HEALTH, ENVIRONMENT AND INNOVATION COMMITTEE

Members present:
Mr R Molhoek MP—Chair
Ms SL Bolton MP
Ms K-A Dooley MP
Mr JP Kelly MP
Mr DJL Lee MP
Dr BF O'Shea MP

Staff present:
Dr J Rutherford—Committee Secretary
Miss A Bonenfant—Assistant Committee Secretary

PUBLIC BRIEFING—CONSIDERATION OF THE AUDITOR-GENERAL REPORT 2: 2024-25—DELIVERING FORENSIC MEDICAL EXAMINATIONS (FOLLOW-UP AUDIT); AND AUDITOR-GENERAL REPORT 8: 2024-25—HEALTH 2024

TRANSCRIPT OF PROCEEDINGS

Monday, 31 March 2025

Brisbane

MONDAY, 31 MARCH 2025

The committee met at 9.32 am.

CHAIR: Good morning. I declare open this public briefing for the committee's consideration of the Auditor-General's reports which are relevant to the portfolio areas of this committee. I acknowledge the Aboriginal and Torres Strait Islander people of this state and their elders past, present and emerging. I also acknowledge the former members of this parliament who have participated in and nourished the democratic institutions of this state. Finally, I acknowledge the people of this state, whether they have been born here or have chosen to make this state their home and whom we represent to make laws and conduct other business for the peace, welfare and good government of this state.

With me here today are: Mr Joe Kelly, member for Greenslopes and deputy chair; Ms Sandy Bolton, member for Noosa; Dr Barbara O'Shea, member for South Brisbane; Ms Kerri-Anne Dooley, member for Redcliffe; and Mr David Lee, member for Hervey Bay. This briefing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the briefing at the discretion of the committee. I remind committee members that officers are here to provide factual or technical information. Any questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of the House.

These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. Please turn your mobile phones off or to silent.

EMMETT, Mr Paul, Acting Deputy Director-General, Health Infrastructure Queensland, Queensland Health

HEBSON, Ms Naomi, Acting Deputy Director-General, Healthcare Purchasing and System Performance Division, Queensland Health

ROSENGREN, Dr David, Director-General, Queensland Health

CHAIR: I welcome representatives from Queensland Health who will brief the committee on two reports which are relevant to this committee's portfolio responsibilities. These are: *Report 2: 2024-25—Delivering forensic medical examinations (follow-up audit)*; and *Report 8: 2024-25—Health 2024*.

For both members and witnesses, please remember to press your microphones on before you start speaking and off when you have finished. I invite you to brief the committee, after which committee members may have some questions for you. Thank you.

Dr Rosengren: Thank you, Chair. I do note your acknowledgment of the traditional custodians. Queensland Health is a substantial contributor to the health outcomes and the wellbeing of our First Nations communities, and I would like to acknowledge our staff, both identified and non-identified, who work tirelessly across the state to do everything they can to improve health outcomes and close the gap for Indigenous Queenslanders. I also pay my respects to elders past, present and emerging.

I am David Rosengren. I am the Director-General for Queensland Health and, at very short notice, I am joined by Naomi Hebson, who is the Acting Deputy Director-General for Healthcare Purchasing and System Performance, and by Paul Emmett, who is the Acting Deputy Director-General for Health Infrastructure Queensland. Neither are explicitly related to the two audit reports, but I do note there are components today around general elements of health performance so Naomi and Paul will no doubt be able to assist then.

As an introduction, Queensland Health has a substantial role to play in the delivery of health services across the state. We are a large, but not the only, provider of health services and we do work closely with the primary care, community and private sectors to ensure that access to timely, effective

and efficient care is available to all Queenslanders. I would like to advocate that we do have a world-class healthcare system in Queensland, although we will never be prepared to suggest that we have it completely perfect as there are always opportunities for improvement.

We operate primarily under the Hospital and Health Boards Act 2011. It provides the overarching framework for the operations, in particular the relationship between the Department of Health and the 16 hospital and health services that deliver health services through their hospitals and community services. The Queensland Ambulance Service is also part of our portfolio. The Department of Health is the system manager and we provide the strategic leadership and the direction to the public health services across Queensland.

We are responsible for the overall management of the Queensland public health system, which includes just under $20 billion worth of activity that we purchase through the 16 hospital and health services and other private contracts, including with the Mater Health Service, to deliver health care. The hospital and health services are responsible for the delivery of the actual clinical care services. They are governed as statutory bodies by independent boards and are under the leadership of a health service chief executive for each of the 16 HHSs.

