Minister for Health

Documents Tabled at the Hearing

Health and Community Services Committee

Tabled 24/7/13 SC

Document 1

TREASURY EXECUTIVE MINUTE

Minute No.

12 September 2012

Deputy Prime Minister and Treasurer

FEDERAL FINANCIAL RELATIONS ACT 2009 – NATIONAL SPECIFIC PURPOSE PAYMENT DETERMINATION 2011-12

Timing: The Determination needs to be signed prior to publication of the 2011-12 Final Budget Outcome.

Recommendation/Issue:

- That you sign the attached Federal Financial Relations Act 2009 – National Specific Purpose Payment Determination 2011-12.

Signed/Not Signed Signature: ..../...../2012

KEY POINTS

- Part 3 of the *Federal Financial Relations Act 2009* (the Act) requires you, through a written Determination, to determine the growth, total amount and the manner in which the amount is to be divided between the States and Territories (the States) for each National Specific Purpose Payment (National SPP).
- The Act stipulates that total funding for each National SPP available to the States will be the total amount of the preceding financial year indexed by the growth factor for the financial year for which the Determination is made.
- The Act requires you to have regard to the Intergovernmental Agreement on Federal Financial Relations (the IGA) when making a Determination.
  - The IGA identifies the manner in which funding under the National SPPs is to be grown and distributed between the States (See Attachment A).
  - The Determination of the growth factors and the distribution between the States is consistent with the terms and conditions contained in the IGA.
- The total amount of the Determination for 2011-12 is $20.1 billion. Advance payments of $20.3 billion were made throughout the 2011-12 financial year based on estimates of each States' entitlement. Residual adjustments totaling $149.7 million, to account for the difference in advances and the determined amounts required as a result of this Determination, are detailed in Attachment B.
  - These residual adjustments will be deducted from the 2012-13 National SPP payments and arise as a result of changes in the underlying growth factor, due to lower growth in population weighted for hospital utilisation.
  - There was no impact on the total funding pool for the National Skills and Workforce Development, Disability and Affordable Housing SPPs as parameters determining the growth factors remain unchanged since the 2012-13 Budget. These National SPPs were

only affected by population data updated in accordance with the Australian Statistician's Determination of State population shares as at 31 December 2011. Changes to this parameter have resulted in a redistribution of State allocations only.

- There were no changes to the National Schools SPP. All parameters, including full-time equivalent student enrolments that determine State allocations remain unchanged since the 2012-13 Budget.

- Residual adjustments will be made in 2012-13 following signing of this Determination.

- Upon making, this Determination becomes a legislative instrument which is subject to disallowance.

- To accord with section 17 of the *Legislative Instruments Act 2003,* a discussion on consultation with the States on matters relating to the National SPPs is included in the Explanatory Statement to this Determination.

- The IGA requires States to spend each National SPP in the service sector relevant to the payment. However, States have full budget flexibility to allocate funds within that sector as they see fit to achieve any mutually agreed objectives for that sector. In order to demonstrate compliance with this requirement each State provides a report within six months of the end of a financial year disclosing amounts that have been spent in the relevant sector.

- The Australian Government Solicitor has been consulted in the preparation of this Determination.

Contact Officer: Ext:

Manager
Commonwealth-State Relations Division

ATTACHMENT A

GROWTH FACTORS OUTLINED IN THE INTERGOVERNMENTAL AGREEMENT ON FEDERAL FINANCIAL RELATIONS

The growth factor outlined in the *Intergovernmental Agreement on Federal Financial Relations* for each National SPP is as follows:

Healthcare – the product of:

- a health specific cost index (a five year average of the Australian Institute of Health and Welfare health price index growth rate);
- growth in population estimates weighted for hospital utilisation; and
- a technology factor (Productivity Commission derived index of technology growth).

Schools (government component) – the product of:

- growth in average government schools recurrent cost; and
- growth in full-time equivalent enrolments in government schools.

Skills and Workforce Development – the sum of:

- 85 per cent Wage Cost Index 1 (comprising safety net wage adjustment weighted by 75 per cent and all groups CPI weighted by 25 per cent); and
- 15 per cent Wage Cost Index 6 (comprising safety net wage adjustment weighted by 40 per cent and all groups CPI weighted by 60 per cent).

Disability Services – a rolling five year average of nominal Gross Domestic Product year-on-year growth. In recognition that the disability services specific purpose payment incorporates funding amounts for the former Disabilities Assistance Package (DAP) which already included a growth rate the DAP component is excluded from this indexation.

Affordable Housing – Wage Cost Index 1 (comprising safety net wage adjustment weighted by 75 per cent and all groups CPI weighted by 25 per cent).

Changes due to National Health Reform Funding

- From 1 July 2012, the National Healthcare SPP was replaced by National Health Reform funding. The Treasury will continue to calculate estimated amounts for the National Healthcare SPP until 2019-20 to ensure that:
  - For 2012-13 and 2013-14, the Commonwealth will provide National Health Reform funding equivalent to the amount that would otherwise have been payable through the National Healthcare SPP (in accordance with the *National Health Reform Agreement*); and
  - National Health Reform funding provided between 2014-15 and 2019-20 is at least $16.4 billion more than what would otherwise have been payable through the National Healthcare SPP (also in accordance with the *National Health Reform Agreement*).

ATTACHMENT B

RESIDUAL ADJUSTMENTS REQUIRED AS A RESULT OF THIS DETERMINATION

The following residual adjustments are required as a result of this Determination. These adjustments will be made in 2012-13 following the signing of the Determination and will be included as an accrual for the 2011-12 financial year.

Table 1: Residual adjustment for the National Healthcare SPP, 2011-12

State	Payments made in 2011-12	Final outcome for 2011-12	Residual adjustment
New South Wales	$4,137,770,883.61	$4,088,870,973.50	-$48,899,910.11
Victoria	$3,099,413,744.57	$3,059,703,898.98	-$39,709,845.59
Queensland	$2,545,427,988.56	$2,505,276,286.59	-$40,151,701.97
Western Australia	$1,311,719,774.56	$1,305,377,723.48	-$6,342,051.08
South Australia	$989,052,525.36	$978,087,805.74	-$10,964,719.62
Tasmania	$279,571,245.06	$277,619,940.12	-$1,951,304.94
Australian Capital Territory	$183,591,392.64	$182,991,296.65	-$600,095.99
Northern Territory	$151,255,955.78	$150,203,654.95	-$1,052,300.83
Total	**$12,697,803,510.13**	**$12,548,131,580.01**	**-$149,671,930.13**

Table 2: Residual adjustment for the National Schools SPP (government schools), 2011-12

State	Payments made in 2011-12	Final outcome for 2011-12	Residual adjustment
New South Wales	$1,245,220,720.46	$1,245,220,720.46	-
Victoria	$876,104,515.30	$876,104,515.30	-
Queensland	$759,953,054.23	$759,953,054.23	-
Western Australia	$378,437,929.70	$378,437,929.70	-
South Australia	$280,421,878.59	$280,421,878.59	-
Tasmania	$99,856,328.08	$99,856,328.08	-
Australian Capital Territory	$56,180,889.48	$56,180,889.48	-
Northern Territory	$59,625,143.51	$59,625,143.51	-
Total	**$3,755,800,459.34**	**$3,755,800,459.34**	**-**

Table 3: Residual adjustment for the National Skills and Workforce Development SPP, 2011-12

State	Payments made in 2011-12	Final outcome for 2011-12	Residual adjustment
New South Wales	$448,010,904.74	$447,997,102.67	-$13,802.06
Victoria	$338,044,663.40	$337,699,610.05	-$345,053.35
Queensland	$268,787,373.10	$267,684,955.79	-$1,102,417.31
Western Australia	$138,636,642.89	$139,627,313.95	$990,671.06
South Australia	$101,350,259.33	$101,425,592.54	$75,333.21
Tasmania	$31,415,137.98	$31,561,146.88	$146,008.90
Australian Capital Territory	$22,824,167.54	$22,994,061.67	$169,894.13
Northern Territory	$14,062,857.64	$14,142,223.06	$79,365.42
Total	**$1,363,132,006.61**	**$1,363,132,006.61**	**-**

Table 4: Residual adjustment for the National Disability SPP, 2011-12

State	Payments made in 2011-12	Final outcome for 2011-12	Residual adjustment
New South Wales	$396,773,533.61	$396,761,295.33	-$12,238.28
Victoria	$284,736,243.86	$284,430,285.47	-$305,958.39
Queensland	$237,270,274.75	$236,292,762.66	-$977,512.09
Western Australia	$110,260,205.29	$111,138,632.12	$878,426.83
South Australia	$114,063,141.11	$114,129,938.98	$66,797.87
Tasmania	$35,012,161.46	$35,141,627.38	$129,465.92
Australian Capital Territory	$17,990,728.03	$18,141,372.95	$150,644.92
Northern Territory	$12,581,201.46	$12,651,574.68	$70,373.22
Total	**$1,208,687,489.58**	**$1,208,687,489.58**	**-**

Table 5: Residual adjustment for the National Affordable Housing SPP, 2011-12

State	Payments made in 2011-12	Final outcome for 2011-12	Residual adjustment
New South Wales	$395,848,806.89	$395,836,225.21	-$12,581.68
Victoria	$288,309,820.21	$287,995,276.81	-$314,543.40
Queensland	$246,129,587.22	$245,124,646.70	-$1,004,940.52
Western Australia	$129,332,919.10	$130,235,994.08	$903,074.98
South Australia	$95,139,894.83	$95,208,567.01	$68,672.18
Tasmania	$32,554,561.87	$32,687,660.53	$133,098.66
Australian Capital Territory	$24,255,746.14	$24,410,618.07	$154,871.93
Northern Territory	$31,031,238.21	$31,103,586.06	$72,347.85
Total	**$1,242,602,574.48**	**$1,242,602,574.48**	-

Table 6: Total Residual Adjustment by State and Territory, 2011-12

State	Schools	Skills	Disability	Housing	Subtotal	Healthcare	Total
New South Wales	-	-$13,802.06	-$12,238.28	-$12,581.68	**-$38,622.02**	-$48,899,910.11	**-$48,938,532.13**
Victoria	-	-$345,053.35	-$305,958.39	-$314,543.40	**-$965,555.14**	-$39,709,845.59	**-$40,675,400.73**
Queensland	-	-$1,102,417.31	-$977,512.09	-$1,004,940.52	**-$3,084,869.92**	-$40,151,701.97	**-$43,236,571.89**
Western Australia	-	$990,671.06	$878,426.83	$903,074.98	**$2,772,172.87**	-$6,342,051.08	**-$3,569,878.21**
South Australia	-	$75,333.21	$66,797.87	$68,672.18	**$210,803.26**	-$10,964,719.62	**-$10,753,916.36**
Tasmania	-	$146,008.90	$129,465.92	$133,098.66	**$408,573.48**	-$1,951,304.94	**-$1,542,731.46**
Australian Capital Territory	-	$169,894.13	$150,644.92	$154,871.93	**$475,410.98**	-$600,095.99	**-$124,685.01**
Northern Territory	-	$79,365.42	$70,373.22	$72,347.85	**$222,086.49**	-$1,052,300.83	**-$830,214.34**
Total	-	-	-	-	-	-$149,671,930.13	**-$149,671,930.13**

Tabled 24/7/13 SC

MSB002

MINISTERIAL SERVICES

HOSPITALITY CERTIFICATION

Please print on Pink Paper

MINISTERIAL OFFICE: Health **DATE OF FUNCTION** 2/07/2012

VENUE Bushfire Restaurant **COST OF FUNCTION** (GST Inclusive) $ 308.10

REASON FOR HOSPITALITY and its connection with official duties in accordance with Ministerial Handbook

Policy discussions regarding Health Boards and Health Payroll System

ATTENDEES: Only people for whom expenditure was incurred * Include Self # Include employee associates

Column 1	Column 2	Column 3	Column 4
Number of State Govt Employees *	Number of Employees of Statutory Bodies #	Number of Other People	Total Number of People
3	0	1	4

	Name of Participants	Organisation of Participants
1	Hon Lawrence Springborg MP	Minister for Health
2	Mrs Claire Mildren	Minister for Health - Staff
3	Mr Mark Wood	Minister for Health - Staff
4	Mr John MacKenzie	4CA Radio
5		
6		

** See overleaf for more lines. Attach additional page if necessary (eg. guest list)

CERTIFICATION AND APPROVAL

Certification of Claimant:

I certify that the above hospitality was for official purposes in accordance with the Ministerial Handbook and the information above represents the true details in relation to the event.

Signature of Claimant Date

(If claimant is Minister, this signature will suffice for Expenditure Approval)

Approval of Expenditure:

The above expenditure is approved for payment in accordance with the Ministerial Handbook.

s73

Signature of Minister 9.7.12 ✓ Date

Office Use Only: CALCULATION - FBT and Non FBT breakdown

Col (1) * Col (2) x Total Cost	= Amount subject to FBT (use account code 53030 for FBT Component)
Col (4) Balance	= Amount not subject to FBT Code to 53010 (tax code P4)

3	308.10	$ 231.08	= $ 231.08	(53030)		
4		Balance	= $ 0.00	(53010)	Total	308.10

{Code balance (53010) to P4}

Please print on pink paper

Please print on yellow paper

Department of the Premier and Cabinet

MSB004

Document Number: 19/23-015

MINISTERIAL OFFICES
EXPENDITURE APPROVAL

Ministerial Office: Health

Financial Year: 2012/13 Urgent payment required by: / / 20

Return Cheque to: _____ Phone: _____

PAYG: Yes / No

VENDOR *(name of person/business to be paid)*	**PARTICULARS**	**AMOUNT**
Hon Lawrence Springborg MP	Hospitality	$308.10
	TOTAL (GST exclusive)	$
	GST Amount	$ 27.60
	APPROVAL TOTAL: (GST inclusive)	$308.10

I certify that:
- Expenditure is approved and in accordance with the Queensland Ministerial Handbook;
- All supporting documentation is attached;
- Where applicable a valid Tax Invoice is attached;
- The purpose of any travel or entertainment is related to official business (unless specifically detailed); and
- When guests are not assisting the Minister details of cost recovery are attached.

APPROVED: Signature s73 ✓

Name (please print) Neil Hamilton-Smith Date: 11/7/12

PREPARED BY: Name (please print) Colleen Miller Date: 9 July 2012

Phone 32340970

MINISTERIAL SERVICES OFFICER:
I certify that:
* approved by competent authority;
* verification of goods supplied/services rendered;
* price or rate of charge correct;
* discounts/allowances correct;
* arithmetically correct;
* not previously paid;
* invoices/requisitions attached; and
* expenditure is recorded against the correct codes.

Signature: s73 s73

Date: 17/07/2012 11/7/12

- **Claims for Domestic Travel - See Overleaf**

Travelex

Pacific Intl Cairns
Cnr Spence St &
The Esplanade

CUSTOMER COPY

MERCHANT ID : 678573464318976
TERMINAL ID : 61004046

NAB Visa Credit
NAB Visa Credit CREDIT
CARD NUMBER (I)

s73

INVOICE NUMBER 1188

AID A0000000031010
TC 94E470BA3454EA54
TVR 0000088000
TSI F800

PURCHASE AUD 308.10
TOTAL AUD 308.10

DATE TIME SEQ NO
02/07/12 20:50:17 001340

APPROVED 00

AUTH NUMBER 233731

Thanks

Bushfire
43 The Esplanade
Cairns QLD 4870
Ph: 07 4051 7888
Fax: 07 4051 9258
ABN 40 010 171 007

2080 Bec B

Tbl 9/1 Chk 1201 Gst 4
02Jul'12 18:26

1 Cascade Light @ 5.50	5.50
1 Architect Chard @ 9.00	9.00
1 See Saw Sauv @ 8.00	8.00
2 Apple Juice @ 5.00	10.00
4 EXPERIENCE @ 46.50	186.00
1 Btl Red Claw Shiraz @ 57.00	57.00
1 Mr Riggs The Gaf @ 9.00	9.00
1 Peppermint @ 4.00	4.00
2 Flat White @ 3.50	7.00
1 Hot Chocolate @ 3.50	3.50
1 Macadamia Browni @ 4.50	4.50
1.5 %	
1.5%	4.60
	303.50
	27.60
Svc Charges	4.60
Total Due	308.10

Tips_____

Total_____

Room Number_____

Print Name_____

Signature_____

* GST Exclusive Item

Tabled 24/7/13

Thanks very much for meeting with me today. It was good to clarify the situation and I am disappointed the Federal Government is not renewing its funding commitment beyond June 30.

As I impressed in the meeting, a letter from the Federal Opposition confirming they will fund the service if elected on September 14 will assist in my bid to secure rescue funds for the organisation for the remainder of the year.

I reiterate that the state government is focused on delivering acute and sub-acute mental health services and is reluctant to fund services which are the responsibility of the Federal Government.

Once again thanks for meeting with me and please contact my office if you have any questions or developments on this issue.

Kind regards,
Gavin King

CAIRNS ELECTORATE OFFICE
46-50 Spence Street Cairns
PO Box 5697 Cairns 4870
Ph: 07 4051 2868 Fax: 07 4038 6760
Hours of Operation: 9am – 4pm

Tabled 24/7/13
&

Deloitte.

Independent Review of HIV Services in Metro North Hospital and Health Service

Final Report

June 2013

Strictly private and confidential

Deloitte.

Contents

Glossary

Abbreviation	Description	Abbreviation	Description
AChSHM	Australasian Chapter of Sexual Health Medicine	MNHHS	Metro North Hospital and Health Service
AIDS	Acquired Immunodeficiency Syndrome	MSHHS	Metro South Hospital and Health Service
AO	Administration Officer	MSM	Men who have sex with men
ART	Anti-retroviral Treatment	NGO	Non-Government Organisation
ASHM	Australian Society for HIV Medicine	NHA	National Healthcare Agreement
ATSI	Aboriginal and Torres Straight Islander	NUM	Nurse Unit Manager
BBV	Blood Borne Virus	OOS	Occasions of Service
CALD	Culturally and Linguistically Diverse	PBS	Pharmaceutical Benefits Schedule
CDU	Communicable Diseases Unit	PEP	Post Exposure Prophylaxis
CEO	Chief Executive Officer	QH	Queensland Health
CU	Chronically Unstable	QuIHN	Queensland Injectors Health Network
ECCQ	Ethnic Communities Council of Queensland	RBWH	Royal Brisbane & Women's Hospital
FTE	Full Time Equivalent	S100	Section 100
GP	General Practitioner	SEQ	South East Queensland
HAART	High Active Antiretroviral Treatment	SHHS	Sexual Health and HIV Service
HHS	Hospital and Health Service	SMO	Specialist Medical Officer
HIV	Human Immunodeficiency Virus	START	Strategic Timing of Anti-Retroviral Treatment Study
HP	Health Practitioner	STI	Sexually Transmissible Infection
HSD	Highly Specialised Drugs	TPCH	The Prince Charles Hospital
MBS	Medical Benefits Schedule	TU	Temporarily Unstable
MNHHB	Metro North Hospital and Health Board	VMO	Visiting Medical Officer

Executive Summary

Executive Summary

Scope

Deloitte was engaged to conduct an independent review of the HIV services provided through the Sexual Health and HIV Service (SHHS) in the Metro North Hospital and Health Service (MNHHS). The terms of reference for the review are outlined on page 16. The review was conducted in the context of the range of service delivery options for the SHHS under consideration by the Metro North Hospital and Health Board (MNHHB).

Three service delivery options have been defined for the independent review.

Table 1: Service Delivery Options

Option 1	Transfer of all non-MNHHS resident STI and HIV patients to their home HHS.
Option 2	In addition to Option 1, transfer of all non-complex STI patients to primary care.
Option 3	In addition to Option 2, transfer of stable HIV patients to primary care (s100 GPs)

The analysis and findings of the review is structured around the following elements:

- Current State – Description and analysis of the current services, focussing on SHHS's HIV services
- Future State – Review of the risks and implications, transition considerations and resourcing associated with each service delivery option
- Contestability Analysis – Outline of considerations of contesting the retained service.

The purpose of this Report is to assist the Department of Health determine an appropriate service delivery model for MNHHS's SHHS.

Background

Under the original service delivery model considered by the MNHHB, the SHHS would only retain the specialist care of HIV patients and complex sexually transmitted infections (STI) patients that are not suitable to be provided in the primary health care sector.

Queensland Health advised that following the 28 February 2013 Board Meeting, the proposed service model was revised and an announcement made 20 March 2013 to staff that there would be no change to the HIV service and changes to the sexual health service would be progressed. During the following week there was increased media coverage and feedback which led to the announcement by the Board Chair on 28 March 2013 that there will be no change to the HIV service, a comprehensive service would continue within Metro North.

The scope of this review was confined to HIV services only. However, where relevant the implications for sexual health services have been identified and described.

Consultation

To conduct this review, Deloitte consulted with a number of stakeholders, including over 38 individuals from Medicare Locals, HHSs, NGOs, current SHHS staff and sexual health and HIV services in other jurisdictions. This consultation formed a valuable component of the analysis of the service delivery options along with considerations for the contestability analysis. The review acknowledges the input, cooperation and contribution of the staff from the SHHS and stakeholders consulted.

Policy context and demand drivers

There have been considerable advances in the treatment of HIV with access to antiretroviral treatment (ART) which in almost all instances has stopped the progression to AIDS. For this reason HIV is now considered a chronic condition rather than a terminal illness. While access to treatment and health outcomes has improved, the incidence and prevalence of HIV and STIs in Queensland has been generally increasing. The presence of STIs does increase HIV transmission risk particularly during sexual contact. This interrelationship and risk has implications for how services are delivered.

From a policy perspective, the Queensland Department of Health committed to the Melbourne Declaration which requires 90% of people living with HIV to be on ART and the introduction of rapid testing to target the estimated 30% of undiagnosed cases of HIV. It is not known what degree of impact these strategies will have on existing sexual health services.

There are significant public health risks and costs associated with increasing prevalence and incidence rates in HIV and STIs.

Executive Summary

Summary of key findings

Key findings of this independent review have been summarised according to the specified terms of reference, which are provided at page 16 and cover:

- Current State – Description and analysis of the current services, focussing on SHHS's HIV services
- Future State – Review of the risks and implications, transition considerations and resourcing associated with each service delivery option
- Contestability Analysis – Outline of considerations of contesting the retained service.

Table 2: Current State - Summary of Key Findings

	Key Findings			
	Patients	% Non- MNHHS	Occasions of Service (OOS)	% Non-MNHHS
Quantification of HIV Specific Throughput	Stable HIV	275	46%	1,332	37%
	Temporarily Unstable	402	49%	3,194	48%
	Chronically Unstable	61	43%	713	37%
	HIV PEP	188	n/a	410	n/a
	Total	**926**		**5,239**	
	- Approximately 14 protocol patients are included in the chronically unstable figures above - Data on the residency of HIV PEP patients is not available				
Distribution of HIV Services to Support the Community	The SHHS provides HIV services through three facilities: • Biala Community Health Centre (Clinic 2) • Redcliffe Community Health Centre • Caboolture Community Health Centre (outreach clinic) Demonstrated by geospatial mapping of services and client residency data, the majority of HIV clients attending the primary HIV Clinic in the Biala Community Health Centre live in the central to northern Brisbane area. The services at Redcliffe and Caboolture support a large number of patients who reside in the northern end of MNHHS. A number of benefits of the current locations of the HIV service were highlighted during consultation including close proximity to a public transport hub and co location with pharmacy services which enabled efficient access. The non-hospital based setting facilitated improved patient anonymity and was consistent with contemporary care models.			
Referral Pathways	There were significant data limitations associated with the recording of referral status for HIV patients with 72% of consultations not recording a referral source. The SHHS through consultation estimated that approximately 10% of patients seen in the primary HIV clinic are self-referred (walk-ins)compared with the data reporting a 1% self referral rate. The referral source data should not be relied upon.			

Executive Summary

Summary of the key findings

Table 2: Current State - Summary of Key Findings (continued)

	Key Findings				
	Consultations According to Model of Care Report	**Stable HIV**	**Temporarily Unstable**	**Chronically Unstable**	**HIV PEP**
HIV Service Profile	Medical Officer Consults Per Patient	2-3 p.a	**6 p.a**	4 p.a	1 p.a
	Nursing Consults Per Patient	1 p.a	6 p.a	**12 p.a**	5 p.a
	Note that the consultations per patient per annum shown above differ to actual patient data which may be due to individual patient clinical reasons.				
Medicare Billing Practices	There are no arrangements in place to support appropriate revenue collection for patients accessing the SHHS. Patients attending the SHHS are not billed against the Medicare Benefits Schedule (MBS). Preliminary investigations into the introduction of MBS billing was undertaken by SHHS medical staff in November 2012. Implementation of a MBS billing Model has not been progressed.				
Pharmaceutical Analysis	Based on analysis of the data provided, the following key findings were made in relation to the pharmaceutical analysis: • **Financial** - All S100 HIV medicines supplied under the s100 arrangements are fully reimbursed by the PBS. Current inventory management practice in QH pharmacies has minimal wastage. • **Regulatory and policy barriers –** there are significant barriers to enabling community pharmacies to dispense S100 medications. Community pharmacies are not permitted to dispense prescriptions written by prescribers employed (or mentored) by a public sector employed specialist. This policy is governed by the Commonwealth Government.				

Executive Summary

Summary of the key findings

Table 3 below summarises the patient and service activity for each of the service delivery options in terms of what is transitioned and retained by patient classification. It should be noted that the options are cumulative with the services retained under option 3 representing the patients transitioned under option1, option 2 and option 3. The risks and implications of transitioning the patient activity outlined below, are described on page 10.

Table 3 Future State – Summary of Patients and Activity Transitioned and Retained by Option

			Transfer of Non-MNHHS Residents				Transfer of Non-Complex STIs				Transfer of Stable HIV			
	Current (2012)		Option 1				Option 2				Option 3			
Patient Classification	**Patients**	**OOS**	**Transitioned**		**Retained**		**Transitioned**		**Retained**		**Transitioned**		**Retained**	
			Patients	**OOS**	**Patients**	**OOS**	**Patients**	**OOS**	**Patients**	**OOS**	**Patients**	**OOS**	**Patients**	**OOS**
Non-Complex STI	4,019	5,282	1,454	1,793	2,565	3,488	2,565	3,488	-	-	-	-	-	-
Complex & Unresolved STI	1,722	5,167	623	1,869	1,099	3,298	-	-	1,099	3,298	-		1,099	3,298
Stable HIV	275	1,332	127	491	148	841	-	-	148	841	148	841	-	-
Newly Diagnosed HIV for Stabilisation & Temporarily Unstable	402	3,194	198	1,542	204	1,652	-	-	204	1,652	-	-	204	1,652
Chronically Unstable Patients	61	713	26	261	35	452	-	-	35	452	-	-	35	452
HIV PEP	188	410	-	-	188	410	-	-	188	410	-	-	188	410
Total	6,667	16,098	**2,428**	**5,956**	**4,239**	**10,141**	**2,565**	**3,488**	**1,674**	**6,653**	**148**	**841**	**1,526**	**5,812**
% of Total Current Patients & OOS (2012) Retained					**64%**	**63%**			**25%**	**41%**			**23%**	**36%**

Note: Refer to page 41 for further detail on the definition of the HIV patient classifications. Page 82 provides the definition of non-complex STI and complex STIs.

Executive Summary

Summary of the key findings

The estimated staffing requirement for each option is presented in Table 4 below along with the staffing levels proposed to the MNHH B in February 2013. The clinical staff FTE requirements have been determined based on the patient numbers and associated activity presented in Table 3 applied to a range of assumptions related to average time per consultation, indirect clinical time and the service's operating hours.

The functions relating the Syphilis Register and Contact Tracer were identified through consultation as more appropriately sitting within the Communicable Diseases Unit along with other similar functions. The FTE required for these functions is not included in the table below. Further details on the assumptions and rationale for the estimated staffing levels is provided at Chapter 6.

Table 4 Future State – Estimated Staffing Requirement by Option

	Key Findings				
	Position	**ToR Proposed FTE**	**Option 1 Transfer of Non-MNHHS Patients**	**Option 2- Transfer of Non-Complex STI**	**Option 3 - Transfer of Stable HIV**
Resourcing Requirements	Medical Officer	1.0 FTE	3.75 FTE	3.0 FTE	2.5 FTE
	Nurses	4.0 FTE	6.0 FTE	4.0 FTE	4.0 FTE
	Psychologist	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE
	Pharmacist	0.5 FTE	1.0 FTE	1.0 FTE	1.0FTE
	Medical Officer (Syphilis Register)	0.5 FTE	-	-	-
	Nurse Syphilis Register	1.0 FTE	-	-	-
	Epidemiologist	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE
	Administration Officer	0.5 FTE	1.0 FTE	0.5 FTE	0.5 FTE
	Nurse Contact Tracer	0.5 FTE	-	-	-
	Total	**9.5 FTE**	**13.25 FTE**	**10 FTE**	**9.5 FTE**

Note: The epidemiologist refers to the HIV Regional Coordinator

Executive Summary

Summary of Risks & Implications

A number of risks and implications associated with each of the service delivery options were identified through the process of the review. These risks and implications have been identified within the context of changes to access of the service. These are important considerations in terms of informing the Department of Health's decision on the future service model for the SHHS. Where possible strategies to mitigate these risks have been identified. Further detail on the risks and implications is provided in Chapter 4 with considerations for progressing each option outlined in Chapter 5.

Table 5: Future State - Summary of Risks, Implications and Proposed Mitigation Strategies by Option

Category	Risks	Implications	Possible Mitigation Strategy	Option 1	Option 2	Option 3
Public Health Risk	There is a public health risk if patients fail to access care and treatment because of resistance to accessing services that may not provide: • Anonymity and confidentiality • Open access (walk in) • No charge/ co-payment • Specialist services • Acceptance of socially marginalised populations	The rates of HIV and STIs increase due to clients not accessing appropriate HIV and STI testing and treatment.	There is no clear mitigation strategy relating to this risk. However, development of a comprehensive communication and education strategy which clearly outlines the revised service delivery model may assist to mitigate this risk.	✓	✓	✓
	Due to the complexity and sensitivity of chronically unstable patients, it is likely that transfer to their resident HHS may create significant patient resistance.	Clients decrease compliance with medication therefore creating a public health risk through potential increase in HIV transmission.	Additional support and patient liaison will be required for this patient cohort. This should be a consideration in the transition process.	✓	✓	✓
	A key patient cohort treated by the SHHS are commercial sex workers, for their sexual health certificates. Transfer of non-complex STI treatment to GPs may result in co-payments being charged, creating financial barriers to care.	Lack of access to sufficient sexual health screening for commercial sex workers may increase the transmission of STIs.	Develop innovative shared-funding arrangements for GP services with NGOs or other service hosts, and examine clients capacity for making co-payments. This process would likely involve Medicare Locals.	✓	✓	✓

Executive Summary

Table 5: Summary of Risks, Implications and Proposed Mitigation Strategies

Category	Risks	Implications	Possible Mitigation Strategy	Option 1	Option 2	Option 3
Clinical Risks of Patient Transfer	Large number of clients proposed to be referred to home resident HHSs. Receiving HHSs may not have the capacity and capability to adequately treat HIV patients, particularly regional HHSs.	Clients may resist transfer due to anonymity concerns of receiving care in the HHS where they reside. These concerns can cause considerable distress to people living with HIV. Receiving HHSs do not have sufficient capacity or capability provide a clinically safe service.	Project managed in stages - initial discussions in first three months and negotiation of transition strategy and implementation plan over the next three months. An outreach strategy would need to consider clinically appropriate arrangements with regional HHSs which do not have the capacity to provide a quality HIV service.	✓	✓	✓
	Due to the complexity and sensitivity of chronically unstable HIV patients, it is likely that the transfer to their resident HHS will be met with patient resistance.	Socially complex patients are very sensitive to changes in treatment. The transfer process may further destabilise these patients. The transfer process required for these patients will be very resource intensive.	A well planned, comprehensive clinical handover process is undertaken which involves all key stakeholders.	✓	✓	✓
	The MNHHS is responsible for quality of care throughout the transition process. Therefore, any reduction of patient safety or quality of care caused by the transition process will be worn by the MNHHS.	The decline in patient quality and safety causes decreased medication compliance. This has the potential to increase HIV and STI transmission.	A well planned, comprehensive clinical handover process is undertaken which involves all key stakeholders.	✓	✓	✓
	Large number of clients are proposed to move to GP primary health care providers	Some clients will not access, or delay access to GP-based services. This creates a potential public health risk if adequate treatment is not provided.	Project managed in stages - initial discussions in first three months and negotiation of transition strategy and implementation plan over the next three months.		✓	✓

Executive Summary

Table 5: Summary of Risks, Implications and Proposed Mitigation Strategies

Category	Risks	Implications	Possible Mitigation Strategy	Option 1	Option 2	Option 3
Funding Implications	Transition of non-MNHHS patients to their home HHS may involve the transfer of budget.	This reduces any financial advantage under the proposed service model.	Negotiation of the funding implications should form a component of the transition and hand over of patients to their host HHS.	✓	✓	✓
	MBS payment structure - disincentive for longer HIV/STI consultations.	Inability to attract GPs to work in HIV and related primary health care.	Explore alternative funding arrangements with the primary care and NGO sector through the Medicare Local		✓	✓
Capacity and Capability of the Primary Care Sector (STI Care)	Unwillingness of some GPs to take on sexual health clients who engage in high risk sexual behaviour.	Inadequate primary health care services for sexual health clients.	Develop support and assistance program with Medicare Local and targeted NGOs to enhance training and capacity of GPs, notably in sexual health with clients with high risk sexual behavior.		✓	✓
	Concerns were raised in regards to the ability of GPs to accurately identify complex STIs and refer as appropriate.	Complex STIs are not accurately diagnosed in the primary care sector.	Implement standardised referral criteria for complex STIs and provide further education to GPs on STI management and use of the referral criteria.		✓	✓
Pathology Arrangements	Reduced Medicare coverage when ordering more than three tests per consultation with a GP.	Patients are required to pay a co-payment for pathology tests ordered. This may create financial barriers for patients accessing STI and HIV care within general practice.	Investigate alternative funding arrangements for the provision of pathology.		✓	✓
Vulnerable Populations	Limited ability of some disadvantaged high risk clients to afford co-payments charged.	Clients fail to access GPs and access to services is reduced creating a potential public health risk if STI/HIV testing and treatment does not occur.	Develop innovative shared-funding arrangements for GP services with NGOs or other service hosts, and examine clients capacity for making co-payments		✓	✓

Executive Summary

Table 5: Summary of Risks, Implications and Proposed Mitigation Strategies

Category	Risks	Implications	Possible Mitigation Strategy	Option 1	Option 2	Option 3
Capacity and Capability of the Primary Care Sector (HIV Care)	Limited availability of s100 GPs and current location in metro Brisbane region only.	Inability to move all stable HIV clients to the primary care sector.	Increase the required number of prescribers in Brisbane to accept Metro North residents, with a focused program developed with Medicare Local and University of Qld			✓
	Due to the complexity of HIV care there are limited financial incentives for GPs to undertake s100 training and a HIV caseload.	Inability to attract a sufficient number of s100 GPs would result in an inability to move stable HIV clients to the primary care sector.	In collaboration with Medicare Local, examine capacity to attract and retain GPs with s100 prescriber accreditation and to invite successful trainees to participate in scheme.			✓
	Unwillingness of some GPs to take on HIV clients.	Inadequate primary health care services for HIV clients.	Develop support and assistance program with the Medicare Local and targeted NGOs to enhance training and capacity of GPs, notably in HIV care with high risk clients.			✓
	Need for s100 GPs to maintain interest in and clinically safe number of HIV clients.	Inadequate number of GP providers will limit access to HIV services.	Ensure training program attracts sufficient numbers of GPs to share reasonable workload, transfer clients on when sufficient number of GPs available			✓
	Clients' seeking HIV care have a lack of confidence in capacity of or acceptance by some GPs.	Clients fail to engage with GPs and access to services is reduced.	Focus on attracting GPs with acceptance of high risk clients, through NGOs or other service provider arrangements, and that clients are transferred to acceptable GP			✓
Pharmaceutical Arrangements	Current s100 dispensing rules require medication to be dispensed in public pharmacies only	Separation of medication dispensing from the point of care creates further fragmentation in patients' treatment pathway. This may impact on medication compliance.	Relevant groups raise the restrictions to the s100 PBS community dispensing arrangements with Commonwealth Government for revision			✓
Demand for Services	There is a likely increase in demand for HIV treatment, primarily due to the national target of 90% of HIV patients on ART, early treatment as prevention and an estimated 30% undetected HIV cohort.	This may exceed the capacity of HIV services.	Additional resources to meet any increases in demand may be required.	✓	✓	✓

Executive Summary

Summary of the key findings

A summary of the contestability analysis is provided in Table 6 below.

Table 6: Summary of Contestability Analysis

	Key Findings
Contestability Analysis	• The information provided through the consultation process identified an interest among non-government providers to deliver all or part of the retained SHHS service under a contracted arrangement. • No similar arrangements were identified in the jurisdictions consulted to deliver specialist HIV and STI management and care. • A detailed service contestability plan would need to be developed to fully assess the service requirements, interface points, cost of service, funding arrangements and clinical, commercial and financial due diligence of prospective operators. • Chapter 7 provides further detail on the outcomes of the contestability analysis.

Introduction

Introduction

Scope

Overview

The purpose of this engagement was to conduct an independent review of the HIV services provided through the Sexual Health and HIV Service (SHHS) in the Metro North Hospital and Health Service (MNHHS). This review included three main components: analysis of the current service provision, review of the service model under consideration of the MNHHB, and an assessment of the capacity and capability of alternative private providers.

The review has been conducted based on the following Terms of Reference:

- Quantification of HIV specific patient throughput for services provided by the MNHHS across the various sites.
- Quantify the number of staff currently dedicated to running the HIV service along with their role description, and actual day-to-day activities. This will include the research activities undertaken within the HIV service. It is proposed that the current HIV staffing levels (9.5 FTEs) has the capacity to meet the clinical demand for HIV and referred sexual health services, including medical, nursing, pharmacy, epidemiology and administrative staff as follows:
    - 1 medical officer
    - 4 nurses
    - 0.5 psychologist
    - 0.5 pharmacist
    - 0.5 admin officer
    - 0.5 medical officer (syphilis register)
    - 1 nurse (syphilis register)
    - 1 epidemiologist
    - 0.5 nurse (contact trace support officer - works with GPs for HIV contact tracing)

Overview (continued)

- Analysis and description of the referral pathways and the interdependencies within the current sexual health service. This will include a comparison of the number of walk-in patients and referred patients to the HIV services.
- Quantification of the services provided to HIV clients, including the processes and procedures undertaken to manage people with HIV. This analysis will include consideration of:
    - Testing and management of newly diagnosed HIV patients until clinically stable
    - Long term specialist treatment of people with HIV
    - Ongoing management of people with HIV under 'Protocol' conditions
    - Post exposure prophylaxis to suspected HIV infection
    - Distribution and location of services to support HIV clients in the community.
- A review of the pharmaceutical arrangements in place to determine the current prescribing, dispensing, storage and stock control processes and procedures. This includes a review of procedures and controls regarding Section 100 drugs.
- Review of the current procedures in place surrounding Medicare billing and identification of any revenue generation opportunities.
- Subject to data availability, review and identify opportunities for contestable service delivery arrangements for the provision of HIV services in the Metro North Catchment Area.

Deliverables

The following deliverables were completed throughout the engagement:

- Project Plan (22nd April 2013)
- Weekly Progress Reports (ongoing)
- Draft Report (14th May 2013)
- Final Report (14th June 2013).

Introduction

Scope

Limitations

The following limitations apply to this Report:

- During the course of the engagement, we relied upon information that was provided to us by the MNHHS and the stakeholders consulted. We will assume that such information was correct and complete and not misleading. We did not undertake any form of audit or other checking process with respect to this information. In addition, any assumptions that are made throughout the engagement were consulted on and documented
- Deloitte does not hold a legal practice licence. Advice on legislation and regulation is provided from a policy and practical perspective only
- Consultation with more than 38 stakeholders was undertaken as part of this engagement including nominated individuals. Wide-scale consultation including with clients of the service was outside the scope of this engagement
- This review was confined to the HIV service within the MNHHS. Therefore the key findings contained in this report are limited to the service delivery options within the MNHHS. The circumstances and assumptions may not be applicable in other settings or regions.

Introduction

Approach

A five staged approach was employed for the independent review of HIV services. The five stages have been summarised below:

- **Stage 1 Project Initiation** – Involved finalising the scope, timeframes, objectives and deliverables of the project.
- **Stage 2 Service Mapping** – Broad mapping of the current sexual health services provided in the MNHHS was undertaken. Detailed mapping of HIV services including volumes of services provided by MNHHS across the various sites. A description of the current service delivery model and the service model under consideration by the MNHHB.
- **Stage 3 Review of Resources & Protocols** – This stage involved significant consultation to determine the resources required to deliver the services under consideration. This stage also included pharmaceutical analysis, and review of revenue practices.
- **Stage 4 Market Assessment** – High level market sounding was undertaken to make an assessment of the capacity and capability of non-government organisations (NGO) and the private sector to deliver the scoped HIV services.
- **Stage 5 Project Finalisation** – Information was consolidated into a Draft and Final Report.

As mentioned above, stakeholder consultation was a significant component of the engagement and was a primary information source. Table 7, outlines the various stakeholders consulted.

Table 7: Stakeholder Consultation Schedule

Organisation	
AMA	Director Sydney Sexual Health Service
Metro North Medicare Local	Director of Melbourne Sexual Health Centre
Metro South Medicare Local	Acting CEO Metro North HHS
Director of Infectious Diseases, Princess Alexandra Hospital	Director of Pharmacy - RBWH
Chair of MAC	Assistant Director Pharmacy RBWH
Director Sexual Health, MNHHS	Executive Director Sub-Acute and Ambulatory Services
Biala Medical Staff	Director of Ambulatory Services
HIV/ AIDS Regional Coordinator for SEQ	Director Pharmacy – TPCH
Health Planning Officer Biala	Micah Projects
NUM Clinic 1 Biala	QuiHN/ QuIVAA
NUM Clinic 2 Biala	Respect Inc.
Pharmacist Biala	Queensland Pharmacy Guild
Syphilis Register Nurse	Healthy Communities
Nurse Practitioner	Family Planning Clinic
Psychologist, Biala	Spiritus Positive Directions
NUM Redcliffe Sexual Health	Taylor Square Private Clinic
Sexual Health Nurse, Redcliffe	Queensland Positive People

Introduction

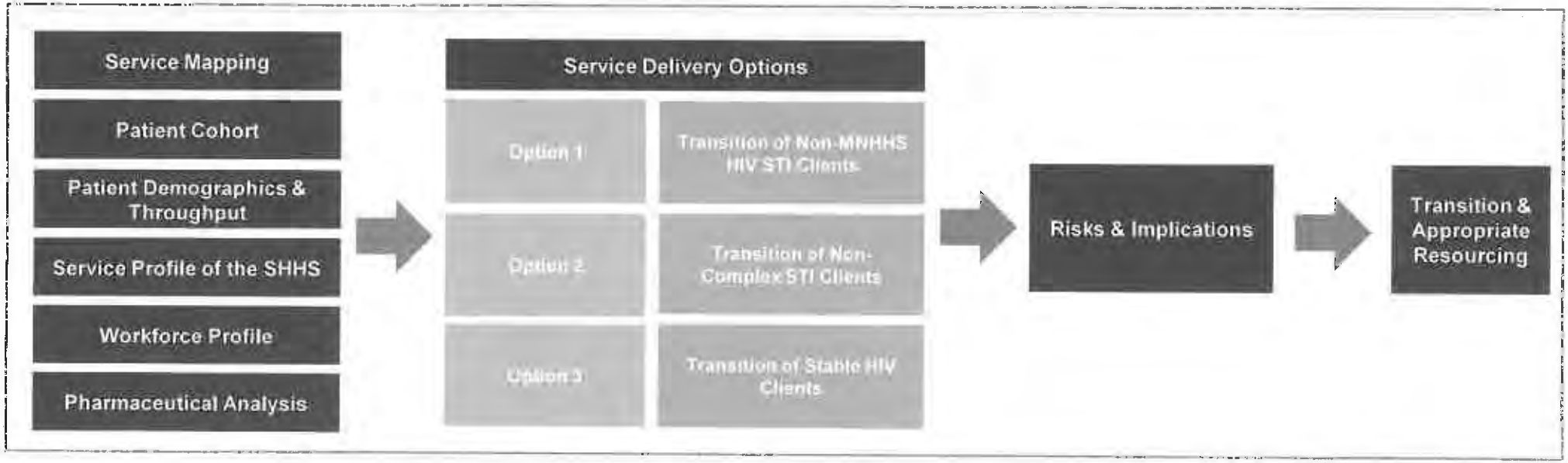
Analysis Framework

Given the wide range of services currently provided by the SHHS and the service delivery model under consideration by the MNHHB, Deloitte considered it was important to undertake a staged approach to understanding and assessing the implications for existing clients and the capacity of alternative service providers to meet the overall sexual health and HIV service needs of the catchment population. To undertake this staged approach, three service delivery options were defined in consultation with MNHHS. A full description of the options is provided in Chapter 3, however a brief description is provided below.

- **Option 1** - Transfer of non-MNHHS STI and HIV patients to their home HHS
- **Option 2** - In addition to Option 1, transfer of non-complex STI patients to primary care
- **Option 3** - In addition to Option 2, transfer of stable HIV patients to primary care

Consultation with a range of relevant and affected stakeholders was completed in order to gauge the implications, risks and implementation issues in transitioning to the service model defined under each option. Key amongst those issues were the effect on at risk populations in the possible changes to provision of non complex sexual health services and HIV services to stable clients. The analysis framework used to review and assess the service delivery options for HIV Services is outlined in Figure 1 below.

Figure 1: Analysis Framework

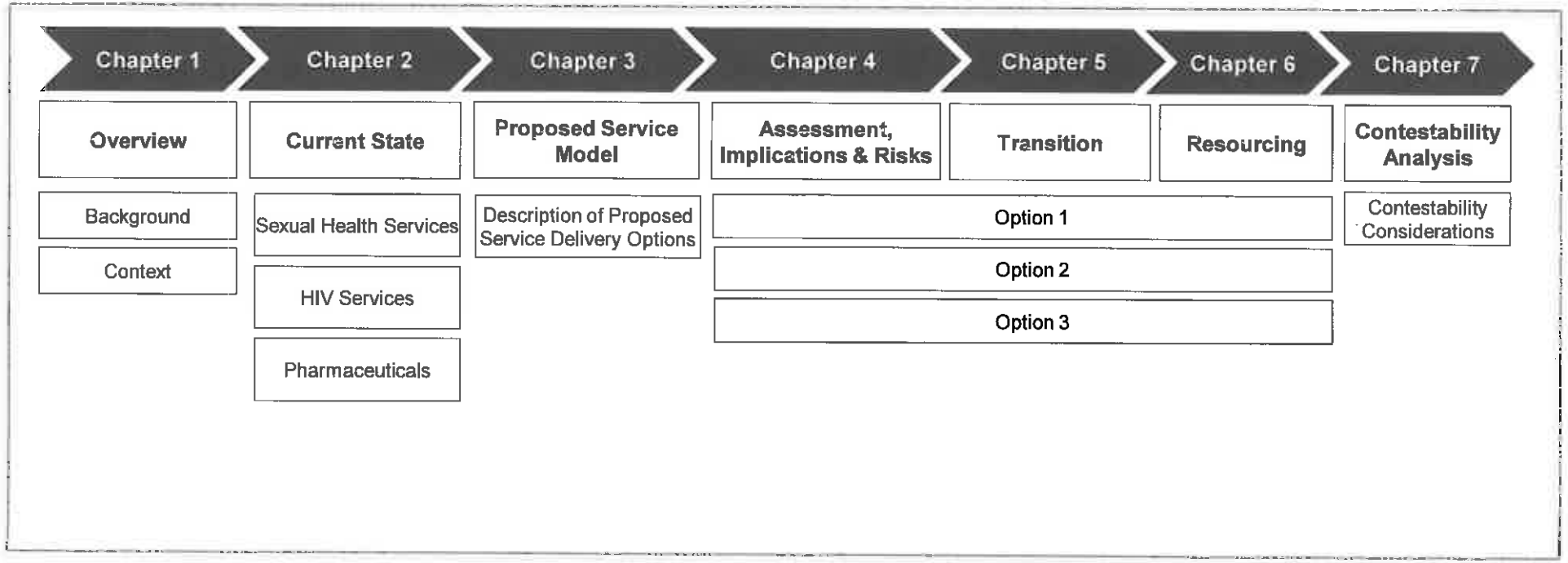


Introduction

Report Structure

The Figure 2 outlines the structure of this Report.

Figure 2: Report Structure



Chapter One

Overview

1 Overview

1.1 Background

Overview

The MNHHS, through the Sexual Health and HIV Service (SHHS) provide access to free multi-disciplinary services, including, sexual health checkups, testing treatment and management of sexually transmittable infections (STIs), testing and management of HIV/AIDS, post exposure prophylaxis (PEP) to suspected HIV infection, and Hepatitis B vaccination for people at risk. These services are currently provided through a number of facilities, including:

- Biala Community Health Centre
- Caboolture Community Health Centre
- Redcliffe Community Health Centre
- Pine Rivers Community Health Centre
- Hot House Indooroopilly (Youth Service).

The method of accessing the services described above is primarily through GP and self referral (walk-ins). Appointment clinics are also conducted.

On the 28th February 2013, the MNHHB considered a change in service delivery model for the SHHS, whereby non-complex STI services and management of Stable HIV patients are dealt with in the primary care sector.

Under the service delivery model under consideration, the SHHS would retain the specialist care of HIV patients which cannot be provided in the primary health care sector. These services include:

- Diagnosis and management of STI on named referral from a GP or Nurse Practitioner (complex STIs)
- Testing and management of newly diagnosed HIV patients until clinically stable (temporarily unstable)
- Long term treatment of clinically unstable HIV patients (chronically unstable)
- Ongoing management of people with HIV monitored under 'Protocol' conditions (chronically unstable)
- PEP to suspected HIV infection.

Furthermore, based on this reduction in service provision, the proposal considered by the Board was that the workforce currently staffing the SHHS be reduced to:

- 1 FTE Medical Officer
- 4 FTE Nurses
- 0.5 FTE Psychologist
- 0.5 FTE Pharmacist
- 0.5 FTE Administration Officer
- 0.5 FTE Medical Officer (Syphilis Register)
- 1 FTE Nurse (Syphilis Register)
- 1 FTE Epidemiologist
- 0.5 FTE Nurse (contact tracer)

Queensland Health advised, following the 28 February 2013 Board Meeting, the proposed service model was revised and an announcement made 20 March 2013 to staff that there would be no change to the HIV service (which required further consideration and consultation) and changes to the sexual health service would be progressed. During the following week there was increased media coverage and feedback which led to the announcement by the Board Chair on 28 March 2013 that there will be no change to the HIV service, a comprehensive service would continue within Metro North and a review undertaken to ensure the service is appropriate.

1 Overview

1.2 Context

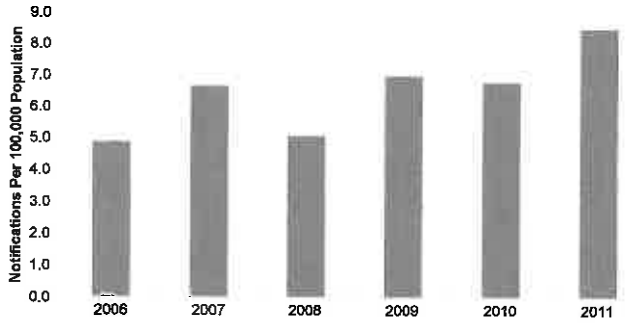
HIV incidence and prevalence

The HIV infects cells in the immune system and the central nervous system. In particular, they attack the T helper lymphocyte, which play a crucial role in the immune system. As the immune system becomes weaker and more damaged, individuals become more vulnerable to chronic, progressive illness, opportunistic infections and cancers, which eventually leads to a diagnosis of AIDS.

Since 1984, there have been 3,455 notification of new HIV diagnosis in Queensland. Most recently in 2012, there were 207 notifications of new HIV diagnosis. In 2011, there was 195 notifications. This equates to a notification rate of new HIV diagnosis in Queensland of 4.3 per 100,000 population. There has been a general increasing trend in both the number of notifications and the notification rate since 1998, when there were 86 notifications and a notification rate of 2.5 per 100,000 population.[1]

While the national rate of new HIV diagnoses stabilised between 2007 to 2010, Queensland rates continued to increase, exceeding the national average in 2010.[2] In 2011, MNHHS had the highest number of notifications of newly diagnosed HIV (74) and the highest notification rate in Queensland (8.5 per 100,000 population)[3] (Chart 1).

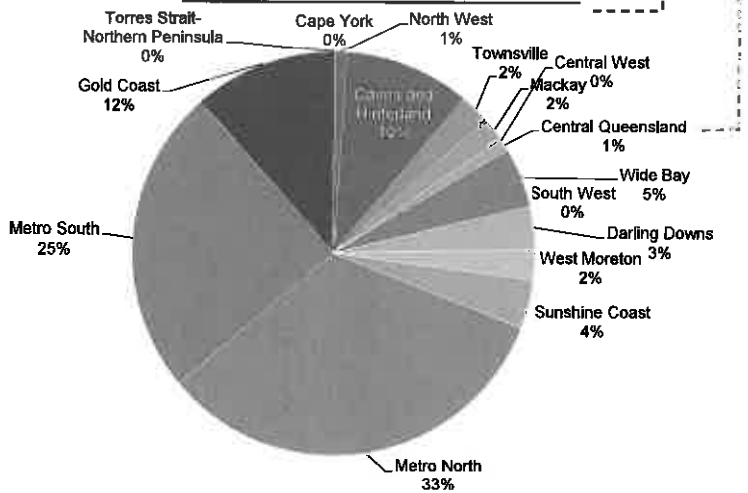
Chart 1: Notification rate of new HIV diagnoses in Metro North (per 100,00 population), 2006-2011



Source: 2011 HIV/ AIDS Report: Epidemiology and Surveillance

Figure 3: Notifications of new HIV diagnoses by HHS, Queensland 2012

HHS	2012
Torres Strait-Northern Peninsula	0
Cape York	0
North West	2
Cairns and Hinterland	21
Townsville	5
Mackay	4
Central West	0
Central Queensland	2
Wide Bay	10
South West	0
Darling Downs	7
West Moreton	5
Sunshine Coast	8
Metro North	68
Metro South	51
Gold Coast	24
Queensland	**207**



Source: 2011 HIV/ AIDS Report: Epidemiology and Surveillance

1 Overview

1.2 Context

HIV incidence and prevalence

The majority of HIV diagnoses occur in general practice sexual health clinics, and not through s100 GPs. The Table 8 outlines the location of HIV diagnoses between January 2011 and March 2013.

Table 8: HIV Diagnoses by Facility, January 2011 to March 2013

Facility	Total
General Practice	182
High Case (s100) Load GPs	44
Hospital	41
Sexual Health Clinics	175
Mater	2
Not Stated	11
Grand Total	**455**

Source: Data extracted from NOCS April 2013

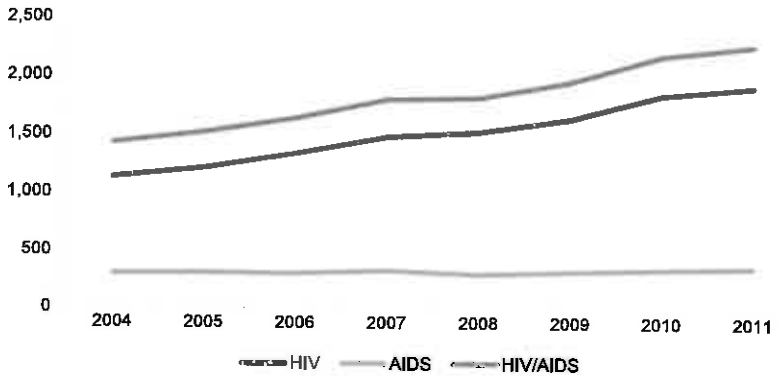
HIV treatment

Considerable advances in HIV treatment have been experienced. People with HIV are primarily treated with high active antiretroviral (HAART), which reduces the virus in the blood (the viral load). While not a cure for HIV, HAART can delay the progression to AIDS, improve the immune system and reduce complications. This has led to lower transmission risks and increased life expectancy of people with HIV/AIDS.[4] Due to these advances in treatment, HIV is now considered a chronic disease rather than a terminal illness.

HIV treatment (continued)

The introduction of a new on-the-spot screening test for HIV that can give results within half an hour will improve the early detection capability. This means people newly infected with HIV can quickly access treatment to delay its progress. Chart 2 shows that people living with HIV who access care in Queensland has increased over time.

Chart 2: People living with HIV and accessing care, Queensland, 2004-2011



Source: 2011 HIV/ AIDS Report: Epidemiology and Surveillance

The stigma and discrimination associated with HIV often results in patients creating stronger confidentiality protections around their treatment and care. Consequently, it is common for patients to seek treatment outside of their residential area. Furthermore, through stakeholder consultation it was revealed that the confidential location (non-hospital based) and visibility of the Biala service was a key reason for attendance at the service.

1 Overview

1.2 Context

STI prevalence and treatment

Evidence suggests a strong relationship between HIV infection and STIs, both in aggravating symptoms and the facilitation of HIV transmission. This has been cited as a key reason behind the integration of sexual health and HIV services.

Increases in the rates of STIs also indicate that people at risk may be becoming less vigilant about safe sex practices, thereby increasing the risk of HIV transmission. Furthermore, the diagnosis of the STI can provide a valuable opportunity to provide further education on sexual health and their risk of HIV. In Queensland, the rates of chlamydia and syphilis are higher than the Australian average. This poses serious concerns given the strong link between STIs and HIV.[5] It must be noted that improvement in surveillance systems and screening practices has contributed to the increase in STI notifications.

The incidence of STIs including chlamydia, gonorrhoea and syphilis has been trending upwards in Queensland over the last two decades. The chlamydia notification rate increased from 6,477 to 18,843 notifications between 2002 to 2012. This represented an increase from 170 to 411.4 notifications per 100,000 population. In the same period, gonorrhoea increased from 27.4 to 58.9 notifications per 100,000 population, while syphilis increased from 3 to 7.2 between 2004 and 2012 (Table 9 and Chart 3).

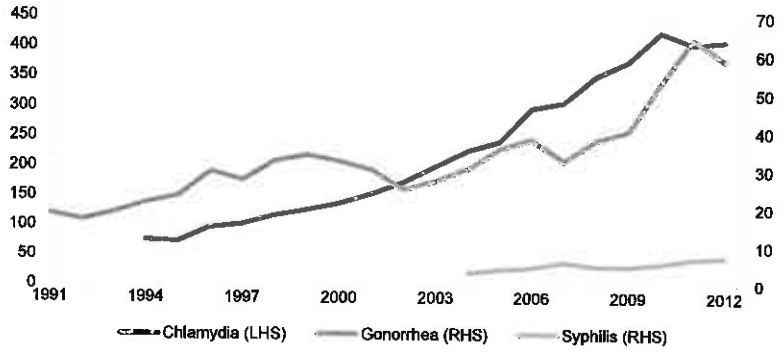
In most cases, chlamydia, gonorrhoea and syphilis can be prevented by the use of condoms with a water based lubricant. Treatment usually involves a course of antibiotics, or penicillin in the case of syphilis.

STI prevalence and treatment

Table 9: Notification rates of STIs by state, 2012 (per 100,000 population)

	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Aust
Chlamydia	350.9	291.6	1,117.80	411.4	292.6	350.4	352.8	502.5	363.8
Gonorrhea	25.2	56.5	677.6	58.9	28.9	6.9	43.6	90.2	60
Syphilis	3.8	6.9	6.5	7.2	7.5	2.7	8.5	3.5	6.9

Chart 3: Notifications of new STIs, Queensland 1991-2012



STIs are treated more frequently in general practice. However, few people attending their GP have STI tests, and frequent STI testing of some high-risk populations in general practice has yet to be achieved.[6] Reasons identified for low STI testing in general practice include: doctors concerns about confidentiality, time restrictions, poor history taking skills and patient embarrassment.[7]

Source: DoHA, National Notifiable Diseases Surveillance System

1 Overview

1.2 Context

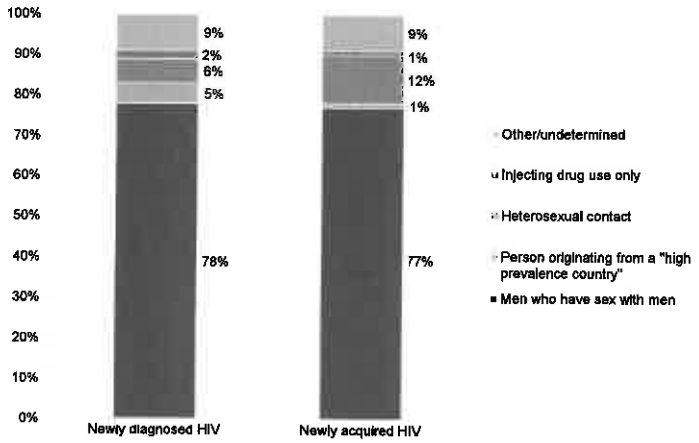
HIV among different population groups

The *Australian Government's 6th National Strategy on HIV 2010-2013* identifies a number of priority population groups, including people living with HIV, gay men and other men who have sex with men, Aboriginal and Torres Strait Islander people, people from (or who travel to) high prevalence countries, sex workers, people in custodial settings and people who inject drugs.

Men who have sex with men

HIV continues to primarily occur through sexual contact between men. Between 2006-2011, men having sex with men accounted for 78% of newly diagnosed HIV cases, and 77% of newly acquired HIV.[8] Chart 4 shows HIV diagnoses by HIV exposure in Queensland in 2011.

Chart 4: HIV diagnoses by HIV exposure, Queensland, 2011



Source: Queensland Health, 2011 HIV/AIDS Report: Epidemiology and Surveillance

Aboriginal and Torres Strait (ATSI) Islander people

There is no significant difference in the notification rate of new ATSI HIV diagnoses between people of Indigenous or non-Indigenous background. Between 2006-2010, the notification rate per 100,000 in Queensland for Indigenous people was 3.7, compared to 4.0 for non-Indigenous people. However, in 2012 there were 8 notifications of new ATSI HIV diagnoses, which is the highest since 2006.[9]

The *National Strategy* recognises that the potential remains for HIV to accelerate among this population group due to:

- The geographical, cultural and social circumstances of these communities
- Sustained high prevalence of STIs in many remote and very remote communities
- The over-representation of Aboriginal and Torres Strait Islander people in prisons and juvenile detention
- Limited access to culturally appropriate services, including primary healthcare
- Higher rates of injecting drug use and sharing of injecting and other equipment.[10]

People from CALD backgrounds

In Queensland, 30% of total notifications of new HIV diagnoses in Queensland were not recorded as Australian-born in 2011. Of which, 19 were born elsewhere in Oceania (mainly Papua New Guinea and NZ), and a further 18 born in Europe, 9 in Asia, 7 in sub-Saharan Africa, and 6 in other high prevalence countries.[11]

The *National Strategy* identified that spread of HIV among people who are from, or who travel, countries with high HIV prevalence is increasingly problematic.

1 Overview

1.2 Context

Government Environment

Core Obligations

In 2011, the Council of Australian Governments signed the National Health Reform Agreement, which affirms the responsibility of the Commonwealth Government for coordinating GP and primary health care services in the community to improve patient care. The Agreement sets out that States work cooperatively with the Commonwealth in the implementation and ongoing operation of the Commonwealth's primary health care initiatives.

For HIV/AIDS and sexual health care, the area previously fell under the National Public Health Outcome Funding Agreement, meaning that public health included all communicable and non-communicable diseases. Under the most recent National Health Reform Agreement, public health activities are funded by the Commonwealth Government, but States have full discretion over the application of public health funding to the outcomes set out in the National Healthcare Agreement (NHA). One of the outcomes under the NHA 2013 is reducing preventable deaths, which includes deaths from sexually transmissible diseases and HIV/AIDS.

HIV/AIDS and STI strategy in Australia

The *United Nations AIDS Political Declaration on HIV/AIDS* recommended six global targets, including universal access to testing and treatment (including ART and rapid testing), as well as reducing HIV through sexual transmission and injecting drug users by 50%.

In line with the *UNAIDS Declaration*, the *Australian Government's 6th National Strategy on HIV 2010-2013* made commitments to reduce the transmission of, and morbidity and mortality caused by HIV and to minimise the personal and social impact of HIV. It set out six key priority action areas, including prevention, diagnosis and testing, treatment, health and wellbeing, human rights legislation and anti-discrimination, surveillance and research.

HIV/AIDS and STI strategy in Australia (continued)

This is mainly through increasing the proportion of people receiving ART (especially those with undetectable viral load) and decreasing the number of people with undiagnosed HIV infection. In addition, the Strategy specifically notes that "*everyone in Australia should have access to high-quality HIV healthcare and appropriate treatments should they need it*".

The NSW, Victorian and Queensland Governments have all included, in their respective state-based HIV strategies:

- A commitment to increase access and help improve the frequency and regularity of HIV testing, as a way to reduce onward transmission of HIV
- Introduction of rapid HIV testing, and at the same time, reduce late diagnosis of HIV
- A target of achieving 90% of people with HIV taking ART treatment, which requires HIV testing to be well targeted, people with HIV are provided with adequate information about the benefits and impact of treatment, and to link them to appropriate care.

Implications for service delivery

The primary objectives of the *UNAIDS Declaration* (towards zero new HIV infections, zero discrimination and zero AIDS-related deaths) is prevention and treatment. New HIV transmissions can be prevented via more frequent and regular testing (especially for vulnerable and at-risk groups), as well as introduction of the rapid testing method in Australia. AIDS related deaths require access to treatment early in the diagnosis and support and allied health services to ensure treatment and medication compliance (particularly for people living with HIV who have other co-morbidities).

These targets are likely to increase demand for HIV-related clinical services in these states. If gaps in the service delivery model arise, this will have far-reaching and counterproductive consequences for HIV/AIDS direction in Australia. In particular, there would be increased transmission risk as a result of reduced testing, as well as non-compliance with medications and treatments. This will increase both the incidence and the prevalence of HIV/AIDS, increasing the need for expensive treatments.

1 Overview

1.2 Context

Models of care

The *National Strategy on HIV* supports a holistic and preventative approach to HIV treatment and wellbeing. The Strategy recognises that services should respond to the needs of people living with HIV in the mainstream health sectors as well as in the HIV-specific sector, including those delivered in community settings. Access to primary care services with general HIV awareness should be combined with specialist HIV general practice and tertiary care to achieve a holistic model of care for people living with HIV.

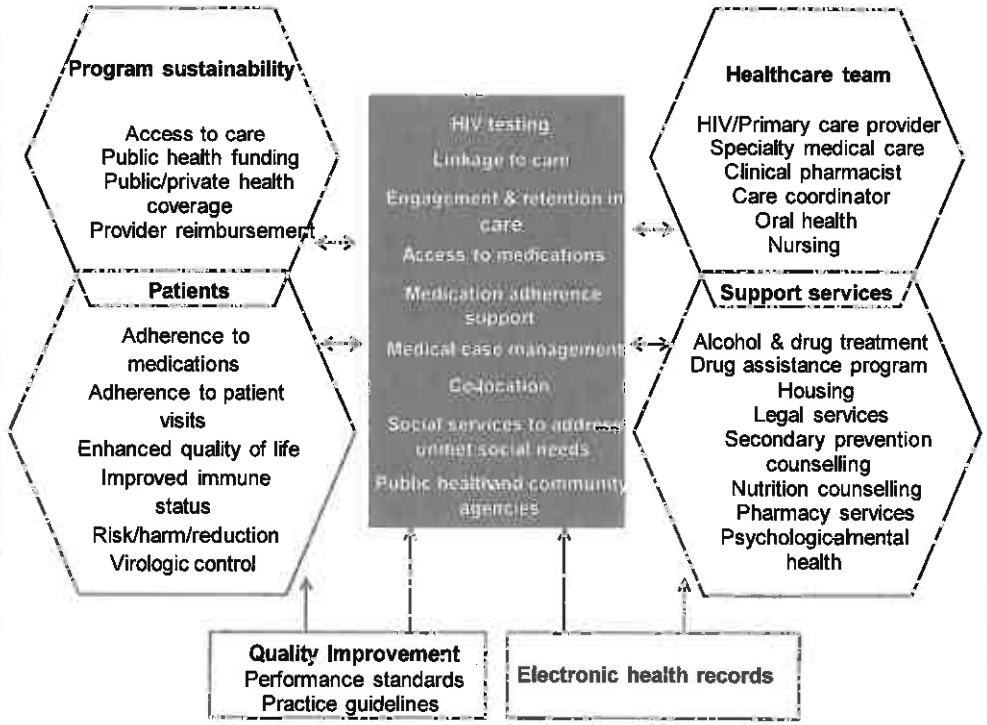
With the availability and success of ART, AIDS related mortality is increasingly uncommon. However, with a longer life expectancy, HIV/AIDS patients have increasingly more complex health problems due to treatment side effects and the psychological effects of living with a chronic illness, and sometimes with associated issues of poverty, social isolation and mental health. This has meant patients are increasingly using hospital outpatient, GPs and community services, which calls for better integration and coordination of health services for HIV patients.[12] Figure 4 shows an example of an integrated care model for HIV.

The Victorian Government initiated a project to develop an integrated service model for HIV clinical services in 2006. The aim was to provide care to people with HIV that covers all parts of the health system, including acute and non-acute care, mental health services, sexual health, and home and community care.[13]

NSW adopted a similar model, recognising that patients with HIV usually have complex needs with a range of co-morbidities such as mental health issues, drug and alcohol use and sexual health issues. As such, this calls for HIV services that are well integrated with other services in the health care spectrum.[14]

Western Australia, South Australia and Queensland have also adopted integrated service models to an extent, but focusing more on maximising the role of GPs in HIV management and HIV "troubleshooting".[15]

Figure 4: Example of an integrated care model



Source: Desert AIDS Project 2013 (USA based Model)[16]

Chapter Two

Current State

2 Current State

2.1 Sexual Health and HIV Service Overview

The Diagram below outlines the structure of Chapter Two, Current State.

2.1	Sexual Health & HIV Service
A	Overview
B	Geographic Analysis
C	Patient Cohorts

2.2	Current Sexual Health Services
A	Facilities
B	Patient Activity Analysis
C	Geographical Analysis

2.3	Current HIV Services
A	Facilities
B	Patient Classification
C	Patient Activity Analysis
D	Geographical Analysis
E	Service Profile
F	Workforce Profile
G	Research Activities
H	Patient Revenue
I	Service Network Analysis

2.4	Pharmaceutical Analysis
A	S100 HSD Program
B	QH Pharmacy Management
C	Utilisation
D	PBS Reimbursement
E	Inventory Management
F	Key Considerations

2 Current State

2.1 Sexual Health and HIV Service Overview

A. Overview

The SHHS currently provides a combined sexual health and HIV service. This service is considered to offer a comprehensive range of services including: sexual health checks, testing and management of STIs, PEP and HIV diagnosis and management. Co-located within the Biala Community Health Centre is the Alcohol & Drug Treatment Services and the Indigenous and Homeless Outreach Community Team. This is consistent with the health needs of people living with HIV in particular, as the challenges / co-morbidities of many people living with HIV require that services are combined with other services, especially mental health and drug and alcohol services.

Furthermore, there is evidence to suggest that most STIs act as a co-factor in the transmission of HIV. Hence, testing and management of STIs is a key component of both delivering care to HIV patients and preventing HIV. The transfer of non-complex STI treatment to the primary care sector, disaggregates HIV services from sexual health. Whilst the scope of this review is focused on HIV services and complex STIs, the risks and implications of transferring non-complex STIs will need to be determined.

The present service delivery model, in its broadest respect is outlined in Figure 5 below. As illustrated there are various service providers involved in the care of people living with both HIV and STIs.

Primary Care - There are currently 12 (including GPs employed within Biala) s100 General Practitioners (GPs) in the Brisbane metropolitan area which provide care and prescribe ARTs for people living with HIV. It must be noted that not all s100 GPs are full time equivalents (FTE) and they are primarily located within three practices, Gladstone Road Medical Centre, Stonewall Medical Centre and Central Brunswick Medical Centre. It has been reported that most s100 GPs in the Brisbane metropolitan region have reached capacity and are unable to take on additional patients. Whilst s100 GPs can prescribe and manage the s100 medications, it is required that they are mentored by a HIV specialist. Currently, the majority of s100 GPs are mentored by medical specialists within the Biala service. This mentoring role of the Biala Service also extends to the broader GP workforce with the service receiving numerous phone calls requesting advice on the management of both HIV and STIs. GPs have reported this specialist advice provided via telephone is a key resource to effectively managing STIs and HIV through the primary care sector.

MNHHS Infectious Diseases & Immunology Units – This service provides acute inpatient and ambulatory care to people living with HIV and its complications. The Royal Brisbane and Women's Hospital and The Prince Charles Hospital are the primary hospitals providing these services in the MNHHS.

NGOs – There are various NGOs which provide support services to people living with HIV, including counselling, consumer advocacy, nutritional and dietary advice. There are also key NGOs which directly provide STI testing and management service. The primary provider in Queensland for this service is Family Planning Queensland. Further detail on the NGOs involved in the provision of HIV services are included in section 2.3l of this Chapter.

Figure 5: Current Service Delivery Model of the Brisbane Sexual Health & HIV Service

2 Current State

2.1 Sexual Health and HIV Service Overview

B. Geographic Analysis

All services within SHHS can be accessed by both self referral and via referral from other health providers. Whilst this enables a high degree of access for all populations requiring HIV and sexual health services, it has resulted in a wide range of patient cohorts accessing the services which do not necessarily reside in the MNHHS. As demonstrated by Figure 6 & 7, individuals attending The Sexual Health and HIV Service reside in a variety of areas across South East Queensland and areas of Central and Northern Queensland. As previously mentioned due to the confidentiality concerns it is common for HIV patients to seek care outside of their residential area. This contributes to the geographic spread of patients attending the service.

2 Current State

2.1 Sexual Health and HIV Service Overview

B. Geographic Analysis

Figure 6: Individuals Attending SHHS by Post Code (2012), Queensland

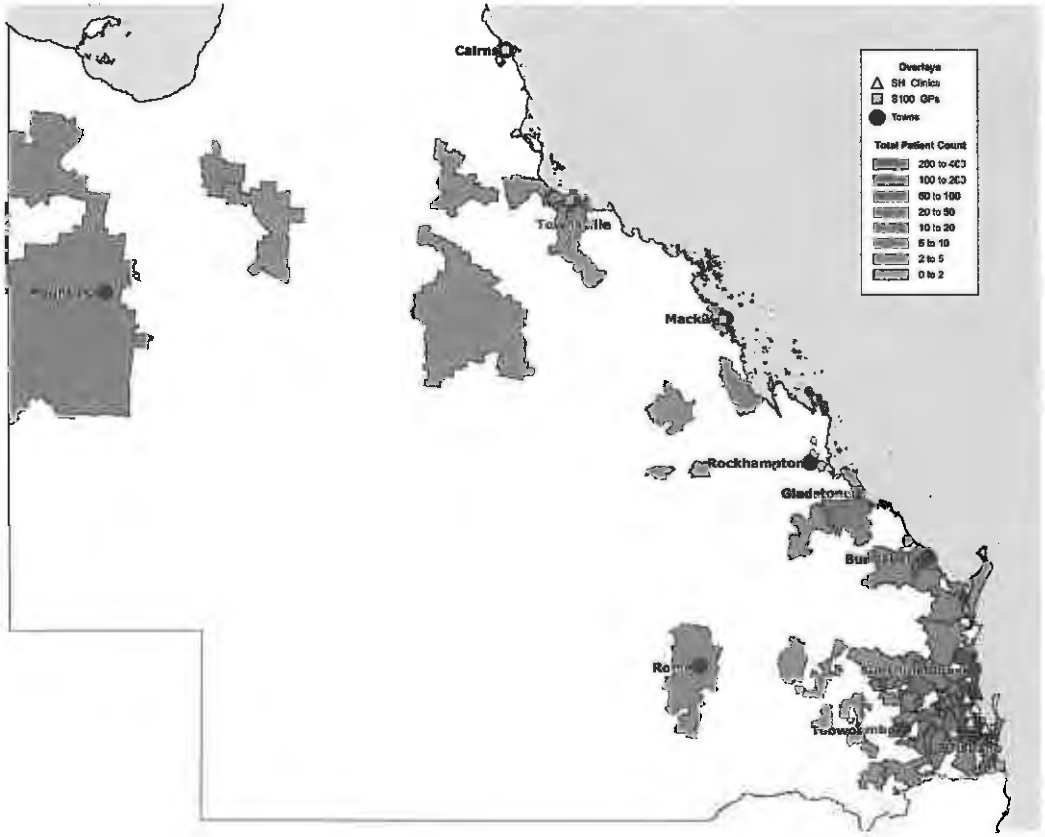
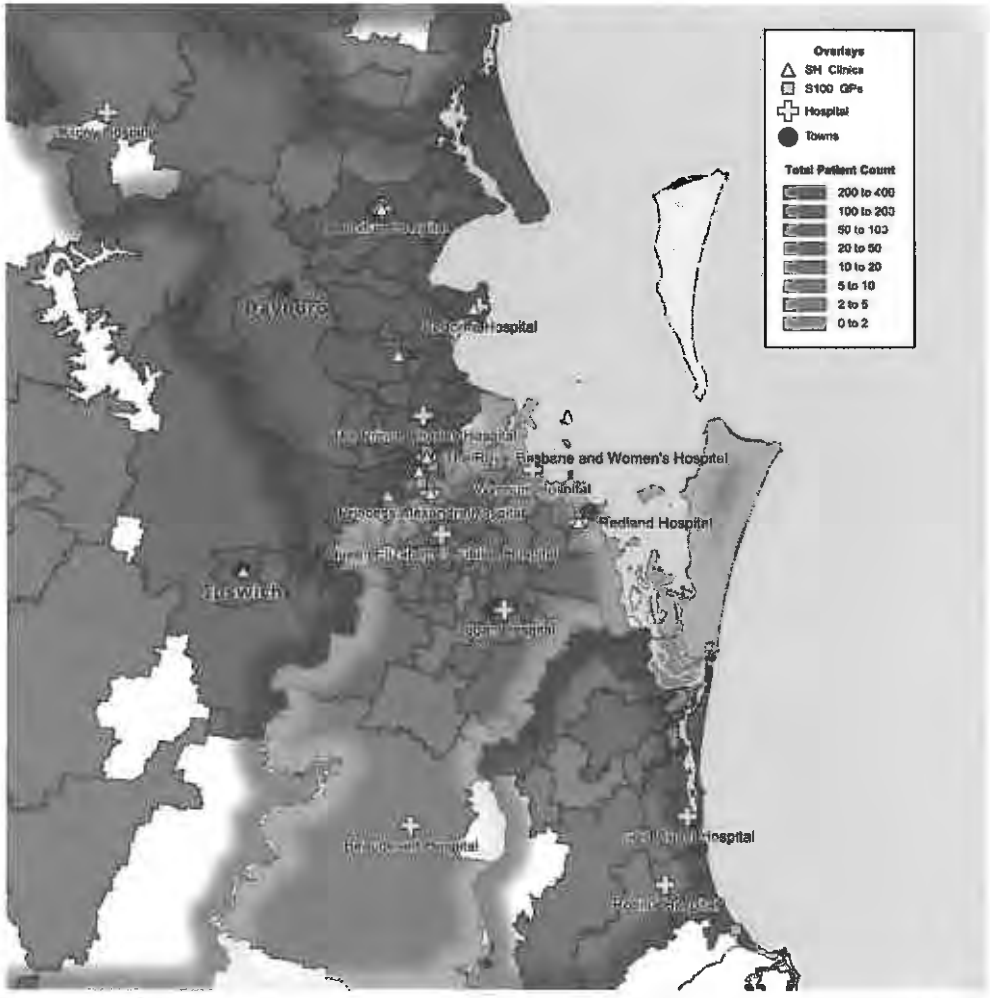


Figure 7: Individuals Attending SHHS by Post Code (2012), SEQ



2 Current State

2.1 Sexual Health and HIV Service Overview

C. Patient Cohorts

In addition to non-metro North HHS patients accessing the SHHS, there are a number of additional patient cohorts which require consideration when altering the service delivery model. These include socially complex patients and Medicare ineligible patients. Socially complex patients refer to those patients which for various psycho-social reasons require additional or specialist HIV care as they have difficulties 'self managing' their condition. Patients typically considered socially complex include, homeless populations, culturally and linguistically diverse populations, some sex workers, intravenous drug users and Aboriginal and Torres Strait Islander (ATSI) populations.

Medicare ineligible patients include those patients which do not hold a valid Medicare Card. These patients are typically overseas travellers from countries which do not have a reciprocal health care arrangement with Australia. Australia currently holds agreements with: the United Kingdom (UK), the Republic of Ireland, New Zealand, Sweden, the Netherlands, Finland, Belgium, Norway, Slovenia, Malta and Italy. The specific entitlements under each arrangement differ significantly. Due to data limitations an accurate quantification of this patient cohort was not possible.

Table 10 below, summarises and describes each of these patient cohorts discussed, and their implications for assessing the service delivery model.

Table 10: Summary of Patient Cohorts

Patient Cohort	Metro-North Patients	Non-Metro North Patients	Socially Complex Patients	Medicare Ineligible
Description	• Includes patients who reside within the Metro - North HHS	• Includes patients currently attending the SHHS which reside in other HHSs	• Homeless populations • Mental health patients • Commercial Sex Workers • Youth • ATSI • CALD populations	• Include overseas patients from countries which do not have reciprocal health care arrangements with Australia.
Implications for Service Delivery Model	• The appropriateness and capacity of alternative providers within the Metro North HHS will need to be considered.	• Availability and capacity of alternative providers in the respective HHSs • The most appropriate transfer mechanism for these patients needs to be determined.	• Patients' ability and willingness to attend alternative providers ie GPs • These patients often require additional support services and specialist care • The capability of GPs to provide comprehensive sexual health services needs to be assessed. • Alterations in service access and quality may result in decreased adherence with medication. This presents a public health risk.	• Patients without a Medicare Card may experience financial barriers to accessing Sexual Health and HIV Services which are MBS billed • Difficulties in access to care may present a public health risk.

2 Current State

2.2 Current Sexual Health Service

A. Facilities

The Sexual Health Service currently operates from 5 different facilities within the MNHHS. Biala Community Health Centre and the Redcliffe Community Health Centre, are the primary facilities in the MNHHS from which the outreach services to the surrounding locations are provided. These outreach clinics include, Caboolture, Pine Rivers and Hot House Indooroopilly. Table 11, provides an overview of these facilities and the services they provide.

Table 11: Sexual Health Service Facilities

	Biala Community Health Centre *Clinic 1 Sexual Health*	Caboolture Community Health Centre	Redcliffe Community Health Centre	Pine Rivers Community Health Centre	Hot House Indooroopilly
Sexual Health Service	• Sexual health checks • Testing, treatment and management of sexually transmissible infections (STIs) and blood borne viruses (BBVs) • HIV testing and initial diagnosis • Post-exposure prophylaxis • Counselling services • Sex worker checks • Hepatitis B vaccination for people at risk • Telephone advice and counselling • Free condoms and lubricant • Health education programs • Syphilis Register.			• Outreach service provided by Redcliffe Community Health Centre • General sexual health services • HIV PEP	• Information about safe sex, healthy sexuality, sexual orientation and relationships • Testing and treatment of STIs and BBVs • PEP for exposure to suspected HIV.
Clinics Provided	• 3 days of walk-in clinics per week (total 13.5 hours) • 2 days of appointment only clinics per week (total 12 hours)	• 1 day per week (nurse practitioner) (total 6 hours) • 1 day per month (medical officer) (total 6 hours)	• 5 days per week (nurse) (total 29 hours) • 1 day per week (medical officer)	• 1 day per week (nurse practitioner) (3.5 hours)	• 1 day per week (nurse practitioner) (3 hours)
OOS (2012)	8,550	193	1,452	167	87

2 Current State

2.2 Current Sexual Health Service

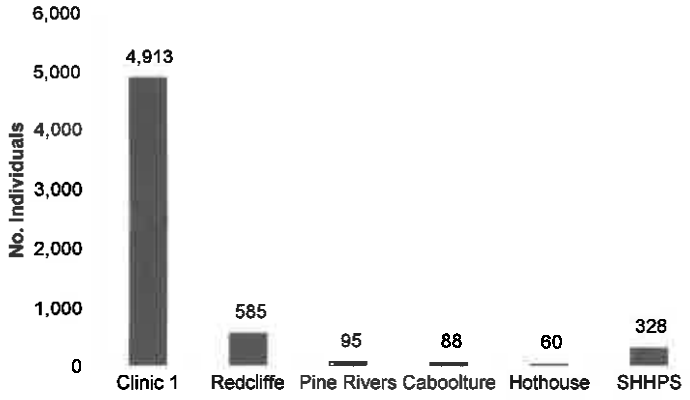
B. Patient Activity Analysis

Patient Demographics & Volume

In 2012, 6,069 patients attended the Sexual Health Services across the MNHHS. 70% of patients attended the primary service, Clinic 1, Biala Community Health Centre, where 8,550 consultations were provided. Analysis into the demographics of the patient cohort, reveals the majority of these patients were male (65%) aged between 25 and 34 years.

It must be noted that data for the Redcliffe and Caboolture Clinics includes patients attending for HIV care. Due to data limitations it was not possible to identify and remove these consultations.

Chart 5: No. Patients Treated in SHHS, by Clinic (2012)



Note: Individuals recorded in the SHHPS clinic are primarily HIV patients and transgender patients receiving counselling.

Chart 6 : No. Consultations by Age Distribution – Clinic 1 (2012)

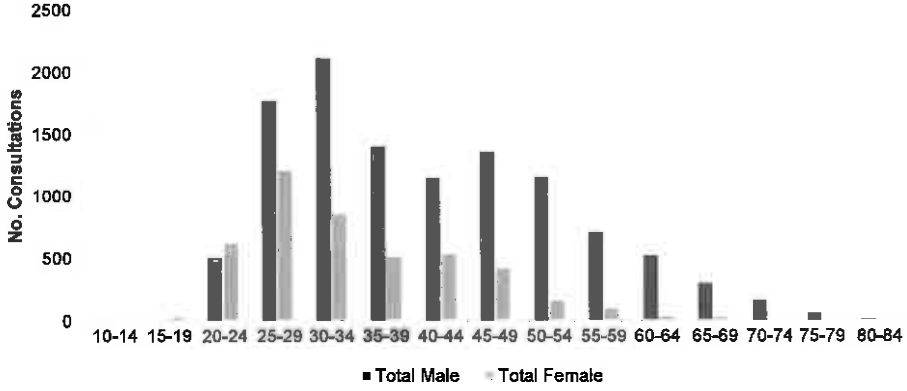
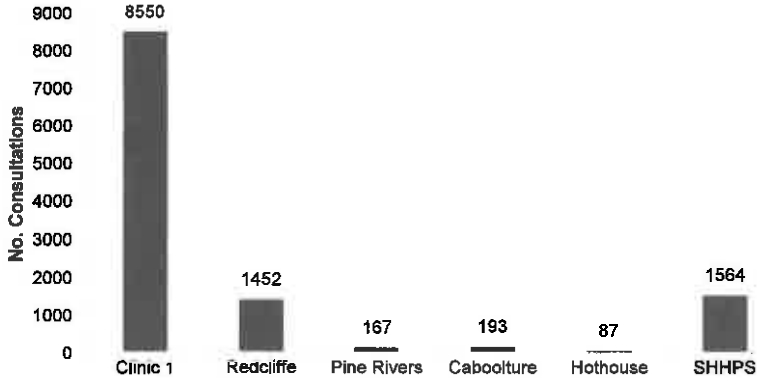


Chart 7: No. Consultations within SHHS, by Clinic (2012)



2 Current State

2.2 Current Sexual Health Service

B. Patient Activity Analysis

Patient Demographics & Volume

As illustrated in Chart 8 below, the majority of patients attending Clinic 1, only attend once (61%). However, this is primarily due to the provision of follow up tests results over the phone rather than through an additional consultation. Analysis into the clinical diagnosis of the three notifiable STIs, demonstrates that the most common case diagnosed and treated within Clinic 1 is chlamydia. It is noted by the Australian Society for HIV Medicine that the vast majority of chlamydia cases can be diagnosed and successfully treated in general practice. [17] It must be noted that Chart 9 only represents the notifiable STIs, there are a multitude of STIs and sexual health issues treated within Clinic 1 of Biala. Analysis of the referral source, reveals that a majority of patients attending Clinic 1, the primary sexual health service, are self-referred (57%). This is illustrated in Table 12.

Chart 8: No. Consultations Per Individual - Clinic 1 (2012)

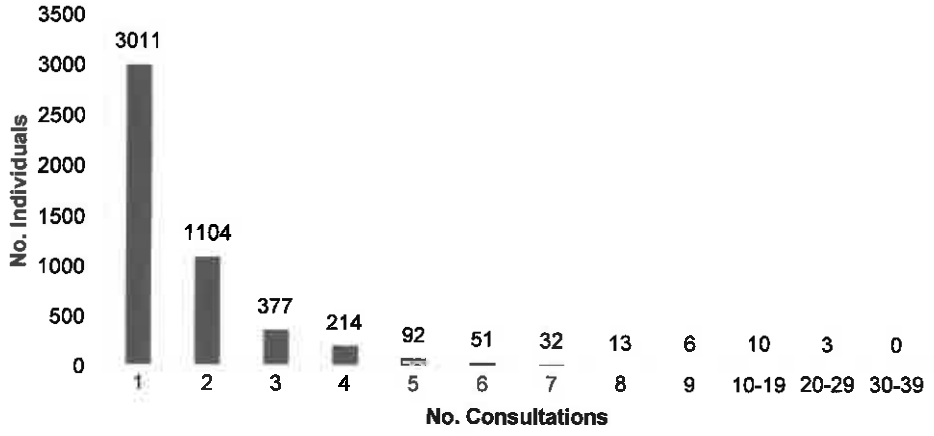


Chart 9: No. Clinical Diagnosis, Notifiable STIs (2012)

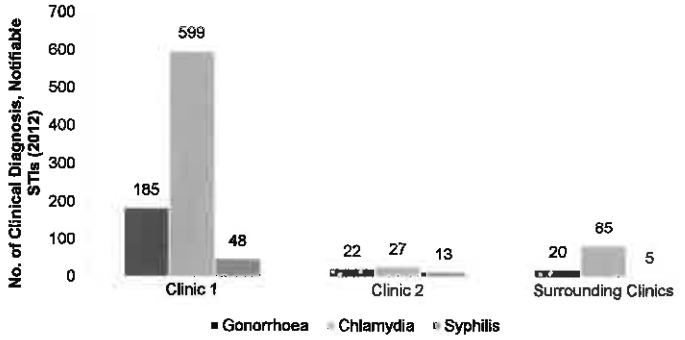


Table 12: No. Consultations by Referral Source – Clinic 1 (2012)

Referral Source	Clinic 1 Consultations	%
Clinic 1 Referral	48	1%
Clinic 2 Referral	8	0%
Correctional Centre Referral	0	0%
GP Referral	57	1%
Hospital Referral	15	0%
Other Health Professional Referral	15	0%
Other	4	0%
Self Referred	4862	57%
Sexual Health Clinic (other)	8	0%
Not Stated	873	10%
Contact Tracing	30	0%
Ongoing Patients	2631	31%
Total	**8551**	**100%**

Note: Data accuracy and quality limitations were raised in relation to the above table. This must be considered when interpreting the data presented above.

2 Current State

2.2 Current Sexual Health Service

C. Geographical Analysis

Patient Residence

Using the recorded postcode for individuals attending Clinic 1, geospatial maps were created to further analyse the geographic spread of patients attending Clinic 1. This also provides an indication of the distance patients currently travel for services. The majority of patients are currently travelling 20km or less to attend the Sexual Health Service within Biala, however there are individuals travelling up to 200km to access sexual health services. Figures 8, 9 & 10 illustrate the results of this analysis.

Figure 8: Distance from clinic to patient's postcode centre (km)

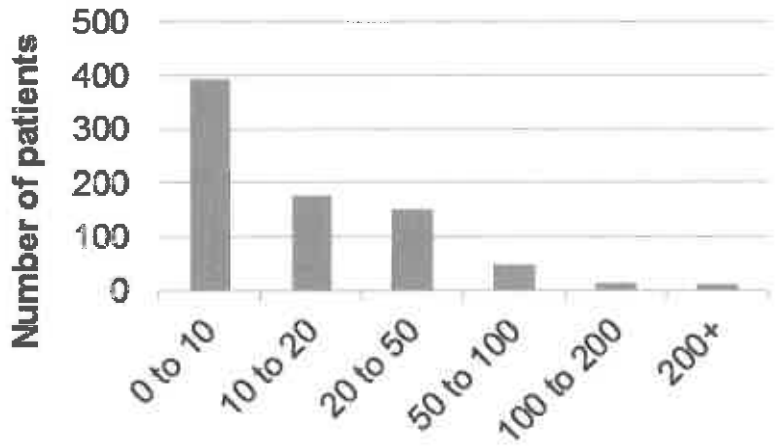
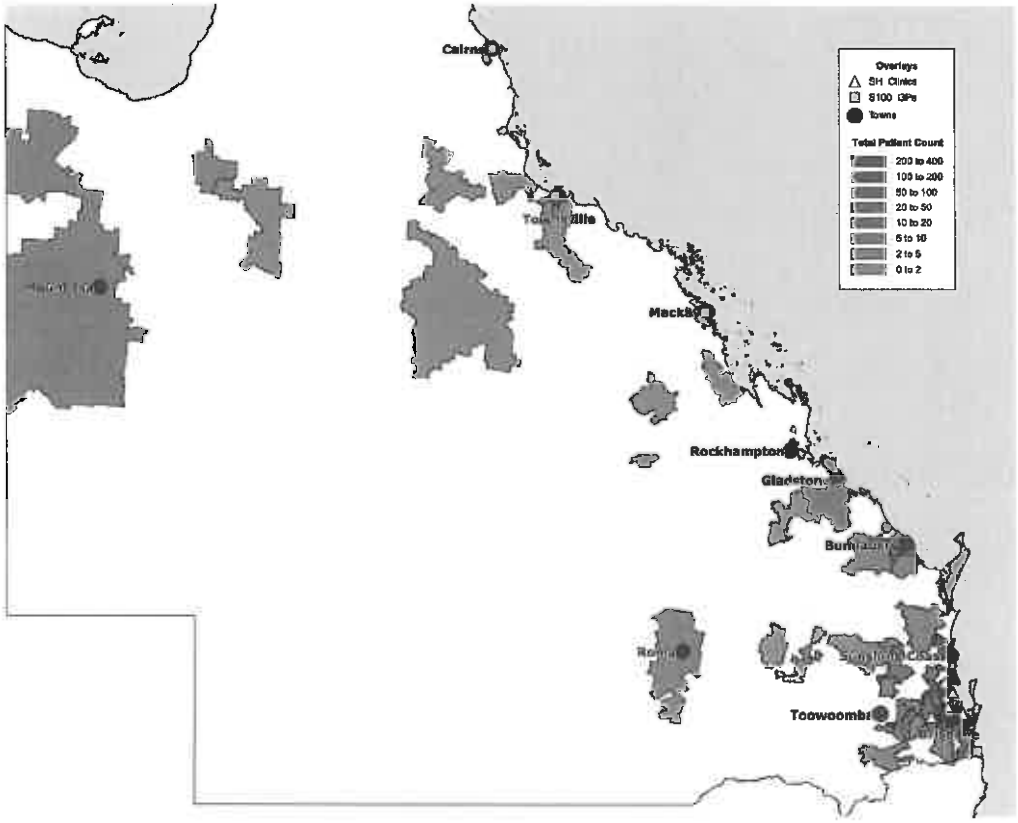


Figure 9: Individuals Attending Clinic 1, by Post Code (2012), Queensland



2 Current State

2.2 Current Sexual Health Service

Figure 10: Individuals Attending Clinic 1, by Post Code (2012), South East Queensland

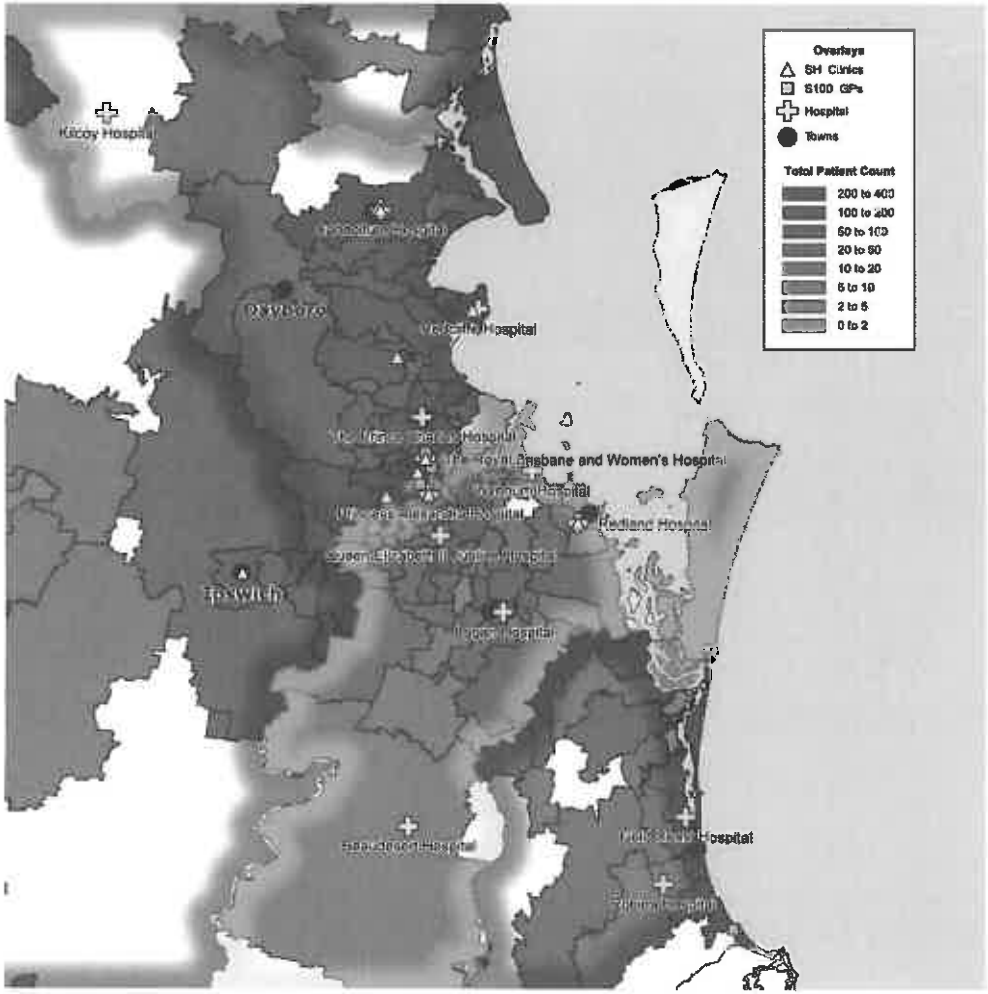


Table 13: Clinic 1 Patient Activity, by HHS

HHS	No. Patients (2012)	OOS (2012)
Cairns and Hinterland	5	6
Central Queensland	12	14
Darling Downs-West Moreton	91	163
Gold Coast	65	110
Mackay	9	10
Metro North	2,291	4,145
Metro South	1,764	3,140
Mt Isa	<5	<5
South West	<5	10
Sunshine Coast-Wide Bay	49	73
Townsville	6	11
Torres Strait-Northern Peninsula	<5	<5
Not Stated	613	864
Total	**4,913**	**8550**

2 Current State

2.3 Current HIV Services

A. Facilities

The HIV Service currently operates from 3 different facilities within the MNHHS. Biala Community Health Centre and Redcliffe Community Health Centre, are the primary facilities in the MNHHS which provides outreach services to Caboolture. Table 14, provides an overview of these facilities and the services they provide.

Table 14: Facilities and services within the MNHHS

	Biala Community Health Centre *Clinic 2 HIV Management*	Caboolture Community Health Centre	Redcliffe Community Health Centre
HIV Service	• Testing and management of stable, temporarily unstable and chronically unstable HIV • Post-exposure prophylaxis • Counselling services	• Testing and management of stable, temporarily unstable and chronically unstable HIV • Post-exposure prophylaxis • Primarily a nurse led clinic	• Testing and management of stable, temporarily unstable and chronically unstable HIV • Post-exposure prophylaxis • Primarily a nurse led clinic
Clinics Provided	• 1-2 Nursing Clinics per day (5 days) (Total 36 hours per/week) • 1-2 Medical Officer Clinics per day (5 days) (Total 43.5 hours per/week)	1 day per week (nurse practitioner) 1 day per month (medical officer)	5 days per week (nurse) 1 day per week (medical officer)

2 Current State

2.3 Current HIV Services

B. Patient Classification

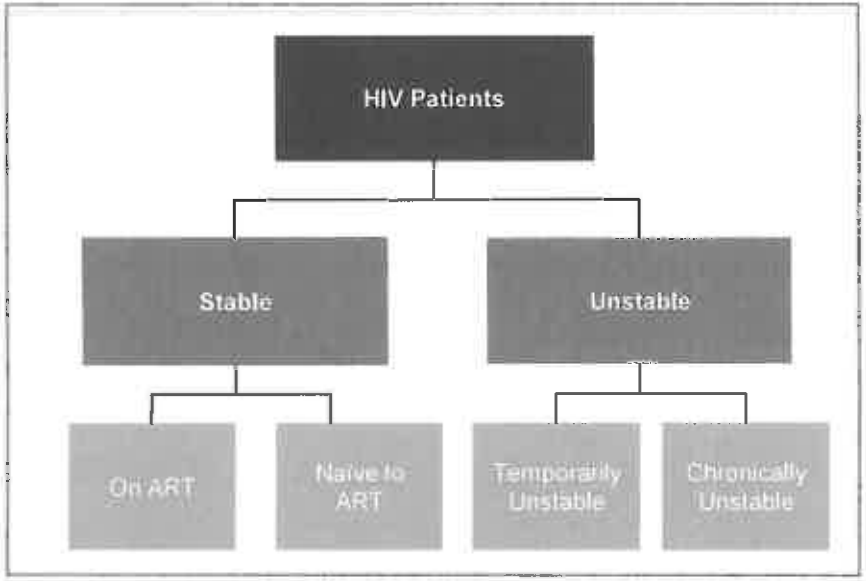
Critical to the analysis of HIV services, is the classification of the patient. HIV patients are classified as either Stable, Temporarily Unstable or Chronically Unstable. The patient classification has an impact on the clinical resources allocated, the care setting and the frequency of clinic attendance. Table 15 below provides a definition of each Patient Classification.

Table 15: Patient Classification Definitions

Patient Classification	Definition
Stable	Stable patients are self-managing and require limited clinical resources. These patients are physically and psychologically stable with no public health concerns. Stable patients may or may not be on ART.
Temporarily Unstable	These patients are newly diagnosed HIV patients or have a new health issue or co-morbidity. Note that newly diagnosed patients also include patients transferring from other services. Stable patients may become temporarily unstable for the following reasons: • Patients not on ART – CD4 decline, HIV symptoms, initiation of ART • Patients on ART – toxicity, dosage change, compliance problems and detectable viral load • All patients – New co-morbidity/ Increased CVD risk / SNAE, STI public health issue, mental health issue, substance use issue, latent tuberculosis treatment and personal 'crisis'.
Chronically Unstable	Patients who are currently not self-managing stable patients. This is due to multiple co-morbidities, psycho-social confounders or public health concerns. These patients require multidisciplinary care including nursing, psychology and medical and external partners. Patients under 'protocol conditions', are considered Chronically Unstable.

Source: HIV Models of Care Final Report 2012

Figure 11: Patient Classifications



Source: HIV Models of Care Final Report 2012

2 Current State

2.3 Current HIV Services

C. Patient Activity Analysis

Patient Demographics & Volume

As at April 2013, there were 738 people living with HIV which are treated through the Biala Community Health Centre and the surrounding clinics (Redcliffe & Caboolture). The majority of these patients (91%) are treated in Clinic 2 of the Biala Community Health Centre. In 2012, 3,874 consultations were undertaken in Clinic 2. Consistent with the epidemiological characteristics of HIV, most consultations conducted in Clinic 2 are for males aged between 35 and 50 years of age. Furthermore, 55% of males attending Clinic 2, have between 1 and 4 consultations per annum. A similar trend is noted for females attending Clinic 2, with 50% of patients having between 1 and 4 consultations per annum.

Chart 10: No. People Living with HIV and Treated by SHHS (April 2013)

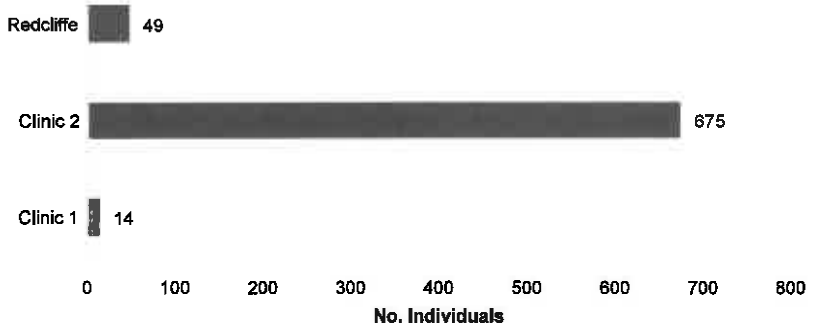


Chart 11: No. Consultations by Age and Gender – Clinic 2 (2012)

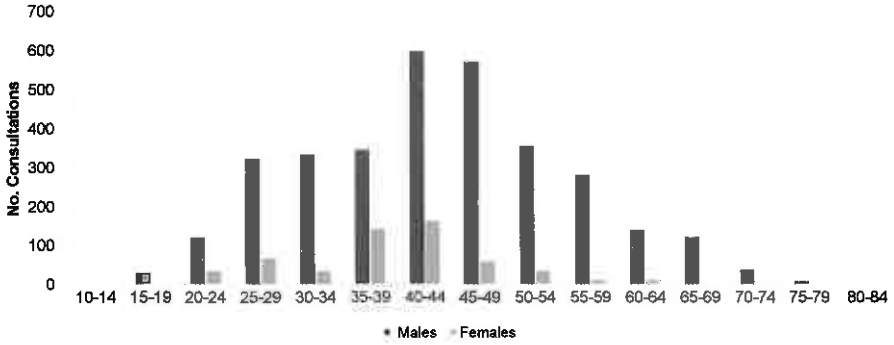
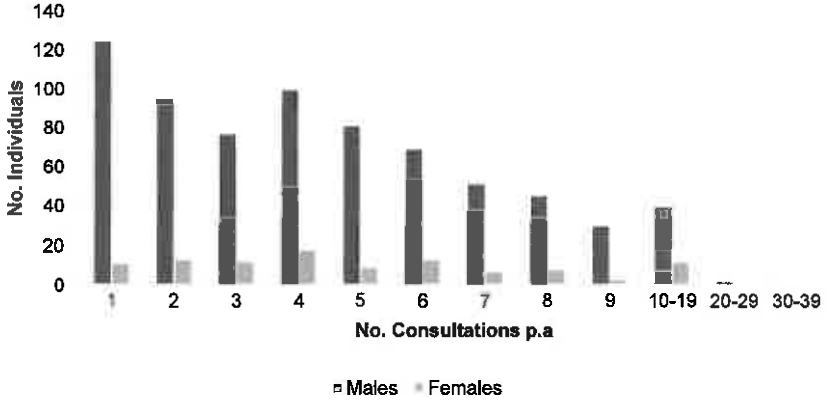


Chart 12: No. Consultations Per Individual, by Gender – Clinic 2 (2012)



2 Current State

2.3 Current HIV Services

C. Patient Activity Analysis

Patient Complexity

As previously discussed, people living with HIV can be categorised into three patient classifications which provides an indication of their clinical and social complexity. The patient classification is a key determinant of the clinical resources required to manage each patient, including: the number of consultations per annum, degree of multidisciplinary care provided, pathology tests ordered and the most clinically appropriate care setting. Analysis of the people living with HIV and attending the Biala Community Health Centre and Redcliffe Community Health Centre, revealed the majority (54%) of patients are considered temporarily unstable. Furthermore, Redcliffe Community Health Centre had the highest proportion of Chronically Unstable HIV patients (18%). Stakeholder consultation revealed the low socioeconomic status of this population contributes to an increase in the social complexity of patients.

Chart 13: No. People Living with HIV, by Patient Classification – Clinic 2 (April 2013)

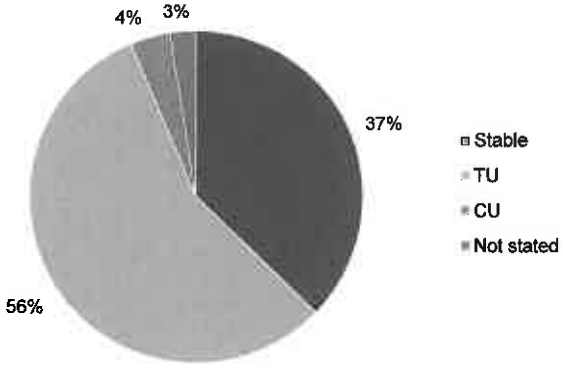


Chart 14: No. People Living with HIV, by Patient Classification – Clinic 1 (April 2013)

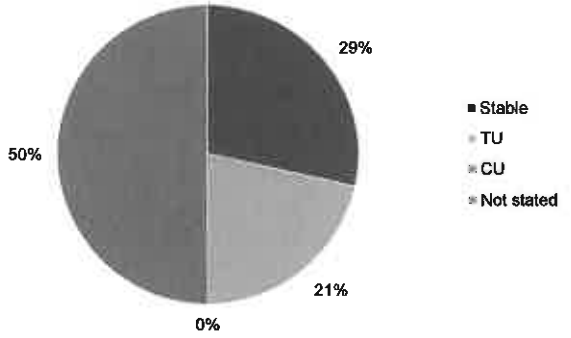
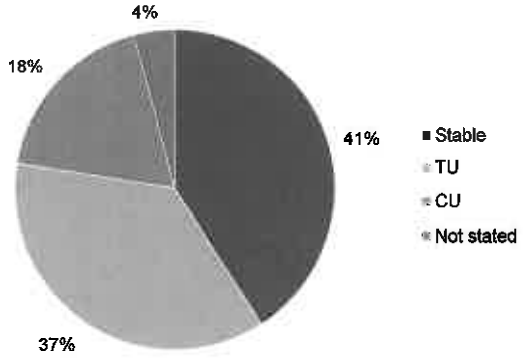


Chart 15: No. People Living with HIV, by Patient Classification – Redcliffe (April 2013)



Note: Data pertaining to the classification of patients is not audited for clinical accuracy. Furthermore, it is common for patients to change between patient classifications. This limitation must be considered when interpreting this data.

2 Current State

2.3 Current HIV Services

C. Patient Activity Analysis

General Practitioners

Health professionals within the Biala Community Health Centre note that a GP is a key element of providing efficient and effective care to people living with HIV. Furthermore, determining the proportion of existing clients of Biala who have a relationship with a GP, is a key component of transitioning to the proposed service delivery model. Staff within the Biala Community Health Centre have recently introduced a practice whereby, patients are encouraged to develop an ongoing relationship with a GP.

Whilst this practice has been enforced within the service, data limitations prevent an accurate analysis of the GP status of each HIV patient. It must also be noted that whilst patients may have a pre-existing relationship with a GP, it was commonly raised in consultation that people living with HIV, in some cases, do not discuss HIV related issues with their GP due to privacy concerns or embarrassment. Instead they will attend Biala for all HIV related issues. This is a further consideration when transitioning HIV care to the primary care sector.

2 Current State

2.3 Current HIV Services

D. Geographical Analysis

Patient Residence

The Biala Community Health Centre is located in Brisbane CBD, in close proximity to a major public transport centre. Furthermore, Biala is considered by numerous health professionals as a Brisbane wide service for HIV and sexual health care. It is also common for people living with HIV to seek care outside of their residential area due to patient privacy and anonymity reasons. These factors, contribute to a large number of non-Metro North HHS residents seeking care at the Biala Community Health Centre. As illustrated in Chart 16, 40% of patients treated in Clinic 2 reside in Metro South. Of which, 56% are temporarily unstable, which has implications for resource utilisation.

Chart 16: No. Individuals Attending Clinic 2 by HHS (April 2013)

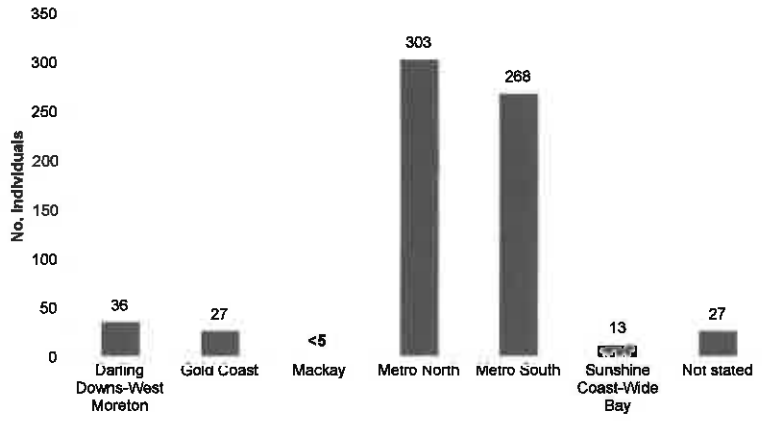


Table 16: No. Individuals Attending Clinic 2 by HHS and Patient Classification (April 2013)

	Stable	TU	CU	Not stated	Total
Darling Downs-West Moreton	13	21	<5		36
Gold Coast	9	17		<5	27
Mackay		<5			<5
Metro North	114	170	10	9	303
Metro South	96	152	14	6	268
Sunshine Coast-Wide Bay	7	5		<5	13
Not stated	12	15			27
Total	251	381	26	17	675

Note: It must be noted that the HIV patients attending the Redcliffe Clinic are not included in the table above, as all clients are from the Metro North HHS.

Using the recorded postcode for individuals attending Clinic 2, geospatial maps were created to further analyse the geographic spread of people living with HIV, which attend Clinic 2. This also provides an indication of the distance patients currently travel for services and their proximity to the current s100 GPs. The majority of patients are currently travelling 10km or less to attend the HIV Service within Biala, however there are individuals travelling up to 200km to access HIV services. Furthermore, all s100 GPs are located in the Brisbane CBD, despite a number of patients living with HIV residing in both the far northern and southern regions of Brisbane.

This analysis also indicates that the central location of the HIV service in the Brisbane CBD is adequate given the majority of people living with HIV reside within 10Km or less of the service. It is also noted that there is large cohort of patients living in the northern suburbs of Brisbane, mainly Redcliffe and Caboolture. This suggests outreach clinics in Redcliffe and Caboolture are required.

It is also evident from this analysis that a significant number of patients attend the Biala Service from other HHSs, particularly the Metro South HHS. It must be noted that it is common for patients to seek services outside of their residential area due to confidentiality reasons. Maintaining confidentiality is considered integral to patient care.

Figures 12, 13 & 14 on the subsequent page illustrate the results of this analysis.

2 Current State

2.3 Current HIV Services

Figure 12: Individuals Attending Clinic 2 by Post Code (2012), South East Queensland

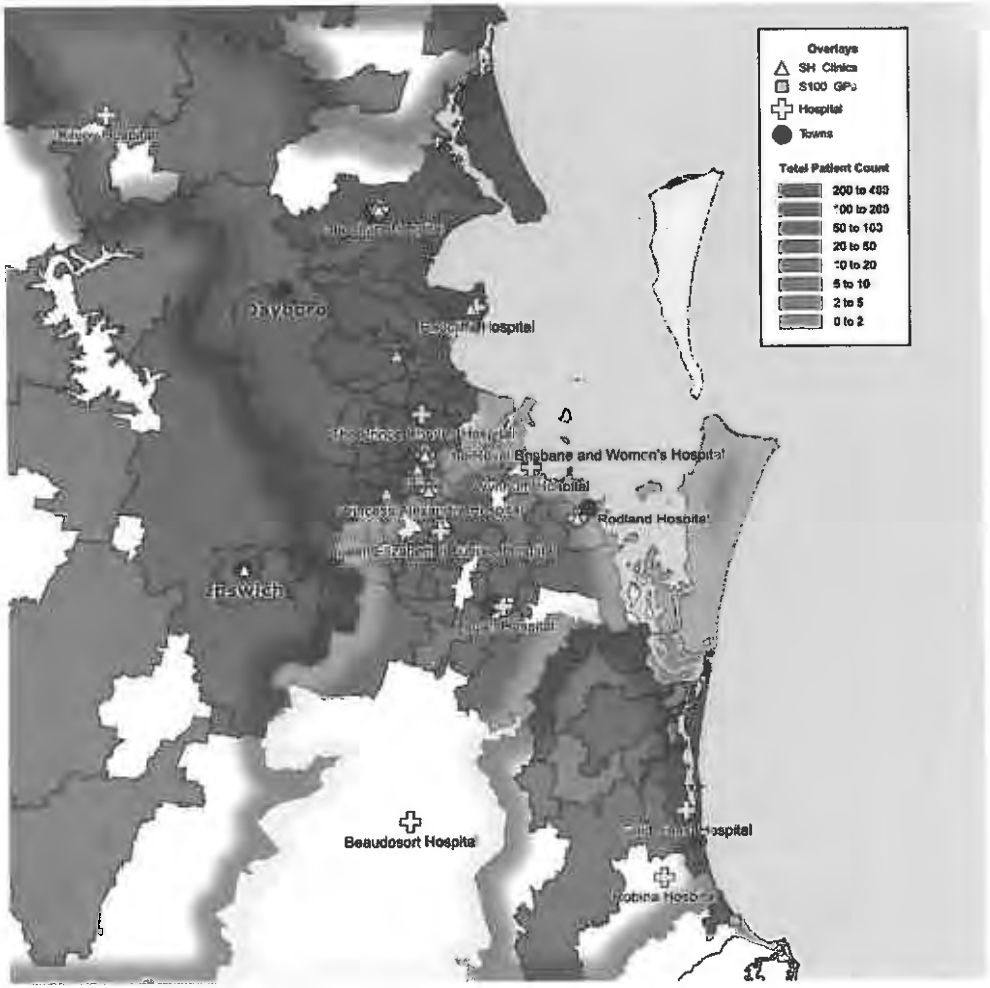


Figure 13: Distance from clinic to patient's postcode centre (km)

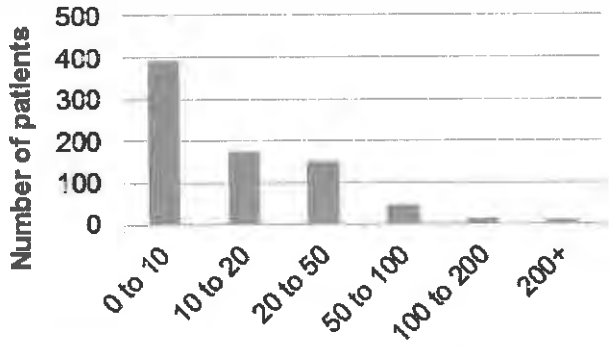
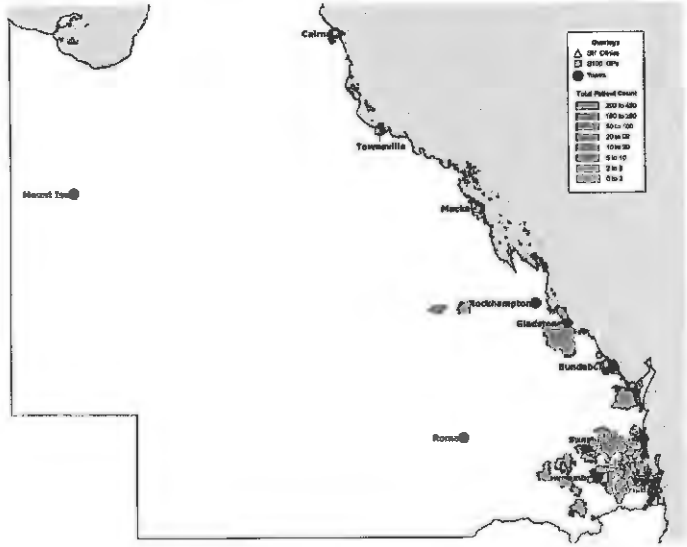


Figure 14: Individuals Attending Clinic 2 by Post Code (2012), Queensland



2 Current State

2.3 Current HIV Services

E. Service Profile

As previously mentioned the patient classification of people living with HIV is a key driver of the resources required to manage each patient. Hence, consideration of the processes and services required to manage each patient type is a critical step in determining the most effective allocation of resources and the most suitable care setting. There are a number of Clinical Guidelines which assist in standardising the care provided to people living with HIV along with contributing to providing best practice care. Guidelines utilised in the management of HIV within Biala, Redcliffe and Caboolture are outlined in Table 17.

Table 18 on the subsequent page, documents the services typically provided to HIV+ patients treated in Biala and the surrounding clinics. Services have been summarised according to the main components of patient management: consultations, processes, pathology and pharmaceuticals. It must be noted that the services and processes outlined in Table 18, are a summary of the care provided in the Biala service. Stakeholder consultations and the HIV Models of Care Final Report (2012) have informed this summary, however, actual services provided varies significantly based on the clinical needs of the patient.

The process required to manage 'protocol patients' is considered complex and is dependent on the behaviours and compliance of the patient. Given this complexity the complete process to manage 'protocol patients has been outlined in Appendix A and is based on the Queensland Health *Protocol for the Management of People Living with HIV Who Place Others At Risk.*

It must be noted that in addition to providing services to patients attending the Biala HIV service, and surrounding clinics, both pharmacists and medical officers in Biala receive numerous phone calls from local GPs and other health service providers. The nature of these phone calls primarily relates to queries on the management of HIV patients and complex STIs. GPs noted this access to specialist advice is a key resource to managing these conditions within the primary care sector.

Table 17: Summary of HIV Related Clinical Guidelines

Guideline	Purpose
Australian Society for HIV Medicine (ASHM) – *Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents*	Provide guidance to HIV care practitioner on the optimal use of antiretroviral (ARV) agents for the treatment of HIV infection in adults and adolescents in Australia. This is adapted from the guidelines utilised in the United States of America.
Queensland Health – *Protocol for the Management of People Living with HIV Who Place Others at Risk*	Describes the mandatory steps for the management of people whose behaviour may expose others to HIV infection.
Queensland Health – *HIV Models of Care Final Report (2012)*	This documents the Model of Care for patients with HIV treated within the Sexual Health and HIV Service in Brisbane and Redcliffe. This Model was developed by the HIV Models of Care Working Group.
Queensland Health - *Queensland Sexual Health and Clinical Management Guidelines*	A set of guidelines developed by the *Clinical Guidelines Editorial Committee* which outlines the best practice processes to managing sexual health conditions. In particular, it provides standardised steps to administering PEP.

2 Current State

2.3 Current HIV Services

E. Service Profile

Table 18: Summary of Services Provided to People Living with HIV

Component	Stable HIV Patients	Temporarily Unstable	Chronically Unstable	PEP
Consultations	• 2 Medical Officer Consultations p.a (on ART) • 3 Medical Officer Consultations p.a (naïve to ART) • 1 Nurse Consultation p.a	• 6 Medical Officer Consultations • 6 Nursing Consultations	• 4 Medical Consultations p.a • 12 Nursing Consultations p.a* • 2 Multi-disciplinary team consultations p.a	• 1 Medical Officer Consultation (initial) • 5 Nurse Consultations (follow-up care)
Processes	• Complete physical examination • Complete patient history – Co-morbidities – Sexual health – Pregnancy – Mental Health Review • Correspondence with other health professionals to manage the patients care	• Complete physical examination • Complete patient history – Co-morbidities – Sexual health – Pregnancy – Mental Health Review • Review results, reports from other providers (correspondence) • Apply/ authorise employment/ social support forms • Contract tracing • Information and education	• Complete physical examination • Complete patient history – Co-morbidities – Sexual health – Pregnancy – Mental Health Review • Review results, reports from other providers (correspondence) • Apply/ authorise employment/ social support forms • Contract tracing • Information and education • Multidisciplinary case management	• Assessed and triaged by Nurse • General health/ medication history • Risk assessment completed • Baseline tests ordered or results discussed • Information provided on sexual health and medications.
Pathology	• Viral Load, FBC, UE, LFT, CA, CD4, Syphilis Serology, Sexual health screen	• HIV Anti-body, FBE, UEG LFTs, CA (PO4), Lymphocyte subsets, HIV PCR RNA, ARV genotypic resistance testing, Syphilis serology, HAV IgG, HBsAg, AntiHBs, AntiHBc, HCV IgG, Sexual Health Screen		• HIV, Hepatitis A, B & C, Syphilis, LFT
Pharmaceuticals	• Review ART dosage • Prescribe ART if required	• Review ART dosage • Prescribe ART if required	• Review ART dosage • Prescribe ART if required	• PEP prescribed

Source: HIV Models of Care Final Report 2012

* Nursing consultations may be in the form of phone calls or other interventions required to manage the patient

2 Current State

2.3 Current HIV Services

F. Workforce Profile

Table 19: Workforce profile summary

Category	Position	FTE	Occupied FTE	Classification Level
		HIV Clinic - Biala		
Nursing	Nurse Unit Manager	1.0 FTE	1.0 FTE	Grade 7
	Clinical Nurse	3.0 FTE	3.0 FTE	Grade 6
	Nurse Practitioner	1.0 FTE	1.0 FTE	Grade 8
	Research Clinical Nurse	1.0 FTE	1.0 FTE	Grade 6
Allied Health	Clinical Psychologist	1.0 FTE	-	HP 5
	Psychologist Senior	1.0 FTE	1.0 FTE	HP 4
	Psychiatrist	0.1 FTE	-	
	Clinical Pharmacist	1.0 FTE	1.0 FTE	HP 4
	Pharmacy Assistant	1.0 FTE	1.0 FTE	OO3
	Temporary Pharmacists	-	-	
Medical	Director	1.0 FTE	1.0 FTE	
	SMO	2.7 FTE	2.7 FTE	
	VMO	0.2 FTE	0.2 FTE	
Administration	Administration Officer	2.0 FTE	1.0 FTE	AO3
	Health Planning Officer	1.0 FTE	1.0 FTE	AO5
		Redcliffe		
Nursing	Nurse Unit Manager	1.0 FTE	1.0 FTE	Grade 7
	Clinical Nurse	2.0 FTE	1.0 FTE	Grade 6
Total		**20.0 FTE**	**16.9 FTE**	

Note: It must be noted that the workforce profile for the Redcliffe Clinic includes the FTE required to manage the sexual health services provided. The specific FTE of the temporary pharmacists varies significantly as they employed on a casual basis to assist with the clinical trials as required.

2 Current State

2.3 Current HIV Services

F. Workforce Profile

The Table 20 below provides an overview of the roles and responsibilities of each of the positions currently employed for the HIV Clinics. This table has been informed by Stakeholder Consultations and review of position descriptions.

Table 20: Description of Roles and Responsibilities

Category	Position	Role and Key Tasks
		Clinic 2 Biala
Nursing	Nurse Unit Manager	The NUM is accountable at an advanced practice level for the coordination of clinical practice and the management of nursing staff within Clinic 2. Key responsibilities: • Include monitoring and review of the budget for nursing services and management of the nursing staff • Clinic roster development • Maintaining professional standards of practice and ensuring clinical practice is compliant with the relevant guidelines.
	Clinical Nurse	• Accountable for the provision, HIV assessment, screening, treatment and intervention services that address the health needs of HIV clients • Nursing staff triage each patient and undertake the preliminary assessment before appointment with the Medical Officer • Clinical Nurses undertake the annual assessment for stable HIV patients
	Nurse Practitioner	• Role is focused on providing sexual health services • Assists in monitoring stable HIV and managing unstable HIV in partnership with the Medical Officers • Management of complicated/ unresolved STIs • Prescribe starter pack of PEP • Staffs the outreach clinics at Indooroopilly, Pine Rivers, Caboolture.
	Research Clinical Nurse	• Responsible for coordinating clinical trials and creating and maintaining a high quality clinical research environment • Liaises with SHHS, District Ethics Committee, Kirby Centre and Pharmaceutical Companies • Ensures that evidence based HIV nursing care is provided to all trial patients • Has undertaken formal research training provided by pharmaceutical companies.

F. Workforce Profile

Table 20: Description of Roles and Responsibilities (continued)

Category	Position	Role and Key Tasks
		Clinic 2 Biala
Nursing	Syphilis Register Nurse (Statewide role)	• Manages the electronic receipt of Syphilis notifications (approximately 150 new cases received per day) for Queensland • Contacts patients to ensure a full sexual health screen, correct treatment administered, follow up care is provided and contact traces all cases.
Allied Health	Psychologist Senior	• Provides clinical psychology and neuropsychology service and leadership within a multidisciplinary team to patients with HIV and/or STIs and Gender Identity Disorder. • Caseload is approximately 8 cases per day • A majority of the caseload is transgender clients, new HIV diagnoses, chronically unstable and protocol patients • Key task is completing psychology assessments for the transitioning of transgender clients
	Clinical Pharmacist	• Responsible for the overall management of of HIV clients' medication • Dispensing ARTs and supporting medications • Provides medication counselling services to the patient • Stock control and inventory management • Submission of PBS claim • Collection and management of patient co-payments • Updating and entry of patient's contact details • Provides follow up medication counselling to clients via telephone (assists with patient monitoring) • Manages the medications used in clinical trial • Assembles detox kits for the alcohol and drug service
	Pharmacy Assistant	• Assembles medications as per the prescription • Assisting with collection and management of patient co-payments.

F. Workforce Profile

Table 20: Description of Roles and Responsibilities (continued)

Category	Position	Role and Key Tasks
		Clinic 2 Biala
Medical	Director	• Represents the SHHS in district level activities • Chair of the Management Committee and Clinical Governance Committee • Undertakes the required administrative functions to manage the service • Provides direct medical evaluation and treatment to patients within the unit (people living with HIV and PEP patients) • Contributes to HIV prevention planning and health promotion/ illness prevention activities (local level) • Provides education and training to a range of health care provides involved in provision of services HIV+ clients • Contributes to multidisciplinary management of HIV+ clients • Undertakes quality improvement activities and meet requirements of clinical trials • Provides mentoring to s100 GPs.
	Senior Medical Officer (SMO)	• Provides direct medical evaluation and treatment to patients within the unit (people living with HIV and PEP patients) • Contributes to HIV prevention planning and health promotion/ illness prevention activities (local level) • Provides education and training to a range of health care provides involved in provision of services HIV+ clients • Contributes to multidisciplinary management of HIV+ clients • Undertakes quality improvement activities and meet requirements of clinical trials • Particular SMOs are also members of various panels including the Prostitution Licensing Authority Panel and Communicable Disease Prevention Panel • Provides mentoring to s100 GPs.
	Visiting Medical Officer (VMO)	• Provide direct medical evaluation and treatment to patients within the unit (people living with HIV and PEP patients) • Contribute to multidisciplinary management of HIV+ clients
Administration	Administration Officer	• Provides receptionist service and administrative support to Clinic 2 • Managing client appointments/procedures (bookings, cancellations, rescheduling, processing referrals) • Patient filing and management of patient records • Provides correspondence support
	Health Planning Officer	• Collects and manages data produced by the SHHS • Quantitatively analyses data produced • Compiles the Annual Sexual Health and HIV Services Statistical Report • Provides adhoc IT support (informal role) • Involved in the implementation of PHICSS

2 Current State

2.3 Current HIV Services

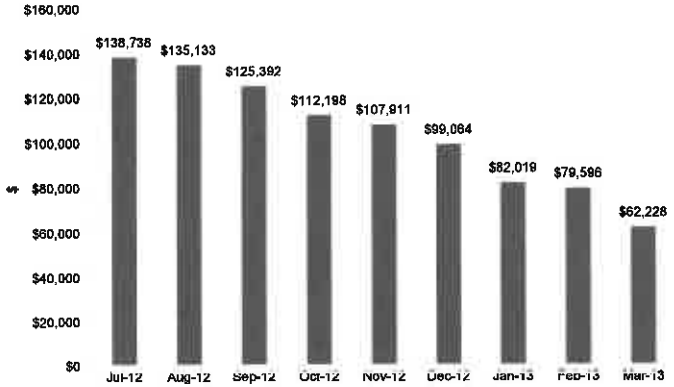
G. Research Activities

The SHHS is involved in research and clinical trials to inform advancements in HIV treatment. Various pharmaceutical companies and the Kirby Institute provide funding for the clinical trials undertaken within Biala. The workforce managing the clinical trials and research includes:

- Research Clinical Nurse (1.0 FTE)
- Senior Medical Officer (0.5 – 0.3 FTE approx.)
- Clinical Pharmacist (adhoc administration and management of medications).

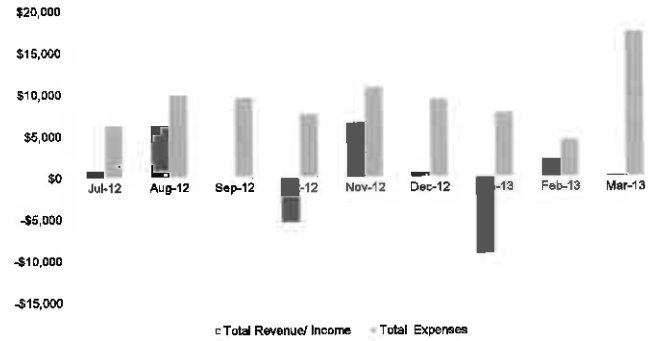
It was reported that the revenue received through research funding generally covers the cost of the clinical nurse only. It is assumed that the balance of labour costs are met through other funding sources. Research funds are managed as part of a Research Trust account which, for the SHHS is declining.

Chart 17: Monthly Balance of MNHHS Trust Fund Account – Community Research Sexual Health (Jul 12-March 13)



Further analysis of the data reveals that payments from research institutes and the pharmaceutical companies are sporadic and are not sufficient to cover the cost of labour expenses and the non-labour expenses for research. The non-labour expenses are primarily for the international postage of pathology tests. Comparison of the revenue and expenses is shown below.

Chart 18: Community Research Sexual Health Fund Revenue and Expense Analysis (Jul 12-March 13)



The primary clinical trial currently occurring within SHHS, is the Strategic Timing of Anti-Retroviral Treatment (START) Study. This clinical trial is evaluating the timing of starting HIV medications and whether the timing has an impact on resistance to HIV medicines, frequency of doctor attendance, cost of medical care and the impact on general health.[18] This clinical trial was described through consultation as integral to the improvement of future HIV treatment and care.

G. Research Activities (continued)

The current patient cohort involved in clinical trials is outlined below.

Table 20: Patient Involved in Clinical Trials, by Patient Classification (2012)

	Stable	Temporarily Unstable	Chronically Unstable	Total
No. Patients	16	30	1	47

Analysis of the primary residence of research patients, reveals 49% reside outside of the MNHHS. However, due to the monitoring requirements of the Clinical Trials, the entire patient cohort would need to be retained by the SHHS.

In addition to the clinical trials undertaken within Biala, a number of the medical and nursing staff of both the Sexual Health Service and the HIV Clinic also undertake research which contributes to or is published in peer-reviewed journals. It is unclear what resources are allocated to these research activities.

2 Current State

2.3 Current HIV Services

H. Patient Revenue Practices

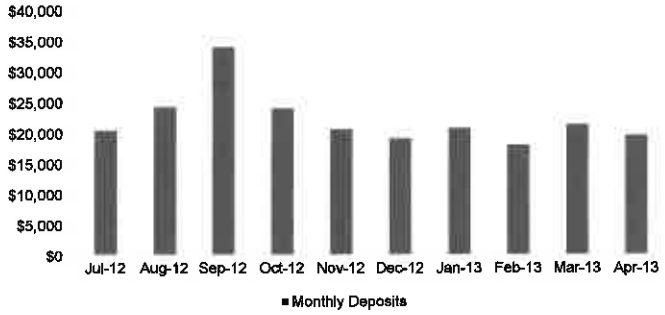
Currently, all patients attending the Biala HIV clinic and surrounding outreach clinics are seen as public patients and pathology is performed by Pathology Queensland. No revenue or cost offset is generated from these patients.

In relation to dispensing medication, a patient co-payment is collected for all medications dispensed through the Biala Pharmacy in line with the PBS requirements. Each patient will pay a co-payment of either $36.10 per script or $5.90 if the patient is a concession card holder. Revenue generated through the collection of patient co-payments is approximately $20,000 per month. This revenue stream is illustrated in Chart 19, below.

It must be noted that other sexual health and HIV services, specifically Cairns and the Gold Coast service have implemented strategies to increase MBS reimbursement for medical and ancillary services. Whilst strategies have been proposed within the SHHS, there are no strategies currently implemented.

The s100 highly specialised drugs funding arrangements are discussed in more detail in the pharmaceutical analysis.

Chart 19: Monthly Deposits (Biala Pharmacy)



MBS Revenue Analysis

Consultations

Whilst MBS patient billing is currently not undertaken within the Biala service, below is an outline of the potential revenue achievable under an MBS billing model. This analysis is based on the number of consultations for each patient classification as outlined in the HIV Models of Care Document 2012.

Table 21: MBS Revenue Analysis - General Practitioner

	Medical Consultations p.a.	MBS Item Number	MBS Rebate	No. Clients (April 2013)	Total $
Stable HIV Clients	2	36	$ 70.30	275	$ 38,665
Newly Diagnosed & TU	6	36	$ 70.30	402	$ 169,564
Chronically Unstable	4	36	$ 70.30	61	$ 17,153
HIV PEP	1	36	$ 70.30	188	$ 13,216
	13			926	$ 238,598

Note: The above table estimates the total HIV service in its current state. The impact the transition of patients under the various service delivery options has not been reflected.

As illustrated above, the MBS revenue achievable for the patient cohort under consideration for transfer to the primary care sector (stable HIV clients) under Option 3 is not substantial relative to the total service.

Based on the current practice of s100 GPs, it is likely that GPs will charge a patient a co-payment to improve the financial viability of providing care to these patients. Under Option 3, this presents a potential cost barrier to patients accessing HIV care. There are public health risks and quality of care issues associated with patients not accessing the required treatment.

2 Current State

2.3 Current HIV Services

H. Revenue Practices Continued

Pathology

Whilst an estimation of the MBS billing potential for pathology could not be undertaken due to the variation in pathology testing there are a number of important considerations associated with this model. Under the MBS Episode Coning Rules, there is an upper limit on the number of items for which Medicare benefits are payable in a patient episode. This cone only applies to services requested by general practitioners for their non-hospitalised patients. Therefore is applicable to the non-complex STI patients being transferred under Option 2, and the stable HIV patients under Option 3.

Pathology services requested for hospital in-patients, or ordered by specialists, are not subject to these coning arrangements.

The rule specifies that when three or more items are requested by a GP in a patient episode, the benefits payable will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. A number of MBS items numbers are excluded from this rule. Pathology tests commonly ordered in HIV Care are on this exclusion list. However, there remains a significant number of MBS item numbers used in STI and HIV care, which are subject to the coning rule. This barrier impacts on both HIV care and sexual health services provided by GPs. For example the Australasian Chapter of Sexual Health Medicine (AChSHM) recommends between 4 and 7 investigations on men who have sex with men for a standard sexual health check.[19] This disparity between best practice management and funding from Medicare creates implications for providing sexual health and HIV care to those patients in general practice.

Through consultation with an interstate private clinic, it was revealed that pathology companies have absorbed the cost the subsequent pathology tests (beyond the 3 tests) as the profit margins can be quite significant on HIV pathology tests and patients require large quantities of tests on a regular basis. It must be noted that this reflects the opinions and practice occurring in one clinic. Further investigation into the possibility of similar arrangements in MNHHS would need to occur.

2 Current State

2.3 Current HIV Services

I. Service Network Analysis

Analysis of the referral pathways to service provides an indication of the accessibility of the service and the clinical appropriateness of patients attending the service. Patients can access the Biala HIV Service (and associated outreach clinics) through a variety of avenues. Through consultation it was determined, the most common referral pathways include:

- General Practitioners (GP)
- HIV Public Health Unit
- Self Referrals (Walk-ins)
- Other HIV Service Providers (transfers of care)
- Sexual Health Clinics
- Medibank Health Solutions (Immigration)
- Queensland Prisons.

Table 22, provides a breakdown of the number of consultations occurring in Clinic 2, by source of enquiry (referral pathway). HIV specific consultations were not identifiable for the remaining outreach clinics.

