MIBB Full Meeting 30 October 2007 Minutes Endorsed

Venue: Level 28 Conference Room, Clayton Utz 71 Eagle Street Brisbane
Duration: 10.15am to 3.00pm (Caucus from 9.30am to 10.15am)

Attendees	
Facilitator	
Michael Klug	Partner, Clayton Utz
Ann Curby	Clayton Utz
Queensland Health Representatives	
Dr Richard Ashby	Executive Director Medical Services Princess Alexandra Hospital (from 1.30pm)
Keith Bowden	A/Director Industrial Relations Human Resources Branch
Dr David Farlow	Director Medical Services – Mackay Hospital
Carissa Hagenbach	Senior Advisor Human Resources Branch
Mary Kelaher	Senior Director Human Resources
Dr Denis Lennox	Rural Medical Advisor
Dr Susan O'Dwyer	Director RAPTS
Michael Reeves	A/Program Manager Industrial Relations Human Resources Branch (until 12noon)
Union Representatives	
Dr Bruce Burrow	Delegate QPSU
Jenny Cannon	Advocate QPSU
Dr Sandy Donald	Vice President QPSU
Dr Coralie Endean	Delegate ASMOFQ
Dr Stephen Morrison	Delegate SDQ
Dr Christian Rowan	Delegate SDQ
Apologies	
Dr Shane George	Treasurer/Assistant Secretary SDQ
Dr Peter Hopkins	Delegate SDQ
Michael Kalimnios	Executive Director, Corporate Services
Susanne LeBoutillier	A/Director Medical Workforce Advice and Coordination
Dr Alex Markwell	Delegate SDQ
Dr Oscar Naar	Delegate QPSU
Dr Colin Page	Delegate QPSU
Dr Ken Pullen	Delegate QPSU
Dr Russell Schedlich	Medical Superintendent – Rockhampton Hospital (by teleconference)
Rupert Tidmarsh	Industrial Officer SDQ
Shirelle Wolfe	Senior Advisor Human Resources Branch
Janene Zillman	Advisor Human Resources Branch

Agenda Item	Action Items
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5. Review of Action Items	
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5.2 Standing Agenda Items	
5.2.1 MIBB Sub Committee Reports	

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6. Other Business

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6.8 ED 25% Loading	**Action 21:** HRB to convene meeting with QPSU.

Claiming Stamp duty on appointment

MIBB Full Meeting Proposed Agenda
Tuesday 30 October 2007

Venue: Level 28 Conference Room, Clayton Utz 71 Eagle Street Brisbane

1. Caucus

MIBB Members

Queensland Health Representatives	
Michael Kalimnios	Executive Director Corporate Services – Queensland Health
Dr David Farlow ✓	Director Medical Services – Mackay Hospital
Dr Russell Schedlich A	Medical Superintendent – Rockhampton Hospital
D Susan O'Dwyer ✓	Director RAPTS
Dr Denis Lennox ✓	Rural Medical Advisor
Susanne LeBoutillier A	A/Director Medical Workforce Advice and Coordination
Mary Kelaher ✓	Senior Director Human Resources Branch
Dr Richard Ashby	Executive Director Medical Services Princess Alexandra Hospital
Dr Paul Zimmerman A	Director of Thoracic Medicine, The Prince Charles Hospital
Union Representatives	
Jenny Cannon	Advocate QPSU
Dr Bruce Burrow	Delegate QPSU
Rupert Tidmarsh A	Industrial Officer ASMOFQ
Dr Christian Rowan	Delegate ASMOFQ
Dr Stephen Morrison	Delegate ASMOFQ
Dr Alex Markwell	Delegate ASMOFQ
Dr Coralie Endean	Delegate ASMOFQ
Dr Peter Hopkins	Delegate ASMOFQ
Dr Oscar Naar	Delegate QPSU
Dr Sandy Donald	Vice President QPSU
Dr Colin Page	Delegate QPSU
Dr Shane George	Delegate ASMOFQ
Facilitator	
Michael Klug ✓	Partner, Clayton Utz
Ann Curby ✓	Clayton Utz
Support and Secretariat Staff	
Beryl Griffin A	Program Manager Human Resources Branch Medical Team
Carissa Hagenbach A	Senior Adviser Human Resources Branch
Janene Zillman A	Adviser Human Resources Branch
Shirelle Wolfe A	Senior Adviser Human Resources Branch

2. CONFIRMATION OF ATTENDANCE

3. APOLOGIES

Rupert Tidmarsh ASMOFQ, Dr Russell Schedlich EDMS Rockhampton, Ms Susanne LeBoutillier A/Director MWAC, Dr Paul Zimmerman Director Thoracic Medicine TPCH, Shirelle Wolfe Senior Advisor HR Branch, Janene Zillman Advisor HR Branch.

4. RATIFICATION OF MINUTES (EB61624)

5. AGENDA ITEMS

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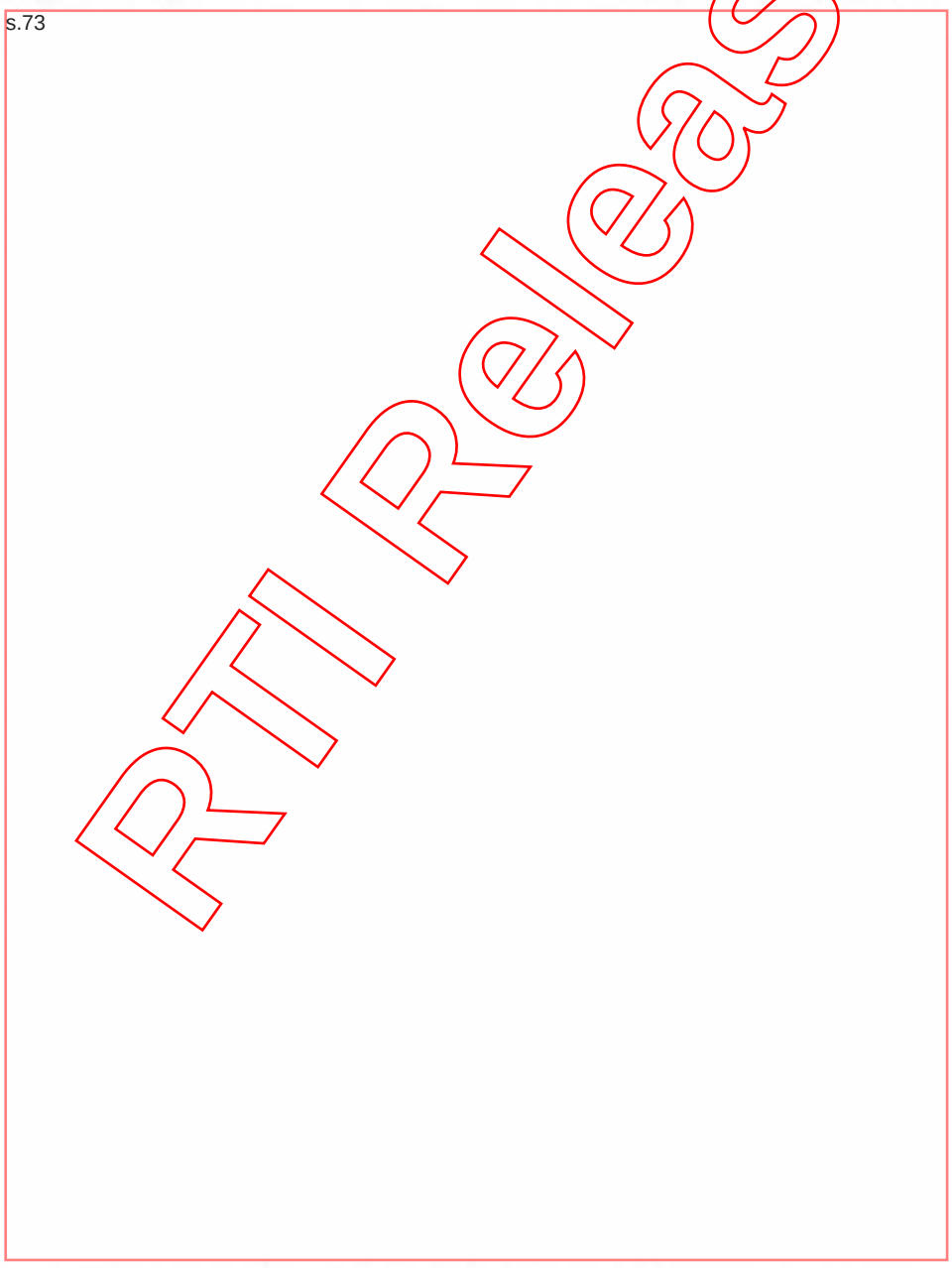

6. OTHER BUSINESS

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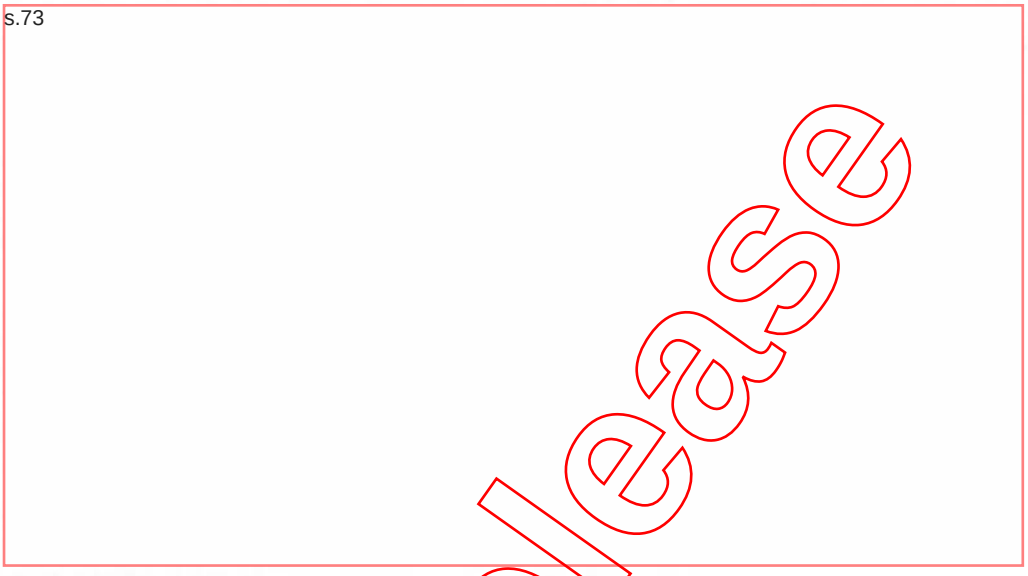

6.8. ED 25% Loading

7. NEXT MEETING DATES

13 November 2007 Short MIBB

27 November 2007 Full MIBB

18 December 2007 Final MIBB 2007

MIBB Full Meeting 25 September 2007 Unconfirmed Minutes

Venue: Level 28 Conference Room, Clayton Utz 71 Eagle Street Brisbane
Duration: 9.30am to 3.00pm (Caucus from 9.30am to 10.00am)

Record of Attendance

Attendees	
Queensland Health Representatives	
Ms Chris Keech	Director, Business Performance & Improvement (proxy for EDCS)
Dr Paul Zimmerman	Director of Thoracic Medicine, The Prince Charles Hospital
Dr Russell Schedlich	Medical Superintendent – Rockhampton Hospital (by teleconference)
Dr Susan O'Dwyer	Director RAPTS
Dr Richard Ashby	Executive Director Medical Services Princess Alexandra Hospital
Dr Denis Lennox	Rural Medical Advisor
Jody Meier	A/Director Medical Workforce Advice and Coordination
Mary Kelaher	Senior Director Human Resources
Union Representatives	
Rupert Tidmarsh	Industrial Officer ASMOFQ
Dr Stephen Morrison	Delegate ASMOFQ
Dr Alex Markwell	Delegate ASMOFQ
Dr Sandy Donald	Vice President QPSU
Dr Oscar Naar	Delegate QPSU
Dr Ken Pullen	Delegate QPSU
Facilitator	
Michael Klug	Partner, Clayton Utz
Ann Curby	Clayton Utz
Apologies	
Jenny Cannon	Advocate QPSU
Dr Bruce Burrow	Delegate QPSU
Dr Peter Hopkins	Delegate ASMOFQ
Dr Coralie Endean	Delegate ASMOFQ
Dr Christian Rowan	Delegate ASMOFQ
Dr Colin Page	Delegate QPSU
Kevin Hegarty	District Manager Sunshine Coast Health Service District
Dr David Farlow	Director Medical Services – Mackay Hospital
Dr Coralie Endean	Delegate ASMOFQ
Dr Shane George	Treasurer/Assistant Secretary ASMOFQ
Michael Kalminios	Executive Director, Corporate Services
Susanne LeBoutillier	A/Director Medical Workforce Advice and Coordination
Support and Secretariat Staff	
Beryl Griffin	Program Manager Human Resources Branch Medical Team
Carissa Hagenbach	Senior Adviser Human Resources Branch
Janene Zillman	Adviser Human Resources Branch
Shirelle Wolfe	Senior Adviser Human Resources Branch

Deleted: Branch

Agenda Item	Actions
2.) Confirmation of Attendance Welcome to Dr Ken Pullen - QPSU	
3.) Apologies	
4.) Ratification of Minutes	Minutes confirmed.
5.1.) Review of Action Items from Last Meeting	
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5.2.) Standing Agenda Items	

Agenda Item	Actions
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5.6.) 25% Emergency Department Loading Not discussed.	
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6.4.) Communications Consultant	

Agenda Item	Actions
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Queensland Government
Queensland Health

MEDICAL IBB GROUP

UNCONFIRMED MINUTES - FULL MEETING

3 May 2007

Level 28 Conference Room, Clayton Utz,
71 Eagle Street Brisbane

1. ATTENDANCE AND APOLOGIES

Unions
Dr Sandy Donald, Vice President (QPSU)
Jenny Cannon, Advocate, Queensland Public Sector Union (QPSU)
Dr Bruce Burrow, Delegate (QPSU)
Rupert Tidmarsh, Industrial Officer (ASMOFQ)
Shirelle Wolfe, Assistant Industrial Officer (ASMOFQ)
Dr Christian Rowan, Delegate (ASMOFQ)
Dr Peter Hopkins, Delegate (ASMOFQ)
Dr Coralie Endean, Delegate, (ASMOFQ) (arrived at 11:45)
Dr Alex Markwell, Delegate, (ASMOFQ) (arrived at 11.45)

Queensland Health
Mary Kelaher, Senior Director Human Resource
Dr Denis Lennox, Rural Medical Advisor
Susanne Le Boutillier, A/Director Medical Workforce Advice and Coordination
Dr David Farlow, Medical Superintendent, Proserpine Hospital (Via Teleconference)
Dr Michael Whiley, Clinical Director, Queensland Health Pathology Service (QHPSS)
Dr Russell Schedlich, Medical Superintendent, Rockhampton Hospital
Dr Paul Zimmerman, Director of Thoracic Medicine, The Prince Charles Hospital (TPCH)
Kevin Hegarty, District Manager, Sunshine Coast Health Service District
Clare Dwyer, Principal Advisor, Human Resources Branch
Graeme Prideaux, Principal Advisor, Human Resources Branch
Janene Zillman, Advisor, Human Resources Branch

Communications Consultant
John Reynolds

Facilitator
Michael Klug, Partner, Clayton Utz

Apologies
Dr Oscar Naar, Delegate, (QPSU)
Dr Colin Page, Delegate, (QPSU)
Dr Mark Mattiussi, District Medical Superintendent, Logan/Beaudesert Health Service District
Dr Nick Buckmaster, Delegate, Australian Salaried Medical Officers Federation Queensland (ASMOFQ)

Visitors
Fiona Wright and Vince Dobbelaar, QFleet

Warren Locke and Diana Schmalkuche, QH Aboriginal and Torres Strait Islander Health Worker Project officers

2. CONFIRMATION OF PREVIOUS MINUTES (27 February 2007)

- To be discussed at next meeting scheduled to take place 31 May 2007.

3. BUSINESS ARISING FROM PREVIOUS MINUTES (27 February 2007)

- To be discussed at next meeting scheduled to take place 31 May 2007.

4. GENERAL BUSINESS

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4.6 Emergency Department 25% loading (ER Circular 24/06)

- Queensland Health clarified the entitlement in that it applies to those doctors who are "permanently working in the ED" (Not relative to actual employment status eg. Temp, perm etc).

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5. Other Business:

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6. Next meeting:

Full meeting to be held on **Thursday 31 May 2007, 10 am - 2 pm** (with the option to convene separate Management and Union caucuses from 9.30 am.)