The Queensland public health service aligns with the principles of the National Health Reform Agreement. We are currently in the process of negotiating a renewal of the National Health Reform Agreement with the Commonwealth. At the moment, there is an agreement for a one-year interim plan while we continue to negotiate a new five-year plan with the Commonwealth.

Queensland achieves its commitments in this agreement through its governance structures by strengthening and supporting local decision-making and accountability through enhancing clinician and consumer engagement and by providing for statewide health system management. The establishment, structure and function of the Queensland Ambulance Service are within the Ambulance Service Act 1991, so they do operate under a separate act from the Hospital and Health Boards Act. Collectively, as an entire system, we work in collaboration to deliver health services across the state.

I will touch very briefly on the machinery-of-government changes and the Department of Health's realignment. Following the election last year, the Office for Women has transitioned to the department of women and Aboriginal and Torres Strait Islander partnerships. The machinery-of-government transitions are coordinated centrally through the PSC—the Public Sector Commission—and they are being managed in a number of tranches. While the physical transfer of the Office for Women has been undertaken, some of the proposed elements with regard to the logistics of that continue to be supported by the Department of Health, with the transfer of payroll and other components to be finalised in the third tranche of the machinery-of-government changes.

With regard to the annual report, which I understand could be looked at, I am happy to answer any questions that the committee may have. Similarly, with regard to the two audit reports that have been flagged, I am happy to take any questions, or provide any comments on statements, from the committee. I might just hand over and do my damnedest to provide quality answers to the questions that you may have.

CHAIR: Thank you. I will go to the deputy chair in a moment. Having only just commenced in the role as director-general, what is your general view or appraisal of the health budget?

Dr Rosengren: The health budget?

CHAIR: Yes, the actual budget.

Dr Rosengren: Being a large consumer of the budget, it is always difficult to say that we do not believe it is sufficient. We certainly do consume a large quantum of Queensland's state budget. We do everything in our operational and governance capabilities to ensure it is used efficiently and productively. We are currently facing some substantial challenges in our budget position relating to extensive commitments that have been made without very clear funding sources being identified. We are currently working with Treasury through the forward budget process to try to address and manage some substantial structural deficiencies in the current budget allocation for Queensland Health.

On top of that, we are facing a growth for service at a rate that exceeds population growth. I am sure the members of the committee are aware of the data around the health needs and health demands for the community and the quantum gap between what you would anticipate for an aging population et cetera and what the health needs truly are. Our growth needs for Queensland Health are substantial and the budget pressures we face in that space on top of a structural deficit are significant as well.

The final comment around budget capability relates to our capital infrastructure program. There is a very ambitious capital program to address substantial deficits in our fixed-bed capacity for our hospitals across the state. Our ability to do that in the current market with the financial pressures continues to be challenged and, going forward, we will be working on understanding how we manage that within a reasonable budget.

Mr J KELLY: You mentioned the amount of the state budget that the health department consumes. As someone trained in health economics, I always like to think about the contribution that it makes to the state's economy. Has Queensland Health done any modelling in terms of what might be the impact on the state's economy if we were to reduce health spending?

Dr Rosengren: I am not sure I completely understand the question.

Mr J KELLY: If we reduced spending on health care and that subsequently had a negative impact on health, what would be the impact on the overall state economy? Has that been modelled?

Dr Rosengren: It gets modelled at all sorts of levels. It gets modelled at the national level and then we will also do targeted assessments at a state level. Every single hospital and health service works with their primary healthcare network to do area needs analysis around the health burden and demand in their community, looking at socio-economic and other factors that impact on health outcomes and understanding what the health needs are. Then we can do an assessment of the gap between what we can deliver and what the health needs analysis for a local community is. We will do that on a regular basis with our primary healthcare networks, recognising the interplay with the public healthcare system.

We will always, on a continuous basis, be making prioritisation decisions around what the local needs analysis demonstrates versus what the funding capability is for the services to be provided. Obviously, because of the federated system that we have and the dual funding model and the role of the state and the Commonwealth, many of the aspects around primary health care and the modelling associated with the investments will be undertaken by the Commonwealth. I think everyone will appreciate that the poorer the health outcomes are for a local community the more significant the negative impact on the economic productivity of the community will be.

Mr J KELLY: You mentioned that one of your challenges is having a number of commitments without funding. Could you specify what those commitments are?