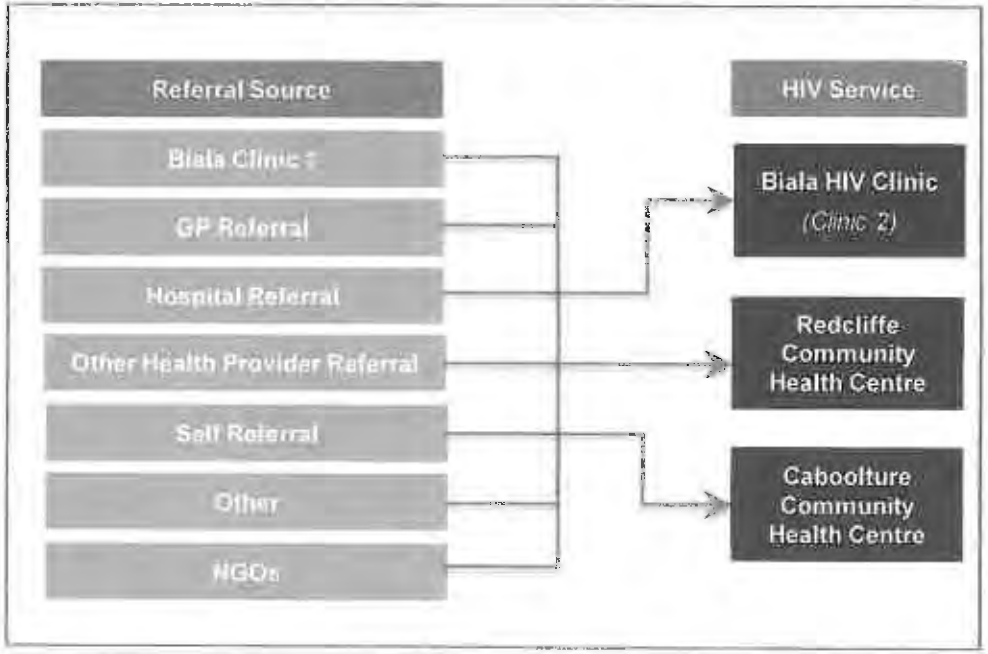
Table 22: Number of Consultations Clinic 2, by Referral Source (2012)

Referral Source	Clinic 2 Consultations	%
Clinic 1 Referral	11	0%
Clinic 2 Referral	5	0%
Correctional Centre Referral	3	0%
GP Referral	15	0%
Hospital Referral	6	0%
Other Health Professional Referral	6	0%
Other	9	0%
Self Referred	37	1%
Sexual Health Clinic (other)	3	0%
Not Stated	2783	72%
Ongoing Patients	996	26%
Total	**3874**	**100%**

Note: Self referred clients are considered walk-in clients.

As noted in Table 22, the majority of consultations conducted in Clinic 2 do not record a referral source or are ongoing patients of Clinic 2. This data limitation makes it difficult to draw accurate conclusions on the referral sources of patients attending Clinic 2. However, excluding these categories, self referred (walk-in) clients (37 consultations) and GP referrals (15 consultations) constitute the primary referral sources. Anecdotal evidence collected through consultations revealed approximately 10% of patients seen in Clinic 2 are self referred. Figure 10 below illustrates the common referral pathways to the Biala HIV Clinic.

Figure 15: Referral Pathways to the Biala HIV Clinic



2 Current State

2.3 Current HIV Services

I. Service Network Analysis

In addition to the formal referral pathways to the Biala HIV Clinics, a number of NGOs have relationships with both the Biala HIV Clinic and the Redcliffe Community Health Centre. These NGOs provide a variety of functions, including provision of support services, referral source for at risk populations, information provision to people living with HIV and consumer advocacy services.

Table 23 below provides an overview of the primary NGOs involved in the provision of services to people living with HIV. Where relevant formal service relationships have been highlighted.

Table 23: Overview of NGOs Involved in Provision of Services to People Living with HIV

NGO	Description	Formal QH Funding Agreement for HIV Services	QH Agreement for Other Services
Queensland Positive People	QPP is a peer-based advocacy organisation which is committed to providing evidence based health promotion programs for HIV+ Queenslanders.	✓	
Spiritus Positive Directions	Positive Directions is a community based, client-centred, wellness orientated program, funded by Queensland Health to provide a care coordination, information and referral service for people living with HIV in Queensland.	✓	
Family Planning Queensland	Family Planning Queensland is a non- profit organisation providing sexual and reproductive health services to the Queensland population. The Redcliffe Clinic has an informal relationship with FPQ, whereby HIV+ clients are referred for contraceptive care.		✓
Queensland Association for Healthy Communities (QAHC)	The Queensland Association for Healthy Communities ('Healthy Communities') is an independent community based organisation which provides support services, advocacy and health promotion programs for HIV+ Queenslanders. Health Communities , through volunteers, has recently introduced a HIV/STI Bulk-Billing Clinic 1 night per week for the LGBT community. This clinic provides the rapid testing for HIV. However, it must be noted that this testing is occurring under an approved clinical trial.		
QuiHN	QuiHN is a organisation providing support services and health promotion programs for intravenous drug users.		✓
Ethnic Communities Council of Queensland (ECCQ)	ECCQ is a Queensland Health Funded Services which administers a HIV/AIDS, Hepatitis and Sexual Health program that works with culturally and linguistically diverse communities across Queensland to ensure access to HIV/AIDS, hepatitis and sexual health information and services.	✓	
MICAH Projects	Micah Projects is a community based not-for-profit organisation which provides support and advocacy services to homeless populations.		

2 Current State

2.4 Pharmaceutical Analysis

A. S100 HSD Program – Conditions of Participation

Prescriber eligibility to prescribe HIV medicines

- A staff hospital specialist, or visiting/consulting hospital specialists in infectious diseases or HIV/AIDS medicines;
- General Practitioners, medical practitioners and non-specialist hospital doctors must complete an approved course in HIV/AIDS medicine to gain accreditation to prescribe;
- Approval from QH for the right to prescribe;
- Hospital based doctors may prescribe maintenance therapy in specific situations where it is impractical for the patient to obtain a prescription from the treating specialist and with their agreement.

Patient eligibility

SERVICE REQUIREMENTS

- Attended a Highly Specialised Drugs (HSD) approved private hospital;
- Attended the private practice of an accredited prescriber;
- Attended a HSD approved public hospital as a:
  - A day-admitted patient
  - Non-admitted patient
  - A patient on discharge.

RESIDENCY REQUIREMENTS

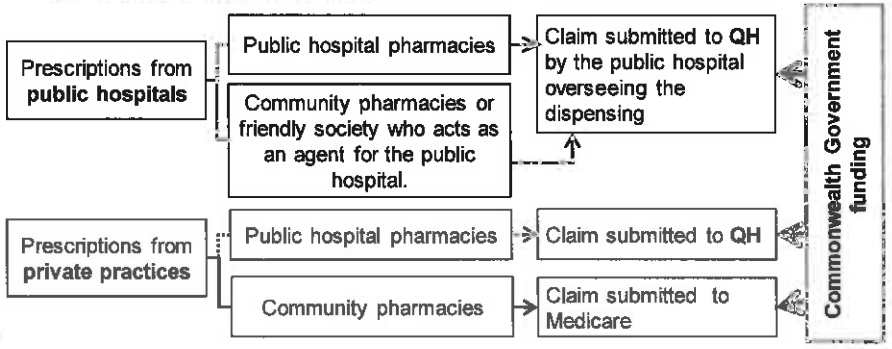
- An Australian resident;
- A person covered by the Reciprocal Health Care Agreement between Australia and the patient's country of residency (only for original prescription);
- An eligible overseas representative (i.e. head of diplomatic mission or consular post, staff of those diplomatic missions or consular posts, or their family members)

Dispensing and reimbursement requirements

- Eligible community patients (see patient eligibility);
- Prescribing was according to the criteria specified in the PBS; and
- Department of Health can satisfy the Commonwealth that adequate and auditable systems are in place (see below).

SUPPLY/CLAIMING REQUIREMENTS

- All medicines supplied under S100 HSD are fully reimbursed by the Commonwealth Government.



Scheme compliance requirements

- Establish an appropriate audit process to ensure validity of claims;
- Undertake audit to include medical records to confirm claims relate only to approved indications;
- Undertake a random sample audit of charts on 3% (subject to review) of issues. Hospitals' returns to Central Office should indicate that this audit has been undertaken; and
- Provide detailed usage information to the Commonwealth (including patient name or identifier code, diagnosis, quantity, cost of drug.

2 Current State

2.4 Pharmaceutical Analysis

B. Management practice in Department of Health pharmacies

Table 24: Overview of pharmacy inventory and financial management practices

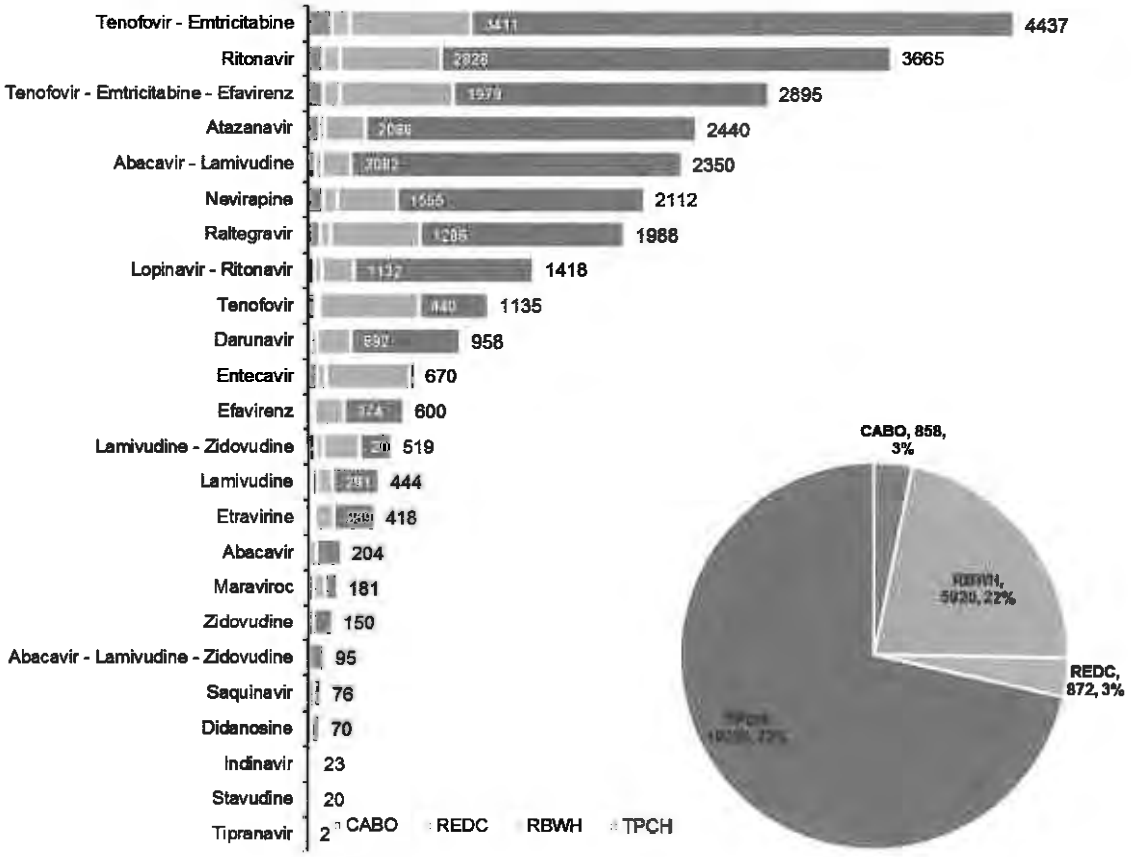
Consideration	Discussion
Inventory management	Individual pharmacies of different health services, including satellite pharmacies operating under the organisational structure of a main hospital pharmacy, purchase HIV medicines individually from QH Central Pharmacy. Responsible pharmacists manage the stock level according to local demand (range and quantity) for HIV medicines in the practice. In general, inventory stock is sufficient to meet the demand for one month.
Dispensing practice	QH pharmacies dispense S100-reimbursed HIV drugs generally at the PBS listed quantities; this typically corresponds to a 2-month supply. Larger quantities of HIV drugs (e.g. supplied together with repeats) may be supplied in a single dispensing according to the PBS "Regulation 24" rule. This only applies under specific patient circumstances e.g. travelling overseas and lack of access to pharmacy before the supply runs out. For non-claimable supply, QH pharmacies dispense 1-month quantity and generally to the nearest pack size. Supply of anti-retroviral therapies outside of PBS approved indications/quantities (i.e. non-claimable supply) rarely happens.
Financial management	QH pharmacies source wholesale supply of pharmaceuticals from QH Central Pharmacy, which has a general mark-up of 4.35%. For a range of specially identified drugs, such as S100 HSD, QH Central Pharmacy will apply a significantly lower level of mark-up. It is worth noting that the PBS pricing of S100 HSD drugs in public and private hospitals allows for a 11.1% wholesaler mark-up. There is no advantage to pool the purchasing of HIV medicines among pharmacies at different health services because QH Central Pharmacy applies bulk-discounts across the entire QH state-based formulary and this discount is not driven by the overall volume of pharmaceuticals purchased, not by volume per transaction. QH pharmacies submit reimbursement claims for supplied medicines at least monthly. QH pharmacies have recently implemented online claiming; this means that claims are submitted at the time of supply, and reimbursement is received within one month. All medicines supplied under S100 HSD are fully reimbursed by the Commonwealth Government The dispensed price for HSD supplied in participating public hospitals excludes a pharmacy mark-up. In Contrast, the dispensed price for HSD supplied by approved community pharmacy includes a mark-up of to $4 to $40 mark-up, depending on the price to pharmacist. The patient contribution, including premiums, is the same as other medicines.
Disposal and wastage management	QH pharmacies manage wastage by standards of pharmacy practice e.g. stock rotation, expiry date check when receiving supply from QH Central Pharmacy. QH pharmacies dispose expired or damaged medicines in accordance to good pharmacy practice. Change of treatment regimen may result in patients having unused medicines. Patients infrequently return unused medicines to QH pharmacies. These drugs are not reused and are not re-entered to the inventory.

2 Current State

2.4 Pharmaceutical Analysis

C. Utilisation

Chart 21: Number of packs of HIV medicines dispensed between April 2012 and March



CABO: Caboolture Clinic

RBWH: Royal Brisbane and Women's Hospital

REDC: Redcliff Sexual Health Services

TPCH: The Prince Charles Hospital: provides satellite pharmacy services to Biala Clinic 2.

Key observations

- Utilisation pattern of HIV medicines broadly reflects current treatment guidelines.
- Pharmacies affiliated with the Brisbane Sexual Health and HIV Services dispensed a total of 26,870 packs of HIV medicines in the year ending March 2013.
- Pharmacies at The Prince Charles Hospital (TPCH)* and Royal Brisbane and Women's Hospital (RBWH) dispensed 94% of the total volume. This is consistent with the relative proportion of HIV patients at different health services.
- Five HIV medicines with the most number of packs dispensed accounted for 58.8% of the total packs of medicines dispensed.
- The utilisation pattern broadly reflects the current treatment guidelines recommended by the US Office of AIDS Research Advisory Council**: use of combination products containing:
  - tenofovir-emtricitabine-efavirenz (Atripla); or
  - tenofovir-emtricitabine, combined with raltegravir or ritonavir boosted with atazanavir or darunavir; or
  - abacavir-lamivudine, combined with efavirenz or raltegravir, or ritonavir boosted atazanavir, darunavir, or lopinavir.
- The observed utilisation pattern vary across different health services for some medicines (e.g. relatively greater use of Atripla at RBWH). This is most probably dependent on the condition profiles of patients at different services (e.g. treatment naïve versus experienced).

* TPCH provides satellite pharmacy service to the Biala Sexual Health Clinic (Clinic 2).

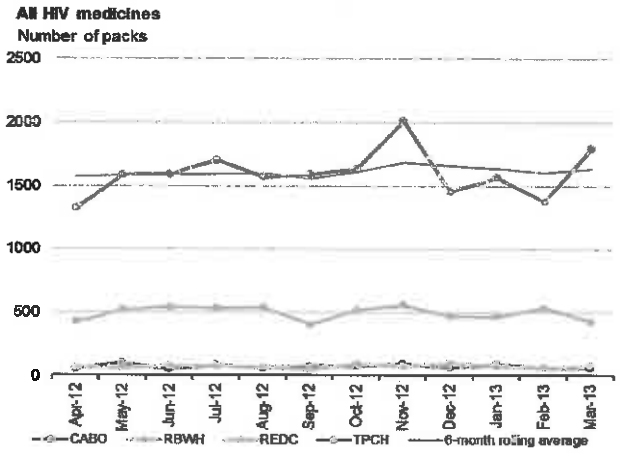
** This guidelines is widely adopted in Australia.

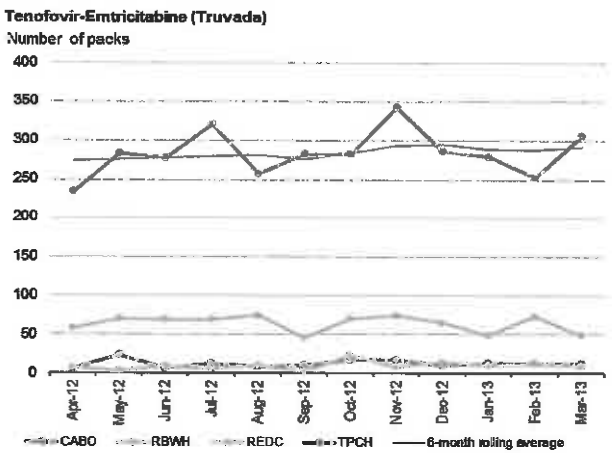
2 Current State

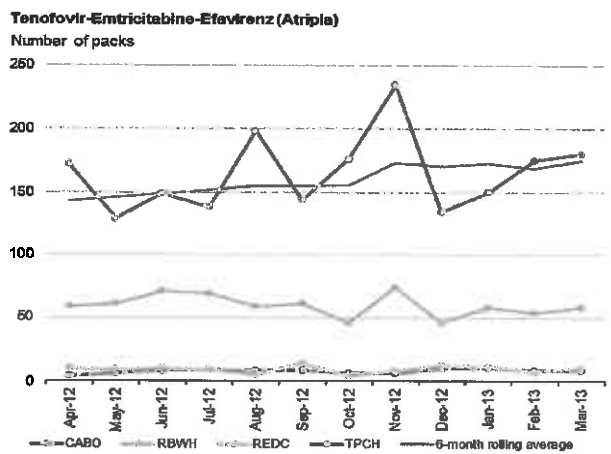
2.4 Pharmaceutical Analysis

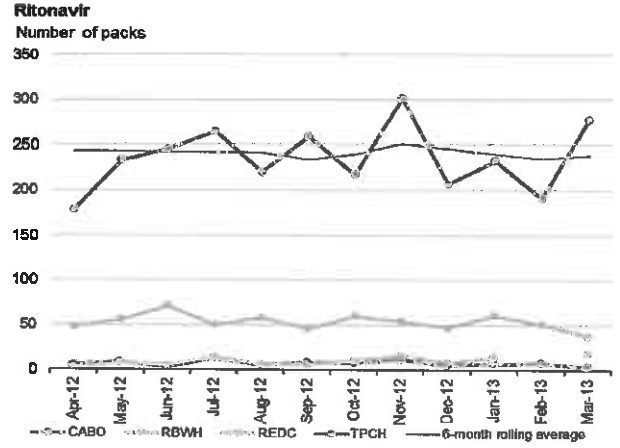
C. Utilisation

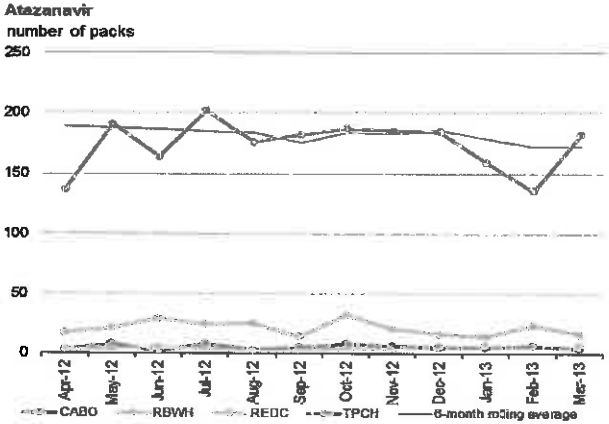
Chart 22: Trend analysis between April 2012 and March 2013











Key observations

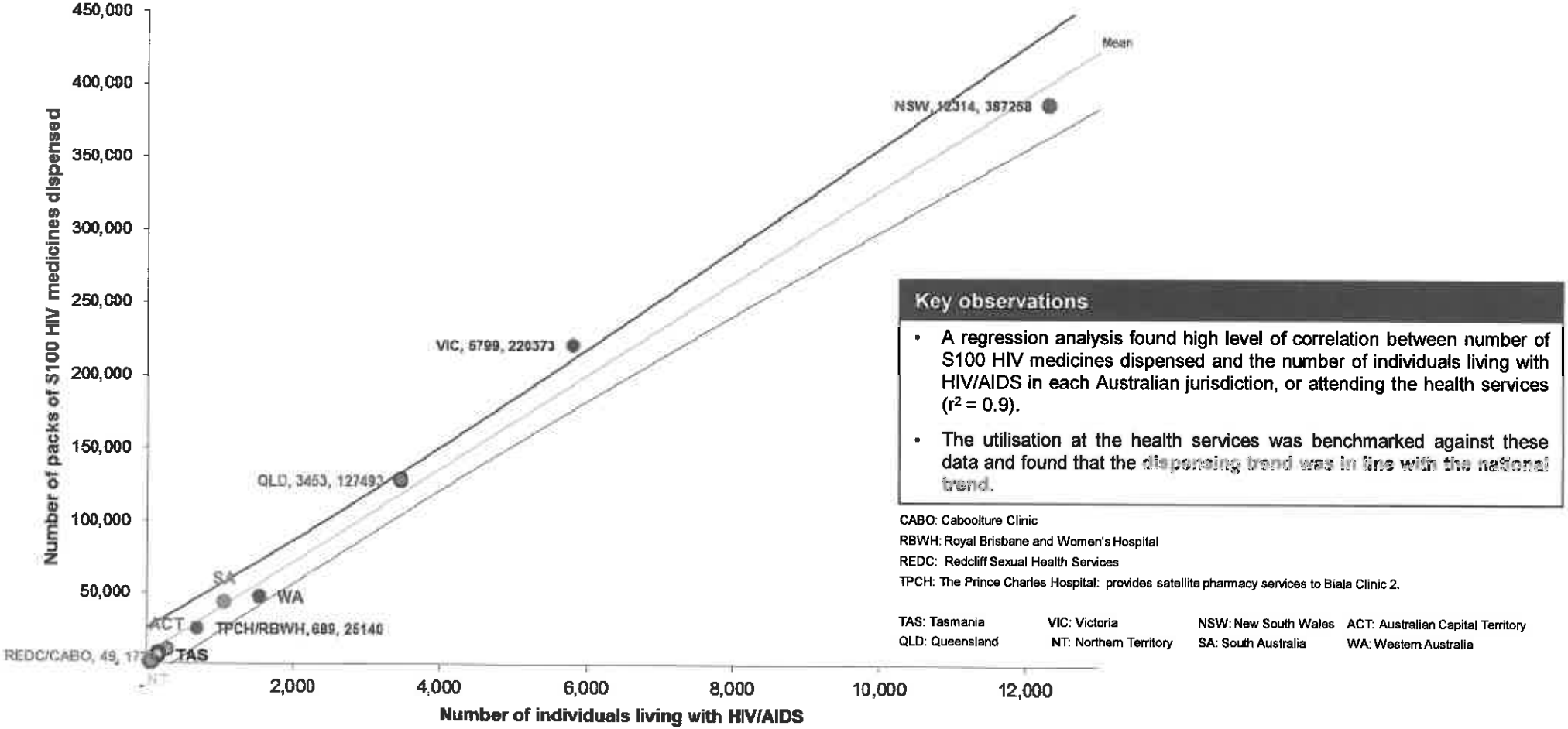
- There were significant month-to month variations in the number of packs dispensed in the 12 months ending march 2013. This is especially the case for TPCH where there were large volume variations (up to 500 packs difference).
- In the 12-month period, there was a 3% increase in the number of packs of HIV medicines dispensed across all sites, based on the 6-month rolling averages (to address the substantial month-to-month variations).
- In the 12-month period, there were growths in the use of combination therapies - Atripla and Truvada - at an average rates of 22% and 8% respectively. Given the rates were higher than that for all HIV medicines (3%), this indicates a shift towards simplifying treatment regimen by using combination products to achieve pill burdens reduction. Indeed, the use of single ingredient products has reduced.

2 Current State

2.4 Pharmaceutical Analysis

C. Utilisation

Chart 23: Number of packs of HIV medicines dispensed between April 2012 and March



Key observations

- A regression analysis found high level of correlation between number of S100 HIV medicines dispensed and the number of individuals living with HIV/AIDS in each Australian jurisdiction, or attending the health services ($r^2 = 0.9$).
- The utilisation at the health services was benchmarked against these data and found that the dispensing trend was in line with the national trend.

CABO: Caboolture Clinic
RBWH: Royal Brisbane and Women's Hospital
REDC: Redcliff Sexual Health Services
TPCH: The Prince Charles Hospital: provides satellite pharmacy services to Biala Clinic 2.

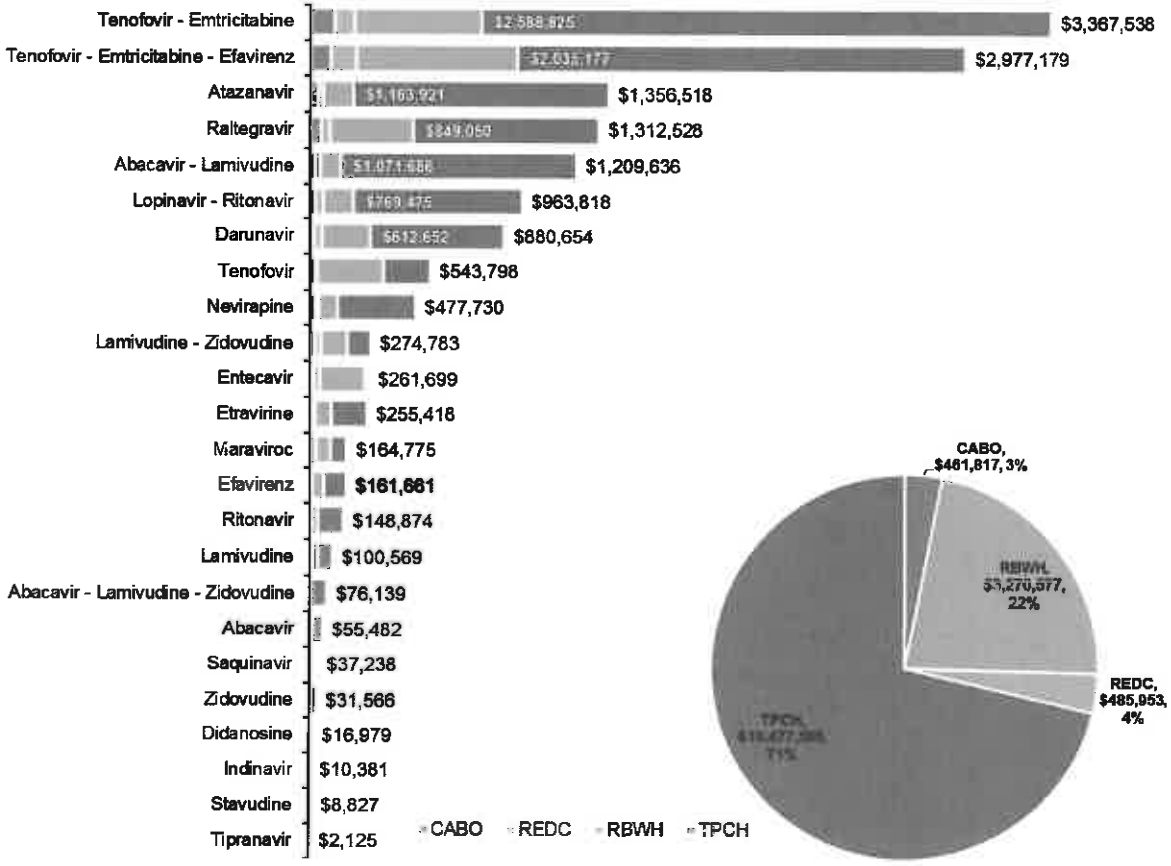
TAS: Tasmania VIC: Victoria NSW: New South Wales ACT: Australian Capital Territory
QLD: Queensland NT: Northern Territory SA: South Australia WA: Western Australia

2 Current State

2.4 Pharmaceutical Analysis

D. PBS Reimbursement

Chart 24: Claim on HIV medicines dispensed between April 2012 and March 2013



CABO: Caboolture Clinic

RBWH: Royal Brisbane and Women's Hospital

REDC: Redcliff Sexual Health Services

TPCH: The Prince Charles Hospital: provides satellite pharmacy services to Biala Clinic 2.

Key observations

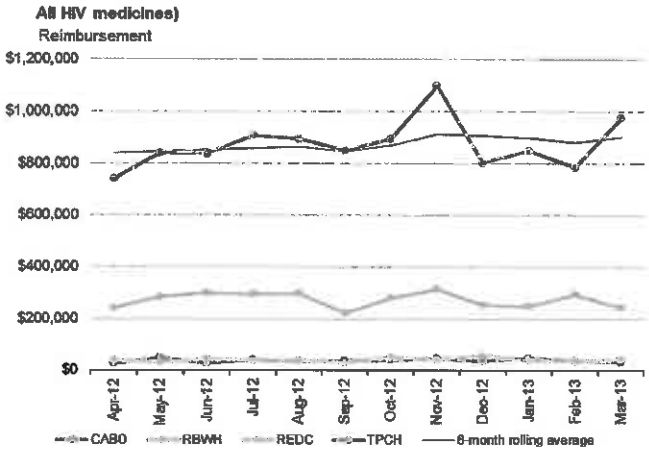
- The claim for HIV medicines supplied by pharmacies affiliated with the Brisbane Sexual Health and HIV Services amounted to a total of $14.69 million in the year ending March 2013. This was fully reimbursed by the Commonwealth Government of Australia.
- Consistent with the utilisation data, pharmacies at The Prince Charles Hospital (TPCH)* and Royal Brisbane and Women's Hospital (RBWH) accounted for 93% of the total claim.
- The five most commonly dispensed HIV medicines accounts for 69.6% of the total claim.
- As expected, the observed distribution of claim by HIV medicines varies in different health services. For example, combination therapy with tenofovir-emtricitabine-efavirenz and raltegravir, and tenofovir had greater shares of the total expenditure at RBWH than in TPCH.
- It is worth-noting that switching between different treatment combinations, in accordance to treatment simplification recommendations (e.g. from a Protease Inhibitor-based treatment to Non-Nucleoside Reverse Transcriptase Inhibitor) will NOT result in difference in expenditure. This is because these combination therapies were listed on a cost-minimisation basis against single ingredients products. For this reason, decision to switch to therapy should be driven by clinical consideration rather than cost consideration.

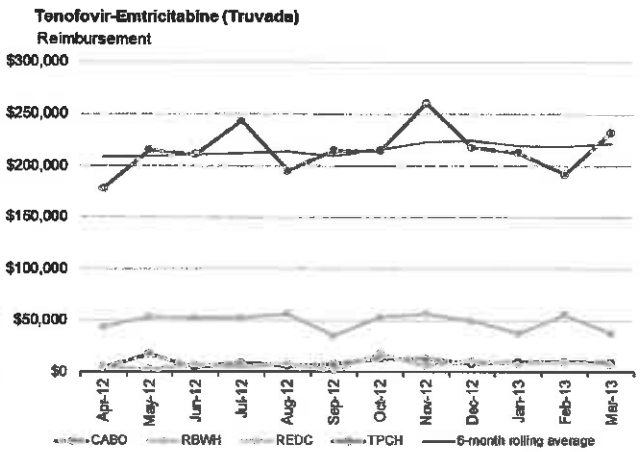
2 Current State

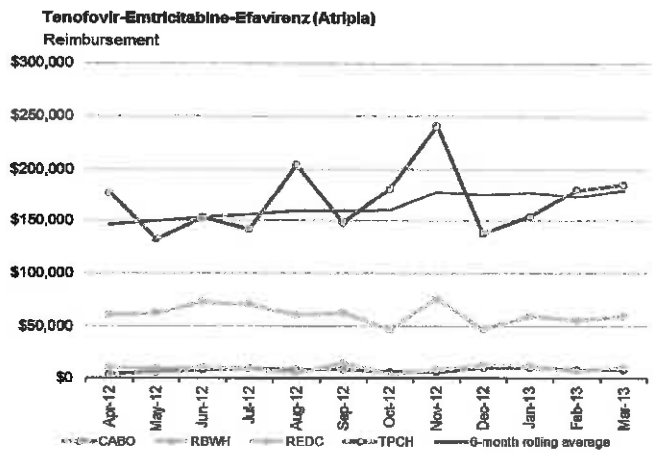
2.4 Pharmaceutical Analysis

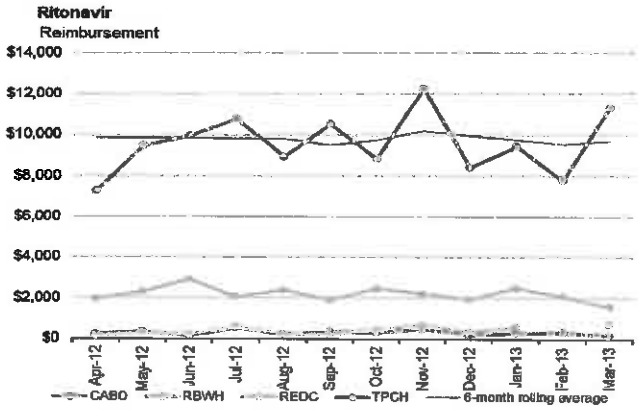
D. PBS Reimbursement

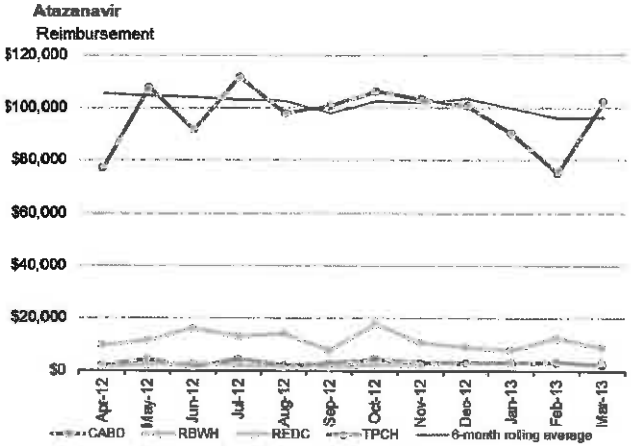
Chart 25: Trend analysis between April 2012 and March 2013











Key observations

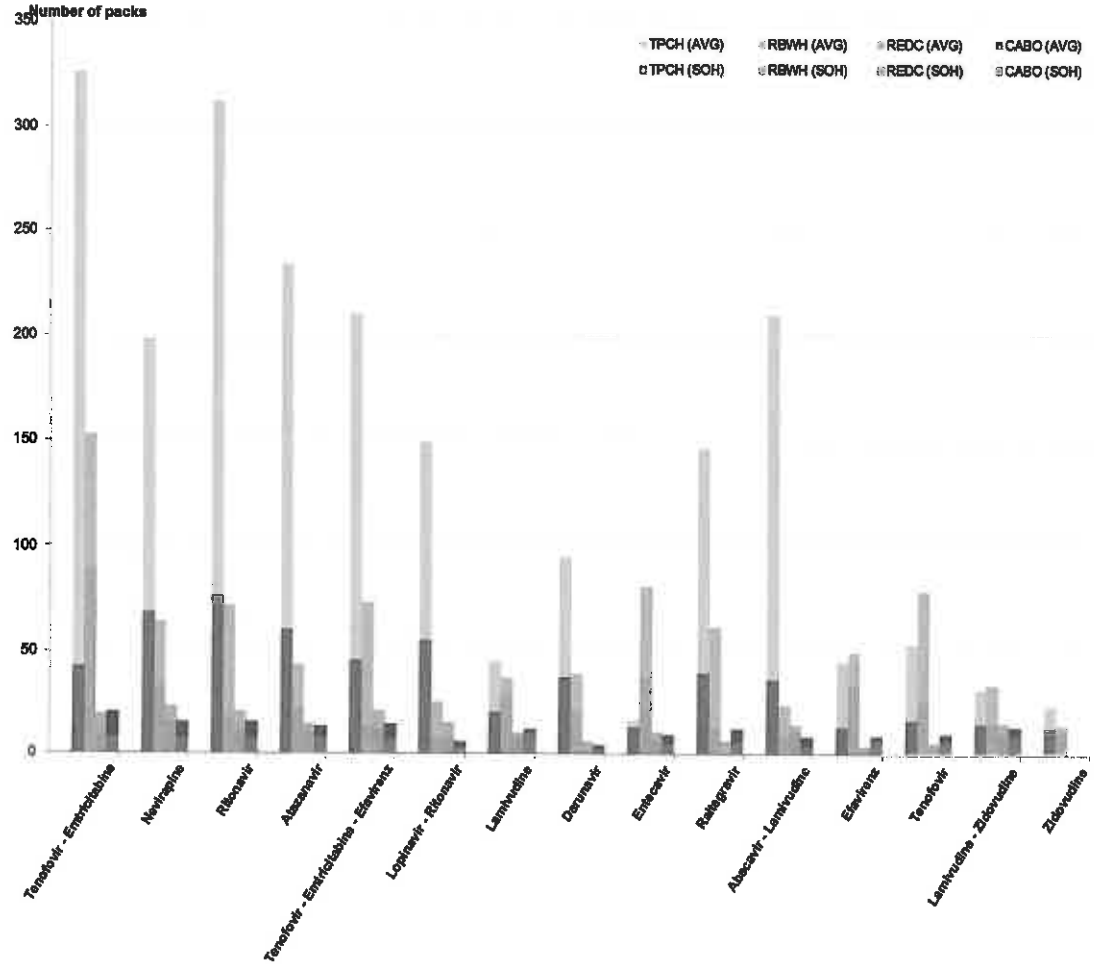
- As expected, there were significant month-to-month variations in the claims for HIV medicines dispensed in the 12 months ending March 2013.
- Overall, there was a 5.53% increase in the claim for HIV medicines dispensed across all sites, based on the 6-month rolling averages (accounting for the month-to-month variations).
- It is worth noting that the growth rate for expenditure should NOT be compared against the growth rate in the number of packs dispensed (i.e. 3%) because the difference is most probably reflective of the switch towards combination therapies in the same period and the cost of combination therapy are typically comparable to individually administered therapies.

2 Current State

2.4 Pharmaceutical Analysis

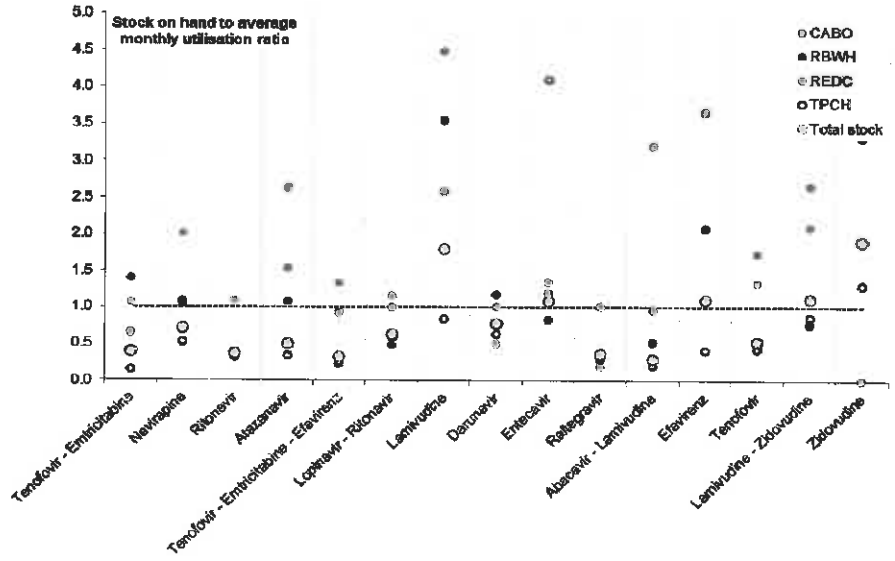
E. Inventory Management

Chart 26: Comparison between stock in the inventory



Key observations

- The monetary value of inventory stock in all pharmacies as at 2 May 2013 amounted to $1.29 Million.
- Stock at the TPCH had the greatest share of stock value, but this is considered low relative to its share of the dispensed volume. TPCH pharmacy generally had a lower level of stock compared to its average monthly utilisation across different HIV medicines (see below), whereas pharmacy at REDC generally held more than 1 month stock.
- Overall, the level of stock (SOH) for HIV medicines is less than the average utilisation per month across all sites. The exceptions are lamivudine and lamivudine-zidovudine combination products.

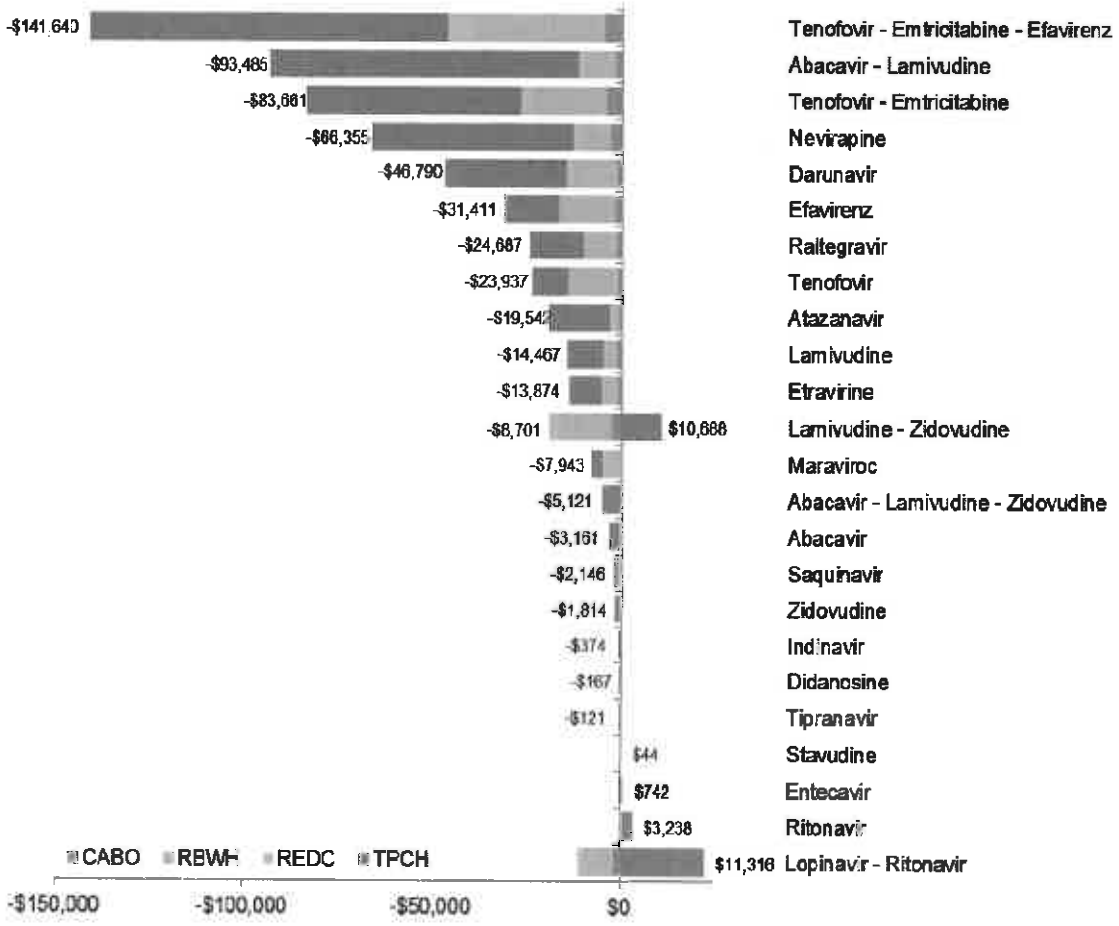


2 Current State

2.4 Pharmaceutical Analysis

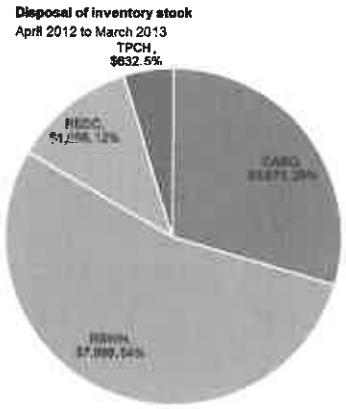
E. Inventory Management

Chart 27: Differences between acquisition costs and reimbursement



Key observations

- Based on the data provided, the current reimbursement for the $100 medicines supplied were not sufficient to cover the acquisition costs for most of the medicines. This is despite the Commonwealth listed price allows for a 11.1% mark-up on the ex-manufacturer prices for medicines supplied by public and private hospitals.
- This has resulted in a loss in revenue of $574,000 in the year ending March 2013.
- The amount of revenue lost correlate with the volume and cost of the HIV medicines.
- There was minimal wastage due to expired goods in the inventory. Most wastage was due to unused broken packs.
- In contrast to the service volume, TPCH had the least wastage compared to other sites.
- Pharmacies had minimal stock wastage but experienced a loss in revenue due to under reimbursement



CABO: Caboolture Clinic

RBWH: Royal Brisbane and Women's Hospital

REDC: Redcliff Sexual Health Services

TPCH: The Prince Charles Hospital: provides satellite pharmacy services to Biala Clinic 2.

2 Current State

2.4 Pharmaceutical Analysis

F. Key Considerations

- **QH will not gain financial advantage** by transferring the dispensing of HIV medicines to community pharmacies because: (1) all HIV medicines supplied by public hospital pharmacies under the S100 HSD arrangements are fully reimbursed by the PBS; (2) current inventory management practice in QH pharmacies has minimal wastage.
- **There are regulatory and policy barriers** to transferring the dispensing of HIV medicines to community pharmacies, which may impede access. For example, community pharmacies are not permitted to dispense prescriptions written by prescribers employed by the public sector, unless the pharmacy is authorised to act as an agent for the public hospital (e.g. when the hospital does not have a pharmacy). The Commonwealth Government governs the dispensing policy and is unlikely to change for Queensland alone.
- Other considerations are listed in the table below.

Table 25: Summary of Services Provided to People Living with HIV

Consideration	Advantages	Disadvantages
Access	Patients may obtain HIV medicines at community pharmacies closer to their regular place of residence. This would improve access, particularly for patients to obtain repeat prescriptions for maintenance therapy.	Smaller community pharmacies may be reluctant to maintain an inventory on a regular basis for HIV medicines because of the relatively high costs and consideration for financial feasibility. Furthermore, pharmacies may not keep the entire range of HIV medicines to avoid wastage or for other commercial reasons. This may result in patients having to pre-order medicines prior to visiting the pharmacy.
Dispensing practice	For their intended purpose, pharmacy inventory at sexual health services do not include medicines for health issues other than HIV/AIDS. HIV patients would need to source medications for other health issues (e.g. high blood pressure or diabetes control) at community pharmacies. For this reason, dispensing HIV medicines at community pharmacies may represent a more holistic pharmacy service for some patients. This is particularly pertinent because of the ageing cohort in individuals living with HIV.	Community pharmacists may not have the specific knowledge in HIV medicines because of a lack of training as part of the undergraduate course. Furthermore, pharmacists may lack the willingness to provide the required pharmacy service, because of perceived complexity and a lack of financial incentive relative to dispensing S85 medicines.
Finance	MNHHS may receive a small savings of about $600,000 annually by transferring pharmaceutical services to community pharmacies because of the inadequate reimbursement for HIV medicines supplied under the PBS relative to the acquisition cost (subject to ascertaining acquisition cost)	From the perspective of the commonwealth government, there may be an increase in the pharmaceutical expenditure because prescriptions dispensed in community pharmacies are subject to the dispensing mark-up.
Privacy	Patients have more choices for pharmacy service providers with whom they would like to share information about their health issue.	Because of the stigma associated with HIV/AIDS, patients may be concerned about obtaining HIV medicines from community pharmacies, which are perceived as having less protection for their privacy

Chapter Three

Proposed Service Delivery Model

3 Proposed Service Delivery Model

3.1 MNHHB Proposed Sexual Health and HIV Services

Overview of the proposed service model

The Metro North Hospital and Health Board (MNHHB) has considered a range of service delivery models for the SHHS. Under the proposed service delivery model presented to the Board for consideration, the SHHS would retain the specialist care of HIV patients and complex STI patients that are not suitable to be provided in the primary health care sector.

These retained services include:

- Diagnosis and management of STIs on named referral from a GP or Nurse Practitioner (dealing with complex and unresolved STIs)
- Testing and management of newly diagnosed HIV until clinically stable
- Long term treatment of clinically unstable HIV
- Ongoing management of people with HIV monitored under 'Protocol' conditions
- Post Exposure Prophylaxis (PEP) to suspected HIV infection.

In addition, the MNHHS recommended that a number of services continue to be provided by the SHHS – these include:

- The Syphilis Register
- A small cohort of HIV Research patients
- Counselling services for HIV patients.

The paper presented to the Board also makes reference to MNHHS residents only accessing the service.

The MNHHS has advised, following the Board Meeting on 28 February 2013, the proposed service model was revised and an announcement made 20 March 2013 to staff that changes to the sexual health service would be progressed, but that there would be no change to the HIV service (which required further consideration and consultation). During the following week there was increased media coverage, which led to the announcement by the Board Chair on 28 March 2013 that: there will be no change to the HIV service; that a comprehensive service would continue within Metro North; and that an independent review undertaken to ensure the service is appropriate.

Overview of the proposed service model (continued)

As a result, under the current service delivery model considered by the MNHHB, it is proposed that non-complex STI patients transfer to the primary care sector, with the SHHS retaining:

- A comprehensive HIV Service, which includes;
    - Diagnosis and management of STIs on named referral from a GP or Nurse Practitioner (dealing with complex and unresolved STIs)
    - Testing and management of newly diagnosed HIV patients until clinically stable
    - Long term specialist treatment of people with HIV
    - Ongoing management of people with HIV under 'Protocol' conditions
    - PEP to suspected HIV infection.

To reflect this progression and subsequent changes to the proposed service delivery model, three service delivery options have been identified for review. This approach has been adopted to assess the risks and implications, transition considerations and resourcing associated with each option of the service delivery model. These alternative service delivery options have been briefly defined below, with a detailed definition of each option provided in Table 26.

- **Option 1** - Transfer of all non-MNHHS STI and HIV patients to their home HHS
- **Option 2** – Option 1 plus transfer of all non-complex STI patients residing in MNHHS to primary care
- **Option 3** – Option 2 plus transfer of stable HIV patients residing in MNHHS to primary care.

In addition to the options described above, a number of key assumptions were made regarding the service delivery model under consideration by the MNHHB and the service delivery options. Those assumptions are:

- ***Unstable HIV Patients*** – The majority of clinically unstable patients are temporarily unstable patients who will likely become clinically stable and once stable are suitable for transition to the primary care sector under Option 3. Typically clients are temporarily unstable for approximately six to twelve months. During that time they would remain in the cohort of patients treated by the SHHS.

3 Proposed Service Delivery Model

3.1 MNHHB Proposed Sexual Health and HIV Services

Overview of the proposed service model (continued)

- ***Complex and Non-Complex STIs*** – There is no standardised or accepted definition of complex and non-complex STIs. Through consultation with key stakeholders and review of current patient activity and relevant factors, it was agreed for the purposes of the review that non-complex STIs constitute approximately 70% of current STI activity, with the remaining 30% comprising complex STIs.
- ***Overseas & Interstate Visitors*** – This small number of patients, poses a potential service variation, as they cannot be diverted to another Queensland HHS and may for a variety of reasons not be suitable patients for primary care health services. It is therefore proposed that they remain clients of the SHHS and MNHHS, subject to the conditions set out in the options.
- ***Statewide service*** – A statewide service is provided by SHHS to a small number of prisoners who are Medicare ineligible and are located outside the Metro North area. For the purpose of analysis this cohort has been assumed to continue to access the SHHS under all options.
- ***Service Access*** – The retained services at the SHHS would be accessed on an appointment only basis and walk-in clinics would no longer be provided, except for HIV PEP patients. No adjustment has been made for the impact of changes to the referral pathways as the information was assessed by the service as not applicable. All options assume that the service operates by GP or Specialist referral only, with no changes to the level of access historically provided to each patient cohort.

3 Proposed Service Delivery Model

3.2 Options Definition

Overview

As noted earlier, the service delivery options have been devised based on three key variations to the proposed service model for the SHHS. The analysis identifies the risks and implications, transition considerations and resourcing associated with each option. The options are defined below:

Table 26: Service Delivery Options

	Option 1 Transfer of Non-MNHHS Residents	Option 2 Transfer of Non-Complex STIs to the primary care sector	Option 3 Transfer of Stable HIV to s100 GPs

Summary of Service Transition	• Patients whom do not reside in MNHHS but attend the SHHS, for both STI management and HIV treatment and management are transferred to their home HHS.	• In addition to Option 1:
		  • All current and future clients attending the SHHS for non-complex STIs are transferred to the primary care sector, principally GPs.
		  • This would result in 70% of sexual health patients being transferred to the primary care sector.
			• In addition to Option 2:
			  • Clinically stable HIV patients are transferred to s100 GPs in the primary care sector.

Summary of Service Retained by MNHHS	• The retained SHHS service is the full Sexual Health and HIV service for MNHHS patients only.
	• (NB This excludes some current non-HIV/STI services, such as Gender Identity Counselling)
		• The SHHS retains:
		  – The diagnosis and management of STIs on named referral from a GP or Nurse Practitioner (dealing with complex and unresolved STIs)
		  – Testing and management of newly diagnosed HIV until clinically stable
		  – Long term specialist treatment of people with HIV
		  – Ongoing management of people with HIV under 'Protocol' conditions
		  – PEP to suspected HIV infection.
			• The SHHS retains:
			  – Diagnosis and management of STIs on named referral from a GP or Nurse Practitioner (dealing with complex and unresolved STIs)
			  – Testing and management of newly diagnosed HIV until clinically stable
			  – Long term treatment of clinically unstable HIV
			  – Ongoing management of people with HIV monitored under 'Protocol' conditions
			  – PEP to suspected HIV infection.

	Option 1	Option 2	Option 3
Non-MNHHS residents (all services)	➡	➡	➡
MNHHS Non-Complex STIs	●	➡	➡
MNHHS Complex STIs	●	●	●
MNHHS Stable HIV	●	●	➡
MNHHS Temporarily Unstable HIV	●	●	●
MNHHS Chronically Unstable HIV	●	●	●
HIV PEP	●	●	●
MNHHS HIV Psychology Services	●	●	●

Transitioned ➡ **Retained** ●

3 Proposed Service Delivery Model

3.3 Patient Activity Summary

Overview of the proposed service model

The table below summarises the patient activity retained and transitioned under each service delivery option.

Table 27: Summary of Service Delivery Model

Patient Classification	Current (2012)		Transfer of Non-MNHHS Residents				Transfer of Non-Complex STIs				Transfer of Stable HIV			
			Option 1				Option 2				Option 3			
	Patients	OOS	Transitioned		Retained		Transitioned		Retained		Transitioned		Retained	
			Patients	OOS	Patients	OOS	Patients	OOS	Patients	OOS	Patients	OOS	Patients	OOS
Non-Complex STI	4,019	5,282	1,454	1,793	2,565	3,488	2,565	3,488	-	-	-	-	-	-
Complex & Unresolved STI	1,722	5,167	623	1,869	1,099	3,298	-	-	1,099	3,298	-		1,099	3,298
Stable HIV	275	1,332	127	491	148	841	-	-	148	841	148	841	-	-
Newly Diagnosed HIV for Stabilisation & Temporarily Unstable	402	3,194	198	1,542	204	1,652	-	-	204	1,652	-	-	204	1,652
Chronically Unstable Patients	61	713	26	261	35	452	-	-	35	452	-	-	35	452
HIV PEP	188	410	-	-	188	410	-	-	188	410	-	-	188	410
Total	**6,667**	**16,098**	**2,428**	**5,956**	**4,239**	**10,141**	**2,565**	**3,488**	**1,674**	**6,653**	**148**	**841**	**1,526**	**5,812**
% of Total Current Patients & OOS (2012) Retained					**64%**	**63%**			**25%**	**41%**			**23%**	**36%**

Note: Refer to page 41 for further detail on the definition of the HIV patient classifications. Page 82 provides the definition of non-complex STI and complex STIs.

Chapter Four

Assessment, Implications & Risks

4 Assessment, Implications & Risks

4.1 Overview

Overview of Assessment Implications & Risks

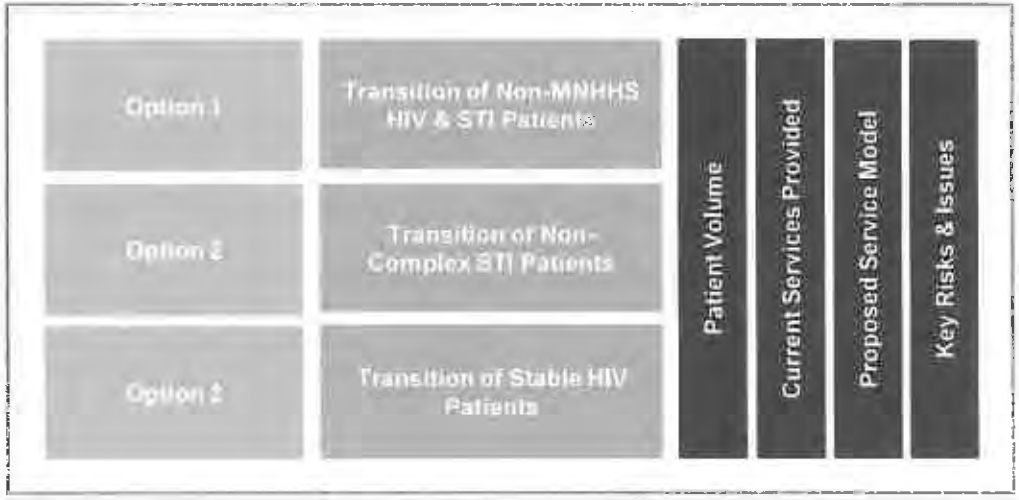
An alteration to the service delivery model presents a number of significant changes to the location of service and model of care. Hence, the review of each service delivery option must appropriately consider implications and risks.

The purpose of the following section is to provide an overview of the following for each service delivery option:

- **Patient Cohort** – Identifies the patient & activity volumes currently provided through the service, along with quantifying the non-MNHHS residents.
- **Current Services Provided** – Describes the current services provided to patients attending the service. This will consider how patients currently access the service.
- **Proposed Service Model** – Describes how the service provision to each patient cohort will change under each service delivery option considered by the MNHHB.
- **Key Risks & Implications** – Primarily based on stakeholder consultation, identifies and describes the key risks and implications of transitioning to the service option under consideration by the MNHHB. This will include consideration of the pharmaceutical arrangements, clinical risks, workforce implications and structural barriers ie regulatory barriers.

Figure 16, illustrates the structure of this section.

Figure 16: Structure of Assessment Implications & Risks



4 Assessment, Implications & Risks

4.2 Option 1 - Non-MNHHS HIV Patients

Overview of Patient Cohort

Table 28: Summary of HIV Patient Cohort, No. of Individuals (April 2013)

HHS	Stable	TU	CU	Total	% of Total
Metro North	136	188	34	358	49%
Metro South	96	153	22	271	37%
Cairns and Hinterland	-	-	-	-	-
Darling Downs West Moreton	13	22	<5	37	5%
Gold Coast	11	17	<5	29	4%
Mackay	-	<5	-	<5	0%
Sunshine Coast / Wide Bay	7	5	<5	13	2%
Central Queensland	-	-	-	-	-
Townsville	-	-	-	-	-
Not Stated	12	16	<5	29	4%
Total	**275**	**402**	**61**	**738**	**100%**

Note: The number of HIV patients displayed above represents the number of active clients as at April 2013.

Current Services Provided

These patients are currently treated within either the Biala HIV Clinic, Redcliffe Clinic or Caboolture Clinic and collect their medications from Queensland Health pharmacies (Biala pharmacy, The Prince Charles Hospital, the Caboolture Hospital, RBWH and Redcliffe Hospital). The full range of pathology tests required are ordered through Pathology Queensland. The SHHS currently does not restrict access to patients who do not reside in the MNHHS.

Option 1 - Proposed Service Model – HIV

Under the proposed service delivery model, all non-MNHHS HIV patients would be transferred to their home HHS for treatment and management.

Transition would occur through an appropriately managed clinical handover process. MNHHS may continue to provide services to HIV patients from rural and regional HHSs through negotiation of an outreach model.

Key Risks & Issues

The key risks and issues associated with transitioning non-MNHHS HIV patients to their resident HHS are outlined below:

- ***Public Health Risk*** – There is a public health risk if patients fail to access care and treatment because of resistance to accessing services that may not provide:
  - Anonymity and confidentiality
  - Open access (walk-in)
  - No charge/co-payment
  - Specialist services
  - Acceptance of socially-marginalised populations.
- ***Clinical Risks of Patient Transfer*** - The MNHHS is responsible for the patients' quality of care throughout the transition process. Therefore, managing the risk of any reduction of patient safety or quality of care during or resulting from the transition process would be the responsibility of the MNHHS.
- ***Capability and Capacity of Regional HHSs*** – A number of HIV patients currently attending Biala for HIV care reside in rural or regional HHSs. The capacity and capability of those HHSs to provide HIV care has not been assessed as part of the review. Transition of these patients would need to consider and address associated clinical risks through appropriate negotiation with the relevant HHSs. This will be particularly important for HHSs receiving a small number of HIV patients, as thy may not be sufficient patient volume to maintain patient safety and quality.

4 Assessment, Implications & Risks

4.2 Option 1 - Non-MNHHS HIV Patients

Key Risks & Issues (continued)

The key risks and issues associated with transitioning non-MNHHS HIV clients to their resident HHS are outlined below:

- ***Public Health Risk*** - The anonymity provided by Biala as a stand-alone Community Health Centre is considered important by patients in maintaining their privacy. Transition to other HHSs may result in significant changes in service delivery models, ie accessing care through a hospital based service. This may result in a perceived or actual loss of anonymity and may therefore discourage patients from accessing care. The potential reduction in access or medication compliance represents a significant public health risk that needs to managed and monitored as part of any transition.
- ***Public Health Risk*** - The SHHS's primary HIV clinic is currently centrally located in the Brisbane CBD, close to a public transport hub. This provides a high level of access to the service, particularly for patients who work in the Brisbane CBD. Transfer of care back to surrounding HHSs may reduce this access for some patients. Any reduction in access to care could impact on medication and treatment compliance, therefore creating a public health risk.
- ***Clinical Risks of Patient Transfer*** - This transfer process must consider the resources to deliver all elements of a clinical hand over, including relevant clinical information, tasks and responsibilities. Transfer to other HHSs should not occur until sufficient capacity and capability of the receiving HHS has been confirmed.
- ***Clinical Risks of Patient Transfer*** – It was reported that a number of stable HIV patients, currently treated by s100 GPs located in the Metro South HHS, have shared care arrangements with specialists within Biala. Transfer of patients residing in Metro South to the HHS would need to consider the impact on and clinical risks associated with altering these shared care arrangements.
- ***Clinical Risks of Patient Transfer*** – Due to the complexity and sensitivity of chronically unstable patients, it is likely that the transfer to their resident HHS may create significant patient resistance. Substantial patient liaison, education and comprehensive clinical handover processes will be required to ensure the safe transfer of this patient cohort.
- ***Vulnerable Populations*** – A number of HIV patients are considered socially complex patients; for example patients with multiple mental health issues, homeless patients, low-socioeconomic patients, men who have sex with men and injecting drug users. There will be additional complexities in transferring these patients to their respective HHS. The public health risks associated with a decline in medication and treatment compliance due to service access issues for this population group are significant and must be considered. HIV patients who are considered temporarily unstable or chronically unstable are often socially complex, therefore requiring additional support to successfully transfer. Temporarily unstable patients account for a large portion of total patient cohort to be transferred.
- ***Funding Arrangements*** - The SHHS is currently funded to provide services to the non-Metro North clients. Therefore, transfer of these patients may result in a request for transfer of budget to the relevant HHS. This would reduces the level of financial advantage accrued to the MNHHS.
- ***Protocol Patients*** - Ongoing management of people with HIV monitored under 'Protocol' conditions involves a variety of stakeholders and liaison with the Communicable Diseases Branch. The residence of the 14 protocol patients is unknown; however, transition of these patients to their host HHS would need to consider the processes required to monitor and manage this patient cohort.
- ***Overseas & Interstate Visitors*** - Quantification of the current number of overseas or interstate visitors requiring HIV PEP could not be determined. However, this population group does not have a host HHS, therefore for the purposes of the review it is assumed to be retained.
- ***Pharmaceutical Arrangements*** – HIV PEP drugs are part of the s100 PBS scheme, and therefore can only be dispensed by a QH pharmacy. It was reported during stakeholder consultations that attending public hospital pharmacies can involve long delays in dispensing medication. Such delays in accessing medication can have an adverse affect on the efficacy of the medication. Host HHSs receiving HIV PEP clients will need to give adequate consideration to medication access.
- ***Public Health Risk*** - Effective and efficient administration of HIV PEP is key to controlling the public health risk associated with HIV.

4 Assessment, Implications & Risks

4.2 Option 1 - Non-MNHHS STI Patients

Overview of Patient Cohort

Table 29: Summary of STI Patient Cohort (2012)

HHS	Number Patients (2012)	% Total Patients	OOS (2012)	% Total OOS
Metro North	3,033	53%	5,868	56%
Metro South	1,814	32%	3,232	31%
Cairns and Hinterland	5	0%	6	0%
Darling Downs West Moreton	95	2%	169	2%
Gold Coast	68	1%	117	1%
Mackay	10	0%	11	0%
Sunshine Coast / Wide Bay	57	1%	87	1%
Central Queensland	12	0%	14	0%
Townsville	8	0%	13	0%
Torres Strait-Northern Peninsula	<5	0%	<5	0%
Not Stated	631	11%	918	9%
Total	**5,741**	**100%**	**10,449**	**100%**

Current Services Provided

An open, walk in service for screening assessment and treatment of STIs, including asymptomatic treatment, is currently provided through Clinic 1 in Biala, Redcliffe Community Health Centre, Caboolture Community Health Centre, Hot House and Pine Rivers Community Health Centre.

Current Services Provided (continued)

It was reported that approximately 10% of consultations with new clients are referred by a doctor or other health service, with the remaining consultations considered 'walk-ins.' The largest age groups presenting to Biala Clinic 1 are people aged 20-24 and 25-29 (57%). The second largest group is men having sex with men (MSM). The number of Aboriginal clients, as with injecting drug users and overseas visitors, is minimal.

The SHHS currently provides access to all clients, regardless of their primary residence.

Option 1 - Proposed Service Model -- STI Patients

This involves the transition of all non-MNHHS clients attending SHHS for sexual health issues, including both non-complex and complex STIs, back to their home HHS. Based on 2012 activity, this would result in the transfer or redirection of approximately 36% of the total STI patients treated.

Key Risks & Issues

The key risks and issues associated with transitioning non-MNHHS STI clients to their resident HHS are outlined below:

- ***Public Health Risk*** – There is a public health risk if patients fail to access care and treatment because of resistance to accessing services that may not provide:
    - Anonymity and confidentiality
    - Open access (walk-in)
    - No charge/co-payment
    - Specialist services
    - Acceptance of socially-marginalised populations.
- ***Clinical Risks of Patient Transfer*** – Considerable patient liaison and preparation of clinical information would be required to ensure that smooth and clinically safe transition occurs for all patients. This is particularly relevant for patients currently attending the service for complex STIs.

4 Assessment, Implications & Risks

4.2 Option 1 - Non-MNHHS STI Patients

Key Risks & Issues (continued)

- ***Clinical Risks of Patient Transfer*** – The MNHHS is responsible for the patients' quality of care throughout the transition process. Therefore, managing the risk of any reduction of patient safety or quality of care during or resulting from the transition process would be the responsibility of the MNHHS.
- ***Capability and Capacity of Regional HHSs*** – A number of STI patients currently attending the SHHS for sexual health care reside in rural or regional HHSs. The capacity and capability of those HHSs to provide STI care was not assessed, nor were the specific reasons for patients attending the Biala service. Transition of these patients will need to consider and address clinical risks associated with the transfer through appropriate negotiation with the relevant HHSs. This will be particularly important for HHSs receiving a small number of patients, as there may not be sufficient patient volume to maintain patient safety and quality.
- ***Public Health Risk*** - MNHHS does not have control over the service delivery model for sexual health in other HHSs. Therefore, upon transfer patients may experience a change in how sexual health services can be accessed. Sufficient patient education and referral mapping would need to occur to ensure patients can continue to access an appropriate level of sexual health care. Deficiencies in access resulting from the transfer, (eg patients being unaware of available services in their home HHS), presents a public health risk.
- ***Public Health Risk*** - The largest at risk groups currently attending the service are those under 25 years of age, and MSM. Those groups are often highly sexually active and typically seek an anonymous service. There are considerable public health risks associated with these groups not accessing care due to perceived reduction in privacy due to their transfer to a home HHS.
- ***Vulnerable Patients*** – Vulnerable populations such as the homeless, sex workers, injecting drug users and low socio-economic populations generally seek the anonymity, accessibility (and current absence of co-payments) of a public sexual health service. They are also unlikely to access a GP for sexual health services (even if they do so for other primary heath care). Again, this potential lack of access to sexual health services could lead to an increase in STI transmission in highly sexually active people, with a concomitant risk of increase in the sexual transmission of HIV. These patients are particularly sensitive to a change in service delivery model.
- ***Overseas Visitors*** – These residents do not have a home HHS, therefore cannot be transferred. Inadequate access to STI testing and treatment services could result in an increase of STI transmission from visitors to the local population. Alternative services which are accessible and affordable would need to be provided to this patient cohort.

4 Assessment, Implications & Risks

4.3 Option 2 - Non-Complex STI Patients

Patient Cohort

Table 30: Summary of Non-Complex STI Clients (2012)

HHS	Number Patients (2012)	OOS (2012)
Metro North	2,123	3,138
Not Stated	442	350
Total	**2,565**	**3,488**

Note: The table above include activity across all surrounding clinics and Biala Clinic 1. This table has been produced based on the estimation that 70% of the current patient activity is considered non-complex STIs.

Current Services Provided

An open walk in service for screening assessment and treatment of STIs, including asymptomatic treatment, is currently provided through Clinic 1 in Biala, Redcliffe Community Health Centre, Caboolture Community Health Centre, Hot House and Pine Rivers Community Health Centre.

It was reported that approximately 10% of consultations with new clients are referred by a doctor or other health service. The largest age groups presenting to Biala Clinic 1 are people aged 20-24 and 25-29 (57%). The second largest group is men having sex with men (MSM). The number of Aboriginal clients, as with injecting drug users and overseas visitors, is minimal.

Option 2 Non-Complex STI Clients - Proposed Service Model

Transfer of non-complex STIs to the primary care sector (GPs) would likely occur at the point of receiving a new referral. Based on 2012 activity, this would result in the transfer or redirection of approximately 36% of the total patients treated.

Key Risks & Issues

The key risks and issues associated with transferring non-complex STI clients residing in MNHHS to the primary care sector are outlined below:

- ***Capacity, Capability and Willingness of Primary Care*** – It was reported through consultation that some GPs are uncomfortable dealing with STIs, especially with MSM clients. While gay friendly GP practices exist within the Metro North catchment area, they are at or near capacity.
- ***Capacity and Capability of the Primary Care*** – It was reported through consultation that there were concerns regarding some GPs skills and ability to effectively manage selected STIs, including syphilis and gonorrhoea. It is likely that additional sexual health education would need to be provided for GPs to support the transition. This would rely on GPs' willingness to accept these clients and participate in education.
- ***Public Health Risk*** - The largest at risk groups currently attending the service are those under 25 years of age, and MSM. Those groups are also among the least likely to have a GP who they would choose to consult for sexual health care. This means that about 50% of the clients who would be suitable for primary health services are unlikely to attend GPs. Young people under 25 years of age are also unlikely to attend a family GP, and in some cases do not have their own Medicare Card. There are considerable public health risks associated with these groups not accessing care.
- ***Public Health Risk*** – Transferring non-complex STI care to the primary care sector, risks a break in the integration of sexual health and HIV care. The acquisition of an active STI can in some cases increase the transmission risk of HIV. Any general reduction in access to or quality of sexual health care is inherently linked to an increased risk of HIV transmission in the community. Furthermore, it was reported through consultation that the diagnosis and management of STIs provides an opportunity to deliver comprehensive education to patients on how to modify their sexual behaviour and reduce their risk of acquiring HIV. Concerns were raised regarding the ability of GPs to provide these services comprehensively

4 Assessment, Implications & Risks

4.3 Option 2 - Non-Complex STI Patients

Key Risks & Issues (continued)

- ***Vulnerable Patients*** – Vulnerable populations such as the homeless, sex workers, injecting drug users and low socio-economic populations generally seek the anonymity, accessibility (and current absence of co-payments) of a public sexual health service. They are also unlikely to access a GP for sexual health services (even if they do so for other primary heath care). This potential lack of access to sexual health services could well lead to an increase in STI transmission in highly sexually active people, with a concomitant risk of increase in the sexual transmission of HIV. There are only limited primary health care services specifically targeted to at risk groups, and it is unlikely that private for profit GP practices will have the capacity and resources to provide accessible services for this group of clients. However, these patients may be willing to attend alternative NGO services were such services more readily available and accessible.
- ***Overseas Visitors*** – While many visitors have travel insurance or are citizens of countries with reciprocal Medicare arrangements with Australia, there is a proportion of clients who will not be able to access a rebate for a GP attendance. Inadequate access to STI testing and treatment services could result in an increase of STI transmission from visitors to the local population. Alternative services which are accessible and affordable will need to be provided to this patient cohort.
- ***Private Pathology*** – While STI management and screening can require up to 10 or more tests at a time, there is capped Medicare rebate coverage when ordering more than three tests per consultation with a GP:
  - When more than 3 items are requested by a GP in a patient episode, the benefits payable will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. The remaining items are regarded as one service for which the benefit payable will be equivalent to that for the item with the third highest Schedule fee (this is known as 'coning')
  - While some pathology tests are excluded from this rule, coning remains a potential cost risk for patients attending GPs for STI care in cases where the private pathology service requires a co-payment for the services provided.
  - The potential requirement for substantial patient co-payments for pathology could discourage patients from attending GPs for STI testing, so increasing the public health risk.

Key Risks & Issues (continued)

- **Commercial Sex Workers** - Commercial sex workers currently attend the Biala service for screening to gain their sexual health certificate required under *The Prostitution Act 1999*. Anecdotal evidence, reported during consultation, suggests that 50 commercial sex workers access the SHHS per month. Accessing this service is a key element to controlling the transmission of STIs. Whilst GPs and Family Planning Queensland provide Sexual Health Certificates, there is potential that access could decrease due to financial barriers caused by co-payments often charged by GPs.

4 Assessment, Implications & Risks

4.3 Option 2 - Retain Complex STI Patients

Patient Cohort

Table 31: Summary of Complex STI Clients (2012)

HHS	Number Patients	OOS (2012)
Metro North	910	2,730
Not Stated	189	568
Total	**1,099**	**3,298**

Note: The table above includes activity across all surrounding clinics and Biala Clinic 1. This table has been produced based on the estimation that 30% of the current patient activity is considered complex STIs as outlined in the assumptions.

There is no accepted definition, no single clear model of care and therefore no data, on complex STIs seen by SHHS, and therefore no way of precisely determining what the patient cohort and work demand would be.

However, it has been proposed by the SHHS that a complex STI represents about 30% of patients and is any condition considered by the referrer to be at need of specialist management such as:

- Genital ulcers and unusual rashes (some genital dermatology)
- Anal warts and herpes, meatal warts
- Women with pelvic pain or dyspareunia if not referred to gynaecology
- Oral or anal symptoms of STIs in MSM
- STIs in newly diagnosed HIV patients
- Sexual and STI anxiety and phobia (definitively exclude infection)
- Male syphilis (a surrogate for MSM).

Current Services Provided

An open walk in service for the screening and assessment of STIs, including complex STIs, is currently provided through Clinic 1 in Biala, Redcliffe Community Health Centre, Caboolture Community Health Centre, Hot House and Pine Rivers Community Health Centre.

Based on current patient activity, it has been estimated that 30% of patients have complex STIs. The remaining 70% attend the service for non-complex STI management. This was confirmed through consultation and review of the data.

Option 2 Complex STI Clients - Proposed Service Model

The service retained would include the diagnosis and management of STI on named referral from a GP or Nurse Practitioner for Metro North HHS residents. Current and future non-Metro North patients would be transferred or redirected to their host HHS. The implications of this are addressed under Option 1.

Key Risks & Issues

The key risks and issues associated with retaining complex STI clients are outlined below. Principally the concern is around the capacity of the primary care sector to provide access and refer patients with complex STIs, particularly for vulnerable populations:

- ***Capability of Primary Care Sector*** – GPs currently have varying levels of education and skills in effectively treating STIs and other sexual health issues. Hence, the cases referred by GPs may differ significantly depending on their current skill base. Well defined referral criteria could assist in standardising this process

4 Assessment, Implications & Risks

4.3 Option 2 - Complex STI Patients

- ***Capability of Primary Care Sector*** – Concerns were raised in regards to the ability of GPs to accurately identify complex STIs and refer as appropriate. Inadequate treatment and management of STIs has public health implications. Consideration should be given to further GP sexual health education along with clearly defined referral criteria and education of the appropriate application of the criteria
- ***Overseas Visitors*** – Overseas visitors with complex STIs, who do not have travel insurance or rights under reciprocal Medicare agreements with Australia, may have difficulty accessing GPs to gain appropriate STI testing and referral to SHHS if required. This could increase the public health risk due to inadequate testing and access to STI treatment.
- ***Vulnerable Populations*** - Vulnerable populations with complex STIs, such as homeless people, low socioeconomic populations and injecting drug users, may due to financial barriers have difficulty accessing GPs to receive testing and referral if required. Again, this presents a public health risk if this population doesn't receive adequate testing and management.

4 Assessment, Implications & Risks

4.4 Option 3 - Transfer of Stable HIV Patients

Overview of Patient Cohort

Table 32: Summary of Stable HIV Patient Cohort (April 2013)

HHS	Stable Patients	%	OOS	%
Metro North	136	49%	814	57%
Not Stated	12	4%	27	2%
Total	**148**	**100%**	**841**	**100%**

Note: The number of HIV patients displayed above represents the number of active clients as at April 2013.

Current Services Provided

These patients are currently treated within either the Biala HIV Clinic, Redcliffe Clinic or Caboolture Clinic and collect their medications from QH Pharmacies (Biala Pharmacy, The Prince Charles Hospital, the Caboolture Hospital, RBWH and Redcliffe Hospital). The full range of pathology tests required are ordered through Pathology Queensland.

Option 3 - Proposed Service Model

Under the proposed service delivery model, stable HIV patients residing in MNHHS are transferrable to GPs with s100 prescribing authority and a capacity to accept new clients. Based on consultation it was determined that a clinically reasonable load for a GP is 20 to 50 stable HIV patients.

(NB Non-Metro North HHS clients would be transferred to their respective HHS, with the decision to transfer suitable clients to s100 GPs, a matter for the resident HHS. The implications of that transfer process are discussed under Option 1).

The retained service for Metro North residents would include:

- Testing and management of newly diagnosed HIV until clinically stable (temporarily unstable)
- Long term specialist treatment of people with HIV (chronically unstable)
- Ongoing management of people with HIV under 'Protocol' conditions
- PEP for suspected HIV infection.

Key Risks & Issues

The key risks and issues associated with transferring the care of stable HIV clients to the primary care sector are outlined below:

- ***Capacity of Primary Care Sector*** - Very limited number of s100 prescribers, and a reported limited interest in undertaking training
- ***Capacity of Primary Care Sector*** - The current cohort of s100 prescribers is located in the centre of Brisbane creating potential geographic barriers to accessing care for patients living outside this area. As demonstrated by the geographical analysis in Chapter 2, there is a large cohort of HIV patients residing in the far northern region of the MNHHS (Caboolture and Redcliffe area).
- ***Funding Arrangements*** – Consultation reported inadequacy of MBS funding for HIV and STI Primary Care would likely result in patient co-payments. This may create financial barriers to treatment for some patients.
- ***Demand for services*** – There is a likely increase in demand for HIV treatment, primarily due to the national target of 90% of HIV patients on ART, early treatment as prevention, and an estimated 30% undetected HIV cohort requiring future treatment.
- ***Clinical Risks of Patient Transfer*** - This transfer process must consider the resources to deliver all elements of a clinical hand over, including relevant clinical information, tasks and responsibilities. Transfer to the primary care sector should not occur until sufficient capacity and capability of the sector has been established.

4 Assessment, Implications & Risks

4.4 Option 3 - Transfer of Stable HIV Patients

Key Risks & Issues

- ***Private Pathology*** – Reduced Medicare coverage when ordering more than three tests per consultation with a GP (HIV and STIs management and screening can require up to 10 or more tests at a time):
  - When more than 3 items are requested by a GP in a patient episode, the benefits payable will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. The remaining items are regarded as one service for which the benefit payable will be equivalent to that for the item with the third highest Schedule fee (this is known as 'coning')
  - Despite this rule it was reported through consultation that pathology companies in some instances do not pass on the costs of the additional tests due to the high number of tests ordered through HIV care and the higher margins for some HIV pathology tests.
- ***Capacity of Primary Care Sector*** - Expansion of the number of s100 prescribers also needs to consider the availability and capacity of specialist mentors. Recent changes to the mentoring arrangements have increased the frequency of mentoring sessions required by new s100 GPs (1st year of prescribing). This is likely to create further capacity issues for both s100 GPs and speciality mentors.
- ***Capability of Primary Care Sector*** – There are concerns regarding the capability and willingness of GPs to have an increased role in sexual health and HIV services, particularly for MSM and socially vulnerable populations.
- ***Capability and Capacity of the Primary Care Sector*** – Training additional s100 GPs will require substantial planning and implementation work with the Metro South HHS, both Metro North and Metro South Medicare Locals, and the University of Queensland as the s100 training body. It is likely that this will be a time-consuming process (up to two years based on trainee numbers).

Key Risks & Issues (continued)

- ***Clinical Risks of Patient Transfer*** – It is likely that a proportion of stable patients will become temporarily unstable, so necessitating specialist care, particularly when prescription of ART is required. This will require well developed protocols and clinical relationships between GPs and specialist services for patients to transfer between these care settings.
- ***Public Health Risk*** - The anonymity and stand-alone location of the Biala Community Health Centre, is considered important by patients concerned about maintaining their privacy. Transition to the primary care sector may create a perceived or actual loss of anonymity and therefore discourage patients in accessing care. This potential reduction in access or medication compliance may pose a significant public health risk.
- ***Public Health Risk*** – There is a public health risk if patients fail to access care and treatment because of resistance to accessing services that may not provide:
  - Anonymity and confidentiality
  - Open access (walk-in)
  - No charge/co-payment
  - Specialist services
  - Acceptance of socially-marginalised populations.
- ***Capability of Primary Care Sector*** - It was reported that, to ensure knowledge and skills are up to date, s100 GPs require a minimum of 20 patients. This is an important consideration for transition to the primary care sector.
- ***Access to Pharmaceuticals*** – Due to regulatory barriers, s100 drugs can only be dispensed through public hospital pharmacies. Dispensing through private community pharmacies would require change to the PBS dispensing rules. Therefore, under the current arrangements patients attending s100 GPs, will still be required to access their medications through QH public hospitals. The impact of potential geographical barriers between medication access points and the location of the dispensing practitioners (s100 GPs) on medication compliance needs to occur. Resistance to accessing medications through alternative hospitals was reported due to the delays in dispensing currently occurring in public hospital pharmacies.

4 Assessment, Implications & Risks

4.5 Summary

Summary of Risks & Implications

Based on the analysis undertaken, it is evident that there are a number of complex risks and implications associated with each of the service delivery options. Table 33 below provides a summary of those risks, implications and proposed mitigation strategies for each option. The majority of these risks can be mitigated through a well planned transition strategy, considerations for which are outlined in Chapter 5. However, there remains a number of unresolved public health risks and implications of moving away from:

- An anonymous service
- A walk in service

Table 33: Summary of Risks, Implications and Proposed Mitigation Strategies

Category	Risks	Implications	Possible Mitigation Strategy	Option 1	Option 2	Option 3
Public Health Risk	There is a public health risk if patients fail to access care and treatment because of resistance to accessing services that may not provide: • Anonymity and confidentiality • Open access (walk in) • No charge/ co-payment • Specialist services • Acceptance of socially marginalised populations	The rates of HIV and STIs increase due to clients not accessing appropriate HIV and STI testing and treatment.	There is no clear mitigation strategy relating to this risk. However, development of a comprehensive communication and education strategy which clearly outlines the revised service delivery model may assist to mitigate this risk.	✓	✓	✓
	Due to the complexity and sensitivity of chronically unstable patients, it is likely that transfer to their resident HHS may create significant patient resistance.	Clients decrease compliance with medication therefore creating a public health risk through potential increase in HIV transmission.	A well planned, comprehensive clinical handover process is undertaken which involves all key stakeholders.	✓	✓	✓
	A key patient cohort treated by the SHHS are commercial sex workers, for their sexual health certificates. Transfer of non-complex STI treatment to GPs may result in co-payments being charged, creating financial barriers to care.	Lack of access to sufficient sexual health screening for commercial sex workers may increase the transmission of STIs.	Develop innovative shared-funding arrangements for GP services with NGOs or other service hosts, and examine clients capacity for making co-payments. This process would likely involve Medicare Locals.	✓	✓	✓

4 Assessment, Implications & Risks

4.5 Summary

Table 33: Summary of Risks, Implications and Proposed Mitigation Strategies (continued)

Category	Risks	Implications	Possible Mitigation Strategy	Option 1	Option 2	Option 3
Clinical Risks of Patient Transfer	Large number of clients proposed to be referred to home resident HHSs. Receiving HHSs may not have the capacity and capability to adequately treat HIV patients, particularly regional HHSs.	Clients may resist transfer due to anonymity concerns of receiving care in the HHS where they reside. These concerns can cause considerable distress to people living with HIV. Receiving HHSs do not have sufficient capacity or capability provide a clinically safe service.	Project managed in stages - initial discussions in first three months and negotiation of transition strategy and implementation plan over the next three months. An outreach strategy would need to consider clinically appropriate arrangements with regional HHSs which do not have the capacity to provide a quality HIV service.	✓	✓	✓
	The MNHHS is responsible for quality of care throughout the transition process. Therefore, any reduction of patient safety or quality of care caused by the transition process will be worn by the MNHHS.	The decline in patient quality and safety causes decreased medication compliance. This has the potential to increase HIV and STI transmission.	A well planned, comprehensive clinical handover process is undertaken which involves all key stakeholders.	✓	✓	✓
	Large number of clients are proposed to move to GP primary health care providers	Some clients will not access, or delay access to GP-based services. This creates a potential public health risk if adequate treatment is not provided.	Project managed in stages - initial discussions in first three months and negotiation of transition strategy and implementation plan over the next three months.		✓	✓

4 Assessment, Implications & Risks

4.5 Summary

Table 33: Summary of Risks, Implications and Proposed Mitigation Strategies (continued)

Category	Risks	Implications	Possible Mitigation Strategy	Option 1	Option 2	Option 3
Funding Implications	Transition of non-MNHHS patients to their home HHS may involve the transfer of budget.	This reduces any financial advantage under the proposed service model.	Negotiation of the funding implications should form a component of the transition and hand over of patients to their host HHS.	✓	✓	✓
	MBS payment structure - disincentive for longer HIV/STI consultations.	Inability to attract GPs to work in HIV and related primary health care.	Explore alternative funding arrangements with the primary care and NGO sector through the Medicare Local		✓	✓
Capacity and Capability of the Primary Care Sector (STI Care)	Unwillingness of some GPs to take on sexual health clients who engage in high risk sexual behaviour.	Inadequate primary health care services for sexual health clients.	Develop support and assistance program with Medicare Local and targeted NGOs to enhance training and capacity of GPs, notably in sexual health with clients with high risk sexual behavior.		✓	✓
	Concerns were raised in regards to the ability of GPs to accurately identify complex STIs and refer as appropriate.	Complex STIs are not accurately diagnosed in the primary care sector.	Implement standardised referral criteria for complex STIs and provide further education to GPs on STI management and use of the referral criteria.		✓	✓
Pathology Arrangements	Reduced Medicare coverage when ordering more than three tests per consultation with a GP.	Patients are required to pay a co-payment for pathology tests ordered. This may create financial barriers for patients accessing STI and HIV care within general practice.	Investigate alternative funding arrangements for the provision of pathology.		✓	✓
Vulnerable Populations	Limited ability of some disadvantaged high risk clients to afford co-payments charged.	Clients fail to access GPs and access to services is reduced creating a potential public health risk if STI/HIV testing and treatment does not occur.	Develop innovative shared-funding arrangements for GP services with NGOs or other service hosts, and examine clients capacity for making co-payments		✓	✓

4 Assessment, Implications & Risks

4.5 Summary

Table 33: Summary of Risks, Implications and Proposed Mitigation Strategies (continued)

Category	Risks	Implications	Possible Mitigation Strategy	Option 1	Option 2	Option 3
Capacity and Capability of the Primary Care Sector (HIV Care)	Limited availability of s100 GPs and current location in metro Brisbane region only.	Inability to move all stable HIV clients to the primary care sector.	Increase the required number of prescribers in Brisbane to accept Metro North residents, with a focused program developed with Medicare Local and University of Qld			✓
	Due to the complexity of HIV care there are limited financial incentives for GPs to undertake s100 training and a HIV caseload.	Inability to attract a sufficient number of s100 GPs would result in an inability to move stable HIV clients to the primary care sector.	In collaboration with Medicare Local, examine capacity to attract and retain GPs with s100 prescriber accreditation and to invite successful trainees to participate in scheme.			✓
	Unwillingness of some GPs to take on HIV clients.	Inadequate primary health care services for HIV clients.	Develop support and assistance program with the Medicare Local and targeted NGOs to enhance training and capacity of GPs, notably in HIV care with high risk clients.			✓
	Need for s100 GPs to maintain interest in and clinically safe number of HIV clients.	Inadequate number of GP providers will limit access to HIV services.	Ensure training program attracts sufficient numbers of GPs to share reasonable workload, transfer clients on when sufficient number of GPs available			✓
	Clients' seeking HIV care have a lack of confidence in capacity of or acceptance by some GPs.	Clients fail to engage with GPs and access to services is reduced.	Focus on attracting GPs with acceptance of high risk clients, through NGOs or other service provider arrangements, and that clients are transferred to acceptable GP			✓
Pharmaceutical Arrangements	Current s100 dispensing rules require medication to be dispensed in public pharmacies only	Separation of medication dispensing from the point of care creates further fragmentation in patients' treatment pathway. This may impact on medication compliance.	Relevant groups raise the restrictions to the s100 PBS community dispensing arrangements with Commonwealth Government for revision			✓
Demand for Services	There is a likely increase in demand for HIV treatment, primarily due to the national target of 90% of HIV patients on ART, early treatment as prevention and an estimated 30% undetected HIV cohort.	This may exceed the capacity of HIV services.	Additional resources to meet any increases in demand may be required.	✓	✓	✓

Chapter Five

Transition

5 Transition

5.1 Overview

Overview

Chapter 4 identified a number of risks and complexities associated with each service delivery option. The purpose of this section is to summarise the key activities and propose an indicative timeframe where it was decided that the service model would be implemented. This has been based on the outcomes of consultation with the service, NGO sector and interstate services.

It is noted that there are significant complexities and risks associated with the options for service delivery that require careful planning to mitigate or offset. Not all the risks identified have a mitigation strategy.

Implications of not addressing risks through a transition process

The implications identified through the process of analysis and consultation of not addressing the risks relate to:

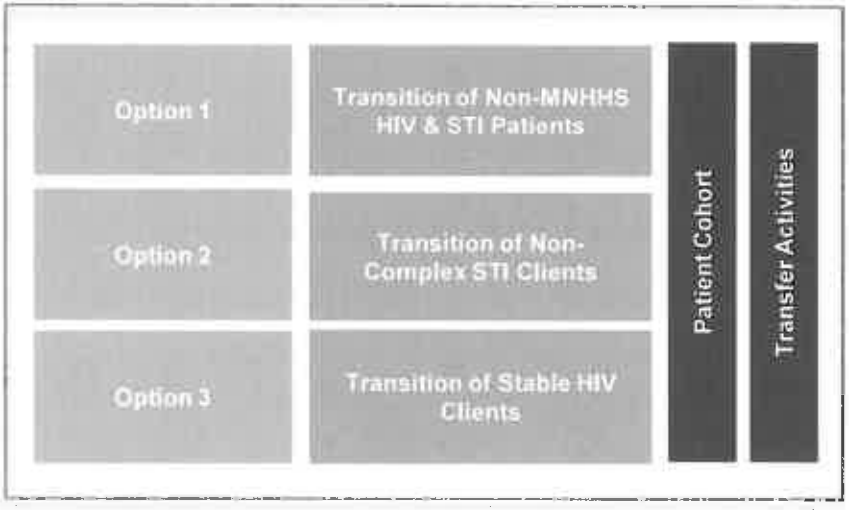
- Reduced and delayed access to screening and treatment
- Increased risk of non-compliance with treatment increasing HIV and STI transmission risks
- Increased cost of treatment related to delayed and inappropriate referral and self referral to emergency departments

Transition activities

The transition activities proposed that seek to address some of the structural risks identified have been outlined according to each Option:

- **Option 1** - Referral and packaging of non-MNHHS residents accessing SHHS back to their home HHS.
- **Option 2** - Development of sexual health service capacity in primary care
- **Option 3** - Development of HIV capability and capacity in primary care.

Figure 17: Structure of Transition



5 Transition

5.2 Option 1 - Transition of Non-MNHHS Residents

Referral and packaging of non-MNHHS residents accessing SHHS back to their home HHS

Patient Cohort

- A total of 2,428 SHHS clients, including HIV clients (stable and unstable) and STI clients (complex and non-complex) are non Metro North HHS residents. The following table summarises the distribution of clients who access SHHS by service type.

Table 34: Summary of the Non-MNHHS Residents attending SHHS

	Service	Patients	OOS
		Non-MNHHS	Non-MNHHS
HIV Service	Stable HIV Clients	127	491
	Newly Diagnosed HIV for Stabilisation & Temporarily Unstable	198	1,542
	Chronically Unstable Clients & Protocol Patients	26	261
Sexual Health	Non-Complex STIs & Screenings	1,454	1,793
	Complex & Unresolved STIs (by referral)	623	1,869
Total		**2,428**	**5,956**

Note: There are 188 PEP patients, however their residence is unknown

It is proposed that the following transition activities be considered where implementation of Option 1 is pursued:

Referral

- Advise non-Metro North HHSs of any changes to the service model that have implications for their services and patient flow
- Establish referral criteria for all HIV and sexual health services that redirects all new referrals for non-Metro North residents back to their home HHS in line with current policy and practice.

Patient Packaging

- Develop protocols and negotiate arrangements with HHSs to appropriately transfer patients who are receiving ongoing care at SHHS (this may exclude non-complex STIs).
- Consider cases where the recipient HHS in more remote or rural Queensland may not have the necessary service model, capacity or resources to continue providing safe and effective care. In these cases outreach arrangements would need to developed. These may also meet the needs of some clients who, for practical and personal reasons, resist having their care transferred to their area of residence.

Careful development and implementation of the proposed service model will need to be undertaken in collaboration with the relevant HHSs. This will require:

- The process to be project managed in stages. To that end it is recommended that initial discussions with HHSs, clinicians and patients commence in the first **three months.**
- Given the numbers of patients, and the need to have clinically appropriate and acceptable arrangements in place before patients are transferred, it is envisaged a further **six months** (at minimum) is required to transfer patients where the activities above can be completed adequately.
- Engaging, attracting and up-skilling a range of GPs in private practice or working with NGOs to meet the health care needs of vulnerable and high risk clients, likely over a period of a further **six months.**
- The SHHS will have a continuing role for the SHHS service over the transition period in providing ongoing expert support and advice to GPs.
- The timeframes for transition, indicated above are dependent on the capacity and capability of the receiving HHS to take on the management of HIV patients and complex STIs.

5 Transition

5.3 Option 2 - Transition of Non-Complex STI Clients

Development of HIV and sexual health service capacity in primary care within MNHHS

Patient Cohort

- 2,565 SHHS clients are MNHHS residents that access services proposed to be delivered by the primary care sector
- The following table summarises the residents to be transferred under this option.

Table 35: Summary of the Patient Cohort to be Transitioned to Primary Care

Service	Patients	OOS
	MNHHS	MNHHS
Non-Complex STIs & Screenings	2,565	3,488
Total	**2,565**	**3,488**

It is proposed that the following transition activities be considered where implementation of Option 2 is pursued:

Transition of Non-Complex STIs

- A detailed plan is developed over the **next three months** to build the capacity of the primary care sector through GPs and NGOs to take on non-complex STI clients. The plan should consider:
  - Capacity and willingness of GPs to meet the increased demand for sexual health care, including among at risk and vulnerable populations
  - Improving access to education for the primary care sector on the effective screening and treatment of non-complex STIs.
  - Enhancement of alternative models for GP primary health care services delivered through participating NGOs
  - Development with the Medicare Local and the SHHS of a system of support and advice to GPs providing additional sexual health care services.
  - The timeframes for transition, indicated above are dependent on the capacity and capability of the receiving HHS to take on the management of complex STIs.

Retention of Complex STIs & HIV Care

- A detailed plan is developed over the **next three months** to refine the model of services retained by the SHHS. The plan should consider:
  - Development of standardised criteria for the referral of complex STIs to the SHHS, ensuring cases referred are clinically appropriate.
  - Liaison with the relevant Medicare Locals to provide the necessary GP education required to effectively implement the referral criteria.
  - Further refinement and adjustment of the standard treatment pathways and models of care utilised in the treatment of complex STIs and HIV. This should align the adjusted workforce resources with the appropriate clinical practices.
  - Document the referral pathways and service relationships with the primary care providers and relevant NGOs involved in the delivery of sexual health and HIV services. This will assist in streamlining access to the service.
  - Align the workforce requirements with the service requirements.

5 Transition

5.4 Option 3 - Transition of Stable HIV Patients

Development of HIV and sexual health service capacity in primary care within MN

Patient Cohort

- 148 SHHS clients are MNHHS residents that access services proposed to be delivered by the primary care sector
- The following table summarises the patients to be summarised under this option.

Table 36: Summary of the Patient Cohort to be Transitioned to Primary Care

Service	Patients	OOS
	MNHHS	MNHHS
Stable HIV Clients	148	841
Total	**148**	**841**

It is proposed that the following transition activities be considered where implementation Option 3 is decided:

Stable HIV

- A detailed plan is developed over the next **three months** to build the capacity of the primary care sector through GPs and NGOs to take on Stable HIV clients. The plan should consider:
  - The number of practitioners required to service the client cohort. It is estimated that between 3 and 7 additional full time GPs with s100 prescribing accreditation are required to deliver services to MN HHS residents who access the SHHS for management of Stable HIV. This is based on the assumption that a GP can manage between 20-50 HIV clients. This would involve an approximate doubling of the s100 GP workforce in Brisbane.
  - Improving incentives for GPs to gain accreditation as a s100 prescriber through the University of Queensland course. Depending on course uptake this could take up to **two years**.
  - Assessing the s100 mentoring requirements. Mentors are almost exclusively public sector medical staff for newly accredited s100 prescribers. Consultation identified recent changes to the role and obligations of the mentors which may materially impact on resource requirements.
  - Supporting existing s100 prescribers at SHHS to practice privately
  - Developing mechanisms that enable the SHHS to continue to deliver specialist advice and support to primary care practitioners.
  - Developing alternative service access points with a range of NGOs for high risk and vulnerable population groups.

Chapter Six

Resourcing

6 Resourcing

6.1 Overview

Overview

An estimate of the potential impact of the proposed service delivery options on the workforce needs of STI and HIV services has been estimated. Figure 18 summarises the key assumptions that have informed the estimates.

Implementation of the service delivery options under consideration by the MNHHB would progressively reduce the number of patients utilising sexual health and HIV services, primarily through transition to alternative care settings or resident HHSs. The volume assumptions are based on 2012 activity and do not incorporate any forecasted changes in demand. This patient activity is presented on the following page is based on the following options and drives the direct clinical FTE requirements:

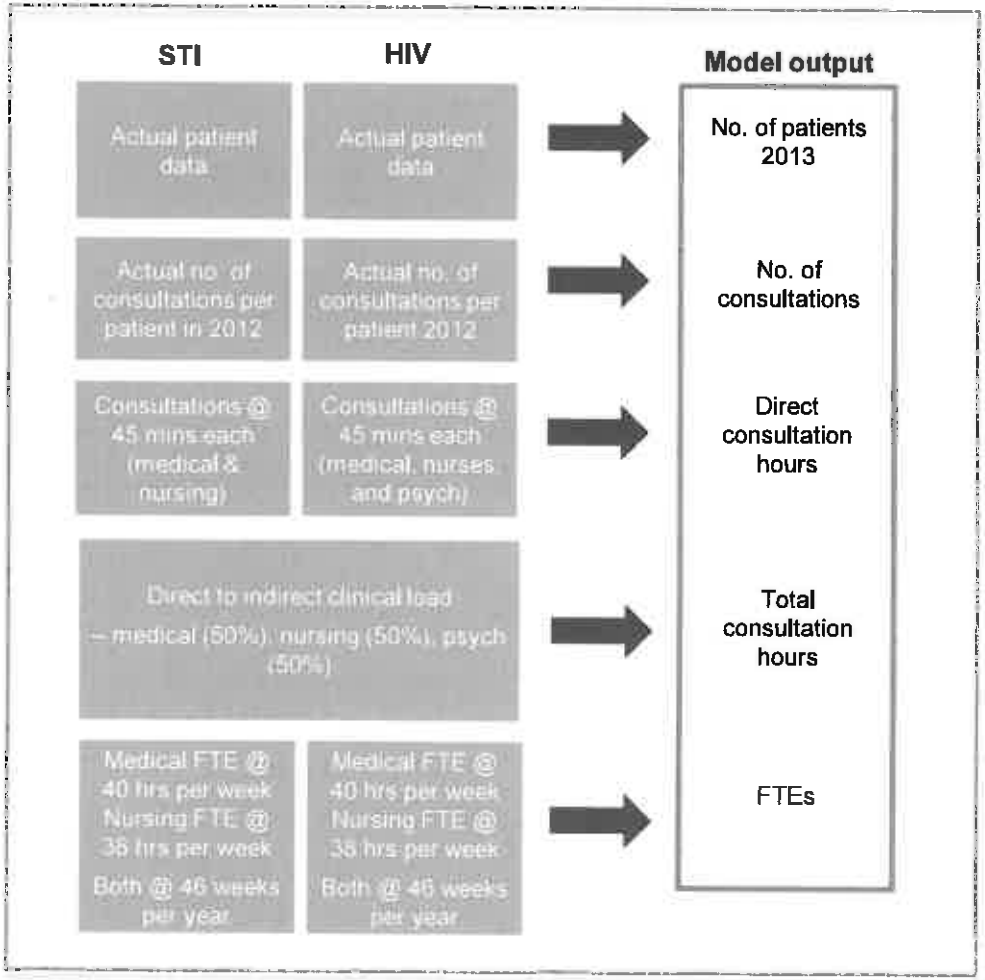
- **Option 1:** All non-Metro North patients (STI & HIV) will need to access services in their respective HHS
- **Option 2:** In addition to Option 1, all non-complex STI patients will transition to the primary care sector
- **Option 3:** In addition to Option 2, all stable HIV patients will transition to s100 GPs.

There is a paucity of evidence surrounding the ratio of indirect and direct clinical time for medical officers, nursing staff and psychologists in the specialist ambulatory setting. The assumed ratios identified in Figure 18, have been estimated through consultation and reference to current practice with consideration given to the increased time associated with completing administration tasks required in the care of people living with HIV, the time required to provide s100 GP mentoring services, providing specialist advice to GPs on the management of cases and accommodating clinical education and training.

The output of the model for sexual health and HIV services has been summarised in Table 37.

The model has incorporated actual patient data for the number of consultations and number of patients. Through this analysis it was identified that the number of consultations per patient, under each patient classification (stable, unstable, chronically unstable) differed to the Model of Care document used by the service. Whilst there are various clinical reasons for this difference, it is an important consideration when interpreting the results of the resourcing assessment.

Figure 18: Summary of Model Assumptions



6 Resourcing

6.2 Clinical Workforce

Overview

The clinical workforce requirements for the service delivery model under consideration by the MNHHB have been estimated and outlined below. These estimates assume successful transition of all patients cohorts and related activity as described in the service delivery options.

Table 37: Estimated patient activity and clinical workforce required for the service delivery model considered by the MNHHB

	Option 1 - Transfer of Non-MNHHS Residents	Option 2 - Transfer of Non-Complex STI Patients	Option 3 - Transfer of Stable HIV Patients
STI Service Patients	3,664	1,099	1,099
HIV Service Patients	575	575	427
Total Patients	**4,239**	**1,674**	**1,526**
STI Consultations (no.)	6,786	3,298	3,298
HIV Consultations (no.)	3,355	3,355	2,514
Total Consultations (no.)	**10,141**	**6,653**	**5,812**
Total FTE	**10.25**	**7.5**	**7.0**
Medical	**3.75**	**3.0**	**2.5**
Nursing	**6.0**	**4.0**	**4.0**
Psychology	**0.5**	**0.5**	**0.5**

6 Resourcing

6.3 Summary

Overview

In addition to the clinical workforce requirements, which are primarily driven by patient activity, there are a number of other positions required to resource the service. The appropriate level of resourcing for the positions involved in the provision of support services or indirect clinical care have been outlined below along with the clinical workforce estimates. Key considerations guiding the FTE estimate for each position have also been included.

Table 38: Workforce Resourcing HIV Services

Category	Position	ToR Proposed FTE	Option 1 FTE	Option 2 FTE	Option 3 FTE	Key Considerations
Medical Officer	Medical Officer	1.0 FTE	3.75 FTE	3.0 FTE	2.5 FTE	• Appropriate consideration of the skill mix required to effectively deliver both sexual health and HIV services will need to occur. • The indirect clinical time incorporated will be used for mentoring, liaison with primary care and providing specialist sexual health and HIV advice.
	Medical Officer (Syphilis Register)	0.5 FTE	-	-	-	• The management of syphilis notifications is a statewide service. Therefore, it is proposed that the most appropriate location of the function should be in the Communicable Diseases Unit (CDU) where the other notifiable diseases are managed.
Nursing	Nurse (Syphilis Register)	1.0 FTE	-	-	-	• The management of syphilis notifications is a statewide service. Therefore, it is proposed that the most appropriate location of the function should be in the CDU where the other notifiable diseases are managed.
	Nurses	4.0 FTE	6.0 FTE	4.0 FTE	4.0 FTE	• Appropriate consideration of the nursing skill mix required to deliver the retained service should occur. • The nurse practitioner is retained under all options to provide specialist clinical input consistent with the role's scope of practice. • A nursing position has been incorporated to have a role in the management of team and coordination of services. This role would have a reduced clinical load.

6 Resourcing

6.3 Summary

Table 38: Workforce Resourcing HIV Services

Category	Position	ToR Proposed FTE	Option 1 FTE	Option 2 FTE	Option 3 FTE	Key Considerations
Nursing	Nurse Contact Tracer (HIV)	0.5 FTE	-	-	-	• The management of HIV notifications is a state-wide role and is currently managed by CDU. It is proposed that the contact tracer function should be co-located with the HIV notifications register in the CDU.
Allied Health	Psychologist	0.5 FTE	0.5 FTE	0.5 FTE	0.5 FTE	• 0.5 FTE was confirmed through consultation as a suitable resourcing level to manage the retained MNHHS HIV patients under all options.
	Pharmacist	0.5 FTE	1.0 FTE	1.0 FTE	1.0 FTE	• The pharmacist at Biala would be required to continue dispensing s100 drugs as community pharmacies are not permitted to do so. • There is no change in pharmacy workload under any of the options.
Administration	Administration Officer	0.5 FTE	1.0 FTE	0.5 FTE	0.5 FTE	• Given the reduced patient volume under options 2 and 3 proposed that 0.5 FTE is estimated • Utilisation of the Metro North Administrative Relief Pool is suggested to provide adequate backfill for this position (annual leave, sick leave etc).
	Epidemiologist	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE	• No change to this position is proposed • This position currently has a regional role in assessing the health needs and addressing service delivery gaps, and coordinates a number of projects including health promotion and patient education • This role would assist in the development of primary care capacity with the Medicare Local.
Total		**9.5 FTE**	**13.25 FTE**	**10.0 FTE**	**9.5 FTE**	

Note: The epidemiologist refers to the HIV AIDs Regional Coordinator

Chapter Seven

Contestability Analysis

7 Contestability Analysis

7.1 Overview

Overview

The Terms of Reference for the independent review of MNHHS Sexual Health and HIV Services includes subjecting the service to a contestability review. The review in this instance relates to assessing the market's appetite to deliver, the retained services delivered by the SHHS under a contractual arrangement. For the purposes of the review, the retained services relate to the treatment and management of people with HIV as well as complex and unresolved STIs (retained Services). No views were provided or sought on pricing and value.

The assessment has been informed through informal market sounding with selected providers in Queensland and interstate as listed below. A scan of arrangements in place in other jurisdictions was also conducted to identify where there may be service contracts in place with non-government providers.

It should be noted that the informal market sounding with providers does not represent a procurement process or should be relied upon for the purpose of determining the capacity and capability of the market to deliver primary and specialist sexual health and HIV services.

List of stakeholders

- Family Planning Queensland
- Spiritus Positive Directions (Anglicare)
- Taylor Square Private Clinic, Sydney
- Healthy Communities
- Micah Projects
- QuiHN
- Respect Inc.
- Metro North Medicare Local
- Metro South Medicare Local
- Sydney Sexual Health Service (Public)
- Melbourne Sexual Health Centre (Public)

Inter-jurisdictional Comparison

Through a scan of publicly available information and consultation with public sexual health services in New South Wales and Victoria, there are no known arrangements between government and private providers to deliver direct clinical services for HIV and STI.

Market Sounding - Views

Through the process of consultation, the following general points were raised by providers on the possibility of retained SHHS services being contested. The providers who raised the points have not been identified as was the agreed process through consultation.

General points

- Market Appetite - A number of providers expressed an interest in being contracted to deliver parts of the retained SHHS service on the basis that:
  - It aligns with their strategic and organisational objectives
  - It could potentially deliver scale and depth to existing services
  - The non-specialist portion of clinical activity could be delivered as part of / expansion of existing services (for some providers)
- Funding / payment models could incorporate a combination of patient co-payment, MBS fees and grant payments for services not covered or poorly covered by other revenue sources
- It is noted that some providers currently charge an out of pocket fee for certain clinical services.

7 Contestability Analysis

7.1 Overview

Market Sounding – Views (continued)

Specific points raised in relation to HIV

- No providers consulted currently deliver HIV treatment and management services in Brisbane (noting that a small trial is currently underway by one provider). The two GP practices, Stonewall Medical Centre and Brunswick Central Medical Centre, currently delivering HIV services in Metro North are at or near capacity.
- A number of providers expressed an interest in participating in a potential contracting arrangement for HIV services for the following reasons:
  - They have existing service arrangements (contracted and uncontracted) in place to provide support services to clients with HIV
  - There is a track record of delivering direct care for other chronic / complex conditions (e.g. mental health)
- A potential contracted arrangement would need to:
  - Recognise the viability issues associated with the MBS not reflecting the needs of the patients
  - Include some specialist equipment that is necessary to operate a service
  - Facilitate access to s100 prescribers and/or mentors
  - Explore improved access arrangements to specialist s100 drugs.

Conclusion

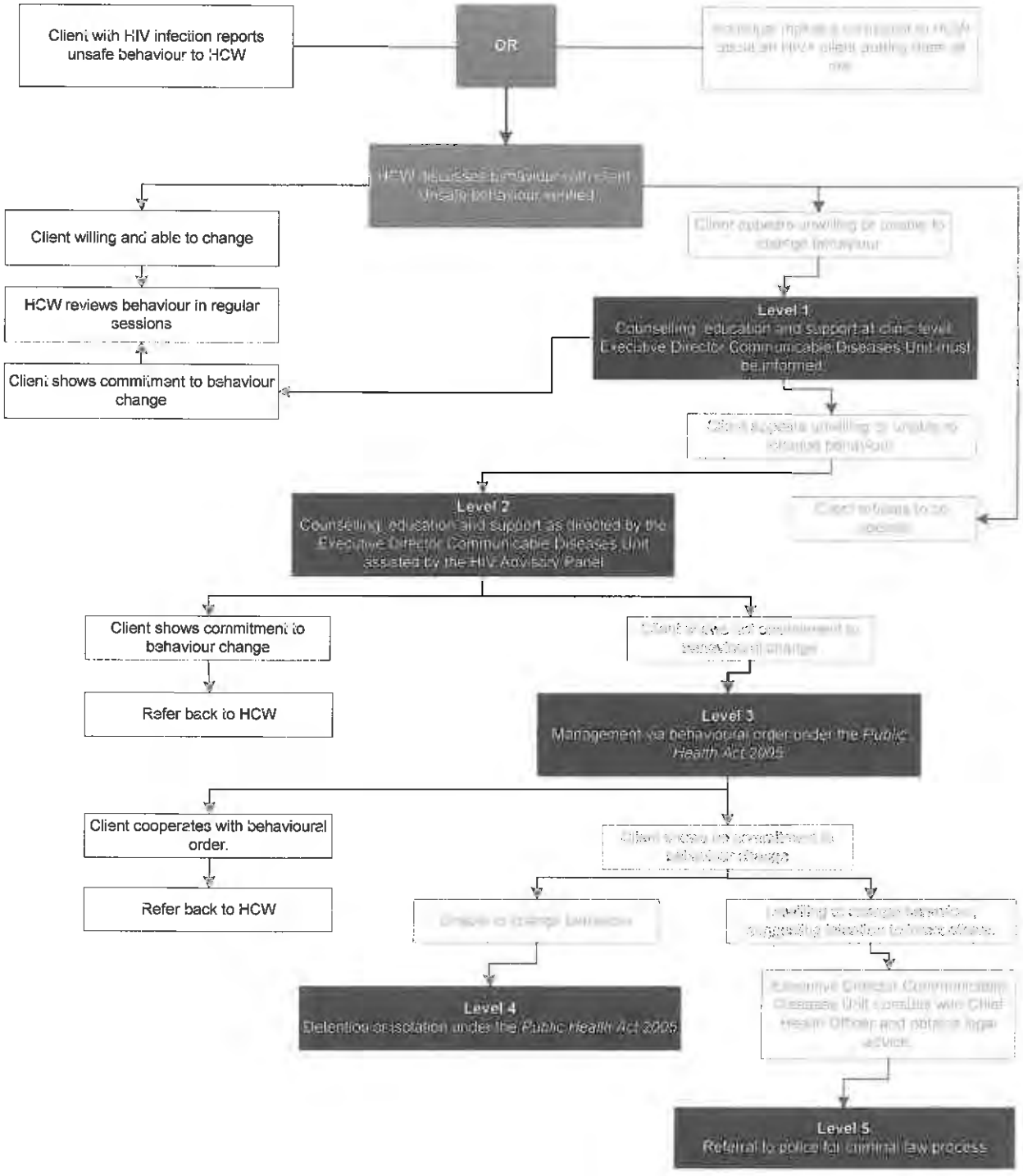
The information provided through the consultation process identified an interest among some external providers to deliver all or part of the retained SHHS service under a contractual arrangement.

One issue with a contestable option that may impact patient access is that many of the providers have a special interest in either a vulnerable population group or a particular service type. An organisation's religious and historical affiliation was also identified as a potential issue that may impact patient access.

A detailed service contestability plan would need to be developed to fully assess the service requirements, interface points, cost of service, funding arrangements and clinical, commercial and financial due diligence.

Appendices

Appendix A
Management of Protocol Patients



Source: Protocol Health Service District – Protocol for the management of people living with HIV who place others at risk

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Figure 1. 2012 performance against National Elective Surgery Targets, by jurisdiction

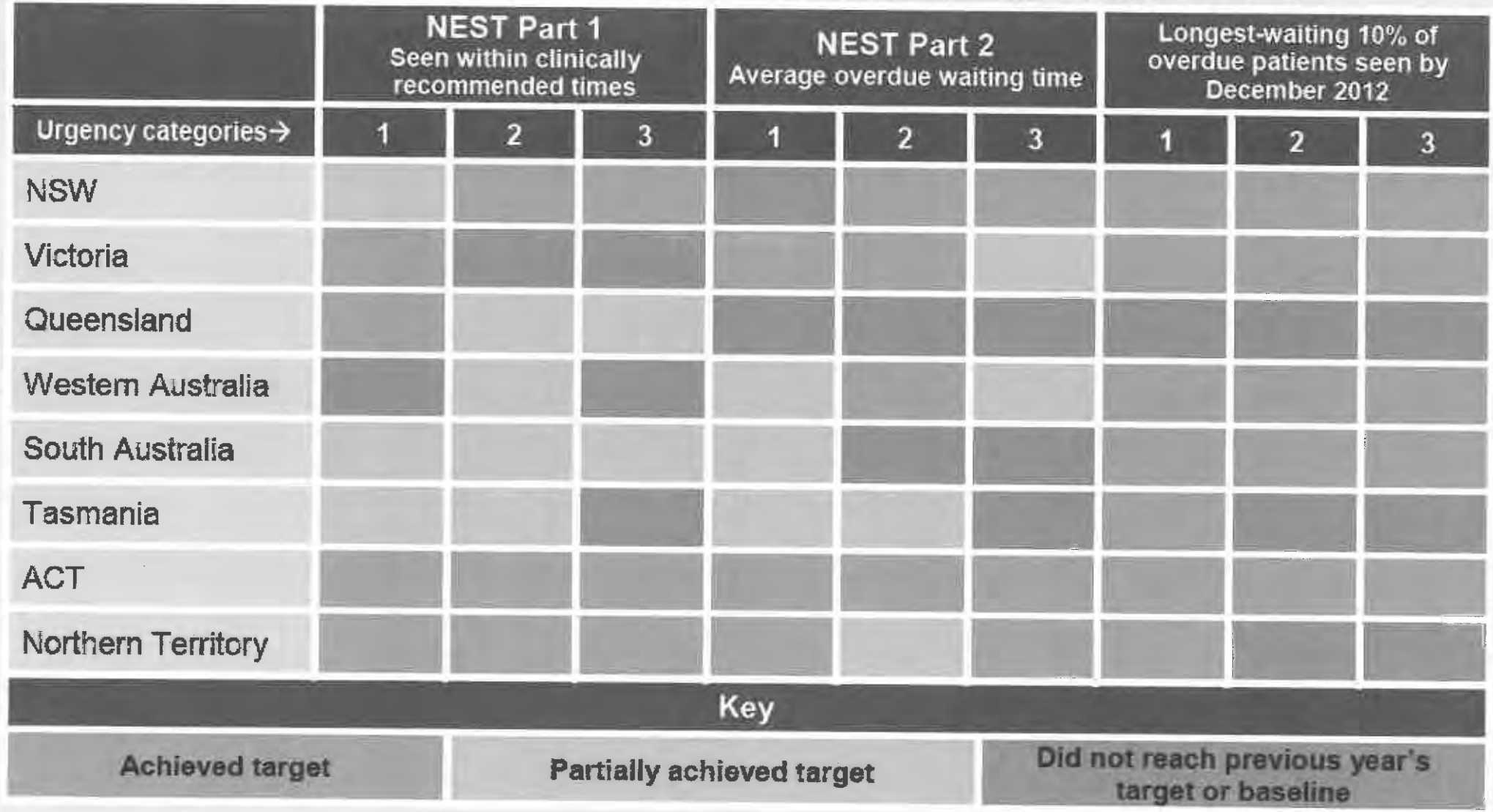


Figure 1. 2012 performance against National Elective Surgery Targets, by jurisdiction

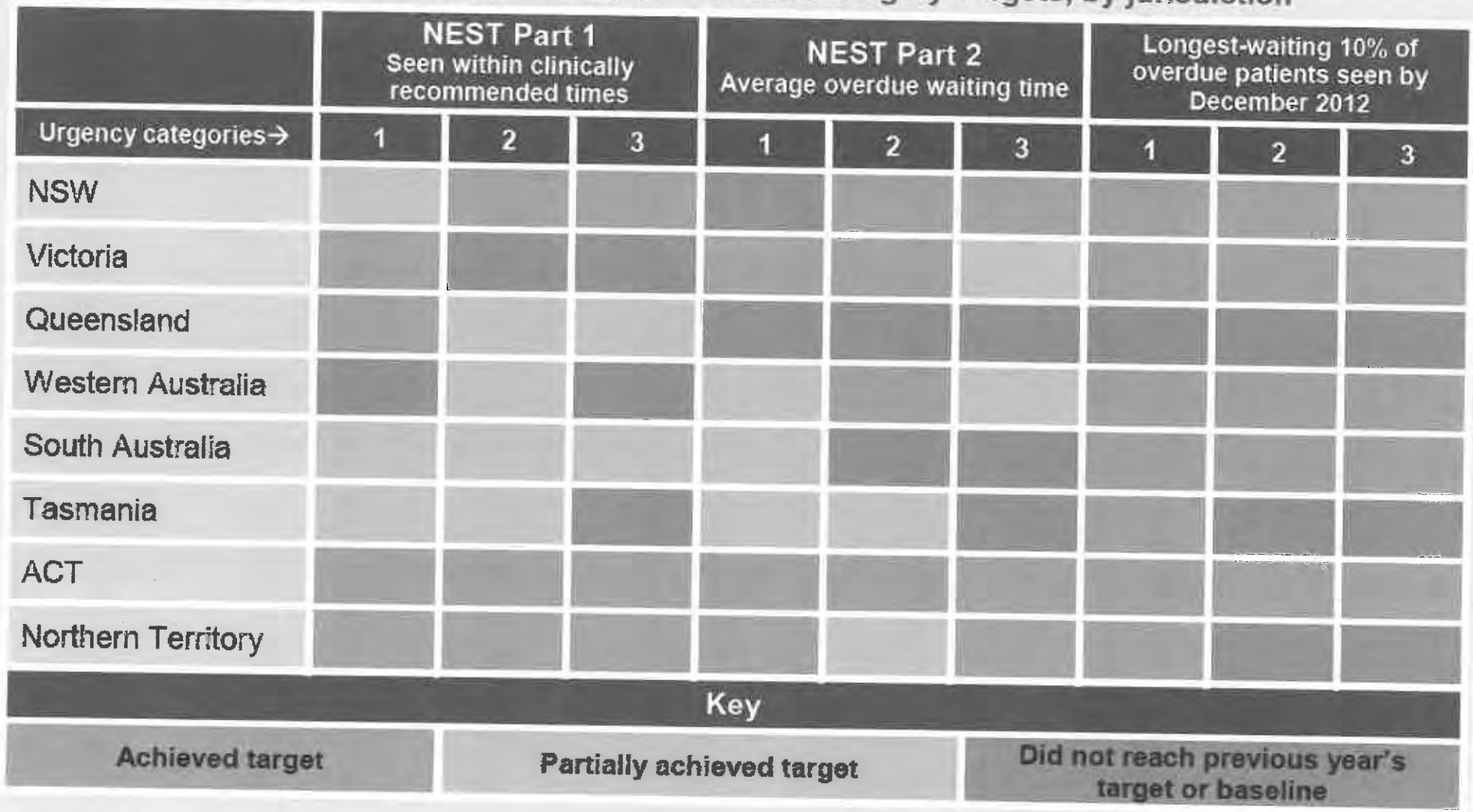
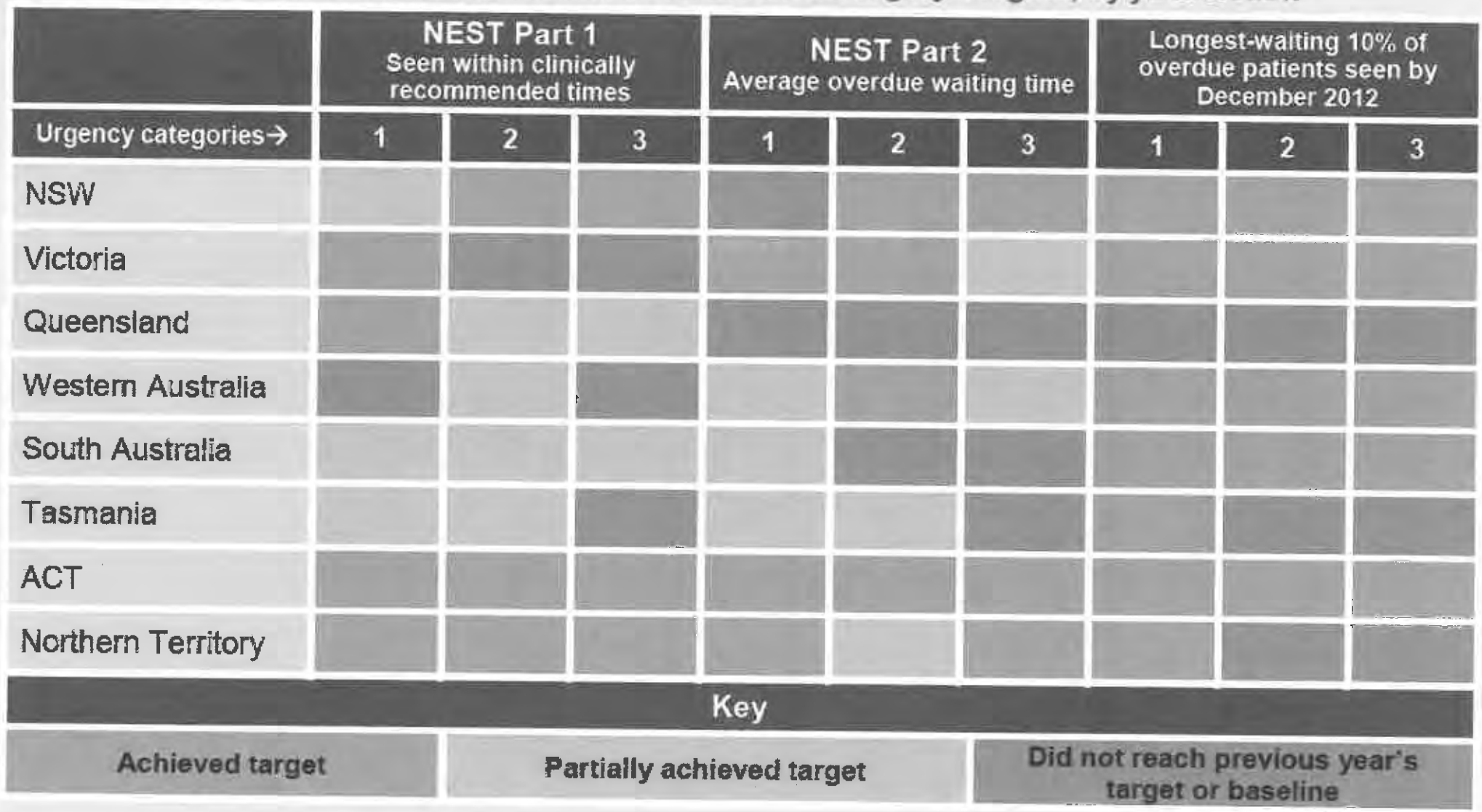


Figure 1. 2012 performance against National Elective Surgery Targets, by jurisdiction



Tabled 24/7/13

Advisory
Riparian Plaza
71 Eagle Street
Brisbane Qld 4000

GPO Box 223
Brisbane Qld 4001
Australia

ABN: 51 194 660 183
Telephone: +61 7 3233 3111
Facsimile: +61 7 3233 3100
www.kpmg.com.au

Privileged and confidential
Dr Tony O'Connell
Director-General
Queensland Health
Level 19
147-163 Charlotte St
Brisbane QLD 4000

Our ref 18486923_2

Contact Sabine Schleicher

By email

22 July 2013

Dear Tony

Public release of SCUH and QCH - Review of Options for the Outsourcing of Clinical and Support Services

We understand that it is the desire of the Minister for Health to release publicly two reports prepared by KPMG for Queensland Health: "Sunshine Coast University Hospital – Review of Options for the Outsourcing of Clinical and Support Services"; and "Queensland Children Hospital – Review of Options for the Outsourcing of Clinical and Support Services", collectively referred to as the Business Cases. This letter sets out some commercial considerations relating to the release of these documents.

The purpose of the Business Cases is to respond to the Government's request for a review of opportunities for the contracted delivery of clinical and operational services at each of SCUH and QCH. The Business Cases provide analysis of a range of potential opportunities to improve the efficiency and effectiveness of clinical and support services. These include identification of clinical and support services which could potentially be delivered through outsourcing arrangements and consideration of whether these outsourcing arrangements have the potential to deliver a Value for Money (VFM) solution for the respective Hospital and Health Services (HHS) and, ultimately, the people of Queensland. A confidential market sounding process was conducted to inform the preparation of the Business Cases.

The Business Cases include commercially sensitive information, such as:

- information which was provided by or relates to certain third parties, including the results of market assessments and market soundings
- commercial and legal information that could prejudice any future procurement process, including details of agency cost structures and estimated potential savings
- information which may, if released, potentially impact the commercial value of firms that may or may not be involved in the delivery of services at the two sites.

From a commercial perspective, it would be preferable to refrain from the public release of the Business Cases at this time. However, this would not preclude the release of the Business Cases at a later stage. Whilst there are some precedents, it is common not to disclose documents relating to a procurement process until the completion of the procurement process.

Given the Minister's desire to make public the Businesses Cases, it is important that the release of the Business Cases is undertaken in a way that does not violate confidentiality provisions, inappropriately attribute information to third parties or prejudice the success of any potential future procurement process. These outcomes would not only have a negative impact on the Queensland Government, but would also potentially devalue any outcome that the Government could achieve for taxpayers. We have therefore prepared a recommended redacted version of the Business Cases and redacted the following information:

- **Market sounding information**
  Any information in respect of the market sounding process and assessment of the market, as this could provide potential tenderers in any outsourcing process with insight on your views as to the nature of the potential competition for the services and could influence the market response
- **Financial analysis**
  Any financial analysis which reveals the existing cost structures, provides an indication of the estimated savings or reveals aspects of the methodology that you may employ to evaluate tenders, including quantitative risk adjustments, as this could influence the bidding behaviour of potential service providers, e.g. in terms of the price offered relative to the National Efficient Price (NEP)
- **Commercially sensitive information**
  Any commercial and legal information that could influence the behaviour of third parties in any future tender process or other commercial dealings
- **Confidential information**
  Any information which is subject to formal confidentiality obligations on Queensland Health or financial information relating to existing contracts
- **Information which has not been verified**
  Information which KPMG has sourced in relation to the case studies, which is principally from publicly available material, but which KPMG has not been able to verify in the time available and hence is not appropriate for release into the public domain.

We have also removed the Appendices, given that they do not add substantively to the analysis in the body of the report but include a large volume of information that may need to be redacted under the above principles, particularly in relation to the results of the market assessment and market sounding process, and detailed legal advice.

Redacting commercially sensitive information is common practice. A recent example is the Detailed Business Case for the proposed Moorebank Intermodal Terminal which was prepared

by KPMG on behalf of the Commonwealth Department of Finance and Deregulation[1]. Significant sections of the document, such as the financial analysis, were redacted from the document, so as not to prejudice a future procurement process.

We have included the following words at the front of the redacted version of the documents:

"Please note that certain information contained within this report has been redacted. The information which has been redacted includes certain financial and commercial information, information in respect of or in relation to competitive procurement processes which may be conducted by Queensland Health in the future, and information which was provided by or relates to certain third parties in relation to which the State has assumed obligations of confidentiality."

Please do not hesitate to contact me, if you have any additional queries in respect of our advice.

Yours sincerely

Sabine Schleicher
Partner

Adrian Box
Partner

[1] www.finance.gov.au/property/property/moorebank-intermodal-freight-terminal/docs/public_release_detailed_business_case.pdf

KPMG

cutting through complexity

QUEENSLAND HEALTH

Queensland Children's Hospital

Review of Options for the Outsourcing of Clinical and Support Services

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Please note that certain information contained within this report has been redacted. The information which has been redacted includes certain financial and commercial information, information in respect of or in relation to competitive procurement processes which may be conducted by Queensland Health in the future, and information which was provided by or relates to certain third parties in relation to which the State has assumed obligations of confidentiality.

Contents

71 Eagle Street
Brisbane QLD 4000

GPO Box 223
Brisbane QLD 4001
Australia

ABN: 51 194 660 183

Telephone: +61 7 3233 3111
Facsimile: +61 7 3233 3100
www.kpmg.com.au

2 July 2013

[redacted]

Brisbane QLD 4000

Dear [redacted],

Queensland Children's Hospital – Review of Options for the Outsourcing of Clinical and Support Services

We were engaged in late March 2013 to develop a VFM Business Case to review the options for the outsourcing of Clinical and Support Services at the QCH by the Department of Health and on behalf of the Queensland Government. Our work has been performed in accordance with the scope of work terms and conditions as outlined in Queensland Health's Acceptance Letter.

Final report

This report is in final form and has been prepared on the basis of our work commencing on 25 March 2013 and carried out up to 2 July 2013.

As part of the development of the VFM Business Case, we have undertaken an extensive market scan and market sounding process with Non-Government Service Providers (NGSPs); consultation with central agencies, the Executive and Board of the Children's Health Queensland Hospital and Health Service (CHQ HHS), clinicians, Department of Health executives, including Queensland Health's Contestability Branch. This research and consultation process has been an important part of the development of the VFM Business Case and has been incorporated in KPMG's independent analysis of potential service delivery options.

Throughout the consultations we were provided with thoughtful analysis of the issues to be considered in analysing outsourcing options. The report's objective is to provide a fulsome discussion of the issues and considerations in respect of each of the outsourcing options.

Information

In undertaking our work we have had access to information provided by CHQ HHS, legal advisers and publicly available information.

Distribution

This report has been prepared exclusively for Queensland Health in relation to the Queensland Children's Hospital. This report must not be used for any other purpose or distributed to any other person or party, except as set out in our engagement contract, or as otherwise agreed by us in writing.

We would like to record our thanks to the Executive and Board of CHQ HHS who have facilitated our work wherever possible.

Finally, we would like to thank you for entrusting KPMG to prepare this report for consideration by the Queensland Government. It has been a privilege to contribute to the consideration of this important public sector reform initiative.

Sabine Schleicher
Partner
sschleicher@kpmg.com.au

Adrian Box
Partner
abox@kpmg.com.au

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- owes you no duty (whether in contract or in tort or under statute or otherwise) with respect to or in connection with the attached report or any part thereof; and
- will have no liability to you for any loss or damage suffered or costs incurred by you or any other person arising out of or in connection with the provision to you of the attached report or any part thereof, however the loss or damage is caused, including, but not limited to, as a result of negligence.

If you are a party other than Queensland Health and you choose to rely upon the attached report or any part thereof, you do so entirely at your own risk.

Limitations

The responsibility for determining the adequacy or otherwise of our terms of reference is that of Queensland Health.

Our terms of reference comprise an advisory engagement which is not subject to Australian, or any other, auditing or assurance standards and consequently no conclusions intended to convey assurance are expressed.

Further, as our terms of reference do not constitute an audit or review in accordance with Australian auditing standards, they will not necessarily disclose all matters that may be of interest to Queensland Health or reveal errors and irregularities, if any, in the underlying information.

In preparing this report, we have had access to information provided by Queensland Health and its legal advisors, commercially sensitive information obtained in the market sounding process and publicly available information. The findings and recommendations in this report are given in good faith but, in the preparation of this report, we have relied upon and assumed, without independent verification, the accuracy, reliability and completeness of the information made available to us in the course of our work, and have not sought to establish the reliability of the information by reference to other evidence.

Any findings or recommendations contained within this report are based upon our reasonable professional judgement based on the information that is available from the sources indicated. Should the project elements, external factors and assumptions change then the findings and recommendations contained in this report may no longer be appropriate. Accordingly, we do not confirm, underwrite or guarantee that the outcomes referred to in this report will be achieved.

We have not compiled, examined or applied other procedures to any prospective financial information in accordance with Australian, or any other, auditing or assurance standards. Accordingly, this report does not constitute an expression of opinion as to whether any forecast or projection of CHQ HHS or any delivery option analysed will be achieved, or whether assumptions underlying any forecast or projection of CHQ HHS are reasonable. We do not warrant or guarantee any statement in this report as to the future prospects of CHQ HHS or any delivery option analysed.

In addition, in preparing this report KPMG has had to make certain estimates as to potential costs, savings, capital expenditure and other items. Those estimates have necessarily been based on hypothetical assumptions as to future events and circumstances. There will inevitably be differences between forecast or projected and actual results, because events and circumstances frequently do not occur as expected or predicted, and those differences may be material. KPMG does not warrant or guarantee any of its estimates, forecasts or projections contained within this report.

1 Executive Summary

1.1 Purpose of this Business Case

The recently released *Blueprint for better healthcare in Queensland*[1] (the Blueprint) outlines the Queensland Government's plan for structural and cultural improvement in the health system. Specifically, the Blueprint details the Queensland Government's willingness to explore opportunities for alternative service delivery models to improve value for money such as outsourcing, co-sourcing, public-private joint ventures and partnering with the private sector and other government agencies.

This Value for Money (VFM) Business Case responds to the Government's request for a review of the opportunities for the contracted delivery of clinical and operational services at the Queensland Children's Hospital (QCH).

The new QCH is being developed to respond to the growing demand for paediatric services in Queensland and to consolidate services currently provided across the Royal Children's Hospital (RCH) and Mater Children's Hospital (MCH). The QCH is currently under construction and is scheduled for opening in late 2014, with client commissioning occurring in 2014. The QCH is being built on land at South Brisbane adjacent to the existing MCH.

The Business Case provides analysis of a range of potential opportunities to improve the efficiency and effectiveness of clinical and support services at QCH, incorporating potential options for non-government service provider (NGSP) delivery of services, without compromising the quality and safety of the provision of health services. The Business Case identifies clinical and support services which could, potentially, be delivered through outsourcing arrangements and tests whether these outsourcing arrangements have the potential to deliver a VFM solution for the Children's Health Queensland Hospital and Health Service (CHQ HHS) and ultimately the people of Queensland in the context of QCH's scheduled opening date in late 2014.

1.2 Overview

In undertaking the analysis for the Business Case, KPMG has drawn on a number of sources of information including in particular:

- **Market research**: KPMG has conducted a scan of the major industry participants - locally, nationally and internationally - that might be expected to have the capability and experience to provide the range of services identified for potential outsourcing at QCH.
- **Market soundings**: KPMG, in conjunction with the Department of Health and CHQ HHS, has conducted a series of 17 meetings with selected market participants to obtain a non-government perspective on issues associated with outsourcing public health services. Among other things, these discussions have provided the market's perspective and have informed the analysis of the potential issues and the assessment of the potential capability and appetite of the market to provide these services.
- **Government and clinical stakeholder consultations**: KPMG has engaged in intensive consultation with the executive and staff of the CHQ HHS and senior officials within the Department of Health, the Department of the Premier and Cabinet and the Treasury. This has involved over 20 interviews with clinicians and other staff of the facility as well as a series of workshops with the CHQ HHS leadership team and briefings of the Board. These discussions have assisted in clearly defining the service requirements and then identifying the opportunities, constraints and risks in relation to the provision of these services by CHQ HHS and / or NGSPs.

[1] Queensland Government, *Blueprint for better healthcare in Queensland*, February 2013, http://www.health.qld.gov.au/blueprint/docs/print.pdf

- **KPMG independent analysis**: In addition to relying on the observations from each of the elements above, KPMG has applied its own experience and expertise in the health care sector, conducting VFM assessments, and commercial analysis of NGSP delivery of public services and associated contractual arrangements to further develop the analysis in this Business Case.

This Business Case has been developed in a compressed timeframe (over a 7-week period) in order to allow Government decision makers to make a decision by mid 2013 given the short timetable for opening of the new hospital.

This Executive Summary does not purport to represent all relevant information and should therefore be read in conjunction with the remainder of the Business Case.

1.3 CHQ HHS versus QCH

QCH accounts for approximately 80% of activity and employs 75% of the workforce within CHQ HHS. CHQ HHS is responsible for the quality of health services provided as well as having the financial responsibility for QCH and other services provided by CHQ HHS. Key additional services provided by CHQ HHS include:

- Research and State-wide programs
- Child and Youth Community Health Services
- Child and Youth Mental Health Services
- State-wide Children's Health Improvement Program.

1.4 Service Outsourcing Options

In considering options relevant to service delivery at QCH a range of service categories were developed. These service categories were defined as:

1.5 Delivery options

As part of the analysis, the opportunities and constraints, potential commercial principles and market precedent for the outsourcing of each service category was considered. Based on this analysis and to reflect the range of potential to in-source or outsource certain services, a range of Delivery Options were developed, reflecting an increasing level of NGSP delivery of services, including:

- Option 1: Base Case – a reflection of the current expected service delivery of QCH by CHQ HHS
- Option 2: Enhanced Base Case – reflecting CHQ HHS delivery with a range of efficiency reform initiatives being implemented
- Option 3: Enhanced Base Case + Facilities Management (FM) – reflecting the potential outsourcing of Soft and Hard FM Services, and CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Option 4: Enhanced Base Case + FM and selective Clinical Support Services Outsourcing – reflecting the potential outsourcing of Soft and Hard FM (as above) as well as the potential outsourcing of selected Clinical Support Services, with CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Option 5: Hybrid – reflecting the potential outsourcing of Soft and Hard FM and some Clinical Support Services as well as selected Clinical Services, with CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Option 6: Full Outsourcing – reflecting the potential outsourcing of all services, i.e. the operation of QCH including FM Services, Clinical Support Services and Operational Services.