[Insert *RecFind number if known]* **[File *Reference No. if known]***
ME02063
Queensland Health
BRIEFING NOTE FOR APPROVAL

……..…….…… OK Dated / /
Noted /Approved / Not Approved **Further information required** ……..……..…… Dated / /

TO: **Executive Director Corporate Services**

FROM: *A/Senior Director*
Human Resources Branch

SUBJECT: **Eligibility for the Emergency Department extended-hours payment for Senior Medical Officers**

PURPOSE
To seek the approval of a strategy regarding an offer to amend the eligibility criteria for the Emergency Department extended-hours payment for Senior Medical Officers (SMO) (25% loading).

RECOMMENDATION
It is recommended that senior officers of Queensland Health meet with Alex Scott, General Secretary Queensland Public Sector Union (QPSU) and Dr Don Kane, President Salaried Doctors Queensland (SDQ) to address previous understandings about eligibility criteria.

FUNDING SOURCE
- Nil.

CURRENT ISSUES
- On 13 September an email was sent from then Senior Director Human Resources to QPSU and SDQ advising amended criteria for payment of 25% loading (attachment A):
  - Districts had discretion to extend payments to Medical Superintendents/Deputy Medical Superintendents and any SMO
  - Working regularly rostered extended-hours shifts in an emergency department.
  - There is no record of Director-General approval for these amended criteria.
  - No funding has been sought or approved.
  - Districts with regional and small hospitals will be affected.
- Human Resources Branch, at the December MIBB, committed to circulating advice regarding the eligibility criteria for the 25% loading by the end of January.
- QPSU and to a lesser extent, SDQ are expecting this advice to be in accordance with this email advice. The email advice was written after some discussions with QPSU advocate Ms Jenny Cannon in relation to eligibility criteria. The advice effectively broadens the applicability of the 25% loading to SMOs who should not have been in receipt of this extra payment. No additional funding was sought with respect to the broadened application.
- There are two options for resolution:
  a) The Director-General endorses the amended criteria. QPSU and SDQ would support this as it reflects a previous understanding. However, Districts would have concerns as there is not additional funding attached.
  b) A high-level discussion with QPSU and SDQ deferring approval at this time in consideration of the imminent renegotiations for medical enterprise bargaining. This option could enable amendments to be fully costed and funded. Unions, especially QPSU are likely to react adversely

Author's Name: Shirelle Wolfe Position: Senior Adviser Unit: Workplace Relations Unit, HR Branch Tel No: 3234 0059 Date: 31 January 2008	Cleared by: Name: Helen Ceron Position: Deputy Senior Director, Industrial Relations Unit: Human Resources Branch Tel No: 3234 0784 Date: 31 January 2008	Cleared by: Name: Russ Wilde Position: A/Senior Director Human Resources Branch Tel No: 3234 1481 Date:

and there may be some adverse response from a small number of SMOs.
- Option B is the recommended option.

PROPOSED ACTIONS
- Human Resources Branch will liaise with the Director-General about the Queensland Health response.
- Human Resources Branch will coordinate a meeting with relevant unions.

BACKGROUND
- 6 March 2006, QPSU and Director-General sign a Memorandum of Understanding regarding the Payment of 25% loading for Emergency Department SMOs (attachment B).
- 13 May 2006, Director-General approves criteria for eligibility of 25% loading. Eligible SMOs were those who worked extended-hours arrangements in emergency departments and were not employed in other roles i.e. Medical Superintendents/Deputy Medical Superintendents (attachment C).
- In mid-2007 QPSU raised the issue of the 25% loading criteria at MIBB. It sought the payment of the 25% loading for s.47(3)(b) Hospital. [redacted] works some extended-hours shifts as well as having an administrative function. According to the Director-General approved criteria, as s.47(3)(b) - personal information was not entitled to the 25% loading (attachment D).
- Since early September 2007 QPSU has sought to extend eligibility of the loading beyond that approved i.e. Medical Superintendents/Deputy Medical Superintendents would be eligible for ED 25% loading.

MEDIA IMPLICATIONS AND KEY MESSAGES
Queensland Health is working with Unions to resolve any issues regarding additional payments to senior medical officers providing emergency services.

ATTACHMENTS:
Attachment A – Email from SDHR to QPSU and SDQ
Attachment B – Memorandum of Understanding – QPSU and Queensland Health
Attachment C – BR027236
Attachment D – QPSU letter to s.47(3)(b) re: s.47(3)(b)

COMMENTS

Author's Name: Shirelle Wolfe Position: Senior Adviser Unit: Workplace Relations Unit, HR Branch Tel No: 3234 0059 Date: 31 January 2008	Cleared by: Name: Helen Ceron Position: Deputy Senior Director, Industrial Relations Unit: Human Resources Branch Tel No: 3234 0784 Date: 31 January 2008	Cleared by: Name: Russ Wilde Position: A/Senior Director Human Resources Branch Tel No: 3234 1481 Date:

Queensland Government
Queensland Health

MEDICAL IBB GROUP

UNCONFIRMED MINUTES OF MEETING

7 FEBRUARY 2006

1. ATTENDANCE AND APOLOGIES

Queensland Health Management
Uschi Schreiber, Director General (1 hour)
Barry Leahy, A/Executive Director, Industrial Relations (1 hour)
Anne Crossland, CHRIRPSC
Daniel Reichelt, CHRIRPSC
Chantal Casey, CHRIRPSC
Damian May, CHRIRPSC
Kevin Hegarty, District Manager, Sunshine Coast HSD
Dr David Farlow, Medical Superintendent, Proserpine Hospital
Dr Mark Mattiussi, District Medical Superintendent/District Manager, Logan/Beaudesert HSD
Susanne LeBoutillier, A/Manager Medical Workforce Advice and Coordination
Dr Paul Zimmerman, Director of Thoracic Medicine TPCH
Dr Denis Lennox, Medical Adviser, Rural Health Services
Dr Michael Daly, Clinical Director Patient Safety, SAHS
Tracey Silvester, Manager, Southern Zone Management Unit

Unions
Dr Nick Buckmaster, President, ASMOFQ
Rupert Tidmarsh, Industrial Officer, ASMOFQ
Dr Alex Markwell, ASMOFQ
Dr Peter Hopkins, ASMOFQ
Dr Christian Rowan, ASMOFQ
Dr Colin Page, QPSU
Jenny Cannon, Advocate, QPSU
Dr Sandy Donald, Delegate, QPSU
Dr Franco Martinese, QPSU

APOLOGIES
Terry Mehan, General Manager, Southern Area Health Service
Dr Daniel Halliday, ASMOFQ
Dr Bruce Burrow, QPSU

2. CONFRIMATION OF MINUTES OF PREVIOUS MEETING

Copies of minutes for meetings on 15 December 2005 and 25 January 2006 were provided at the meeting and are to be confirmed at the meeting on 28 February 2006.

3. BUSINESS ARISING FROM PREVIOUS MEETING

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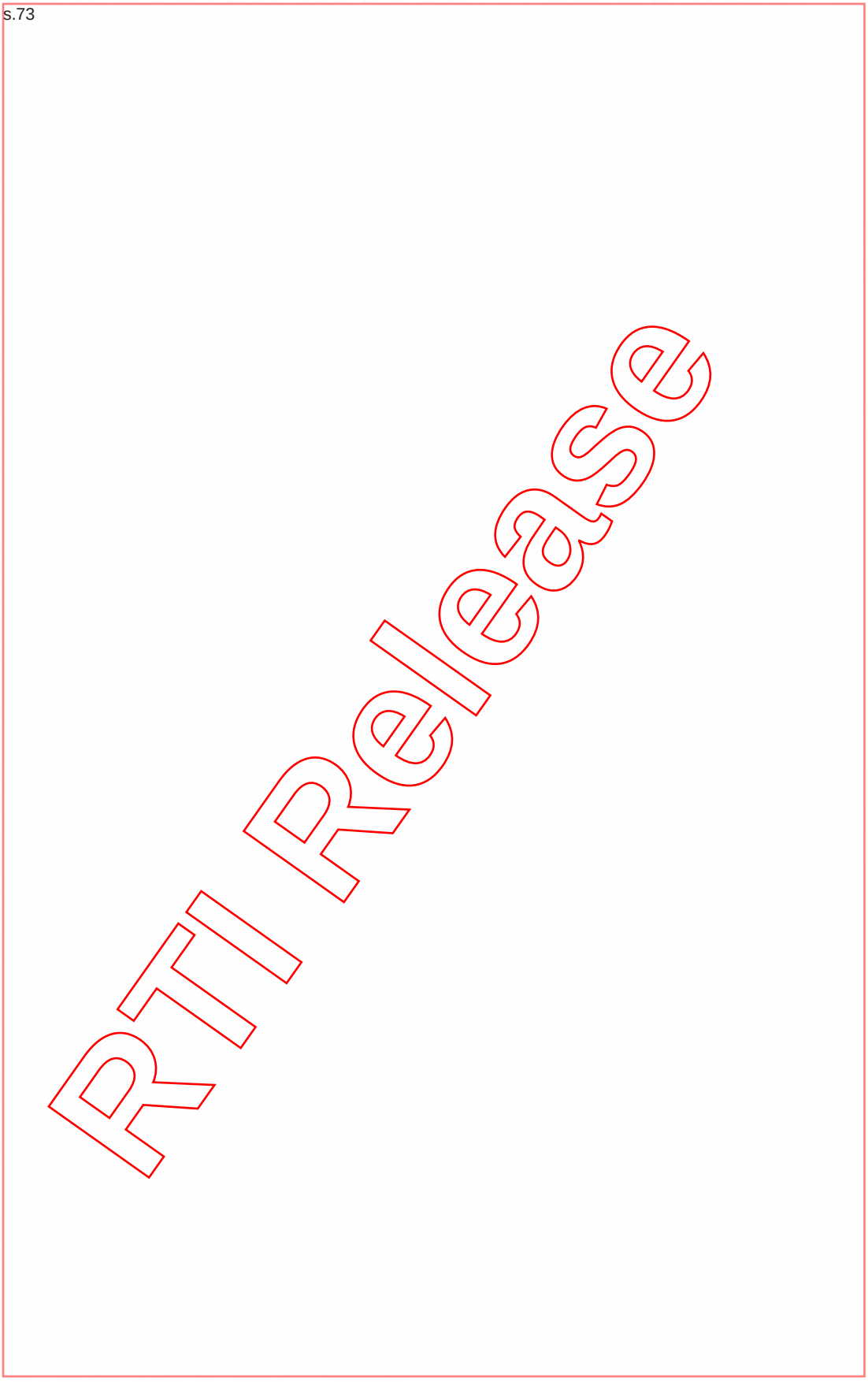

4. NEW BUSINESS

4.1 Premier's Announcements (Ms Schreiber and Mr Leahy present for this item)

- Extensive discussion occurred regarding the announcement made by the Premier on 3 February about, largely, improvement to private practice arrangements.
- QPSU voiced concerns regarding the consultation undertaken in developing the package and the adequacy of the distribution of benefits in the final package.
- Ms Schreiber acknowledged that normal processes had not been followed but also stressed that events have occurred in both an industrial and a political climate which are far from normal. She reaffirmed Queensland Health's commitment to MIBB and her personal commitment and support for the group and its processes.
- Ms Schreiber advised that as details of the package had been released by the Premiers' office, there was little scope, or time, to make significant changes to the break-up of the package. Minor adjustments only could be considered, and any proposals for these would be required by 2:00pm 07/02/06
- QPSU advised that they would present their concerns regarding the process undertaken to the Premier. QPSU asked QH to consider how to repair damage done to image of MIBB.
- Ms Schreiber acknowledged QPSU's concerns and agreed to find opportunities to repair any damage to the perception of unions and MIBB by staff, on the understanding that all parties agreed that the current situation was not created by any of the parties
- QH provided clarification of some benefits:
  - Option B participants will have Option A paid for their overtime and penalties
  - Option A improvements flow to Option P
  - Substantial effort has been expended to find a way to provide benefits to Emergency Department physicians in a way that could prevent flow-ons. The trust funds were the only viable solution.
  - Medical Superintendents in receipt of MM allowance to receive specialists Option A allowance. Medical Superintendents in receipt of CM allowance to receive SMO's Option A allowance.
  - No grandfathering to continue for those currently receiving it.
  - Inaccessibility Incentive Scheme to apply to MSRPPs/MORPPs from 01/09/05. Improvements for other doctors to apply from 01/01/06.

  - Public Health specialists to be offered 'specialists' Option A allowance. Public Service SMOs to be offered 'SMOs' Option A allowance.
  - ASMOFQ advised that the Specialists Private Practice SubGroup has been considering model to maximise PP revenue
  - Option A allowance is not included for on-call
- QPSU provided a rationale for further increases for Emergency Department SMOs and reinforced their concerns about distribution of the benefit.
- QH advised that the Private Practice proposal could be further developed by the SubGroup on the understanding that it must be cost neutral to QH.

ACTION:

- QH to advise the DG of the outcome of discussions.
- Specialists Private Practice SubGroup to prepare a brief for approval for cost neutral improvements to private practice arrangements by end of April.
- Agreement by all parties that the clause allowing the Director-General discretionary power to authorise payments in area 4 to be deleted.

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5. GENERAL BUSINESS: Sub Group Reports

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5.2 Specialists Private Practice Sub Group

5.2.1 Private Practice Discussion Paper

- Agreed to brief Director General on generation of further private practice revenue for QH through creating incentives in Option A.
- QH expressed concern over:
    - Impact on current Option A revenue
    - Do not want to bring 'extra' patients into the system.
    - Needs to be easy to understand and administer
    - Need full cost impacts – preferably cost neutral.
    - Need implementation plan and understanding of required changes to current practices
- QH expressed concern about impact of reducing facility and admin fees – to what extent is the infrastructure and admin staff supported by these fees?

ACTION:

- Sub Group to prepare brief by end of April.

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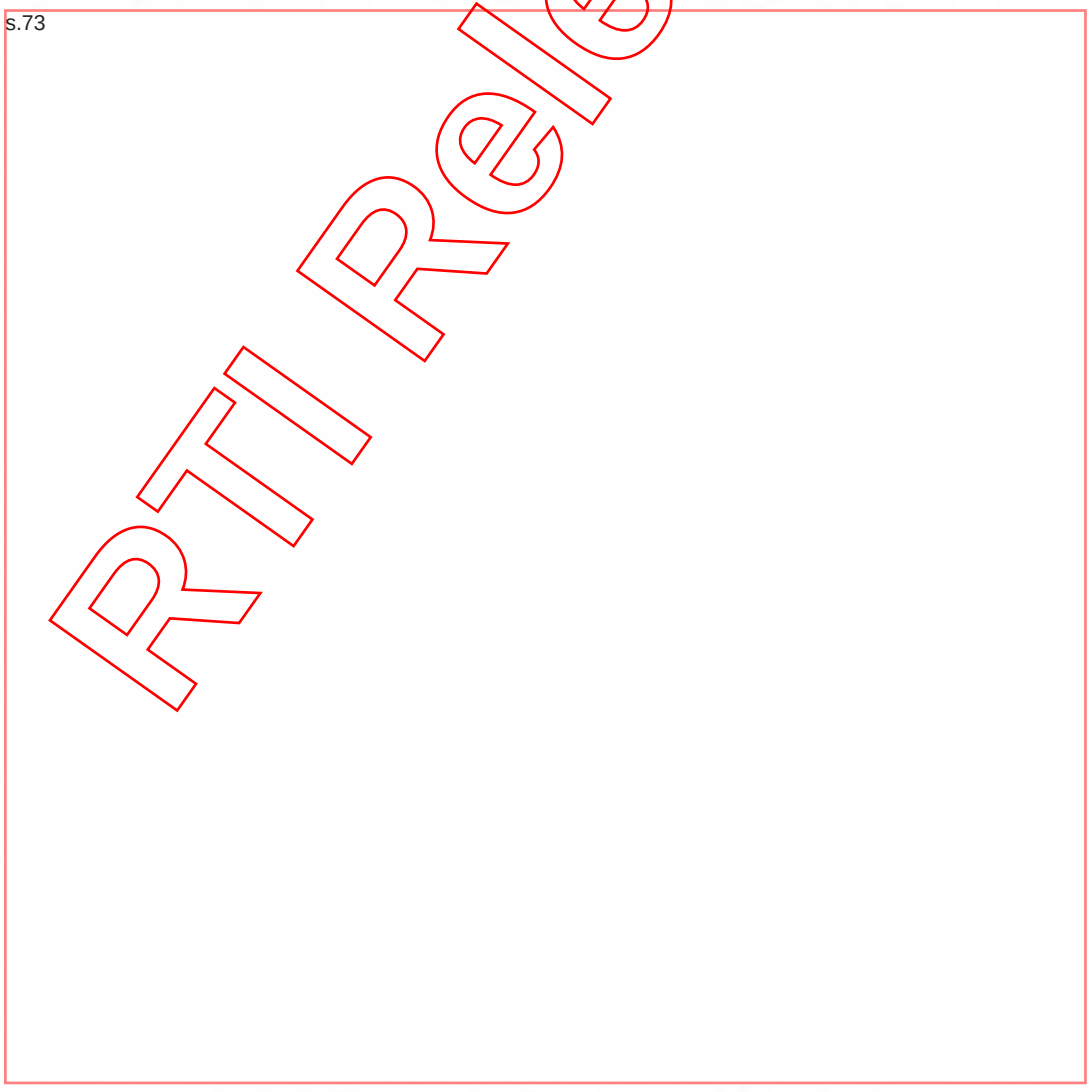