Dr Rosengren: I might potentially throw to my purchasing and performance colleague to help me on this particular issue. There are a number of commitments around service delivery that have been made and which have been delivered that do not have current or recurrent funding. One particular example at the moment is that we have significant pressures on our acute hospital system. It might be market failure or it might be purely access to supply for residential aged care and for the National Disability Insurance Scheme. We have up to 10 per cent of our acute hospital bed occupancy currently filled with patients who are simply waiting for a transition to subacute step-down care.

One initiative that we are currently delivering on without a funding source is: a substantial number of beds—over 500 beds—have been purchased out of private or other sectors to try to release pressure and step-down. An inability to find funding moving forward for those 500 beds is, essentially, the size of one of our medium-sized regional hospitals being brought back into the system from a capacity point of view at a time when we know our capacity pressures are intense. That is one example of a commitment that is being delivered that does not have a funding source, for now or moving into the forward estimates, that puts substantial pressures on the budget. I will see whether Naomi wants to add to that as she has significant oversight to purchasing within the hospital and health services.

Ms Hebson: In terms of a general understanding, as David just said, often we will have initiatives that we will look at to try to deliver across the system such as an expanded bed platform and working in partnership with the private sector to do that. Often with those initiatives we look to test the waters, so to speak, to ensure they are delivering good value outcomes for us. As they mature and we understand the value-add to the system, we will be looking to continue those into the future. It is initiatives like that, as David outlined, that we will be particularly focused on, trying to stabilise bed capacity and access across the system going forward.

Mr J KELLY: The impression I drew from that statement, though, is that a previous government might have made election commitments or commitments that have not been funded, but in fact what you have outlined is a problem that is well known and well understood in the health system. In Mackay two weeks ago we had 50 out of 320 beds filled with aged-care and NDIS folks waiting for a placement. That is not an election commitment; that is someone trying to deal with a problem in our healthcare system, isn't it? If we fail to deal with that, what are the consequences of that?

Dr Rosengren: That is one example of where we have commitments that we must meet that we do not have adequate budget allocation for. There will be other ones including the increase in ratios for nurses and midwives in our maternity units. There will be commitments that have been made with regard to long-stay patient initiatives and agreements with the Civil and Administrative Tribunal services with regard to managing the outflow of our patients. Then there will be other funding for hospital and health services around their general activity delivery. There are multiple contributors and a substantial structural challenge that we have in our budget moving forward. Certainly the pressure on the acute system as a result of the subacute burden is one of our many very complicated elements that we are trying to manage moving forward.

Ms DOOLEY: My questions are around assets. How many hospitals are beyond useful life because appropriate refurbishments, redevelopment and capital maintenance projects have not been completed? The report says that it is at 37.4 per cent compared to five to 10 years ago.

Dr Rosengren: That is a challenging question for me to answer. I might require some assistance. There will be elements of our hospital infrastructure that will be beyond useful life that require substantial maintenance improvements. Holistically, it would be challenging for me to say that we had a hospital that was beyond useful life that we were continuing to operate out of. That would present a substantial challenge for me to declare that, but there are elements of our infrastructure within our broader hospitals where we are very actively managing risk with regard to the vitality and the capacity of that infrastructure.

If I can give just one example I am dealing with right now, in Townsville Hospital the lifts in their main building are well beyond the replacement time cycle. They are undergoing continuous repairs as a result of them breaking down. They are now at the stage where we are struggling to find replacement parts because the technology advancement means that is very challenging. We are carrying a risk there. The cost burden associated with replacing the lifts at Townsville Hospital is not insignificant. The challenge we have is that our Sustaining Capital budget is well overdrawn extensively multiple times and the ability for us to sign off on a contract to replace the lifts when there is no budget allocation and no funding source to do that presents a challenge for us.

That is just one example of a piece of infrastructure within a larger hospital that carries a substantial risk for us. I raise that simply because I have had correspondence with the chief executive of the health service in the last week about that one explicitly. If the committee are happy, I will hand over to the deputy director-general of infrastructure, who will probably provide a more sophisticated response.

Mr Emmett: The reason I am unable to say what percentage of our hospitals are end of life is that, as the director-general has referenced, there are multiple different assets within health facilities that need to be replaced over time. Naturally, that would happen. Twenty-five years to 30 years is the traditional life span of an asset. We are coming towards the end of life for some of our assets. Townsville is a really good example with the lifts. We have been continuing to replace the items within. We are now coming towards the end of the life span of those assets and the replacement. We are working with all of our HHSs to make sure that we are identifying items that are coming towards the end of their life span. Then the Sustaining Capital Program will allow us to address those items when we get better additional funding.

