The Board noted the action register and the items that had been actioned and included in the agenda papers. The Board noted items #65 and #66 were not included in the Agenda as reported and requested that the status of Action items are correctly updated for future meetings.
Dr Bob McGregor provided an overview of the selection process for the Lead Clinician Group. 64 applications were received with 13 selected from Medical, Nursing & Allied Health. This number will be refined to 8-10 final members with the next step being to appoint a Clinical Chair.

ACTION: CE to ensure Action Register is correctly updated.

2.0 STRATEGIC MATTERS

2.1 Strategic Plan Review and Consultation

The Board approved the 2013 Strategic Planning Forum with the rescheduling from Monday 11 February to Friday 15 February 2013 commencing at 10.30am at UQ Ipswich. Discussions held on the facilitator for the forum and the Board agreed to an external facilitator. The Board recommended the facilitator review the agenda and the timing surrounding this. The Board discussed proposed attendees to include Lead Clinicians and some junior staff, key nurses, the Chair of WMOML and the CEO of Ipswich City Council . The Board noted the draft invitation should be sent out from the Chair. The Board also requested that all staff were invited to participate through a modified feedback form. The Board noted the current Operational Plan format which will be used as a template for the 2013/14 Operational Plan.

ACTION: Open the feedback to all staff.

ACTION: Meeting with the Board & Dr Geoff Mitchell on 15 Feb 2013 at UQ Ipswich commencing at 10.00am to be rescheduled to 9.00am.

ACTION: Advise EDPS&P's office of proposed additions to the attendee list and amendment to signing of Invitation.

DECISION: The Board approved the proposed process with amendments to the "values" section on the feedback form.

2.2 Queensland Centre for Mental Health Research (QCMHR)

Prof John McGrath QCMHR joined the Board meeting at 1pm and provided an overview of the QCMHR.

ACTION: Prof McGrath to be invited to Strategic Plan Review.

2.3 Barrett Adolescent Centre

The Board noted the paper provided regarding the update of the Barrett Adolescent Strategy. The EDMHSS provided an overview of the project plan.

2.4 Lead Clinician Group (update provided by Dr Bob McGregor at Actions Arising)

2.5 Wolston Park Golf Club

The Board noted the paper provided and requested the Chief Executive to progress the requirement for Legal Representation to recover outstanding fees owed by Wolston Park Golf Club. The Chief Executive will provide further information to the Finance Committee. The Board noted the Attachments referred to in the Paper were not provided.

ACTION: WMHHS's business relationships with this and other Golf Clubs will be addressed at a future Board meeting

ACTION: The CE to ensure attachments to papers are provided where indicated.

3.0 GENERAL MATTERS

3.1 For Decision

3.1.1 Policies – Nil for approval

The Chair indicated the Board may wish to consider a Policy relating to treating surgical patients in turn, given our poor performance in this area. Progress will be monitored in the first instance before a decision is made.

3.2 For Discussion

3.2.1 Occupational Health and Safety Report

3.2.2 The Board noted the content of the Occupational Health and Safety Reports provided. The Board noted there were no notifiable incidents with very few resulting in ongoing claims against the WMHHS.Patient Safety and Quality Report

The Board noted the Patient Safety and Quality Report and discussed the reportable events in December. The Board requested a trend graph for Reportable Events. There were no reportable pressure ulcers or Falls for December however the graph showed 39 and 58 respectively. The CE will check this discrepancy to see if the graph is cumulative. The CE advised that one will be reported for January. CE advised that a medication safety panel will be commencing shortly to address medication errors. Discussions held on the incidence of Healthcare Associated Infections and the issue that we may not meet our targets.
The Board noted the positive, significant drop in Complaints over December.

ACTION: CE to include a trend graph for Reportable Events.
CE to check the information on the graph regarding recording of pressure ulcers.

ACTION: A report on Infections will be provided to the Safety & Quality committee.

3.2.3 Health Service Chief Executive Report

The CE spoke to the items addressed in the HSCE report and discussion ensued on the following items:

a) Paxton Partners
b) Cost Centre Managers Training – EDFC provided an update to the Board.
c) Springfield Mater Proposal – CE to meet with small steering committee next week to discuss.
d) Home & Community Care
e) Esk Working Party
f) Maternity Services Review
g) Mid Year Budget Review – discussion followed with EDFC
h) Readiness Assessment Re-evaluation Update – Chair sought clarification of the process
i) Palliative Care Project – CE confirmed this is now at sign off stage. Will be brought back to the Board for discussion.
j) GP Liaison Officer – about to be advertised.

3.2.4 Financial Performance Report

The Board noted the Business and Finance Report. Discussion followed regarding:

a) Recouping the costs of VR payments
b) Projected end of year position. The Board noted this is the first time the end of year forecast is a small surplus, and commended the CE and the team for the result.
c) Activity reduction
d) Contestability – Workshop held on 9 January 2013.
e) Financial Audits
f) Budget Mid Year Review
g) Activity Review

The Board advised the EDFC that Board members were not paid on a "per meeting" basis and therefore calculations relating to budget were independent of the number of meetings.

ACTION: EDFC to provide the board with a schedule of financial audits.

3.2.5 Turnaround Plan Update

The Board noted the increase of the total value of the turnaround plan. WMHHS is currently on target with our MOHRI FTE. No decrease in the work that is currently being done is planned.

ACTION: CE to request information regarding natural attrition rates with A/EDW.

3.2.6 HHS Performance Report

The Board noted the monthly summary progress report with discussions held on the challenges NEST is facing in regards to meeting targets. A particular area of concern was highlighted as Orthopaedics. CE to continue with strategic initiatives. WMHHB held discussions on the proposed implementation of a new policy if an improvement is not shown.

ACTION: CE to remove Weekly Neat graph from the Board report.

4.0 CORPORATE GOVERNANCE AND COMMITTEES

4.1 Board Committees

4.1.1 Executive Committee

18 January 2013 – Draft minutes circulated to Board Members. Draft currently with Chair for checking prior to circulation.

The Executive Committee made two recommendations to the Board. The first that the Board and Executive hold a joint communications session (post the Strategic Plan review) to develop consistent, key messages for promotion and stakeholder engagement, and secondly to approve progressing discussions with the Ipswich Hospital Foundation (IHF) for management of the new car park utilising their paperless ticketing system. It was also recommended that the CE encourage the IHF to provide appropriate resources in the car park for patrons who still need help with the system.

DECISION:
The Board approved a joint workshop with the Executive to develop common communication messages.
The Board approved the progression of the implementation of the paperless ticketing system for the new Hospital Car Park.

4.1.2 Audit and Risk Committee

No meeting this month. Next scheduled meeting – Friday 15 February 2013.

4.1.3 Finance Committee

18 January 2013. – Draft minutes circulated for comment to meeting chair. The Board endorsed the EDFC to pursue further debt recovery strategies.

DECISION: The Board endorsed the EDFC to engage an alternative debt recovery company.

4.1.4 Safety and Quality Committee

No meeting this month. Next scheduled meeting – Friday 15 February 2013.

5.0 MATTERS FOR NOTING

5.1 Correspondence

The Board noted further correspondence as per previously published on Board portal.
Correspondence received recently as follows:

Director General – Dr Tony O'Connell - Re: Appropriate processes in managing nursing and midwifery staff locum cover
Minister for Health-Lawrence Springborg MP: Re: Commonwealth Funding reduction mitigation strategies.

Board Calendar & Work Plan
Discussions held on timing of Board sub committee meetings and difficulty of providing timely update to the Board when the sub committee meetings are held one week in advance of the Board meeting.

ACTION: Sub Committee Chairs to review committee dates. Chair and Board Support to propose Board meeting dates for second half of year and provide update to Board members.

ACTION: Board Support to forward correspondence to CE.

6.0 MEETING FINALISATION

6.1 Review Actions

6.2 Meeting Evaluation – Discussions held regarding formatting of Board paper template.

ACTION: Board Support to amend Board paper to include Author, delete approval lines and reposition check list to top of document. EDFC to provide examples of other Financial Statements for Finance Committee to review.

6.3 Next Meeting – Feb 22nd at Laidley Hospital.

ACTION: Board members to suggest invitees to In Camera stakeholder session for February Board meeting.

ACTION: Board Support to re-evaluate catering for future meetings.

6.4 Meeting Close
The meeting closed at 5.20pm

The Board undertook a meeting evaluation.

Minutes authorised by Chair as an accurate record of proceedings	
[redacted]	22/2/13.
Dr Mary Corbett **Chair, West Moreton Hospital and Health Board**	**Date**

Board Meeting Summary

West Moreton Hospital and Health Board

Board Meeting: Friday, 25 January 2013

Location: Anderson Room, The Park Centre for Mental Health, Wacol

Dr Mary Corbett
Chair

Tim Eltham
Deputy Chair

Paul Casos

Dr Robert McGregor

Melinda Parcell

Professor Julie Cotter

Alan Fry OBE QPM

Attendees: Dr Mary Corbett, Paul Casos, Dr Bob McGregor, Melinda Parcell, Alan Fry OBE QPM, Professor Julie Cotter
Apologies: Tim Eltham

Invitees: Lesley Dwyer Chief Executive (CE), Melissa Fellows Board Secretary, Ian Wright Executive Director Finance and Corporate (EDFC), Sharon Kelly Executive Director Mental Health and Specialised Services (EDMHSS), Professor John McGrath-Queensland Centre for Mental Health Research (QCMHR).
Stakeholder invitees: Ms Annastacia Palaszczuk (Member for Inala & Opposition Leader) and Ms Jo-Ann Miller (Member for Inala) were both apologies, but Mr Greg Fowler, Senior Health Advisor to Ms Palaszczuk attended in their place.

Board members had toured The Park in the week preceding this meeting, therefore the first order of the day was morning tea with staff and an informal opportunity to further understand the opportunities and challenges of the facility. The Board then welcomed Mr Greg Fowler to the Stakeholder session and Sharon Kelly provided an overview and update of the mental health plan for The Park and Integrated Mental Health Strategy for West Moreton. Mr Fowler commented on the importance of a sound strategy for mental health and was very supportive of the integration of ATODS into Integrated Mental Health services. He also remarked on the importance of the services provided by the Barrett Adolescent Centre to the community, and that community-based care still incurred costs.

The Board meeting commenced with strategic discussions around the review of the Strategic Plan 2012-2016. A workshop including clinicians, staff and stakeholders is scheduled for Friday 15 February 2013 at UQ Ipswich and all staff will have the opportunity to provide feedback.

The next topic was a presentation by Prof John McGrath, who provided an excellent overview of the evolution of the QCMHR and the key areas of research being undertaken.

The Board were provided with an update on the Expert Panel review of the services provided by the Barrett Adolescent Centre and were pleased with the progress.

On recommendation from the Executive Sub Committee, the Board approved a joint workshop with the Executive to develop common communication messages for the Hospital and Health Service. In relation to the new car park at Ipswich Hospital, the Board approved the progression of the implementation of the paperless ticketing system.

The Board discussed the standing agenda reports and were pleased to hear about the trialling of a patient medication safety panel. The Board noted the progress made towards an end of year balanced budget and commended the Chief Executive and the team for implementing suitable processes and controls while still achieving a safe service. The Board discussed current debt recovery strategies and endorsed the Executive Director of Finance & Corporate to engage an alternative company for future collections.

The Board noted correspondence received including that from the Minister for Health regarding Commonwealth Funding reduction mitigation strategies and from the Director General regarding provider panels for Maternity services.