A diagrammatic representation of these options is presented below:

1.6 Key observations from consultation, market research and market sounding

In support of our analysis, a summary of the key observations from the consultation, market research and the market sounding is as follows:

1.6.1 Key observations from Stakeholder Consultation

The key observations from the clinical stakeholder consultation interviews, the workshops and other interactions with CHQ HHS are:

- Options involving outsourcing up to and including some Clinical Support Services are generally supported and largely allow QCH's vision to be delivered
- There is strong support for Hard and Soft FM Services outsourcing as well as Information and Communication Technology (ICT) systems
- The creation of QCH and the location of the hospital on the Mater Health Service (MHS) South Brisbane campus has been controversial throughout the history of the project. The creation of one central hub is considered an enabler to deliver high quality, efficient healthcare
- QCH is scheduled to reach Building Completion (PC) in July 2014, with significant transition/commissioning already under way. Any preparation for outsourcing needs to occur in parallel so as to not jeopardise the scheduled hospital opening, noting this parallel process may result in sunk capital costs
- CHQ HHS needs certainty as soon as possible to enable efficient transition from Royal Children's Hospital (RCH) and Mater Children's Hospital (MCH) to QCH
- Options involving outsourcing of Clinical Support Services or Full Outsourcing are controversial. MHS is seen as the primary option for Full Outsourcing given MHS' established capability in providing tertiary paediatric services
- Key concerns raised by CHQ HHS in respect of Clinical Support Services and Full Outsourcing include:
  - The additional interface risk that is created (between Clinical Support Services and Operational Service if responsibility is separated)
  - Quality of state-wide service delivery potentially compromised through lack of connectivity of IT systems
  - The lack of directly comparable precedents and track record of delivery (in particular with respect to Full Outsourcing)
  - [redacted]
  - The quality of care in light of an operator's profit motive
  - The difficulty in creating the right incentives to ensure provision of training, education and research services
  - The impact of Full Outsourcing on the CHQ HHS and related concerns about viability given the scale of QCH as percentage of CHQ HHS

[redacted]

- Some benefits of outsourcing acknowledged by CHQ HHS are:
  - Potential benefits in relation to ongoing workforce management and flexibility
  - Benefits from non Government sector innovation, e.g. flatter management structure, better ICT system, review of staffing models, leading to the potential for financial savings.

1.6.2 Key observations from Market Research

The key observations from the case study review and market scan in relation to Full Outsourcing are:

- There are a range of precedents for the NGSP delivery of public health services both within Queensland, nationally and internationally. These precedents include some examples of the provision of complex services and well developed education and research programs, however, there is very little precedent for the provision of complex paediatric services under such a model
- In relation to these precedents it is important to note that:
  - the majority relate to the provision of a narrow band of services or services that are less complex
  - with the exception of not-for-profit operators, there are limited comparable precedents for the NGSP delivery of large public tertiary teaching hospitals
  - with the exception of MCH, which is the closest in comparison for provision of tertiary paediatric services by a NGSP, we have not identified any direct comparator that incorporates a similar breadth, scale or complexity of services
- The experience of Full Outsourcing has been mixed with some continuing to operate successfully, but a number being returned to Government delivery
- Some examples of NGSPs that provide more complex services as well as education and research include UnitingHealth, Ramsay and MHS
- Further examples include Western Australian facilities Joondalup and Midland Health Campus (noting that service provision has yet to commence), which have outsourced all services, but are less complex facilities (generally equivalent to Clinical Services Capability Framework(CSCF) level 4 to 5 than QCH up to CSCF level 6)
- International examples of NGSP delivery include the 706 bed Bragga Hospital (Portugal), the 300 bed Hospital de La Ribera (Valencia, Spain), the 220 bed Hospital de Manises (Valencia, Spain), the Hinchingbrooke Hospital NHS Trust (UK) and the 310 bed Saint Göran Hospital (Stockholm, Sweden).

The key observations from the case study review and market scan in relation to Clinical Support Services are:

- There are a number of NGSPs that have been successfully delivering Clinical Support Services for many years particularly in imaging, pathology and pharmacy services, although with less direct experience in Queensland or in the tertiary paediatric setting
- The most common Clinical Support Services that are outsourced are pathology, pharmacy, oncology and imaging
- There does not appear to be any providers that would offer the full range of Clinical Support Services under the terms of a single contract, except in the Full Outsourcing model

1.7 Evaluation of Service Outsourcing and Delivery Options

All options for service outsourcing are considered to provide the potential for a VFM outcome, but with varying degrees of opportunity and potential risk. However, it is considered that the Delivery Options most likely to deliver VFM are:

- Option 4: Enhanced Base Case + FM and selective Clinical Support Services Outsourcing – reflecting the potential outsourcing of Soft and Hard FM Services as well as the potential outsourcing of selected Clinical Support Services, with CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Option 5: Hybrid – reflecting the potential outsourcing of Soft and Hard FM Services and some Clinical Support Services as well as selected Clinical Services, with CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Option 6: Full Outsourcing – reflecting the potential outsourcing of all services, i.e. the operation of QCH including FM Services, Clinical Services as well as Operational Services.

The success of Option 4 and Option 5 will be the driven by the successful management of interfaces created by the potential outsourcing. Service fragmentation has the potential risk of impacting on patient safety and quality of health outcomes, however we note that these interfaces are successfully managed in the NGSP sector.

[redacted]

1.9 Conclusions

1.9.1 Full Outsourcing option

While Full Outsourcing is considered to have the potential to deliver value for money, given the timeframe of opening the QCH in late 2014, and the current level of NGSP capability for complex tertiary services [redacted] It therefore bears the most significant risks in respect of the successful transition and opening of QCH, including:

[redacted]

- This would be the first Full Outsourcing contract for the operation of a hospital in Queensland since the introduction of National Efficient Price (NEP). This means:
  - There are still known problems with the NEP that remain to be clarified by the Independent Hospital Pricing Authority, including appropriate loading for paediatric services, treatment of education and training and research. The working party on the treatment of education & training and research is expected to conclude its work in 24 months;
  - Price risk transfer would be limited as a result as any pricing framework would need to respond to the changes in NEP methodology
  - While a level of demand risk is likely to be able to be transferred, the ability to transfer demand risk in a manner equivalent to current HHS arrangements remains uncertain

[redacted]

- The disparate nature of the workforce being drawn from both RCH and MCH and the associated challenges of forming a coherent workforce

[redacted]

[redacted]

[redacted]

In addition, the potential long term implications on pricing and service delivery of having a single NGSP as the provider of State-wide paediatric services needs to be carefully considered. The Full Outsourcing will have less ability to represent a contestable benchmark given the unique nature of the hospital, rather the NGSP will become the only provider.

Based on the above, the risks associated with pursuing Full Outsourcing are considered substantial and, if they eventuated, could outweigh the potential benefits.

1.9.2 FM and Clinical Support Services

We consider the outsourcing of FM Services and selected Clinical Support Services to offer the potential to deliver VFM. Provision of Hard and Soft FM Services have some synergies in service delivery and are hence suggested to be bundled. This will also minimise contractual interface risk and contract management requirements for CHQ HHS.

[redacted]

We note that Clinical Support Services are discrete. Outsourcing of Clinical Support Services may create a level of interface risk with the provision of Operational Services that will need to be carefully managed to ensure quality of care and the achievement of efficient outcomes.

Only few providers offer more than one specialty. The services are hence suggested to be offered as separable portions. There is potential for increased efficiency that may result in financial savings.

Dependent on the number of services outsourced, there is the potential for financial savings in the order of [redacted] as compared to the Enhanced Base Case (or [redacted] as compared to the Base Case) over a comparative term of 15 years.

However, the complexity of the contract arrangements will require significant investment in a highly skilled contract management team to effectively commission, negotiate and manage the contracts.

1.9.3 Hybrid Model

The objective of the Hybrid model is to maximise scope for NGSP innovation and efficiencies, promoting a blend of in-sourcing and outsourcing of service provision without the risks associated with Full Outsourcing.

[redacted]

[redacted]

We consider that a Hybrid delivery model offers the potential to deliver VFM and harnesses a mix of in-sourcing and outsourcing of services.

Dependent on the number of services outsourced, there is the potential for financial savings in the order of [redacted] as compared to the Enhanced Base Case (or [redacted] as compared to the Base Case) over a comparative term of 15 years.

1.10 Implementation Issues

In the context of the above summary, we note the following in respect of the various delivery options.

In relation to Option 4 (Enhanced Base Case + FM + Clinical Support) and Option 5 (Hybrid):

- Should Option 4 or 5 be selected, then based on the proposed indicative timeline, a competitive tender process for FM Services and Clinical Support Services would need to be initiated no later than July 2013.[4]
- Separate teams for both FM Services and Clinical Support Services outsourcing will be required, in addition to the existing commission/transition team.
- This would enable NGSP to be appointed by Practical Completion and assist with the transition and commissioning of QCH.
- CHQ HHS would need to implement the proposed range of Enhanced Base Case initiatives for Operational Services, Corporate Support Services and any Clinical Support Services that were not outsourced – dedicated resources would need to be assigned to this task in order to increase the likelihood of successful incorporation
- The potential for outsourcing some or all Corporate Support Services should be further investigated, including via further analysis in conjunction with the Contestability Branch, to enable HHS-wide and State-wide efficiencies and effective integration

[redacted]

[4] We note separate arrangements for the QCH Energy Plant are discussed in Section 1.8 above.

- Key challenges relate to:
  - The need for a highly efficient governance and approvals process as well as utilisation of some elements of the existing project team to enable an immediate / efficient commencement of the process
  - The development of a highly skilled contract management and implementation management team by CHQ HHS and / or the Department of Health
  - The need for significant additional resourcing to manage the multiple concurrent activities, with particular consideration to be given to the related commissioning planning for QCH.

A project budget of approximately is required to enable the implementation of this option.

In relation to Option 6 (Full Outsourcing) it is noted:

- Key challenges relate to:
  - The need for a highly efficient governance and approvals process as well as utilisation of some elements of the existing project team to enable an immediate / efficient commencement of the process
  - The development of a highly skilled contract management and implementation management team by CHQ HHS and / or the Department of Health
  - The need for significant additional resourcing to manage the multiple concurrent activities, particular consideration needs to be given to the related commissioning planning for QCH. A scenario approach will need to be adopted.

A project budget of approximately is required to enable the implementation of this option.

2 Introduction

2.1 Blueprint for better healthcare in Queensland

The recently released Blueprint[5] outlines the Queensland Government's plan for structural and cultural improvement in the health system.

The Blueprint details a range of changes to the health system under four principal themes:

- Health services focused on patients and people
- Empowering the community and our health workforce
- Providing Queenslanders with value in health services
- Investing, innovating and planning for the future.

Specifically, the Blueprint details the Queensland Government's willingness to explore opportunities for alternative service delivery models to improve value for money such as outsourcing, co-sourcing, public-private joint ventures and partnering with other government agencies. This includes examining the delivery of support services, such as pathology and diagnostic imaging, along with entire hospitals services, particularly at new hospitals and other greenfield sites.

2.2 Purpose of this Business Case

This Business Case responds to the Government's request for a review of the opportunities for the contracted delivery of clinical and operational services at the QCH. The Business Case provides an analysis of a range of potential opportunities to improve the efficiency and effectiveness of clinical and support services at QCH, incorporating potential options for NGSP delivery of services, without compromising on the quality and safety of the provision of health services. The Business Case identifies clinical and support services which could, potentially, be delivered through outsourcing arrangements or partnership with the private sector and tests whether these arrangements have the potential to deliver a VFM solution for CHQ HHS and ultimately the people of Queensland in the context of QCH's schedule completion date of late 2014.

2.3 Approach to the assessment of options

The broad approach adopted in preparing this Business Case has involved stakeholder consultations and market research; identification of relevant services and outsourcing options; and qualitative and quantitative evaluation of outsourcing options. The process has drawn on a range of inputs as follows:

- **Market research**: KPMG has conducted a scan of the major industry participants - locally, nationally and internationally - that might be expected to have the capability and experience to provide the range of services identified for potential outsourcing at QCH.
- **Market soundings**: KPMG, in conjunction with the Department of Health and CHQ HHS, has conducted a series of 17 meetings with selected market participants to obtain a non-government perspective on issues associated with outsourcing public health services. Among other things, these discussions have provided the market's perspective and have informed the analysis of the potential issues and the assessment of the potential capability and appetite of the market to provide these services.

[5] Queensland Government, *Blueprint for better healthcare in Queensland*, February 2013, http://www.health.qld.gov.au/blueprint/docs/print.pdf

- **Government and clinical stakeholder consultations**: KPMG has engaged in intensive consultation with the executive and staff of the CHQ HHS and senior officials within the Department of Health, the Department of the Premier and Cabinet and the Queensland Department of Treasury and Trade (the Treasury). This has involved over 20 interviews with clinicians and other staff of the facility, a series of workshops with the CHQ HHS leadership team and briefings of the Board. These discussions have assisted in clearly defining the service requirements and then identifying the opportunities, constraints and risks in relation to the provision of these services by CHQ HHS and / or NGSPs.
- **KPMG independent analysis**: In addition to relying on the observations from each of the elements above, KPMG has applied its own experience in the health care sector, conducting VFM assessments and commercial analysis of NGSP delivery of public services and associated contractual arrangements to further develop the analysis in this Business Case.

This Business Case has been developed in a compressed timeframe (over a 7-week period) in order to allow Government decision makers to make a decision by mid 2013 given the short timetable for opening of the new hospital.

2.4 Structure of this report

This Business Case follows the structure and content as outlined below:

- **Introduction**: outlines the strategic direction for this Business Case set by the Blueprint and the subsequent Government direction for a VFM Business Case
- **QCH background and scope**: describes the vision and scope of the QCH project, including related developments, as well as the current status of the project
- **Service delivery plans**: describes the strategic policy context for health planning, the current Health Service Plan for CHQ HHS, and the updates to activity projections that have formed the basis for analysis in this business case based on the most recent population projections

- **Criteria for evaluation of service outsourcing options**: sets out a series of criteria that are used to evaluate delivery options in this report under the following headings – strategic and operational; workforce development and management; provider capability and appetite; commercial, financial and legal
- **Service definition**: provides a summary of the various health services to be provided at QCH, segmented into categories that are relevant for potential outsourcing – Operational Services; Clinical Support Services; Corporate Support Services; FM Services: Governance and Executive Functions
- **Service outsourcing options**: describes the Base Case and Enhanced Base Case that provide the benchmark for public delivery of services in this Business Case, as well as the broad commercial approach that would be adopted to outsource each of the main service categories, including relevant precedent models
- **Qualitative VFM evaluation**: provides an evaluation of the potential advantages and disadvantages of outsourcing each of the main service categories, including an indicative scoring of the options, and identifies a shortlist of Delivery Options for Government consideration

- **Summary & recommendations**: a summary of the findings of the Business Case and the proposed recommendations for Government's consideration

3 QCH Background and Scope

This section provides background on the development of the QCH and related facilities. It describes the project vision, the scope of the facilities and the workforce implications of the development.

3.1 Scope of the QCH

The new QCH is being developed to respond to the growing demand for paediatric services in Queensland and to consolidate services currently provided across the RCH and MCH.

3.1.1 Project vision

The vision for QCH is to provide 'best possible health for every child and young person, in every family, in every community in Queensland, bringing together Queensland's best paediatric specialists in one purpose built facility'.

There are four core components of this vision:

- Providing excellent care for children and their families
- Support the delivery of specialist paediatric health services across the State
- Developing new knowledge, through research, to contribute to national and international improvements in child health
- Education and training of the next generations of staff.

3.1.2 QCH Project

The $1.4 billion QCH project comprises the development of the QCH and the QCH Energy plant, provision of land for Family Accommodation and the Adolescent Drug and Alcohol Withdrawal Services (ADAWS) which is currently managed by Mater Health Services (MHS).

The project also includes vacation of the South Brisbane Telephone Exchange, realignment of Graham Street and relocation of the Leukaemia Foundation of Queensland accommodation. The associated Academic and Research Project includes the development of the Academic and Research Facility (A+RF) and refurbishment of the former bank building for the Children's Health Foundation Queensland.

Abigroup is the managing contractor for the development of the QCH main building and QCH Energy Plant, and the contractor for the Academic and Research Facility.

3.1.2.1 QCH

The QCH is a specialist public tertiary teaching hospital at South Brisbane which will consolidate paediatric services currently provided at the RCH and the MCH to provide specialist paediatric care for children from birth to 16 years of age and up to 18 years for existing patients. Mental health and oncology will provide services to new and current patients up to 18 years.

The QCH is currently under construction and is scheduled for completion in late 2014, with client commissioning occurring in 2014. The QCH is being built on land at South Brisbane adjacent to the existing MCH. The building will be twelve levels high.

QCH capacity is expected to include:

- 359 beds including 266 overnight beds
- 14 operating theatres
- 48 emergency treatment bays.

The QCH is planned to operate within this capacity until 2021-22, noting room for further expansion. This capacity of 359 beds will increase the current combined capacity of 288 funded beds at the RCH and MCH as at June 2008.

3.1.2.2 QCH Energy Plant

The QCH Energy Plant will be a tri-generation, three level structure, providing heating, cooling, power services and emergency power services to the QCH, A+RF Facility and future expansion site. It will use natural gas to generate the hospital's energy requirements during peak periods. It is to be completed in January 2014.

3.1.2.3 Academic & Research Facility

The A+RF is a nine storey building which includes wet and dry research floors, pathology, medical record and medical records stores, a connection to QCH via a pedestrian tunnel, retail and staff amenities with capacity for 450 research staff. This facility is located adjacent to QCH and has been designed for future expansion.

Apart from Government funding, the facility has also received funding from Queensland University of Technology (QUT), University of Queensland (UQ) and Translational Research Institute (TRI). A Deed of Commitment has been executed by QUT, UQ and TRI to facilitate the construction of this facility. Upon completion of the facility it is expected that QUT, UQ and TRI will be provided with long term peppercorn lease however these organisations will be required to pay outgoings for the day to day operation of the facility.

The aim of the facility is collaborative research and a Research Committee will be responsible for governance in respect of the use of research space and equipment on Levels 5 – 8 of the facility. Unless the Research Committee deems otherwise, the use of the premises (Levels 5 – 8) has been agreed as 50% for the Department of Health and 25% each for UQ and QUT. The Research Committee will develop guiding principles for research practice prior to the lease commencement date.

3.1.2.4 Children's Health Foundation

The Royal Children's Hospital Foundation was established in 1986 to raise funds for research, equipment and services at the Royal Children's Hospital. In 2012, the Royal Children's Hospital Foundation was renamed the Children's Health Foundation Queensland (the Foundation) with a continuing role at the RCH along with providing support to the new QCH and to children across Queensland through partnerships with local communities and projects.

The Foundation is governed by a Board of 10 and led by a CEO appointed in 2013.

The Foundation raised $6.4 million in donations and other contributions and provided $3.5 million in grants over the period November 2011 – June 2012.[6] These grants included approximately $2.4 million to research, $92,000 to clinical and patient services, $44,000 to volunteer expenses and $944,000 to other Foundation grants. In 2010-2011, around $7.8 million in grants were distributed.

The Foundation will move into the old Bank of NSW building on the corner of Vulture and Stanley Streets. This building requires a refurbishment, and is being developed by Kane Constructions. This is a separate lease space, and is not integrated with the rest of the QCH precinct.

The Foundation is currently also responsible for managing a significant volunteer workforce (approximately 500 volunteers).

3.1.2.5 Land for Family Accommodation

Land on Vulture Street is planned for development for family accommodation. Ronald McDonald House Charities (RMHC) are the providers for this accommodation.

[6]Children's Health Foundation Queensland, 2011-12 Annual Report, page 37

3.1.2.6 Adolescent Drug and Alcohol Withdrawal Service (ADAWS)

This service commenced on Clarence Street in South Brisbane in 2010 and supports adolescents (13-18 years) to combat alcohol and drug addictions. This service is currently operated by MHS but is proposed to transfer to QCH and form part of the community based services delivered by CHQ HHS once QCH opens in 2014.

3.1.3 Hub and spoke model

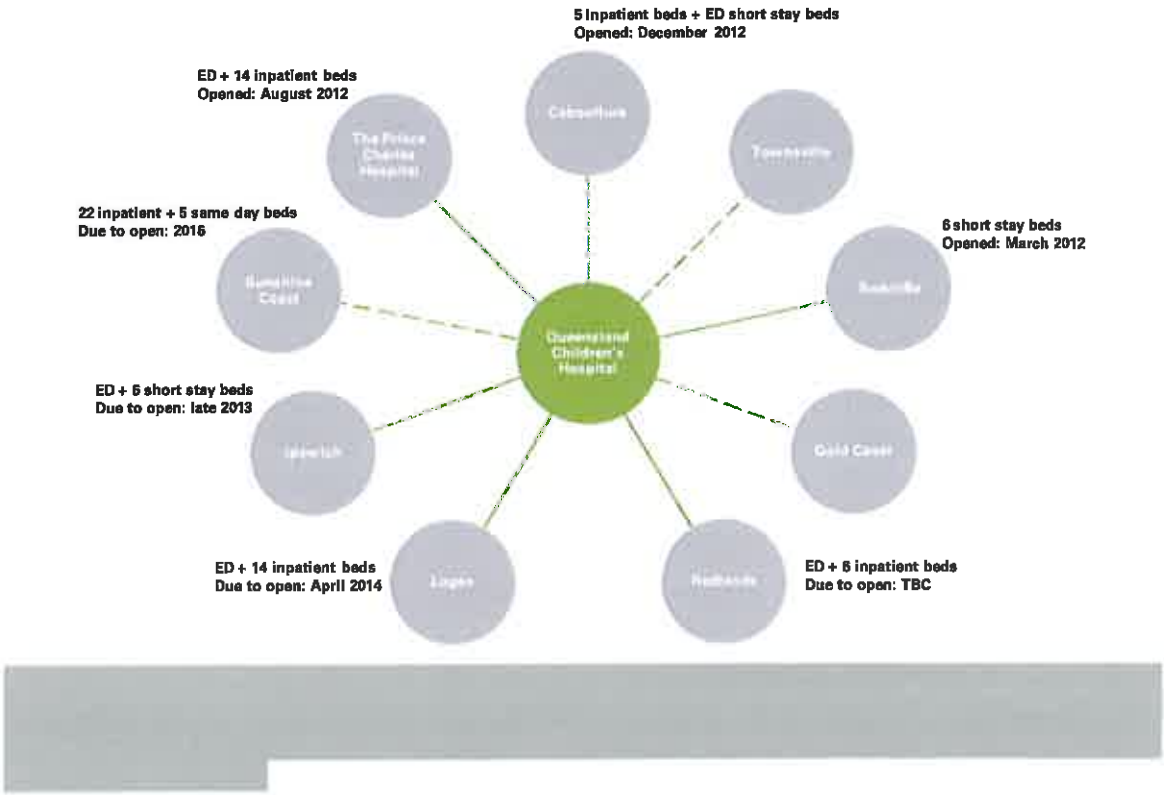
The South East Queensland (SEQ) Paediatric Planning Report (refer section 4.3.1 for further detail) recommended building greater Brisbane paediatric service capability at CSCF level 4 in other hospitals (i.e. spokes) through a mix of multi-day and same day beds, emergency department spaces and outpatient rooms to support the highly specialist role of the QCH when completed.

In that regard, physical expansions of children's health services have already occurred through the construction of paediatric emergency departments at The Prince Charles Hospital, Redcliffe Hospital, Caboolture Hospital and Redlands Hospital. Additional services will also come online through completion of:

- Ipswich Hospital - Paediatric Emergency Department (ED) & 6 short stay beds (scheduled to open late 2013)
- Logan Hospital - Paediatric ED & 14 paediatric inpatient beds (scheduled to open April 2014).

The role of the QCH is to provide clinical, educational and support services to this state-wide network of children's health services, in addition to the increased services delivered through the additional resources at the QCH facility. We note that the nature of QCH's obligation to support the state-wide network will need to be defined (for example, through a Service Agreement with other HHSs).

Figure 3-1: Hub and spoke model



3.1.6 Delivery program and current status

The QCH project is currently under construction and is planned for completion in late 2014, with client commissioning scheduled as outlined below.

The timetable for the delivery of the QCH project is set out in Table 3-2 below.

Table 3-2: QCH Project Timetable

Building completion	Target Date
QCH Energy Plant Building	Jan 2014
QCH Main Building	Jun 2014
Academic & Research Facility	Nov 2014

A range of client commissioning activities will occur post building completion in preparation for building occupancy.

4 Service delivery plans

This section describes key elements of the policy and organisational context for development of the Health Services Plan (HSP) by CHQ HHS. It also examines the demand levels and bed requirements assumed in the HSP, including updated population projections which have led to a revision of activity estimates. CHQ HHS has adopted these revised activity estimates for current planning purposes and they will therefore be assumed to apply to the various delivery options considered later in this business case.

4.1 Strategic Context

As discussed in section 2.1, the recently released Blueprint details a range of changes to the health system, including the Queensland Government's willingness to explore opportunities for alternative service delivery models to improve value for money such as outsourcing, co-sourcing, public-private joint ventures and partnering with the private sector and other government agencies. This will include examining the delivery of support services, along with entire hospitals services, particularly at new hospitals and other greenfield sites.

On 30 April 2013, the Independent Commission of Audit Final Report - February 2013 was publicly released. In particular, recommendation 66 relates to this project which states[11]:

> *'To achieve improved efficiency of public hospital services, the Government should progressively expand contestable markets, initially in metropolitan areas, for the private provision of:*
>
> - *clinical services – which happens already with some elective surgery, but in greenfield hospital developments could go far wider;*
> - *clinical support services such as pathology, radiology and pharmacy;*
> - *non-clinical support services such as catering, cleaning, laundry and ward support.'*

The Government response tabled on 30 April 2013, supported this recommendation, noting the establishment of the Contestability Branch within the Department Health as immediate evidence of action being taken to deliver on the Commission of Audit's recommendations. It also noted that the Government remains *'fully committed to ensuring all Queenslander's have access to a free public hospital system'.*

Planning for QCH service delivery occurs in the context of significant organisational and health funding reforms occurring at the State and national level. These changes include:

- The establishment of HHSs in Queensland, limited by geographical boundary, with the exception of the CHQ HHS which has state-wide responsibilities. Each HHS has been established as a statutory body, with decision making devolved to the local level
- The establishment of a new Chief Executive Officer (CEO), Chair and Board for each HHS, including a greater level of responsibility and accountability at the local level. Each HHS is required to meet key performance indicators as set out in its Service Agreement set by the Department of Health in its role as System Manager (the State). The *Children's Health Queensland Hospital & Health Service 2012-13 Service Agreement* details the profile for CHQ HHS, and sets targets for a range of factors including safety, quality and access to services, efficiency and financial performance
- Consistent with the above changes, the implementation of the national health reforms changes the role of the states and territories to make them the managers of the public hospital system. The Department of Health's role in Queensland is now to focus on system-wide policy, planning and service purchasing and supporting system-wide quality and safety and service innovation. This has necessitated a higher level of financial, workforce and service planning at the HHS level

[11] Queensland Government, *Queensland Commission of Audit- Final Report, February 2013.*

- There has also been a push to improve the transparency and efficiency of public hospital funding through the establishment of the National Health Funding Pool and Independent Hospital Pricing Authority (IHPA) and the implementation of a nationally consistent Activity Based Funding (ABF) model. Under the model, ABF will apply to admitted acute services, emergency department services and some outpatients services from 1 July 2012 and to other non-admitted services, mental health and subacute services commencing from 1 July 2013. Block grants will continue to apply for service types for which ABF may not be appropriate, or further work to develop a model is required (e.g. small rural hospitals)
- The IHPA sets the NEP that will be used to determine the Commonwealth share of public hospital funding. Under the ABF arrangements, the Commonwealth will fund 45% of the NEP for growth in activity from 2014-15 and 50% of the NEP for growth in activity from 2017-18. The states and territories will be responsible for funding the remaining cost of services in their public hospitals above the level of funding received from the Commonwealth.

4.2 Service delivery principles

The service delivery vision for QCH aligns with its overall vision (as discussed in 3.2.1). This is to achieve the 'best possible health for every child and young person, in every family, in every community in Queensland, bringing together Queensland's best paediatric specialists in one purpose built facility'.

To support this vision and key objectives, there are a number of key principles guiding the development of the state-wide service delivery role the CHQ HHS provides, including:

- Services to children must be safe, sustainable and achieve outcomes of the highest quality
- The core philosophy of child and family-centred care drives CHQ HHS' outcomes, decision and recommendations
- Children's services should be responsive and respectful to the diverse and specific needs of children and families everywhere in Queensland;
- Consultation with key stakeholders is critical to inform, identify, confirm and support the CHQ HHS state-wide role
- Focus on the 'whole child' is essential rather than a diagnosis specific or organ based approach
- Building resilience and the capacity for self management in families is key
- Parents are the experts in the care of the child
- The organisation utilise, enhance and build on skills already available

Collectively all HHSs will take responsibility for the movement of children within the Queensland systems and support those caring for children closer to a child's home.

4.3 Health service plans

Planning for the QCH began over 5 years ago, with the following documents providing context for the current service planning commitments for the QCH.

4.3.1 SEQ Paediatric Planning Report (2009)

The purpose of this report was to identify and respond to future service demand issues following consultation with relevant stakeholders. The key recommendations of the report were to:

- Build greater Brisbane paediatric service capability at CSCF level 4 in other hospitals through a mix of multi-day and same day beds, emergency department spaces and outpatient rooms to support the highly specialist role of the QCH. The report identified high priority areas as

Caboolture, Ipswich, Logan, Redcliffe and Redland hospitals, given the growth in child (0-14 years) population

- Develop a workforce plan to build capability and support services with multidisciplinary, speciality paediatric health staff
- Develop a formal children's health service network with the QCH as the hub for state-wide services
- Implementation of strategies to increase public awareness of local acute, ambulatory and primary care services in greater Brisbane and metropolitan facilities. These strategies are intended to reduce the number of children presenting at the highly specialised ED services at RCH and MCH, when their presenting condition could be safely managed at their local hospital
- Development of the CSCF paediatric module in 2009, that defines six standardised levels of capability requirements for public and private health services
- Development of a state-wide, whole-of-system (adult and children) demand management strategy
- As a result of this report, the State government announced an investment for an additional 45 short stay beds and 27 overnight beds required in SEQ to support service demand as a result of population growth in Brisbane.

4.3.2 Queensland Children's Hospital – Health Service Planning Report (2009)

This report revised a number of health service planning assumptions in the *QCH Health Service Plan 2008-2018*, to allow for updated population and inpatient activity projections, new government policy and capital funding, new and enhanced models of care and refinement to paediatric planning across Queensland.

These key findings were:

- While the catchment for QCH remained largely unchanged, the decision to enhance the delivery of secondary level paediatric services and paediatric emergency services at other metropolitan hospitals will allow QCH to focus on providing tertiary specialist services for the whole of Queensland, as well as secondary services for its local area in Inner Brisbane
- QCH to act as a hub for state-wide networks for multiple speciality paediatric services including through physical outreach services, use of telehealth and the provision of some sub-speciality services at other metropolitan Brisbane hospitals
- As a result of neonatal service planning undertaken in 2009, it was agreed to increase the number of Neonatal Intensive Care Unit (NICU) cots planned for the Gold Coast University Hospital to 12 to provide a more balanced distribution of cots in South East Queensland with improved access for residents and babies. This resulted in an increase of 6 day medical beds and 6 adolescent beds for QCH, continuing to meet the commitment for 359 public beds in the QCH
- A number of new and expanded services to be provided at the QCH (see section 4.3.3)
- The bed numbers and services proposed for the QCH proposed beds will be adequate to meet demand until just before 2021, provided the successful implementation of the SEQ Paediatric Plan occurs. Space for future expansion has been included in the QCH plans to allow for future population growth.

4.3.3 Service delivery model

QCH will be the central hub of child and youth health services. Its scope will include:

- CSCF level 5 and 6 paediatric services to the state-wide catchment and some interstate and international populations (e.g. Papua New Guinea)

- QCH will provide CSCF level 4 paediatric services to a local catchment (with some other hospitals across Queensland also able to provide CSCF level 4 paediatric services to their local communities)
- QCH will provide specialist referral services for new patients referred up to the age of 16 years and up to 18 years for existing patients. Mental health and oncology will provide services to new and current patients up to 18 years.
- QCH will support the provision of paediatric services through a 'hub and spoke' model with regional hospitals and other hospitals in the Greater Brisbane metropolitan area by means of joint specialists appointments, workforce rotation, outreach clinics, teaching, consultancy and telehealth services
- QCH will provide the central focus for teaching and research activity in partnership with universities and other educational institutions.

The scope of the QCH supports the key principle of health service delivery in Queensland that, wherever possible, people should be able to access care as close to home as practical, while still ensuring patient quality and safety including through hospitals adhering to their CSCF capability.

The QCH will provide new and expanded services, including:

- Adolescent service
- Obesity services
- Rehabilitation service.

The services to be provided at the QCH are detailed in the service definition in Section 7.

4.3.4 Role of the CHQ HHS

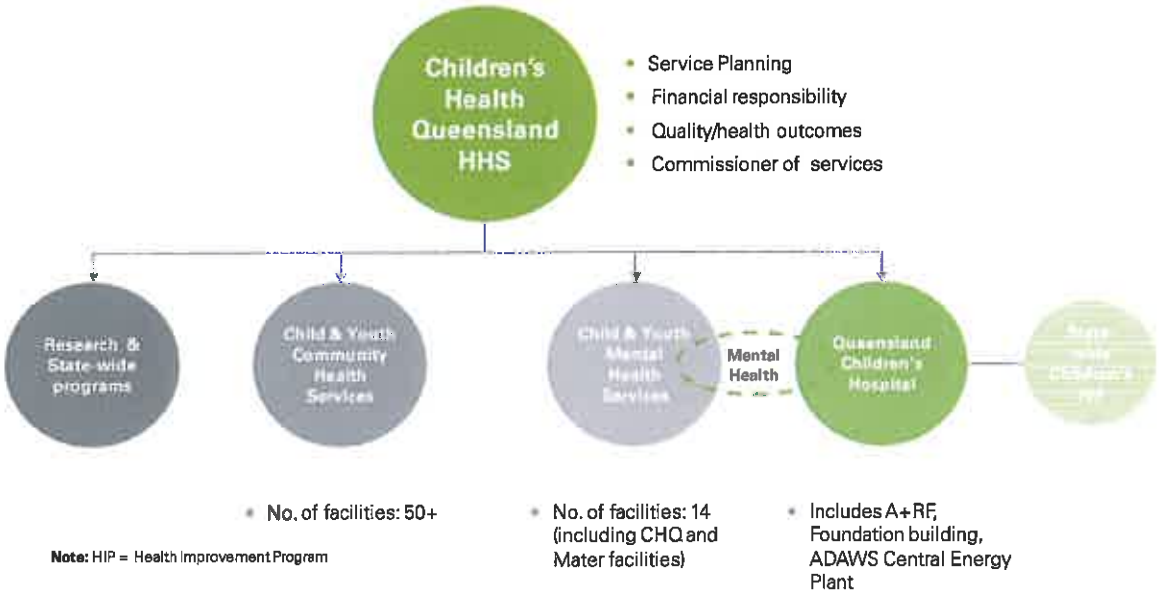
The role of CHQ HHS is to manage:

- the Royal Children's Hospital (until the transition to the QCH)
- delivery of the new QCH
- Child and Youth Mental Health Services
- Child and Youth Community Health Services throughout Brisbane
- tertiary outreach services throughout Queensland
- level 5 and 6 paediatric services for Queensland and surrounds (i.e. northern New South Wales).

Since its inception in July 2012, the Board has demonstrated its commitment to budget integrity through the implementation of cost efficiency measures (approx 6% in FY 2012-13) and to patient care (evidenced by its delivery of all clinical KPIs in the Service Agreement with the Department of Health).

Figure 4-1 below shows the relationship between CHQ HHS and the QCH.

Figure 4-1: Role of CHQ HHS and QCH



Stakeholder consultation during 2012-13 on the development of the state-wide Children's Health Improvement Program (HIP) role for CHQ HHS has identified three initiatives:

- **Care coordination for children with complex health care needs** – through an established network of Care Coordinators to integrate and coordinate care across acute, community and primary health care sectors, based on child's and family's needs.
- **Establishment of clinical advice and transfer service** – designed to give clinicians across Queensland 24/7 access to clinical advice, particularly in relation to transferring children.
- **Paediatric education and training** – through CHQ HHS adopting a lead role in support and capacity building through paediatric inreach, outreach and online education and training.[12]

An external website to provide resources for families for care of their child and transfer of child health responsibilities from the Department of Health is also seen as a priority, but is outside of the state-wide role development process.

The CHQ HHS will continue to manage the community section of Child and Youth Mental Health Services and Child and Youth Community Health Services (including services such as hearing clinics, infant feeding support) throughout Brisbane.

4.4 Health care needs

CHQ HHS is currently in the process of updating its Health Service Plan to incorporate updated population and patient demand projections following the incorporation of the 2011 Census data into the Department of Health's Acute Inpatient Modelling Tool. The updated Health Services Plan is due for release in December 2013.

For the purposes of this Business Case, the following 2006 Census data have been used to develop activity projections and bed numbers.

4.4.1 Population Projections Update

The QCH will provide specialist paediatric care for children from birth to 16 years of age and up to 18 years for existing patients. Mental health and oncology will provide services to new and current patients up to 18 years.

Please note the following population projections are based on Australian Bureau of Statistics Census data which categorise the population of children as being 0-14 year and 15-19 years, rather than up to 16 or 18 years consistent with the scope of the QCH.

4.4.1.1 Population 0-19 years of age

In 2011, there were 1,225,889 0-19 year olds in Queensland. This age group is expected to increase to 1,520,609 by 2026, an increase of 24 per cent.

Table 4-1 summarises the estimated growth in the paediatric and adolescent population in Queensland by Age Groups and Geographic Location.

Table 4-1: Queensland 0-19 years Population Projections to 2016 by Age Group

Age Group	2011	2016	2021	2026	Change 2011-2026	% Change 2011-2026
0–4	318,357	335,466	359,898	380,892	62,535	20%
5–9	293,654	339,329	357,289	382,022	88,368	30%
10–14	299,013	313,033	358,816	377,123	78,110	26%
Total 0-14	**911,024**	**987,833**	**1,076,003**	**1,140,037**	**229,013**	**25%**
15–19	314,865	320,248	335,321	380,572	65,707	21%
Total 0-19	**1,225,889**	**1,308,081**	**1,411,324**	**1,520,609**	**294,720**	**24%**

Source: Population Projections (Medium Series) by Age and Sex, for Statistical Local Areas (ASGC2011) and Hospital and Health Services 2012, Queensland (based on 2006 census figures; released April 2012), Queensland Government Office of Economic and Statistical Research, Estimated Population by Statistical Local Area, 2012 Edition.

For the purposes of this population review, the HHS's have been grouped into Geographic Groups to understand the change by area of residence.

Figure 4-2: HHS Geographic Groups

HHS (2012) Geographic	HHS (2012)
North Queensland HHS	Cairns and Hinterland
	Cape York
	North West
	Torres Strait-Northern Peninsula
	Townsville
Central and Western Qld	Central Queensland
	Central West
	Darling Downs
	Mackay
	South West
Gold Coast	Gold Coast
Brisbane	Metro North
	Metro South
Sunshine Coast/Wide Bay	Sunshine Coast
	Wide Bay
West Moreton	West Moreton

The regions expecting the largest increase in the number of children aged 0-19 years over the period 2011 - 2026 are Brisbane, in particular Metro South, and West Moreton.

Table 4-2: Queensland 0-19 years Population Projections to 2016 by Age Group and Geographic Location

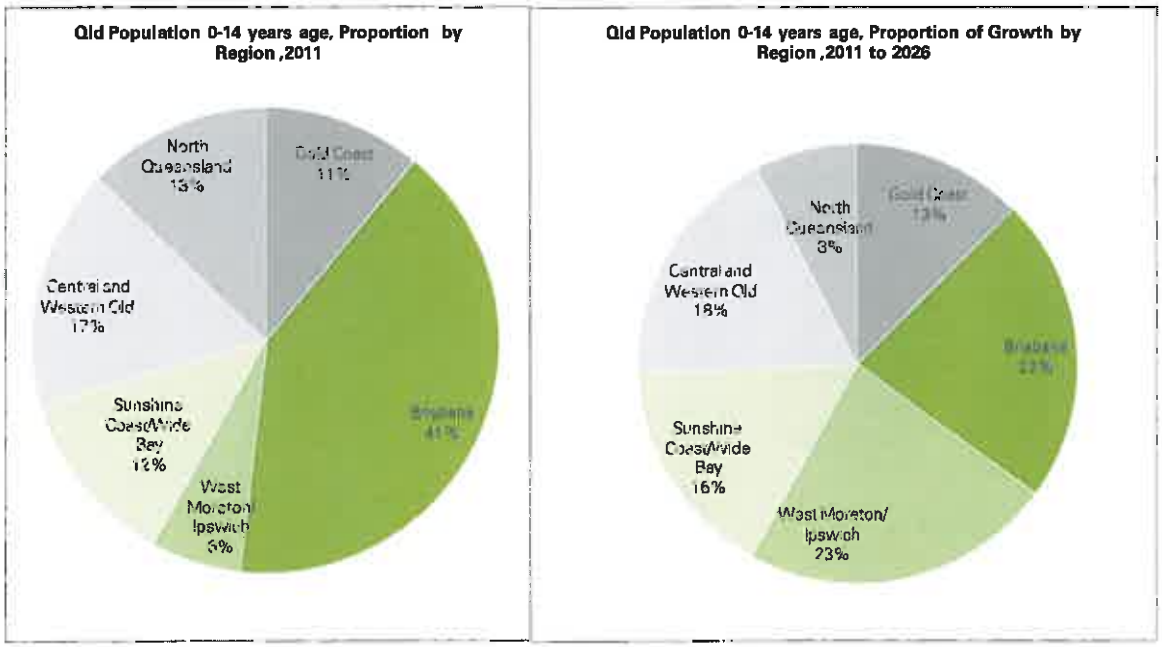
Age Group	HHS (2012) Geographic Groups	2011	2016	2021	2026	Change 2011-2026	% Change 2011-2026
0-14	North Queensland HHS	115,906	121,295	128,192	133,150	17,244	15%
	Central and Western Qld	151,676	163,995	179,998	193,052	41,376	27%
	Gold Coast	100,574	111,987	122,996	129,433	28,859	29%
	Brisbane	371,647	395,617	416,165	423,081	51,434	14%
	Sunshine Coast/Wide Bay	114,200	124,761	139,636	151,581	37,381	33%
	West Moreton	57,021	70,178	89,415	109,740	52,719	92%
Total 0-14		911,024	987,833	1,076,003	1,140,037	229,013	25%
15-19	North Queensland HHS	38,990	38,816	39,772	44,279	5,289	14%
	Central and Western Qld	48,822	48,795	50,700	57,228	8,406	17%
	Gold Coast	36,693	38,327	40,612	45,934	9,241	25%
	Brisbane	134,722	137,303	142,463	156,151	21,429	16%
	Sunshine Coast/Wide Bay	37,632	36,914	38,238	44,062	6,430	17%
	West Moreton	18,596	20,093	23,536	32,918	14,412	78%
Total 15-19		314,865	320,248	335,321	380,572	65,707	21%
Total 0-19		1,225,889	1,308,081	1,411,324	1,520,609	294,720	24%

Source: Population Projections (Medium Series) by Age and Sex, for Statistical Local Areas (ASGC2011) and Hospital and Health Services 2012, Queensland(based on 2006 census figures; released April 2012), Queensland Government Office of Economic and Statistical Research, Estimated Population by Statistical Local Area, 2012 Edition.

4.4.1.2 Population 0-14 years of age

In 2011, 41 per cent of the Paediatric population resided in Brisbane. The population estimate by 2026 indicates that only 22 per cent of the increase will be in Brisbane, with the majority of the growth occurring in West Morton/Ipswich, followed by Brisbane (Metro North and South), then central and western Queensland.

Figure 4-3: Distribution of 0-14 year population across Queensland



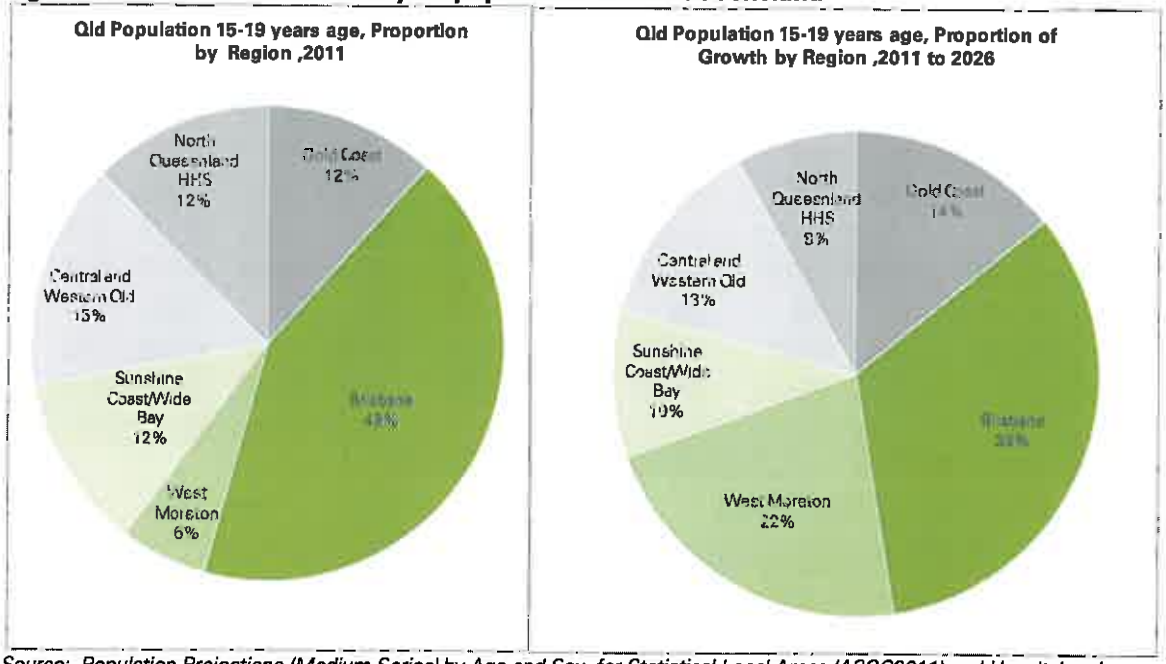
Source: Population Projections (Medium Series) by Age and Sex, for Statistical Local Areas (ASGC2011) and Hospital and Health Services 2012, Queensland(based on 2006 census figures; released April 2012), Queensland Government Office of Economic and Statistical Research, Estimated Population by Statistical Local Area, 2012 Edition.

4.4.1.3 Population 15-19 years of age

In 2011, 43 per cent of the adolescent population resided in Brisbane. The population estimate by 2026 indicates that 33 per cent of the increase will be in Brisbane (Metro North and South), with the

majority of the growth occurring in West Morton/Ipswich, followed by Gold Coast then central and western Queensland.

Figure 4-4: Distribution of 15-19 year population across Queensland



Source: Population Projections (Medium Series) by Age and Sex, for Statistical Local Areas (ASGC2011) and Hospital and Health Services 2012, Queensland(based on 2006 census figures; released April 2012), Queensland Government Office of Economic and Statistical Research, Estimated Population by Statistical Local Area, 2012 Edition.

4.4.2 Activity projections

Inpatient activity projections are based on the Acute Inpatient Model (base year 2010-11 and 2006 Census population figures). This includes some assumptions for reverse flow of paediatric services to The Prince Charles Hospital, Gold Coast, Logan and Ipswich, but does not include the full impact of the SEQ Paediatric Plan which includes additional Paediatric Emergency Departments and overnight beds in other SEQ hospitals. The impact of this reverse flow would be to increase the capacity in the SEQ network for Paediatric Beds through a Hub and Spoke model.

In 2010-11, there were 36,852 separations of which 19,835 (or 53.8 per cent) related to same day admissions. Of the total number of separations, 74 per cent were related to medical activity, 24 per cent to surgical activity, 2 per cent procedural activity[13]. In 2016-17, separations are expected to increase by 5 per cent to 38,842.

The reduction in bed days from 2010-11 to 2016-17 is related to the reverse flows built into the Acute Inpatient Model that take into account the new paediatric services opening in other areas of the State, but as noted above does not include all reverse flows in this initial model.

[13] Procedural activity, as per Queensland Health capital works group, is defined as interventional cardiology and diagnostic GI endoscopy. The surgical capital works group includes all medical subspecialties that potentially require surgical intervention.

5 Current contractual, employment and regulatory arrangements

The content of section 5 has been redacted.

6 Criteria for evaluation of service outsourcing options

This section sets out the criteria that will be used to evaluate each of the government and non-government service outsourcing options under consideration. The outsourcing options are described in Section 8 and the qualitative evaluation of the outsourcing options against the criteria is in Section 9.

6.1 Approach

The criteria for the evaluation of delivery options have been developed in consultation with the QCH executive and senior clinicians. The existing vision and objectives for the QCH were important considerations in developing the criteria. In addition, efforts were made to ensure that the criteria would:

- Allow an objective analysis and meaningful measurement and assessment of options
- Enable differentiation in the evaluation of options
- Be mutually exclusive

The evaluation criteria are listed in the table in section 6.2 below, and have been grouped into four categories:

- Strategic and Operational
- Workforce Development and Management
- Provider Capability and Appetite
- Commercial, Financial and Legal.

For each criterion, a range of factors have been identified for consideration when assessing the extent to which a delivery option meets the criterion. These factors are listed as supplementary 'Drafting Notes' for each criterion.

6.2 Evaluation criteria

6.2.1 Strategic and Operational

1. Achieving the vision for QCH – Providing excellent care for children and their families

The ability to deliver high quality, highly specialised paediatric (both general and specialist care) and adolescent health services in accordance with relevant health care standards and that:

- meet or exceed relevant performance benchmarks (including safety and quality)
- provide a healing environment for children and their families
- support delivery of specialist paediatric services across the State
- provide health services that are accessible and responsive to demand
- have the flexibility to grow and adapt to changes in the way healthcare services are delivered.

Drafting notes: This criterion includes assessment of the level of opportunity for meeting or enhancing operational and service outcomes to deliver on Government's requirements as set out in the Health Services Plan. In addition, the criterion includes the extent to which the option enables flexibility in service provision to adapt to changes in healthcare services and promotes a seamless patient journey.

2. Achieving the vision for QCH – Delivery of paediatric health services across the State and nationally in the support of:

- Seamless paediatric services
- A robust referral process with no service gaps
- Appropriate involvement of non acute, primary care and community services

The impact that the delivery model will have on the delivery of services at other locations including the ability of QCH to support rural facilities and regional hospitals through consultation, telemedicine and outreach services and new and expanded children's health services in the greater Brisbane metropolitan area (Prince Charles, Ipswich, Logan, Caboolture, Redland and Redcliffe hospitals)

Drafting notes: The criterion includes the assessment of the potential impact on the state-wide tertiary paediatric services and referral networks including supporting and work collaborative with the Royal Flying Doctors and QAS for collaborative clinical support. It includes assessment of the achievement of the strategic, operational and workforce management criteria in relation to these broader health system impacts.

3. Achieving the vision for QCH – Developing new knowledge through research

The ability to provide excellence in research and excellent care through collaboration and enquiry and to provide opportunities to integrate patient care with strong research capabilities.

Drafting notes: This criterion assesses the extent to which the option supports a research culture supported by partnerships and infrastructure to establish and sustain an Academic and Research Facility; and supports the development of new knowledge through research and innovation in health care practices.

4. Achieving the vision for QCH – Education and training

The ability to fully integrate patient care with comprehensive and contemporary education and skills training capabilities for health professionals and vocational students.

Drafting notes: This criterion assesses the extent to which the option fosters integration across patient care, education and vocational training, linkages with other educational institutions, and provides a high quality education for the next generation of staff as well as opportunities for continued learning and skills development by existing staff, including continual competency assessments that promote safe practices.

6.2.2 Workforce Development and Management

5. Workforce recruitment, retention and management

The ability to manage the significant challenges associated with attracting, retaining, transferring and managing sufficient, quality staff with paediatric skills and experience in time to support the commissioning and operational commencement of the QCH and to cope with future requirements for health care professionals and other skilled staff.

Drafting notes: This criterion includes assessment of the extent to which the option can manage recruitment risks, including advance offers to staff; reliably achieve the quality and number of staff required; and create an environment and promote a culture that will be conducive to ongoing staff satisfaction and retention; and ensure that WorkCover and other workforce requirements are managed appropriately.

6. Industrial relations implications

The extent to which industrial relations implications can be minimised and managed under the delivery model.

Drafting notes: This criterion includes assessment of the existing industrial relations and any anticipated changes in arrangements and the implications on the proposed model,

6.2.3 Provider Capability and Appetite

7. Provider capability and capacity

The capability and capacity of service provider(s) to deliver the required services under the delivery model.

Drafting notes: This criterion includes assessment of the existence of appropriate providers, the capacity of such providers to deliver on the requirements and the capability and experience (proven track record) of such providers to deliver on the specific needs.

8. Provider appetite

The ability to attract sufficient willing service providers to ensure that there is genuine competition to provide the services.

Drafting notes: This criterion assesses the extent to which the option is likely to be of interest to private sector participants based on feedback from the market sounding and commercial analysis of transferred risks.

6.2.4 Commercial, Financial and Legal

9. Cost efficiency and budget certainty

The extent to which the model facilitates, through competitive tension, governance arrangements, and contractual provisions, the potential for:

- cost optimisation
- budget certainty.

Drafting notes: This criterion includes assessment of the potential of the model to deliver quantitative value for money (VFM) and the ability to deliver the services for the expected cost including through leveraging economies of scale and managing the one off and on-going costs involved in changing to any new commercial arrangements.

10. Level of risk transfer

The extent to which the model facilitates the transfer of risk from Government to a suitable counter-party.

Drafting notes: This criterion includes the assessment of the level of risk transferred from Government as well as the complexity of interface arrangements.

11. Impact on existing contracts and arrangements

The impact of the delivery model on the current contractual arrangements.

Drafting notes: This criterion includes assessment of the impact of the delivery model on the existing contractual or operational arrangements. For example, the extent to which amendment, compensation or termination of existing contracts is required and the level of change that may be required to manage the contractual arrangements of the delivery model.

12. Commercial flexibility

The ability to adjust the quantity, quality and type of services over time to be consistent with available funding and purchasing objectives.

Drafting notes: The criterion includes the extent to which the option enables flexibility in service provision without being unduly expensive or incurring unforeseen costs; avoids excessive contract variations and is not administratively onerous; and allows the purchaser to vary (up or down) the volume, type or quality of services in line with funding constraints.

13. Other legal/regulatory issues

The potential legal/regulatory issues and complexities associated with implementation of the delivery model.

Drafting notes: This criterion includes assessment of the lack of legal/regulatory complexity associated with the implementation of the delivery model. For example, this might include consideration of hospital licensing / accreditation, privacy issues (e.g. patient confidentiality), etc.

7 Service definition

7.1 Introduction

The purpose of this section of the Business Case is to define the full scope and standard of services that must be delivered at the QCH. These requirements will ultimately be purchased by the Department of Health and are separate to the public and non-government service provider delivery models that will be examined later in the report. In effect, they constitute the outputs (and some intermediate outputs) that are required to be delivered regardless of provider.

7.2 Overview of Service Categories

The required services will be categorised and described under the broad functional headings listed in the diagram below. These groups primarily reflect common provider activities and capabilities and, as such, will constitute a convenient basis to support the analysis of the service outsourcing options discussed in subsequent sections.

Note CHQ HHS specific terminology has been used where relevant throughout this section to provide clarity and consistency.

7.3 Governance and Executive Functions

7.3.1 Scope of service

These services relate to high-level management responsibility of the CHQ HHS Board and Executive to develop and implement policies, service plans and other initiatives. The central focus of the CHQ HHS is to deliver the new QCH and associated community and mental health services as well as outreach services across the State. QCH will be the central point of a state-wide paediatric network, designed to cater for the future health needs of children and young people in Queensland.

The Board and Executive have overall responsibility for hospital performance, including financial outcomes, compliance with relevant laws, regulations and standards in addition to the overall responsibility for the HHS.

The Governance and Executive functions have been distinguished between those relevant to the HHS as a whole and any executive functions to 'manage' the QCH (i.e. in the event of a full outsourcing it is expected that a QCH facility level 'management' would be required).

For the purposes of this analysis, the Governance and Executive Functions exclude certain Corporate Support Services, as defined in Section 7.8 below, which are more routine and operational in nature and potentially more suitable for outsourcing independent from a full outsourcing option.

7.3.2 Detailed service description

The following table summarises the main roles and activities falling within the category of Governance and Executive Functions.

Governance and Executive Function – CHQ HHS	
Service	**Description**
Service planning	• Health Service Planning HHS • Workforce planning HHS
Policy development	• CHQ HHS policy development • Implementation of CHQ HHS organisational policies
Regulatory compliance	• Compliance with relevant laws, regulations, policies and standards • National and State quality and safety standards • Hospital accreditation • Risk & Audit –already have a shared outsource model
Ethics processes	• Procedures • Operational processes
Executive functions	• Operational, workforce and financial management • Strategic decision-making • Negotiation and management of Service Agreement with the Department Health and other key agreements • Stakeholder management • Communicate CHQ HHS operational priorities to QCH and other sites
Contract management	• Management of outsourcing contracts, supply contracts, etc
State-wide Delivery	• Supporting and developing an integrated state-wide network of children's health services
Community Engagement	• Community Liaison Group • community and consumer liaison and engagement

Governance and Executive Function – QCH	
Service	**Description**
Executive functions	• Operational, workforce and financial management • Strategic decision-making • Negotiation and management of Purchasing Agreement with CHQ HHS and other key agreements • Stakeholder management • Liaison and management of foundation relationship and academic and research partnerships
Contingency planning	• Policy and procedure • Maintenance and testing of plans

Incident management	• Procedures • Operational management of incidents
Policy development	• Development of QCH policies and procedures
Risk management	• Clinical risk • Corporate risk
Service planning	• Health Service Planning QCH • Workforce planning QCH
Regulatory compliance	• Compliance with relevant laws, regulations, policies and standards • National and State quality and safety standards • Hospital accreditation • Risk & Audit
Ethics processes	• Procedures • Operational processes
Contract management	• Management of outsourcing contracts, supply contracts, etc
Quality and Safety	• Ongoing monitoring • Quality and safety programs and initiatives to drive quality and safety • Development of standards and procedures on quality and safety

7.4 Clinical Services

7.4.1 Scope of service

The scope of Clinical Services seek to define the full range of medical and surgical inpatient services, emergency department, outpatient, rehabilitation and other clinical services that are provided at QCH.

7.4.2 Detailed service description

The following table summarises the main clinical services required to be provided at QCH.

Clinical Services	
Service	**Description**
Critical Care Services	• Emergency Medicine Services • Paediatric Intensive Care Services • High Dependency Services • Retrieval Service • Anaesthetic and Pain Management Services • Cardiac Services
Rehabilitation and Complex Care Services	• Rehabilitation • Complex Care Services
Medical Services	• Adolescent Medicine • Allergy and Immunology Services • Dermatology • Diabetes and Endocrine Services • General Paediatric Services • Genetic Services • Infectious Diseases Services • Metabolic Services • Medical Ward Services • Motion Analysis Service • Nephrology and Renal Services • Neurology • Oncology and Haematology • Palliative Care • Respiratory Medicine • Sleep Service • Rheumatology Services • Day Services • Outpatients Services
Surgical Services	• Burns Services • Ear, Nose and Throat Services • Gastroenterology • Liver Transplantation Services • Neurosurgery Services • Oral Health Services • Oro-Maxillary Services • Orthopaedic Services • Paediatric Surgery Services (including urology and neonatal surgery) • Plastic and Reconstructive Surgery • Day Services • Surgical Neonatal Intensive Care Services • Operating Suite • Trauma Service

	• Outpatients Services
Underpinning operational processes	• Bed management and patient flow • Infection Control • Clinical risk management • Workplace health & safety
Allied Health Services	• Audiology • Creative Therapy (including art and music therapy) • Nutrition and Dietetics (including patient menu development) • Occupational Therapy • Orthotic and Prosthetic Services • Psychology Services • Physiotherapy Services (including hydrotherapy) • Social Work • Speech Pathology
Child and Youth Mental Health	• Inpatient (including CFTU, adolescent inpatient unit) • Community (including community clinics, infant mental health teams, access and extended hours team, ADAWS, cluster-based programs including forensics and state-wide programs)
Child and Youth in-reach services	• Child Development Program • Child Protection Services
Out-of-hospital services	• Outreach • Hospital in the Home
Special treatment diagnostic and advice services	• Interventional radiology • Clinical pathology • Consultation and MDT participation

7.4.3 Facility Lens to Clinical Services

It is noted that the Clinical Services can also be viewed in terms of a facility-based lens (i.e. identifying which clinical services interface with other services) which can assist in identifying specific services which may be more suitable for outsourcing.

In addition, it is noted that specific Clinical Services may be identified as suitable for commissioning at a DRG or SRG level.

Clinical Services	Emergency Care	Outpatients	Ambulatory/ Day-care	Short Stay Inpatient	Inpatient – public	Inpatient – intermediate	Community
Critical Care Services	✓						
Rehabilitation and Complex Care Services	✓	✓			✓	✓	✓
Medical Services		✓	✓	✓	✓	✓	
Surgical Services		✓	✓	✓	✓	✓	
Underpinning Operational Processes	✓	✓	✓	✓	✓	✓	✓
Allied Health Services	✓	✓	✓	✓	✓	✓	✓
Child and Youth Mental Health					✓	✓	✓
Child and Youth In-Reach Services		✓	✓	✓	✓	✓	✓
Special treatment diagnostic and advice services	✓	✓	✓	✓	✓	✓	

7.5 Education and Training

7.5.1 Scope of service

The scope of these services comprises QCH's role in undergraduate and post graduate education including the QCH role in supporting the Academic and Research Facility.

7.5.2 Detailed service description

The following table summarises the main components of Education and Training.

Education	
Service	**Description**
Undergraduate education	• Placement and teaching of medical students • Placement and teaching of nursing undergraduates • Placement and teaching of allied health undergraduates
Postgraduate education	• Placement and management of postgraduate medical training • Placement and management of postgraduate nurse training • Placement and management of postgraduate allied health training
Continuing workforce development	• Continuing education and training of the non-clinical workforce • Continuing education and training of the clinical workforce
Education and Training facilities and infrastructure	• Specific training facilities e.g. skills laboratories • E&T offices and education spaces
Library Services	• Physical facilities • On-line resources • Librarian services

7.6 Research and Development

7.6.1 Scope of service

The scope of these services relates to research and development conducted by QCH staff within the QCH facility. It includes facilitation of clinical and applied research and collaboration with Academic and Research Facility (A+RF).

Research and Development excludes services provided on campus by A+RF foundation members. These services are outside the scope of this outsourcing analysis.

7.6.2 Detailed service description

The following table summarises the main components of Research and Development.

Research	
Service	**Description**
Liaison with A+RF	• Access of A+RF to QCH and research subjects • Partnerships with UQ, QUT and TRIs • Queensland Children's Medical Research Institute • Formal and informal partnerships in research activities • Other key relationships to support research
Research infrastructure and support	• A+RF • Research support services and assistants • Research governance • Statistics and epidemiology • Equipment and maintenance • Ethics Committee • Research methodology training and mentoring
Facilitation of clinical research	• Allocation of time and resources for a range of clinical research initiatives, including clinical trials
Facilitation of applied research	• Allocation of time and resourced for a range of applied research initiatives including service model improvement
Research	• Basic science • Clinical science • Applied science • Clinical trials • Device development
Research sources / funds	• Government research funds • Research charities • Industry funds

7.7 Clinical Support Services

7.7.1 Scope of services

Clinical Support Services comprise diagnostic and treatment services such as diagnostic imaging, nuclear medicine, pathology and pharmacy and some selected additional services. In addition, for the purposes of this analysis, these services will include the Central Sterilising Department and Biomedical Services. Each service includes the supply, maintenance and replacement of specialist equipment associated with that service.

7.7.2 Detailed service description

The following table summarises the Clinical Support Services required to be provided at QCH.

Clinical Support Services	
Service	**Description**
Central Sterile Study Department	• Sterile service production and distribution
Medical Imaging	• Undertake diagnostic imaging • Reporting • Quality Assurance • Advice services
Medical Photography	• Production of specifically requested high quality photographs
Pathology Services	• Processing • Reporting • Quality Assurance • Advice services
Pharmacy Services	• Receipt, storage and distribution • Advice services
Queensland Poisons Information Centre[25]	• Provision of an information line to professionals and public
Rehabilitation Engineering	• Provision of bespoke design and construction of patient equipment
Medical Physics	• Support and advice in relation to diagnostic imaging modalities and use of radioactive materials including radiation protection
Biomedical Services	• Health technology management and information • Health technology maintenance • Customisation of health equipment • Radiation safety and compliance testing

[25] This is a statewide service hosted by RCH, with block funding is provided by the Queensland Government. It is understood that discussions to make this part of a national service are being progressed.

7.8 Corporate Support Services

7.8.1 Scope of service

Corporate Support Services include a range of services such as the delivery of finance, human resources/payroll, Information & Communications Technology (ICT) functions. The Corporate Support Services exclude the Governance and Executive Functions described in section 7.3.2.

7.8.2 Detailed service description

The following table summarises the main components of the corporate support services.

Corporate Support Services	
Service	**Description**
Finance	• Generating and being accountable for effective, timely and transparent financial reporting, including generation of periodic and annual financial reports • Management reporting • Liaising with external, internal and Government auditors • Business Performance and Analysis
People Services	• Sourcing and selecting talent / staff • Ensuring a safe and healthy working environment/OHS • Developing effective workplace models/developing and implementing change initiatives • Developing effective learning and development programs • Staff performance management • Liaising with stakeholders regarding industrial relations, enterprise bargaining and employment policy • Implementation of timely, accurate and effective payroll systems • Staff rehabilitation (return to work)
ICT	• Day-to-day running of the healthcare and enterprise ICT systems by providing customer, service delivery, desktop, end-user, device or field support • Operating and maintaining telecommunications devices, clinical applications, and a range of wireless technologies • Designing and developing software information security and testing
Health information management	• Managing health information
Legal	• Responding to and being responsible for all legal issues associated with hospital operations, including any provision of legal services, legal advice or litigation
Marketing, Media & Communication	• Community and external stakeholder engagement • Event organisation
Medical Equipment Supply	• Sourcing, procurement, maintenance, disposal, and replacement of medical equipment
Procurement of medical supplies	• Sourcing and procurement of medical supplies • Inventory and distribution management
Document management	• Archiving • Off - site storage • Vital Records management

Patient Bookings & Admissions Office	• Jointly managed by nursing and administrative staff, includes elective surgery and other elective medical procedures which require admission
Room Booking Service	• Establishment, implementation and operation of a room booking service to support the effective delivery of the Functions and the Services
Transcription services	• Typing of medical letters to general practitioners dictated by medical staff

7.9 Soft Facilities Management Services

7.9.1 Scope of service

Soft FM Services comprise a range of hotel and back-of-house functions related to cleaning, catering, waste management, linen laundering and distribution, porterage and bulk store distribution.

7.9.2 Detailed service description

The following table summarises the main activities required to be performed for each Soft FM Service.

Soft Facilities Management Services	
Service	**Description**
Reception	• Reception and switchboard services
Orderly and Patient Support Services	Patient support services are directed by clinical staff in undertaking their duties. Services include: • Assisting in movement of patients within the facility • Assisting in the movement of equipment throughout the facility • Movement of deceased patients and mortuary duties
Bulk Store Distribution Service	• Provision of an ad hoc and scheduled distribution service to ensure the prompt and safe distribution of materials and supplies (e.g. fuel, stores, mail, pharmaceuticals and equipment) • Maintenance of stock control system including requisitioning and replenishment of stock • Safe and secure storage of all onsite stock • Management of the loading docks • Operation and management of all materials handling equipment such as forklifts, pallet jacks and trolleys • Securing, collecting and sorting all mail, delivery and dispatch of all mail within the facility • Movement of pharmacy, specimens, samples and pathology related items • Movement of medical gasses
Waste Services	• Collection and removal of non-hazardous, non-clinical and non-radioactive waste from the Facility, specifically, • General waste (capable of being disposed of in landfill) • Garden, building and engineering waste relating to the Facility Maintenance Services • Sanitary, catering, sewerage and grease trap waste • Recyclable waste • Clinical waste • Hazardous waste pharmaceutical and radioactive and radiological and other toxic

	waste generated by the service providers
Non-emergency offsite patient transport	• Transport of patients outside hospital (currently not provided)
Ward Hotel, Cleaning and Domestic Services	• Comprehensive cleaning and domestic services on a scheduled, periodic and reactive basis, flexible to meet the demand peaks and troughs in clinical services • Stocking and replenish cleaning consumables • Preparation of a cleaning plan • Janitorial services
Internal Linen Distribution Services	Internal linen distribution, including: • Receipt of clean linen provided to QCH • Regular segregation and collection of used linen as well as replacement of curtains and bed screens • Distribution of clean and collection of dirty linen within the facility • Ad-hoc linen replacement service to meet abnormal or emergency demands • Linen supply & laundering • Supply and delivery of clean linen and collection of dirty linen to/from the loading dock. Uniform supply for staff: • service enables staff to try on, fit and order new uniforms, distribution of uniforms to staff • uniform supply and replacement
Catering Services	Patient catering service, including, • Providing a patient meal ordering system • providing patient meals at scheduled meal times and on an ad hoc basis • providing a portable water service for patients • managing the internal distribution of the catering service; • Patient menu development • Supply, maintenance and replacement of catering equipment, crockery and cutlery, etc • Grocery Supply • Implement a food safety program • Staff catering services

7.10 Hard Facilities Management Services

7.10.1 Scope of service

Hard FM Services comprise a range of services related to the operation and maintenance of the facility.

7.10.2 Detailed service description

The following table summarises the main activities included in the scope of Hard FM services.

Hard Facilities Management Services	
Service	**Description**
General Services	• Establishment, implementation and maintenance of an integrated management service that ensures all Services are delivered as a seamless single service
FM Help Desk	• Establishment, implementation and operation of a help desk to support the effective delivery of the Functions and the Services
Building Maintenance Services	• Maintenance of the Facility (except grounds, gardens and paths) to ensure the Facility is fit for the intended purposes and complies with all Laws
Grounds & Gardens Maintenance Services	• Maintenance of all Grounds and Gardens to maintain an aesthetically pleasing environment and ensure the Facility is fit for the intended purposes
Pest Control Services	• Programmed and reactive internal and external pest control of the Facility
Security Services	• Coordination and management of all scheduled and ad hoc security requirements across the Facility
Carparking Services	• Comprehensive management of carparking on the Site (undertaken by MHS)
Central Energy Facility	• Management and Maintenance of all systems and distribution networks for all Utilities, reticulated Medical Gases and reticulated Laboratory Gases on the Site, and monitoring of stock levels for the supply of portable Medical Gases and portable Laboratory Gases[26]

[26] The Central Energy Facility has a scheduled completion date of January 2014. Further work is required to determine how to best integrate within a potential Hard & Soft FM contract.

7.11 Summary

The purpose of this section was to provide a framework for the definition of service categories to assist in the consideration of potential delivery options in subsequent sections. Based on the above, the proposed service definition framework is as follows:

8 Service Outsourcing Options

8.1 Introduction

Section 7 categorised the services provided at QCH and summarised those services into broad service categories as follows:

- Hard FM Services
- Soft FM Services
- Corporate Support Services
- Clinical Support Services
- Operational Services (including Clinical Services, Education & Training and Research & Development)
- Governance & Executive Function (only relevant in the full outsourcing option).

The analysis presented in this section considers each of those service categories and assesses their potential to be delivered by a NGSP. Section 9 will then build on this analysis and provide a detailed qualitative evaluation of the merits of service outsourcing options in consideration of the evaluation criteria.

8.2 Key assumptions

The analysis presented in this section is based on the following key assumptions:

8.2.1 Operational Services outsourcing

Operational Services are comprised of Clinical Services, Education & Training and Research & Development.

Given the importance of the vision for the new QCH, there is a very strong link between the three elements of Operational Services. As a result, for the purpose of the analysis of this Business Case, it has been assumed that it is sub-optimal to outsource the components of Operational Services on their own, or outsource Operational Services in isolation of all other service categories. Certain exceptions to this may apply in relation to services that have limited interrelationship with other Operational Services and can therefore be seen as discrete services.

Should a NGSP provide Operational Services, a decision would also need to be made about the outsourcing of service categories up to and including Operational Services and the relevant aspects of the Governance & Executive Function (i.e. Full Outsourcing).

8.2.2 Level of outsourcing

The analysis presented in this section assumes that service provision by a NGSP would involve all (or substantially all) of the services within a service category being outsourced. It is acknowledged that there are a range of possible contracting arrangements, including where individual services or elements of services are provided by multiple parties (public and NGSP). However, for the purpose of the analysis, a further breakdown beyond the service categories summarised above is generally not assumed (with the primary exception of Clinical Support Services given the disparate nature of the services within this service category).

8.2.3 Enhanced Base Case

The Enhanced Base Case is predicated on a number of internal reform initiatives that CHQ HHS has identified that can be implemented to increase operational efficiency in service delivery and will be used as the benchmark to compare alternative service delivery options.

8.2.4 CHQ HHS' function as a health service

The Governance & Executive Function is comprised of a number of services provided on a health service level, including service planning and policy development.

This Business Case assumes that these services remain a responsibility of CHQ HHS and are not subject to an outsourcing decision. However, there are a range of Governance & Executive Functions, including service planning, which could be provided by a NGSP at a facility level. These services would only be outsourced in a Full Outsourcing model and not in their own right. Refer to Subsection 4.3.4 for a full breakdown of the CHQ HHS and QCH services.

In a Full Outsourcing model, the role of CHQ HHS in respect of QCH fundamentally shifts from a provider of public health services to the contract manager of public health services. This is in addition to their state-wide role (refer to Subsection 4.3.4 for further detail). This approach is not unique – it is the same transition the Department of Health has been required to make in its transition to System Manager as part of national health reforms that commenced on 1 July 2012, and it is similar to the contract management arrangement that has been adopted by Queensland Health / Department of Health with the MHS over many years. Appropriate project development and contract management become essential to the success of individual projects and ultimately the success of the health service.

8.3 Base Case

8.3.1 Overview

The Base Case describes how services planned for QCH are provided across the RCH and MCH campuses.

Both sites deliver a range of secondary, tertiary and quaternary services up to CSCF Level 6. There are some differences of focus, however. For instance, the RCH has a strong profile in Oncology and Gastroenterology, while the MCH takes a leading role in Cardiac Surgery. Both hospitals provide a range of out-of-hospital services across Queensland.

At present, most FM Services and Clinical Support Services are provided in-house or with support from the Royal Brisbane and Women's Hospital (RBWH) or the wider MHS campus. This has traditionally been the case as a result of the co-location of the RCH and the RBWH and the whole-of-campus philosophy of MHS. The Base Case assumes outsourcing of selected FM services at the site, such as ground maintenance.

Clinical Services at the RCH are provided under a Service Agreement between the Department of Health and the CHQ HHS. Service Agreements are publicly available documents which define the activities to be delivered and the outcomes that are to be achieved by Hospital and Health Services in return to the funding provided to them. They set out activity targets, key performance indicators and list key government priorities which are to be achieved by the relevant HHS.

Clinical Services at the MCH are provided under a Service Agreement between the Department of Health and MHS. This is a commercial in confidence agreement and sets out activity targets to be delivered in return for the funding provided.

Service Agreements are a key part of the Government's commitment to return operational responsibility to local Hospital and Health Boards, while concurrently maintaining appropriate levels of service for the community that achieve uniform quality standards across the health system as a whole.

As part of the Service Agreement, a Hospital and Health Service Performance Framework is established. This Framework sets out the way in which the Department of Health monitors the performance of the Hospital and Health Service and includes a protocol for managing concerns about performance should they arise.

Ultimately, it is envisaged that as Hospital and Health Services mature over time and demonstrate sustained performance, Service Agreements will become less prescriptive and provide greater local autonomy such that Hospital and Health Services can further prioritise the uses for the funding they are provided in line with local priorities.

CHQ HHS is responsible for providing paediatric services to the Brisbane Metropolitan community and tertiary paediatric services to all Queensland children in accordance with its Service Agreement and priorities set out by the Board at a local level. The Base Case assumes that all services which CHQ HHS are responsible for are managed under a traditional delivery model, whereby services are managed in-house and any external arrangements with external/private parties are established through one-off contractual arrangements.

8.3.2 Opportunities and constraints

As noted above, CHQ HHS operates under a Service Agreement between itself and the Department of Health. The Service Agreement outlines the services that the Department of Health will purchase from CHQ HHS and monitors CHQ HHS's activities.

The CHQ HHS's performance is assessed against national benchmarks (such as the National Emergency Access Targets and the National Elective Surgery Targets) and the CHQ HHS's delivery of priorities set by the Department of Health and, ultimately, the Government.

The Service Agreements are based on a range of factors such as volume/activity requirements of the CHQ HHS with adjustments for low volume, high cost services. It is the intention of The Department of Health that from 2013-14 it will link activity targets and pricing to the National Efficient Price (NEP) across all Hospital and Health Services, in order to drive the Government's commitment to achieve the NEP across all Services by the beginning of 2014/15. The implications of this for QCH are discussed in section 8.4 on the Enhanced Base Case. The challenge for QCH is to create a trajectory of financial management which brings it to the NEP during 2014-15, and from 2015-16 onwards. Thereafter, it is likely that further savings will be needed as there is an expected continuing downward pressure through the newly adopted national pricing mechanism.

It is likely that the progress of savings schemes will be challenged by the constraints of existing Enterprise Bargaining Agreements (EBAs) and the transition costs arising through the transfer to the QCH. QCH's opportunity to create efficiencies will be greatly enhanced as flexibility around EBAs is created by the Queensland Government. However, despite the flexibility permitted by these changes, any amendments will require significant cultural change and will therefore be challenging to implement.

[redacted]

8.3.3 Purchasing Model

The Department of Health Purchasing Model is derived from the NEP as calculated by the Independent Hospital Pricing Authority. Effectively, the model is a calculation tool which takes into account a range of factors such as health needs assessments and future growth planning to determine the most appropriate mix of 'activity' to be purchased across the health system from the budget delivered to the Department of Health each year.

It comprises two modules:

- A growth module, which calculates the activity to be purchased

- A calculation module, which calculates and applies the impact of purchasing adjustments

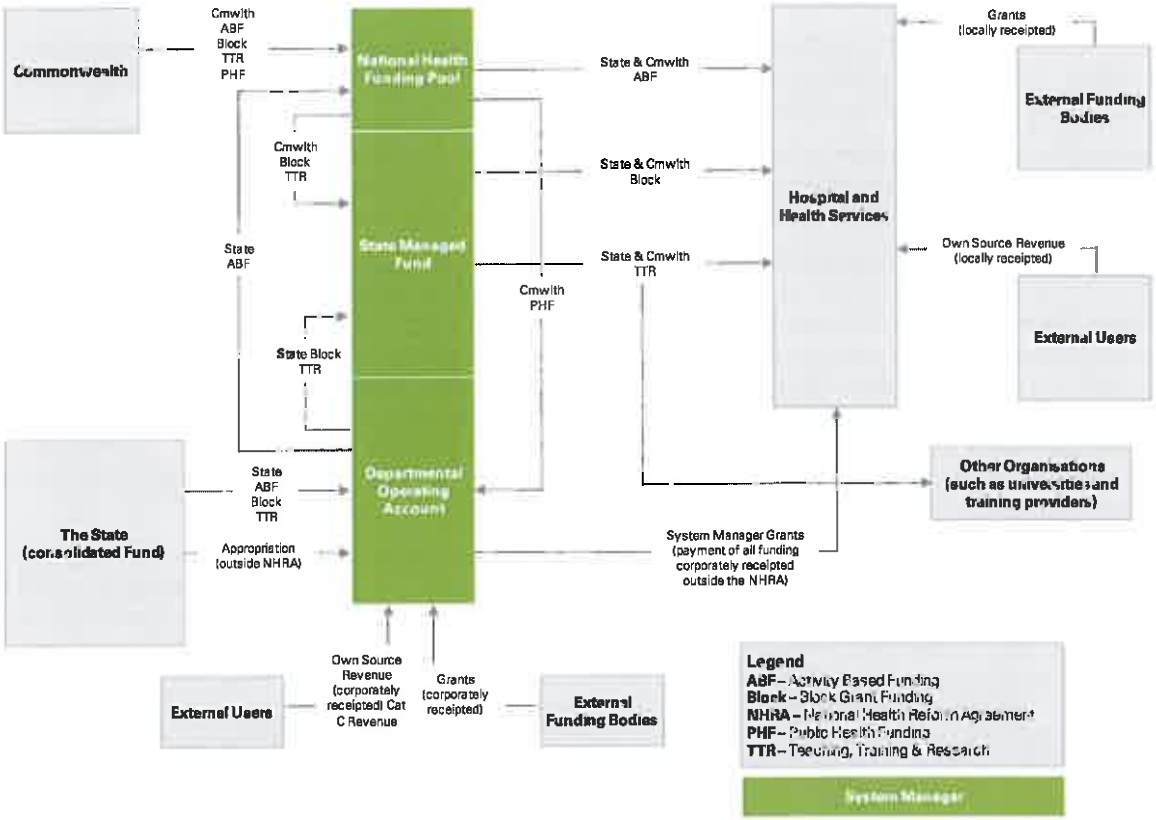
The model generates the overall level of activity to be purchased by the Department of Health across the course of a given year, which is then broken down further (in the form of Service Agreements) into the areas and functions covered by each of the HHSs.

Different weightings and allowances exist within the model for differing cohorts. For paediatric patients treated at a specifically nominated paediatric teaching facility, weightings on individual DRGs will apply. The weightings are derived based on current benchmark costs. This effectively translates to an average loading of [redacted] on top of the benchmark price. This loading does not apply to other SEQ paediatric services, such as Prince Charles.

Regardless of the options for outsourcing, the role of the Department of Health and the Purchasing Model would remain unchanged.

The diagram below illustrates the funding flows to CHQ HHS.

Figure 8-1: Funding flows to CHQ HHS



Source: Children's Health Queensland Hospital and Health Service- 2012-13 Service Agreement November revision

8.3.4 Key commercial principles and risk allocation

The key commercial principles relevant to this option include:

8.3.4.1 Pricing and cost management

- Under the Base Case, CHQ HHS is responsible for the risks surrounding the management of operating costs, the delivery of services and in mitigation of any increased demand that may arise due to the sudden onset of an unforeseen event (such as a more severe winter flu season than

expected) which causes activity levels to be higher than the amount purchased by the Department of Health.

- The Board maintains the risk associated with any cost over-runs as well as any impact on service delivery. This may extend to the Government in situations where a particularly difficult service delivery decision is required, such as the cessation of a service.
- Similarly, the Board is exposed to the need to address any sudden funding changes (such as the mid-year fiscal adjustment adopted by the Federal Government in December 2012).
- The controls available to address these risks are minimal – the Board has capacity to implement savings measures, such as the reduction or cessation of elective surgery, but these are generally seen as extremely unpalatable from a service delivery perspective and often leads to an inability to meet KPIs such as elective surgery targets. The Board has no control over fluctuations to the NEP (or the Queensland State price, if that forms the basis of the price at which services are purchased by the Department of Health).
- Queensland has commenced transitioning to the proposed national ABF model being developed by the Independent Hospital Pricing Authority, and State Government has committed to using the national model as far as practicable by 2013-14.
- The Commonwealth has also committed to fund 45% of the efficient growth in public hospital activity from 1 July 2014, increasing to 50% from 1 July 2017.
- Looking forward, in 2014-15 when the NEP is proposed to be used as the full basis for funding to the largest (i.e. non-block funded) facilities, there may be increased funding risk, as the final impacts of a fully implemented NEP (and the actual NEP for 2014-15) will not be known until later in FY14.

8.3.4.2 Demand management

- This is likely to be a large risk under the Base Case as the CHQ HHS is fully exposed to risks around demand management.
- That is, where demand for paediatric services outstrips the capacity of CHQ HHS to supply those services (due to activity targets being achieved), any additional activity will need to be funded through efficiencies achieved throughout the year (or simply ceased).
- It should be noted that the experience to date (i.e. one financial year) has been that where both activity and financial targets are achieved, the Department of Health has been able to apportion additional financial resources to address excess demand. However, this approach cannot be relied upon going forward as continued cost-pressures will likely make such arrangements highly challenging, if not impossible.

8.3.4.3 Performance management

- As with the financial/cost risks and demand management requirements, responsibility for ensuring performance against key indicators is fully retained by the CHQ HHS under the base case.
- The Service Agreement sets out the requirements of the CHQ HHS and the Board is responsible for delivering those services. Although some minor outsourcing arrangements may occur, ultimate responsibility for performance rests with the Board in the Base Case.
- In a situation where underperformance occurred, the Department of Health and Minister for Health have powers and an escalation framework in which these can be addressed. However, no financial penalty or capacity to recover funds (in the event of a budget deficit being delivered) exists.

8.3.4.4 Contract term

For the Base Case this is not applicable.

8.4 Enhanced Base Case

8.4.1 Description

The Enhanced Base Case is similar in structure to the Base Case in that it assumes that CHQ HHS is responsible for each of the service categories within its oversight function.

The key difference between the two is that the Enhanced Base Case builds upon the Base Case by identifying material, implementable and sustainable efficiencies to the operation of QCH, without the use of material outsourcing. These initiatives were developed by the CHQ HHS Executive and Clinical Leadership group as part of the VFM Business Case work. These efficiencies must also meet the Department of Health's required standards.

The table below details the criteria used to identify and evaluate the identified reforms in the Enhanced Business Case.

Table 8-1: Criteria to evaluate Enhanced Base Case reforms

Criteria	Description
Material	• Does the reform relate to a significant area of cost for the HHS? • Will the reform result in material quantifiable net savings? • Are the savings real rather than notional dollars?
Implementable	• Is achieving the reform within the control of the HHS? • Is it evidence based? • Will the key stakeholders support the reform? • What are other barriers to success? How significant are they? • Can it be achieved within the timeframe?
Sustainable	• Is the reform a recurrent plan rather than temporary financial restraint? • What are the mechanisms to assure the ongoing delivery of savings?
Able to meet required standard	• How will the reform impact on current performance standards? • How will it meet or exceed safety and quality standards? • Does it create risk for other sites and services within the HHS?

A summary of the identified reforms in the Enhanced Base Case is in the below table.

Table 8-2: Enhanced Base Case reform initiatives

Reform initiative	Description	Implementation plan	Likelihood of success[27]	Expected savings
Inpatient wards	Economies of scale from efficiencies due to increased ward sizes/scale, synergies due to paediatric specialists in one facility	Reduction in overall NHPPD rates due to larger ward sizes compared to RCH Transition to 80% RN / 20% EN profile in wards where appropriate will reduce nursing labour costs Improved discharge planning activities and utilisation of journey boards - result in 0.5 day reduction in ALOS for medical and surgical overnight, or 20 o/n beds (85% occupancy) Flexible nursing rosters due to assignment of 6/8/10 hr shifts Increase use of TOIL/TIL during periods of low and high activity Improve reverse flow of patients to the hospital of residence as soon as possible		

[27] Likelihood of success is as determined by CHQ HHS

Reform initiative	Description	Implementation plan	Likelihood of success[27]	Expected savings
Clinical Service Integration	Economies of scale due to integration of two medical workforces. Increased ratio of patient episodes to medical staff. Reduction in junior medical staff	Effective implementation of changes to medical staffing arrangements from integration of RCH and MCH Ability to achieve economies of scale with minimal integration issues		
Combined PICU + HDU	Larger combined PICU + HDU will have a more efficiently staffed unit Receiving staffing (medical/nursing/allied health) + CBIT management processes in line IC new unit Develop a retrieval model and benchmark to RCH Melbourne	Effective unit configuration of 26 PICU and 10 HDU beds resulting in lowering of NHPPD rate Appropriate assignment of the medical workforce to one facility as opposed to providing dual campus coverage , resulting in medical workforce efficiencies		
Operating Theatre Utilisation	Increasing theatre utilisation to provide surgeons with either full day lists or 2 x 4 hour sessions, resulting in increased productivity, and reduced overtime for late finishes	Increase in theatre session time, utilisation of theatres due to combining all surgical volumes Expected to be able to meet expected surgical demand with one less operating theatre (savings from one less theatre)		
ED + Short Stay Unit	Change SSU model (6 beds at RCH / 6 beds at MCH), 18 at QCH – move more inpatient admissions to SSU, reviewing staffing model for more efficiencies incl. NHHPD, and extended pharmacy hours	Achieving efficiencies in aligning medical and nursing workforce to the College of Emergency Medicine benchmarks (1 RN per 1,000 presentations and 1 SMO to 5,000 presentations) Implementing effective clinical consumables and inventory systems, resulting in savings from merging RCH and MCH EDs Increasing the SSW capacity from the current 2 x 6 bed Short Stay Wards into one 18 bed Observation Unit, reducing the demand to admit patients to inpatient wards		
Clinical Support Services	Change skill mix for Allied Health, Pharmacy, CSSD, Imaging, Medical and Nursing admin, and research admin. Align work profile to benchmark levels for higher levels of activity	Effective implementation of workplace reforms in line with activity benchmarks Achieving economies of scale from combining facilities with minimal integration issues		
Outpatient	Reforms including electronic check-in, improved hours of operation, support service availability, Change staffing mix. Private Practice incentives restrict possible	Achieving enhancements to ICT, introduction of staggered appointment times, and improved staff mix profiles, resulting in efficiency in reception workload and staffing		

Reform initiative	Description	Implementation plan	Likelihood of success[27]	Expected savings
	practice change i.e. A/H or Nursing Clinics			
Corporate Support Services	Change staffing mix. Minimal additional resources above RCH capacity for the larger QCH	Achieving expected efficiencies in clinical support and research management functions due to integrating facilities Expectation that only minimal additional resources above the current RCH capacity would be required to adequately service the larger facility for these functions Expectation that a pro-rata allocation for executive and corporate support services will be transferred from MHS for supporting MCH		
Total				

8.4.2 Purchasing Model

The purchasing model under the Enhanced Base Case is assumed to be substantially the same as that of the Base Case. Funding is provided via the purchasing model using the same purchasing methodology. See section 8.3.3 above.

8.4.3 Key commercial principles and risk allocation

The key commercial principles and risk allocation under the Enhanced Base Case are assumed to be substantially the same as that of the Base Case. See section 8.3.4 above.

8.5 Hard FM Services

8.5.1 Overview

The full range of Hard FM Services can be considered for outsourcing. Outsourcing the management of maintenance and lifecycle, as well as the other Hard FM Services through a single contract, is frequent practice in built facilities, and there are several precedents for outsourcing of the Hard FM Services in hospitals.

8.5.2 Opportunities and constraints

The opportunities that may be generated through outsourcing Hard FM Services include:

- *High strategic and operational alignment* – outsourcing Hard FM Services will facilitate the achievement of strategic and operational objectives to lower whole of life costs through proper ongoing maintenance and lifecycle, and ensure that the facility is kept in condition fit for the purpose of delivering the Operational Services including clinical care. Having a well-maintained facility assists with meeting of OH&S requirements and is also important for staff and patient morale.
- *Alignment with market precedents* – there are several precedents for outsourcing of Hard FM Services at Australian hospitals.
- *Integration with other services* – delivery of Hard FM Services with other services such as Soft FM Services by a single provider is likely to increase the attractiveness and efficiencies attained.

Market sounding and precedent, has revealed that there are sufficient players willing to accept contracts to deliver Hard FM and Soft FM Services separately or as a package.

- *Operational innovations* – outsourcing of Hard FM Services to a NGSP may result in operational innovations that could result in more efficient delivery of Hard FM Services.
- *Optimal risk transfer for new facility* – As a new facility, it is easier to contract on a fixed cost basis for maintenance and lifecycle than it is for existing facilities. Transferring risk for the condition of older facilities can be difficult and contractors are often uncomfortable with pricing this risk.

Conversely, outsourcing Hard FM Services may be subject to the following constraints:

- *Security Services* – Security Services may be excluded from the scope of a Hard FM contract at QCH on the basis that the campus is adjacent to the MHS campus and it may be more efficient and more effective in terms of staff safety to contract MHS security to perform these services.
- *Risk transfer* – while QCH is a new facility, the ability to fully transfer asset condition risk may be somewhat constrained by not having the Hard FM Service provider involved in the QCH design and construction. Further analysis of the existing contracts is required.
- *QCH Energy Plant* – we note that the QCH Energy Plant is due for practical completion in January 2014 and that further analysis is required on how to best integrate its operations and maintenance in the context of a Hard FM outsourcing arrangement.

8.5.3 Roles and responsibilities

If outsourcing of Hard FM Services is pursued, the NGSP will be responsible for the delivery of Hard FM Services to specified performance standards, and for maintaining the condition of the QCH facilities. Other responsibilities include:

- *Performance monitoring and reporting* – the NGSP will be responsible for producing a periodic performance report for CHQ HHS that indicates performance (including failures) against the contract requirements.
- *Subcontracting strategy* – the NGSP will be responsible for determining which services it performs directly and which it subcontracts. For direct performance of services, the NGSP will need to determine the level of staff required.
- *Planned maintenance and lifecycle schedule* – on a regular basis, the contractor will need to submit and agree a schedule of planned maintenance and lifecycle for the coming period (year, for example). It will then be responsible for ensuring that maintenance and lifecycle replacement is performed in the agreed windows.
- *Reactive maintenance* – the contractor will be required to respond and rectify unplanned maintenance issues within a designated timeframe. Timeframes will vary depending on the severity of the issue. In the critical hospital environment, the contractor will need to be mobilised and ready to respond to urgent issues at all times.
- *Systems provision* – the Hard FM Contractor will be responsible for selecting, installing and configuring automated systems including the services helpdesk which hospital staff will be able to use to report Hard FM issues. (Note that if Soft and Hard FM services are contracted together, a single services helpdesk system can be used to report all FM service issues. This is one benefit to bundling Soft and Hard FM Services.)
- *Staff training and management* – the contractor will be responsible for training staff. This includes training hospital staff in how to use the services helpdesk.

CHQ HHS's responsibilities:

- *Establishing and negotiating the contract* – CHQ HHS's primary responsibility would be to establish and negotiate appropriate contractual arrangements with the NGSP that deliver Value

For Money, define the requisite services and sufficiently motivate performance to required standards;

- *Payment for services* – CHQ HHS's would be responsible for paying the Hard FM Contractor for successful performance of the services scope. An important aspect to payment is determination of the correct amounts – this requires validation of reported performance statistics;
- *Management of contract* – CHQ HHS will be responsible for the ongoing management of the contract to determine the overall performance of the NGSP against the contract terms as well as specific issues, for example proposed maintenance schedules. All things going well, the contract management function should be more akin to a partnership with mutually aligned interests to ensure the ongoing successful performance of the Hard FM Services and to facilitate improvement or efficiency. Where performance is inadequate, escalation and/or enforcement mechanisms need to be in place – agreed as part of the contract negotiation – so as to allow CHQ HHS to enforce the contract and achieve the required performance.
- *Dispute resolution* – In cases where performance is consistently inadequate, CHQ HHS may need to commence dispute resolution mechanisms stipulated in the contract to ensure delivery of services.

8.5.4 Key commercial principles and risk allocation

The expected risk allocation should deliver the following main benefits:

- Relative budget certainty for CHQ HHS through the transfer of cost risk
- Performance of the Hard FM Services to the required standards through the contractual transfer of performance risk
- Abstraction of service delivery from CHQ HHS, enabling it to focus on its primary mission of delivering healthcare through the new QCH and associated facilities.

The key commercial principles relevant to this option include:

8.5.4.1 Pricing and cost management

It is usual for long term contracts to feature benchmarking and/or market testing of costs every five years. This process enables the resetting of the cost base by reference to market pricing persisting at the time of benchmarking. This mechanism is to protect the contractor over the longer term from pricing shocks and enable the avoidance of material risk premiums.

A large part of the Hard FM Service budget is the cost of lifecycle replacement of equipment and building materials. In order to pass lifecycle cost risk to bidders, CHQ HHS will need to provide bidders with the full schedule of materials and items subject to lifecycle, in order for the contractor to have a good basis for pricing. Lifecycle risk may be more acceptable to contractors if they are also responsible for Soft FM Services, and in particular cleaning, as proper ongoing cleaning can improve the expected life of building materials, furniture and equipment.

To the extent that lifecycle cost risk is transferred, bidders will need to provide a schedule indicating how items and materials will be periodically replaced, and calculating the forecast lifecycle spend for each year over the contract term. The lifecycle plan will then be updated each year by agreement between the contractor and CHQ HHS, and any upside savings could be shared. This type of arrangement will require clear and certain funding commitments for 'capital' from Government which is not how this currently operates.

8.5.4.2 Demand risk

Hard FM Service contracts may feature an adjustment to the fee corresponding to the utilisation of the hospital and/or number of hospital beds that are open. However, other examples have transferred this risk, with full transfer of demand risk, subject to modification of the facility. Therefore, it is expected that all, or substantially all, demand risk should be able to be transferred in relation to Hard FM Services.

An exception to this would be in relation to the cost of utilities required for the operation of the facility. Transferring this risk is unlikely to provide value for money, in particular given that the provider was not involved in the design and construction of the facility.

8.5.4.3 Performance management

The NGSP's performance of Hard FM Services will be assessed against the contract requirements. The contract requirements should be output-based rather than prescriptive, to enable the NGSP to innovate and deliver best-practice

However, to the extent that services need to be provided in a particular way in the hospital environment, the contract service specification should reference all applicable and requisite policies.

The NGSP will receive periodic payments for delivery of the services. The payment mechanism should reflect both the performance of services according to KPIs and the "availability" of facility areas (according to a contractual definition) during the period. Abatement for inadequate performance should be set at appropriate levels to motivate performance.

The contract should also feature default clauses which are triggered through repeated or persistent inadequate performance or abatement exceeding defined thresholds. If the NGSP defaults, it would be required to present a plan to rectify performance. Failure to rectify within an agreed, reasonable timeframe could lead to termination.

8.5.4.4 Contract term

In the case that lifecycle risk is transferred, the term should be long enough to include a major lifecycle replacement cycle and to create an incentive for diligent ongoing maintenance as appropriate to minimise the whole of life cost. This is likely to require at least a 15-25 year contract. If it is determined that lifecycle risk cannot be transferred as part of a Hard FM Service outsourcing contract, then a shorter contract period is possible (around 5 years).

Further analysis in respect of the existing contracts with Abigroup is required to determine whether inclusion of life cycle is appropriate and would be considered likely to result in a VFM outcome.

8.5.5 Precedent for outsourcing

A range of Australian hospitals have outsourced Hard FM Services as part of a Full Outsourcing contract. These include Midland Health Campus (WA, currently under construction), Joondalup Health Campus (WA), Latrobe Regional Hospital (VIC), Modbury Public Hospital (SA) and Mildura Base Hospital (VIC).

Other Australian hospitals have employed Hard FM Services outsourcing including Royal Women's Hospital (VIC), The new Royal Children's Hospital (VIC), Casey Hospital (VIC) and Royal North Shore Hospital (NSW). Hard FM Services has also been included in a number of recent transactions, such as Fiona Stanley (WA), The New Bendigo Hospital (VIC), and The New Royal Adelaide Hospital (SA).

It is noted that RCH currently outsources substantial elements of Hard FM Services to RBWH.

8.6 Soft FM Services

8.6.1 Overview

Like Hard FM Services, the full range of Soft FM Services can be considered for outsourcing. This comprises a range of hotel and back-of-house functions related to cleaning, catering, waste management, linen laundering and distribution, porterage and bulk store distribution (refer to Section 7 for a detailed discussion on the Soft FM Services).

8.6.2 Opportunities and constraints

The outsourcing of Soft FM Services can enable QCH to realise the following opportunities:

- *High strategic and operational alignment* – outsourcing of Soft FM Services is highly aligned with the strategic and operational goals for QCH, in particular in relation to achieving the vision for the new hospital.
- *Alignment with market precedents* – there are several precedents for outsourcing of Soft FM Services at Australian hospitals. Market sounding has revealed that there are sufficient players willing to accept contracts to deliver Hard FM and Soft FM Services separately or as a package.
- *Integration with other services* – delivery of Soft FM Services with other services such as Hard FM Services and / or on-site retail facilities by a single provider is likely to increase the attractiveness and efficiencies attained. The bundling of Hard FM Services and Soft FM Services provides a range of potential benefits, including:
  - [redacted]
  - Single interface – a single help desk structure for FM Services removes the issues of multiple interfaces and therefore increases the effectiveness of risk transfer
  - Single performance reporting framework – similar to the help desk, this provides for a singular reporting framework to manage and monitor the service performance
  - Economies of scale – provides opportunities for economies of scale. Based on market sounding feedback, savings of up to [redacted]% were expressed to be possible if Hard FM and Soft FM Services were bundled
- *Operational innovations* – outsourcing of Soft FM Services to NGSP may result in operational innovations that could result in more efficient delivery of Soft FM Services. These operational innovations could include automated solutions for the delivery of linen and catering services.
- *Optimal risk transfer for new facility* – As a new facility, it is easier to contract on a fixed cost basis than it is for existing facilities. Transferring risk for the condition of older facilities can be difficult and NGSPs may be uncomfortable with pricing this risk.

Conversely, the outsourcing of Soft FM Services presents QCH with a range of challenges including:

- *Workforce integration* – integration of NGSP's workforce with clinicians and healthcare staff employed by CHQ HHS may cause challenges.
- *Tailored service delivery* – outsourcing of a range of Soft FM Services such as catering, linen and porterage at paediatric facilities can be difficult. CHQ HHS must ensure that the NGSP adapts and tailors these services to the specific needs of children, for example the current use of personalised blankets.

8.6.3 Roles and responsibilities

If outsourcing of Soft FM Services is pursued, the NGSP will be responsible for the delivery of all Soft FM Services to specified performance standards. Other responsibilities include:

- *Performance monitoring and reporting* – the NGSP will be responsible for producing a periodic performance report for CHQ HHS that demonstrates that all performance standards have been achieved.
- *Staffing and subcontracting strategy* – the NGSP will be responsible for determining which services it performs directly and which it subcontracts. For direct performance of services, the NGSP will need to determine the level of staff required
- Under the outsourcing arrangement, CHQ HHS's responsibilities will include:
- *Payment for services* – CHQ HHS's primary responsibility will be to pay the NGSP for delivery of Soft FM Services. This payment may be made monthly or quarterly and will depend on the delivery of services to a required performance standard
- *Management of contract* – CHQ HHS will be responsible for the ongoing management of the contract to determine the overall performance of the NGSP as well as specific issues, for example proposed maintenance schedules. All things going well the contract management function should be more akin to a partnership with mutually aligned interests to ensure the ongoing successful performance of the soft FM services and to facilitate improvement or efficiency.
- *Negotiation and dispute resolution* – Where performance is persistently inadequate, CHQ HHS may need to negotiate with the contractor and/or enforce the contract to achieve the required performance. If no resolution is achieved, CHQ HHS may need to commence a formal dispute process.

8.6.4 Key commercial principles and risk allocation

Outsourcing of Soft FM Services to NGSP will allow transfer of risks and enable CHQ HHS staff to focus on managing delivery of healthcare. Some of the key commercial principles are summarised below.

8.6.4.1 Pricing and cost management

The NGSP will be required to provide a starting cost and basis for indexation of operating costs. The operating costs will be managed through a benchmarking/market testing process every five years. The benchmarking/market testing process should reference operating costs to the market and if required prices from three tenders should be sought.

8.6.4.2 Demand management

The NGSP is likely to bear the demand risks associated with delivery of the Soft FM Services. This is typical of contracts awarded to NGSP for delivery of Soft FM Services at hospitals. Exceptions to this are likely to relate to food services, in which some form of volume payment is likely to be required and linen (in relation to the actual processing of linen as opposed to the distribution).

8.6.4.3 Performance management

NGSP's performance in relation to the Soft FM Services will be assessed against a set of service specifications. Service specification for all Soft FM Services should be output-based and not prescriptive, to enable the private sector to innovate and deliver best-practice. Service specification should also reference all required policies for working in a hospital environment.

The NGSP will receive periodic payments for the delivery of the services. The payment mechanism should reflect the performance of services according to KPIs and should feature abatement for inadequate performance (this is commonly effected by using a points system where points are accumulated during the payment period for each performance incident). Repeated inadequate performance or abatement exceeding a certain threshold can trigger default. If the NGSP defaults, they may be required to present a plan to rectify performance. Failure to rectify within reasonable timeframe leads to termination.

8.6.4.4 Contract term

If Soft FM Services were tendered in isolation a term of up to 10 years would be appropriate (with 5-7 years being potentially possible). Options to extend could be presented but the ability to retender should also be retained. If tendering with Hard FM Services or other services, a break clause or ability to market test pricing should be incorporated. This principle is relatively standard in Australian PPP projects.

A longer initial term incentivises the private sector to invest in technology. [redacted]

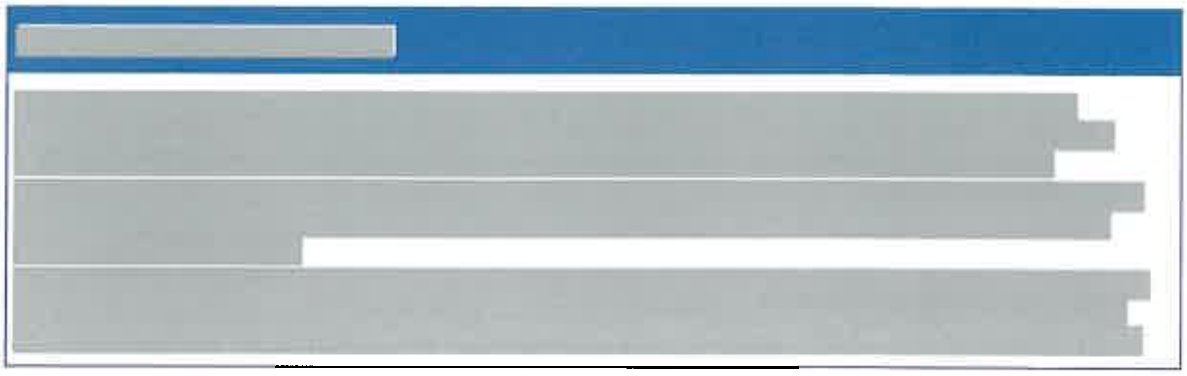
8.6.5 Precedent for outsourcing

A range of Australian hospitals have outsourced Soft FM Services as part of a Full Outsourcing contract. This includes Midland Health Campus (WA, currently under construction), Joondalup Health Campus (WA), Latrobe Regional Hospital (VIC), Modbury Public Hospital (SA) and Mildura Base Hospital (VIC).

Other Australian hospitals that have outsourced Soft FM Services include Royal Women's Hospital (VIC), and Royal North Shore Hospital (NSW). Soft FM Services has also been included in a number of recent transactions, such as Fiona Stanley Hospital (WA), The New Bendigo Hospital (VIC), and the New Royal Adelaide Hospital (SA).

We have not identified any precedent for outsourcing Soft FM Services in a tertiary paediatric hospital.

[redacted]



8.7 Corporate Support Services

8.7.1 Overview

The Corporate Support Services for QCH include usual corporate functions such as HR, payroll, finance and accounting, legal, communications, document management and ICT support, as well as services which are more specific to a medical environment such as medical equipment supply, inventory and distribution of medical supplies, patient bookings and admission services, and medical transcription.

Most of these services are currently being provided by either CHQ HHS or the Department of Health. It is noted that some of the roles and functions that the HHS and facilities are to provide in this area are still being consolidated since the establishment of the HHSs in Queensland. As Corporate Support Services should be, the teams and systems are structured to service the whole HHS or even provide state-wide support (for example, Department of Health payroll).

The nature of Corporate Support Services is disparate, and the total spend on each service tends to be small, with the exception of medical equipment supply and ICT support. The benefit of outsourcing Corporate Support Services such as HR or finance and accounting therefore is likely to be marginal, if anything, in the context of the broader HHS budget.

Some of the Corporate Support Services are being investigated for outsourcing across the State through the Department of Health's Contestability Branch including information technology desktop support.

Provision of Information and Communications Technology services (ICT) and a Managed Equipment Service (MES) however have larger budgets and further consideration of outsourcing these services is warranted.

The scenarios which should be considered further are:

- Outsourcing of ICT support, either individually or as part of a larger bundle of services
- Outsourcing of Payroll services either individually or as part of a larger bundle of services
- Outsourcing of some medical equipment supply, as part of a larger bundle of outsourced services (noting that due to timeframe outsourcing of medical equipment supply is likely to be problematic); and
- Outsourcing of corporate support services under the full outsourcing model. In this case the appointed hospital operator would be responsible for corporate services relating to the hospital. CHQ HHS will need to maintain capability and resources to oversee the operator's performance and to provide the services to the remainder of the HHS.

8.7.2 Opportunities and constraints

The opportunities that may be generated through outsourcing Corporate Support Services include:

- *ICT support* – There is a deep market of companies that could tender to offer ICT support, with outsourcing benefits including a clear definition of service levels, competitive level of professional skill, and budget certainty.
- *Payroll Services* – as this service is being devolved to the HHS there are potential enhanced services to be gained by outsourcing including HR systems to enable the capturing of training data and credentialing information.
- *Managed equipment supply* – medical and ICT equipment are high budget items. Outsourcing this function, via a Managed Equipment Service (MES) may provide relative budget certainty depending on the risk transfer achievable. This would provide the opportunity for potential conversion of capital expenditure to recurrent expenditure. Furthermore, while this would also require clarity of future capital funding for equipment replacement, we understand that Treasury has indicted preliminary support for a mechanism to enable this (noting there may be issues due to time constraints).
- *HHS-wide contract* – ICT and managed equipment supply could be outsourced on the basis of the entire HHS in order to properly alleviate need to retain these functions substantially at a corporate level.

Conversely, outsourcing Corporate Support Services may be subject to the following constraints:

- *Full Outsourcing model* – Under the Full Outsourcing model, most of the more significant functions such as HR and finance and communications will still need to be delivered by CHQ HHS, as it will still maintain overarching responsibility for these functions on an HHS-wide level, and will need to maintain oversight of the performance of these functions for the hospital.
- *ICT scope and broader Department of Health policies* – What is meant by ICT, and what is proposed to be outsourced, needs to be carefully classified. This definition of scope must reflect clear objectives for outsourcing ICT and complement Department of Health and CHQ HHS's broader ICT strategy, policies, and architecture. It must also reflect market appetite for certain risks, such as system development and integration. These broader considerations may limit the scope of what ICT services can be outsourced to the private sector, and what value for money can be achieved.
- *Payroll and broader Department of Health policies* – What services would be transferred as part of payroll i.e. rostering systems
- *MES* – how medical equipment in particular is sourced and maintained may also be subject to Department of Health policy, and this may constrain the potential value of outsourcing. This would be similar to the situation regarding outsourcing of Clinical Support Services for non-ICT equipment, for example, medical equipment.

8.7.3 Roles and responsibilities

If outsourcing of ICT Services is pursued for the whole HHS, the NGSP will be responsible for the delivery of ICT Services to specified performance standards, and for maintaining the condition of the QCH ICT equipment. Other responsibilities may include:

- Providing reactive support, scheduled upgrades to systems, issuing of ICT equipment including telephones and computers and so on. It would also be appropriate to consider maintenance of software systems.
- Selection, development and/or configuration of systems to interface with the Department of Health's systems for electronic health records, cost statistics collection etc. This would be dependent on broader Department of Health IT policies and architecture decisions.

CHQ HHS will be responsible for:

- defining the service specification and communicating and managing through changes to IT policies.

If the use of an MES is pursued, the contractors would be responsible for:

- Purchasing, installing and configuring medical equipment
- Ongoing maintenance of equipment.

CHQ HHS will be responsible for:

- clearly defining its equipment needs, in terms of the type, number and detailed specifications.

Where Full Outsourcing is pursued:

- The hospital operator will necessarily take over Corporate Support Services with reference to the QCH (i.e. facility level), including ICT and medical equipment supply.
- CHQ HHS will need to maintain capability to oversee the operator's performance, manage contractual obligations and maintain overarching control. With regard to communications, for example, CHQ HHS should maintain control over external communications.
- CHQ HHS will also need to maintain capability to fulfil its obligations as an HHS. For example for financial reporting, CHQ HHS will need to generate financial reports for the whole HHS including QCH.

8.7.4 Key commercial principles and risk allocation

The key commercial principles for ICT outsourcing would need significant further discussion and assessment to determine an optimal value for money approach.

With regard to a Managed Equipment Service, there are few precedents for this within Australia. Fiona Stanley is the best example (currently under development), where the MES has been bundled into a contract with a broad range of services. Again, as per the ICT example, the key commercial principles would need significant further discussion and assessment to determine an optimal value for money approach.

8.7.5 Precedent for outsourcing

Certain Australian hospitals have outsourced Corporate Support Services as part of a Full Outsourcing contract. This includes Midland Health Campus (WA, currently under construction), Joondalup Health Campus (WA), Latrobe Regional Hospital (VIC), Modbury Public Hospital (SA) and Mildura Base Hospital (VIC).

Other Australian hospitals that have outsourced Corporate Support Services include Fiona Stanley (WA, currently under construction).

Other innovative models have been used internationally including the NHS Shared Business Services JV (UK).

8.8 Clinical Support Services

8.8.1 Overview

Clinical Support Services comprise a range of services, including:

- Central Sterilising
- Medical Imaging

- Medical Photography
- Pathology Services
- Pharmacy Services
- Queensland Poisons Information Centre
- Rehabilitation Engineering
- Medical Physics
- Biomedical Services

8.8.2 Opportunities and constraints

At present, most Clinical Support Services are provided under a Service Agreement between the Department of Health and CHQ HHS. In establishing a contract with NGSPs (whether one or multiple providers) these Service Agreements can be leveraged as any NGSP will need to deliver to at least the same standards and KPIs as defined in the current agreements. Only some services have clear KPIs.

In determining the opportunities regarding contract structures which services are likely to be taken to market needs to be considered. The table below summarises this analysis.

Table 8-3: Opportunity analysis

Service	Mature market	Competitive	Precedents	Risks/opportunity
Central Sterile Supply Department (CSSD)	✓✓	✓	✓	Typically bundled with theatre service delivery [redacted]
Medical Imaging	✓✓✓✓	✓✓✓✓	✓✓✓✓	May be possible to transfer equipment ownership to provider and reduce capex spend via a MES
Medical Photography	✓	✓	✓	Currently provided by RBWH
Pathology Services[28]	✓✓✓	✓✓✓	✓✓✓	Proposed provider Queensland Pathology
Pharmacy Services[29]	✓✓✓✓	✓✓✓✓	✓✓✓✓	Leverage move to QCH to start with new service from day one
Queensland Poisons Information Centre[30]	✓✓	✓	✓	Proposed to be a National function, with discussions underway
Rehabilitation Engineering	✓✓	✓	✓	Currently provided by RBWH
Medical Physics	✓	✓	✓	Currently provided by Queensland Biomedical Services
Biomedical Services	✓	✓	✓	Currently provided by

[redacted]

Service	Mature market	Competitive	Precedents	Risks/opportunity
				Queensland Biomedical Services

Table 8-3 above illustrates that imaging, pathology, and pharmacy services all have the potential to be considered for outsourcing as there is a mature market with sufficient precedents. In addition to the assessment above the following points should be noted:

- **Imaging:** diagnostic imaging is an integral part of the patient journey. To separate this from Clinical Services results in organisational boundaries being traversed which could increase the risk of service fragmentation without attention to interface management. We note that many private hospital outsource this service.

  The equipment is in the process of being procured for the new QCH therefore the savings that could be achieved through outsourcing may be reduced as NGSP operating philosophy will not influence equipment selection, ie. number and type of machines as well as potentially converting capital purchasers into a service agreement, with performance risk of the equipment being passing to the private operator.

  Paediatric imaging is often time consuming and low volume, impacting on overall cost of service. Private sectors efficiencies will be limited to overall throughput, ie. machine utilisation will not be comparable to adult settings.
  It should be noted that a number of providers were happy to purchase existing equipment and this should be considered as part of any decision to outsource. The prospect of delivering value needs to be balanced with the consideration of a change in risk profile.

- **Pathology:** Pathology Queensland (QPath) is the current planned provider. The majority of pathology tests for the QCH will be conducted at the QLD pathology laboratory at the A&RF. This on site presence is essential to minimise results turn around times for the provision of results to the critical clinical services in a tertiary children's health facility.

- **Pharmacy:** delivery of pharmacy services within the QCH context is an integral part of the patient journey. In addition, for paediatric services there is an increased level of complexity regarding drug dosage accuracy. It should be noted that these services have been successfully outsourced at other hospitals however service quality and patient safety should be further tested as part of the outsourcing decision. As with pathology, the contestability branch of the Department of Health is reviewing central pharmacy services across the State. While this is a complementary

review and there is no service overlap, key findings from the review should be factored into the QCH decision, in particular in respect to compounding.

The opportunities that may be generated through outsourcing Clinical Support Services include:

- *Operational innovations* – where there is market and provider maturity, outsourcing of Clinical Support Services to NGSPs may result in operational innovations that could result in more efficient delivery of services. These operational innovations include access to innovative service delivery methods that will improve both the efficiency and effectiveness of these Clinical Support Services. Technology investment examples include: the use of iPads and iPhones to receive radiology reports, paperless pathology services improving turnaround times and real time drug replenishment.
- *Optimal risk transfer* – As a new facility, and with a range of changes to service methods to be implemented, this provides the opportunity to capture the benefits of risk transfer for select services.

Conversely, outsourcing Clinical Support Services may be subject to the following constraints:

- *Lack of mature service provider market:* there are some strong service providers for pharmacy, imaging and pathology services however, competition is limited and this could reduce the ability of QCH (or the broader Queensland Health) to drive additional cost and quality savings in the longer term.
- *New hospital delivery risk:* given the time pressures to deliver the new facilities by November 2014, QCH would have significant risk of not having all services in place on time to open the QCH if additional service contracting is being undertaken. The advantages of having a new service in place from day one needs to be balanced with not jeopardising the scheduled commissioning date of QCH.

8.8.3 Roles and responsibilities

If outsourcing Clinical Support Services is pursued, the NGSP will be responsible for the delivery of Clinical Support Services to specified performance standards including service quality, volumes and mix. Other responsibilities include:

- *Performance monitoring and reporting* – the NGSP will be responsible for producing monthly performance reports for CHQ HHS that indicates performance is in line with contract terms.
- *Staffing and subcontracting strategy* – the NGSP should be allowed to determine which services it performs directly and which, if any, it may subcontract. For all performance outcomes, whether or not subcontracted, the NGSP will be held to account by CHQ HHS.
- *Equipment upgrading and maintenance* – where relevant, and possible, the NGSP will be responsible for planned and unplanned equipment maintenance. In addition, depending on contract scope and duration the NGSP may also be responsible for the upgrade and replacement of equipment, for example imaging, to ensure service quality is maintained. While the opportunity for the NGSP to select the initial items of equipment is unlikely to be possible (due to construction and commissioning timelines), the equipment will be new and thus the ability to transfer this responsibility on an ongoing basis should be obtainable.

Under the outsourcing arrangements, CHQ HHS's responsibilities will include:

- *Payment for services* – CHQ HHS will be responsible for paying the NGSP for delivery of Clinical Support Services in line with the terms set out in the contract. This will typically be monthly and will include adjustments for non delivery or reductions in service quality.
- *Management of contracts* – CHQ HHS will be responsible for the ongoing management of the contract. This will include overseeing the strategic and commercial aspects of the arrangements, tracking service outcomes, compliance and regulatory requirements, monitoring service quality, KPIs and costs against agreed contract service levels and managing contract change requests to

control contract variation and therefore cost escalation. As mentioned in the Base Case section this will require significant up-skilling of the current in-house resources as evidence suggests that there is a substantial skills gap within Government to be able to deliver this type of function effectively.

- *Negotiation and dispute resolution* – Where performance is persistently inadequate, CHQ HHS may need to negotiate with the contractor and / or enforce the contract to achieve the required performance. If no resolution is achieved, CHQ HHS may need to commence a formal dispute process.

8.8.4 Key commercial principles and risk allocation

The risk allocation should deliver the following main benefits:

- Increased budget certainty for CHQ HHS through efficient pricing and risk transfer arrangement where this is possible and practicable
- Establishing outcome driven performance measures and incentive schemes that deliver improved Clinical Support Services
- Enhancing contract performance management (and monitoring) to enable instances of underperformance to be acted upon.

Some of the key commercial principles relevant to these services are summarised below.

8.8.4.1 Pricing & cost management

For Clinical Support Service contracts to be attractive to the market, contract transparency will be critical. A fee for service arrangement is the most common contracting model which reduces the ability to transfer demand risk to the service provider, but provides incentives for efficiency. Under this model, any material volume and/or case mix changes which impact total contract cost may require contract variations. In contrast wage and IR risk should be borne by the providers.

Factoring in the requirement for teaching and research commitments within the contract could be treated in one of two ways:

- pass through any additional costs incurred for these services
- a higher base cost which will enable these services to be bundled as part of any core service offer. The complexity will be in determining the outcome measures in support of these incremental costs.

As with the Base Case situation, there will be a need (although challenges in control of this risk) to put in place incentives to manage service variations and also to encourage tracking of unnecessary testing and repeat orders (thus driving more efficient behaviours by the service providers).

8.8.4.2 Demand management

Clinical Support Services contracts typically have variation clauses which will impact the ability to transfer demand risk. Fixed price arrangements will also include variation clauses within tolerances. This results in CHQ HHS continuing to own the majority of risk around demand management. In setting commercial terms, adequate tolerances would need to be agreed to avoid inefficient contract variation practices. CHQ HHS would need to adequately understand demand mix and be able to negotiate the most efficient volumes and variances.[32]

An exception is within pathology service where it is possible to negotiate a fee for service arrangement where the provider is more able and willing to own and manage demand risk.

[32] We note that the volume of demand will be dependent on the successful implementation of the hub and spoke model across SEQ.

8.8.4.3 Performance management

NGSP's performance in relation to the Clinical Support Services will be assessed against a set of service specifications. Service specification for Clinical Support Services should be output-based and not prescriptive, to enable the NGSP to innovate and deliver best-practice. Service specification should also reference all required policies for working in hospital environment and should require compliance with stringent quality assurance measures (both internally and externally). In addition, third party audits are expected for some services. The requirement for these quality measures and external audits should be written into the contract and this will enable CHQ HHS to focus its KPI tracking on key KPIs that relate to efficient patient outcomes. This will reduce this burden.

Similar to Soft FM and Hard FM Services above, if the NGSP defaults, they may be required to present a plan to rectify performance. Failure to rectify within a reasonable timeframe leads to termination.

8.8.4.4 Contract term

Market evidence supports the premise that contract terms for individual Clinical Support Services vary when they are stand-alone contracts. In addition, where a service includes a capex investment for equipment the contract duration is likely to be at least 10 years. Service based arrangements require a shorter contract term.

[redacted]

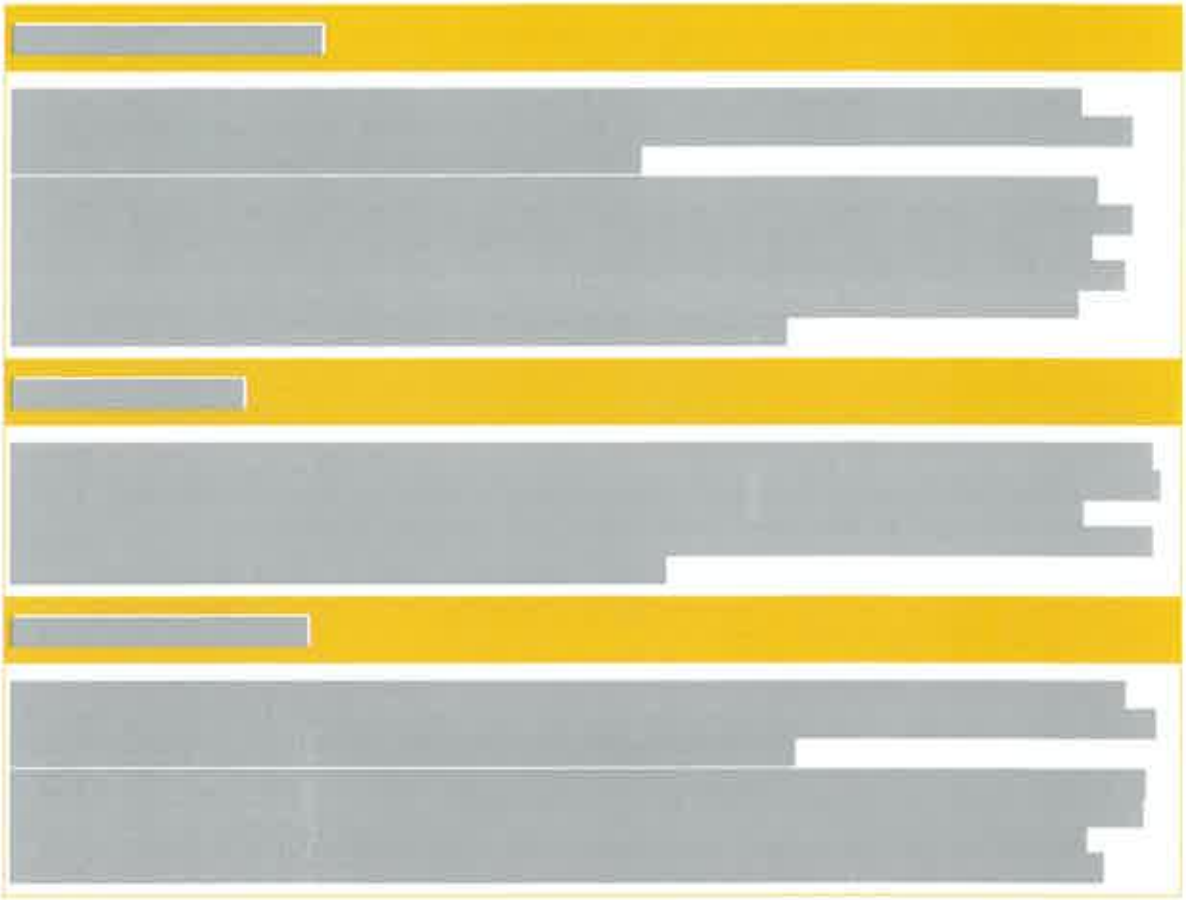
8.8.5 Precedent for outsourcing

A range of Australian hospitals have employed Clinical Support Service outsourcing as part of a Full Outsourcing Contract. This includes Midland Health Campus (WA, currently under construction), Joondalup Health Campus (WA), Modbury Public Hospital (SA), and Mildura Base Hospital (VIC). Of these Modbury, Joondalup and Mildura are operational at this point and/or remain the responsibility of a NGSP.

Other hospitals/health services have outsourced selective Clinical Support Services such as imaging, pathology and pharmacy.

A number of innovative models for outsourcing of Clinical Support Services have been successfully employed internationally. This includes the Independent Sector Treatment Centres (UK) and GSTS Pathology – Tripartite JV (UK). [redacted]

[redacted]



8.9 Operational Services

8.9.1 Overview

Operational Services are comprised of the following service streams:

Clinical Services: the full range of medical and surgical inpatient services, emergency department, outpatient, rehabilitation and other clinical services that are provided at QCH

Education & Training: undergraduate and post graduate education including the QCH role in supporting the Academic and Research Facility

Research & Development: facilitation of clinical and applied research and collaboration with Academic and Research Facility

As mentioned in section 8.2.1, Operational Services outsourcing inevitably refers to the Full Outsourcing model (i.e. outsourcing of all services up to and including Operational Services and the relevant aspects of the Governance & Executive Function). Those services that would be retained by the State include all health service-wide Governance & Facility Function services. The only exception to this is where discrete services are selected for potential outsourcing as part of a Hybrid option.

8.9.2 Opportunities and constraints

8.9.2.1 Clinical Services

The opportunities that may be generated through outsourcing Operational Services include:

- *NGSP responsibility to manage service delivery* – CHQ HHS has the opportunity to outsource the management of QCH to a NGSP while retaining its overall function as a health service as well its responsibility for other elements of non-QCH service delivery. As such, a NGSP would bear a significant portion of the clinical responsibilities (depending on the commercial structuring), e.g. with regard to demand management, workforce recruitment and management and service delivery. This may also provide the opportunity for a focused commercial approach to service delivery while maintaining a clear commitment to the vision and quality requirements
- *Cost efficiency and budget certainty* – assuming the option can deliver service prices equivalent or lower than the NEP, the opportunity exists for CHQ HHS to deliver economies of scale and thus cost savings and budget certainty to the State.
- *Contestability benchmark* – the creation of a contestable benchmark and partnership with the NGSP sector for the provision of services that may assist in driving HHS-wide and system-wide change, innovation and efficiency. However, it is noted that the consolidation of tertiary paediatric services into a single provider may have a material impact on the ability to achieve system-wide impacts from this benchmark.
- *Role of CHQ HHS* – assist in delivering a mind-set change in relation to the increased role in commissioning services as opposed to a requirement for direct service provision.
- *Workforce management* – the ability to access the benefits of NGSP workforce management models and industrial frameworks that can assist in mitigating the significant transition and on-ongoing workforce management risks.
- Conversely, outsourcing Operational Services may be subject to the following constraints:
- *Scope of outsourcing* – as mentioned above, Operational Services would only be outsourced in a Full Outsourcing model. Consequently, a range of complexities need to be managed with a view to commencement of services at the QCH in November 2014.
- *Market capability* – market sounding has revealed that with the exception for MHS, there is very limited track record in the provision of tertiary level paediatric services.
- *Developing and managing the contract* – the arrangements for Full Outsourcing for a hospital of the size and nature of QCH will be highly complex and bespoke. Significant resources would need to be devoted to both the development as well as the contract management phase to ensure that the State's and the project's objectives are appropriately reflected in the contract terms. Subsequent management of the contract will further require a significant number of dedicated and highly skilled staff to protect and manage the State's position on a day-to-day basis.

8.9.2.2 Education and Training

With the occupation of the QCH in November 2014, the QCH/MHS campus will be the major provider of education and training in Queensland for health professionals in children's services. This creates the opportunity for critical mass for undergraduate and postgraduate learning across the full range of specialties. It also creates an opportunity for innovation in delivery methods for Education & Training and the creation of new professional roles.

Under the options for outsourcing of Clinical Support and Clinical Services, it will be important for the emphasis on delivery and innovation in Education & Training to be maintained. This is a key concern of stakeholders as described elsewhere. To this end the NGSP would need to be clear on their costing and pricing methodologies for Education & Training, and CHQ HHS would need to have a robust performance management framework for these services. They will also need to properly resource and maintain education facilities and infrastructure on the QCH site. Similarly, clarity on how funds flow from the University of Queensland and other primary education providers on site at the QCH will need to be provided.

Besides undergraduate and postgraduate training, there will be continuing professional and wider staff development requirements. Some of these are mandatory e.g. in Medicine and Nursing.

8.9.2.3 Research and Development

From November 2014, the QCH will operate alongside the A+RF and the MHS. There are consequently considerable opportunities for research growth and the strengthening of research relationships and interfaces with clinical services. This will straddle a range of research, from basic science through to later phase clinical trials. These activities are intrinsically important but they are also vital to the continuation of a high performing tertiary children's service in Queensland. Without strong Research & Development, the QCH will struggle to attract high quality clinicians and maintain leading edge services.

It is therefore important that outsource suppliers are clear on their costing and pricing methodologies for service time spent on research activities, and that research infrastructure and facilities on the QCH site are properly resourced and maintained. It is also important that CHQ HHS/Department of Health agree appropriate and robust performance frameworks in conjunction with academic partners. There will need to be clear agreements on how funds flow for research activities across all the options.

8.9.3 Roles and responsibilities

The distribution of roles and responsibilities between the CHQ HHS and the QCH facility is set out in Section 7.

Currently, and under all options except Full Outsourcing, the CHQ HHS will continue a role as a service provider, under Service Agreement with the Department of Health. Under the Full Outsourcing option, the CHQ HHS will cease to directly deliver services and will become the contract manager for the delivery of services. There are a number of possible models, but it is anticipated that the Full Outsourcing provider will manage the QCH facility and take responsibility for subcontracting arrangements for the range of services it does not provide directly. Whether providing services directly, sub-contracting or contracting via a special purpose vehicle, the Clinical Services Provider would remain responsible to CHQ HHS for the delivery of services to the requisite standard.

CHQ HHS will remain accountable at a HHS level for the delivery of services at the right quality, volume and price, and with the appropriate transfer of risk to the NGSP.

Given the scale of QCH as a proportion of CHQ HHS responsibility, this creates an opportunity (and requirement) to further consider the ongoing role of the HHS in order to ensure efficient delivery of service outcomes.

8.9.4 Key commercial principles and risk allocation

The expected risk allocation should deliver the following main benefits:

- achieves overall value for money delivered through efficient pricing, a conducive commercial structure and budget certainty over the duration of the project
- substantial transfer of risks associated with Operational Service delivery
- implement an output driven performance management and payment regime that allows for appropriate consequences in instances of operator underperformance.
- The key commercial principles relevant to this option include:

8.9.4.1 Pricing and cost management

The risk of changes in operating costs for the provision of operational services should be borne by the NGSP and managed through active monitoring and control of its operating budget. The contract achieves the transfer of this cost risk through a fixed price regime for an extended period of time where service prices may be expressed as a discount to a benchmark price, such as the Queensland price per WAU or the National Efficient Price.

The relativity of the contracted price with the benchmark may be subject to adjustment mechanisms to mitigate cost risks for the provider and government given the relatively long duration of the contract. For example, the provider may be concerned that increases in the benchmark price may not keep pace with its own cost base, perhaps because of productivity improvements achieved in the wider health system or convergence of provider costs promoted by the ABF system. One response could be for the parties to agree to allow price reset points during the term of the contract to achieve a sustainable pricing structure over the long term.

8.9.4.2 Demand management

The demand for Clinical Services is subject to significant growth and variability associated with population growth, increases in level of patient acuity, changes in health service provision and models of care, increasing prevalence of chronic disease and other factors. These long-term demand risks need to be managed by governments and cannot be transferred cost-effectively under a Full Outsourcing contract. Consequently, the ABF mechanism provides a suitable basis for government to purchase the volume of services it requires to meet demand. Market precedent and feedback indicates that providers are comfortable with this general approach.

Implementing this payment mechanism involves balancing some of the same fundamental issues that arise in the Base Case. On the one hand, the hospital must be responsive to the health needs that arise and it cannot be allowed to turn away or postpone unplanned patient admissions. On the other hand, the government will expect some stability in the volume of services that are purchased on an annual or other periodic basis and it will require the ability to constrain demand to affordable levels.

These concerns are typically addressed by the Government determining the level and mix of services that the NGSP is required to manage at the hospital in each period within a range that effectively results in a cap (and potentially a floor) for service payments and activity volumes. The payment cap restricts payments for services provided in excess of the target volume, unless they are specifically requested by Government. Payment for additional services is again typically done on a price per unit basis (usually on a discounted basis). The payment floor guarantees the NGSP will be paid for a minimum volume of services. This is necessary to enable the NGSP to recover fixed costs which it cannot vary cost-effectively period to period.

Additionally, some flexibility may be retained in this regime to allow for unexpected activity fluctuations which may allow a re-set of the minimum payment and/or the payment cap.

8.9.4.3 Performance management

Rigorous performance management arrangements are critical to ensure that the NGSP delivers health services to the standards of quality, effectiveness and safety expected for public health services generally in the State. Since the hospital must form an integral part of the overall Queensland hospital system, the nature of the services and the standards of performance that are specified should, in principle, be consistent with those applying to other hospitals in Queensland.

The main differences under an outsourcing contract relative to conventional delivery are likely to lie in the way the contract incentivises compliance with the State's requirements. Service failures should result in obligations to rectify the failures but may also result in deductions from the service payments or other remedies under the contract. Since performance risk is transferred to a non-government entity, these commercial drivers can be stronger than would apply under conventional Service Agreement.

This will require that careful consideration is given to the way the system of performance standards and payment abatements is designed and calibrated to avoid unintended distortion of provider behaviour or increased service prices that may not represent good value for money for the State.

In the event of significant or sustained service failures, the contract would permit the government to terminate the NGSP and claim costs to rectify the failures and facilitate the procurement of a replacement service provider. The contract would require that the NGSP provide a substantial performance bond to the government which may be drawn on to secure recovery of costs in this

circumstance. The termination regime may also include instances where Government may terminate the NGSP in instances that are not directly related to underperformance (e.g. for convenience and force majeure).

8.9.4.4 Contract term

Setting the duration of contract term involves balancing a range of objectives in order to provide a commercially attractive proposition that delivers a VFM outcome for Government. Key considerations in relation to the contract term include:

- efficient long-term pricing of services
- reasonable long-term certainty of pricing
- the NGSP's ability to recoup upfront implementation costs over a reasonable timeframe
- the ability to maintain relativity with market conditions and to allow contestability of service provision.

[redacted]

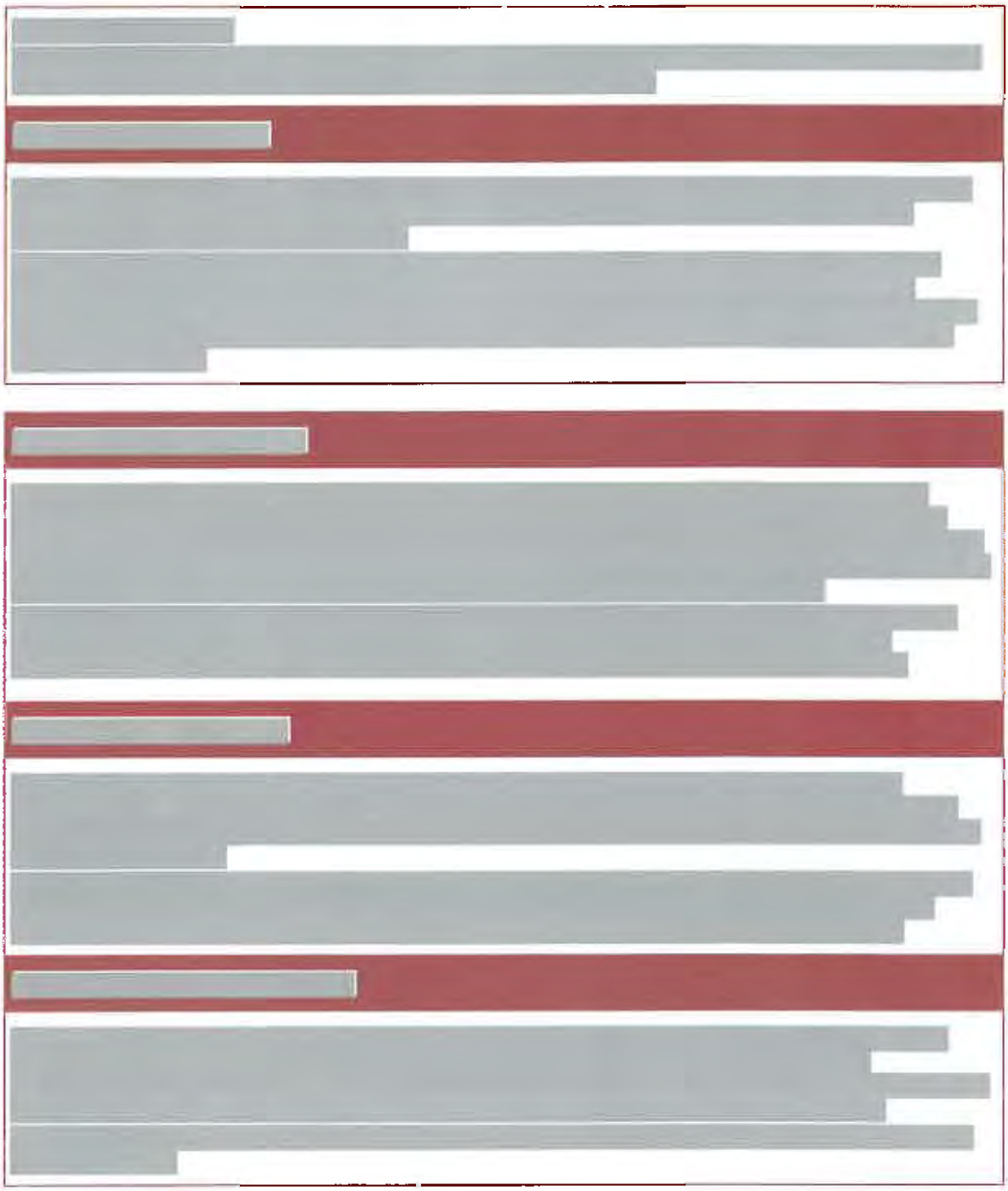
8.9.5 Precedent for outsourcing

Certain Australian hospitals have employed full Clinical Services outsourcing. These include Midland Health Campus (WA, currently under construction), Joondalup Health Campus (WA), Latrobe Regional Hospital (VIC), Modbury Public Hospital (SA) and Mildura Base Hospital (VIC).

With the exception of MCH, which is the closest in comparison for provision of tertiary paediatric services by a NGSP, we have not identified any direct comparator that incorporates the breadth, scale or complexity of services.

