METRO SOUTH HEALTH

Service Plan of two clinical streams – Surgical services and Aged care and rehabilitation services

Service Directions

May 2013
Our Vision:
To positively impact people’s lives by helping create better health services.

Our Mission:
To use our management consulting skills to provide expert advice and support to health funders, service providers and users.
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## Abbreviations

<table>
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABIOS</td>
<td>Acquired Brain Injury Outreach Service</td>
</tr>
<tr>
<td>ACAT</td>
<td>Aged Care Assessment Team</td>
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<tr>
<td>ALOS</td>
<td>Average length of stay</td>
</tr>
<tr>
<td>BIRS</td>
<td>Brain Injury Rehabilitation Service</td>
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<tr>
<td>BIRU</td>
<td>Brain Injury Rehabilitation Unit</td>
</tr>
<tr>
<td>CSCF</td>
<td>Clinical Service Capability Framework</td>
</tr>
<tr>
<td>DEMOS</td>
<td>Dementia Outreach Support</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>GEM</td>
<td>Geriatric Evaluation and Management</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HHS</td>
<td>Hospital and Health Services</td>
</tr>
<tr>
<td>HITH</td>
<td>Hospital in the Home (hospital substitution service)</td>
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<tr>
<td>HMA</td>
<td>Healthcare Management Advisors</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
</tr>
<tr>
<td>MBNCU</td>
<td>Moreton Bay Nursing Care Unit</td>
</tr>
<tr>
<td>MSH</td>
<td>Metro South Health</td>
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<tr>
<td>MS PMMS</td>
<td>Metro South Persistent Pain Management Service</td>
</tr>
<tr>
<td>PAH</td>
<td>Princess Alexandra Hospital</td>
</tr>
<tr>
<td>QEII</td>
<td>Queen Elizabeth II Jubilee Hospital</td>
</tr>
<tr>
<td>QSCIS</td>
<td>Queensland Spinal Cord Injuries Service</td>
</tr>
<tr>
<td>RACF</td>
<td>Residential Aged Care Facilities</td>
</tr>
<tr>
<td>SIU</td>
<td>Spinal Injury Unit</td>
</tr>
<tr>
<td>SPOT</td>
<td>Spinal Outreach Team</td>
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<tr>
<td>TCP</td>
<td>Transition Care Program</td>
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</tbody>
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Introduction

1.1 BACKGROUND

Metro South Health (MSH) covers the regions of Brisbane (south of the Brisbane River), Logan, Redlands and the eastern portion of the Scenic Rim, an area of approximately 3800 km². Of the 17 Hospital and Health Services (HHSs) established in Queensland in July 2012, MSH has the largest population - approximately 1 million people (approximately 22% of Queensland’s population) and had the largest purchasing agreement with Queensland Health of $1.6 billion (approximately 16.5% of the total $9.7 billion allocated by Queensland Health in HHSs purchasing agreements).

The majority of the MSH population catchment resided in the Brisbane LGA (58%) or, from a physical facility perspective, the Princess Alexandra / Queen Elizabeth II Jubilee hospital catchment area (50%). The small part of the Scenic Rim LGA that falls into the MSH catchment comprises only 1% of the MSH population.

MSH facilities and services include hospital services, community and primary health services, mental health services and oral health services. MSH includes the following public hospital services:

- Princess Alexandra Hospital (PAH)
- Queen Elizabeth II Jubilee Hospital (QEII)
- Logan Hospital
- Beaudesert Hospital
- Redland Hospital
- Wynnum Hospital.

At the PAH, MSH provide state-wide specialist services for:

- Acquired Brain Injury, including an Acquired Brain Injury Outreach Service (ABIOS)
- Amputee Limb Service
- Spinal Injury Unit including a Spinal Outreach Team (SPOT)
- Transplantation including liver, kidney, bone, cartilage and corneas.

1.1.1 Surgical services

Surgical services are offered at five of the six MSH hospitals: PAH, QEII, Logan, Redland and Beaudesert (note that although general surgical services are offered at Beaudesert Hospital, actual surgery (in theatre) does not currently occur at this hospital), but the case mix (type, complexity) and volume vary significantly between hospital sites.

