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
Mr M Bailey MP

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

PUBLIC BRIEFING—QUEENSLAND HEALTH PORTFOLIO AREA BRIEFING

TRANSCRIPT OF PROCEEDINGS

Monday, 31 March 2025

Brisbane

MONDAY, 31 MARCH 2025

The committee met at 10.33 am.

CHAIR: Good morning. I declare open this public briefing into Queensland Health's portfolio area. My name is Robert Molhoek. I am the member for Southport and chair of the committee. I acknowledge the Aboriginal and Torres Strait Islander people of this state and their elders past, present and emerging. With me here today are: Mr Joe Kelly MP, the member for Greenslopes and deputy chair; Ms Sandy Bolton MP, the member for Noosa; Mr David Lee MP, the member for Hervey Bay; Ms Kerri-Anne Dooley MP, the member for Redcliffe; and Hon. Mark Bailey MP, the member for Miller, who is substituting for Dr Barbara O'Shea MP, the member for South Brisbane.

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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: Welcome. I invite you to brief the committee, after which members will have some questions for you. Please remember to press your microphones on before you start speaking and off when you are finished.

Dr Rosengren: Thank you, Chair. Recognising this is a new session, I will reinforce my earlier statements around the critical importance of Queensland Health working in partnership with the other system providers for health care to focus on improving health outcomes and closing the gap for Indigenous Queenslanders. I would very much like to acknowledge our staff, both identified and non-identified, who work across the state in all aspects of health services to support First Nations health service delivery. I pay my respects to elders past, present and emerging.

It is slightly repetitive but for the new member of the committee, I am David Rosengren. I am the Director-General for Queensland Health. I am accompanied by Naomi Hebson, who is the Acting Deputy Director-General for Healthcare Purchasing and System Performance, and Paul Emmett, who is the Acting Deputy Director-General for Health Infrastructure Queensland. Chair, would you like me to go back over an overview of the department and its functions, or are you comfortable with that?

CHAIR: We are comfortable to move forward.

Dr Rosengren: Thank you.

Mr BAILEY: Welcome, Dr Rosengren, Ms Hebson and Mr Emmett. Thank you for appearing this morning. In relation to Queensland Health's capital program on pages 66 and 67 of the annual report, I note that, while 58 Queensland Health projects were completed in 2023-24, there is reference to much construction underway, and to do, to meet the increasing demand on the Queensland health system. What date did the Sangster review into Queensland's hospital and health capital building program commence?

Mr Emmett: 23 December.

Mr BAILEY: Director-General, have you seen the draft report and the final report?

Dr Rosengren: I have seen the draft report. The final report is with cabinet for consideration. I understand that that is planned, at some stage, on the cabinet agenda.

Mr BAILEY: Have you seen the final report?

Dr Rosengren: I have seen the draft report, and the final report is with the minister. It came via me to the minister but it is currently sitting with the minister for his consideration.

Mr BAILEY: You have seen the final report as well as the draft report?

Dr Rosengren: The final report is very similar to the draft report so, yes, I have seen the final report.

Mr BAILEY: What date was the draft report from Mr Sangster provided to you?

Dr Rosengren: Forgive me, I will have to look at the dates. It was on the date it was scheduled, based on the terms of reference. I do not have the date, off the top of my head.

Mr BAILEY: If you can provide it later, that will be fine.

CHAIR: We will place that on notice.

Mr BAILEY: Was the final report provided within the 60 days that was specified at the beginning?

Dr Rosengren: The final report was provided to me on the date that it was due, based on the terms of reference, and it was provided to the minister's office on the date that the terms of reference specified for it to be delivered.

Mr BAILEY: Thank you. Will the draft report, as well as the final report, be released to the public?

Dr Rosengren: The report is a report of cabinet so I would have to refer that to cabinet for consideration.

Mr BAILEY: I think there was a commitment given by the minister and the government that the final report would be released for transparency and openness, which I acknowledge, but I see no commitment at this point that the draft report would be released to the public for openness and transparency. I ask the question in that line. Obviously, the public may well be interested in whether there are any substantial differences between the draft and the final report.

Dr Rosengren: As with my earlier answer, it is a report that was commissioned by cabinet. It is my understanding that the report will be considered by cabinet and that cabinet makes the determination around the public release of the document. I do not believe I am in a position to answer that question.

Mr BAILEY: Are you saying that the potential release of the draft report for the public is a matter for the minister?

Dr Rosengren: It is a matter for the cabinet to consider, would be my answer. I am unfamiliar with the process, I apologise.

CHAIR: I have allowed a little bit of latitude. I think we need to get back to the annual report.