The Board discussed the timing of Board sub committee meetings in relation to the provision of information from these meetings to the monthly Board Meetings. A review will be held of sub committee dates by their respective Chairs.

The next Board meeting will be held at Laidley Hospital on Friday 22 February 2013.

Queensland Government

West Moreton Hospital and Health Service

Board Meeting - 22 February 2013

22. Feb 2013 at 09:00 - 17:00

Laidley Hospital

West Moreton Hospital and Health Board

BOARD COMMITTEE AGENDA PAPER

Committee: West Moreton Hospital and Health Board			
Meeting Date:	**22 February 2013**	**Agenda Item Number:**	**3.2.5**
Agenda Subject:	**Turnaround Plan Update**		
Action required:	☐ For Approval	☐ For Discussion	☒ For Noting
Author: Linda Hardy	**Position:** Executive Director Performance Strategy & Planning		**Date:** 14 February 2013

☐ Recommendation/s are consistent with Strategic Plan
☐ Funding impacts are included within approved budget
☐ Risks are identified and mitigation/management strategies included
☐ Implications for patient and/or staff care and well-being have been identified

Proposal

That the West Moreton Hospital and Health Board:

Note the information contained within this paper in relation to the February 2013 Summary Turnaround Plan Progress Report.

Background

1. The Board endorsed the WMHHS Turnaround Plan on 26 October 2012. The Turnaround Plan continues to have multiple strategies undergoing diagnostics and solutions design to further contribute to the financial performance requirements of the WMHHS, including the revised $4.3M Commonwealth funding reduction.
2. A significant body of work has been implemented to deliver the target FTE position by January 2013, and further financial efficiency savings by March 2013, and in future months.
3. The service review process has several built-in 'tollgates' to ensure the strategies within the Turnaround Plan, or those undergoing diagnostics and solutions design, considered to be of a political or reputational risk in nature, and/or considered to result in a significant impact to service delivery, will be submitted to the Board for approval prior to implementation.

Key Issues or Risks

4. The value of strategies within the Turnaround Plan for the month of February has decreased $315K to $11.841M total due to the exclusion of the Barrett Adolescent Centre saving strategies within the Mental Health Division.
5. It should be noted that alternate strategies have been developed and are being implemented within the Mental Health Division to offset the original Barrett Adolescent Centre part year savings $592K. The $277K alternative saving strategies have resulted in the net decrease of $315K previously mentioned above.
6. The additional commonwealth funding reduction of $4.3M is being included in the Turnaround Plan to ensure a balanced end of year position.

7. **Turnaround Plan Progress Overview**

- Target WMHHS MOHRI FTE = 2570. YTD February actual MOHRI FTE = 2584
- WMHHS has a further 14 MOHRI FTE reduction required to realise the 174 target (this is a decrease from 38 MOHRI FTE position required in the January report ie: 24 MOHRI FTE reduction from December to February reporting period overall)
- In total, a further 101.87 MOHRI FTE is still to be realised from within the Turnaround Plan strategies in out months.

Consultation

8. Executive Directors have been consulted and signed off on allocated targets and Work Streams documented within the Turnaround Plan.

Financial and Other Implications

9. The risks associated with not delivering the MOHRI FTE and financial savings within the required timeframes remain due to organisational capacity and capability, and have been impacted by the additional $4.3M saving required within the current financial year. A rigorous reporting and governance framework has been implemented in conjunction with an enhanced Workforce Engagement Strategy and Performance and Accountability Framework to mitigate the risks associated with not delivering the required savings.

Strategic and Operational Alignment

10. Aligned to the achievement of a balanced budget position and ensuring the WMHHS attains financial health into the future.

Recommendation

Note the information contained within this paper in relation to the February 2013 Summary Turnaround Plan Progress Report.

WEST MORETON HOSPITAL & HEALTH SERVICE
Feb-13
TURNAROUND PLAN

	Tracking over Budget FTE /Not compliant
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Workstream Reference	Labour (FTE) Strategy	Due to Commence	2012-2013 Value	MOHRI FTE Reduction	MOHRI FTE Reduction Performance
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1.2	Communications & Engagement Team Structure & Model	25-Nov-12	$65,082	3.00 FTE	Green
1.3	IH Foundation Position	23-Dec-12	$24,847	0.84 FTE	Blue
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5.4	Security at the Plaza	25-Nov-12	$62,609	1.63 FTE	Amber
5.5	Operational Services Restructure	25-Nov-12	$38,695	3.53 FTE	Green
5.6	Review Hotel Services - inefficiency, utilisation of less demanding hours	11-Nov-12	$0	2.60 FTE	Blue
5.7	Corporate and Corporate Support Functions (including District Wide), including Service Manager at The Park	24-Feb-13	$87,721	2.00 FTE	Green
6.1	EFTRU defer opening to post 1/7/13	11-Jul-2012	$2,397,895	0.00 FTE	Green
6.2	Relocation of Patients within the Park to reduce staffing costs	1-Mar-13	$952,549	12.79 FTE	Green
6.3	Non-Clinical Model of Service Redesign and Realignment: Mailroom at The Park	14-Oct-12	$47,578	1.00 FTE	Blue
6.4	Model of Care Redesign - Mental Health Rehab at The Park	1-Mar-13	$625,312	6.50 FTE	Green
6.5	Mental Health (Corporate 3.1FTE /IMHS)	1-Mar-13	$301,493	4.63 FTE	Green
6.6	Mental Health Nursing Structure	31-Mar-13	$97,053	3.80 FTE	Green
6.7	CYMSH HPs	1-Mar-13	$33,650	1.00 FTE	Green
6.8	Mental Health IMHS Clinical Support	1-Mar-13	$145,504	1.00 FTE	Green
6.9	The Park restructure Abolish 4 x HP5s and creating 3 new HP5 PIDs	1-Mar-13	$46,194	1.00 FTE	Green
6.10	Administration (and data management) Review Mental Health & The Park	1-May-13	$76,335	1.50 FTE	Green
6.11	Review Mental Health	1-Jul-12	$61,799	0.00 FTE	Blue
6.12	QCMHR	1-Mar-13	$20,703	1.00 FTE	Green
6.13	DSO Position - Remove from budget build from 31.03.13	31-Mar-13	$80,191	1.00 FTE	Green
6.14	ESO - 1FTE transferred to Offender Health 993398 from 24.09.2012	1-Oct-12	$53,914	1.00 FTE	Green
6.15	QCMHL	6-Jan-13	$950	0.20 FTE	Green
6.16	Drug Court - Service to cease from 01 May 2013	1-May-13	$123,261	7.00 FTE	Green
6.17	Review Mental Health	31-Dec-12	$487,247	12.13 FTE	Green
7.1	Demand Management (10 FTE to be found)	19-Sep-2012	$911,379	11.48 FTE	Green
7.2	Allied Health Efficiencies	08-Aug-2012	$191,240	1.90 FTE	Green
7.3	Medical Workforce Realignment with current purchasing agreement	08-Aug-2012	$302,750	0.80 FTE	Green
7.4	Radiology - resource model	6-Jan-13	$94,258	2.00 FTE	Blue
7.5	ED Medical Model and VMO/Medical Vacancy Management and Growth now known as RMOs (JHO/SHO)	6-Jan-13	$265,135	5.00 FTE	
7.6	Medical Imaging Administration Efficiencies	9-Dec-12	$122,171	3.00 FTE	Green
7.7	Rational use of Pharmacy	05-Sep-2012	$135,105	2.00 FTE	Blue
8.1	Nursing & Midwifery Review	25-Nov-12	$332,582	9.60 FTE	Green
8.2	Safety & Quality	9-Dec-12	$129,886	2.00 FTE	Green
8.3	Rural FTE efficiencies / CSO Rationalisation and Redesign Rural FTE Efficiencies (Gatton .5FTE Medical, Esk 1FTE Nurse, Esk 05-00 Stream, Boonah 1FTE, Esk ?? 1 FTE Medical, ?? 0.5FTE - Boonah); Esk - 1 FTE Nurse dropped effective Nov; Esk 0.5 OO - dropped November) Gatton - 0.5 Medical dropped Nov	6-Jan-13	$387,700	5.11 FTE	
8.4	Education, Training & Development (inc Medical Admin Growth 2.9) Note: Could be 4.47FTE	6-Jan-13	$220,657	3.93 FTE	Green
9.1	Occupational Health & Safety/Workforce	1-May-13	$58,532	3.40 FTE	Green
			$11,841,366	**180.10 FTE**	

Please note decrease in MOHRI FTE from 190.88 to 180.10 relates to the exclusion of Barrett FTE (Mental Health) and introduction of alternative Mental Health reduction FTE strategies.

Turnaround Plan: MOHRI FTE SERVICE REVIEWS vs ACTUAL — Feb-13

Division	Planned monthly FTE reductions as agreed in Turnaround Plans												
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Chief Executive - Service Review Plan					2	0.84	2						4.84
Chief Executive - Actual					1		3.84						4.84
Finance and Corporate - Service Review Plan						2	19.18	1					22.18
Finance and Corporate - Actual				2	5.72	1	1.65	-2.88					7.49
Performance, Strategy and Planning						1	4.5						5.5
Performance, Strategy and Planning - Actual					1	1	3.5						5.5
Allied and Community Health - Service Review Plan	1.94		1.8	0.8	1.53	0.2	15.48	0.5	1.9	0.5	0.5	0.2	25.35
Allied and Community Health Actual	2.94		1.8	0.8	4.99			1.69					12.22
Infrastructure and Ipswich Hospital Expansion - Service Review Plan				2.6	5.16		6.2		1		1.5		16.46
Infrastructure and Ipswich Hospital Expansion Actual				6.63	4.51	0.85		1.7					13.69
Mental Health and Specialised Services - Service Review Plan	1.63			3	12.79		7.2	0.8	13.5	8.63	7.5	0.5	55.55
Mental Health and Specialised Services Actual			2	6.58	5		5.28	1.3					20.16
Medical Services and Ipswich Hospital - Service Review Plan	0.3	2.4		12.48	0	1	10						26.18
Medical Services and Ipswich Hospital Actual					-5.26	1.42	-1.41	9.9					4.65
Nursing, Midwifery and Rurals - Service Review Plan				1.1	10.6	1.81	6.13	1					20.64
Nursing, Midwifery and Rurals Actual				1.73	2.4	-1.21	3.4	2.36					8.68
Workforce - Service Review Plan											3.4		3.4
Workforce Actuals							1						1
Planned HHS Reduction	**3.87**	**2.4**	**1.8**	**19.98**	**32.08**	**6.85**	**70.69**	**3.3**	**16.4**	**9.13**	**12.9**	**0.7**	**180.1**
Actual HHS Reducation	**2.94**	**0**	**3.8**	**17.74**	**19.36**	**3.06**	**17.26**	**14.07**	**0**	**0**	**0**	**0**	**78.23**

West Moreton Hospital and Health Board
BOARD MEETING MINUTES

Date:	Friday 22 February 2013	Time:	10.40am to 4.50pm	Location:	Laidley Hospital

Members
Dr Mary Corbett, Chair
Timothy Eltham, Deputy Chair
Dr Robert McGregor, Board Member
Paul Casos, Board Member
Melinda Parcell, Board Member
Professor Julie Cotter, Board Member
Alan Fry OBE QPM, Board Member
Ex Officio Standing Invitees
Lesley Dwyer, Health Service Chief Executive (CE)
Ian Wright, Executive Director Finance and Corporate (EDFC)
Melissa Fellows, Secretary
Other Invitees
Jacqui Keller, Corporate Counsel and Secretary
Invitees to Stakeholder Session
Cr Tanya Milligan, Lockyer Valley Deputy Mayor
Adrian Shepley – Vietnam Veterans/Laidley Community Reference Group (dissolved)
Marjory Cusack – Catholic Ladies & Hospital Auxiliary/Laidley Community Reference Group (dissolved)

STAKEHOLDER SESSION

The Board held a stakeholder session from 10.40am to 11.18am with Cr Tanya Milligan, Lockyer Valley Deputy Mayor, Mr Adrian Shepley, Vietnam Veterans/Laidley Community Reference Group (dissolved), Mrs Marjory Cusack, Catholic Ladies & Hospital Auxiliary/Laidley Community Reference Group (dissolved). Adrian Shepley spoke of his concerns that there is no longer a Maternity unit at the Laidley Hospital. He also raised concerns regarding problems faced by patients and family members in securing transport to and from health appointments and facilities. Marjory Cusack advised of the many fundraising activities that the Auxiliary undertake in order to donate resources to the Laidley Hospital. She also raised concerns regarding the waiting list and times for Oral Health in Laidley. The Chair advised of the issues in being able to recruit dentists to the area. Cr Milligan gave a brief overview of her background and role in the Lockyer Regional Council and expressed her delight at the support provided by staff at the Laidley Hospital during the recent floods. It was noted that the Laidley Community Reference Group was dissolved when the Board commenced. Discussions followed regarding the reforming of this group.