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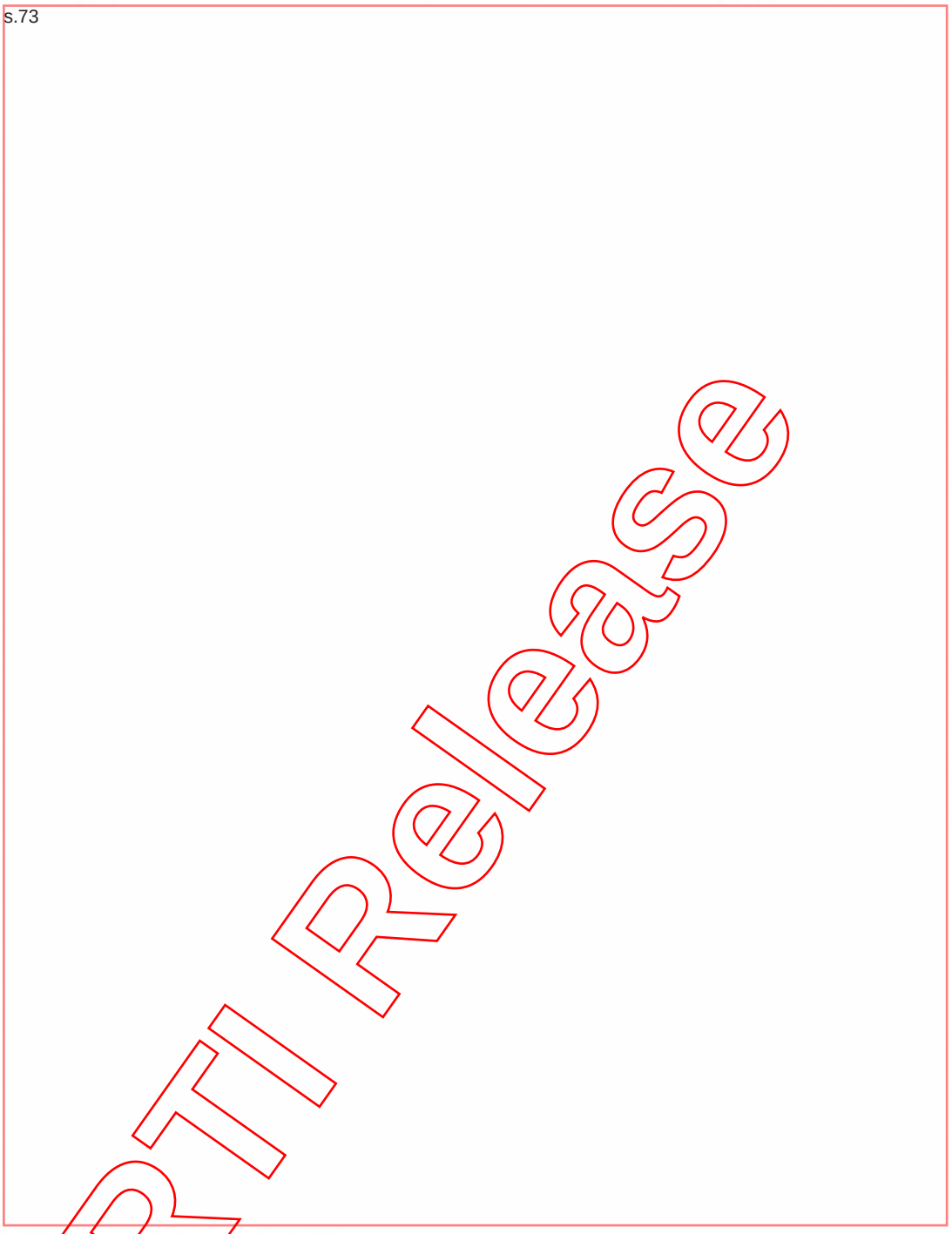

6. NEXT MEETING

9:00 Tuesday 28 February

Level 3 (Videoconferencing Room) QHB

[Insert RecFind number if known] **ME02038**

……..…… OK Dated / /
Noted /Approved / Not Approved **Further information required** ……..…… Dated / /

Queensland Health
BRIEFING NOTE FOR ENDORSEMENT

TO: **Executive Director Corporate Services**

FROM: *Senior Director Human Resources*

SUBJECT: **Payment of the Emergency Department Extended Hours benefit to** s.47(3)(b).

PURPOSE

To seek endorsement of the strategy to resolve the issue of s.47(3)(b) eligibility for the Emergency Department Extended Hours Contract (ED contract).

RECOMMENDATION

It is recommended that:

- The agreement to extend the ED contract to s.47(3)(b) is honoured for 2007 only as the decision to extend the contract to s.47(3)(b) was made in error.
- s.47(3)(b)
- That advice is circulated to the Districts clarifying the circumstances under which the ED contract can be offered to SMOs.

FUNDING SOURCE

- N/A

CURRENT ISSUES

- Human Resources Branch agreed at the December Medical Interest Based Bargaining (MIBB) group meeting to circulate advice regarding the eligibility criteria for the ED contract by the end of January.
- The Human Resources Branch has held previous meeting with Queensland Public Sector Union (QPSU) in September 2007 to discuss the eligibility criteria and through these discussions and subsequent emails agreement was reached that significantly amended the eligibility criteria. This was done without full access to all relevant information.
- The amended criteria broaden the eligibility for the ED contract beyond those SMOs for whom it was originally intended and budgeted. No additional funding has been sought.
- s.47(3)(b) - personal information
- QPSU and to a lesser extent, Salaried Doctors Queensland (SDQ), are expecting that the clarifying criteria will be in accordance with an email sent to Ms Jenny Cannon, QPSU advocate on 13 September 2007 (attachment A).
- The ED benefit is not an award entitlement and is offered to eligible SMOs on a contract basis.

PROPOSED ACTIONS

- Queensland Health maintains the position that Districts that the ED benefit is a recruitment and retention incentive for SMOs working solely in emergency departments. Circular ER 24/06 (attachment B) be updated to clearly state that this is the basis for eligibility for an ED contract.
- s.47(3)(b) - personal information

Author's Name: Shirelle Wolfe Position: Senior Advisor Industrial Relations Unit: Human Resources Branch Tel No: 3234 0059 Date: 29 January 2008	Cleared by: Name: Helen Ceron Position: Deputy Senior Director Industrial Relations Unit: Human Resources Branch Tel No: 3234 0784 Date:	Cleared by: Name: Russ Wilde Position: Senior Director Human Resources Unit: Human resources Branch Tel No: 3234 1481

s.47(3)(b) - personal information

BACKGROUND

- In January 2006, Caboolture Emergency Department had to close for a period due to insufficient staffing of senior medical officers. Other emergency departments were struggling to recruit sufficient numbers of senior medical officers.
- This came in the wake of the negotiations and certification of the *Medical Officers' Certified Agreement 2005 (No.1)*. There was some level of dissatisfaction amongst senior medical officers about the increases provided for in the Agreement.
- The ED benefit was announced post EB and provided for a targeted payment to SMOs working extended hours arrangements in emergency departments.
- s.47(3)(b) - personal information
-
- The QPSU made further representations to Human Resources Branch that were ultimately successful, arguing that any SMO who works regularly rostered shifts in an extended-hours arrangement and is required to do so by the District should receive an ED contract.
- Management concerns were noted on the original brief to the Director General (attachment D) that this arrangement is limited to emergency physicians only working in Emergency Departments and not employed in other roles.
- Human Resources Branch correspondence to the District allowed for an extension of this ED benefit for Medical Superintendents provided that the District requires them to work extended-hours shifts (attachment A).
- QPSU and SDQ have indicated at MIBB that their position was that all SMOs who do any extended hours shifts in emergency departments should be paid the supplementary loading regardless of the number of shifts or the frequency, or whether they are working in other departments.
- There is a degree of unrest amongst SMOs at s.47(3)(b) Hospital due to their perceptions of inequity about the application of the ED loading. The Executive Director of Medical Services, Dr Terry Hanelt, has indicated that several SMOs, employed in other areas of the hospital but who also work some extended hours shifts in ED, would be unwilling to work their rostered ED shifts if they did not receive the loading and s.47(3)(b) did.
- Funding has not been approved by Cabinet Budget Review Committee for this broader application.
- QPSU has signed a Memorandum of Understanding with Queensland Health that confirms it will not pursue further claims based on this payment in compliance with the Certified Agreement (attachment E).

MEDIA IMPLICATIONS AND KEY MESSAGES

Author's Name: Shirelle Wolfe Position: Senior Advisor Industrial Relations Unit: Human Resources Branch Tel No: 3234 0059 Date: 29 January 2008	Cleared by: Name: Helen Ceron Position: Deputy Senior Director Industrial Relations Unit: Human Resources Branch Tel No: 3234 0784 Date:	Cleared by: Name: Russ Wilde Position: Senior Director Human Resources Unit: Human resources Branch Tel No: 3234 1481

ATTACHMENTS:

Attachment A – Email correspondence
Attachment B – Circular ER 24/06
Attachment C – Letter to s.47(3)(b) re: s.47(3)(b)
Attachment D - Briefs BR027753 and BR027236 to Director General
Attachment E – Memorandum of Understanding – QPSU and Queensland Health

COMMENTS

Author's Name: Shirelle Wolfe Position: Senior Advisor Industrial Relations Unit: Human Resources Branch Tel No: 3234 0059 Date: 29 January 2008	Cleared by: Name: Helen Ceron Position: Deputy Senior Director Industrial Relations Unit: Human Resources Branch Tel No: 3234 0784 Date:	Cleared by: Name: Russ Wilde Position: Senior Director Human Resources Unit: Human resources Branch Tel No: 3234 1481

[Insert *RecFind number if known]* **[File *Reference No. if known]***

Queensland Health
EXECUTIVE MANAGEMENT TEAM BRIEFING NOTE
FOR ENDORSEMENT

……..…….…… OK Dated / /
Noted /Approved / Not Approved **Further information required** ……..……..…… Dated / /

TO: **Executive Director, Policy Planning and Resourcing**

FROM: *Senior Director Human Resources*

SUBJECT: **Clarification of eligibility for Senior Medical Officers' entitlement to 25% Emergency Department Supplementary Option A payment.**

PURPOSE

To seek the endorsement of a position for Queensland Health with regards to the 25% Supplementa Option A payment for Senior Medical Officers (SMOs) working extended hours shifts in emergency departments.

RECOMMENDATION

It is recommended that the

FUNDING SOURCE

- Funding has been approved by Cabinet Budget Review Committee for Option 1 only.

CURRENT ISSUES

- Queensland Public Sector Union (QPSU) circulated a copy of a letter addressed to s.47(3)(b) District Manager s.47(3)(b) regarding one of its members, s.47(3)(b), at Medical Interest Based Bargaining (MIBB) meeting on Tuesday 28 August, 2007 (attachment A).
- QPSU is acting on behalf of s.47(3)(b) Hospital, with regards to his claim for the Supplementary Option A payment for emergency department SMOs who participate in an extended-hours roster. s.47(3)(b) works some extended hours shifts in ED, as well as performing clinical duties in other areas of the hospital.
- Human Resources Branch has provided advice to the District Manager, s.47(3)(b) s.47(3)(b) that HRB does not consider s.47(3)(b) eligible for the Supplementary ED payment.
- The current Supplementary Option A contracts are very loosely worded (attachment B) and do not give clear guidelines for eligibility that conform with the intent of this payment.
- QPSU and the Australian Salaried Medical Officers' Federation, Queensland (ASMOFQ) indicated at the MIBB meeting that their position was that all SMOs who do any extended hours shifts in emergency departments should be paid the supplementary loading regardless of the number of shifts or the frequency, or whether they are working in other departments.
- There is a degree of unrest amongst SMOs at s.47(3)(b) Hospital due to their perceptions of inequity about the application of the ED loading. The s.47(3)(b) has indicated that several SMOs, employed in other areas of the hospital but who also work some extended hours shifts in ED, would be unwilling to work their rostered ED shifts if they did not receive the loading and s.47(3)(b) did.

Author's Name: Shirelle Wolfe Position: Senior Advisor Unit/District: Industrial Relations Tel No: 32340059 Date: 8 January 2008	Cleared by: Name: Helen Ceron Position: Unit/District: Tel No: Date:	Cleared by: (GM/ED) Name: Position: AHS: Tel No: Date:

- QPSU indicated via email on Wednesday 5 September, that as their member's claim was unsuccessful, they would expect that criteria for eligibility for the loading to be listed as an item for discussion at a specially convened MIBB meeting prior to 20 September 2007.
- HRB expects that QPSU will escalate this matter to the Queensland Industrial Relations Commission (QIRC) should the union not be in agreement with the Queensland Health position.
- Human Resources Branch needs to be able to present a firm position on this matter.

PROPOSED ACTIONS

- Clarification needs to be provided to Districts and medical officers about the intent and scope of application for this loading.

Option 1

- Queensland Health maintains the position that the 25% supplementary Option A loading is a recruitment and retention incentive for ED SMOs only.
- The loading would apply to SMOs who perform clinical duties in a designated emergency department only.
- Circular ER 24/06 be updated to clearly state the eligibility for this loading.
- The Supplementary Option A contracts be amended to reflect the eligibility criteria as outlined in the updated Circular ER 24/06 for new contracts.
- Doctors who have current Option A supplementary contracts would continue to receive the loading until such time as the contract expires.
- At contract renewal, the eligibility criteria would be applied and doctors would receive Supplementary Option A contracts in line with this criteria.
- This would conform to the intent of the payment, which was to provide extra remuneration (and therefore incentive) to ED SMOs who, due to the nature of extended-hours rostered shifts were unable to access the same level of private practice earnings or overtime as other specialists.
- Cabinet Budget Review Committee has approved funding as per the intent of this loading as a recruitment and retention strategy (attachment C).
- A significant risk with option 1 is the threat of withdrawal of labour by SMOs who would become ineligible for the loading, now and in the future. This is particularly likely in regional hospitals where medical officers may work across several departments including ED.
- The current *Medical Officers' Certified Agreement*, clause 6.3.7 (a) provides for Senior Medical Officers engaged prior to the date of certification of the agreement to participate in weekend extended hours arrangements on a voluntary basis (attachment D).
- It would be expected that the Unions would disagree with this option and seek to escalate this to the QIRC.

Option 2

- Queensland Health extends the loading to all SMOs who work any extended-hours shifts in designated emergency departments.
- This would permanently change the purpose of the loading from a recruitment and retention incentive for those unable to access private practice due to working regular extended-hours shifts to a reward and recognition payment that is over and above what SMOs receive in any other specialty area.
- This could be perceived as inequitable by medical officers in other specialties where recruitment and retention is also difficult and the same lack of access to private practice earnings and overtime

applies.

- Funding has not been approved by Cabinet Budget Review Committee for this broader application.
- This option may increase the willingness of SMOs to work extended-hours shifts in emergency departments.

Option 3

- Queensland Health extends the loading to SMOs who work a pre-determined minimum number of extended-hours shifts in designated emergency departments.
- A previous brief to the Director-General (attachment E) recommended that an eligibility criteria apply as such:

  The relevant Emergency Department Senior Medical Officer must be participating in and working shifts which result in the SMO performing ordinary hours during an afternoon shift and/or on the weekend. The shift arrangement performed by the Emergency Department SMOs should on an average provide for two afternoon shifts or one afternoon shift and one weekend shift in a week or pro rata for part-time emergency Department SMOs.

- Funding has not been approved by Cabinet Budget Review Committee for this broader application.
- This option may be more acceptable to

BACKGROUND

- In January 2006, Caboolture Emergency Department had to close for a period due to insufficient staffing of senior medical officers. Other emergency departments were struggling to recruit sufficient numbers of senior medical officers.
- This came in the wake of the negotiations and certification of the *Medical Officers' Certified Agreement 2005 (No.1)*. There was some level of dissatisfaction amongst senior medical officers about the increases provided for in the Agreement.
- The Supplementary Option A payment was announced as part of the Premier's additional package for medical officers in February 2006.
-

MEDIA IMPLICATIONS AND KEY MESSAGES

SMOs threatening to withdraw from providing services to emergency departments would be considered extremely newsworthy and result in negative publicity for Queensland Health.

