EXHIBIT 261

West Moreton Hospital and Health Service

TURNAROUND PLAN SERVICE REVIEW PROPOSAL

The Park-Mental Health Rehabilitation and Allied Health Services Review

30 October 2012

DOCUMENT HISTORY

Version	Date	Prepared by	Comments
First Draft v1	23/10/12	Tawanda Machingura	Reviewed, feedback considered
Final Draft v2	26/10/12	Tawanda Machingura	Consultation and Review
Final	30/10/12	Tawanda Machingura	Submitted to Sharon Kelley

THE PROPOSAL

1. Proposal Details

1.1 Background (including current functions and structure)

The review of the Mental Health Rehabilitation Model at the Park Centre for Mental Health was sponsored by the Executive Director of Mental Health and the Executive Director of Allied Health and supported by the West Morton District Consultative Forum *(Consultation Paper Attachment 10, dated 27 July 2012).* The aim of the review is to realign rehab and allied health services at the Park to ensure accountability to consumer treating team enabling recovery.

The reviewer was specifically asked to;

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

The service review was conducted by a Programme Manager/ Director of Allied Health Services at the Park Centre for Mental Health. .

The reviewer was a newly recruited leader of the rehabilitation and allied health workforce at the Park. The reviewer initially put together a working group that consisted of all the rehabilitation coordinators and allied health seniors at the Park. An action Plan was then developed (Appendix 1). A total of six weeks was spent conducting the review whilst attending to day to day management and clinical activities required of the role.

Rehabilitation and Allied Health Staff from the service and other stakeholders were invited to participate in the review and were offered group and individual sessions with the reviewer. The aim was to ensure that all stakeholders were provided the opportunity to participate. A consumer survey was conducted during the review period to gather the views of consumers. In addition to this, the reviewer accessed relevant literature and supporting documentation as detailed further in the body of the report. During this time a number of activities were conducted:

- Visits to the units
- Survey of client satisfaction with rehab and allied health
- Attendance at ward round
- Meetings with groups of staff, including allied health staff, nursing staff, medical staff and rehabilitation staff
- Individual meetings with staff
- Attendance at the rehabilitation team planning day
- Meetings with other key staff, including the Clinical Directors, Nursing Directors, clinical nurse consultants, team leaders, consumer advisors, consumer companions, the state benchmarking team and discipline seniors
- Review of relevant documentation, including policies, procedures and work instructions, a pre-commissioning and planning document, clinical files, benchmarking data and previous service reviews.

Review of the current rehabilitation service

The rehabilitation model was reviewed and rewritten for the new tertiary service and for the interim services while the new facility was being built. The project ran between October 1999 and January 2000. It was in response to this project that the current model of service was established.

The Rehabilitation Service is comprised of three multidisciplinary teams responsible for the development delivery and evaluation of a comprehensive range of rehabilitation programmes. These programmes respond to consumer needs in the High Security Inpatient Service, Secure Mental Health and Rehabilitation Unit (Medium Secure) and Extended Treatment and Rehabilitation. While the Rehabilitation Service was established in order to coordinate and lead the development and delivery of rehabilitation interventions in each of The Park's clinical programmes, it is not intended to be the sole provider of rehabilitation which is widely documented as a responsibility of all staff.

The main strengths of the current rehab service are the diversity, flexibility, creativity and commitment of its staff as well as having a team with a dedicated focus in rehabilitation. Having a multidisciplinary team working together, ensures that rehabilitation programs remain a priority and are delivered consistently to consumers. The availability of the rehab team to all wards across the campus promotes mostly recreation activities and prevents boredom, idleness and general ill health. There are also some psycho educational and living skills programs provided to those who are at a similar cognitive level or who require specific learning needs.

However there are a number of weaknesses. Firstly the rehabilitation services have taken on board more than what they can realistically provide. The expectation that the few rehab staff on board are responsible for individual rehabilitation programmes of all clients at the Park is unrealistic. In ET&R for example rehabilitation staff took over the role of supervising clients in activities of daily living relating to personal hygiene and home maintenance when they had as much as 3 times the current staffing levels. There is also a perception that the rehab team is a multidisciplinary team and has the range of skills and capacity required to provide rehabilitation to all clients. In reality the current rehab teams are essentially allied health teams and/ or a few nurses and nonprofessional staff.