ACTION: Reinstatement of Laidley Community Reference Group to be included on the agenda for the Community Engagement Workshop.

ACTION: Letters to be sent to stakeholders thanking them for their attendance at the Stakeholder Session and summarising the matters discussed.

ACTION: Information and statistics to be provided in regards to Laidley Oral Health by the Director of Oral Health, including with respect to the recruitment of dentists and dental therapists and the referral booking process.

IN CAMERA SESSION

The Board held an in-camera session to discuss the performance of the CE against her key performance indicators.

OPEN SESSION

1.0 MEETING OPENING

1.1 Attendance
No apologies.

1.2 Adoption of Agenda
The agenda was adopted with no alterations.

1.3 Declaration of Director's Interests
Nil.

1.4 Confirmation of Minutes and Meeting Summary
The minutes of the meeting held on 25 January 2013 were confirmed as a true and accurate record of proceedings. An amendment to the draft Board Meeting Summary relating to the Barrett Adolescent Centre was advised.

ACTION: Amend the draft Board Meeting Summary in the manner advised prior to distribution to interested parties.

1.5 Actions Arising
The Board noted the action register and the items that had been actioned and included in the agenda papers. For future meetings, actions included in the Board papers are to have "Actioned" against their status. It was noted that item 76 was not included in the CE report, but would be addressed verbally later in the meeting during the CE Report discussion.

2.0 STRATEGIC MATTERS

For Decision

2.1 NIL to be discussed.

For Discussion

The Board noted a number of items that will need to be discussed in future meetings, namely the Annual Report, the changeover to payroll, long term planning and IT infrastructure investment.

ACTION: Long term planning discussion to be added to the agenda for the March Board Meeting. Other items including payroll, palliative care, etc. to be added to the agenda when the need arises.

2.2 Esk Model of Care
The Board noted the updated version of the Esk Health Service Preliminary Discussion Paper. The CE advised that the amendment made to the demographic data does not alter any recommendations in the paper. It was noted that this is a preliminary paper prepared by the working party and is for noting by the Board only. Discussions held regarding what the Board would like to see in this paper when it is returned to the Board for a decision. These include a holistic view being taken in regards to transport and accommodation issues for patients and families, the involvement of the Medicare Local in the review and the identification of risks and mitigation strategies.

ACTION: CE to provide a strategy surrounding all the Rural Health Services for presentation at the April Board meeting.

2.3 Review of the Executive Structure
The Board held an in-camera session with the CE present to discuss the review of the Executive Structure.

2.4 Review of Strategic Planning Forum

The Chair requested feedback from the Board in regards to the Strategic Planning Forum held on Friday 15 February. It was noted that having a much broader group of people present contributed to the success of the day. The lack of discussion around the KPIs was disappointing and will require more work by the Executive and Board out of session.

ACTION: The Board requested that the slide presentation from Prominence be circulated.

2.5 Health Promoting Hospitals
The Board noted the agenda paper on Health Promoting Hospitals and the lack of information available.

ACTION: CE to take to Strategic Partnerships Forum to discuss with IHF.

ACTION: To be brought back to the Board at the April Board Meeting for inclusion in the CE's report.

2.6 Golf Club Arrangements
The Board noted the paper on the Wolston Park Golf Club Lease and Other Golf Club Business relationships.

ACTION: CE to provide briefing to the Minister regarding taking legal action to recover overdue fees.

3.0 GENERAL MATTERS

3.1 For Decision

3.1.1 Policies
Nil for approval.
The CE gave a verbal update on the No Smoking Policy. The Ipswich Hospital will become a complete smoke free zone on 31 May – World No Tobacco Day. A Working Party is being established to implement this policy.

ACTION: CE to bring a draft Policy to the Board for approval at the March board meeting.

3.2 For Discussion

Safety Reports

3.2.1 Occupational Health and Safety Report
The Board noted the content of the Occupational Health and Safety Reports provided. The Board noted the two new KPI's included in this report, Hours Lost versus Occupied FTE and unscheduled absence rate.

ACTION: CE to request benchmarking with like facilities with data being included in the next report.

3.2.2 Patient Safety and Quality Report
The Board noted the content of the Patient Safety and Quality Report. Discussions held on the cessation of the Ipswich Hospital Courtesy Bus once the new car park is operational and the implications for the community.

ACTION: Data to be included to reflect the amount of complaints that escalate to the HQCC.

ACTION: CE to provide commentary on strategies to reduce pressure ulcers.

ACTION: CE to investigate if feedback is provided to patients who have raised concerns as part of the Patient Feedback Survey.

ACTION: Communication strategies to be developed in regards to the possible cessation of the Ipswich Hospital Courtesy Bus service.

ACTION: Patient Safety Board Agenda Paper template to be updated.

ACTION: CE to provide explanation of SAC 2 and SAC 3 trend data provided in the report.

Management Reports

3.2.3 Health Service Chief Executive Report

The CE spoke to the items addressed in the HSCE report and discussion ensued on the following items:

a) Flood Management
b) Lead Clinician Group Implementation – Event to be organised for the Board to meet the group.
c) Springfield Mater Proposal
d) Maternity Services Review
e) Risk and Compliance Update – Clinical Incident
f) Attrition Rate (CE advised attrition rate of 9%).

ACTION: Event to be organised for Board to meet members of the Lead Clinician Group.

ACTION: CE to provide details regarding budget for Springfield Mater proposal.

3.2.4 Financial Performance Report

The Board noted the Financial Performance Report. Notes entitled "Finance Committee Meeting" were tabled. Discussion followed regarding:

a) Current operating position – surplus advised of $650,000.
b) Tracking against targets.
c) Turnaround Plan
d) Paxton Report
e) Internal Audits
f) Revenue Audit

The Board commended the EDFC on all the good work that has been done to date. EDFC provided the Board with examples from other Health Services in relation to financial reporting. Discussions held on alternative reporting styles.

ACTION: The Board to provide feedback to EDFC on other Health Services' reporting styles at the conclusion of the meeting.

3.2.5 Turnaround Plan Update

CE suggested that this report is no longer necessary and will be included in CE report in future. CE highlighted that a Medical Situation Room has been established.

ACTION: CE to include Turnaround Plan update in future CE reports.

3.2.6 HHS Performance Report

The Board noted the monthly summary progress report with discussions held on the NEAT targets. CE highlighted the increase in patients presenting to the Emergency Department. The new Orthopaedic Surgeon that commenced at the Hospital on a 6 month contract is working well and decreasing the waiting list. Discussions held on the waiting times currently being experienced in theatre for surgeons. CE exploring funding for innovation to improve operating theatre efficiencies.

ACTION: Chair and CE to discuss recasting HHS Performance Report for future meetings.

ACTION: CE to discuss the length of time taken to prepare the theatre in between operations with the EDMS&IH.

4.0 CORPORATE GOVERNANCE AND COMMITTEES

4.1 Board Committees

4.1.1 Executive Committee
No meeting this month. Next scheduled meeting – Friday 12 April 2013.

4.1.2 Finance Committee
19 February 2013 –Chair of the Finance Committee advised that the Queensland Treasury Corporation presented to the Finance Committee on Tuesday 19 February. The Finance Committee Chair and representative on the Board of the Ipswich Hospital Foundation (IHF) also provided a verbal update on the last IHF board meeting. The message from the IHF is that they are willing to invest in research but want an expert panel involved as reviewers and mentors. The need for a WMHHS Research Strategy was noted.

4.1.3 Audit and Risk Committee
No meeting this month. Next scheduled meeting – Friday 8 March 2013.

4.1.4 Safety and Quality Committee
No meeting this month. Next scheduled meeting – Friday 15 February 2013.

5.0 MATTERS FOR NOTING

5.1 Correspondence

5.1.1 Reply to Minister re Mitigation of $4.3M
Noted by Board.

5.1.2 Invitation from Meals on Wheels
Noted by Board. AF to attend as guest speaker in the Chair's place.

ACTION: Chair to send letter to Meals on Wheels advising that AF is able to attend in the Chair's place.

5.1.3 Letter from Queensland Teachers' Union re Barrett Adolescent Centre
Noted by Board.

5.1.4 Letter from Barton Deakin PL re Patient Transport
Noted by Board.

ACTION: Chair to respond to Barton Deakin PL welcoming a meeting to discuss their proposal.

5.2 Board Calendar and Work Plan

Dates confirmed and Chair will advise of venues for Board meetings for July to December 2013.

ACTION: Board Support to send appointments to Board members for all committee meetings.

ACTION: Chair to determine venues for Board meetings for July to December 2013. Appointments and Board Calendar to be updated by Board Support.

6.0 OTHER BUSINESS

Boonah Community Reference Group – Chair attended this meeting on Tuesday 12 February and provided an overview to the Board.

7.0 MEETING FINALISATION

7.1 Review Actions

7.2 Meeting Evaluation

7.3 Next Meeting – Friday 22 March 2013 at Ipswich Community Health Plaza.

7.4 Meeting Close

The meeting closed at 4.50pm.

Minutes authorised by Chair as an accurate record of proceedings	
Dr Mary Corbett Chair, West Moreton Hospital and Health Board	22/03/2013 Date

West Moreton Hospital and Health Service

Board Meeting

Apr 26, 2013 at 09:00 AM - 05:00 PM

Level 8 Conference Room

Tower Block

Ipswich Hospital

West Moreton Hospital and Health Board

BOARD COMMITTEE AGENDA PAPER

Committee: West Moreton Hospital and Health Board			
Meeting Date:	**26 April 2013**	**Agenda Item Number:**	**2.4**
Agenda Subject:	**Barrett Adolescent Centre**		
Action required:	☐ For Approval	☐ For Discussion	☒ For Noting
Author: Sharon Kelly	**Position:** Executive Director Mental Health & Specialised Services		**Date:** 17 April 2013

☐ Recommendation/s are consistent with Strategic Plan
☐ Funding impacts are included within approved budget
☐ Risks are identified and mitigation/management strategies included
☐ Implications for patient and/or staff care and well-being have been identified

Proposal

That the West Moreton Hospital and Health Board:

Note The update of the Barrett Adolescent Strategy

Background

1. A project plan titled Barrett Adolescent Strategy was tabled by the Chief Executive at the meeting of the West Moreton Hospital and Health Board on 23 November 2012.