ATTACHMENTS:

COMMENTS

Author's Name: Shirelle Wolfe Position: Senior Advisor Unit/District: Industrial Relations Tel No: 32340059 Date: 8 January 2008	Cleared by: Name: Helen Ceron Position: Unit/District: Tel No: Date:	Cleared by: (GM/ED) Name: Position: AHS: Tel No: Date:

[Insert *RecFind number if known]* **[File *Reference No. if known]***
ME02063

Queensland Health
BRIEFING NOTE FOR APPROVAL

……..…….…… OK Dated / /
Noted /Approved / Not Approved **Further information required** ……..……..…… Dated / /

TO: **Director-General**

FROM: *Executive Director Corporate Services*

SUBJECT: **Eligibility for the Emergency Department extended-hours payment for Senior Medical Officers**

PURPOSE
To seek the approval of a strategy regarding an offer to amend the eligibility criteria for the Emergency Department extended-hours payment for Senior Medical Officers (SMO) (25% loading).

RECOMMENDATION
It is recommended that senior officers of Queensland Health meet with Alex Scott, General Secretary Queensland Public Sector Union (QPSU) and Dr Don Kane, President Salaried Doctors Queensland (SDQ) to address previous understandings about eligibility criteria.

FUNDING SOURCE
- Nil.

CURRENT ISSUES
- On 13 September an email was sent from then Senior Director Human Resources to QPSU and SDQ advising amended criteria for payment of 25% loading (attachment A):
  - Districts had discretion to extend payments to Medical Superintendents/Deputy Medical Superintendents and any SMO
  - Working regularly rostered extended-hours shifts in an emergency department.
- There is no record of Director-General approval for these amended criteria.
- No funding has been sought or approved.
- Districts with regional and small hospitals will be affected.
- Human Resources Branch, at the December MIBB, committed to circulating advice regarding the eligibility criteria for the 25% loading by the end of January.
- QPSU and to a lesser extent, SDQ are expecting this advice to be in accordance with this email advice. The email advice was written after some discussions with QPSU advocate Ms Jenny Cannon in relation to eligibility criteria. The advice effectively broadens the applicability of the 25% loading to SMOs who should not have been in receipt of this extra payment.
- There are two options to address this matter:
  a) The Director-General endorses the amended criteria. QPSU and SDQ would support this as it reflects a previous understanding. However, Districts would have concerns as there is not additional funding attached.
  b) A high-level discussion with QPSU and SDQ deferring approval at this time in consideration of the imminent renegotiations for medical enterprise bargaining. This option could enable amendments to be fully costed and funded. Unions, especially QPSU are likely to react adversely and there may be some adverse response from a small number of SMOs.
  - Option b) is the recommended option.

Author's Name: Shirelle Wolfe Position: Senior Adviser Unit: Workplace Relations Unit, HR Branch Tel No: 3234 0059 Date: 31 January 2008	Cleared by: Name: Helen Ceron Position: Deputy Senior Director, Industrial Relations Unit: Human Resources Branch Tel No: 3234 0784 Date: 31 January 2008	Cleared by: Name: Russ Wilde Position: A/Senior Director Human Resources Branch Tel No: 3234 1481 Date	Cleared by: Name: Michael Kaliminios Position: Executive Director Corporate Services Tel: 3234 1685 Date

PROPOSED ACTIONS

- Human Resources Branch will liaise with the Director-General about the Queensland Health response.
- Human Resources Branch will coordinate a meeting with relevant unions.

BACKGROUND

- On 6 March 2006, the QPSU General Secretary and Director-General sign a Memorandum of Understanding regarding the Payment of 25% loading for Emergency Department SMOs (attachment B).
- On 13 May 2006, the Director-General approved criteria for eligibility of 25% loading. Eligible SMOs were those who worked extended-hours arrangements in emergency departments and were not employed in other roles i.e. Medical Superintendents/Deputy Medical Superintendents (attachment C).
- In mid-2007 the QPSU raised the issue of the 25% loading criteria at MIBB. It sought the payment of the 25% loading for s.47(3)(b) - personal information Hospital. s.47(3)(b) works some extended-hours shifts as well as having an administrative function. According to the Director-General approved criteria, as s.47(3)(b) - personal information was not entitled to the 25% loading (attachment D).
- Since early September 2007 QPSU has sought to extend eligibility of the loading beyond that approved i.e. Medical Superintendents/Deputy Medical Superintendents would be eligible for ED 25% loading.

MEDIA IMPLICATIONS AND KEY MESSAGES

Queensland Health is working with Unions to resolve any issues regarding additional payments to senior medical officers providing emergency services.

ATTACHMENTS:

Attachment A – Email from SDHR to QPSU and SDQ
Attachment B – Memorandum of Understanding – QPSU and Queensland Health
Attachment C – BR027236
Attachment D – QPSU letter to s.47(3)(b) re: s.47(3)(b)

COMMENTS

Author's Name: Shirelle Wolfe Position: Senior Adviser Unit: Workplace Relations Unit, HR Branch Tel No: 3234 0059 Date: 31 January 2008	Cleared by: Name: Helen Ceron Position: Deputy Senior Director, Industrial Relations Unit: Human Resources Branch Tel No: 3234 0784 Date: 31 January 2008	Cleared by: Name: Russ Wilde Position: A/Senior Director Human Resources Branch Tel No: 3234 1481 Date	Cleared by: Name: Michael Kaliminios Position: Executive Director Corporate Services Tel: 3234 1685 Date

Human Resources Branch

Instructions for administering senior medical officer (SMO) three year private practice supplementary benefit contracts covering 2009-2012 financial years

Option A – Senior Medical Officer (SMO) (Non-specialists)

Please make the following changes before having the contracts executed:

1 Insert the SMO's name into the front page of the contract;

2 insert the current date on page one of the contract;

3 insert the SMO's name and address under 'Parties' on page one of the contract;

4 insert the SMO's name next to the signature block (last page) of the contract.

Insert the following details into Schedule One:

5 the commencement date (1 September 2009 in most circumstances);

6 the name of the Health Service District or equivalent;

7 the name of the hospital/s or health facility/ies at which the SMO is to provide the services;

8 the relevant supplementary benefit percentage i.e.

- Area 1: 35%
- Area 2: 40%
- Area 3: 45%
- Area 4: 50%

Note: Area loadings are specified in ER Circular 47/06 (or as amended or updated from time to time). If you are unsure, please contact the Medical Team, Human Resources Branch on (07) 3234 1440.

Option A – Staff Specialist

Please make the following changes before having the contracts executed:

1 Insert the Specialist's name into the front page of the contract;

2 insert the current date on page one of the contract;

3 insert the Specialist's name and address under 'Parties' on page one of the contract;

4 insert the Specialist's name next to the signature block (last page) of the contract.

Insert the following details into Schedule One:

5 the commencement date (1 September 2009 in most circumstances);

6 the name of the Health Service District or equivalent;

7 the name of the hospital/s or health facility/ies at which the Specialist is to provide the services;

8 the relevant supplementary benefit percentage i.e.

- Area 1: 50%
- Area 2: 55%
- Area 3: 60%
- Area 4: 65%

Note: Area loadings are specified in ER Circular 47/06 (or as amended or updated from time to time). If you are unsure, please contact the Medical Team, Human Resources Branch on (07) 3234 1440.

Option A – Non-clinical Medical Superintendent (NCMS)

Please make the following changes before having the contracts executed:

1 Insert the NCMS's name into the front page of the contract;

2 insert the current date on page one of the contract;

3 insert the NCMS's name and address under 'Parties' on page one of the contract;

4 insert the NCMS's name next to the signature block (last page) of the contract.

Insert the following details into Schedule One:

5 the commencement date (1 September 2009 in most circumstances);

6 the name of the Health Service District or equivalent;

7 the name of the hospital/s or health facility/ies at which the NCMS is to provide the services;

8 the relevant supplementary benefit percentage i.e.

- Area 1: 50%
- Area 2: 55%
- Area 3: 60%
- Area 4: 65%

Note: Area loadings are specified in ER Circular 47/06 (or as amended or updated from time to time). If you are unsure if a medical superintendent is clinical or non-clinical, please contact the Medical Team, Human Resources Branch on (07) 3234 1440.

Option A – Clinical Medical Superintendent (CMS)

Please make the following changes before having the contracts executed:

1 Insert the CMS's name into the front page of the contract;

2 insert the current date on page one of the contract;

3 insert the CMS's name and address under 'Parties' on page one of the contract;

4 insert the CMS's name next to the signature block (last page) of the contract.

Insert the following details into Schedule One:

5 the commencement date (1 September 2009 in most circumstances);

6 the name of the Health Service District or equivalent;

7 the name of the hospital/s or health facility/ies at which the CMS is to provide the services;

8 the relevant supplementary benefit percentage i.e.

- Area 1: 35%
- Area 2: 40%
- Area 3: 45%
- Area 4: 50%

Note: Area loadings are specified in ER Circular 47/06 (or as amended or updated from time to time). If you are unsure if a medical superintendent is clinical or non-clinical, please contact the Medical Team, Human Resources Branch on (07) 3234 1440.

Option A – Contract Medical Officer (CMO)

Please make the following changes before having the contracts executed:

1 Insert the CMO's name into the front page of the contract;

2 insert the current date on page one of the contract;

3 insert the CMO's name and address under 'Parties' on page one of the contract;

4 insert the CMO's name next to the signature block (last page) of the contract.

Insert the following details into Schedule One:

5 the commencement date (1 September 2009 in most circumstances);

6 the name of the Health Service District or equivalent;

7 the name of the hospital/s or health facility/ies at which the CMO is to provide the services.

Note: If you are unsure of how to action this contract, please contact the Medical Team, Human Resources Branch on (07) 3234 1440.

Option A – Public Service Medical Officer (PSMO)

Please make the following changes before having the contracts executed:

1 Insert the PSMO's name into the front page of the contract;

2 insert the current date on page one of the contract;

3 insert the PSMO's name and address under 'Parties' on page one of the contract;

4 insert the PSMO's name next to the signature block (last page) of the contract.

Insert the following details into Schedule One:

5 the commencement date (1 September 2009 in most circumstances);

6 the name of the Health Service District or equivalent;

7 the name of the hospital/s or health facility/ies at which the PSMO is to provide the services.

Note: If you are unsure of how to action this contract, please contact the Medical Team, Human Resources Branch on (07) 3234 1440.

Option B – Individual Contract

Please make the following changes before having the contracts executed:

1 Insert the Specialist's name into the front page of the contract;

2 insert the current date on page one of the contract;

3 insert the Specialist's name and address under 'Parties' on page one of the contract;

4 insert the Specialist's name next to the signature block (last page) of the contract.

Insert the following details into Schedule One:

5 the commencement date (1 September 2009 in most circumstances);

6 the name of the Health Service District or equivalent;

7 the name of the hospital/s or health facility/ies at which the Specialist is to provide the services;

8 the correct administration fees and facility charges;

9 the relevant supplementary benefit percentage i.e.

- Area 1: 50%
- Area 2: 55%
- Area 3: 60%
- Area 4: 65%

10 Have the Specialist complete and execute the election contained in Schedule Three.

Note: Area loadings are specified in ER Circular 47/06 (or as amended or updated from time to time). If you are unsure, please contact the Medical Team, Human Resources Branch on (07) 3234 1440.

Option B – Company Contract

Please make the following changes before having the contracts executed:

1 Insert the Specialist's name and the name of the company into the front page of the contract;

2 insert the current date on page one of the contract;

3 insert the Specialist's name and address under 'Parties' on page one of the contract;

4 insert the name of the company, ABN and address under 'Parties' on page one of the contract;

5 insert the Specialist's name next to the signature block (last page) of the contract.

6 insert the name of the company next to the signature block (last page) of the contract.

Insert the following details into Schedule One:

7 the commencement date (1 September 2009 in most circumstances);

8 the name of the Health Service District or equivalent;

9 the name of the hospital/s or health facility/ies at which the Specialist is to provide the services;

10 the correct administration fees and facility charges;

11 the relevant supplementary benefit percentage i.e.

- Area 1: 50%
- Area 2: 55%
- Area 3: 60%
- Area 4: 65%

12 Have the Specialist complete and execute the election contained in Schedule Three.

Note: Area loadings are specified in ER Circular 47/06 (or as amended or updated from time to time). If you are unsure, please contact the Medical Team, Human Resources Branch on (07) 3234 1440.

Option B – Partnership Contract

Please make the following changes before having the contracts executed:

1 Insert the Specialist's name and the name of the partner/s into the front page of the contract;

2 insert the current date on page one of the contract;

3 insert the Specialist's name and address under 'Parties' on page one of the contract;

4 insert the partner/s names, ABN and address under 'Parties' on page one of the contract;

5 insert the Specialist's name next to the signature block (last page) of the contract.

6 insert the name of the partner/s next to the signature block (last page) of the contract. Add additional signature blocks as required for each additional partner.

Insert the following details into Schedule One:

7 the commencement date (1 September 2009 in most circumstances);

8 the name of the Health Service District or equivalent;

9 the name of the hospital/s or health facility/ies at which the Specialist is to provide the services;

10 the correct administration fees and facility charges;

11 the relevant supplementary benefit percentage i.e.

- Area 1: 50%
- Area 2: 55%
- Area 3: 60%
- Area 4: 65%

12 Have the Specialist complete and execute the election contained in Schedule Three.

13 Ensure Schedule four is completed.

Note: Area loadings are specified in ER Circular 47/06 (or as amended or updated from time to time). If you are unsure, please contact the Medical Team, Human Resources Branch on (07) 3234 1440.

Option P – Contracts

Please make the following changes before having the contracts executed:

1 Insert the Specialist's name into the front page of the contract;

2 insert the current date on page one of the contract;

3 insert the Specialist's name and address under 'Parties' on page one of the contract;

4 insert the Specialist's name next to the signature block (last page) of the contract.

Insert the following details into Schedule One:

5 the commencement date (1 September 2009 in most circumstances);

6 the name of the laboratory at which the Specialist is employed and will provide services;

7 whether the specialist is eligible to receive the incentive payment;

8 the relevant supplementary benefit percentage i.e.

- Area 1: 50%
- Area 2: 55%
- Area 3: 60%
- Area 4: 65%

Note: Area loadings are specified in ER Circular 47/06 (or as amended or updated from time to time). If you are unsure, please contact the Medical Team, Human Resources Branch on (07) 3234 1440.

Emergency Department – Extended Hours Benefit

The Emergency Department – Extended Hours Benefit is only available to those medical officers who meet the requirements of the contract. If you are unsure if a medical officer meets the requirements in order to receive this additional benefit, please contact the Medical Team, Human Resources Branch on (07) 3234 1440.

Please make the following changes before having the contracts executed:

1 Insert the SMO's name into the front page of the contract;

2 insert the SMO's name and address under 'Parties' on page one of the contract;

3 insert the SMO's job title and Option A contract date under 'Background' on page one of the contract;

4 insert the start and end date under 'Term' on page two of the contract;

5 insert the SMO's name next to the signature block (last page) of the contract.

Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract

Emergency department option A is considered an extension of Option A for specific limited circumstances.

All of the criteria set out in a standard Option A contract must be met prior to entering into an additional Emergency Department Option A contract and the specialist must have initially signed an option A contract as well as the additional criteria listed below:

Proposed Application Principles for New Contracts

Criteria to be met:

1. Applicable only for an *Emergency Department*; AND
2. An *extended hours arrangement* must exist; AND
3. The SMOs *rostered ordinary hours* are worked in accordance with the *extended hours arrangement* *with at least 80 percent of shifts worked in the emergency department*; AND
4. The SMOs *rostered ordinary hours* include the working of shifts where the majority of the shift is after 4.00pm Monday to Friday and/or the weekend; AND
5. A contract is signed.
6. Simply having performed services in an emergency department will not attract Emergency Department Extended Hours Benefit Contract

Definitions

Emergency Department	As listed in the Quarterly Public Hospitals Performance Report: - http://www.health.qld.gov.au/performance/docs/QHQPHPR as amended or varied. Features: • A high level department with emergency medicine specialists and trainees employed at all times. • An emergency department is a discrete unit within a public hospital.
Extended hours arrangement	Means with respect to the hours of operation of an Emergency Department, when Senior Medical Officers' rostered ordinary hours coverage is provided *in accordance with the Certified Agreement* at least from:

	- 8.00am to 10.00pm Monday to Friday; and - on weekends.
In accordance with the Certified Agreement	Means that an arrangement had to exist prior to MOCA1 OR the arrangement has been approved through the MIBB/MCG.
Rostered ordinary hours	Means all of the hours a SMO is engaged to perform for that position.