PAH has the highest volume of surgery of the five hospitals and is the only quaternary hospital in the catchment (providing the only state-wide liver and kidney transplant services in Queensland). PAH is the largest of the hospitals both in physical size and volume of services.
1.1.2 Aged care and rehabilitation services

Hospital rehabilitation programs

Rehabilitation services provided in hospital include a mix of:

- Post-operative rehabilitation provided in outpatient clinics
- Sub-acute rehabilitation provided in a designated rehabilitation unit,
- Sub-acute rehabilitation provided by ‘clinical intent’ in situ in the acute wards (e.g. at Redland Hospital)
- Specialised state-wide rehabilitation services through the Division of Rehabilitation at PAH – the Brain Injury Rehabilitation Service (BIRS) and Queensland Spinal Cord Injuries Service (QSCIS).

Post-operative rehabilitation via outpatient clinics are available at all hospitals providing surgical services. For patients who received surgery at Redland Hospital, some outpatient clinics are physically provided at Wynnum Hospital.

The Division of Rehabilitation also provides outpatient amputee rehabilitation through the Amputee Clinic and persistent pain management and rehabilitation through the Metro South Persistent Pain Management Service (MS PPMS).

Community services

MSH is responsible for a range of community services including: Aged Care Assessment Team (ACAT) services; the Community Adult Rehabilitation Service (CARS), transitional care programs (TCP), chronic disease, post-acute, hospital substitution services (HITH) and residential aged care facilities (RACFs).

Residential Aged Care

MSH has a 128 bed RACF co-located at Redland Hospital. The facility provides a multidisciplinary approach to care and residents, relatives, carers and other health professionals are involved in the individual care planning process. The service operates within a maintenance framework in the frail aged and dementia units, and a recovery / rehabilitation framework in the psychogeriatric unit (Daintree).

1.2 PURPOSE OF THIS REPORT

The purpose of this document is to present the MSH Service Directions for two clinical streams: Surgical Services and Aged Care and Rehabilitation Services.

This document is supported by detailed Context and Demand Analysis provided in a separate technical paper.

1.2.1 Service direction development

MSH engaged Healthcare Management Advisors (HMA) to undertake the service planning project. The service planning was undertaken in three main stages:

1) Stakeholder consultation (see Appendix A)
2) Data analysis of QHAPDC data and Hardes modelling data (see Context and Demand Analysis technical paper)
3) Stakeholder workshop to refine draft service directions (see Appendix B).
2 Overarching MSH principles

This chapter presents the agreed Overarching MSH Principles developed to guide development of the Service Direction. These principles align with Queensland Health Policy and MSH Strategic Directions (2012-2016). These Principles have been categorised as ‘short term priorities’ for implementation.

Short term priorities

Business model:

1. MSH is the main public health service provider in the Brisbane South, Redland and Logan–Beaudesert region.
2. MSH provides community health services for rehabilitation, oral health, mental health and screening services.
3. Residential aged care is not the core business of MSH. However, MSH is committed to providing appropriate ‘specialised’ services for residential aged care.
4. MSH will continue to support and encourage academic relationships through research programs and centres of excellence, as well as joint appointments with universities.

Catchment:

1. MSH recognises itself (including hospitals and community health services) and its people as one catchment.
2. People in the MSH catchment should be able to receive best possible service within the catchment, and where possible at their local hospital.
3. MSH will develop a centralised waiting list across the catchment for specialist outpatient services to better manage demand and waiting lists times.
4. MSH will continue to appoint clinical staff (including medical, nursing and allied health) in a conjoint fashion between at least 2 MSH hospitals to promote continuity of services across the catchment. MSH will also encourage public-private joint appointments of staff e.g. with the Mater or Greenslopes private hospitals. IT support needs to be developed to better manage payment of conjoint appointment to reduce the administrative burden.

Model of care:

1. MSH will undertake clinical redesign reviews to improve access to services and improve the patient journey.
2. MSH will implement new and innovative models of care to manage the growth in per capita health expenditure to ensure that health services and outcomes are affordable and sustainable.
3. MSH will work to develop models of care that promote hospital avoidance where possible/appropriate.
This chapter presents the agreed Service Directions for the Surgical Services clinical stream. There are four service directions, grouped by service planning categories: model of care; where / role delineation and relationships; and volume / size.