Ms DOOLEY: Thank you for your presentations. I am the member for Redcliffe. Under the former government there was a car park built, and we were told that there could be more levels built on top of it. I have since been advised that that cannot happen because the structure was not built correctly. Could you clarify that for me?

Mr Emmett: I certainly can. There was some misleading information. The asset was always futureproofed for three additional levels. The feedback that we got during stage 1 of the capacity expansion program has confirmed that we can build three additional levels on top of that car park. That will be happening as per the capital expansion program stage 1 works. There was some information out there in relation to the car park—it was to do with the soil—but it is factually incorrect. We can build the additional three levels.

Ms DOOLEY: Secondly, I believe there is a matter of cultural sensitivity around the scar tree. I am wondering why consultation was not done prior to the design of the hospital being confirmed, because we are waiting on that now.

Mr Emmett: There had been previous consultation during the design of the early stages of the hospital. As we made our way through the replanning and we have re-looked at multiple different areas within the facility, it has brought the tree more to prominence. That has meant we have done additional consultation, and we are currently in conversations with our local First Nations people to

make sure we are addressing the culturally modified tree in the most appropriate way. It had been addressed, but the replanning and the design of the building meant that we needed to go back to make sure we were all on the right path to deliver the appropriate design around the culturally modified tree.

CHAIR: I remind members that we are straying away from the content of the audit reports. I appreciate your passion for local efforts, member for Redcliffe.

Ms BOLTON: With regard to residential aged care and the purchase of beds, what occurs when the facilities in that area are already oversubscribed?

Dr Rosengren: This is a systemic challenge that we have across all areas of Queensland whereby the market availability for aged care is not consistent with the realised demands for aged care. We are seeing that in both the disability and the aged-care sector. We work very closely with residential facilities to optimise access. We are in competition with many sectors. The private hospital system is as eager to have access to beds as the public hospital system. Then we have people who are obviously in community who are requiring access. We are operating in a resource limited and highly competitive environment.

We have dedicated teams across our hospital and health services whose primary role is to work to support discharge planning, discharge negotiating and trying to navigate and to prioritise access for our clients who require aged care. We are in the process of exploring an opportunity to create and invest in dedicated aged-care brokers. 'Broker' may not be the terminology that we will land on, but there is a private market out there currently in brokers whose job is to work with families to navigate and identify beds. Queensland Health is trying to identify a workforce opportunity to bring in dedicated specialist staff whose primary role is to optimise the relationships, the navigation, the timing and the accessibility.

One of the challenges with a public healthcare system, which is the system of last resort, is that the patients we end up having in our beds are often the most complicated from the point of view of cognitive disorders, dementia and substantial behavioural challenges. We have an increasing challenge where aged-care homes are sending people into our public hospital emergency departments and declining to take them back on the basis of their inability to continue to meet the needs of individual residents with regard to behavioural issues. That presents a challenge.

We have substantial programs systemically across the state embedded in the health services to optimise that. We are about to embark on a major project to look at where we can further optimise and negotiate. I would also mention that we are the provider of aged-care services in quite a number of our hospital and health services, particularly in rural and regional centres where we are, in some cases, the only provider. Many of our multipurpose health facilities in rural and remote Queensland are also the aged-care providers for those communities. Even in our metropolitan areas—Metro North, for example—we continue to be a provider of residential aged care. We are a participator in, as well as a customer of, the aged-care sector.

Ms BOLTON: You spoke about how the demand for health services has exceeded population growth. Are these the types of issues that have contributed to that increase?

Dr Rosengren: That would be one contributor. There is both an increase in demand and pressure on the bed capacity that we have because patients, particularly our complex ones, can be stranded in our hospitals for very extended periods of time.

CHAIR: Has there been any analysis done about the further impact of our aging population and how you are going to manage those issues in the future?