From: Greg Coonan
To: Edmund Lynch
Date: 20/12/2010 5:01 pm
Subject: Re: list of Emergency Departments and the list of persons receiving ED 25 percent

Edmund,

When we checked the list the other day, I thought Beaudesert WAS included.

Greg

Greg Coonan
Program Manager
Workplace Relations Unit
People and Culture Strategic Services
Queensland Health

Ph: (07) 323 41440
Fax: (07) 323 40314

>>> Edmund Lynch 20/12/2010 3:59 pm >>>
Dear Carl

cc only. Thanks for the help. Much appreciated as ever.

Edmund Lynch
Senior Advisor
Workplace Relations
People and Culture Strategic Services
Queensland Health
Level 15
Queensland Health Building
147 - 163 Charlotte Street
Brisbane Qld 4000
Phone 07 32340059
Edmund_Lynch@health.qld.gov.au

>>> Edmund Lynch 20/12/2010 2:37 pm >>>
Greg / Helen

On or about 26 August a report was run which suggested that there were **329** persons receiving the ED 25 percent in July / August 2010.

After we met last week we asked Carl to run another report.

Running such a further report for December 2010 - January 2011 may not be helpful in providing details in that those months would**not** be reflective of the broader year.

As such Carl after discussion arranged for a report for the period October - November 2010.

The report came up with a figure of **314** people receiving ED 25 percent.

We then asked that as a second part of this request there be an examination of the hospitals that are indicated on the Quarterly Public Hospitals Performance Report. The hospitals for whcih emergency departments are reported in the Quarterly Public Hospitals Performance Report has been the basis of the QH definition of emergency department put in consultations with the unions. There are 27 such hospitals that report for**Emergency Departments** (list attached).

I met with Carl and our analysis has found that of the 314 there were 14 who were **not** within the Emergency Departments listed in the Quarterly Public Hospitals Performance Report.

These 14 came from Emerald (1), Beaudesert (4) and Cherbourg (3) and Kingaroy (6).

Despite this Kingaroy uses the language "Emergency Department" on its QHEPS site (see attached). Emerald uses the language "Emergency Department" on its QHEPS site (see attached).

A second action item from our having met last week was to seek Nick Lord's input as this is a matter in which his guidance and direction would be invaluable.

Edmund Lynch
Senior Advisor
Workplace Relations
People and Culture Strategic Services
Queensland Health

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QUEENSLAND HEALTH
DIRECTOR-GENERAL
BRIEF FOR DECISION

Our Ref:	**Dept ref no. (BR, DG) ME02443**
Date:	**9 December 2010**
TO	**Deputy Director-General**
FROM	**Greg Coonan A/Program Manager, Medical Team, Workplace Relations Unit**
SUBJECT	**Negotiations on Private practice policies for senior medical officers**
Requested by	**Helen Ceron, Deputy Executive Director People and Culture Corporate**
Decision required by	**16 December 2010**

RECOMMENDATION

- That you sign letters to Mr Alex Scott , General Secretary, Queensland Public Sector Union of Employees and Dr Nick Buckmaster, President Salaried Doctors Queensland in relation to ongoing consultation that has been occurring with relevant unions in relation to private practice policies for senior medical officers.

BACKGROUND SUMMARY

- People & Culture Strategic Services (PaCSS) and the Private Practice Management Committee (PPMC) have been consulting with relevant unions in relation to private practice policies for senior medical officers (SMOs) including most recently on 29 November 2010. These define the private practice benefits options available to SMOs employed by Queensland Health under three year contracts and will replace out-dated private practice IRMs as HR Policies.

ISSUES

- There remain outstanding issues between Queensland Health and unions in relation to the circumstances in which the additional 25 percent benefit is payable for Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract (“ED 25 %”).

- ED 25% was introduced in February 2006 to retain doctors working in public hospital emergency departments and importantly to attract new medical staff to that area of practice to alleviate the then crisis in emergency medicine service delivery. The rationale advanced for the extra remuneration was that emergency physicians were then the only group who work extended hours and incurred the resultant lifestyle impacts. A consequence of this work pattern is not only the inability to earn private practice income during what are normal working hours for most doctors, but also outside those hours due to the shift work commitment.

- With the assistance of the PPMC discussions on ED 25% are continuing at the same time as more general consultation on the private practice policies.

- On 29 November 2010 the QPSU advised PaCSS that it intends maintaining a position that it the resolution of the wording for Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract is required prior to finalising consultation on the private practice policies generally. Salaried Doctors Queensland (SDQ) has not articulated a view departing from the QPSU position.

- The interests of advancing consultations may be well served by providing the QPSU and the SDQ with the letters which form **attachments 1 and 2.**

- The letters note that consultation on the other private practice policies will be concluded but a separate document be developed to outline arrangements for the application of ED 25 %. Discussion with the unions suggest that complex negotiations would be required if Queensland Health seeks to place limitations on the broad application of the arrangement.

CONSULTATION WITH STAKEHOLDERS

- Extensive consultation has occurred with the PPMC which has indicated that it will be guided by PaCSS.

- Consultation has taken place with a number of Health Service Districts to gain further insight as to the manner in which ED 25 percent is operating.

FINANCIAL IMPLICATIONS

- There would be no financial impact of signing the letters.

ATTACHMENTS

1. Draft letter to Mr Alex Scott , General Secretary, Queensland Public Sector Union of Employees

2. Draft letter to Dr Nick Buckmaster, President, Salaried Doctors Queensland

APPROVED / NOT APPROVED
Deputy Director-General
Comments

Michael Walsh
Deputy Director-General

/ /

Political Representatives

Local Government

- Statewide

State Government

- Statewide

Federal Government

- Statewide

Author: Edmund Lynch Senior Advisor Workplace Relations Unit People and Culture Strategic Services 07 3234 0059	**Cleared by:** Greg Coonan A/Program Manager Workplace Relations Unit People and Culture Strategic Services 07 3234 1440 Signed on:
Cleared by: Peter Ashton A/Director People and Culture Strategic Services 07 3235 9524 Signed on:	**Cleared by:** Helen Ceron Deputy Executive Director People and Culture Strategic Services 07 3234 0784 Signed on:
Cleared by: Dulise Maxwell Executive Director People and Culture Strategic Services 32341481 Signed on:	

Proposed Implementation of Extended Hours of Work for SMOs

Following consultation meeting on 2/10/07 and subsequent feedback it is proposed to conduct a secret ballot of Emergency Department SMOs to determine whether the following proposal is accepted. This will be held on Tuesday 16th October 2007 at 0815 after the ED handover meeting.

1. **Rationale:** To improve senior cover in the emergency department for extended hours 0700-2200 to provide improved supervision for junior medical staff and to reduce on call and fatigue for senior medical staff. Currently the emergency department is staffed from 1700 to 0800 and all day on weekends by junior medical staff with supervision by SMOs on call. This is unsatisfactory from the junior medical officers position and results in excessive on call demands and fatigue for the SMOs

2. **Type of work to be performed:** The emergency department is staffed by junior medical staff 24 hours per day. The ED SMOs will provide on duty services from 0800 to 2200 Monday to Friday and weekend shifts at least 0800-1630 Sat and Sun. this will allow for enhanced supervision and teaching of junior staff.

3. **Consultation:** All ED SMOs will be consulted about the proposed roster prior to its introduction. They will have input into the roster and self rostering will be offered. Following informal consultation over preceding months a formal consultation meeting was held on 2nd October 2007 and the proposal was agreed subject to final approval by secret ballot as required by the Medical Officers certified Agreement. This was to be conducted after two weeks to allow for further consideration.

4. **Number and mix of existing staff:** It is proposed that the current allocation of junior medical staff will remain and that the senior shifts allocated will be additional. This will be facilitated by the addition of two extra SMO positions. Further staffing enhancements will be pursued via the Emergency Network.

5. **Implementation Timeframe:** It is proposed that the new roster be implemented when the first of two new SMO positions is filled. (These positions were allocated for the purpose of providing extended hours senior medical cover.) Anticipated introduction from Nov 2007 as soon as approved with appropriate notification of rosters.

6. **Length, timing and frequency of work periods:** It is proposed that there be a mix of 8 and 10 hour shifts which will vary depending on whether all staff are available or one is on leave. As staffing levels allow the number of 10 hour shifts will be increased to allow for increasing rostered days off . Full cover will be provided from 0800 to 2200 M-F and at least 0800-1630 on weekends.

7. **Shifts:** 0800-1630 8 hours
   1130-2200 10 hours
   0800-1830 10 hours
   1330-2200 8 hours.
8. **Confirmation that ordinary work hour requirements can be met without the need to roster overtime:** The two new positions (2.0FTE) will allow for evening shifts (10 x 8 hours per fortnight) and weekend shifts (8 x 10 hours per f/n)

9. **Method of rostering:** Self rostering will be offered. Initially it was agreed that the Director of Medical Services will oversee the roster preparation in the absence of any interest in self rostering.

10. **Arrangements for maintenance of communication and participation in QA and Education activities.** The proposed roster will allow for an increase in available time for QA and educational activities as there will be extra senior staffing during all afternoons. The proposed 8 th SMO position will allow for allocated protected time for admin and teaching tasks. A general medical education committee is being established

11. **Identification of Fatigue etc:** This roster should considerably reduce the incidence of fatigue due to reduced on call requirements per individual. Current fatigue reporting will continue and fatigue reviewed regularly at medical staff meetings.

12. **Circumstanced under which the extended hours arrangements will be suspended:** This will be negotiated by SMO staff and it is anticipated that if SMO staff falls below 5 persons then they may elect to suspend the arrangements.

Agreement to implement the extended hours arrangements will be subject to agreement by the majority of the SMOs involved in the extended roster.

If supported by the SMOs and their unions the proposal will be forwarded to MIBB for consideration and endorsement.

If agreement can not be reached either party may seek to have the MIBB group facilitate further consultation.

If agreed the rosters will be managed according to clauses 6.3.4 and 6.3.5 of the Medical Officers Certified Agreement No 1 2005

ED 25 Percent Discussions
15 November 2010
Non-endorsed

(discussions were on a without prejudice basis and the document circulated on 15/11 headed not QH Policy)

Venue: Level 15, Large Conference Room, 147-163 Charlotte Street, Brisbane QLD 4000
Duration: 10:00am – 11:00am

ATTENDENCE

Queensland Health Representatives	
Helen Ceron	Deputy Executive Director, People and Culture Strategic Services
Greg Coonan	Acting Program Manager, Workplace Relations Unit
Taresa Rosten (Chair)	Director, Workplace Relations Unit
Edmund Lynch	Senior Advisor, Workplace Relations Unit
Union Representatives	
Jenny Cannon	Industrial Officer, Queensland Public Sector Union
Dr Colin Page	Emergency Physician & Clinical Toxicologist, Department of Emergency Medicine, Princess Alexandra Hospital
Rupert Tidmarsh	Industrial Officer, Salaried Doctors Queensland

Discussion	*Outcomes/Actions*
Taresa Rosten noted that the last meeting was held on 27 September and thanked all for attending. Key issues for further discussion: • hours that need to be worked to attract ED 25% • definition of an Emergency Department Discussion was held around the requirement of all hours needing to be worked in ED. Queensland Health suggested a requirement of 80% of shifts to be worked in ED as a potential option for discussion. Taresa noted QH sees this percentage as being reasonable and consistent with the intent of the benefit. Taresa outlined the features that QH suggests for discussion regarding the definition of an emergency department. A without prejudice document was tabled for discussion. In relation to point 3 in the document (80% of shifts worked in ED), Colin Page stressed his view that he considered the contracts loose, and doesn't want to see persons disadvantaged (e.g. due to certain family responsibilities) or the possibility of rorting. Colin noted he is not attracted to the concept of a percentage, and cited examples of SMOs spending 50% of time in an ED and 50% in intensive care, or 50% of time in a Director role. Rupert Tidmarsh and Jenny Cannon agreed that 50/50 scenarios are a problem. Taresa queried what others perceived as a reasonable amount of hours or % required attract the benefit. Colin commented he regarded any hours worked in ED may be	

contributing to the after hours roster. Jenny and Colin considered it was the role of management to stop people flitting in and out of ED. Colin commented that whatever was agreed between the parties will never cover all circumstances. Helen Ceron noted Colin's offer to be available to interpret eligibility. Colin highlighted he doesn't want to tighten the hours such that it makes it hard to recruit emergency physicians. Discussion was held around point 4 (majority of shift after 4 and weekends), and there was general agreement around the wording of this principle. Colin noted that 99% of the time SMOs contribute to an after hours roster. Taresa stressed another important aspect to consider is the administration of these contracts. Discussion was held around the possibility of ED contracts shorter than 3 years to give flexibility to changed circumstances. Edmund Lynch noted that an Option A Contract is a prerequisite for being offered an ED contract. Jenny noted both run for 3 years. Helen emphasised the intent of the benefit payment is to reward those doing extended hours. Jenny expressed a view that it is possible to contribute to an after hours roster without doing after hours duties. Taresa invited feedback regarding the two proposed emergency department definition features (under definitions in tabled document). Colin and Jenny agreed it would be beneficial to define an ED. Jenny suggested (without prejudice) "facility staffed to provide emergency services for emergency after hours". Rupert suggested "discrete emergency department – staffed full time". Jenny commented the definition needs to acknowledge appointment to a position for a period of time by the District. Finalisation of the Private Practice policies was discussed. Taresa noted the QPSU had advised at the last PPMC meeting that finalisation of PP policies could not occur prior to resolution of ED 25% principles. Jenny, Colin and Rupert reconfirmed this is their view. Helen canvassed the possibility of a Director-General letter to QPSU and SDQ regarding PP policies and ED 25%. Parties agreed to meet again on 29 November 2010.	**PACSS to further investigate administrative feasibility of variable ED 25% arrangements.** **Parties to provide further feedback on definition of Emergency Department.** **Queensland Health to prepare D-G letter regarding PP policies and ED 25%.** **PACSS to schedule next meeting.**

Meeting Closed: 11:00am

Next Meeting: 29 November 2010 10 am

Emergency Department Loading Discussions
29 November 2010
Non-endorsed

Venue: Level 15, Large Conference Room, 147-163 Charlotte Street, Brisbane QLD 4000
Duration: 10:00am – 11:00am

ATTENDENCE

Queensland Health Representatives	
Greg Coonan (Chair)	Acting Program Manager, Workplace Relations Unit
Estelle Quarello	Project Manager, Workplace Relations Unit
Fiona Heap	Advisor, Workplace Relations Unit
Union Representatives	
Jenny Cannon	Industrial Officer, Queensland Public Sector Union
Dr Colin Page	Emergency Physician & Clinical Toxicologist, Department of Emergency Medicine, Princess Alexandra Hospital
Rupert Tidmarsh	Industrial Officer, Salaried Doctors Queensland

Discussion	*Outcomes/Actions*
	1. WRU to forward minutes from previous meeting (15 November) to union reps for feedback. 2. Queensland Health to respond to the definition of "Emergency Department" previously provided by the unions. 3. Queensland Health to investigate and provide examples of areas where misappropriate use is occurring (detail facility and specific circumstances). 4. WRU to arrange next meeting (early 2011).

Meeting Closed: 11:00am

Next Meeting: early 2011

From: Edmund Lynch
To: Dion Matley
Date: 2/02/2010 11:05 am
Subject: ED Emergency Re B48 and B49
Attachments: Edmund Lynch.vcf

Dear Dion

I refer to your email of Friday re ED and the need to ensure clarity around who gets the ED 25 percent.

We will hopefully receive B48, B49 and B50 back from Lauren today. They have been with her area since 24/12. That which appear below subject to your thoughts, once settled, will need to go back top Lauren to be incorporated in a formatted B48 and B49, hopefully with aq quick turnaround.

I was unable to find a definition of "true" emergency department.

For HR Policy B48, I propose as follows.

Emergency Department Option A is considered an extension of Option A **for specific limited** circumstances. The Emergency Department must be a true emergency department.

All of the criteria set out in a standard Option A contract must be met prior to entering into an additional Emergency Department Option A contract.

· The specialist has initially signed an Option A contract and
· The specialist must be employed in a Queensland Health Emergency Department; and MUST be working all of their hours of work in an Emergency Department;
· The specialist's ordinary hours of work is an extended-hours arrangement with hours worked between at least from 8.00am until 10.00pm Monday to Friday: and (b) weekend coverage. "All of their hours of work" means Full-time engagement in the Emergency Department only; or Part-time engagement in the Emergency Department only.
· The specialist signs an Emergency Department Extended Hours Benefit Contract,
· Contracts commence on the commencement date and end on the termination date unless terminated earlier in accordance with the contract.