Mr BAILEY: Thank you, Chair. I am coming to the annual report. In relation to the proposed Queensland Cancer Centre site, there is a six-storey building there that is the former school of nursing. I think everyone understands that the RBWH site is a very tight and crammed site. That building has been emptied of all staff and services in preparation for the construction of the Queensland Cancer Centre that was scheduled in the current quarter of this year. There has obviously been a decision to put that off for another three years. What happens to the old school of nursing building and the space? Does it gather dust? Does it get demolished in the short-term? What is the plan, given the decision to put back the Queensland Cancer Centre so far? What happens to that building?

Dr Rosengren: I am unaware of the decision you are making reference to: to not to progress with the Queensland Cancer Centre. I would be happy to take that on notice, if you could provide me with some clarity. That is not an announcement or a decision that I am familiar with.

Mr BAILEY: I am referring to the Queensland Cancer Centre being put back at least three years by the government. That has been well reported. The construction site, which I was shown by RBWH staff when I visited in December, involves using land that is partly road and partly the old school of

nursing building, which is was a substantial, six-storey building. I have here a picture, which I am happy to table—with the permission of the member for Greenslopes, who happens to be in it. It is a very substantial, large building on the site. Director-General, if you cannot answer it, I understand. That is fine. I am happy for you to take it on notice. If the Queensland Cancer Centre construction is put back three years, as has been reported, there is a lot of capacity and space there that suddenly is empty. The question is: does it sit there or does it get demolished? What is the plan?

Dr Rosengren: Again, I am not familiar with any formal announcement. The announcement you described is not an announcement that I am aware of, so I would need to take that on notice and for you to provide me with that for me to be able to comment.

CHAIR: We are straying a little into areas of policy. As you have already pointed out, there are a number of things before cabinet for consideration. If we can move along, we do need to deal with the—

Mr BAILEY: I am happy to move along, Chair.

CHAIR: Is the committee happy to accept the photo you have tabled? I do not see any issue with it.

Mr J KELLY: It looks like a pretty good photo of me!

CHAIR: The committee notes that the member for Greenslopes is looking particularly resplendent on that occasion! We will accept that as tabled.

Ms DOOLEY: My question is around workforce capacity building. We know with the current workforce there are challenges. With capital expansion works in the mix, how are we going to grow the workforce needed to continue? In particular, what can be done to retain existing staff whilst being able to increase the workforce as needed?

Dr Rosengren: Clearly, workforce growth is one of the biggest priorities for Queensland Health moving forward. From a strategy point of view, in order to meet our workforce demands we need to increase the training pipelines of workforce into health care, recognising—and I think in my introduction earlier this morning I referenced this—that we are one contributor to health services in Queensland and that there are other sectors. We are a major contributor, though—disproportionately—to the training of the healthcare workforce as a public acute healthcare system. Training our workforce and pipelines in is one priority; retaining the workforce that we have and keeping them in our workforce is another strategy.

The third pillar of our strategy is to retrain our existing workforce to optimise their scope so they can operate at the maximum scope of their capability. There is a fourth pillar, which is about workforce reform—new workforce models and new workforce considerations. In the earlier session I made reference, for example, in our conversations around aged care to considering a workforce of residential aged-care brokers, a new capability that we do not have. Taking an example from the private and other sectors, we see an opportunity to create a model that delivers on something that is critically important for us but releases our clinical staff to concentrate on the clinical components of care rather than negotiating the complexities of interfacing with the Commonwealth aged-care sector. They are the four main pillars that we need to focus on moving forward. The current government has made a substantial commitment to grow our workforce over the coming six years consistent with the deliverables of the capital expansion program.

With regard to your specific question about retaining our workforce, we spend a substantial amount of time and effort supporting our workforce from the point of view of environment and culture; trying to maintain, where it is reasonable and appropriate, flexible workforce circumstances; looking at ways to improve the way we roster and the way we support our staff with regard to access to the workforce et cetera. We have a whole range of strategies. One of the greatest ways to retain our workforce will be to allow them to operate at their maximum scope of practice to give the opportunity to be fulfilled in the clinical trade in which they have trained. There are substantial opportunities for us to look at our clinical workforce and our non-clinical workforce and identify what is the optimum scope for them based on their skills, their capabilities and their contribution and by releasing our workforce from the tasks that interfere with their ability to concentrate on their scope. That is about reducing the administrative burdens that we might place on them and releasing them to deliver face-to-face clinical care.