Dr Rosengren: That is a continuous conversation, Chair. At the Queensland Clinical Senate that was held last week the topic was workforce. The keynote address from a very well known demographer really identified the pressures on the system associated with the aging population and how the shape of the curve as our population ages over the next 10 years is going to continue to shift to the right. There is a quantum increase in the burden of people over the age of—it is probably safer in this room to say over 70. We know that as people get older they are now living with multiple comorbidities. They have survived many coincidental illnesses, so when they do get sick the burden on the system as they are aging in terms of their frailty, their social challenges, their needs et cetera becomes substantially higher. We know that the utilisation of health services in older age is a substantially higher burden. We are very aware of the compounding impacts. We also have a contextual understanding of how that is impacting on our workforce supply. As the age of the population shifts to the right, that is also our workforce with regard to trying to retain workforce at the same time to meet those needs.

CHAIR: I acknowledge Mark Bailey, the member for Miller, who has joined us in the gallery and will be joining us on the committee a bit later.

Mr J KELLY: I want to come back to these commitments without funding. You mentioned that you have been doing some work with Treasury in relation to those. I assume that you have been exploring a whole range of options in relation to those. You mentioned things like the additional beds you are buying to deal with aged-care and NDIS patients, and ratios in maternity units. Is one of the options that is being considered simply walking away from those commitments and cutting those services?

Dr Rosengren: We will always operate within the funding envelope that is provided to us as a department. Well, moving forward we will always operate within the funding envelope. We will be very reluctant to walk away from commitments whereby that will have a substantially adverse impact on the current delivery of health services. The challenges we face are that, because of the structural gap, any growth funding that is provided to the department that does not address the structural gap will be sunk into fixing the structural gap. We will try desperately not to withdraw from the delivery of services, but our ability to deliver growth in services and meet ongoing needs will be substantially challenged if we do not have capacity to fund the structural gap, because all growth funding will end up being sunk into what has already been committed rather than what we know is the percentage increase year on year of demand.

Mr J KELLY: Has there been any discussion around the possibility of walking away from ratios in maternity units?

Dr Rosengren: It is my understanding that a specific commitment has been made by the current government to commit to that. I think that is—

CHAIR: You are starting to stray a bit from the context of the report.

Mr J KELLY: With respect, Chair, I am asking questions that relate to the opening statement of the witness. I think that is within context.

CHAIR: I will allow it, but we will go to the member for Hervey Bay in just a moment. Have you finished with that line of questioning?

Mr J KELLY: Yes.

Mr LEE: Congratulations on your appointment, Dr Rosengren. I have a question around information systems. There seem to be some huge legacy issues with the management of information systems. In 2024 the Annual Cyber Threat Report identified health as one of the five most vulnerable areas for cybersecurity. This is an issue that has been red-flagged since 2021. There are a number of references to audits, risks and failing to appropriately respond to recommendations. I am keen to know what plans we have to mitigate risks in relation to information systems. Is there a process you are considering in terms of possibly redesigning the IT architecture around that?

Dr Rosengren: We have substantial challenges, like many large organisations, with regard to IT infrastructure. We have a number of legacy systems that still operate as they were developed 30-plus years ago. That generates some risks for us in two areas. Obviously, technology has substantially changed. We are still using software programs that were developed 30 years ago, so that limits interoperability and capability. One of the challenges in particular we are currently facing is that legacy IT infrastructure operates in coding systems and underlying architecture that is no longer. We have a risk which we are managing on a regular basis with regard to having a human workforce that has the ability to maintain and sustain some of our infrastructure, from a software point of view in particular.

Since I have come into the role as director-general and worked towards preparing budget submissions, we have a clearly identified list of substantial investments which we will be working with Treasury through budget considerations to try and address over the forward years. We do carry some substantial risks with regard to our legacy information technology systems across Queensland Health.

Mr LEE: Is there a plan to address that moving forward?

Dr Rosengren: First and foremost, we have a very well developed risk structure around managing those with regard to how we monitor, track and try to ensure functionality. For many of these, the replacement of infrastructure, the software, is the only real solution moving forward. We are resubmitting budget bids through our budget process to seek Treasury support to provide the investment necessary to uplift those systems. I understand there have been multiple attempts over time of the prioritisation of budget availability because these are substantial cost investments. It is an ongoing challenge for us.

Mr LEE: I have a related question which relates to payroll. Overpayments recovered from staff increased to $67.6 million, and that was $17.8 million over the previous year. There is obviously a real difficulty in terms of the recovery of those repayments related to industrial relations legislation. What plans and processes are you putting in place to reduce the potential of overpayments to staff?