For HR Policy B49 SMO Non specialists, I propose as follows:-

Emergency Department Option A is considered an extension of Option A **for specific limited** circumstances. The Emergency Department must be a true emergency department.

All of the criteria set out in a standard Option A contract must be met prior to entering into an additional Emergency Department Option A contract.

· The non specialist has initially signed an Option A contract and
· The non specialist must be employed in a Queensland Health Emergency Department; and MUST be working all of their hours of work in an Emergency Department;
· The non specialist's ordinary hours of work is an extended-hours arrangement with hours worked between at least from 8.00am until 10.00pm Monday to Friday: and (b) weekend coverage. "All of their hours of work" means Full-time engagement in the Emergency Department only; or Part-time engagement in the Emergency Department only.
· The non specialist signs an Emergency Department Extended Hours Benefit Contract,
· Contracts commence on the commencement date and end on the termination date unless terminated earlier

in accordance with the contract.

Edmund Lynch

Senior Advisor
Workplace Relations
People and Culture Corporate
Queensland Health
Level 15
Queensland Health Building
147 - 163 Charlotte Street
Brisbane Qld 4000
Phone 07 32340059
Edmund_Lynch@health.qld.gov.au

Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract

Emergency department option A is considered an extension of Option A for specific limited circumstances.

All of the criteria set out in a standard Option A contract must be met prior to entering into an additional Emergency Department Option A contract and the specialist must have initially signed an option A contract as well as the additional criteria listed below:

Proposed Application Principles for New Contracts

Criteria to be met:

1. Applicable only for an *Emergency Department*; AND
2. An *extended hours arrangement* must exist; AND
3. The SMOs *rostered ordinary hours* are worked in accordance with the *extended hours arrangement*; AND
4. The SMOs *rostered ordinary hours* include the working of shifts where the majority of the shift is after 4.00pm Monday to Friday and/or the weekend; AND
5. A contract is signed.

Definitions

Emergency Department	As listed in the Quarterly Public Hospitals Performance Report. - http://www.health.qld.gov.au/performance/docs/QHQPHPR as amended or varied.
Extended hours arrangement	Means with respect to the hours of operation of an Emergency Department, when Senior Medical Officers' rostered ordinary hours coverage is provided *in accordance with the Certified Agreement* at least from: - 8.00am to 10.00pm Monday to Friday; and - on weekends.
In accordance with the Certified Agreement	Means that an arrangement had to exist prior to MOCA1 OR the arrangement has been approved through the MIBB/MCG.
Rostered ordinary hours	Means all of the hours a SMO is engaged to perform for that position.

The State of Queensland acting through Queensland Health

Name:

Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A Contract

Date:

Parties

The State of Queensland acting through Queensland Health of 147-163 Charlotte Street, Brisbane in the State of Queensland (**Queensland Health**)

of

(**SMO**)

Background

A The SMO is employed by Queensland Health as a .

B The SMO and Queensland Health have entered into an Option A Contract dated (**Option A Contract**).

C In addition to the payments and benefits made by Queensland Health to the SMO pursuant to the Certified Agreement and the terms of the Option A Contract, Queensland Health and the SMO have agreed that, in consideration for the SMO working their ordinary hours of work through an Extended Hours arrangement in an emergency department, Queensland Health will pay the SMO the Emergency Department Extended Hours Benefit on the terms set out in this Contract.

Agreed Terms

1 Definitions

For the purpose of this document:

Award means the *District Health Services - Senior Medical Officers' and Resident Medical Officers' Award – State 2003*.

Certified Agreement has the same meaning as in the Option A Contract.

Emergency Department Extended Hours Benefit has the meaning given by **clause 3.1** of this document.

Extended Hours means, with respect to the hours of operation of an emergency department, when Senior Medical Officers' rostered ordinary hours coverage is provided in accordance with the Certified Agreement at least from:

(a) 8.00am until 10.00pm Monday to Friday; and

(b) weekend coverage.

Senior Medical Officers (SMO) means Senior Medical Officers as classified

under the Award working in an emergency department.

Supplementary Benefit has the same meaning as in the Option A Contract.

Supplementary Benefit Percentage has the same meaning as in the Option A Contract.

2 Term

This document will commence on and terminate on unless terminated earlier in accordance with this document.

3 Emergency Department Extended Hours Benefit

3.1 Where the SMO works in an emergency department providing Senior Medical Officers' coverage during Extended Hours as defined above and the SMO's rostered ordinary hours include working of shifts where the majority of the shift is after 4.00pm Monday to Friday and/or on the weekend, the SMO's entitlement to the Supplementary Benefit under the Option A Contract will be increased by adding a further 25% to the Supplementary Benefit Percentage as set out in **Item 5 of Schedule 1** to the Option A Contract (**Emergency Department Extended Hours Benefit**).

3.2 If the SMO is entitled to payment of the Emergency Department Extended Hours Benefit under **clause 3.1** then the Option A Contract will continue with full force and effect as if the Emergency Department Extended Hours Benefit forms part of the Supplementary Benefit in the Option A Contract.

3.3 In the event that Queensland Health decides to permanently close the emergency department, permanently cease to operate the emergency department during Extended Hours or suspend the operation of the emergency department during Extended Hours then the SMO's entitlement to the Emergency Department Extended Hours Benefit will continue until 26 consecutive weeks have expired since the emergency department ceased operating during Extended Hours

3.4 In the event that the SMO decides to withdraw from participating in Extended Hours coverage then the SMO's entitlement to the Emergency Department Extended Hours Benefit will immediately cease.

4 Termination

4.1 The agreement evidenced by this document will automatically terminate in the event that the Option A Contract terminates for any reason.

Executed as an agreement.

Signed for and on behalf of)
Queensland Health by)
) .....
.....)
(print name) District Manager, a duly)
authorised person in the presence of:)

.....
Witness

.....
Name of Witness (print)

Signed sealed and delivered)
by)
in the presence of:) .....

.....
Witness

.....
Name of Witness (print)

From: Michael Kalimnios
To: Dion Matley; Helen Ceron
CC: DDGCS_Correspondence DDGCS_Correspondence
Date: 28/01/2010 9:05 pm
Subject: Fwd: Emergency Department Extended Hours Benefits Contracts.

Can you please provide advice directly (and provide cc to me)

Michael k.

>>> Terry Hanelt 27/01/2010 12:30 pm >>>
Michael,
There is a significant problem with interpretation of payment of this allowance (the 25% extra allowance

s.47(3)(b) - Personal information

I have recently had a SMO apply for transfer at level from s.47(3)(b) Hospital. He is employed there as a s.47(3)(b) and works in the wards and in the ED. All was progressing until the payment of the ED 25% allowance came up. He has been receiving that allowance at s.47(3)(b) I have obtained the documents that confirm this payment. He is now not willing to take up the position at Gympie.
The problem is that there are some SMO's working part of their hours in ED and the rest of their time in the wards or other duties such as anaesthetics who are being paid the ED 25% allowance and other doing the same duties who are not being paid the allowance. Gympie adheres to the rules as stated by corporate office and thus disadvantages itself in recruitment.
I ask the following -
Is it equitable that a SMO who works 0.75 FTE in ED under an extended hours arrangement and does no other work for QH gets the allowance; whilst a SMO who works 0.75 FTE in ED under an extended hours arrangement and works 0.25 FTE for QH in another clinical area does not get paid the allowance?
Is it reasonable that some Districts are paying the 25% ED allowance when the terms of the Contract are not being fulfilled?

s.47(3)(b) - personal information

Is it reasonable for some Districts to pay the 25% ed allowance to ineligible SMO's in what I see as a recruitment and retention tactic?
I believe that an audit needs to be done to identify all SMO's being paid the ED 25% allowance and then

their contract of employment and rosters be reconciled to determine the number of Districts and SMO's receiving the allowance contrary to the conditions of the contract. This would allow an assessment of the magnitude of the problem.
This problem really needs to be fixed.
I am happy to provide further information and/or copies of old e-mails I have been able to identify in relation to this matter.
Terry H

Dr Terry Hanelt
Director of Medical Services,
Gympie Hospital
Medical Officer, Clinical Governance Support Unit
Southern Cluster,
Sunshine Coast - Wide Bay Health Service District
Phone: 61 7 54898404
Fax: 61 7 54898410
E-mail: Terry_Hanelt@health.qld.gov.au

Enquiries to: Greg Coonan
Program Manager
Workplace Relations Unit
Telephone: 3234 1440
Facsimile: 3234 0314
File Ref: ME02437

Mr Alex Scott
General Secretary
Queensland Public Sector Union of Employees
PO Box 15175
CITY EAST QLD 4002

Dr Don Kane
President
Salaried Doctors Queensland
PO Box 153
KELVIN GROVE QLD 4059

Cc
Dr Colin Page
Emergency Physician & Clinical Toxicologist
Department of Emergency Medicine
Princess Alexandra Hospital

Dear Mr Scott and Dr Kane

I refer to ongoing consultation that has been occurring with relevant unions in relation to private practice policies. These private practice policies are intended to define the private practice benefits options available to senior medical officers employed by Queensland Health under three year contracts.

I note that there currently remains a difference of opinion between Queensland Health and unions in relation to policy wording around the circumstances in which the addition 25 percent benefit is payable for Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract. Consultation most recently occurred on 29 November 2010 with People and Culture Strategic Services.

Such consultation is continuing at the same time as more general consultation on the policies with the assistance of the Private Practice Management Committee, to finalise any other outstanding aspects of the policies.

I am conscious that the QPSU has indicated that it sees the resolution of the policy wording for Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract as desirable prior to finalising consultation on the private practice policies generally. I am in agreement in this regard, but should it be the case that aspects of the private practice policies are fully consulted on apart from the wording around Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract I would like it known that such wording once consultation has finalised, will also form a relevant part of policy, even it the wording of such is included subsequently.

Should you require further information, Queensland Health's contact is Greg Coonan, Acting Program Manager, Workplace Relations Unit, on telephone 3234 1440.

Yours sincerely

Michael Walsh
Acting Deputy Director-General
Corporate Services

Prepared by: Edmund Lynch
Senior Advisor
Workplace Relations Unit
People and Culture Strategic Services
3234 0059
November 2010

Checked by: Greg Coonan
A/Program Manager
Workplace Relations Unit
People and Culture Strategic Services
3234 1440
November 2010

Cleared by: Taresa Rosten
Director
People and Culture Strategic Services
3235 9524
November 2010

Cleared by: Helen Ceron
Deputy Executive Director
People and Culture Strategic Services
3222 2908
November 2010

Cleared by: Dulise Maxwell
Executive Director
People and Culture Strategic Services
32341481
November 2010

Document name: ME02437 S:\CSD\HRB\WR\Medical Team\correspondence\letters\letter to unions re Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract.

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Telephone: 3234 1440
Facsimile: 3234 0314
File Ref: ME02437

Mr Alex Scott
General Secretary
Queensland Public Sector Union of Employees
PO Box 15175
CITY EAST QLD 4002

Dear Mr Scott

I refer to ongoing consultation that has been occurring with relevant unions in relation to private practice policies. These define the private practice benefits options available to senior medical officers employed by Queensland Health under three year contracts.

I note that there currently remains a difference of opinion between Queensland Health and unions in relation to policy wording around the circumstances in which the additional 25 percent benefit is payable for Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract. Consultation most recently occurred on 29 November 2010 with People and Culture Strategic Services.

These discussions are continuing at the same time as more general consultation on the policies, with the assistance of the Private Practice Management Committee, to finalise any outstanding aspects of the policies.

I am conscious that the QPSU has indicated that it sees the resolution of the policy wording for Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract as desirable prior to finalising consultation on the private practice policies generally.

Once consultation on the private practice policies are concluded (apart from the wording around Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract) I would like to confirm that any wording on that particular aspect of private practice will form part of a relevant private practice policy, even if final consultation on that aspect

were to follow the conclusion of consultation on the balance of matters and the commencement of such policies.

Should you require further information, Queensland Health's contact is Greg Coonan, Acting Program Manager, Workplace Relations Unit, on telephone 3234 1440.

Yours sincerely

Michael Walsh
Acting Deputy Director-General
Corporate Services

Prepared by: Edmund Lynch
Senior Advisor
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November 2010

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Mr Alex Scott
General Secretary
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PO Box 15175
CITY EAST QLD 4002

Dear Mr Scott

I refer to ongoing consultation that has been occurring with relevant unions in relation to private practice policies. These define the private practice benefits options available to senior medical officers employed by Queensland Health under three year contracts.

I note that there currently remains a difference of opinion between Queensland Health and unions in relation to policy wording around the circumstances in which the additional 25 percent benefit is payable for Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract. Consultation most recently occurred on 29 November 2010 with People and Culture Strategic Services.

These discussions are continuing at the same time as more general consultation on the policies, with the assistance of the Private Practice Management Committee, to finalise any outstanding aspects of the policies.

I am conscious that the QPSU has indicated that it sees the resolution of the policy wording for Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract as desirable prior to finalising consultation on the private practice policies generally.

Consultation on the other private practice policies will be concluded but a separate document be developed to outline arrangements for the application of ED 25 %.

Should you require further information, Queensland Health's contact is Greg Coonan, Acting Program Manager, Workplace Relations Unit, on telephone 3234 1440.

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Yours sincerely

Michael Walsh
Acting Deputy Director-General
Corporate Services

Prepared by: Edmund Lynch
Senior Advisor
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3234 0059
December 2010

Checked by: Greg Coonan
A/Program Manager
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3234 1440
December 2010

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A/Director
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3235 9524
December 2010

Cleared by: Helen Ceron
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People and Culture Strategic Services
3222 2908
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Cleared by: Dulise Maxwell
Executive Director
People and Culture Strategic Services
32341481
December 2010

Document name: ME02437 S:\CSD\HRB\WR\Medical Team\correspondence\letters\letter to QPSU re Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract.

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Enquiries to: Greg Coonan
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Workplace Relations Unit
Telephone: 3234 1440
Facsimile: 3234 0314
File Ref: ME02444

Dr Nick Buckmaster
President
Salaried Doctors Queensland
PO Box 153
KELVIN GROVE QLD 4059

Dear Dr Buckmaster

I refer to ongoing consultation that has been occurring with relevant unions in relation to private practice policies. These define the private practice benefits options available to senior medical officers employed by Queensland Health under three year contracts.

I note that there currently remains a difference of opinion between Queensland Health and unions in relation to wording around the circumstances in which the additional 25 percent benefit is payable for Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract. Consultation most recently occurred on 29 November 2010 with People and Culture Strategic Services.

These discussions are continuing at the same time as more general consultation on the policies, with the assistance of the Private Practice Management Committee, to finalise any outstanding aspects of the policies.

I am conscious that the QPSU has indicated that it sees the resolution of the wording for Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract as desirable prior to finalising consultation on the private practice policies generally.

Consultation on the other private practice policies will be concluded but a separate document be developed to outline arrangements for the application of ED 25 %.

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Should you require further information, Queensland Health's contact is Greg Coonan, Acting Program Manager, Workplace Relations Unit, on telephone 3234 1440.

Yours sincerely

Michael Walsh
Acting Deputy Director-General
Corporate Services

Prepared by: Edmund Lynch
Senior Advisor
Workplace Relations Unit
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3234 0059
December 2010

Checked by: Greg Coonan
A/Program Manager
Workplace Relations Unit
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3234 1440
December 2010

Cleared by: Peter Ashton
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People and Culture Strategic Services
3235 9524
December 2010

Cleared by: Helen Ceron
Deputy Executive Director
People and Culture Strategic Services
3222 2908
December 2010

Cleared by: Dulise Maxwell
Executive Director
People and Culture Strategic Services
32341481
December 2010

Document name: ME02444 S:\CSD\HRB\WR\Medical Team\correspondence\letters\letter to SDQ re Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract.

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Fax
3234 1482

From: Shauna Taylor
To: Dion Matley
Date: 8/02/2010 4:31 pm
Subject: Option A ED extended hours contract

Dion,
Are you able to contact me Tuesday to discuss this?

I left a message with Josh on Friday and he indicated that who would return my call.

Thanking you

Shauna

From: Shauna Taylor
To: Dion Matley
CC: Lyn Forrest
Date: 23/06/2010 1:34 pm
Subject: Option A extended hours in ED

Dion,
Any progress on the Option A extended hours in ED contract clarification? In my opinion, the current arrangement is not equitable for the other doctors not on this contract.

s.47(3)(b) - personal information

I personally think that a doctor who agrees to accept additional remuneration for working in the after hours period in the emergency department should be expected to work more than one evening shift each week. Certainly the other doctors do (and work in theatre and on the wards as well). Or these doctors could work more of the weekend shifts if they are not going to work more than one evening shift each week.

I would be grateful if documented clarification on this issue could be forwarded to me to assist with the doctor's rostering at Gladstone Hospital as soon as it is available.