One thing we are doing at the moment that receives very significant positive impact is using technology to improve the relationship, particularly for our clinicians and their patients. You may be familiar with the concept of—this is just one example—ambient listening, which is an artificial intelligence capability that has the ability to listen to the consultation between the clinician and the

patient. That is then converted into a very sophisticated clinical record of the consultation so that the clinician can concentrate on face-to-face contact with the patient and engage with the patient and their families. They can concentrate on that, and then there is an ambient listening supported summary of that consultation which they then just check and edit to improve the accuracy. From that they can then, through a voice command, generate a discharge letter back to the general practitioner, for example. If they wish to organise pathology or radiology, a simple voice command can then generate all the request work. It is about emerging technologies that facilitate the clinicians to practise their trade and improve the efficiency and the productivity of the time they spend with the patient. That is just one example I would call out of the sorts of things we are currently doing to invest in our workforce, to pilot new technologies and to work with our clinical workforce.

The other thing I would mention is that last week the Queensland Clinical Senate, which brings together clinical leaders from across the state, met for a dedicated session on workforce optimisation and workforce development. There were significant conversations around the things we need to be doing as a system to make sure we train and retain the workforce, recognising that in a fixed workforce environment we are mature enough and comfortable enough to know that our workforce at times will move across sectors. When I talk about retaining, we want to retain our workforce into the healthcare system—that is the retention. If we do that and we support a strong private sector or strong community sector or strong primary healthcare sector, that is advantageous to all of us in the fixed workforce environment. That is part of our strategy.

Ms DOOLEY: Being a registered nurse myself, I am always keen to see the role of nurse practitioners expand. Does Queensland Health have a plan for that, particularly to help in our regional and remote communities, where we struggle sometimes to get specialists?

Dr Rosengren: I have been working with the Office of Rural and Remote Health to have some fairly serious conversations around how we are investing and growing our workforce models for rural and regional areas in particular. Nurse practitioners is one model, but then we have the RIPRN program, which is a rural special skills program to support our nurses in regional, rural and remote areas to have increased skills and capabilities. We will also look at the role of paramedics in many of our rural and remote areas for what they can contribute. On top of the human workforce that is in sight, we are also going to ramp up our virtual healthcare capabilities so that we can provide our nursing staff or our medical staff in our rural, regional and remote areas with the confidence that by using telehealth or videohealth they can connect in through our virtual hospital, through the ambulance clinical hub or through our 13HEALTH centre and get access to expert clinical support and advice to assist them to deliver their services according to their registration, skill sets and environment. We can support our workforce with both the training and the resources but also by providing technologically assisted virtual support, and that has been very effective.

CHAIR: While you are talking about workforce, could you comment on Queensland's dependence on overseas trained workers? I think Townsville at one point were recruiting a significant number of doctors from the UK, and I know from previous visits to those services at Maryborough that they were looking to recruit key positions from overseas. How is that overseas recruitment going and are the current migration policies making it easier or more difficult? How are we travelling in that space?

Dr Rosengren: Overseas recruitment is important because it allows us to bring in a workforce that is already trained. That is a very effective short-term, here-and-now solution. It is less so in the immediate to longer term; growing and retaining our own workforce will be more effective. We do need to be very careful, because there is an international shortage of healthcare professionals and, in the same way that we struggle with our domestic supply, the capacity to access internationally trained clinicians is not at the level it has previously been at. We will work as a system, as Queensland Health, to support the HHSs in recruitment campaigns, to support the HHSs when it comes to some of the immigration processes that they need to navigate, including sponsorship et cetera, and to support them around orientation and capturing our workforce coming in.

A large amount of the work with regard to immigration policy is Commonwealth determined and there are many conversations—and I am sure some of you will be familiar with the Commonwealth reform program around working with particularly the medical professional colleges around international graduates. There is work being done to streamline the processes for international applicants with healthcare credentials so they do not have to go through multiple sequential steps. Ideally, the Commonwealth reform program is trying to do parallel processing of the various visa applications and registration processes and working with the professional agencies et cetera. That is a piece of work that the Commonwealth continues to drive. It is probably more focused on the medical

specialty workforce. Then we work very closely with the HHSs to support them around allied health, nursing, medical et cetera in more of the midgrade workforce. It is important, but I would not want to see that be considered as the solution to our workforce problems at a macro level moving forward.

Ms BOLTON: I return to increased demand, and I am going to mental health now. What is in the pipeline not only for services, especially for our needed development and the delivery of specialised children and youth mental health facilities?

Dr Rosengren: There is certainly an increased burden in the community with child and adolescent mental health. That is a challenge for us with regard to professional workforce who are specially trained in that space as well as in our traditional models to address that. We have a number of strategies and programs in our Better Care Together forward plan with regard to our mental health programs. We are in the process of doing a reassessment of Better Care Together, just to sense-check whether the programs that we forecast X number of years ago still align with where our specific needs are moving forward, to make certain that we are prioritising our investments in the right areas. That would be not inconsistent with any major investment program. At a midpoint you would be reassessing the forward plan to make certain we are confident that where we are investing is consistent with where the needs are. It also is a valuable thing for us to undertake because workforce supply is a major determination at times of the services that can be delivered. We need to make sure we are investing from a mental health perspective into areas where we have the ability to actually deliver the services; otherwise, the investment does not deliver anything for us.