**Model of care**

<table>
<thead>
<tr>
<th>Service Direction #S1: Increase number of same day procedures, where appropriate and feasible. If significant volumes of additional day surgery are identified by clinicians, MSH should:</th>
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<tr>
<td>• prioritise the development of day surgery units at PAH (by commissioning infrastructure already in existence); and</td>
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<tr>
<td>• review costs to develop a day surgery unit at Logan (once the new ED development is complete) and compare this with the costs of public-private partnerships for day surgery and/or outsourcing day surgery to private providers.</td>
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**Timeframe:** Short to medium term priority

**Notes**
QEII is already building an endoscopy day surgery centre that will increase the capacity of its surgical theatres.
Where / Role delineation and Relationships

**Service Direction #S2:** Create and manage a central waiting list for a) all outpatients and b) identified surgical services and procedures. MSH will work with hospitals and the Medicare Local to develop:

- a central referral process for GPs, which will include criteria for acceptance on a specialty by specialty basis (where possible), building on existing referral criteria.
- a mechanism to feedback information to GPs when their patients were not accepted to a waiting list and why.
- a mechanism to facilitate allocation of procedures across MSH hospitals based on complexity, waiting times / demand and appropriate list structure (e.g. mix of complex and less complex surgeries on one list).
- a process to review waiting lists and re-allocate patients if required to other MSH hospitals.
- a screening process for patients referred for specific types of surgery (e.g. back surgery) which have high proportions of patients not requiring actual surgery. This should build on the screening processes trialled for patients referred for back surgery.

**Timeframe:** *Short term priority*

**Notes**

Examples of hospitals roles would be:

- ENT – PAH and Logan
- Vascular Access – PAH, QEII and Logan
- Urology – PAH, QEII and Redland (outpatients only)
- Simple general surgery – PAH, QEII, Logan and Redland
- Colorectal surgery – PAH and QEII
- Back surgery (orthopaedics and neurology) – PAH, QEII and Logan
- Joint replacements (orthopaedics) – PAH, QEII, Logan and Redland
- Carpal tunnel decompression (orthopaedics) – PAH, Logan and Redland
- Ophthalmology – PAH, QEII and Redland
- Facial skin cancer (plastics) – PAH and Redland

**Service Direction #S3:** Development of suitable IT to support operation of the centralised waiting list.

**Timeframe:** *Short term priority*
### Volume / size

<table>
<thead>
<tr>
<th>Service Direction #S4:</th>
<th>Promote greater levels of self-sustainability across non-tertiary MSH hospitals (QEII, Logan Hospital and Redland Hospital) where appropriate (up to the appropriate CSCF level for the hospital).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timeframe:</strong></td>
<td><em>Short to medium term priority</em></td>
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</table>
4 Service Directions – Aged Care and Rehabilitation Services

This chapter presents the agreed Service Directions for the Aged Care and Rehabilitation Services clinical stream. There are ten service directions, grouped by service planning categories: model of care; volume / size; where; and role delineation / relationships.

Model of care

**Service Direction #ARI:** Develop a model of care for Geriatric Evaluation and Management (GEM) within MSH. The model of GEM will be developed as a joint-collaboration between the Geriatric and Aged Rehabilitation Teams and the General Medicine Teams, as follows:

- A multidisciplinary team for management of GEM patients will be established to be led by a Geriatrician and include a geriatric nurse, allied health (e.g. physiotherapy, occupational therapy, dietician) and general medicine staff.

- A review of potential GEM patient volume will be undertaken to identify which hospitals will warrant establishment of a GEM unit with dedicated beds, and those that will operate GEM teams within the sub-acute rehabilitation units. Benchmarking estimates a current need for approximately 270 GEM beds in the catchment, as follows: 160 at PAH; 28 at QEII; 57 at Logan Hospital and 25 at Redland Hospital (based on a ratio of 16.25 GEM beds per 100 acute beds).

**Timeframe:** Short to medium term priority

**Notes**

Development will require collaboration between sub-acute rehabilitation units and general medicine units to ensure services are not duplicative and that patients are identified early, transferred at the appropriate time and that there is potential for medical consults within the GEM unit as required.

Efficiency gains from developing a GEM model of care include a reduced ALOS for general medicine beds, reduced bed-block in the acute settings and the interdisciplinary approach will be beneficial for the health outcomes of patients.

To be efficient, there will need to be a critical mass of patients to warrant development of a GEM unit. There are likely to be sufficient patients at PAH and Logan Hospital to develop a unit at these hospitals. Where there are not sufficient patients to develop a dedicated GEM unit, the GEM model of care should be implemented through the use of a multidisciplinary team without forming a specific unit. Actual number of GEM beds required should be calculated based on benchmarks from other jurisdictions (e.g. Victoria) or from estimates based on current potential population.
Service Direction #AR2: Develop new inpatient rehabilitation sub-categories within MSH for:
- aged rehabilitation (e.g. 65 years plus).
- working age / adult rehabilitation (e.g. aged under 65 years).