Thanking you

Shauna

From: Edmund Lynch
To: Lina Ma
Date: 3/08/2010 3:58 pm
Subject: Re: Advice on SMO - DEM Extended Hours Benefit with Option A contract DRAFT REPLY
Attachments: Edmund Lynch.vcf

Dear Lina

You are most welcome Lina. Will come back to you further shortly.

Kind regards

Edmund Lynch
Senior Advisor
Workplace Relations
People and Culture Strategic Services
Queensland Health
Level 15
Queensland Health Building
147 - 163 Charlotte Street
Brisbane Qld 4000
Phone 07 32340059
Edmund_Lynch@health.qld.gov.au

>>> Lina Ma 3/08/2010 12:35 pm >>>
Hi Edmund

Thanks for your advice.

Just wanting to clarify, that the contract's definition of shift is dependent on the number of hours a SMO is actually allocated for a particular shift (ie not based on a 8 hour shift). Therefore, if a SMO is allocated to work a 5 hour shift and start *after* 1.30pm, they would be eligible to attract the ED 25% as the majority of their shift is after 4pm, provided they meet the other criteria.

Please do not hesitate to contact me on 5470 5938 if you have any questions.

Regards
Lina

Lina Ma
A/People and Culture Advisor| People and Culture
Southern Cluster| Sunshine Coast-Wide Bay Health Service District
P 5470 5938 | **E** Lina_Ma@health.qld.gov.au

>>> On 2/08/2010 at 4:48 pm, Edmund Lynch <Edmund Lynch@health.qld.gov.au> wrote:
Hi Lina

Emergency department option A is considered an extension of Option A for specific limited circumstances.

All of the criteria set out in a standard Option A contract must be met prior to entering into an additional Emergency Department Option A contract and the specialist must have initially signed an option A contract.

The criteria you have quoted of "*SMO's rostered ordinary hours include working of shifts where the majority of the shift is after 4pm."* is one of a number of criteria that must be satisfied in order to be eligible for the emergency department extended hours benefit contract.

In the instance you have cited where the SMO only works 5 hours per week on Thursdays were that SMO to commence at 130pm and work as ordinary hours a five hour shift and **even proportion** of his or her shift would be after 4pm and an **even proportion** before 4pm. This would not be sufficient to attract the ED 25 %.

Edmund Lynch

Senior Advisor
Workplace Relations
People and Culture Strategic Services
Queensland Health
Level 15
Queensland Health Building
147 - 163 Charlotte Street
Brisbane Qld 4000
Phone 07 32340059
Edmund_Lynch@health.qld.gov.au

>>> Lina Ma 28/07/2010 11:14 am >>>
Hi Dion

Just a quick question, I was hoping you could provide clarification on the wording of the Emergency Department Extended Hours Benefit Contract for a SMO with an Option A contract (see attached).

It states under clause 3.1, "*SMO's rostered ordinary hours include working of shifts where the majority of the shift is after 4pm."*

Our SMOs in question only work 5 hours per week on Thursday afternoons. The contract does not specifically state how long a 'shift' is and as such, we are unsure of how many hours they would be required to work after 4pm to be eligible. eg does the contract assume that a shift is 8 hours and therefore require at least 4 hrs be worked in the extended hours timeframe? Or, if the SMO started their shift after 1.30pm then they would be eligible as they would have worked more than 2.5 hours.

I appreciate your assistance in this one. If you have any questions, please do not hesitate to contact me on 5470 5938.

Warm regards
Lina

Lina Ma
A/People and Culture Advisor| People and Culture
Southern Cluster| Sunshine Coast-Wide Bay Health Service District
P 5470 5938 | **E** Lina_Ma@health.qld.gov.au

From: Edmund Lynch
To: Lina Ma
Date: 3/08/2010 4:24 pm
Subject: Re: Advice on SMO - ED Extended Hours Benefit with Option A contract
Attachments: Edmund Lynch.vcf

Hi Lina

Thank you for your further email dated 3 August 2010 in which you detail a slightly different proposed hours of work to that proposed in your original email.

Emergency department option A is considered an extension of Option A for specific limited circumstances.

All of the criteria set out in a standard Option A contract must be met prior to entering into an additional Emergency Department Option A contract and the specialist must have initially signed an option A contract.

The criteria you quoted in your original email of "*SMO's rostered ordinary hours include working of shifts where the majority of the shift is after 4pm."* is one of a number of criteria that must be satisfied in order to be eligible for the emergency department extended hours benefit contract.

In your 3 August 2010 email you have detailed a situation in which the SMO only works 5 hours per week on a Thursday, commences after 130pm and works as ordinary hours a five hour shift. A majority of his or her shift would indeed then be after 4pm, thereby satisfying one of the criteria to attract the ED 25 %.

We can only advise on the specifics of particular situations. If there is a further particular scenario please do not hesitate to contact us further.

Kind regards

Edmund Lynch
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147 - 163 Charlotte Street
Brisbane Qld 4000
Phone 07 32340059
Edmund_Lynch@health.qld.gov.au

>>> Lina Ma 3/08/2010 12:35 pm >>>
Hi Edmund

Thanks for your advice.

Just wanting to clarify, that the contract's definition of shift is dependent on the number of hours a SMO is actually allocated for a particular shift (ie not based on a 8 hour shift). Therefore, if a SMO is allocated to work a 5 hour shift and start *after* 1.30pm, they would be eligible to attract the ED 25% as the majority of their shift is after 4pm, provided they meet the other criteria.

Please do not hesitate to contact me on 5470 5938 if you have any questions.

Regards
Lina

Lina Ma
A/People and Culture Advisor| People and Culture
Southern Cluster| Sunshine Coast-Wide Bay Health Service District
P 5470 5938 | **E** Lina_Ma@health.qld.gov.au

>>> On 2/08/2010 at 4:48 pm, Edmund Lynch <Edmund Lynch@health.qld.gov.au> wrote:
Hi Lina

Emergency department option A is considered an extension of Option A for specific limited circumstances.

All of the criteria set out in a standard Option A contract must be met prior to entering into an additional Emergency Department Option A contract and the specialist must have initially signed an option A contract.

The criteria you have quoted of "*SMO's rostered ordinary hours include working of shifts where the majority of the shift is after 4pm.*" is one of a number of criteria that must be satisfied in order to be eligible for the emergency department extended hours benefit contract.

In the instance you have cited where the SMO only works 5 hours per week on Thursdays were that SMO to commence at 130pm and work as ordinary hours a five hour shift and **even proportion** of his or her shift would be after 4pm and an **even proportion** before 4pm. This would not be sufficient to attract the ED 25 %.

Edmund Lynch

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147 - 163 Charlotte Street
Brisbane Qld 4000
Phone 07 32340059
Edmund_Lynch@health.qld.gov.au

>>> Lina Ma 28/07/2010 11:14 am >>>
Hi Dion

Just a quick question, I was hoping you could provide clarification on the wording of the Emergency

Department Extended Hours Benefit Contract for a SMO with an Option A contract (see attached).

It states under clause 3.1, "*SMO's rostered ordinary hours include working of shifts where the majority of the shift is after 4pm."*

Our SMOs in question only work 5 hours per week on Thursday afternoons. The contract does not specifically state how long a 'shift' is and as such, we are unsure of how many hours they would be required to work after 4pm to be eligible. eg does the contract assume that a shift is 8 hours and therefore require at least 4 hrs be worked in the extended hours timeframe? Or, if the SMO started their shift after 1.30pm then they would be eligible as they would have worked more than 2.5 hours.

I appreciate your assistance in this one. If you have any questions, please do not hesitate to contact me on 5470 5938.

Warm regards
Lina

Lina Ma
A/People and Culture Advisor| People and Culture
Southern Cluster| Sunshine Coast-Wide Bay Health Service District
P 5470 5938 | **E** Lina_Ma@health.qld.gov.au

From: Helen Ceron
To: Terry Hanelt
Date: 10/02/2010 5:13 pm
Subject: Re: Emergency Department Extended Hours Benefits Contracts.

Terry

Thank you for your feedback. I concur it is a QH responsibility to ensure entitlements are paid and received lawfully and after receipt of your email, Dion and I discussed how best this can be undertaken for the application of the ED 25% payment. Your suggestion of an audit is worthy of further consideration and I will raise it with Michael Kalimnios.

Regards
Helen

>>> Terry Hanelt 8/02/2010 2:45 pm >>>
Helen,
Seems Dion has passed the ball to you on this one.
Dion's reply would seem to address what will happen in the future to try to prevent future illegitimate contracts being signed.
My concern is in relation to doctors and District Managers who signed contracts that were not true and correct and the consequences of these actions.
This is a matter of concern in that I think it probably constitutes a type of fraud; it creates an unfair recruitment and retention tool; and it creates unrest amongst staff. The planned future policy/procedure will not cause these illegitimate contracts to cease being in effect.
I believe QH has an obligation to conduct an audit to see who is getting the 25% allowance and check that these doctors are working all their ordinary hours in an Emergency Department under an extended hours arrangement. To fail to do so could be seen as condoning payments contrary to entitlements. If I have come up with this s.47(3)(b) how widespread may it be? Queensland Health gets enough adverse media attention without this potentially being highlighted. I have a few staff who are quite hot and bothered about doctors receiving the 25% ED allowance despite doing less ED work than they do. I understand their frustration at the apparent inaction over this issue.
Can I please be informed if QH is planning to do something about doctors currently receiving this allowance illegitimately so I can pass this on to the staff raising concerns.
Terry H

Dr Terry Hanelt
Director of Medical Services,
Gympie Hospital
Medical Officer, Clinical Governance Support Unit
Southern Cluster,
Sunshine Coast - Wide Bay Health Service District
Phone: 61 7 54898404
Fax: 61 7 54898410
E-mail: Terry_Hanelt@health.qld.gov.au

>>> Dion Matley 8/02/2010 1:24 pm >>>

Good afternoon Terry,

Thank you for the questions and concerns raised in your email of 27 January 2010. Michael Kalimnios

has requested a response be prepared and forwarded to you on his behalf. People and Culture Corporate has prepared this response as we have responsibility for the policies associated with private practice/supplementary benefits.

Your interpretation of the application of the private practice/supplementary benefit Option A Emergency Department ("ED") extension contract ("the ED contract") is correct:The senior medical officer must have signed a private practice/supplementary benefit Option A contract; AND The senior medical officer MUST be working all of their hours of work in an ED; AND The ordinary hours of work are being performed under an extended hours roster which covers 7.00amand 10.00pmMonday to Sunday.

"All of their hours of work" means:Full-time engagement in the Emergency Department only; OR Part-time engagement in the Emergency Department only.

This definition is, we believe, where confusion is created:ER Circular 24/06 explains the general operation of the ED contract; The definition of "all of their hours of work" is a policy decision which is not contained in ER Circular 24/06, IRM 2.7-12 OR the ED contract itself; It is possible that employees who administer the ED contracts are not aware of the full requirements of entering into the contract.

People and Culture Corporate propose to address these issues by:Replacing IRM 2.7-12 with two new HR Policies for specialists and non-specialists. These will be finalised in the coming weeks and will contain clarification information on this very issue including definitions of "all of their hours of work" along with what is viewed as "performed under an extended hours roster". The policies will be subject to Private Practice Board of Management approval (which includes QPSU and SDQ representatives); and The existing ED contract released in 2009 will be reviewed to determine any required amendments to give effect to the new policies.

I trust this information is addresses your questions and concerns. If you do have any further queries please contact Helen Ceron on 3234 0784.

Kind Regards

Dion

Dion Matley
Program Manager Medical
Workplace Relations Unit
People & Culture Corporate
Queensland Health

Ph: 07 3234 1440 Fax: 07 3234 0314

>>> Terry Hanelt 27/01/2010 12:30 pm >>>
Michael,
There is a significant problem with interpretation of payment of this allowance (the 25% extra allowance for Emergency Department SMO's).
s.47(3)(b) - personal information

s.47(3)(b) - personal information

s.47(3)(b)

s.47(3)(b) and works in the wards and in the ED. All was progressing until the payment of the ED 25% allowance came up. He has been receiving that allowance at s.47(3)(b) . I have obtained the documents that confirm this payment. He is now not willing to take up the position at Gympie.
The problem is that there are some SMO's working part of their hours in ED and the rest of their time in the wards or other duties such as anaesthetics who are being paid the ED 25% allowance and other doing the same duties who are not being paid the allowance. Gympie adheres to the rules as stated by corporate office and thus disadvantages itself in recruitment.
I ask the following -
Is it equitable that a SMO who works 0.75 FTE in ED under an extended hours arrangement and does no other work for QH gets the allowance; whilst a SMO who works 0.75 FTE in ED under an extended hours arrangement and works 0.25 FTE for QH in another clinical area does not get paid the allowance?
Is it reasonable that some Districts are paying the 25% ED allowance when the terms of the Contract are not being fulfilled?

s.47(3)(b) - personal information

Is it reasonable for some Districts to pay the 25% ed allowance to ineligible SMO's in what I see as a recruitment and retention tactic?
I believe that an audit needs to be done to identify all SMO's being paid the ED 25% allowance and then their contract of employment and rosters be reconciled to determine the number of Districts and SMO's receiving the allowance contrary to the conditions of the contract. This would allow an assessment of the magnitude of the problem.
This problem really needs to be fixed.
I am happy to provide further information and/or copies of old e-mails I have been able to identify in relation to this matter.
Terry H

Dr Terry Hanelt
Director of Medical Services,
Gympie Hospital
Medical Officer, Clinical Governance Support Unit
Southern Cluster,
Sunshine Coast - Wide Bay Health Service District
Phone: 61 7 54898404
Fax: 61 7 54898410
E-mail: Terry_Hanelt@health.qld.gov.au

From: Fiona Heap
To: Sharyn Meares
Date: 29/03/2010 2:38 pm
Subject: Re: Emergency_Department_Extended_Hours
Attachments: Emergency_Department_Extended_Hours_Definition - Updated 15.01.10.DOC

Hi Sharyn

Please find attached the current version of the Emergency Department Extended Hours Option A contract template.

This version is slightly updated from the template that was sent out in August 2009. To avoid confusion with multiple contracts we'd recommend you delete (or archive) the old template and only use this one from now on.

As per the DDG Memo which was originally sent with the private practice contracts, these templates are not to be changed in any way apart from in the higlighted areas (date, name, address, etc.).

Please do not hesitate to contact us if you have any questions or concerns regarding this matter.

Kind regards

Fiona

Fiona Heap
A/Advisor

Workplace Relations Unit
People & Culture Corporate, Queensland Health
Ph: (07) 3234 1626 | E: Fiona_Heap@health.qld.gov.au

>>> Sharyn Meares 29/03/2010 1:56 pm >>>
Hi Fiona

Page 1 Background, Column A has been modified.

Thanks for sorting this for me.

Regards

Sharyn Meares
Manager
Private Practice Unit
Ambulatory Care Services
Ph: 07 3636 1423
M: s.73

From: Lyn Forrest
To: Matley, Dion
CC: Forrest, Lyn
Date: 11/02/2010 7:38 am
Subject: Re: extended hours (new question!!)

Thanks, Dion.In the original Circulars regarding the private practice option there was no mention of SMO (non-generalists) being able to take up Option B. However MOCA 2 seems to include this. Is there a different Option A and B contract for the SMOs than there is for the specialists or are the same contracts used regardless of level?

Lyn Forrest
Senior Employee Relations Advisor
Gladstone Hub
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PO Box 299
Gladstone 4680
Ph (07)4976 3262
Fax (07)49729147
lyn_forrest@health.qld.gov.au

>>> Dion Matley 10/02/2010 5:44 pm >>>
Hi Lyn,

To assist with your meeting, I would note to the docs the following points:

1. The proper application of the ED 25% is for those docs working "all of their hours" in an ED. Yes, it was to boost attraction and retention but it was also in recognition that docs working all of their hours in an ED do not have the capacity to bill private patients and cannot enter into the more lucrative option B contracts. Those docs flitting in and out of ED and working elsewhere may in fact have that Option B capacity.

2. QH is well aware of the potential for inconsistent application of the ED 25%. Due to various factors the full details and definitions associated with the ED 25% were not properly committed to writing by QH and the unions.

3. QH may well conduct an audit of those docs getting ED 25% and make decisions with respect to recovering overpayments OR the definition may be made more liberal in terms of reducing the % from 100% of hours to maybe 75% for example? This will all be subject to a DDGCS brief.

In terms of your issues:

1. You are correct - any doctor commencing BEFORE 16 November 2009 cannot be forced to work weekends.

However, you need to read clause 6.3 in its proper context. It is all about those SMOs who have traditionally only worked Mon to Fri. Clause 6.3 was put in place to ensure that if their hours were extended, proper consideration was given, hence MIBB approval.