Key Issues or Risks

2. The project plan identifies five areas of risk. With respect to each of the identified risk areas:
   a. Time frames have been extended to allow the Expert Clinical Reference Group (ECRG) to provide their report.
   b. It is anticipated the draft outcomes will be presented to the Planning Group on 26 April 2013.
   c. The Centre's current consumers are continuing to receive the care that is most appropriate for them.
   d. Stakeholder communication continues.
   e. Chief Executive, Lesley Dwyer and Executive Director Mental Health & Specialised Services, Sharon Kelly, have visited a non-Government sector model in Cairns that potentially could be replicated for the provision of services.
   f. Both the consumer and carer representatives of the ECRG have been engaged throughout the process to ensure a wider viewpoint.

Consultation

3. The ECRG continues to meet regularly to develop the proposed model into the future.
4. The Planning Group has oversighted the development of a stakeholder engagement plan, terms of reference for the ECRG, a media protocol and fact sheets (posted on the internet).
5. All correspondence from stakeholders (email, ministerials etc) and media enquiries have and are being responded to in a timely manner with consistent key messages being utilised.
6. Chief Executive of Children's Health Queensland Hospital and Health Service, Peter Steer, has been engaged and consulted as the process has continued in light of their over-arching Statewide responsibility for Youth Mental Health Services.

Financial and Other Implications

7. It is not possible at this stage to indicate financial implications in the absence of a likely preferred model.
8. However, as noted in the Project Plan, it is assumed that the existing recurrent funding for BAC and the additional future funding earmarked for the former Redlands Unit will be utilised to fund the endorsed model(s) of care.

Strategic and Operational Alignment

9. Both the ECRG and the Planning Group are mindful that the final endorsed model(s) of care will
   a. need to clearly articulate a contemporary model(s) of care for extended treatment and rehabilitation for adolescents in Queensland.
   b. be evidenced based, sustainable, align with Statewide Mental Health Policy, service planning frameworks and funding models whilst acknowledging no capital funding is available.
   c. replace the existing services provided by Barrett Adolescent Centre.

Recommendation

10. That the West Moreton Hospital and Health Board:

Note The update of the Barrett Adolescent Strategy

Attachments

1. Nil.

Committee: West Moreton Hospital and Health Board			
Meeting Date:	**26 April 2013**	**Agenda Item Number:**	**3.3.1**
Agenda Subject:	**Chief Executive Report**		
Action required:	☐ For Approval	☐ For Discussion	☒ For Noting
Author: Lesley Dwyer	**Position: Chief Executive**		**Date: 19 April 2013**

☐ Recommendation/s are consistent with Strategic Plan
☐ Funding impacts are included within approved budget
☐ Risks are identified and mitigation/management strategies included
☐ Implications for patient and/or staff care and well-being have been identified

Current Significant Issues

Financial integrity and budget

1. Financial integrity and budget continues to be a focus for the Executive and management teams of the Hospital and Health Services (HHS). Further discussion and reporting is contained within the monthly finance performance report.

Projected End of Year Financial Position

2. There has been considerable improvement in March for the projected end of year financial position, which is $6.9M. This considerable improvement has not previously been predicted as previous forecasts have been based on an expenditure profile over the past 3 years. This expenditure profile no longer supports reliable forecasting due to the significant changes in the operational expenditure profile of the Hospital and Health Service in the recent past.

External audit

3. PricewaterhouseCoopers (PwC) are contract external auditors to the Queensland Audit Office (QAO) for West Moreton HHS. A team of 4 PwC auditors spent the week starting 08 April 2013 at Ipswich Hospital conducting an initial audit. Interviews of the Executive started on the 08 March 2013 visit were also completed in this time.
4. There has been no direct feedback from this initial audit, however, PwC seemed comfortable with the work performed to date as part of the financial readiness project.

Financial Readiness Project

5. A HHS Financial Readiness Officer has continued preparing the first set of financial statements and general year end processes for West Moreton HHS, however, the project was put on hold while she acted in the role of Chief Finance Officer, during his time away on leave. The project is progressing well with the following achievements during the past month:
   a) The note on Key Management Disclosure (AASB Related Party Transactions) has been drafted and socialised with the Executive
   b) A proposal for the continued use of the Financial Management Assurance process 2012/13 within the HHS

Service Agreement Amendment Windows

6. The West Moreton HHS Service Agreement can be amended through 4 windows during the financial year. The following Window adjustments are active:
   a) **Service Agreement Amendment Window 2**. Service Agreement amendments have been agreed and the Deed of Amendment has now been signed off by the Director General.
   b) **Service Agreement Amendment Window 3**. Service Agreement amendments have been agreed and amount to a net increase of revenue of $5.4M. Of note are 2 significant amendments:
      i. **Extended Forensic Treatment and Rehabilitation (EFTRU).** The initially proposed withdrawal of EFTRU funding was $2.2M has been reduced to $0.4M.
      ii. **VR Reimbursement.** The funding allocation to WMHHS to reimburse Voluntary Redundancy payments carried by the HHS has increased from $0.824 to $2.6M.

37. Qld Times preparing article on new mums. Media statement on the "changing face of maternity" being developed e.g. covering how services have changed and improved over the years.
38. Qld Times asked follow up questions from Ian Berry MP re: security at Ipswich Health Plaza. Previous responses from WMHHS was supplied to MP.
39. Payroll and redundancies continue to feature in media across Qld.
40. Announcement of new Health Ombudsman mentioned in all Qld media.
41. Expect further queries from Qld Times re: WMHHS budget & redundancies, as well as Barrett Adolescent Centre

Strategic Services and Partnerships Committee

42. This committee meets bimonthly and membership consists of:
43. West Moreton Hospital and Health Service Executive
44. Professor Geoffrey Mitchell –University of Queensland
45. Ms Chris Went – CEO St Andrews Hospital, Ipswich
46. Ms Sue Scheinflug – CEO West Moreton Oxley Medicare Local
47. Mr John Hammond – Chief Superintendent, West Moreton Local Ambulance Service
48. Mr Tom Yates – CEO Ipswich Hospital Foundation
49. The format of the meetings are that the committee "workshop" particular subjects looking for opportunities to partner and combine effort.
50. At the April meeting the committee considered education and learning opportunities and issues across our region.
51. An outcome from this meeting is that representatives from the committee will visit the Geelong region in Victoria to see how this type of partnership has been working across a similar geographic area to seek key learning to accelerate our partnerships.
52. The Geelong region has a G21 Regional alliance which is of particular interest to the group and has been discussed in the context of development of a Health Atlas.
53. "G 21 works as a forum to discuss regional issues across interest groups and municipalities resulting in better co-ordinated research, consultation and planning. G21 supports the delivery of projects that benefit the region across municipal boundaries and is a platform for the region to speak with one voice to all levels of government.
54. G21 is the official Strategic Planning Committee for the G21 region and, as such, is responsible for leading the development and implementation of the region's strategic plan. In this role, G21 works closely with, and provides advice to, Regional Development Australia (RDA), the Regional Management Forum (RMF) and the state and federal governments on the region's needs and priorities."

Health Promoting Hospitals

55. Previous information has been presented to Board in regard to West Moreton Hospital and Health Service attaining Health Promoting Hospital accreditation via the World Health Organisation.
56. This has been discussed at the Strategic Services and Partnerships Committee and in particular as an initiative that may be supported by the Ipswich Hospital Foundation.
57. The meeting discussed the need to develop a priority work plan for the committee and although Health Promoting Hospital accreditation is worthwhile exploring, the committee felt that this initiative may need to be explored as a strategic partnership goal later in the year.
58. In the interim further information is being sought in regard to this status being conferred an alliance rather than a single entity.

Ipswich Hospital Expansion

59. The Project Managers report will be available on the Board Portal.
60. The Commissioning phase of the project has multiple parts and necessitates interim moves for some areas. The Ipswich Hospital Expansion Steering Committee has raised several risk in ensuring that all time frames are met whilst maintaining business continuity. A 'Commissioning Expert" will be engaged through the project funds to lead I have asked for support with expertise to lead this phase of the project moves.

West Moreton Hospital and Health Board
BOARD MEETING MINUTES

Date:	Friday 26 April 2013	Time:	9.00am to 5.45pm	Location:	Ipswich Hospital, Level 8 Conference Room

Members
Dr Mary Corbett, Chair
Timothy Eltham, Deputy Chair
Dr Robert McGregor, Board Member
Paul Casos, Board Member
Melinda Parcell, Board Member
Alan Fry OBE QPM, Board Member
Professor Julie Cotter, Board Member
Ex Officio Standing Invitees
Lesley Dwyer, Health Service Chief Executive (CE)
Ian Wright, Executive Director Finance and Corporate (EDFC)
Jacqui Keller, Corporate Counsel and Secretary (CCS)
Invitees to Stakeholder Session
Mr Ian Berry MP, State Member for Ipswich
Mr Sean Choat MP, State Member for Ipswich West
Mr Carl Wulff, Chief Executive Officer, Ipswich City Council
Other Invitees
Sharon Kelly, Executive Director Mental Health and Specialised Services (EDMHSS) (Items 2.4 and 2.5 only)
Alan Millward, Executive Director Workforce (EDW) (Items 2.1 and 2.2 only)
Dr Peter Osborne, Director Oral Health Services (DOHS) (Item 2.6 only)
Professor Geoff Mitchell, Professor of General Practice and Palliative Care, The University of Queensland (GM) (Item 2.3 only)
David Roberts, Partner, Ernst & Young (as observer)
Sean Lowry, Senior Manager, Ernst & Young (as observer)

STAKEHOLDER SESSION

The stakeholder session opened at 9.00am.

Mr Sean Choat MP advised of the positive feedback he has received from his constituents regarding the quality of care they have received at Ipswich Hospital. He noted that he has received a number of enquiries with respect to the continuation of the Midwifery Group Practice program. He requested that he be kept informed of any major changes to WMHHS services so that he can be ready to respond to constituents' queries as they arise. Mr Choat also shared his views on the locality for any future expansion of WMHHS services. He also kindly offered his services and facilities to assist with community engagement activities.

Mr Carl Wulff requested that communication flows between WMHHS and the Mayor and Councillors of Ipswich City Council be improved so that they are kept aware of what WMHHS is doing and how it affects the community. He also shared his views with respect to expansion of WMHHS on the current Ipswich Hospital site and surrounds. Mr Wulff also discussed opportunities for WMHHS and Ipswich City Council to work together with respect to shared services delivery.

Mr Ian Berry MP also requested that he be kept informed of major changes to WMHHS services so that he can respond to his constituents. He also shared his views with respect to expansion opportunities for WMHHS.

The stakeholder session closed at 9.30am.

IN CAMERA SESSION

The Board held an in-camera session, commencing at 9.30am. The CE joined the in-camera session midway through to discuss the proposed new WMHHS organisational structure. The in-camera session was adjourned

at 10.35am for the Board members to attend morning tea with Ipswich Hospital staff, to be resumed later in the day.