Timeframe: Short to medium term priority

Notes
The rehabilitation goals of working age people are more likely to focus around functional goals to be able to return to work and therefore will be more intensive in nature and timelines. Rehabilitation goals for ‘aged’ rehabilitation are more likely to focus on returning to a level of functioning to support independent living.

Creating a distinction between the two types of rehabilitation allows for different staffing models to be allocated, if required.

The distinction between aged rehabilitation and working age rehabilitation is particularly important at PAH where there is a significant amount of trauma care management for people under 65 years.

In developing the distinction in the models of care, care should be taken to allocate patients to the type of rehabilitation required rather than an allocation based simply on age (e.g. some people aged greater than 65 may still be working and physically capable of undertaking work orientated goals for rehabilitation).

Volume / size

Service Direction #AR3: MSH will work to address the current and expected future short fall in inpatient rehabilitation beds (not including GEM or state-wide services) in a staged approach as follows:
- address aging infrastructure of inpatient rehabilitation at PAH campus and Wynnum Hospital through most economical option (short term).
- address the current shortfall of inpatient rehabilitation beds (estimated at between 30 to 50 beds, concentrated in the Logan-Beaudesert and Redland areas) through:
  - development of additional inpatient rehabilitation beds at Logan Hospital (24 beds planned in the new development) (short term).
  - development of new inpatient rehabilitation beds at Redland Hospital (short to medium term).

Timeframe: Short to medium term priority

Notes
Queensland Health has inpatient adult rehabilitation estimates based on the population of the catchment areas of 19.3 beds per 100,000 weighted adult population (or 29.7 beds per 100,000 population-unweighted) in 2011. Using this benchmark an estimate of 307 inpatient rehabilitation beds in the MSH catchment is required. MSH inpatient rehabilitation services
currently provide 119 beds (76 at PAH, 28 at QEII and 15 at Wynnum Hospital). It is also estimated that non-MSH hospitals provide approximately 141 beds (mostly located in the PAH-QEII catchment area – estimate number of beds as follows: 45 beds at Greenslopes Private Hospital, 48 beds at Mater Private Hospital South Brisbane, 20 beds at Sunnybank Private Hospital, 8 beds at Canossa Private Hospital, 15 beds at St Vincent’s Private and 5 beds at Mater Private Hospital Redland). Therefore, based on the Queensland Health population based benchmark for subacute rehabilitation beds, there is an estimated shortfall of 48 inpatient rehabilitation beds. The shortfall is estimated to be greater in the Logan-Beaudesert area (in the order of 90 beds based on population), with an oversupply of 87 beds in the PAH / QEII catchment due to the private hospitals in this area.

Other benchmarks estimate need based on hospital output. A ‘rule of thumb’ estimate of inpatient rehabilitation bed requirements based on hospital output is 8.75% to 10% (based on information from a Victorian\(^1\) and Queensland\(^2\) hospital, respectively). Using this type of benchmark, there is a current shortfall of approximately 25 to 35 inpatient rehabilitation beds in the MSH catchment, mostly in the Logan-Beaudesert area, with a small oversupply at QEII.

**Service Direction #AR4:** Review the estimated inpatient rehabilitation shortfall in 5 years to assess the impacts of the new models of care. If a significant shortfall is still observed (say, over 40 beds), MSH should look to implement the most economical option to obtain more beds (e.g. invest in infrastructure and new beds, public private partnership for new beds, or purchase of beds/services from the private sector).

**Timeframe:** Medium term priority

**Notes**

The shortfall estimates listed above in Service Direction #AR3 only articulate the current shortfall in inpatient rehabilitation beds. As the population of the catchment grows, so too does the estimated shortfall in inpatient rehabilitation beds up to 160 beds by 2021 (based on Queensland Health population benchmark of 19.3 beds per 100,000 weighted adult population (or 34.64 beds per 100,000 population-unweighted)). This shortfall is predicted to be greatest in the Logan-Beaudesert area (up to 135 beds) and Redland area (65 beds), with a small over-supply in the PAH-QEII area (oversupply of 40 beds).