Child and youth mental health is a major priority. There is some work being done looking at step-up step-down specific for child and youth mental health services, and we are doing a piece of work from a strategic planning perspective to look at the challenges in that space. They are also disproportionately identified in our emergency departments as long-stay emergency department patients because of the challenges, particularly in regional areas, with regard to getting access to specialist child and youth services in regional areas. We are noticing that. That is an area of work and, from a planning point of view, we are doing an analysis to understand how we can tackle that.

Ms BOLTON: Going back in the forecast of contributors to increased demand, besides the areas you have already identified, has anything come about that was never identified?

Dr Rosengren: Can you provide me with a better understanding of what you are asking?

Ms BOLTON: Over the last decade in the forecasting about where the demand would be, has anything come up that had not been calculated into those forecasts done a decade ago?

Dr Rosengren: I would need to take that on notice for an evidence-based answer to your question. Based on a professional understanding of the environment, I think it is well recognised that the incidence of neurodiverse and other challenges in our paediatric population is increasing. I am not an expert to be able to determine what the drivers of it are, but our autism spectrum disorders et cetera often have substantial behavioural related implications associated with them, and there is a complexity about teasing out the separation between developmental behaviour disability types of challenges versus true mental health challenges. Many of our young and adolescent mental health patients also have substantial disability components to them, whether they might be related to drug and alcohol related issues or other developmental delays, so there is a complexity around the disability sector and our capacity to manage that. In many ways, the inability of the disability sector to provide a response to these really complex young behaviourally challenged people results in them being in our emergency departments with serious behavioural challenges which then become packaged up as a mental health problem. There is a lot of complexity in that space and we are looking at trying to find models that are both medical mental health and disability intervention to try and see if we can help manage that volume of patients.

Ms BOLTON: Regarding the palliative and end-of-life care strategy, are we close to the progress including that very much needed 50 per cent nursing funding for our palliative care community like Katie Rose hospice?

Dr Rosengren: Again—and I do not know whether Naomi has anything—I would have to take that on notice, sorry, to give you a specific answer to that one.

Ms BOLTON: Wonderful. Thank you.

Mr BAILEY: I have a question on the capital program. Director-General, you said that you were not aware of any delays for the Queensland Cancer Centre.

Dr Rosengren: I am not aware of any announcements that have been made that have determined a specific decision to delay the Queensland Cancer Centre.

Mr BAILEY: I was not talking about announcements; I asked whether you are aware of any issues around delays to the Queensland Cancer Centre, which was often announced by Queensland Health as starting construction this quarter.

Dr Rosengren: I might refer to my capital expert around the scheduling and the programming.

Mr Emmett: The QCC is an alliance. It is not a two-stage managing contractor process. The QCC is a different process than our other capacity expansion program. It is an alliance with the contractor and with the design team and the plan always was that towards the end of January and the first quarter of this year we would finish the schematic design and we would start into the detailed design, which is where we are currently sitting. I do not actually know if there was a commitment that we would be starting construction in the first quarter, but it certainly is delivering as per the program of the design for the project.

Mr BAILEY: So when is construction scheduled to start on the Queensland Cancer Centre?

Mr Emmett: There is no contractor currently engaged on QCC at the moment. That is the process we were always taking. It is an alliance. We did have a contractor in for those early stages to make sure we got the brains trust sitting behind that so we could deal with a really complex site, as you have already mentioned. The construction will start midyear, I would imagine.

Mr BAILEY: Have there been any discussions with the federal government as a co-funder to the project in terms of changes to scope or funding?

Mr Emmett: Not to my knowledge, no.

Mr BAILEY: What happens with the old school of nursing building there? I understand that the director-general might not be aware, but you might have a better idea. Is it going to be demolished soon? What are the plans for that—

Mr Emmett: The program has not been announced about what we would be doing with that building. It will obviously be demolished because it is in the way for the new QCC. I would have to come back to you with a program. I do not have that program in front of me, sorry.

Mr BAILEY: All right. Are you happy to take that on notice?

Mr Emmett: Yes.

Mr BAILEY: Fantastic; that is great. Moving on, we have a pill-testing pilot that will close this Friday. Director-General, have you or the minister received the final report in relation to its effectiveness?

Dr Rosengren: No. The report is not due until mid-April, so I have not received a report.

CHAIR: Member, we are starting to stray outside of the annual report.

Mr BAILEY: Respectfully, Chair, pill testing is mentioned in the annual report in—

CHAIR: I will allow some latitude.