International precedents include the 706 bed Bragga Hospital (Portugal), the 300 bed Hospital de La Ribera (Valencia, Spain), the 220 bed Hospital de Manises (Valencia, Spain), the Hinchingbrooke Hospital NHS Trust (UK) and the 310 bed Saint Göran Hospital (Stockholm, Sweden).

[redacted]



8.10 Governance and Executive Function

8.10.1 Overview

The Governance & Executive Functions for the CHQ HHS and QCH are set out in Section 7.3.

This section discusses the management of the facility level Governance & Executive Functions i.e. the management of the QCH facility.

8.10.2 Opportunities and constraints

The CHQ HHS will continue to have operational responsibility for the QCH facility in all options up to Full Outsourcing and therefore any opportunities and constraints are relevant to Full Outsourcing only.

Under the Full Outsourcing option, CHQ HHS will need a contractual basis for assurance that all statutory and mandatory requirements are met. These will extend to quality and performance measures required – e.g. the performance measures required by the National Health Performance Authority. They must also extend to delivery of the QCH education and research missions. The majority of these requirements can be contracted to a NGSP to ensure that the NGSP delivers services at the requisite standard to enable CHQ HHS to meet its compliance obligations.

However, a further constraint is the impact on CHQ HHS as a result of Full Outsourcing given the proportion of responsibility that QCH represents. This option has the risk of creating inefficiencies at the HHS level and places into question the ongoing role of CHQ HHS. This issue would need further consideration, however, some options in relation to this may include the creation of a more streamlined HHS that delivers certain services and manages the QCH contract.

8.10.3 Roles and responsibilities

The distribution of roles and responsibilities within the facility is largely covered in the Operational Services section above. In addition, the potential impact on CHQ HHS would need to be considered and resolved.

8.10.4 Key commercial principles and risk allocation

The commercial principles are expected to be substantially similar to that of Operational Services above.

8.10.5 Precedent for outsourcing

The precedents for Governance and Executive Function are substantially similar to that of Operational Services.

8.11 Summary and Conclusion

The above sections have provided an overview of:

- the opportunities and constraints
- roles and responsibilities
- key commercial principles and risk allocation
- precedents for outsourcing

The analysis presented in this section has considered the above in the context of each of the service categories and their potential to be delivered by a NGSP. Based on this analysis, it would appear that there is a prima facie potential to outsource any or all of the services at QCH.

Section 9 builds on this analysis and provides a detailed qualitative evaluation of the merits of service outsourcing options in consideration of the evaluation criteria.

9 Qualitative VFM evaluation

This section provides a qualitative evaluation of each outsourcing option, as described in Section 8. This assessment draws on an analysis of case studies and experience in the Australian and international context, stakeholder and workshop feedback (including of qualitative risks), market sounding and other issues and concerns that have arisen for consideration in the development of the Business Case. It should be noted that while the following discussion is qualitative in nature, it includes a summary in relation to the "service efficiency and budget certainty" evaluation criterion. However, the quantitative VFM assessment is considered in more detail in Section 10.

9.1 Approach

The evaluation of each option has been conducted on the assumption that the Base Case and each outsourcing option would be subject to the same standards of quality and service requirements. That is, they would each be expected to deliver the same scope, quantity and quality of services for public patients. Hence, for example, while practices in non-government hospitals may be drawn on to inform the evaluation, the evaluation is not directly between government and non-government hospitals but between government and non-government provision of the same public hospital services.

The evaluation of the Base Case is assumed to include the Enhanced Base Case, unless otherwise stated, because the additional efficiency measures assumed in the Enhanced Base Case generally do not materially impact the evaluation of each criterion, other than the criterion related to service efficiency and budget certainty for which the quantitative differences are outlined in Section 10. It should also be noted that, where the Base Case is compared to outsourcing of service categories such as Soft FM Services or Corporate Support Services, the evaluation is with respect to the relevant component of the Base Case.

The qualitative evaluation includes an indicative rating of each outsourcing option for the purposes of illustrating the relative extent to which the outsourcing of each service category achieves each evaluation criterion. The evaluation criteria have not been weighted and the ratings are not intended to be summed to derive an overall 'rating'. However, general conclusions may be drawn from the evaluation as summarised in Section 9.6. The following table summarises the rating system.

Table 9-1: Rating system

Rating	Description
✓✓✓✓✓	Delivery model fully or almost fully satisfies the evaluation criterion by meeting all or substantially all criterion requirements
✓✓✓✓	Delivery model satisfies the evaluation criterion by meeting most of the criterion requirements
✓✓✓	Delivery model satisfies the evaluation criterion by meeting some of the criterion requirements
✓✓	Delivery model is effective in satisfying few of the criterion requirements
✓	Delivery model just satisfies the evaluation criterion by meeting minimum criterion requirements
x	Delivery model is ineffective in meeting the criterion requirements

9.2 Strategic and Operational evaluation criteria

9.2.1 Introduction

The Productivity Commission's review into *Public and Private Hospitals* (2009) assessed the extent to which public and private hospitals each achieve a range of quality and patient safety indicators.[34]

The Commission selected those indicators that best indicate whole-of-hospital performance (rather than disease or injury specific) and where published data is available for public and private hospitals, including:

- Accreditation
- Readmission and returns
- Adverse events
- Mortality ratios
- Obstetric outcomes.

In general, data on these quality indicators shows no statistically significant difference in quality outcomes between public and private hospitals.

However, in each case there are a range of factors that makes meaningful comparisons difficult, including:

- No adjustment to the statistics for hospital casemix (where particular diagnostic categories may have a higher risk of readmission) or patient risk characteristics (such as age, gender and co-morbidities);
- Voluntary reporting of data, which may lead to self-selection of data or under reporting; and
- Other data deficiencies, for example admissions to another hospital would not be included in readmission rates.

The complexity in measuring quality and patient safety is supported by the Melbourne Institute of Applied Economic and Social Research, who noted in their submission to the PC review that:

"...hospital quality is a multi-faceted concept that covers aspects such as effectiveness of treatment, timeliness of service delivery, quality of amenities, technological sophistication, incidences of in-hospital adverse events and so on. Constructing, comparing and synthesizing measures across different quality dimensions are a challenging task..."

9.2.2 Achieving the vision for QCH – Providing excellent care for children and their families

9.2.2.1 Evaluation criterion

This criterion is qualitative in nature and is focused on the ability to deliver high quality, highly specialised paediatric (both general and specialist care) and adolescent health services in accordance with relevant health care standards. Its components include to:

- meet or exceed relevant performance benchmarks (including safety and quality)
- provide a healing environment for children and their families
- support delivery of specialist paediatric services across the State
- provide health services that are accessible and responsive to demand

[34] Productivity Commission, Public and Private Hospitals - Research Report, http://www.pc.gov.au/projects/study/hospitals/report

- have the flexibility to grow and adapt to changes in the way healthcare services are delivered.

9.2.2.2 Evaluation

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓

9.2.2.3 Base Case

There are no reasons to believe that QCH will not achieve an excellent standard of patient care, particularly given the current performance outcomes at the RCH and MCH. Nevertheless, there are significant challenges in transitioning to a major paediatric tertiary facility and these will need to be managed effectively if the objective of excellent patient care is to be fully achieved.

Factors that may impact on the quality of patient care will include the transition of workforce from the RCH and MCH and establishment of a new culture that supports the vision set out for the QCH.

9.2.2.4 Hard and Soft FM Services

Hard FM Services have only an indirect bearing on the quality of patient care. However the contractual framework, based on a detailed service specification, close monitoring of performance and payment abatements for service failures, should provide a strong incentive for high-quality services to be provided without compromising the quality of patient care.

Soft FM Services have a direct bearing on the quality of patient care, particularly services such as cleaning, catering and porterage which affect hospital hygiene, safety, aesthetic appearance and the overall patient experience.

Clinical stakeholder feedback raised concerns about the Soft FM Service staff needing to be integrated with the clinical staff on wards (as appropriate to their role) and a need to be trained to support a family and child centred ethos to service delivery.

Overall, the outsourcing of Soft FM Services may have a positive impact on patient care through improvements in service delivery, but this will need to be balanced with staff integration, and tailoring to the needs of children and their families.

The contractual framework, based on a detailed service specification, close monitoring of performance and payment abatements for service failures, should provide a strong incentive for high-quality services to be provided, but the less tangible measures of supporting the ethos of care and tailoring to specific children and families needs may be more difficult to measure and to enforce contractually.

9.2.2.5 Corporate Support Services

Stakeholder feedback suggests that the outsourcing of particular corporate support functions, including ICT and certain HR functions (such as payroll), are expected to improve the efficiency and effectiveness of current service delivery and patient care. However it is noted that this benefit needs to be balanced with consideration of the impact of outsourcing on any loss of integration of systems and processes with other HHSs and State-wide systems.

9.2.2.6 Clinical Support Services

The outsourcing of Clinical Support Services could have a significant impact on the quality of patient care across all areas.

Stakeholder feedback suggested limited support for the outsourcing of Clinical Support Services with considerable concern about the outsourcing of high complexity, specialised pathology, pharmacy and medical imaging services. Clinical staff noted they believed it was important to retain the specialised and multidisciplinary approach used for these services which would make in-house service delivery preferable.

The contractual incentives that lead to consistent standards of service and to responsive delivery may create a risk of over-servicing which would negatively impact the financial sustainability of the Service.

These risks may be mitigated to the extent that the purchasing decision remains with the multi-skilled team working on the ward, integrating consulting capabilities associated with each clinical support service.

Outsourcing means that the patient journey between Clinical Support Services and Clinical Services traverses organisational boundaries. This may increase the risk of fragmentation of service delivery (both within the QCH and with wider HHSs and community sector) that may in turn impact on the whole of patient journey. Protocols for patient hand-over and information flows will be critical.

Many of the Clinical Support Service providers interviewed in market sounding have extensive experience in integration within the hospital and primary health care network. Many noted significant improvements in quality of service provision because of their ability to use innovative and tailored processes, systems and technologies which improve integration, effectiveness and patient outcomes (particularly in the areas of diagnostic imaging and pathology).

Overall Clinical Support Service outsourcing provides the opportunity to gain from established, specialised providers with 24-hour access, up-to-date technology and using skilled and experienced resources. Many of the quality of service delivery risks can be managed through robustness in the contractual framework, which should establish clear quality standards and drive performance with rigorous performance monitoring and reporting, backed up by payment adjustments for poor performance.

However, there is only a small market able to provide complex paediatric Clinical Support Services in Australia, and the impact of the small number of players may impact on the competitiveness, cost savings and service delivery standards in this area, especially over the longer term when there is no in-house capability as an alternative model.

9.2.2.7 Operational Services (Selected/all)

The outsourcing of Operational Services has the greatest potential impact on the quality of service delivery.

Many of the risks, issues and benefits of outsourcing Operational Services are similar to the Clinical Support Services discussion above. That is, outsourcing Operational Services provides the opportunity to gain from established, specialised providers who introduce new methods (models of care, work practices, technological improvements) which achieve excellent patient outcomes and contribute to diversity and innovation across the public sector as a whole.

The degree of improvement expected compared to an in-house model, needs to be balanced with the possible risks of implementation, fragmentation and difficulties in state-wide service delivery.

A further concern about the outsourcing of Clinical Services is the risk that the NGSP may seek to restrict access for certain complex cases that are more costly to provide. Given that QCH will be the only tertiary paediatric service in Queensland and Northern New South Wales, this needs careful attention in any service agreement.

[redacted]

These risks would need to be managed through the development of carefully structured KPIs and payment arrangements and effective contract management.

As with Clinical Support Services, a key risk, which is difficult to mitigate, is that there is only a small market able to provide complex paediatric clinical services in Australia. The impact of the small number of players may impact on the competitiveness, cost savings and service delivery standards in this area, especially over the longer term when there is no in-house capability as an alternative model. This cannot be easily mitigated and needs to be a key consideration in the outsourcing of Operational Services at QCH.

9.2.2.8 Conclusion

Overall, the Base Case, FM Services outsourcing and Corporate Support Services outsourcing were assessed as fully or almost fully satisfying the criterion for excellent patient care. The outsourcing of Clinical Support Services and Operational Services were rated slightly lower due to potential issues about fragmentation of service delivery; market capability and attractiveness for complex, low volume care; and commercial incentives of an outsourced provider that may compromise the objectives of excellent patient care.

9.2.3 Achieving the vision for QCH – Delivery of paediatric health services across the State and nationally

9.2.3.1 Evaluation criterion

The delivery of paediatric health services across Queensland and nationally is focused on:

- Seamless paediatric services
- A robust referral process with no service gaps
- Appropriate involvement of non acute, primary care and community services.

This is focused on the impact that the delivery model will have on the delivery of services at other locations, including the ability of QCH to support rural facilities and regional hospitals through consultation, telemedicine and outreach services and new and expanded children's health services in the greater Brisbane metropolitan area (Prince Charles, Ipswich, Logan, Caboolture, Redland and Redcliffe hospitals).

9.2.3.2 Evaluation

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	✓✓✓✓	✓✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓

9.2.3.3 Base Case

As a public hospital under the direction of CHQ HHS, QCH is expected to be a hub for paediatric service delivery, assisting other public hospitals across the State and facilitating all necessary transfers of patients and patient information between facilities to achieve optimal health outcomes. Another key component of this role is to provide support for the education and training of other staff across the State in paediatric health service delivery. This State-wide role is a key part of the QCH vision.

9.2.3.4 Hard and Soft FM Services

Hard and Soft FM Services, and the nature of their delivery, are not expected to have any material bearing on the State-wide functions and outcomes expected of QCH.

9.2.3.5 Corporate Support Services

Depending on the way Corporate Support Services are outsourced, there is a considerable risk of a lack of integration of some ICT business solutions with those in other HHSs, which is expected to impact on State-wide service delivery. This may be able to be mitigated through contract specifications for integration and compatibility for ICT business solutions with in-house solutions currently being used by other HHSs across the State.

9.2.3.6 Clinical Support Services

With outsourcing of Clinical Support Services at QCH, there is a risk of loss of integration of some services across Queensland. This is due to adoption of different ICT solutions limiting the accessibility of clinical information across the network. This is particularly important in the transfer of imaging information from/to other HHSs, e.g. secondary referral hospitals. However, this risk should be able to be mitigated through contract specifications for integration and compatibility for ICT business solutions with in-house solutions currently being used by other HHSs across the State, and will be further mitigated by moving to a full electronic patient record.

9.2.3.7 Operational Services (Selected/all)

Under NGSP delivery, QCH may integrate less effectively with other public hospitals in the State due to separate management systems, contractualised relationships with other providers, and ICT systems. This may impair the flow of patients and patient information between facilities and achievement of optimal health outcomes. The impact of this may be that the paediatric services at other hospitals are not enhanced effectively, driving further demand for paediatric service delivery at the QCH, especially for secondary paediatric care in the greater Brisbane area.

This may be able to be mitigated through contractual arrangements to an extent, however it may be difficult to qualify and enforce the support of State-wide capabilities and relationship development that would be needed to drive high quality State-wide service delivery, without including these paediatric facilities in overall contractual arrangements.

9.2.3.8 Conclusion

Overall, the Base Case, FM Services outsourcing and Corporate Support Services outsourcing were assessed as meeting most of the criterion requirements for excellent patient care. The outsourcing of Corporate Support Services, Clinical Support Services and Operational Services were rated lower due to potential issues associated in moving away from State-wide common systems.

9.2.4 Achieving the vision for QCH – Developing new knowledge through research

9.2.4.1 Evaluation criterion

The ability to provide excellence in research and excellent care through collaboration and enquiry and to provide opportunities to integrate patient care with strong research capabilities.

9.2.4.2 Evaluation

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓

9.2.4.3 Base Case

The establishment of the QCH, and its close integration with the A+RF, will require a continued commitment to the research capability already present at the MCH and RCH if it is to achieve the research vision for the new facility.

While this existing capability can be drawn from, establishing the new A+RF may present additional challenges including managing the mulitple linkages with universities, other research organisations and researchers. Research funding will need to be maintained and renewed, however the paediatric focus of the research is considered to assist.

9.2.4.4 Hard FM Services

Hard FM Services, and the nature of their delivery, are not expected to have any material bearing on research outcomes at QCH.

9.2.4.5 Soft FM Services

Soft FM Services, and the nature of their delivery, are not expected to have any material bearing on research outcomes at QCH.

9.2.4.6 Corporate Support Services

Outsourcing of Corporate Support Services is expected to assist in research capability through the outsourcing of ICT services. This is expected to enhance Base Case capability through better access and functionality supporting research needs where possible. However, this is not a material enough difference to result in a different assessment for this service category.

9.2.4.7 Clinical Support Services

While outsourced providers understood that research was a key component of a specialised paediatric tertiary hospital, some (particularly Clinical Support Service providers) discussed that quarantined time for research would need to be compensated as this would take time away from service delivery.

Where Clinical Support Services have a purely commercial and transactional focus, they are unlikely to contribute to research that is integrated with patient care. While research activities could be purchased from Clinical Support Services providers, if required, there is a concern that it may be difficult to adequately specify and remunerate these services.

9.2.4.8 Operational Services (Selected/all)

Some research activities, such as integrating patient care with research or ensuring cooperation with the A+RF, may be difficult to specify and remunerate appropriately in an outsourcing contract. These difficulties may result in insufficient emphasis on research and the vision for QCH not being fully achieved.

To the extent that research is a discretionary activity, dependent, for example, on clinician interests and capabilities and availability of surplus funds within divisional budgets, there is a likelihood in a constrained funding environment that research activity will decrease in both public and non public sector.

Overall, there are a number of risks identified with outsourcing, including variable capability and interest in this space. These risks may be able to be managed through the service specification, KPIs

and payment arrangements, but need to be balanced against the benefits expected from outsourcing Operational Services.

9.2.4.9 Conclusion

Overall, the rating was the same for all criteria, other than outsourcing of Operational Services which was rated lower. The ability to deliver on the research function was considered to be high across for Operational Services because of the current capability of the RCH and MCH, and the assumption that a lot of the staff and capability would transfer, even in an outsourced model.

9.2.5 Achieving the vision for QCH – Education and training

9.2.5.1 Evaluation criterion

The ability to fully integrate patient care with comprehensive and contemporary education and skills training capabilities for health professionals and vocational students.

9.2.5.2 Evaluation

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓	✓✓✓

9.2.5.3 Base Case

The RCH and MCH have a track record of being excellent providers of education and training. It is therefore expected that the QCH will be able to build effectively on this capability. There is a high level of commitment from the CHQ HHS executive and clinicians to achieving the vision for education and training at QCH. New partnerships have been established in respect of the A+RF.

9.2.5.4 Hard FM Services

Hard FM Services, and the nature of their delivery, are not expected to have any material bearing on education and training outcomes at QCH.

9.2.5.5 Soft FM Services

Soft FM Services, and the nature of their delivery, are not expected to have any material bearing on education and training outcomes at QCH.

9.2.5.6 Corporate Support Services

Outsourcing of Corporate Support Services is expected to improve on education and training capability through the outsourcing of ICT services. This is expected to enhance Base Case capability through better access, functionality and tailoring to the education and training needs of the workforce. It may also facilitate opportunities to enhance simulated learning and training facilities.

9.2.5.7 Clinical Support Services

While outsourced providers understood that education and training was critical to the future workforce for a specialised paediatric tertiary hospital, some discussed that quarantined time for education and training would need to be compensated as this would take time away from service delivery.

Where Clinical Support Services have a purely commercial and transactional focus, they are may not contribute to education and training that is integrated with patient care (and instead recruit experienced staff). While education and training activities could be purchased from Clinical Support

Services providers, if required, there is a concern that it may be difficult to adequately specify and remunerate these services.

Education and training activities require integration with Clinical Support Services to be delivered effectively, for example, in multi-disciplinary teams, lectures on clinical support topics, and exposure of students to patient care involving Clinical Support Services. There is a risk that the provision of Clinical Support Services by an external provider may diminish opportunities for education and training involving these services, depending on how these services are contracted.

9.2.5.8 Operational Services (Selected/all)

Historically, education and training of medical staff has occurred more significantly in the public sector, and public hospitals have also been the main provider of allied health and nursing student clinical placements, however, this holds no longer true with companies such as Ramsay investing heavily in the eduction and training of medical staff. While public hospitals are motivated to provide medical education because of the future workforce and social benefits that it will ultimately bring, NGSPs need to justify the provision of education and training in commercial terms – this is done via the need to attract, retain and develop their workforce.

NGSP may bring innovative education and training tools and methods and enhance education and training outcomes.

Overall, there are a number of risks identified with outsourcing, including variable capability and interest in this space. These risks may be able to be managed through the service specification, KPIs and payment arrangements, but need to be balanced against the benefits expected from outsourcing Operational Services.

9.2.5.9 Conclusion

The ability to deliver on the education and training function was considered to be lower for the Operational Services because it was felt with a commercial impetus, there may be less commitment to the education and training vision.

9.3 Workforce development and management

9.3.1 Workforce recruitment, retention and management

9.3.1.1 Evaluation criterion

The ability to manage the significant challenges associated with attracting, retaining, transferring and managing sufficient, quality staff with paediatric skills and experience in time to support the commissioning and operational commencement of the QCH and to cope with future requirements for health care professionals and other skilled staff.

9.3.1.2 Evaluation

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓	✓✓✓

9.3.1.3 Base Case

As a major new paediatric facility in an attractive location and able to draw on the RCH and MCH paediatric workforces, QCH is expected to have a large number of strong applicants for positions. It is assumed that the clinical workforce will largely be drawn from RCH and MCH staff, with some limited additional recruitment of staff nationally and internationally to fill shortage services.

[redacted] It is expected that once established, QCH will continue to provide an excellent environment to recruit and retain health professionals based on its paediatric speciality focus, and the current retention and culture at the RCH and MCH.

CHQ HHS will need to devote considerable management resources to the recruitment/transition task, including on-boarding processes, early employment and accommodation of staff, and bringing the cultures of the RCH and MCH together. While these risks exist for all service delivery options, they are nevertheless major risks that will need to be managed effectively by CHQ HHS under this option.

In order to make a like-for-like comparison between options, this analysis assumes that all options, including the Base Case, involve adequate transitional funding from Queensland Health to support the recruitment/transition process and other lead-up activities to opening QCH.

9.3.1.4 Hard and Soft FM Services

The NGSP would recruit and manage the Hard FM Service workforce, relieving CHQ HHS of this task, as Hard FM Services are currently predominantly provided by RBWH. Although this workforce group is only relatively small (compared with other service delivery options) this would be of benefit during the onerous ramp-up phase for QCH.

Soft FM Services are currently provided in house. Moving to an outsourced model for service provision, would impact on a significant number of staff . Dependent on the arrangement with a potential NGSP, there may be a cost impact to Government and/or the Mater of an outsourced provider not transitioning staff at the RCH or MCH.

However, the utilisation of the NGSP industrial awards is likely to provide a range of benefits in relation to staff management and performance of FM Services.

9.3.1.5 Corporate Support Services

As with FM Services, the specialised NGSP(s) would manage workforce recruitment effectively, allowing CHQ HHS to focus on the recruitment and transition of clinical and clinical support staff. However as noted there may be a cost impact to Government and/or the Mater of an outsourced provider not transitioning staff at the RCH or MCH.

9.3.1.6 Clinical Support Services

If only some clinical services are outsourced, this may result in disparities across equivalent roles in Clinical Support Services and Clinical Services.

9.3.1.7 Operational Services (Selected/all)

[redacted]

This option provides the greatest cost consequence for Government and the Mater if existing workforces do not transition with the new provider(s), potentially triggering substantial redundancies.

9.3.1.8 Conclusion

Overall, models were rated the same, except for Operational Services (Selected) and Operational Services which were rated lower due to the potential negative effect of outsourcing on the willingness of staff to transfer to a NGSP. However, it is noted that the ability to utilise NGSP industrial arrangements would provide a potentially significant benefit in terms of driving cultural change and enhancing workforce efficiency.

9.3.2 Industrial relations implications

9.3.2.1 Evaluation criterion

The extent to which industrial relations implications can be minimised and managed under the delivery model.

9.3.2.2 Evaluation

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓

9.3.2.3 Base Case

The Queensland Government has committed to changing to change industrial laws and instruments to streamline awards and simplify entitlements. However, the legacy of existing arrangements means that managing industrial relations is likely to remain a challenge for health system managers in a public sector environment. Even if the industrial arrangements are changed, there are likely to be grandfathering arrangements which may mean any benefits take time to be realised.

9.3.2.4 Hard and Soft FM Services

Outsourcing of Soft FM Services would relieve CHQ HHS of some industrial relations risks. Non-government providers are able to implement more flexible work practices than public sector counterparts. Provider capability to manage and mitigate industrial relations risks should be key consideration should these Services to be tested for outsourcing.

9.3.2.5 Corporate Support Services

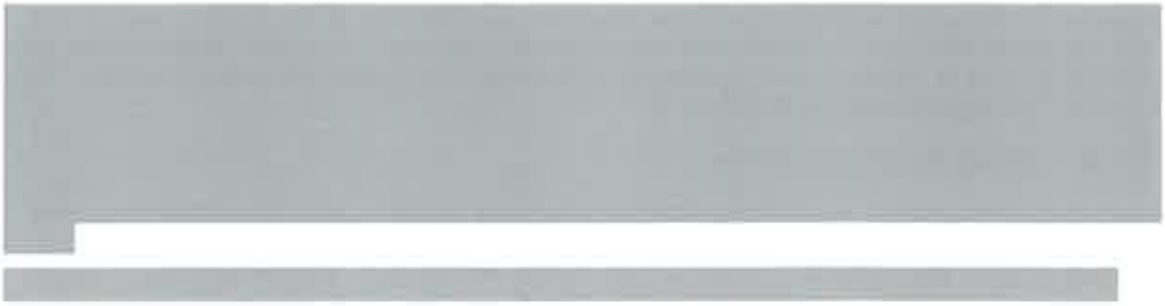
The issues and benefits are substantially the same as for Hard and Soft FM Services.

9.3.2.6 Clinical Support Services

Outsourcing of selected Clinical Support Services moves into areas of traditional public sector delivery and there is greater risk of opposition by unions to private sector service models. In addition, this may create a wage disparity between similar roles (such as management and director roles) between those in Clinical Support and Operational Service delivery.

9.3.2.7 Operational Services (Selected/all)

The outsourcing of Operational Services would allow a transformation of the industrial relations arrangements across the entire facility, resulting in more flexible work practices and potentially enabling significant innovation in models of care. Flexible working arrangements and the associated service reforms are likely to be the main factors contributing to private sector efficiencies in service delivery.



9.3.2.8 Conclusion

Overall, all service delivery options have been rated the same for industrial relations implications. While the outsourcing of Operational Services provides the long term industrial relations benefit of all staff being employed in the one system (minimising the number of industrial instruments that apply to the workforce) and the greatest level of flexibility to negotiate terms and conditions of employment, the transition will be much more difficult than for other service delivery options.

9.4 Provider capability and appetite

9.4.1 Provider capability and capacity

9.4.1.1 Evaluation criterion

The capability and capacity of service provider(s) to deliver the required services under the delivery model.

9.4.1.2 Evaluation

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓

9.4.1.3 Base Case

CHQ HHS is expected to have the capability and capacity to open and sustain QCH as a major tertiary teaching hospital, due to the experience and capability contributed by both clinical and executive paediatric speciality staff from both the RCH and MCH.

The QCH will provide new and expanded services, including adolescent services, obesity services and rehabilitation services and these are expected to require development of capability to ensure the required level of service delivery is met. All other Clinical Services are expected to draw on the existing capability and capacity at the MCH and RCH.

9.4.1.4 Hard and Soft FM Services

There are a number of market providers of Hard and Soft FM Services who have demonstrated capability and capacity in an Australia public sector context. Feedback from the market sounding supported both the appetite and capability to deliver these services.

9.4.1.5 Corporate Support Services

While there is some limited market capability and capacity to outsource Corporate Support Services, there will be a greater number of market participants if discrete services are outsourced separately (e.g. ICT). However, it is noted that some of the roles and functions that the HHS and facilities are to

provide in this area are still being consolidated since the establishment of the HHSs in Queensland which may make defining some of the roles more difficult. In addition it is noted that some areas of Corporate Support Services are the subject of investigation for State-wide outsourcing such as Information Technology Desk-top Support.

9.4.1.6 Clinical Support Services

There is market capability in an Australian context in providing Clinical Support Services to public (and private) hospitals, but many providers specialise in a particular area (such as medical imaging, pathology or pharmacy services). A risk for this area is the number of providers with speciality paediatric experience which is required for complex cases.

As was noted in analysis against criterion 1, there is only a small market able to provide complex paediatric clinical support services in Australia, and the impact of the small number of players may impact on the competitiveness, cost savings and service delivery standards in this area, especially over the longer term when there is limited in-house capability as an alternative model. This cannot be easily mitigated and needs to be a key consideration in the outsourcing of clinical support services at QCH.

9.4.1.7 Operational Services (Selected/all)

There is a very limited market for the provision of paediatric services.

9.4.1.8 Conclusion

Overall, Corporate Support Services, Clinical Support, Operational Services (Selected) were rated as slightly below the Base Case. Operational Services was rated slightly lower again due to the limited market and very limited track record of NGSPs in relation to paediatric services.

9.4.2 Provider appetite

9.4.2.1 Evaluation criterion

The ability to attract sufficient willing service providers to ensure that there is genuine competition to provide the services.

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	✓✓✓✓✓	✓✓✓✓✓	✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓

9.4.2.2 Base Case

CHQ HHS has the appetite to open and sustain QCH as a major tertiary teaching hospital, and is able to draw on the experience and capability that is expected to be drawn upon from clinical and executive paediatric speciality staff from both the RCH and MCH.

9.4.2.3 Hard and Soft FM Services

There are a number of market providers of Hard and Soft FM Services who have demonstrated appetite to deliver Hard and Soft FM Services to public and private hospitals across Australia or have an appetite to further develop their footprint in soft FM service delivery in Australian public hospitals.

Many providers have an appetite especially for bundling Soft and Hard FM Services together, which may create synergies and cost savings.

9.4.2.4 Corporate Support Services

While there is some limited market appetite to outsource Corporate Support Services, there will be a greater number of market participants if discrete services are outsourced separately (eg ICT). Market sounding suggests limited interest in corporate support services, unless it is bundled with other services (such as Full Outsourcing, and Hard and Soft FM Services).

9.4.2.5 Clinical Support Services

There is a small market able and willing to provide complex paediatric Clinical Support Services in Australia.

9.4.2.6 Operational Services (Selected/all)

There is a very small group that is able to provide tertiary paediatric services across all areas needed at QCH. Having said this, market sounding suggests at least two private providers would be interested in Full Outsourcing of the QCH.

9.4.2.7 Conclusion

Overall, the Clinical Support Service, Operational Services (Selected) and Operational Services options have lower ratings due to the number of market players that have the willingness to deliver tertiary paediatric clinical services.

Corporate Support Services was rated lower because there are a limited number of market providers who had the appetite to provide the whole Corporate Support Service, and there was an unwillingness to simply provide this service unless other service bundles were being outsourced with it. There is expected to be greater market appetite for the outsourcing of specific services within Corporate Support Services, such as ICT or payroll, although this was not a key focus of market sounding discussions.

9.5 Commercial, financial & legal criteria

9.5.1 Cost efficiency and budget certainty

9.5.1.1 Evaluation criterion

The extent to which the model facilitates the potential for cost optimisation and certainty through competitive tension, governance arrangements and contractual provisions.

9.5.1.2 Evaluation

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓	✓✓✓✓	✓✓✓✓✓

9.5.1.3 Base Case

The Base Case is considered to offer the ability to absorb additional activity at marginal cost, however, minimal cost efficiencies are expected given constraints arising from existing Industrial Awards and work practices.

9.5.1.4 Hard and Soft FM Services

The potential contracting out of Hard and Soft FM Services is considered to result in higher budget certainty, as well as efficiency, through the introduction of more flexible work practices and the opportunity for staff to be employed on less restrictive industrial instruments.

9.5.1.5 Corporate Support Services

Corporate Support Services are generally fixed and vary only marginally with activity. Contracting out of Corporate Support Services is expected to increase cost efficiencies through more efficient work practices and ICT systems.

9.5.1.6 Clinical Support Services

Outsourcing of Clinical Support Services is expected to bring cost efficiencies. Budget certainty is not considered to increase, and may even decrease, as services have a significant variable component and QCH may lose the ability to absorb additional activity at marginal cost. This will depend on the structure of the service agreement with the Clinical Support Service provider.

9.5.1.7 Operational Services (Selected/all)

Any Full Outsourcing contract is expected to be priced with reference to NEP. There are teething issues with NEP for paediatrics, as well as research, education and training. Given the immaturity of the pricing regime, significant pricing risk is expected to be retained by CHQ HHS. In respect of demand risk, this is expected to be substantially transferred within contractually set boundaries. CHQ HHS is expected to retain demand risk outside these boundaries.

9.5.1.8 Conclusion

Overall, the risk rating is the similar across all service delivery options, with different advantages and disadvantages applying across the models. While increased cost efficiency is expected the greater the degree of outsourcing, outsourcing could increase the potential for cost impacts from demand increases in service delivery and therefore negatively impact on budget certainty. Full Outsourcing has the potential to lead to overall better cost efficiency and budget certainty if a discount to the NEP is able to be achieved.

9.5.2 Level of risk transfer

9.5.2.1 Evaluation criterion

The extent to which the model facilitates the transfer of risk from Government to a suitable counter-party.

9.5.2.2 Evaluation

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	N/A	✓✓✓	✓✓✓	✓✓✓	✓✓✓✓	✓✓✓✓✓

9.5.2.3 Base Case

All risks are fully absorbed by CHQ HHS.

9.5.2.4 Hard and Soft FM

Scope for Hard and Soft FM Services can be clearly specified. Good level of risk transfer (e.g IR, performance and price) can be expected as a result in respect to these services.

9.5.2.5 Corporate Support Services

Scope for Corporate Support Services can be clearly specified. Good level of risk transfer can be expected as a result in respect of these services.

9.5.2.6 Clinical Support Services

Clinical Support Service providers will need to act and form part of the wider QCH team, e.g. participation in complex care cases. While services can be relatively well defined, there is ambiguity in terms of level of input required to support education, research and training activities as well as provision of clinical advice.

A good level of risk transfer (e.g. IR, performance and price) can be expected in respect to these services if interfaces are carefully managed.

9.5.2.7 Operational Services (Selected/all)

Under Full Outsourcing, a high level of industrial, workforce, demand, operational and implementation risk transfer to the NGSP can be expected.

9.5.2.8 Conclusion

Overall, the risk transfer from Government to another provider increases with greater degrees of outsourcing. However, it is important to recognise that ultimately Government retains demand and overall service delivery risk through its accountability to the public.

9.5.3 Impact on existing contracts

9.5.3.1 Evaluation criterion

The impact of the delivery model on the current contractual arrangements.

9.5.3.2 Evaluation

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	N/A	✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓

9.5.3.3 Base Case

N/A

9.5.3.4 Hard and Soft FM Services

Further analysis is required in respect of the existing contract with Abigroup for the construction of QCH and the interface between a potentially hard FM Provider and this contract, e.g. warranties and defects liability period. However, it is not expected that any material issues should arise in the outsourcing of FM Services.

9.5.3.5 Corporate Support Services

Further analysis is required in respect of the existing directive for HHS to rely upon ICT support from Queensland Health and what ICT decision can now be made by individual HHSs.

9.5.3.6 Clinical Support Services

[redacted]

9.5.3.7 Operational Services (Selected/all)

[redacted]

9.5.3.8 Conclusion

Overall, it is not expected that there are any existing contracts that will have a material impact.

[redacted]

9.5.4 Commercial flexibility

9.5.4.1 Evaluation criterion

The ability to adjust the quantity, quality and type of services over time to be consistent with available funding and purchasing objectives.

9.5.4.2 Evaluation

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓	✓✓✓	✓✓

9.5.4.3 Base Case

At present, the Department of Health has a reasonably high degree of flexibility in relation to the variation of service purchase volumes on an annual basis.

9.5.4.4 Hard and Soft FM Services

It is not expected that outsourcing Hard and Soft FM Services will have any material impact on the commercial flexibility of service purchase arrangements.

9.5.4.5 Corporate Support Services

It is not expected that outsourcing Corporate Support Services will have any material impact on the commercial flexibility of service purchase arrangements.

9.5.4.6 Clinical Support Services

It is not expected that outsourcing Clinical Support Services will have any material impact on the commercial flexibility of service purchase arrangements.

The term of Clinical Support Services is expected to be 5 years, limiting the duration in which QCH is bound to the contractual agreement. There is a concern that QCH will be able to absorb marginal activity, whereas under an outsourced fee for service arrangements there is less ability to control total costs.

9.5.4.7 Operational Services (Selected/all)

[redacted]

9.5.4.8 Conclusion

Overall, it is expected that there will be a degree of commercial flexibility across all outsourcing models. Operational Services (Selected) and Operational Services were rated slightly lower as the degree of commercial flexibility would be reduced through the commitment to a long-term service contract.

9.5.5 Other legal/regulatory issues

9.5.5.1 Evaluation criterion

The potential legal/regulatory issues and complexities associated with implementation of the delivery model.

9.5.5.2 Evaluation

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Hard and Soft FM	Corporate Support	Clinical Support	Operational Services (Selected)	Operational Services
Rating	✓✓✓✓	✓✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓

9.5.5.3 Base Case

The Enhanced Base Case includes a number of outsourced services predominantly with other divisions of Queensland Health.

9.5.5.4 Hard and Soft FM Services

Limited regulatory issues are expected to emerge. However, Soft FM Service providers will need to comply with special requirements in terms of dealing with children, e.g. additional screening requirements, blue cards.

9.5.5.5 Corporate Support Services

In outsourcing Corporate Support Services it is important to ensure that the outsourcing contract will stipulate the compliance with all relevant legislation, e.g. privacy laws.

9.5.5.6 Clinical Support Services

Each of the potential providers consulted as part of the market sounding is well aware of accreditation requirements. Outsourcing of imaging would require the licensing of the imaging department Level and the satellite imaging to comply with private licensing requirement. The licensing requirement is triggered by the need to administer sedation. Preliminary discussions have been held with Private Health Regulatory Unit within the Department of Health. Confirmation of compliance of the imagining department will be required.

9.5.5.7 Operational Services (Selected/all)

A contract to outsource Operational Services would be complex and would require ongoing active contract management. The entire hospital would need to be licensed to be compliant with the

private licensing requirements. It is important to remember that CHQ HHS cannot contract out ultimate responsibility for QCH and potential service delivery issues.

9.5.5.8 Conclusion

Overall, Clinical Support Services, Operational Services (Selected) and Operational Services were not rated as highly due to additional accreditation and licensing requirements that would be imposed on QCH if these services were outsourced.

9.6 Conclusion

The following table summarises the key observations in respect of each service category and its suitability for outsourcing.

	Positives	Negatives	Suitable for outsourcing yes/no
Hard and Soft FM Services	• Good market capacity and capability • Opportunity for risk transfer • Potential for financial savings	• Need to carefully manage building warranties and defects liabilities under Managing Contractor Contract	Yes
Corporate Support Services	• Significant potential for innovation and VFM	• Potential loss of connectivity impacting on continuum of care • Need for efficient linkages across HHS and broader QLD system	Yes - but only with Operational Services or via discrete contracts
Clinical Support Services	• Private providers would bring latest ICT solution to enable efficient service provision • Opportunity for risk transfer • Potential for financial savings • Workforce management	• Market not deep for all selected Clinical Support Services • Potential interface risk with Clinical Services	Yes
Operational Services (Selected)	• Allows for private sector innovation and VFM • Better management of demand peaks • Service contract will clearly articulate service scope and KPIs	• Potential to impact on continuity of patient journey • Management of interface with other services	Yes
Operational Services	• Opportunity for risk transfer • Potential for financial savings • Workforce management	• Creation of a single NGSP for provision of paediatric services, lack of benchmark • Difficulty in the application of NEP in paediatric setting, significant price risk likely to be retained • Lack of state wide connectivity impacting on continuum of care	Yes

The qualitative evaluation has considered each of the service categories and their potential to be delivered by a NGSP against the evaluation criteria detailed in Section 6. Based on this analysis, it would appear that, although there are a range of issues and constraints for each, there is a prima facie potential to outsource any or all of the services at QCH.

9.7 Delivery options

Based on qualitative evaluation and the analysis of the opportunities & constraints, potential commercial principles and market precedent for the outsourcing of each service category, a range of

Delivery Options were developed, reflecting an increasing level of NGSP delivery of services, including:

- Option 1: Base Case – a reflection of the current expected service delivery of QCH by CHQ HHS
- Option 2: Enhanced Base Case – reflecting CHQ HHS delivery with a range of efficiency reform initiatives being implemented
- Option 3: Enhanced Base Case and FM Services – reflecting the potential outsourcing of Soft and Hard FM Services, and CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Option 4: Enhanced Base Case and FM Services and selective Clinical Support Services Outsourcing – reflecting the potential outsourcing of Soft and Hard FM (as above) as well as the potential outsourcing of selected Clinical Support Services, with CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Option 5: Hybrid – reflecting the potential outsourcing of Soft and Hard FM Services and some Clinical Support Services as well as selected Clinical Services , with CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Option 6: Full Outsourcing – reflecting the potential outsourcing of all services, i.e. the operation of QCH including FM Services, Clinical Support Services and Operational Services.

A diagrammatic representation of these options is as below:

Section 10 builds on this analysis and provides a quantitative evaluation of the merits of the delivery options.

10 Quantitative VFM evaluation

The content of section 10 has been redacted.

11 Implementation strategy

The content of section 11 has been redacted.

12 Summary and recommendations

12.1 Overview

The purpose of this section is to provide an overview of the findings of the Business Case and a set of recommendations for further consideration. This summary has drawn on the various elements of the Business Case and the process to develop the Business Case including in particular:

- **Market research**: KPMG has conducted a scan of the major industry participants - locally, nationally and internationally - that might be expected to have the capability and experience to provide the range of services identified for potential outsourcing at CHQ HHS.
- **Market soundings**: KPMG, in conjunction with the Department of Health and CHQ HHS, has conducted a series of 17 meetings with selected market participants to obtain a non-government perspective on issues associated with outsourcing public health services. Among other things, these discussions have provided the market's perspective and have informed the analysis of the potential issues and the assessment of the potential capability and appetite of the market to provide these services.
- **Government and clinical stakeholder consultations**: KPMG has engaged in intensive consultation with the executive and staff of the CHQ HHS and senior officials within the Department of Health, the Department of the Premier and Cabinet and the Treasury. This has involved over 20 interviews with clinicians and other staff of the facility as well as a series of workshops with the CHQ HHS leadership team and briefings of the Board. These discussions have assisted in clearly defining the service requirements and then identifying the opportunities, constraints and risks in relation to the provision of these services by CHQ HHS and / or NGSPs.
- **KPMG independent analysis**: In addition to relying on the observations from each of the elements above, KPMG has applied its own experience and expertise in the health care sector, conducting VFM assessments, and commercial analysis of NGSP delivery of public services and associated contractual arrangements to further develop the analysis in this Business Case.

This Business Case has been developed in a compressed timeframe (over a 7-week period) in order to allow Government decision makers to make a decision by mid 2013 given the short timetable for opening of the new hospital.

This Executive Summary does not purport to represent all relevant information and should therefore be read in conjunction with the remainder of the Business Case.

12.2 CHQ HHS versus QCH

QCH accounts for approximately 80% of activity and employs 75% of the workforce within CHQ HHS. CHQ HHS is responsible for the quality of health services provided as well as having the financial responsibility for QCH and other services provided by CHQ HHS. Key additional services provided by CHQ HHS include:

- Research and State-wide programs
- Child and Youth Community Health Services
- Child and Youth Mental Health Services
- State-wide Children's Health Improvement Program.

12.3 Service Outsourcing Options

In considering options relevant to service delivery at QCH a range of service categories were developed. These service categories were defined as:

12.4 Delivery options

As part of the analysis, the opportunities and constraints, potential commercial principles and market precedent for the outsourcing of each service category was considered. Based on this analysis and to reflect the range of potential to in-source or outsource certain services, a range of Delivery Options were developed, reflecting an increasing level of NGSP delivery of services, including:

- Option 1: Base Case – a reflection of the current expected service delivery of QCH by CHQ HHS
- Option 2: Enhanced Base Case – reflecting CHQ HHS delivery with a range of efficiency reform initiatives being implemented
- Option 3: Enhanced Base Case + Facilities Management (FM) – reflecting the potential outsourcing of Soft and Hard FM Services, and CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Option 4: Enhanced Base Case + FM and selective Clinical Support Services Outsourcing – reflecting the potential outsourcing of Soft and Hard FM (as above) as well as the potential outsourcing of selected Clinical Support Services, with CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Option 5: Hybrid – reflecting the potential outsourcing of Soft and Hard FM and some Clinical Support Services as well as selected Clinical Services, with CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)

- Option 6: Full Outsourcing – reflecting the potential outsourcing of all services, i.e. the operation of QCH including FM Services, Clinical Support Services and Operational Services.

A diagrammatic representation of these options is presented below:

12.5 Key observations from consultation, market research and market sounding

In support of our analysis, a summary of the key observations from the consultation, market research and the market sounding is as follows:

12.5.1 Key observations from Stakeholder Consultation

The key observations from the clinical stakeholder consultation interviews, the workshops and other interactions with CHQ HHS are:

- Options involving outsourcing up to and including some Clinical Support Services are generally supported and largely allow QCH's vision to be delivered
- There is strong support for Hard and Soft FM Services outsourcing as well as Information and Communication Technology (ICT) systems
- The creation of QCH and the location of the hospital on the Mater Health Service (MHS) South Brisbane campus has been controversial throughout the history of the project. The creation of one central hub is considered an enabler to deliver high quality, efficient healthcare
- QCH is scheduled to reach Building Completion (PC) in July 2014, with significant transition/commissioning already under way. Any preparation for outsourcing needs to occur in parallel so as to not jeopardise the scheduled hospital opening, noting this parallel process may result in sunk capital costs
- CHQ HHS needs certainty as soon as possible to enable efficient transition from Royal Children's Hospital (RCH) and Mater Children's Hospital (MCH) to QCH
- Options involving outsourcing of Clinical Support Services or Full Outsourcing are controversial. MHS is seen as the primary option for Full Outsourcing given MHS' established capability in providing tertiary paediatric services

- Key concerns raised by CHQ HHS in respect of Clinical Support Services and Full Outsourcing include:
  - The additional interface risk that is created (between Clinical Support Services and Operational Service if responsibility is separated)
  - Quality of state-wide service delivery potentially compromised through lack of connectivity of IT systems
  - The lack of directly comparable precedents and track record of delivery (in particular with respect to Full Outsourcing)
  - [redacted]
  - The quality of care in light of an operator's profit motive
  - The difficulty in creating the right incentives to ensure provision of training, education and research services
  - The impact of Full Outsourcing on the CHQ HHS and related concerns about viability given the scale of QCH as percentage of CHQ HHS
- Some benefits of outsourcing acknowledged by CHQ HHS are:
  - Potential benefits in relation to ongoing workforce management and flexibility
  - Benefits from non Government sector innovation, e.g. flatter management structure, better ICT system, review of staffing models, leading to the potential for financial savings.

12.5.2 Key observations from Market Research

The key observations from the case study review and market scan in relation to Full Outsourcing are:

- There are a range of precedents for the NGSP delivery of public health services both within Queensland, nationally and internationally. These precedents include some examples of the provision of complex services and well developed education and research programs, however, there is very little precedent for the provision of complex paediatric services under such a model
- In relation to these precedents it is important to note that:
  - the majority relate to the provision of a narrow band of services or services that are less complex
  - with the exception of not-for-profit operators, there are limited comparable precedents for the NGSP delivery of large public tertiary teaching hospitals
  - with the exception of MCH, which is the closest in comparison for provision of tertiary paediatric services by a NGSP, we have not identified any direct comparator that incorporates a similar breadth, scale or complexity of services
- The experience of Full Outsourcing has been mixed with some continuing to operate successfully, but a number being returned to Government delivery
- Some examples of NGSPs that provide more complex services as well as education and research include UnitingHealth, Ramsay and MHS
- Further examples include Western Australian facilities Joondalup and Midland Health Campus (noting that service provision has yet to commence), which have outsourced all services, but are less complex facilities (generally equivalent to Clinical Services Capability Framework(CSCF) level 4 to 5 than QCH up to CSCF level 6)
- International examples of NGSP delivery include the 706 bed Bragga Hospital (Portugal), the 300 bed Hospital de La Ribera (Valencia, Spain), the 220 bed Hospital de Manises (Valencia, Spain),

the Hinchingbrooke Hospital NHS Trust (UK) and the 310 bed Saint Göran Hospital (Stockholm, Sweden).

The key observations from the case study review and market scan in relation to Clinical Support Services are:

- There are a number of NGSPs that have been successfully delivering Clinical Support Services for many years particularly in imaging, pathology and pharmacy services, although with less direct experience in Queensland or in the tertiary paediatric setting
- The most common Clinical Support Services that are outsourced are pathology, pharmacy, oncology and imaging
- There does not appear to be any providers that would offer the full range of Clinical Support Services under the terms of a single contract, except in the Full Outsourcing model
- [redacted]

12.6 Evaluation of Service Outsourcing and Delivery Options

All options for service outsourcing are considered to provide the potential for a VFM outcome, but with varying degrees of opportunity and potential risk. However, it is considered that the Delivery Options most likely to deliver VFM are:

- Option 4: Enhanced Base Case + FM and selective Clinical Support Services Outsourcing – reflecting the potential outsourcing of Soft and Hard FM Services as well as the potential outsourcing of selected Clinical Support Services, with CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Option 5: Hybrid – reflecting the potential outsourcing of Soft and Hard FM Services and some Clinical Support Services as well as selected Clinical Services, with CHQ HHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Option 6: Full Outsourcing – reflecting the potential outsourcing of all services, i.e. the operation of QCH including FM Services, Clinical Services as well as Operational Services.

The success of Option 4 and Option 5 will be the driven by the successful management of interfaces created by the potential outsourcing. Service fragmentation has the potential risk of impacting on patient safety and quality of health outcomes, however we note that these interfaces are successfully managed in the NGSP sector.

[redacted]

12.8 Conclusions

12.8.1 Full Outsourcing option

While Full Outsourcing is considered to have the potential to deliver value for money, given the timeframe of opening the QCH in late 2014, and the current level of NGSP capability for complex tertiary services, [redacted] It therefore bears the most significant risks in respect of the successful transition and opening of QCH, including:

[redacted]

- This would be the first Full Outsourcing contract for the operation of a hospital in Queensland since the introduction of National Efficient Price (NEP). This means:
  - There are still known problems with the NEP that remain to be clarified by the Independent Hospital Pricing Authority, including appropriate loading for paediatric services, treatment of education and training and research. The working party on the treatment of education & training and research is expected to conclude its work in 24 months;

[redacted]

- Price risk transfer would be limited as a result as any pricing framework would need to respond to the changes in NEP methodology
- While a level of demand risk is likely to be able to be transferred, the ability to transfer demand risk in a manner equivalent to current HHS arrangements remains uncertain

[redacted]

- The disparate nature of the workforce being drawn from both RCH and MCH and the associated challenges of forming a coherent workforce

[redacted]

In addition, the potential long term implications on pricing and service delivery of having a single NGSP as the provider of State-wide paediatric services needs to be carefully considered. The Full Outsourcing will have less ability to represent a contestable benchmark given the unique nature of the hospital, rather the NGSP will become the only provider.

Based on the above, the risks associated with pursuing Full Outsourcing are considered substantial and, if they eventuated, could outweigh the potential benefits.

12.8.2 FM and Clinical Support Services

We consider the outsourcing of FM Services and selected Clinical Support Services to offer the potential to deliver VFM. Provision of Hard and Soft FM Services have some synergies in service delivery and are hence suggested to be bundled. This will also minimise contractual interface risk and contract management requirements for CHQ HHS.

[redacted]

We note that Clinical Support Services are discrete. Outsourcing of Clinical Support Services may create a level of interface risk with the provision of Operational Services that will need to be carefully managed to ensure quality of care and the achievement of efficient outcomes.

Only few providers offer more than one specialty. The services are hence suggested to be offered as separable portions. There is potential for increased efficiency that may result in financial savings.

Dependent on the number of services outsourced, there is the potential for financial savings in the order of [redacted] as compared to the Enhanced Base Case (or [redacted] as compared to the Base Case) over a comparative term of 15 years.

However, the complexity of the contract arrangements will require significant investment in a highly skilled contract management team to effectively commission, negotiate and manage the contracts.

12.8.3 Hybrid Model

The objective of the Hybrid model is to maximise scope for NGSP innovation and efficiencies, promoting a blend of in-sourcing and outsourcing of service provision without the risks associated with Full Outsourcing.

[redacted]

We consider that a Hybrid delivery model offers the potential to deliver VFM and harnesses a mix of in-sourcing and outsourcing of services.

Dependent on the number of services outsourced, there is the potential for financial savings in the order of [redacted] as compared to the Enhanced Base Case (or [redacted] as compared to the Base Case) over a comparative term of 15 years.

12.9 Implementation Issues

In the context of the above summary, we note the following in respect of the various delivery options.

In relation to Option 4 (Enhanced Base Case + FM + Clinical Support) and Option 5 (Hybrid):

- Should Option 4 or 5 be selected, then based on the proposed indicative timeline, a competitive tender process for FM Services and Clinical Support Services would need to be initiated no later than July 2013.[52]
- Separate teams for both FM Services and Clinical Support Services outsourcing will be required, in addition to the existing commission/transition team.

[52] We note separate arrangements for the QCH Energy Plant are discussed in Section 1.8 above.

- This would enable NGSP to be appointed by Practical Completion and assist with the transition and commissioning of QCH.
- CHQ HHS would need to implement the proposed range of Enhanced Base Case initiatives for Operational Services, Corporate Support Services and any Clinical Support Services that were not outsourced – dedicated resources would need to be assigned to this task in order to increase the likelihood of successful incorporation
- The potential for outsourcing some or all Corporate Support Services should be further investigated, including via further analysis in conjunction with the Contestability Branch, to enable HHS-wide and State-wide efficiencies and effective integration

[redacted]

- Key challenges relate to:
  - The need for a highly efficient governance and approvals process as well as utilisation of some elements of the existing project team to enable an immediate / efficient commencement of the process
  - The development of a highly skilled contract management and implementation management team by CHQ HHS and / or the Department of Health
  - The need for significant additional resourcing to manage the multiple concurrent activities, with particular consideration to be given to the related commissioning planning for QCH.

A project budget of approximately [redacted] is required to enable the implementation of this option.

In relation to Option 6 (Full Outsourcing) it is noted:

[redacted]

- Key challenges relate to:
  - The need for a highly efficient governance and approvals process as well as utilisation of some elements of the existing project team to enable an immediate / efficient commencement of the process
  - The development of a highly skilled contract management and implementation management team by CHQ HHS and / or the Department of Health

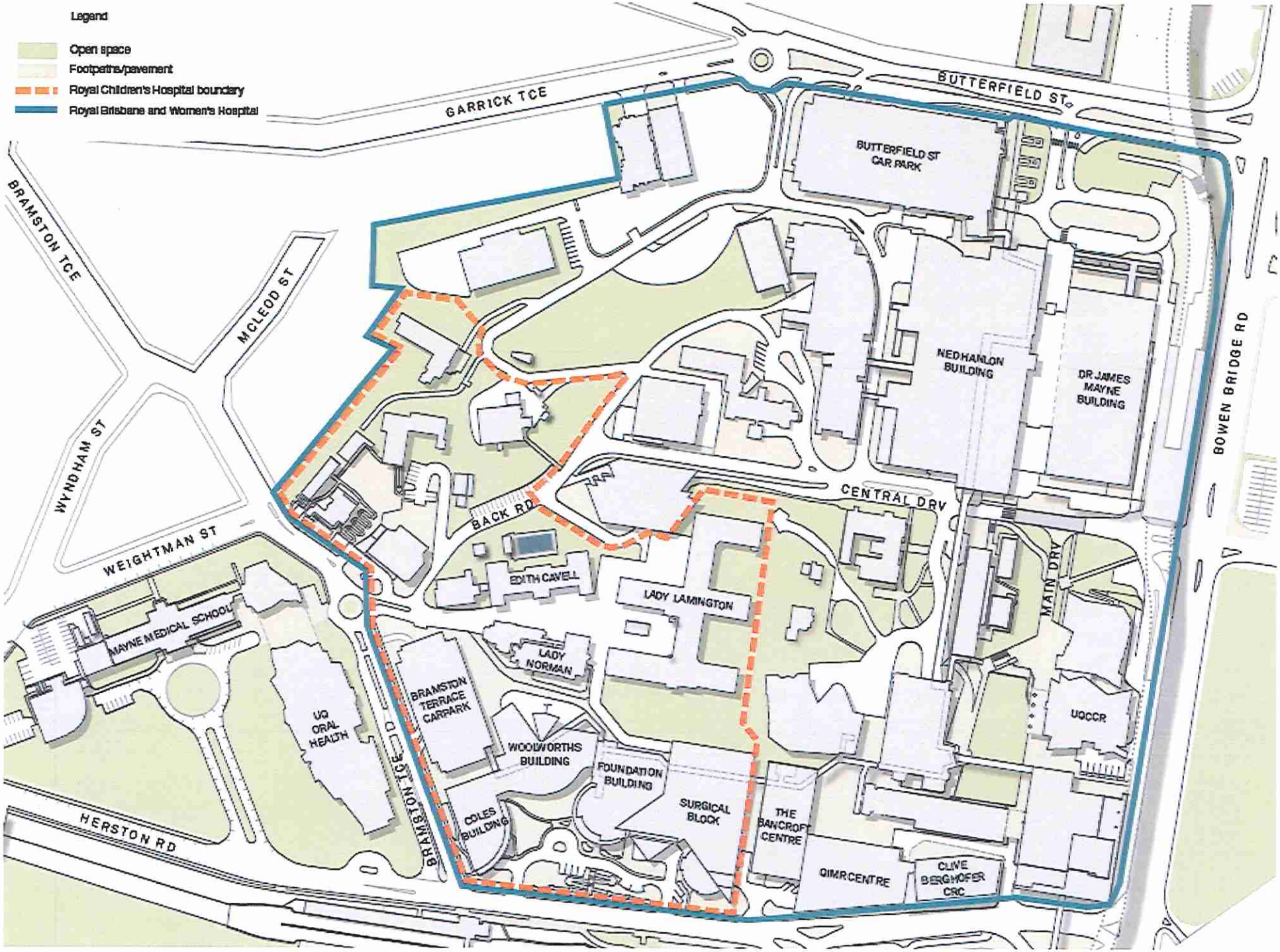
- The need for significant additional resourcing to manage the multiple concurrent activities, particular consideration needs to be given to the related commissioning planning for QCH. A scenario approach will need to be adopted.

A project budget of approximately [redacted] is required to enable the implementation of this option.

13 Glossary

Acronyms	Description
ABF	Activity Based Funding
ADAWS	Adolescent Drug and Alcohol Withdrawal Service
AGVs	Automatic Guided Vehicles
AHC	Australian Hospital Care
aIM tool	Acute Inpatient Modelling tool
A+RF	Academic and Research Facility
BAFO	Best and Final Offer
CEO	Chief Executive Officer
CHQ HHS	Children's Health Queensland Hospital and Health Service
Corrs	Corrs Chambers Westgarth
CSCF	Clinical Services Capability Framework
CSSD	Clinical Sterilising Services Department
CY	Calendar Year
DART	Domiciliary Acute care and Rehabilitation Team
DRG	Diagnosis Related Group
EBA	Enterprise Bargaining Agreement
ED	Emergency Department
EOI	Expression of Interest
FBC	Final Business Case
FM	Facilities Management
The Foundation	Children's Health Foundation Queensland
FTE	Full-time Equivalent
FW Act	Fair Work Act 2009 (Cth)
FY	Financial Year
HCoA	Health Care of Australia
HHB Act	Hospital and Health Boards Act 2011 (Qld)
HIP	Health Improvement Program
HIA	Health Insurance Act 1973(Cth)
HITH	Hospital in the Home
HDU	High Dependency Unit
HHS	Hospital and Health Service
HSP	Health Services Plan
ICT	Information Communication Technology
ICU	Intensive Care Unit
IHPA	Independent Hospital Pricing Authority
KPI	Key Performance Indicator
LOS	Length of Stay
MES	Managed Equipment Service
MCH	Mater Children's Hospital
MHS	Mater Health Services
MPCH	Mater Private Children's Hospital

Acronyms	Description
MRI	Magnetic Resonance Imaging
NEP	National Efficient Price
NGSP	Non-government service provider
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NHS	National Health Service
NICU	Neonatal Intensive Care Unit
NPV	Net Present Value
NSW	New South Wales
O&HS	Occupational Health and Safety
PBC	Preliminary Business Case
PC	Practical Completion
PHF Act	Private Hospital Facilities Act1999 (Qld)
PICU	Paediatric Intensive Care Unit
PPP	Public - Private Partnership
Q&A	Question and answer
QAS	Queensland Ambulance Service
QCH	Queensland Children's Hospital
QCHP	Queensland Children's Hospital Project, Health Infrastructure Branch
QH	Queensland Health
QIMR	Queensland Institute of Medical Research
Qld	Queensland
Qpath	Queensland Pathology
QUT	Queensland University of Technology
QWAU	Queensland Weighted Activity Unit
RBWH	Royal Brisbane and Women's Hospital
RCH	Royal Children's Hospital
RFBB	Request for Binding Bid
RoPP	Rights of Private Practice
SA	South Australia
SEQ	South-East Queensland
SJOGH	St John of God Health Care
SRG	Service Related Group
Transfer of Business Act	Fair Work Amendment (Transfer of Business) Act 2012(Cth)
TRI	Translational Research Institute
UQ	University of Queensland
UK	United Kingdom
VIC	Victoria
VFM Business case	Value for Money Business Case
WA	Western Australia
The Wesley	The Wesley Hospital



Tabled 29/7/13

Tabled 24/7/13

Advisory
Riparian Plaza
71 Eagle Street
Brisbane Qld 4000

GPO Box 223
Brisbane Qld 4001
Australia

ABN: 51 194 660 183
Telephone: +61 7 3233 3111
Facsimile: +61 7 3233 3100
www.kpmg.com.au

Privileged and confidential
Dr Tony O'Connell
Director-General
Queensland Health
Level 19
147-163 Charlotte St
Brisbane QLD 4000

Our ref 18486923_2

Contact Sabine Schleicher

By email

22 July 2013

Dear Tony

Public release of SCUH and QCH - Review of Options for the Outsourcing of Clinical and Support Services

We understand that it is the desire of the Minister for Health to release publicly two reports prepared by KPMG for Queensland Health: "Sunshine Coast University Hospital – Review of Options for the Outsourcing of Clinical and Support Services"; and "Queensland Children Hospital – Review of Options for the Outsourcing of Clinical and Support Services", collectively referred to as the Business Cases. This letter sets out some commercial considerations relating to the release of these documents.

The purpose of the Business Cases is to respond to the Government's request for a review of opportunities for the contracted delivery of clinical and operational services at each of SCUH and QCH. The Business Cases provide analysis of a range of potential opportunities to improve the efficiency and effectiveness of clinical and support services. These include identification of clinical and support services which could potentially be delivered through outsourcing arrangements and consideration of whether these outsourcing arrangements have the potential to deliver a Value for Money (VFM) solution for the respective Hospital and Health Services (HHS) and, ultimately, the people of Queensland. A confidential market sounding process was conducted to inform the preparation of the Business Cases.

The Business Cases include commercially sensitive information, such as:

- information which was provided by or relates to certain third parties, including the results of market assessments and market soundings
- commercial and legal information that could prejudice any future procurement process, including details of agency cost structures and estimated potential savings
- information which may, if released, potentially impact the commercial value of firms that may or may not be involved in the delivery of services at the two sites.

From a commercial perspective, it would be preferable to refrain from the public release of the Business Cases at this time. However, this would not preclude the release of the Business Cases at a later stage. Whilst there are some precedents, it is common not to disclose documents relating to a procurement process until the completion of the procurement process.

Given the Minister's desire to make public the Businesses Cases, it is important that the release of the Business Cases is undertaken in a way that does not violate confidentiality provisions, inappropriately attribute information to third parties or prejudice the success of any potential future procurement process. These outcomes would not only have a negative impact on the Queensland Government, but would also potentially devalue any outcome that the Government could achieve for taxpayers. We have therefore prepared a recommended redacted version of the Business Cases and redacted the following information:

- **Market sounding information**
  Any information in respect of the market sounding process and assessment of the market, as this could provide potential tenderers in any outsourcing process with insight on your views as to the nature of the potential competition for the services and could influence the market response
- **Financial analysis**
  Any financial analysis which reveals the existing cost structures, provides an indication of the estimated savings or reveals aspects of the methodology that you may employ to evaluate tenders, including quantitative risk adjustments, as this could influence the bidding behaviour of potential service providers, e.g. in terms of the price offered relative to the National Efficient Price (NEP)
- **Commercially sensitive information**
  Any commercial and legal information that could influence the behaviour of third parties in any future tender process or other commercial dealings
- **Confidential information**
  Any information which is subject to formal confidentiality obligations on Queensland Health or financial information relating to existing contracts
- **Information which has not been verified**
  Information which KPMG has sourced in relation to the case studies, which is principally from publicly available material, but which KPMG has not been able to verify in the time available and hence is not appropriate for release into the public domain.

We have also removed the Appendices, given that they do not add substantively to the analysis in the body of the report but include a large volume of information that may need to be redacted under the above principles, particularly in relation to the results of the market assessment and market sounding process, and detailed legal advice.

Redacting commercially sensitive information is common practice. A recent example is the Detailed Business Case for the proposed Moorebank Intermodal Terminal which was prepared

by KPMG on behalf of the Commonwealth Department of Finance and Deregulation[1]. Significant sections of the document, such as the financial analysis, were redacted from the document, so as not to prejudice a future procurement process.

We have included the following words at the front of the redacted version of the documents:

"Please note that certain information contained within this report has been redacted. The information which has been redacted includes certain financial and commercial information, information in respect of or in relation to competitive procurement processes which may be conducted by Queensland Health in the future, and information which was provided by or relates to certain third parties in relation to which the State has assumed obligations of confidentiality."

Please do not hesitate to contact me, if you have any additional queries in respect of our advice.

Yours sincerely

Sabine Schleicher
Partner

Adrian Box
Partner

[1] www.finance.gov.au/property/property/moorebank-intermodal-freight-terminal/docs/public_release_detailed_business_case.pdf

KPMG

cutting through complexity

QUEENSLAND HEALTH

Sunshine Coast University Hospital

Review of Options for the Outsourcing of Clinical and Support Services

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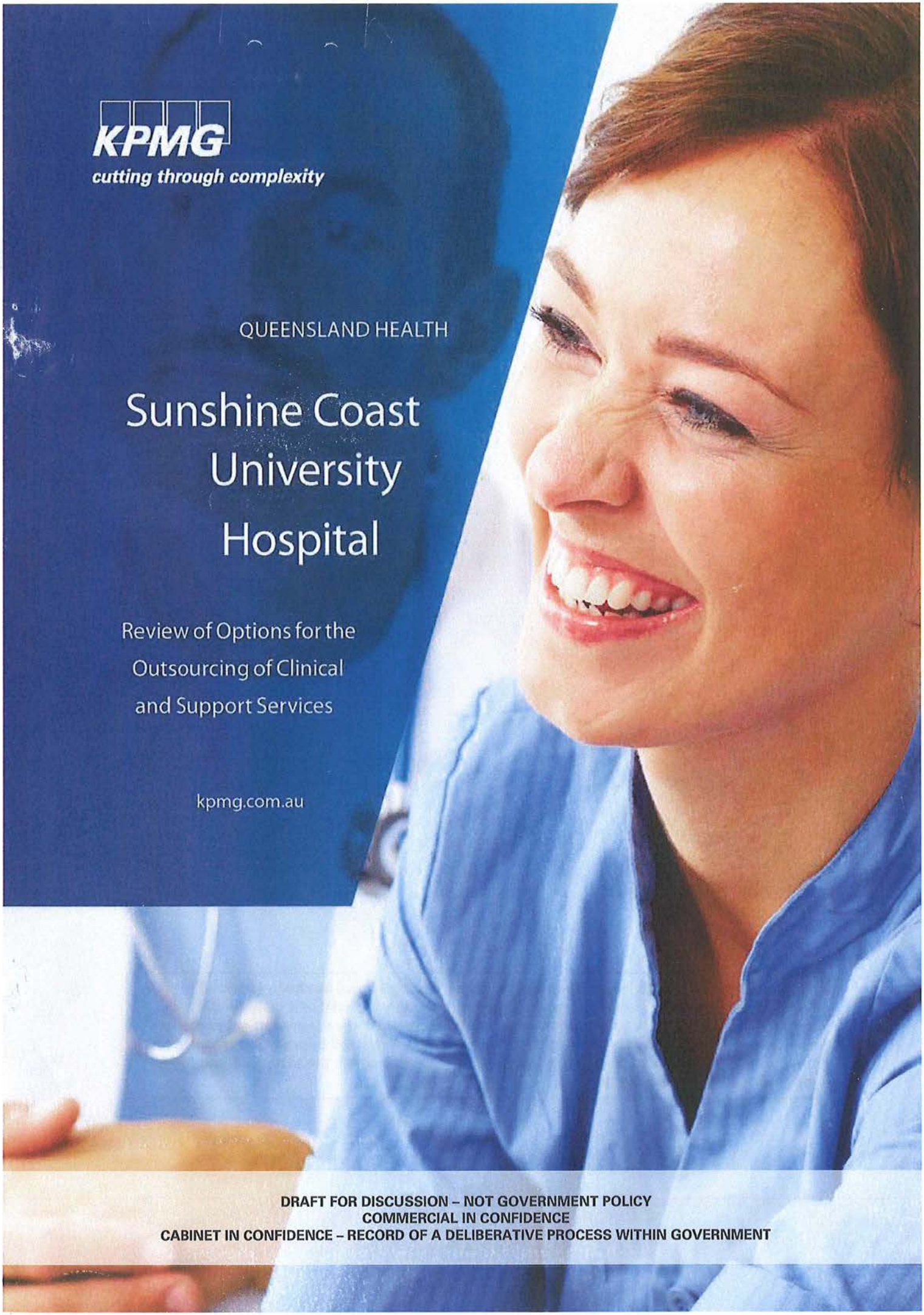


DRAFT FOR DISCUSSION – NOT GOVERNMENT POLICY
COMMERCIAL IN CONFIDENCE
CABINET IN CONFIDENCE – RECORD OF A DELIBERATIVE PROCESS WITHIN GOVERNMENT

Please note that certain information contained within this report has been redacted. The information which has been redacted includes certain financial and commercial information, information in respect of or in relation to competitive procurement processes which may be conducted by Queensland Health in the future, and information which was provided by or relates to certain third parties in relation to which the State has assumed obligations of confidentiality.

Contents

71 Eagle Street
Brisbane QLD 4000

GPO Box 223
Brisbane QLD 4001
Australia

ABN: 51 194 660 183

Telephone: +61 7 3233 3111
Facsimile: +61 7 3233 3100
www.kpmg.com.au

28 June 2013

[redacted]

Dear [redacted]

Sunshine Coast University Hospital (SCUH) – Review of Options for the Outsourcing of Clinical and Support Services

We were engaged on 1 March 2013 to develop a value for money (VFM) Business Case to review the options for the outsourcing of clinical and support services at the SCUH by the Department of Health and on behalf of the Queensland Government. Our work has been performed in accordance with the scope of work terms and conditions as outlined in Queensland Health's Acceptance Letter.

Final report

This report has been prepared on the basis of our work commencing on 1 March 2013 and carried out up to 28 June 2013.

As part of the development of the Business Case, we have undertaken an extensive market scan and market sounding process with Non-Government Service Providers (NGSPs); consultation with central agencies, the Executive and Board of the Sunshine Coast Hospital and Health Service (SCHHS), clinicians, Department of Health executives, including Queensland Health's Contestability Branch. This research and consultation process has been an important part of the development of the VFM Business Case and has been incorporated in KPMG's independent analysis of potential service delivery options.

Throughout the consultations we were provided with thoughtful analysis of the issues to be considered in analysing outsourcing options. The report's objective is to provide a detailed discussion of the issues and considerations in respect of each of the outsourcing options so as to enable an informed decision by Government.

Information

In undertaking our work we have had access to information provided by SCHHS, legal advisers and publicly available information.

Distribution

This report has been prepared exclusively for Queensland Health in relation to the SCUH. This report must not be used for any other purpose or distributed to any other person or party, except as set out in our engagement contract, or as otherwise agreed by us in writing.

We would like to record our thanks to the many people involved in the engagement, including in particular representatives of the Department of Health and the Board, Executive and representatives of SCHHS who have facilitated our work wherever possible. Finally, we would like to thank you for entrusting KPMG to prepare this report for consideration by the Queensland Government. It has been a privilege to contribute to the consideration of this important public sector reform initiative.

Adrian Box
Partner
abox@kpmg.com.au

Important Notice

If you are a party other than Queensland Health, KPMG:

- owes you no duty (whether in contract or in tort or under statute or otherwise) with respect to or in connection with the attached report or any part thereof; and
- will have no liability to you for any loss or damage suffered or costs incurred by you or any other person arising out of or in connection with the provision to you of the attached report or any part thereof, however the loss or damage is caused, including, but not limited to, as a result of negligence.

If you are a party other than Queensland Health and you choose to rely upon the attached report or any part thereof, you do so entirely at your own risk.

Limitations

The responsibility for determining the adequacy or otherwise of our terms of reference is that of Queensland Health.

Our terms of reference comprise an advisory engagement which is not subject to Australian, or any other, auditing or assurance standards and consequently no conclusions intended to convey assurance are expressed.

Further, as our terms of reference do not constitute an audit or review in accordance with Australian auditing standards, they will not necessarily disclose all matters that may be of interest to Queensland Health or reveal errors and irregularities, if any, in the underlying information.

In preparing this report, we have had access to information provided by Queensland Health and its legal advisors, commercially sensitive information obtained in the market sounding process, and publicly available information. The findings and recommendations in this report are given in good faith but, in the preparation of this report, we have relied upon and assumed, without independent verification, the accuracy, reliability and completeness of the information made available to us in the course of our work, and have not sought to establish the reliability of the information by reference to other evidence.

Any findings or recommendations contained within this report are based upon our reasonable professional judgement based on the information that is available from the sources indicated. Should the project elements, external factors and assumptions change then the findings and recommendations contained in this report may no longer be appropriate. Accordingly, we do not confirm, underwrite or guarantee that the outcomes referred to in this report will be achieved.

We have not compiled, examined or applied other procedures to any prospective financial information in accordance with Australian, or any other, auditing or assurance standards. Accordingly, this report does not constitute an expression of opinion as to whether any forecast or projection of SCHHS or any delivery option analysed will be achieved, or whether assumptions underlying any forecast or projection of SCHHS are reasonable. We do not warrant or guarantee any statement in this report as to the future prospects of SCHHS or any delivery option analysed.

In addition, in preparing this report KPMG has had to make certain estimates as to potential costs, savings, capital expenditure and other items. Those estimates have necessarily been based on hypothetical assumptions as to future events and circumstances. There will inevitably be differences between forecast or projected and actual results, because events and circumstances frequently do not occur as expected or predicted, and those differences may be material. KPMG does not warrant or guarantee any of its estimates, forecasts or projections contained within this report.

1 Executive Summary

1.1 Purpose of this Business Case

The recently released *Blueprint for better healthcare in Queensland*[1] (the Blueprint) outlines the Queensland Government's plan for structural and cultural improvement in the health system. Specifically, the Blueprint details the Queensland Government's willingness to explore opportunities for alternative service delivery models to improve value for money such as outsourcing, co-sourcing, public-private joint ventures and partnering with the private sector and other government agencies.

This Value for Money (VFM) Business Case responds to the Government's request for a review of the opportunities for the contracted delivery of clinical and operational services at Sunshine Coast University Hospital (SCUH).[2]

The Business Case provides analysis of a range of potential opportunities to improve the efficiency and effectiveness of clinical and support services at SCUH, incorporating potential options for non-government service provider (NGSP) delivery of services. The Business Case identifies clinical and support services which could, potentially, be delivered through outsourcing arrangements and tests whether these outsourcing arrangements have the potential to achieve the vision of 'providing excellent care through collaboration, enquiry and education' and deliver a VFM solution for the Sunshine Coast Hospital and Health Service (SCHHS) and ultimately the people of Queensland.

1.2 Overview

In undertaking the analysis for the Business Case, KPMG has drawn on a number of sources of information including in particular:

- **Market research**: KPMG has conducted a scan of the major industry participants, locally and nationally and internationally, that might be expected to have the capability and experience to provide the range of services identified for potential outsourcing at SCUH. In addition, KPMG has prepared case studies of relevant precedent projects in Australia and internationally involving NGSP delivery of relevant public health services.
- **Market soundings**: KPMG, in conjunction with the Department of Health and SCHHS, has conducted a series of 10 meetings with selected market participants to obtain a non-government perspective on issues associated with outsourcing public health services. Among other things, these discussions have provided the market's perspective and informed the analysis of the potential issues and the assessment of the potential capability and appetite of the market to provide these services.
- **Government and clinical stakeholder consultations**: KPMG has engaged in intensive consultation with the executive and staff of the SCHHS. This has involved over 30 interviews with clinicians and other staff, and a series of briefings and discussions with the Clinical Leadership Group, the SCHHS Board, as well as with Sunshine Coast TAFE and University of Sunshine Coast. KPMG has also consulted with senior officials within the Department of Health, the Department of Premier and Cabinet and the Treasury. These discussions have assisted in clearly defining the service requirements and then identifying the opportunities, constraints and risks in relation to the provision of these services by SCHHS and / or NGSPs.

[1] Queensland Government, *Blueprint for better healthcare in Queensland*, February 2013, http://www.health.qld.gov.au/blueprint/docs/print.pdf
[2], Media release, *Blueprint for the future in Queensland healthcare*, February 2013, http://statements.qld.gov.au/Statement/2013/2/27/blueprint-for-the-future-in-queensland-healthcare

- **KPMG independent analysis**: In addition to relying on the observations from each of the elements above, KPMG has applied its own experience in the health care sector, conducting VFM assessments and commercial analysis of NGSP delivery of public services and associated contractual arrangements to further develop the analysis in this Business Case.

This Executive Summary does not purport to represent all relevant information and should therefore be read in conjunction with the remainder of the Business Case.

1.3 Service Outsourcing Options

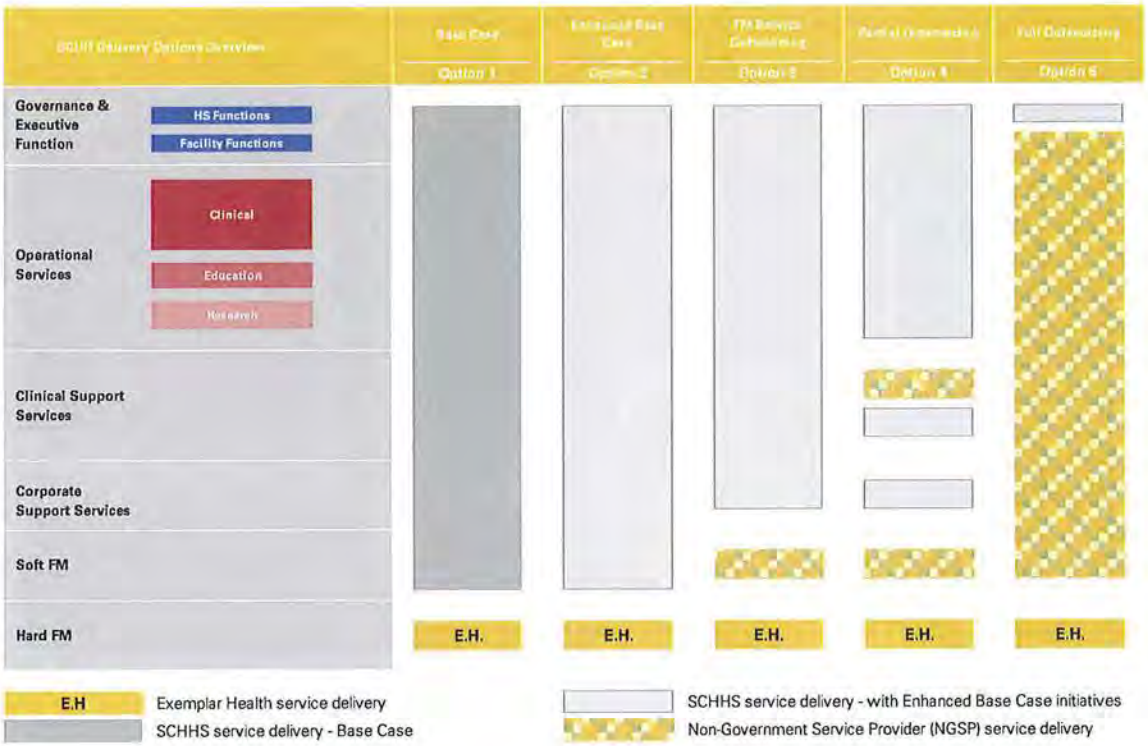
In considering options relevant to service delivery at SCUH, a range of service categories were developed. These service categories were defined as:

Further detail on the services within each of these service categories is as follows:

As part of the analysis, the opportunities and constraints, potential commercial principles and market precedent for the outsourcing of each service category was considered. Based on this analysis and to reflect the range of potential options to in-source or outsource certain services, a range of Delivery Options were developed, reflecting an increasing level of NGSP delivery of services, including:

- Base Case – a reflection of the current expected service delivery of SCUH by SCHHS
- Enhanced Base Case – reflecting SCHHS delivery with a range of efficiency reform initiatives being implemented
- Soft FM Services – reflecting an amendment to the existing PPP contract with Exemplar Health to incorporate Soft FM Services, and SCHHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Partial Outsourcing – reflecting the Soft FM Services amendment (as above), as well as the potential outsourcing of selected Clinical Support Services, with SCHHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Full Outsourcing – reflecting the potential outsourcing of all Operational Services.

A diagrammatic representation of these options is as below:



1.4 Key observations from consultation, case study review / market scan and market sounding

In support of our analysis, a summary of the key observations from the consultation, case study review / market scan and the market sounding is as follows.

1.4.1 Key observations from Clinical Stakeholder Consultation

The key observations from the clinical stakeholder consultation interviews, the workshops and other interactions with SCHHS are:

- Despite a number of significant financial challenges, SCHHS has achieved budget surpluses over the past 2 years and improved performance against key indicators – this has been supported by effective clinician participation in key strategic and operational decision making, in conjunction with the Executive Leadership Team – and provides a strong foundation for continued positive performance into the future
- Options involving outsourcing up to and including some Clinical Support Services (biomedical services and clinical sterilisation) are generally supported and largely allow SCUH's vision to be delivered
- Options involving outsourcing of all Clinical Support Services or Full Outsourcing are more challenging. Key issues raised during consultation include:
  - The additional interface risk that is created (between Clinical Support Services and Clinical Services if responsibility is separated)
  - Quality of SCHHS service delivery potentially compromised from fragmentation
  - The quality of care in light of an operator's profit motive

- The difficulty in creating the right incentives to ensure provision of training, education and research services
- Concern that Full Outsourcing may materially vary SCHHS role and functions and impact on viability of the health service
- The possibility that control, rather than risk, is transferred and that this creates a significant position of power in future dealings with the State under the contract.

- Some potential benefits of outsourcing that were acknowledged are:
  - Potential benefits in relation to ongoing workforce management and flexibility
  - Potential for benefits from NGSP innovation, e.g. flatter management structure, better ICT systems, review of staffing models, that may provide the opportunity for financial savings.

1.4.2 Key observations from Case Studies & Market Scan

The key observations from the case study review and market scan in relation to Full Outsourcing are:

- There are a range of precedents for the NGSP delivery of public health services both within Queensland, nationally and internationally. These precedents include examples of the provision of complex services and well developed education and research programs
- In relation to these precedents it is important to note that:
  - we have not identified a direct comparison that has the combination of breadth of services, complexity of services, scale of education and research and regional location
  - the majority relate to the provision of less breadth, scale or complexity of services
  - with the exception of not-for-profit operators, there is very few comparable precedents for the NGSP delivery of large public tertiary teaching hospitals
  - there are a number of international examples of NGSP delivery of public health services – while it is difficult to undertake a direct comparison, an observation is that many of these relate to smaller facilities and less complex services.
- The experience of Full Outsourcing has been mixed with some continuing to operate successfully, but a number being returned to Government delivery. The reasons for these issues are varied, but many relate to unsustainable pricing and / or risk allocation
- Some examples of NGSPs, in a metropolitan setting, that provide higher complexity services as well as education and research include UnitingHealth (the Wesley), St Vincent's (Sydney and Melbourne) and Mater (Brisbane).
- Further examples include Western Australian facilities Joondalup and Midland Health Campus (noting that service provision has yet to commence), which have outsourced all services, but are less complex facilities (generally equivalent to CSCF Level 4 to 5) than SCUH (up to CSCF level 6).
- International examples of NGSP delivery include the 706 bed Bragga Hospital (Portugal), the 300 bed Hospital de La Ribera (Valencia, Spain), the 220 bed Hospital de Manises (Valencia, Spain), the Hinchingbrooke Hospital NHS Trust (UK) and the 310 bed Saint Göran Hospital (Stockholm, Sweden).

The key observations from the case study review and market scan in relation to Clinical Support Services are:

- There are a number of NGSPs that have been successfully delivering Clinical Support Services for many years particularly in imaging, pathology and pharmacy services although with less direct experience in QLD
- The most common Clinical Support Services that are outsourced are pathology, pharmacy, and imaging

[redacted]

1.4.3 Key observations from Market Sounding

The key observations from the market sounding process in relation to Full Outsourcing / provision of Operational Services are:

[redacted]

1.5 Evaluation of service outsourcing and Delivery Options

Based on the above evaluation, all options for service outsourcing are considered to provide the potential for a VFM outcome, but with varying degrees of opportunity and potential risk. However, it is considered that the Delivery Options likely to provide the greatest potential VFM are the Partial Outsourcing and the Full Outsourcing options.

Full Outsourcing option is considered to have the potential to deliver the best financial, workforce management and risk transfer outcomes (once established), while noting that it bears significant risks including absence of demonstrated track record for services of the scale, breadth and complexity as well as that may impact on the ability to achieve a competitive outcome.

Partial Outsourcing option would also provide a VFM outcome with reduced potential benefits in relation to financial outcomes, workforce and risk transfer, but with a number of the significant potential risks of Full Outsourcing being avoided or substantially mitigated. It also combines the benefits of the opportunity for the implementation of the Enhanced Base Care efficiency reforms by SCHHS.

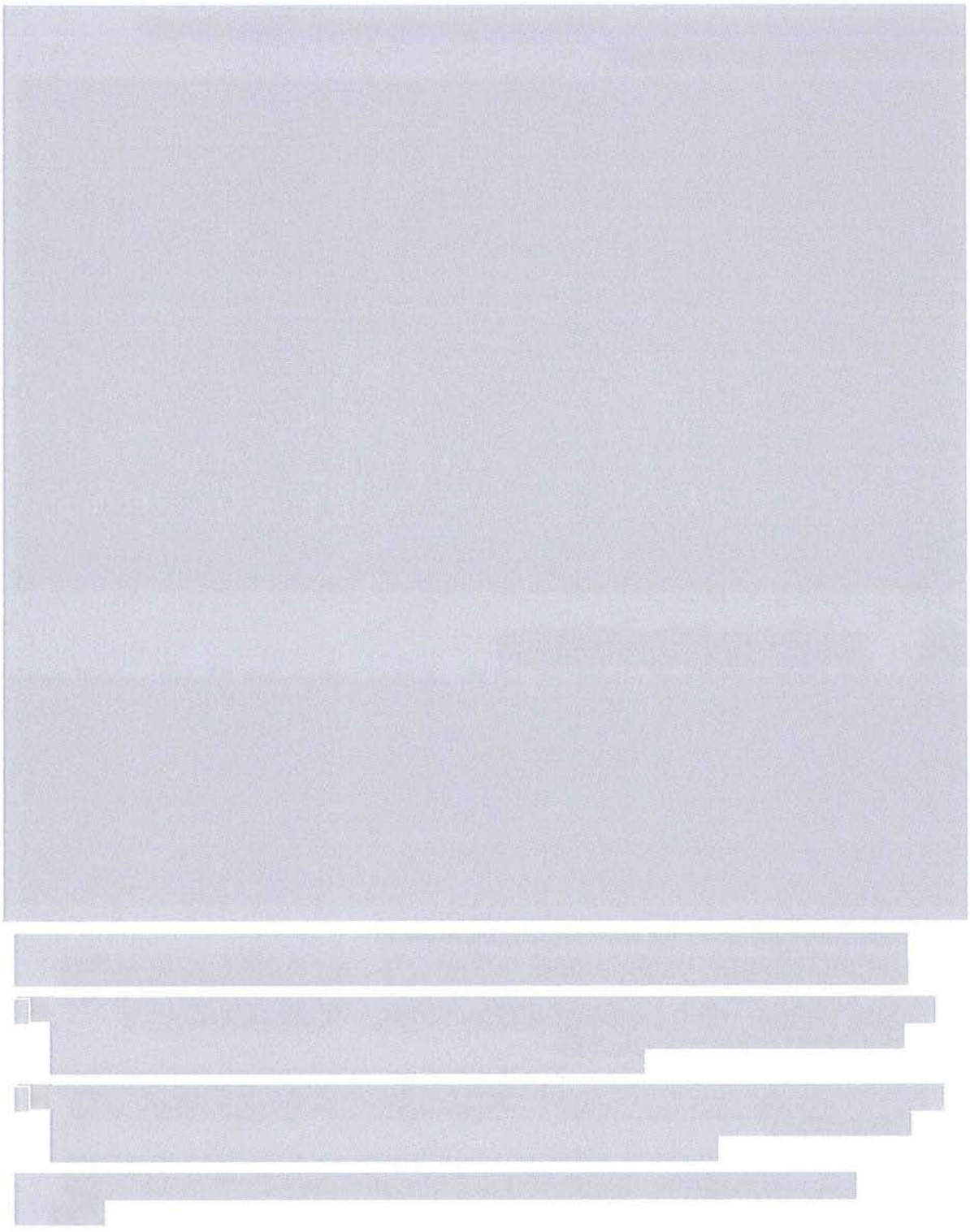
The Soft FM Services option is considered to be a highly viable option, with clear value for money potential and low risk. It is therefore recommended for implementation regardless of decision on other outsourcing options.

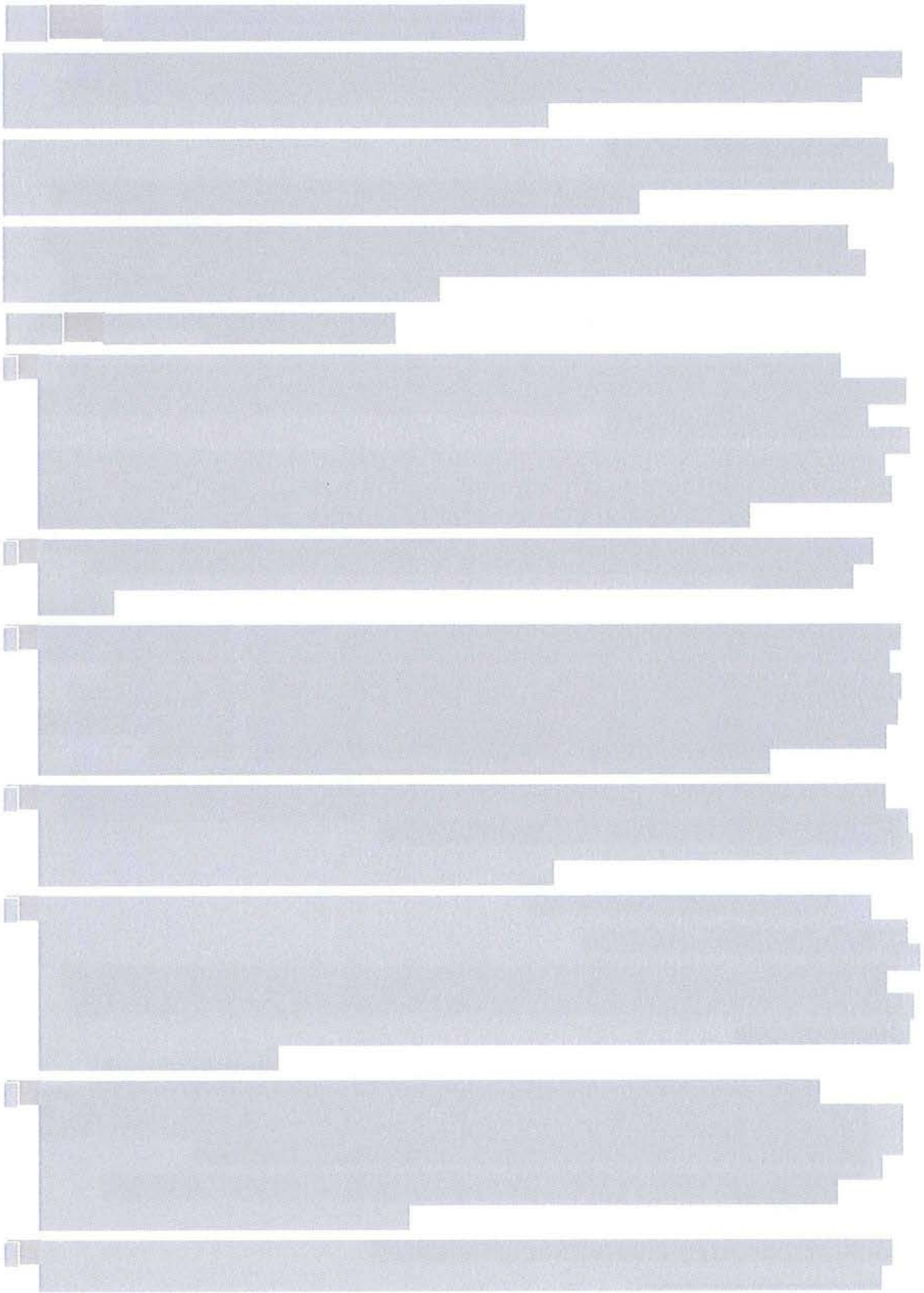
A summary of the key advantages and disadvantages of these options is as follows:

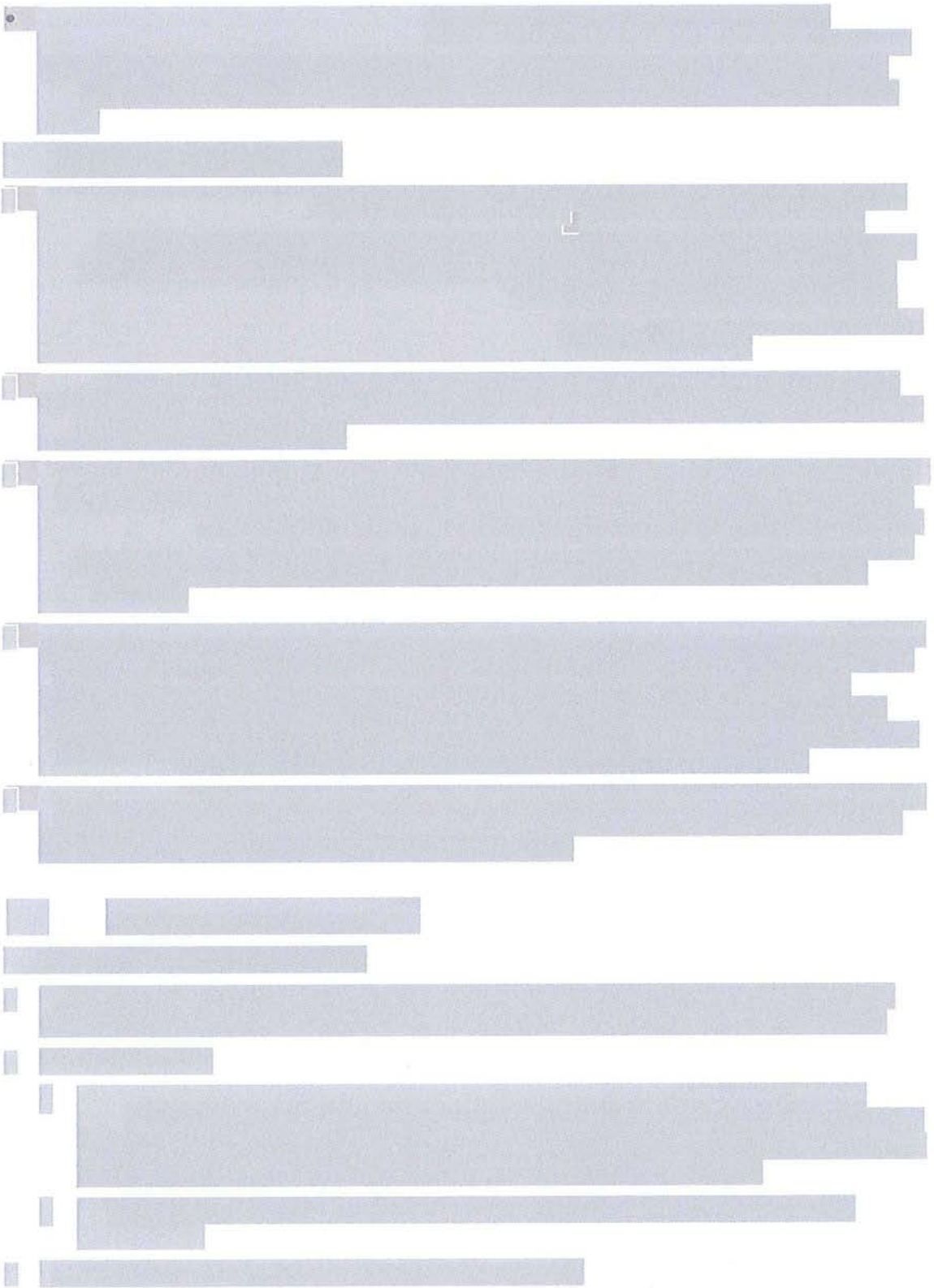
Full Outsourcing Option	Partial Outsourcing Option
Positives / Opportunities	
• Provides the opportunity for a focused commercial approach to service delivery while maintaining a clear commitment to the vision and quality requirements • Potential for increased efficiency that may result in financial savings • The creation of a contestable benchmark and partnership with the NGSP sector for the provision of services that may assist in driving HHS-wide and system-wide change, innovation and efficiency • Assist in delivering a mind-set change in relation to the increased role in commissioning services as opposed to a requirement for direct service provision • Benefits of material risk transfer to the NGSP and the certainty of a contractual framework • The ability to access the benefits of NGSP workforce management models and industrial frameworks that can assist in mitigating the significant recruitment and on-ongoing workforce management risks •	• Provides a mixed model solution enabling – continued public sector provision of Operational Services and thus direct control over the manner in which Operational Services are delivered and the vision is achieved – the incorporation of Enhanced Base Case reform initiatives for the services to remain as in-source services and generate improved VFM to enable increased investment in front line services – the opportunity to explore the option of partnering with the non-Government sector to identify and assist in the implementation of further reform initiatives, while SCHHS remains responsible for direct service delivery – the benefits of NGSP delivery of key support services • Potential for increased efficiency that may result in financial savings • The creation of a contestable benchmark and partnership with the NGSP sector for the provision of certain services that may assist in driving HHS-wide and system-wide change, innovation and efficiency (although noting that this is relevant to a smaller scope of services than the Full Outsourcing option) • Assist in delivering a mind-set change in relation to the increased role in commissioning services as opposed to a requirement for direct service provision (although noting that this is relevant to a smaller scope of services than the Full Outsourcing option) • Benefits of material risk transfer to the NGSP and the certainty of a contractual framework (although noting that this is relevant to a smaller scope of services than the Full Outsourcing option) • The ability to access the benefits of NGSP workforce management models and industrial frameworks that can assist in mitigating the significant recruitment and on-ongoing workforce management risks for the relevant services – in particular Soft FM Services (although noting that these benefits are less than for the Full Outsourcing option)

Full Outsourcing Option	Partial Outsourcing Option
Issues / Challenges	
• There is limited demonstrated track record of NGSP delivery of services of equivalent breadth, complexity and scale – we have not identified a direct comparison that has the combination of breadth of services, complexity of services, scale of education and research and regional location	• A number of key project risks will continue to be retained by the SCHHS and will require significant further development from their current status, to effectively mitigate and manage. These include: – The capability change as a result of the increased complexity and scale of services to be delivered at SCUH – The need for a clear research strategy – The workforce needs analysis, recruitment strategy and successful transition – The ability to achieve the targeted Enhanced Base Case initiatives and the resulting efficiencies
	• The combined complexity of the Clinical Support Service transactions, the Soft FM modification, implementation of Enhanced Base Case initiatives and management of the above key risks, will require significant additional dedicated resourcing and thus increase the risk of not successfully achieving these outcomes (noting that the current PPP and change activities will continue)
• The complexity of Clinical Services and in particular the education and research requirements would require careful specification in the contract – a failure to adequately specify requirements may lead to sub-optimal operational outcomes	• The effective achievement of a mixed-model outcome will require significant cultural change within the SCHHS to effectively capture the benefits
• The complexity of the contract arrangements will require significant change in SCHHS resourcing and capability to effectively manage the contract and to operate a mixed provider HHS – any failure to appropriately manage the contract will increase the risk to Government	• The outsourcing of Clinical Support Services may create a level of interface with the provision of Clinical Services that will need to be carefully managed to ensure quality of care and the achievement of efficient outcomes
	• The outsourcing of relevant Clinical Support Services may have a negative impact on some of the State-wide initiatives that may be further considered, in particular in relation to pathology services
• The successful integration of SCUH with the remainder of the HHS (in particular Nambour), resulting from the mixed provider model, would need to be carefully managed and has the potential to create operational challenges and a level of inefficiency	
• The contractual arrangements will require careful consideration to deliver the potential for VFM, while achieving effective risk transfer, driving the desired performance behaviour and providing sufficient flexibility – while a level of	• The contractual arrangements will require careful consideration to deliver the potential for VFM, while achieving effective risk transfer, driving the desired performance behaviour and providing sufficient flexibility

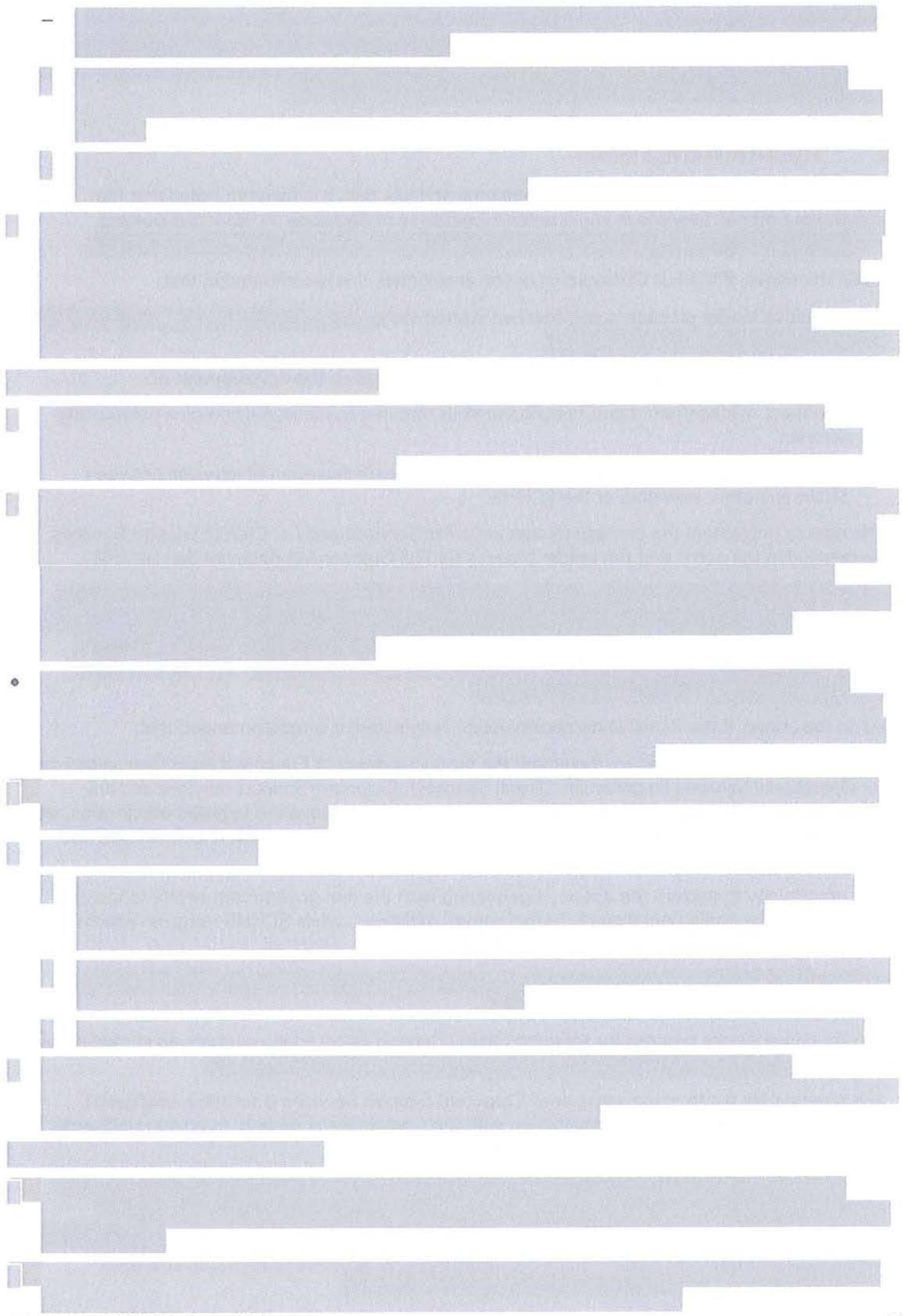
Full Outsourcing Option	Partial Outsourcing Option
demand risk is likely to be able to be transferred, the ability to transfer demand risk in a manner equivalent to current HHS arrangements remains uncertain • There is a risk of market capture arising from the dominant role of SCUH within SCHHS	







[3] Media statement, Minister for Health, 30 April 2013, http://statements.qld.gov.au/Statement/2013/4/30/its-official-queensland-hospitals-wont-be-privatised



1.9 Recommendations

Given the strong expected value for money outcome and low risk, it is recommended that the outsourcing of Soft FM Services is implemented regardless of decisions on other outsourcing options

Based on the above, if the Full Outsourcing option is selected, it is recommended that:

- A competitive tender process is commenced immediately
- SCHHS commence an organisational change process, including the development of:
  - a contract management team to build the skills required to manage a complex outsourcing contract
  - an integration team to plan and implement an effective integration of services between SCUH and other elements of the SCHHS.
- The right to implement the process to outsource FM Services and / or Clinical Support Services be retained in the event that the tender process for Full Outsourcing does not deliver VFM

Based on the above, if the Partial Outsourcing option is selected, it is recommended that:

- SCHHS dedicates resources to implement the proposed range of Enhanced Base Case initiatives for Operational Services (in particular Clinical Services), Corporate Support Services and any Clinical Support Services that are not outsourced in order to achieve the targeted efficiencies, and that a detailed plan to further assess and achieve successful implementation is developed and closely monitored
- The opportunity to explore the option of partnering with the non-government sector to identify, and assist in the implementation of, further reform initiatives, while SCHHS remains responsible for direct service delivery, is further investigated
- A competitive tender process for selected Clinical Support Services is commenced immediately
- The potential for outsourcing some or all Corporate Support Services is further investigated, including via further analysis in conjunction with the Contestability Branch, to enable HHS-wide and State-wide efficiencies and effective integration

2 Introduction

2.1 Blueprint for better healthcare in Queensland

The recently released *Blueprint for better healthcare in Queensland*[4] (the Blueprint) outlines the Queensland Government's plan for structural and cultural improvement in the health system.

The Blueprint details a range of changes to the health system under four principal themes:

- Health services focused on patients and people
- Empowering the community and our health workforce
- Providing Queenslanders with value in health services
- Investing, innovating and planning for the future.

Specifically, the Blueprint details the Queensland Government's willingness to explore opportunities for alternative service delivery models to improve value for money such as outsourcing, co-sourcing, public-private joint ventures and partnering with the private sector and other government agencies. This includes examining the delivery of support services, such as pathology and diagnostic imaging, along with entire hospitals services, particularly at new hospitals and other greenfield sites.

On release of the Blueprint, the Minister announced a 'review of value for money offered by partnership models' at SCUH.[5]

On 30 April 2013, the Independent Commission of Audit Final Report - February 2013 was publicly released. In particular, recommendation 66 relates to this project which states[6]:

'To achieve improved efficiency of public hospital services, the Government should progressively expand contestable markets, initially in metropolitan areas, for the private provision of:

- *clinical services – which happens already with some elective surgery, but in greenfield hospital developments could go far wider;*
- *clinical support services such as pathology, radiology and pharmacy;*
- *non-clinical support services such as catering, cleaning, laundry and ward support.'*

The Government response, also tabled on 30 April 2013, was to support this recommendation, noting the establishment of the Contestability Branch within the Department of Health as immediate evidence of action being taken to deliver on the Commission of Audit's recommendations. It also noted that the Government remains *'fully committed to ensuring all Queenslander's have access to a free public hospital system'*.

2.2 Purpose of this business case

2.2.1 Government Direction

This Business Case responds to the Government's request for a review of the opportunities for the contracted delivery of clinical and operational services at the SCUH. The Business Case provides analysis of a range of potential opportunities to improve the efficiency and effectiveness of clinical and support services at SCUH, incorporating potential options for non-government service provider (NGSP) delivery of services. The Business Case identifies clinical and support services which could,

[4] Queensland Government, *Blueprint for better healthcare in Queensland*, February 2013, http://www.health.qld.gov.au/blueprint/docs/print.pdf
[5], Media release, *Blueprint for the future in Queensland healthcare*, February 2013, http://statements.qld.gov.au/Statement/2013/2/27/blueprint-for-the-future-in-queensland-healthcare
[6] Queensland Government, *Queensland Commission of Audit- Final Report, February 2013.*

potentially, be delivered through outsourcing arrangements and tests whether these outsourcing arrangements have the potential to achieve the vision of 'providing excellent care through collaboration, enquiry and education' and deliver a VFM solution for the SCHHS and ultimately the people of Queensland.

2.2.2 VFM assessments undertaken prior to this study

In 2012, the Queensland Government requested the development of a Business Case under the State's Value for Money Framework to consider the VFM potential of including Soft Facilities Management (FM) Services in the scope of the SCUH Public Private Partnership (PPP). In addition, the Government requested a preliminary assessment of the potential to include major equipment and Information and Communications Technology (ICT) in the scope of the PPP contract or to procure via a Managed Services Agreement (MSA).

The Soft FM Business Case concluded that including Soft FM in the scope of the PPP is the preferred option for the delivery of these services and has the potential to deliver significant VFM.

The Equipment Preliminary Assessment concluded that including equipment management services in the scope of the PPP had VFM potential, but that additional design and specification work needed to be completed as the SCUH project progresses, to inform further analysis and before a decision is made.

There are significant operating interfaces between Soft FM Services, equipment management services and the provision of clinical and support services. Therefore, if Government chooses to outsource clinical service delivery, it is likely that Soft FM Services and certain equipment management services would be included in the scope of any contract.

Accordingly, a decision on outsourcing Soft FM Services and/or equipment management services at SCUH was deferred to allow this Business Case to consider broader service outsourcing options.

2.3 Approach to the assessment of options

The broad approach adopted in preparing this Business Case has involved stakeholder consultations and market research; identification of relevant services and outsourcing options; and qualitative and quantitative evaluation of outsourcing options. The process has drawn on a range of inputs as follows:

- **Market research**: KPMG has conducted a scan of the major industry participants - locally, nationally, and internationally - that might be expected to have the capability and experience to provide the range of services identified for potential outsourcing at SCUH. In addition, KPMG has prepared case studies of relevant precedent projects in Australia and internationally involving NGSP delivery of relevant public health services.
- **Market soundings**: KPMG, in conjunction with the Department of Health and SCHHS, has conducted a series of 10 meetings with selected market participants to obtain a non-government perspective on issues associated with outsourcing public health services. Among other things, these discussions have provided the market's perspective and informed the analysis of the potential issues and the assessment of the potential capability and appetite of the market to provide these services.
- **Government and clinical stakeholder consultations**: KPMG has engaged in intensive consultation with the executive and staff of the SCHHS. This has involved over 30 interviews with clinicians and other staff of the facility, and a series of briefings and discussions with the Clinical Leadership Group, the SCHHS Board, as well as with Sunshine Coast TAFE and University of Sunshine Coast. KPMG has also consulted with senior officials within the

Department of Health, the Department of Premier and Cabinet and the Treasury. These discussions have assisted in clearly defining the service requirements and then identifying the opportunities, constraints and risks in relation to the provision of these services by SCHHS and / or NGSPs.

- **KPMG independent analysis**: In addition to relying on the observations from each of the elements above, KPMG has applied its own experience in the health care sector, conducting VFM assessments and commercial analysis of NGSP delivery of public services and associated contractual arrangements to further develop the analysis in this Business Case.

2.4 Structure of this report

The Business Case is based on the following structure and content:

- **Introduction**: outlines the strategic direction for this Business Case set by the Blueprint and the subsequent Government direction for a VFM Business Case
- **SCUH background and scope**: describes the vision, objectives and scope of the SCUH project, including related developments, as well as the current status of the project
- **Service delivery plans**: describes the strategic policy context for health planning, the current Health Service Plan for SCHHS, and the updates to activity projections that have formed the basis for analysis in this business case based on the most recent population projections

[redacted]

- **Criteria for evaluation of service outsourcing options**: sets out a series of criteria that are used to evaluate delivery options in this report under the following headings – strategic and operational; workforce development and management; provider capability and appetite; commercial, financial and legal
- **Service definition**: provides a summary of the various health services to be provided at SCUH, segmented into categories that are relevant for potential outsourcing – Operational Services; Clinical Support Services; Corporate Support Services; Soft FM Services and Governance and Executive Functions
- **Service outsourcing options**: describes the Base Case and Enhanced Base Case that provide the benchmark for public delivery of services in this Business Case, as well as the broad commercial approach that would be adopted to outsource each of the main service categories, including relevant precedent models
- **Qualitative VFM evaluation**: provides an evaluation of the potential advantages and disadvantages of outsourcing each of the main service categories, including an indicative scoring of the options, and identifies a shortlist of Delivery Options for Government consideration

[redacted]

3 SCUH Background and Scope

This section provides background on the development of the SCUH and related facilities, notably the Sunshine Coast University Private Hospital (SCUPH) and the Skills Academic and Research Centre (SARC). It describes the project objectives, the scope of the facilities and the workforce implications of the development.

3.1 Scope of the SCUH

The previous Queensland Government approved the investment in 450 beds at SCUH in 2016, expanding to 738 beds by 2021.

Exemplar Health (comprising Lend Lease, Spotless Group, Capella Capital and Siemens), entered into a PPP with the State in 2012 to design, construct and part finance SCUH and provide certain FM services.

In addition, Ramsay Health Care entered a Service Agreement with the State in 2011 to build and operate a private hospital co-located at the Kawana campus.

3.1.1 Project vision and objectives

The vision for SCUH is to 'provide excellent care through collaboration, enquiry and education'.

As a university hospital, there are three core components of this vision:

- providing excellent patient care
- developing new knowledge, through research, to contribute to national and international improvements in patient care; and
- education and training of the next generations of staff to perform all three components.

In order to deliver the vision for the SCUH, the project team and selected partners will work together to achieve the project objectives set out in Table 3-1 below:

Table 3-1: SCUH project objectives

Objective	Description
On-time delivery	SCUH is: • delivered in accordance with the announced timeframes.
On-budget delivery	SCUH is: • delivered within the announced capital budget • efficient and affordable to operate.
Fitness-for-purpose over the long term	SCUH: • facilitates the provision of outstanding patient care, research and education • is well designed and functional • is accessible and responsive to demand • is able to grow and adapt to meet service demand and changes in the way healthcare services are delivered • achieves Ecologically Sustainable Development (ESD) objectives.
Workforce deliverability	Design that: • assists in the attraction and retention of a high quality, skilled workforce • recognises the significant challenge of successfully delivering a step-change in both healthcare capacity and capability.
Whole-of-life efficiencies	Design that: • generates operational efficiencies that are sustainable over the long term.
Best practice	Design that:

Objective	Description
	• is based on proven concepts • reflects national and international best practice.
Partnership	Delivering the project: • through a culture of mutual respect and cooperation • in an environment that fosters: • innovation • continuous improvement • cost efficiency • transparency • open, honest and timely communication.

3.1.2 Facility

SCUH will be a university hospital providing a comprehensive range of tertiary inpatient and outpatient services for adults and children, as well as education and research.

SCUH will be the tertiary hub for the SCHHS and surrounding region. The catchment will extend north to Bundaberg and south to northern metropolitan areas of Brisbane such as Caboolture and Redcliffe. SCUH will also provide some secondary services to its immediate population.

Current planning details a complementary role for NGH with it functioning as the NGH campus of SCUH, under a 'one hospital – two campus' approach. This would see NGH still functioning as a major hospital offering medical and surgical services (primarily lower complexity elective), an intensive care unit (ICU) and an emergency department (ED), as well as mental health and sub and non-acute care.

The capacity of SCUH, once fully utilised in 2021, includes:

- a total of 738 beds, including 666 overnight beds and 72 same day beds
- capacity for approximately 31,000 overnight admissions and 32,000 same day admissions per year
- approximately 65,000 ED presentations per year; and
- approximately 350,000 non-admitted occasions of service per year.

The capability of SCUH, initially and when fully utilised in 2021, is shown in Table 3-2 below.

Table 3-2: SCUH capability

Service			CSCF Level	
			2016	2021
Surgical services **Anaesthetics** **Perioperative services (1)** **Rehabilitation services**	Medical services Intensive care services Cardiac services Medical imaging services	Emergency services Pathology services	6	6
Medical oncology services	Radiation oncology service		5	6
Children's emergency services **Haematological malignancy services**	Maternity services Nuclear medicine Mental health services (2)	Renal services Medication services	5	5
Children's surgical services **Children's anaesthetic**	Children's medical services Children's cancer services	Neonatal	4	5
Children's ICU	Mental health services (3)		4	4

Notes:
(1) Day surgery services at Level 4 for both periods.
(2) Mental health: child and youth ambulatory and acute inpatient services; adult ambulatory and acute inpatient services; older persons acute inpatient services; and emergency services.
(3) Mental health perinatal and infant services.

The increase in SCHHS capacity and capability provided by SCUH in 2016 will address projected demand growth and reverse patient flows to Brisbane. SCUH will enable SCHHS to address the ongoing drivers for the supply of hospital services particularly population growth, as it expands through to 2021. NGH, which is currently the major referral hospital in the SCHHS, will continue to operate as a significant facility once SCUH opens in 2016 and the Private Hospital will retain its capacity and staffing levels to service private demand.

Given the significant increase in SCHHS capacity required for SCUH, and the associated impact on workforce and operations, commissioning of SCUH is scheduled to occur in stages. Services have been planned around operating whole services in a single location where appropriate (such as specialist maternity, paediatrics and special care nursery) while at the same time providing a critical mass of services to support the tertiary level care that will be delivered at SCUH and providing equitable access to secondary services across the whole health service.

3.1.3 PPP

The scope of the PPP with Exemplar Health includes the following elements:

- masterplan the Kawana Campus (excluding the Private Hospital component), subject to certain constraints
- design, construct and commission:
  - the Facility – SCUH, SARC, Carpark and Central Energy Plant and associated infrastructure for the campus, including internal roads, parkland and utility services
  - Designated Commercial Areas – including suitable commercial retail developments to support the operation of SCUH
  - Kawana Way Duplication
- finance the capital funding requirements, net of a significant Government Contribution, planned to be provided at the back end of construction in the form of a capital contribution, not a loan
- provide FM services (Hard FM Services), including maintenance services for building, grounds, engineering, utilities and certain items of Equipment as well as Carpark management, security, FM help desk and pest control
- carpark operations – assume demand risk and collect revenues associated with the Carpark
- commercial retail operations – assume the development and operations risk for the Designated Commercial Areas within SCUH.

Exemplar Health are not currently contracted to provide Soft FM Services.

Further, whilst Exemplar Health is responsible for the procurement, supply, installation and commissioning of all equipment required for the SCUH, the Department of Health is responsible for leading the specification and selection. The Department of Health retains the supply cost risk and is responsible for maintenance and lifecycle replacement for certain medical equipment and ICT equipment/devices. The Department of Health also retains full responsibility for ICT applications (software) and their integration.

3.1.4 Related developments

3.1.4.1 Sunshine Coast University Private Hospital

The State entered into a Service Agreement with Ramsay Health Care in 2011 to develop and operate a Private Hospital co-located on the future SCUH campus.

The contractual arrangements with Ramsay are in two parts, one relates to the development of the hospital to be operated as a private facility. Secondly, there is a Service Agreement under which the State will purchase up to the equivalent of 110 beds worth of activity in the 200-bed private facility for public patients. This arrangement commences in December 2013 and will conclude in 2018.

The SCUPH is scheduled to open in late 2013, with the following clinical services capability and capacity.

Table 3-4: SCUPH Clinical Services Capability Level

Core clinical Service Streams (on-site)	CSCF Level
General Medicine	5
General Surgery	5
Respiratory Medicine	5
Orthopaedics	5
ENT	5
Other clinical Service Streams (on-site)	**Level**
Gastroenterology	5
Colorectal Surgery	5
Neurosurgery	4
Plastics Surgery	5
Urology	5
Cardiology	5
Endocrinology	5
Supporting clinical services (on-site)	**Level**
Anaesthetics	5
Critical Care	ICU5/CCU5
Diagnostic Imaging	4
Operating Suite	5
Pathology	4
Pharmacy	4
Supporting clinical services (on-site or off-site)	**Level**
Nuclear Medicine	4

Source: Collocation Agreement, Schedule 3 – Clinical Services Provisions, Part 1 Specification

Table 3-5: SCUPH Bed numbers

Service	Bed Numbers
Overnight Beds	160
ICU Beds	8
Day Chemotherapy chairs	8
Day Patient Chairs	24
Total	**200**

Source: Collocation Agreement, Schedule 3 – Clinical Services Provisions, Part 1 Specification

3.1.4.2 Skills, Academic and Research Centre

The SARC will provide dedicated education and research facilities to help train the existing and future hospital workforce and attract clinicians to the campus with research opportunities.

The vision for the SARC is:

- development of an integrated, collaborative and comprehensive education, skills training and research facility for health professionals
- provision of tools and training to improve the skills of doctors, nurses and allied health professionals

- enhancement of the quality of patient care
- fostering of connectivity and collaboration across the domains of education, patient care and research.

The SARC is being delivered as a partnership between SCHHS and Foundation Members, the University of Sunshine Coast (USC), Sunshine Coast Institute of TAFE and a medical school provider.

USC will deliver undergraduate and some postgraduate training across a range of programs, including nursing, social work, psychology, nutrition and dietetics, biomedical sciences, public health, sports science, occupational therapy and paramedical training.

Sunshine Coast Institute of TAFE will deliver education and training to meet the development needs of both medical and non-medical workers including diploma in nursing (enrolled), dental assistant, assistant in nursing, community mental health assistant, health care assistant, aged care assistant, certificate in occupational health and safety, certificate in youth work, diploma in IT networking, certificate in business administration, MS office training, certificate in teaching and assessing, certificate in hospitality, certificate in horticulture, and certificate in security operations.

The SARC will be integrated as part of SCUH in the buildings around The Hub, and the ground floor and first level of the eastern building. The SARC will include a number of shared and dedicated spaces including: 400 seat auditorium; two 150 seat lecture theatres; library; simulation suite, including potential configuration as an operating theatre, intensive care bed and patient bedroom; e-learning labs; three clinical research laboratories; multi-purpose learning areas; dedicated workspace for each of the Foundation Members; quiet rooms; small group meeting rooms; informal meeting areas; and staff and student hubs.

3.1.4.3 Kawana Health Innovation Park

Supporting the other components of the Kawana Campus is an opportunity to develop a commercial Health Innovation Park, referred to as the KHIP.

Potential uses shortlisted to be included on the masterplanned campus are:

- consulting suites – either integrated within SCUH or located in close proximity on the Kawana Site (noting the SCUPH includes a range of consulting suites on the ground floor of its ward buildings)
- biomedical research / development hub – the development of a research and development hub at an appropriate point in the future, complementary to the SARC
- on-site carer's and dependent's accommodation.

3.1.5 Workforce development

At the end of March 2013, the SCHHS workforce was 3,468 FTE. The majority of the workforce was female (73%), with significant proportions part-time (55%) and over 55 years (21%, with an increase of 4% over 5 years). The increasing proportion of part-time employees has resulted in SCHHS employing around 30% more employees to cover the required FTE.

SCHHS has undertaken extensive workforce planning to prepare for the opening of SCUH. This started in 2011 at the strategic level, with broad projections produced based on aggregated data available at the time. This included analysis of trends such as part-time/full-time ratios, turnover and changes to age mixes applied to activity projections.

In 2013, a more detailed process has been undertaken using the Department of Health workforce planning tool, WorkMAPP, and extensive consultation with clinical and other staff at the department level. Due to the need to plan for the transition period to SCUH, this latest planning work has concentrated on SCUH workforce requirements for 2016-17, but has also incorporated HHS wide services such as the Community Integrated and Sub-Acute Services group. The methodology utilised activity metrics agreed by each department. These included metrics such as Weighted Activity Units (WAU), separations, theatre cases and beds as appropriate to the service. Some departments also incorporated workforce redesign into the projections; however this next step was not complete for all departments at the time of writing.

Based on the available data t is estimated that SCUH will require approximately 2,500 FTE in 2016-17, rising to 3,700 in 2021-22. Overall, the SCHHS will require approximately, 4,600 FTE in 2016-17, rising to almost 6,000 by 2021-22 (including the staff associated with SCUH).

Table 3-6 below, provides a summary of some workforce strategies and actions relevant to the management of this significant risk.

Table 3-6: Strategies and Actions 2011-17

Strategic Directions	2011-2012	2013-2017	2017-2021
Growing a knowledgeable, skilled, competent, and culturally capable workforce	• Develop a retention plan • Develop an education framework	• Cultural change • Increase student capacity • Support ageing workforce	• Support skills development and acquisition • Review and update retention plan
Building a sustainable workforce which meets service needs and financial constraints	• Develop a recruitment plan • Marketing strategy • Collaboration with • Ramsay Health Care on workforce planning	• Major recruitment drive (from 2015) • Marketing activities	• Review and update • recruitment plan • Ongoing recruitment drive
Optimising distribution of the workforce to achieve equitable access to health care	• Develop a transition plan • Collaboration with government and education sectors to progress education and training pathways	• Pilot projects for new and redesigned work roles • New models of learning and simulated environments	• Cultural diversity within workforce to reflect community cultural diversity • Further introduction of new and redesigned work roles

3.1.6 Delivery program and current status

The PPP (as at end May 2013) has seen the following stages of work completed:

- The design has been developed through an extensive User Group consultation process, of which two of three sub-stages have been completed
- The Design Report for Sub-Stage B has been submitted by Exemplar Health and is in the process of being reviewed by the State
- Prototype suite, featuring 25 of the most commonly occurring rooms/spaces in the hospital, has been installed, inspected by Users and a range of clinical scenarios tested as part of Sub-Stage B of the design development process
- Initial site establishment works have been completed, including installation of fencing, access roads, site offices etc

- Earthworks and piling for the first multi-level car park has been completed and structural concrete works are underway
- Bulk earthworks for the main hospital buildings have been completed and piling commenced.

In terms of the SCUPH, the building envelope and infrastructure works are substantially complete and the internal fit-out is well underway. Commissioning completion is on schedule for December 2013.

4 Service delivery plans

This section describes key elements of the policy and organisational context for development of the Health Services Plan (HSP) by SCHHS. It also examines the demand levels and bed requirements assumed in the HSP, including updated population projections which have led to a revision of activity estimates. SCHHS has adopted these revised activity estimates for current planning purposes and they will therefore be assumed to apply to the various delivery options considered later in this Business Case.

4.1 Strategic Context

As discussed in Section 2.1, the recently released *Blueprint for better healthcare in Queensland* (the Blueprint, February 2013) details a range of changes to the health system, including the Queensland Government's willingness to explore opportunities for alternative service delivery models to improve value for money such as outsourcing, co-sourcing, public-private joint ventures and partnering with the private sector and other government agencies.

This will include examining the delivery of support services, such as pathology and diagnostic imaging, along with entire hospitals services, particularly at new hospitals and other greenfield sites.

In addition, planning for SCUH occurs in the context of significant organisational and health funding reforms occurring at the State and national level. These changes include:

- The establishment of Hospital and Health Services (HHS) in Queensland under the *Hospital and Health Boards Act 2011*. Each HHS has been established as a statutory body, with decision making devolved to the local level under independent Boards.
- Each HHS is required to meet key performance indicators as set out in its Service Agreement set by the Department of Health in its role as System Manager (the State). The *Sunshine Coast Hospital & Health Service 2012-13 Service Agreement* details the hospital and health service profile for SCHHS, and sets targets for a range of factors including safety, quality and access to services, efficiency and financial performance.
- Consistent with the above changes, the implementation of the national health reforms changes the role of the States and Territories to make them the managers of the public hospital system. The Department of Health's role in Queensland is now to focus on system-wide policy, planning and service purchasing and supporting system-wide quality and safety and service innovation. This has necessitated a higher level of financial, workforce and service planning at the HHS level
- There has also been a push to improve the transparency and efficiency of public hospital funding through the establishment of the National Health Funding Pool and Independent Hospital Pricing Authority (IHPA) and the implementation of a nationally consistent Activity Based Funding (ABF) model. Under the model, ABF will apply to admitted acute services, emergency department services and some outpatients services from 1 July 2012 and to other non-admitted services, mental health and subacute services commencing from 1 July 2013. Block grants will continue to apply for service types for which ABF may not be appropriate, or further work to develop a model is required (e.g. small rural hospitals)
- The IHPA sets the National Efficient Price (NEP) that will be used to determine the Commonwealth share of public hospital funding. Under the ABF arrangements, the Commonwealth will fund 45% of the NEP for agreed growth in activity from 2014-15 and 50% of the NEP for agreed growth in activity from 2017-18. The States and Territories will be responsible for funding the remaining cost of services in their public hospitals above the level of funding received from the Commonwealth.

4.2 Service delivery vision and strategic directions

The vision for the SCHHS is 'Health and Wellbeing through Exceptional Care'.

The SCHHS *Strategic Plan 2013-2017*[7] (Strategic Plan) explains that in order to achieve its vision, the SCHHS:

- will work in and with the community to improve people's health, including partnerships with consumers, Medicare Local, Regional Councils, other government and non-government organisations, health care providers, and community groups
- will provide exceptional services to ensure community confidence
- will ensure that people feel respected, safe, valued and listened to and that their dignity is maintained
- commits to fundamentally changing health care delivery across the health service, including establishment of the new SCUH from 2016.

The SCHHS has set the following strategic objectives for 2013-2017:

- Care is person centred and responsive
- Care is safe, accessible, appropriate and reliable
- Care through engagement and partnerships with our consumers and community
- Caring for people through sustainable, responsible and innovative use of resources
- Care delivered by an engaged, competent and valued workforce.

Relevant strategies outlined in the Strategic Plan are to:

- Optimise current and future physical infrastructure, including delivery of SCUH on time, within budget and with planned service capability and capacity
- Manage and deliver the design, construction and commissioning of the SARC to facilitate improvements in clinical practice and workforce development
- Meeting the current and future workforce needs of the organisation through workforce planning and development.

4.3 Health care needs and service plans

4.3.1 Health Service Plan 2012-2022

SCHHS delivers public health care throughout the Sunshine Coast and Gympie region at hospital facilities and health services including:

- NGH
- Caloundra Health Service
- Gympie Health Service
- Maleny Soldiers' Memorial Hospital
- a range of community health services from 24 sites including Nambour, Maroochydore, Gympie, Noosaville, Caloundra, Kawana, Tewantin, Cooroy, Mountain Creek, Buderim, Beerwah, Tin Can Bay and Mooloolaba

[7] Sunshine Coast Hospital and Health Service, *Strategic Plan 2013-2017*, December 2012, http://www.health.qld.gov.au/sunshinecoast/docs/govn/schhs_stratplan.pdf

- services provided to public patients at the Noosa Private Hospital (operated by Ramsay Health Care).

The SCHHS Health Services Plan 2012-2022 details the:

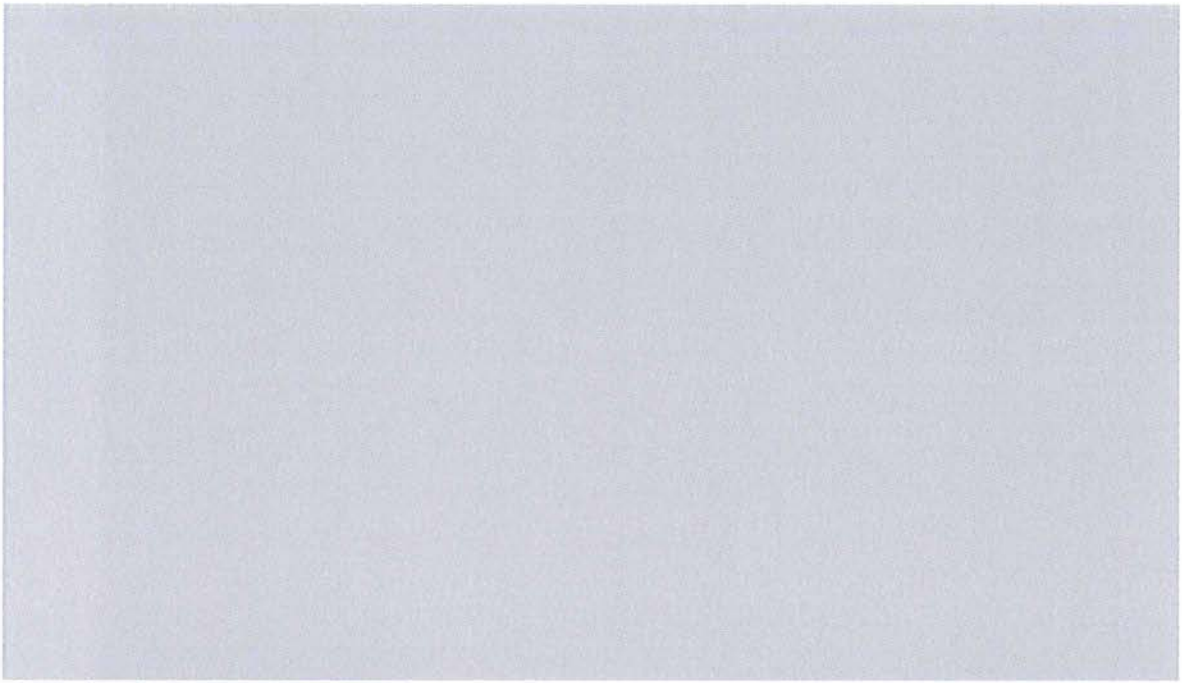
- health needs of this community and how it is likely to change over the 10 year period, given changes in population, demography and activity
- HHS responses to meeting these needs
- service priorities between 2012 and 2016/17.

4.3.1.1 SCHHS service configuration

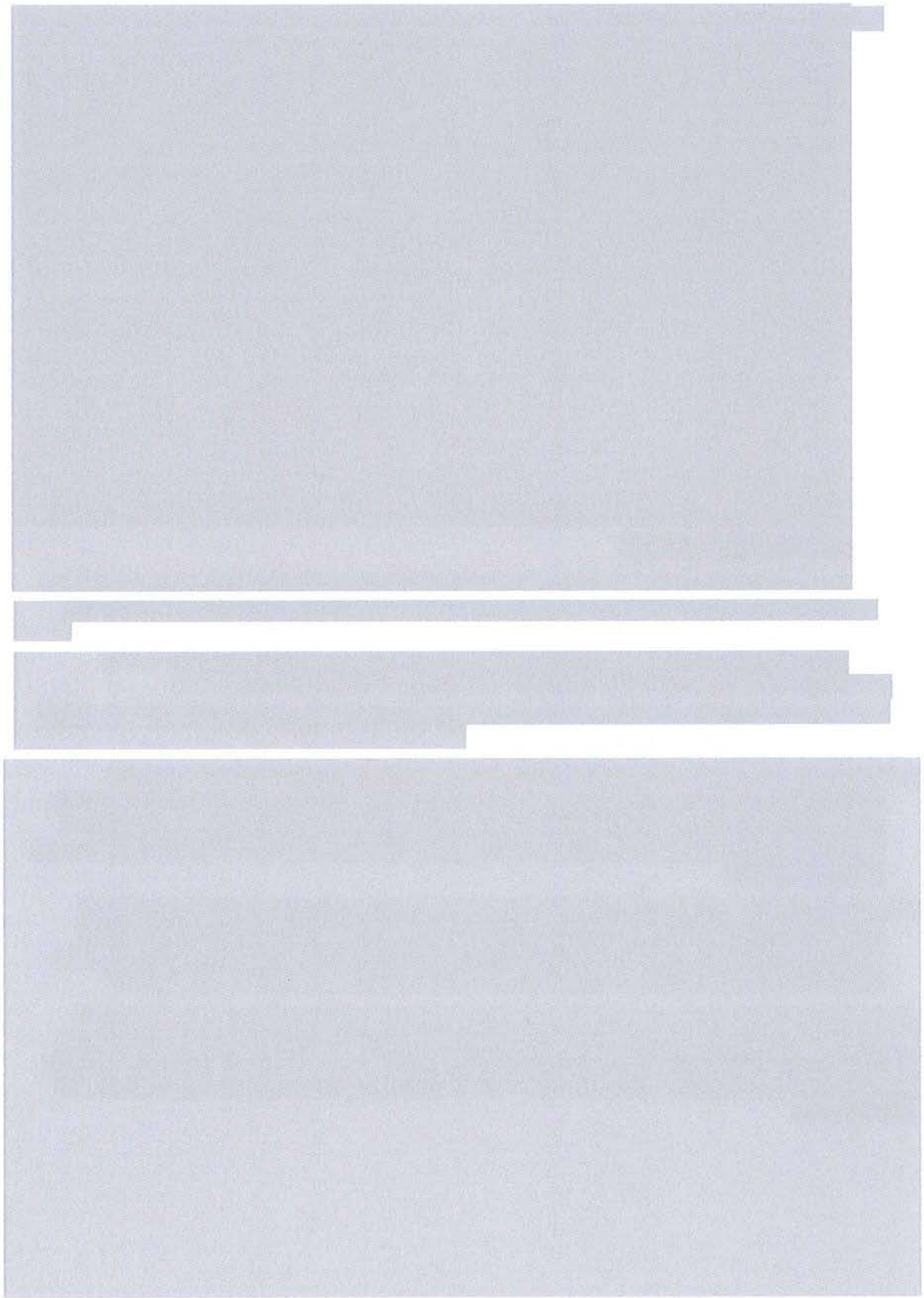
The opening of SCUH in 2016 will be a key component in addressing the health needs across Sunshine Coast and Gympie region and it will require the realignment of services across facilities. The SCHHS *Health Services Plan 2012-2022* sets out the progressive adjustment of services that will be required

As noted above, in addition to services being delivered at public facilities, SCHHS will purchase a range of medical and surgical services for public patients from Ramsay Health Care's co-located private hospital, from December 2013 until 2018. Ramsay will provide up to 110 beds for public patients as part of the SCHHS strategy to manage the interim demand for health care services.

4.3.1.3 Service demand



proportion of the health need, as determined in the HSP, that would be met under each scenario.



5 Current contractual, employment and regulatory arrangements

The content of Section 5 has been redacted from this document.

6 Criteria for evaluation of service outsourcing options

This section sets out the criteria that will be used to evaluate the potential to outsource each service category. The outsourcing options are described in Section 8 and the qualitative evaluation of the outsourcing options against the criteria is in Section 9.

6.1 Approach

The criteria for the evaluation of options have been developed in consultation with the SCHHS executive and senior clinicians. The existing vision and objectives for the SCUH were important considerations in developing the criteria. In addition, efforts were made to ensure that the criteria would:

- allow an objective analysis and meaningful measurement and assessment of options
- enable differentiation in the evaluation between options
- be mutually exclusive.

The evaluation criteria are listed in section 6.2, below, and have been grouped in to four categories:

- Strategic and Operational
- Workforce Development and Management
- Provider Capability and Appetite
- Commercial, Financial and Legal.

For each criterion, a range of factors have been identified for consideration when assessing the extent to which a delivery option meets the criterion. These factors are listed as supplementary 'Drafting Notes' for each criterion.

6.2 Evaluation criteria

6.2.1 Strategic and Operational

Achieving the vision for SCUH – Providing excellent patient care

The ability to deliver high quality patient care in accordance with relevant health care standards and that meets or exceeds relevant performance benchmarks (including safety and quality); to provide a healing environment that is integrated with external services and that achieves high levels of wellness in the community; and to provide health services that are accessible, responsive to demand and have the flexibility to grow and adapt to changes in the way healthcare services are delivered.

[Drafting notes: This criterion includes assessment of the level of opportunity for meeting or enhancing operational and service outcomes to deliver on Government's requirements for a tertiary hospital delivering the full scope and volume of services defined in the Health Services Plan. In addition, the criterion includes the extent to which the option enables flexibility in service provision to adapt to changes in healthcare services and promotes a seamless patient journey.]