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\(^1\) Personal discussion with Sue Race - Divisional Director Subacute & Aged Care Services, Western Health (March 2013).

\(^2\) Personal discussion with Assoc Prof Paul Varghese –Director of Geriatric Medicine, Princess Alexandra hospital (April 2013).
Service Direction #AR5: MSH will advocate to the Department of Health for a review of state-wide rehabilitation services (Brain Injury Rehabilitation Unit (BIRU) and Spinal Injury Unit (SIU)) to assess need for additional state-wide services in other Queensland locations. In doing so a review should also assess:

- demand and future demand for services at the PAH location and the potential impact on bed numbers.
- demand and future demand for adult disability services (e.g. people under 65) for people suffering from debilitating conditions e.g. neurodegenerative diseases or young people with head injuries.

Timeframe: Short term priority

Service Direction #AR6: MSH will look to improve patient flow through BIRU and SIU by:

- increasing the capacity of the Brain Injury Rehabilitation Day Unit (BIRD) and strengthening links to community service to reduce the ALOS for patients in the BIRU;
- examining the cost-effectiveness of developing a model for slow stream rehabilitation for spinal injury and brain injury patients in the MSH catchment
- reviewing the current governance arrangements for Casuarina Lodge.

Timeframe: Medium to long term priority

Notes

State-wide services at PAH are the Brain Injury Rehabilitation Unit (BIRU) and the Spinal Injury Unit (SIU). These are the only state-wide services of this nature in Queensland and run at 95%-100% occupancy. As the population and demand has increased over the last few years, it has been increasingly difficult for the BIRU and SIU to meet demand, resulting in long waiting times for patients.

Most jurisdictions (e.g. Vic, NSW and SA) have at least two state-wide services for Brian Injury Services. The size of Queensland (in geographic terms and in population density) would warrant an additional Brain Injury Unit, which is consistent with Queensland state-wide trauma planning (2006) which stated that development for rehabilitation for trauma services should be enhanced at the PAH BIRU as well as the development of other services throughout Queensland.3

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Where

**Service Direction #AR7:** GEM and inpatient rehabilitation should be co-located with an acute facility (if possible).

**Timeframe:** Short to medium term priority

**Notes**

PAH and QEII have co-located inpatient rehabilitation units (76 beds and 28 beds, respectively), but inpatient rehabilitation services in Redland are located in a stand-alone facility (Wynnum hospital, 15 beds), and Logan Hospital does not have any official sub-acute beds (although 24 inpatient rehabilitation beds are planned in the current on-site development).

Benefits to having sub-acute beds co-located with an acute facility are the ability to efficiently transfer patients from the acute to the sub-acute setting with minimal transport costs, plus the ability to co-manage patients who are borderline medically stable with the acute clinicians.

To maximise the efficiency of patient flow from the acute to the sub-acute setting, an ‘assessment’ team to identify appropriate patients in the acute setting is required.

**Service Direction #AR8:** Reduction of aged care residential beds by MSH appears appropriate for the current population demands of the catchment. The location of the Redland Residential Care facility is appropriate in the short to medium term. However, long term planning may need to consider the possibility of moving the facility to a more centralised location.

**Timeframe:** Short to medium term priority

**Notes**

There are currently 5,686 residential aged care beds (high and low care) in the Brisbane South catchment (for the purposes of this planning exercise, only the Brisbane South Catchment has been considered). Current Aged Care Planning benchmarks are 91.3 residential beds per 1,000 aged 70 plus. In the Brisbane South catchment, this represents approximately 61,449 people. Applying the aged care planning benchmarks indicated that prior to the closure of Moreton Bay Nursing Care Unit (MBNCU), the Brisbane South catchment was oversupplied in residential aged care beds at 101%. After the closure of MBNCU, this dropped to 99%. This small variation down could be managed by:

- the possible sale of MBNCU bed licences to other providers
- the release of additional bed licences to meet population growth by DoHA (this is currently set at an additional 988 residential aged care beds for the Brisbane South region that have been allocated but are not yet operational).

As MSH is providing a ‘specialised’ service for residential aged care, there is not a strong case for relocating the existing physical infrastructure. However, it is noted that competing priorities for the physical space at Redland Residential Care may provide overall economic incentive to re-locate the facility in the future.