Mr BAILEY: Thank you. So the pilot is finishing before the final report is being considered. Director-General, have you ever met with CheQpoint, which is conducting the pilot?

Dr Rosengren: I do not believe CheQpoint have requested to meet with me at any stage, no.

Mr BAILEY: But you have not sought a meeting with them, given that this is a pilot and obviously an important measure in terms of prevention?

Dr Rosengren: The pilot has been undertaken. An evaluation was commissioned at the time that the pilot was commenced and it is the evaluation that will determine the impact and the significance moving forward.

Mr BAILEY: I note that your previous answer was a fairly technical answer in relation to potentially preventive hospitalisations. I understand your answer and it makes sense to me. Outside of the technical definition of what a potentially preventable hospitalisation is, broadly speaking as a preventive measure—and you have, no doubt, a lot of experience in emergency departments—would you not agree that pill testing is a preventive health measure given, for instance, the identification of nitazenes in Queensland and Australia which are very potent? They have now been identified in fact by CheQpoint, which I believe Queensland Health used as the basis of their alerts.

CHAIR: Member, I think we are straying into an opinion. Is there a direct question in there?

Mr BAILEY: I am simply asking the director-general, as somebody who has clinical experience, whether pill testing is a preventive measure.

Dr Rosengren: I do not think the evidence has been provided and the evaluation has been determined to be the process for us to get the qualitative analysis of the testing that has been done, the substances and the impacts of that. Without that information, any answer I give would be purely speculative. It is not something I can answer at this point in time without the evaluation.

Mr J KELLY: As a follow-up question, both in relation to pill testing and the decision to stop puberty blockers, it seems to me that in normal clinical processes and practices it is actually required and regular and good practice that you review clinical processes and practices to determine whether they are effective and safe or whether there are better options out there. It seems to me this decision to stop things like pill testing before a review has been done and the decision to stop hormone treatment before a decision has been made seems to be quite out of step with the way other clinical matters are dealt with. Have you been provided with any information that suggests there are significant safety concerns around the continuation of these two practices? Is that the reason that is driving the cessation of these two practices?

Dr Rosengren: With regard to pill testing, it was a pilot for a specific timeframe with the intention to then undertake an evaluation to determine where things would happen next. That is exactly the process that has been followed. There is nothing stopping a pill-testing company from continuing to pill-test. The only thing we are not doing is funding that for them, but there is a framework for the pill-testing agencies to put in an application and seek approval. That still exists as it is. In terms of the pilot that we funded for a timeframe, that is coming to its completion and we are now waiting for the evidence from the analysis, which is being undertaken independently by the University of Queensland, to inform us to then be able to advise government on future policy direction.

With regard to the puberty-blocking question, there is a substantial amount of evidence being considered nationally and internationally that raises questions around the validity of the role of puberty blockers and hormonal therapies. The evidence base to support the positive impact has been challenged substantially around the world, and the evidence to understand whether the treatment might potentially cause harm is also being challenged. The decision to pause the treatment is for the purposes of us undertaking a very detailed evidence analysis of, firstly, the typical assessment of evidence of a clinical treatment or therapy, in the same way as if we were introducing a new drug or a new machine technology. The review will look at the evidence base to support these things: does the treatment work, first and foremost; is the treatment safe; and then what are the ethical considerations that need to be taken into consideration in the context of the treatment? The expectation is that the review team will provide a report back by the end of November to provide advice to government around health policy. As the chair has said, that is a space not for me to comment on, but that is the process that is in place at the moment.

Mr J KELLY: Just as a point of comparison, how long did Queensland Health continue to use pelvic mesh after concerns were raised around the use of pelvic mesh?

Dr Rosengren: I cannot answer that question. I would have to take that on notice.

CHAIR: We are straying a bit from the annual report. It is an opportunity to ask questions about the financial reports and performance data, so I ask that we come back a bit.

Mr LEE: I have a question in relation to strategic service planning. Then I will have a follow-up question in terms of objective business case analysis. Does service planning for new hospitals consider the highest diagnostic related groupings based on postcode? If not, is any type of health needs analysis done on postcodes when planning for new facilities?

Dr Rosengren: I might defer to my expert next to me to help with that one, if that is okay.

Ms Hebson: When we do planning, we look at what we call patient flows, so, yes, postcode in terms of where patients flow through to a system, not necessarily postcode in terms of local generic area that may sit around that hospital. If I can give an example, Townsville is a level 5 clinical facility, so it provides cardiac care. For residents who live within the north-west or Mount Isa, when we look at planning for cardiac care in Townsville we assume that those patients continue to flow through to Townsville. So, yes, it is on postcode but it is not localised postcode; it is informed by where patients are flowed through to access that care and the local postcode of where that patient resides.