Achieving the vision for SCUH – Developing new knowledge through research

The ability to provide excellence in research and excellent care through collaboration and enquiry and to provide opportunities to integrate patient care with strong research capabilities.

[Drafting notes: This criterion assesses the extent to which the option fosters integration and teamwork across patient care and research; supports the establishment and sustainability of the SARC; and supports the development of new knowledge through research and innovation in health care practices.]

Achieving the vision for SCUH – Education and training

The ability to fully integrate patient care with comprehensive and contemporary education and skills training capabilities for health professionals and vocational students.

[Drafting notes: This criterion assesses the extent to which the option fosters integration across patient care, education and vocational training, linkages with other educational institutions, and provides a high quality education for the next generations of staff as well as opportunities for continued learning and skills development by existing staff, including continual competency assessments that promote safe practices.]

Impact on other Health Service operations

The impact that the delivery model will have on the delivery of accessible and high quality patient care at other locations.

[Drafting notes: The criterion includes the assessment of the potential impact on other locations such as Nambour, other SCHHS facilities or the broader QLD health system. It includes assessment of the achievement of the strategic (e.g. self-sufficiency), operational (e.g. continuity of care), and workforce management (e.g. flexible rostering across hospitals) criteria in relation to these broader health system impacts.]

6.2.2 Workforce Development and Management

Recruitment, retention and workforce management

The ability to manage the significant challenges associated with attracting, retaining, transferring and managing sufficient, quality staff in time to support the progressive commissioning and expansion of the SCUH and to cope with future requirements for health care professionals and other skilled staff.

[Drafting notes: This criterion includes assessment of the extent to which the option can manage recruitment risks, including advance offers to staff and alignment of recruitment with the SCUH ramp-up; reliably achieve the quality and number of staff required; create an environment and culture that will be conducive to ongoing staff satisfaction and retention; and ensure that WorkCover and other workforce requirements are managed appropriately.]

Industrial relations implications

The extent to which industrial relations implications can be minimised and managed under the delivery model.

[Drafting notes: This criterion includes assessment of the existing and anticipated industrial relations arrangements and the implications / challenges in implementing the proposed model, including the risk of any delay to commencing services at SCUH.]

6.2.3 Provider Capability and Appetite

Provider capability and capacity

The capability and capacity of service provider(s) to deliver the required services under the delivery model.

[Drafting notes: This criterion includes assessment of the existence of appropriate providers, the capacity of such providers to deliver on the requirements and the capability and experience of such providers to deliver on the specific needs.]

Provider appetite

The ability to attract sufficient willing service providers to ensure that there is genuine competition to provide the services.

[Drafting notes: This criterion assesses the extent to which the option is likely to be of interest to private sector participants based on feedback from the market sounding and commercial analysis of transferred risks.]

6.2.4 Commercial, Financial and Legal

Cost efficiency and budget certainty

The extent to which the model facilitates, through competitive tension, governance arrangements, and contractual provisions, the potential for:

- cost optimisation, and
- budget certainty.

[Drafting notes: This criterion includes assessment of the potential of the model to deliver quantitative value for money (VFM) and the ability to deliver the services for the expected cost including through leveraging economies of scale and managing the one off and on-going costs involved in changing to any new commercial arrangements.]

Level of risk transfer

The extent to which the model facilitates the transfer of risk from Government to a suitable counter-party.

[Drafting notes: This criterion includes the assessment of the level of risk transferred from Government as well as the complexity of interface arrangements (including interface risks created by multiple contractual arrangements).]

Impact on existing contracts

The impact of the delivery model on the current contractual arrangements.

[Drafting notes: This criterion includes assessment of the impact of the delivery model on the existing contractual arrangements. For example, the extent to which amendment, compensation or termination of existing contracts is required. This will include a consideration of the private hospital contracts, the PPP, the SARC JVA and any other existing contractual arrangements (e.g. at NGH).]

Commercial flexibility

The ability to adjust the quantity, quality and type of services over time to be consistent with available funding and purchasing objectives.

[Drafting notes: The criterion includes the extent to which the option enables flexibility in service provision without being unduly expensive or incurring unforeseen costs; avoids excessive contract variations and is not administratively onerous; and allows the purchaser to vary (up or down) the volume and type of services in line with funding constraints.]

Other legal/regulatory issues

The potential legal/regulatory issues and complexities associated with implementation of the delivery model.

[Drafting notes: This criterion includes assessment of the potential legal/regulatory challenges associated with the implementation of the delivery model. For example, this might include consideration of hospital licencing / accreditation, competition issues, privacy issues (e.g. patient confidentiality), etc.]

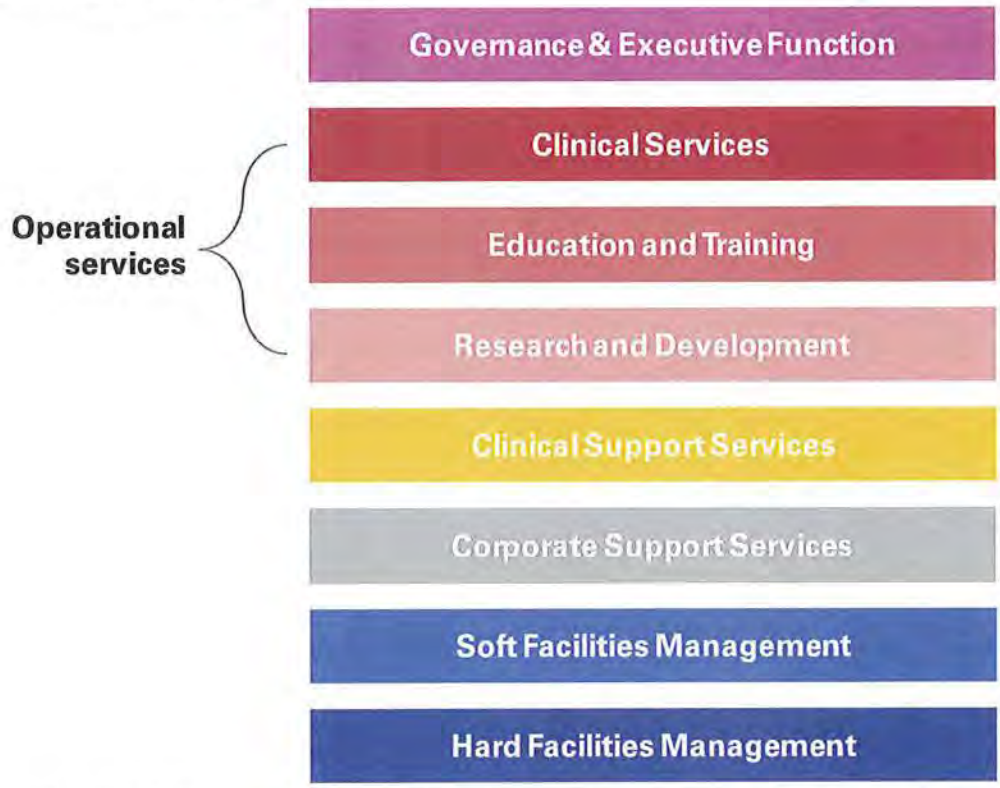
7 Service Definition

7.1 Introduction

The purpose of this section of the Business Case is to define the full scope and standard of services that must be delivered at the SCUH. These requirements will ultimately be purchased by the Department of Health and are separate to the public and non-government service provider delivery models that will be examined later in the report. In effect, they constitute the outputs (and some intermediate outputs) are required to be delivered regardless of provider.

7.2 Overview of Service Categories

The required services will be categorised and described under the broad functional headings listed in the diagram below. These groups primarily reflect common provider activities and capabilities and, as such, will constitute a convenient basis to support the analysis of the service outsourcing options discussed in subsequent sections.



Note that SCHHS terminology has been used where relevant to provide clarity and consistency.

7.3 Governance and Executive Functions

7.3.1 Scope of service

These services relate to high-level management responsibilities of the SCHHS Board and executive to develop and implement policies, service plans and other initiatives. The Board and executive have overall responsibility for hospital performance, including financial outcomes, and for ensuring that the hospital complies with all relevant laws, regulations and standards. Relevant executive functions have been distinguished between those relevant to the HHS as a whole and any executive functions that

are, or would be, regional to 'manage' the SCUH (i.e. in the event of Full Outsourcing it is expected that a SCUH facility level 'management' would be required.)

For the purposes of this analysis, the Governance and Executive Functions exclude certain Corporate Support Services, as defined in section 7.7 below, which are more routine and operational in nature and potentially more suitable for outsourcing independent from a full outsourcing option.

7.3.2 Detailed service description

The following table summarises the main roles and activities falling within the category of Governance and Executive Functions.

Governance and Executive Function	
Service	**Detailed Description**
HHS Functions	
Executive functions	• Operational, workforce and financial management • Strategic decision-making • Negotiation and management of Purchasing Agreement with Queensland Health and other key agreements • Stakeholder management
Policy development	• Development of local policies and procedures (HHS wide)
Service planning	• Health Service Planning • Workforce planning
Regulatory compliance	• Compliance with relevant laws, regulations, policies and standards • National and State quality and safety standards • Hospital accreditation • Risk & Audit
Contract management – HHS	• Management of PPP contract, major service outsourcing contracts, SARC JVA, etc
Facility functions	
Executive function	• Operational, workforce and financial management • Strategic decision making • Negotiation and management of Purchasing Agreement with CHQ HHS and other key agreements • Stakeholder management • Liaison and management of foundation relationship and academic and research partnerships
Facility management	• Management of issues relating directly to the running of SCUH including incident and risk management, regulating compliance (in relation to the facility) and central management of facility services.
Policy development	• Development of local policies and procedures (facility specific) including ethics processes.

7.4 Clinical Services

7.4.1 Scope of service

The scope of Clinical Services are determined by the *SCHHS Health Services Plan 2012 – 2022* (HSP) which defines the full range of medical and surgical inpatient services, emergency department, outpatient, rehabilitation and other clinical services that are required to meet the estimated population health need across the SCHHS including at SCUH. The HSP also sets out the role delineation level for each service in accordance with the Clinical Services Capability Framework version 3.1 (CSCF), consistent with the SCUH's role as a major tertiary teaching hospital.

Clinical Services have been defined to include participation by pathologists, pharmacists, radiologists and similar clinical support roles in multi-disciplinary teams and other clinical and administration functions.

7.4.2 Detailed service description

The following table summarises the main Clinical Services required to be provided at SCUH and the associated service level in accordance with the CSCF.

Clinical Services	
Service	**Detailed Description**
Emergency and Acute Medicine	• Local Emergency Services • Acute Medicine • Critical care services • Trauma services, cross speciality and associated critical care services
Diagnoses and Treatment of Long Term Conditions	• Diagnoses and treatment planning for the range of long term conditions • Delirium management • Tertiary rehabilitation services
Cancer Care	• Diagnosis and treatment planning • Radiation Oncology • Medical Oncology • Advice to other specialties
Surgical Services	• Local acute and emergency surgery • Local elective surgery
Complex Medical and Surgical Services	• Neurology • Neurosurgery • Cardiology • Cardiac surgery • Renal medical • Renal surgery • Complex GI medical • Complex GI surgery
Mental Health Services	• Adult inpatient, outpatient and community services
Allied Health	• Diagnostic, technical, therapeutic, rehabilitation, patient care and support services such as: • Physiotherapy • Occupational Therapy • Speech Pathology • Nutrition

	• Dentistry • Prosthetics and Orthotics • Consultation and liaison services
Obstetrics, Maternity and Neonatal	• Local uncomplicated maternity • High risk obstetrics and foetal physiology • Neonatal intensive care
Gynaecology	• Local acute and elective gynaecology • Complex and tertiary gynaecology
Children's Services	• Local acute children's services • Local children's developmental services • Local children's mental health
Non-medical Clinical and Rehabilitation Services	• Physiotherapy • Dietetics • Occupational Therapy • Speech Pathology • Social Work
Special Treatment Diagnostic and Advice Services	• Interventional radiology • Clinical pathology • Consultation and MDT participation

7.5 Education and Training

7.5.1 Scope of service

The scope of these services comprises SCUH's role in undergraduate and postgraduate education including SCHHS' role in supporting SARC. Education and Training exclude services provided on campus by SARC foundation members. These services are outside the scope of this outsourcing analysis.

7.5.2 Detailed service description

The following table summarises the main components of Education and Training.

Education	
Service	**Detailed Description**
Undergraduate education	• Placement and teaching of medical students • Placement and teaching of nursing undergraduates • Placement and teaching of allied health undergraduates
Postgraduate education	• Placement and management of postgraduate medical training • Placement and management of postgraduate nurse training • Placement and management of postgraduate allied health training
Education and Training facilities and infrastructure	• Specific training facilities e.g. skills laboratories • E&T offices and education spaces

7.6 Research and Development

7.6.1 Scope of service

The scope of these services relates to research and development conducted by SCUH staff within the SCUH facility. It includes facilitation of clinical and applied research and collaboration with SARC foundation members.

Research and Development excludes services provided on campus by SARC foundation members. These services are outside the scope of this outsourcing analysis.

7.6.2 Detailed service description

The following table summarises the main components of Research and Development.

Research	
Service	**Detailed Description**
Liaison with SARC	• Access of SARC to SCUH and research subjects • Partnerships with Sunshine Coast University and TAFE
Research infrastructure and support	• Grant application assistance • Statistics and epidemiology • Research assistants • Equipment and maintenance • Ethics committee • Research methodology training and mentoring
Facilitation of clinical research	• Allocation of time and resources for a range of clinical research initiatives, including clinical trials
Facilitation of applied research	• Allocation of time and resources for a range of applied research initiatives including service model improvement
Research	• Basic science • Clinical science • Applied science • Clinical trials • Device development
Research sources / funds	• Government research funds • Research charities • Industry funds

7.7 Clinical Support Services

7.7.1 Scope of services

Clinical Support Services comprise diagnostic and treatment services such as diagnostic imaging, nuclear medicine, pathology and pharmacy. In addition, for the purposes of this analysis, these services will include the CSSU, non-emergency patient transport, and BTS.

Each service includes the supply, maintenance and replacement of major specialist equipment associated with that service. Other equipment, furniture, fixtures and fittings required by each Clinical Support Service are supplied and maintained under the PPP contract.

7.7.2 Detailed service description

The following table summarises the Clinical Support Services required to be provided at SCUH.

Clinical Support Services	
Service	**Detailed Description**
Diagnostic Imaging	• Diagnostic imaging • Reporting • Quality Assurance
Nuclear Medicine	• Reporting • Quality Assurance
Diagnostic Pathology	• Diagnostic testing and reporting • Quality Assurance
Medication Services	• Receipt, storage and distribution • Clinical pharmacy advice, consultation, liaison, medication management services
Hospital demand management and capacity allocation	• Patient tracking • Admission avoidance • Incident management • Liaison with other facilities within the HHS and elsewhere (mostly Brisbane public and private facilities)
CSSU	• Sterile service production and distribution
BTS	• Health technology management and information • Medical equipment installation, inspection, testing, calibration, movement, tracking, etc; • Health technology maintenance • Customisation of health equipment • Radiation safety and compliance testing
Non-emergency patient transport	• Transfer of patients between health facilities

7.8 Corporate Support Services

7.8.1 Scope of service

Corporate Support Services involve the delivery of finance, human resources/payroll, Information & Communications Technology (ICT), legal, marketing, media & communication services, reception and switchboard, medical records and medical typing and workforce training and development. The Corporate Support Services exclude the Governance and Executive Functions described in Section 7.3.2.

7.8.2 Detailed service description

The following table summarises the main components of the corporate support services.

Corporate Support Services	
Service	**Detailed Description**
Finance	• Generating and being accountable for effective, timely and transparent financial reporting, including generation of periodic and annual financial reports • Management reporting • Liaising with external, internal and Government auditors • Internal SCUH budget allocation
HR/Payroll	• Sourcing and selecting talent/staff • Ensuring a safe and healthy working environment/OH&S • Developing effective workplace models/developing and implementing change initiatives • Developing effective learning and development programs • Staff performance management framework • Liaising with stakeholders regarding industrial relations, enterprise bargaining and employment policy • Implementation of timely, accurate and effective payroll systems • Staff rehabilitation (return to work)
ICT	• Day-to-day running of the healthcare and enterprise IT system by providing customer, service delivery, desktop, end-user, device or field support • Operating and maintaining telecommunications devices, clinical applications, and a range of wireless technologies. • Designing and developing software, information security and testing.
Legal	• Responding to and being responsible for all legal issues associated with hospital operations, including any provision of legal services, legal advice or litigation.
Marketing, Media & Communication	• Community and external stakeholder engagement • Event organisation
Document management	• Archiving • Off-site storage
Patient Bookings and Admissions	• Jointly managed by nursing and administrative staff, includes elective surgery and other elective medical procedures which require admission
Transcription services	• Typing of medical letters to general practitioners dictated by medical staff
Continuing workforce development	• Continuing education and training of the non-clinical workforce • Continuing education and training of the clinical workforce
Library Services	• Physical facilities • On-line resources • Librarian services

7.9 Soft Facilities Management Services

7.9.1 Scope of service

Soft FM Services comprise a range of hotel and back-of-house functions related to cleaning, catering, waste management, linen laundering and distribution, porterage and bulk store distribution.

The Soft FM Business Case recommended that the following services be contracted as a discrete package:

- Reception and switchboard - these services were regarded as having close links to hospital management because of monitoring of staff rostering and provision of communications equipment including mobile phones and paging services
- Medical records and medical typing - these services are considered to be more appropriate for inclusion in corporate support services because of the close relationship with hospital administration and an apparent lack of appetite for these services from Soft FM providers
- Hazardous, clinical and radioactive waste - responsibility to remove these wastes is recommended to remain with the clinical services operator, whether government or non-government, on value for money grounds
- Non-emergency patient transport – the Soft FM Business Case recommended that these services should remain with SCHHS to align with services across SCHHS facilities and to take advantage of economies of scale. We note that these services have been defined in this Business Case as part of Clinical Support Services, refer section 7.7.
- Linen and uniform laundering services – the Soft FM Business Case assumed that these services would be provided by the Department of Health's centralised laundering facility and would be subject to any future state-wide services following a review of that facility that is currently underway.

7.9.2 Detailed service description

The following table summarises the main activities required to be performed for each Soft FM Service.

Soft FM Services			
Service	**Detailed Description**		
Management	• Oversight and managerial functions • Development and updating of policies and procedures		

[14] MBM, Sunshine Coast University Hospital (SCUH) Project Soft FM Services Operation Costs, November 2012, p.3.

	• Provision of help-desk and related monitoring and reporting functions		
Reception	• Reception and switchboard		
Cleaning services	• Comprehensive cleaning and domestic services on a scheduled, periodic and reactive basis; flexible to meet the demand peaks and troughs in clinical services • Stocking and replenish cleaning consumables • Preparation of a cleaning plan		
Catering services	• Patient catering service, including; • Providing a patient meal ordering system • providing patient meals at scheduled meal times and on an ad hoc basis • providing a potable water service for patients • managing the internal distribution of the catering service; • Patient menu development • Supply, maintenance and replacement of catering equipment, crockery and cutlery, etc • Grocery Supply • Implement a food safety program		
Waste management services	• Collection and removal of non-hazardous, non-clinical and non-radioactive waste from the Facility, specifically; • General waste (capable of being disposed of in landfill) • Garden, building and engineering waste relating to the Facility Maintenance Services • Sanitary, catering, sewerage and grease trap waste • Recyclable waste • Clinical waste • Hazardous waste pharmaceutical and radioactive and radiological and other toxic waste generated by the service providers		
Linen distribution services	• Internal linen distribution, including: • Receipt of clean linen provided to SCUH • Regular segregation and collection of used linen as well as replacement of curtains and bed screens • Distribution of clean and collection of dirty linen within the facility • Ad-hoc linen replacement service to meet abnormal or emergency demands • Linen supply & laundering: • Supply and delivery of clean linen and collection of dirty linen to/from the loading dock • Uniform supply for patients & staff: • service enables staff to try on, fit and order new uniforms; distribution of uniforms to staff		

	• uniform supply and replacement		
Orderly services	• Patient support services are directed by clinical staff in undertaking their duties. Services include: • Assisting in movement of patients within the facility • Movement of pharmacy, specimens, samples and pathology related items • Janitorial services • Movement of deceased patients and mortuary duties • Support to Interventional Suite, ICU, CCU and procedure rooms (including cleaning equipment, tidying areas, packing/unpacking surgical instruments, etc) • Ad hoc assistance to medical staff and patients (including assistance during medical emergencies, bed making, distributing meals, moving patients to/from bed and toilet areas, purchasing of consumable items for patients, guiding visitors, packing and unpacking patient belongings, providing assistance with personal effects, etc)		
Bulk store distribution services	• Provision of an ad hoc and scheduled distribution service to ensure the prompt and safe distribution of materials and supplies (e.g. fuel, stores, mail, pharmaceuticals and equipment) • Management of the loading docks • Operation and management of all materials handling equipment such as forklifts, pallet jacks and trolleys • Maintenance of stock control system including requisitioning and replenishment of stock • Safe and secure storage of all onsite stock • Securing, collecting and sorting all mail; delivery and dispatch of all mail within the facility • Movement of medical gasses		
Total			

Note terminology consistent with that used in the Soft FM Business Case has been utilised for the purpose of this analysis.

7.10 Hard Facilities Management Services

7.10.1 Scope of service

For the purposes of this report, the scope of Hard FM services is assumed to be that already outsourced as part of the PPP contract. The existing PPP contract between Queensland Health and Exemplar Health includes the following services:

- General management services

- Help Desk and Room Booking Services
- Building Maintenance Services
- Utilities, Medical Gas and Laboratory Gas Management Services
- Grounds and Gardens Maintenance Services
- Pest Control Services
- Security Services
- Carparking Services.

7.10.2 Detailed service description

The following table summarises the main activities included in the scope of Hard FM services as delivered by Exemplar Health.

Hard FM Services	
Service	**Detailed Description**
General Management Services	• Establishment, implementation and maintenance of an integrated management service that ensures all Hard FM Services are delivered as a seamless single service
Help Desk and Room Booking Services	• Establishment, implementation and operation of a help desk and room booking service to support the effective delivery of the Functions and the Services
Building Maintenance Services	• Maintenance of the Facility (except grounds, gardens and paths) to ensure the Facility is Fit for the Intended Purposes and complies with all Laws
Utilities, Medical Gas and Laboratory Gas Management Services	• Management and Maintenance of all systems and distribution networks for all Utilities, reticulated Medical Gases and reticulated Laboratory Gases on the Site, and monitoring of stock levels for the supply of portable Medical Gases and portable Laboratory Gases
Grounds and Gardens Maintenance Services	• Maintenance of all Grounds and Gardens to maintain an aesthetically pleasing environment and ensure the Facility is Fit for the Intended Purposes
Pest Control Services	• Programmed and reactive internal and external pest control of the Facility
Security Services	• Coordination and management of all scheduled and ad hoc security requirements across the Facility • Participation in site incident response
Carparking Services	• Comprehensive management of carparking on the Site

7.11 Summary

The purpose of this section was to provide a framework for the definition of service categories to assist in the consideration of potential delivery options in subsequent sections. Based on the above, the proposed service definition framework is as follows:

8 Service Outsourcing

8.1 Introduction

This section provides a high-level description of the purchasing arrangements that apply to the Base Case and Enhanced Base Case and the contractual arrangements that would be likely to apply to various outsourcing options. The outsourcing options are based on the service categories discussed in Section 7 and comprise:

- Soft FM Services
- Corporate Support Services
- Clinical Support Services
- Clinical Services including Education & Training and Research & Development (and discussed in this section as part of a Full Outsourcing option).

For the Base Case and each outsourcing option, the discussion will consider the roles and responsibilities of the government and non-government parties in providing the relevant services. It will focus in particular on how the option would manage key the risks of variability in demand, service performance and operating costs. In relation to each outsourcing option, relevant Australian precedents will be identified for outsourcing similar services.

8.2 Scope of outsourcing

The focus of this section is on the contracting models appropriate for each service category; it is not primarily concerned with the optimal bundling of these outsourcing options to form a delivery option, that is, the combination of government and non-government delivery of all services at SCUH. This latter issue will be deferred to Section 9, following the qualitative evaluation of each outsourcing option.

In light of this approach, the following points may be noted about the scope of each option under consideration:

- Base Case – comprises all services that are required to be provided at SCUH, with the exception of Hard FM services that are already outsourced under the PPP contract
- Enhanced Base Case – has the same scope as the Base Case but involves the implementation of a number of internal reform initiatives that would not require outsourcing but which would improve the efficiency of government delivery of the services
- Soft FM – comprises all the services listed in Section 7, subject to any future developments in relation to state-wide provision of selected services, such as laundry, should that prove better value for money
- Clinical Support Services – comprises all the services listed in Section 7, subject to any future developments in relation to state-wide provision of selected services, such as pathology, should that prove better value for money. If outsourced in isolation from Operational Services, Clinical Support Services could be procured under a single contract or, more likely, under multiple contracts, given the specialist nature of the services within this service category. This could lead to situations where some of these services may be retained in-house. In addition, Clinical Support Services involve significant specialist medical equipment and it is possible that supply and maintenance of this equipment could be included in the outsourcing contract. As noted previously, the optimum procurement arrangements for equipment need further detailed investigation and are beyond the scope of this report. Equipment is currently assumed to remain a government responsibility
- Operational Services – comprises all of the Clinical, Education and Research services listed in Section 7. Components of Clinical Services could, in principle, be outsourced separately, including

to the co-located private provider or other off-site providers – any options to do so are, for the purpose of this Business Case, considered to be options available within the Enhanced Base Case (i.e. as an efficiency reform). In the context of SCUH, Full Outsourcing means non-government provision of all Operational Services, Clinical Support Services, Corporate Services and Soft FM Services, but not Hard FM Services which are already outsourced under the current PPP contract. Consequently, this section does not describe Operational Services as an outsourcing option in itself and instead the focus is on a Full Outsourcing option

- Governance & Executive Function – comprises a number of services provided on a health service level, including service planning and policy development as well as some services provided at a facility level or on behalf of a specific facility. This Business Case assumes that the district-wide services remain a responsibility of SCHHS and are not subject to an outsourcing decision. In addition, the facility level services would only be outsourced in a Full Outsourcing model and not in their own right. Consequently, these services are not discussed separately from the Full Outsourcing option.

8.3 Base Case

8.3.1 Overview

Under the Base Case, the provision of services at SCUH would be managed by SCHHS using a traditional delivery model whereby services are managed and provided in-house by public sector employees, although there are typically a large number of small contracts with external parties for specific goods and services. A major existing contract for SCUH relates to the PPP contract involving the development of the facility and the ongoing provision of Hard FM services for a term of 25 years.

SCHHS would manage services at SCUH, along with the other hospitals in its responsibility, in accordance with the annual Service Agreement with the Department of Health. Service Agreements are publicly available documents which define the activities to be delivered and the outcomes that are to be achieved by HHSs in return for the funding provided to them. They set out activity targets, key performance indicators and list key government priorities (such as initiatives related to election commitments) which are to be achieved by the relevant HHS.

Service Agreements are a key part of the Government's commitment to return operational responsibility to local Hospital and Health Boards, whilst maintaining appropriate levels of service for the community that achieve uniform quality standards across the health system as a whole.

As part of the Service Agreement, a HHS Performance Framework is established. This Framework sets out the way in which the Department of Health monitors the performance of the HHS and includes a protocol for managing concerns about performance should they arise. Ultimately, it is envisaged that as HHSs mature over time and demonstrate sustained performance, Service Agreements will become less prescriptive and provide greater local autonomy such that HHSs can further prioritise the uses for the funding they are provided in line with local priorities.

8.3.2 Issues influencing the purchasing structure

Under the 2011 National Healthcare Reform Agreement and the State legislation passed in 2012, local Health Districts were replaced with HHS empowered with the functions of statutory bodies. Each has its own Board with membership drawn from the health sector, business and the community. The policy intent is to provide greater local community input and increased accountability at a local level in order to deliver health services that are adaptable to the requirements of the different geographic areas of the State. In addition, these reforms are expected to deliver improved clinical performance for patients and better financial outcomes with greater control of costs. SCHHS therefore has the responsibility for delivery of high quality but affordable services through the Service Agreements and will be held to account accordingly by the Department of Health.

The Service Agreement involves the monitoring of performance against national benchmarks (such as the National Emergency Access Targets and the National Elective Surgery Targets) and the delivery of priorities set by the Department of Health and, ultimately, the Government. Of particular

importance are the volume/activity requirements of the SCHHS. In 2013-14 the Department of Health intends to link activity targets to the NEP in order to drive the Government's commitment to achieve the NEP across all Hospital and Health Services by the beginning of 2014/15. The challenge for SCHHS is to create a trajectory of financial management which brings it successfully on or below the NEP during 2013-14 and to maintain this when SCUH is opening and begins to ramp-up activity. Thereafter, it is likely that further savings will be needed as there is an expected continuing downward pressure through the newly adopted national pricing mechanism.

It is likely that the progress of savings schemes will be challenged by the constraints of existing Enterprise Bargaining Agreements (EBAs) and the transition costs associated with establishing a major new tertiary hospital service. The opportunity to create efficiencies, even within the Base Case, will be enhanced as flexibility around EBAs is created by the Queensland Government. However, despite the flexibility permitted by these changes, any amendments will require significant cultural change and will therefore be challenging to implement.

8.3.3 Purchasing Model

The framework for purchasing services and managing performance is embodied in the Service Agreement between the Department of Health and the SCHHS. The Service Agreement is designed to[15]:

- Specify the hospital services (with respect to outcomes and outputs), other health services, teaching, research and other services to be provided by the HHS
- Specify the funding to be provided to the HHS for the provision of the services
- Define the performance measures for the provision of the services
- Specify the performance and other data to be provided by the HHS to the Director-General
- Provide a platform for greater public accountability
- Ensure State and Commonwealth Government priorities, services, outputs and outcomes are achieved
- Facilitate the progressive implementation of a purchasing framework that incorporates activity based funding
- Set out the performance management arrangements that the System Manager will put in place to fulfil its statutory responsibility for the overall management of the public health system (through the HHS Performance Framework)

Service agreements are underpinned by legislation that requires each HHS (through the Hospital and Health Board Chair) and the Director-General to enter into a binding agreement.

8.3.4 Key commercial principles and risk allocation

The Service Agreement involves an allocation of service delivery risks between the Department of Health and, in this case, the SCHHS. The allocation broadly reflects the capacity of these entities to manage the risks, with most funding risks lying with the Department while operational responsibilities are devolved to the HHS. Ultimately, however, each of these purchasing and providing entities is owned by the Queensland Government. The way in which the model manages the key demand, performance and cost risks is discussed below.

8.3.4.1 Demand management

The demand for Clinical Services is subject to significant growth and variability and is a major funding risk for the State and Commonwealth Governments. The Department of Health is responsible for managing this long-term demand risk. It seeks to allocate short-term responsibility for managing demand to the HHS under the annual Service Agreements which cap the volume of activity that will be purchased through the ABF arrangements. Where demand for services outstrips the capacity of

[15] Queensland Health, Hospital and Health Service Performance Framework, 2012-13, p.12.

SCHHS to supply those services (due to activity targets being achieved), the Department of Health expects that any additional activity will need to be funded through efficiencies achieved throughout the year (or simply ceased).

8.3.4.2 Performance management

The responsibility for ensuring the provision of services which meet expected standards of quality, effectiveness, access, safety and other requirements is fully transferred to SCHHS under the Base Case. The Service Agreement sets out the requirements of the SCHHS, including a detailed list of KPIs and associated monitoring arrangements, and the Board is responsible for delivering the services and meeting the required standards. Although some minor outsourcing arrangements may occur, ultimate responsibility for performance rests with the Board.

In a situation where under-performance occurs, the Department of Health and Minister for Health have powers and an escalation framework through which these can be addressed. The HHS Performance Framework sets out a range of interventions or levers that may be applied in response to a performance issue. They include:

- Requirement to investigate, report and account for a performance issue
- Requirement to develop and submit a recovery plan (or turnaround plan for financial performance), with agreed milestones, to address a performance issue
- Increased frequency of monitoring
- Requirement for independent review/validation on the issue
- Appointment of external resources and expertise, including the requirement for a HHS to work with an external corporate mentor who will be responsible for providing assurance to the System Manager that development activities are progressing and any corporate risks are being managed effectively.
- Issuing of a direction in response to an audit, investigation or clinical review commissioned by the Director-General
- Appointment of external parties to the HHS
- HHS to 'show cause' as to why governance and/or management arrangements should not be changed
- Appointment of an administrator and/or replacement of Hospital and Health Board.
- The ultimate power is set out in section 275 of the HHB Act which provides for the Governor in Council (i.e., the Governor at the request of the Minister) to dismiss the Board, if he/she believes it is in the public interest to do so. However, no financial penalty applies for performance failures and there is no capacity to recover funds in the event of a budget deficit being delivered.

8.3.4.3 Pricing and cost management

The SCHHS is responsible for managing the risk of operating costs. This is achieved through the Service Agreement which is intended in future years to base activity payments on the NEP (or the Queensland State price, if that forms the basis of the price at which services are purchased by the Department of Health). The SCHHS has no control over fluctuations in this price which is determined through national (or State, if applicable) cost benchmarks.

Under these arrangements, the SCHHS must manage its unit costs to levels that do not exceed the NEP. Since Queensland hospital costs generally exceed the NEP, this is likely to require efficiency savings (i.e. measures to deliver a given volume of outputs at less cost).

8.4 Enhanced Base Case

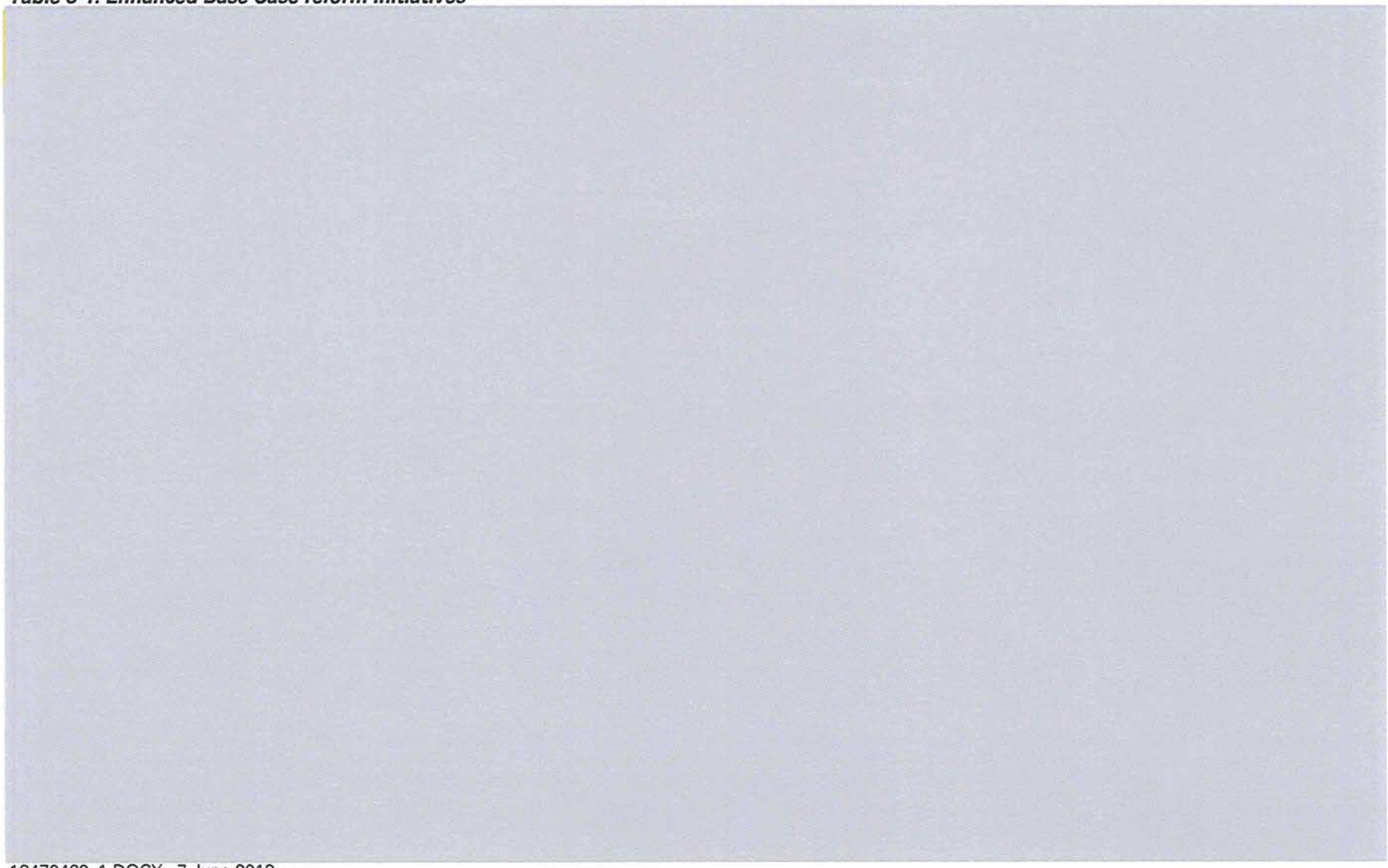
8.4.1 Overview

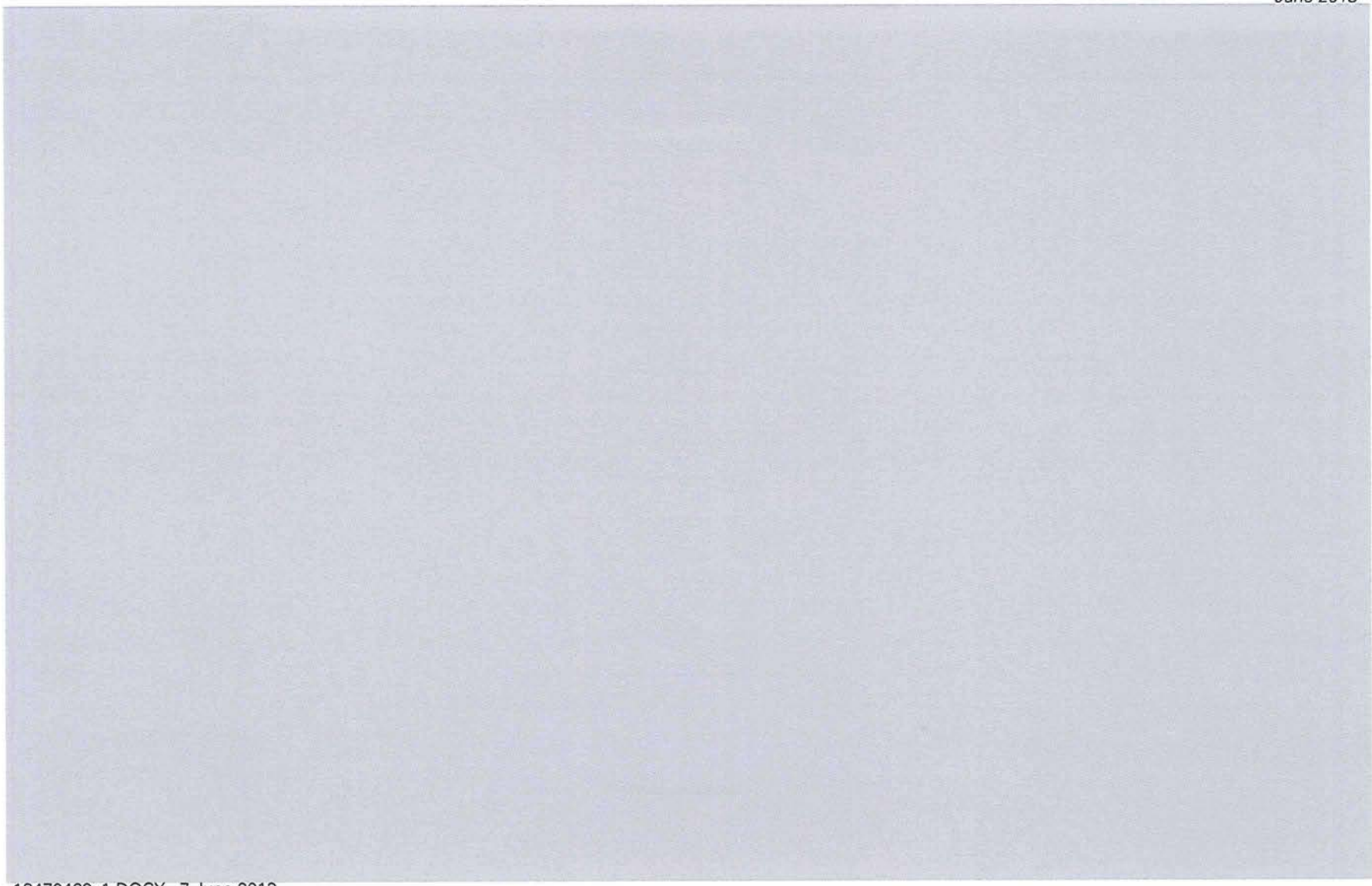
The Enhanced Base Case is similar in structure to the Base Case in that it assumes that SCHHS remains responsible for delivering public health services at SCUH.

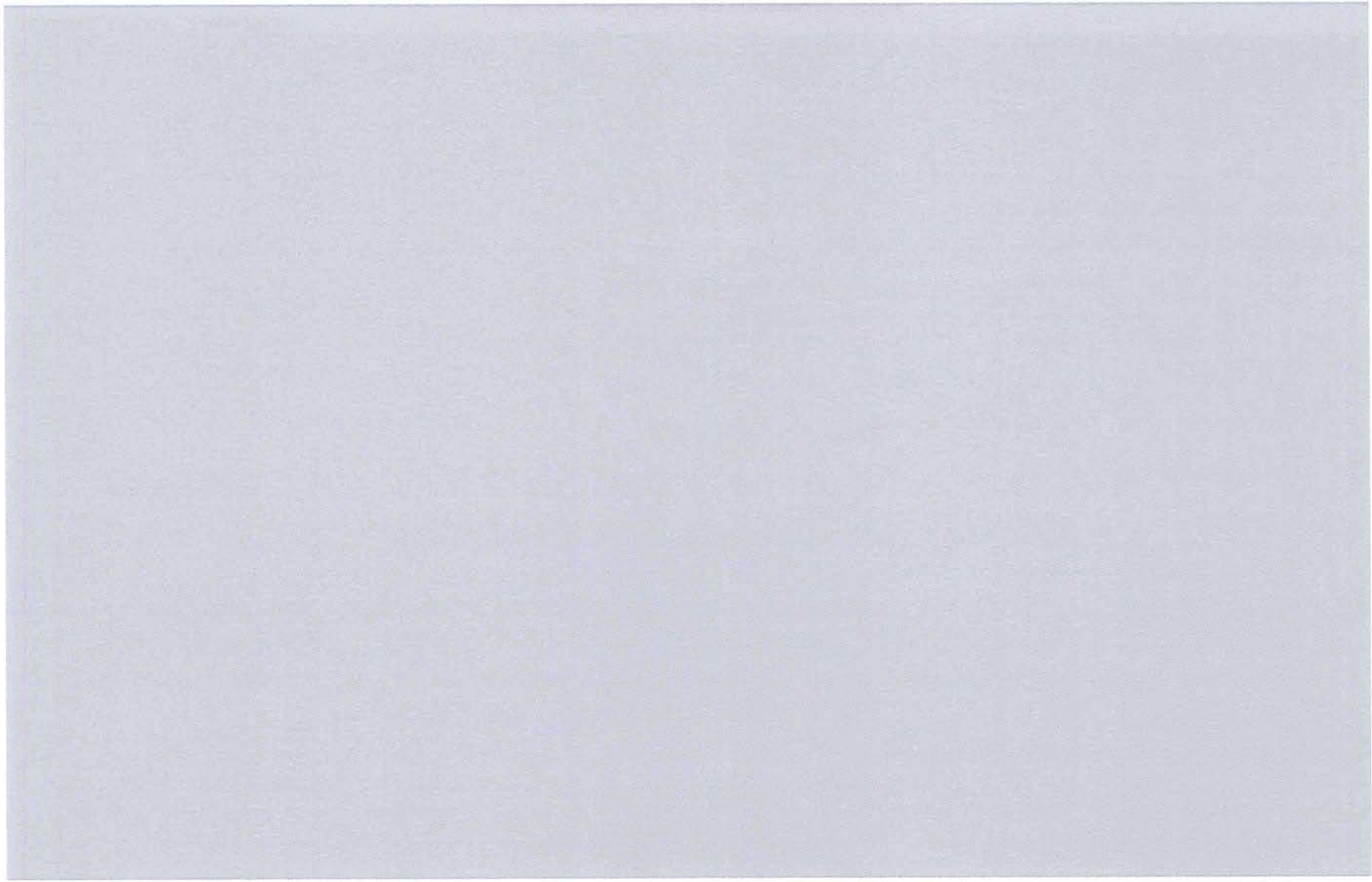
The key difference between the two options is that the Enhanced Base Case builds upon the Base Case by identifying material, implementable and sustainable efficiencies to the operation of SCUH, without the use of material outsourcing. These efficiencies must also meet standards required by Queensland Health.

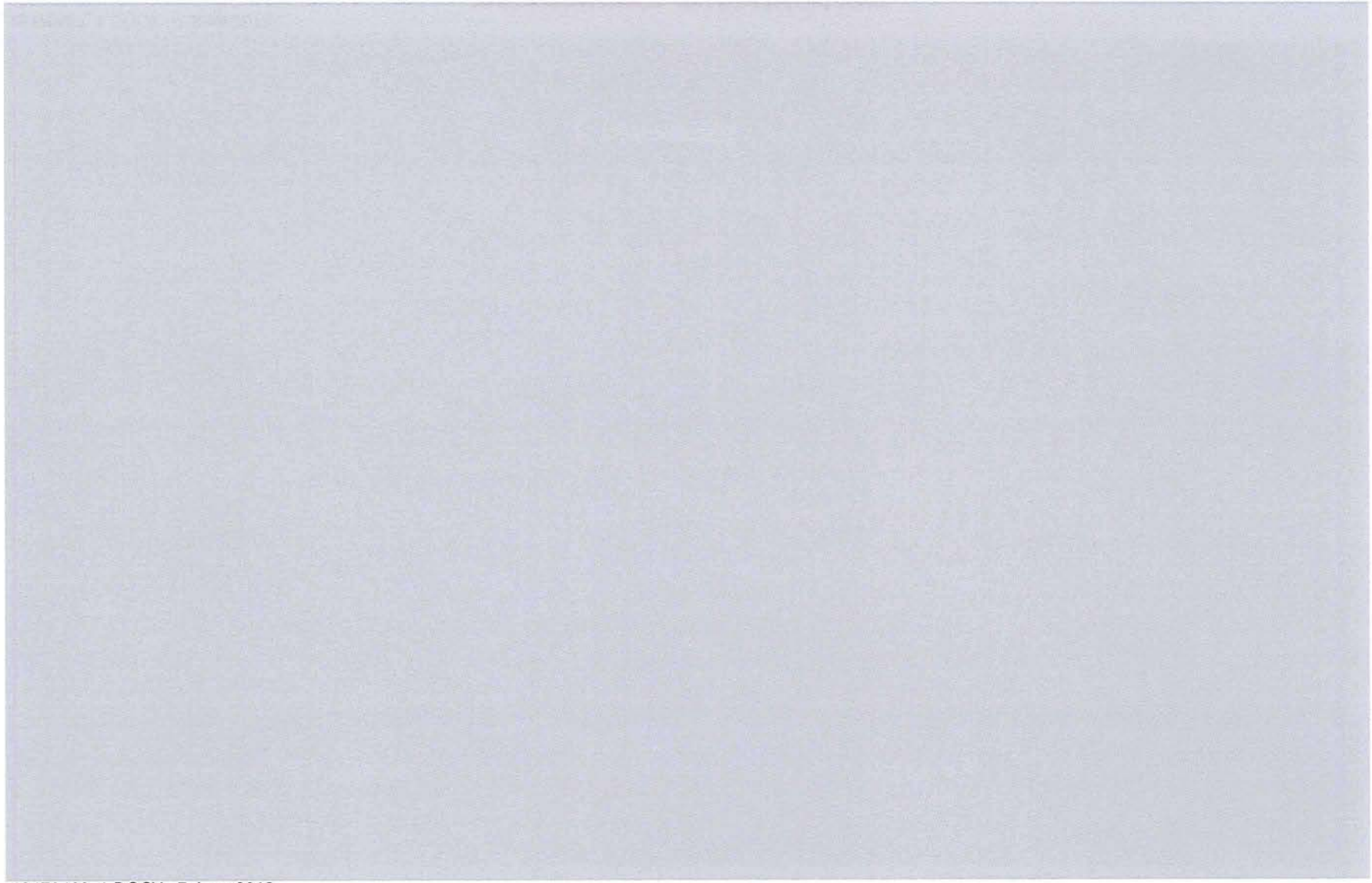
8.4.2 Summary of reform initiatives

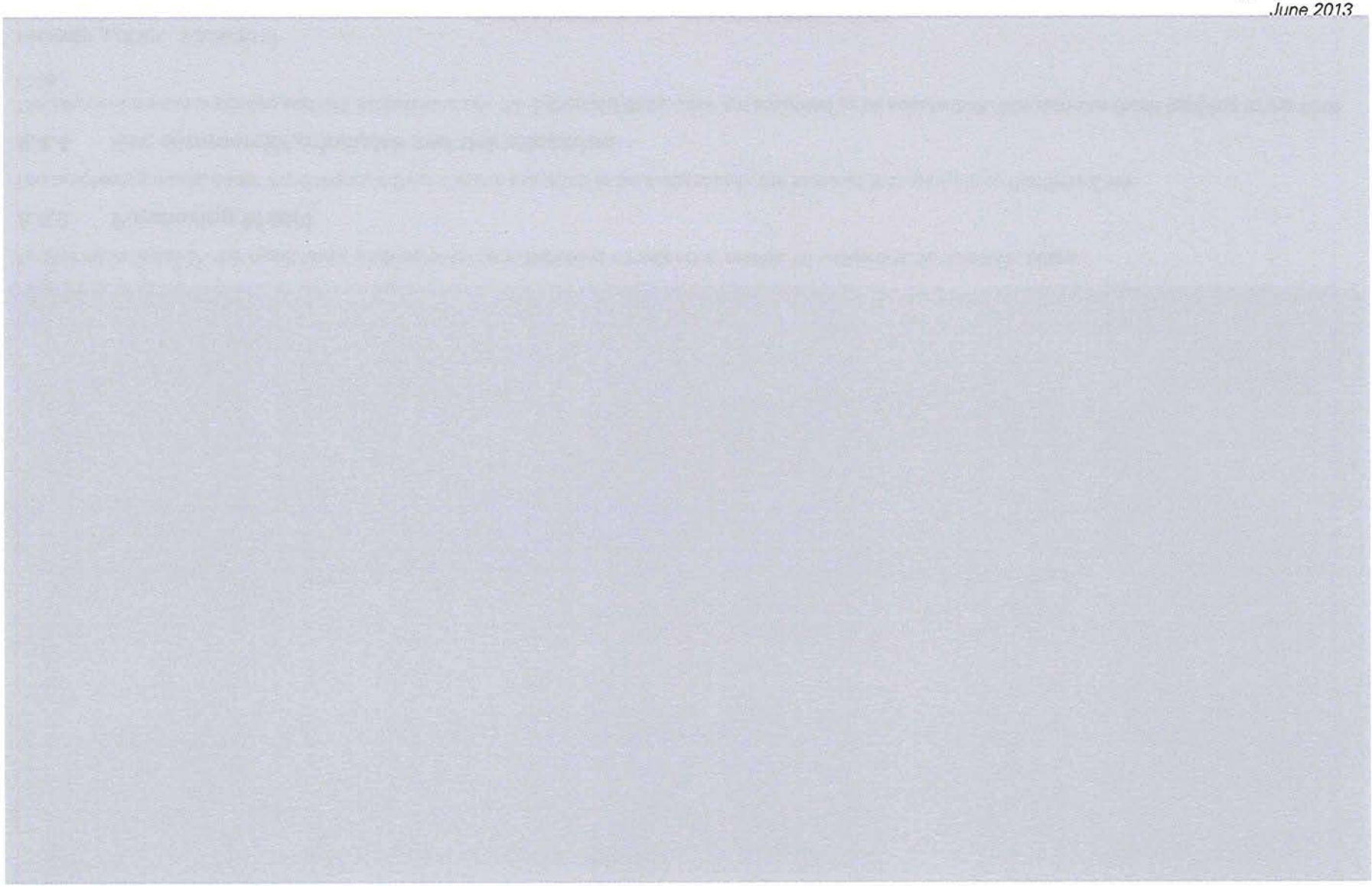
Table 8-1: Enhanced Base Case reform initiatives











Further information on the quantitative analysis of these initiatives is contained in section 10 – Quantitative Analysis, below.

8.4.3 Purchasing Model

The purchasing model under the Enhanced Base Case is assumed to be substantially the same as that applying to the Base Case.

8.4.4 Key commercial principles and risk allocation

The key commercial principles and risk allocation under the Enhanced Base Case are assumed to be substantially the same as those applying to the Base Case.

8.5 Soft FM Services

8.5.1 Overview

The full range of Soft FM Services can be considered for outsourcing. This comprises a range of hotel and back-of-house functions related to cleaning, catering, waste management, linen laundering and distribution, porterage and bulk store distribution (refer to Section 7.9 for a detailed discussion on the Soft FM Services). The services should be bundled in one contract to create a single point of responsibility and to take advantage of synergies in the joint provision of these services.

8.5.2 Issues influencing the outsourcing structure

8.5.3 Roles and responsibilities

Experience with other support service contracts in the health sector indicates that Soft FM Services should be procured from a single provider to take advantage of synergies between these services. For example, flexible working arrangements allow contractors to manage overlaps in portering, cleaning and security roles more effectively. In addition, bundling of these services creates a single point of responsibility which avoids the need for SCHHS to manage interfaces between services and

allows for more efficient contract management.

The NGSP would be responsible for managing all operational risks associated with the delivery of the full range of Soft FM Services. The contract would require (as is the case with the current PPP contract) that the NGSP coordinate with, and avoid disruption to, the core hospital services. The services would be specified under an output specification and would be subject to a detailed performance monitoring regime, including abatement of service payments for failures to achieve the specified standards.

The main contract management responsibilities include:

- *Payment for services* – Payment may be made monthly or quarterly and will be depend on the delivery of services to the required performance standards
- *Performance monitoring* – The primary responsibility for performance management lies with the NGSP which must maintain the necessary performance monitoring and reporting systems and has a mandated self-reporting responsibility under the contract. However, the service users also have an interest and responsibility in performance monitoring and reviewing the regular reports prepared by the contractor
- *Negotiation and dispute resolution* – Where performance is persistently inadequate, SCHHS may need to negotiate with the contractor and/or enforce the contract to achieve the required performance. If no resolution is achieved, SCHHS may need to commence a formal dispute process or exercise its rights to terminate the contract.

8.5.4 Key commercial principles and risk allocation

The outsourcing of Soft FM Services to a NGSP would allow a high level of operational risk transfer, enabling SCHHS to focus on managing the delivery of core healthcare services. The way in which the outsourcing option manages the key demand, performance and cost risks is discussed below.

8.5.4.1 Demand management

Once a hospital is fully commissioned and operating at capacity, the demand for most Soft FM Services is relatively stable and the NGSP would generally manage variability in the level of services required as part of its day to day operations. Exceptions to this are likely to relate to food services, in which some form of volume payment is likely to be required, as well as linen supply and laundering (but not linen distribution which has a fairly stable level of activity).

8.5.4.2 Performance management

NGSP's performance in relation to the Soft FM Services will be assessed against a set of service specifications. The specification should be output-based and not prescriptive, to enable the private sector to innovate and deliver best practice. Service specification should also reference all required policies for working in a hospital environment.

The NGSP will receive periodic payments for the delivery of the services. The payment mechanism should reflect the performance of services according to KPIs and should feature abatement for inadequate performance (this is commonly effected by using a points system where points are accumulated during the payment period for each performance incident). Repeated inadequate performance or abatement exceeding a certain threshold can trigger default. If the NGSP defaults, they may be required to present a plan to rectify performance. Failure to rectify within reasonable timeframe leads to termination.

8.5.4.3 Pricing and cost management

The NGSP is responsible for managing operating costs and must ensure that they are contained within the contracted service fee since this fee will only be adjusted for indexation and any agreed adjustments for volume-based payments. However, the contracted service fee is subject to potential adjustment through a benchmarking/market testing process which is typically applied every five years. The benchmarking/market testing process should reference operating costs to the market and, if required, prices from three tenders should be sought.

8.5.4.4 Contract term

If Soft FM Services were tendered in isolation, a term of up to 10 years would be appropriate (with 5-7 years being potentially possible). Options to extend could be presented but the ability to retender should also be retained. This principle is relatively standard in Australian PPP projects.

A longer initial term incentivises the private sector to invest in technology. This was highlighted at the Royal North Shore Hospital, where the Soft FM Service contractor preferred a long initial term as it enabled investment in AGVs

8.5.5 Precedent for outsourcing

A range of Australian hospitals have outsourced Soft FM Services as part of a Full Outsourcing contract. This includes Midland Health Campus (WA), Joondalup Health Campus (WA), Latrobe Regional Hospital (VIC), Modbury Public Hospital (SA) and Mildura Base Hospital (VIC).

Other Australian hospitals that have outsourced Soft FM Services include Fiona Stanley (WA), Royal Women's Hospital (VIC), The New Bendigo Hospital (VIC), the New Royal Adelaide Hospital (SA), the Orange and Bathurst Hospitals (NSW), the Newcastle Mater Hospital (NSW), the Long Bay Forensic and Prison Hospital (NSW) and the Royal North Shore Hospital (NSW). In relation to commissioned hospitals, these services are understood to be operating satisfactorily although the Royal North Shore Hospital encountered contractual difficulties with its facilities management services when the new hospital opened in 2012.

8.6 Corporate Support Services

8.6.1 Overview

The Corporate Support Services for SCUH involve the delivery of finance, human resources/payroll, Information & Communications Technology (ICT), legal, marketing, media & communication services, reception and switchboard, medical records and medical typing and workforce training and development.

8.6.2 Issues influencing the outsourcing structure

Options for the outsourcing of Corporate Support Services at SCUH need to take into account some special characteristics of these services:

- Many of the services are currently being provided by SCHHS on behalf of the hospitals and other facilities in the HHS, although these hospitals also provide specific corporate services (e.g. Reception and Switchboard) and maintain a level of local corporate services capability that is integrated with the HHS (e.g. Finance). This will continue to be the case with SCUH which will develop its own corporate services capabilities, including capabilities that will be integrated with the corporate services provided across the HHS.
- The nature of Corporate Support Services is disparate, and the total spend on each service tends to be relatively small.

These factors may constrain the way in which these services are outsourced, with the following implications being particularly relevant:

- Outsourcing Corporate Support Services at SCUH under a single contract may not be VFM if it creates difficulties in terms of integration of Corporate Support Services across the HHS and if it leads to diseconomies due to the need to maintain separate SCHHS services for other hospitals in the HHS.
- The scope of retained and transferred Corporate Support Services would require careful consideration under a Full Outsourcing approach. The integration issues mentioned above would need to be balanced against the NGSP desire to maintain a significant in house Corporate Support

Services capability because of the relationship with core management functions of the hospital. In addition, SCHHS would want to limit its interfaces with the NGSP and to avoid being responsible for providing certain Corporate Support Services to the NGSP.

- Further investigation is required as to the manner of procurement of ICT which involves a substantial investment and has the potential to have a major transformative impact on both SCUH and the HHS. It is likely that outsourcing of these services should be implemented on a whole of HHS basis, and not just at SCUH. However, if Full Outsourcing is adopted, the NGSP would be likely to view ICT as integral to implementing its model of care and business processes at SCUH. This may have adverse implications for developing ICT systems that can be integrated effectively across SCHHS. Any integrated solution must reflect clear user objectives and the broader SCHHS ICT strategy, policies, and architecture. It must also reflect market appetite for certain risks, such as system development and integration.

8.6.3 Roles and responsibilities

Outsourcing of Corporate Support Services is likely to provide best value for money if pursued at a HHS level rather than just at SCUH, given the integrated nature of these services. SCHHS would be responsible for specifying these services and monitoring the operator's performance, managing contractual obligations and maintain overarching control. The NGSP's responsibilities would primarily relate to providing essentially transactional or processing activities as specified.

Where Full Outsourcing is pursued, the hospital operator would necessarily take over Corporate Support Services with reference to the SCUH (i.e. facility level), including ICT. Since these services are inputs to the hospital operations, they would not be of direct concern to SCHHS (which would manage the facility under a high-level output specification) except to the extent that SCHHS depends on specific outputs of SCUH corporate processes to perform its HHS management functions (e.g. SCHHS will need to generate financial reports for the whole HHS including SCUH).

If outsourcing of ICT Services is pursued for the whole HHS, the NGSP will be responsible for the delivery of ICT Services to specified performance standards, and for maintaining the condition of the SCUH ICT equipment. Other responsibilities may include:

- Providing reactive support, scheduled upgrades to systems, issuing of ICT equipment including telephones and computers and so on. It would also be appropriate to consider maintenance of software systems
- Selection, development and/or configuration of systems to interface with the Department of Health systems for electronic health records, cost statistics collection etc. This would be dependent on broader the Department of Health IT policies and architecture decisions.

SCHHS will be responsible for defining the service specification and communicating and managing through changes to IT policies.

8.6.4 Precedent for outsourcing

- Certain Australian hospitals have outsourced Corporate Support Services as part of a Full Outsourcing contract. This includes Midland Health Campus (WA), Joondalup Health Campus (WA), Latrobe Regional Hospital (VIC), Modbury Public Hospital (SA) and Mildura Base Hospital (VIC). Other Australian hospitals that have outsourced Corporate Support Services include Fiona Stanley (WA).
- Other innovative models have been used internationally including the NHS Shared Business Services JV (UK).

8.7 Clinical Support Services

8.7.1 Overview

Clinical Support Services comprise a range of services, including Medical Imaging, Pathology Services, Pharmacy Services, Central Sterilising and Biomedical Technology Services. Given the specialist nature of these services, they are likely to be procured under separate contracts.

8.7.2 Issues influencing the outsourcing structure

Clinical Support Services are currently planned to be provided in-house at SCUH. However, it is also important to note that a range of State-wide initiatives are being considered in relation to some of these services. These assessments could have implications for the provision of services at SCUH, including the ability to utilise efficient state-wide services.

The existence of competitive markets for some services and the evidence of precedent projects suggests that there is potential to outsource the majority of these services, in particular, medical imaging, pathology services and pharmacy services. The following table summarises this analysis.

Service	Mature market	Competitive	Precedents	Risks/opportunity
Medical Imaging	✓✓✓✓	✓✓✓✓	✓✓✓✓	May be possible to transfer equipment ownership to provider and reduce capex spend
Pathology Services	✓✓✓	✓✓✓	✓✓✓	May be potential for scale efficiencies with a private provider
Pharmacy Services	✓✓✓✓	✓✓✓✓	✓✓✓✓	May be potential for scale efficiencies with a private provider
Central Sterilising Supply Unit	✓	✓	✓	Typically bundled with theatre service delivery
Biomedical Technology Services	✓	✓	✓	Minor service which may be difficult to outsource other than as part of Full Outsourcing

these services would be outsourced in separate, service-specific contracts due to the specialist nature of the providers and because there would be little advantage in bundling (the main interface is with Operational Services rather than between Clinical Support Services and the single NGSP responsible for "wrapping" the services would add unnecessary overheads).

In each case, the analysis assumes that the outsourced services would primarily comprise transactional/processing activities and that the consultation functions carried out on wards within Multi-Disciplinary Teams would remain a Clinical Service provided by SCHHS (other than in a Full Outsourcing case).

The outsourced services could be responsible for the maintenance of specialist medical equipment, as applicable, and there is an opportunity for these providers to assume supply and replacement risk, depending on the nature and duration of the contract that is adopted. However, the issue of

equipment supply and management across SCUH is a complex issue

The appropriate approach, including government delivery options, would merit further detailed investigation once a decision has been made about the broad scope of outsourcing of Operational Services and Clinical Support Services.

8.7.3 Roles and responsibilities

If the outsourcing of Clinical Support Services is pursued, the NGSP would be responsible for the delivery of Clinical Support Services to specified performance standards including service quality, volumes and mix. Other responsibilities include:

- *Performance monitoring and reporting* – the NGSP will be responsible for producing monthly performance reports for SCHHS that indicates performance is in line with contract terms.
- *Staffing and subcontracting strategy* – the NGSP should be allowed to determine which services it performs directly and which, if any, it may subcontract. For all performance outcomes whether or not subcontracted the NGSP will be held to account by SCHHS.
- *Equipment upgrading and maintenance* – where relevant, and possible, the NGSP will be responsible for planned and unplanned equipment maintenance. In addition, depending on contract scope and duration the NGSP may also be responsible for the upgrade and replacement of equipment, for example imaging, to ensure service quality is maintained. While the opportunity for the NGSP to select the initial items of equipment is unlikely to be possible (due to construction and commissioning timelines), the equipment will be new and thus the ability to transfer this responsibility on an ongoing basis should be obtainable.

Under the outsourcing arrangements, SCHHS' responsibilities would include:

- *Payment for services* – SCHHS would be responsible for paying the NGSP for delivery of Clinical Support Services in line with the terms set out in the contract. This would typically be monthly and would include adjustments for non-delivery or reductions in service quality.
- *Management of contracts* – SCHHS would be responsible for the ongoing management of the contract. This would include overseeing the strategic and commercial aspects of the arrangements, tracking service outcomes, compliance and regulatory requirements, monitoring service quality, KPIs and costs against agreed contract service levels and managing contract change requests to control contract variation and therefore cost escalation. .
- *Negotiation and dispute resolution* – Where performance is persistently inadequate, SCHHS may need to negotiate with the contractor and / or enforce the contract to achieve the required performance. If no resolution is achieved, SCHHS may need to commence a formal dispute process.

8.7.4 Key commercial principles and risk allocation

The risk allocation should deliver the following main benefits:

- Efficient pricing achieved in competitive markets and enhanced by labour market flexibility and improved work practices and systems
- Reliable and high quality services driven by outcome-focussed performance measures, payment incentives and other contractual mechanisms
- Transfer of operational risks to specialist providers with the scale, technology, skills and other resources to manage these risks effectively.

- The way in which the outsourcing option manages the key demand, performance and cost risks is discussed below.

8.7.4.1 Demand management

Clinical Support Services contracts typically rely on fee for service arrangements whereby the NGSP is paid according to the volume of services that it provides based on a fixed schedule of rates. The contract may restrict volumes within agreed limits or it may allow for pricing adjustments or contract variations if volumes exceed these limits. These arrangements mean that demand risk is effectively retained by SCHHS which is better able to manage these risks in the context of total hospital activity. However, SCHHS would need to ensure that it adequately understands its demand mix and quantum in order to negotiate the most efficient volumes and variation mechanisms.

As with the Base Case situation, there would be a need to put in place mechanisms to track unnecessary testing and repeat orders and appropriate incentive which drive efficient behaviours by the service provider.

8.7.4.2 Performance management

The NGSP's performance of Clinical Support Services will be assessed against service specifications and KPIs as set out in the outsourcing contract. The service specification should be output-based and not prescriptive to enable the NGSP to innovate and deliver best practice. The specification should also reference all required policies for working in a hospital environment and should require compliance with stringent quality assurance measures (both internally and externally). In addition, third party audits are expected for some services. The payment for services at the agreed rates will be subject to compliance with these quality measures and external audits, as well as achievement of KPIs that relate to patient outcomes. Serious service failures or contract breaches may result in requirements to present a plan to rectify performance. Failure to rectify within reasonable timeframe would lead to termination and replacement of the provider.

8.7.4.3 Pricing and cost management

Contracting on a fee for service basis means that responsibility for all operating costs is transferred to the NGSP which must manage the risk of variability in these costs within its agreed schedule of rates, subject to prescribed adjustments for cost inflation or any agreed volume or casemix adjustments. The provider should be able to manage this risk effectively over the relatively short duration of the outsourcing contract.

The NGSP would be responsible for maintaining SCUH equipment that is used in the delivery of the relevant services and, depending on the equipment procurement arrangements that are adopted, it is possible that some NGSPs could be responsible for equipment ownership risks as well. This may necessitate a longer-term contract to amortise the equipment cost and could also involve a mechanism to allow some resetting of the schedule of rates based on market prices.

Any requirement for teaching and research activities could be dealt with in the contract in one of two main ways:

- direct pass-through of any additional costs incurred for these services; or
- a higher base cost which will enable these services to be bundled as part of any core service offer. The complexity will be in determining the outcome measures in support of these incremental costs.

8.7.4.4 Contract term

Market evidence supports the premise that contact terms for individual Clinical Support Services vary when they are stand-alone contracts. In addition, where a service includes a capex investment for equipment the contract duration is likely to be at least 10 years. Service based arrangements require a shorter contract term. In summary:

- Medical Imaging – where medical imaging equipment is included in the contract, a minimum contract term of 10 years will be required in order for the private sector to amortise equipment cost, current market preference is for a longer term – up to 20 years. Where equipment remains with SCHHS this initial term can be 5 years.
- Pathology services – a 5-year contract term is considered sufficient, as limited investment by Pathology providers is necessary given that SCUH has existing laboratory infrastructure.
- Pharmacy – 5 plus 5 is a typical contract term.

8.7.5 Precedent for outsourcing

A range of Australian hospitals have employed Clinical Support Service outsourcing as part of a Full Outsourcing Contract. This includes Midland Health Campus (WA) which opens in 2015, Joondalup Health Campus (WA), Modbury Public Hospital (SA), and Mildura Base Hospital (VIC). Of these Modbury, Joondalup and Mildura are operational at this point and or remain the responsibility of a NGSP.

Other hospitals/health services have outsourced selective Clinical Support Services such as imaging and pathology.

A number of innovative models for outsourcing of Clinical Support Services have been successfully employed internationally. This includes the Independent Sector Treatment Centres (UK) and GSTS Pathology – Tripartite JV (UK).

8.8 Full Outsourcing

8.8.1 Overview

As indicated in Section 8.2, the outsourcing of Operational Services entails contracting with a NGSP that would assume responsibility for the entire hospital, apart from services included under the PPP contract. This is necessary to achieve effective transfer of operational risks and to give a NGSP maximum opportunity to optimise service delivery across the entire facility. While it may be value for money to procure some services from specialist providers (e.g. some Clinical Support Services), this would be primarily a business decision for the NGSP which would sub-contract these services.

Consequently, this section focuses on a Full Outsourcing option rather than on outsourcing of Operational Services in isolation. Full Outsourcing comprises the following service streams:

- Clinical Services: the full range of medical and surgical inpatient services, emergency department, outpatient, rehabilitation and other clinical services that are provided at SCUH
- Education & Training: undergraduate and post graduate education including the SCUH role in supporting the SARC
- Research & Development: facilitation of clinical and applied research and collaboration with SARC
- Clinical Support Services, as outlined above
- Soft FM Services
- Corporate Support Services and Governance and Executive Functions, in both cases only in so far as they relate to the facility.

The scope of Full Outsourcing would exclude Hard FM Services which are already contracted under the PPP contract.

8.8.2 Issues influencing the outsourcing structure

A Full Outsourcing approach for SCUH would have important consequences for the role and activities of SCHHS, recognising that SCUH will constitute the majority of the services provided within the HHS. SCHHS would cease to have direct responsibility to manage services at this facility and would instead control services indirectly through the contract that is developed with a NGSP and the ongoing management of that contract. This will require a major change in resourcing, skills and management focus on the part of SCHHS.

It is assumed that, in performing this contract management role, SCHHS would continue to be accountable to the Department of Health for the delivery of services within the HHS in accordance with the annual Service Agreement. This would be likely to have implications for the nature of the contract with the NGSP, since SCHHS would want to ensure that its obligations to the Department

are passed to the NGSP insofar as those obligations relate to activities at SCUH. If SCHHS does not pass through these obligations effectively, it will be exposed to funding and performance risks that it will have difficulty managing by other means.

There is a further issue, however, in that the nature of the obligations that are passed through into the Full Outsourcing contract must be acceptable to the market or, at least, able to be contracted on a value for money basis. It is likely, as discussed below, that NGSPs will place firm parameters around the nature of the demand and performance risks that they are prepared to bear in exchange for enforceable commitments to manage risks within the specified parameters. This, in turn, may have "upstream" consequences for the obligations that are contained in the Service Agreement between the Department of Health and SCHHS.

The Full Outsourcing contract would also need to be carefully structured to ensure that it manages SCUH's education and research functions adequately. These services pose special challenges because they involve a split accountability for results between SCUH and SARC. In addition, the arrangements for specifying and accurately costing these services are not well developed in public hospitals generally. SCHHS places a high priority on the delivery of Education & Training and Research & Development services and it will be important to ensure that there is clarity in terms of the NGSP's accountabilities and payment arrangements and that there is a robust performance management framework for these services.

As noted in Section 8.6.2, it is expected that a Full Outsourcing provider would want to control its own Corporate Support Service capability and it would be likely to view ICT as integral to implementing its model of care and business processes at SCUH. These outcomes may have

adverse implications for Corporate Support Services that integrate effectively across SCHHS and consequently the scope and specification of the Full Outsourced services would require careful consideration.

8.8.3 Roles and responsibilities

Under a Full Outsourcing model, the role of SCHHS shifts fundamentally from a provider of public health services to the contract manager of public health services at SCUH. Nevertheless, SCHHS would remain accountable at a HHS level for the delivery of services at the quality, volume and price required under the Service Agreement with the Department of Health and it would seek to manage its responsibilities by transferring appropriate service risks to the Full Outsourcing contractor at SCUH.

The Full Outsourcing contractor would be responsible for the provision of all services at SCUH, other than Hard FM Services provided under the PPP contract. The Full Outsourcing contractor may choose to subcontract some of its services, for example, certain Clinical Support Services, but it would remain responsible to SCHHS for the delivery of services to the requisite standard. SCHHS may manage the PPP and Full Outsourcing contracts separately, or it may assign or delegate its powers in relation to the former contract to the Full Outsourcing contractor.

8.8.4 Key commercial principles and risk allocation

The expected risk allocation should deliver the following main benefits:

- Achievement of value for money through efficient pricing and a commercial structure that is conducive to a relatively high level of budget certainty over the duration of the project
- Substantial transfer of risks associated with Clinical and Support Service delivery
- Implementation of an output-focussed performance management and payment regime that allows for flexibility and innovation in service delivery while ensuring appropriate consequences for operator underperformance relative to required outputs and service standards.

The way in which the outsourcing option manages the key demand, performance and cost risks is discussed below.

8.8.4.1 Demand management

The demand for Clinical Services is subject to significant growth and variability associated with population growth, increases in level of patient acuity, changes in health service provision and models of care, increasing prevalence of chronic disease and other factors. These long-term demand risks need to be managed by governments and cannot be transferred cost-effectively under a Full Outsourcing contract. Consequently, the ABF mechanism provides a suitable basis for government to purchase the volume of services it requires to meet demand. Market precedent and feedback indicates that providers are comfortable with this general approach.

Implementing this payment mechanism involves balancing some of the same fundamental issues that arise in the Base Case. On the one hand, the hospital must be responsive to the health needs that arise and it cannot be allowed to turn away or postpone unplanned patient admissions. On the other hand, the government will expect some stability in the volume of services that are purchased on an annual or other periodic basis and it will require the ability to constrain demand to affordable levels.

[redacted]

8.8.4.2 Performance management

Rigorous performance management arrangements are critical to ensure that the NGSP delivers health services to the standards of quality, effectiveness and safety expected for public health services generally in the State. Since the hospital must form an integral part of the overall Queensland hospital system, the nature of the services and the standards of performance that are specified should, in principle, be consistent with those applying to other hospitals in Queensland.

The main differences under an outsourcing contract relative to conventional delivery are likely to lie in the way the contract incentivises compliance with the State's requirements. Service failures should result in obligations to rectify the failures but may also result in deductions from the service payments or other remedies under the contract. Since performance risk is transferred to a non-government entity, these commercial drivers can be stronger than would apply under a conventional Service Agreement.

This will require that careful consideration is given to the way the system of performance standards and payment abatements is designed and calibrated to avoid unintended distortion of provider behaviour or increased service prices that may not represent good value for money for the State.

In the event of significant or sustained service failures, the contract would permit the government to terminate the NGSP and claim costs to rectify the failures and facilitate the procurement of a replacement service provider. The contract would require that the NGSP provide a substantial performance bond to the government which may be drawn on to secure recovery of costs in this circumstance. The termination regime may also include instances where Government may terminate the NGSP in instances that are not directly related to underperformance (e.g. for convenience and force majeure).

8.8.4.3 Pricing and cost management

The risk of changes in operating costs for the provision of operational services should be borne by the NGSP and managed through active monitoring and control of its operating budget. The contract achieves the transfer of this cost risk through a fixed price regime for an extended period of time where service prices may be expressed as a discount to a benchmark price, such as the Queensland price per WAU or the National Efficient Price.

[redacted]

8.8.4.4 Contract term

Setting the duration of contract term involves balancing a range objectives in order to provide a commercially attractive proposition that delivers a VFM outcome for Government. Key considerations in relation to the contract term include:

- efficient pricing of services over the contract term
- reasonable certainty of pricing over the contract term

- the NGSP's ability to recoup upfront implementation costs over a reasonable timeframe
- the ability to maintain relativity with market conditions and to allow contestability of service provision.

Precedent (asset and non-asset) transactions have shown a term of 15 to 25 years. Based on the market soundings, it is possible that the minimum term for a commercially viable structure could be around 10 - 20 years. A potential option could be for the government to contract for a 15-year term but with the option, at the government's discretion, to test the market after 10 years.

8.8.5 Precedent for outsourcing

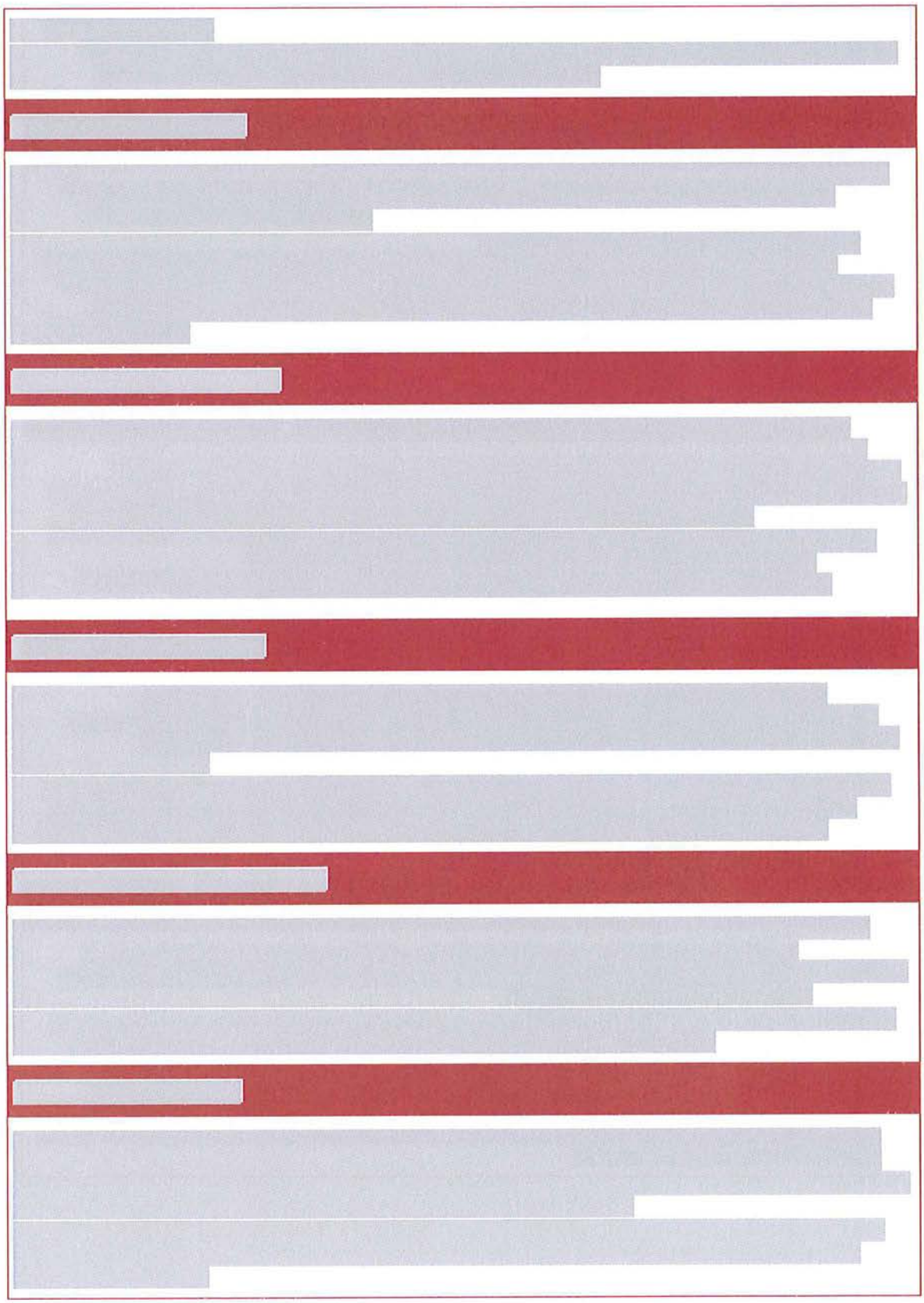
Certain Australian hospitals have employed Full Outsourcing. These include Midland Health Campus (WA), Joondalup Health Campus (WA), Latrobe Regional Hospital (VIC), Modbury Public Hospital (SA) and Mildura Base Hospital (VIC).

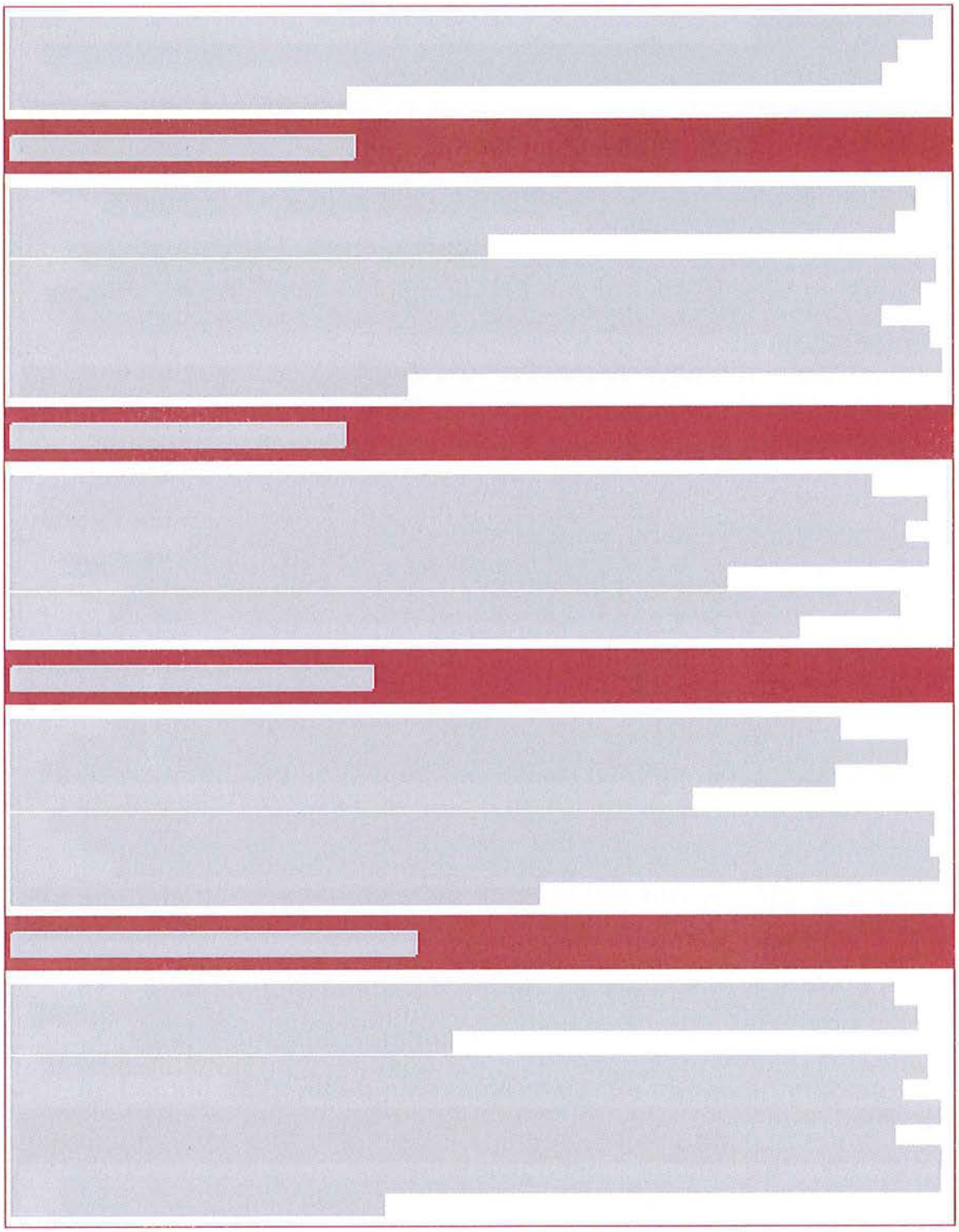
In summary, there are few comparable Australian precedents for the outsourcing of large public tertiary teaching hospitals in a regional location. Some examples of non-Government service providers in a metropolitan setting that provide higher complexity services as well as education and research include UnitingHealth (The Wesley), St Vincent's (Sydney and Melbourne) and Mater (Brisbane).

Further examples include Western Australian facilities of Joondalup Health Campus and Midland Health Campus which have outsourced all services, but are less complex facilities (generally equivalent to CSCF Level 4 to 5). Joondalup has been operating successfully for a number of years. It is noted that Midland Health Campus has not yet been commissioned (scheduled for opening in 2015). The Fiona Stanley Hospital (opening 2014) in Perth is a tertiary level facility with the same CSCF Level of SCUH (6) but clinical services will continue to be provided by the public sector with support services provided by a NGSP (Serco).

International precedents include the 706 bed Bragga Hospital (Portugal), the 300 bed Hospital de La Ribera (Valencia, Spain), the 220 bed Hospital de Manises (Valencia, Spain), the Hinchingbrooke Hospital NHS Trust (UK) and the 310 bed Saint Göran Hospital (Stockholm, Sweenden).

A high level summary of some of these precedents is provided below. Further detail on precedent projects is contained in Appendix 12.





8.9 Governance and Executive Function

8.9.1 Overview

The Governance & Executive Functions are set out in Section 7.3, which makes a distinction between SCHHS functions and facility-level functions at SCUH. The Governance & Executive Functions would continue to be provided by SCHHS in all outsourcing options other than Full Outsourcing, where the facility level functions would be provided by the NGSP.

8.9.2 Issues influencing the outsourcing structure

Under the Full Outsourcing option, SCHHHS would need a contractual basis for assurance that all statutory and mandatory requirements are met. These would extend to required quality and performance measures, e.g. the performance measures required by the National Health Performance Authority. Hence, while regulatory compliance is a core responsibility of SCHHS across the hospitals in the HHS, it may contract its compliance obligations in relation to SCUH to a NGSP which would indemnify SCHHS for any loss or liability flowing from a breach of its obligations.

As noted above, a Full Outsourcing option would have a major impact on the Governance and Executive functions given the proportion of HHS services associated with SCUH. This option has the risk of creating inefficiencies in the provision of Governance and Executive functions at the HHS level and it could also have implications for the structure of SCHHS, both locally and in terms of its relationship with the Department of Health as a whole.

8.9.3 Roles and responsibilities

SCHHS would remain responsible for the majority of Governance and Executive functions, although under Full Outsourcing, the facility-level functions, plus compliance with relevant laws and regulations at SCUH, would become the responsibility of the NGSP. The contractual arrangements in this latter scenario would largely follow those discussed above in relation to Full Outsourcing.

8.9.4 Key commercial principles and risk allocation

The commercial principles are broadly similar to those applying to Full Outsourcing, as described above, and involve full transfer of the relevant management responsibilities and the associated performance risk.

8.9.5 Precedent for outsourcing

The precedent for Governance and Executive Function are substantially similar to that of Full Outsourcing.

8.10 Summary and Conclusion

This section has provided an overview of outsourcing options based on the main service categories within SCUH, having regard to:

- Issues influencing the outsourcing structure
- Roles and responsibilities of SCHHS and the NGSP
- Key commercial principles affecting the allocation of risks between the parties
- Precedents for outsourcing similar services in Australia

There is considerable experience and established contractual models in relation to the outsourcing of Soft FM Services, Corporate Services and selected Clinical Support Services. There are also a number of precedents for outsourcing Operational Services in the context of a Full Outsourcing model , although none correspond directly to the circumstances at SCUH involving a major tertiary,

teaching hospital in a regional setting. In addition, the experience with some of the earlier contract models has been mixed with some services needing to be resumed by the State. Section 9 builds on this analysis and provides a detailed qualitative evaluation of the merits of service outsourcing options in relation to the evaluation criteria set out in Section 6.

9 Qualitative VFM evaluation

This section provides an evaluation of each outsourcing option, as described in Section 8, against the evaluation criteria set out in Section 6. The following discussion is qualitative in nature but includes a summary, in relation to the "service efficiency and budget certainty" evaluation criterion, of the results of the quantitative VFM assessment of each delivery option. The quantitative VFM assessment is considered in more detail in Section 10.

9.1 Approach

The evaluation of each option has been conducted on the assumption that the Base Case and each outsourcing option would be subject to the same service specification, that is, they would each be expected to deliver the same scope, quantity and quality of services for public patients. Hence, for example, while practices in non-government hospitals may be drawn on to inform the evaluation, the evaluation is not directly between government and non-government hospitals but between government and non-government provision of the same public hospital services.

The evaluation of the Base Case is assumed to include the Enhanced Base Case, unless otherwise stated, because the additional efficiency measures assumed in the Enhanced Base Case generally do not materially impact the evaluation of each criterion, other than the criterion related to service efficiency and budget certainty. It should also be noted that, where the Base Case is compared to outsourcing of sub-components such as Soft FM Services or Corporate Support Services, the evaluation is with respect to the relevant component of the Base Case.

The qualitative evaluation includes an indicative rating of each Delivery Option for the purposes of illustrating the relative extent to which each delivery option achieves each evaluation criterion. The evaluation criteria have not been weighted and the ratings are not intended to be summed to derive an overall score. However, general conclusions may be drawn from the evaluation as summarised in section 9.14. The ratings for each criterion and option were developed in a workshop involving senior SCHHS clinicians and executive staff.

The following table summarises the rating system.

Rating	Description
✓✓✓✓✓	Delivery model fully or almost fully satisfies the evaluation criterion by meeting all or substantially all criterion requirements.
✓✓✓✓	Delivery model satisfies the evaluation criterion by meeting most of the criterion requirements.
✓✓✓	Delivery model satisfies the evaluation criterion by meeting some of the criterion requirements.
✓✓	Delivery model is effective in satisfying few of the criterion requirements.
✓	Delivery model just satisfies the evaluation criterion by meeting minimum criterion requirements.
×	Delivery model is ineffective in meeting the criterion requirements.

9.2 Achieving the vision for SCUH – Providing excellent patient care

9.2.1 Evaluation criterion

The ability to deliver high quality patient care in accordance with relevant health care standards and that meets or exceeds relevant performance benchmarks; to provide a healing environment that is integrated with external services and that achieves high levels of wellness in the community; and to

provide health services that are accessible, responsive to demand and have the flexibility to grow and adapt to changes in the way healthcare services are delivered.

9.2.2 Evaluation summary

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓	✓✓✓✓✓

Overall, the Base Case was assessed as fully or almost fully satisfying the criterion for excellent patient care. The outsourcing of Soft FM Services and Corporate services would not detract from and could potentially enhance these outcomes. Outsourcing of Clinical Support Services was rated lower primarily because of concerns, expressed by SCHHS, about commercial incentives leading to over-servicing or compromising the objective of excellent patient care, as well as potential for an additional interface risk between Clinical Support Services and Clinical Services. While there were certain concerns in relation to the impact of the 'profit' motive of NGSPs, it was generally felt that NGSPs also provided excellent patient care.

9.2.3 Evaluation commentary

The Productivity Commission's review into *Public and Private Hospitals* (2009) assessed the extent to which public and private hospitals each achieve a range of quality and patient safety indicators.[16]

The Commission selected those indicators that best indicate whole-of-hospital performance (rather than disease or injury specific) and where published data is available for public and private hospitals, including:

- Accreditation
- Readmission and returns
- Adverse events
- Mortality ratios
- Obstetric outcomes.

In general, data on these quality indicators shows no statistically significant difference in quality outcomes between public and private hospitals.

However, in each case there are a range of factors that makes meaningful comparisons difficult, including:

- No adjustment to the statistics for hospital casemix (where particular diagnostic categories may have a higher risk of readmission) or patient risk characteristics (such as age, gender and co-morbidities)
- Voluntary reporting of data, which may lead to self-selection of data or under reporting

Other data deficiencies, for example admissions to another hospital would not be included in readmission rates.

- The complexity in measuring quality and patient safety is supported by the Melbourne Institute of Applied Economic and Social Research, who noted in their submission to the PC review that:

"...hospital quality is a multi-faceted concept that covers aspects such as effectiveness of treatment, timeliness of service delivery, quality of amenities, technological sophistication, incidences of in-

[16] Productivity Commission, Public and Private Hospitals - Research Report, http://www.pc.gov.au/projects/study/hospitals/report

hospital adverse events and so on. Constructing, comparing and synthesizing measures across different quality dimensions are a challenging task..."

9.2.3.1 Base Case / Enhanced Base Case

There are no reasons to believe that SCUH will not achieve an excellent standard of patient care consistent with that provided in other major tertiary teaching hospitals in Queensland. Nevertheless, there are significant challenges in transitioning to a major tertiary facility and these will need to be managed effectively if the objective of excellent patient care is to be fully achieved.

SCHHS expects the hospital will be able to provide the full range of services required under the HSP, including managing complex cases and achieving the planned level of flow reversals from Brisbane hospitals.

As a public hospital under the direction of SCHHS, SCUH is expected to:

- pursue and build on existing SCHHS initiatives to provide care in the most appropriate setting including acute care, preventative and primary healthcare and sub-acute and rehabilitation services.
- be responsive to demand and to ensure access on the basis of health need. It will give priority to access targets established under the Blueprint, including the National Emergency Access Target and the National Elective Surgery Target.

As the largest hospital in the HHS, SCUH will have a key role in delivering Purchasing Intentions and KPIs as set out in the Service Agreement between the Department of Health and SCHHS. In 2012-13, these Purchasing Intentions related to:

- Purchasing activity on the basis of health need
- Care in the most appropriate setting
- Chronic disease management / admissions avoidance
- Improved clinical and cost effectiveness
- Best practice models of care
- Ensuring patient safety
- Quality improvement payment

9.2.3.2 Soft FM Services

Soft FM Services can have an indirect bearing on the quality of patient care, particularly services such as cleaning, catering and portering which affect hospital hygiene, safety, aesthetic appearance and the overall patient experience.

The outsourcing of Soft FM Services is not expected to have an adverse effect on patient care and could have a positive impact. This is because the contractual framework, based on a detailed service specification, close monitoring of performance and payment abatements for service failures, should provide a strong incentive for high-quality services to be provided.

9.2.3.3 Corporate Support Services

Corporate Support Services have a limited and indirect bearing on the quality of patient care and there is no reason to expect that outsourced corporate services would materially enhance or detract from the standard of patient care offered at SCUH.

9.2.3.4 Clinical Support Services

The outsourcing of Clinical Support Services provides the opportunity to gain from established, specialised providers with 24 hour access, up-to-date technology and using skilled and experienced resources.

The contractual framework should establish clear quality standards and drive performance with rigorous performance monitoring and reporting, backed up by payment adjustments for poor performance. The quality and responsiveness of outsourced services should be more reliable than in-house services which are not subject to these contractual controls and financial incentives.

Clinical Support Services are assumed to comprise "transactional" or "processing" services and to exclude consulting services which remain part of the core clinical functions of the hospital. However, in practice, it may be difficult to fully separate the transactional component of the service since this also requires skills that may contribute the consulting functions.

The contractual incentives that lead to consistent standards of service and to responsive delivery may however, create a risk of over-servicing. Where the provider is separated from the multi-disciplinary team providing care to the patient, and is motivated by commercial considerations, there may be a tendency to provide unnecessary tests. This, in turn, could lead to a diversion of funds from patient care. These risks may be mitigated to the extent that the purchasing decision remains with the multi-skilled team working on the ward, integrating consulting capabilities associated with each clinical support service. In addition, it would be important to have an appropriate payment and KPI framework that discouraged the production of unnecessary tests. This potential concern is supported by the discussion on demand risk and the preference for a fee for service arrangement, as noted in Section 8 – Service Outsourcing. Therefore, a framework that provides an incentive for high efficiency and volumes (on the positive side), would also need to be carefully managed in relation to risks of over servicing (on the negative side).

Outsourcing means that the patient journey between Clinical Support Services and Clinical Services traverses organisational boundaries. In some circumstances, this could complicate the process of clinical hand-over and make it more difficult than if the process were managed between service providers located within the one public sector organisation. However, it is noted that these 'core clinical' functions are provided by Clinical Support Service providers under contracts observed as part of the precedent analysis and the market sounding and that this interface appears to be appropriately managed.

Outsourcing of services necessarily entails the removal of capabilities from the public sector and their replacement with private capabilities. However, given the close inter-dependence of Clinical Support Services and Clinical Services, including the provision of clinical support consulting capabilities within multi-disciplinary teams, there may be a need to duplicate in-house some of the capabilities that are purchased from the private providers. Unless foreseen at the outset, this could mean that some projected efficiency savings from outsourcing are not achieved in practice. Alternatively, an outsourcing model may be developed that mitigates some of these interface issues.

9.2.3.5 Full Outsourcing

The outsourcing of Operational Services provides the opportunity to gain from established, specialised providers who introduce new methods (models of care, work practices, etc) which achieve excellent patient outcomes and contribute to diversity and innovation across the public sector as a whole.

There are a number of examples locally, nationally and internationally of non-government providers successfully providing excellent care to public patients in a tertiary hospital environment. This includes providers such as Mater which successfully delivers clinical services to public patients under the Department of Health service agreement with standard purchasing requirements and KPIs, etc.

A key concern about the outsourcing of Operational Services relates to the willingness and ability of a provider motivated by commercial concerns, and constrained by a contract, to provide the specified services to the full range of patients who may present to the hospital. There is a risk that the private provider may tend to restrict access for certain complex cases that are relatively difficult and risky for the patients involved or more costly to provide.

This risk is more manageable in metropolitan areas where NGSPs have good opportunities to manage demand due to the ready availability of major tertiary public hospitals. There is a concern, therefore, about access to healthcare for certain complex cases in the Sunshine Coast if a private provider is not able to rely on nearby public hospitals to manage cases that it is not equipped to service. However, it is also noted that many of these concerns relate to the operation of a private hospital under the private hospital funding arrangement. As the consideration of options for this Business Case relates to NGSP delivery of public services, in line with the public funding framework, this is not a directly comparable issue.

There is also a risk that hospital managers and clinicians will be motivated by commercial drivers to the detriment of certain non-commercial objectives that may prevail in a public hospital context and that are conducive to good patient care. Of particular concern is the risk that interaction between clinicians will be impaired, reducing collaboration in the provision of clinical services. This concern was refuted by NGSPs in the market sounding, who felt that they provided exceptionally high quality of care and that while profit was a key driver, a successful business was based on the need to provide high quality services.

These risks would need to be managed through the development of carefully structured KPIs and payment arrangements and effective contract management.

9.3 Achieving the vision for SCUH – Developing new knowledge through research

9.3.1 Evaluation criterion

The ability to provide excellence in research and excellent care through collaboration and enquiry and to provide opportunities to integrate patient care with strong research capabilities.

9.3.2 Evaluation summary

The following table summarises the qualitative evaluation of each outsourcing option.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓

Overall, the Base Case, Soft FM Service, Corporate Support Service and Clinical Support Service outsourcing options were rated as achieving this criterion to a moderate degree, primarily because of the significant challenges to SCHHS establishing a viable research function. The Full Outsourcing option was assessed as having some potential advantages in terms of a commercial focus to research activities but, acknowledging that these services may be difficult to specify and remunerate appropriately, this option was assessed as slightly lower.

9.3.3 Evaluation commentary

9.3.3.1 Base Case / Enhanced Base Case

The establishment of the SCUH, and its close integration with the SARC, will require a substantial enhancement of the research capability within the SCHHS if it is to achieve the research vision for the new facility. Challenges include attracting appropriate Foundation Members to the SARC,

recruiting leading researchers, establishing linkages with universities and other research organisations and obtaining research funding from a range of government and private institutions. SCUH must build these capabilities in a highly competitive environment for research talent and funding. Consequently, the Base Case is expected to achieve this criterion to a moderate degree by satisfying some of the requirements.

9.3.3.2 Soft FM Services

Soft FM services, and the nature of their delivery, are not expected to have any material bearing on research outcomes at SCUH.

9.3.3.3 Corporate Support Services

Outsourcing of Soft FM Services and Corporate Support Services is not expected to have any material bearing on research outcomes at SCUH.

9.3.3.4 Clinical Support Services

The outsourcing of Clinical Support Services will only be pursued if it results in budget savings relative to in-house delivery. Assuming that at least some of these savings are retained as surpluses within SCHHS, they may potentially be directed to more discretionary areas such as research.

Where Clinical Support Services have a purely commercial and transactional focus, they are unlikely to contribute to research that is integrated with patient care. While research activities could be purchased from Clinical Support Service providers, if required, there is a concern that it may be difficult to adequately specify and remunerate these services. However, it should be noted that a number of positive observations were made from the market sounding, where the more sophisticated providers demonstrated a clear understanding of the need for and benefits of research. They furthermore provided details of reasonably significant research programs in relation to Clinical Support Services.

9.3.3.5 Full Outsourcing

The outsourcing of Operational Services will only be pursued if it results in budget savings relative to in-house delivery. Assuming that at least soe of these savings are retained as surpluses within SCHHS, they may potentially be directed to more discretionary areas such as research.

Some research activities, such as integrating patient care with research or ensuring cooperation with SARC, may be difficult to specify and remunerate appropriately in an outsourcing contract. These difficulties may mean that research does not fully achieve the vision for SCUH.

To the extent that research is a discretionary activity, dependent, for example, on clinician interests and capabilities and availability of surplus funds within divisional budgets, there is a risk in a constrained funding environment that a public operator will contribute more to research than a private operator. However, in the current and expected constrained funding public environment, this ability for discretionary investment will become an increasing challenge, without directly identifiable benefits arising.

In addition, and consistent with comments above, it should be noted that a number of positive observations were made from the market sounding, where the more sophisticated providers demonstrated a clear understanding of the need for and benefits of research. They furthermore provided details of reasonably significant research programs in relation to Clinical Services.

Competition for research funding is fierce and based on reputation and there is risk that a private operator would make the necessary long-term investment to be a successful player. While there are international examples of successful tertiary research institutions, especially in the US, these have generally grown organically over a very long period of time.

Managing these risks would require that the service specification, KPIs and payment arrangements are structured appropriately.

9.4 Achieving the vision for SCUH – Education and training

9.4.1 Evaluation criterion

The ability to fully integrate patient care with comprehensive and contemporary education and skills training capabilities for health professionals and vocational students.

9.4.2 Evaluation summary

The following table summarises the qualitative evaluation of each delivery option.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓

Overall, the Base Case was rated as satisfying this criterion, primarily because of the experience of SCHHS and its commitment to the vision for these services. The Soft FM Service and Corporate Support Service outsourcing options do not detract from these outcomes. The provision of education and training under the other outsourcing options may be more difficult to specify and remunerate appropriately and non-government providers may be less motivated by the education and training vision. While there was some concern in relation to the Clinical Support Service option, it was not considered material. However, the Full Outsourcing was rated slightly lower because Clinical Services have a more critical bearing on the achievement of education and training outcomes and the breadth of Educational and Training is more extensive than is commonly provided by NGSPs.

9.4.3 Evaluation commentary

9.4.3.1 Base Case / Enhanced Base Case

The SCHHS has a track record of being an excellent provider of education and training and expects the SCUH to be able to build effectively on this capability. There is a high level of commitment from the SCHHS executive and clinicians at NGH to achieving the vision for education and training at SCUH.

9.4.3.2 Soft FM Services

Soft FM Services, and the nature of their delivery, are not expected to have any material bearing on education and training outcomes at SCUH.

9.4.3.3 Corporate Support Services

Outsourcing of Corporate Support Services is not expected to have any material bearing on education and training outcomes at SCUH.

9.4.3.4 Clinical Support Services

Education and training activities require integration with Clinical Support Services to be delivered effectively, for example, in multi-disciplinary teams, lectures on clinical support topics, and exposure of students to patient care involving Clinical Support Services. There is a risk that the provision of Clinical Support Services by an external provider may diminish opportunities for education and training involving these services, depending on how these services are contracted.

Outsourcing of Clinical Support Services may also share some of the risks noted below in relation to Full Outsourcing, however, this was considered to be less material and therefore was not rated lower than the other options.

9.4.3.5 Full Outsourcing

Education and training is generally conducted in public hospitals because medical education has historically been considered, in part, a public good. In other words, the benefits are mainly captured by parties other than the direct providers of the education. While public hospitals are motivated to provide medical education because of the social benefits that it will ultimately bring, NGSPs need to justify the provision of education and training in commercial terms and to ensure that the cost is adequately compensated through the contract with the State. This means that NGSPs are more likely to deliver the minimum required education and training services and, as a result, may be less likely to achieve the educational vision for SCUH than a public provider.

The fact that education and training is generally conducted by the public sector means that NGSPs are generally less experienced at providing these services. It also means that students and educators may perceive a NGSP as offering a less attractive opportunity until the NGSP can establish the hospital's reputation for a providing a strong medical education.

It should be noted however, that many of these concerns were refuted during the market sounding exercise. Many NGSPs clearly acknowledged the need for and benefits of education and training. This included a clear recognition that this was required for the recruitment and retention of their workforce, the development of capabilities to deliver the required services, the appetite of clinicians to be involved in education and the financial benefits of education focused on more efficient work practices (without the compromise of required quality of care). In some instances, the size of the education program of the NGSPs was substantial.

There is a risk that education and training services may not be contracted successfully if it proves difficult to specify the services appropriately or to create the correct financial incentives. These difficulties arise in part because of the split responsibilities for medical education and training between medical schools and government health providers and the lack of data about the effort applied by the latter to delivering medical education.

9.5 Impact on other Health Service operations

9.5.1 Evaluation criterion

The impact that the delivery model will have on the delivery of accessible and high quality patient care at other locations.

9.5.2 Evaluation summary

The following table summarises the qualitative evaluation of each delivery option.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓✓✓✓	✓✓✓✓✓	✓✓✓✓	✓✓✓✓✓	✓✓✓

The Soft FM Service outsourcing options was rated strongest on this criterion because it supplement the integration benefits achieved under the Base Case with the potential to extend NGSP models to other facilities by example or actual rationalisation of services. Corporate Support Services was seen to have a number of positives in relation to managing ICT issues and creating a more positive operational environment. However, it was also noted that many of these services have significant HHS-wide and state-wide interface and that this would need to be carefully managed. The Full Outsourcing option was rated lowest primarily because of the material impact on the HHS that this option would require, in addition to the need to manage the inter-relationships with NGH and the metro hospitals in Brisbane.

9.5.3 Evaluation commentary

9.5.3.1 Base Case / Enhanced Base Case

As a public hospital under the direction of SCHHS, SCUH is expected to integrate effectively with other public hospitals in the HHS facilitating all necessary transfers of staff, patients, patient information, etc between facilities to achieve optimal health outcomes.

9.5.3.2 Soft FM Services

The introduction of NGSP work methods and practices at SCUH may create useful models which may be extended to other facilities within SCHHS. This could occur through benchmarking and internal management reforms, outsourcing or some expansion and centralisation of the services provided from SCUH.

9.5.3.3 Corporate Support Services

As with Option 1, the outsourcing of Corporate Support Services may create the potential to extend NGSP practices at SCUH to other hospitals, possibly rationalising these other services through expansion of the outsourcing model.

Depending on the way corporate services are outsourced, there is a risk of a lack of integration of some ICT business solutions across the HHS.

However, it was also noted that many of these services have significant HHS-wide and state-wide interface and that this would need to be carefully managed.

9.5.3.4 Clinical Support Services

As with Options 1 and 2, the outsourcing of Clinical Support Services may create the potential to extend NGSP practices at SCUH to other hospitals, possibly rationalising these other services through expansion of the outsourcing model.

If outsourcing of Clinical Support Services is not extended to other hospitals, there is a risk of lack of integration of some services across the HHS, restricting movement of staff and possibly requiring duplication of some resources. However, we understand that this level of interface is comparatively limited and this was therefore not considered a material differentiator.

9.5.3.5 Full Outsourcing

Under NGSP operation, SCUH may integrate less effectively with other public hospitals in the HHS (in particular NGH) due to separate management systems, contractualised relationships with other providers, etc. This may impair the flow of staff, patients and patient information between facilities and achievement of optimal health outcomes.

There is a risk that the NGSP subject to contracted service volumes and motivated by commercial interests will manage demand more rigorously than a public provider, restricting access when contracted volumes are likely to be exceeded. In addition, a non-government provider may restrict access to certain relatively complex cases because they are difficult or costly to treat. If this was to occur, it may have an impact on both NGH and other metro facilities.

Furthermore, given the significant scale of SCUH as a proportion of SCHHS, this would have a material impact on operations and require significant organisational change.

9.6 Recruitment, retention and workforce management

9.6.1 Evaluation criterion

The ability to manage the significant challenges associated with attracting, retaining, transferring and managing sufficient, quality staff in time to support the progressive commissioning and expansion of the SCUH and to cope with future requirements for health care professionals and other skilled staff.

9.6.2 Evaluation summary

The following table summarises the qualitative evaluation of each delivery option.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓

Overall, the Soft FM Services, Corporate Support Services and Clinical Support outsourcing options were rated strongly because of the experience and capability of NGSP to recruit and manage the relevant specialist workforces. While the Base Case and Full Outsourcing options confront similar challenges, the latter was rated more strongly because it provides the opportunity to access non-government industrial arrangements to more effectively manage the workforce issues. While it is noted that many existing constraints within the public sector industrial environment are being addressed, this will nonetheless require significant cultural change in order to harness these benefits.

9.6.3 Evaluation commentary

9.6.3.1 Base Case / Enhanced Base Case

As a major new facility in an attractive location, SCUH is receiving strong interest from a number of high quality recruits. It is likely that, once established, SCUH will continue to provide an excellent environment to recruit and retain health professionals.

SCHHS faces a significant challenge in recruiting the required number of the skilled professionals in a constrained timeframe. It is estimated that around 2,500 new staff will be required upon initial opening of the facility in 2016. SCHHS will need to devote considerable management resources to the recruitment task, including on-boarding processes and early employment and accommodation of staff. While these risks are not a feature of public sector delivery, per se, they are nevertheless major risks that will need to be managed effectively by SCHHS under this option.

Furthermore, during the operational phase, SCHHS will face significant workforce management issues in order to meet the service requirements in an efficient manner. As noted above, while many existing constraints within the public sector industrial environment are being addressed, this will nonetheless require significant cultural change in order to harness these benefits.

9.6.3.2 Soft FM Services

The NGSP would recruit and manage the Soft FM workforce, relieving SCHHS of these tasks. This would be of particular benefit during the onerous ramp-up phase for SCUH. Private providers have the experience, systems and nationwide resources to manage these workforce issues more effectively than SCHHS for the specialised staff required. Furthermore, the NGSP industrial environment is seen as positive in terms of long-term workforce management.

9.6.3.3 Corporate Support Services

As with Soft FM Services, the specialised NGSP(s) would manage workforce issues effectively and would relieve SCHHS of these tasks. Furthermore, the NGSP industrial environment is seen as positive in terms of long-term workforce management.

9.6.3.4 Clinical Support Services

As with other outsourcing options, the specialised NGSP(s) would manage workforce issues effectively and would relieve SCHHS of these tasks. Furthermore, the NGSP industrial environment is seen as positive in terms of long-term workforce management.

9.6.3.5 Full Outsourcing

Advice from the market sounding is that NGSPs should be able to manage the substantial recruitment and mobilisation task associated with the opening of SCUH. Consequently, SCHHS has the benefit of being relieved of a significant operational risk which should be able to be managed effectively by the non-government sector.

The NGSP will expect to be fully compensated for the costs and risks associated with the recruitment of staff and ongoing workforce management. In order to make a like for like comparison between options, this analysis assumes that all options, including the Base Case, involve adequate transitional funding to support the recruitment process and other lead-up activities to opening SCUH.

Furthermore, the NGSP industrial environment is seen as significant positive in terms of long-term workforce management.

9.7 Industrial relations implications

9.7.1 Evaluation criterion

The extent to which industrial relations implications can be minimised and managed under the delivery model.

9.7.2 Evaluation summary

The following table summarises the qualitative evaluation of each delivery option.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓	✓✓

The options were assessed in line with the increasing expectation of negative industrial response as the level of outsourcing occurs. This is particularly the case for Clinical Support Services and Clinical Services.

9.7.3 Evaluation commentary

9.7.3.1 Base Case / Enhanced Base Case

As this option involves no material outsourcing it is considered positive in relation to this criterion.

9.7.3.2 Soft FM Services

This option involves more significant outsourcing and is therefore considered to have a greater potential for negative industrial reaction.

9.7.3.3 Corporate Support Services

Similar to Option 2, this option involves more significant outsourcing and is therefore considered to have a greater potential for negative industrial reaction.

9.7.3.4 Clinical Support Services

Similar to Options 2 and 3, this option involves more significant outsourcing and is therefore considered to have a greater potential for negative industrial reaction. Given the nature of these services this is considered more likely than for Options 2 and 3.

9.7.3.5 Full Outsourcing

Similar to Options 2, 3 and 4, this option involves more significant outsourcing and is therefore considered to have a greater potential for negative industrial reaction. Given the nature and scale of these services this is considered as a material risk and thus has been rated lower than the other options.

9.8 Provider capability and capacity

9.8.1 Evaluation criterion

The capability and capacity of service provider(s) to deliver the required services under the delivery model.

9.8.2 Evaluation summary

The following table summarises the qualitative evaluation of each delivery option.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓

Overall, there is strong market capability to deliver Soft FM Services and the main Clinical Support Services. In the case of Full Outsourcing, there is demonstrated experience to provide comparable services in a private hospital environment but the capability and demonstrated track record of some of the potentially interested providers does not include the provision of tertiary services and none have experience of tertiary services in a regional setting. There is likely to be significant market capability to provide Corporate Support Services, although it has not been possible to investigate this adequately through the market sounding process.

9.8.3 Evaluation commentary

9.8.3.1 Base Case / Enhanced Base Case

SCHSS expect to have the capability and capacity to successfully ramp-up and operate SCUH as a major tertiary teaching hospital. There are some significant challenges in terms of the need for a capability change to the level of tertiary service and the provision of the extensive research and education requirements. Nevertheless, there is obviously strong capability with the Queensland public health system to deliver the required services at SCUH.

9.8.3.2 Soft FM Services

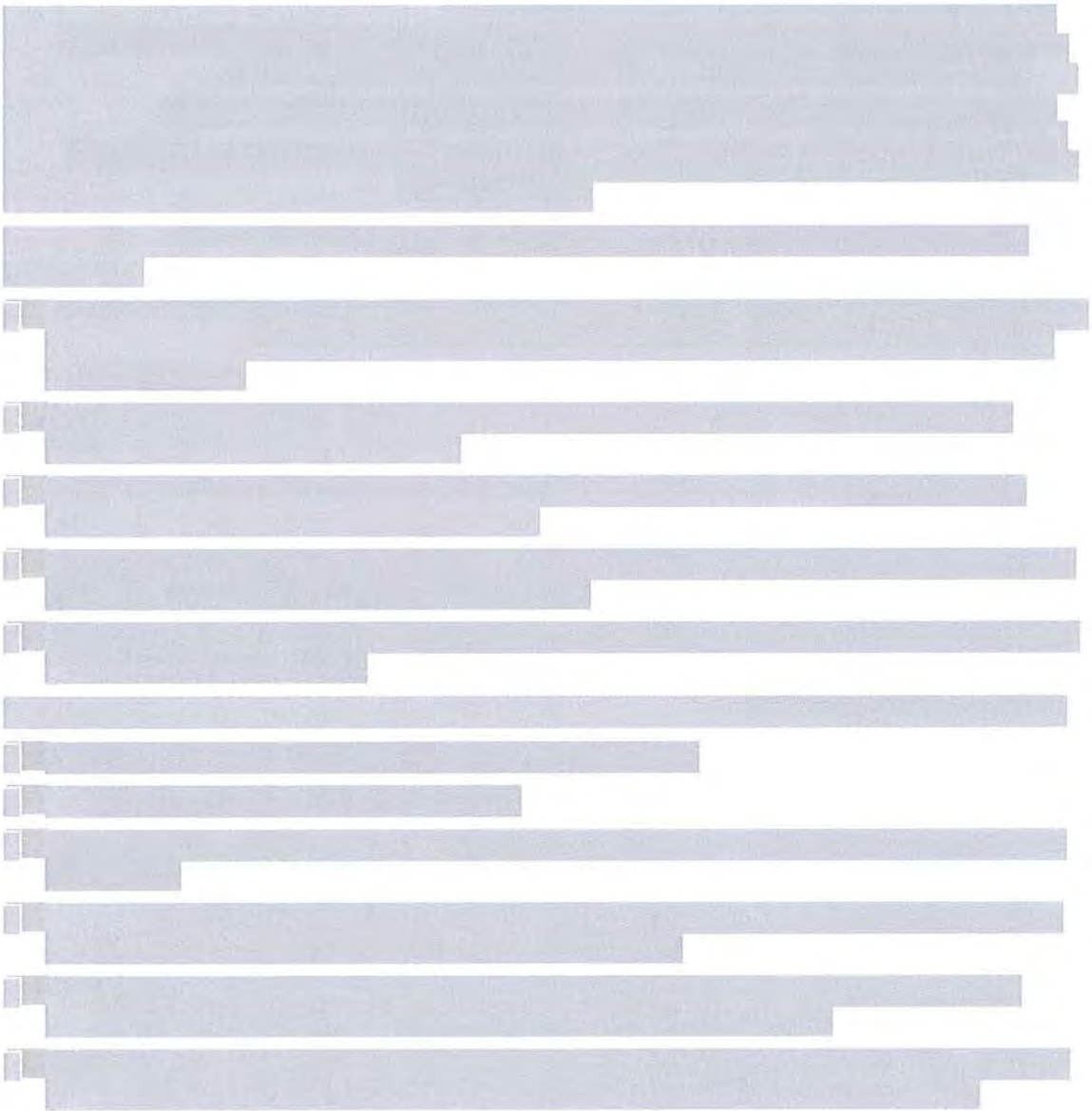
[redacted]

9.8.3.3 Corporate Support Services

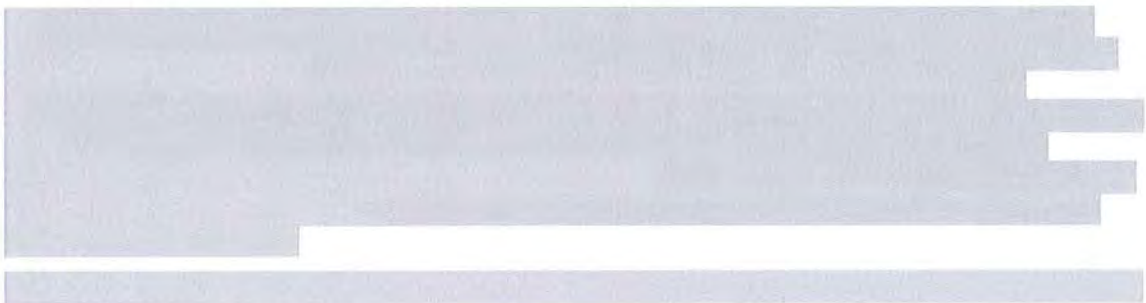
It is expected that significant market capability would be present to provide Corporate Support Services, however, this has not been fully tested as part of this Business Case. It is expected

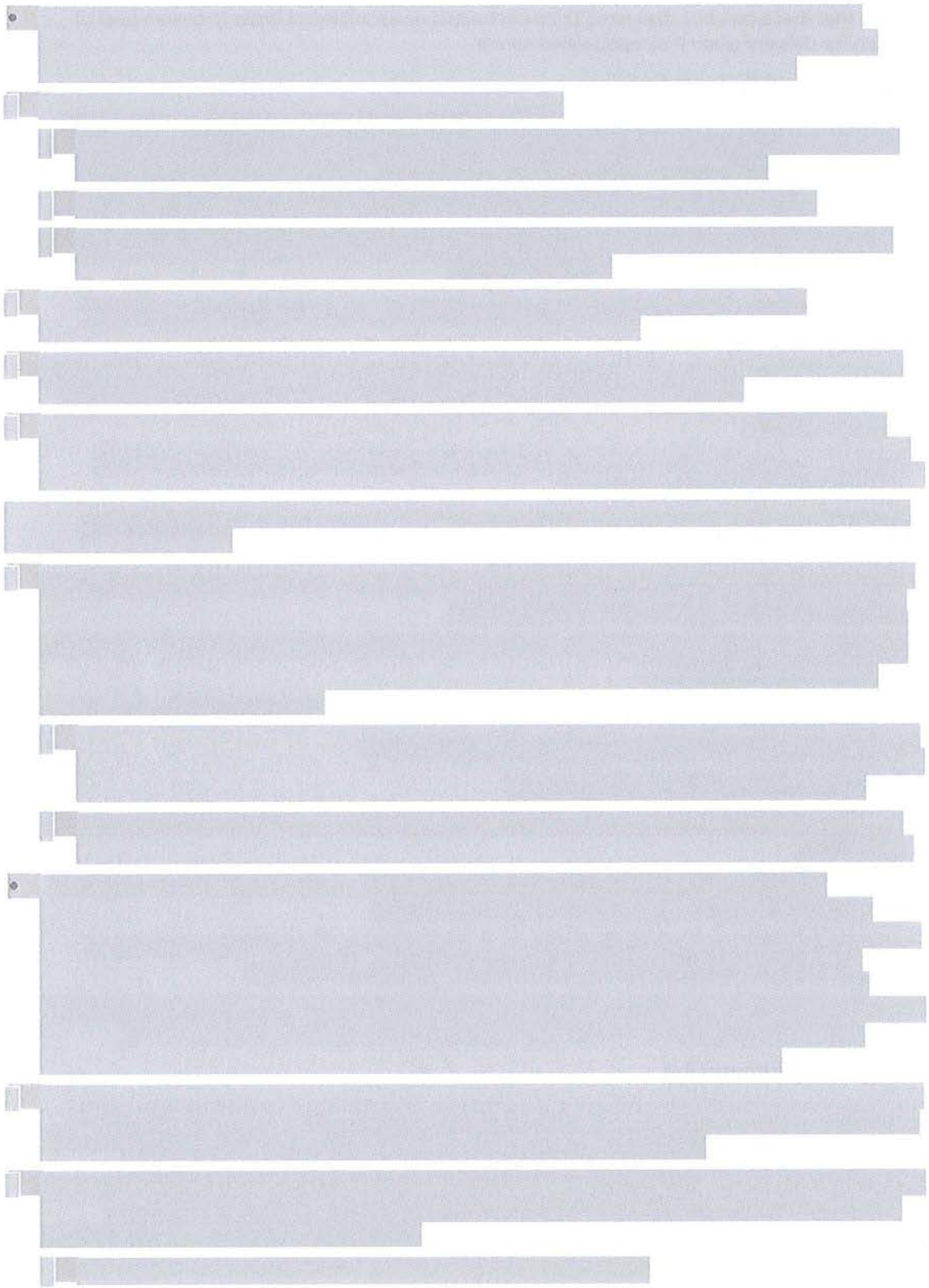
however, that these services may need to be contracted on an individual basis to ensure best of breed service delivery given their specialised nature.

9.8.3.4 Clinical Support Services



9.8.3.5 Full Outsourcing





9.9 Provider appetite

9.9.1 Evaluation criterion

The ability to attract sufficient willing service providers to ensure that there is genuine competition to provide the services.

9.9.2 Evaluation summary

The following table summarises the qualitative evaluation of each delivery option.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓	✓✓✓✓✓	✓✓✓

Overall, there is strong market interest to provide any or all of the services. However, the risks and complexities of Full Outsourcing make it more difficult to get a clear view on the likely market response in that case.

n current indications, there should be sufficient capability and appetite to enable a viable and competitive tender process.

9.9.3 Evaluation commentary

9.9.3.1 Base Case / Enhanced Base Case

SCHHS has a strong appetite to operate SCUH as a public health service.

9.9.3.2 Soft FM Services

9.9.3.3 Corporate Support Services

It is expected that significant market appetite would be present to provide Corporate Support Services, however, this has not been fully tested as part of this Business Case.

9.9.3.4 Clinical Support Services

9.9.3.5 Full Outsourcing

[redacted]

9.10 Cost efficiency and budget certainty

9.10.1 Evaluation criterion

The extent to which the model facilitates the potential for cost optimisation and certainty through competitive tension, governance arrangements and contractual provisions.

9.10.2 Evaluation summary

The following table summarises the qualitative evaluation of each delivery option.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓✓	✓✓✓✓	✓✓✓	✓✓✓✓	✓✓✓✓

[redacted]

9.10.3 Evaluation commentary

The Productivity Commission's review into *Public and Private Hospitals* also assessed the relative costs of the public and private health sectors.

The report finds comparable efficiency levels across the sectors at a national level, based on the Commission's experimental estimates of cost per casemix-adjusted separation in 2007-08. There were differences found between jurisdictions and in the composition of costs, for example:

- medical and diagnostics costs and prostheses costs were higher in private hospitals
- capital costs were estimated to be somewhat higher in public hospitals (noting that this result was reliant on a range of data sources and adjustments to make the data more comparable)

- the combined cost of nursing and other salaries, allied health, operating rooms and specialist suites, critical care, hotel costs, supplies, and on-costs were on average higher for public hospitals.

The Commission's findings were made subject to significant qualification, due to adjustments made to address inconsistent and/or incomplete data, and differences between hospitals in the types of patients treated and services provided.

To these must be added the fact that this VFM study is concerned with non-government provision of public health services, not typical private health services.

9.10.3.1 Base Case / Enhanced Base Case

9.10.3.2 Soft FM Services

Soft FM Services would be outsourced on the basis of fixed prices subject to indexation (e.g. to CPI) and some volume adjustments (e.g. for patient meals). Consequently, the contract would deliver reasonable budget certainty over a period of around 5 to 7 years when the contract would be subject to market testing and relet for a further 5-year period. Assuming the initial contract had not been significantly under-priced, there should be reasonable stability in contract costs in real terms over the long-term.

9.10.3.3 Corporate Support Services

The cost effectiveness of outsourcing Corporate Support Services is uncertain and would probably need to be tested in the market to determine whether material savings may be achieved. As with Soft FM Services, these services would be contracted on a fixed price basis, with indexation, over a term of around 5 years.

9.10.3.4 Clinical Support Services

Outsourcing of Clinical Support Services would generally be on a fee for service basis and consequently demand risk would remain with the government. However, prices would be fixed for the term of the contract, subject to indexation and any other pre-agreed adjustment factors, and consequently there would be a high degree of certainty about unit costs.

9.10.3.5 Full Outsourcing

The cost of NGSP delivery of services at SCUH cannot be estimated at this stage with the precision necessary to make reliable assessments of VFM relative to government service provision. While the various precedents for NGSP delivery of public health services point to potential cost savings relative to government delivery, the diverse service mix, scale, contractual arrangements and other features of these precedents prevents any meaningful statements about costs that might be relevant to the specific circumstances of SCUH. Consequently, the cost of NGSP delivery has been estimated with regard to the funded efficient level on the assumption that the State would be unlikely to contract at a price above this level.

9.11 Level of risk transfer

9.11.1 Evaluation criterion

The extent to which the model facilitates the transfer of risk from Government to a suitable counter-party.

9.11.2 Evaluation summary

The following table summarises the qualitative evaluation of each delivery option.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓	✓✓✓	✓✓	✓✓✓✓	✓✓✓✓✓

Overall, the outsourcing options should achieve a high level of risk transfer (although probably not to the same degree for Corporate Support Services). The highest level of risk transfer would be achieved under Full Outsourcing because of the scope of services provided, the ability to transfer a level of annual demand risk and the single point responsibility provided by the NGSP for all hospital services and risks.

9.11.3 Evaluation commentary

9.11.3.1 Base Case / Enhanced Base Case

Under the Base Case, substantially all the risks of operating SCUH would be retained by the State, other than the Hard FM Service risks that have already been transferred to Exemplar and some risks that would be transferred routinely under the various minor contracts for goods and services that would ordinarily be entered into by a public hospital.

9.11.3.2 Soft FM Services

9.11.3.3 Corporate Support Services

The scope of risk transfer for outsourced Corporate Support Services is expected to be broadly consistent with that outlined above in relation to Soft FM Services. However, the level of risk transfer may be lower in practice because of the relatively smaller size of the providers, the limited securities that would be provided and the use of a less rigorous contracting structure. The main point of interface that would need to be managed would concern the existing SCHHS executive functions.

9.11.3.4 Clinical Support Services

Outsourcing of Clinical Support Services is expected to achieve a high level of risk transfer. In addition, there is the likelihood that the State would be able to transfer responsibility for maintenance of specialised medical equipment associated with these support services, including potentially the transfer of supply and replacement risks.

It is likely that the greatest value for money would be achieved by selecting the best providers of each type of Clinical Support Service rather than seeking to bundle these services with a single provider. However, this would entail management of a number of contracts with multiple points of interface with Clinical Services.

It is likely that some level of demand risk will be able to be transferred but much of this will need to be managed by SCHHS via its contract and service request methodologies.

9.11.3.5 Full Outsourcing

Full Outsourcing is expected to permit a high level of risk transfer while still achieving budget savings. Significant transferred risks include operating cost risk, performance risk, industrial relations risk, and compliance with laws and standards. In addition, SCHHS should be able to transfer a degree of demand risk through annual purchasing agreements and, in so doing, give effect (in relation to SCUH) to SCHHS' activity commitments to the Department of Health under the annual Service Agreement.

Full outsourcing creates a single point of responsibility for Operational Services and Support Services and means that all internal and external interfaces (including sub-contracts) are managed by the NGSP. If the PPP contract is assigned or delegated to the NGSP, this single point of responsibility would comprise all hospital services, including Hard FM services.

However, given the mixed track record of previous outsourcing, it is noted that the risk and impact of default is potentially material and that a number of risks are retained by Government regardless of the contractual structure.

9.12 Impact on existing contracts

9.12.1 Evaluation criterion

The impact of the delivery model on the current contractual arrangements.

9.12.2 Evaluation summary

The following table summarises the qualitative evaluation of each delivery.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓

Overall, there are limited impacts on existing contractual arrangements that should prevent outsourcing options.

9.12.3 Evaluation commentary

9.12.3.1 Base Case / Enhanced Base Case

By definition, the Base Case maintains and does not have any adverse impact on the existing contracts that SCHHS has with each of Ramsay, Exemplar, SARC and the various outsourcing arrangements currently established by NGH.

9.12.3.2 Soft FM Services

[redacted]

9.12.3.3 Corporate Support Services

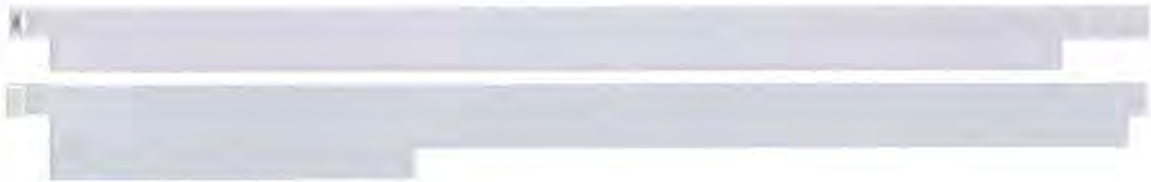
The inclusion of Corporate Support Services in the outsourced services is not expected to have any material contractual impact on existing SCHHS contracts.

9.12.3.4 Clinical Support Services

[redacted]

9.12.3.5 Full Outsourcing

[redacted]



9.13 Commercial flexibility

9.13.1 Evaluation criterion

The ability to adjust the quantity, quality and type of services over time to be consistent with available funding and purchasing objectives.

9.13.2 Evaluation summary

The following table summarises the qualitative evaluation of each delivery option.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓✓✓✓	✓✓✓	✓✓✓	✓✓	✓✓

Overall, government delivery is likely to allow the greatest flexibility although the purchaser-provider framework introduces some rigidities of a contractual approach. Furthermore a NGSP may have some benefits of being able to utilise any available physical capacity for private beds. Adequate flexibility is therefore likely to be achieved under the outsourcing options if the contract is structured appropriately. Nevertheless, where major change is required, a formal process would need to be followed including negotiations and appropriate compensation to the provider.

9.13.3 Evaluation commentary

9.13.3.1 Base Case / Enhanced Base Case

Recent reforms including the Service Agreement with the Department of Health, the creation of independent Boards and the introduction of ABF purchasing arrangements together introduce a degree of rigidity in terms of the quantity, quality and type of services that are provided by SCHHS on an annual basis. Nevertheless, SCHHS remains a government instrumentality operating within an administrative rather than contractual framework and there is inherently a potential for a high level of flexibility to respond to government requirements.

9.13.3.2 Soft FM Services

Soft FM Services can respond effectively to this criterion because they are procured under an output specification which imposes an inherent flexibility on the contractor and the specification is now fairly sophisticated in the Australian market and workable in a health context. In addition, Soft FM Services are, by their nature, relatively stable so that periodic fluctuations in hospital activity are able to be accommodated without complex adjustment mechanisms or variations (although there are some volume-based adjustments, eg for patient meals). Soft FM Services would be contracted with five yearly review periods and any significant adjustments to the scope of services could be made at that point or otherwise by contract variation.

9.13.3.3 Corporate Support Services

Corporate Support Service contracts are likely to share many of the attributes of Soft FM Services outlined above in terms of output specifications, relative stability of services and short-term contracts.

9.13.3.4 Clinical Support Services

Clinical Support Service contracts are likely to be established on a fee for service basis which inherently permits flexibility in the mix of services that are provided, including a wide range of discrete, relatively routine services. Nevertheless, providers are likely to seek a reasonable level of stability in the volumes of services that they provide and require additional compensation for variations outside agreed ranges. These contracts would generally be on a short-term (eg. five year basis) and significant changes in the type of services may be made at that point or otherwise by contract variation. The contract should provide a clear pathway and obligations on the parties to facilitate variations.

9.13.3.5 Full Outsourcing

A Full Outsourcing contract would be established on an output basis and at a level that requires the NGSP to display a high degree of flexibility in meeting the health needs that present to the hospital. In addition, as discussed in Section 8, SCHHS would want to ensure that, as far as possible, its obligations to the Department of Health under the Service Agreement are effectively passed through to the NGSP under the Full Outsourcing contract. This would require that kinds of flexibilities that are expected in the Service Agreement are reflected in the Full Outsourcing contract (and it would mean that the NGSP would price its services accordingly).

Furthermore a NGSP may have some benefits of being able to utilise any available physical capacity for private beds.

Nevertheless, once these arrangements are contracted, the NGSP would expect them to be maintained and any changes to the contract terms would require that the parties enter into a formal contract variation process or other formal adjustment process set out in the contract. The contract should provide a clear pathway and obligations on the parties to facilitate any required contract variations. In areas where changes are likely to occur, such as volume adjustments outside the agreed annual activity range, the contract should establish a routine process and clear parameters for negotiating required changes.

9.14 Other legal/regulatory issues

9.14.1 Evaluation criterion

The potential legal/regulatory issues and complexities associated with implementation of the delivery model.

9.14.2 Evaluation summary

The following table summarises the qualitative evaluation of each delivery option.

Option	Base Case	Soft FM	Corporate Support	Clinical Support	Full Outsourcing
Rating	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓	✓✓✓

Overall, there does not appear to be any significant regulatory impediment to the outsourcing of Soft FM Services, Corporate Support Services or Clinical Support Services.

9.14.3 Evaluation commentary

9.14.3.1 Base Case / Enhanced Base Case

Government service delivery arrangements already operate in the current regulatory environment and therefore are not adversely impacted in relation to this criterion.

9.14.3.2 Soft FM Services

There are not expected to be any regulatory issues that would impede or materially impact outsourcing of Soft FM services.

9.14.3.3 Corporate Support Services

There are not expected to be any regulatory issues that would impede or materially impact outsourcing of Soft FM services.

9.14.3.4 Clinical Support Services

SCHHS is subject to a health service directive that requires it to enter into an agreement with the Health and Services Support Agency in relation to the purchase of certain state-wide services, namely diagnostic pathology services, biomedical technology and related specialists services and central pharmacy. The Department of Health would need to amend and reissue this directive, or issue a new directive, if it were to permit SCHHS to enter into an outsourcing contract for any of these services. However, we understand that there will not be any material impediments to achieving this for the majority of services.

Each of the potential providers consulted as part of the market sounding is well aware of the accreditation requirements applicable to their services.

9.14.3.5 Full Outsourcing

Private hospital licensing requirements under the *Private Health Facilities Act 1999* (Qld) would potentially apply to SCUH on the basis that it would be operated by a NGSP. If so, the contractor would need to obtain a licence and comply with the requirements of that Act. Alternatively, the State could amend the Act to make it clear that a facility operated on behalf of the State in these circumstances would not be a private hospital.

A NGSP may require the ability to operate a separate area within SCUH as a private hospital in order to treat privately-insured patients and be eligible to receive all revenues applicable to a private hospital. A "private hospital" declaration would be required under the *Private Health Insurance Act 2007* (Cth) in respect of the relevant area for the purposes of private health insurance benefits, the MBS and PBS.

As part of the analysis for this Business Case, formal advice was received from the Private Health Regulation group that, but for some comparatively minor capital amendments that may be required, there would not be material reason that these requirements could not be met.

9.15 Conclusion on qualitative VFM

9.15.1 Summary of advantages and disadvantages of outsourcing options

The following table summarises some of the main advantages and disadvantages in respect of each outsourcing option and assesses the overall suitability for outsourcing of each option, either as a separate contract or bundled with other services.

	Advantages	Disadvantages	Suitability for Outsourcing
Soft FM Services	• Demonstrated potential for savings • Strong market capability and interest • Relatively easy to implement	• Minimal	*Separate*: Medium / High *Bundled*: **High** -
Corporate Support Services	• Potential for VFM, including potential for innovation, esp. in ICT	• Outsourcing at SCUH could adversely affect residual SCHHS corporate services and executive functions (diseconomies, loss of integration, loss of control) • Potential lack of integration of ICT systems across SCHHS • May need to be linked to wider Queensland Health reform • Contractual issues such as potential for variations, contractor default, etc	*Separate*: **Medium** – but market could be tested for discrete services *Bundled*: **Low** – limited single provider capability, except within a Full Outsourcing option
Clinical Support Services	• Potential for VFM, including potential for innovation, esp. in ICT • Strong market capability and interest • Transfer of operational risks	• Interface risk with multiple providers • Potential for over-servicing • Contractual issues such as potential for variations, contractor default, etc •	*Separate*: **Medium / High** – market should be tested for discrete services *Bundled*: **Low** – limited single provider capability, except within a Full Outsourcing option
Full Outsourcing	• Opportunity to benefit from innovative models of care, new work practices, systems and technologies • Examples of NGSP capability in (metropolitan) tertiary private and public hospitals • Potential for prices below National Efficient Price and capital savings • High operational risk transfer including workforce management and SCUH mobilisation	• Limited demonstrated track record of required breadth of education and research or delivery of complex services in a regional setting • • Difficulty of adequately specifying and incentivising education and research •	Medium

	Advantages	Disadvantages	Suitability for Outsourcing
	• Contractually committed standards of performance and levels of activity	• Difficulty of ensuring integration with other health services	

The qualitative evaluation has considered each of the outsourcing options against the evaluation criteria detailed in Chapter 6. Based on this analysis, it would appear that, although there are a range of issues and constraints for each, there is a prima facie potential to outsource any or all of the services at SCUH.