Dr Rosengren: It is a real challenge, with the complexity and size of our workforce and the complexity of the industrial frameworks of all of the various workforce groups. There are substantial inconsistencies with regard to conditions across them, which makes our payroll system extraordinarily complicated to continually update and maintain to meet all of the very highly specific needs of every particular group. One of the significant strategies as we move forward with regard to our bargaining approach is to try and see if we can reduce complexity and increase standardisation across many of these conditions. It is challenging when you have a workforce with so many different components that work at so many different levels and work across a 24-hour system. It does create complexity.

The other thing we are doing is safeguarding our payroll systems. This is a conversation moving forward around working with Treasury on budget submissions, but we are seeking support to invest in an uplift in our payroll systems, particularly to move to a cloud-based environment for better sustainability and reliability of the SAP systems that sit in behind the payroll to make it work effectively. There is a range of things. One thing we have become very good at is making sure we are paying people on time and ensuring people are not being underpaid. There has been a substantial improvement in working with our workforce and trying to maintain workforce satisfaction and retention et cetera. We will continue to work very intensely in that space around the accuracy of that.

In relation to the timeliness of payroll submissions, we have a big program rolling out across the entire state. It is almost completed for our nursing and midwifery workforce. The integrated workforce management system is a digital process for rostering. It will help improve the accuracy of the way rosters are created and submitted into the payroll system and reduce the volume of forms that people need to fill out for adjustments et cetera. Again, it is a very complicated workforce, but progressively we will be rolling out the IWFM Program across all of our professional groups over time—it is an expensive program—pending budget availability. That will also increase the accuracy as well as the timeliness of our payroll.

Mr LEE: You will hopefully look at other jurisdictions and see what they are doing, because that can be quite informative. I have an infrastructure related question. You mentioned earlier that there is an ambitious capital program in play. I think what is particularly important is the accuracy of financial reporting for each of those HHSs in terms of operational maintenance and capital commitments. What work is being done in relation to asset management key terms? I think there was something like half a dozen different terms. You have anticipated maintenance, deferred maintenance, postponed capital maintenance, forecast life cycle replacement et cetera. It is very subjective and ambiguous. Are you doing anything in relation to trying to provide better clarity so we get accuracy and better accountability in our financial reporting systems?

Dr Rosengren: That was an issue identified in the audit report. A draft document which identifies all of those terms you reference and provides much more specificity and consistency is currently out with the hospital and health services for a consultation process. Feedback on that will then be collated. I think the timeframe anticipated to receive that consultation and finalise it is in May. Then we will be embedding that into the process moving forward. Our Office of Health Statutory Agencies, which oversees the relationship with the health and hospital services, is proactively working with all of our HHSs around implementing the anticipated changes into the forward annual reports, which is where this is described and documented moving forward. We would hope that for the 2025-26 annual reports we would have those adjustments all implemented. As well as that, we are working through our recording systems which capture maintenance requirements and the strategic asset maintenance program to implement all of that terminology and consistency to address that deficit identified by the audit report.

Dr O'SHEA: Thank you for your briefing and thank you for the work that you do in delivering health services for Queenslanders. I know it is very difficult. Moving to *Delivering forensic medical examinations (follow-up audit)*, it was very sad to read about the 57 per cent increase in sexual offences in Queensland over the last six years, with 10,000 cases in 2023. What strategies are in place for looking at the demand for forensic medical examiners across the state and trying to match that to demand, particularly given that an examination might take between one and three hours and the person doing the examination might then have to prepare a court report or even attend court as well?

Dr Rosengren: As a specialist emergency physician of 30-plus years, it is a topic dear to my heart personally, having worked in emergency departments and provided care for victims of sexual assault on a regular basis. You are correct that the time required to provide empathetic, detailed and forensically accurate care to victims of sexual assault is substantial, and it is challenging in a very busy emergency department environment to do that, not only technically well but also clinically well. There has been a large amount of work done in recent times to highlight the importance of the timely initiation of care for victims of sexual assault, and the audit report does identify that there are still some opportunities for improvement with regard to how that is monitored and how we record and report on that, and a substantial amount of work is being done working in a cross-departmental steering committee to look at how we are capturing that information, reporting on it and making that available.

There has been some reform which is still in place and requires ongoing work for our Forensic Medicine Unit, which provides the overarching system, leadership and governance for our forensic workforce. Included in that is the development of a training program which we can provide for our staff across the state who undertake the forensic examinations. In our larger services, where workforce capacity allows, we are training the workforce to be dedicated for that purpose rather than to carry it as an additional burden to the task of being an emergency department clinician in their own right, recognising, as you identify, the timeframes. We have broadened and continue to broaden our training capabilities and are working on a multidisciplinary workforce. We are broadening from just the forensic officer model and increasing the capability for specialist nurses to be trained in forensic examinations as well as investing in allied health and other support services such as social work to provide psychological support to the victims of sexual assault.