Mr LEE: I guess my concern about that is: if it is on the basis of flow then the point of clinical care may be very different to that location, particularly in regional and remote areas. Where I am going with that is service planning more or less being based as close as possible—the actual clinical case—to where people live.

Ms Hebson: We have what is called a clinical capabilities framework that sits across all of our healthcare settings. That is a framework that helps guide the level of clinical care that each hospital and health service and facility should provide, based on the level of skill sets and access that that facility has. We are continually working with hospital and health services as a principle to provide care as close to home as possible. It is not always possible to do that. We cannot provide cardiothoracic surgery at every facility across Queensland, but absolutely where we get into providing local care within the relevant clinical capability framework we will always engage and promote in trying to ensure that care as close as possible to home is not only delivered but also planned for from a utilisation rate going forward.

Mr LEE: In relation to business case analysis for the construction of new facilities, what independent, arm's-length and objective analysis is routinely conducted in the business case for new hospital proposals? Does the business case for new facilities consider the implications for the sustainability of other healthcare services in the proposed hospital location? From the business case analysis, is there a really good objective analysis of the explicit and implicit assumptions underlying that business case and is it free of political pressure?

Dr Rosengren: I think it is probably reasonable to defer that to my infrastructure expert, if you are happy with that.

Mr Emmett: Before we do a business case we do a master plan of the campus to allow us to make sure that we are looking at the right campus to deliver the health care to be provided. A clinical planning service strategy will feed into that as well. It is completely non-political. We look at all uses of the site that they currently have and then we also look at adjacent sites and the campus—the precinct associated with that campus. The business case is then informed from the outcome of the master plan to make sure we are delivering connections, adjacencies and a campus that can grow with future growth within whatever area that is being delivered in. The business case looks at multiple different opportunities on any campus in Queensland. It allows us to make sure we are looking at all construction types—from modular for speed but a traditional build as well. The business case is informed from the master plan, but it really goes into that level of detail that you would expect to understand the asset that is currently there. We look at the asset life left—the life expectancy that is left within the current existing infrastructure—and then we look at how we can add to that. We also look at a staging approach within the business cases.

CHAIR: I think what the member for Hervey Bay wants to know directly is how much attention is given to Hervey Bay and the aging population in planning health services.

Mr Emmett: A lot.

Mr LEE: I was interested in a little bit of clarity around 'we'. I am presuming the business case is prepared by the hospital and health service and then there are objective eyes that are cast over that analysis to ensure it is accurate.

Mr Emmett: It is prepared in partnership with hospital and health services. Health Infrastructure Queensland will lean in and assist the hospital and health service to deliver the master plan first, and then when we come into the business case Health Infrastructure Queensland will lead that, in partnership with the HHS. They have a process to play throughout the whole life cycle—both sections.

Mr LEE: In relation to infrastructure—we touched on this earlier with some of the ambiguity around key asset management terms—the annual report indicates an anticipated maintenance of $35.23 million. It just seems very low.

Dr Rosengren: That is just for the Department of Health. This is the Department of Health annual report. Each hospital and health service will have their own annual report with their own analysis of that. That is how I understand that figure.

CHAIR: I assume the detail of that would be in all the various health service annual reports?

Dr Rosengren: That is correct.

Ms DOOLEY: Regarding the pause on maternity services in both Cooktown and Biloela since 2022, do you have an indication of when these maternity services will come back online?

Dr Rosengren: We are working very hard, particularly for Cooktown, around getting a very traditional doctor/medical-led model, because Cooktown is very isolated from the point of view of the ability to get access in and out in the event that there are complexities. Similar to Weipa, which has a medical model of birthing, we are working very hard at Cooktown to deliver on that as well. There are some infrastructure improvements planned for Cooktown with regard to rebuilding of the hospital

and improving the operating theatre and the birthing services, but that is not an absolute determinant. The ability to recommence birthing in Cooktown is very much dependent on the ability to identify an obstetrically trained workforce which will particularly be a rural generalist with specialist training in obstetric medicine. There is actually a global shortage of that particular skill set. The challenge we have is that by pulling someone out of one location to fix a gap there, we will create another gap somewhere and collapse a birthing service elsewhere. Currently we are working very actively towards delivery on that. It is a commitment from the government that we are working very hard on right now.

With regard to Biloela and many of our other services, there is an opportunity for us to look at models of birthing in our rural and regional communities—the role of midwives, the use of our virtual midwifery and obstetric service as a support. We are having a rural maternity summit in Longreach on Friday, which I will be attending, which will be specifically diving into, among other things, alternative workforce models and scopes of practice, so that we can really identify a more sustainable, long-term model for birthing in our regional communities.