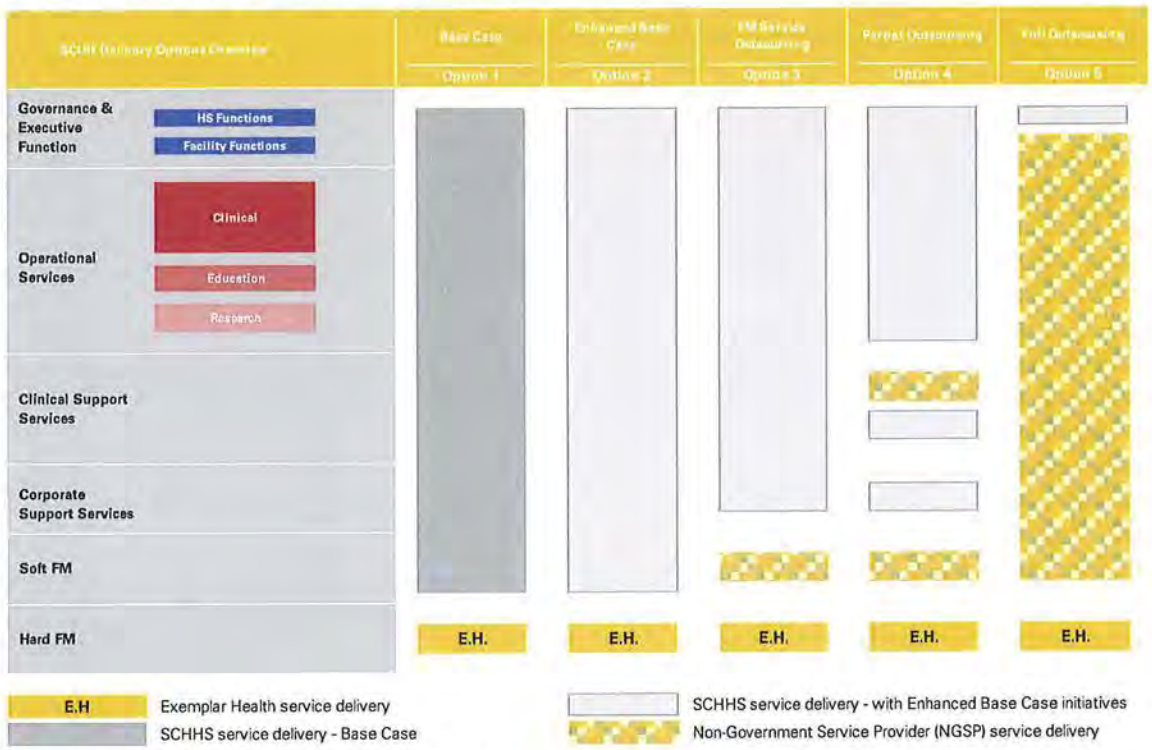
9.15.2 Delivery Options

On the basis that there is the potential to outsource any or all services, a range of Delivery Options have been developed, reflecting an increasing level of NGSP delivery of services, including:

- Base Case – a reflection of the current expected service delivery of SCUH by SCHHS
- Enhanced Base Case – reflecting SCHHS delivery with a range of efficiency reform initiatives being implemented
- Soft FM Services only –
- Partial Outsourcing – reflecting the Soft FM Services amendment (as above), as well as the potential outsourcing of selected Clinical Support Services, with SCHHS delivery of the remaining services (but incorporating the Enhanced Base Case initiatives for non-outsourced services)
- Full Outsourcing – reflecting the potential outsourcing of all Operational Services

This report recommends that the Government consider the merits of these outsourcing Delivery Options relative to conventional Delivery Options comprising the Base Case or Enhanced Base Case.

A diagrammatic representation of these options is as below:



Based on the above evaluation, all options for service outsourcing are considered to provide the potential for a VFM outcome, but with varying degrees of opportunity and potential risk. However, it is considered that the Delivery Options likely to provide the greatest potential VFM are the Partial Outsourcing and the Full Outsourcing options.

Full Outsourcing option is considered to have the potential to deliver the best financial, workforce management and risk transfer outcomes (once established), while noting that it bears significant risks including absence of demonstrated track record for services of the scale, breadth and complexity [redacted] that may impact on the ability to achieve a competitive outcome.

Partial Outsourcing option would also provide a VFM outcome with reduced potential benefits in relation to financial outcomes, workforce and risk transfer, but with a number of the significant potential risks of Full Outsourcing being avoided or substantially mitigated. It also combines the benefits of the opportunity for the implementation of the Enhanced Base Care efficiency reforms by SCHHS.

[redacted]

10 Quantitative VFM evaluation

The content of Section 10 has been redacted from this document.

11 Implementation strategy

The content of Section 11 has been redacted from this document.

12 Glossary

Acronyms	Description
ABF	Activity Based Funding
AHC	Australian Hospital Care
aIM tool	Acute Inpatient Modelling tool
BAFO	Best and Final Offer
BTS	Biomedical Technology Services
CCU	Critical Care Unit
Corrs	Corrs Chambers Westgarth
CSCF	Clinical Services Capability Framework
CSSU	Clinical Sterilised Supplies Unit
CT	Computed Tomography
CY	Calendar Year
DVA	Department of Veterans' Affairs
EBA	Enterprise Bargaining Agreement
ED	Emergency Department
EOI	Expression of Interest
ESD	Ecologically Sustainable Development
FBC	Final Business Case
FM	Facilities Management
FTE	Full-time Equivalent
FW Act	Fair Work Act 2009 (Cth)
FY	Financial Year
HCoA	Health Care of Australia
HHB Act	Hospital and Health Boards Act 2011 (Qld)
HHS	Hospital and Health Service
HIA	Health Insurance Act 1973(Cth)
HIP	Health Improvement Program
HSP	Health Services Plan
ICT	Information Communication Technology
ICU	Intensive Care Unit
IHPA	Independent Hospital Pricing Authority
JVA	Joint Venture Agreement
KHIP	Kawana Health Innovation Park
KPI	Key Performance Indicator
LOS	Length of Stay
MBS	Medicare Benefits Schedule
MES	Managed Equipment Service
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
MSA	Managed Services Agreement
NEP	National Efficient Price
NGH	Nambour General Hospital

Acronyms	Description
NGSP	Non-government service provider
NHRA	National Health Reform Agreement
NHS	National Health Service
NPV	Net Present Value
NSW	New South Wales
OH&S	Occupational Health and Safety
PBC	Preliminary Business Case
PBS	Pharmaceutical Benefits Scheme
PC	Practical Completion
PET	Positron Emission Tomography
PHF Act	Private Health Facilities Act 1999 (Qld)
PPP	Public Private Partnership
Q&A	Question and answer
QH	Queensland Health
Qld	Queensland
QWAU	Queensland Weighted Activity Unit
RFBB	Request for Binding Bid
RoPP	Rights of Private Practice
SA	South Australia
SARC	Skills Academic and Research Centre
SCHHS	Sunshine Coast Hospital and Health Service
SCUH	Sunshine Coast University Hospital
SCUPH	Sunshine Coast University Private Hospital
SEQ	South-East Queensland
SJOGH	St John of God Health Care
SPECT	Single Photon Emission Computed Tomography
The Blueprint	Blueprint for better healthcare in Queensland
Transfer of Business Act	Fair Work Amendment (Transfer of Business) Act 2012(Cth)
Treasury	Queensland Department of Treasury and Trade
UK	United Kingdom
UQ	University of Queensland
USC	University of Sunshine Coast
VFM Business case	Value for Money Business Case
VIC	Victoria
WA	Western Australia
WAU	Weighted Activity Units

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GCUH Private Service Options: Clinical and Functional Analysis

Gold Coast Hospital and Health Service

December 2012

Final Version 1.0

pwc

Table of Contents

Section 1

Executive summary

Introduction

Significant changes have occurred across the Queensland public healthcare system including the establishment of 17 statutory bodies (Hospital and Health Services) with the responsibility to efficiently, effectively and economically deliver hospital and other health services. This, together with significant capital development such as the Gold Coast University Hospital (GCUH), provides the Gold Coast Hospital and Health Service (GCHHS) with the opportunity to explore alternate health service delivery models to best ensure quality and safe healthcare delivery that represents value for money and meets the healthcare needs of the community.

This report presents an indicative analysis of the feasibility of providing a select range of clinical and clinical support services through four service delivery models namely, full public provision, full private provision, partial private provision (through for example, a joint venture or partnership arrangement) and an internal commercial operations unit (COU) managed within the GCHHS. This assessment is one component of a due diligence process being undertaken by the GCHHS to inform decision making with respect to which models may be further explored.

Of note, is the need to consider the GCHHS strategic intent and objectives in the context of reading this report, namely:

1. Better services for patients
2. Better healthcare to the community
3. Valuing our employees and empowering frontline staff
4. Empowering local communities
5. Value for money
6. Openness
7. Health knowledge technical precinct

The report is structured into six sections:

1. **Executive summary** The first section of the report summarises the indicative feasibility assessment for each service. It provides an outline of the scope, approach used, descriptors of the service delivery models considered and assessment criteria used, and the assumptions underpinning the assessment that will assist in understanding the detailed information provided in subsequent sections. The Executive Summary also lists potential opportunities identified during the financial analysis and the generic high level risks associated with the progression of alternative service delivery models.

   Sections two and three highlight key factors that require detailed consideration prior to progressing the development of any service delivery models and risks that exist for models other than full public provision. Those factors and risks that are applicable across all services have been provided as a single list on pages X and Y respectively; they need to be added to those specific to each service.

Introduction (cont')

2. **Commercialisation and leasing** Section two provides an overview of commercialised business units, commercialised operating units and potential leasing opportunities.
3. **Clinical services options analysis** Section three provides detailed information for each clinical service with respect to the models considered feasible, factors to consider prior to progressing the development of any models, benefits and risks, examples where alternative service delivery models are operating and the financial analysis illustrating variances found between public and private sector costs by cost bucket where available. The costing data constraints and points of note contained in Appendix one should be read when considering the financial analysis.
4. **Clinical support services summaries*** Section four provides detailed information for each clinical support service with respect to the models considered feasible, implementation considerations, benefits and risks, and examples where alternative service delivery models are operating. Due to data reporting limitations, a financial assessment of the efficiencies of delivery through alternative models was not completed.
5. **Next steps** Section five outlines some recommended next steps that are required to progress the analysis and establishment of more formal private service provision arrangements.
6. **Appendices** Seven appendices provide (i) costing data constraints and points of note, (ii) cost bucket data definitions, (iii) cost bucket analysis, (iv) detailed service cost analysis, (v) DRG to service mapping, (vi) glossary and (vii) references.

* Services were categorised as 'clinical support' where they would not typically have an independent episode of care (ie. they are a part of another service delivery).

Guide to interpreting this document

The analysis of each of the services has been structured in a standard format for ease of reference.

1 **Services are assessed on a feasibility scale against assessment criteria**

The feasibility assessment for the described options for each service were measure against the following feasibility scale.

Feasibility level	*Definition*
High	Limited to no impediments, cost saving potential
Medium	Significant impediments requiring mitigation, cost comparable or limited saving
Low	Major impediments or barriers, cost negative

2

	Clinical	Clinical support	Clinical flow	Workforce	Financial
Full Private					
Partial Private					
Description of option analysed	This section will describe parameters of the option considered highly feasible.				
Implementation Considerations	• This section will list any specific considerations if the analysed option is to be implemented. • This section will also highlight the identified impediments to alternative options				

3

Relevant examples
Examples where similar private service provision arrangements are in place will be identified throughout the report by this symbol.

Benefits
Potential benefits of engaging in a full or partial private service provision model will be identified throughout the report by this symbol.

Risks
Potential risks of engaging in a full or partial private service provision model will be identified throughout the report by this symbol.

Scope

The GCHHS is exploring opportunities to improve the efficiency of services ahead of the completion and opening of the GCUH in late 2013 and has identified a range of possible services, financial arrangements and locations that could be operated through private or other commercial arrangements. This includes consideration of partnering with the private sector, the establishment of commercial business units within the GCHHS and the leasing of vacant space to a private provider acknowledging the intent of Healthscope to build and operate a private hospital collocated with the GCUH.

PwC was engaged to conduct a high level feasibility analysis of the following adult services being provided through alternative service models in preparation to performing detailed due diligence on potential commercial arrangements:

- Radiotherapy cancer services (radiation oncology/radiotherapy)
- Medical imaging, including Nuclear Medicine/PET
- Cardiology, cardiac surgery and acute chest pain service
- Cardiovascular interventional suites
- Maternity
- General medical and surgery
- Operating theatres
- CSSD
- Soft FM services.

Analysis to identify what model/models may best suit each service, the benefits and risks, and implementation considerations for each of the above listed services was completed. This included a high level assessment of the financial / economic factors to determine that outsourcing or other commercial arrangements would meet Government value for money requirements.

An assessment of the impact on the projected growth in services was limited to the extent of service planning information that was available. The evidence of successful implementation in other health services was limited to the conceptual models for such services and did not include interrogation of the actual arrangements.

In addition to the above selected services, an analysis of the cost variances between public / private endoscopy services has also been provided for consideration.

Assumptions and points of note

The feasibility assessment for each service was based on the following assumptions. Constraints and points of note specific to the costing data used can be found on page 62.

- We have assumed that the safety & quality standards , and process efficiency of public and private providers is the same. Where a service delivered publicly is identified as not meeting standards or efficiencies there may be further benefits to the service being provided privately.
- There is private sector interest in partnering with the GCHHS to provide healthcare services
- We have assumed that GCHHS providing each of the nominate services as a public entity is the default option and therefore has not been independently validated, i.e. if no private service provision option is feasible or there is no private sector interest in providing a service, GCHHS will provide as per current service plans.
- The facilities management infrastructure within GCUH is able to support the operations of dual services where required for example, linen and porterage.
- Service planning has confirmed the need and priority of each service assessed (PwC has not conducted any demographic assessment of need)
- Services provided by a private provider on GCHHS premises will meet the requirements of the Private Health Facilities Act 1999 and associated regulation and standards.

Analysis approach

There are three basic steps of identifying, analysing and confirming the feasible options that were completed as outlined in the diagram below.

1. Identify and describe options

The identification and description of business model options, and specified assessment criteria to frame the evaluation.

Business model descriptions

Description details are provided on page 11

The business model descriptions provide a high level overview of the sourcing options for consideration in the context of each specific service

Full private provision | *Partial private provision* | *Full public provision* | *Commercial operations unit*

Assessment criteria

Criteria description details are provided on page 14

Criteria were developed to assess the feasibility of providing the respective services through the fully private or partially private business models

Clinical | *Clinical support* | *Clinical flow* | *Workforce*

Financial | *ICT* | *Asset maintenance* | *Contract*

2. Analyse options

The analysis approach addressed the services from two perspectives (identified below). Each service is presented in section 3 in a summary dashboard of findings starting from page 14.

Financial analysis

Cost analysis per service
Cost analysis of cost buckets.

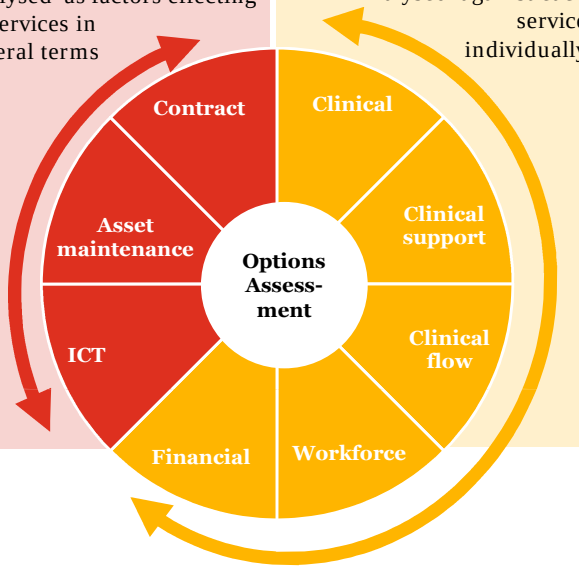
Cost comparison between public and private service provision provides indications for potential cost savings from publicly available NHCDC

DRG to Service Mapping → *Public & private cost data* → *Cost groupings & findings*

Business impact analysis

Analysed as factors effecting all services in general terms

Analysed against each service individually



3. Confirm feasibility of options

The options analysis was cross-referenced with previous stakeholder consultation. Further consultation will need to occur to refine the business /clinical model options.

Business model descriptors

GCUH has 3 core options for clinical service provision, which can be combined with a range of alternative arrangements for clinical support services. The table below provides a high level description of the sourcing options that have been considered in this analysis.

Clinical services options

Full private provision

The entire service is provided by a private provider through a commercial arrangement. GCUH would not provide the service; public patients would access the private service for which GCHHS would be billed.

A private provider may use its own staff to deliver the service in GCHHS infrastructure or deliver public services out of private infrastructure.

- Radiotherapy
- Endoscopy

Partial private provision

The private provider maintains responsibility for delivering the service, but this may be under an arrangement of either where GCHHS purchasing extra services or other partnership models are entered into.

- Cardiology, cardiac surgery & ACP
- Cardiovascular interventional suite
- General medicine
- General surgery

No private provision

There would be no change to the current planned arrangements for service provision by the public hospital.

- Maternity

Clinical support services options

GCHHS manages the service

All support services are provided by GCHHS with contractual arrangements with a private provider for servicing the private service.

Private Provider manages the service

All support services provided by private provider with contractual arrangements with GCUH for servicing the public service.

- Medical imaging
- Operating Theatre
- CSSD

Part GCHHS / Part Privately managed

A combination of (a) and (b) (e.g.. a private provider may choose to contract cleaning services but provide their own catering services).

- Soft FM

N.B. An option for the public and private providers to maintain individual clinical support services was not considered as this would be a duplication of services which would not meet the principles articulated by the Director General regarding PPP models.

Alignment with the VfM Framework

While the *Queensland Government Value for Money Framework* (VfM) does not directly apply to the context of delivering health services, the intent of the GCHHS directly aligns with the aim of the Queensland Government Policy, namely to:

- deliver improved services and value for money through appropriate risk sharing between public and private sector parties
- encourage private sector innovation
- optimise asset utilisation.

The value for money assessment allows procuring agencies to establish whether service delivery has been structured to appropriately meet the service output while continuing to ensure reasonable stewardship of financial resources. The assessment of value for money is expected to encompass all aspects of the proposal including both quantitative and qualitative elements with benefits of a private partnership model including:

- maximising the use of private sector skills
- allocating risks to the party best able to manage or absorb each particular risk
- forcing the public sector to focus on outputs and benefits from the start
- the quality of service has to be maintained for the life of the PPP.

The following table aligns the VfM Framework stages and elements with the steps recommended for GCHHS to ensure the service delivery models selected are in-line with Government intent. Those steps highlighted indicate those completed through this feasibility assessment.

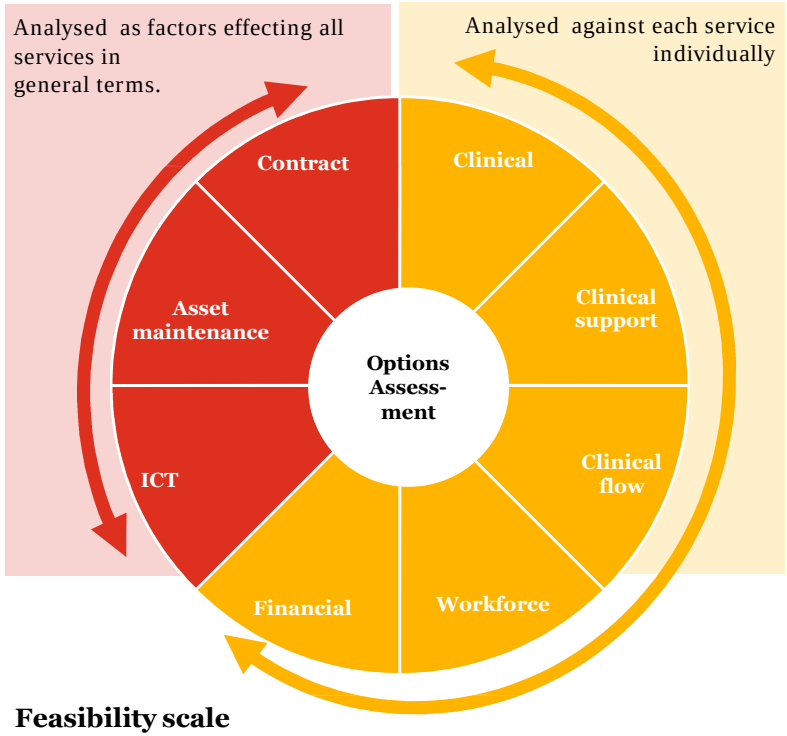
Note: In line with the VfM imperative, the financial analysis drives the overall feasibility rating. The feasibility level applied to the financial assessment criteria will the maximum feasibility level for the service. For example, where the financial analysis indicates a medium level of feasibility for financial, and all other criteria are at a high level, the service delivery model overall feasibility level will be medium.

Alignment with VfM Framework (cont')

PPP STAGE	FEASIBILITY			PROCUREMENT		DELIVERY
	Service Identification	Preliminary Assessment	Business Case Development	Expressions of Interest	Bidding Process	Management of the Agreements
GCHHS steps as per the VfM elements	• Identify those services suitable for a partnership model • Scoping of the service requirement • Analysis of the options to meet the service requirement	• Preliminary risk analysis • High level financial analysis • Preliminary consideration of legislative approval issues • Preliminary market sounding • Preliminary consideration of whole-of-government policy issues • Preliminary consideration of regulatory issues • Preliminary public interest assessment • Consideration of procurement strategies • Consideration of procurement strategies	• Development of the RFI / output specifications • Completion of risk analysis & development of a Risk Allocation Matrix • Market Sounding • Completion of Public Interest Assessment • Completion of the workforce management plan • Development of the partnership model • Value for money assessment • Completion of Business Case for Board approval	• Development of Tender documentation • Public notification and invitation • Briefing of potential proponents • Evaluation of Tenders	• Development & negotiation of Contract • Notification of the Tender outcome	• Formation of contract management team • Proactive management of contracts

Assessment criteria

The following criteria were used to assess the feasibility of providing the respective service through the fully private or partially private business models described on page 11. This assessment completes steps within the Service Identification and Preliminary Assessment stages of the Queensland Government VfM Framework. A summary of the assessment is provided on page 15.



Feasibility scale

The feasibility assessment for the described options for each service were measure against the following feasibility scale (used in the table on the following page)

Feasibility level	*Definition*
High	Limited to no impediments, cost saving potential
Medium	Significant impediments requiring mitigation, cost comparable or limited saving
Low	Major impediments or barriers, cost negative

Analysis factor	Description
Clinical	The level to which clinical safety & quality standards mandated through legislation / government agreement or policy can be achieved; models of care / evidence based practice.
Clinical support	The required clinical support services are available and support the end-to-end patient journey.
Clinical flow	Patient access to services is not hindered & continuity of care is supported as patients move between GCHHS and private provider care (Service Agreement access KPIs can be met on or higher than the set target).
Workforce	The required workforce is appropriately qualified and skilled and is readily available (e.g. through an existing service or completed recruitment process).
Financial	The level of opportunity in cost reduction.

Analysis factor	Description
ICT	GCHHS's capacity to support private ICT system requirements and share relevant information between service partners.
Asset maintenance	The ability to assign responsibility for the management and maintenance of assets.
Contract	The ability to meet probity requirements, design contractual arrangements to minimise risk and optimise service provision, and manage the contractual terms.

Feasibility assessment summary

The following tables summarise the assessment of each service delivery model's ability to meet the feasibility assessment criteria. An ability to fully meet all criteria is indicative that the business model warrants further consideration for that service for example, a fully private service model appears to be a feasible option for radiotherapy; a partially private service model appears feasible for maternity.

	Model	Overall Rating	Clinical	Clinical Support	Clinical Flow	Workforce	Financial
Radiotherapy Cancer Services	*Full Private*	High	High	High	High	Medium	N/A
	Partial Private	Medium	Medium	High	High	Medium	N/A
Cardiac Surgery, Cardiology & Acute Chest Pain	*Full Private*	Medium	Medium	Medium	Medium	High	Medium
	Partial Private	High	High	High	High	High	High
Cardiovascular interventional suites	*Full Private*	Medium	High	High	High	High	Medium
	Partial Private	Low	Low	High	Low	Medium	Medium
Maternity	*Full Private*	Medium	High	High	High	High	*Medium*
	Partial Private	Medium	High	High	High	High	*Medium*
General Medicine	*Full Private*	Medium	Medium	High	High	Medium	Medium
	Partial Private	High	High	High	Medium	High	High
General Surgery	*Full Private*	High	High	High	High	Medium	High
	Partial Private	High	High	High	High	High	High
Endoscopy	*Full Private*	High	High	High	High	High	High
	Partial Private	Low	Low	High	Low	Medium	High
Clinical Support Services*							
Medical Imaging	*Full Private*	High	High	High	High	High	High
	Partial Private	Low	High	High	Medium	High	Medium
Operating Theatres	*Full Private*	High	High	High	High	High	High
	Partial Private	High	High	High	Medium	High	Medium

*Soft FM & CSSD services were not assessed in the same format and therefore the feasibility is discussed in more detailed in Section Four.

Cost bucket variances & opportunities

The financial analysis undertaken included examining the breakdown of the specific item costs (cost buckets) associated with each service as reported through the National Hospital Cost Data Collection (NHCDC) reports. The following tables summarise consistent variances found and discusses potential opportunities that may exist.

Cost Bucket	Variance explanation	Opportunity possibility	Opportunity
Ward Medical	Private specialists' direct billing to Medicare and lower on-costs result in medical costs appearing significantly lower in the private sector	✓	• Increased Own Source Revenue opportunities when treating public patients as private patients in the public sector • The potential to purchase private sector services at a cost lower than the public sector.
Ward Nursing	Lower private sector nursing salaries and on-costs generally result in lower nursing costs for services*	✓	• Potential to purchase private sector services at a cost lower the public sector particularly general surgery, cardiac surgery and cardiovascular interventional suite services.
Allied Health	The ability for some allied health services to be billed to Medicare and lower no-costs result in lower private sector allied health costs	✓	• Potential to purchase private sector services at a cost lower the public sector particularly general surgery, cardiac surgery, cardiology and cardiovascular interventional suite services.
Non-clinical Salaries	Lower private sector non-clinical salaries and on-costs is thought to explain the generalised lower non-clinical costs	✓	• Potential to purchase private sector services at a cost lower the public sector particularly general surgery, cardiac surgery and cardiovascular interventional suite services.
Emergency Department	The private sector does not generally provide emergency department services; those that do not generally provide the same range of services as the public sector eg. trauma	✗	
Operating Room	The private sector can provide operating room services more efficiently than the public sector	✓	• Improve theatre efficiency by contract a private provider to manage the operating room service
Specialist Procedure Suites	The high cost of prosthetics is thought to result in the significantly higher cost of specialist procedure services	✓	• There may be an opportunity to purchase private sector services at a cost lower the public sector cost if prosthetics are provided by the public sector.

** Hospital & medical costs. Productivity Commission. (2007). Figure 5.1 Composition of general hospital costs by sector, 2007-08*

Cost bucket variances & opportunities (cont')

Cost Bucket	Variance explanation	Opportunity possibility	Opportunity
Pharmacy	Pharmacy costs are lower in the private sector due to costs being covered by the Pharmaceutical Benefits Scheme (PBS) and the individual patient	✓	• There may be an opportunity to purchase private sector services at a cost lower than the public sector cost however, as this is part of a state wide service, it is recommended discussions progress through the Health System Support Agency CEO.
Pathology	Pathology costs are lower in the private sector due to costs being covered by Medicare	✓	• There may be an opportunity to purchase private sector services at a cost lower the public sector cost however, as this is part of a state wide service, it is recommended discussions progress through the Health System Support Agency CEO.
Imaging including Nuclear Medicine	Pathology costs are lower in the private sector due to costs being covered by Medicare	✓	• Increased Own Source Revenue opportunities when treating public patients as private patients in the public sector • The potential to purchase private sector services at a cost lower than the public sector.
Prosthetics	The significantly higher private sector prosthetic costs are due to the use of more expensive prosthetics	✗	• Private provider could leverage the public service supply contracts
Supplies	The higher private sector costs of supplies is thought to be due to the public sector's ability to access scales of economy	✗	• Private provider could leverage the public service supply contracts
Hotel Services	The higher private sector costs for hotel services is thought to be due to the provision of differing levels of service (eg, catering options)	✗	• Private provider could leverage the public service contracts

Section 2

Commercialisation and leasing

Commercial operating unit (COU)

A COU model best suits those services able to generate the revenue required to self fund the service. Services where this appears to be possible include Radiotherapy, Specialist Outpatient and Endoscopy services.

The scope of this engagement included an assessment of the feasibility of establishing Commercial Business Units (CBU) through the Queensland Government policy framework for the "Commercialisation of Government Business Activities in Government". This policy has specific application to departments and agencies. There is no reference to its application within a Statutory Body, and there is no reference to any power to create a CBU in the Hospital and Health Boards Act 2011.

However, the GCHHS may wish to consider operating selected services on a commercial basis using internal structures and mechanisms; for the purpose of this report, such a unit is termed a "Commercial Operating Unit".

A COU is defined as a service within the GCHHS which is formally established to operate on a commercial basis i.e. self funding. Funding arrangements and key performance indicators would be formalised through an Agreement between the GCHHS Chief Executive and respective Service Director. Performance monitoring and management would be managed within the GCHHS.

Relevant Government policy

- HHS as a statutory body is a commercial entity (body corporate) and can engage in commercial arrangements (Financial Accountability Act 2009 & Financial and Performance Management Standard 2009); The Service Delivery Statement 2012 confirms the flexibility HHS's have with respect to service delivery arrangements.
- Notwithstanding the absence of any specific support in the relevant policy or in the governing legislation, if a CBU were to be established within a HHS such action would result in:
  - additional (& unnecessary) bureaucracy
  - an additional direct reporting line from the CBU to the Minister
  - increased compliance requirements particularly with respect to performance monitoring & reporting to Treasury
  - requirement for the CBU to compete on equal terms with the private sector including:
    - payment of tax equivalents
    - earning a commercial return & payment of dividend to Treasury
- Existing HHS arrangements provide for increased accountabilities and the use of robust performance management processes.

Commercial operating unit (COU)

Implementation considerations

Policy

- Legal advice will be required to ensure a complete understanding of government and legislative requirements including competitive neutrality requirements

Services

- Due diligence and further detailed assessment will be required to identify competition for delivery and which services would be successful under this model

Governance

- Clear accountabilities and responsibilities will need to be assigned with defined governance pathways
- The interface with GCHHS management will need to be articulated

Agreement

- GCHHS will need to identify:
  - the HHS requirements e.g. which service(s) are to be provided and what are the expected operating costs
  - the impact of a COU on GCHHS resources e.g. will the COU be expected to cover the cost of equipment or just operating expenses
- commercial professional advice will be required to ensure the Agreement clearly articulates GCHHS requirements, performance standards and consequences when requirements are not met

Workforce

- Industrial obligations will still apply to the operating unit and will need to be met
- Details of the relationship between COU staff and the GCHHS will need to be determined e.g. GCHHS employees assigned to the COU or contractors engaged to work in the COU.

Revenue generating potential

- The ability to use revenue to reinvest under a COU would require confirmation with the System Manager
- Under Option B of the QH Right of Private Practice (RoPP) policy, the MBS revenue received in public hospitals for private services is split three ways. An administration and facility charge is deducted (average 45%) which is retained by the public hospital. The remaining revenue (net revenue) is retained by the specialist up to a threshold amount (currently $191,318). After the threshold amount is reached, the specialist retains 33.3% of the net revenue with 66.6% paid to the local Study, Education and Research Trust Account (SERTA).
- Whilst there is validity in pursuing this model as an option, further analysis will be required to understand the extent of commercial activities GCHHS can engage in and the impact of policies relating the commercial neutrality
- The extent of commercial activities may range from basing operations on commercial business practices (e.g. self-sustaining revenue to offset costs), to fully competing in the private market to maintain a profitable business
- Further analysis is required to establish the extent to which the revenue would support the services. This is outside of the scope of this high level feasibility assessment.

Benefits

- Services are able to employ innovative solutions that may be difficult to progress as a standard HHS service such as use of revenue to provide additional services or purchase new equipment.

Risks

- Activity levels may be insufficient to sustain a standalone commercial entity within GCHHS
- Perception of a reduction in services if revenue fluctuations do not support sustained increased activity and/or use of additional equipment purchased.

Leasing Analysis

Our analysis indicates a mid point leasing rate of $500/m² per annum may be achievable by leasing unused floor space to private health care providers.

Opportunity

- Hospital infrastructure already constructed but unused by the GCUH represents an opportunity cost to the HHS. Recouping revenue from the leasing of unused floor space offsets ongoing cleaning, maintenance, and infrastructures costs.

Analysis

- Analysis conducted by PwC incorporating both industry insight and comprehensive market research, found the market value of floor space within a Queensland hospital setting to range between $400/m² to $650/m² per annum depending on the location of floor space and quality of fit out.
- For the purposes of high level quantification of leasing revenue a mid point of **$500/m2** per annum could be used to encompass varying locations of unused hospital floor space.

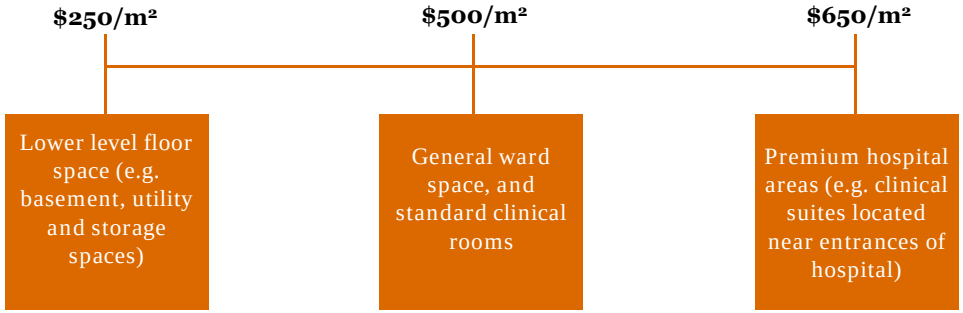
Benefits of leasing unused space

- Cost recovery and potential for revenue – cost of vacant space offsets ongoing cleaning, maintenance, and capital costs.
- Higher utilisation of constructed hospital floor space.
- Increased private patient access to services through additional health care provider lease holders.

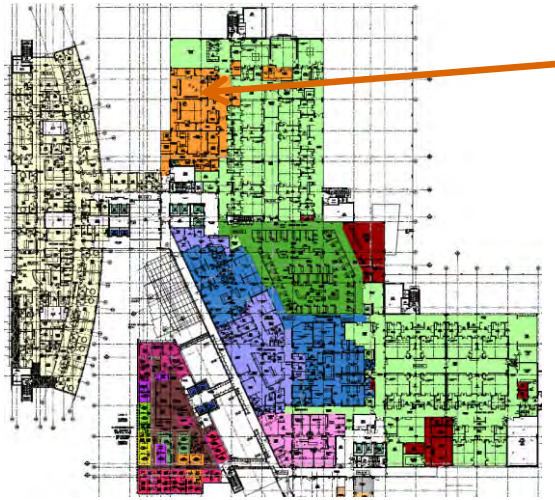
Risk of leasing unused space

- Space is tied up and unable to be used in a rapid growth scenario.
- Leasing small areas of unused space may not be feasible if it disrupts patient flow and continuum of care of surrounding services.

Market value per annum of leasing rates achievable in a Queensland hospital setting



Indicative used/unused GCUH floor space analysis



Unused space identified provides revenue opportunity from leasing to private provider.

Note – PwC has not quantified actual unused floor space. This diagram is illustrative only.

Source: Rates determined by PwC analysis incorporating both industry insight and market research.

Section 3

Clinical services options analysis

Feasibility	Full Private	Partial Private
	High	Medium

Radiotherapy cancer services

For the purposes of this report, Radiotherapy has been considered as a discrete service and does not include other services that may be provided through a comprehensive Radiation Oncology service. Due to radiotherapy being predominantly provided through an outpatient type service and subject to reporting requirements which are different to hospitals, costing data was not available for analysis. However, information provided by the GCHHS indicates that the private sector can provide Radiotherapy Services at a significantly lower cost than the public sector

	Clinical	Clinical support	Clinical flow	Workforce
Full Private				
Partial Private				
Description of option analysed	Private provider is responsible for meeting all required clinical standards, and model of care is agreed with GCHHS.	Private provider interacts with related GCHHS clinical support services (e.g. Allied Health, Pathology, Renal etc) and participates in MDT care planning.	Public patients have a specific referral pathway with clearly defined protocols for the transfer of patient information and care.	Private provider is fully responsible for the recruitment and capability development of the entire service workforce.
Implementation Considerations	• The provision of a MDT approach to care across GCHHS, QH peers and the private provider is critical • Continuity of staffing required by the private provider to allow for better integrated and team-based care • Service integration potentially enhanced through conjoint appointments • CSCF Level 6 requirements should be in contract	• The service will require access to clinical support services required to provide a CSCF level 6 service which may need to be facilitated by the GCHHS • Allied Health team support required to be provided by GCHHS	• The level of service able to be provided must be at CSCF level 6 to achieve GCHHS goal of Gold Coast patients being treated in Brisbane currently returning to the Gold Coast for treatment • Arrangements for the treatment of inpatients will need to be included in the contract	• How allied and ancillary staff will be sourced e.g. either contracted through private provider or provided by GCHHS • Impact of delayed decision making on ability to recruit • Ability of the private provider to source appropriate workforce due to the wage differential and access to education and training

Benefits

- Better services for patients through potential increased choice of treatment locations if private provider has multiple service locations
- Better healthcare to the community through integrated public & private sector health planning
- Potential access to additional Commonwealth funding for private provider e.g. registrar positions
- Potential for lower cost to GCHHS (see cost analysis commentary)

Radiotherapy cancer services (cont')

Other considerations

- **Equipment**
  - Equipment is leased because the ability to recoup the investment of the capital over time and the private provider is able to receive a subsidy from the Govt for leased capital equipment.
- **Licensing**
  - Pending arrangements for the use of GCHHS assets, licenses held by GCHHS may require transferring to the private provider
- **Policy**
  - Legal advice will be required to ensure a complete understanding of the obligations with respect to the National Healthcare Agreement and Health Insurance Act, and any exemptions that may be required

Please refer to the previous section on Commercial Operating Units for information on this model for the Radiotherapy service.

Relevant examples

- **Premion Cancer Care, Queensland:** provides private radiotherapy services in multiple locations across south east Queensland. The services they provide include treatment of head and neck cancers.
- **Cairns, Queensland:** Radiation Oncology Queensland (ROQ) provides public patient radiotherapy services. The HHS provides the physical space, equipment, CT planning and Allied Health staff. ROQ provides all other staff and manages the service.
- **Toowoomba, Queensland:** St Vincent's Hospital and Radiation Oncology Queensland provide public patient radiotherapy and oncology services under service agreement with the HHS. The HHS provides accommodation for inpatients requiring this service in Toowoomba Hospital however the service agreements are currently under review.
- **Wagga Wagga, New South Wales:** Riverina Cancer Care Centre is a cooperative partnership which provides public patient radiotherapy and chemotherapy services through a contractual arrangement with the NSW State Government. RCCC treatment services include head and neck cancers.
- **Lismore, NSW:** North Coast Cancer Institute is public funded and managed as a commercial business unit, providing radiation, haematology & medical oncology services
- **Western Australia:** Genesis Cancer Care provides public patient radiotherapy services through a partnership arrangement with the Western Australian State Government
- **Mildura, Victoria:** Ramsay Health Care provides multidisciplinary public patient cancer services through the contract with the Victorian State Government.

Radiotherapy cancer services - cost analysis comments

Previous detailed costing analysis has been undertaken for the Queensland Health Radiation Oncology Cost Modelling Advisory Group. The details of this cost analysis have been reviewed as part of the feasibility analysis for radiation therapy for the GCUH.

The major points to note from the cost analysis are outlined below. These matters need to be considered in undertaking any market sounding for the feasibility of the private or commercial provision of radiation therapy for the GCUH.

- Radiation therapy services provided through outpatient clinics in Queensland public hospitals are private services and attract MBS rebates (85% of scheduled fee) for activity and Commonwealth Health Program Grants (HPG) for equipment.
- Most of the radiation therapy activity (90% -95% depending on complexity of cases) in public hospitals is delivered to outpatients.
- The public hospital outpatient private services are bulk billed and therefore patients do not pay a gap. Radiation therapy services delivered by private providers usually incur a gap payment of between 30% - 100% above the MBS scheduled fee. The inclusion of the gap payment increases the revenue for private providers.
- Radiation therapy services in public hospitals usually include an allied health team that is not usually included by private providers. In the case of the GCUH, this team would be approximately 6FTE when the two linear accelerators (linacs) are operational.
- The Australian Healthcare Agreement has strict requirements in relation to the relationship between public and private services and these requirements make some models potentially unviable as they would require approval by the Australian Government. One of the models that may be problematic is the direct contracting with a private radiation therapy provider.
- Public contracting of private provision needs to comply with national and state competition policy.
- The estimates indicate that the private sector is 21% - 36% more cost effective than public hospital provision, depending on the private sector model. The cost effectiveness is based on lower cost of capital and recurrent capital costs, higher HPG payments, lower software costs and higher proportion of MBS revenue retained by the service.

High level risks assessment - Radiotherapy cancer services

The following high level risks apply to radiotherapy cancer services and are provided in the context of a service being provided by any model other than a full public service. A more detailed risk assessment and the development of mitigation strategies will be required prior to the progressing individual service models.

Risk	Likelihood	Consequence	Rating	Possible Mitigation Strategies
GCHHS has to resume delivering radiotherapy cancer services unexpectedly and does not have the requisite workforce capability or required timeframes to maintain continuity of service	Possible	Major	High	• Robust tender selection and due diligence to support successful provider selection • Development and implementation of transition plans for the operational return of each service to GCHHS
Inability of a private provider to recruit the required workforce to deliver radiotherapy cancer services at a CSCF level 6	Possible	Major	High	• Tender timeframes need to allow for GCHHS to plan and commence the services should the private provider risk be realised
Industrial issues limit the extent to which the preferred radiotherapy model can be implemented	Possible	Major	High	• Inclusive stakeholder consultation • GCHHS prepares to provide service until negotiations and handover is complete
Reduced quality of care due to the inability of a provider to meet required service requirements for radiotherapy cancer services	Unlikely	Extreme	High	• Robust procurement (tender specification and selection) processes • Quality [standards] requirements included in contract • Robust contract management (i.e. performance monitoring and management inclusive of consequences when contractual obligations are not met)

High level risks assessment - Radiotherapy cancer services

Risk	Likelihood	Consequence	Rating	Possible Mitigation Strategies
Inability to progress preferred radiotherapy cancer services models due to legislative, regulatory and policy requirements not able to be met (e.g. Commonwealth does not approve transfer of ownership of service)	Possible	Major	High	• Tender document preparation needs to be comprehensive in articulating requirements to be met by private provider • Program planning for tender process to include allocated time for the investigation into mandatory requirements
The radiotherapy cancer service scope of treatments delivered is limited due to an inability to meet Level 6 CSCF requirements	Possible	Major	High	• Clarity to be gained on the private provider capability resulting from market intelligence research • Identify early in the contract process the service level requirements • Robust contract management where providers have committed to delivery of services at agreed levels
Performance targets for radiotherapy cancer services are not met, for example, activity targets	Possible	Major	High	• Robust contract management process • Ensure mitigation/resolution measures are defined and agreed
Endorsed cancer treatment pathway inclusive of MDT's is not followed	Possible	Major	High	• Tender document preparation needs to be comprehensive in articulating requirements to be met by private provider

High level risks for all services (cont')

Risk	Likelihood	Consequence	Rating	Possible Mitigation Strategies
Radiotherapy cancer services will not be ready to commence in the timeframes required for GCUH plans	Possible	Major	High	• Program planning for tender process must have realistic timeframes • Contract closure needs to occur with sufficient time for staff recruitment • Confirm continuation of services being provided outside of GCHHS in the interim and revise timeframes • Ensure high level of detail is requested through the tender documentation to reduce start up time upon appointment
Poor continuity of care due to poor information flow and/or differing clinical pathways	Likely	Moderate	High	• Active management of adherence to agreed models of care for both the public and private providers • Agreed patient information sharing protocols established at the outset
Education and research will not be supported in line with GCUH strategic plan	Possible	Minor	Medium	• Contractual requirement for participation and education and research
Additional costs that may be associated with non-MBS billable MDT involvement limits potential cost efficiency opportunities	Possible	Moderate	Medium	• Ensure comprehensive cost analysis is included in tender evaluation criteria and apply value for money assessment to results

Feasibility	Full Private	Partial Private
	Medium	High

Cardiology, cardiac surgery & acute chest pain service

The data indicates the private sector is able to provide part of these services more efficiently than the public sector. Additionally, a private provider may not have the resources or interdependent services required to provide a complete service. For example, the 24hr workforce required to provide an acute chest pain service or the availability of acute intensive care facilities. This analysis considered the feasibility of cardiac services listed above as a complete service offering.

	Clinical	Clinical support	Clinical flow	Workforce	Financial
Full Private					
Partial Private					
Description of option analysed	Both public and private providers are involved in the delivery of care in line with agreed models of care. Private provider operates independent service and public purchases services as required.	If providers are co-located, arrangements for shared clinical support services are negotiated. GCHHS may provide access to interdependent services .	Clear protocols describe the referral of patients to the private provider and the flow of patient information between private & public providers.	Each provider sources and manages their respective workforce.	GCHHS purchases additional capacity as required through a commercial arrangement.
Implementation Considerations	• Confirmation of the ability of a private provider to provide the complete range of services e.g. a private provider may not have the workforce required to provide a 24hr acute chest pain service or some of the more complex cardiology patients.	• Agreement will be required on the level of interdependent public sector services a private provider may require access to (e.g. intensive care).	• Acute chest pain service would require allocated space to assess and treat incoming patients either in emergent or non-emergent scenarios • The patient flow for acute chest pain through Emergency must be clearly defined with supporting policies and procedures.	• Medical salary costs could be offset under Option A arrangements by increasing the level of private patient identification and billing within the public service.	• Cost analysis has been completed against each service independently due to large variance in cost weightings • Potential for cost savings has only been identified for cardiac surgery (see financial analysis pages).

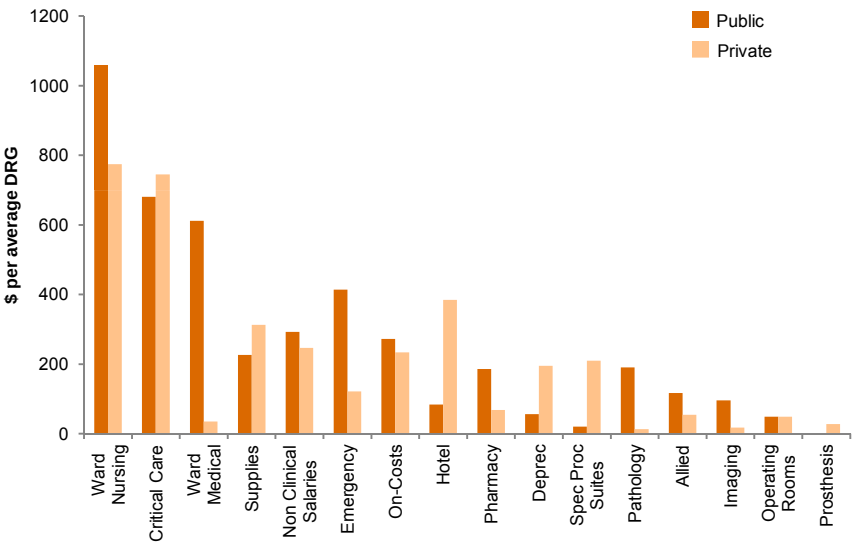
Relevant examples
- No suitable examples were found for these services.

Benefits
- Efficiencies through the ability to share resources across a single service
- Potential for better value for money for part of the cardiac service through cost efficiencies

Risks
- Disruption to patient care as patients move between interdependent services such as intensive care and theatre that are managed by the GCHHS
- Increase patient risk due to alternative Emergency access points for ACP patients.

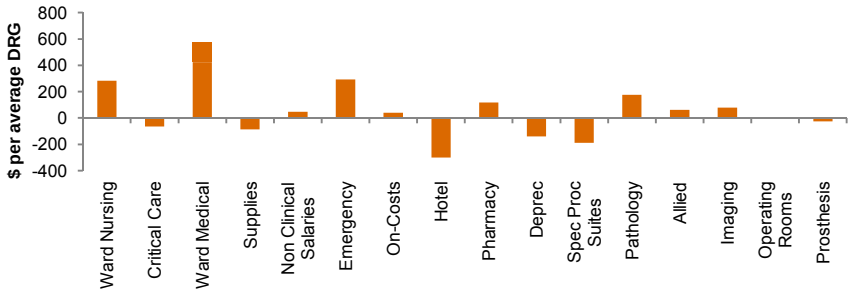
Cardiology

Cost bucket breakdown

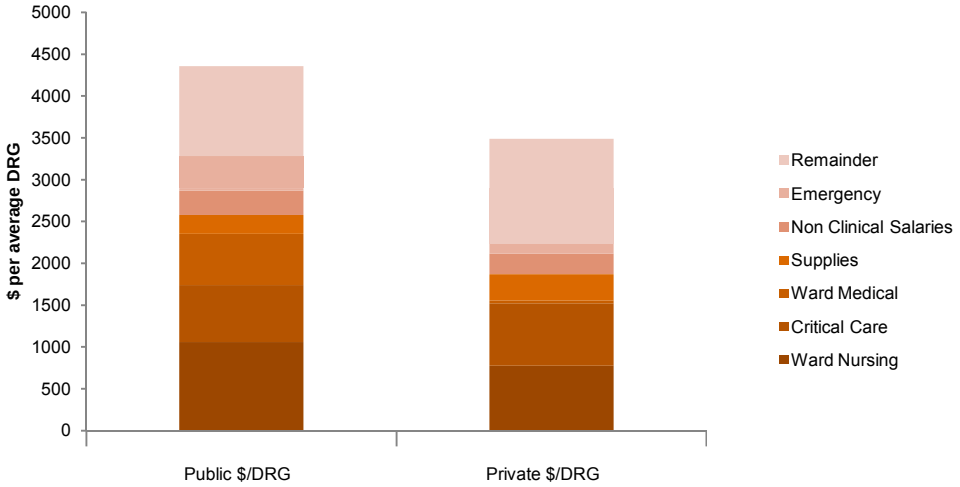


Cost variance - public v private

Positive variance indicates lower cost private provision of service



Cost per average DRG



Cost variance findings

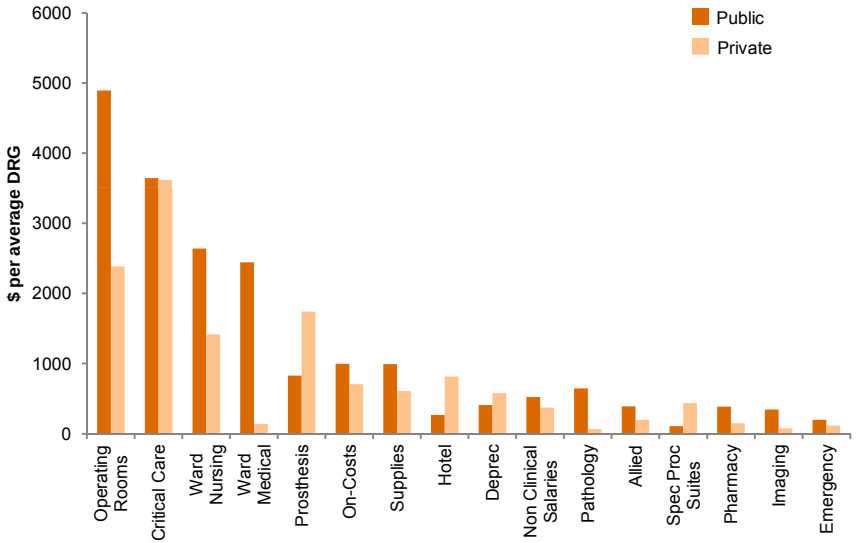
- **Financial evidence does not suggest that private provision of Cardiology services may be achievable at lower cost.**
- An opportunity ($859/DRG) in medical labour exists due to a private provider being able to bill Medicare directly for the provision of medical salaries, and nursing salaries being less in the private sector
- Whilst Emergency Department costs appear $292/DRG less in private sector, this saving does not appear sustainable for a more complex public patient casemix

Casemix cost analysis

- A low quantity and moderate variety of services are performed with 2,128 separations spread across 17 DRG's
- Average cost/DRG is $4,358 public, $3,490 private
- Indicative total cost for the service is $9.3M public, $7.4M private
- The top 10 DRG's by total cost are the same for both Public & Private with only a slight variation in ranking within the top 10.
- The top 5 DRG's make up 65% of total cost and activity

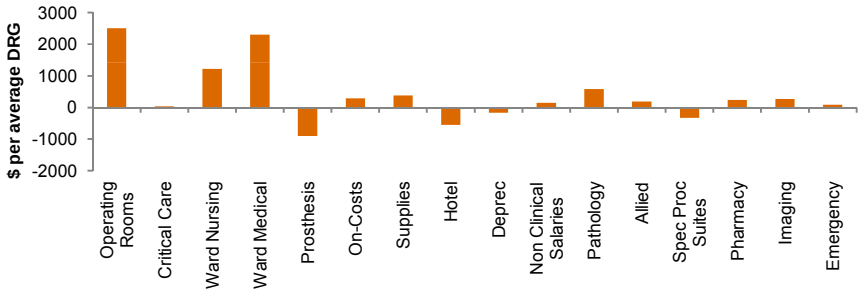
Cardiac surgery

Cost bucket breakdown

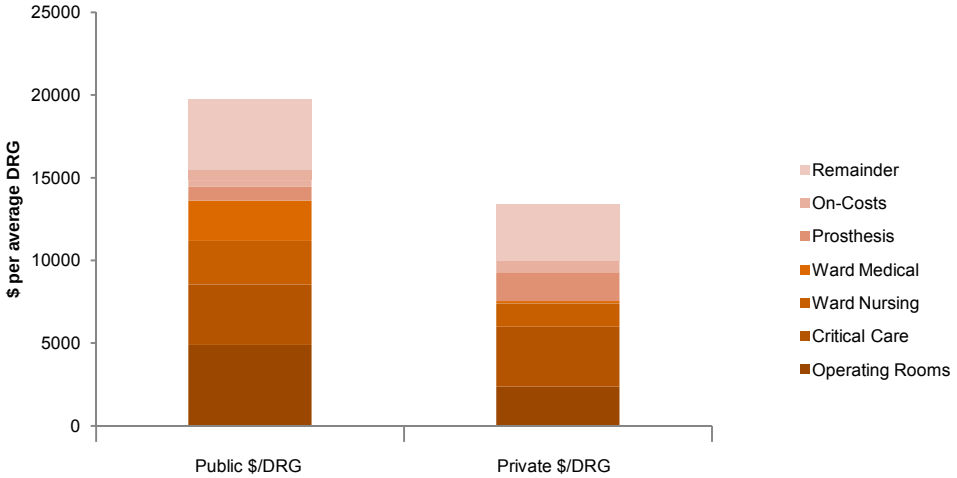


Cost variance - public v private

Positive variance indicates lower cost private provision of service



Cost per average DRG



Cost variance findings

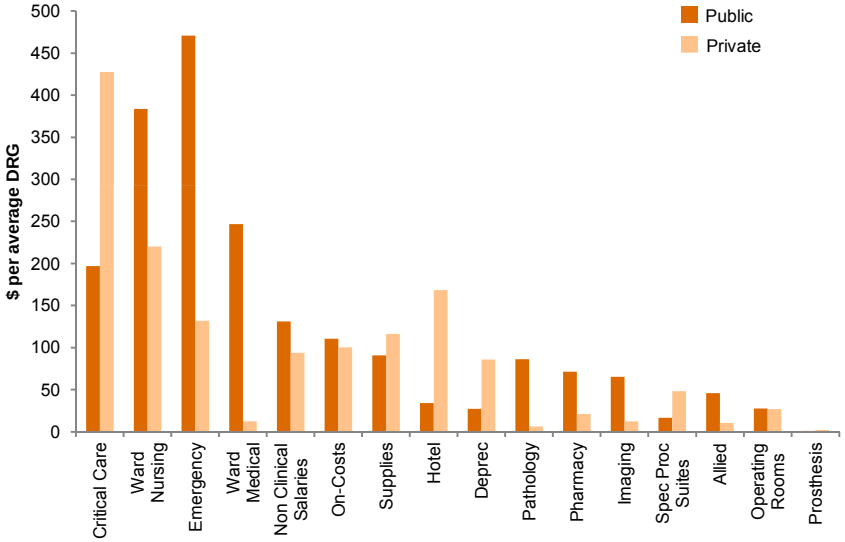
- **Financial evidence suggests that private provision of Cardiac surgery may be achievable at lower cost due to savings in labour related costs, and an opportunity to reduce private prosthetics costs.**
- An opportunity ($3,525/DRG) in medical labour exists due to a private provider being able to bill Medicare directly for the provision of medical salaries, and nursing salaries being less in the private sector
- Operating room costs may be $2,512/DRG less in the private sector due to reduced nursing salaries and the on charge of medical salaries to Medicare
- Using public sector buying power to procure prosthesis may provide a $909/DRG reduction in private costs

Casemix cost analysis

- A low quantity and moderate variety of services are performed with 354 separations spread across 15 DRG's
- Average cost/DRG is $19,717 public, $13,405 private
- Indicative total cost for the service is $6.9M public, $4.7M private
- The top 10 DRG's by total cost are the same for both Public & Private with only a slight variation in ranking within the top 10.
- The top 5 DRG's make up 60% of total cost but constitute only 38% of activity

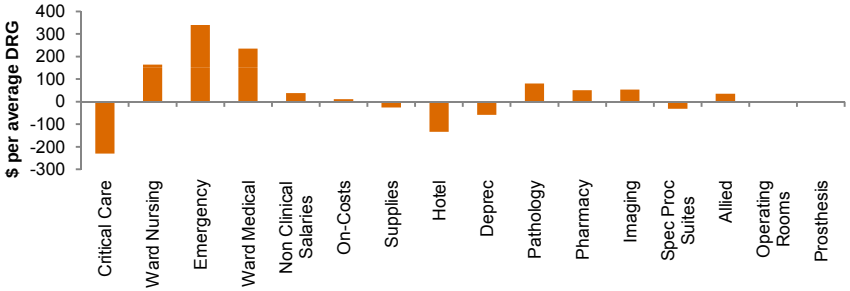
Acute chest pain service

Cost bucket breakdown

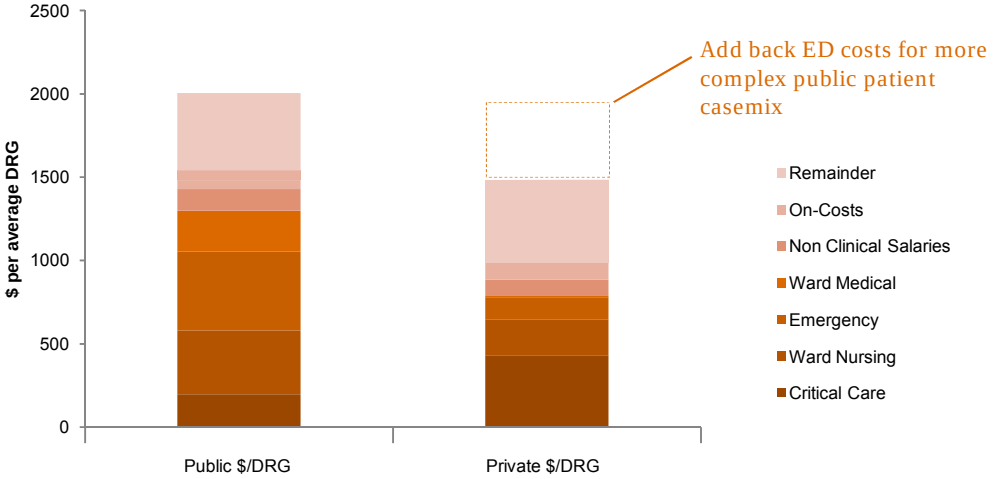


Cost variance - public v private

Positive variance indicates lower cost private provision of service



Cost per average DRG



Cost variance findings

- **Financial evidence does not suggest that private provision of Acute chest pain services may be achievable at lower cost.**
- Whilst Emergency Department costs appear $500/DRG less in private sector, this saving does not appear sustainable for a more complex public patient casemix
- A significant $230/DRG higher cost of critical care in a private setting appears due to a longer stay in these units in a private setting
- Potential savings in medical labour of $398/DRG are offset by a higher level of ED service than is currently depicted in the private costing

Casemix cost analysis

- A low quantity and low variety of services are performed with 2,004 separations spread across 3 DRG's
- Average cost/DRG is $2,005 public, $1,483 private
- Indicative total cost for the service is $4.0M public, $2.9M private
- Chest pain (F74Z) accounts for >60% of separations and total cost in both public and private
- DRG's included do not include presentation of chest pain directly to ED

Feasibility	Full Private	Partial Private
	Medium	Low

Cardiovascular interventional suites

The data indicates cardiovascular interventional services are more expensive in the private sector, however this is due to the significantly higher cost of prosthetics. If prosthetic costs are removed, the private sector costs are significantly less than public sector costs and there is feasibility in the private provider provisioning this discrete service. Partial private provision has been defined as a split of select procedures between the public and private provider.

	Clinical	Clinical support	Clinical flow	Workforce	Financial
Full Private					
Partial Private					
Description of option analysed	Private provider is responsible for the complete service delivery for public and private patients.	If providers are co-located, arrangements for shared clinical support services are negotiated. GCHHS may provide access to interdependent services.	Clear protocols describe the referral of patients to the private provider and the flow of patient information between private & public providers.	Private provider is responsible for developing requisite workforce. May leverage Option B public medical officers to supplement the workforce.	GCHHS purchases services from a private provider through a commercial arrangement.
Implementation Considerations	• Services provided to patients would be disjointed and overly complicated if split between public and private in a partial private model.	• Agreement will be required on the level of interdependent services a private provide may require access to and how emergent care might be managed	• Scheduling of designated clinical space for both public and private access needs to address: – accessibility of the service for emergency procedures; – ability to meet temporal and location separated services	• Under a partial private model, sustaining a full time workforce arrangement for either maybe difficult.	• High prosthetic costs reduce the efficiency of a private service; a mechanism to reduce the cost of prosthetics will need to be established e.g. GCHHS purchases and provides prosthetics.

Relevant examples

- *Sydney, New South Wales:* The Eastern Heart Clinic is a private [cardiac catheter] service owned and operated by a group of Cardiologists. Public patient services are provided through a contractual arrangement with the NSW State Government.

Benefits

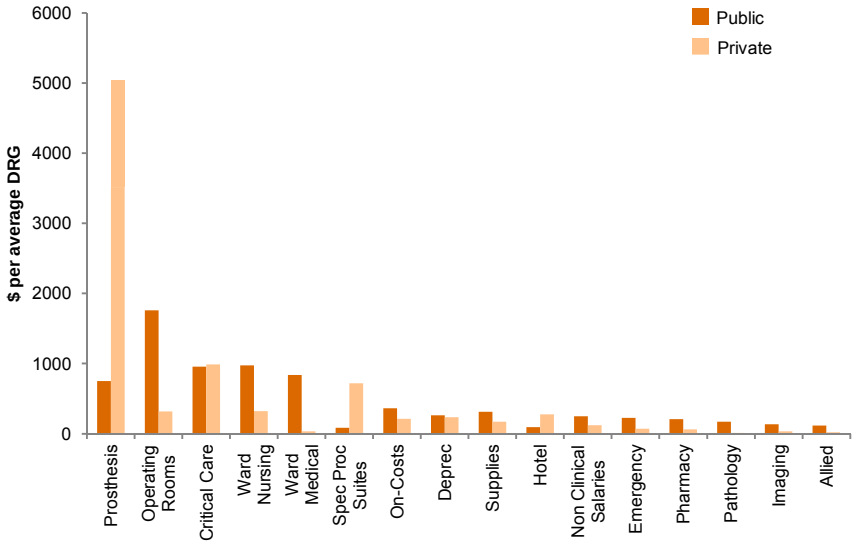
- Improved coordination of public and private lists particularly for surgeons and anaesthetists.

Risks

- High cost of prosthetics in the private sector make private service provision unviable
- Potential patient safety risk where emergency cardiovascular procedures are not able to be performed due to split provider arrangement.

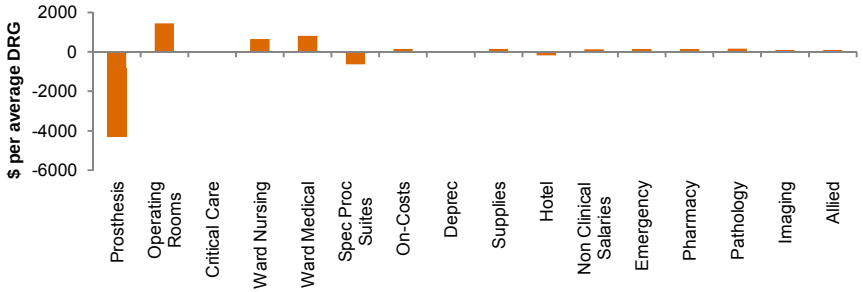
Cardiovascular interventional suites

Cost bucket breakdown

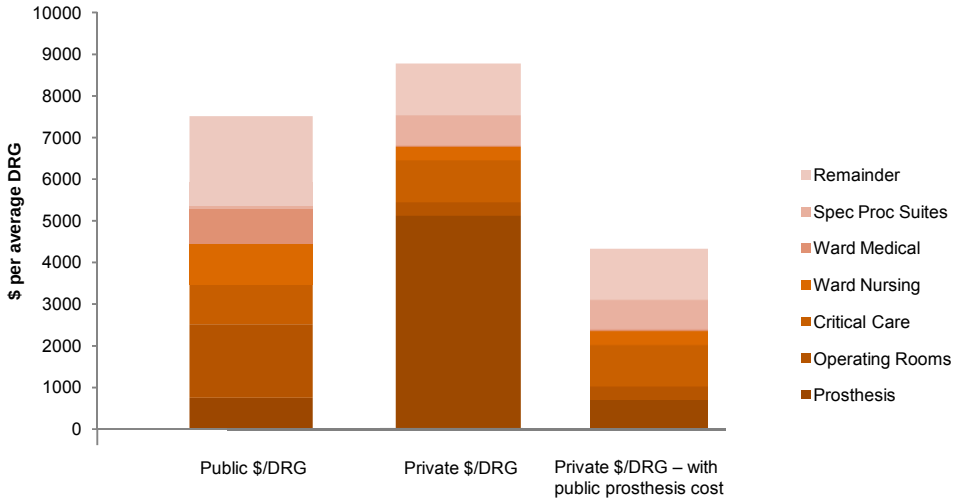


Cost variance - public v private

Positive variance indicates lower cost private provision of service



Cost per average DRG



Cost variance findings

- **Financial evidence suggests that private provision of services may be at a significantly lower cost if a cost effective solution for providing prosthesis to private providers could be achieved.**
- Prosthesis costs are the major cost contributor to private costs, contributing $4,279/DRG additional cost. The 2009 Productivity Commission report[1] has indicated that the private sector may pay up to four times that of the private sector for the same prosthesis
- Less significant savings in operating rooms, nursing and medical salaries are also indicated.

Casemix cost analysis

- A low quantity and moderate variety of services are performed with 1,824 separations spread across 14 DRG's
- Average cost/DRG is $7,511 public, $8,629 private
- Indicative total cost for the service is $13.7M public, $15.7M private
- The top 5 DRG's by total cost and separations in a public setting make up 78% of costs.

[1] Australian Government Productivity Commission Research Report – December 2009 – Public and Private Hospitals

	Full Private	Partial Private
Feasibility	Medium	Medium

Maternity

There appears to be limited feasibility for the service to be provided by a private provider due to the comparability of price across public and private sectors. It does appear feasible for the purchase of discrete (additional) service quantities from a private provider at costs comparable to that of the public sector. There were no other strategic drivers identified that increased the feasibility of this option.

	Clinical	Clinical support	Clinical flow	Workforce	Financial
Full Private					
Partial Private					
Description of option analysed	GCHHS is responsible for providing the complete service. Private provider operates independent service and public purchases services as required.	If providers are co-located, arrangements for shared clinical support services are negotiated. GCHHS may provide access to interdependent services eg, neonatal intensive / special care.	Clear protocols describe the referral of patients to the private provider and the flow of patient information between private & public providers.	Each provider sources and manages their respective workforce.	GCHHS purchases additional capacity as required through a commercial arrangement.
Implementation Considerations	• Under a partial provider model, there needs to be clear agreement on the default model of care to be applied to each patient group, including post natal care.	• Agreement will be required on the level of interdependent services a private provide may require access to.	• Protocols will need to be developed and agreed for – assessing the suitability and referral of patients – identifying the time at which patients will be referred – the delineation of responsibilities for each service provider.		• The service price would require negotiation to obtain the service at a cost comparable to the public sector.

Relevant examples

- *Burnie, Tasmania:* North West Private Hospital provides public patient maternity services through a contractual arrangement with the Tasmanian State Government.

Benefits

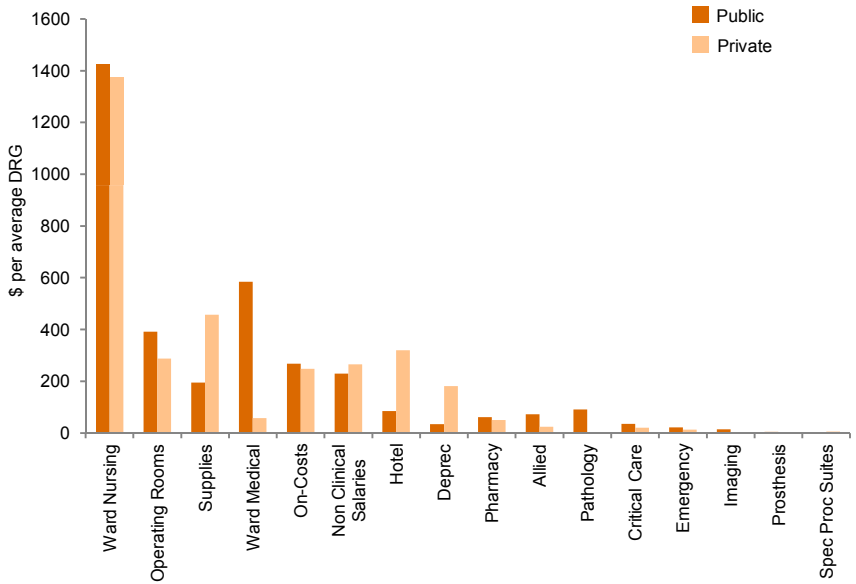
- The purchase of additional capacity would provide GCHHS with the ability to manage demand spikes with minimal disruption to patients.

Risks

- Poor continuity of care as patients cross public and private services
- Insufficient GCHHS capacity to meet both public and private neonatal special care service demands
- Patient dissatisfaction due to perceived inequities due to some GCHHS patients being treated as private patients.

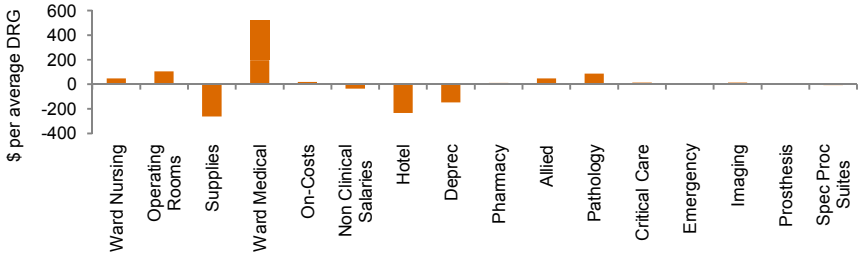
Maternity

Cost bucket breakdown

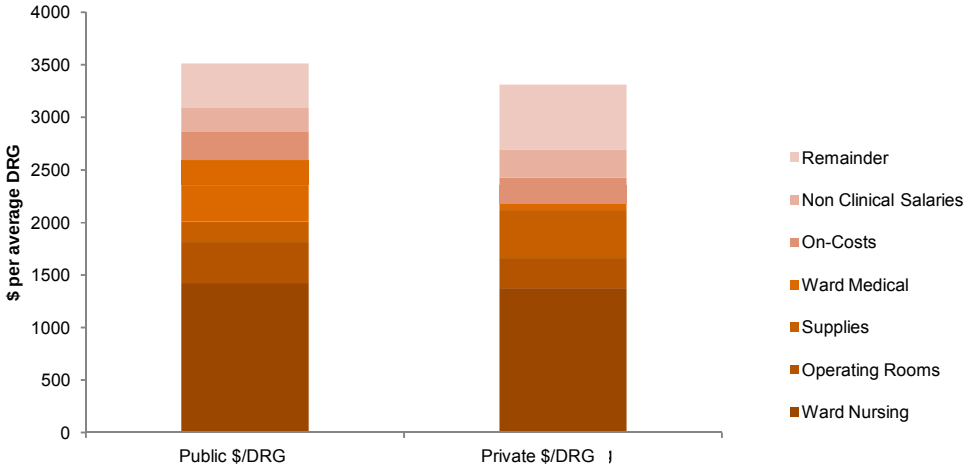


Cost variance - public v private

Positive variance indicates lower cost private provision of service



Cost per average DRG



Cost variance findings

- **Financial evidence does not suggest significant cost savings from Maternity services operated in a private setting. Potential exists to purchase 'overflow' beds at marginally similar cost to public provision of service from a private provider.**
- Nursing costs in private appears on par with public cost even though private pays lower salaries. Potentially due to higher nurse to patient ratios, and/or higher nursing skill mix in private sector
- Supply costs are higher in the private sector, though limited explanation as to the makeup of supplies is provided to allow sufficient analysis of the cause

Casemix cost analysis

- A moderate quantity and moderate variety of services are performed with 6,180 separations spread across 13 DRG's
- Average cost/DRG is $3,511 public, $3,312 private
- Indicative total cost for the service is $21.7M public, $20.5M private
- The top 3 DRG's make up 66% (public) and 73% (private) of total cost and 52% of activity. DRG's include vaginal delivery - CSCC - O60B, caesarean delivery - CSCC - O01C, & vaginal del single uncomp - O01C

Feasibility	Full Private	Partial Private
	Medium	High

General medicine

The data indicates it is feasible to consider the provision of general medicine services through a private provider. However, it is thought that the range and complexity of services provided may vary across the public and private sectors, and private providers may not wish to provide the full range of general medicine services but provide additional capacity for a prescribed range of services as required by GCHHS.

	Clinical	Clinical support	Clinical flow	Workforce	Financial
Full Private					
Partial Private					
Description of option analysed	GCHHS is responsible for providing the complete service. Private provider operates independent service and public purchases services as required.	If providers are co-located, arrangements for shared clinical support services are negotiated. GCHHS may provide access to interdependent services eg, ICU.	Clear protocols describe the referral of patients to the private provider and the flow of patient information between private & public providers.	Each provider sources and manages their respective workforce.	GCHHS purchases additional capacity as required through a commercial arrangement.
Implementation Considerations	• The range of services a private provider could provide requires confirmation • The services that may be purchased by a private provider may be targeted eg. Subacute.	• Agreement will be required on the level of interdependent services a private provide may require access to.	• Referral criteria and protocols to ensure continuity of care for patients who have co-morbidities and multiple episodes / points of care each year will need to be developed. • If the private provider only services specific conditions within General Medicine, there are additional challenges for internal referrals, particularly where patients are admitted without a clear diagnosis	• The impact of alternative service delivery models on specialist training pathways needs to be discussed with specialist Medical Colleges	• The identified cost efficiencies for private providers may not be achievable if the private provider is responsible for the full range of case complexity *(see cost variance findings on next page)*

Relevant examples

- Some Queensland hospitals have used the private sector to purchase additional capacity on an 'as needs' basis for example, Bundaberg Base Hospital has purchased medical capacity from the Friendly Society Hospital
- *Mildura, Victoria*: Ramsay Healthcare provides public services including general medicine through a contractual arrangement with the Victorian Government.

Benefits

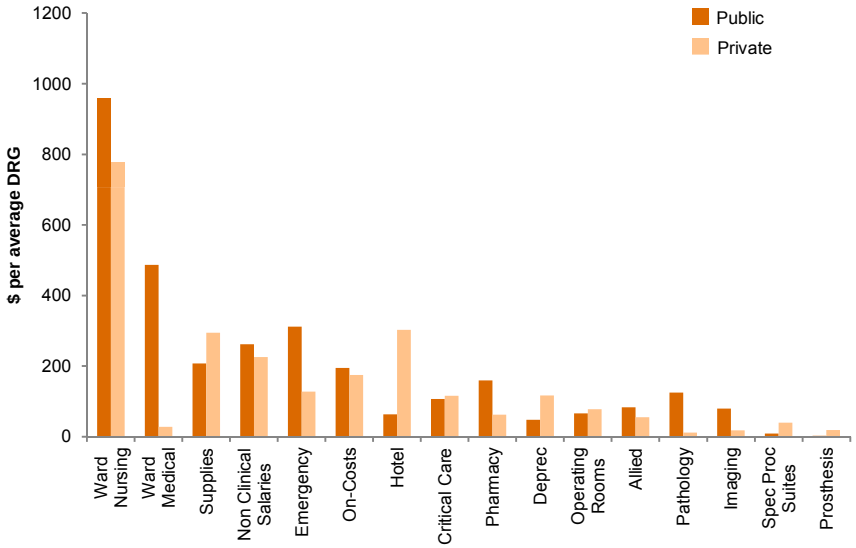
- Ability to manage demand spikes with minimal disruption to patients.
- Ability to segment the service to have select conditions treated through a more cost efficient model

Risks

- A private provider is not able to provide the services required by the GCHHS
- Patient care is compromised / patients are confused due to frequent movement between GCHHS and a private provider.
- GCHHS purchases additional services from private provider over and above what they are budgeted to deliver

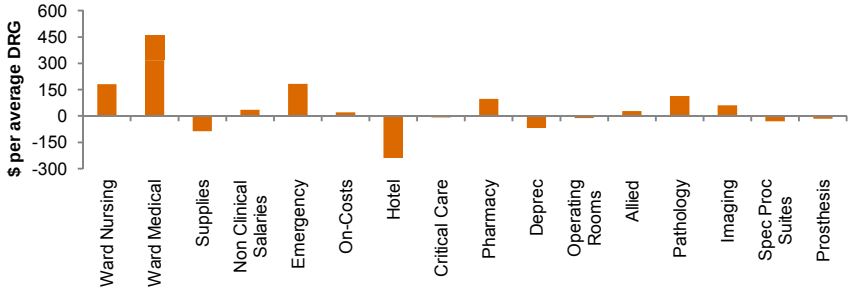
General medicine

Cost bucket breakdown

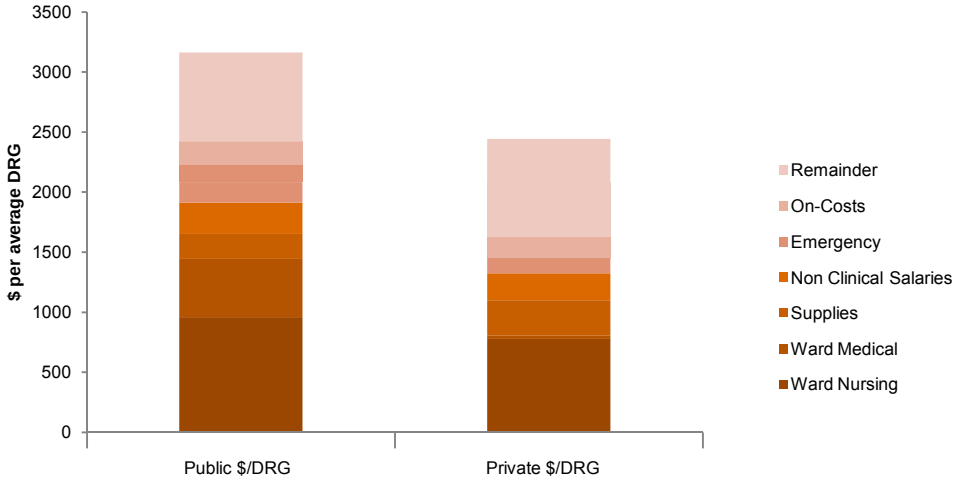


Cost variance - public v private

Positive variance indicates lower cost private provision of service



Cost per average DRG



Cost variance findings

- **Financial evidence suggests that private provision of General Medicine may be achievable at lower cost due to savings in labour related costs.**
- A large opportunity ($639/DRG) in medical labour exists due to a private provider being able to bill Medicare directly for the provision of medical salaries, and nursing salaries being less in the private sector
- Emergency Department costs appear less in private sector due to less complex cases and less private hospitals running Emergency Departments.

Casemix cost analysis

- A high quantity and variety of services are performed with 13,902 separations spread across 82 DRG's
- Average cost/DRG is $3,162 public, $2,444 private
- Indicative total cost for the service is $44M public, $34M private
- Individual DRG costs vary widely with the highest total cost DRG (E65A) contributing only 7% of total service cost in public and private
- The top 10 DRG's make up 46% of total cost and 36% of activity for both public and private .

Feasibility	Full Private	Partial Private
	High	High

General surgery

The data indicates it is feasible to consider the provision of general surgery services through a private provider. However, it is thought that the range and complexity of services may vary across the public and private sectors and private providers may not wish to provide the full range of general surgery services but provide additional capacity for a prescribed range of services as required by GCHHS.

	Clinical	Clinical support	Clinical flow	Workforce	Financial
Full Private					
Partial Private					
Description of option analysed	GCHHS is responsible for providing the complete service. Private provider operates independent service and public purchases services as required.	If providers are co-located, arrangements for shared clinical support services are negotiated. GCHHS may provide access to interdependent services eg, ICU.	Clear protocols describe the referral of patients to the private provider and the flow of patient information between private & public providers	Each provider sources and manages their respective workforce	GCHHS purchases additional capacity as required through a commercial arrangement
Implementation Considerations	• The range of services a private provider could provide requires confirmation • Agreement on appropriate levels 0f pre and post operative care (including specialist outpatients), linked to evidence based practice	• Responsibilities for the management of interdependent services/facilities to be shared by both the GCHHS and a private facility operating within the GCUH eg, CSSD and operating theatres will need to be delineated (refer to clinical support services page 51)	• Treatment and management of emergency and trauma cases would need to be clearly defined under a full private provision • Referral pathways will need to be clearly defined and well communicated to the primary and community care providers	• The impact of alternative service delivery models on specialist training pathways needs to be discussed with specialist Medical Colleges	

Relevant examples

- Queensland public hospitals purchases selected surgical services from private providers across Queensland through the Surgery Connect program
- *Mildura, Victoria*: Ramsay Healthcare provides public services including surgery through a contractual arrangement with the Victorian Government.

Benefits

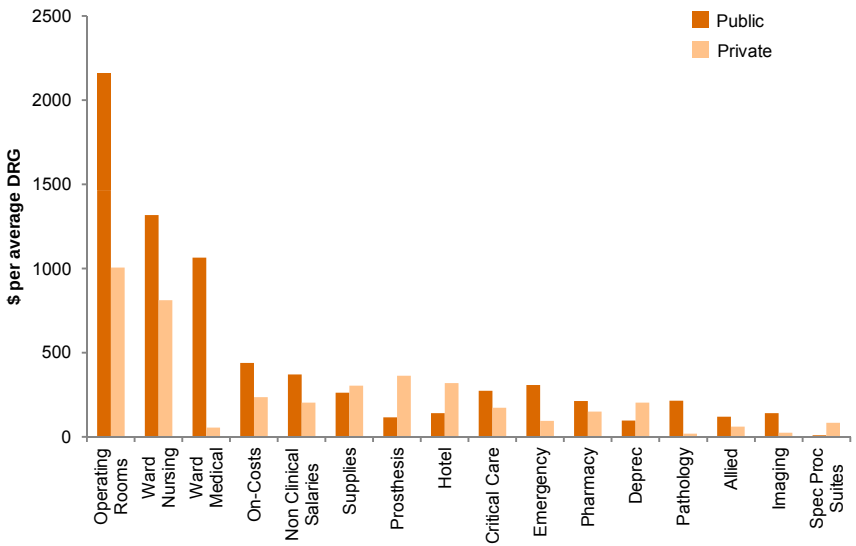
- Ability for the GCHHS to manage demand spikes with minimal disruption to patients.
- Ability to segment the service to have select conditions treated through a more cost efficient model

Risks

- Disruption to patient flow as patients move between interdependent services such as intensive care and theatre.
- GCHHS purchases additional services from private provider over and above what they are budgeted to deliver

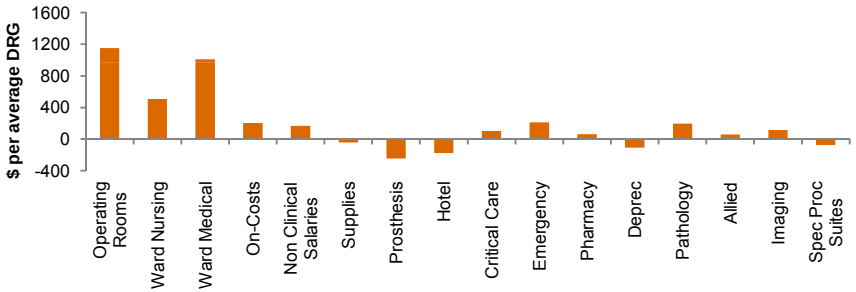
General surgery

Cost bucket breakdown

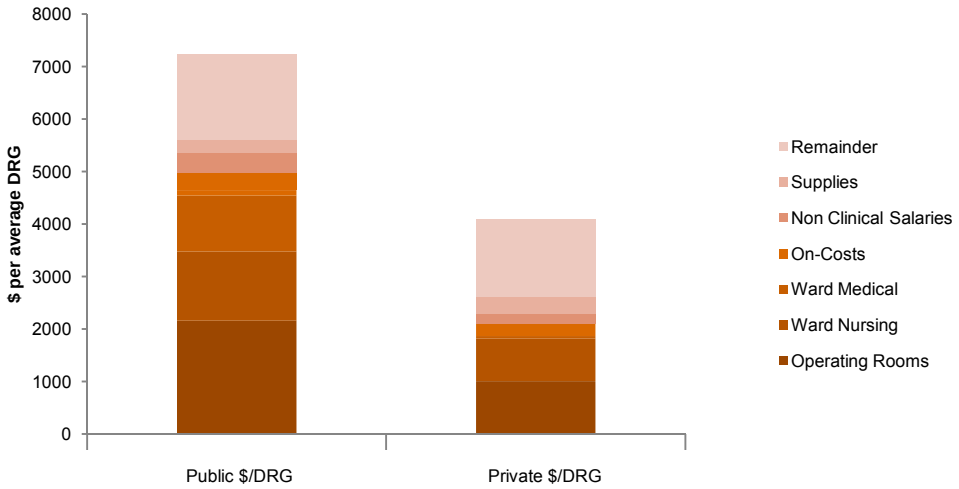


Cost variance - public v private

Positive variance indicates lower cost private provision of service



Cost per average DRG



Cost variance findings

- **Financial evidence suggests that private provision of General Surgery may be achievable at lower cost due to savings in labour related costs.**
- An opportunity ($1,517/DRG) in medical labour exists due to a private provider being able to bill Medicare directly for the provision of medical salaries, and nursing salaries being less in the private sector
- Operating room costs appear $1,153/DRG less in the private sector due to reduced nursing salaries and the on charge of medical salaries to Medicare

Casemix cost analysis

- A low quantity and moderate variety of services are performed with 1,290 separations spread across 22 DRG's
- Average cost/DRG is $7,234 public, $4,093 private
- Indicative total cost for the service is $9.3M public, $5.3M private
- Individual DRG costs vary widely with the highest total cost DRG (Appendicectomy - CSCC - G07B) contributing 20% in public and private, accounting for 26% of separations.
- The top 5 DRG's make up 48% of total cost for both sectors and 56% of activity

Feasibility	Full Private	Partial Private
	High	Low

Endoscopy

The data indicates the private sector can provide endoscopy services more efficiently than the public sector. Partial private provision has been defined as a split of select procedures between the public and private provider.

	Clinical	Clinical support	Clinical flow	Workforce	Financial
Full Private					
Partial Private					
Description of option analysed	Private provider is responsible for the complete service delivery for public and private patients.	If providers are co-located, arrangements for shared clinical support services are negotiated. GCHHS may provide access to interdependent services.	Clear protocols describe the referral of patients to the private provider and the flow of patient information between private & public providers.	Private provider is responsible for developing requisite workforce. May leverage Option B public medical officers to supplement the workforce.	GCHHS purchases services from a private provider through a commercial arrangement.
Implementation Considerations	• Services provided to patients would be disjointed and overly complicated if split between public and private in a partial private model.	• Agreement will be required on the level of interdependent services a private provide may require access to and how emergent care might be managed	• Scheduling of designated clinical space for both public and private access could decrease the accessibility of the service for emergency procedures.	• Under a partial private model, sustaining a full time workforce arrangement for either maybe difficult.	• High prosthetic costs reduce the efficiency of a private service; a mechanism to reduce the cost of prosthetics will need to be established e.g. GCHHS purchases and provides prosthetics.

Relevant examples

- *Mildura, Victoria*: Ramsay Healthcare provides public services including endoscopy through a contractual arrangement with the Victorian Government.

Benefits

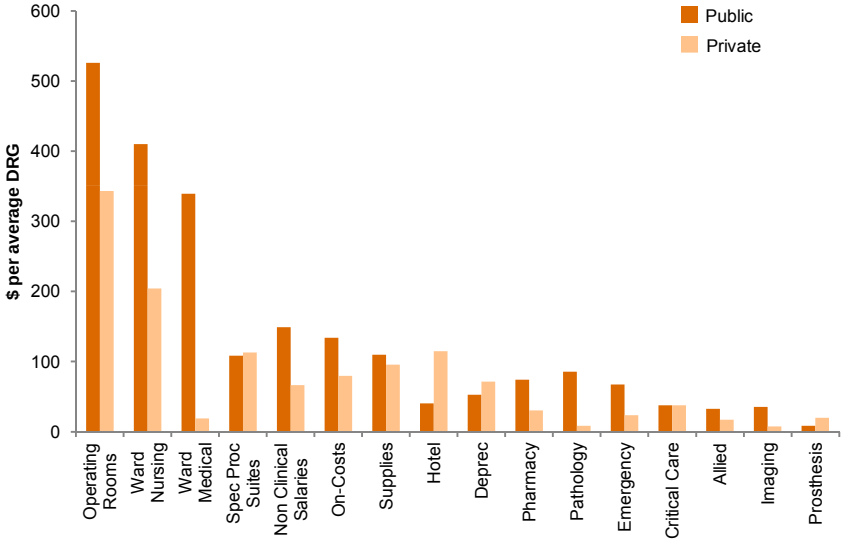
- Improved coordination of public and private lists particularly for surgeons and anaesthetists.

Risks

- Potential patient safety risk where emergency procedures are not able to be performed due to a split provider arrangement.

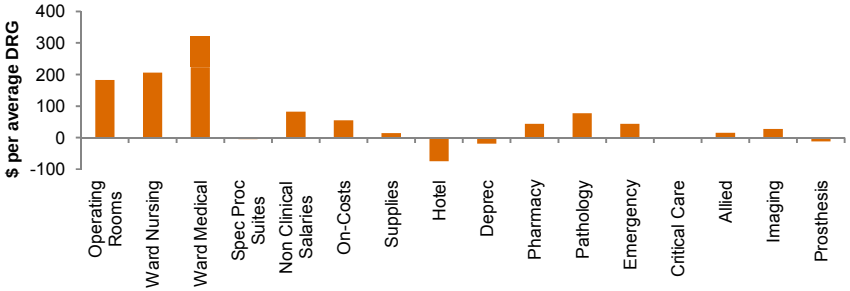
Endoscopy

Cost bucket breakdown

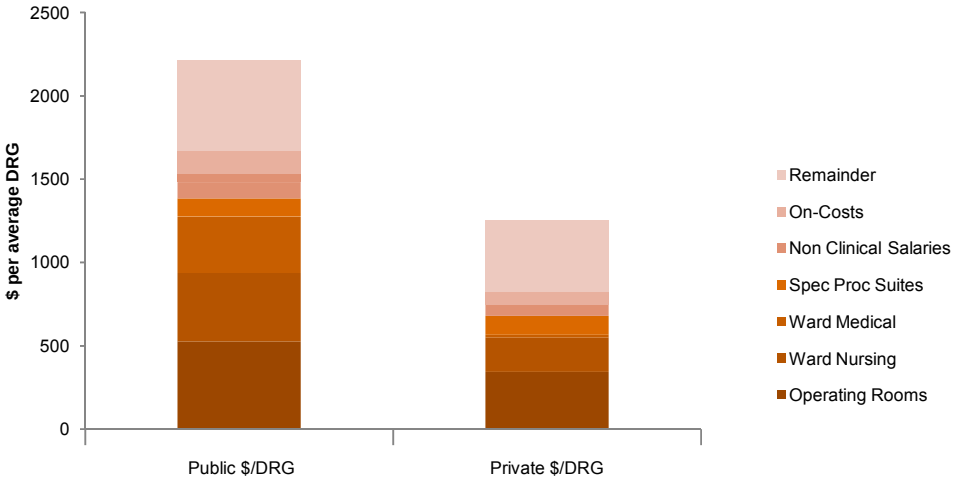


Cost variance - public v private

Positive variance indicates lower cost private provision of service



Cost per average DRG



Cost variance findings

- **Financial evidence suggests that private provision of Endoscopy may be achievable at lower cost due to savings in labour related costs.**
- An opportunity ($527/DRG) in medical labour exists due to a private provider being able to bill Medicare directly for the provision of medical salaries, and nursing salaries being less in the private sector
- Operating room costs may be $182/DRG less in the private sector due to reduced nursing salaries and the on charge of medical salaries to Medicare

Casemix cost analysis

- A moderate quantity and moderate variety of services are performed with 4,731 separations spread across 19 DRG's
- Average cost/DRG is $2,212 public, $1,253 private
- Indicative total cost for the service is $10.5M public, $5.9M private
- The top 5 DRG's make up 54% (public) and 52% (private) of total cost and 72% of activity.
- The top 10 DRG's by total cost are the same for both Public & Private with only a slight variation in ranking within the top 10.

High level risks for all services

The following high level risks apply to all services and are provided in the context of a service being provided by any model other than a full public service for consideration when progressing decisions with respect to service models. A more detailed risk assessment and the development of mitigation strategies will be required prior to the progressing individual service models.

Risk	Likelihood	Consequence	Rating	Possible Mitigation Strategies
GCHHS has to resume delivering outsourced services unexpectedly and does not have the requisite workforce capability or required timeframes to maintain continuity of service	Possible	Major	High	• Robust tender selection and due diligence to support successful provider selection • Development and implementation of transition plans for the operational return of each service to GCHHS
Inability of a private provider to recruit the required workforce	Possible	Major	High	• Tender timeframes need to allow for GCHHS to plan and commence the services should the private provider risk be realised • Consider leveraging public workforce in partnership model
Industrial issues limit the extent to which the preferred model can be implemented	Possible	Major	High	• Inclusive stakeholder consultation • GCHHS prepares to provide service until negotiations and handover is complete
Reduced quality of care due to the inability of a provider to meet required quality and safety standards	Unlikely	Extreme	High	• Robust procurement (tender specification and selection) processes • Quality [standards] requirements included in contract • Robust contract management (i.e. performance monitoring and management inclusive of consequences when contractual obligations are not met)

High level risks for all services (cont')

Risk	Likelihood	Consequence	Rating	Possible Mitigation Strategies
There is an inability to expand services due to the amount of GCUH space leased to a private provider	Possible	Major	High	• Limiting the space available for leasing through a detailed understanding of demand needs across the life of the leasing contract
Inability to progress preferred service models due to legislative, regulatory and policy requirements not able to be met	Possible	Major	High	• Tender document preparation needs to be comprehensive in articulating requirements to be met by private provider • Program planning for tender process to include allocated time for the investigation into mandatory requirements
The scope of services delivered is limited due to an inability to meet requisite CSCF requirements	Possible	Major	High	• Clarity to be gained on the private provider capability resulting from market intelligence research • Identify early in the contract process the service level requirements • Robust contract management where providers have committed to delivery of services at agreed levels
GCHHS targets (including NEAT and/or NEST) not met due to actions (or lack of) on the part of the private provider	Possible	Major	High	• Clearly define operational requirements needed from the private provider in the contract • Ensure mitigation/resolution measures are defined and agreed

High level risks for all services (cont')

Risk	Likelihood	Consequence	Rating	Possible Mitigation Strategies
Performance targets are not met for example, activity targets	Possible	Major	High	• Robust contract management process • Ensure mitigation/resolution measures are defined and agreed
Poor continuity of care due to poor information flow and/or differing clinical pathways	Likely	Moderate	High	• Active management of adherence to agreed models of care for both the public and private providers • Agreed patient information sharing protocols established at the outset
Services will not be ready to commence in the timeframes required for GCUH plans	Possible	Major	High	• Program planning for tender process must have realistic timeframes • Contract closure needs to occur with sufficient time for staff recruitment • Confirm continuation of services being provided outside of GCHHS in the interim and revise timeframes • Ensure high level of detail is requested through the tender documentation to reduce start up time upon appointment
Education and research will not be supported in line with GCUH strategic plan	Possible	Minor	Medium	• Contractual requirement for participation and education and research

Implementation considerations

Sections two (clinical services analysis) and three (clinical support services summaries) of the full report provide a detailed analysis of specific issues identified against the assessment criteria at a service level that must be considered prior to progressing the development of any models. However certain issues were found to be relevant to all or most services and are summarised below.

Continuity of Care

- The mechanisms for sharing of public patient information will need further detailed process analysis upon the appointment of any private provider to ensure appropriate flow of clinical information
- Clinical guidelines, clinical pathways and models of care for public patients need to be agreed for each service where a private provider is engaged, with evidence-based practice being the guiding principle
- Further investigation will be required to determine if and when formal referral processes for public patients will need to be developed and implemented
- Early agreement must be gained on the approach to patient assessment and prioritisation to ensure equity of access, timeliness of care and performance in line with national targets.

Procurement

- Any additional tender processes to engage a private provider will have a time impact
- Tender specifications will need to be detailed for each service individually to ensure the needs of the service are appropriately presented.

Workforce

- Consideration will need to be given in service planning with private providers as to the extent of GCHHS clinical support staff that may be required for each service e.g. Allied Health for radiotherapy
- The impact of alternative service delivery models on specialist training pathways needs to be discussed with specialist Medical Colleges
- The involvement of private providers needs to assess the impact on the ability for specialist medical trainees to access GCHHS training activities

Implementation considerations (cont')

Clinical support services

- Arrangements for accessing public sector interdependent services, such as ICU, must be clarified for each service

Transition

- A plan to manage the transition to the new service models will need to be developed
- A plan to manage communication of the new service models with each stakeholder group will need to be developed

Quality and safety

- The standards and protocols required for each service need to be identified and agreed where necessary
- The agreed mechanisms to monitor safety & quality of privately procured services need to be developed

Contract management implications

In the summary of the assessment criteria, three criteria areas were identified as having the same or similar implications across all services reviewed. The summary of analysis results is provided below for matters relating to these criteria: contracts, asset maintenance and ICT implications

Contract Management

There are two main contractual options for GCHHS to consider when engaging in private service provision options:

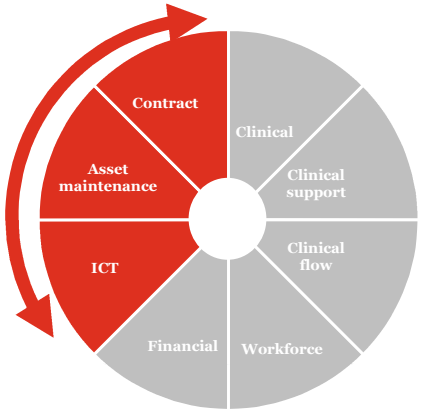
a) **Fully outsourced service:** GCHHS maintains coordination of the service and the private provider assumes full responsibility for the management and operations of the service

b) **Sub-contracted service:** GCHHS retains responsibility for the service, managing the needs of the hospital, however the private provider will deliver specified aspects of the service as per the contract

Under either option, GCHHS need to reach with the private provider regarding the leasing and maintenance arrangements for related assets.

The introduction of any form or private service provisioning or partnership will transform GCHHS from a service delivery agency to a strategic purchasing agency. Procurement and contract management capabilities will play a larger role in GCHHS's activities than initially planned.

GCHHS will be required to understand KPI's in a way that translates performance into operational requirements to be provided by the private provider. For example, minimum theatre availability levels would be contractually defined to support NEST targets if operating theatre was managed and serviced privately.



Implementation Considerations

- **Procurement capability and processes:** Contract negotiation and management processes must be standardised and well understood across the HHS
- **Contract flexibility:** the ability to adjust activity volumes with emerging priorities across services will need to be built into the contract
- **Education, training & research:** the extent and nature of involvement from the private provider to be agreed
- **Reporting and activity targets:** the reporting of activity and how activity will be managed must be defined.
- **Service specifications:** listed below are several areas that are suggested for inclusion into the contract with a private provider

- Quality & safety standards & protocols
- CSCF & workforce requirements
- Sharing of patient information
- Clinical model of care & clinical pathways
- Referral processes
- Patient assessment and prioritisation guidelines
- Credentialing, privileging and scope of practice
- Incident monitoring & reporting
- Accessing clinical support services or supporting clinical input (e.g. ICU, Allied Health)

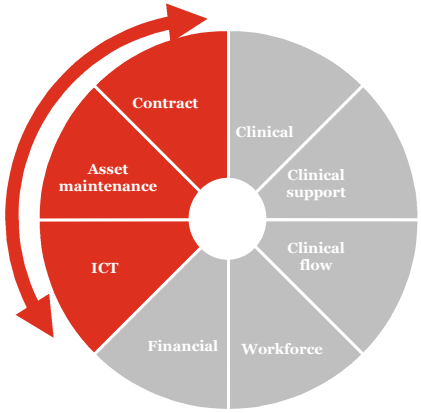
Contract management implications

Based on recent negotiations between Fiona Stanley Hospital and Serco Australia Pty Ltd, there are some key commercial issues that underpin the contractual agreements that are useful for guiding GCHHS in the tender and contract development processes.

	Issue	Principles
Fee structure	Meeting service specifications	The private provider will receive a fee for provision of the service consistent with the service specifications.
	Total services fee	The fee will be determined by calculating, and then aggregating, individual fees for the individual Services.
	Volume risk	For services where GCHHS desires to transfer volume risk, the individual service fee shall be a fixed fee based on the service specifications.
	Variable fee	For services where it is uneconomic for GCHHS to transfer volume risk, the individual Service fee shall be a variable or volume-based fee based on the consumption of the service.
	Inflation	Fees will be indexed annually, or adjusted in line with National Efficient Price indexes to maintain the real value of the fee to the private provider.
Service Delivery	Continuous improvement	The payment mechanism will encourage continuous improvement in the efficiency and effectiveness of the services provided by the private provider over the term of the contract.
	Quality of service delivery	Where the performance of the private provider falls below the service specifications and the KPIs, consequences will apply appropriate to the below-standard service. This will apply to the extent that poor service equates to reduced or no fee being payable to the private provider, or other relevant clinical consequences.
	Performance	Where the services exceed the service specifications and deliver clear and quantifiable additional value to the state, the private provider's performance will be appropriately recognised.
	Innovation	The payment mechanism incentivises the private provider to look for better ways of delivering Services to provide cost savings to the State without compromising the intent of the service specifications.
	Ongoing Value-for-Money	Certain services will be contested in the marketplace on an ongoing basis to ensure that value-for-money is obtained during the life of the contract.

Source: Fiona Stanley Hospital Facilities Management Services Project, Project Summary, February 2012, Government of Western Australia, Department of Health

ICT implications and asset maintenance



ICT

A high level assessment of the feasibility of GCUH's capacity to support private provider ICT systems, networks and telephony was conducted through interview with HHS project staff. The table below provides information that indicates private providers may be accommodated. Some additional considerations were identified that will need to further exploration:

- How access can be shared between GCHHS and private provider if required?
- What processes will need to be in place to manage dual systems if ICT systems can not be shared?
- Will CARPS and RFID systems be most appropriately shared for private provider use?

ICT infrastructure implications	Supporting infrastructure
All physical service areas within GCUH can be supported by ICT infrastructure	• Integrated networks for clinical and building engineering services • Local Area Networks (LAN) are available across the entire GCUH facility • Full wireless coverage across the facility • Uninterruptable power supply (UPS) • High speed cables
Private providers will be able to implement their own ICT systems if necessary	• Secure networks can be created for private services within GCUH • Current infrastructure can be utilised
The future growth of GCUH services can be accommodated by proposed ICT infrastructure	• Secure communities available for private services when required • Facility can be fully populated with ICT infrastructure when required

Asset maintenance

It is assumed private providers will use GCHHS infrastructure and equipment when providing contracted services; the management and maintenance of these assets is critical for the delivery of safe services. Factors requiring consideration in the context of each service include:

- what management model will best safeguard GCHHS interests eg. leasing or a Managed Equipment Service (MES)
- where the responsibility for maintenance will lie ie. GCHHS, private provider, MES
- inclusion of maintenance scheduling and respective activity targets in respective agreements.

Section 4

Clinical support services options analysis

Feasibility	Full Private	Partial Private
	High	Low

Medical imaging including nuclear medicine

The data indicates the private sector can provide medical imaging services more efficiently than the public sector. Partial private provision has been defined as a split of select procedures between the public and private provider.

	Clinical	Clinical support	Clinical flow	Workforce	Financial
Full Private					
Partial Private					
Description of option analysed	Private provider is responsible for the complete service delivery for public and private patients.	If providers are co-located, arrangements for shared clinical support services are negotiated. GCHHS may provide access to interdependent services.	Clear protocols describe the referral of patients to the private provider and the flow of patient information between private & public providers.	Private provider is responsible for developing requisite workforce. May leverage Option B public medical officers to supplement the workforce.	GCHHS purchases services from a private provider through a commercial arrangement.
Implementation Considerations	• Services provided to patients would be disjointed and overly complicated if split between public and private in a partial private model	• Agreement will be required on the level of interdependent services a private provide may require access to and how emergent care might be managed	• Scheduling of designated clinical space for both public and private access could decrease the accessibility of the service for emergency procedures	• Under a partial private model, sustaining a full time workforce arrangement for either maybe difficult.	• Imaging costs are significantly less in the private sector due to costs being covered by Medicare rather than the service provider.

Relevant examples

- *Melbourne, Victoria*: Eastern Health Medical Imaging (EHMI) is a partnership which provides public & private sector imaging services across the Eastern Metropolitan Region . Radiologists are private specialists; all other services are provided by the public sector (Prince of Wales Hospital).
- *Burnie, Tasmania*: Public patient medical imaging services are provided by a private provider through a contractual arrangement with the Tasmanian State Government
- Launceston, Tasmania: Public patient nuclear medicine services are provided by a private provider through a contractual arrangement with the Tasmanian State Government.

Benefits

- Potential increased access to services if provided by private provider with existing medical imaging services in other locations
- Reduced complexity of shared model where 2 separate entities provide the same services in the same facility.

Risks

- Potential patient safety risk where emergency procedures are not able to be performed due to a split provider arrangement.

Feasibility	Full Private	Partial Private
	High	High

Operating theatres

The data indicates the private sector can provide operating theatre services more efficiently than the public sector. Partial private provision has been defined as two operators providing the service using the same equipment and workspace; theatres and/or session times would be allocated to each operator.

	Clinical	Clinical support	Clinical flow	Workforce	Financial
Full Private					
Partial Private					
Description of option analysed	Private provider is responsible for managing the service for both GCHHS and private providers.	Arrangements for shared clinical support services such as CSSD are negotiated.	Clear protocols describe the flow of patients in, within and out of the service.	Medical staff provided by the entity providing patient. Nursing and other ancillary / support staff provided by service manager. Cleaning and porterage staff will be dedicated to the service.	GCHHS engages a service manager through a commercial arrangement. Collocated private entity purchases theatre services from GCHHS.
Implementation Considerations	• Service manager would schedules theatres for specific sessions • Session lists would be managed by surgeon responsible for respective list • Single manager increases flexibility in the use and utilisation of resources.	• How interfacing services will be managed (eg. CSSD, pre-admission) requires identification • Instruments and consumables are managed and provided by the service manager	• Protocols for the use of space within the complex to reduce confusion particularly in the scenario of a dual management model will need to be developed • Scheduling of designated clinical space for both public and private access needs to address ability to meet temporal and location separated services	• Ability to accommodate dual workforces within the infrastructure (change rooms, staff rooms, administrative work stations, recovery monitoring stations) does not appear feasible but will need to be confirmed	• The private sector can provide operating room services more efficiently than the public sector.

Relevant examples

- *Mildura, Victoria*: Ramsay Healthcare provides public services including operating theatres through a contractual arrangement with the Victorian Government.

Benefits

- Improved OT utilisation with a managed service with set performance outputs
- Improved coordination of public and private lists particularly for surgeons and anaesthetists.

Risks

- Potential patient safety risk due to two entities providing surgical services within the one complex
- Inability for GCHHS to meet NEST targets due to reduced theatre utilisation.

	Full Private	Partial Private
Feasibility	High	Low

CSSD

Due to the nature of service operations of CSSD, the assessment criteria were not able to be applied as per the analysis for other services.

The most feasible service models have been identified as either a full private provision or full public provision i.e. a single operator model. The feasibility of a partial private service provision or dual operator model was assessed as low for the following reasons:

- The infrastructure is unlikely to be able to support dual services which would require greater physical space and level of activity than has been planned for processing areas currently
- Potential for increased safety risks with dual operations or partial models
- Workforce resource management would be more complex
- Coordinated workflows and standard operating protocols would be critical.
- Instruments would need to be clearly identified in the scenario of each entity owning their respective instruments

Given the level of integration between operating theatres and CSSD, it appears feasible that these services are provided by the same provider, whether that be public or private.

Soft FM services

Preliminary analysis indicates there is significant cost variability of soft FM services across the public and private services. This variance is assumed to be due to the private sector providing a different type of some services for example, catering – increased choice options for food and beverages

The models considered for the provision of Soft FM Services were:

- dual operating where each provider providing their own soft FM services
- single operating model where a single provider (public or private) provides soft FM services for both providers
- a mixture of dual and single operator models.

The table below identifies the indicative operating model and outlines key factors when considering the preferred operating model for each FM service.

Soft FM Service	Key Factors	Implications	Indicative Operating Model
Catering	• GCUH kitchen is designed as a cold plating kitchen • Limited facilities for hot production will be available; however, installation of the chilled plating lines means that hot food cannot be plated • Limited cold room and freezer capacity • The proposed patient menu ordering system could be utilised for private meal ordering and collation	• Segregation of food stock will not be possible • A private provider will only be able to provide a cold plating service • GCHHS could provide food services; different menus could be accommodated • GCUH could accommodate a separate mid meals service with each ward having a kitchenette and beverage bay	Single or Dual (using a cold plating arrangement only)
Cleaning	• There will be cleaners rooms in each ward / department • It may be possible to allocate basement space for storage / cleaning of large equipment	• The lack of bulk storage space will require consumables (toilet rolls, hand towels etc) to be held in wards • It may be possible to hold some bulk chemicals in the basement	Single or Dual

Soft FM services (cont')

Soft FM Service	Key Factors	Implications	Indicative Operating Model
Clinical Supplies	• There will be no space at GCUH for bulk storage of clinical supplies • GCUH will be adopting a "Just-in-Time" system which allows for short term (<4 hrs) of imprest trolleys on the dock • Wards / Departments will have capacity for 2-3 days supply	• Dock capacity will be in demand requiring scheduling of deliveries • Private provider may be able to leverage QH supply chain and logistics arrangements	Single or Dual (using a Just-in-Time arrangement only)
Linen	• There is no bulk linen holding capacity on-site; there is short term holding capacity (<4 hrs) for a "roll-on roll-off" system in the clean dock • Linen bays in wards & clinical departments will house imprest trolleys • There will be capacity for holding dirty linen waiting collection in the dirty dock	• A private provider would be able to leverage the QH contract with Group Linen Supply on a charge back arrangement • A separate linen service could be managed using identifiers such as coloured trolleys	Single or Dual (using a roll-on roll-off arrangement only)
Porterage	• A devolved (ward based) porterage model will be implemented at GCUH • The information system to be used (Computer Aided Radio Personnel System - CARPS) could be used to task 2 service providers	• The operational logistics of using the CARPS system would need to be worked out • It is expected that the GCUH WiFi capability (used for CARPS) could be used for a separate private system if required • Additional training will be required to ensure GCUH staff understand how the two systems operate and interconnect (eg. theatres, medical imaging)	Single or Dual

Soft FM services (cont')

Soft FM Service	Key Factors	Implications	Indicative Operating Model
Security	• GCHHS has indicated GCUH security staff would not be able to respond to private service security issues • GCUH security staff could support the private servicer through CCTV, access control, duress monitoring, reporting an escalation of issues to the private security provider • GCHHS would control keying and access cards	• The private provider will need to provide a separate security service • Access requirements for the private provider would need to be discussed	Single
[Dock] Stores	• Services for the GCUH were designed to minimise the requirement for on-site storage. The supplier will manage an off-site storage area and distribution centre to allow for "Just-in-Time" delivery	• A private provider will need to source external storage space	Single
Waste	• There will be disposal rooms in wards/departments • There will be holding capacity for clean and dirty bins in the dirty dock • There is capacity for two garbage compactors	• The private provider may be able to leverage QH contracts for waste disposal • If using a dual system, bins would need to be separately identified and segregated • A barcoding system could be used to support a dual model; this would allow the tracking of waste and weight for charging purposes	Single or Dual (with clear identification of each provider's waste)

Relevant examples

- *Newcastle, New South Wales*: Medirest provides the soft FM services for the Mater Hospital including catering, cleaning, waste management, materials management, linen services, retail management and function catering
- *Perth, Western Australia*: Serco Australia has been contracted to provide non-clinical facilities management and support services at the Fiona Stanley Hospital (including engineering and building maintenance, security, ground maintenance, linen, cleaning, catering, waste services, managed equipment services, transport, procurement, sterilisation, reception and clerical services).

Section 5

Next steps

Next steps

The Queensland Government Value for Money Framework (VfM) as outlined on page X describes the process required to procure and manage service delivery through a private partnership. Use of the stages and elements within the VfM will assist GCHHS to ensure the service delivery models selected are in-line with Government and GCHHS Board intent. Those steps highlighted indicate where external support could provide value.

- Identify those services to progress to a more detailed assessment including:
  - identify approvals and licenses required
  - identify regulatory requirements (inclusive of standards)
  - confirm expected benefits
- Confirm whole-of-government policy requirements (including procurement)
- Confirm the approval process to be followed
- Obtain Board approval(s) to proceed.

- Develop a plan to meet all industrial obligations
- Sound the market
- Assess public interest
- Develop stakeholder communication plan
- Complete stakeholder consultation
- Obtain Board approval to proceed.

- Develop Tender Specifications for each service
- Develop Tender selection process (including due diligence checks on proposed providers)
- Conduct Tender process
- Prepare draft contracts including KPIs
- Develop performance management framework including consequences for underperformance

- Develop the commissioning process for each service
- Establish GCUH contract management processes
- Negotiate service contracts

- Monitor service performance
- Manage contracts
- Evaluate realisation of benefits

- Develop transition plans for the return of each service to GCHHS provision

Appendices

Appendix 1: Costing data constraints and points of note

When comparing public and private hospital service cost buckets, a number of constraints should be noted. These constraints however do not significantly alter the indicative findings of the financial analysis.

- Costing data is based upon the Round 12 (2007-2008) National Hospital Cost Data Collection (NHCDC). Public cost data within this report is based upon Queensland public hospital costs, while private costing data is based upon national private hospital costs. This differing geographical collection of costs still provides insightful relativity between public and private hospital costs. The Round 12 data is the most recent set of data which presents public and private data with consistent data definitions.
- Total costs for public and private hospital services presented in this report are based upon the episodes of care being purchased through the Gold Coast 2012-2013 Service Agreement, multiplied by the average Diagnosis Related Group (DRG) cost for a casemix of DRG's allocated to the specific service.
- Clinically similar diagnoses were defined according to the widely accepted system of Australian Refined Diagnosis-Related Groups (AR-DRG). As the AR-DRG system is only applied to acute-care admitted-patient services, it was not possible to compare costs for other hospital services (e.g. radiotherapy cancer services); in this instance non-financial considerations were used to compare the provision of radiotherapy cancer services.
- Due to the use of weighted averages, wide distribution of services within the data provided, non specific nature of cost data utilised, and limited transparency as to cost bucket inclusions, absolute costs as presented in this report should not be relied upon. However, relativity between public and private cost of service provision provides insightful evidence for the purposes of this report.
- Revenue (activity based funding) has been excluded from this analysis due to the mismatch between base date of current Weighted Activity Unit (WAU) rate of $4,808 being based on 2011 dollars, while the NHCDC cost data is based upon 2008 dollars. Cost escalation of 8% per year has been noted since 2008.
- Costs excluded from NHCDC data include:
    - Capital works, building depreciation (equipment depreciation is included), asset re-valuations and adjustments, and patient travel (including retrievals and ambulance services) were not included in Queensland Public NHCDC costs.
    - Corporate overheads (including administration costs of corporate office (including the Information Division) and the Area Health Services, as well as corporate Shared Services which provide financial, payroll and HRM services across all Districts were also excluded from Queensland Public NHCDC costs, due to an inability to meaningfully allocate these costs to specific hospitals.
    - Costs directly billed to patients (e.g. medical and diagnostic costs for private patients) are not collected for the NHCDC. Reference is made to this fact throughout the financial analysis sections of this report.

Appendix 2: Cost Bucket Data definitions

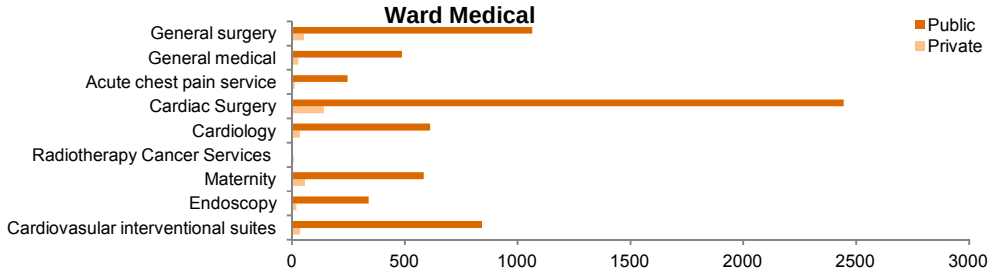
The following definitions are adapted from the National Hospital Cost Data Collection Round 12 (2007-2008) and identify the cost bucket inclusions utilised in the data.

The NHCDC data reports individual cost buckets by direct & overhead costs. For the purposes of this report, direct and overhead costs have been grouped together for each individual cost bucket.

Allied Health	The Allied Health cost bucket includes clinical services which are delivered by qualified Allied Health professionals who have direct patient contact in areas like audiology, physiotherapy, podiatry, etc.
Critical Care	The Critical Care cost bucket covers the Intensive Care and Coronary Care Units.
Emergency Department (ED)	The ED cost bucket covers the area of the hospital where patients who present in an unscheduled manner can be triaged, assessed and treated. The ED must conform to the requirements of the Australian Council on Healthcare Standards trauma guidelines, with the capacity to provide complex, multi -system life support (including medical ventilation and invasive cardiovascular monitoring (for a limited period of time).
Imaging	The Imaging cost bucket covers the area of diagnostic and therapeutic imaging produced under the direction of a qualified technician and reported by a medical practitioner.
Non-clinical salaries	This cost bucket includes all other costs of service provision for each inpatient separation.
Operating Rooms	The Operating Rooms cost bucket covers the area of a hospital where significant surgical procedures are carried out under surgical conditions under the supervision of qualified medical practitioners. The operating room must be equipped to deliver general anaesthesia and conform to the College of Anaesthetics and the Faculty of Intensive Care standards.
Pathology	Pathology cost bucket includes costs of diagnostic clinical laboratory testing for the diagnosis and treatment of patients.
Pharmacy	The Pharmacy cost bucket covers the area of the hospital responsible for the provision of pharmaceuticals. This includes the purchase, production, distribution, supply and storage of drug products and clinical pharmacy services.
Supplies	Supplies is an abbreviation for the supplies and ward overheads cost bucket. It includes costs for goods and services, medical and surgical supplies, ward overheads and clinical department overheads. In other words, it includes all costs attributed to a ward that are not included in any other cost buckets.
Ward Medical	This is also known as medical clinical services, includes the salaries and wages of all medical officers including seasonal payments. Note that medical costs may also be found in other buckets that have a medical salary and wages component e.g Imaging, Pathology, Critical Care, Operating Rooms, Emergency Department, Specialist Procedure Suits, Allied Health and Pharmacy.
Ward Nursing	This bucket includes nursing salaries and wages reported in Clinical Service Areas.

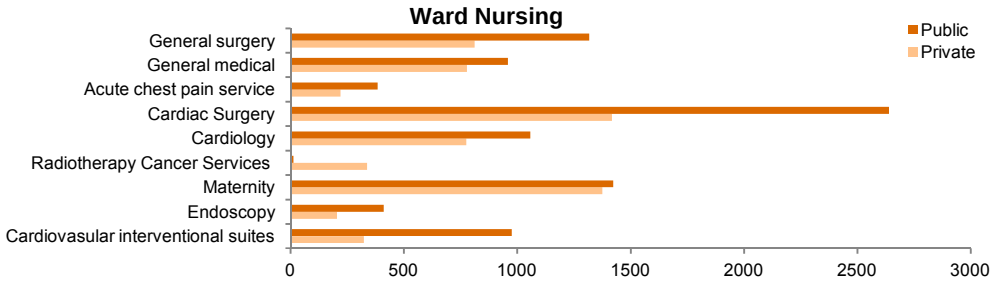
Appendix 3: Cost Bucket Analysis

The following graphs indicate the variance found between public and private sector hospital costs by service area. The apparent anomaly with Radiotherapy Cancer Services may be explained through the fact that this service is predominantly provided in an outpatient setting.



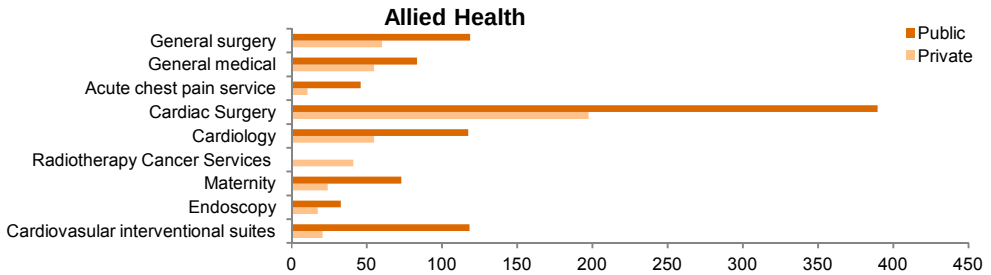
Includes Medical officer salaries & wages reported in clinical service areas

- Medical salary costs are significantly less in the private sector due to costs being covered by Medicare and the private patient rather than the service provider.



Includes Nursing salaries & wages reported in clinical service areas

- Nursing salary costs are generally less in the private sector as the private sector pay rates are lower
- The exception noted is for maternity where staffing ratios may be higher in the private sector.

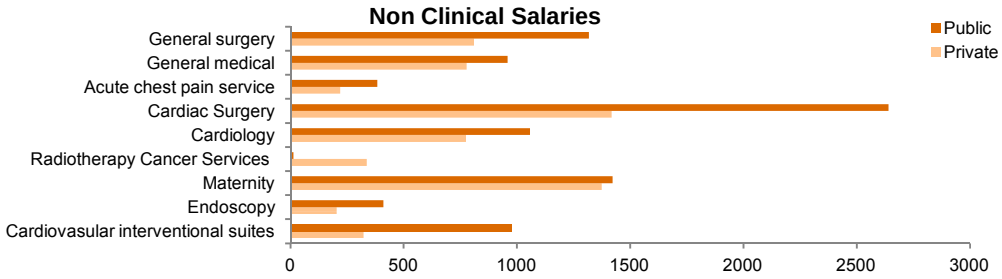


Includes costs associated with clinical services delivered by qualified Allied Health professionals

- Allied Health costs are significantly less in the private sector due to costs being covered by Medicare and the private patient rather than the service provider.

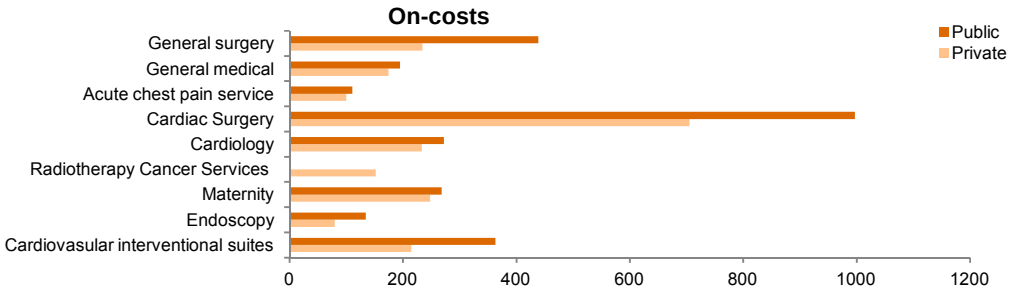
Appendix 3: Cost Bucket Analysis

The following graphs indicate the variance found between public and private sector specific hospital costs by service area



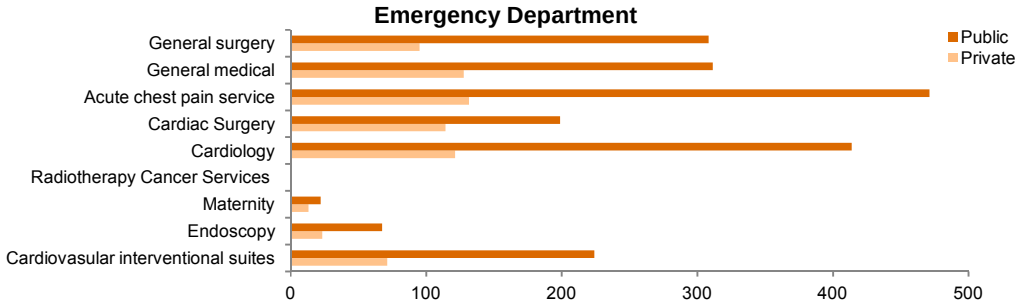
Includes all other costs of service provision for each inpatient separation

- Non-clinical salary costs are generally less in the private sector as the private sector pay rates are lower
- The exception noted is for maternity where staffing ratios may be higher in the private sector
- Costs may be covered elsewhere due to service arrangements eg, private providers may contract in services such as cleaning rather than employ staff.



Includes superannuation, termination payments, workers compensation, long service leave etc

- Salary on-costs are generally less in the private sector as the private sector pay rates are lower.

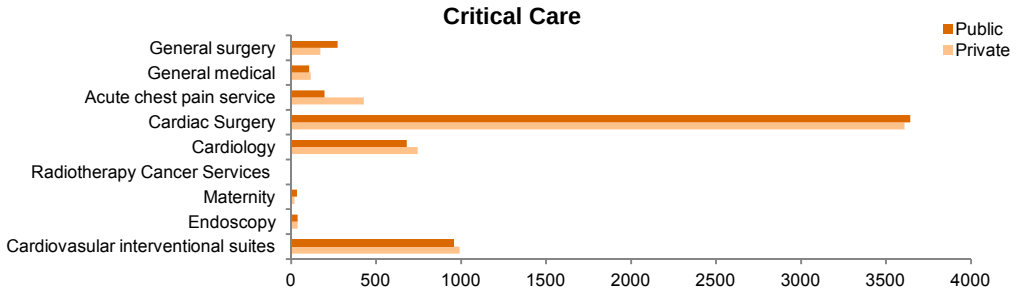


Includes costs associated with emergency department services

- The private sector provides emergency department services more efficiently than the public sector; it is expected that the significant variance between public and private sector Emergency Department costs are due to the private sector providing limited emergency department services
- The apparent anomaly with Radiotherapy Cancer Services is explained through the fact that this service is not provided in an emergency department environment.

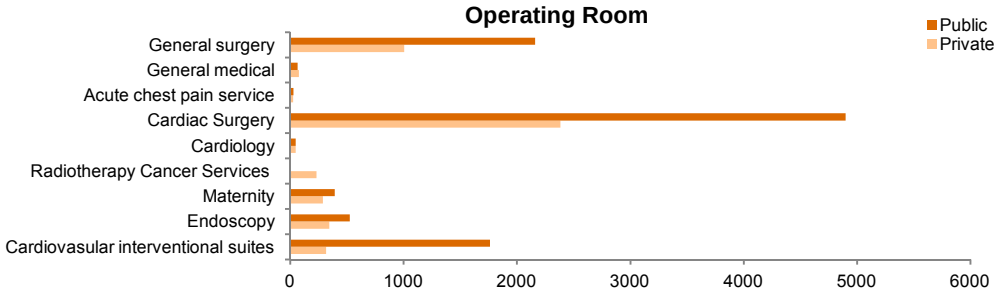
Appendix 3: Cost Bucket Analysis

The following graphs indicate the variance found between public and private sector specific hospital costs by service area



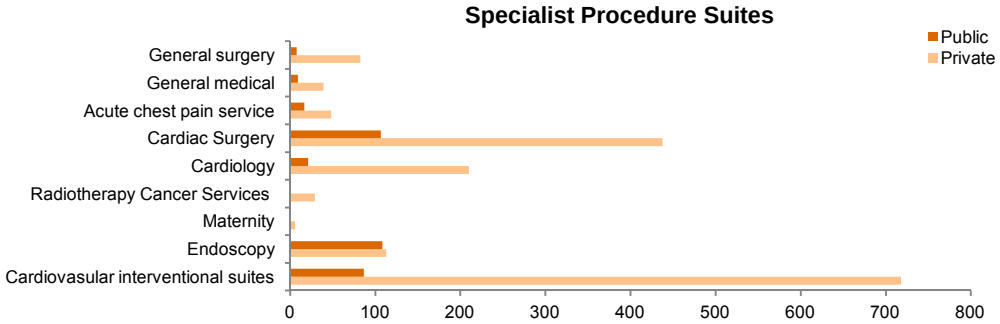
Includes Intensive Care and Coronary Care Units

- Critical care costs are comparable across the public and private sectors
- The apparent anomaly with Radiotherapy Cancer , Maternity and Endoscopy Services is explained through the fact that these services are not generally provided in a critical care environment.



Includes costs associated with services provided in operating rooms

- The private sector can provide operating room services more efficiently than the public sector.

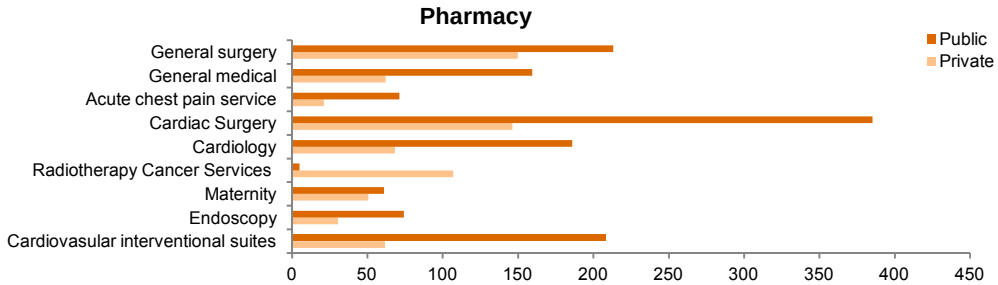


Includes costs to provide diagnostic and therapeutic procedures in a specifically equipped environment; does not include Operating Room costs

- The cost of providing specialist procedure suites is higher in the private sector; the significant variance for general surgical, general medical, cardiology, cardiovascular interventional and cardiac surgical services is thought to be due to the higher costs of prosthetics.

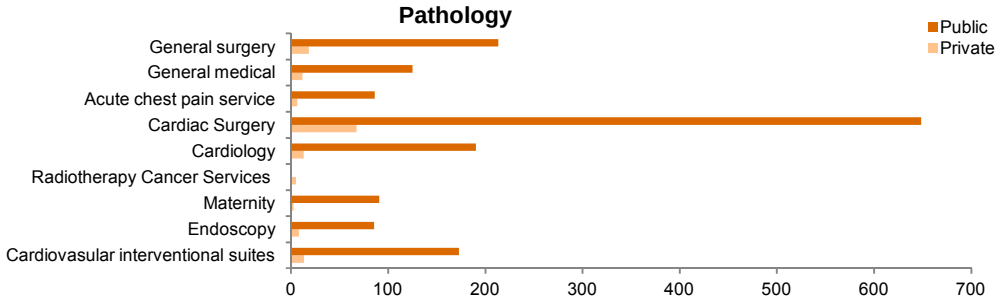
Appendix 3: Cost Bucket Analysis

The following graphs indicate the variance found between public and private sector specific hospital costs by service area



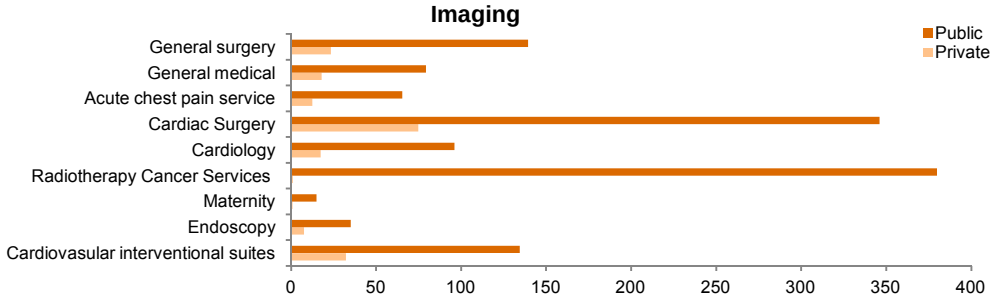
Includes costs associated with the purchase, production, supply & storage of drug products and clinical pharmacy supplies

- Pharmacy costs are lower in the private sector due to costs being covered by the Pharmaceutical Benefits Scheme and the private patient rather than the service provider.



Includes costs associated with diagnostic clinical laboratory testing

- Pathology costs are significantly less in the private sector due to costs being covered by Medicare rather than the service provider.

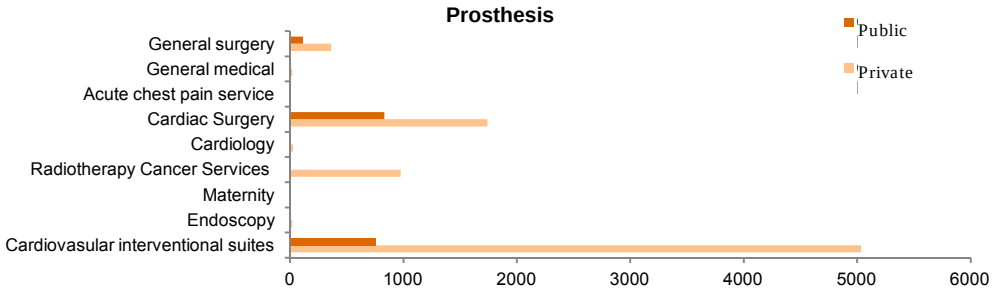


Includes costs associated with diagnostic and therapeutic imaging

- Imaging costs are significantly less in the private sector due to costs being covered by Medicare rather than the service provider.

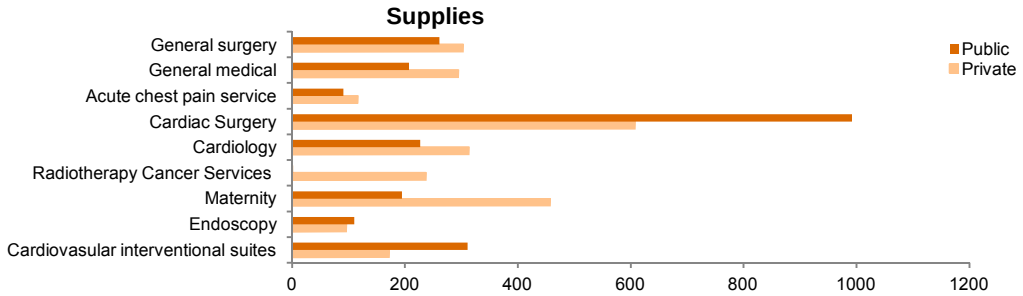
Appendix 3: Cost Bucket Analysis

The following graphs indicate the variance found between public and private sector specific hospital costs by service area



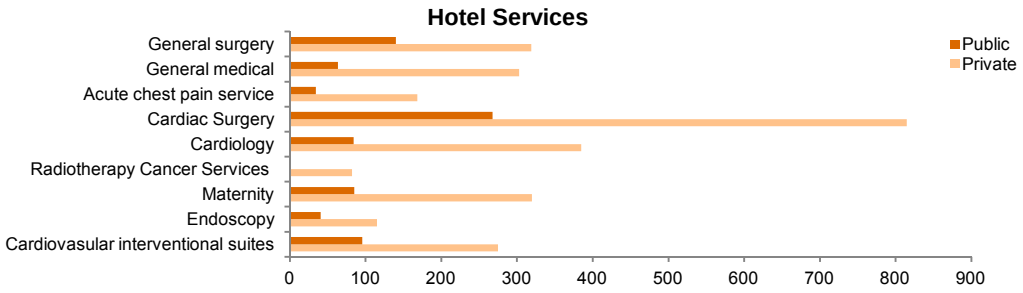
Includes costs of all prosthesis

- Prosthetic costs are significantly higher in the private sector. This is expected to be due to:
  - more expensive prosthetics are used by private specialists
  - costs are initially covered by the private provider but invoiced to the patient (for claiming through private health insurance).



Includes costs for goods & services, medical and surgical supplies, ward overheads and clinical department overheads (all ward costs not included in other cost buckets)

- Generally supplies are more expensive in the private sector. This is expected to be due to volume purchased and the scales of economy that the public sector is able to access.

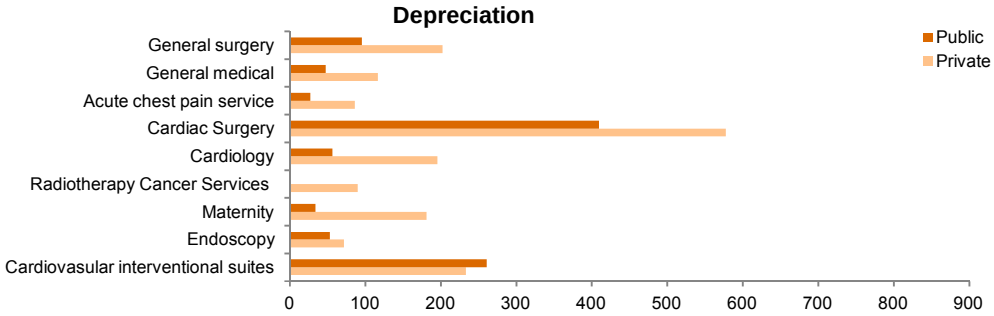


Includes items such as food service, linen, grocery supplies and recorded as overheads

- Hotel service costs are significantly higher in the private sector. This is expected to be due to the provision of differing levels of hotel services for example, catering options for food and beverages; use of different linen. Scales of economy may also be a factor.

Appendix 3: Cost Bucket Analysis

The following graphs indicate the variance found between public and private sector specific hospital costs by service area



Includes depreciation for items that are durable to support production for an appreciable period of time and purchased outright or donated

- The depreciation cost bucket is not a significant cost driver in any service, and is therefore of little material impact to the overall analysis
- The variance in depreciation costs in public and private sectors may be due to being recorded on a differing basis, or being applied on a different quality of assets
- It is expected that depreciation expenditure would be similar for a private or public operator in the GCHHS.

Appendix 4: Detailed service cost analysis - Maternity

Summary Financial Analysis	Average $ Per DRG			# Separations	Total $		
Source: DOHA National Hospital Cost Data Collection. 2007-2008 Round 12 Cost Weight reports.	Public	Private	Difference (+ve = private cheaper)	GCUH	Public	Private	Difference (+ve = private cheaper)
$ Cost Buckets	A	B	C	D	E	F	G
Ward Nursing	1,422.7	1,374.3	48.5		8,792,413	8,492,977	299,436
Operating Rooms	391.5	287.1	104.4		2,419,580	1,774,208	645,373
Supplies	194.8	457.4	-262.6		1,203,728	2,826,817	-1,623,089
Ward Medical	584.5	57.9	526.6		3,612,076	357,739	3,254,338
On-Costs	268.2	247.9	20.3		1,657,205	1,531,795	125,410
Non Clinical Salaries	229.0	265.7	-36.8		1,414,914	1,642,112	-227,199
Hotel	85.0	319.8	-234.8		525,472	1,976,321	-1,450,848
Deprec	34.1	181.0	-147.0		210,436	1,118,638	-908,202
Pharmacy	61.1	50.7	10.4		377,511	313,441	64,070
Allied	72.8	24.0	48.8		450,098	148,315	301,783
Pathology	90.7	2.5	88.2		560,585	15,377	545,208
Critical Care	35.3	20.3	15.0		218,236	125,679	92,556
Emergency	22.1	13.3	8.8		136,776	82,213	54,563
Imaging	14.9	0.8	14.1		92,042	4,817	87,225
Prosthesis	5.0	3.4	1.6		31,205	21,167	10,037
Spec Proc Suites	-	5.9	-5.9		-	36,320	-36,320
Total $	**3,511.7**	**3,312.0**	**199.7**	**6,180**	**21,702,278**	**20,467,936**	**1,234,342**

A Average $ cost per DRG for each cost bucket based upon QLD public hospital cost data and casemix determined by DRG's and SRG's mapped to Maternity services

B Average $ cost per DRG for each cost bucket based upon national private hospital cost data and casemix determined by DRG's and SRG's mapped to Maternity services

C $ cost variance per DRG between public and private provision of service

D Total number of separations per service determined by allocating the number of separations in the GCUH service agreement by SRG level based upon the weighting of separations in total QLD public hospital data.