The program developed by the rehabilitation team includes a variety of activities and shows some engagement with a several community support agencies. The graph below shows the number of activities provided by each team in 2012:

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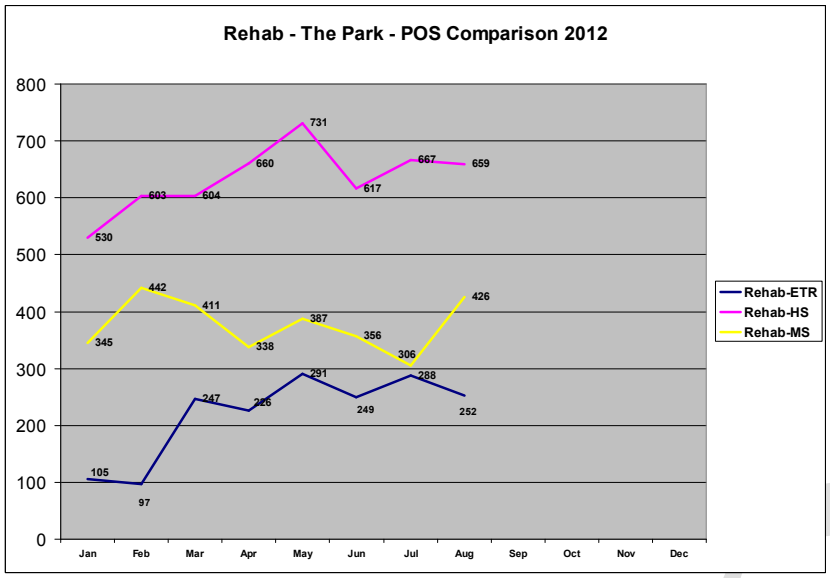
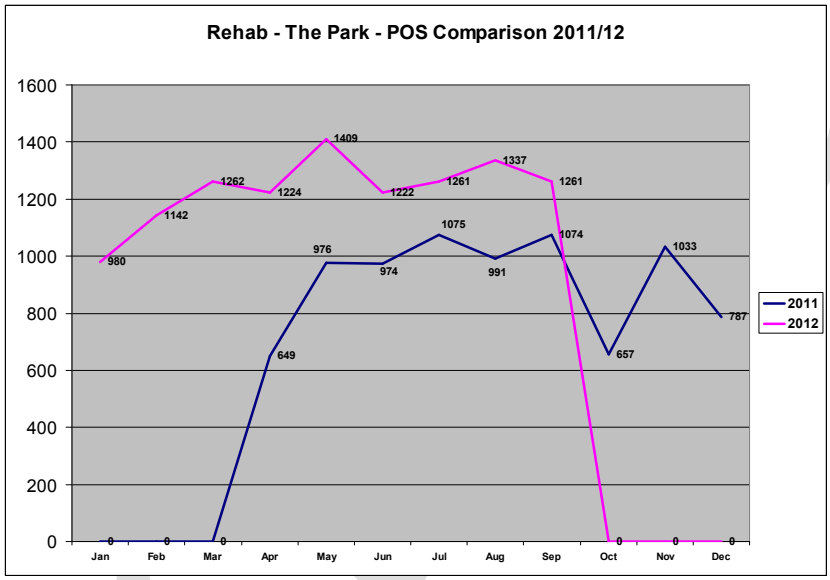
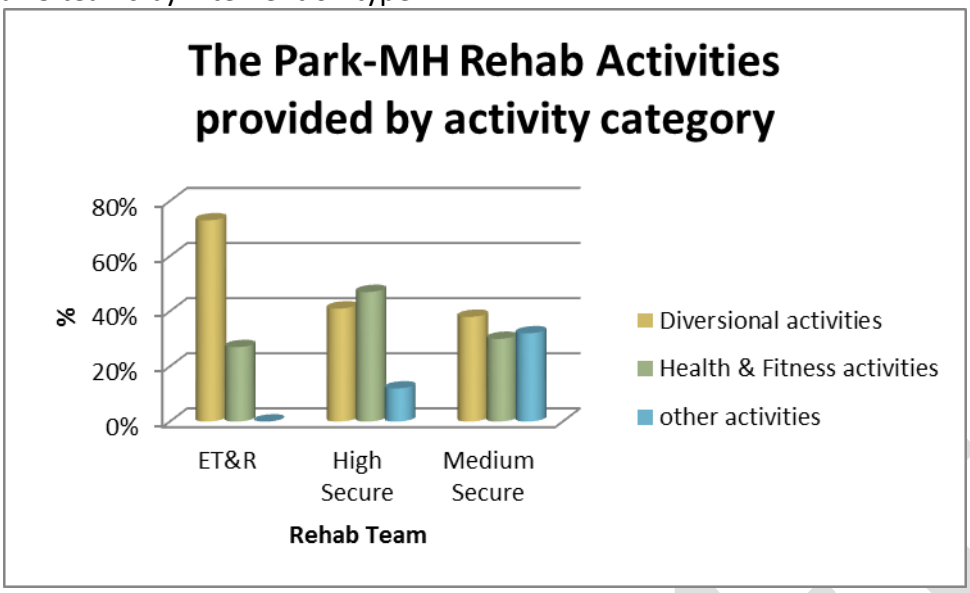