As I said at the start, Cooktown presents a slightly more complex challenge because of the way it can get totally isolated and cut off and the ability to get in and out of there. We have a different tier system according to the various facilities around what are absolute essentials in order to deliver a safe service. I would like to stress that at Cooktown and Biloela at the moment they do have maternity services. They do not have at the moment birthing services. We do have midwives. They are delivering antenatal and postnatal care. It is just that the actual childbirth process, because of the inherent risks associated with it, is currently not available in those two locations.

Ms BOLTON: The QAO report indicates complexities with data sharing between the Queensland Ambulance Service and emergency departments. Is this due to what you spoke about earlier with regard to the age of the systems? In addition to that, why do we not have the information from our private hospitals, especially around ambulance services?

Dr Rosengren: With regard to the interoperability between Ambulance and Health, again, there is a substantial history. The Ambulance Service has previously been associated with other emergency services and most of its infrastructure technology, information technology, comes from a totally different background. Its requirements as frontline, on-the-road paramedics are totally different from the digital requirements that we have in a hospital environment. I do not believe anywhere there is a system whereby ambulance and hospital use the same system. We have made substantial progress on interoperability, and in much more recent times. In fact, I am working very closely with Ambulance and with Naomi's team, which looks after the performance data, on validating real-time data matching between Ambulance data and our Health data so that we can bring it together. Then we can track the time stamps and the journey of care from the time the phone conversation is had through to the time the patient is discharged from hospital. There are technical solutions for that.

In terms of issues around private hospital data, there is certainly private hospital data that we do have. They are required through regulatory processes to report on substantial amounts of data. Where it is commercial-in-confidence data, we do not have access to it. The private system does provide substantial data to the Commonwealth with regard to Commonwealth datasets. They have dual obligations: a large amount of data goes to the Commonwealth around the Commonwealth funding et cetera; where it is relevant to us we also, through our regulatory relationship with the privates, get some data. Many of the private hospitals do not use digital medical records—they are still on paper records—so the interface between Ambulance and their systems is far more primitive than we have in the public sector.

Ms BOLTON: When you have hospitals that are providing emergency capacity, information is not available with regard to ambulances and where they are going and when they are on bypass?

Dr Rosengren: Are you referencing the Noosa Hospital as your example?

Ms BOLTON: Yes.

Dr Rosengren: Ambulance absolutely will have all of that information around their relationship—arrival time, off-load time, release time et cetera—but the Noosa Private Hospital does not operate on the electronic medical record system that we use, so the hospital-based clinical data is not similar to what we have in our public system across the board. There is a complexity there. The privates are beginning to move into an ieMR—integrated electronic Medical Record environment. It is very costly for them.

Mr BAILEY: Are you aware of any patient aggression incidents in emergency departments stemming from the so-called real-time data since it has commenced?

Dr Rosengren: I have not had anything escalated to me as the director-general specifically on that, no.

Mr BAILEY: Nothing has come through the department to you on this?

Dr Rosengren: I have not received any information that suggests that there is any specific incidence of violence or aggression. I am aware of statements in media around the specific issue, but I have not had any specific cases as per your question put to me that I am aware of as the director-general.

Mr BAILEY: I would certainly suggest maybe having a look at that. I am getting feedback from staff in emergency departments that they are having some cases where people come and have to wait quite a period of time, quite different to how they have read the real-time data. That has come from a number of different sources. I just put that on the record. When will the Townsville Hospital expansion open?

Dr Rosengren: I cannot answer that question explicitly. It has only had a contract for stage 1 and a stage 2 contract for construction does not yet exist. I will hand over to Paul.

Mr Emmett: There is no confirmed timeline at the moment. As the director-general has mentioned, stage 1 was wrapped up in December. We are waiting to go back to market for stage 2. We have a fully documented building ready to go.

Mr BAILEY: But unknown at this stage?

Mr Emmett: Yes.

Mr BAILEY: In terms of the Bundaberg Hospital, can you advise whether there have been any directions or engagement in terms of the project team in relation to the scope of that, particularly any downsizing of the Bundaberg Hospital's scope?

Dr Rosengren: I think for the best answer I will refer to my expert on infrastructure.

Mr Emmett: There has been no de-scoping of the Bundaberg Hospital. It is tracking as per stage 1 and the early works program.

Mr BAILEY: The minister was asked about this and refused to clarify the matter, and you are saying that you do not believe there is any change to the actual scope.

Mr Emmett: From Health Infrastructure Queensland, as we are delivering the project, there has been no change to the scope of the project.

Mr BAILEY: At this point in time?

Mr Emmett: That is correct.