OPEN SESSION

1.0 MEETING OPENING

The meeting opened at 11.05am.

1.1 Attendance
The apology of Dr Bob McGregor was recorded. There were no other apologies.

1.2 Adoption of Agenda
The agenda was adopted with no alterations.

1.3 Declaration of Interests
Mary Corbett, Chair, declared that she is currently Acting Chair of the Southbank Institute of Technology Board until most likely the end of June 2013. No other interests were declared.

1.4 Confirmation of Minutes and Meeting Summary
The minutes of the meeting held on 22 March 2013 were confirmed as a true and accurate record of proceedings, subject to the initials used for Dan Bitmead and Joanne Johnson being corrected in Item 2.3.

The Board Meeting Summary prepared with respect to that meeting was also approved, subject to the last sentence of the third paragraph being replaced with "It was decided that those services would be relinquished back to the Department of Health and Aging and the Department of Communities from June this year which will allow us to focus on delivery of acute services."

1.5 Confirmation of Minutes – Board Risk Management and Board Planning Workshops
The minutes of the Board Risk Management and Board Planning Workshops held on 12 April 2013 were adopted in principle, but they are to be changed to be a summary of outcomes from the Board Workshop, rather than minutes.

1.6 Actions Arising
The Board noted the action register and the items that had been actioned and included in the agenda papers.

2.0 STRATEGIC MATTERS

For Decision

2.1 Workforce Engagement Strategy

EDW joined the meeting. The Board discussed the Workforce Engagement Strategy.

DECISION: The Board approved the Workforce Engagement Strategy, subject to it being amended to (a) recognise that there are barriers to workforce engagement; and (b) clarify the linkage between the different engagement strategies (e.g. Clinician Engagement Strategy).

EDW left the meeting.

For Discussion

2.2 Partnership Opportunities with The University of Queensland (Agenda Item 2.3)

Professor Geoff Mitchell (GM) joined the meeting. GM talked through the various opportunities for WMHHS to partner with The University of Queensland in the areas of education and training, clinical opportunities and

research. GM tabled a presentation titled "West Moreton HHS and research" and spoke specifically about WMHHS's strategic environment for research and a possible structure for WMHHS's research strategy.

ACTION: Research Development Strategy to be developed and brought back to Board for approval.

GM left the meeting.

2.3 Barrett Adolescent Centre (Agenda Item 2.4)

EDMHSS joined the meeting and provided an update on the Barrett Adolescent Strategy, namely that the Planning Group is awaiting the report from the Expert Clinical Reference Group, which it will then form into a number of recommendations. The Board discussed the community engagement that is taking place and that is planned with respect to the strategy.

ACTION: Strategy re the future of Barrett Adolescent Centre to be developed and brought back to Board for approval.

2.4 Financial Comparative Analysis – Forensic Mental Health Hospitals Vic, NSW, Qld (Agenda Item 2.5)

The Board discussed the outcomes from the financial comparative analysis and benchmark of costs and activity of inpatient services across WMHHS, Forensicare (Victoria) and Justice, Forensic Mental Health Network (New South Wales). It was noted that the outcomes now form part of the Mental Health and Specialised Services Division Operational Plan.

ACTION: Update of actions against data contained in Financial Comparative Analysis – Forensic Mental Health Hospitals to be provided at October Board meeting.

EDMHSS left the meeting.

2.5 Oral Health Services (Agenda Item 2.6)

DOHS joined the meeting to discuss the following issues with respect to WMHHS Oral Health Services:

- plans for the additional Commonwealth funding
- waiting lists
- referral booking process
- recruitment of dentists and dental therapists
- staffing models (e.g. outsourcing)
- plans for rural oral health services.

ACTION: Update on achievement of activity targets to be provided to Board at October Board meeting.

ACTION: CE Report to include "fast facts" on WMHHS Oral Health Services on a quarterly basis.

DOHS left the meeting.

2.6 Human Resource Management Transformation Roadmap (Agenda Item 2.2)

EDW joined the meeting. The Board discussed the Human Resource Management Transformation Roadmap, noting that it is achievable within current resources. The Board requested that the document be renamed "Revitalisation Roadmap". EDW left the meeting.

2.7 Springfield/Mater Proposal Update

The Board discussed the update provided with respect to the Springfield/Mater Proposal. A document titled "Briefing to WMHH Board Chair 19.03.2013 re: Springfield" was tabled. The Board noted that Chris Thorburn, Acting Executive Director Corporate Governance and Strategy, is now the lead in relation to this matter.

ACTION: Springfield/Mater Proposal to be brought back to the Board in May for approval.

2.8 2012-2013 Annual Report Process and Timeline

The Board discussed the process and indicative timeline for the preparation of the 2012-13 annual report.

ACTION: Timeline to be amended to include a draft of the annual report going to the Audit and Risk Committee and the Board at their July meetings.

ACTION: Draft Table of Contents and Key Messages to be provided to Board when available.

3.0 GENERAL MATTERS

For Decision

3.1 Policies

3.1.1 Smoke Free Environment Policy

The Board discussed the revised WMHHS Smoke Free Environment Policy.

DECISION: The Board approved the revised WMHHS Smoke Free Environment Policy.

ACTION: Update on implementation of Smoke Free Environment Policy to be brought back to the Board in August.

For Discussion

3.2 Safety Report

3.2.1 Occupational Health and Safety

The Board noted the contents of the Occupational Health and Safety report and praised the quality of the report. The Board noted that there were no items in which WMHHS was identified as being "non-compliant".

ACTION: Update to be provided on amber items in Occupational Health and Safety report.

3.2.2 Patient Safety and Quality

The Board noted the contents of the Patient Safety and Quality report. The Board noted the increase in pressure ulcers and requested some clarity regarding the graphs on page 154. They also noted the prevalence of information regarding complaints, but not regarding compliments.

ACTION: CE to advise what y axis is on page 154.

ACTION: Report to include details of compliments as well as complaints.

ACTION: Board to be advised of process for improving services based on complaints received.

ACTION: Data to be collected regarding courtesy bus complaints, specifically an understanding of the nature of the complaint.

3.3 Management Reports

3.3.1 Chief Executive Report

The Board noted the contents of the Chief Executive Report.

3.3.2 Financial Performance Report

EDFC tabled a presentation with respect to WMHHS's financial position. The Board discussed the contents of this presentation and the Financial Performance Report. Discussions focussed on the treatment of the projected surplus.

3.3.3 HHS Performance Report

The Board noted the contents of the HHS Performance Report. Discussions focused on strategies for achieving the NEST target.

ACTION: Report to show trajectory from July 1 to meet NEST.

ACTION: Report to be revised to limit the amount of detail to key indicators.

ADJOURNMENT OF OPEN SESSION AND RESUMPTION OF IN-CAMERA SESSION

The Board meeting was adjourned to allow for the resumption of the in-camera session. The Board continued the in-camera session with the CE in attendance to discuss the proposed new WMHHS organisational structure.

RESUMPTION OF OPEN SESSION

4.0 CORPORATE GOVERNANCE AND COMMITTEES

4.1 Corporate Governance

4.1.1 Flying Minute – Consultation Draft Revised Strategic Plan

The Board noted the outcome of the flying minute of the Board with respect to the approval of the Consultation Draft Revised Strategic Plan.

4.1.2 Flying Minute – Refurbishment of the Trumpy Home

The Board noted the outcome of the flying minute of the Board with respect to the approval of non-recurrent expenditure for refurbishment of the Trumpy Home.

4.1.3 Flying Minute – Replacement of Air Conditioning at Gatton Hospital

The Board noted the outcome of the flying minute of the Board with respect to the approval of non-recurrent expenditure for Stage One replacement of air conditioning at Gatton Hospital.

4.2 Committees

4.2.1 Finance Committee

The Chair, Finance Committee discussed the Committee's recommendation with regard to the car park agreement with IHF. However the documents had not been made available to the Board prior to the meeting.

ACTION: The recommendations made at the Finance Committee on 23 April 2013 are to be circulated to the Board as a flying minute to allow the members sufficient time to consider the papers.

5.0 MATTERS FOR NOTING

5.1 Correspondence

The Board noted the correspondence included in the Board Pack.

6.0 SAFETY AND QUALITY TOUR (Agenda Item 7.0)

The Board toured the Medical Assessment and Planning Unit at Ipswich Hospital while receiving an update on safety and quality matters pertaining to the unit.

7.0 MATTERS FOR NOTING (Continued – Agenda Item 5.0)

7.1 Other (Agenda Item 5.2)

7.1.1 Medicare Local Strategy Update (Agenda Item 5.2.1)

The Board received an update on the Medicare Local Strategy and noted the recruitment challenges faced in implementing that strategy.

7.1.2 Ernst & Young Risk Management Workshop (Agenda Item 5.2.2)

The Board noted that the Risk Management Workshop was held on 12 April 2013 and that the Risk Management Framework will shortly be brought to the Board for approval.

7.1.3 Asset Workshop (Agenda Item 5.2.3)

The Board noted that the Asset Workshop has been scheduled for 3 May 2013.

7.1.4 Palliative Care Report (Agenda Item 5.2.4)

The Board considered the information provided with respect to the Collaborative Palliative Care Model 2013-2015.

7.1.5 Maternity Services Review (Agenda Item 5.2.5)

The Board considered the information provided with respect to the Maternity Services Review.

ACTION: Executive Committee to consider Maternity Services Review in more detail.

7.1.6 Board Calendar and Work Plan (Agenda Item 5.2.6)

Paul Casos advised that he would not be available to attend the May Board meeting. Tim Eltham advised that he would not be available to attend the July Board meeting.

The Board discussed the opportunity to hold more meetings at Ipswich to allow a greater understanding of the Clinical services provided, rather than having alternate meetings at rural facilities. The Board will however st visit each facility at least annually.

ACTION: Chair and CCS to revise locations for Board meetings.

8.0 OTHER BUSINESS (Agenda Item 6.0)

8.1 Stakeholder Invitees to Next Board Meeting (Agenda Item 6.1)

The Board discussed the possibility of holding the next Board meeting at Ipswich Hospice. Tim Eltham will suggest possible stakeholders.

8.2 Other Business

- The Chair provided an update on the Boonah Community Reference meeting.
- The Chair provided an update on her attendance at the Ipswich Community Forum.
- The Chair provided an update on the last meeting with the Director-General.
- The Chair advised that she will be in Mackay on 10 May for a summit regarding the Queensland Plan.
- The Chair advised that she will not be able to attend the Board Chairs' meeting on 2 July 2013 and is looking for a delegate to attend on her behalf. To be discussed further at the May Board meeting.
- It was noted that Estimate Committee hearings will be occurring in the second week of July.
- Invitation for Board members to attend Diamantina Health Partners Forum on 1 and 2 May.
- CheckUp Census Report has been uploaded to BoardEffect.

- Regional Development Australia is meeting on 7 May. Tim Eltham is attending that meeting.
- The prescribed employer process was noted, with the view being that a more inclusive rather than representative approach should be taken.
- Board development opportunities, particularly with respect to patient safety and quality and asset management.
- Invitation to Commission of Audit presentation 9 May.

ACTION: CCS to upload the Chair's speaking notes from the Ipswich Community Forum to BoardEffect.

The Board also discussed the suicide from the Ipswich Hospital walkway to car park on 24 April 2013. The Board considered the risks associated with the walkway.

ACTION: CE to ensure that associated risks are on the risk register and to provide an update on the actions taken with respect to those risks and WMHHS' long term strategy in this space.