The 70 plus population of Redland LGA is expected to growth at a higher rate than the Brisbane (South) LGA. However, actual numbers of people aged 70 plus are currently (and
expected to remain) higher in Brisbane compared to Redland. Although there is no clinical necessity to have the Residential Aged Care Facility co-located with an acute facility, it is sensible to maintain the Redland Residential Facility in the short to medium term considering the fabric is of reasonable quality having been recently constructed. In future, it may be worthwhile to investigate more centralised locations for a residential aged care facility in the longer-term.

**Service Direction #AR9:** MSH to review the population demand for residential aged care services, compared to the services available in say five years’ time (2018), to assess whether this has implication for MSH’s new role focusing on ‘specialised’ residential aged care.

**Timeframe:** Medium term priority

**Notes**
This will allow for the effects of current systemic changes at the national and local level to stabilise, for example:
- the move to provide only specialised residential aged care services by MSH
- the reduction in overall bed numbers for MSH residential aged care services
- implementation of additional support services to the private sector by MSH (e.g. Dementia Outreach Support)
- the Living Longer. Living Better National aged care reforms.

**Relationships / Role delineation**

**Service Direction #AR10:** Maintain dementia outreach support to private sector Residential Aged Care Facilities (RACFs) to improve hospital avoidance for patients and to increase the capability of private facilities to take patients with difficult/challenging behaviours (that may otherwise create a bed block in the acute system).

**Service Direction #AR11:** Establish a Cognitive Assessment and Management Unit, of up to 8 beds, at Redland Residential Care for the admission of patients from Residential Aged Care Facilities who are demonstrating severe behavioural and psychological symptoms of dementia.

**Timeframe:** Short term priority
Notes
The Dementia Outreach Support (DEMOS) program provides individualised training and support to private RACFs in the MSH catchment with the aim of up-skilling private RACF staff to better manage difficult patients, reduce unnecessary hospital admissions, reduce private RACF refusal to take difficult patients and hence reduce the demand for ‘last resort’ aged care residential beds.

The DEMOS program has shown good results to date and it is planned to expand the service to two outreach teams (up from one team). DEMOS program will review in an ongoing fashion the types of training and supports needed and provided.

The establishment of a Cognitive Assessment and Management (CAM) Unit at Redland Residential Care will enable DEMOS staff to provide short term alternative accommodation to RACF residents which will support intensive management of their severe behavioural and psychological symptoms of dementia.

| Service Direction #AR12: Improve access to and integration of community-based aged care and rehabilitation services across the continuum of care. |
| Timeframe: Short term priority |

Notes
Current community-based aged care and rehabilitation services in MSH are fragmented, with different eligibility criteria and different staff mixes as a result of ad hoc funding arrangements.

A review of the current services should be undertaken to determine opportunities to improve access to these services and to better integrate with acute and primary care services.
## APPENDIX A  STAKEHOLDER CONSULTATIONS

<table>
<thead>
<tr>
<th>Metro South Health Executive</th>
<th>Consultation date</th>
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<tbody>
<tr>
<td>Brett Bricknell</td>
<td>19/12/12</td>
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<tr>
<td>Executive Director, Logan-Bayside Health Network</td>
<td></td>
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<tr>
<td>Dr Jennifer King</td>
<td>18/12/12</td>
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<tr>
<td>Executive Director, PAH- QEII Health Network</td>
<td></td>
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<tr>
<td>Dr Susan O’Dwyer</td>
<td>18/12/12</td>
</tr>
<tr>
<td>Executive Director, Medical Services</td>
<td></td>
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<tr>
<td>Veronica Casey</td>
<td>18/12/12</td>
</tr>
<tr>
<td>Executive Director, Nursing and Midwifery Services</td>
<td></td>
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<tr>
<td>Gail Gordon</td>
<td>19/12/12</td>
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<tr>
<td>Executive Director, Allied Health Services</td>
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### Surgical Services

#### Princess Alexandra Hospital
- Professor Stephen Lynch  
  Chair, Division of Surgery, PAH  
  17/1/13 (teleconference)
- Sean Birgan  
  Director of Nursing, Division of Surgery, PAH  
  19/12/12
- Helen Werder,  
  Assistant Director of Nursing (Theatre) PAH  
  30/1/13
- Dr Chris Joyce  
  Director of Intensive Care Unit PAH  
  5/3/13

#### Logan Hospital
- Edwina Conroy  
  Nursing Director, Division of Surgery, Logan Hospital  
  13/2/13 (teleconference)