POS data also show that the number of activities provided has been increasing. Comparison of 2011 and 2012 data show a significant increase in the quantity of activities provided by the Rehab team. It is possible however that the increase could be reflecting increased compliance with recording POS data in CIMHA rather than an increase in activity. The graph below shows that number of activities provided has increased;



However, the existing activity program is not adequately structured to meet all individual clients' needs. Activities provided are mostly recreational with other categories of activities being unavailable to consumers. The graphs below show the number of activities provided

by all 3 teams by intervention type:



While the model was intended to be integrative, it was consistently reported in stakeholder interviews that the clinical and rehabilitation teams now work largely in isolation of each other.

In mid 2012 the Rehabilitation Service initiated the development of a survey to establish consumer satisfaction with the current service provision of the rehabilitation service and to identify opportunities for improvement. The then Rehabilitation Service Coordinator facilitated the development of the survey with the assistance of consumer consultants, rehabilitation service staff and Service Education and Research Unit (SERU).With the draft of the existing survey recently finalised, the newly convened allied health leadership team agreed to use this instrument to inform the service review. Minor amendments to the survey were made to invite feedback about allied health services. Results from this survey indicate that;

- Consumers who completed the survey were generally positive about the services they receive from allied health and rehabilitation staff. This was reflected in a number of compliments with respect to allied health and rehabilitation services.
- Respondents reported spending more time with rehabilitation staff than their allied health counterparts each week. However, a request to increase the range and availability of rehabilitation programs was a strong theme of consumer feedback.
- Some consumers identified a lack of access to allied health staff. Some respondents attributed this to what they saw as a significant workload for allied health staff.

One of the strengths of the rehabilitation service to date has been its capacity to consistently provide a service to consumers. Dismantling the existing rehab structure carries the significant risk that programmes may no longer be consistently delivered. If a comparable level of service is to be maintained a new structure would need to support the delivery of these services.

Review of Allied Health services

Allied Health functions as part of a multidisciplinary-team service and provides discipline-specific assessment, case conceptualisation and interventions (e.g. psychological assessments of symptoms, risk, cognition, and personality, and development of evidence-based interventions). Allied Health staff utilise a multidisciplinary specialist level of skills and contribute to conceptualisation of complex functioning of consumers, collaborate with each other, and assist other health professionals (e.g., nursing, medical and rehab services) in diagnostic clarification, behaviour management support, and holistic treatment planning.

Clinical Allied Health staff are operationally managed by the respective Business Unit Director, or their delegate, which has historically been the Discipline Senior (HP5). Cost Centre management is retained by the respective Business Unit Directors

The clear strength of the Allied Health is that the staff operate from a multi-disciplinary perspective and deliver discipline specific work (individual and group-based). Staff therefore draw upon, and integrate, strengths from their own respective disciplines. They also support other teams (e.g., nursing team, the Rehabilitation Services team) in the management of patients on and off ward. Most importantly, the Allied Health staff deliver an advanced level of care with minimal supervision, while also supervising postgraduate students completing their clinical placements at MSU.