9.0 MEETING FINALISATION (Agenda Item 8.0)

9.1 Review Actions (Agenda Item 8.1)

9.2 Meeting Evaluation (Agenda Item 8.2)

A meeting evaluation was conducted, with the following suggestions made:
- move any recommendations arising out of a Committee meeting closer to the top of the agenda
- ensure long term planning items discussed at workshop on 12 April 2013 are added to agenda
- consider circulating an agenda for future stakeholder sessions or providing further guidance on stakeholder session discussion topics.

9.3 Next Meeting (Agenda Item 8.3)

The next meeting is scheduled for 24 May 2013, with the location to be decided.

9.4 Meeting Close (Agenda Item 8.4)

The meeting closed at 5.45pm.

Minutes authorised by Chair as an accurate record of proceedings	
[redacted]	24/5/13
Dr Mary Corbett **Chair, West Moreton Hospital and Health Board**	**Date**

West Moreton Hospital and Health Service

Board Meeting

May 24, 2013 at 09:00 - 17:00

Ipswich Hospice

37 Chermside Road

Eastern Heights

West Moreton Hospital and Health Board

BOARD COMMITTEE AGENDA PAPER

Committee: West Moreton Hospital and Health Board			
Meeting Date:	24 May 2013	**Agenda Item Number:**	4.3
Agenda Subject:	Barrett Adolescent Strategy - Recommendations		
Action required:	☒ For Approval	☐ For Discussion	☐ For Noting
Author: Sharon Kelly	**Position:** Executive Director, Mental Health & Specialised Services	**Date:** 15 May 2013	

☐ Recommendation/s are consistent with Strategic Plan
☐ Funding impacts are included within approved budget
☐ Risks are identified and mitigation/management strategies included
☐ Implications for patient and/or staff care and well-being have been identified

Proposal

That the West Moreton Hospital and Health Board:

Note the attached recommendations of the Expert Clinical Reference Group (ECRG) (Attachments 1 and 2).
Approve recommendations from Barrett Adolescent Strategy Planning Group (Attachment 3).
Approve development of a communication and implementation plan, inclusive of finance strategy, to support the closure of Barrett Adolescent Centre (BAC) on 30 September 2013.
Approve media statement (Attachment 4).
Note the need for a verbal briefing (at the earliest convenience) between the Minister for Health, and the West Moreton Hospital and Health Board Chair and Chief Executive.

Background

1. A project plan titled Barrett Adolescent Strategy was tabled by the Chief Executive at the meeting of the West Moreton Hospital and Health Board (the Board) on 23 November 2012.
2. Project updates were provided to the Board on 25 January and 26 April 2013.
3. A Planning Group has oversighted an ECRG of senior child and youth mental health experts to develop a Service Model Elements document according to the project plan.
4. Membership of the ECRG included multidisciplinary clinicians, a consumer representative, a carer representative, an inter-state clinician, and a representative of the Department of Education, Training and Employment. The ECRG met between 1 December 2012 and 24 April 2013.
5. The Park is designated to become an adult secure forensic facility within the Queensland Plan for Mental Health 2007-17. This process will progress to the next stage when the Extended Forensic Treatment and Rehabilitation Unit opens on 28 July 2013. The provision of adolescent services within the future forensic environment is not considered appropriate or safe, and poses a potential risk to adolescent consumers.
6. The current BAC is an aged facility that has been designated not-fit-for-purpose in the provision of inpatient services into the future. The state-funded capital project to build a replacement facility for BAC in Redlands has ceased due to unresolvable building and environmental barriers, and none of this capital funding is available to build the facility elsewhere.

Key Issues or Risks

7. The ECRG submitted a *Preamble* and the *Service Model Elements of an Adolescent Extended Treatment and Rehabilitation Services* document (refer Attachments 1 and 2) to the Chair of the Planning Group on 8 May 2013. These documents were reviewed by the Planning Group on 15 May 2013.
8. The Planning Group accepted all recommendations of the ECRG, with some caveats for note (refer Attachment 3).
9. The Service Model Elements document (and the associated recommendations for an alternative model of service) allows for the safe and timely closure of BAC.
10. Given 10 out of 16 young people from the current BAC inpatient group are aged 17 years or over, and that the length of stay is up to 2 years in several cases, it is considered clinically adequate to provide a four month timeframe to complete discharge planning and aim to close BAC 30 September 2013.

11. The closure of BAC is not dependent on the next stages of progressing and consulting on a statewide service model; instead, the closure process is relevant to the needs of the current and wait-list consumer group of BAC, and the capacity for 'wrap-around' care in their local community services. The Planning Group noted this was feasible to commence now.

Consultation

12. The Planning Group has oversighted the development of a stakeholder engagement plan, terms of reference for the ECRG, a media protocol and fact sheets (posted on the internet).
13. All correspondence from stakeholders (email, ministerials etc) and media enquiries have and are being responded to in a timely manner with consistent key messages being utilised.
14. An updated media statement is attached for approval (refer Attachment 4).
15. The next phase of statewide consultation and service planning for adolescent extended treatment and rehabilitation services is proposed to be collaboratively led by Children's Health Services and the Mental Health Alcohol and Other Drugs Branch.
16. It is proposed that West Moreton HHS will develop a new communication and implementation plan with regard to the closure of BAC to ensure sensitive and comprehensive communication with consumers, families, staff, key stakeholders, and the community.

Financial and Other Implications

17. It is not possible at this stage to detail financial implications. It is proposed that West Moreton HHS convene a finance working group (as part of a broader implementation plan) to define the operational funds associated with the BAC, and to submit a plan to the Board for the transfer of these funds to the HHSs that will deliver the alternative service/s. The Mental Health Alcohol and Other Drugs Branch is a recommended working group member.
18. Historically, intentions to close BAC have generated significant consumer, staff and community concern, and have attracted media attention. It is anticipated that this will be partially addressed through the recommendations of the ECRG and Planning Group, and the identification of alternative, local service delivery.

Strategic and Operational Alignment

19. Both the ECRG and the Planning Group have been mindful that the final endorsed model(s) of care:
    a. need to clearly articulate a contemporary model(s) of care for extended treatment and rehabilitation for adolescents in Queensland; and
    b. be evidenced based, sustainable and align with statewide mental health policy, service planning frameworks and funding models.
20. The closure of BAC and removal of adolescent services from The Park forensic site aligns with both the strategic direction of the HHS and the Queensland Plan for Mental Health 2007-17.

Recommendation

21. **Note** the attached recommendations of the Expert Clinical Reference Group (ECRG) (Attachments 1 and 2).
    Approve recommendations from Barrett Adolescent Strategy Planning Group (Attachment 3).
    Approve development of a communication and implementation plan, inclusive of finance strategy, to support the closure of BAC on 30 September 2013.
    Approve media statement (Attachment 4).
    Note the need for a verbal briefing (at the earliest convenience) between the Minister for Health, and the West Moreton Hospital and Health Board Chair and Chief Executive.

Attachments

1. Preamble
2. Service Model Elements of an Adolescent Extended Treatment and Rehabilitation Service
3. Recommendations of the Planning Group
4. Media Statement

Committee: West Moreton Hospital and Health Board

Agenda Item Number: 4.3

Attachment: 1

Attachment 1

Proposed Service Model Elements
Adolescent Extended Treatment and Rehabilitation Services (AETRS)

Preamble

Mental health disorders are the most prevalent illnesses affecting adolescents today. Of particular note is the considerable evidence that adolescents with persisting and severe symptomatology are those most likely to carry the greatest burden of illness into adult life. Despite this, funding for adolescent (and child) mental health services is not proportional to the identified need and burden of disease that exists.

In the past 25 years, a growing range of child and youth mental health services have been established by Queensland Health (and other service providers) to address the mental health needs of children and adolescents. These services deliver mental health assessment and treatment interventions across the spectrum of mental illness and need, and as a service continuum, provide care options 24 hours a day, seven days a week. No matter where an adolescent and their family live in Queensland, they are able to access a Child and Youth Mental Health Service (CYMHS) community clinic or clinician (either via direct access through their Hospital and Health Service, or through telehealth facilities). Day Programs have been established fc adolescents in South Brisbane, Toowoomba and Townsville. Acute mental health inpatient units for adolescents are located in North Brisbane, Logan, Robina, South Brisbane and Toowoomba, and soon in Townsville (May/June 2013). A statewide specialist multidisciplinary assessment, and integrated treatment and rehabilitation program (The Barrett Adolescent Centre [BAC]) is currently delivered at The Park Centre for Mental Health (TPCMH) for adolescents between 13 and 17 years of age with severe, persistent mental illness. This service also offers an adolescent Day Program for BAC consumers and non-BAC consumers of West Moreton Hospital and Health Service.

Consistent with state and national mental health reforms, the decentralisation of services, and the reform of TPCMH site to offer only adult forensic and secure mental health services, the BAC is unable to continue operating in its current form at TPCMH. Further to this, the current BAC building has been identified as needing substantial refurbishment. This situation necessitates careful consideration of options for the provision of mental health services for adolescents (and their families/carers) requiring extended treatment and rehabilitation in Queensland. Consequently, an Expert Clinical Reference Group (ECRG) of child and youth mental health clinicians, a consumer representative, a carer representative, and key stakeholders was convened by the Barrett Adolescent Strategy Planning Group to explore and identify alternative service options for this target group.

Between 1 December 2012 and 24 April 2013 the ECRG met regularly to define the target group and the needs, conduct a service gap analysis, consider community and sector feedback, and review a range of contemporary, evidence-based models of care and service types. This included the potential for an expanded range of day programs across Queensland and community mental health service models delivered by non-government and/or private service providers. The ECRG have considered evidence and data from the field, national and international benchmarks, clinical expertise and experience, and consumer and carer feedback to develop a service model elements document for Adolescent Extended Treatment and Rehabilitation Services in Queensland. This elements document *is not a model of service* – it is a conceptual document that delineates the key components of a service continuum type for the identified target group. As a service model elements document, it will not define how the key components will function at a service delivery level, and does not incorporate funding and implementation planning processes.

The service model elements document proposes four tiers of service provision for adolescents requiring extended mental health treatment and rehabilitation:

- **Tier 1** – Public Community Child and Youth Mental Health Services (existing);
- **Tier 2a** – Adolescent Day Program Services (existing + new);
- **Tier 2b** – Adolescent Community Residential Service/s (new); and
- **Tier 3** – Statewide Adolescent Inpatient Extended Treatment and Rehabilitation Service (new).

The final service model elements document produced was cognisant of constraints associated with funding and other resources (e.g., there is no capital funding available to build BAC on another site). The ECRG was also mindful of the current policy context and direction for mental health services as informed by the National Mental Health Policy (2008) which articulates that *'non acute bed-based services should be community based wherever possible'.* A key principle for child and youth mental health services, which is supported by all members of the ECRG, is that young people are treated in the least restrictive environment possible, and one which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to family, educational, social and community networks.

The ECRG comprised of consumer and carer representatives, and distinguished child and youth mental health clinicians across Queensland and New South Wales who were nominated by their peers as leaders in the field. The ECRG would like to acknowledge and draw attention to the input of the consumer and carer representatives. They highlighted the essential role that a service such as BAC plays in recovery and rehabilitation, and the staff skill and expertise that is inherent to this particular service type. While there was also validation of other CYMHS service types, including community mental health clinics, day programs and acute inpatient units, it was strongly articulated that these other service types are not as effective in providing safe, medium-term extended care and rehabilitation to the target group focussed on here. It is understood that BAC cannot continue in its current form at TPCMH. However, it is the view of the ECRG that like the Community Care Units within the adult mental health service stream, a design-specific and clinically staffed bed-based service is essential for adolescents who require medium-term extended care and rehabilitation. This type of care and rehabilitation program is considered life-saving for young people, and is available currently in both Queensland and New South Wales (e.g., The Walker Unit).