E Total $ cost per cost bucket for public provision of service based on number of GCUH separations expected. E = A x D

F Total $ cost per cost bucket for private provision of service based on number of GCUH separations expected. F = B x D

G Total $ cost variance per cost bucket between public and private provision of service

Appendix 4: Detailed service cost analysis - Endoscopy

Summary Financial Analysis	Average $ Per DRG			# Separations	Total $		
Source: DOHA National Hospital Cost Data Collection. 2007-2008 Round 12 Cost Weight reports.	Public	Private	Difference (+ve = private cheaper)	GCUH	Public	Private	Difference (+ve = private cheaper)
$ Cost Buckets							
Operating Rooms	526.1	343.8	182.3		2,489,212	1,626,550	862,662
Ward Nursing	410.4	204.4	205.9		1,941,390	967,042	974,348
Ward Medical	339.6	18.8	320.8		1,606,572	88,727	1,517,845
Spec Proc Suites	108.3	113.0	-4.7		512,417	534,827	-22,409
Non Clinical Salaries	149.2	66.5	82.6		705,733	314,764	390,969
On-Costs	134.2	79.5	54.8		635,040	375,890	259,150
Supplies	110.0	95.7	14.3		520,387	452,958	67,429
Hotel	40.4	114.9	-74.5		191,253	543,536	-352,283
Deprec	52.9	71.6	-18.8		250,043	338,901	-88,858
Pharmacy	74.2	30.5	43.7		351,123	144,207	206,916
Pathology	85.5	8.3	77.3		404,657	39,074	365,583
Emergency	67.4	23.4	44.0		319,013	110,818	208,196
Critical Care	37.7	37.7	0.0		178,355	178,186	169
Allied	32.7	17.3	15.4		154,715	81,831	72,884
Imaging	35.2	7.6	27.6		166,354	35,763	130,591
Prosthesis	8.6	20.0	-11.5		40,548	94,723	-54,175
Total $	**2,212.4**	**1,253.0**	**959.4**	**4,731**	**10,466,813**	**5,927,797**	**4,539,016**

Appendix 4: Detailed service cost analysis - General surgery

Summary Financial Analysis	Average $ Per DRG			# Separations	Total $		
Source: DOHA National Hospital Cost Data Collection. 2007-2008 Round 12 Cost Weight reports.	Public	Private	Difference (+ve = private cheaper)	GCUH	Public	Private	Difference (+ve = private cheaper)
$ Cost Buckets							
Operating Rooms	2,158.8	1,005.2	1,153.6		2,785,103	1,296,796	1,488,307
Ward Nursing	1,317.3	811.1	506.2		1,699,415	1,046,398	653,017
Ward Medical	1,064.2	53.8	1,010.3		1,372,885	69,412	1,303,473
On-Costs	438.7	234.0	204.7		565,986	301,916	264,070
Non Clinical Salaries	370.6	202.0	168.6		478,169	260,636	217,533
Supplies	260.8	302.9	-42.1		336,486	390,778	-54,293
Prosthesis	115.5	362.8	-247.3		149,022	468,119	-319,097
Hotel	140.1	318.9	-178.8		180,713	411,407	-230,694
Critical Care	273.2	171.2	102.0		352,520	220,928	131,592
Emergency	308.2	95.1	213.1		397,607	122,688	274,919
Pharmacy	213.0	149.8	63.2		274,859	193,293	81,566
Deprec	95.5	202.4	-106.9		123,241	261,129	-137,888
Pathology	213.2	18.4	194.8		275,029	23,775	251,254
Allied	118.6	60.2	58.3		152,957	77,717	75,240
Imaging	139.3	23.4	116.0		179,776	30,166	149,609
Spec Proc Suites	7.7	82.4	-74.7		9,933	106,368	-96,435
Total $	**7,234.7**	**4,093.8**	**3,140.9**	**1,290**	**9,333,700**	**5,281,527**	**4,052,173**

Appendix 4: Detailed service cost analysis - General medicine

Summary Financial Analysis	Average $ Per DRG			# Separations	Total $		
Source: DOHA National Hospital Cost Data Collection. 2007-2008 Round 12 Cost Weight reports.	Public	Private	Difference (+ve = private cheaper)	GCUH	Public	Private	Difference (+ve = private cheaper)
$ Cost Buckets							
Ward Nursing	958.2	777.2	180.9		13,341,262	10,821,922	2,519,339
Ward Medical	486.8	27.9	458.9		6,778,498	389,013	6,389,485
Supplies	207.3	294.4	-87.0		2,887,068	4,098,744	-1,211,676
Non Clinical Salaries	261.8	225.5	36.3		3,644,978	3,139,779	505,200
Emergency	311.3	127.6	183.7		4,334,661	1,776,410	2,558,251
On-Costs	194.9	174.5	20.5		2,714,272	2,429,098	285,173
Hotel	63.5	302.9	-239.4		884,529	4,217,299	-3,332,770
Critical Care	106.5	115.6	-9.2		1,482,235	1,609,728	-127,493
Pharmacy	159.4	62.2	97.2		2,219,339	865,762	1,353,577
Deprec	47.6	116.7	-69.1		662,362	1,624,340	-961,979
Operating Rooms	65.7	77.8	-12.1		915,212	1,083,180	-167,968
Allied	83.2	54.9	28.3		1,159,145	764,556	394,589
Pathology	125.1	11.7	113.3		1,741,422	163,467	1,577,955
Imaging	79.3	18.0	61.3		1,104,628	251,096	853,532
Spec Proc Suites	8.9	39.2	-30.3		124,304	545,876	-421,572
Prosthesis	2.8	18.5	-15.7		38,984	257,701	-218,717
Total $	**3,162.4**	**2,444.6**	**717.8**	**13,924**	**44,032,898**	**34,037,972**	**9,994,927**

Appendix 4: Detailed service cost analysis *- Cardiovascular interventional suites*

Summary Financial Analysis	Average $ Per DRG			# Separations	Total $		
Source: DOHA National Hospital Cost Data Collection. 2007-2008 Round 12 Cost Weight reports.	Public	Private	Difference (+ve = private cheaper)	GCUH	Public	Private	Difference (+ve = private cheaper)
$ Cost Buckets							
Prosthesis	753.2	5,032.8	- 4,279.6		1,373,832	9,179,783	- 7,805,951
Operating Rooms	1,761.9	316.8	1,445.1		3,213,767	577,838	2,635,930
Critical Care	958.5	990.8	- 32.3		1,748,336	1,807,209	- 58,873
Ward Nursing	975.5	322.4	653.1		1,779,354	588,076	1,191,279
Ward Medical	839.4	36.2	803.3		1,531,147	65,993	1,465,153
Spec Proc Suites	86.6	717.9	- 631.3		157,918	1,309,463	- 1,151,545
On-Costs	363.1	214.6	148.5		662,239	391,415	270,823
Deprec	260.6	233.3	27.3		475,348	425,524	49,824
Supplies	310.8	171.8	139.0		566,878	313,382	253,496
Hotel	95.7	274.7	- 179.1		174,507	501,102	- 326,595
Non Clinical Salaries	248.8	119.1	129.7		453,896	217,306	236,591
Emergency	224.0	71.3	152.8		408,661	130,026	278,635
Pharmacy	208.0	61.8	146.2		379,342	112,688	266,654
Pathology	172.9	13.2	159.7		315,459	24,140	291,320
Imaging	134.5	32.4	102.1		245,333	59,037	186,296
Allied	118.3	20.5	97.8		215,776	37,417	178,359
Total $	**7,511.9**	**8,629.6**	**- 1,117.7**	**1,824**	**13,701,794**	**15,740,399**	**- 2,038,605**

Appendix 4: Detailed service cost analysis - Acute chest pain

Summary Financial Analysis	Average $ Per DRG			# Separations	Total $		
Source: DOHA National Hospital Cost Data Collection. 2007-2008 Round 12 Cost Weight reports.	Public	Private	Difference (+ve = private cheaper)	GCUH	Public	Private	Difference (+ve = private cheaper)
$ Cost Detail							
Critical Care	196.8	427.5	-230.7		394,370	856,593	-462,224
Ward Nursing	383.7	220.3	163.5		768,992	441,445	327,547
Emergency	471.0	131.7	339.3		943,863	263,972	679,891
Ward Medical	246.7	12.3	234.4		494,312	24,678	469,634
Non Clinical Salaries	131.2	93.8	37.3		262,834	188,048	74,786
On-Costs	110.5	100.1	10.4		221,462	200,571	20,890
Supplies	90.8	116.4	-25.6		181,965	233,184	-51,218
Hotel	34.2	168.5	-134.3		68,483	337,640	-269,157
Deprec	27.3	85.9	-58.6		54,694	172,195	-117,501
Pathology	86.0	6.4	79.7		172,421	12,739	159,682
Pharmacy	71.2	21.0	50.2		142,652	42,124	100,528
Imaging	65.4	12.5	52.9		130,992	24,999	105,993
Spec Proc Suites	16.6	48.2	-31.6		33,294	96,614	-63,319
Allied	45.9	10.6	35.3		92,030	21,236	70,794
Operating Rooms	27.6	26.8	0.8		55,247	53,716	1,531
Total	**2,004.9**	**1,482.0**	**522.9**	**2,004**	**4,017,613**	**2,969,754**	**1,047,859**

Appendix 4: Detailed cost analysis - Cardiac Surgery

Summary Financial Analysis	Average $ Per DRG			# Separations	Total $		
Source: DOHA National Hospital Cost Data Collection. 2007-2008 Round 12 Cost Weight reports.	Public	Private	Difference (+ve = private cheaper)	GCUH	Public	Private	Difference (+ve = private cheaper)
$ Cost Buckets							
Operating Rooms	4,896.5	2,384.0	2,512.5		1,732,373	843,452	888,921
Critical Care	3,643.7	3,608.3	35.4		1,289,142	1,276,605	12,537
Ward Nursing	2,639.8	1,417.4	1,222.4		933,937	501,468	432,469
Ward Medical	2,444.6	141.5	2,303.0		864,876	50,079	814,798
Prosthesis	830.2	1,739.9	-909.6		293,738	615,555	-321,818
On-Costs	996.6	705.0	291.5		352,583	249,444	103,139
Supplies	992.2	607.6	384.5		351,034	214,984	136,050
Hotel	267.4	814.6	-547.1		94,622	288,201	-193,579
Deprec	409.7	577.5	-167.8		144,946	204,300	-59,354
Non Clinical Salaries	522.7	372.3	150.4		184,936	131,709	53,227
Pathology	648.2	67.5	580.7		229,336	23,881	205,456
Allied	389.5	197.3	192.1		137,799	69,819	67,981
Spec Proc Suites	106.7	437.5	-330.8		37,742	154,792	-117,050
Pharmacy	385.1	146.2	238.9		136,242	51,708	84,534
Imaging	346.0	74.9	271.2		122,430	26,493	95,937
Emergency	198.7	114.2	84.5		70,309	40,400	29,909
Total $	**19,717.7**	**13,405.7**	**6,312.0**	**354**	**6,976,047**	**4,742,892**	**2,233,155**

Appendix 4: Detailed cost analysis - Cardiology

Summary Financial Analysis	Average $ Per DRG			# Separations	Total $		
Source: DOHA National Hospital Cost Data Collection. 2007-2008 Round 12 Cost Weight reports.	Public	Private	Difference (+ve = private cheaper)	GCUH	Public	Private	Difference (+ve = private cheaper)
$ Cost Buckets							
Ward Nursing	1,057.4	774.8	282.6		2,250,536	1,649,049	601,487
Critical Care	681.0	745.0	-64.0		1,449,281	1,585,552	-136,270
Ward Medical	611.9	35.5	576.4		1,302,399	75,575	1,226,824
Supplies	226.7	313.1	-86.5		482,465	666,475	-184,010
Non Clinical Salaries	292.8	246.7	46.1		623,169	525,092	98,076
Emergency	413.7	121.3	292.4		880,521	258,147	622,374
On-Costs	272.3	233.4	38.9		579,622	496,819	82,803
Hotel	84.0	384.6	-300.6		178,844	818,583	-639,739
Pharmacy	185.9	68.2	117.7		395,715	145,113	250,603
Deprec	56.4	195.5	-139.1		120,056	416,018	-295,962
Spec Proc Suites	21.0	209.9	-188.9		44,618	446,707	-402,089
Pathology	190.4	13.2	177.2		405,268	28,038	377,230
Allied	117.3	54.7	62.6		249,693	116,490	133,203
Imaging	96.1	17.4	78.7		204,446	37,013	167,433
Operating Rooms	49.4	49.5	-0.1		105,114	105,302	-187
Prosthesis	1.9	27.6	-25.7		4,086	58,728	-54,642
Total $	**4,358.3**	**3,490.4**	**867.9**	**2,128**	**9,275,834**	**7,428,702**	**1,847,133**

Appendix 5: DRG to service mapping - Maternity

DRG	DRG Description	Separations #	Separations %	Total cost per DRG ($) Public	Total cost per DRG ($) Private	Total cost ($) Public	Total cost ($) Private	% of total cost per DRG Public	Ranking Public	% of total cost per DRG Private	Ranking Private
O60B	Vaginal Delivery -CSCC	1768	29%	3,747	4,524	6,622,849	7,996,202	31%	1	39%	7
O01C	Caesarean Delivery -CSCC	806	13%	7,278	5,467	5,868,966	4,408,579	27%	2	22%	3
O60C	Vaginal Del Single Uncompl	665	11%	2,869	3,917	1,908,789	2,606,040	9%	3	13%	8
O66A	Antenatal&Oth Obstetric Adm	680	11%	2,457	1,592	1,671,777	1,083,219	8%	4	5%	12
O01B	Caesarean Delivery +SCC	175	3%	8,647	6,383	1,516,664	1,119,564	7%	5	5%	2
O60A	Vaginal Delivery +CSCC	219	4%	5,349	5,159	1,170,524	1,128,946	5%	6	6%	6
O01A	Caesarean Delivery +CCC	68	1%	11,576	8,283	789,917	565,211	4%	7	3%	1
O61Z	Postpartum & Post Abortn-OR Pr	250	4%	2,506	1,745	625,783	435,751	3%	8	2%	9
O66B	Antenatal&Oth Obstetric Adm,SD	1174	19%	494	304	579,790	356,794	3%	9	2%	13
O02B	Vaginal Delivery +OR Pr -CSCC	58	1%	5,274	5,023	307,143	292,525	1%	10	1%	5
O64A	False Labour <37 Wk/+CCC	177	3%	1,702	1,188	302,031	210,818	1%	11	1%	10
O02A	Vaginal Delivery +OR Pr +CSCC	38	1%	6,985	5,655	264,343	214,010	1%	12	1%	4
O64B	False Labour >=37 Wk -CCC	101	2%	712	537	71,900	54,228	0.3%	13	0.3%	11
	TOTAL	**6180**				**$21,700,476**	**$20,471,886**				

Appendix 5: DRG to service mapping - Endoscopy

DRG	DRG Description	Separations #	Separations %	Total cost per DRG ($) Public	Total cost per DRG ($) Private	Total cost ($) Public	Total cost ($) Private	% of total cost per DRG Public	Ranking Public	% of total cost per DRG Private	Ranking Private
G44C	Other Colonoscopy, Sameday	1498	32%	1,334	702	1,998,385	1,051,624	19%	1	18%	1
G45B	Other Gastrpy+N-Mjr Dig Dis,SD	875	18%	1,234	533	1,079,191	466,133	10%	2	8%	6
G42A	Oth Gastroscopy+Mjr Digest Dis	139	3%	6,706	4,111	932,594	571,711	9%	3	10%	2
G45A	Other Gastrpy+N-Mjr Digest Dis	156	3%	5,501	3,342	856,108	520,108	8%	4	9%	3
Z40Z	Follow Up +Endoscopy	750	16%	1,090	635	817,579	476,296	8%	5	8%	4
G46C	Complex Gastroscopy,SD	543	11%	1,483	837	805,601	454,678	8%	6	8%	7
G44B	Other Colonoscopy-CSCC	197	4%	4,044	2,376	797,907	468,800	8%	7	8%	5
G46A	Complex Gastroscopy+CSCC	61	1%	10,932	6,907	670,404	423,571	6%	8	7%	8
G46B	Complex Gastroscopy-CSCC	115	2%	5,649	3,048	652,420	352,022	6%	9	6%	9
G44A	Other Colonoscopy+CSCC	46	1%	10,252	6,127	469,010	280,299	4%	10	5%	10
H41A	Ercp Cx Theraputic Pr + CSCC	21	0%	12,596	9,248	270,445	198,561	3%	11	3%	11
H41B	Ercp Cx Theraputic Pr - CSCC	37	1%	6,637	3,709	247,747	138,450	2%	12	2%	12
H42C	Ercp Oth Theraputic Pr -CC	50	1%	4,113	1,976	205,477	98,717	2%	13	2%	15
G42B	Oth Gastroscopy+Mjr Dig Dis,SD	158	3%	1,092	571	172,397	90,146	2%	14	2%	16
H42A	Ercp Oth Theraputic Pr +CSCC	14	0%	11,795	7,743	167,176	109,745	2%	15	2%	14
H40Z	Endospic Pr Bleed Oes Varices	13	0%	10,212	9,123	136,141	121,623	1%	16	2%	13
H42B	Ercp Oth Theraputic Pr +Mcc	14	0%	6,695	3,528	95,831	50,499	1%	17	1%	17
K40Z	Endosc/Invest Pr Metab Dsdr-CC	35	1%	2,073	1,198	71,854	41,525	1%	18	1%	18
G43Z	Complex Colonoscopy	7	0%	2,792	1,268	20,766	9,431	0%	19	0%	19
	TOTAL	**4731**				**$10,467,034**	**$5,923,941**				

Appendix 5: DRG to service mapping - General Surgery

DRG	DRG Description	Separations #	Separations %	Total cost per DRG ($) Public	Total cost per DRG ($) Private	Total cost ($) Public	Total cost ($) Private	% of total cost per DRG Public	Ranking Public	% of total cost per DRG Private	Ranking Private
G07B	Appendicectomy - CSCC	339	26%	6,019	3,041	2,039,972	1,030,662	22%	1	20%	1
T01A	OR Proc Infect& Paras Dis+CCC	21	2%	35,932	22,029	744,386	456,364	8%	2	9%	2
G08B	Abdom & Oth Hrn Pr 0<A<60-CSCC	159	12%	4,139	2,195	657,669	348,776	7%	3	7%	4
X06B	Other Pr Other Injuries - CSCC	128	10%	4,923	3,379	627,732	430,857	7%	4	8%	3
G08A	Abdom & Oth Hern Pr A>59/+CSCC	81	6%	6,760	3,358	548,971	272,699	6%	5	5%	5
X06A	Other Pr Other Injuries + CSCC	30	2%	15,564	8,422	461,077	249,498	5%	6	5%	7
G04A	Peritoneal Adhesolysis A>49+CC	24	2%	19,272	11,042	459,136	263,064	5%	7	5%	6
G12A	Oth Digest Sys OR Pr+CSCC	26	2%	17,333	7,742	445,258	198,880	5%	8	4%	11
G04B	Prtnl Adhly A>49/+CC	31	2%	11,081	5,776	348,931	181,881	4%	9	3%	12
E02C	Other Respiraty Sys OR Pr-CSCC	91	7%	3,357	2,197	306,695	200,718	3%	10	4%	10
G04C	Peritoneal Adhesolysis A<50-CC	39	3%	7,496	3,898	295,053	153,431	3%	11	3%	16
G07A	Appendicectomy + CSCC	28	2%	10,599	6,510	294,230	180,718	3%	12	3%	13
T01B	OR Proc Infect& Paras Dis+SMCC	25	2%	11,898	9,057	293,317	223,279	3%	13	4%	8
Z01B	OR Pr+Dx Oth Cnt Hlth Srv-CSCC	86	7%	3,213	2,433	276,899	209,678	3%	14	4%	9
K09Z	Other Endcrn, Nutr& Meta OR Pr	14	1%	17,458	11,479	240,510	158,140	3%	15	3%	14
Z01A	OR Pr+Dx Oth Cnt Hlth Srv+CSCC	40	3%	5,989	3,337	240,078	133,768	3%	16	3%	18
T01C	OR Proc Infect & Paras Dis-CC	25	2%	9,516	4,557	239,523	114,702	3%	17	2%	19
G12B	Oth Digest Sys OR Pr-CSCC	40	3%	5,918	3,351	238,458	135,024	3%	18	3%	17
E02A	Other Respiratry Sys OR Pr+CCC	12	1%	18,260	12,553	226,970	156,033	2%	19	3%	15
X04B	Other Pr Inj Lowr Limb A<60-CC	34	3%	5,060	2,233	169,817	74,941	2%	20	1%	20
X04A	Other Pr Inj Lwr Lmb A>59/+CC	8	1%	12,389	6,618	103,946	55,526	1%	21	1%	21
E02B	Other Respiratry Sys OR Pr+SCC	9	1%	8,281	5,612	76,341	51,736	1%	22	1%	22
	TOTAL	**1290**				**$ 9,334,970**	**$5,280,377**				

Appendix 5: DRG to service mapping - General medicine

DRG	DRG Description	Separations #	Separations %	Total cost per DRG ($) Public	Total cost per DRG ($) Private	Total cost ($) Public	Total cost ($) Private	% of total cost per DRG Public	Ranking Public	% of total cost per DRG Private	Ranking Private
E65A	Chrnic Obstrct Airway Dis+CSCC	416	3%	7,221	5,641	3,006,090	2,348,339	7%	1	7%	13
E65B	Chrnic Obstrct Airway Dis-CSCC	518	4%	4,533	3,509	2,348,638	1,818,083	5%	2	5%	14
G67B	Oesphs, Gastr&Mis Dig A>9-CSCC	1,387	10%	1,691	1,535	2,345,017	2,128,682	5%	3	6%	36
E62B	Respiratry Infectn/Inflam+SMCC	367	3%	5,867	4,568	2,155,579	1,678,317	5%	4	5%	10
E62A	Respiratry Infectn/Inflamm+CCC	187	1%	10,657	7,633	1,994,710	1,428,697	5%	5	4%	9
E62C	Respiratory Infectn/Inflamm-CC	483	3%	3,381	2,834	1,633,042	1,368,838	4%	6	4%	11
T60A	Septicaemia + CSCC	136	1%	10,763	8,145	1,466,040	1,109,439	3%	7	3%	57
G67A	Oesphs, Gastr&Mis Dig A>9+CSCC	265	2%	5,538	4,271	1,465,077	1,129,893	3%	8	3%	35
B63Z	Dmntia&Chrnic Disturb Crbrl Fn	100	1%	14,248	8,024	1,419,762	799,563	3%	9	2%	1
X60C	Injuries A<65	981	7%	1,288	1,119	1,263,300	1,097,541	3%	10	3%	70
L63B	Kdny & Unry Trct Inf A>69/+SCC	300	2%	4,177	3,481	1,251,698	1,043,132	3%	11	3%	51
L63C	Kdny & Unry Trct Inf A<70-CSCC	399	3%	2,711	1,931	1,081,970	770,669	2%	12	2%	52
G66B	Abdmnl Pain/Mesentrc Adents-CC	785	6%	1,363	1,128	1,069,885	885,422	2%	13	3%	34
D63B	Otitis Media & Uri - CC	561	4%	1,614	1,431	904,958	802,351	2%	14	2%	7
F73B	Syncope & Collapse - CSCC	414	3%	2,071	2,201	856,576	910,345	2%	15	3%	27
E69C	Bronchitis & Asthma A<50 -CC	443	3%	1,853	1,834	821,305	812,883	2%	16	2%	19
Z64B	Oth Fctr Infl Health Status,SD	833	6%	886	508	737,681	422,959	2%	17	1%	81
E70B	Whoopng Cgh &Acte Brnchio-CC	255	2%	2,879	2,419	734,502	617,145	2%	18	2%	21
L63A	Kdny & Unry Trct Inf +CCC	58	0%	11,087	8,833	641,967	511,454	1%	19	2%	50
Z64A	Oth Fctr Infl Health Status	145	1%	4,367	4,277	631,474	618,460	1%	20	2%	80

Appendix 5: DRG to service mapping - General medicine (cont')

DRG	DRG Description	Separations #	Separations %	Total cost per DRG ($) Public	Total cost per DRG ($) Private	Total cost ($) Public	Total cost ($) Private	% of total cost per DRG Public	Ranking Public	% of total cost per DRG Private	Ranking Private
F73A	Syncope & Collapse + CSCC	112	1%	5,436	4,485	607,558	501,269	1%	21	1%	26
G70A	Other Digestive System Diag+CC	113	1%	4,920	3,435	557,021	388,896	1%	22	1%	38
J68A	Major Skin Disorders	84	1%	6,426	4,522	537,822	378,467	1%	23	1%	47
D63A	Otitis Media & Uri + CC	140	1%	3,668	2,952	514,820	414,326	1%	24	1%	6
G70B	Other Digestive System Diag-CC	354	3%	1,358	1,078	480,934	381,772	1%	25	1%	39
T61A	Pstop&Psttr Inf A>54/+CSCC	93	1%	5,064	3,839	470,514	356,695	1%	26	1%	59
X60A	Injuries A>64 + CC	90	1%	5,211	4,783	468,519	430,038	1%	27	1%	68
H60A	Cirrhosis & Alc Hepatitis +CCC	37	0%	12,282	8,768	452,904	323,323	1%	28	1%	40
Z63A	Other Aftercare + CSCC	53	0%	8,378	4,253	444,321	225,555	1%	29	1%	78
T63B	Viral Illness A<60 -CC	227	2%	1,837	1,544	417,287	350,730	1%	30	1%	64
Z62Z	Follow Up -Endoscopy	216	2%	1,855	742	400,239	160,096	1%	31	0%	77
G66A	Abdmnl Pain/Mesentrc Adents+CC	125	1%	3,155	2,609	393,471	325,377	1%	32	1%	33
E69B	Brnchts&Asthma A>49/+CC	126	1%	3,087	2,553	389,467	322,096	1%	33	1%	18
X63B	Sequelae Of Treatmnt-CSCC	162	1%	2,376	1,679	384,673	271,829	1%	34	1%	73
B64B	Delirium-CCC	73	1%	5,151	4,600	378,290	337,824	1%	35	1%	3
E67B	Respirtry Signs & Symptm -CSCC	196	1%	1,869	1,648	366,477	323,143	1%	36	1%	16
X63A	Sequelae Of Treatmnt+CSCC	45	0%	7,836	4,658	353,889	210,365	1%	37	1%	72
G61A	Gi Haemorrhage A>64/+CSCC	123	1%	2,777	2,561	341,439	314,881	1%	38	1%	28
G64Z	Inflammatory Bowel Disease	110	1%	3,059	1,921	337,138	211,717	1%	39	1%	32
J67A	Minor Skin Disorders	88	1%	3,737	3,076	327,089	269,234	1%	40	1%	45

Appendix 5: DRG to service mapping - General medicine (cont')

DRG	DRG Description	Separations #	Separations %	Total cost per DRG ($) Public	Total cost per DRG ($) Private	Total cost ($) Public	Total cost ($) Private	% of total cost per DRG Public	Ranking Public	% of total cost per DRG Private	Ranking Private
W61Z	Multiple Trauma - Signif Procs	24	0%	13,569	7,519	323,268	179,133	1%	41	1%	67
T60B	Septicaemia - CSCC	66	0%	4,878	3,779	321,861	249,346	1%	42	1%	58
T62A	Fever Of Unknown Origin + CC	62	0%	5,092	4,062	313,828	250,348	1%	43	1%	61
H63A	Dsrd Lvr-Mal,Cirr,Alc Hep+CSCC	36	0%	8,629	6,028	311,047	217,290	1%	44	1%	43
T61B	Postop&Posttr Infect A<55-CSCC	90	1%	3,355	2,475	303,037	223,552	1%	45	1%	60
Z61Z	Signs & Symptoms	111	1%	2,708	1,378	300,698	153,014	1%	46	0%	76
T64A	Oth Infectous&Parstic Dis+CSCC	27	0%	11,111	6,814	296,934	182,099	1%	47	1%	65
F63A	Venous Thrombosis + CSCC	22	0%	13,429	5,455	290,721	118,094	1%	48	0%	22
E70A	Whoopng Cgh &Acte Brnchio+CC	44	0%	6,595	4,358	287,596	190,045	1%	49	1%	20
F63B	Venous Thrombosis - CSCC	90	1%	3,173	2,725	284,955	244,722	1%	50	1%	23
T62B	Fever Of Unknown Origin - CC	100	1%	2,783	1,934	278,181	193,317	1%	51	1%	62
H60B	Cirrhosis & Alc Hepatitis+SCC	41	0%	6,561	3,747	269,124	153,697	1%	52	0%	41
T63A	Viral Illness A>59/+CC	76	1%	3,271	2,883	250,048	220,388	1%	53	1%	63
H63B	Dsrd Lvr-Mal,Cirr,Alc Hep-CSCC	80	1%	3,130	1,416	249,320	112,791	1%	54	0%	44
G69Z	Oesphs & Misc Dig Sys Dis A<10	87	1%	2,646	1,699	230,501	148,005	1%	55	0%	37
T64B	Oth Infectous&Parstic Dis-CSCC	71	1%	3,138	1,993	224,279	142,444	1%	56	0%	66
E69A	Bronchitis & Asthma A>49 + CC	45	0%	4,673	3,999	212,494	181,846	0%	57	1%	17
J67B	Minor Skin Disorders, Sameday	239	2%	857	666	205,148	159,427	0%	58	0%	46
Z63B	Other Aftercare - CSCC	56	0%	3,657	1,276	204,553	71,373	0%	59	0%	79
E64Z	Pulmonry Oedema & Resp Failure	33	0%	6,187	4,639	203,154	152,325	0%	60	0%	12

Appendix 5: DRG to service mapping - General medicine (cont')

DRG	DRG Description	Separations #	Separations %	Total cost per DRG ($) Public	Total cost per DRG ($) Private	Total cost ($) Public	Total cost ($) Private	% of total cost per DRG Public	Ranking Public	% of total cost per DRG Private	Ranking Private
B64A	Delirium+CCC	15	0%	13,244	8,374	198,918	125,773	0%	61	0%	2
E67A	Respiratry Signs & Symptm+CSCC	41	0%	4,747	3,256	195,207	133,894	0%	62	0%	15
X60B	Injuries A>64 - CC	151	1%	1,243	1,877	187,851	283,665	0%	63	1%	69
D64Z	Laryngotracheitis&Epiglottitis	118	1%	1,535	1,292	181,418	152,699	0%	64	0%	8
F67A	Hypertension + CC	28	0%	5,365	3,696	148,377	102,219	0%	65	0%	24
X64A	Ot Inj,Pois&Tox Ef Dx A>59/+CC	28	0%	4,725	3,427	134,593	97,619	0%	66	0%	74
G61B	Gi Haemorrhage A<65 - CSCC	72	1%	1,802	1,310	130,099	94,578	0%	67	0%	29
S65A	Hiv-Related Diseases +CCC	3	0%	37,988	0	129,852	0	0%	68	0%	54
F67B	Hypertension - CC	56	0%	2,220	1,994	124,175	111,534	0%	69	0%	25
X61Z	Allergic Reactions	94	1%	1,200	1,519	112,491	142,394	0%	70	0%	71
H60C	Cirrhosis & Alc Hepatitis-CSCC	36	0%	2,958	1,444	106,320	51,902	0%	71	0%	42
X64B	Ot Inj,Pois&Tox Eff Dx A<60-CC	95	1%	1,106	589	105,054	55,946	0%	72	0%	75
B75Z	Febrile Convulsions	61	0%	1,624	1,119	98,576	67,923	0%	73	0%	5
K61Z	Severe Nutritional Disturbance	8	0%	11,586	9,648	92,408	76,951	0%	74	0%	49
B74Z	Nontraumatic Stupor & Coma	21	0%	2,826	2,822	60,301	60,216	0%	75	0%	4
S65C	Hiv-Related Diseases -CSCC	5	0%	10,652	9,031	55,168	46,773	0%	76	0%	56
S65B	Hiv-Related Diseases +SCC	3	0%	16,017	5,735	44,795	16,039	0%	77	0%	55
G63Z	Uncomplicated Peptic Ulcer	16	0%	2,142	1,604	35,278	26,417	0%	78	0%	31
J68B	Major Skin Disorders, Sameday	56	0%	520	366	29,301	20,624	0%	79	0%	48
G62Z	Complicated Peptic Ulcer	5	0%	5,067	3,902	26,243	20,209	0%	80	0%	30
S60Z	Hiv, Sameday	9	0%	1,370	0	12,488	0	0%	81	0%	53
Z65Z	Mult,Oth&Unspcfd Congntl Anmls	3	0%	2,985	2,671	7,730	6,917	0%	82	0%	82
	TOTAL	**13924**				**$44,030,532**	**$34,037,388**				

Appendix 5: DRG to service mapping - Cardiology

DRG	DRG Description	Separations #	Separations %	Total cost per DRG ($) Public	Total cost per DRG ($) Private	Total cost ($) Public	Total cost ($) Private	% of total cost per DRG Public	Ranking Public	% of total cost per DRG Private	Ranking Private
F62B	Heart Failure & Shock - CCC	345	16%	4,363	3,815	1,507,088	1,317,795	16%	1	18%	1
F62A	Heart Failure & Shock + CCC	121	6%	10,684	8,340	1,288,014	1,005,432	14%	2	14%	3
F60B	Crc Dsrd+Ami-Inva Inve Pr-CSCC	309	15%	3,679	2,661	1,135,604	821,376	12%	3	11%	4
F71B	N-Mjr Arythm&Condctn Dsrd-CSCC	466	22%	2,434	2,209	1,134,195	1,029,350	12%	4	14%	2
F60A	Crc Dsrd+Ami-Inva Inve Pr+CSCC	125	6%	8,054	5,612	1,008,712	702,867	11%	5	9%	5
F71A	N-Mjr Arythm&Condctn Dsrd+CSCC	100	5%	5,920	4,260	593,749	427,258	6%	6	6%	6
F75C	Other Circulaty System Dx-CSCC	146	7%	3,336	2,717	486,238	396,016	5%	7	5%	7
F75A	Other Circulatry System Dx+CCC	28	1%	12,096	7,810	340,256	219,692	4%	8	3%	11
F66A	Coronary Atherosclerosis + CC	108	5%	3,126	2,716	338,647	294,231	4%	9	4%	8
F75B	Other Circulatry System Dx+SCC	53	2%	6,110	4,372	322,771	230,958	3%	10	3%	10
F66B	Coronary Atherosclerosis - CC	189	9%	1,515	1,545	286,646	292,322	3%	11	4%	9
F40Z	Circ Sys Dx+Ventilator Support	10	0%	21,522	15,625	207,207	150,433	2%	12	2%	13
F61Z	Infective Endocarditis	14	1%	12,859	13,226	180,859	186,021	2%	13	3%	12
F70B	Mjr Arrhythmia&Crdc Arrst-CSCC	57	3%	2,717	2,243	153,539	126,753	2%	14	2%	15
F60C	Crc Dsrd+Ami-Inva Inve Pr Died	29	1%	4,283	4,478	124,423	130,088	1%	15	2%	14
F70A	Mjr Arrhythmia&Crdc Arrst+CSCC	15	1%	6,556	4,957	99,344	75,114	1%	16	1%	16
F68Z	Congenital Heart Disease	13	1%	5,136	1,625	69,227	21,903	1%	17	0%	17
	TOTAL	**2128**				**$9,276,519**	**$7,427,609**				

Appendix 5: DRG to service mapping - Cardiac surgery

DRG	DRG Description	Separations #	Separations %	Total cost per DRG ($) Public	Total cost per DRG ($) Private	Total cost ($) Public	Total cost ($) Private	% of total cost per DRG Public	Ranking Public	% of total cost per DRG Private	Ranking Private
F04A	Crd Vlv Pr+Pmp-Inv Inves+CCC	32	9%	1,348,107	989,437	41,717	30,618	19%	1	21%	1
F06A	Coronary Bypass-Inv Inves+CSCC	45	13%	1,149,802	794,025	25,528	17,629	16%	2	17%	2
F06B	Coronary Bypass-Inv Inves-CSCC	28	8%	586,607	381,704	20,916	13,610	8%	3	8%	3
F05A	Coronary Bypass+Inv Inves+CCC	12	3%	507,620	358,207	41,530	29,306	7%	4	8%	4
F04B	Crd Vlv Pr+Pmp-Inv Inves-CCC	17	5%	494,891	327,977	29,264	19,394	7%	5	7%	5
F07A	Other Cardthor/Vasc Pr+Pmp+CCC	9	2%	478,786	211,348	54,990	24,274	7%	6	4%	10
E01B	Major Chest Procedure - CCC	36	10%	455,219	323,297	12,764	9,065	7%	7	7%	6
F05B	Coronary Bypass+Inv Inves-CCC	14	4%	439,733	284,687	30,897	20,003	6%	8	6%	7
F03Z	Crdc Valv Pr+Pmp+Inv Inves	7	2%	323,309	219,406	48,884	33,174	5%	9	5%	9
E01A	Major Chest Procedure + CCC	15	4%	320,593	221,085	22,008	15,177	5%	10	5%	8
F07B	Other Cardthor/Vasc Pr+Pmp-CCC	7	2%	233,116	128,423	32,378	17,837	3%	11	3%	13
F09A	Oth Cardiothor Pr-Pmp+CCC	8	2%	207,653	176,638	25,837	21,978	3%	12	4%	11
F69B	Valvular Disorders - CSCC	99	28%	188,274	148,559	1,901	1,500	3%	13	3%	12
F69A	Valvular Disorders + CSCC	19	5%	131,003	100,389	6,774	5,191	2%	14	2%	14
F09B	Oth Cardiothor Pr-Pmp -CCC	6	2%	111,253	77,702	18,984	13,259	2%	15	2%	15
	TOTAL	**354**				**$ 414,372**	**$ 272,015**				

Appendix 5: DRG to service mapping *- Cardiovascular interventional suites*

DRG	DRG Description	Separations #	Separations %	Total cost per DRG ($) Public	Total cost per DRG ($) Private	Total cost ($) Public	Total cost ($) Private	% of total cost per DRG Public	Ranking Public	% of total cost per DRG Private	Ranking Private
F10Z	Perc Corony Intervent+Ami	276	15%	9,691	10,218	2,671,012	2,816,263	19%	1	18%	4
F42B	Crc Dsrd-Ami+Ic In Pr-Cmpdx/Pr	576	32%	4,380	1,936	2,523,798	1,115,542	18%	2	7%	14
F42A	Crc Dsrd-Ami+Ic In Pr+Cmpdx/Pr	194	11%	8,880	3,857	1,719,508	746,863	13%	3	5%	13
F15Z	Perc Crny Intervent-Ami+Stent	264	14%	6,469	9,154	1,709,218	2,418,640	12%	4	15%	6
F12Z	Cardiac Pacemaker Implantation	151	8%	9,198	17,314	1,388,247	2,613,189	10%	5	17%	5
F41A	Crc Dsrd+Ami+Inva Inve Pr+CSCC	84	5%	11,262	6,027	941,597	503,907	7%	6	3%	11
F41B	Crc Dsrd+Ami+Inva Inve Pr-CSCC	129	7%	6,782	3,621	876,321	467,880	6%	7	3%	12
F01A	Implntn/Replcmnt Aicd Ttl+CSCC	39	2%	22,167	64,389	858,476	2,493,635	6%	8	16%	1
F01B	Implntn/Replcmnt Aicd Ttl-CSCC	30	2%	12,175	53,602	367,953	1,619,962	3%	9	10%	2
F19Z	Oth Trns-Vsclr Perc Crdc Intrv	22	1%	12,423	11,916	269,783	258,773	2%	10	2%	10
F17Z	Cardiac Pacemaker Replacement	36	2%	4,863	13,259	176,892	482,297	1%	11	3%	8
F18Z	Crdc Pcmkr Revsn -Dvc Rplcmnt	9	0%	9,370	5,609	84,785	50,753	1%	12	0%	9
F16Z	Perc Crny Intervent-Ami-Stent	11	1%	7,148	5,623	77,615	61,056	1%	13	0%	7
F02Z	Aicd Cmpnt Implntn/Replcmnt	4	0%	9,486	25,112	34,334	90,891	0%	14	1%	3
	TOTAL	**1824**				**$13,699,538**	**$15,739,649**				

Appendix 5: DRG to service mapping - Acute chest pain

DRG	DRG Description	Separations #	Separations %	Total cost per DRG ($) Public	Total cost per DRG ($) Private	Total cost ($) Public	Total cost ($) Private	% of total cost per DRG Public	Ranking Public	% of total cost per DRG Private	Ranking Private
F72A	Unstable Angina + CSCC	80	4%	4,899	3,934	391,273	314,200	10%	1	11%	1
F72B	Unstable Angina - CSCC	456	23%	2,357	1,946	1,074,833	887,410	27%	2	30%	2
F74Z	Chest Pain	1,468	73%	1,741	1,205	2,555,811	1,768,956	64%	3	60%	3
	TOTAL	**2004**				**$4,021,917**	**$2,970,566**				

Appendix 6: Abbreviations

AR-DRG	Australian Refined Diagnosis-Related Groups
CBU	Commercial Business Unit
COU	Commercial Operations Unit
CSCF	Clinical Services Capability Framework
DRG	Diagnostic Related Group
ED	Emergency Department
GCHHS	Gold Coast Hospital and Health Service
NHCDC	National Health Costing Data Collection
ROQ	Radiation Oncology Queensland
WAU	Weighted Activity Unit

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This report is a confidential document that has been prepared by PwC at the request of Gold Coast Hospital and Health Service (GCHHS), in accordance with our engagement terms, with the scope of analysis determined according to subsequent discussions and email correspondence.

The information, including designs, estimates, forecasts, opinions and assumptions (together "Information") contained in this report have been prepared by PwC from material provided by, and discussions with, GCHHS and publicly available information.

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PwC has based its report on Information received or obtained, on the basis that such information is accurate and complete. PwC and its respective agents, directors, officers and employees make no express or implied representation or warranty as to the accuracy, reliability or completeness of the Information.

Minister for Health

Correspondence

Health and Community Services Committee

Hon Lawrence Springborg MP
Minister for Health

Level 19
147-163 Charlotte Street Brisbane 4000
GPO Box 48 Brisbane
Queensland 4001 Australia
Telephone +61 7 3234 1191
Facsimile +61 7 3229 4731
Email health@ministerial.qld.gov.au

25 JUL 2013

Mr Trevor Ruthenberg MP
Chair
Health and Community Services Committee
Parliament House
George Street
BRISBANE QLD 4000

Dear Mr Ruthenberg

I write to seek assistance in relation to a report concerning the Gold Coast University Hospital (GCUH) which I tabled at the Health and Community Services Committee Estimates Hearing held on 24 July 2013.

Following the hearing, it has come to my attention that I inadvertently tabled a 2008 report relating to the GCUH (Hansard reference, page 49), when it was my intention to table the December 2012 PricewaterhouseCoopers (PwC) report titled *GCUH Private Service Options: Clinical and Functional Analysis*. It is clear from the Hansard record that my discussion in the hearing at the time was in reference to the alternative options for delivery of clinical and non-clinical services at the GCUH.

On this basis, I seek the indulgence of the Committee to not publish the 2008 report. Furthermore I would appreciate the Committee's consideration in tabling and publishing the attached PwC report.

Should you require any further information in relation to this matter, Mr Andrew Bibb, Senior Policy Advisor, on telephone 324 74834 will be available to assist you.

Yours sincerely

LAWRENCE SPRINGBORG MP
Minister for Health

Minister for Community Services, Child Safety and Disability Services

Answers to Questions on Notice

Health and Community Services Committee

Question on Notice

No. 1

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

I refer to page 4 of the SDS and ask the Minister to please outline, in detail, what programs, services, grants, staff or any other cuts or reductions in expenditure make up the amount of in excess of $37M that constitutes the difference between the budgeted allocation for the 2012-13 financial year for the Department of Communities, Child Safety and Disability Services, and the estimated actual expenditure for that financial year?

ANSWER

The 2012–13 published Budget for the Department of Communities, Child Safety and Disability Services was approximately $2.564 billion. The 2012–13 Budget of $2.564 billion incorporates 2012–13 budget savings measures announced in the last budget and disclosed at last year's Estimates hearing. The 2012–13 Estimated Actual of $2.526 billion reflects the achievement of the published Budget Savings measures and represents a spend of 98.5 per cent of the published budget.

Question on Notice

No. 2

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

I refer to page 15 of the SDS, and ask the Minister to please outline why less than half of the 2012–13 capital purchases budget was expended and provide a full list of capital projects that were deferred as a result of delays in the commencement and completion of projects, as outlined in the SDS, amounting to a difference of nearly $28.8 million between the budget and estimated actual figures, and when those funds will now be spent?

ANSWER

The 2012–13 capital purchases for the department achieved an estimated actual expenditure of $26.773 million, against planned expenditures of $55.569 million.

Delays in achievement of capital milestones are largely due to the late 2012–13 Budget, subsequent wet season delays and project timeframe impacts due to the late 2012 and early 2013 disaster events.

Unspent funding from 2012–13 has been deferred into future years and provides a source of funds for the department's capital acquisition program. Remaining funds have been converted from capital to operating funding.

Question on Notice

No. 3

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

I refer to page 18 of the SDS, and ask the Minister to please outline what grants and subsidies were cut or reduced to constitute the nearly $25 million difference between the budgeted expenses for the 2012–13 financial year and the estimated actual expenses for that year, broken down by organisation name, project name, funding amount and date funding changed?

ANSWER

The Department of Communities, Child Safety and Disability Services' Income Statement on page 18 of the SDS shows a Grants and Subsidies budget in 2012–13 of almost $1.755 billion and estimated actual expenditure of almost $1.732 billion and represents a spend of 98.6 per cent of the published grants and subsidies budget.

In addition to this, growth funding of over $100 million between 2012-13 Estimated Actual and 2013-14 Estimate is due to the allocation of funds for the transition to DisabilityCare, funding for pay equity for the social and community services sector and additional growth and escalation funding.

Question on Notice

No. 4

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

I refer to page 4 of the SDS, and ask the Minister to please (a) outline in detail what programs were cut to constitute the more than $87 million difference between the budgeted expenditure for the 2012–13 financial year and the estimated actual for that year for the Social Inclusion Service; and (b) outline what programs will be further cut to constitute the further decrease of an additional $5 million in the 2013–14 estimate for Social Inclusion Services?

ANSWER

The 2013–14 State Budget delivered on 4 June 2013 provides over $2.580 billion in operating funding for the Department of Communities, Child Safety and Disability Services.

The department is committed to supporting and protecting the wellbeing of vulnerable Queenslanders and supporting excellence in the delivery of frontline human services to Queenslanders.

While the Departmental Budget Summary SDS does show a funding difference for Social Inclusion Services of $87.658 million, this is largely matched by a reduction in Social Inclusion costs and is due to:

- Transfer of the Family Support Program from Social Inclusion Services to Child Safety Services.
- The net effect of deferrals of unspent but committed funding from 2012–13 to 2013–14 including Homelessness funding and capital grants for neighbourhood and multipurpose community centres. These funds will be expended in 2013–14.
- In 2012–13, the department undertook a major post machinery-of-government review of asset holdings, including review of property, plant and equipment values and useful life. This review resulted in a depreciation expense for Social Inclusion Services which now reflects the actual utilisation of departmental assets by this service area.
- A number of other funding adjustments were also made through the financial year to reflect the new organisational structure following the machinery-of-government changes in April 2012.

Question on Notice

No. 5

Asked on Tuesday, 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

I refer to page 2 of the SDS, will the Minister outline what interactions or meetings she had involving the Moreton Bay Regional Community Association, including the date of any meeting, who attended the meeting and the purpose of the meeting.

ANSWER

Information relating to the meeting schedule of the Minister for Communities, Child Safety and Disability Services can be obtained through the public release of the Minister's diary. Something that was not available when the Labor Party was last in power.

Question on Notice

No. 6

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

I refer to page 7 of the SDS, and ask the Minister to please outline for the past three financial years (as at 30 June) how many children were in the care of the Department of Child Safety, broken down by age, gender, Indigenous status and geographical location of the child at the time of the order being imposed?

ANSWER

Data for the period ending 30 June 2013 cannot be provided as the Department of Communities, Child Safety and Disability Services is required to comply with national reporting guidelines which stipulate that data extraction for a financial year can only occur eight weeks following the end of the period. In the case of 30 June 2013 data this is 31 August 2013.

Data on those children subject to protective orders as at 30 June 2012, 2011 and 2010 by Indigenous status, region, gender and age group is published on the department's 'Our Performance' website which can be accessed from the following link:
http://www.communities.qld.gov.au/childsafety/about-us/our-performance/summary-statistics/protective-orders

Question on Notice

No. 7

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

I refer to page 7 of the SDS, and ask the Minister to please outline the number of complaints made to the Disability and Communities Complaints Unit each month for the 2011–12 and 2012–13 financial years and the 2013-14 financial year to date, broken down by service delivery area?

ANSWER

The following table provides the number of complaints made to the Disability and Communities Complaints Unit each month for the 2011–12 and 2012–13 financial years and the 2013–14 financial year as at 8 July 2013, broken down by service delivery area.

Month	Communities	Disability Services	Total
July 2011	12	20	32
August 2011	12	31	43
September 2011	14	47	61
October 2011	38	17	55
November 2011	18	19	37
December 2011	3	20	23
January 2012	2	21	23
February 2012	6	18	24
March 2012	3	22	25
April 2012	10	13	23
May 2012	0	7	7
June 2012	1	15	16
Total 2011–12	**119**	**250**	**369**
July 2012	4	15	19
August 2012	5	10	15
September 2012	2	17	19
October 2012	5	17	22
November 2012	1	14	15
December 2012	0	11	11
January 2013	3	10	13
February 2013	39	12	51
March 2013	38	13	51
April 2013	7	12	19
May 2013	2	18	20
June 2013	1	10	11
Total 2012–13	**107**	**159**	**266**
As at 8 July 2013	0	2	2
Total as at 8 July 2013	**0**	**2**	**2**

Question on Notice

No. 8

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

What proportion of the additional disaster relief funding will be made available to residents other than those in the Bundaberg and Burnett regions?

ANSWER

See Question on Notice 15.

Question on Notice

No. 9

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

Will a progress report be made available to indicate the level of funding and support for neighbourhood centres?

ANSWER

See Question on Notice 17.

Question on Notice

No. 10

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

I refer to page three of the Department of Communities, Child Safety and Disability Services Service Delivery Statement and specifically in reference to the $117.2 million over four years to provide support for up to 256 young adults with disability exiting the care of the State. Can the Minister please outline how this commitment will specifically assist young people exiting the care of the state living with a disability?

ANSWER

Young adults with disability exiting the care of the State are a vulnerable group of young people and it is important that the Queensland Government continues to meet the needs of these young Queenslanders.

The Queensland Government is investing $117.2 million over the next four years to provide essential supports for young people who will be exiting the care of the State.

This is a critical time in the lives of these young people. A time when they are transitioning from one phase of their lives to another. This can be very overwhelming for any young person; and especially so for a young person who has specialist disability support needs. The supports provided through this funding are vitally important in assisting these young people to begin their lives as adults in the community.

This funding will provide access to much needed therapy supports to begin, or in some cases, continue the journey toward adulthood. Funding from this allocation will be provided for young adults to attend counselling and psychology sessions that will assist them with understanding and better managing behaviours that present challenges in their lives. Eligible young people will also be funded to enable them to access speech and occupational therapy services.

The Government's $117.2 million investment will also assist these young people to access in-home supports to help them with daily tasks such as showering or preparing meals. Essential supports will also be provided to enable these young people access community and social events so that they can participate as a valued member of the community.

This investment will add to the Queensland Government's expenditure of $46.4 million in 2012–13 which provided supports to 426 young adults with a disability who exited State care.

The Queensland Government is about investing in the future of our young people; to empower them, with the right amount of support that will help them to move forward with their lives and grasp new opportunities as they arise.

Question on Notice

No. 11

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

I refer to the Government's investment of $55 million over four years for young people with a disability leaving school outlined on page three of the Department of Communities, Child Safety and Disability Services Service Delivery Statement and ask, how will this money help support these young people and their families?

ANSWER

In 2012–13 the Queensland government made a large investment to meet the needs of young people with a disability, and the Queensland government is proud to be able to continue increasing the supports available in 2013–14 and beyond. This year the Queensland government has committed $55 million over four years to support up to 1200 young people with a disability who are leaving school.

Each year hundreds of young people leave school wondering what life holds for them and what will happen next. This transition can create anxiety for young people and their families, particularly where the young person has a disability. It is important that young people with a disability are supported during this time.

The $55 million in funding support over four years will help these young people to develop their life skills and find pathways to help them with their transition to life after school. Young people with a disability leaving school will be able to use this support to develop new life skills such as accessing public transport, money management or domestic skills. It will also help these young people to remain in contact with their friends, as well as support them to make new friends and connections in their community. Importantly young people with a disability will be supported to contribute to our communities and help others through doing volunteer work, and developing work skills to assist them in gaining employment.

These young people are the future of our State and this funding will see them provided with valuable opportunities to live the life of their choice.

Question on Notice

No. 12

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

The Department of Communities, Child Safety and Disability Services Service Delivery Statement references, on page three, $26.4 million over four years to help support people with spinal cord injuries and I ask the Minister to outline how this will assist these people?

ANSWER

The Queensland Government is committed to assisting people who have suffered spinal cord injuries. When a person sustains a spinal cord injury it is often sudden, and in many instances, traumatic. Further, people with a spinal cord injury face significant pressures when they are able to leave hospital and return to life in the community.

Through the $26.4 million Spinal Cord Injuries Response initiative, a coordinated whole-of-Government approach is delivered to support people with newly acquired spinal cord injuries, enabling transition to community living following acute inpatient care and rehabilitation in the Spinal Injuries Unit at the Princess Alexandra Hospital.

This funding will be provided over four years and administered through the Department of Communities, Child Safety and Disability Services. This initiative supports a person's safe and timely discharge from hospital by providing funding to cover a range of support and services, including specialist aids and equipment, community housing, home modifications and up to 65 hours per week of in-home personal disability care and support to over 100 people transitioning from the Princess Alexandra Hospital to their homes. This vital funding will support them to live at home in their own community.

Returning home can be a difficult and challenging experience for people with a spinal cord injury and this funding will provide the extra help and support for their care needs and rehabilitation. The funding will also support them to access employment, social and other opportunities in the community.

This funding will provide individuals with a newly acquired spinal cord injury returning to their families and communities from the Spinal Injuries Unit with reassurance that they will receive ongoing support through experienced service providers.

The allocation of this funding over four years will assist with the flow of patients through the Spinal Injuries Unit and as a result reduce the high costs associated with delays in discharge from the Princess Alexandra Hospital.

Question on Notice

No. 13

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

Page three of the Department of Communities, Child Safety and Disability Services Service Delivery Statement outlines the government's commitment to DisabilityCare Australia in Queensland. Can the Minister outline what the government is doing to strengthen disability services across Queensland to support this scheme?

ANSWER

Ensuring Queensland is ready for DisabilityCare Australia, the national disability insurance scheme (NDIS), is a priority for the Queensland Government. A number of important initiatives are already well underway to support the transition which will take place in Queensland from 1 July 2016.

In December 2012, the Queensland Government announced a commitment to provide an additional $868 million over a period to 2018–19 to address the historical under-funding of disability services in Queensland, and to support the full implementation of DisabilityCare Australia in Queensland. This is in addition to the record State funding for specialist disability services of $959 million in 2012-13. In 2013-14 Queensland's record funding of $990 million includes the first tranche of $25 million committed as part of Queensland's commitment of $2.03 billion in funding for DisabilityCare Australia by 2019–20.

The 2013-14 budget will enable the Queensland Government to build on the work already undertaken through 2012-13 to strengthen disability services across Queensland in preparation for the transition to DisabilityCare Australia.

On 4 September 2012, the Premier announced the launch of the Your Life Your Choice self-directed support framework. Your Life Your Choice supports the principles of DisabilityCare Australia in recognising that a person with a disability and their family should be at the centre of the decision-making process and have choice and control over their support. Self-directed support is the key plank of the NDIS and the early transitioning of people with a disability to this service model ensures that Queensland is well placed for the roll out of DisabilityCare Australia.

Your Life Your Choice is also creating opportunity for non-government providers to review their business models to move towards the consumer driven environment that will be created under the NDIS; it is key to readying the sector for the NDIS. Through Your Life Your Choice the Queensland Government is helping people with a disability, their families and carers, and non-government service providers, to have the skills and confidence for how disability services will be delivered in the future.

The Sector Readiness and Workforce Capacity initiative is also integral to Queensland's preparation for transition to the NDIS and will deliver accredited and non-accredited training to the sector workforce and people with a disability. The aim of this initiative is to assist with preparations for future reforms in the disability sector, including the NDIS, and to respond to the changing needs across the social inclusion and child safety sectors. This initiative started in May 2013.

Planning is well underway in Queensland to ensure the state is ready to transition to DisabilityCare Australia from 1 July 2016. The Queensland Government is working with key consumer, carer, provider and advocacy representatives to develop and deliver an NDIS transition plan through the NDIS Planning and Implementation Group. This Group was established in February 2013, and has met three times this year. The Group will support the Department of Communities, Child Safety and Disability Services to develop a Queensland NDIS work program for the period 2013 to 2016. This plan will be completed by December 2013, and will focus on building awareness about what the NDIS will mean, as well as building skills for consumers and disability providers.

This work program will form the basis for a joint NDIS transition plan with the Australian Government and DisabilityCare Australia which will cover the period from 2016 to 2019. This joint NDIS transition plan will be completed by December 2014 and will map how Queensland will deliver the NDIS from 1 July 2016, including how and when eligible clients will enter the scheme.

Other ways in which the Government is working to strengthen disability services include:

- The establishment of the Parent Connect program, which links families of babies and newly diagnosed children with a disability to support services. This supports the Government's recognition of the need for early intervention.
- The provision of funding to meet a number of critical demand pressures which will provide certainty of support for young people with a disability exiting the care of the state; young people with a disability leaving school; and for people who have sustained spinal cord injuries to support them to transition successfully back into the community. This funding will also provide reassurance for their families and carers.
- Reducing red tape so that service providers can get on with the job of providing services for people with a disability.

The Queensland Government is committed to providing a contemporary and quality disability service system that responds to the needs of Queenslanders with a disability, their families and carers; a system that is focused on person centered care and quality frontline services. This will ensure that Queensland is ready for the transition to DisabilityCare Australia which will commence from 1 July 2016.

Question on Notice

No. 14

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

Page two of the Department of Communities, Child Safety and Disability Services Service Delivery Statement states that the government is strengthening disability services in preparation for Queensland's transition to DisabilityCare Australia and I ask, what is the government doing to support carers of people with a disability?

ANSWER

The Queensland Government recognises the enormous contribution provided by over 500,000 Queensland carers to ensure their loved ones are supported and have a good quality of life.

To address the historical under-funding of disability services in Queensland, which has placed a large burden on Queensland carers to provide for the shortfall in support, the Queensland Government is investing $1.43 billion in disability services across Queensland in 2013-14. This funding not only supports people with a disability to receive reasonable and necessary support, it also provides carers with some respite from their caring role, and more certainty that their loved one will receive the support that they require.

In addition, following the Premier signing the Heads of Agreement with the Australian Government on 8 May 2013 for the implementation of DisabilityCare in Queensland, carers can have certainty of support for their loved ones into the future. The Queensland government will be committing $2.03 billion in funding for the full implementation of DisabilityCare Australia by 2019–20.

The Queensland government, in recognising the important and vital role of carers, has identified Respite as a priority for carers. That is why the Queensland Government is investing in excess of $80 million in Respite services across Queensland in 2013-14.

Flexible Respite, in particular, is a key component in the Queensland Government's commitment to delivering extra respite hours for young people aged between 16 and 25 years, with high needs disabilities. In 2012-13, $5.5 million was provided for this initiative which assisted 233 people with a disability, along with their carers. In 2013-14 $5.5 million will again be provided for this initiative.

Respite services can strengthen a family's ability to care for a family member with a disability, and support the family to stay together. Respite services provide a way for carers of a person with disability to take a break from their caring role.

The Queensland Government has also committed $16.065 million over three years for the Elderly Parent Carer Innovation Trial. This trial will provide innovative strategies for sustainable accommodation options for people with disabilities once their elderly parent carers are no longer able to look after them at home. This will provide these carers with certainty that their loved one will be supported into the future.

The Queensland government also provides support to Queensland carers through the provision of the Carer Business Discount Card - which provides eligible carers with discounts on goods and services from participating businesses; and the Companion Card – which allows people with a disability who have a lifelong need for attendant care support to take part in activities and visit venues in the community. Companion Cardholders present their card when

purchasing tickets at participating businesses and are issued with a second ticket for their companion at no charge.

In order to support the Queensland government to plan for the transition to DisabilityCare Australia in Queensland from 1 July 2016, the government has established the Queensland NDIS Planning and Implementation Group. To ensure key stakeholders are represented in the planning and preparation for Queensland's transition, the group includes people with disability, families and carers, disability service providers, advocacy organisations, mental health organisations, peak and carer bodies.

Queensland carers and carer organisations will also have the opportunity to provide the government with direct input into the transition planning for DisabilityCare Australia through the Queensland Carers Advisory Council.

The Queensland Government is committed to providing a contemporary and quality disability service system that responds to the needs of Queenslanders with a disability, their families' and carers.

Question on Notice

No. 15

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

I refer to page 13 of the Department of Communities, Child Safety and Disability Services Service Delivery Statement, specifically in reference to $2.5 million in 2013-14 ($5 million over two years) committed to respond to communities impacted by Tropical Cyclone Oswald. Can the Minister outline how this money will help assist communities impacted by Tropical Cyclone Oswald? Further, what actions have been taken by the Minister to review how well her department responded with community recovery assistance following Tropical Cyclone Oswald in January this year?

ANSWER

The Department of Communities, Child Safety and Disability Services is currently working with the Department of Health to implement a $5 million community recovery package that will provide community development, personal support and community mental health services to the affected areas of Bundaberg and North Burnett over the next two years.

Recovery from a disaster can be a long term process and these services will provide ongoing support to severely affected communities. The Community Development program will employ two Community Development Officers each in Bundaberg and the North Burnett, to support community-led recovery initiatives and build on the strengths and capacities in each community. Examples of activities that may be implemented as part of the community development program include youth arts projects commemorating the event, or preparedness workshops for seniors in the community.

The personal support program will be delivered by UnitingCare Community and will provide counselling and support to individuals and families experiencing personal, social or emotional issues as a result of Tropical Cyclone Oswald and associated rainfall and flooding. The community mental health services, which are being implemented by the Department of Health, will provide both group-based and individual counselling support to people who have been affected by disasters and are struggling to get back to a sense of normality, or who are having trouble coping emotionally. The program will also provide mental health information to individuals, families, carers and communities about recognising the signs of distress and where to seek help. Disasters affect people in many different ways and it is important to have these services available to minimise the need for other interventions – such as clinical mental health services – down the track.

The $5 million community recovery package follows on from a major state-wide community recovery operation responding to the effects of Tropical Cyclone Oswald across the state. This operation included extensive outreach, community recovery centres, coordination of non-government support agencies and paying of grants.

However, the department has provided a great deal of support to other affected locations across the State, particularly those that have experienced multiple events over a number of years.

As part of its relief and recovery services following Tropical Cyclone Oswald, the department coordinated a wide range of personal support and counselling services in the immediate aftermath of the disaster, as well as providing grants under the Personal Hardship Assistance Scheme in 23 local government areas, including other hard-hit regions such as the Lockyer Valley, South Burnett and Rockhampton.

Areas that have ongoing need for support due to repeated impacts are able to access additional funding for personal support services under Category A of the National Disaster Relief and Recovery Arrangements. The department has funded one such program in the Lockyer Valley until December 2013.

As with any disaster, the department considers the learnings from these types of events. A number of opportunities for improvement have been identified including systems and electronic databases to manage logistics and deployment of government staff, information management systems, enhancing partnership arrangements with service providers, and alternative recovery models.

Question on Notice

No. 16

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

With reference to page 18 of Budget Paper 4, the government is funding an additional $22.2 million over four years for payment of foster and kinship allowances to keep pace with the current growth rates of children in out of home care. Can the Minister please outline what measures are being taken to reduce the numbers of children coming into care?

ANSWER

During the election campaign in 2012, the Queensland Government committed to strengthen Queensland families and protect children.

I am pleased to advise that we delivered on this commitment during the 2012–13 State Budget.

Fostering Families comprises three new intensive family services that have been funded for $2 million per annum over two years under this election commitment. Fostering Families services are tasked with providing intensive support to both statutory and non-statutory client families where neglect is the main presenting factor.

Another way this Government has delivered on its commitment was through the establishment of the Child Protection Commission of Inquiry.

The Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection,* report was provided to the Queensland Government on 1 July 2013. It provides a clear roadmap for the child protection system over the next 10 years.

One of the proposed key objectives is to reduce the number of children and young people coming into care by diverting families from the statutory child protection system.

The roadmap also includes a new family support system for vulnerable children and families who may otherwise come in contact with the statutory child protection system.

The Government is currently considering the Carmody Report. Our response will build on what we and other jurisdictions have that is making a positive difference.

Evidence demonstrates that if families are supported in the right way early, before issues escalate, the need for more invasive child protection intervention can be reduced. Children achieve better lifetime outcomes if they are cared for safely by their family at home.

We have an opportunity to develop an effective and responsive secondary service system that can support families early to address issues when they first arise.

There are a number of initiatives within our current family support system that show promising signs of reducing the demand on the child protection system.

The Family Intervention Services have demonstrated success in addressing child protection concerns and supporting parents to care safely for their children at home and reduce the need for further statutory intervention.

Family Intervention Services can be engaged in an intervention with a family's agreement providing family preservation services to statutory child protection clients.

By responding to the needs of families earlier, the expected longer term outcomes are a reduction in the volume of reports to Child Safety and in the number of children in out-of-home care.

Intervention with parental agreement enables the Department of Communities, Child Safety and Disability Services to provide support and assistance to a child in need of protection and their family, without the use of a court order.

The Referral for Active Intervention Services program responds to vulnerable families with children and young people, from unborn through to 18 years, who are at risk of involvement in the statutory child protection system.

Case managers work collaboratively with families to identify and prioritise their presenting needs and provide intensive support and engagement with specialist services.

The Helping Out Families intensive family support services trial in South East Queensland has shown some positive results in reducing the demand on the child protection system.

Evaluation data from 2012 showed that the number of notifications and substantiations for South East Queensland region decreased by 3 and 5 per cent respectively between the pre-Helping Out Families trial to the post-Helping Out Families trial period. In contrast, the rest of Queensland recorded an increase in the number of notifications and substantiations, by 17 and 16 per cent respectively.

Subsequent evaluation findings released in January 2013 indicate re-reporting to Child Safety reduced by almost 40 per cent for clients engaged with Helping Out Families services compared with those who did not engage.

The trial of the Helping Out Families initiative in South East Queensland is providing some preliminary evidence that where alternative and appropriate pathways to the statutory child protection system are made available and explicit for referrers, they will use them.

The Aboriginal and Torres Strait Islander Family Support Services are community controlled prevention and early intervention services that provide family support services to Aboriginal and Torres Strait Islander children and their families.

The objective of the intervention is to reduce the likelihood that ongoing intervention by the department will be required and to divert families from the statutory child protection system.

The overall program for these Aboriginal and Torres Strait Islander family support services is being reviewed by the department to see whether the program's efficiency and effectiveness can be improved.

It is expected that the findings of this review will be used to re-shape the program and better align the program with the reforms suggested by the Carmody Inquiry into Child Protection which called for increased emphasis on prevention and early intervention.

Strengthening the sector to support families before issues escalate is a key component of increasing the safety and wellbeing of children.

As Commissioner Carmody has found, we need to shift our focus and investment more to prevention and early intervention. This is the unfinished business of previous inquiries and of the previous Government.

Question on Notice

No. 17

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

With reference to page 18 of Budget Paper 4, can the Minister outline the role of Neighbourhood Centres in supporting Queenslanders?

ANSWER

The Department of Communities, Child Safety and Disability Services funds a total of 122 Neighbourhood Centres across the State to respond to identified and emergent needs of local communities with a priority on vulnerable individuals and families.

They network with, and provide pathways to, other services which provide specific targeted responses (such as counselling and homelessness services) and actively promote community engagement and connectedness. Service delivery is flexible and culturally inclusive providing a range of prevention and early intervention community and centre-based activities that best meet the identified needs of vulnerable individuals and families.

Volunteers are welcomed and actively engaged in meaningful projects at Neighbourhood Centres that contribute to the local community.

One example of the good work Neighbourhood Centres are doing can be found in Charters Towers, where a group of visiting services operate from the department funded centre on a regular basis. Local residents who were already using the centre for community meetings, parenting groups and social activities are now able to access Centrelink staff, financial counsellors and family support services when using the centre instead of travelling to the next town where these services are based.

The $3.8 million allocated per annum in Budget Paper 4 includes $1.4 million for the continuation of 13 Neighbourhood Centres previously funded under the Community Development initiative and $400,000 to help ensure the viability of neighbourhood centres across the State. This allocation also includes $1.8 million in funds for the Emergency Relief initiative.

In 2013–14, the department will also provide in total capital grants of $3.690 million for Neighbourhood Centres in Winton, Proserpine and Upper Ross River. The department has also allocated capital works funding of $2.321 million to progress the construction of Neighbourhood Centres in Mount Isa and Chinchilla.

In 2013–14, the department will commence work with interested local governments and Neighbourhood Centres to develop and implement a contemporary framework for Neighbourhood Centres.

Question on Notice

No. 18

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

The front page of the Department of Communities, Child Safety and Disability Services Service Delivery Statement sets out the budget for the Minister's portfolio and particularly notes a budget increase across Communities, Child Safety and Disability Services. Can the Minister explain the budget increase and what this means for Queenslanders?

ANSWER

The 2013–14 State Budget provides more than $2.580 billion in operating funding to the Department of Communities, Child Safety and Disability Services to support and protect the wellbeing of vulnerable Queenslanders. This represents an increase of $16.270 million in comparison to the 2012–13 Budget.

In addition, the department's administered budget provides more than $268 million in concessions and personal benefits payments to eligible Queenslanders, an increase of over $25 million in comparison to the 2012–13 Budget.

The budget reflects additional funding to prepare for the rollout of DisabilityCare Australia, the national disability insurance scheme, with the first $25 million of an additional $868 million in State funds over a period to 2018–19.

Funding has been allocated to meet a number of critical demand pressures, including:

- $7 million in 2013–14 as part of $25.1 million over four years for Foster and Kinship Carer Allowances to meet demand from increasing numbers of children in out-of-home care
- $5.5 million in 2013–14 as part of $55 million over four years to provide assistance for up to 1200 young people with disability leaving school
- $11.52 million in 2013–14 as part of $117.2 million over four years to provide support for up to 256 young adults with disability exiting the care of the State
- $1.735 million in 2013–14 as part of $26.4 million over four years to provide support for up to 108 people with spinal cord injuries to leave the Princess Alexandra Hospital and live in the community.

Funding totalling $15.2 million over four years has also been provided to continue the Emergency Relief program and to continue to support 13 Neighbourhood Centres formerly funded under the Community Development initiative.

Capital grants funding of $22.119 million has been provided, including:

- $7.5 million for the Elderly Parent Carer Innovation Trial aimed at developing innovative strategies that will provide sustainable living options for adults with a disability when they can no longer be cared for by their elderly parents. The Elderly Parent Carer Innovation Trial will provide capital grants up to $1 million and small grants up to $50,000 for residential construction, modification or acquisition projects.
- $6.257 million for Community Care grants
- $2.790 million for Multi-Purpose and Neighbourhood Centres

- $0.900 million to commence the Upper Ross River Community Centre.

The Budget also commits $5 million over two years to help rebuild the lives of those affected by Cyclone Oswald in January this year.

The budget also continues to deliver on Government commitments:

- $6.5 million to fund extra respite for people with high needs disabilities aged 16 to 25 years and their families and carers and to establish Parent Connect
- $2 million for Fostering Families
- $375,000 for counselling services for victims of child abuse and sexual assault, including access to telephone counselling for children from regional areas
- Caring for Our Community essential equipment grants for community and volunteer groups.

Question on Notice

No. 19

Asked on 2 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

I refer to the front page of the Department of Communities, Child Safety and Disability Services Service Delivery Statement expenditure on child safety and ask, how is the Newman Government encouraging more people to become foster carers in Queensland?

ANSWER

Foster and kinship carers are everyday people who do extraordinary work in keeping children and young people safe from harm.

Their dedication and commitment to the role is rarely publicly recognised and I thank every one of those carers for the love and support they give to children and young people who are not able to safely live at home.

The Newman Government is always looking for more carers. Sadly, there are over 8000 children in Queensland who are not able to live at home and just over 4500 carer families to look after them.

That is why the Assistant Minister, Tarnya Smith MP, and I launched a foster carer recruitment initiative on 3 March 2013, during Foster and Kinship Carer Week.

The 'Is there room?' foster care recruitment initiative aims to attract more foster carers and to ease the demand on current carers. The campaign also aims to raise awareness about the foster carer role and different types of care.

The campaign uses a grassroots level community engagement approach because 'word of mouth' has been identified as an effective recruitment approach.

The Newman Government is asking the Queensland community if they too have room in their lives and their hearts for one more child or young person.

Under the initiative, Members of Parliament, local government mayors, peak bodies, foster care agencies and staff will engage with their local business and community groups to recruit foster carers.

A suite of promotional resources has been distributed to a wide range of government and non-government organisations across the State to support and promote the recruitment of more foster carers. These include: foster care service providers, libraries, schools, churches, parents, citizen committees, child safety service centres and local government offices.

There is also a dedicated website for anybody interested in becoming a carer. The website has a self-assessment tool to help those thinking about becoming a carer to consider what is involved and to evaluate their own capacity to be a carer, before expressing an interest by completing an online form.

In 2013–14, the Newman Government also funds $35 million to non-government organisations to recruit, train, assess and support foster and kinship carers. These services are responsible for recruiting and maintaining adequate numbers of carers in their local areas to meet their service delivery targets.

These non-government organisations recruit carers through promotions at local events such as sports fixtures, community events and advertising.

These initiatives build on the work started by the previous Assistant Minister, Mr Rob Molhoek MP, who assisted with the development of free Community Service Announcements, for broadcast across the Austereo network in Queensland. The announcements are also available on the department's website.

On 23 May 2013, national coverage of Queensland foster carers was featured when carers Mrs Janice and Mr Bernard Cormick appeared on Channel 7's 'Sunrise' program to talk about their experience of providing foster care for 26 years.

Being a foster carer can be such a rich and rewarding experience and most of the foster carers I meet say they appreciate how important it is to help kids who need a safe home.

Carers are not only needed for providing long-term care — we are also looking for people who could provide emergency, respite or short-term care.

Minister for Community Services, Child Safety and Disability Services

Questions taken on Notice at Hearing and Responses

Health and Community Services Committee

Question taken on Notice during the Estimates Hearing

Asked on 24 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

I refer the Minister to the staffing details on page 6 of the SDS. Will the Minister provide details of the exact numbers of job losses for each of the department's service areas – Child Safety Services, Disability Services and Social Inclusion Services – at the end of 2012–13?

ANSWER

With reference to page 6 of the SDS the 2012–13 budget staffing was 6045. The estimated actual for 2012–13 was 5910, a decrease of 135.

- Child Safety Services: 52
- Disability Services: 75
- Social Inclusion: 8

This decrease relates primarily to support and corporate roles. This has been largely through natural attrition, cessation of temporary staff and voluntary redundancies of permanent staff.

Question taken on Notice during the Estimates Hearing

Asked on 24 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

How many staff are on stress leave or sick leave due to the sacking or retrenchment of public servants in your department?

ANSWER

In respect to the question raised by the Member for Gaven, the department is unable to source the number of employees on sick leave for stress-related conditions as it is not incumbent upon employees to disclose the nature of their illness to access their sick leave entitlements.

What I am able to advise is that in the 2012–13 financial year there were a total of 16 accepted workers' compensation claims for psychological injuries. This represents a reduction from 33 accepted psychological claims in 2011–12 and 36 accepted psychological claims in 2010–11.

Question taken on Notice during the Estimates Hearing

Asked on 24 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

Do children all have Medicare cards when they arrive at a foster family?

ANSWER

No

Whenever a child is placed in out-of-home care, the Child Safety Officer is required to either:

- obtain the child's Medicare card details from the parent/s and provide the information to the carer; or
- arrange for the child to have their own Medicare card.

If the child's Medicare enrolment details are not able to be obtained from the parent a direct request can be made to Medicare Australia by the department.

A doctor or pharmacist is able to directly request Medicare enrolment details from Medicare Australia which may be necessary in emergent situations. If medical care or pharmaceuticals are required by a child for whom an existing Medicare card number is not available, the carer must have accurate information about the personal details of the mother and the child in order to assist the doctor or pharmacist to make a request for the Medicare card number.

Question taken on Notice during the Estimates Hearing

Asked on 24 July 2013

THE ESTIMATES COMMITTEE asked the Minister for Communities, Child Safety and Disability Services (MS DAVIS)—

QUESTION

How many applications might there be waiting to be processed to become a foster carer at the moment?

ANSWER

The numbers and progress of applications change on a daily basis with much of the work undertaken by non-government foster and kinship care services.

Upon receipt, applications are progressed as a matter of priority.

Individual files are opened and the application is actively managed and monitored by regions.

The steps for processing and deciding an application are streamlined to ensure that a decision can be made as quickly as possible.

Many of the steps can occur concurrently, which greatly reduces the time required.

From the date of application, the department has 90 days to decide the outcome. However, this timeframe can be extended, with the agreement of the applicant, for the minimum time required to decide the outcome.

Finalised child protection data is not available until approximately eight weeks after the end of the relevant period. The department is required to comply with national reporting guidelines, data quality processes and analysis and interpretation of the data.

I am pleased to report that 533 new carer families commenced from 1 January to 31 May 2013. This is a significant number of people who have put their hand up to volunteer in this important role.

Minister for Community Services, Child Safety and Disability Services

Documents Tabled at the Hearing

Health and Community Services Committee

QCOSS Queensland Council of Social Service

QCOSS Commentary State Budget 2013-14

The 2013-14 State Budget provides some relief to a community services sector still reeling from significant cuts in 2012-13. There are no new major cuts to the sector this year, rather there are some welcome, mostly small, initiatives to ease last year's pain.

This budget, however, does not put Queensland in a strong position to support vulnerable Queenslanders for the long-term, or lead the way in delivering high quality prevention and early intervention services to reduce demand on 'crisis' services - a key message in the *Queensland Commission of Audit Final Report*.

Welcome announcements in the budget include the increased investment of $18 million over four years for emergency relief and neighbourhood centres, 3.06 per cent indexation for state grants, a significant increase in the electricity rebate, increased funding for the Home Energy Emergency Assistance Scheme (HEEAS), and some small increases in spending in health and education. This is complemented by the good news announced in the lead up to the budget – the Queensland Government's contribution to DisabilityCare Australia and additional funding for the National Rental Affordability Scheme (NRAS).

Despite some improvements in concessions, the budget contains a number of revenue-raising measures that will add to cost-of-living pressures for some households. These include the additional levy for emergency services on rates and the increase in the duty payable on some insurance premiums. While the increase in the insurance duty will fund DisabilityCare Australia, only 12.82 per cent of the revenue is required for this purpose. While the government maintains that Queensland is one of the lowest taxing states in the country the impact of these revenue raising measures is likely to most impact those who can least afford it.

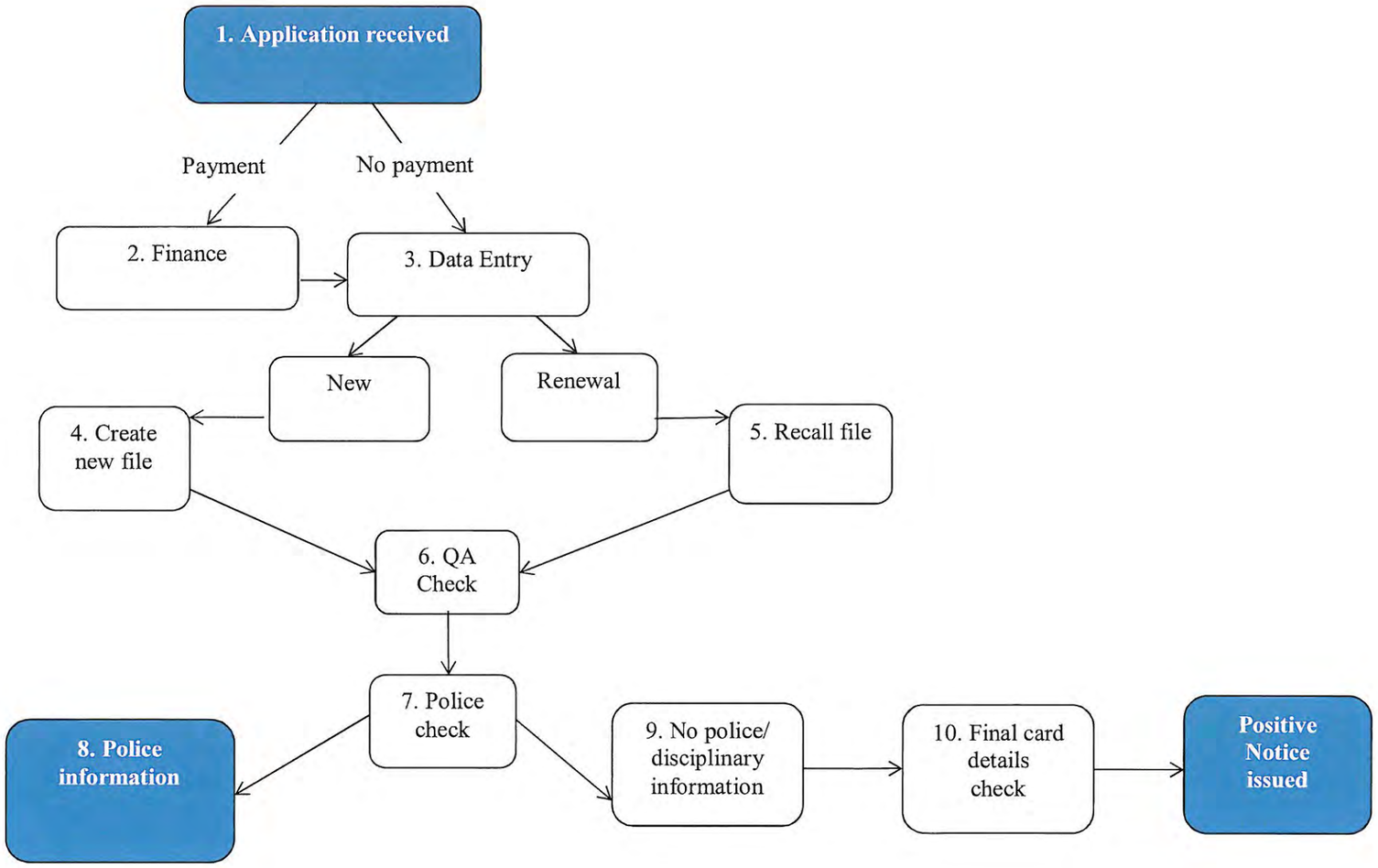
While much emphasis has been placed on the growing cost of expenditure on services, the *Queensland Commission of Audit Interim Report* cites evidence that on a per capita basis Queensland currently invests less than the Australian average on services such as housing, communities and education. In areas where expenditure is higher than average, such as in health, this needs to be contextualised by the fact we have had historical underinvestment in this area, and the knowledge that we are still catching up on the backlog of investment required by our health system. To be the highest performing state providing for our citizens we need to invest in prevention and early intervention and crisis services.

We need to start measuring social, and not just financial, outcomes in Queensland, and use this information to start a constructive dialogue about the type of programs, supports and community service systems that are needed. These should generate improvements in areas such as employment participation and educational achievement, and achieve reductions in financial stress, homelessness, mental health issues and child protection notifications to name but a few.

Overview of Blue Card Workflow Process

Diagram 1: Files with no police or disciplinary information

(assumes receipt of a complete application which does not require additional information/clarification from applicant/employer)

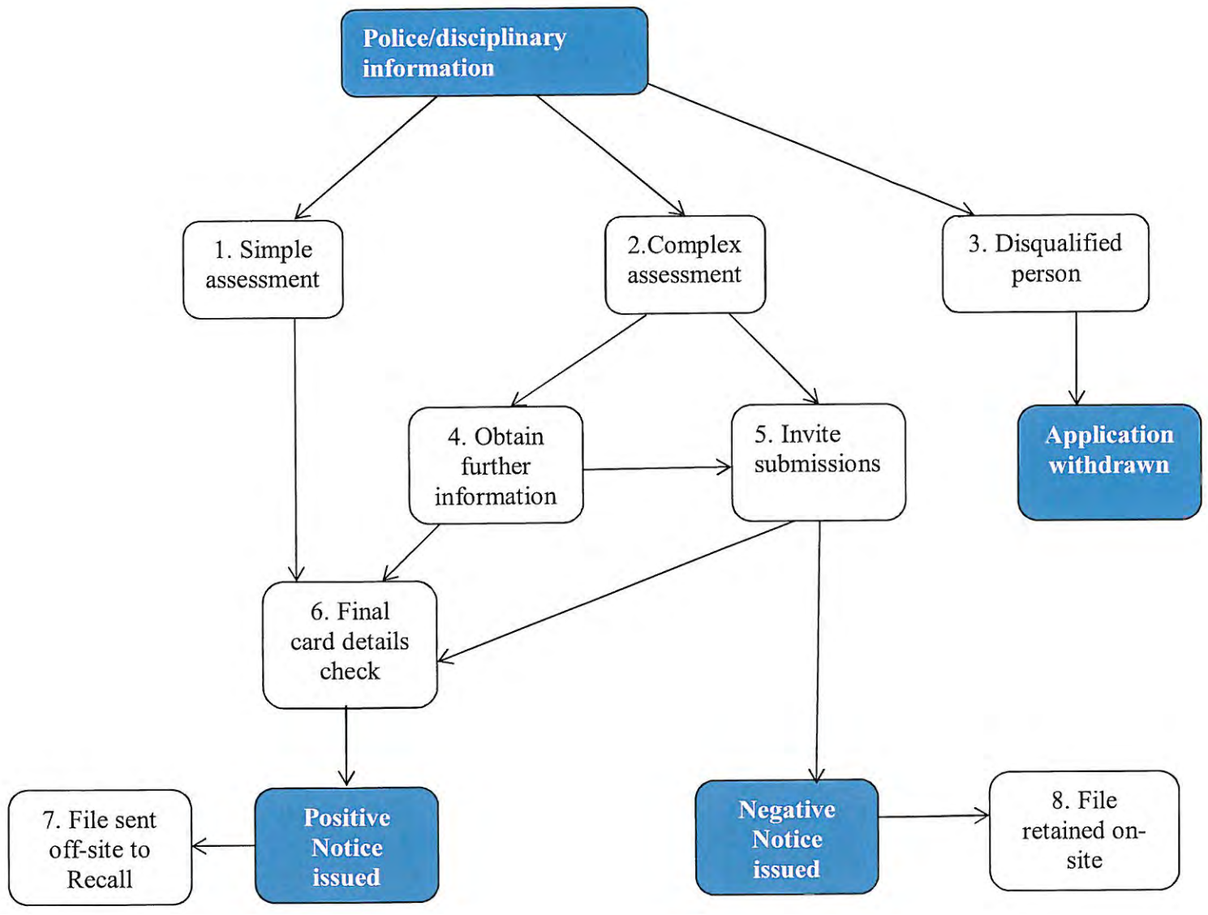


Processing steps

1. **Application received:** form accessed from CCYPCG website, printed, completed, signed and sent via mail/fax/email/in-person.
2. **Finance:** For applications where a fee is payable, payment is processed via B-Point (CBA) and receipt issued through Finance1.
3. **Data Entry:** All applications manually data entered into CCYPCG blue card database.
4. **Create new file:** Where a new applicant submits an application, a new file is created.
5. **Recall file:** Where an existing applicant submits a renewal application, their file is obtained from off-site storage.
6. **QA check:** A quality assurance check is undertaken to ensure all required information has been provided and accurately entered into the database. This is an important step to ensure that the information which will be used to conduct a criminal history check is correct and complete.
7. **Police check:** relevant applicant details are sent via secure transfer to QPS to obtain a criminal history check.
8. **Police information:** file forwarded to Legal team for assessment (see diagram 2)
9. **No police/disciplinary information:** CCYPCG obtains automatic system update for applicants with no criminal history.
10. **Final card details check:** Details for printing on blue card confirmed and applicant information sent to 3rd party provider to print positive notice letter and blue card.

Overview of Blue Card Workflow Process

Diagram 2: Files with police or disciplinary information

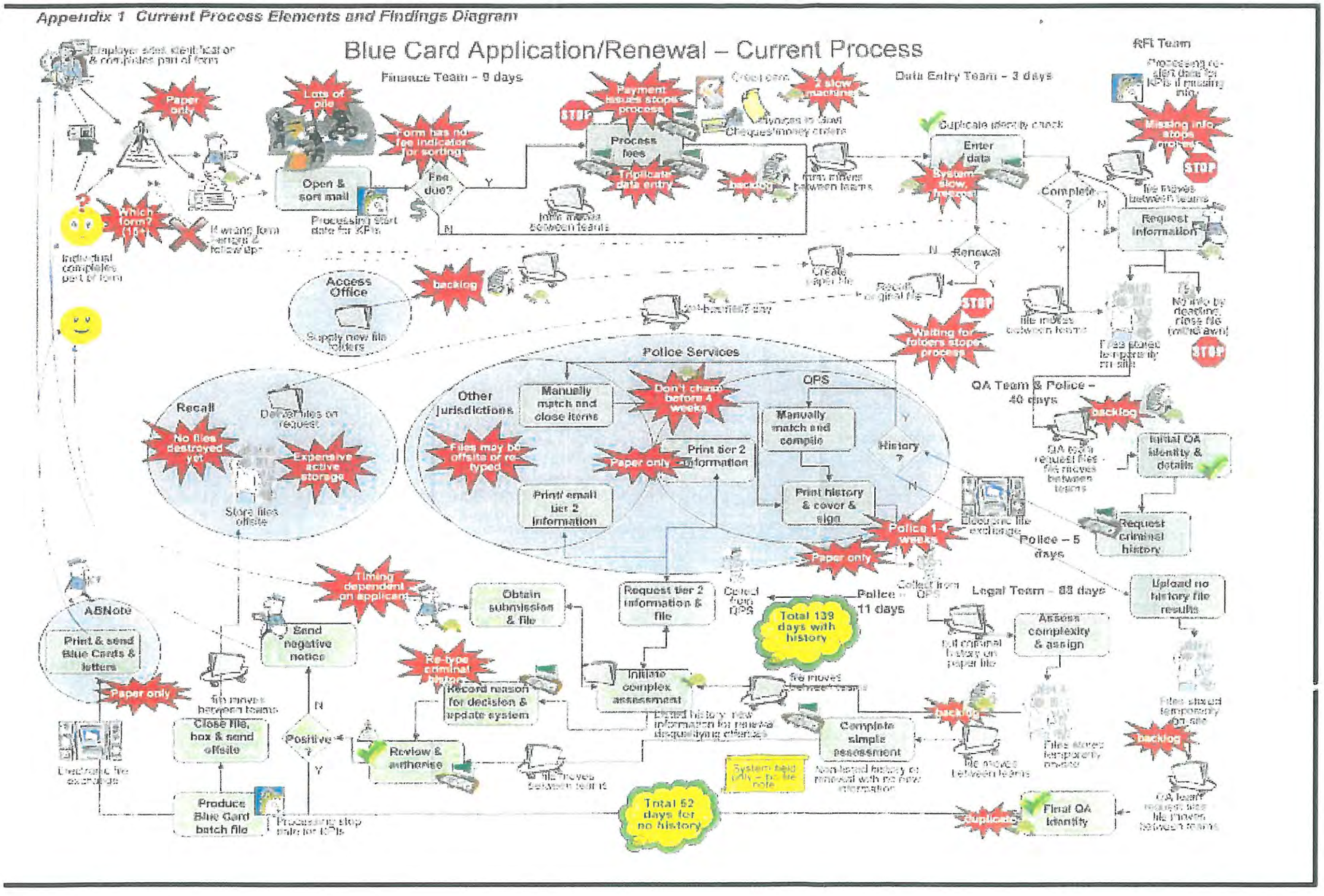


Legal team steps

1. **Simple assessment:** Review of criminal history reveals non-concerning offences – simple electronic approval process completed.
2. **Complex assessment:** Review of criminal history indicates further information required from external agencies (eg police briefs, court transcripts) and/or submissions from the applicant.
3. **Disqualified person:** Criminal history disqualifies applicant from holding a blue card (application is invalid) – application is withdrawn.
4. **Obtain further information:** CCYPCG obtains additional information from external agencies in relation to police/disciplinary information.
5. **Invite submissions:** where police/disciplinary information is serious/child-related and indicates application may be rejected, applicant is invited to provide submissions/materials to support their eligibility for a blue card.
6. **Final card details check:** Details for printing on blue card confirmed and applicant information sent to 3rd party provider to print positive notice letter and blue card.
7. **File sent off-site to Recall:** Hard copy file secured and sent to off-site storage.
8. **File retained on-site:** Files where applicant issued a negative notice secured and filed within CCYPCG offices.

Tabled 24/7/13

Appendix 1 Current Process Elements and Findings Diagram



Premier of Queensland

Executive Building
100 George Street Brisbane
PO Box 15185 City East
Queensland 4002 Australia
Telephone +61 7 3224 4500
Facsimile +61 7 3221 3631
Email ThePremier@premiers.qld.gov.au
Website www.thepremier.qld.gov.au

For reply please quote: *SHP/KJ – TF/13/6688 – DOC/13/61766*

0 8 MAY 2013

S.73 Irrelevant

Dear [redacted]

Thank you for your email of 29 March 2013 about the Regional Community Association of Moreton Bay (RCAMB). I apologise for the delay in responding.

I appreciate your practical suggestions to appoint an administrator for the RCAMB and agree that our focus should be on helping Queenslanders, particularly those most in need. That is why, following RCAMB's recent notification that it was insolvent and no longer able to provide community services, the Government took immediate action to ensure ongoing services to clients.

In the first instance, my Cabinet colleague, the Honourable Tracy Davis MP, Minister for Communities, Child Safety and Disability Services arranged for an alternative service provider to deliver the services RCAMB had previously provided. Interim arrangements are now in place with Pine Rivers Neighbourhood Association Incorporated, so that vulnerable Queenslanders in the Moreton Bay region, who need help, are able to continue to access the support they need locally.

While services have been restored with minimal interruption, the Government is also looking into the serious concerns raised about the misuse of taxpayers' funds. On 25 March 2013, the Department of Communities, Child Safety and Disability Services and Queensland Health jointly appointed PricewaterhouseCoopers to undertake an independent financial and governance audit of the organisation. The Crime and Misconduct Commission has also commenced an investigation into allegations of official misconduct.

Finally, I would like to assure you that I am personally committed to restoring accountability and faith in good government in Queensland. I will continue to insist on the highest standards of performance from the ministry and other members of the Government, so that Queenslanders can again trust and look to their government representatives for leadership and effective local advocacy.

Thank you again for bringing your views and suggestions to my attention. I hope this information is of assistance to you.

Yours sincerely

CAMPBELL NEWMAN

Tabled 24/7/13

Ministerial Diary[1]

Minister for Communities, Child Safety and Disability Services

1 February 2013 – 28 February 2013

Date of Meeting	Name of Organisation/Person	Purpose of Meeting
1 February 2013	Child Safety Service Centre, Bundaberg	Meet and visit with Child Safety Officers
1 February 2013	Bundaberg Community Recovery Centre	Meet and visit Department staff in the Centre
1 February 2013	Steve Bennett MP	Inspect and tour flood affected areas in and around Burnett Electorate
1 February 2013	Bundaberg Evacuation Centre	Visit, tour and talk to residents in the Centre
2 February 2013	Liz Cunningham MP, Mayor of Gladstone and Senior Media Advisor	Visit and tour Boyne Valley local flood affected areas
4 February 2013	Governor	Attend swearing in of Minister Crisafulli
4 February 2013	Director-General and Chief of Staff	Pre-Cabinet Briefing
4 February 2013	Government Ministers	Pre-Cabinet Briefing with Premier
4 February 2013	Government Ministers	Cabinet Meeting
4 February 2013	Laidley residents	Tour of flood affected streets in Laidley
4 February 2013	Laidley Community Recovery Centre	Meet and visit Department staff in the Centre
4 February 2013	Laidley Crisis Care Accommodation	Meet and visit Department staff in the Centre
4 February 2013	Laidley residents	Tour of flood affected streets in Laidley
6 February 2013	Gin Gin Community Recovery Centre	Meet and visit Department staff in the Centre
6 February 2013	Gayndah Recovery Centre	Meet and visit Department staff in the Centre
6 February 2013	Mundubbera Community Centre	Meet and visit Department staff in the Centre
6 February 2013	Army and SES Workers	Attend local cricket game between Army and SES in Bundaberg
7 February 2013	Lowmead Recovery Centre	Meet and visit Department staff in the Centre
7 February 2013	Baffle Creek SES	To visit Baffle Creek SES depot and

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		Community Donation Centre
7 February 2013	Winfield Colonial Community Centre	Meet and visit Department staff in the Centre
8 February 2013	Acting Commissioner Barry Salmon	General discussion on portfolio matters
8 February 2013	Gold Coast Community Recovery Centre	Meet and visit Department staff in the Centre
8 February 2013	Beenleigh Community Recovery Centre	Meet and visit Department staff in the Centre
8 February 2013	Moorooka Community Recovery Centre	Meet and visit Department staff in the Centre
9 February 2013	Wooloowin Community Recovery Centre	Meet and visit Department staff in the Centre
9 February 2013	Logan Community Recovery Centre	Meet and visit Department staff in the Centre
11 February 2013	Director-General and Chief of Staff	Pre-Cabinet Briefing
11 February 2013	Chief of Staff and Media Advisors	Pre-Cabinet Briefing
11 February 2013	Government Ministers	Pre-Cabinet Briefing with Premier
11 February 2013	Government Ministers	Cabinet Meeting
12 February 2013	Director-General	General catch up on portfolio issues
12 February 2013	Chief of Staff and Media Advisors	General catch up on portfolio issues
12 February 2013	Ministerial Staff and Department Staff	Briefing on Elderly Parent Carer Innovation Trial
12 February 2013	St John's Cathedral	Attend service of Healing for past adoption
13 February 2013	Duke of Edinburgh State Advisory Council and Ministerial Staff	Discussion about Duke of Edinburgh Awards
13 February 2013	CEO of Community Resource Unit	General discussion on portfolio issues
14 February 2013	Director-General	General catch up on portfolio issues
14 February 2013	Chief of Staff and Media Advisors	General catch up on portfolio issues
14 February 2013	Ministerial Staff and Department Staff	Discussion and Budget Prep Meeting
18 February 2013	Director-General and Chief of Staff	Pre-Cabinet Briefing
18 February 2013	Chief of Staff and Media Advisors	Pre-Cabinet Briefing
18 February 2013	Government Ministers	Pre-Cabinet Briefing with Premier
18 February 2013	Government Ministers	Cabinet Meeting
19 February 2013	Logan City Council	Attend Logan City Council Summit
20 February 2013	Governor	Attend swearing in for Minister Walker
20 February 2013	Assistant Minister and Queensland Centre for Domestic and Family Violence Research	General discussion on relevant portfolio matters
20 February 2013	Department Staff	Briefing on Restrictive Practices
20 February 2013	NDIS Working Group	Regular meeting with group

20 February 2013	Department Staff and Ministerial Staff	General briefing on policy issues
21 February 2013	Queensland Centre for Domestic Violence	Attend and address Family Research Seminar
21 February 2013	NDIS Implementation Group	Regular meeting with group
21 February 2013	Queensland Council on Social Services (QCOSS)	General meeting to discussion relevant portfolio matters
21 February 2013	Director-General	Performance Agreement
24 February 2013	Government Ministers	Formal deputations for Fraser Coast Community Cabinet
24 February 2013	Government Ministers	Official Government Reception for Fraser Coast Community Cabinet
25 February 2013	Fraser Coast Regional Council and Government Ministers	Breakfast with Fraser Coast Regional Council for Community Cabinet
25 February 2013	Government Ministers	Cabinet Meeting
25 February 2013	Maryborough Child Safety Service Centre and Assistant Minister	Visit to Child Safety Service Centre and Disability Service Centre
26 February 2013	Chief of Staff and Media Advisors	General catch up on portfolio issues
26 February 2013	Child Safety Advisory Group	Attend regular group meeting
26 February 2013	Queensland Coordinator, CREATE	General discussion on relevant portfolio matters
26 February 2013	Ministerial Staff and Department Staff	Briefing on Domestic Violence and Adoption Act
27 February 2013	Chief of Staff and Media Advisors	General catch up on portfolio issues
27 February 2013	Department Staff	Pre-Briefing on ATSIA and Social Services Cabinet Committee
27 February 2013	Assistant Minister	General catch up on portfolio issues
27 February 2013	Policy Advisor	Discussion on Foster and Kinship Carer Recruitment Launch
27 February 2013	Aboriginal and Torres Stair Islander Affairs Cabinet Committee	Inaugural Cabinet Committee Meeting
28 February 2013	Social Services Cabinet Committee	Regular Committee Meeting
28 February 2013	Queensland Disability Advisory Council	Attend Council meeting
28 February 2013	Ministerial Staff and Department Staff	Discussion and Budget Prep Meeting
28 February 2013	Director General	General catch up on portfolio matters
28 February 2013	Cabinet Budget Review Committee (CBRC)	Regular Committee meeting

Ministerial Diary[1]

Minister for Communities, Child Safety and Disability Services

1 March 2013 – 30 March 2013

Date of Meeting	Name of Organisation/Person	Purpose of Meeting
1 March 2013	Chief of Staff	Briefing on portfolio issues
2 March 2013	Calisto Park Equestrian Centre (CPEC)	Minister to attend CPEC Official Opening
2 March 2013	Caboolture PCYC Community Campus	Attend celebration and Launch of Lagoon Creek Cafe and Function Room - Better Together
3 March 2013	Foster & Kinship Carer Week Committee – Lorraine Dupree, Chairperson	Attend Foster and Kinship Carer Week celebration
4 March 2013	Director General and Chief of Staff	Pre-Cabinet briefing
4 March 2013	Government Ministers	Pre- Cabinet Brief
4 March 2013	Government Ministers	Cabinet Meeting
5 March 2013	Director General	Regular catch up on portfolio issues
5 March 2013	Ministerial Staff	Staff meeting on portfolio issues
5 March 2013	Michael Hogan and Ministerial Staff	Meeting to discuss blue and yellow card
5 March 2013	Michael Hogan and Ministerial Staff	Departmental Meetings
5 March 2013	Ministerial and Department Staff	CBRC Briefing
6 March 2013	Ministerial staff and Departmental Staff	Pre brief for Standing Council on Disability Reform
6 March 2013	Cabinet Budget Review Committee	Regular Committee Meeting
6 March 2013	Dr Chris Davis MP and Kincare	Meeting to discuss funding
6 March 2013	Ministerial staff and Departmental Staff	Attend Ministerial Advisory Committee on Women and Girls in Sport and Recreation
6 March 2013	Government Ministers	Parliament sitting all required
6 March 2013	The Speaker	Attend afternoon tea for – display of apology to children who were placed in

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		adult mental institutions
7 March 2013	Director General	Regular catch up on portfolio issues
7 March 2013	Ministerial Staff	Staff meeting on portfolio issues
7 March 2013	Ministerial and Department Staff	Briefing on Standing Council on disability reforms
7 March 2013	Lucas Moore, CREATE Foundation	To discuss the new CREATE Report
7 March 2013	Robert Cavallucci	Discuss Under 1 Roof
7 March 2013	Minister Jenny Macklin	Phone hook-up to discuss portfolio issues
8 March 2013	The United Nations International Women's Day	Attend UN Women International Women's Day 2013 Breakfast
8 March 2013	NDIS Secretariat	Standing Council on Disability Reform
8 March 2013	Career and Education Opportunities Enterprises	Attend BBB Indigenous Women's Luncheon
8 March 2013	CGU Chinchilla Multi-Tenant Service Centre	Meeting to discuss CGU Chinchilla Multi-Tenant Service Centre
8 March 2013	Governor	Attend Reception to Celebrate International Women's Day 2013
11 March 2013	Director General and Chief of Staff	Pre-Cabinet Briefing
11 March 2013	Ministerial Staff	Staff meeting on portfolio issues
11 March 2013	Government Ministers	Pre-Cabinet Briefing
11 March 2013	Government Ministers	Cabinet Meeting
11 March 2013	Ministerial and Departmental Staff	National Disability Insurance Scheme submission
12 March 2013	Departmental Staff	Funeral Service
13 March 2013	Community Recovery	Attend Red Cross Opening of Homelessness Service Hub - Townsville
14 March 2013	Assistant Minister and Chief of Staff	Catch up on portfolio related matters
14 March 2013	Ministerial staff and Departmental staff	Pre Social Services Cabinet briefing
14 March 2013	Social Services Cabinet Committee	Social Services Cabinet Committee Meeting
14 March 2013	Departmental and Ministerial Staff	Cabinet submission briefing
14 March 2013	Departmental Staff	Meeting to discuss Accommodation Support and Respite Services
16 March 2013	AEG Ogden	Attend QLD Reds v Western Force - As the Acting Minister for Sport
18 March 2013	Director General and Chief of Staff	Pre-Cabinet Briefing
18 March 2013	Ministerial Staff	Staff meeting on portfolio issues
18 March 2013	Government Ministers	Pre-Cabinet Briefing
18 March 2013	Government Ministers	Cabinet Briefing
19 March 2013	Director General	Catch up on portfolio issues
19 March 2013	Ministerial Staff	Staff meeting on portfolio issues

19 March 2013	Dale Shuttleworth MP, Member for Ferny Grove	Meeting to discuss Ferny Grove electorate issues
19 March 2013	Assistant Minister	Catch up regarding portfolio issues
20 March 2013	Disaster Management Cabinet Committee	Disaster Management Cabinet Committee Meeting
20 March 2013	Aaron Dillaway MP	Leaders BBQ for School Captains in Bulimba Electorate
21 March 2013	Director General	Catch up on portfolio issues
21 March 2013	Ministerial Staff	Staff meeting on portfolio issues
21 March 2013	Ministerial and Department Staff	Accommodation Support and Respite Services Briefing
21 March 2013	Departmental Staff	Infrastructure replacement program
21 March 2013	Jon Grayson, Director General of the Department of Premier and Cabinet and Ministerial Staff	Accommodation Support and Respite Services meeting
21 March 2013	LNP MP's and Staff	One Year Anniversary BBQ
21 March 2013	Steve Davies MP and Andy Gourley, Director of Red Frogs	Coffee catch up regarding Red Frogs
22 March 2013	Governor	Attend Government House - Morning tea to acknowledge the role of Foodbank in Queensland
22 March 2013	Built Environment Parliament Queensland (BEMPQ)	Attend BEMPQ Conference
25 March 2013	Government Ministers	Pre-Cabinet Meeting
25 March 2013	Government Ministers	Cabinet meeting
25 March 2013	Minister Mander and Ministerial Staff	COAG Planning Meeting
26 March 2013	Salvation Army Red Shield Appeal	Attend Salvation Army Red Shield Appeal Official Opening Function 2013
26 March 2013	Ministerial staff	Meeting on portfolio issues
26 March 2013	Noreen Lopes, Gallan Place	Meeting to discuss Gallan Place (Aboriginal and Torres Strait Islander Counselling Services)
26 March 2013	Departmental and Ministerial Staff	Briefing on portfolio matters
26 March 2013	Departmental and Ministerial Staff	Briefing regarding Select Council on Housing and Homelessness
27 March 2013	Director General	Catch up on portfolio issues
27 March 2013	Director General	Meeting to discuss child death review
27 March 2013	Assistant Minister	Meeting on portfolio related matters
27 March 2013	Wendy Lovell	National Partnership on Homelessness discussion
27 March 2013	Pru Goward	National Partnership on Homelessness discussion
28 March 2013	COAG Select Council on Housing and Homeless	COAG Select Council on Housing and Homelessness Meeting

Ministerial Diary[1]

Minister for Communities, Child Safety and Disability Services

1 April 2013 – 30 April 2013

Date of Meeting	Name of Organisation/Person	Purpose of Meeting
2 April 2013	Departmental staff and Ministerial staff	Briefing on matters for Cabinet meeting
2 April 2013	Government Ministers	Premier and Minister Pre-Cabinet meeting
2 April 2013	Government Ministers	Cabinet meeting
2 April 2013	Mary McLean Financial Councillors' Association of Queensland Inc.	Meeting to discuss financial counselling services
2 April 2013	Departmental staff and Ministerial staff	Briefing to discuss Forensic Disability Service
3 April 2013	Chief of Staff and Media Advisors	Daily meeting
3 April 2013	Policy Advisors	Weekly policy meeting
3 April 2013	Assistant Minister	Weekly policy meeting
3 April 2013	The Spot Community Service Ltd.	Minister and local MP visit new facility in Parkinson
3 April 2013	Assistant Minister, Director-General, Policy Advisor and Chris Boyle, departmental officer	Meeting with Churchill Fellowship recipient and departmental staff member Chris Boyle regarding family intervention programs
4 April 2013	Chief of Staff and Media Advisors	Daily meeting
4 April 2013	Government Ministers	Executive Council
4 April 2013	Bryan Smith, Foster Care Queensland	Meeting with Minister, Chief of Staff and Policy Advisor
4 April 2013	Lindsay Wegner, Peakcare Queensland Inc.	Meeting with Minister and Policy Advisor
4 April 2013	Duke of Edinburgh State Committee Conference	Meeting to discuss Award program
6 April 2013	Young Men's Christian Association (YMCA) Queensland Youth Parliament	Minister and Policy Advisor attend launch
8 April 2013	Policy Advisor	Briefing on matters for Cabinet meeting

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8 April 2013	Director-General, Chief of Staff	Briefing on matters for Cabinet meeting
8 April 2013	Chief of Staff and Media Advisors	Daily meeting
8 April 2013	Government Ministers	Premier and Minister Pre-Cabinet meeting
8 April 2013	Government Ministers	Cabinet meeting
	Neil Carrington and Denis Loaney, Act for kids	Meeting with Minister and Chief of Staff to discuss financial support
8 April 2013	Pam Parker, Mayor, Logan City Council, Chief of Staff	Presentation of 'Two Year Plan' post the recent 'Logan: City of Choice Summit' held in February 2013
9 April 2013	Chief of Staff and Media Advisors	Daily meeting
9 April 2013	Policy Advisor and Departmental staff	Briefing to discuss youth recommissioning – consideration of memorandum
9 April 2013	Departmental staff	Briefing for Cabinet submission
9 April 2013	Premier	Meeting
9 April 2013	Departmental staff	Pre-brief for Social Services Cabinet Committee
10 April 2013	Endeavour Foundation	Attend official opening of a new Disability Assistant Project (DAP) House in Cairns
10 April 2013	Edmonton Child Safety Services Centre	Visit
10 April 2013	Youth Empowered Towards Independence (YETI)	Visit
10 April 2013	Chief of Staff and Media Advisors	Daily meeting
11 April 2013	Departmental staff	Pre-briefing for Social Services Cabinet Committee
11 April 2013	Government Ministers	Social Services Cabinet Committee meeting
11 April 2013	Director-General, Policy Advisor, Regional Executive Director and Departmental staff	Briefing regarding North Coast Regional operational issues
11 April 2013	Chief of Staff	Question time preparation
12 April 2013	The Breavehearts inc.	ThankShoe Awards ceremony
14 April 2013	Chief of Staff	Question time preparation
15 April 2013	Departmental staff and Ministerial staff	Briefing on matters for Cabinet meeting
15 April 2013	Chief of Staff and Media Advisors	Daily meeting
15 April 2013	Government Ministers	Premier and Minister Pre-Cabinet meeting
15 April 2013	Government Ministers	Cabinet meeting
15 April 2013	Government Members	Party room meeting
16 April 2013	Chief of Staff and Media Advisors	Daily meeting
16 April 2013	Government Minister, Director-General	Meeting to discuss disability services matter for Caloundra constituent

17 April 2013	Policy Advisors, Departmental staff	Briefing regarding Branch Infrastructure and Wide Area Network (BIWAN) project
17 April 2013	Assistant Minister	Weekly policy meeting
18 April 2013	Garth Morgan, Executive Director, Queensland Aboriginal and Torres Strait Islander Human Services Coalition	Meeting to discuss
18 April 2013	Siyavash Doostkhah – Director, Youth Affairs Network Queensland	Meeting with youth policy stakeholder to discuss engagement program
18 April 2013	Dr David Solomon AM – Queensland Integrity Commissioner	Meeting to discuss compliance checks
19 April 2013	Media Advisor	Media preparation
21 April 2013	Government Ministers	Community Cabinet – Ayr
21 April 2013	Debra Cochran and Majella Meehan, Burdekin Community Association	Community cabinet deputation
21 April 2013	Brenda-Anne Parfitt, Flexi Queensland	Community cabinet deputation
21 April 2013	Kate Jacka and Matthew Magin, ONE VOICE Whitsunday Housing Action Group	Community cabinet deputation
21 April 2013	Kay Duggan, President and Elvie Dickinson, Treasurer, Burdekin Neighbourhood Centre Association	Community cabinet deputation
21 April 2013	Government Ministers	Community Cabinet Official Government Reception
21 April 2013	Rosemary Menkens MP, Member for Burdekin	Dinner function
22 April 2013	Burdekin Shire Council	Cabinet Breakfast meeting
22 April 2013	Government Ministers	Cabinet meeting
23 April 2013	Director-General	Briefing
23 April 2013	Chief of Staff and Media Advisors	Daily meeting
23 April 2013	Director-General	Briefing regarding Accommodation Support & Respite Services (AS&RS)
23 April 2013	YES House Specialise Youth Homeless Service	Visit
23 April 2013	Logan Youth Foyer Support Service	Visit
23 April 2013	Red Frog Corporate Appeal Dinner	Attending
24 April 2013	Government Ministers	Cabinet meeting
26 April 2013	Media Advisors	Media preparation
29 April 2013	Director-General, Chief of Staff	Briefing on matters for Cabinet meeting
29 April 2013	Chief of Staff and Media Advisors	Daily meeting
29 April 2013	Government Ministers	Premier and Minister Pre-Cabinet

		meeting
30 April 2013	Government Minister	Optional briefing: Vegetation Management laws
30 April 2013	Chief of Staff and Media Advisors	Daily meeting
30 April 2013	Director-General	Pre-briefing regarding Standing Council on Communities and Disability Services (SCCDS) meeting
30 April 2013	Director-General	NDIS Planning and Implementation Group meeting

Ministerial Diary[1]

Minister for Communities, Child Safety and Disability Services

1 May 2013 – 31 May 2013

Date of Meeting	Name of Organisation/Person	Purpose of Meeting
1 May 2013	Assistant Minister and Ministerial Staff	Weekly Meeting
1 May 2013	Acting Queensland Children's Commissioner & Ministerial Staff	Discussions on Commission for Children & Young People & Child Guardian
1 May 2013	Federal Minister for Families, Community Services and Indigenous Affairs and Minister for Disability Reform	Telephone Meeting
1 May 2013	DV Connect Crisis Support Queensland	Attend event Twilight Walk & Candle-Light Ceremony
2 May 2013	Ministerial staff and Department Staff	Briefing on Disability Conference
3 May 2013	Council of Australian Government (COAG) Select Council, Canberra	Attend National Meeting on Women's Issues
3 May 2013	Standing Council on Communities and Disability Services, Federal Ministers, Canberra	Attend National Forum
6 May 2013	Ministerial Staff	Pre-Cabinet Briefing
6 May 2013	Government Ministers	Cabinet Meeting
6 May 2013	Chief of Staff	Meeting on portfolio matters
7 May 2013	Departmental and Ministerial Staff	Cabinet Submission Briefing
7 May 2013	Ministerial Staff	Synapse and Aboriginal & Torres Strait Islander response Briefing
7 May 2013	NDIS Planning and Implementation Group	Meeting
7 May 2013	Kiwanis International	Minister attended General Meeting of Kiwanis International
8 May 2013	Assistant Minister	Weekly meeting

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8 May 2013	Departmental and Ministerial Staff	Discussion on Human Resources
8 May 2013	Ministerial Staff	Discussion on diary
8 May 2013	Departmental & Ministerial Staff	Pre-briefing for Cabinet Committee Aboriginal and Torres Strait Islander Affairs (CCATSIA)
8 May 2013	Autism Qld Inc.	National Disability Insurance Scheme (NDIS) announcement
8 May 2013	Cabinet Committee	Cabinet Committee Aboriginal & Torres Strait Islander Affairs (CCATSIA)
9 May 2013	Member for Murrumba, Moreton Downs State School, Deception Bay	Visit Centre
9 May 2013	Departmental & Ministerial Staff	Budget Meeting
9 May 2013	Director General	Meeting on Policy Matters
9 May 2013	Departmental & Ministerial Staff	Cabinet Briefing on Cost of Medical Aids and Equipment
11 May 2013	Act for Kids Ball	Attend event as guest of Act for Kids
13 May 2013	Departmental staff	Cabinet submission briefing
13 May 2013	Government Ministers	Cabinet
14 May 2013	Westpac & Volunteers Qld	Attend event 'One Big Thank You' launch event for Volunteering Week
14 May 2013	Dale Shuttleworth MP, Arana Hills Library	Attend event, 'Ask the Boss Friday' initiative
14 May 2013	Lisa France MP	Meeting
15 May 2013	PeakCare Qld Inc. & Professor Dr. James Anglin	Introductory breakfast meeting
15 May 2013	Assistant Minister	Weekly Meeting
15 May 2013	Departmental Staff	Briefing on Community Packaged Care and Residential Care Services
15 May 2013	Queensland Disability Advisory Council	Meeting
15 May 2013	Departmental & Ministerial Staff	Pre-Briefing on Social Services Cabinet Committee
16 May 2013	Social Services Cabinet Committee	Social Services Cabinet Committee meeting
16 May 2013	Saxon Rice MP, Red Hill Community Sports Club	Attend event for Volunteers Awards
16 May 2013	Departmental and Ministerial Staff	Discuss Policy Matters
16 May 2013	Ministerial Staff	Briefing on recommissioning Youth Second Round
20 May 2013	Department Staff	Briefing on Cabinet Submission
20 May 2013	Department Staff	Pre-Cabinet meeting
20 May 2013	Government Ministers	Cabinet meeting
21 May 2013	Minister Jenny Macklin MP	Telephone meeting

21 May 2013	Attorney-General, Government Members	Parliamentary briefing on Youth Justice
21 May 2013	Government Members	This meeting did not go ahead.
21 May 2013	Department Staff	Ethiopian Ad Hoc Adoption briefing
21 May 2013	Department Staff	Pre-brief – Domestic Violence legislation
21 May 2013	Government Minister	Meeting regarding Domestic Violence Legislation
22 May 2013	Picabeen Community Association Inc	Visit Centre for Volunteer Week
23 May 2013	Assistant Minister for Emergency Volunteers	Discussion relating to cross-department initiatives
23 May 2013	Ministerial and Department Staff	Elderly Parent Carer Innovation Trial update
23 May 2013	Ministerial and Department Staff	Briefing to discuss disability sector quality audit grants and development grants
23 May 2013	Government Member	Meeting to discuss Child Safety office at Wynnum
26 May 2013	Government Ministers	Community Cabinet Thursday Island
27 May 2013	Government Ministers	Community Cabinet Thursday Island
28 May 2013	Ipswich Women's Centre Against Domestic Violence, Stakeholders	Visiting Centre for meet and greet with clients and staff
28 May 2013	ALARA Association Inc Ipswich, Member for Ipswich, Stakeholders	Visiting Centre for meet and greet with clients and staff
29 May 2013	Ministerial Staff	Policy Briefing
29 May 2013	Assistant Minister	Weekly Meeting
29 May 2013	Ministerial and Department staff	Queensland Carers Advisory Council forum
29 May 2013	Ministerial and Department staff	Briefing on Centre of Excellence for Behaviour Support
29 May 2013	Auditor General and Deputy Auditor General	Meeting
29 May 2013	Her Excellency The Governor of Queensland	Attend reception for World MS day at Government House
30 May 2013	Women's Legal Service	Attend Domestic Violence Awareness Month breakfast
30 May 2013	Ministerial and Department staff	Pre-Briefing for Social Services Cabinet Committee
30 May 2013	Government Ministers	Social Services Cabinet Committee Meeting
30 May 2013	Homelife Association Inc, Caboolture	Visiting Centre
30 May 2013	Caboolture Regional Domestic Violence Service	Visiting Centre

Tabled 24/7/13

That is my understanding. So it did not take urging in this House, it did not take the squawking of the Leader of the Opposition for us to take action, we took action as early as November 2012 and we will not stand over here and engage in the same sort of Nuttall quasi-investigation that those opposite were into. How outrageous, how disgraceful. We will just get Gordon Nuttall in here, we will ask him if he is a good bloke. Yes, he is a good bloke. Off the hook. Come into parliament, defend him, and never properly investigate it. That is the Labor standard and we will have nothing to do with it.

Small Business

Mr HART: My question without notice is also to the Premier. Premier, can you please update the House on what action this government has taken to support business in this state?

Mr NEWMAN: That is indeed the more appropriate question for this place this afternoon, because rather than the sort of politics we have heard already, it is really ultimately about how to get this state back on track. We have been doing a lot because we know how essential small business is to the Queensland economy. We have been cutting red and green tape. We have been giving small business the support that it needs to prosper. Over 320 red-tape reduction initiatives have been identified and more than 150 have already been implemented. Easing the burden of red tape will stimulate the economy and create jobs for Queenslanders. The government has saved business approximately $7 million a month by removing the waste levy; it has changed plumbing and drainage regulation saving the kitchen and bathroom industry approximately $25 million a year; it has increased the payroll tax exemption threshold to $1.1 million; it has established the independent Office of Best Practice Regulation; it has established a task force to cut environmental impact assessment time frames by half; and it has lowered the costs associated with assessments.

I was in my electorate of Ashgrove last Friday and I visited over 10 local small businesses in the motor dealer and smash repairer field to tell them the good news. I talked to the owners of Manny's Mechanical Repairs, Greer's Smash Repairs, Alderley Automotive, Australian Mechanical Supplies, Pickering Smash Repairs, Repco Motortech Automotive, Crowhurst Motors, Mac's Auto Service Centre, Hagen Performance Motors and Pedders Suspension and I told them that an environmental licence will no longer be required for the operation of their motor vehicle workshops, that they do not need to pay a fee of up to $1,515 and, I think, 20c anymore, or put the certificate on the wall anymore.

That is a great bit of news for local businesses. I went to Carline Enoggera and spoke to Andrew Dredge, the owner. He has received many local business achievement awards from Quest newspapers. What did he say about the removal of green tape? He said—

Any saving in time and money is always welcome from small business in a tough economic climate. It was great to get that feedback. I stressed to the people whom we spoke to and I stress to all people in small business today that we will listen to them, we will consult with them and we want to get more reforms going. We want to get the reforms right to make sure this is a great state with great opportunity. My message to small businesses is this: tell us what else we need to do and give us the specifics. If it makes sense, it will happen. They do not have to worry about those opposite, any more. They do not have to worry about their total inability to understand what drives small business. These days they have friends on this side of the chamber, because we want to create great jobs for Queenslanders.

Regional Community Association Moreton Bay

Mr MULHERIN: My question is to the Minister for Communities, Child Safety and Disability Services. Yesterday when the minister was asked about the activities of the Regional Community Association Moreton Bay she confirmed the group delivered emergency relief funding, and said—

What is terrific is that they are still delivering that to the community.

I ask: will the minister advise if she is aware of claims by the association members that this group is in such disarray that, despite the hard work of staff, it has been forced to stop distributing funding to families who are in dire straits?

Ms DAVIS: I thank the honourable member for his question. It was my understanding that the community organisation was delivering all of those services that it is funded to do. It does a very good job, as do all of the neighbourhood centres across Queensland, in delivering and doing referral work for our most vulnerable Queenslanders. As I have just indicated, we will continue to support the community organisation in delivering its work. The funding that the department provides to community and neighbourhood centres is a little flexible. If that is what the organisation is choosing not to deliver at the moment, then that is a matter for the community centre. I can say that our department is working hard with the community centre to ensure its viability.

Tabled 24

the organisation beyond ensuring that the money it is provided is expended for the purposes for which it is given. However, despite this fact I am pleased to report that my department has worked tirelessly to ensure that what support could be provided to staff at RCAMB has been provided.

ABSENCE OF MINISTER

Mr STEVENS (Mermaid Beach—LNP) (Manager of Government Business) (10.01 am): I wish to advise the House that the Minister for Science, Information Technology, Innovation and the Arts is absent from the House this week. Minister Walker is undertaking an investment attraction mission to China, followed by his attendance at the 2013 BIO International Convention in Chicago. Minister Langbroek is acting minister during this absence.

NOTICE OF MOTION

Commission of Audit

Mr PITT (Mulgrave—ALP) (10.02 am): I give notice that I shall move—

That this House:

- notes it is now 47 days since the secret Costello audit report was presented to the government;
- notes the Premier committed to finally reading the secret report at Easter; and
- calls on the Premier to outline to the House the report's 155 secret recommendations and the impact they will have on jobs and services.

QUESTIONS WITHOUT NOTICE

Regional Community Association Moreton Bay

Ms PALASZCZUK (10.02 am): My question is to the Minister for Communities, Child Safety and Disability Services. After the minister's undertaking that she would appoint auditors to examine the Regional Community Association Moreton Bay based at Redcliffe, will the minister advise on what date she appointed the auditors and on what date they arrived in Redcliffe to commence work?

Ms DAVIS: I thank the honourable member for the question. The audit, which is being undertaken by PricewaterhouseCoopers, was engaged by the Minister for Health so the member might like to direct that question to him. When it comes to this particular matter—that is, of the RCAMB—the opposition has zero credibility. While we are out there making sure that important community services continue to be delivered to the people on the Redcliffe peninsula, those opposite are shedding crocodile tears and pretending to care about the Redcliffe people and their community.

What is the real motive of those opposite in pursuing this matter? They would have us believe it is their concern about the workers and their concern about the delivery of services into the Redcliffe community, but recently the *Courier-Mail* had a front-page article which read 'EXCLUSIVE: Failed federal MPs boost state Labor. Lucky Losers'.

Ms Palaszczuk: What has this got to do with anything?

Ms DAVIS: It has a lot to do with it.

Mrs MILLER: I rise to a point of order, Madam Speaker.

Madam SPEAKER: Order! Member for Bundamba, what is your point of order?

Mrs MILLER: I would like to table all the local government councillors who are in this chamber today, and you are out of line.

Madam SPEAKER: Order! You are out of order. Please take your seat. I warn the member under standing order 253A. The minister has the call in respect to answering a question. I call the minister.

Ms DAVIS: Thank you, Madam Speaker. I refer back to this quite interesting article that appeared in the *Courier-Mail* titled 'Lucky Losers'. I will take a moment to read from that article. It states—

QUEENSLAND Labor MPs beaten in the federal election would be parachuted into winnable state seats under options being considered in secret party talks.

It is believed Shayne Neumann and Yvette D'Ath are in line to bolster state ranks after a likely wipeout in the September 14 federal poll.

Mr Neumann and Ms D'Ath would take up the state seats of Ipswich and Redcliffe respectively---covering the federal electorates of Blair and Petrie which they now represent. The move would bolster Labor's thin state ranks and could fast-track its response to the Newman government's dominance.

Labor MPs told the *Courier-Mail* that discussions involving the idea of Mr Neumann and Ms D'Ath moving to the state level had taken place within the party and were still a live option.

Their interest in Redcliffe is only Yvette D'Ath staring down the barrel of defeat at the upcoming state election. They do not care about the people of Redcliffe. They do not care about the workers of the Redcliffe community association. We are about ensuring that services continue to be delivered in the area, and that is exactly what we are doing.

Regional Community Association Moreton Bay

Ms PALASZCZUK: My question is to the Minister for Communities, Child Safety and Disability Services. The minister mentioned previously that an audit was being undertaken by her department. Will the minister confirm that the audit being done by her department of the Regional Community Association Moreton Bay is an actual, thorough forensic audit?

Ms DAVIS: I thank the honourable member for the question. It is true that my department was making some investigations into the Redcliffe community association. As the opposition well knows, there were some allegations made about that organisation and the department is looking into it. With regard to a forensic audit, which I have never suggested that the department—

Ms Palaszczuk: You said an audit.

Ms DAVIS: I take the interjection. At no time did I say that our department was undertaking a forensic audit. What our department is doing is ensuring that vital community services continue to be delivered on the Redcliffe peninsula. That is what my department has been doing. After the announcement or contact by the Redcliffe community association that it was unable to provide those services into the community, we implemented a contingency plan. As I mentioned in my ministerial statement, departmental officers were working with the Pine Rivers Neighbourhood Association, a well-regarded local community association.

Ms PALASZCZUK: Madam Speaker, I rise to a point of order. The minister clearly said the fact is that the government has already appointed an auditor. I table the press release.

Madam SPEAKER: Order! Leader of the Opposition, take your seat. That is not a point of order under the standing orders.

Opposition members interjected.

Madam SPEAKER: Order! Let us have order in the House. At this point I will not accept the tabling of the document. I will make a more detailed ruling as to the timing of tabling. The minister has the call, and I call the minister.

Ms DAVIS: Thank you, Madam Speaker. The opposition leader again shows that she is not interested in the vital community services that need to be delivered on the Redcliffe peninsula, and that is what our department is doing. Our department is making arrangements with the Pine Rivers Neighbourhood Association, which had a great relationship with RCAMB in the past and so understands the needs of the Redcliffe community.

The Leader of the Opposition can pretend to have an interest in what is happening in Redcliffe. However, what she is interested in is nothing more than recycling federal Labor members after the next federal election.

Madam SPEAKER: I would ask the minister to stay relevant to the question.

Ms DAVIS: I have already answered the question with regard to the audit. At no time did I suggest—and I acknowledge the press release—that it talks about a forensic audit, which was what the question was about. We are working with the Pine Rivers Neighbourhood Association in order to deliver services out in the community. That is what is important. In fact, the member for Petrie has been very happy with the way that the Department of Communities has been working to get those services on the ground. Those opposite shed crocodile tears and pretend to care. In fact, the only people they care about are their own.

Queensland Parliamentary
Library and Research Service
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Newspaper article from: **Courier Mail**
Date: **Thursday 28/03/13** Page: **6**

Staff bid to oust board.

Mark Solomons

MEMBERS of the community association that Scott Driscoll secretly controlled to the benefit of his wife's company are staging a revolt to try to remove board members associated with the embattled MP.

Five had by yesterday put their names to a call for an emergency meeting on April 8 in a bid to take over the body and ensure it continues to provide emergency social services to its 500 or so clients in the community.

The Courier-Mail yesterday met staff of the taxpayer-funded Regional Community Association Moreton Bay who said they feared for their jobs and the future of essential services for clients with mental health problems, the homeless and victims of domestic violence.

The staff said they were shocked and disgusted that no one from the State Government had visited them, despite the widely publicised problems at the centre, and they had not been able to tell employees whether they would be paid this week.

No one had visited or inspected documents in recent weeks, they said, except board members.

Staff said they had been surprised to hear a statement in Parliament by Communities Minister Tracy Davis that her department was "working hard" with RCAMB.

"We want (Premier Campbell) Newman and the minister to come and see us," said one staffer, who did not want to be named. "Where are the CMC?" another asked. "We're waiting for them.".

Len Thomas, a former police officer and RCAMB member who is backing the move to overhaul the board, said there were members "ready to step up" and take over the governance of the association. "We can change the constitution if necessary," he said. "(The Department of) Communities needs to act today to guarantee continuity.".

Staff said acting RCAMB president Brian Roselt and treasurer Geoff Jamieson, both close political associates of Mr Driscoll, had not been returning their calls.

Mr Thomas gave The Courier-Mail a letter from the Office of Fair Trading showing that

its records had Mr Roselt as president, effective March 11, but made no mention of Mr Jamieson. Instead Terry Rogers is shown as treasurer.

This is despite Mr Rogers having been forced off the RCAMB board by Mr Driscoll last year after he asked questions about the ownership of Norsefire, Mr Driscoll's wife Emma's company, which has earned $120,000 in consulting fees from RCAMB over the past 12 months.

Mr Jamieson, who was Mr Driscoll's election campaign treasurer, this week told The Courier-Mail there was "no impropriety" and "no irregularities" at RCAMB. "We've got a short-term cash-flow problem as a result of the media reports about Scott Driscoll," he said.

Mr Jamieson said he had only found out this week that Emma Driscoll had been on the payroll.

The Department of Health last week hired PricewaterhouseCoopers to carry out a forensic audit of RCAMB.

ALAS
Adoption Loss Adult Support Australia Inc.

Meeting Thursday 13th June 2013 with Hon. Tracy Davis.

We, ALAS has requested this meeting to discuss the follow on from the Queensland Apology 27th November 2012.

As the Hon. Desley Scott said in her speech,
"I have chosen consciously to speak about issues that need to carry forward the intent of our apology. Without meaningful, prompt action to redress the harm done to forced adoption mothers and without sustaining services for women's health care, an apology is just a page of words, however well intentioned. Hopefully a national framework for implementing the recommendations of the Senate Community Affairs Reference Committee inquiry will guide a consistent response for all state and territory governments. I encourage the government to engage with the community organisations working for forced adoption mothers, their children and families, to give meaning to this apology with concrete action. Our regret is profound and our apology sincere and heartfelt."

WE wish to discuss;

A Qld State Working Committee to work with Federal Governments Working Committee for past forced adoptions.

Intergrated State Birth Certificates.

Changes to Vetos (now Contact Statement)

Funding for specialised PTSD trained counsellors.

Easier access to birth records and fee.

Permanent memorial for forced adoption victims, (not just Commemorative Book on level 4 of Library).

Leaflets and information readily available to Medical Centres, Universities, Schools, Libraries and Churches and organisations.

Redress for victims.

Postal PO Box 137 Holland Park 4121 Mobile 0417 077 159
Website www.alasqld.com Email alasqld@alasqld.com Blog www.alasqld.blogspot.com

http://www.financialcounsellingaustralia.org.au/Corporate/News/Newman-Government-asked-to-Fund-Financial-Counesll#

Newman Government asked to Fund Financial Counesllng

13/06/2013

13th June 2013 - Financial Counselling Australia has today written to the Premier of Queensland, Campbell Newman, expressing disappointment that last week's budget did not include funding for financial counselling. The letter calls on the Queensland Government to fund a dedicated financial counselling program.

Queensland is now the only State and Territory Government that does not provide specific funding for a generalist financial counselling program (see table below for a break down for the other States/Territories).

By 30th June, around 20 Queensland financial counsellors will have lost their jobs or had their hours reduced because of funding cuts. The telephone financial counselling helpline is also cutting back its opening hours. It was previously open to help Queenslanders in financial difficulty, from 8 am to 6 pm each working day. From June 30th, this will reduce to 9.30 am to 4.30 pm.

"The loss of financial counselling positions in Queensland will mean that thousands of Queenslanders with credit and debt issues will not be able to get assistance", said Fiona Guthrie, Executive Director of Financial Counselling Australia.

"While we appreciate the Queensland Government's budgetary restraints, investing in financial counselling saves money, with fewer costs borne downstream by the health and social services system", said Ms Guthrie. "At a time when cost of living pressures are acute, particularly with energy, financial counsellors are a front-line service that are needed more than ever."

From the beginning of 2009 up until the major floods of 2011 in Queensland, the previous state government provided $2 million per annum for financial counselling. After the floods, the Commonwealth provided $2 million through its disaster response funding, with the State providing $0.5 million. The expiry of funding from both of these sources has led to the current reductions in services.

If Queensland were to provide the same per capita investment in financial counselling as the average for the other States and Territories ($1.14 per head), it would invest $5.2 million per annum.

Anyone who is in financial difficulty can contact a free and independent financial counsellor on 1800 007 007.

Media Contact: Fiona Guthrie, 0402 426 835

Correction - 21st June 2013 - the correct figure for funding from the Queensland State Government is $1.2 million.

Funding for Generalist Financial Counselling Programs across Australia

*Comparison of annual funding per capita for financial counselling by State and Territory – ranked by per capita expenditure – **at 30th June 2013***

Jurisdiction	State/Territory Funding *($ million)*	Population *(million)*	Per capita
Western Australia	8.19	2.4	$3.43
Tasmania	1.37	0.5	$2.68
Victoria	6.30	5.6	$1.24
Australian Capital Territory	0.44	0.4	$1.20
New South Wales	6.03	7.3	$0.83
Northern Territory	0.18	0.2	$0.79
South Australia	1.10	1.6	$0.67
Queensland	0.00	4.5	$0.00

Queensland
Youth Strategy

connecting young Queenslanders
2013

Great state. Great opportunity.

Queensland Government

For more information on the Queensland Youth Strategy, visit the youth website www.qld.gov.au/youth follow us on twitter @qldyouth, email youth@communities.qld.gov.au or call us on 13 QGOV (7468).

Foreword

The Queensland Government is committed to providing young Queenslanders with the connections and support they need to reach their potential, to be capable and resilient, to take responsibility for their actions, to look after themselves and those around them, and to enjoy happy, healthy and productive lives.

That's what the Queensland Youth Strategy is all about. This plan sets out the Queensland Government's commitment to delivering the right services, in the right locations at the right time.

We want to make sure we use emerging technologies to hear what young people have to say and give them and their families easy access to the information they need.

We will continue to work with communities and the non-government sector to shape the future of services for our young people. By working together we can get the best results possible for Queensland's youth.

We are excited to launch the Queensland Youth Strategy and look forward to it helping to deliver great opportunities for young people in this great state

Hon Campbell Newman MP
Premier

Hon Tracy Davis MP
Minister for Communities,
Child Safety and Disability Services

Introduction

Every area of a young person's life is connected — their health and wellbeing is linked to how they achieve at school just as their education is linked to their future success at work and as active and contributing members of society.

The Queensland Youth Strategy aims to provide connections for young people and to guide the development and coordination of activities and services for young people aged 12–21 years.

The Queensland Youth Strategy is for all young Queenslanders - from every family, from every region of the state, and from every background.

The Queensland Government's vision for Young People

Our vision is for Queensland's young people to be:

- connected, taking hold of opportunities, and fulfilling their individual potential
- confident, resilient, responsible and safe
- good citizens who participate in their communities.

We need the support of all Queenslanders to make this vision a reality for our young people.

This strategy enables the framework for the Queensland Government's direction on engaging, supporting and working with young people, their families, with our communities, local governments and the youth sector as we know that we can be most effective when we work together.

To achieve our vision, the strategy focuses on six action areas for connecting young people to:

- family, friends and social networks
- education, training and employment
- health and wellbeing
- volunteering and participation
- supports and services
- arts and culture

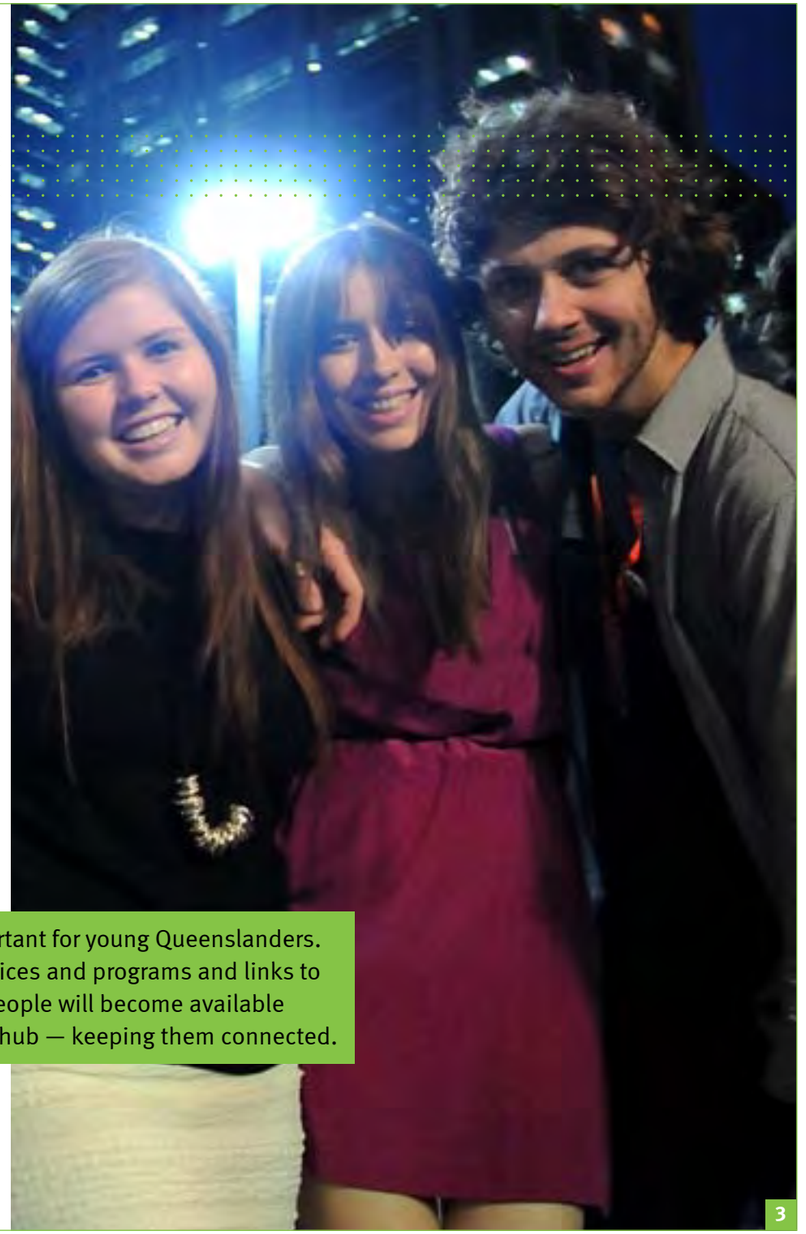
Guiding principles

The strategy is guided by a set of principles that recognises:

- better connections are made when young people are valued and seen as being individual and unique. A 'one size fits all' approach cannot cater to the diversity of young people's experiences. Programs and services must meet the different life experiences, circumstances and needs of young people
- all young people have strengths and abilities that, when nurtured and affirmed, help them achieve throughout their lives, and be resilient when there are setbacks
- young people are best supported when the family as a whole is strengthened
- young people most often connect with information, each other, and the world around them through the digital world

The key approaches this strategy takes to make connections include:

- engaging with young people through contemporary digital technologies
- providing practical resources and services to support a diverse range of young people, particularly those who need additional support and guidance to address challenges
- strengthening early intervention responses for young people before challenges become problems
- encouraging young people's participation in their communities
- building strong partnerships with the non-government sector and local and state government agencies to foster better collaborations.