However, some of the weaknesses of Allied Health are that they do not maximise on each of their disciplines' strengths and resources for better client outcomes. For instance there is a small number of examples of allied health staff leading group programmes although this skill set is available. There are also very few shared processes between allied health disciplines. Allied Health leadership is limited to single disciplines as a result they are not always well represented and lobbied for (partly due to small numbers of allied health professionals and also due to absence of allied health professionals in management roles on the units). The division between allied health professionals between the two teams (allied health and rehabilitation services) further perpetuates this small presence. Lastly allied health staff do not fully utilise the Queensland Health statewide mental health electronic medical record/ database, CIMHA in a consistent manner. CIMHA could be used to input their POS (provisions of service) contacts, NCRAs (non consumer related activities) or clinical notes. There is therefore no easily accessible information on allied health staff activities that could potentially be used for lobbying for resources, benchmarking, research and could improve communication with other teams (The Park) internally and/or externally (other HHS districts).

General Health Services Allied Health Staff

The allied health positions in General Health Services are currently managed by the Director of Clinical services and provide a service across all units at the Park. The General Practice Nurse (CNC) at General Health Services (GHS) currently operationally supervises the Podiatry position ie signs the leave forms, organises locums and co-ordinates his appointments plus contacts District Podiatrist when needed. For physiotherapy and dietetics the CNC currently orders equipment, and is the contact person for sick leave. Currently the Physio, Dietetics and Podiatry positions are professionally managed by the District Discipline Seniors. Exercise Physiology is managed by the Rehab Team Leader in High Secure Unit and does not operate on a district wide basis.

Barrett Allied Health Services (BAC)

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

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

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

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

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

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

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Summary of findings and recommendations

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

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

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

Current Structure

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

1.2 Scope of Initiative

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

The reviewer was specifically asked to;

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

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

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

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

1.3 Deliverables

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

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

Financial deliverables are presented in other parts of this document.

1.4 Potential Dependencies

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

1.5 Potential Impact of Initiative

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

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

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

Proposed Structure

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

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

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

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

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

2. Business Benefits

2.1 Business Benefits and Outcomes

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

2.2 Non-Financial Benefits

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

2.3 Financial Benefits

A total financial saving of $1 686 167.00 (mostly recurrent) will be realized through this proposed restructure as summarized below;

All Rehab and AH Disciplines Totals					
Discipline	**Appointed FTE**	**Approved FTE**	**Proposed FTE**	**MOHRI FTE Reduced**	**Savings**
ETNR	**11.1**	**20**	**9**	**11**	**$1,005,501**
SMHRU	**8.26**	**11**	**10.5**	**0.5**	**$48,057**
HS	**17**	**21**	**17**	**4**	**$517,345**
BAU	**4.53**	**4.5**	**3.5**	**1.03**	**$95,043**
GHS	**2.6**	**3.13**	**3.13**	**0**	**$20,221**
EFTRU	**1.8**	**2.8**	**2.8**	**0**	**0**
Total	**45.29**	**62.43**	**45.93**	**16.53**	**$1,686,167.00**

A detailed breakdown on financial savings is under the "Savings Worksheet" section of this document and also detailed further in the appendix.

3. Evaluation

Change	Key Performance Indicator/ measures	Timeline
Integration and partnerships with the wider community services.	• Membership in interagency forums • Service agreements with key community services. • Number of consumers accessing services from other agencies • Number of agencies providing services at the Park • Consumer, carer, staff and NGO satisfaction	• June2013- ongoing
Integrated model of service delivery	• Financial indicator 1: Savings • Financial indicator 2: reduction in MOHRI FTEs • Staff will feel more supported within the new structure • Reduction in average length of stay • Consumer, Families and Carers will be	January 2013-ongoing

	much more satisfied	
Data collection and information management	• Number of complaints/incidences relating to communication • Number of staff using CIMHA • Staff satisfaction	March 2013 -ongoing
Allied health governance	• Number of allied health leadership positions reflected in the service's operational structure.	January 2013-ongoing
Professional and leadership development	• Number and category of programmes accessible to consumers • Consumer satisfaction • Staff satisfaction • Families/ carers satisfaction	March 2013 -ongoing
Resourcing	• Consumer satisfaction • Staff satisfaction • Financial savings	January 2013-ongoing