There has also been reform and continued reform working with Forensic Science Queensland, FSQ, which is now part of the Department of Justice, and continuing to, from an evidentiary base, analyse the forensic kits we use to ensure we are optimising the quality of the kits to get the best possible specimens and the best possible evidence. We are continuing, through Forensic Medicine Queensland central agency, to support the training and the uplift of the staff to continue to make them confident and competent with the kits as they evolve. That is an ongoing project being invested in across our hospital and health services to optimise the access to services for Queenslanders.

Dr O'SHEA: Given that there is a 25 per cent increased conviction rate when the samples have been taken by a dedicated forensic medical examiner, what is the progress on giving feedback to the doctor or nurse who is taking the samples about the DNA recovery?

Dr Rosengren: Again, that is being managed by our central agency, Forensic Medicine Queensland. They work closely with the health services, as well as the legal system, and provide continuous quality assurance review of the outcomes associated with those cases where the forensic specimens are used for the purposes of a court process. Where there are improvement opportunities, that is coordinated, managed and then communicated across the network of trained physicians through Forensic Medicine Queensland.

Ms BOLTON: You mentioned the broadening of training. How long does it take to become qualified?

Dr Rosengren: I might need to take that question on notice to provide you with a specific answer. Previously the training required an external agency and required travel and substantial time, whereas now, because we have developed a program being led through Forensic Medicine Queensland, we can provide that training in-house and we can scale it up and scope it to be far more accessible, including the Forensic Medicine Queensland team being able to travel out to regional areas to deliver training if they have a critical mass. I know that there is a weekend or a two-day program that they do, but there is also reading and preparation work, so I would have to come back to you with an explicit answer, but we have an intention to significantly improve the convenience and the ease of access to training by providing that through our own internal capabilities rather than being dependent on an external agency.

Ms BOLTON: Basically, remote and regional areas have full access and so that is not an issue?

Dr Rosengren: On top of that, we run a 24-hour-a-day advisory service through Forensic Medicine Queensland. For clinicians working in a remote area, even if they are trained—it might be a once-every-two-years presentation to the clinic—the skill capability will be impossible to maintain unless they are doing these things on a regular basis. Using telehealth through Forensic Medicine Queensland, any clinician can access an experienced forensic clinician and get that support through tele or video health to support them at the time. We can provide expert assistance into a clinical space across the state at any time to support a clinician if their training is not reasonably up to date or the volume of cases they have does not give them the confidence every time.

Mr J KELLY: The Auditor-General report touches on preventable hospitalisations as a focus area. Could you step me through whether any strategies have been developed in relation to this area and how things like cutting pill testing and the use of puberty blockers for transitioning teens fits into strategies around preventable hospitalisations?

Dr Rosengren: With regard to potentially preventable hospitalisations, Queensland has for a number of years appeared to be on the higher end and a bit of an outlier relative to the jurisdictions. There is an element to the way we capture, collect and report on our data that increases the reporting on that. The primary areas for this in particular will be related to diabetes care and then to other chronic disease such as ischemic cardiac disease, so probably congestive cardiac failure, and chronic respiratory disease. When you drill down into the data, they are the high-marker areas where we have that challenge. We obviously monitor and report on that at an individual HHS level. The incidence of it over time stays relatively static. All of our analysis say that there are components of the way we report on our data, because every jurisdiction does it slightly differently, that push us up higher with regard to our data collection. We monitor that on a very regular basis. We have, in our funding model, incentive programs. There are models within the way we commission and purchase activity to incentivise the health services not to have hospital complications. We try not to say we disincentivise or penalise, but there are models to do that. Before I hand over to see if Naomi has more to add to that, issues around pill testing and hormone therapy have no relationship in any form to potentially preventable hospitalisations that I am aware of. Naomi, do you want to add?

Mr J KELLY: I will ask a follow-up question. There are a number of young people whose families have come to see me. Some of those were in the clinic on the day the decision was made and so they were not offered that particular treatment modality. There are reports from the family, so obviously this is second-hand, that for me, as a clinician—when I listen to the clinical impacts on these young people—will lead to them being hospitalised with mental health issues. Certainly in relation to pill testing, if you are taking an illicit substance which does go on to damage you, you will end up in hospital. How do those two things not relate to preventable hospitalisations?