The service model elements document (attached) has been proposed by the ECRG as a way forward for adolescent extended treatment and rehabilitation services in Queensland.

There are seven key messages and associated recommendations from the ECRG that need to underpin the reading of the document:

1. Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework

- The proposed service model elements document is a conceptual document, not a model of service. Formal consultation and planning processes have not been completed as part of the ECRG course of action.
- In this concept proposal, Tier 2 maps to the Clinical Services Capability Framework for Public and Licensed Private Health Facilities Version 3.1 (CSCF) Level 5 and Tier 3 maps to CSCF Level 6.

Recommendations:

a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.

b) Formal planning including consultation with stakeholder groups will be required.

2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component

- It is understood that the combination of day program care, residential community-based care and acute inpatient care has been identified as a potential alternative to the current BAC or the proposed Tier 3 in the following service model elements document.
- From the perspective of the ECRG, Tier 3 is an essential component of the overall concept, as there is a small group of young people whose needs cannot be safely and effectively met through alternative service types (as represented by Tiers 1 and 2).
- The target group is characterised by severity and persistence of illness, very limited or absent community supports and engagement, and significant risk to self and/or others. Managing these young people in acute inpatient units does not meet their clinical, therapeutic or rehabilitation needs.

- The risk of institutionalisation is considered greater if the young person receives medium-term care in an acute unit (versus a design-specific extended care unit).
- Clinical experience shows that prolonged admissions of such young people to acute units can have an adverse impact on other young people admitted for acute treatment.
- Managing this target group predominantly in the community is associated with complexities of risk to self and others, and also the risk of disengaging from therapeutic services.

Recommendation:

a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.

3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk

- Interim arrangements (after BAC closes and before Tier 3 is established) are at risk of offering sub optimal clinical care for the target group, and attention should be given to the therapeutic principles of safety and treatment matching, as well as efficient use of resources (e.g., inpatient beds).
- In the case of BAC being closed, and particularly if Tier 3 is not immediately available, a high priority and concern for the ECRG was the 'transitioning' of current BAC consumers, and those on the waiting list.
- Of concern to the ECRG is also the dissipation and loss of specialist staff skills and expertise in the area of adolescent extended care in Queensland if BAC closes and a Tier 3 is not established in a timely manner. This includes both clinical staff and education staff.

Recommendations:

a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.
b) Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.
c) BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.

4. Duration of treatment

- A literature search by the ECRG identified a weak and variable evidence base for the recommended duration of treatment for inpatient care of adolescents requiring mental health extended treatment and rehabilitation.
- Predominantly, duration of treatment should be determined by clinical assessment and individual consumer need; the length of intervention most likely to achieve long term sustainable outcomes should be offered to young people.
- As with all clinical care, duration of care should also be determined in consultation with the young person and their guardian. Rapport and engagement with service providers is pivotal.

Recommendation:

a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.

5. Education resource essential: on-site school for Tiers 2 and 3

- Comprehensive educational support underpins social recovery and decreases the likelihood of the long term burden of illness. A specialised educational model and workforce is best positioned to engage with and teach this target group.
- Rehabilitation requires intervention to return to a normal developmental trajectory, and successful outcomes are measured in psychosocial functioning, not just absence of psychiatric symptoms.
- Education is an essential part of life for young people. It is vital that young people are able to access effective education services that understand and can accommodate their mental health needs throughout the care episode.
- For young people requiring extended mental health treatment, the mainstream education system is frequently not able to meet their needs. Education is often a core part of the intervention required to achieve a positive prognosis.

Recommendations:

a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.

b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

6. Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration

- There is no true precedent set in Queensland for the provision of residential or bed-based therapeutic community care (by non-government or private providers) for adolescents (aged up to 18 years) requiring extended mental health care.
- The majority of ECRG members identified concerns with regard to similar services available in the child safety sector. These concerns were associated with:
  - Variably skilled/trained staff who often had limited access to support and supervision;
  - High staff turn-over (impacting on consumer trust and rapport); and
  - Variable engagement in collaborative practice with specialist services such as CYMHS.

Recommendations:

a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.

b) Governance should remain with the local CYMHS or treating mental health team.

c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.

7. Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas)

- Equity of access for North Queensland consumers and their families is considered a high priority by the ECRG.

Recommendations:

a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.

b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.

Committee: **West Moreton Hospital and Health Board**

Agenda Item Number: **4.3**

Attachment: **2**

Attachment 2

Proposed Service Model Elements Adolescent Extended Treatment and Rehabilitation Services (AETRS)	
Attribute	**Details**
Service Delivered	The aim of this platform of services is to provide medium term, recovery oriented treatment and rehabilitation for young people aged 13 – 17 years with severe and persistent mental health problems, which significantly interfere with social, emotional, behavioural and psychological functioning and development. The AETRS continuum is offered across a range of environments tailored to the individual needs of the young person with regard to safety, security, structure, therapy, community participation, autonomy and family capacity to provide care for the young person. The AETRS functions as part of the broader, integrated continuum of care provided for young Queenslanders, that includes acute inpatient, day program and community mental health services (public, private and other community-based providers).
Over-arching Principles	The delivery of an Adolescent Extended Treatment and Rehabilitation Service continuum will: • develop/maintain stable networks • promote wellness and help young people and their families in a youth oriented environment • provide services either in, or as close to, the young person's local community • collaborate with the young person and their family and support people to develop a recovery based treatment plan that promotes holistic wellbeing • collaborate with other external services to offer continuity of care and seamless service delivery, enabling the young person and their family to transition to their community and services with ease • integrate with Child and Youth Mental Health Services (CYMHS), and as required, Adult Mental Health Services • recognise that young people need help with a variety of issues and not just illness • utilise and access community-based supports and services where they exist, rather than re-create all supports and services within the mental health setting • treat consumers and their families/carers in a supportive therapeutic environment provided by a multidisciplinary team of clinicians and community-based staff • provide flexible and targeted programs that can be delivered across a range of contexts and environments • have the capacity to deliver services in a therapeutic milieu with family members; support and work with the family in their own environment; and keep the family engaged with the young person and the mental health problems they face • have capacity to offer intensive family therapy and family support • have flexible options from 24 hour inpatient care to partial hospitalisation and day treatment with ambulant approaches; step up/step down • acknowledge the essential role that educational/vocational activities and networks have on the recovery process of a young person

Proposed Service Model Elements Adolescent Extended Treatment and Rehabilitation Services (AETRS)	
Attribute	**Details**
	• engage with a range of educational or vocational support services appropriate to the needs of the young person and the requirements of their treatment environment, and encourage engagement/reengagement of positive and supportive social, family, educational and vocational connections.
Key Distinguishing Features of an AETRS	Services are accessed via a tiered, least-restrictive approach, and may involve combinations of service types across the tiers. **Tier 1:** **Public Community Mental Health Services (Sessional)** • Existing Locations: All Hospital and Health Services (HHSs). • Access ambulatory care at a public community-based mental health service, within the local area. • Interventions should consider shared-care options with community-based service providers, e.g. General Practitioners and *headspace*. **Tier 2a: Level 5 CSCF.** **Day Program Services (Mon – Fri business hours).** • Existing Locations: Townsville (near completion), Mater, Toowoomba, Barrett Adolescent Centre (BAC). • Possible New Locations: Gold Coast, Royal Children's Hospital CYMHS catchment, Sunshine Coast. Funds from existing operational funds of BAC and Redlands Facility. Final locations and budget to be determined through a formal planning process. • Individual, family and group therapy, and rehabilitation programs operating throughout (but not limited to) school terms. • Core educational component for each young person – partnership with Education Queensland and vocational services required. This may be provided at the young person's school/vocational setting, or from the day program site. • Flexible and targeted programs with attendance up to 5 days (during business hours) a week, in combination with integration into school, community and/or vocational programs. • Integrated with local CYMHS (acute inpatient and public community mental health teams). • Programs are delivered in a therapeutic milieu (from a range of settings including day program service location, the family home, school setting etc.). • Programs will support and work with the family, keeping them engaged with the young person's recovery. • Consumers may require admission to Adolescent Acute Inpatient Unit (and attend the Day Program during business hours). • Proposal of 12 - 15 program places per Day Program (final places and budget should be determined as part of formal planning process).

Proposed Service Model Elements Adolescent Extended Treatment and Rehabilitation Services (AETRS)	
Attribute	**Details**
	Tier 2b: **[1]Community Residential Service (24h/7d).** • Existing Locations: Nil services currently. Note: Cairns Time Out House Initiative for 18y+. • Possible New Locations: Sites where Day Programs are currently delivered; Townsville identified as a priority in order to meet the needs of North Queensland families. Funding from existing operational funds of BAC and Redlands Facility. Final locations and budget to be determined through a formal planning process. • Day Program attendance as in Tier 2a during business hours. • This tier incorporates a bed-based residential and respite service for adolescents after-hours and on weekends (in the community). • There is potential for one or more of these services to provide 'family rooms', that will temporarily accommodate family members while their young person attends the Day Program or the Adolescent Acute Inpatient Unit (for example, in Townsville). • Integrated with local CYMHS (acute inpatient, day program and public community mental health teams). • Residential to be a partnership model for service delivery between a community-based service provider and QH – multidisciplinary staffing profile including clinical (Day Program) and community support staff (community-based provider). Partnership to include clinical governance, training and in-reach by CYMHS. • Residential component only provides accommodation; it is not the intervention service provider but will work closely with the intervention service provider to maintain consistency in the therapeutic relationship with the young person. • On-site extended hours visiting service from CYMHS Day Program staff. **Tier 3: Level 6 CSCF.** **Statewide Inpatient Extended Treatment and Rehabilitation Service (24h/7d)[2].** • Possible Location: S.E. Qld. Source of capital funding and potential site not available at current time[3]. Acknowledge accessibility issues for young people outside S.E. Qld.

[1] Note: The Department of Health takes a 'provider agnostic' view in determining non clinical support and accommodation services. Decisions to contract service providers will be determined by service merit, consumer need and formal planning and procurement processes.

[2] The Department of Health acknowledges the dedicated school and expertise provided by the Department of Education Training and Employment (DETE). The Department of Health values and supports partnership with DETE to ensure that adolescents have access to appropriate educational and vocational options to meet their educational/vocational needs.

[3] Until funding and location is available for Tier 3, all young people requiring extended treatment and rehabilitation will receive services through Tiers 1 and 2a/b (i.e., utilising existing CYMHS community mental health, Day Programs and Acute Inpatient Units until the new Day Programs and residential service providers are established). It is emphasised that this is not proposed to be a clinically preferred or optimal solution, and significant risks are associated with this interim measure.