4. Risk Management

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

5. Communication and Consultation

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

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

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

6. Recommendation

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

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

RISK ANALYSIS

Risk Analysis

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

An analysis of the proposal risk exposure against the Integrated Risk Management Framework identifies the following risk profile for the proposal.

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

The Park staff are heavily unionised therefore it will be imperative to adequately consult with unions before any changes are implemented. The reviewer has involved a wide range of staff and this has significantly reduced the likelihood of unions being a major impediment.

LIKELIHOOD		CONSEQUENCES				
		Negligible	**M**inor	**M**oderate	**M**ajor	**E**xtreme
	Rare	Low	Low	Low	Medium	High
	Unlikely	Low	Medium	Medium	High	Very High
	Possible	Low	Medium	High	Very High	Very High
	Likely	Medium	High	Very High	Very High	Extreme
	Almost **C**ertain	Medium	Very High	Very High	Extreme	Extreme

COMMUNICATION

EXHIBIT 261

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

SAVINGS WORKSHEET

The Park AH Position Occupancy and Savings

All Disciplines/ All units

EXTENDED TREATMENT AND REHABILITATION					
Discipline	**Appointed FTE**	**Approved FTE**	**Proposed FTE**	**MOHRI FTE Reduced**	**Savings**
Nursing	1	2	0	2	$248, 823
Social Work	2.51	4	2.51	1.49	$141, 180
Occupational therapy	2	3	1	2	$189,700
Psychology	2.5	4	2.5	1.5	$192,213
Operational staff	3	7	3	4	$233,585
Total ETNR	**11.1**	**20**	**9**	**11**	**$1,005,501.00**

SECURE MENTAL HEALTH REHABILITATION UNIT					
Discipline	**Appointed FTE**	**Approved FTE**	**Proposed FTE**	**MOHRI FTE Reduced**	**Savings**
Nursing	0	1	1	1	0
Social Work	2	2	2	0	0
Occupational therapy	1.76	3.5	3	0.5	$48,057
Psychology	1.5	1.5	1.5	0	0
Operational staff	3	3	3	0	0
Total SMHRU	**8.26**	**11**	**10.5**	**0.5**	**$48,057**

HIGH SECURITY					
Discipline	**Appointed FTE**	**Approved FTE**	**Proposed FTE**	**MOHRI FTE Reduced**	**Savings**
Nursing	1	2	0	2	$248,823
Social Work	5	6	5	1	$139,117
Occupational therapy	4.5	6	5	1	$129,405
Psychology	4	4.5	4.5	0	0

Operational staff	2.5	2.5	2.5	0	0
Total HS	**17**	**21**	**17**	**4**	**$517,345.00**

BARRETT ADOLESCENT CENTRE					
Discipline	**Appointed FTE**	**Approved FTE**	**Proposed FTE**	**MOHRI FTE Reduced**	**Savings**
Social Work	1	1	1	0	0
Occupational therapy	2	2	1	1	$95,043
Psychology	1	1	1	0	0
Speech therapy	0.53	0.5	0.5	0.03	0
Operational staff	0	0	0	0	0
Total BAU	**4.53**	**4.5**	**3.5**	**1.03**	**$95,043**

EFTRU					
Discipline	**Appointed FTE**	**Approved FTE**	**Proposed FTE**	**MOHRI FTE Reduced**	**Savings**
Social Work	0	1	1	0	0
Occupational therapy	1	1	1	0	0
Psychology	0.8	0.8	0.8	0	0
Operational staff	0	0	0	0	0
Total	**1.8**	**2.8**	**2.8**	**0**	**0**