Mr BAILEY: Last year the Queensland parliament passed the Health and Other Legislation Amendment Bill (No. 2) 2023, which amended the Termination of Pregnancy Act 2018 and the Criminal Code Act 1899 to enable nurses and midwives to perform medical terminations through the use of termination-of-pregnancy drugs. Can you advise the committee how any future developments, in terms of termination-of-pregnancy drugs or procedures, could be made without legislative amendments, given that there is now a gag in parliament on new legislation or any motions in relation to the issue of termination of pregnancy?

CHAIR: I think we are straying from the general content of the annual reports.

Mr BAILEY: I think that legislation was within that year of 2023-24.

CHAIR: I am not sure the reports cover in any detail issues around termination of pregnancy.

Mr J KELLY: With respect, page 72 does deal with the Queensland Women's Strategy, which would deal with this, I believe.

CHAIR: It is a bit of a long bow. I will allow the question. We will see where this goes.

Dr Rosengren: The specific question?

Mr BAILEY: Can you advise the committee on how any future developments in terms of termination-of-pregnancy procedures or drugs could be made without legislative amendments, given there is a gag in parliament now in terms of new legislation or motions on the termination of pregnancy?

Dr Rosengren: I am not aware of any specific work or advice I have received on that so I am unable to provide an answer, sorry.

Mr BAILEY: Right, okay. Fantastic. On page 5 of the annual report we see 'new ways of accessing care, integrating more effectively with the broader health sector, and expanding our workforce'. Nurse-led clinics certainly would fall into that category and were announced previously. However, the Gladstone nurse-led clinic opened in November and, compared to the hours that were announced by Queensland Health of 8 am to 10 pm seven days a week, we actually found that the hours were severely cut by more than 40 per cent. This is in a shift town, Gladstone being a well-known energy powerhouse of Queensland. It is now a nine-to-five clinic. We are now seeing reviews happening of the Mount Gravatt nurse-led clinic and the Brisbane CBD nurse-led clinic along similar lines. Is this not a reduction in terms of primary care in our communities in those areas in terms of Queensland Health's provisions?

Dr Rosengren: The nurse-led clinics have been delivered as per the budget that was allocated by the government of the day. In fact, it is one of the challenges from a structural perspective, which we referenced in our earlier conversation. We did have to, without budget, spend substantial money on the infrastructure to create the clinics and then the clinics have been based on local consultation with the staff et cetera. Each one of them is different, based on the local needs and consistent with the budget that was allocated to deliver those services.

Mr BAILEY: In terms of the cost of a procedure in a nurse-led clinic as opposed to the cost of a procedure in an emergency department, surely the nurse-led clinic cost would be a lot lower and surely we want people going to nurse-led clinics for relatively minor matters rather than clogging up our emergency departments. I understand your issue around the budget, but I am talking about the hours being cut and I am talking about the broader issue of what is value for money given how much emergency departments are an expense to you and the department. Surely having nurse-led clinics drawing that demand from emergency departments seven days a week, 14 hours a day, is an asset for our health system.

Dr Rosengren: I hope very much to be able to answer that with specificity once we have done our scheduled and planned review of the clinics and their activity and their cost, but at this point in time I do not have the specifics. You referenced that there will be a review. It was scheduled that there will be a review. We are allowing the clinics to run for a full six months to ensure we get sufficient data around volume and to give the clinics an opportunity to get sufficient volume. Then we will undertake a review and then I will be able to provide much more clarity around the cost impact and the value that you are referencing.

Mr BAILEY: There is a Gympie nurse-led clinic that has not yet opened. When is that likely to open?

Dr Rosengren: The Gympie nurse-led clinic is scheduled to be opened; however, they have had some difficulties with regard to the infrastructure and some water pipe leakages which the lease owner is currently working through. The Sunshine Coast health service is working with the Queensland accommodation office to try to resolve those issues around the infrastructure for the clinic to open. We are waiting for the landlord to be able to work with us around getting that resolved.

Mr BAILEY: Just to be clear, the review of nurse-led clinics does involve a proposal to cut the hours significantly; does it not?

Dr Rosengren: I am not aware of anything. The nurse-led clinics have been opened, as I have referenced, with the budget that was allocated.

CHAIR: We are starting to stray into areas of opinion. I think the director-general has answered your questions. I am going to wrap things up because we are over time.

Mr J KELLY: The annual report is quite broad. I had a number of questions I have not been able to get to. Is there any opportunity to put a couple of questions on notice?

CHAIR: Sure.

Mr J KELLY: I will supply those to the secretariat by the end of the day.

CHAIR: That concludes this briefing. Thank you everyone who has participated today. A transcript of these proceedings will be available on the committee's webpage in due course. We have five questions on notice. Thank you for your very fulsome and open answers. Thank you for giving us such a large part of your day to be here today. I declare this public briefing closed.

The committee adjourned at 11.32 am.