#### QEII Hospital
- Dr Sanjeev Naidu  
  Director of Surgery, QEII Hospital  
  31/1/13

#### Redland Hospital
- Dr Jack Ashworth  
  Director of Surgery, Redland Hospital  
  6/3/13
- Mellissa Knox  
  Nursing Director - Surgical, Redland Hospital  
  29/1/13
- Lorraine Stevenson  
  Director of Nursing and Midwifery  
  29/1/13

### Aged Care and Rehabilitation Services

#### Princess Alexandra Hospital
- Dr Tim Geraghty  
  Chair, Division of Rehabilitation, PAH  
  19/12/12
- Kate Wood  
  Director of Nursing, Division of Rehabilitation, PAH  
  19/12/12
- Dr Paul Varghese  
  Director, Geriatric and Rehabilitation Unit, PAH  
  19/12/12
- Professor Len Gray,  
  Director of the Centre for Research in Geriatric Medicine at the University of Qld and staff geriatrician at PAH  
  12/3/13 (teleconference)

#### QEII Hospital
- Dr Amanda Siller  
  Director, Geriatric and Rehabilitation Unit, QEII Hospital  
  5/3/13
Residential Aged Care (RACF, Dementia Outreach Service and new Cognitive Assessment and Management Service)

Ms Margaret Broomfield  
Director of Nursing, Residential Aged Care Services  
Moreton Bay Nursing Care Unit, Wynnum  
5/3/13

Community Aged Care (Transition Care Program, Aged Care Assessment Teams, Community Rehabilitation)

Narelle Jenke – Acting Director of Aged Care, Community and Primary Health Services, arranged Meetings with: ACAT managers – Monica Barrett and Loretta; TCP program managers – Kathy Viggenbine, Wendy Marshall and Lyn Garner; HACC Manager – Brett Jones; Community Rehabilitation (Allied Health) Manager – Michelle Currin.  
29/1/13

APPENDIX B  WORKSHOP ATTENDEES

Surgical Services – 9:30-11:30am Tuesday 16 April 2013

<table>
<thead>
<tr>
<th>Surgical Service Workshop</th>
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<tbody>
<tr>
<td>Dr Jennifer King</td>
<td>Executive Director, PAH- QEII Health Network</td>
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<tr>
<td>Gail Gordon</td>
<td>Executive Director, Allied Health Services</td>
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<tr>
<td>Professor Stephen Lynch</td>
<td>Chair, Division of Surgery, PAH</td>
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<tr>
<td>Sean Birgan</td>
<td>Director of Nursing, Division of Surgery, PAH</td>
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<tr>
<td>Dr Brian McGowan</td>
<td>Director of Surgery, Logan Hospital</td>
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<tr>
<td>Dr Sanjeev Naidu</td>
<td>Director of Surgery, QEII Hospital</td>
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<td>Dr Gerald Holtmann</td>
<td>Director of Gastroenterology, Metro South Health</td>
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<td>Mike Kerin</td>
<td>Director, QEII Hospital</td>
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<tr>
<td>Paula Foley</td>
<td>Project Officer, Division of Surgery, PAH</td>
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<td>Tania Hobson</td>
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<tr>
<td>Anthony Peet</td>
<td>Program Manager, Health Service Planning, MSH</td>
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Aged Care and Rehabilitation Services – 11:00am-1:00pm Wednesday 17 April 2013

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<tr>
<th>Aged Care and Rehabilitation Workshop</th>
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<tr>
<td>Brett Bricknell</td>
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<tr>
<td>Executive Director, Logan-Bayside Health Network</td>
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<td>Dr Tim Geraghty</td>
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<tr>
<td>Dr Paul Varghese</td>
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<td>Director, Geriatric and Rehabilitation Unit, PAH</td>
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<tr>
<td>Ms Margaret Broomfield</td>
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<td>Director, Community Aged Care Services</td>
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<tr>
<td>Kay Toshach</td>
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<td>Executive Director, Planning, Engagement and Reform</td>
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<td>Sally Taranec</td>
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<td>Stream Leader, Patient Flow, Ambulatory Care and Hospital Avoidance</td>
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<td>Narelle Janke</td>
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<td>Nursing Director, Hospital Avoidance</td>
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<tr>
<td>Elisa Underhill</td>
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<td>Calcutta Group (observer)</td>
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<tr>
<td>Belinda Jacobsen</td>
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<td>Senior Planning Officer, West Moreton HHS (observer)</td>
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