Proposed Service Model Elements Adolescent Extended Treatment and Rehabilitation Services (AETRS)	
Attribute	**Details**
	• For young people whose needs could not be met by Tiers 1 and 2 above, due to risk, severity or need for inpatient extended treatment and care. These young people's needs are not able to be met in an acute setting. • In-patient therapeutic milieu, with capacity for family/carer admissions (i.e. family rooms). • All other appropriate and less restrictive interventions considered/tested first. • Proposal for approximately 15 beds – this requires formal planning processes. • Medium term admissions (approximately up to 12 months; however, length of stay will be guided by individual consumer need and will therefore vary). • Delivers integrated care with the local CYMHS of the young person. • Individualised, family and group rehabilitation programs delivered through day and evening sessions, available 7 days/week. These must include activity based programs that enhance the self esteem and self efficacy of young people to aid in their rehabilitation. As symptoms reduce, there is a focus on assisting young people to return to a typical developmental trajectory. • Consumers will only access the day sessions (i.e. Day Program components) of the service if they are an admitted consumer. • Programs maintain family engagement with the young person, and wherever possible adolescents will remain closely connected with their families and their own community. • Young people will have access to a range of educational or vocational support services delivered by on-site school teachers and will be able to continue their current education option[4]. There is an intentional goal that young people are integrated back to mainstream community and educational/vocational activities. • Flexible and targeted programs will be delivered across a range of contexts including individual, school, community, group and family.
Service specifications and other descriptors to illustrate service elements	
Target Age	• 13 - 17 years, with flexibility in upper age limit depending on presenting issue and developmental (as opposed to chronological) age.
Diagnostic Profile	• Severe and persistent mental health problems that significantly interfere with social, emotional, behavioural and psychological functioning and development. • Treatment refractory/non responsive to treatment - have not been able to remediate with multidisciplinary community, day program or acute inpatient treatment. • Mental illness is persistent and the consumer is a risk to themselves and/or others. • Medium to high level of acuity requiring extended treatment and rehabilitation.

[4] The provision of education at this level requires focused consideration; an on-site school and education program is proposed as a priority.

Suggested modelling attributes	
Average duration of treatment	**Tier 2a:** **Level 5 Day Program Services (Mon – Fri business hours)** • Up to 12 months; flexibility will be essential. • There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this. **Tier 2b:** **Community Residential (24h/7d)** • Up to 12 months; flexibility will be essential. • There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this. • Access to a community residential service requires the young person to be actively participating in a program with CYMHS. **Tier 3:** **Level 6 Statewide Inpatient Extended Treatment and Rehabilitation Service (24h/7d)** • Up to 12 months; flexibility will be essential. • There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this. • Young people may be discharged from this Service to a Day Program in their local community.
Staffing Profile	**Tier 2a:** **Level 5 Day Program Services (Mon – Fri business hours)** • Multidisciplinary, clinical. • Plus staffing from community sector. • DETE. **Tier 2b:** **Community Residential Service (24h/7d)** • Multidisciplinary, clinical. • Plus staffing from community sector. **Tier 3:** **Level 6 Statewide In-patient Extended Treatment and Rehabilitation Service (24h/7d)** • Multidisciplinary, clinical. • DETE.
Additional notes	
Referral Sources and Pathways	While service provision across all Tiers of this AETRS continuum is based on interdisciplinary collaboration and cross-agency contribution, a referral to Tiers 2a, 2b and/or 3 will require a CYMHS assessment (i.e., single point of entry). Increased accessibility to AETRS for consumers and their families across the State is a key priority.

	The Tier 3 statewide service will establish a Statewide Clinical Referral Panel. All referrals will be received and assessed by the Panel, which has statewide representation from multidisciplinary mental health clinicians and the community sector.
Complexities of Presentation	• Voluntary and involuntary mental health consumers. • The highest level of risk and complexity.

This document was endorsed by the Expert Clinical Reference Group of the Barrett Adolescent Strategy on 8 May 2013.
Please read in conjunction with the v5 Preamble.

Dr Leanne Geppert
Chair, Expert Clinical Reference Group

Committee: **West Moreton Hospital and Health Board**

Agenda Item Number: **4.3**

Attachment: **3**

Attachment 3

Adolescent Extended Treatment and Rehabilitation Services (AETRS) Planning Group Recommendations

1. Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework

ECRG Recommendations	Planning Group Recommendations
a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.	**Accept.** The responsibility for this task at a statewide level sits with the Mental Health Alcohol and Other Drugs Branch and the Children's Health Services. A collaborative partnership is proposed.
b) Formal planning including consultation with stakeholder groups will be required.	**Accept.** This body of work should be incorporated into the statewide planning and implementation process (as above).

2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component

ECRG Recommendation	Planning Group Recommendation
a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.	**Accept with caveats.** Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework *(in draft)*. However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in Queensland to meet the requirement of this recommendation. Contestability reforms in Queensland may allow for this service component to be provider agnostic.

3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk

ECRG Recommendations	Planning Group Recommendations
a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.	**Accept.**
b) Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.	**Accept.** While this may be a complex process for some consumers and their individual needs, it was noted that this course of action could start immediately, and that it was feasible. The potential to utilise current BAC operational funds (temporarily) to 'wrap-around' each consumer's return to their local community was noted as a significant benefit. The relevant local community should play a lead role in the discharge of the consumer from BAC and their return to home. The local services need to be consulted around their ability to provide 'wrap-around' care.
c) BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.	**Accept.** The ECRG and the Planning Group strongly supported this recommendation.

4. Duration of treatment

ECRG Recommendation	Planning Group Recommendation
a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.	**Accept with caveats.** This issue requires further deliberation within the statewide planning process. The duration of treatment needs some parameters to be set, however, this is primarily a clinical issue that is considered on a case-by-case basis by the treating team and the consumer.

5. Education resource essential: on-site school for Tiers 2 and 3

ECRG Recommendations	Planning Group Recommendations
a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.	**Accept with caveats.** The Planning Group recommends removing *"Band 7"* from the ECRG recommendation. All educational services need to be evaluated by Department of Education, Training and Employment (DETE) on a case-by-case basis, taking into consideration service model, location, student numbers and complexity. The Planning Group supports the statement that educational resources are essential to adolescent extended treatment and rehabilitation services. The Planning Group recommends consultation with DETE once a statewide model is finalised.
b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).	**Accept with caveat.** The Planning Group recommends this statement should be changed to read as: Strong consideration should be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

6. Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration

ECRG Recommendations	Planning Group Recommendations
a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.	**Accept.** Note that this service could be provider agnostic.

b) Governance should remain with the local CYMHS or treating mental health team.	**Accept.**
c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.	**Accept.**

7. Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas)

ECRG Recommendations	Planning Group Recommendations
a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.	**Accept.**
b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.	**Accept.**

Committee: **West Moreton Hospital and Health Board**

Agenda Item Number: **4.3**

Attachment: **4**

Attachment 4

MEDIA HOLDING STATEMENT

Xxx 2013

Please attribute the following to West Moreton Hospital and Health Service Chief Executive, Ms Lesley Dwyer:

1. IF NO DECISION IS MADE

No decision about the future of Barrett Adolescent Centre has been made.

The Expert Clinical Reference Group has now concluded its investigation of options for a statewide model of care for young people requiring longer term mental health treatment.

The group has put forward seven recommendations for consideration, and these recommendations are now being considered by West Moreton Hospital and Health Service.

Our goal is to ensure no adolescent goes without the expert mental health care they require. Any decision made by the Health Service will take into account the need for a consistent, best-practice approach to caring for young people requiring longer term mental health treatment.

We must also consider the delivery of contemporary models of care for young mental health consumers in an environment that is safe for them and this may include partnerships with non-government organisations.

2. IF DECISION IS MADE TO CLOSE BAC

West Moreton Hospital and Health Service is committed to ensuring no adolescent goes without the expert mental health care they require.

It has been determined that it is in the best interests of young people requiring longer term mental health treatment that Barrett Adolescent Centre (based at The Park Centre for Mental Health) will close. The Park is a high secure adult mental health facility. It is not a suitable place for adolescents. Our goal now is to ensure our youth are cared for in an environment that is best suited to them. It is in the best interests of young people that they are not cared for in the same environment as adult mental health consumers who require high secure care.

The Barrett Adolescent Centre will close by the end of September 2013. However, I can assure consumers, their families and the community that closure of the Barrett Adolescent Centre will not mean that this very important type of mental health care for young people will no longer be available in Queensland. On the contrary, it is planned to direct additional, new mental health resources to local communities across the State, so that young people have greater access to high quality mental health services closer to home. These additional resources will specifically support young people with longer term mental health needs.

The decision to close Barrett Adolescent Centre follows thorough investigations by an Expert Clinical Reference Group which put forward seven recommendations for a statewide service for young people requiring longer term mental health.

West Moreton Hospital and Health Service has accepted all seven of the recommendations from the Expert Clinical Reference Group. The HHS will now work closely with other hospital and health services across the state, as well as other mental health care providers to action these recommendations and establish services that meet the needs of these young people. Under a new statewide model of care, Queensland's youth will continue to receive the excellent mental health care that they have always received.

ENDS

Media contact:

West Moreton Hospital and Health Board
BOARD MEETING MINUTES

Date:	Friday 24 May 2013	**Time:**	9.00am to 5.45pm	**Location:**	Ipswich Hospice Care, 37 Chermside Road, Eastern Heights

Members
Dr Mary Corbett, Chair
Timothy Eltham, Deputy Chair
Dr Robert McGregor, Board Member
Paul Casos, Board Member (Apology)
Melinda Parcell, Board Member
Alan Fry OBE QPM, Board Member
Professor Julie Cotter, Board Member

Ex Officio Standing Invitees
Lesley Dwyer, Health Service Chief Executive (CE)
Ian Wright, Executive Director Finance and Corporate (EDFC)
Jacqui Keller, Corporate Counsel and Secretary (CCS)

Invitees to Stakeholder Session
Ros Holloway, Director of Hospice Services, Ipswich Hospice Care
Rosie Laidlaw, Advance Care Planning Nurse Consultant, WMHHS
Melanie McBain, Nurse Unit Manager, Palliative Care and Oncology, Ipswich Hospital

Other Invitees
Matthew Bannan, Customer Service Manager, WorkCover Queensland (for Item 3.4 only)
Chris Thorburn, Acting Executive Director Corporate Governance and Strategy (for Items 4.1 and 4.2 only)
Sharon Kelly, Executive Director Mental Health and Specialised Services (for Item 4.3 only)

TOUR OF IPSWICH HOSPICE CARE

The Board members attended a tour of the Ipswich Hospice Care facilities from 9.00am to 9.35am, led by Ros Holloway, Director of Hospice Services.

STAKEHOLDER SESSION

The stakeholder session opened at 9.45am.

Melanie McBain, Nurse Unit Manager, Palliative Care and Oncology, Ipswich Hospital, provided an overview of the WMHHS palliative care service, including the services provided to patients in their home. Ms McBain noted the gap that the Hospital fills for patients where GPs won't visit them at home, and the work that is currently being undertaken with West Moreton Oxley Medicare Local to improve this situation, particularly after hours.

Ros Holloway, Director of Hospice Services at Ipswich Hospice Care outlined the respite services that Ipswich Hospice Care provides to patients and carers. Ms Holloway also explained the volunteer program at Ipswich Hospice Care.

Rosie Laidlaw, Advance Care Planning Nurse Consultant, WMHHS, provided an overview of the work that she has been doing in advance care planning and the encouragement of palliation in residential aged care facilities. She commented on the need for the public promotion of the importance of Advanced Health Directives (AHDs) and Enduring Powers of Attorney (EPOAs).

ACTION: CCS to circulate AHD and EPOA documents and information to Board members.

The stakeholder session closed at 10.20am.