We know the digital world is important for young Queenslanders. That's why information about services and programs and links to digital tools and apps for young people will become available through a dedicated online youth hub — keeping them connected.

A snapshot — young people in Queensland

Queensland young people are learning, creating, working, caring, contributing and living life in diverse ways throughout our great state.

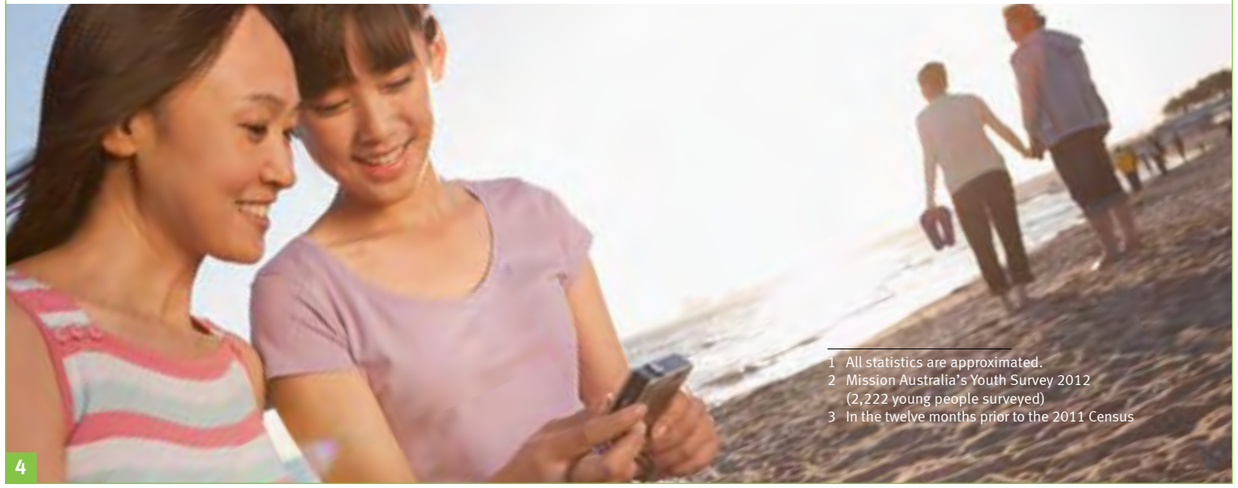
The latest census data shows more than 587,500 young people aged 12 to 21 live in Queensland and of these:

- 33 per cent live outside Queensland's major cities
- 2.1 per cent have a disability
- 13.5 per cent were born overseas
- 5.75 per cent are Aboriginal or Torres Strait Islander
- 9.1 per cent speak a language other than English at home[1]

A recent survey found that 84.4 per cent of 15 to 19 year old Queenslanders lived at home. As a group, they most valued friends, family, school, and physical and mental health. They were concerned about coping with stress, school/study and body image. The internet was their primary source of information, even ahead of parents and friends.[2]

We also know that:

- tertiary attendance rose 25 per cent in the five years to 2011: the majority of the 98,121 students were full-time
- studying increased from 43.7 per cent in 2006 to 46.5 per cent in 2011
- almost all used the internet — most to access social networking sites
- 16.2 per cent did voluntary work, making up 14.8 per cent of all Queensland volunteers[3]



1 All statistics are approximated.
2 Mission Australia's Youth Survey 2012 (2,222 young people surveyed)
3 In the twelve months prior to the 2011 Census

Investing in Queensland's young people

The State Government invests in wide-ranging services that assist young Queenslanders through education and training, employment, youth justice, health, transport, community safety, housing, community services, child safety, disability services, arts, sport and recreation, and the environment. We want to invest in services that deliver results for our young people.

While most young people grow up in happy, healthy families, some young people are doing it tougher than others. Exposure to risk factors like family conflict and parental stress, abuse or neglect, poverty, housing stress, unemployment, disengagement from school, teen pregnancy and drug and alcohol misuse increases their vulnerability and can dim their hopes.

The Queensland Government's investment direction is on people, programs and systems: offering the right services in the right location to the young people who need our help.

The *Better Services for Queenslanders* plan[4], the state's response to the Queensland Commission of Audit, is a key driver to change the way we invest in services.

For young people, this means services that:

- make a positive difference in their lives, encourage smart choices, and enable connections and actions to make the most of opportunities
- respond to their needs and aspirations — and are readily accessible, particularly for those at risk
- focus on building their skills and knowledge
- provide help earlier, before a problem gets too big and support responsibility, resilience and self-reliance

One of the ways in which we will ensure the right services are delivered in the right location to the right young people is through the Queensland Government investing its youth program funding in ways that will:

- achieve better value for money
- rebalance investment toward prevention and early intervention
- enable greater consumer choice
- make a difference to consumers
- reduce red tape
- partner with and leverage the investment, innovation and enterprise of the community and corporate sectors

4 www.treasury.qld.gov.au/coa-response/better-services.shtml

Areas of connection

The Queensland Youth Strategy will deliver six areas of connection to benefit young Queenslanders.

Areas of connection		Government action areas	Benefits for young people
1	**Families, friends and social networks**	■ Information for young people ■ Information for families and parents ■ Youth support	■ Safe, caring family environment ■ Parents supported to develop skills in parenting young people ■ Better access to information and support networks
2	**Education, training and employment**	■ Schools and learning environment ■ Training services ■ Employment services	■ Effective learning environments ■ Educational attainment and achievement ■ Work skills that are in demand ■ Job opportunities
3	**Health and wellbeing**	■ Sport and recreation activities ■ Hospitals and health services ■ Mental health services ■ Youth justice responses	■ Improved physical health and wellbeing ■ Good mental health ■ Safer communities
4	**Volunteering and participation**	■ Youth leadership programs ■ Youth volunteering	■ Active in community and civic life ■ Develop decision-making and leadership skills ■ Increased engagement
5	**Supports and services**	■ Information for young people about youth services ■ Youth support ■ Support for young people at risk of homelessness	■ Access contemporary supports and services ■ Help to achieve personal goals ■ Safe, stable accommodation (for those unable to live at home)
6	**Arts and culture**	■ Art and cultural activities ■ Online workshops and programs ■ Awards and festivals	■ Participate in creative arts and culture ■ Celebrate and be recognised for creative contributions ■ Develop skills to join in and enjoy arts and culture

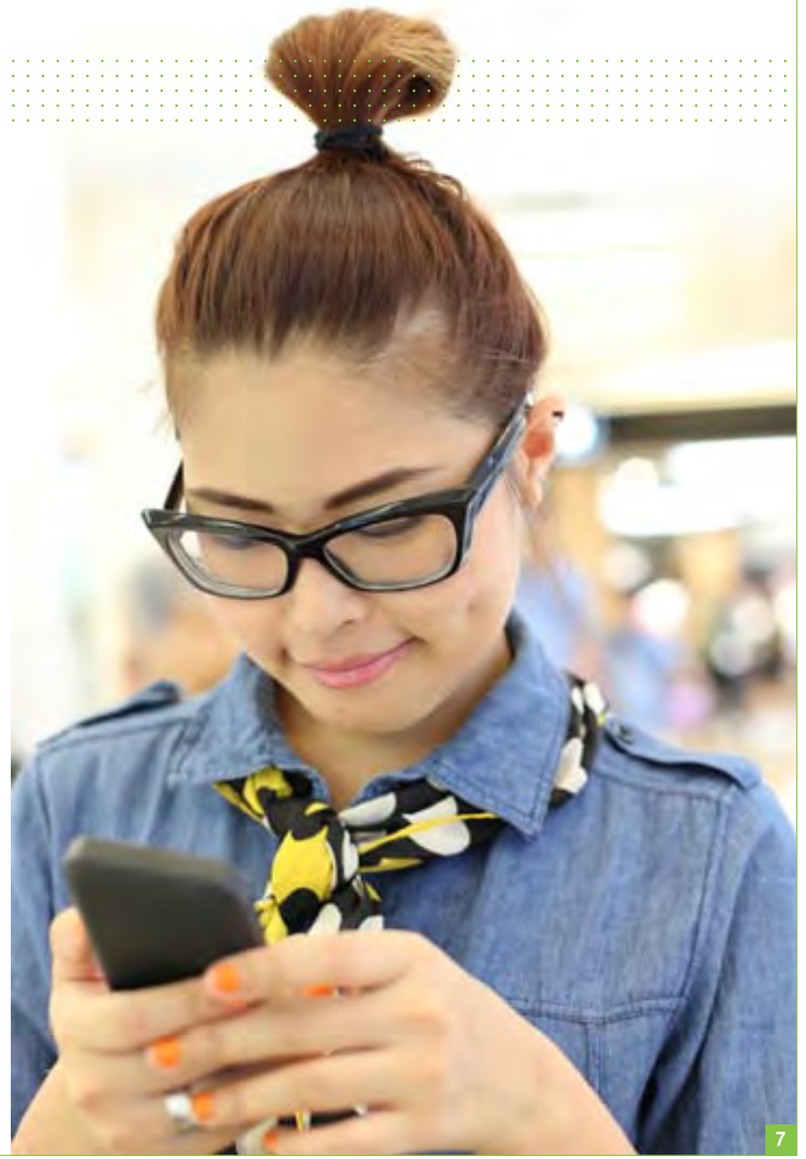
1 Connecting to families, friends and social networks

What is the Government's approach to connecting young people with family, friends and social networks?

The Queensland Government recognises that family and friends are the most important influence in a young person's life. Families influence a young person's self-esteem, wellbeing and safety which in turn affect school performance and later, participation as active citizens in our society.

For some young people the transition from adolescence to adulthood is challenging. Families will be able to easily access information and advice, including apps to prepare young people for this transition, wherever they live.

The Queensland Government will provide early intervention and support for those families who need it. Where young people are at risk of harm in their family, funded services will work with them and their family to keep them safe.



Areas of connection

How will we know we're connecting young people to family, friends and social networks?

- Young people and families will be able to more readily find the information they need to support them.
- Fewer young people will experience homelessness.
- More parents needing information or assistance with parenting will get the help they need.

Further information on the actions Government is taking to connect young people with family, friends and social networks can be found at "Connection 1" in the Appendix.

2 Connecting to education, training and employment

What is the Government's approach to connecting young people with education, training and employment?

A young person's participation and achievement at school, training or university impacts on their long-term economic and social wellbeing.

We want young people to be better informed about their study and job opportunities. The longer young people can be engaged with school and learning, the better start they have in entering the workforce and building a secure future.

The Queensland Government is committed to providing young people with vocational information, training opportunities and pathways to jobs.

How will we know we're connecting young people to education, training and employment?

- More young people will attain Year 12 or equivalent.
- More young people will participate in training or further study.
- More young people will be working.

Further information on the actions Government is taking to connect young people to education, training and employment can be found at "Connection 2" in the Appendix.

3 Connecting to health and wellbeing

What is the Government's approach to connecting young people with health and wellbeing?

Fitness, healthy eating and body image are critical for young people's good health, now and in later life. Young Queenslanders also need access to supports and services that promote positive mental health.

Young people should be able to participate in both their local communities and in the digital world, knowing they are safe from anti-social behaviour, abuse and violence.

Equally, the Queensland Government believes young people must be held accountable for their actions when they have committed a crime and they should receive assistance to help make positive changes in their lives.

How will we know we're connecting young people to health and wellbeing?

- More young people will be active.
- More young people will report improved physical health.
- More young people will report better mental health.
- More young people will feel safe.
- More young people will act responsibly and lawfully.

Further information on the actions government is taking to improve the health and wellbeing of young people in Queensland can be found at "Connection 3" in the Appendix.

4 Connecting to volunteering and participation

What is the Government's approach to connecting young people to volunteering and participation?

Getting young people involved is good for them and good for Queensland. By participating in volunteering, sport and other community activities young people develop their character and resilience, as well as decision-making and leadership skills and make an important contribution to their community.

Areas of connection

Volunteering gives young people the opportunity to have fun and acquire new skills. It can also be an important path to employment.

The state government believes young Queenslanders are responsible for making the most of the opportunities in their community, respecting others and voicing their opinions constructively on issues that matter to them. We need to provide access to contemporary digital channels to help this happen effectively.

How will we know we're connecting young people to participation and volunteering?

- More young people will volunteer in their communities.
- More young people will take on leadership roles.
- More young people will have their voices heard.

Further information on the actions Government is taking to connect young people to volunteering and participation can be found at "Connection 4" in the Appendix.

5 Connecting to supports and services

What is the Government's approach to connecting young people to supports and services?

Some young people need extra help. We will provide them with access to high quality, effective support services that meet their individual needs. For example, those young Queenslanders who cannot live at home will be assisted to access safe, stable accommodation. Youth services will work with young people in ways that make a difference — by assisting them to achieve their personal goals and stay connected with their family and community, as well as with education, training and employment

We will make sure young people have information about youth services in ways that will work for them.

How will we know we're connecting young people to supports and services?

- More young people will access the right services at the right time.
- More young people will have their say on issues that affect them.
- Youth services will be more transparent and accountable: there will be less red tape.

Further information on the actions Government is taking to connect young people to supports and services can be found at "Connection 5" in the Appendix.

6 Connecting to arts and culture

What is the Government's approach to connecting young people to arts and culture?

Young people's participation in arts, culture and creative expression has a range of benefits for them and their communities.

The transmission of culture across generations is vital for all young people, including young Aboriginal and Torres Strait Islander people and young people from culturally diverse backgrounds. Participating in cultural activities inspires pride in heritage and identity. These factors contribute to the development of resilient, healthy and socially connected young people.

Engagement in the arts provides positive opportunities for young people to creatively express themselves and their culture. We want to ensure that young people's contributions to the arts in Queensland are recognised and supported.

How will we know that we're connecting young people to arts and culture?

- Young people will join in cultural events and activities.
- More young Queenslanders will be recognised for their creative achievements.

Further information on the actions Government is taking to connect young people to arts and culture can be found at "Connection 6" in the Appendix.

Appendix: Action Plan 2013–2014

Introduction

The Queensland Youth Strategy aims to guide the development, support and connectedness of young people in Queensland so that they can help shape their own economic and social futures, and those of their communities and the world around them. The strategy is for young Queenslanders from every family, from every region of the state and from every background.

This Action Plan, which will be updated annually, outlines in practical terms what the Government will do to achieve the objectives of the strategy and connect young people to:

- family, friends and social networks
- education, training and employment
- health and wellbeing
- volunteering and participation
- supports and services
- arts and culture.

1. Connecting to families, friends and social networks

The Queensland Government recognises that family is the most important influence in a young person's life. Families influence a young person's sense of self-esteem, wellbeing and safety which in turn affect school performance and later participation as active citizens in our society.

What will Government do to connect young people to family, friends and social networks in Queensland?

Actions	Agency
A wide range of non-government support services including neighbourhood centres will be funded to assist young people or families address issues that impact on their personal, social or emotional wellbeing and safety.	Department of Communities, Child Safety and Disability Services
Kids Helpline will continue to be funded to provide a free 24-hour counselling service for kids and young people aged 5–25 years.	
The Regional Children's Telephone Counselling initiative will continue to provide 24/7 telephone counselling support for children and young people up to 18 years from regional areas across Queensland on issues including peer pressure, sexual health, social isolation, suicide, bullying, safety and abuse.	
Parentline will continue to provide phone counselling and support services for Queensland parents and primary caregivers to nurture positive, caring relationships between parents, children and teenagers.	
A range of targeted services for young people who experience complex challenges and/or who are vulnerable and at risk will be provided.	
Up to 240 young people with a high needs disability, aged 16 to 25, and their carers, will get extra respite hours through an investment of $22 million over four years.	
Post-school funding will continue to assist school leavers with disabilities plan for the future.	
A two-year, $4 million intensive family intervention program will be trialled, giving about 300 families practical support, advice helplines and information.	
A $3.2 million package of initiatives, increasing to $3.7 million in 2014–15, will strengthen the network of supports and services designed to provide more coordinated care for children and their families across Queensland.	
Parent Connect will provide assistance to parents, including young parents, of newborns with a disability.	

Actions	Agency
Community organisations will provide accommodation and support services for families and individuals experiencing homelessness or at risk of homelessness.	Department of Communities, Child Safety and Disability Services and Department of Housing and Public Works
$28.9M over four years has been committed to enhancing Maternal and Child Health Services to provide additional access to home visits and community clinics in the first 12 months following birth.	Department of Health
A Health Visiting Program for families, including young parents, with children up to three years of age, will continue under the Helping Out Families program, through the Gold Coast Hospital and Health Service and Children's Health Queensland.	
Child and Youth Community Health Services including general child health consultations, parenting services including young parents programs, Triple P Positive Parenting education, allied health and nutrition and diversity programs, will continue for children and their families at community locations.	
Information about services and programs and links to digital tools and apps for young people, their family and friends will be available through www.qld.gov.au/youth.	All agencies, informed by the Office for Youth, Department of Communities, Child Safety and Disability Services

2. Connecting to education, training and employment

A young person's participation and achievement at school, training or university links to their long-term economic and social wellbeing. We want young people to be better informed about their study and job opportunities.

What will Government do to connect young people to education, training and employment?

Actions	Agency
Queensland students will benefit from enhanced learning opportunities through investment of $328.2 million in state schools over four years and an additional $293.8 million in recurrent funding and $81.3 million towards non-state schools to move Year 7 to secondary school from 2015.	Department of Education, Training and Employment
Young adolescents transitioning from primary to secondary school will get more support for their academic, social and emotional needs.	
Remaining learning areas of Prep to 10 Australian Curriculum will be implemented.	
The Queensland Government will work with universities to widen participation of low socio-economic and Indigenous people in tertiary study.	
The *Solid partners Solid futures plan 2013–16* will ensure Aboriginal and Torres Strait Islander Queenslanders are supported and engaged in learning from early childhood education and care, through to schooling, training, tertiary education and employment.	
The Great Skills Real Opportunities five year plan to revitalise Queensland's VET sector, will support young Queenslanders to access and complete the skills training they need to get a job.	
The VET in Schools initiative will deliver better alignment to employment pathways for young people in their senior phase of learning.	
Local government traineeships will be offered in flood-affected communities, creating new employment opportunities for 15 to 24 year olds. Local government authorities will receive wage subsidies for 120 new traineeships.	
The Youth Support Coordinator initiative through funding of $9.6 million annually, will support at-risk young people to stay at school, re-engage in education or training or transition to employment.	
500 scholarships of up to $20,000 will be made available to women leaving school, returning to study or changing careers in specified male-dominated fields of study experiencing skills shortages.	

2. Connecting to education, training and employment (continued)

Actions	Agency
The Gateway to Industry Schools Program will continue to help young people transition from school to work while completing school and gaining formal qualifications.	Department of Education, Training and Employment
The Queensland Minerals and Energy Academy, assisting young people to prepare for careers in the resources sector, will be supported.	
Funding of $1 million over four years will provide school chaplaincy services to support young people.	
Funding of up to $86 million will provide 10,000 additional apprenticeships over six years to meet Queensland's anticipated skills shortage.	
The QSchools smartphone app will provide a convenient way for people to receive up-to-the minute information from and about schools. This app will be particularly useful to parents who have students in different schools, as the app manages updates from multiple schools in a single view.	
Queensland will continue to support the Take the Stand app, developed by all Australian education authorities, to create safe and supportive school environments that are free from bullying, harassment and violence.	
The Certificate 3 Guarantee will give Queenslanders access to a government subsidised training place up to and including their first certificate III level qualification in priority training areas and will give every year 12 graduate access to fee-free priority training courses within one year of leaving school.	
The Community Learning Program, with $47 million over five years, will provide additional support for Queenslanders with diverse needs, including young people, to gain a qualification.	
Funding of $3 million will improve training pathways for young people into agricultural sciences and economics.	Department of Agriculture, Fisheries and Forestry
The Agribusiness Gateway Schools program, available in 22 secondary schools, will continue to successfully transition participants from school into further education, training, and/or employment in the agribusiness sector.	
The National Regional Initiative—Western Downs, empowering local businesses and community leaders to take charge of their local skills agenda, will be delivered.	

2. Connecting to education, training and employment (continued)

Actions	Agency
Funded programs will enable local businesses to tap into contemporary skills and workforce development strategies that will lift the productive capacity of their businesses and, in turn, the region.	Department of Agriculture, Fisheries and Forestry and AgriFood Skills Australia
The School to Industry Partnership Program, developing and strengthening partnerships between rural industry and schools, including engagement of producers through the AgForce Rural Champion Volunteer Program, will continue.	
The web-based learning management system Rural Skills Online will continue in Queensland schools.	Department of Agriculture, Fisheries and Forestry, and Rural Skills Queensland
National Science Week will be supported, acknowledging and celebrating scientific achievements and encouraging interest in science, particularly among school students.	
A catalogue of science, technology, engineering and maths (STEM) education programs and activities operating across Queensland will be collated and maintained.	Department of Science, Information Technology, Innovation and the Arts
GroupX will deliver its I Choose Technology activities, which are dedicated to promoting ICT tertiary studies and careers, primarily through high school visits and career expos.	
Queensland Museum's statewide network will provide programs for young people including curriculum-based education activities, workshops and school-based apprenticeships, encouraging participation and attendance.	
Queensland Museum will provide young people in schools access to object-based learning using museum collections through a statewide loan service of kits aligned to national curriculum.	
Science students will be mentored through internships at the Museum of Tropical Queensland in Townsville.	
State Library of Queensland will provide onsite and online public programs and learning opportunities for young people, including student research support, online literature festivals and literacy workshops and programs.	
Students in tourism will be part of a workshop informing the industry's 20 year development plan and will be represented at the annual DestinationQ tourism forum.	Department of Tourism, Major Events, Small Business and the Commonwealth Games

3. Connecting to health and wellbeing

Fitness, healthy eating, mental wellbeing and healthy body image are critical for young people's good health, now and in later life. Young people should be safe in their communities. They should be able to participate in both their physical communities and in the digital world, knowing they are safe from anti-social behaviour, abuse and violence.

What will Government do to improve the health and wellbeing of young people in Queensland?

Actions	Agency
The $47.8 million Get in the Game initiative will support sport and recreation at the grassroots level, encouraging greater participation of children and young people through: ■ *Get Started* program, which involves giving eligible young people aged 5 to 17 the opportunity to join a sport and recreation club by providing up to $150 for membership/participation fees. ■ *Get Going* program, which encourages more young people to join clubs by giving clubs one-off grants up to $10,000 for equipment, training and activities. ■ *Get Playing* program, which provides up to $100,000 in funding to assist local sport and recreation organisations with facility development.	Department of National Parks, Recreation, Sport and Racing
The Young Athlete Assistance Program will continue to assist athletes under the age of 18 with travel and accommodation costs to attend championship events.	
The Play by the Rules initiative, which aims to make sport inclusive, safe and fair for all involved, will be promoted.	
One-off commitment funding for sport and recreation organisations for facility development, to increase participation opportunities for young people and other groups.	
Healthy eating programs will be promoted under the National Partnership Agreement on Preventative Health through clubs with junior members across Queensland.	
A framework for improved coordination of current and future initiatives will advance youth participation in sport and recreation, including a strategy for closer ties with schools.	
The Indigenous Community Sport and Recreation Program and the Deadly Sports Program will continue.	
Counselling services for child victims of abuse will receive a $1 million boost over four years. Non-government counsellors will deliver additional services for victims of child abuse and sexual assault.	Department of Communities, Child Safety and Disability Services

Actions	Agency
The Safer Schoolies Initiative will continue to respond to the large number of school leavers who attend key Schoolies locations in Queensland, working in partnership with community organisations and councils to improve schoolies' safety and reduce the potential impact on communities.	Department of Communities, Child Safety and Disability Services
A multimedia presentation package for use in schools will be part of an annual Safer Schoolies communication strategy to encourage school leavers to adopt safe behaviours during their end-of-school holidays.	
Extension of the *drinksafe* precinct trials, to keep young people safe when they are having fun and celebrating with friends, will be evaluated.	Department of Justice and Attorney-General
Boot camps, incorporating structured activities and support designed to deter youths from reoffending, will receive $5.5 million and be trialled over two years.	
A blueprint for the future of youth justice, seeking to reduce youth offending and build safer communities, will be developed. This will include the expansion of the boot camp program, review of the *Youth Justice Act 1992*, development of more effective sentencing options, better managing demand for youth justice services, addressing the causes of crime and improving youth detention services.	
School education programs will receive $1 million over four years to teach young people how to protect themselves and their friends and to report suspected abuse and sexual assault.	Department of Education, Training and Employment
Key community stakeholders, including youth groups and services, will be consulted as part of the review of alcohol management plans in discrete Indigenous communities.	Department of Aboriginal and Torres Strait Islander and Multicultural Affairs
Officers-in-charge, school-based police officers and Adopt-a-Cop will continue work with schools, P&Cs and local communities to stimulate school and community-based policing.	Queensland Police Service
Queensland's 54 Police Citizens Youth Clubs (PCYCs) will work statewide to deliver a range of crime-prevention and youth development initiatives including the PCYC Emergency Services Cadets Program.	PCYC in partnership with Queensland Police Service
The Sun Effects Booth app will continue to be available for free through the iTunes store. The app involves a quiz about behaviours in the sun, uploading a photo of the face and a tailored simulated image of how the face might look in the future. The app also provides information about the five recommended sun protection methods and allows the user to check the daily UV Index for their location.	Department of Health

Actions	Agency
School-based youth health nurses in state secondary schools will continue to provide services including individual health consultations, group health education and whole-of-school health promotion.	Department of Health
Indigenous youth health workers' knowledge and skills will be developed under the National Partnership Agreement on Indigenous Early Childhood Development.	
Access for young Aboriginal and Torres Strait Islander people to sexual and reproductive health services will be increased under the National Partnership Agreement on Indigenous Early Childhood Development.	
A mental health transition service for 8 to 18 year olds with early onset mental illness and complex care needs from Child and Youth Mental Health Services to clinical, community and cultural support services in their communities will continue to be implemented under Making Tracks.	
The Regional Network of Indigenous Alcohol, Tobacco and other Drugs (ATODS) Youth Program will continue to provide a focused treatment model for Aboriginal and Torres Strait Islander young people with substance misuse problems in key locations under Making Tracks.	
A program to improve access to primary health care for young Aboriginal and Torres Strait Islander people at the Brisbane Youth Detention Centre will be implemented under Making Tracks.	
Mental health and substance use transition services will be delivered to Aboriginal and Torres Strait Islander clients leaving the Brisbane Youth Detention Centre.	
The newly established Queensland Mental Health Commission will include young people as a priority group.	
Information, safety tips and updates about the weather and natural disasters will be provided to young people through a range of online tools including Facebook, Twitter, YouTube, Pinterest, blogs and Vine.	Department of Community Safety
The Youthful Prisoner Program, for 18 to 20 year old offenders at the Woodford Correctional Centre, will continue.	
A case management model targeted at young offenders between 17 and 21 years of age will be developed.	

4. Connecting to volunteering and participation

Young Queenslanders need to find their place in society so they can engage with — and participate in — civic life, volunteering, sport and community activities. Through volunteering and participation, young people develop their character and resilience, as well as decision-making and leadership skills.

What will Government do to connect young people to volunteering and participation?

Actions	Agency
The Queensland Plan school program will encourage principals and teachers to foster discussion between students and the wider community about their hopes for the future.	Department of Education, Training and Employment and Department of Environment and Heritage Protection
Over three years, 50 young Queensland delegates will be sponsored to attend ANZAC Day ceremonies at Gallipoli and across the Western Front in Europe, encouraging their interest in our nation's history.	Department of Education, Training and Employment
More young Queenslanders will be encouraged to participate in the Duke of Edinburgh Award, presenting a range of positive youth development activities, leadership and community engagement.	
New and emerging online and multimedia communication technology and tools will be used to encourage young people to get involved.	All agencies, informed by the Office for Youth, Department of Communities, Child Safety and Disability Services
The annual Youth Parliament will build young community representatives' skills to influence public decision-making.	Department of Communities, Child Safety and Disability Services in partnership with Queensland Parliament
The Indigenous Youth Leadership program and Eric Deeral Indigenous Youth Parliament will develop skills and encourage a stronger voice among young Aboriginal and Torres Strait Islander Queenslanders.	
The Office for Youth will work collaboratively with young people and community organisations to develop appropriate services, programs and resources.	Department of Communities, Child Safety and Disability Services

4. Connecting to volunteering and participation (continued)

Actions	Agency
The Queensland Indigenous Land and Sea Junior Ranger Program will promote connections to community through the ability to work “on country”.	Department of Environment and Heritage Protection
The Queensland Wetlands Program will offer curriculum-based learning opportunities, encouraging students to connect with their natural environment.	
Volunteering opportunities for young people will be promoted through the Queensland State Emergency Service	Department of Community Safety
Volunteering opportunities for young people will be promoted through the Queensland Rural Fire Service	
Young Queenslanders will be encouraged to volunteer to support their local community sport and recreation clubs through participation in the Challenge, Achievement and Pathways (CAPS) leadership program	Department of National Parks, Recreation, Sport and Racing

5. Connecting to supports and services

Young people who need extra help require access to high quality, effective support services that meet their individual needs, at a time and place right for them. We will ensure young people are front and centre of youth supports and services. This means ensuring that key information and support is available in a way that is meaningful to them.

What will Government do to connect young people to supports and services?

Actions	Agency
Practical guidelines, tools and resources will be developed to support youth programs and organisations that work with young people.	Department of Communities, Child Safety and Disability Services
The Office for Youth will coordinate expert advice on young people and implications for policy and service delivery.	
Social media, as well as more traditional forms of community engagement, will be used to get young people’s opinions on issues that affect them.	
The Your Life Your Choice framework will give young people with a disability and their families, greater choice and control over the services they receive. This is will help get Queensland ready for DisabilityCare Australia, the national disability insurance scheme.	
Supported accommodation for young people at risk of disengaging from training and/or education due to homelessness, such as Youth Foyers, will be explored as part of the realignment of specialist homelessness services	Department of Communities, Child Safety and Disability Services and Department of Housing and Public Works
The online Road Rules practice test will continue to help prepare learner drivers for the road rules examination for a car, motorbike or heavy vehicle.	Department of Transport and Main Roads
Place-based initiatives targeting young Aboriginal and Torres Strait Islander people will help improve access to education, employment, health and housing opportunities.	Department of Aboriginal and Torres Strait Islander and Multicultural Affairs
Young people and their families will continue to get housing assistance through Rent Connect, Bond Loans and rental grants.	Department of Housing and Public Works
A homelessness strategy, including actions to reduce the number of young homeless people, will be released.	
Young people transitioning from state care will be prioritised for social housing assistance.	

6. Connecting to arts and culture

Young people contribute to all facets of creativity and culture. Cultural and creative participation has a range of social benefits for young people including improved problem solving and creative thinking, increased self-esteem and confidence, and the development of social and emotional skills. We want to ensure that young people's contributions to culture and the arts in Queensland are recognised while supporting their continued involvement in creative activities.

What will Government do to connect young people to creativity and culture?

Actions	Agency
National Youth Weeks events and activities will promote and celebrate young people's achievements.	Department of Communities, Child Safety and Disability Services
Funding programs and other initiatives will actively encourage young people's involvement in Queensland's cultural life — as artists, participants and audiences.	Department of Science, Information Technology, Innovation and the Arts
Artist-facilitated workshops and programs related to exhibitions and collections at the Queensland Art Gallery/Gallery of Modern Art will target 13 to 17 year olds.	
Screen Queensland will deliver film programs for young people through the Cine Sparks International Film Festival and family films at the Brisbane International Film Festival.	
Screen Queensland will recognise and encourage emerging filmmakers including secondary and tertiary students and independent filmmakers through the Queensland New Filmmakers Awards.	
Queensland Museum will collaborate with youth organisations and groups to expand young people's access to the museum spaces and collections.	
The biennial Queensland Music Festival will help grow young people's engagement with music as audiences and participants.	
The Queensland Theatre Company's range of programs — including Theatre Residency Weeks, QTC Youth Ensemble, Young Playwrights' Program, Artists in Residence in Schools and the Wesfarmers Resources Regional Acting Studio — will encourage young people's engagement with theatre as audiences and participants.	

Actions	Agency
The State Library of Queensland, through The Edge, will provide opportunities for young people to explore creativity across the arts, technology, science and enterprise (e.g. introductory digital workshops).	Department of Science, Information Technology, Innovation and the Arts
The Aboriginal Centre for the Performing Arts will provide high quality, nationally accredited training in dance, music and theatre for Aboriginal and Torres Strait Islander young people, from Certificate III to Advanced Diploma in Performing Arts.	
The Artist-in-Residence initiative invests in high quality arts education projects that encourage creative practice between students, educators, artists and arts and cultural organisations.	
Young Queenslanders will be provided with social, cultural and intellectual benefits through agreements with international counterparts, preparing them for their place in the global community.	Department of Education, Training and Employment

Queensland Youth Strategy *connecting young Queenslanders*

3364_June2013

Minister for Community Services, Child Safety and Disability Services

Correspondence

Health and Community Services Committee

Hon Tracy Davis MP
Minister for Communities, Child Safety and Disability Services

QUEENSLAND GOVERNMENT

Level 13
111 George Street Brisbane 4000
GPO Box 806 Brisbane
Queensland 4001 Australia
Telephone +61 07 3235 4280
Facsimile +61 07 3012 7704
Email ccsds@ministerial.qld.gov.au

Your reference:
Our reference: CLLO

31 JUL 2013

Mr Trevor Ruthenberg
Chair Health and Community Services Committee
c/ Health and Community Services Committee
Parliament House
Cnr George and Alice Streets
BRISBANE QLD 4000

RECEIVED
31 JUL 2013
HEALTH AND COMMUNITY SERVICES COMMITTEE

Dear Mr Ruthenberg Trevor

Thank you for the opportunity to comment on the Hansard from the Health and Community Services Committee Estimates hearing on 24 July 2013.

I note the errors below that need correction with the relevant page number of the transcript below:

- Page 64 of the transcript I was quoted as saying $1.3 billion in relation to state government's overall investment in disability services across Queensland in 2013–14. This figure should read $1.43 billion. I refer to the correct amount ($1.43 billion) a second time within the response.
- On page 92 of the transcript I was quoted as saying there were 590 young people aged 12 to 21 living in Queensland. This actual figure should be 590,000.

As per standing arrangements I would like to request that these errors be amended in the transcript.

If you require any further information or assistance in relation to this matter, please contact Dr Nancy Spencer, Director, Corporate and Executive Services, Department of Communities, Child Safety and Disability on 322 46031.

Yours sincerely

Tracy Davis MP
Minister for Communities, Child Safety and Disability Services

Minister for Aboriginal and Torres Strait Islander and Multicultural Affairs

Answers to Questions on Notice

Health and Community Services Committee

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 1

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

I refer to page 5 of the SDS, and ask the Minister to please outline (a) the programs, services or grants that were cut or reduced to constitute the difference of over $22 million between budgeted expenditure for the 2012-13 financial year and estimated actual expenditure for that year, divided between Aboriginal and Torres Strait Islander Services and Multicultural Affairs and (b) outline what programs, services or grants will be cut or reduced to constitute the further cut to the 2013-14 estimated budget, divided between Aboriginal and Torres Strait Islander Services and Multicultural Affairs?

ANSWER:

(a)

The difference between budgeted expenditure for the 2012-13 financial year and estimated actual expenditure for 2012-13 does not relate to any cuts to programs, services or grants in Aboriginal and Torres Strait Islander Services or Multicultural Affairs.

For Multicultural Affairs, additional funding of $0.4 million was provided in both 2012-13 and 2013-14 for multicultural grants.

For the Aboriginal and Torres Strait Islander Services budget, the reduction relates to expenditure deferred to 2013-14 and 2014-15.

A large proportion of this difference relates to the revised timing of the Remote Indigenous Land and Infrastructure Program Office Infrastructure Development project. A total $38.022 million was allocated for the development of infrastructure and/or sub-divisions in 12 remote Indigenous communities to provide serviced land to support the National Partnership Agreement on Remote Indigenous Housing social housing construction targets for 2012-2014. Timing of works is affected by native title approvals, consents from councils and wet season impacts that limit the available construction times. The $38.022 million has been programmed over three years with $19.6 million deferred for works to be undertaken in 2013-14 and 2014-15.

(b)

No programs, services or grants will be cut or reduced to constitute the reduction in the 2013-14 budget from 2012-13 estimated actuals.

For the Aboriginal and Torres Strait Islander Services budget, the reduction includes the full year impact of fiscal repair measures implemented in 2012-13, the department's contribution to the cost of natural disasters and one-off costs in 2012-13 including severance payments made to staff taking voluntary redundancy and a capital grant of $939,000 provided to the Islanders Board of Industry and Service for the construction of the Saibai Island store.

For Multicultural Affairs, additional funding of $0.4 million was provided in both 2012-13 and 2013-14 for multicultural grants.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 2

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

I refer to page 13 of the SDS, and ask the Minister to please provide (a) an outline of the organisations that will be receiving grant funding in 2013-14, including the purpose of the grant and the amount to be received and (b) a list of organisations, that were funded in 2012-13, including the purpose of the grant and the amount received?

ANSWER:

(a) The 2013-14 grants have not been allocated at this date with the exception of the following:

Recipient	Total Allocated (excluding GST)	Purpose of grant
Cape York Welfare Reform		
Balkanu Cape York Development Corporation	208,742	Cape York Welfare Reform - Aurukun Sewing Centre
Hope Vale Aboriginal Shire Council	80,000	Cape York Welfare Reform - Hope Vale Retail Precinct
Hope Vale Aboriginal Shire Council	105,000	Cape York Welfare Reform - Hope Vale Business Development Officer
Cape York Partnerships	1,800,000	Cape York Welfare Reform - Parenting Program
Other Cape York Institute	400,000	Cape York Welfare Reform – Core Operations
Townsville Fire Ltd	50,000	“Fire Up” Initiative

(b) Grants allocated in 2012-13 include:

Recipient	Total Allocated (excluding GST)	Purpose of grant
Urban and Regional operations		
AFL Queensland	5,000	LEAP into Junior AFL at Pine Rivers
Allans Bus and Vending Service	4,200	Rain Forest Cup Carnival
Anglicare—Biloela	4,000	Indigenous Women Powering On Conference
Australian College of Community Services Ltd	16,500	Cunnamulla Community Workshops—mental health, alcohol and other drugs and building effective relationships
Australian Indigenous Youth Academy Inc	10,000	Australian Indigenous Youth Academy (AIYA) School Based Traineeship Program
Binambi-Barambah Aboriginal Corporation	5,000	Binambi Barambah Cultural Enrichment Camps
BoysTown	8,348	Thiess Construction Trades Assistant
Buddina State School	3,000	Building Cultural confidence of Aboriginal and Torres Strait Islander students project
Bud-Ja-Djan Aboriginal and Torres Strait Islander Men's Council Inc.	5,000	Bud-Ja-Djan Aboriginal and Torres Strait Islander Cultural Dance Program
Burnside State School	2,310	Who You? ID Kits
Burnside State School	3,470	Murries on the Move—Bundaberg
Business Enterprise Centre Ipswich Region Inc	10,000	Indigenous Enterprise Development Program
Cairns Regional Council	9,548	Active Games In The Park, Gordonvale
Cairns Regional Council	5,008	Active Games In The Park, Manoora
Cairns Regional Council	4,540	Active Games In The Park, Mooroobool
Cairns Regional Council	7,717	Active Women
Cairns West State School	11,933	Traditional Indigenous Games Carnival, Cairns West and Gordonvale
Care Goondiwindi Association Inc.	3,148	Holiday Fun Activities and Programs
Care Goondiwindi Association Inc.	5,285	June and July Holidays Activities-Goondiwindi
Cavendish Road High School	7,500	My Future, My Plan
Central West Aboriginal Corporation	4,650	Longreach Indigenous Cultural Exhibition

Recipient	Total Allocated (excluding GST)	Purpose of grant
Central West Aboriginal Corporation	6,100	Western Queensland Indigenous Traditional Dance Troupe
CEO Enterprises	5,000	Black, Bold and Beautiful Unsung Heroes Indigenous Women Inspiring Leadership Calendar
Charleville & Western Areas Aboriginal and Torres Strait Islander Community Health Limited	8,000	Hit DV 4 6
Cooee Elders Incorporated	10,000	Supporting Families for a Safe Community
Cunnamulla Aboriginal Corporation for Health	7,900	Bigi Nagala: A Dream Dreamed
Cunnamulla P-12 State School	8,096	Cunnamulla Performing Arts Program
Darumbal Community Youth Services Inc.	5,500	Top 30 Countdown—Addressing Offending Behaviour
Department of Justice and Attorney General	9,000	Watch Cunnamulla Mediation Training
Department of Justice and Attorney-General	7,500	Willing to Learn School – Cairns
Department of Transport and Main Roads	8,100	Murri's on the Move
Fitzroy Basin Elders Committee Inc.	4,000	Junior Ranger program (Fitzroy Basin Elders Committee)
Foundation for Young Australians	3,000	Indigenous Youth Healing Forum/ Aboriginal and Torres Strait Islander Youth Summit /Change it UP initiative
Fraser Coast Regional Council	1,800	Hervey Bay Whale Festival
FTL Investments (fee-for-service)	3,000	Traditional Indigenous Games Training
Garbutt State Primary School	5,000	Garbutt State School Garden and Cultural Space Program
Gidarjil Corporation	9,600	Bundaberg Indigenous Art Workshop
Girudala Community Cooperative Society Ltd	3,000	Learning from our Elders
Glenala State High School	8,000	Homework Centre – After School Hours
Glenala State High School	10,000	Inala Indigenous EXPO Project
Glendyne Education & Training Centre	9,100	Hervey Bay Deadly Pathways
Gold Coast Drug Council Inc.	5,000	Homes for Life
Gold Coast Football Club - Gold Coast Suns	10,000	No Boundaries Indigenous Program

Recipient	Total Allocated (excluding GST)	Purpose of grant
Gundala Kindergarten (Auspicing body)	10,000	Cultural Identity program
Gunya Meta Inc.	3,000	Sterritt Project
Inala Elders Aboriginal & Torres Strait Islander Corporation	12,000	Inala Elders Suicide Prevention and Mental Health Program
Innisfail East State School	7,600	Traditional Indigenous Games Carnival, Innisfail
Ipswich City Council	5,000	Indigenous Youth Advisory Council Leadership and Skill Development program
James Cook University	7,000	Pathways to Excellence (Stage 3)
Justine Parsons and Lisa Campbell	9,000	Cultural Beginning (Dance and Song) Program
Jute Theatre Company	30,451	Proper Solid (Jute Creative Arts) project
Kamilaroi Frogs Inc.	9,910	Active Communities, Active Culture – Dirranbandi A-Day
Kirrawe Indigenous Corporation	10,000	Kirrawe Youth Project
Kirrawe Indigenous Corporation	3,000	Qantas Airline Experience
Kiyua Performing Arts	2,000	Pathways to Excellence in Performing Arts (PEPA)
Kulila Kindergarten Association Inc.	5,172	Kulila Swimming and Traditional Dance Lessons
Kurbingui Sporting Association Inc.	10,000	Australian Indigenous Warriors Program
Kurbingui Youth Development	6,000	Pick Up Sticks Program
KYC Trust & Jabani Jinna	8,767	KYC After School Homework Program
Logan District Aboriginal & Torres Strait Islander Corporation for Elders	10,000	Murri Men's Maintenance Program
Mareeba State School	3,400	Traditional Indigenous Games Carnival, Mareeba
Mitchelton State High School	10,000	Mentoring and Case Management for five Aboriginal and Torres Strait Islander Grade 8 students.
Mitchelton State High School	2,500	Big Brother/Big Sister Murri Mentoring Program
Mitchelton State High School	7,500	Breakfast and Lunch Program for High School Students at Mitchelton State High School

Recipient	Total Allocated (excluding GST)	Purpose of grant
Moreton Bay Regional Council (fee for service)	3,850	"Outside in Art" – a project to support post release Aboriginal and/or Torres Strait Islander inmates in their art through mentoring
Mt Gravatt State School	2,500	The Aboriginal and Torres Strait Islander Parent & Community Engagement (ATSIPACE) Project
Mulungu Aboriginal Corporation Medical Centre	10,000	Resilient and Deadly - Mareeba
Murra Innovations	10,000	Moving into Employment in the Disability Sector
Murrigunyah Aboriginal and Torres Strait Islander Corporation for Women	10,000	Building Resilient Families
Murrigunyah Aboriginal and Torres Strait Islander Corporation for Women	10,000	What Works Program
Murringunyah Aboriginal and Torres Strait Islander Corporation for Women	10,000	Murringunyah Youth and Family Engagement Program
Nalingu Day Respite	1,500	Elder Respite Through Art
Natjul Indigenous Performing Arts	10,000	Natjul Indigenous Performing Arts - Community and Family Safety Workshops
Nintiringanyi Cultural Training Centre	3,000	Indigenous Youth Healing Forum/ Aboriginal and Torres Strait Islander Youth Summit /Change it UP initiative
North Coast Region Indigenous Education Unit	9,700	Empowerment of Aboriginal and Torres Strait Islander families to positively influence their child's education journey in primary or secondary schools.
North Queensland Cowboys	5,000	"Try for 5!" Program
North Stradbroke Island Aboriginal & Islander Housing Co-operative	3,000	Quandamooka Forum Operating Costs
North West Queensland Indigenous Catholic Social Service (NWQICSS)	10,000	Sewing and Craft Arts Project
Outlook Training and Resource Centre	5,000	Australian Indigenous Warriors Program
PCYC Camp Bornhoffen	10,000	Where to From Here?
Pullenvale State School	5,000	Suite of Oral Histories
QLD Aboriginal and Torres Strait Islander Child Protection Peak	8,000	National Aboriginal and Islander Children's Day 2012.

Recipient	Total Allocated (excluding GST)	Purpose of grant
Queensland Police Citizens Youth and Welfare Association – Ipswich Branch	5,622	Breaking the Cycle
Regional Development Australia	5,000	Moreton Bay Aboriginal and Torres Strait Islander Regional Employment, Education and Training Summit and Report
Roadcraft Driver Education	8,357	Goories Driving Towards Employment
Rockhampton Regional Council	5,000	Toonooba – Our River Our Home
South Burnett Police Citizen Youth Club (PCYC)	5,000	B.I.G.G. P.H.A.T. Program
South West Indigenous Network Inc	10,000	2013 Western Rivers Cup – Cricket Competition
Spinifex State College (Junior Campus)	5,358	Breakfast Program - Spinifex State School (Junior Campus)
Sports Scene Super Warehouse (fee-for-service)	4,650	Traditional Indigenous Games Training
Student Athlete Sport & Education Network Ltd	9,922	SASE @ TAFE Pathways Pilot Basketball Project
Synapse Training	5,000	Acquired Brain Injury Project
The Eidsvold Aboriginal Housing and Community Development Society Ltd	9,900	Deadly Start Eidsvold Early Childhood Project (part 1—early childhood programs)
The Eidsvold Kindergarten	9,900	Deadly Start Eidsvold Early Childhood Project (part 2—trainee professional development)
The Institute of Urban Indigenous Health	10,000	Mums & Bubs Club Gym and Swim School
The Rockhampton All Blacks Sports Club Inc	5,000	All Blacks Sports Club Inc – Commercial Kitchen for a Strong and Healthy Community
The Rockhampton All Blacks Sports Club Inc	4,000	7th Annual National Indigenous Basketball Championships - Hobart
The Roman Catholic Trust Corporation for the Diocese of Rockhampton (trading as the Diocesan Catholic Education Office)	4,425	DEADLY LEARNING – Year 10 Career and Future Learning Planning
Titans 4 Tomorrow Limited	20,000	Titans and Youth Justice Mentoring Workshops
Titans 4 Tomorrow Limited	10,000	Titans Achievement Program—North Stradbroke Island
Townsville Flexible Learning Centre	10,000	BRIDGING our Confidence Project (BRIDGE Arts Project)
University of Southern Queensland	9,990	Burunga-m Gambay

Recipient	Total Allocated (excluding GST)	Purpose of grant
Urangan State High School	1,000	Urangan State High School Sport Scholarships Proposal
Warriors Committee Inc	1,850	Warrior Women Say No to Violence
Cape York Welfare Reform		
Cape York Partnerships	490,000	Cape York Welfare Reform - Ohub Leaders
Balkanu Cape York Development Corporation	47,199	Cape York Welfare Reform - Aurukun Sewing Centre
Hope Vale Foundation	368,000	Cape York Welfare Reform - Hope Vale Banana Farm
Hope Vale Aboriginal Shire Council	114,583	Cape York Welfare Reform - Hope Vale Business Development Officer
Aurukun Shire Council	20,833	Cape York Welfare Reform - Aurukun Business Development Officer
Balkanu Cape York Development Corporation	78,723	Cape York Welfare Reform - Women's Enterprise Development Facilitator
Cape York Partnerships	1,285,538	Cape York Welfare Reform - Parenting Program
Family Responsibilities Commission	98,460	Cape York Welfare Reform - Ending family violence program
Bamanga Bubu Ngadimunku via Department of Families, Housing, Community Services and Indigenous Affairs.	111,000	Cape York Welfare Reform - Mossman Gorge community and municipal services
Balkanu Cape York Development Corporation	132,500	Cape York Welfare Reform - Enterprise Stimulus
Balkanu Cape York Development Corporation	40,000	Cape York Welfare Reform - Arts Marketing
Balkanu Cape York Development Corporation	47,500	Cape York Welfare Reform - Land Trust governance
Cape York Partnerships	600,000	Cape York Welfare Reform - Program Management
Cape York Aboriginal Australian Academy	428,125	Cape York Welfare Reform - CYAAA Language and Culture
Community Safety Plans		To support initial actions contained within the Community Safety Plan that aim to reduce crime and violence and make the community feel safer and stronger
Aurukun Shire Council	7,500	
Bamanga Bubu Ngadimunku Inc	7,500	
Cherbourg Aboriginal Shire Council	10,000	

Recipient	Total Allocated (excluding GST)	Purpose of grant
Doomadgee Aboriginal Shire Council	7,500	
Hope Vale Aboriginal Shire Council	7,500	
Kowanyama Aboriginal Shire Council	10,000	
Lockhart River Aboriginal Shire Council	10,000	
Mapoon Aboriginal Shire Council	10,000	
Mornington Shire Council	7,500	
Napranum Aboriginal Shire Council	10,000	
Northern Peninsula Area Regional Council	10,000	
Palm Island Aboriginal Shire Council		
Pormpuraaw Aboriginal Shire Council	10,000	
The Coen Justice Group Incorporated	7,500	
Torres Shire Council		
Woorabinda Aboriginal Shire Council	10,000	
Wujal Wujal Aboriginal Shire Council	10,000	
Yarrabah Aboriginal Shire Council	10,000	
Local Indigenous Partnership Agreements (LIPA)		
Mapoon Aboriginal Shire Council	57,096	Mapoon Early Learning Centre Project Manager
Napranum Aboriginal Shire Council	50,000	Young Adults Leadership and Capability Program
Pormpuraaw Aboriginal Shire Council	35,000	Sports and Recreational Master Plan - Local Indigenous Partnership Agreement Projects
Cherbourg Volatile Substance Misuse program		
South Burnett PCYC	12,900	Cherbourg Volatile Substance Misuse program
South Burnett PCYC	10,406	Cherbourg Volatile Substance Misuse program

Recipient	Total Allocated (excluding GST)	Purpose of grant
Queensland Police Service	12,242	Cherbourg Volatile Substance Misuse program
South Burnett PCYC	6,215	Cherbourg Volatile Substance Misuse program
Cherbourg State School	3,000	Cherbourg Volatile Substance Misuse program
South Burnett CTC	9,900	Cherbourg Volatile Substance Misuse program
Australian Indigenous Ministries	9,000	Cherbourg Volatile Substance Misuse program
Multicultural Queensland Partnerships Program (MQPP)		
Mercy Family Services, Toowoomba	7,500	Strengthening Refugee and Migrant Communities Project
Nuba Orphanage and Widows Home Inc	3,000	'We Can Make It'
University of Southern Queensland, Multicultural Centre	5,000	Expanding Vocational Horizons for Refugees and Migrants in the Toowoomba Area
Multicultural Centre for Mental Health & Well-Being Inc	5,000	'Living without Fear'
Blackbird International Limited	5,000	Finding Family and Storian Workshops
Community Information Centre Townsville Inc	5,000	English Classes: Skills Towards Employment Project (STEP)
ASSI 150 SEQ committee *(Museum and Gallery Services Queensland Limited)*	5,000	Australian South Sea Islander 150th Celebrations, SEQ
Bundaberg South Sea Islanders Action Association	8,500	OLGETA - Blackbirding Blong Bundaberg 1863-2013
Australian South Sea Islander Arts and Cultural Development Org. *(MARABISDA INC.)*	8,500	Changing Waves: Bringing our history to our future
Mackay Regional Council	3,000	Multicultural Swimming Program
Pacific Islands Reference Group Inc *(Ethnic Communities Council of Queensland Ltd)*	8,500	Capacity Building Project

Recipient	Total Allocated (excluding GST)	Purpose of grant
Riverview Neighbourhood House Association Inc	7,000	United Africa: Goodna-Ipswich
Deception Bay Community Youth Programs Assoc Inc	3,000	Engaging Pacific Islander Youth and Community (EPIYC) Project Stage 1
Contact Inc	4,000	Be-Spoken
Pasifika Pioneers *(Nerang Neighbourhood Centre)*	5,000	Pasifika Horizons
Townsville Intercultural Centre Ltd	7,000	Building Stronger Refugee Communities in Townsville
The Corporation of the Trustees of the Roman Catholic Archdiocese of Brisbane, St Paul's Catholic Primary School	5,000	Building Links - Strengthening Connections
Gold Coast Multicultural Arts Group in Collaboration	6,000	Afghan Women Social and Cultural Participation
MultiLink Community Services Inc	5,000	Talanoa Pasifika
AFL Queensland Limited	9,535	AFL Queensland Multicultural Schools Cup
Islamic Women's Association of Qld Inc	7,000	Creating Acceptance and Racial Tolerance Project (Creating ART Project)
Together for Humanity Foundation Limited	5,000	Challenging Cultural Thinking
Ethnic Broadcasting Association of Queensland Limited	5,000	2013 NEMBC Conference
International House	5,000	Home Away from Home
Cairns & District Chinese Assoc Inc	10,000	Cairns Chinese New Year Street Festival - Year of the Snake 2013
Buddha's Light International Association Qld Inc	10,000	2013 Chinese New Year
Queensland Chinese United Council	3,000	Chinese Festival 2013
Valley Chamber of Commerce	3,000	Chinese New Year 2013 Historical Exhibition - Sojourners & Settlers
Surfers Paradise Alliance Ltd	5,000	Surfers Paradise Chines New Year Festival
Bundaberg Regional Council	3,000	Chinese New Year Celebrations 2013
Innisfail & District Historical Society Incorporated	1,500	Italian Exhibition
Crescents of Brisbane	2,500	Creswalk 2013
Polonia Polish Association of QLD Inc	3,000	Wiosna Polish Multicultural Spring Festival 2013
Iranian Society of Queensland	1,500	Persian Festival

Recipient	Total Allocated (excluding GST)	Purpose of grant
Brisbane Multicultural Arts Centre Inc	7,000	Transcultural Dance Festival
Halifax Progress Association Incorporated	2,000	Halifax Heritage Day
Into People Inc.	5,000	Into Global Celebration 2013
St Patricks Day Parade Association Incorporated	10,000	Brisbane St Patrick's Day Parade and Irish Fair 2013
Te Korowai Aroha Inc	5,000	Waitangi Multicultural Day
Taiwan Friendship Association of Queensland Incorporation	4,000	Brisbane Lunar New Year Multicultural Festival 2013
The Japanese Society of Gold Coast Incorporated	2,000	Japan and Friends Day 2013 - Natsumatsuri
Kingston Community Enterprises Inc.	3,500	Numbelli Fest 2013
Fraser Coast Cultural Festival Inc	4,000	Fraser Coast Cultural Festival 2013
The Korean Society of Queensland Inc.	1,000	Korean Multicultural Festival 2013
Toowoomba International Multicultural Society Inc	10,000	Toowoomba Languages and Cultures Festival 2013
Pacific Unity Qld Inc	5,000	Pacific Unity Festival 2013
Buddha's Light International Association Qld Inc	15,000	Buddha Birth Day Festival 2013
Vanuatu Australian South Sea Islander Community Inc	5,000	ASSI 150 Project 2013 Exhibition
Australian South Sea Islanders Secretariat Incorporated	2,000	Australian South Sea Islanders 150th Commemoration and Festival August 2013
Australian-Italian Festival Association Inc	15,000	Australian Italian Festival
Gold Coast Multicultural Festival Association Inc.	20,000	2013 Gold Coast Multicultural Festival
Ethnic Community Council of Logan Inc.	6,000	Queensland Kaleidoscope Multicultural Street Festival - Logan City
Mareeba Multicultural Festival *(Tablelands Regional Council)*	15,000	Mareeba Multicultural Festival 2013 - Cultural Influences
Dalby Welcoming Community Committee *(Dalby Chamber of Commerce & Industry Inc)*	4,000	Dalby's Delicious & DeLIGHTful Festival
Rotary Club of Bundaberg Sunrise Inc	10,000	Bundaberg Multicultural Festival
Gladstone Multicultural Association Inc	5,000	Gladstone Multicultural Festival 2013

Recipient	Total Allocated (excluding GST)	Purpose of grant
Australian Taiwanese Chamber of Commerce Queensland Inc	10,000	Taiwan Festival
Federation of Indian Communities of QLD Incorporated	6,000	Diwali (Indian Festival of Lights)
Roman Catholic Trust Corporation for the Diocese of Townsville	10,000	Mount Isa Multicultural Festival
Into People Inc.	4,000	Into Global Rhythms Fest 2013
Multicultural Association of Caboolture Shire Inc	4,000	Caboolture Multicultural Festival 2013
Greek Orthodox Community of St George Brisbane	20,000	Paniyiri Greek Festival 2013
Brisbane French Festival	10,000	Brisbane French Festival 2013
Maranoa Regional Council	2,000	Food and Fire Fest 2013
Shree Sanatan Dharam Hindu Assoc of Queensland Inc	2,000	Deepawali Fest 2013
Shire of Tara Development Association Inc (Incorporating Tara Shire Tourist Association)	2,000	Tara Festival of Culture and Camel Races
Jabiru Community Youth & Children's Serv Assoc Inc	10,000	Zillmere Festival - One Place, Many Cultures
Qld Eidfest Association Inc	7,000	EIDFEST 2013
Queensland African Communities Council	6,000	Africa Day Festival 2013
GOPIO Queensland	4,000	India Day Fair 2013
Gold Coast Chinese Club Inc	5,000	Gold Coast Festivals Gala 2012, Dragon Boat Regatta & Multicultural Festivals
St Johns Community Care Ltd	5,000	Greek Festival
Runcorn Heights Primary P&C Association	1,000	RHSS Multifest 2013
Danish Association 'Heimdal' Inc	7,000	The Scandinavian Festival
Pasifika Vibes Festival Committee *(Deception Bay Community Youth Programs Assoc Inc)*	4,000	Pasifika Vibes Festival
FESTURI - a multicultural celebration Inc	6,000	The Village 2013 - Multicultural Festival
Griffith University (t/a Qld Conservatorium RC)	2,000	Encounters: India

Recipient	Total Allocated (excluding GST)	Purpose of grant
Perhimpunan Indonesia Queensland Incorporated	1,500	The Indonesian Food and Arts Festival
Multicultural Community Centre Ltd	2,000	Technicolour Festival
Townsville Intercultural Centre Ltd	15,000	Cultural Fest 2013
Ipswich Events Corporation Ltd.	15,000	Global Fiesta 2013
Central Highlands Regional Council	10,000	2013 Central Highlands Multicultural Festival
Central Queensland Multicultural Assoc Inc	6,000	Taste of the World
Rockhampton Regional Council	4,000	Rockhampton Cultural Festival
Pasifika Gold Coast 2013 Community Working Group *(Multicultural Communities Council Gold Coast)*	2,500	Pasifika Gold Coast 2013
Pacific Communities Council FNQ Inc	1,500	2013 Pacific Communities Festival & Pacific Islands Art Exhibition
Cairns Multicultural Committee	10,000	Tropical Wave Festival 2013
Islamic Society of Queensland Inc	1,000	Commemoration of the Birth of Holy Prophet Mohammed
Hazara Association of Australia Inc	1,500	New Year Celebration (Nowroz)
Chin Community in Queensland Inc	1,500	Chin National Day
Brisbane Festival of Tibet *(Chenrezig Inc)*	1,000	Brisbane Festival of Tibet 2013
Queensland Rohingya Community Inc	2,000	Rohingya Cultural Annual Event 2013
Queensland's Iranian House of Music Inc	2,000	Nowruz Festival
Shree Sanatan Dharam Hindu Assoc of Queensland Inc	1,500	Festival of Colours (aka Holi)
African Communities Association Gold Coast Inc	1,000	Cultural Harmony on the Gold Coast
Queensland Kurdish Newroz Committee *(Multicultural Development Association Inc)*	1,500	Newroz Kurdish New Year Celebration
Association of Burundian Communities of Queensland Inc	1,500	Burundi Cultural Showcase
Maltese Australian Gold Coast Association Incorporated	1,000	Malta's National Day
Gold Coast Hebrew Congregation Inc	2,500	Chanukah in the Park 2013
Brisbane Tamil School Inc	1,000	Annual Cultural Concert

Recipient	Total Allocated (excluding GST)	Purpose of grant
Nigerian Community Association in Queensland	1,000	Independence Celebration
Nepalese Association of Queensland Inc.	2,000	Dashain/Tihar 2013 Celebration
Whitsunday Australian South Sea Islander United Community	1,000	WASSIUC 2013 150th Anniversary Celebrations
Ethiopian Community Association of QLD Incorporated	2,000	Ethiopian New Year Festival: Enqutatash
Serbian Orthodox Ecclesiastic School Community St Nikolas	1,500	Brisbane Serbian Festival
The Ramakrishna Vedanta Centre of Queensland Inc	1,500	Annual Cultural Celebration
Cairns Indonesian - Australian Association	1,000	Gebyar Indonesia
Tamil Association Queensland Inc	2,000	Festival of Lights - Deepavali 2013
SriLanka Society of Qld Inc	1,500	The Sinhala & Tamil New Year Cultural Festival
Spirit of Africa Cultural Association	1,500	African Day Celebration Festival
Australia Qld Fujian Association Inc	1,500	Chinese Moon Festival Performance Party
Netherlands Association of Queensland Inc	1,000	Dutch Cultural Festival
Dias-Mendis Pty Ltd	1,000	Ariona - Experiencing the Vibrancy of Sri Lanka
The Rwandan Association of Queensland Inc.	1,500	Rwandan Cultural Festival
Gujarati Association of Queensland Inc	1,500	Sharad Poonam
Cairns Bhutanese Community Inc	1,500	Cairns Bhutanese Day 2013
Bhutanese Australian Association of Qld *(Multicultural Association of Caboolture Shire Inc)*	1,000	Dashain Tihar 2013
Gereja Kristus Brisbane Incorporated	1,000	Indonesian Culture Event - Nusantara 2013
Queensland Telugu Association Inc	1,000	Cultural Celebrations - Deepavali 2013
Eritrean Australian Women's & Families Support Network Inc	1,000	Tenth Year Anniversary of the Eritrean Australian Women and Family Support Network
Mainland Chinese Society Queensland (MCSQ) Inc	1,500	The 11th Brisbane Chinese Cultural Festival
Brisbane Maharashtra Mandal Inc	1,000	Ganpati Festival 2013
Brisbane Maharashtra Mandal Inc	1,000	Diwali Festival 2013
Logan South Sudanese Multicultural Development Association *(Qld African Comm Council)*	2,500	Logan South Sudanese Cultural Festival
The Corporation of the Trustees of	1,500	Dipawali - Festival of Light

Recipient	Total Allocated (excluding GST)	Purpose of grant
the Order of the Sisters of Mercy in Queensland		
Malayalee Association of Queensland	1,000	Vishu Celebration and Talent Show 2013
Central Queensland African Association Inc	1,500	African Day Celebration
Islamic Society of Mackay	5,000	Festival of Ramadan 2013
Association of Queensland Soni Samaj Inc	1,000	Diwali and Nutan Varash 2013
Jewish Educational Institute Chabad House Brisbane Inc	7,000	Chanukah in the City 2013
Bundaberg & District ASSI Action Group	9,000	Vanuatu-Australian South Sea Islander 150th Anniversary Invitational Rugby League Tour
Italian Festival Inc	20,000	Italian Week Coordination
Ethnic Communities Council of Queensland Limited	20,000	FECCA 2013 National Biennial Conference
Hakka Association of Queensland	2,000	2013 Multicultural and Dragon Boat Festival
Community Action for a Multicultural Society (CAMS)		
Multilink Community Services Inc	94,468	Target Community Worker (Pacific Islander Communities)
Multicultural Development Association Inc	88,912	Multicultural Community Worker (Statewide)
The Ethnic Communities Council of Queensland Limited	64,738	Multicultural Community Worker - Coordinator
Townsville Multicultural Support Group Inc	88,911	Multicultural Community Worker
Queensland Program of Assistance for Survivors of Torture and Trauma Association Inc	47,234	Target Community Worker (African Communities)
The Corporation of the Trustees of the Order of the Sisters of Mercy in Queensland	88,911	Multicultural Community Worker
Kenalwyn Bundaberg and District Neighbourhood Centre Inc	44,456	Multicultural Community Worker
Multicultural Communities Council Gold Coast Inc	88,911	Multicultural Community Worker
Multicultural Development Association Inc	47,234	Target Community Worker (Refugee Communities)
The Roman Catholic Trust Corporation for the Diocese of Cairns - Centacare Cairns	88,911	Multicultural Community Worker

Recipient	Total Allocated (excluding GST)	Purpose of grant
The Corporation of the Synod of the Diocese of Brisbane - Anglicare Southern Queensland	88,912	Multicultural Community Worker (Ipswich)
Nambour Community Centre Inc	44,456	Multicultural Community Worker
George Street Neighbourhood Centre Association Inc	44,456	Multicultural Community Worker
Queensland Council of Social Service Inc	88,912	Multicultural Community Worker
Multicultural Development Association Inc	94,469	Grant Access Worker
Neighbourhood Centre Caboolture Inc	88,911	Multicultural Community Worker
Hervey Bay Neighbourhood Centre Inc	44,456	Multicultural Community Worker
Mackay Regional Council	47,234	Target Communities Worker
Multicultural Development Association Inc	44,456	Multicultural Community Worker (North Brisbane)
Access Community Services Limited	88,912	Multicultural Community Worker
Local Area Multicultural Partnership (LAMP)		
Brisbane City Council	44,456	Multicultural Policy Officer
Cairns Regional Council	44,456	Multicultural Policy Officer
Cassowary Coast Regional Council	44,456	Multicultural Policy Officer
Gladstone Regional Council	44,456	Multicultural Community Relations Officer
Gold Coast City Council	44,456	Multicultural Policy Officer
Ipswich City Council	44,456	Multicultural Policy Officer
Local Government Association of Queensland Inc	63,906	Local Area Multicultural Partnerships - Coordinator role
Logan City Council	44,456	Multicultural Policy Officer
Mackay Regional Council	44,456	Multicultural Policy Officer
Moreton Bay Regional Council	44,456	Multicultural Planning and Development Officer
Rockhampton Regional Council	44,456	Multicultural Policy Officer
Toowoomba Regional Council	44,456	Multicultural Policy Officer
Townsville City Council	44,456	Multicultural Policy Officer
Lockyer Valley Regional Council	44,456	Multicultural Policy Officer
The Ethnic Communities Council of Queensland Limited	132,043	Multicultural Affairs Queensland Core Funding
Other Grants		

Recipient	Total Allocated (excluding GST)	Purpose of grant
Cape York Institute	400,000	Cape York Welfare Reform - Core Operations
Queensland Council of Social Service Inc (QCOSS) (paid via Department of Communities)	30,000	ATSI Human Services Coalition 2011-12
Department Of Families Housing Community Services & Indigenous Affairs	120,000	Parents Supporting Learning
Department Of Families Housing Community Services & Indigenous Affairs	150,000	Indigenous Data Clearinghouse contribution
Department Of Families Housing Community Services & Indigenous Affairs	55,000	MCATSIA population project
Arts Queensland	10,000	Cairns Indigenous Art Fair (CIAF) - Arts Qld
Monash University	5,000	"Closing the Gap on Indigenous Birth Registration" ARC Linkage Project - Year One Funding
Torres Shire Council	10,000	Contribution to Kai Kai Gardens project operational costs
Islanders Board of Industries & Services	939,079	Saibai Island Retail Store capital grant

Note: The grants and subsidies budget item included on Page 13 of the Service Delivery Statement also includes expenditure in relation to National Partnership Agreement on Remote Indigenous Housing infrastructure development program.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 3

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

I refer to page 11 of the SDS, and ask the Minister to please outline what capital programs were cut or reduced to constitute the difference between budgeted expenditure for the 2012-13 financial year and estimated actual expenditure for that year?

ANSWER:

No capital programs were cut or reduced in the 2012-13 financial year. $1.6 million has been carried over from 2012-13 into 2013-14 for deferred capital projects within Retail Stores and other potential emerging capital requirements across the DATSIMA property portfolio.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 4

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

I refer to page 13 of the SDS, and ask the Minister to please outline in detail, by organisation, purpose and amount the grants and subsidies (a) that were cut resulting in the difference of nearly $25 million between budgeted expenditure for the 2012-13 financial year and estimated actual expenditure for that year and (b) will be cut to obtain a further reduction for 2013-14 financial year?

ANSWER:

(a)

The difference between budgeted expenditure for grants and subsidies in the 2012-13 financial year and the estimated actual expenditure for 2012-13 does not relate to any cuts.

A large proportion of the difference relates to the revised timing of the Remote Indigenous Land and Infrastructure Program Office Infrastructure Development program. A total $38.022 million was allocated for the development of infrastructure and/or sub-divisions in 12 remote Indigenous communities to provide serviced land to support the National Partnership Agreement on Remote Indigenous Housing social housing construction targets for 2012-2014. Timing of works is affected by native title approvals, consents from councils and wet season impacts that limit the available construction times. The $38.022 million has been programmed over three years with $19.6 million deferred for works to be undertaken in 2013-14 and 2014-15.

(b)

The difference between the 2012-13 Estimated Actual for grants and subsidies and the 2013-14 Estimate does not represent any cuts. It reflects $4.4 million of the Remote Indigenous Land and Infrastructure Program Office Infrastructure Development program deferral allocated to 2014-15 and a one-off grant of $939,000 provided in 2012-13 to the Islanders Board of Industry and Service for the construction of the Saibai Island store, offset by deferrals from 2012-13.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 5

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

I refer to page 7 of the SDS, and ask the Minister to please outline (a) how many departmental staff are located in rural and remote areas of Queensland, (b) the total amount of incentive payments paid to remote and rural staff in 2011-12, 2012-13 and 2013-14 and (c) why the Minister has cut the incentive payment as outlined in Question on Notice number 324 of 2013?

ANSWER:

(a)

52 staff (headcount) were located in 'remote and regional locations' as defined in the Remote and Regional Locations Incentive Scheme procedure as at 30 June 2013. 47 of those were eligible for the final incentive payment under the scheme for the period 1 January 2013 to 30 June 2013;

(b)

The total amount of incentive payments paid to eligible staff for:

a. 2011 – 2012 was $495,962;

b. 2012 – 2013 was $466,812;

c. Nil in 2013 – 2014, as the incentive payment ceased as of 1 July 2013.

(c)

Eligible employees within the Department of Aboriginal and Torres Strait Islander and Multicultural Affairs appointed to specific remote and regional locations, are able to access a number of incentives and entitlements under the Remote and Regional Locations Incentive Scheme.

A discretionary retention and attraction incentive payment was introduced by the former Department of Child Safety to attract and retain professional staff in remote and regional

locations. This payment was extended by the then Department of Communities in July 2011 to the entire department, including those work areas that subsequently transitioned to DATSIMA in April 2012.

There is limited turnover of DATSIMA staff in remote and regional locations and consequently there is no business requirement for the continuation of this discretionary incentive payment in the current fiscal environment.

All other regulatory entitlements prescribed under an Award or Public Service Commission Directive, continue to be paid to eligible DATSIMA staff in remote and regional centres, including locality allowances, additional leave entitlements, concessional travel, and accommodation assistance.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 6

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

I refer to page 3 of the SDS, and ask the Minister to please outline the status of the government's Alcohol Management Plans Review, in particular how many Indigenous councils have made submissions to the review, the number of staff and their title and position allocated to the work of the review, the cost of the review to date and the timeframe for implementation?

ANSWER:

The State Government is currently reviewing Alcohol Management Plans (AMPs) operating in 19 discrete Indigenous communities covering 15 Local Government Areas (the Review). The Review commenced in October 2012.

The Review is community led and driven. It adopts a community by community approach to take into account the unique histories, needs and aspirations of each community. No time frames have been set for the Review to enable each community to participate at its own pace.

Each community has been asked to develop their own community proposal about the future of alcohol management and how to reduce alcohol-related violence. So far, no community proposals have been received by the Department of Aboriginal and Torrs Strait Islander and Multicultural Affairs (DASTIMA).

There are no staff within DATSIMA dedicated wholly to oversee the conduct of the review. It is part of the work undertaken by various officers ranging from an Executive Director (SES 2); a Director (SO); a Manager (AO8); a Policy Officer (AO5); and an Administrative Officer (AO3). The AMP review is a part of their core business, and these staff also undertake other functions within the department.

DATSIMA staff attached to regional offices support the Review on a needs basis. They range from Senior Officers to Project Support Officers at the AO4 classification.

In 2012-13 $30,000 was allocated towards the cost of the Mayors to meet with the Minister in Cairns on 3 October 2012 when the Review's Terms of Reference and methodology were discussed and released publicly. In addition, approximately $11,000 has been spent on staff travel to communities for consultations with council and community stakeholders and for attendance at the Mayor's meeting of 3 October 2012.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 7

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

I refer to page 3 of the SDS, will the Minister outline what actions his department is undertaking to ensure that Indigenous Councils across Queensland are adequately funded, in light of the drastic funding cuts undertaken by the Minister for Local Government and Resilience?

ANSWER:

I'm not aware of any "drastic funding cuts" to Indigenous Councils undertaken by the Minister for Local Government, Community Recovery and Resilience. However, I am aware that the Minister announced recently that a small proportion of the councils' $32 million annual grant funding will be quarantined to be used as incentive payments for councils which operate with a high level of efficiency and accountability.

There are 16 Indigenous Local Government Councils in Queensland and the Department of Aboriginal and Torres Strait Islander and Multicultural Affairs works in partnership with these Councils to assist them in meeting the needs of their communities.

These councils operate under the *Local Government Act 2012* along with all other local government Councils in Queensland and are accountable to their community for their local government decisions, actions and services.

The Department of Local Government, Community Recovery and Resilience (DLGCRR) has portfolio responsibility for all Local Government Councils including Indigenous Local Government Councils. The DLGCRR supports Indigenous local governments by assisting them to improve their strategic and corporate governance, enhance their financial management and planning, and build financial sustainability including, for example, by increasing own source revenue and stimulating business development to increase employment opportunities in their communities.

Further questions regarding funding of Indigenous Councils in relation to their local government responsibilities should be referred to the Minister for Local Government, Community Recovery and Resilience.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 8

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

What arrangements does the Government have in place to ensure that services to discrete Indigenous communities are delivered in the most efficient and effective way so that community needs are met to the greatest extent possible?

ANSWER:

The Queensland Government is committed to driving real and enduring change for Aboriginal and Torres Strait Islander Queenslanders and their communities through effective and efficient service delivery.

At a whole of government level, early on, the Government identified the need for a specific across-portfolio arrangement to ensure the coordination of policy, programs and services for Aboriginal and Torres Strait Islander Queenslanders and to drive and oversee the implementation of Government priorities for Aboriginal and Torres Strait Islander affairs.

The Cabinet Committee on Aboriginal and Torres Strait Islander Affairs (the Cabinet Committee) has been established to drive the implementation of the Government's reform agenda in Aboriginal and Torres Strait Islander affairs.

This brings together Ministers with the ability to effect real change and address historically intractable issues in a range of policy areas. The Minister for Aboriginal and Torres Strait Islander and Multicultural Affairs and Minister Assisting the Premier chairs the Cabinet Committee which comprises the following Ministers:

- The Minister for Health
- The Minister for Education, Training and Employment
- The Minister for Police and Community Safety
- The Minister for Communities, Child Safety and Disability Services

- The Minister for Housing and Public Works
- The Minister for Local Government, Community Recovery and Resilience.

The Cabinet Committee oversees the Queensland Government's significant reform agenda to support Aboriginal and Torres Strait Islanders living in the discrete Indigenous communities with economic opportunities, opportunities to own their own home and to improve life outcomes.

The reform agenda includes:

- Removing barriers to home ownership;
- Supporting economic development and opportunities;
- The Alcohol Management Plan review;
- Identifying opportunities for freehold and resolving land tenure issues to support economic development and home ownership; and
- Building the capacity of Indigenous Local Councils.

The Cabinet Committee has also commenced a process of mapping State Government services and expenditure for 2013-14 which will guide this work. Service and expenditure mapping enables the State Government to identify areas of unmet need, opportunities to collaborate on key government priorities such as increasing employment, and redirect funds from services that are less effective to those which are more likely to result in positive outcomes.

At the agency level, the Department of Aboriginal and Torres Strait Islander and Multicultural Affairs drives the coordination of whole of government policy and program delivery. By working in close partnership with Local Government, DATSIMA assists Councils and Trustees to enable them to make the decisions that are needed to grow a promising future for these communities. Working with a governance structure that generates clear direction and access across all relevant agencies means that DATSIMA is able to effectively drive progress.

DATSIMA's team comprises staff who have developed strong stakeholder relationships which provides a direct link for local input to ensure the involvement of all levels of government as well as a means by which on-the-ground cross-agency issues can be resolved expeditiously.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 9

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

Can the Minister please advise how the work of the Family Responsibilities Commission is helping to improve the lives of residents in the four communities where the Commission operates?

ANSWER:

The Family Responsibilities Commission (FRC) is a major element in the implementation of the Cape York Welfare Reform (CYWR) in the communities of Aurukun, Hope Vale, Mossman Gorge and Coen.

A key finding of an independent evaluation of the CYWR, publically released on 28 March 2013, is that the CYWR has made progress in restoring social norms and local authority. The evaluation reported that the foundations and enablers for a shift away from welfare dependence have been established.

The evaluation also found evidence of subtle and fundamental behaviour changes leading to improvements in money management, responsibility for children, school attendance, educational attainment and attitudes to work.

A notable benefit reported in the evaluation report is that the establishment of the FRC is a key driver of change in social norms and as a vehicle for restoring Indigenous authority and leadership in the four CYWR communities.

The evaluation reported that the FRC has had an impact in encouraging and assisting community members to better meet the needs of their children and families. A successful feature of the operation of the FRC has been the engagement and guidance of local Aboriginal leaders as Commissioners, working through issues with community members referred to the FRC in order to tackle antisocial behaviour and restore social norms.

This is evidenced by the improved school attendance particularly in Aurukun where the published school attendance rate at Aurukun increased from 46.1 per cent in the first term of 2008 to 70.9 per cent in 2012. The evaluation report states that data analysis has linked this improvement to the conferencing activity of the FRC.

The *Family Responsibilities Commission Act 2008* requires that the FRC be notified if community residents: do not meet their obligations to send their children to school; do not meet tenancy obligations; are subject to a child safety notice; or are convicted of an offence in the Magistrates Court.

The FRC Commissioner and Local Commissioners, conduct conferences with those community members, who are 'notified' to the FRC. This not only includes the community member who has received a notice, but also other members of their family that can benefit from the assistance of the FRC.

The aim of the conferencing is to resolve the problems that caused referral to the FRC. The FRC may case manage clients through case plans that address issues such as alcohol and substance abuse, parenting support and poor school attendance including referrals to a range of relevant support services provided as part of the CYWR investment in communities.

If people do not work with the FRC to satisfactorily address problems, the FRC Commissioners can also order income management of their welfare entitlements.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 10

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

What benefits does the Government expect to obtain from the 12 month extension of the Cape York Welfare Reform Trial?

ANSWER:

The Government's decision to extend the Cape York Welfare Reform (CYWR) to the end of 2014 allows consolidation of the gains to date, while also addressing areas that the CYWR evaluation identified as requiring greater focus, in particular, youth engagement, economic development and home ownership opportunities.

The evaluation released on 28 March 2013, found that more work is needed to remove barriers to home ownership and to improve economic opportunities available to the communities. In 2014, efforts to make home ownership on Indigenous lands possible will build on the significant progress made during 2013. To date a total of 75 Home Ownership Expressions of Interest have been received from Cape York Welfare Reform communities. While this is just the first step of the process toward 99-year, renewable home ownership leases, it does indicate significant interest on the part of applicants.

Further effort will be directed to coordinating community-based home ownership activities, working with applicants to progress the application through all stages of the process and assisting Councils and Trustees in building their understanding and knowledge of home ownership responsibilities and processes.

Economic participation will also be improved through support to provide accredited, industry based training and employment support to Cape York Welfare Reform community members in mining and construction. This will build on the highly successful Hope Vale Banana Farm project which harvested its first crop in June this year, and the development of the Mossman Gorge Gateway Tourism project that opened in early 2013.

The department will also work closely with the Australian Government to achieve the best benefits from the Remote Jobs and Communities Program. This program commenced in July 2013 and provides employment and economic participation services in remote communities.

Further work is also being undertaken to develop a response for young people who have become disengaged from high school to re-engage these students in either the local school, boarding school or an alternative education stream.

It was always the intention that what has been learnt from the CYWR should be applied to benefit all Indigenous communities. This Government is also keen to see efficiencies in the expenditure of the funding, and that consideration be given to modifying the service model to have a greater focus on home ownership, economic participation and addressing issues around disengaged youth.

This extension will maintain the welfare reform model during the next 12 months while allowing time to properly assess the evaluation report to determine the successful elements of the CYWR, and plan how the benefits of the welfare reform initiatives could potentially be rolled out to other Indigenous communities from 2015.

While there has been progress in the CYWR communities, the evaluation found that there is still more to do in terms of facilitating behavioural change and strengthening social responsibility. The benefits that have been delivered to date must be maintained throughout 2014.

In this regard a successful feature of the CYWR trial has been the operation of the Family Responsibilities Commission (FRC), with the guidance of local Aboriginal Elders and other local leaders as Commissioners, to work through issues with community members referred to the FRC in order to tackle antisocial behaviour.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 11

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

Can the Minister please advise what progress is being made in the review of Alcohol Management Plans across the 19 discrete Indigenous communities?

ANSWER:

The State Government is currently reviewing Alcohol Management Plans (AMPs) operating in 19 discrete Indigenous communities covering 15 Local Government Areas (the Review). The Review commenced in October 2012 with the public release of the Terms of Reference and Review's methodology.

The Review is community led and driven. It adopts a community by community approach to take into account the unique histories, needs and aspirations of each community. No time frames have been set for the Review to enable each community to participate at its own pace.

The Review involves three broad phases:

1. Each community is to develop a community proposal and government assistance will be provided where invited by the community;

2. In partnership with each community, develop transition plans for those who wish to move away from their AMP or alternative strategies to reduce alcohol-related harm for those who wish to retain their AMP; and

3. Implementation and monitoring of the transition plans and alternative strategies to ensure that levels of alcohol-related harm and violence continue to reduce.

I have met with the Mayors of the discrete Indigenous communities and with Community Justice Groups (CJGs) to outline the Review's Terms of Reference and its methodology.

Councils and CJGs have been asked to work together with other community stakeholders such as local police, school principals and health workers to develop community proposals.

I am advised that, thus far, 13 of the 15 Local Government Areas with an AMP have commenced developing their proposals and are at various stages of development: Mornington Island, Doomadgee; Pormpuraaw; the Northern Peninsula Area; Lockhart River; Yarrabah; Mapoon; Napranum; Wujal Wujal; Hope Vale; Woorabinda; Cherbourg; and Palm Island.

The Department of Aboriginal and Torres Strait Islander and Multicultural Affairs (DASTIMA) has provided assistance to each of the communities when requested. Assistance has included: providing fact sheets about the Review's Terms of Reference and methodology; providing community specific profiles with information regarding services and levels of alcohol-related harm together with data from the Quarterly Bulletins and the Annual Bulletin for 2011-12; assisting with community surveys; and attending meetings with community members and stakeholders.

Formal meetings to discuss the AMP Review occurred in November 2012 in: the Northern Peninsula Area; Mornington Island; and Doomadgee. Officers from DATSIMA have also met with the Cherbourg Aboriginal Shire Council and the South Burnett Regional Council to discuss a joint proposal from the two Councils.

The Kowanyama Aboriginal Shire Council has asked that government officers visit their community to discuss the Review and their community's proposal in August 2013 on a date to be confirmed.

As part of the Review I have written to the Local Governments of neighbouring regional centres seeking their feedback.

Feedback has been sought from key stakeholders regarding the AMP Review.

To date, 23 submissions, letters and emails have been received from Indigenous Local Governments, neighbouring Councils, stakeholders and members of the public as follows:

- one from the Pormpuraaw Aboriginal Shire Council regarding efforts to reduce sly grog;
- three from neighbouring Local Governments: Mount Isa City Council, South Burnett Regional Council and the Carpentaria Shire Council;
- one joint letter from the Cherbourg Aboriginal Shire Council and the South Burnett Regional Council; and
- 18 from stakeholders and members of the public.

A working group has been established including officers from DATSIMA, the Queensland Police Service and the Department of Justice and Attorney-General to identify options to reduce the sale of illegal alcohol in the communities.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 12

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

How is the Government working with industry to improve employment prospects and business opportunities for Indigenous Queenslanders?

ANSWER:

The Department of Aboriginal and Torres Strait Islander and Multicultural Affairs (DATSIMA) is leading the development of a whole-of-government Aboriginal and Torres Strait Islander economic participation policy. As the overarching policy for Aboriginal and Torres Strait Islander affairs in Queensland, it will outline the Queensland Government's longterm vision and direction to support the economic independence of Aboriginal and Torres Strait Islander peoples by increasing their involvement in the Queensland economy. This will be achieved by supporting Aboriginal and Torres Strait Islander peoples to get jobs, stay in jobs, own business and build wealth.

When released, the Aboriginal and Torres Strait Islander economic participation policy will highlight how all Queensland Government agencies are working together and with community, public, private and not-for-profit sectors to achieve the common goal of ensuring that Aboriginal and Torres Strait Islander Queenslanders are economically independent and share in the wealth and prosperity of Queensland's growing economy.

Job creation is an important part of the challenge. My Department has delivered on a commitment under the government's first Six Month Action Plan (July – December), by negotiating five memoranda of understanding with the Queensland Resources Council, Queensland Farmers' Federation, Constructions Skills Queensland, AgForce Queensland and Leighton Contractors Pty Ltd to promote Aboriginal and Torres Strait Islander economic participation in the resources, construction and agricultural industries.

The key emphasis of these agreements has been working with industry to identify and address any impediments to Aboriginal and Torres Strait Islander engagement within these industries – either as employees or as sub-contractors on major projects.

In most instances, these memoranda of understanding represent new relationships between the Government and key industry groups and builds on the Queensland Government's commitment to growing a four-pillar economy.

I welcome the decision by the Queensland Resources Council (QRC) to enter into its third successive tripartite agreement with the Queensland and Australian Governments to address Aboriginal and Torres Strait Islander participation in the resources sector.

The QRC agreement is underpinned by action plans focused on the north-west mineral province and the Bowen Basin and supports existing high levels of Aboriginal and Torres Strait Islander participation within this industry.

New memoranda of understanding have also been signed with the Queensland Farmers' Federation and AgForce, both of which are key players in the pastoral, agricultural, horticultural, cane growing and affiliated industries.

These industries present many opportunities for Aboriginal and Torres Strait Islander economic participation, but have had relatively low participation rates in recent years.

Lastly, two agreements have been signed to increase Aboriginal and Torres Strait Islander participation in the Construction Industry.

The first of these agreements is with Construction Skills Queensland, the peak body for this industry, and it focuses on increasing Aboriginal and Torres Strait Islander entry level participation in the building and construction industries and in enhancing access by Aboriginal and Torres Strait Islander businesses to major projects within this sector.

The second agreement – with Leighton Contractors Pty Ltd – represents a partnership with an Industry leader and major employer in the construction sector.

This agreement provides for my Department to work with Leightons to increase opportunities for Aboriginal and Torres Strait Islander businesses and individuals to be employed on major projects undertaken by the company.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 13

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

What is the Newman Government doing to ensure that Queensland's rich cultural diversity is celebrated appropriately across the state and in recognition of the many ethnic and cultural backgrounds which have contributed to Queensland's present?

ANSWER:

Queensland has a richly diverse population, and this government wants to ensure this diversity is recognised and celebrated in appropriate ways across the state.

Cultural celebrations bring Queenslanders from all backgrounds together to celebrate not only our rich cultural diversity, but the aspirations and values that bind us together as one community.

Queenslanders will celebrate their inaugural Queensland Multicultural Week from Saturday 31 August to Sunday 8 September 2013. This is a new week-long celebration of cultural diversity stretching the length and breadth of the state.

Queensland Multicultural Week will support the growth of strong multicultural communities in Queensland by promoting cross-cultural awareness and highlighting cultural diversity as a positive and valuable resource for all Queenslanders.

Funding priorities for the 2012-2013 Multicultural Queensland Partnerships Program included events to be held during Queensland Multicultural Week. The week includes more than 20 community events across the state funded through this annual grants round. The program of events will also feature a regional concert series, the Queensland Multicultural Awards ceremony and the first citizenship ceremony to be held in the new Queensland Multicultural Centre.

In addition to Queensland Multicultural Week activities, in 2012, I approved total funding of $0.65 million for 128 organisations to deliver 134 multicultural events and community projects within the 2013 calendar year across Queensland.

I also approved total funding of $41,000 for nine events and projects that commemorate the 150th anniversary of the arrival of Australian South Sea Islanders in Queensland.

Queenslanders are currently preparing submissions to take part in and celebrate our cultural diversity through a new funding program for multicultural events across the state.

Grants of up to $20,000 are available under the Valuing Diversity Grants Program for multicultural community events to be held in 2014.

Funding for events under the Valuing Diversity Grants program will be available in two categories–Signature Events and Culturally Diverse Events–providing grants up to $20,000 and $10,000 respectively.

These community-based events give us all the chance to share, acknowledge and respect our differences while strengthening understanding of cultural diversity in the wider community.

NAIDOC Week 2013

My department supports our Aboriginal and Torres Strait Islander Queenslanders through many initiatives including the celebration of significant days and weeks throughout the year, including National Apology day, Mabo Day, Reconciliation Week, National Sorry Day and NAIDOC Week.

NAIDOC (National Aborigines and Islanders Day Observance Committee) began in the early 1920s to increase awareness in the wider community of the status and treatment of Indigenous Australians.

NAIDOC Week is a celebration of Aboriginal and Torres Strait Islander cultures, histories and achievements; and an opportunity to recognise the contributions of Indigenous Australians in various fields.

Across the state, we supported many NAIDOC Week events, including the Musgrave Park Family Fun Day, held here in Brisbane. Some of the other significant events which were supported included:

- The official launch and flag raising ceremony, held on Sunday, 7 July at Jagera Arts Centre, 121 Cordelia Street, South Brisbane, in which I attended
- NAIDOC Church Service, Scrub Hill Farm, Hervey Bay, and
- NAIDOC Week Opening celebrations, Tagai Horn Island Campus, Horn Island.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 14

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

What is the Government doing to support a greater appreciation of the state's multicultural diversity, and to recognise those community members who work to achieve that outcome?

ANSWER:

The government appreciates the social and economic benefits multiculturalism has contributed to Queensland through jobs, exports, tourism, cross-cultural exchange and quality of life.

We have all benefited from our state's rich diversity - culturally, socially and economically and the government supports a range of initiatives that promote cultural diversity as a positive and valuable resource for Queensland.

Queenslanders will celebrate their inaugural Queensland Multicultural Week from Saturday 31 August to Sunday 8 September 2013. This is a new week-long celebration of cultural diversity stretching the length and breadth of the State.

In addition to over 20 community events across the state, the program of events will feature the Queensland Multicultural Awards ceremony.

The Queensland Multicultural Awards are a great opportunity to recognise contributions and achievements of individuals and organisations that support strong diverse communities across Queensland. They promote appreciation of the state's multicultural diversity and celebrate work and volunteering efforts that make Queensland a great state.

The nominations are inspirational. From volunteers in leadership roles in community organisations, to those grassroots volunteers whose efforts make a world of difference to those they support, the nominations present a compelling picture of the valuable resource cultural diversity is to the state of Queensland.

This year's winners are sure to come from diverse ages and backgrounds, but they will all have one thing in common - a commitment to achieving cultural harmony and opportunities for those who might be marginalised because of their cultural background.

The 2013 awards will include the recognition of Queensland's first Cultural Diversity Ambassadors. This category recognises community members who have demonstrated an outstanding and sustained commitment to promoting the values of multiculturalism and harmonious community relations.

The addition of an Australian South Sea Islander category this year acknowledges the 150-year anniversary of the arrival of the first South Sea Islanders in Australia and this significant milestone for all Queenslanders. The award will recognise work to promote awareness, recognition and support for Australian South Sea Islanders in Queensland.

While we are operating in a tight fiscal environment, we are determined to support events promoting positive community relations that help Queenslanders realise the long-term social and economic benefits of cultural diversity.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 15

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

What funding is available to support multicultural events across the state to celebrate Queensland's wonderful cultural diversity and to provide opportunities for all Queenslanders to experience the many different cultures which are represented across the state?

ANSWER:

The Queensland Government is committed to strengthening Queenslanders' understanding of the long term economic and social benefits of cultural diversity.

My department's multicultural grants program ensures Queenslanders have the opportunity to celebrate our wealth of cultural diversity through a variety of great events across the state.

In 2012-13, I approved total funding of $0.65 million for 128 organisations to deliver 134 multicultural events and community projects across Queensland in 2013 under the Multicultural Queensland Partnerships Program.

Funding of $88,000 was allocated for 22 diverse cultural events to be held during Queensland Multicultural Week in 2013 - the new week-long celebration of cultural diversity stretching the length and breadth of the State.

I also approved total funding of $41,000 for nine events and projects in 2013 that commemorate the 150th anniversary for the arrival of Australian South Sea Islanders in Queensland.

Under a new funding program announced in June this year, Queenslanders will be able to take part in and celebrate our cultural diversity through multicultural events across the state in 2014.

Funding for events under the Valuing Diversity Grants Program is available in two categories - Signature Events and Culturally Diverse Events - providing grants up to $20,000 and $10,000 respectively.

Signature Events are typically major multicultural events and festivals conducted around the state.

Culturally Diverse Events focus on events which promote broader acceptance and understanding of the culture and heritage of small and emerging cultural communities.

Funding will support celebrations of cultural diversity and the promotion of its benefits to Queensland. It will also promote cohesion and harmony within Queensland's culturally diverse society, and provide opportunities for Queenslanders to participate in a broad range of cultural activities.

These community-based events give us all the chance to share, acknowledge and respect our differences while strengthening understanding of cultural diversity by the wider community.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 16

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

How is the State Government working with Queensland's Australian South Sea Islanders and the communities in which they live to celebrate the 150th anniversary of the arrival of the first Australian South Sea Islanders?

ANSWER:

The 150th anniversary of the arrival of the first Australian South Sea Islanders is a significant occasion, not only for the Australian South Sea Islander community, but for all Queenslanders.

It is an opportunity to celebrate Australian South Sea Islanders' unique culture and the valuable contribution they have made to the economic, cultural and regional development of Queensland, despite hardship, discrimination and disadvantage.

The Queensland Government has been working to ensure the anniversary receives appropriate recognition across the state. This year I have visited Rockhampton, Mackay and Burdekin to promote the anniversary and engage with Australian South Sea Islander community members. A planned visit to Bundaberg had to be postponed because of the floods, but I will be visiting there in the near future. I have also met with an established Australian South Sea Islander group in my own electorate, and with other groups as I have travelled around the state.

Next month, the Premier and I will host a reception at Parliament House to recognise Queensland's Australian South Sea Islander history, their contribution to the state's development, and the contribution the current population continues to make.

I was also able to negotiate with Australia Post for the issue of a commemorative pre-stamped envelope earlier this year to recognise the significance of 2013 for Australian South Sea Islanders.

The Queensland Government provided priority funding for 150th anniversary projects through the Multicultural Queensland Partnerships Program annual grants round. Funding for nine grants totalling $41,000 was provided to support events and projects across Queensland that acknowledge the 150th anniversary, strengthen community capacity or promote awareness of the Australian South Sea Islander community.

Additionally, $9000 was provided to assist the historic Vanuatu-Australian South Sea Islander 150th Anniversary Invitational Rugby League Tour of Queensland in February and March 2013.

The Queensland Government has also worked closely with Australia Post in consultation with members of the Australian South Sea Islander community to develop a special commemorative envelope marking this important milestone.

In acknowledgment of the anniversary, the 2013 Queensland Multicultural Awards have included an Australian South Sea Islander category, recognising work within and for the Australian South Sea Islander community.

The State Library of Queensland, Queensland Museum and Queensland Art Gallery are currently presenting a range of exhibitions and events which mark the contribution of Australian South Sea Islanders to Queensland over the last 150 years. This program runs between June and November this year.

Marking the occasion in a different but lasting way, the Queensland State Archives has successfully nominated 67 items relating to Australian South Sea Islanders for inscription on the United Nations Educational, Scientific and Cultural Organization (UNESCO) Australian Memory of the World Register. This is a significant achievement that I hope will lead to an increase in public awareness of the unique culture and history of Australian South Sea Islanders.

My department is promoting the anniversary and the many community and local government events and initiatives happening around the state on the department's website and I would encourage all Queenslanders to get involved.

HEALTH AND COMMUNITY SERVICES COMMITTEE

2013 ESTIMATES PRE-HEARING

QUESTION ON NOTICE

No. 17

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS (MR ELMES)—

QUESTION:

What processes does the Government have in place to support better and more appropriate programs and services to recognise Queensland's cultural diversity?

ANSWER:

The Queensland Government is committed to maximising the benefits of the cultural diversity of our great state, as well as making sure all Queenslanders can access opportunities and support to get ahead.

The Queensland community is becoming increasingly culturally diverse. According to the 2011 Census, Queensland is home to more than 220 languages, 100 religious beliefs and people from more than 220 countries.

One in five Queenslanders was born overseas and more than one third were either born overseas or have at least one parent born overseas, and one in ten Queenslanders speak a language other than English at home.

This is why my Department is preparing a new Cultural Diversity Policy to ensure we are responsive to genuine community need and in a way that aligns with the Government's priorities. The whole-of-government policy will be part of a new practical approach and commitment to meeting the needs of Queensland's culturally diverse communities and to ensuring all Queenslanders benefit from our cultural diversity.

The Policy will ensure all Queenslanders can access the benefits of our State's cultural diversity, and that everyone living in Queensland has the opportunities to participate in our economy and our community.

In addition to the new Cultural Diversity Policy, we have established the Cultural Diversity Roundtable, comprising key business and community leaders from a diverse range of

religious and cultural backgrounds to provide advice to the Government on opportunities to promote unity and respect across the State.

The Roundtable is chaired by the Assistant Minister for Multicultural Affairs, Mr Robert Cavallucci, and meets bi-monthly.

I am confident that the new Cultural Diversity Policy, programs and projects that will stem from the Policy, and the wise counsel of the Roundtable, will ensure that the needs of our culturally diverse population will continue to be met, and I look forward to continuing to respond to future needs as they evolve.

To ensure Multicultural Affairs Queensland and the government are connected to the views and aspirations of culturally diverse communities a community stakeholder engagement model will be developed this year. The model will include the holding of regular theme-based, and general forums with culturally diverse community leaders in Brisbane and regionally.

Additionally, a program has commenced linking local members of Parliament across Queensland with culturally diverse communities with a high representation in their electorate. The members of Parliament will have direct access to the Minister to raise issues and opportunities presented by their constituents.

To ensure that Multicultural Affairs Queensland has strong and effective regional service delivery a regional service delivery model will be developed. The model will ensure that the department's regional offices and funded programs are working together to achieve the government's outcomes across the State.

For the first time, we will have departmental officers working at a regional level dedicated to the cultural diversity agenda. Two cultural diversity officers will be employed in the South East Queensland regional office of the department, initially on a trial basis, to engage with culturally diverse communities across the region, to work alongside cultural diversity workers employed by NGOs and local government.

Minister for Aboriginal and Torres Strait Islander and Multicultural Affairs

Documents Tabled at the Hearing

Health and Community Services Committee

Tabled 24/7/13

Media release

The Honourable Glen Elmes MP
Minister for Aboriginal and Torres Strait Islander and Multicultural Affairs
Minister assisting the Premier

Cape York Welfare Reform Trial

The Queensland Government has finally welcomed the Cape York Welfare Reform Trial (CYWRT) evaluation report but says the trial in its current form cannot continue.

Minister for Aboriginal and Torres Strait Islander and Multicultural Affairs, Glen Elmes said in its present state the CYWRT will end on the 31st December, 2013.

"This report is more than a year overdue and while it indicated there were positives to take away from the trial it makes no sense to restrict those positive outcomes to just the four trial communities of Aurukun, Coen, Hope Vale and Mossman Gorge," Mr Elmes said.

"The trial achieved some great results in areas of school attendance, the care and protection of children and community safety, but why shouldn't these outcomes be encouraged in all Indigenous communities.

"Yesterday I visited Cherbourg and Murgon where there is no welfare reform trial, but these communities need similar assistance.

"Another positive outcome of the trial was the work of the Newman Government's Family Responsibility Commission (FRC).

"With the support of the local communities, it helped create sustainable employment opportunities, increased parental responsibility and restored social norms.

"The Newman Government is looking at finding practical support mechanisms for Aboriginal and Torres Strait Islander communities to improve the lives of individuals and families and the FRC is one area that we could look at modifying and adopting throughout Queensland.

"We know there are no quick solutions to rectifying the challenges of past decades, and there are still many challenges ahead, but this trial shows what is possible when people take responsibility for their own actions.

"The Newman Government is determined to ensure all Indigenous children have access to a good education, training and employment so they can participate in the wider economy.

"Increasing employment and business opportunities, including home ownership across the entire State are key priorities for us."

The Cape York Welfare Reform trial is a partnership between the Australian and Queensland Governments, the Cape York Institute, regional organisations and the four communities of Aurukun, Coen, Hope Vale and Mossman Gorge.

[ENDS] 27 March 2013 **Media Contact:** Lynette Keep 0419 620 299

Tabled 24/7/13

Townsville Bulletin

Alcohol bans discriminatory: Newman

AAP | February 6th, 2013

QUEENSLAND Premier Campbell Newman says alcohol bans in indigenous communities are "discriminatory" and he'll press on with a review despite a warning from Prime Minister Julia Gillard.

Ms Gillard has used her annual Closing the Gap address to warn her government will act against any state or territory alcohol policy she judges to be irresponsible.

Ms Gillard has told parliament she fears "rivers of grog" are returning to Aboriginal communities.

She held particular concerns about Queensland's review of alcohol management plans in 19 indigenous communities and the Northern Territory government's decision to dismantle a banned drinkers register.

Mr Newman responded by saying alcohol-related problems were not confined to indigenous communities and Australia as a whole had a problem with alcohol.

"I simply say the policy of discrimination against Aboriginal people is not appropriate," he told reporters in Ipswich on Wednesday.

"We need to tackle alcohol abuse issues across the board."

Mr Newman went to the last election promising a review of the plans, which restrict or prohibit the sale and possession of alcohol and carry penalties including jail time for breaches.

Mr Newman said they had not worked to reduce alcohol-related violence.

But his minister for Aboriginal and Torres Strait Islander Affairs Glen Elmes later said there were signs the plans had been effective in reducing crime and boosting school attendance.

Under the review, it will be up to individual communities to decide on the future of the restrictions.

But Mr Elmes has said communities that want to ditch alcohol management plans will have to show they can maintain public safety.

The Newman government's review has attracted some strong criticism, including from leading indigenous academic Professor Marcia Langton who has warned any easing of the bans will threaten lives, especially those of women and children.

In her address on Wednesday, Ms Gillard said indigenous leader Noel Pearson had described the Newman government's plans as a tragedy.

"I call on the Liberal National Party to exercise extreme caution in reviewing remote community alcohol restrictions in Queensland," the prime minister said.

Mr Elmes on Wednesday accused the prime minister of engaging in a vote-grabbing exercise.

"This has got all the feeling to me of trying to buy votes in Sydney and Melbourne and elsewhere rather than truly looking after the best interests of people in indigenous communities," he told ABC television.

He said indigenous communities would only have more access to alcohol if they could make a case that change would not result in increased harm to women and children and lower school attendance rates.

"If those safeguards aren't put in place, than we won't allow any change," Mr Elmes said.

He said it was time for a review and indigenous communities had been asked at the end of last year what changes they wanted, if any.

He said the mayor of Aurukun was in favour of keeping the alcohol management plan in his community.

But Mr Elmes said that did not mean there weren't still issues in Aurukun with home brewing and sly grogging, where a bottle of rum could fetch up to $300.

Minister for Aboriginal and Torres Strait Islander and Multicultural Affairs

Correspondence

Health and Community Services Committee

FRC
FAMILY RESPONSIBILITIES COMMISSION

Family Responsibilities Commission
Cairns Commonwealth Centre
Level 2, 107 Lake Street
PO Box 5438
Cairns Qld 4870

Ph: 07 4057 3870
Fax: 07 4041 0974
www.frcq.org.au

Monday, July 29, 2013

Mr. TJ Ruthenberg
Chairman
Health and Community Services Committee
Parliament House
George Street
Brisbane Qld 4001

Dear Chairman,

I am writing in relation to the Health and Community Services Committee Estimates hearing for the Department of Aboriginal and Torres Strait Islander and Multicultural Affairs on Wednesday July 24, 2013 which commenced at 7.30pm.

I have identified a clarification that I need to bring to the Committee's attention.

On page 96 of Hansard of my Comments read as follows:

"if a person turns up half an hour late in Aurukun, they are marked absent for half a day....."

I have been now informed by the Principal of the Cape York Aboriginal Australian Academy that the position as at the date of the Hearing was;

"If a person turns up half an hour late for school in Aurukun, the precise time of arrival is recorded by Student Case Managers and in all cases where there are patterns of regular late attendance the family is visited to discuss strategies to support parents/guardians to get their children to school on time. Consistent with State-wide practices, half day penalties only apply when a child attends later than two hours of commencement of the school day."

I respectfully request that my comment on this matter be altered to record current practice.

I sincerely apologise to the Committee for my comment as it clearly stated a position which I now know to be incorrect.

I would respectfully ask that my comment be corrected to record the actual position. I would be happy for the Principals comment to be inserted in lieu of my example about Aurukun's School attendance.

Yours faithfully,

David Glasgow
Commissioner

Minister for National Parks, Recreation, Sport and Racing

Answers to Questions on Notice

Health and Community Services Committee

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 1

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to the Minister's responsibilities in relation to North Stradbroke Island at page 3 of the SDS. Can the Minister commit to preparation of the Plan of Management for Peel Island and Naree Budjong Djarra, within the meaning of section 111 of the *Nature Conservation Act 1992* by 30 June 2015, which is the end date for committed funding for the implementation of the North Stradbroke Island Strategy?

ANSWER:

I thank the Committee for the Question.

The State, represented by the Department of National Parks, Recreation, Sport and Racing, is jointly responsible with the Quandamooka People, represented by the Quandamooka Yoolooburrabee Aboriginal Corporation (QYAC) for managing protected areas in the North Stradbroke Island region. This includes joint responsibility for decision making, park planning and management under an Indigenous Management Agreement.

The State has funded the QYAC a total of $2 million with a capacity development grant which can be used towards the development of a land and sea management plan. The State has also funded the employment of a joint management coordinator to facilitate outcomes under the Indigenous Management Agreement on behalf of the QYAC at a cost of $300,000 over three years.

The financial allocation to cover operational expenses associated with implementing joint management on North Stradbroke Island under the Indigenous Management Agreement for the 2012-13 financial year included:

- a total operating budget of $0.96 million, which includes the funding of island-based ranger positions, vehicles, plant and equipment and accommodation;
- regional technical support totalling $0.25 million;
- capital works funding of $0.77 million; and
- other special projects, totalling $0.22 million, including implementation of the Minjerribah Recreation Area.

The department is contractually bound under the Indigenous Management Agreement to prepare a management plan, as per section 111 of the *Nature Conservation Act 1992* for the following Indigenous Joint Management Areas:

- Naree Budjong Djara National Park;
- Naree Budjong Djara National Park (Recovery);
- Naree Budjong Djara Conservation Park;
- Myora Conservation Park;
- Main Beach Conservation Park;
- Teerk Roo Ra National Park; and
- Teerk Roo Ra Conservation Park.

The department has been working with the QYAC to develop a project plan to commence the management planning process. There are a number of planning tasks to be undertaken, including facilitating a park folio workshop with the joint partners, developing an interim management statement, fire management strategy, pest management strategy, and tourism and visitor management strategy, culminating in a protected area management plan. Concurrently with this work, the QYAC propose to develop an Aspirations and Caring for Land and Sea Country Management Plan which will complement the statutory management plan. This is anticipated to be finalised by 30 June 2015.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 2

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to page 3 of the SDS and ask; will the Minister please list, by area, all controlled burn-offs planned for land managed by the Department for this fire season and detail whether each of these burn-offs has been completed, partially completed or cancelled?

ANSWER:

I thank the Committee for the Question.

As at 30 June 2013, for the calendar year the Department of National Parks, Recreation, Sport and Racing, through its Queensland Parks and Wildlife Service (QPWS), has carried out some 97 planned burns over an area of about 254,400 hectares. The amount of burning is less than what is normally expected for this time of the year, due to the adverse seasonal conditions across the State that has impacted on the department's capacity to undertake planned burning.

Due to the extensive nature of the department's planned burning program, a regional summary is provided in the table* below:

QPWS Region		**Available**	**Implemented**	
		(Number)	(Number)	(Hectares)
Regional Operations West	Northern	112	24	27,530
	Central	91	32	209,674
	South West	118	10	8,578
Regional Operations East	Great Barrier Reef Marine	19	17	2,228
	Sunshine and Fraser Coast	120	11	5,661
	South East	129	3	741
	Total	**589**	**97**	**254,412**

As part of a comprehensive planning process, the department annually identifies sections of its parks and forests estate in a rolling program of planned burning for protection and ecological purposes. Priority is given to burns that achieve community protection outcomes, for example hazard reduction burns in protection zones adjacent to urban interface, public recreation areas, and infrastructure.

This forward rolling program identifies desirable burns that have been peer group reviewed and that are ‘ready to go’ as the opportunity arises.

In implementing planned burns, QPWS targets weather conditions optimal to the burn objectives and that minimise risks and impacts of the burn on surrounding communities. The final decision on proceeding with a burn is made on the morning of the proposed burn to ensure that: weather conditions are favourable; pre-burn preparations are satisfactory; and that operational tactics have been refined as necessary.

The rolling program deliberately identifies more planned burns than will be implemented to provide the flexibility for regional staff to continually review, adapt and prioritise their planned burns in consideration of: variable seasonal conditions; localised vegetation growth rates, fuel loads and curing rates, and weather conditions; fire danger rating; fire programs by neighbouring land holders; recent wildfire history; and other factors. Planned burns that are not undertaken are rolled over to the following year’s planned burn program for review.

Planned burning is only one element of the department’s fire season preparedness activities. Other aspects include maintaining an extensive network of fire control lines; maintaining a well-equipped and skilled workforce; continuous upgrading of wildfire response capability; and maintaining systems and databases that support fire management, wildfire response, and reporting.

In regard to 2012/13 Service Delivery Statement performance measures the department met its target of 5% of the parks and forests estate subjected to planned burning under the Fire Management System.

* Table notes:

- Data on planned burns implemented is at 30 June 2013.
- Available planned burns are those that have been peer group reviewed and are available for implementation subject to the range of conditions necessary to achieve the burn objectives, as identified in the burn proposal.
- The Fire Management System utilised by department provides the framework for the planning, approval, implementation and reporting of planned burn activity.
- Planned burns often serve multiple purposes.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 3

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to NPRSR SDS page 2 will the Minister list all the sporting events he attended where he was the guest in a corporate box including the company that invited the Minister and any government stakeholder in attendance?

ANSWER:

I thank the Committee for the Question.

As the Minister for National Parks, Recreation, Sport and Racing I attend a number of sporting events, a small number of them as an invited guest in a corporate box.

One of the first actions of the Newman Government was to remove the long-held taxpayer funded corporate box gravy train utilised by former Labor Ministers and their Labor mates.

As part of the Newman Government's commitment to restore accountability in government, Ministers' monthly diaries, including mine, are published on the Cabinet website. These diaries include details of events I attend in my portfolio, such as sporting events.

I also note that the Opposition Office obtained a version of my diary under Right to Information application number 12-351.

I thank the hosts of events I've attended for their invitation and hospitality. As an invited guest, not a host unlike former Labor Ministers, I am not privy to a list of other guests in attendance.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 4

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

With reference to NPRSR SDS page 18 will you list all the grant and infrastructure funding to the benefit of Rugby League related programs for the year 2011-12, 2012-13 and expected 2013-14?

ANSWER:

I thank the Committee for the Question.

Page 18 of the SDS relates to an increase in Sport and Recreation grants totalling $3.8 million. These grants are estimated to increase in 2013-14 mainly due to the deferral of expenditure in relation to the Newman Government's Get in the Game program where grants have been awarded and announced to recipients, however not all expenditure was expended in 2012-13 with payments also dependent on recipients achieving contractual milestones.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 5

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

With reference to page 87 of the Capital Statement and capital works in Blackbraes National Park; will the Minister confirm if these capital programs are in response to the Government's decision to allow grazing in Blackbraes National Park? Further for all five national parks and eight national reserve properties will the Minister provide (a) a breakdown of all funding allocated to allow grazing (b) a list of specific capital projects required to facilitate grazing and (c) any income the Government is forecast to receive from graziers for the use of the protected area estate including agistment fees and contribution towards capital expenditure?

ANSWER:

I thank the Committee for the Question.

The Department of National Parks, Recreation, Sport and Racing undertakes a wide range of capital works projects across its estate each year. Blackbraes National Park has been a focus in recent years. The fencing works delivered at this Park have proven to be particularly timely, given the extraordinary drought and animal welfare crisis being experienced in northern and western Queensland. The works in the Capital Statement were approved prior to the Government's decision to assist the drought affected graziers.

(a) In response to the crisis, this Government announced that five national parks and eight National Reserve System properties would be opened up for cattle suffering drought hardship. To ensure that these parks and reserves are able to contain cattle and to minimise possible environmental impacts, I approved a maximum allocation of $0.5 million to support the delivery of urgent capital improvements such as boundary fencing and infrastructure for conservation benefit. All other costs are to be borne by the graziers.

    It is possible that only a portion of this allocation will be spent. Areas were selected due to a number of factors including their previous grazing histories and, as such, infrastructure such as some fencing, bores and windmills are still present. A full breakdown of all funding cannot be provided as many projects are still in the planning phase and the full extent of works is not yet known.

(b) Priority fence repairs are likely at Moorrinya, Blackbraes, Nairana and Mazeppa National Parks. Some fencing works are required on the National Reserve System properties although many of the fences on these lands are in good condition due to recent and current grazing operations.

The most significant fencing project currently underway is the boundary fence at Moorinya which will prevent cattle from wandering onto the Aramac Torrens Creek Road on the eastern boundary of the Park. This fence will both protect cattle and drivers on this well used country thoroughfare.

Cattle exclusion fences are also being built at Moorrinya and Blackbraes National Parks to protect areas of high conservation value and the historic "Shirley Homestead" at Moorrinya. At Nairana and Mazeppa National Parks repairs to boundary fences and internal fences will benefit long term conservation management programs to control the invasive buffel grass.

(c) The Government is not charging agistment fees to drought affected graziers out of compassion for their dire financial and emotionally difficult situation. While the grazier is not required to pay agistment fees, they are required to pay all other expenses associated with the movement and management of cattle under the permit.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 6

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

With reference to page 20 of the SDS and the budgeted financial statements of the Department; will the Minister provide the amount of revenue collected from user charges at each National Park listed individually?

ANSWER:

I thank the Committee for the Question.

User charges revenue collected across the State is managed through centralised financial systems covering multiple tenures, funding classes and permits types. These centralised financial systems increase efficiency and reduce duplication allowing more funds to be utilised for park management.

As such, budget and reporting information is undertaken collectively rather than categorised down to each permit type and location throughout the State.

The exception to this is for six Recreation Area Management locations in accordance with s230 of the *Recreation Areas Management Act 2006*, where revenue collected in 2012-13 was:

Recreation Area Management Location	2012-13 Revenue Collected ($)
Green Island	613,725
Cooloola	2,050,333
Fraser Island	3,717,015
Inskip Point	925,795
Moreton Island	786,719
Bribie Island	1,184,458
TOTAL	9,278,045

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 7

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

With reference to page 5 of the SDS which shows a significant underspend in the racing industry; will the Minister account for this $26 million underspend, and provide an itemised breakdown of the 2012-13 and 2013-14 racing budgets?

ANSWER:

I thank the Committee for the Question.

Please refer to my answer to Estimates Pre-Hearing Question on Notice No. 17.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 8

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

What provision has the Minister made for increased distribution of prize money for horse racing, harness racing and dog racing in Queensland, beyond that which is in the budget documents?

ANSWER:

Under the *Racing Act 2002* (the Act), the Queensland All Codes Racing Industry Board, trading as Racing Queensland, is the approved control body for the three codes of racing in Queensland.

Under the Act, the Minister may not to direct the all-codes board in regard to prize money allocations. Racing Queensland is the body responsible for prize money allocations.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 9

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

What is the Sports Minister's current plan to link major sport events to tourism in Queensland, along the lines of the Victorian model?

ANSWER:

I thank the Committee for the Question.

This matter falls under the Minister for Minister for Tourism and Major Events, Small Business and Commonwealth Games' portfolio. I refer the Committee to the relevant Minister.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 10

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

What provisions have been made to ensure that all horses, both recreational and commercial, have achieved a set level vaccination for Hendra virus in Queensland by 30 June 2014?

ANSWER:

I thank the Committee for the Question.

This matter falls under the Minister for Agriculture, Fisheries and Forestry's portfolio. I refer the Committee to the relevant Minister.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 11

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to the SDS, particularly the Income Statement which shows an increase in user charges revenue attributed to in the notes as 'predominantly relates to National Parks' compensation payments received for access to state forests under the *Petroleum and Gas (Production and Safety) Act 2004* and the *Forestry Act 1959*.'

Will the Minister outline which state forests revenues are received from, the type of activity and the amount derived from each activity and why this has increased so significantly from the 2012-13 Budget to the 2012-13 Estimated Actual?

ANSWER:

I thank the Committee for the Question.

The Department of National Parks, Recreation, Sport and Racing receives compensation from the petroleum and gas industry for the impact of any industry activities carried out on land that is managed by the department.

Compensation is paid on a per hectare basis for activities including the installation of gas wells and well pads, gas and water pipelines, roads and access tracks. The terms of compensation agreements are confidential.

State forests and timber reserves impacted by coal seam gas activities to date include Barakula, Beilba, Belington Hut, Boondandilla, Braemar, Brucedale, Combabula, Condamine, Daandine, Doonkuna, Dunmore, Emu, Expedition, Forrest, Gurulmundi, Hallett, Hinchley, Kumbarilla, Stephenton, Targinie, Trinidad 1, Ula Ula; Western Creek and Yuleba State Forests and Callide Timber Reserve.

The increase in revenue is the result of the department receiving compensation payments made in advance during 2012-13.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 12

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to the LNP's election policy commitment of $16 million over 3 years for the Get in the Game program.

Can the Minister outline how the government has increased this commitment to a total of $47.8 million over the three years?

ANSWER:

I thank the Committee for the Question.

The first round of programs under the Get in the Game initiative were well received by grass roots sport and recreation clubs and families, with demand far exceeding initial budget allocations for the programs.

The Department of National Parks, Recreation, Sport and Racing received 928 applications requesting over $6.8 million from the *Get Going* program, 243 applications requesting $18.57 million from the *Get Playing* program, and the first allocation of 6,000 vouchers under *Get Started* were issued in the first six days. This led to increasing the budget for the first round of *Get Started* from $900,000 to $1.8 million, so an additional 6,000 children and young people could be supported by the Program.

To meet future program demands, which will always be high due to the nature of the industry being mostly volunteer-run not-for-profit sport and recreation community organisations, the department realigned funding programs not supporting grassroots sport and recreation clubs, programs that were deemed to be a duplication of funding, and identified services being discontinued.

No funding programs have been cut. The budget to support the increase in this commitment has been identified from programs that have wound up, including the Sport and Recreation Active Inclusion Program, Sport and Recreation Infrastructure Program and long term commitments that will run their course over the next two financial years.

These changes have enabled the department to deliver a more streamlined approach to supporting sport and recreation by providing programs that are simpler and more efficient, and increase the investment to groups and individuals at the grassroots level who need it most.

In 2013-14, the increased funding will allow approximately 25,000 vouchers to be provided under the *Get Started* program. Round 2 of the Program opened on 15 July 2013, and on the first day almost 3,000 vouchers were issued to eligible children and young people. The department anticipates the number of vouchers issued under this round will exceed the first round, providing more than 12,000 vouchers across Queensland.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 13

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to the Capital budget statement, in particular note 2 relating to the "Kerra-Lyn" vessel. Are there any other vessels currently being commissioned?

What is the total project cost of these vessels and when are they expected to commence operations?

What savings, if any, will be achieved by the commissioning of these new vessels?

ANSWER:

I thank the Committee for the Question.

The Department of National Parks, Recreation, Sport and Racing, through the Queensland Parks and Wildlife Service, owns and maintains a fleet of vessels to conduct field operations in the marine environment. In fulfilling this responsibility, in the 2012-13 financial year the department has commissioned four new replacement vessels. In addition to this, the department has signed a contract for the construction of a new 24-metre long range patrol vessel.

These particular vessels patrol the Great Barrier Reef Marine Park as part of the Great Barrier Reef Field Management Program, and are jointly funded by the Queensland Government and the Commonwealth Government. A key objective associated with the procurement of these new vessels was to provide fit for purpose vessels (with the capacity to safely and effectively undertake multiple roles in a wide range of sea conditions) while minimising on-going and whole of life costs.

The four new vessels commissioned in 2012-13 were secured on time and on budget at a total cost of $1.15 million. These vessels are based at Cairns, Airlie Beach (two vessels) and Yeppoon.

The performance of these vessels has met and exceeded project objectives, significantly improving the service delivery capacity of the Great Barrier Reef Field Management Program. The new vessels can operate in more difficult weather conditions, substantially increasing efficiencies through the program's 'days at sea' capacity, and have provided on-going cost and maintenance efficiencies.

Construction has commenced on the new 24-metre vessel to replace the “Kerra Lyn” and the new vessel is expected to be delivered on time and on budget in April 2014. This new vessel will be the largest and most technologically advanced vessel in the Queensland Government fleet. Importantly, this is a project that supports the employment of Queenslanders and our State’s economy.

The new vessel will improve operational capacity and efficiencies with state of the art design and technologies including the capability to operate at more than twice the speed for the same fuel consumption as the vessel it is replacing, which translates to less travel time to achieve its objectives. It is also equipped with solar power modules supporting critical systems, further reducing on-going operational costs.

The new vessel will have a range of up to 2,000 nautical miles, an ability to operate away from port for up to 12 weeks and capacity to carry up to 16 staff overnight. It is also able to carry two smaller craft which can work independently of the main vessel.

The department is continuing to monitor its fleet composition with respect to current and future on-water service delivery requirements to ensure the fleet is fit for purpose and provides efficient and effective operations. The procurement of these new vessels, supported with sound business planning and improved service delivery efficiencies, has allowed the department to reduce its fleet by seven vessels – this is a 14 per cent reduction over the 2012-13 financial year, providing further savings.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 14

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to the changes in performance measures outlined in the SDS. What changes were made to these performance measures and why?

ANSWER:

I thank the Committee for the Question.

In developing its 2013-14 performance measures, the Department of National Parks, Recreation, Sport and Racing ensured its key departmental priorities were represented and measured either efficiency or effectiveness of services delivered by government.

This represented a significant change in the department's key areas of focus as shown by the fact that only three of the 10 measures in the 2012-13 Service Delivery Statement, were retained:

- Delivery of visitor and tourism facility and park management infrastructure projects on Queensland Parks and Wildlife Service (QPWS) managed estates, as measured by the capital works activity index;
- Percentage of athletes selected for national teams from the Queensland Academy of Sport; and
- Participant satisfaction with the department's sport and active recreation programs.

For the National Parks service area, two new performance measures have been developed:

- By measuring the percentage of the Protection and Wildfire Mitigation Zones prescribed burning target achieved on QPWS managed estate to protect life and property, the department is demonstrating it is directing its efforts to protect key community interests; and
- By measuring the percentage of the QPWS managed estate prescribed burning target achieved to protect life, property and biodiversity, the department is following the recommendation of the 2009 Victorian Bushfires Royal Commission that a 5 per cent target for prescribed burning of the State should be established. The department aims to achieve at least 80 per cent of the recommended 5 percent burn in 2013-14.

For the Recreation and Sport service area, two new performance measures have been developed:

- By measuring the ratio of elite athlete direct coaching and specialist services costs to administration support costs will demonstrate the department's efficiency in its service delivery; and
- By measuring the percentage of young people who access the Get Started program becoming new members of sport and recreation clubs the department demonstrates its programs are increasing the number of children and young people for whom sport and recreation is now affordable.

For the Racing service area, two new performance measures have been developed to reflect the department's key areas of focus:

- Percentage of the *Racing Act 2002* annual assessment non-compliance issues resolved within required timeframes relates to governance oversight; and
- Percentage completed and reported within 10 working days relates to timely delivery of licensed racing animal drug samples analysis results.

Some of the measures published in the 2012-13 Service Delivery Statement remain of operational significance, and information on these will continue to be collected and reported in the department's Annual Report.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 15

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to the variation in the balance sheet in particular increases in cash assets relating to the Curtis Island Environmental Management Precinct of $20.9 million.

What is the source of this funding and will it be recurrent?

How much is to be expended per annum and are there any conditions on this expenditure?

ANSWER:

I thank the Committee for the Question.

The $20.9 million in cash assets for the management of the Curtis Island Environment Management Precinct represents funds transferred from the Coordinator-General to the Department of National Parks, Recreation, Sport and Racing.

The Coordinator-General originally received and held these funds as an upfront financial contribution from the four liquefied natural gas (LNG) proponents for the management of the precinct.

Deeds executed between the State and each of the LNG proponents commits the LNG proponents to contribute towards the management of the precinct over the next 25 years.

The contributions comprised of an initial upfront contribution of $5 million from each LNG proponent. The contributions are not recurrent, however the department can seek additional contributions should this initial amount be exhausted before the end of the 25 year term. The cash assets currently held by the department includes this initial upfront contribution from each proponent and an additional $0.9 million accrued in bank interest while the funds were held by the Coordinator-General.

The Deeds commit the State to use the funds on conservation and visitor management activities on and around the precinct. A publically consulted Curtis Island Environmental Management Precinct Land Management Plan will guide management activities on the precinct and includes actions such as conducting fire and pest control programs, upgrading vehicle access tracks and improving visitor facilities.

It is anticipated that the first three years of management will have a higher level of annual expenditure, at approximately $2 million per annum, to address a number of outstanding environmental issues relating to historical rubbish dumping and poor vehicle track alignments. Annual recurrent expenditure will likely be in the vicinity of $1.2 million.

The department was assigned the State's responsibilities under the Deeds in 2013, acknowledging its expertise in delivering land management activities and its existing field capacity and role in managing other areas of Curtis Island.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 16

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to the Sport and Recreation Disaster Recovery Program. How much was expended on this program in 2012-13? What were the sources of this funding including funds reallocated from other programs?

ANSWER:

I thank the Committee for the Question.

Queensland was affected by disaster events in early 2013, particularly by ex-Tropical Cyclone Oswald and the associated flooding, heavy rain and winds, which left a major impact on local grassroots sport and recreation clubs. These events resulted in a total of 54 local government areas being declared for support from the Natural Disaster Relief and Recovery Arrangements.

The Sport and Recreation Disaster Recovery Program provides assistance of up to $25,000 to local sport and recreation organisations to re-establish facilities and activities following a natural disaster. The most recent round also allowed affected clubs to seek assistance with developing mitigation strategies to reduce future impacts from natural disasters. The Program was released on 10 February 2013 and closed on 15 April 2013.

The program had an initial budget of $1 million, which was exhausted after six weeks.

Due to the significant level of damage experienced by sport and recreation organisations, the department prioritised funding for this program. Through prudent financial management, almost $2.9 million was identified for redirection to support affected clubs across Queensland.

Funding of almost $3.9 million has been approved to assist 226 affected sport and recreation clubs across Queensland to get back to providing sport and recreation services to their local communities. The Minister initially approved funding for 227 sport and recreation clubs; however, one organisation lapsed its approved grant due to insurance covering the total cost of repairs.

As at 30 June 2013, just over $3.7 million of this funding was paid.

Sport and recreation clubs play an important role in bringing local communities together. The additional funding allocated to this program ensured that every club eligible for assistance was able to recover, repair and mitigate for future disasters.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 17

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to the Racing Industry Capital Development Scheme, in particular $26.6 million being deferred. What is the total allocation for this program and when will the full list of projects be made available?

ANSWER:

I thank the Committee for the Question.

The Racing Industry Capital Development Scheme is a $110 million approved funding program.

Racing Queensland is responsible for submitting business cases to the Government, seeking funding for projects under the Industry Infrastructure Strategy. All expenditure is subject to final approval of individual project business cases by the Government under the Industry Infrastructure Strategy.

There has been no deferral of approved projects from 2012-13. The amount of $26,643,000 identified in the Service Delivery Statement has been deferred to out-years to better reflect forecast expenditure. This is expected to be allocated to projects identified in business cases to be provided by Racing Queensland.

A total of $7,225,775 has been allocated to approved projects in 2013-14. These projects are:

Project	2013-14 ($)
Gold Coast Turf Club Phase One	4,564,155
Toowoomba Turf Club	2,661,620

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 18

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to the outsourcing of management of the Active Recreation Centres. Who are the successful proponents of the tender process? What savings will this measure achieve?

ANSWER:

I thank the Committee for the Question.

The Department of National Parks, Recreation, Sport and Racing has recently completed an open market process to identify new operators for the Leslie Dam, Magnetic Island and Yeppoon Active Recreation Centre sites.

The department received a very positive response to the expression of interest process with a range of organisations registering their interest to operate the sites.

The department is currently negotiating lease arrangements with the successful operators, which are expected to be finalised by late July 2013.

I recently announced the successful operators for each of the sites.

YMCA of Brisbane is the successful operator for the Leslie Dam site. YMCA proposes to use the site for school camps, sport coaching clinics, music groups and activities for disadvantaged young people, hire of facilities by community and corporate groups, plus trade shows and events. The site is seen as a good fit with YMCA's business, which is a well proven and established organisation.

Apex Queensland Youth Camps is the successful operator for the Magnetic Island site. Apex proposes to use the site for camps for school children and other opportunities for community and corporate groups, with potential for visitors to be taken on excursions with a focus on marine/reef and environmental education activities. Apex has operated Apex Camp Mudjimba on the Sunshine Coast for over 30 years with good experience in operating outdoor education centres.

Police-Citizens Youth Club (PCYC) is the successful operator for the Yeppoon site. PCYC proposes to use the site for youth development for North Queensland with adventure based learning and development activities and school, sport and community group camps. PCYC is a well-established organisation with strong experience in running youth development centres.

The new operators will assume full responsibility for operating the sites including meeting all operating, maintenance and capital upgrades costs.

The 2012-2013 State Budget identified that these alternative management arrangements will realise the Queensland Government estimated savings of $2.9 million over three years.

The open market process represents an excellent outcome for local communities and other users with the sites opening for business in the near future.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 19

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to the Get in the Game Get Started vouchers program. What is the administration cost of delivering these vouchers and what measures, if any, were undertaken to reduce this cost?

ANSWER:

I thank the Committee for the Question.

Get Started is one of three programs which form the Government's $47.8 million Get in the Game initiative. *Get Started* assists children and young people who can least afford or may otherwise benefit from joining a sport or recreation club.

Get Started grants are administered through the Office of State Revenue's (OSR) QGrants system. This system will provide a 'one stop shop' to members of the public and community organisations applying for Queensland Government funding, which should reduce the costs of administering funding programs across multiple agencies.

The benefits of using QGrants for *Get Started* are that both clubs and parents/guardians are able to apply online, and approved payments are processed automatically. OSR quotes the cost of processing a grant payment electronically as $0.04 per payment. This is a recognised saving on the manual payment process undertaken by the Grants Administration team in Sport and Recreation Services. The Queensland Commission of Audit Report quotes this cost as being $0.58 per $100 payment (i.e. $0.87 for a $150 *Get Started* voucher).

A review was conducted at the conclusion of round one to improve the efficiency of *Get Started*. One of the key recommendations was to work with OSR to improve system functionality. These changes were implemented prior to the release of round two and will reduce the impact on internal resources.

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES PRE-HEARING
QUESTION ON NOTICE

No. 20

asked on Tuesday, 2 July 2013

THE HEALTH AND COMMUNITY SERVICES COMMITTEE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

I refer to the Queensland Government's Expression of Interest for ecotourism facilities on and near national parks. How much revenue does the government anticipate these facilities will generate for national park management?

ANSWER:

I thank the Committee for the Question.

The Queensland Government is committed to growing tourism as a key pillar of our four pillar economy. An integral part of this commitment is to make Queensland a world-leading ecotourism destination by 2020.

On 18 April 2013, the Parliament passed changes to the *Nature Conservation Act 1992* to allow private ecotourism facilities on national park. Following this legislation change, the Government released an Expression of Interest process seeking new, innovative and sustainable ecotourism investment proposals on and adjacent to national parks. This Expression of Interest opened on 27 June 2013 and will close at 5pm on 27 September 2013.

As part of this Expression of Interest and following the legislation changes an Implementation Framework was developed and released for community consultation. This implementation framework provides a robust and transparent model for the assessment and approval of proposals for ecotourism facilities on national parks. It recognises that any proposed ecotourism facilities will have environmental, social and financial benefits and costs that need to be considered when assessing each proposal, and that assessment needs to occur in the context of the governing legislative provisions.

The framework informs potential investors and the broader community on how the department will assess ecotourism facility proposals, the matters that will be considered, and the approval and leasing arrangements for successful proposals.

I look forward to informing the Committee of proposed ecotourism investment initiatives following the assessment of Expressions of Interest received.

Minister for National Parks, Recreation, Sport and Racing

Questions taken on Notice at Hearing and Responses

Health and Community Services Committee

HEALTH AND COMMUNITY SERVICES COMMITTEE

ESTIMATES
QUESTION TAKEN ON NOTICE AT THE HEARING

No. 1

asked on Wednesday, 24 July 2013

MR BYRNE ASKED THE MINISTER FOR NATIONAL PARKS, RECREATION, SPORT AND RACING (MR DICKSON)—

QUESTION:

How much disease testing is being undertaken to sample potential sources within national park feral animal populations? Is Biosecurity Queensland involved? What diseases are considered to be problematic and are being actively screened for?

ANSWER:

I thank the Member for the Question.

Biosecurity Queensland and the Australian Quarantine and Inspection Service have undertaken exotic animal disease testing on national parks in the past as part of federal and state surveillance programs and the Queensland Parks and Wildlife Service support such work where requested.

Biosecurity Queensland is the lead agency in Queensland for exotic animal disease testing, monitoring and response across all tenures. Biosecurity Queensland falls under the portfolio responsibilities of the Minister for Agriculture, Fisheries and Forestry.

Minister for National Parks, Recreation, Sport and Racing

Correspondence

Health and Community Services Committee

Hon Steve Dickson MP
Minister for National Parks, Recreation,
Sport and Racing

QUEENSLAND GOVERNMENT

Level 7
111 George Street Brisbane 4000
Box is 15187 City East
Queensland 4002 Australia
Telephone +61 7 3224 7477
Facsimile +61 7 3012 7725
Email NPRSR@ministerial.qld.gov.au

25 July 2013

Mr Trevor Ruthenberg MP
Chair
Health and Community Services Committee
Parliament House
George Street
BRISBANE QLD 4000

Dear Mr Ruthenberg

I write to you regarding the Estimates Hearing for the portfolio of National Parks, Recreation, Sport and Racing held on 24 July 2013 by the Health and Community Services Committee. Upon reviewing the Hansard Proof from the Estimates Hearing I have identified a clarification that I would like to bring to the Committee's attention.

I understand my office have already submitted a number of minor corrections to the Hansard Proof.

The below clarification relates to the transcript on page 106 of the Hansard Proof in relation to expenditure on stadiums.

Attributable to myself (**Mr DICKSON**):

"Last year we spent $37 million keeping our Queensland stadiums running."

The published budget in 2012-13 for Sport and Recreation Services funding to Stadiums Queensland was $27.481 million. The revised budget was $26.231 million.

The $37 million I was referring to was the published budget for the 2011-12 financial year when we came into office in 2012. The published budget was $37.300 million. The revised budget was $35.621 million

I would ask that this additional information be provided with the Committee's final Estimates Report. I hope this information is of assistance to you. Should you have any further enquiries, please contact Ms Johanna de Winter, Chief of Staff in my office on telephone 3224 7477.

Yours sincerely

Steve Dickson MP
Minister for National Parks, Recreation, Sport and Racing

Hon Steve Dickson MP
Minister for National Parks, Recreation,
Sport and Racing

QUEENSLAND GOVERNMENT

Level 7
111 George Street Brisbane 4000
Box Is 15187 City East
Queensland 4002 Australia
Telephone +61 7 3224 7477
Facsimile +61 7 3012 7725
Email NPRSR@ministerial.qld.gov.au

30 July 2013

Mr Trevor Ruthenberg MP
Chair
Health and Community Services Committee
Parliament House
George Street
BRISBANE QLD 4000

Dear Mr Ruthenberg

I write to you regarding the Estimates Hearing for the portfolio of National Parks, Recreation, Sport and Racing on 24 July 2013, by the Health and Community Services Committee. I understand my office have already submitted a number of minor corrections to the Hansard Proof however I have identified the following clarifications that I would like to bring to the Committee's attention. The clarifications are attributable to myself.

Page 105 'Queensland is blessed with over 12.5 million hectares of national parks, marine parks, and other reserves protecting a unique and diverse array of landscapes, species, ecotourism systems, our rich Indigenous culture and heritage, and five World Heritage listed areas – more than any other state or territory'.

As marine parks are additional to the 12.5 million hectares described, I request 'marine parks' be removed from the record. I also request the Committee amend the record from 'ecotourism systems' to 'eco systems'.

Page 106 'In June together with my colleague the Hon. Jann Stuckey, Minister for Tourism, I called for expressions of interest for a new and innovative concept to showcase Queensland's national parks and grow a four-pillar economy'.

It was my intention to discuss the government's call for more than one expression of interest, and I request that the Committee approve that the record reflect this by amending 'for a new and innovative concept' to 'for new and innovative concepts'.

Page 107 'This government is rejuvenating country racing by allocating $4 million to country racing over the next four years', beginning in 2012-13'.

As the rejuvenation of the country racing industry began in 2012, I request the Committee approve 'the next' be removed to read 'over four years'.

Page 108 - 'Mr Chairman, I think the word 'you' should not really be used. It is a parliamentary term'.

It was my intention to state 'you' is not a parliamentary term, and I believe I said it during the Hearing. I request the record be amended to 'It is not a parliamentary term'.

Page 111 'It has just come to my attention that there have been 6,244 vouchers in the first ten days since the opening on 15 July this year, so I think that is a ringing endorsement of success that I am hearing relating to Get in the Game, and I will use this as an advertising tool'.

I would like to clarify to the Committee that there were 6,244 vouchers were applied for in the first ten days, and I request that 'applied for' be inserted between 'vouchers' and 'in'.

Page 114 'I have been told there are four million cats Australia-wide, so please forgive me'.

It was my intention to clarify that I had been advised there are fourteen million feral cats Australia-wide. I request the Committee approve the insertion of fourteen million feral between 'are' and 'cats'.

I would ask that these clarifications be accepted by the Committee and provided included in the final Estimates Report. Should you have any further enquiries, please contact Mrs Lisa Myers in my office on 3224 7477.

Yours sincerely

Steve Dickson MP
Minister for National Parks, Recreation, Sport and Racing

FINAL PAGE