General Health Services					
Discipline	**Appointed FTE**	**Approved FTE**	**Proposed FTE**	**MOHRI FTE Reduced**	**Savings**
Physiotherapy	0.5	0.5	0.5	0	0
Dietetics	1	1	1	0	0
Podiatry	0.1	0.13	0.13	0	0
Speech therapy	0	0.5	0.5	0	
Exercise Physiology	1	1	1 (OO4)	0	$20,221
Operational staff	0	0	0	0	0
Total	**2.6**	**3.13**	**3.13**	**0**	**$20,221**

Total savings:

All Rehab and AH Disciplines Totals					
Discipline	**Appointed FTE**	**Approved FTE**	**Proposed FTE**	**MOHRI FTE Reduced**	**Savings**
ETNR	**11.1**	**20**	**9**	**11**	**$1,005,501**
SMHRU	**8.26**	**11**	**10.5**	**0.5**	**$48,057**
HS	**17**	**21**	**17**	**4**	**$517,345**
BAU	**4.53**	**4.5**	**3.5**	**1.03**	**$95,043**
GHS	**2.6**	**3.13**	**3.13**	**0**	**$20,221**
EFTRU	**1.8**	**2.8**	**2.8**	**0**	**0**
Total	**45.29**	**62.43**	**45.93**	**16.53**	**$1,686,167.00**

Total Saving Summary				
Direct Labour Savings (On-costs should include overtime if applicable)				
		Salary Costs (including On-Costs)		
Position Title/ Classification	**FTEs**	**Cost Year 1**	**Cost Year 2**	**Cost Year 3**
		$		
		$		
(A) Total Direct Labour Savings		**$**	**$**	**$**
Associated Labour Savings (List any other interconnected positions)				
		Salary Costs (including On-Costs)		
Position Title/ Classification	**FTEs**	**Cost Year 1**	**Cost Year 2**	**Cost Year 3**
		$		
		$		
(B) Total Associated Labour Savings		**$**	**$**	**$**

Non-Labour Savings (List any costs currently incurred ie PC levy, RAS, travel, fleet reductions**)**			
Type of Expenditure	**Cost Year 1**	**Cost Year 2**	**Cost Year 3**
	$		
	$		
(C) Total Non-Labour Savings	**$**	**$**	**$**
Total Summary Savings	**$**	**$**	**$**
**Costings are calculated using corporate costing template*			

Individual Impact analysis

Most positions are unoccupied. The occupied positions are the ones described on the impact analysis below.

Individual Position Impact Analysis						
Cost Centre	**Position ID**	**Position Title**	**Position Level**	**Budget**	**Incumbent**	**Change Management Plan**
996203	30469736	Exercise Physiologist	HP3	$95,043	Tegan Archibald	Position to be reclassified to OO4 when incumbent leaves. Incumbent wanting to go and study medicine.
996240	30469617	Occupational Therapist	HP3	$95,043	Kim Hoang	Incumbent can be placed in other vacant OT positions at The Park.
996123	30469729	Occupational Therapist	HP3	$95,043	Karen Miles	Incumbent wants redundancy
996140	30469738	Social Worker	HP3	$46,339	Colleen Freeman	Incumbent is on a temporary contract and can be moved to position number 304697730 in the same unit.
996123	30469676	Therapy Aide	OO3	$108,403	n/a	Incumbents have already been moved. Positions can be closed.
996123	30469676	Rehab Coordinator	HP5	$140,420	Dominic Mitchell	Incumbent wants redundancy
996143	30469675	Rehab Coordinator	HP5/NG7	0	Daniel Volk	Position temporarily occupied and will be advertised as permanent. Incumbent welcome to apply.

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996544	30469596	ATSI	AO5	0	Bobby Haggan	This position needs to be realigned in a team of other ATSI workers or consumer advocates.
996203	30469733	Nurse	NG6	$221,229		The incumbent can be placed into the wider nursing stream.

ENDORSEMENT AND VALIDATION

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

Name:	**Signature:**
Position: Executive Director <Insert Title>	**Date: / /**
Division:	**Contact No:**
Comment:	

Validation
Validation Stage confirms the robustness of the Business Proposal.

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

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

SUPORTING DOCUMENTS AND ATTACHMENTS

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