Dr Rosengren: In the context of potentially preventable hospitalisations that the audit report captures and references, those sorts of admissions do not get recorded as potentially preventable hospitalisations. That is the context of the answer I provide.

Ms DOOLEY: My question is also around performance. The report did say that Queensland now ranks second last out of the eight states for preventable hospital admissions. Can you comment on what impact satellite health centres are having on the number of emergency department presentations?

Dr Rosengren: Our satellite health centres are seeing substantial volumes of attendances. At the moment they do not appear to have had a material reduction on the volume of demand in our emergency departments. It presumably suggests that they are providing a service for latent need in the community. If you look at the trajectory and the volume and the complexity of patients attending our emergency departments, they continue to increase as they have previously. The satellite health centres will undergo an evaluation process, which is earmarked to occur this year, so we will look in more detail at the specifics to analyse the data, the evidence, the case mix and the impact that has on the specific case mix in our emergency departments. The growth in demand for our emergency departments continues at the same time as the satellite health centres and the minor injury and illness clinics have volumes of activity that they are delivering.

CHAIR: I want to ask a question in respect of the report and some of the discussion around elective surgeries. What are you doing to address elective surgeries and any long waitlists?

Dr Rosengren: I will start and, as she is the expert in this, I am sure Naomi will add to it. The current government has made a commitment to stabilise elective surgery waitlists by October 2025, so a substantial amount of work is being done to optimise access to planned elective surgery. Surgery in our hospital system consists of two components: emergency or unplanned surgery; and elective surgery or planned surgery. We have seen a growth in demand for our elective surgery—our planned care surgery—by about 15 per cent, period on period, in recent years. At the same time, the capacity for us to optimise and maximise the delivery of volume has increased. We are getting better and better, more efficient and more productive. However, even with that growth in efficiency and capacity, we have increased by about 12 per cent so that month on month there is this continued gap between the increasing stream of referrals and the ability for us to meet the demand. This is at the same time as the volume of demand for emergency surgery is also increasing at roughly the same percentage. That creates substantial pressure on our infrastructure, which is why the capital expansion program is so important for more capacity.

It is not just our elective surgery which we report on that is growing; it is our emergency surgery as well. When we do our data analysis, the emergency surgery is true emergency; it is not people coming off the elective list escalating to emergency. It is a true increase in need and demand. The strategy, while we invest in new infrastructure and try to grow our workforce at record rates, is to partner with the private sector through our Surgery Connect program and to capitalise on that.

The current government has provided $100 million to invest in a surge program for Surgery Connect to deliver 10,000 additional elective surgery cases. We are working very actively to continue to drive access to the community for their planned care while, at the same time, optimising our internal capability to deal with the growth in emergency surgery. We are optimising all of our models, such as shifting from overnight surgery to day-case, same-day surgeries et cetera to optimise our assets.

I think the really important statistic that people probably do not understand is: more than 80 per cent of the total activity in our public hospitals is unplanned emergency care. Our elective surgery and our elective activity is only about 18 per cent of the total activity that we deliver. The pressure in elective is real and substantial, but it is at the same time as our acute hospital system is really sweating its assets and capabilities around emergency medicine and surgery activity. The system is working very hard. Surgery Connect is a very effective program. I do not know whether Naomi needs to add anything.

Ms Hebson: Not a lot more. I acknowledge that there are short-, medium- and long-term strategies that we are exploring at this stage. As David highlighted, Surgery Connect is a unique program in Queensland where we partner with the private sector to provide elective surgery for patients who are currently on our public waiting list. The expansion, or the surge capacity, will see an additional 10,000 patients referred through that program this year, based on historical throughput rates. We are equally working with the hospital and health services to identify any additional internal capacity they may be able to bring online. At the same time, as David recognised, we want to look at increasing utilisation—ensuring our feeder capacity is working to its fullest capacity across the system. There is a multitude of strategies that we are currently looking at employing, not only in terms of seeing more patients in time but also looking to ensure we are increasing our capacity and utilisation across our planned care platform.

CHAIR: Thank you. That is a good spot to finish because we are slightly over time. That concludes this briefing. Thank you to all who have participated. Thanks to our Hansard reporters. A transcript of these proceedings will be available on the committee's webpage in due course. There are no questions on notice. I declare this public briefing closed.

The committee adjourned at 10.32 am.