Where an ED has run 24-7 either pre MOCA1 or after, and docs have been doing those rosters, they cannot simply refuse to do them now based on clause 6.3. There is the provision in the EB that any time

outside ordinary hours is overtime anyway, so reasonable management direction can dictate that the hours need to be worked.

2. Yes, our next meeting is on 23 February 2009. No, we have not been inundated. Probably due to the fact that most EDs were already doing extended hours - the only applications I have seen have been from other occupational groups who feel the need to work beyond the standard hours, into the evening etc.

Cheers

Dion

Dion Matley
Program Manager Medical
Workplace Relations Unit
People & Culture Corporate
Queensland Health

Ph: 07 3234 1440 Fax: 07 3234 0314

>>> Lyn Forrest 9/02/2010 4:19 pm >>>
Hi, Dion, your favorite stalker again! I am trying to prepare for a meeting with all our other SMOs who won't get the ED contract. I am assuming they will be not feeling all that cooperative.

Issue 1

With this in mind, can you clarify the position for SMOs employed after MOCA 1 and prior to MOCA 2 in regard to 6.3.7 (a). This is the same in both MOCAs and reads:

Senior Medical Officers engaged prior to the date of certification of this agreement will not be required to participate in weekend extended hours arrangements, unless they choose to do so voluntarily.

Does this mean that SMOs engaged after MOCA 1 could not refuse to have weekend shifts up until the signing of MOCA 2 but now they can because they were employed prior to MOCA 2 being signed?

Issue 2

MOCA 1 and 2 talk about a formal consultation process and extended hours arrangements being lodged with the MIBB group for endorsement. I would be surprised if this happened with the Gladstone agreement which was a continuation of a longstanding work practice. Is the MIBB Group alive and well and inundated with agreements that they have endorsed?

Lyn Forrest
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Central Queensland Health Service District
PO Box 299
Gladstone 4680
Ph (07)4976 3262
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lyn_forrest@health.qld.gov.au

From: Clare Dwyer
To: Chris BELL; Dion Matley; Julie White
CC: Thomas Brauns
Date: 15/01/2010 10:19 am
Subject: Re: Fwd: Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract

Hi Chris.

You have the correct Emergency Department Extended Hours Benefit Contract. It wasn't updated to refer to MOCA2 as it was released pre-MOCA2, however it refers back to the Option A contract which refers to MOCA1 'or a replacement agreement'. There is nothing to be concerned about in relation to the ED contracts already signed. I've asked my colleague Tom Brauns to send you an updated ED Contract template with reference to MOCA2 when he has had a chance to update this, so you could use this in the future.

Regards, Clare.

Clare Dwyer
Principal Advisor
Workplace Relations Unit
People and Culture Corporate
Queensland Health

Ph: 07 323 40003
Email: Clare_Dwyer@health.qld.gov.au

>>> Julie White 15/01/2010 9:52 am >>>
Hi Dion/Clare,

Hoping you or the right person in People and Culture can assist Chris Bell with this.

kind regards
Julie

Julie White
Principal Lawyer
Legal Unit
Queensland Health
Ph: (07) 323 40534
Fax: (07) 323 41977

Available Tuesday, Thursday and Friday

>>> Chris BELL 12/01/2010 3:30 pm >>>
To whom it may concern

I have a template for the "Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract " and use it issue contracts for staff specialists with right of private

practice who work in Emergency Dept after hours.

A doctor today has pointed out that in this document - page 2 of contract, section **Certified Agreement** refers to Medical Officers (Queensland Health) Certified Agreement (No 1) 2005. Apparently that reference is not up to date.

I may be using an old template for the contract and was previously unaware of this.

Can you confirm that the attached template is the correct template for the current "Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract" contract?

If not, please email me a document to be used as the current template.

If this request is not appropriate for the LALU then please let me know and I will redirect my request for information.

Kind regards

Chris

Chris Bell
Private Practice Manager Logan Beaudesert
Southside Health Service District
Phone (07) 3299 8788
Fax (07) 3299 8963

chris_bell@health.qld.gov.au

From: Shauna Taylor
To: Dion Matley
Date: 8/02/2010 4:45 pm
Subject: Re: Option A ED extended hours contract

Thanks Dion. I appreciate that you are also busy, so no problem.

I am considering how to manage the other SMOs who may also want to consider the option of an Option A contract - extended hours. The ED requires 3 FTE SMOs to cover it and I may need to consider a selection process for granting Option A extended hours ED contracts. It potentially could be quite divisive for the staff here because staff have generally worked a combination of both ward and ED work. If these doctors receive additional remuneration it may be that they are required to work the bulk of their ordinary hours in the after-hours period.

We are funded for 8 SMOs - 4 of which practice procedural medicine (either obstetrics or anaesthetics), one works half time in s.47(3)(b) and half time in ED. s.47(3)(b) - personal information s.47(3)(b) - personal information

I look forward to discussing this with you.

Thanks

Shauna

From: Shauna Taylor
To: Dion Matley
Date: 12/07/2010 11:05 am
Subject: Re: Option A extended hours in ED

Dion,
Any progress on this issue of the Option A extended hours ED contract?

Regards,

Shauna

>>> Dion Matley 24/06/2010 10:39 am >>>

We are currently committed to a policy position where a person needs to work all of their hours in an approved ED to be entitled to the allowance contract. We have presented this position to the unions who verbally indicated they would not agree with that position and want something along the lines of "approved shifts on an extended hours roster" would be suitable. We are hoping to come to some agreement over the next week. Stay tuned.

In terms of your comments I would argue that the doctor is refusing a lawful request regarding the hours being performed. One cannot stipulate to management that a certain roster will not be worked if that roster is stipulated at the outset as being a possibility. If you look at the Certified Agreement, hours of work and rosters can be mutually agreed but where this does not occur management have the right to make the final decision. This is a matter independent of the ED contract issue.

Cheers
Dion

Dion Matley
Program Manager
Workplace Relations Unit
People and Culture Strategic Services
Queensland Health

Ph: 07 3234 1440 Fax: 07 3234 0314

>>> Shauna Taylor 23/06/2010 1:34 pm >>>
Dion,
Any progress on the Option A extended hours in ED contract clarification? In my opinion, the current arrangement is not equitable for the other doctors not on this contract. s.47(3)(b) - personal information

s.47(3)(b) - personal information

I personally think that a doctor who agrees to accept additional remuneration for working in the after

hours period in the emergency department should be expected to work more than one evening shift each week. Certainly the other doctors do (and work in theatre and on the wards as well). Or these doctors could work more of the weekend shifts if they are not going to work more than one evening shift each week.

I would be grateful if documented clarification on this issue could be forwarded to me to assist with the doctor's rostering at Gladstone Hospital as soon as it is available.

Thanking you

Shauna

From: Helen Ceron
To: Taresa Rosten
CC: Dion Matley
Date: 24/05/2010 2:24 pm
Subject: Re: Pro rata ED extended hours arrangements

Taresa
the meeting to discuss [redacted] occurred on 10 March 2008. at the meeting was Michael K, Brett McCredie, Jenny Cannon and Rupert Tidmarsh. s.47(3)(b) - personal information
s.47(3)(b) - personal information

Am reasonably sure Shirelle drafted a letter confirming the above.
Helen

>>> "Taresa Rosten" <Taresa_Rosten@health.qld.gov.au> 6/05/2010 2:19 pm >>>
Thanks Jenny

On talking to my principals about this issue I have been clearly advised that there was a meeting held between the senior reps of QPSU and QH late in 2008 on this issue where an understanding was reached that the ED 25% would only apply to those working full time in EDs.

To assist me to ascertain further information I may need to gather, can you advise: were you privy to that meeting or its outcomes or have any comment on this?

Happy to discuss if you would like to give me a call.
T

Taresa Rosten
Director Workplace Relations
People and Culture Corporate
Queensland Health
ph 32359524
Mobile: s.73

>>> "Jenny A. Cannon" <jenny.cannon@doctorsunionqld.com.au> 5/05/2010 11:04 am >>>
Taresa

As agreed I now forward you relevant correspondence relating to an agreement reached between QH and the Uniions in situations where a MO is appointed to a facility and there is a requirement for part of their ordinary hours to be worked in the ED on an extedned hours roster.

Regards
Jenny Cannon

Queensland Health Emergency Department Extended Hours Benefit Contract Arrangements. 13 December 2011

(1) Applies to SMOs engaged under the District Health Services Senior Medical Officers' and Resident Medical Officers' Award – State 2003, who have entered into an Option A contract and who work in an emergency department with approved extended hours rosters as set out in this document.

(2) Does not apply to:

- VMOs
- MSRPPS or MORPPs

(3) These provisions are to be read in conjunction with other private practice policies, the SMO's Option A contract and the Emergency Department Extended Hours Benefit contract.

(4) Ref docs:

- Medical Officers' (Queensland Health) Certified Agreement (No. 2) 2009
- District Health Services Senior Medical Officers' and Resident Medical Officers' Award – State 2003
- *(Supplementary Benefit/Right to Private Practice Benefits Options – Senior Medical Officers – Specialists HR Policy B48)*
- *(Supplementary Benefit/Right to Private Practice Benefits Options – Senior Medical Officers – Non-specialists HR Policy B49)*
- *Op A Supplementary Benefit Contract – Staff Specialist contract*
- *Op A Supplementary Benefit Contract – Senior Medical Officer contract*
-

(5) The Emergency Department Extended Hours Benefit contract for SMOs was introduced in 2007 to assist with:

- retention of SMOs employed at that time working in public hospital emergency departments with extended hours rosters as defined below and attraction of new medical staff to the practice area of emergency medicine with extended hours rosters as defined below

(6) Eligibility

- Pursuant to clause 6.13 of the Medical Officers' (Queensland Health) Certified Agreement (No. 2) 2009, upon appointment an SMO will be offered a supplementary benefit/private practice benefits option.

- The Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract is an extension of supplementary benefit/right to private practice benefits Option A Emergency Department Extended Hours Benefit contract for a SMO with an Option A contact must be offered to an SMO working in an emergency department with an extended hours roster as defined below.
-

(8) Emergency Department Extended Hours Benefit contract criteria

- .
- In determining whether an Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract is applicable, the MS and/or DMS is to ensure

- The emergency department has an extended hours roster as defined below
- The SMO is rostered to work their ordinary hours or an agreed proportion of their ordinary hours in the emergency department.
- The SMO's rostered ordinary hours (or an agreed proportion of the SMOs ordinary hours) are worked in accordance with the extended hours arrangement.
- The SMO's rostered ordinary hours include the working of shifts where the majority of the shift is after 4.00pm Monday to Friday and / or the shift is worked on the weekend
- An Option A contract has already been signed.

(9) Working ordinary hours in an Emergency Department as well as in another role within the public hospital facility

- Where an SMO is not working full-time in an emergency department, the MS or DMS will determine what percentage of the SMO's ordinary working hours are required to be worked in the emergency department and shall document this.
- Only those hours for which an SMO is rostered in the emergency department will attract the 25% payment
- The ad hoc working hours in an emergency department does not qualify an SMO for the ED 25% payment
- Time worked in an Acute Primary Care Clinic or other work area does not qualify an SMO to receive the payment of ED 25 percent on those hours worked in that area.

(10) Cessation of Extended Hours Benefit contract

- In the event the SMO withdraws from participating in extended hours arrangements in the emergency department, ceases to have a current Option A contract, or terminates employment with Queensland Health, the SMO's entitlement to the emergency department extended hours benefit will immediately cease.

In the event that Queensland Health decides to permanently close the emergency department, permanently cease to operate the emergency department during Extended Hours or suspend the operation of the emergency department during Extended Hours then the SMO's entitlement to the Emergency Department Extended Hours Benefit will continue until 26 consecutive weeks have expired since the emergency department ceased operating during Extended Hours

(11) Definitions

Emergency Department for the purpose of Queensland Health Emergency Department Extended Hours Benefit Contract Arrangements.	A dedicated area in a public hospital that is organised and administered to provide emergency care to those in the community who perceive the need for, or are in need of, acute or urgent care including hospital admission. Locations where the Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract as an extension of supplementary benefit/right to private practice benefits Option have been offered to an SMO with an Option A contact are listed in annexure 1
Extended hours roster	Means, with respect to the hours of operation of an emergency department, rostered ordinary hours coverage by medical officers provided in accordance with the medical officers' certified agreement from:

	7.00am to 10.00pm Monday to Friday; and weekend cover.

Annexure 1*

Locations where the Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract as an extension of supplementary benefit/right to private practice benefits Option have been offered to an SMO with an Option A contact include the following:-

Bundaberg Hospital
Beaudesert Hospital
Caboolture Hospital
Cairns Base Hospital
Caloundra Hospital
Gladstone Hospital
Gold Coast Hospital
Gympie Hospital
Hervey Bay Hospital
Ipswich Hospital
Logan Hospital
Mackay Base Hospital
Maryborough Hospital
Mount Isa Hospital
Nambour Hospital
Princess Alexandra Hospital
Queen Elizabeth II Jubilee Hospital
Redcliffe Hospital
Redland Hospital
Robina Hospital
Rockhampton Base Hospital
Royal Brisbane & Women's Hospital
Royal Children's Hospital
The Prince Charles Hospital
Toowoomba Hospital
Townsville Hospital

* In the event that a District or a group of Doctors wished to implement new extended hours arrangements and roster in an Emergency Department not listed above the process under clause 6.3 of MOCA2 is to be followed including referring such a proposal to the MOCA2 Consultative Group for endorsement.

Shirelle M Wolfe

From: Dan Goldman <Dan.Goldman@together.org.au>
Sent: Monday, 5 June 2017 2:24 PM
To: Darryl Turner
Cc: stephen.morrison@s.47(3)(b) ; Sandy Donald; Mark Uzelin; r.lamont@amaq.com.au
Subject: DG ED25 Components 13 December 2011
Attachments: ED25 Components 13 December 2011.doc; Edmund Lynch1.vcf

Categories: ED Allowance

Dear all, please see below and attached.

Dan Goldman | Acting Assistant Branch Secretary| ***Together***

www.together.org.au |dan.goldman@together.org.au | 1800 177 244

From: Edmund Lynch [mailto:Edmund_Lynch@health.qld.gov.au]
Sent: Tuesday, 13 December 2011 3:23 PM
To: rupert.sdq@s.47(3)(b) ; Jenny A. Cannon <Jenny.Cannon@together.org.au>
Cc: Greg Coonan <Greg_Coonan@health.qld.gov.au>
Subject: ED25 Components 13 December 2011

Dear Jenny and Rupert

Thank you for your consultation time with the Workplace Relations Unit on the afternoon of Tuesday 13 December 2011 on the topic of Emergency Department Extended Hours Benefit. Please find attached a document which I believe reflects the outcome of that consultation.

Edmund Lynch
B. Econ. B. LLB
A/Principal Advisor
Workplace Relations Unit
Queensland Health
Level 15
Queensland Health Building
147 - 163 Charlotte Street
Brisbane Qld 4000
Phone 07 323 40003
Edmund_Lynch@health.qld.gov.au

5 May 2011

Tabled 15 November 2010

Without Prejudice 15 November 2010
For discussion 10 am 15 November 2010. This is not QH Policy

Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A contract

Emergency department option A is considered an extension of Option A for specific limited circumstances.

All of the criteria set out in a standard Option A contract must be met prior to entering into an additional Emergency Department Option A contract and the specialist must have initially signed an option A contract as well as the additional criteria listed below:

Proposed Application Principles for New Contracts

Criteria to be met:

1. Applicable only for an *Emergency Department*; AND
2. An *extended hours arrangement* must exist; AND
3. The SMOs *rostered ordinary hours* are worked in accordance with the *extended hours arrangement with at least 80 percent of shifts worked in the emergency department*; AND
4. The SMOs *rostered ordinary hours* include the working of shifts where the majority of the shift is after 4.00pm Monday to Friday and/or the weekend; AND
5. A contract is signed.
6. Simply having performed services in an emergency department will not attract Emergency Department Extended Hours Benefit Contract

Definitions

Emergency Department	As listed in the Quarterly Public Hospitals Performance Report: - http://www.health.qld.gov.au/performance/docs/QHQPHPR as amended or varied. Features: • A high level department with emergency medicine specialists and trainees employed at all times. • An emergency department is a discrete unit within a public hospital.

Extended hours arrangement	Means with respect to the hours of operation of an Emergency Department, when Senior Medical Officers' rostered ordinary hours coverage is provided *in accordance with the Certified Agreement* at least from: - 8.00am to 10.00pm Monday to Friday; and - on weekends.
In accordance with the Certified Agreement	Means that an arrangement had to exist prior to MOCA1 OR the arrangement has been approved through the MIBB/MCG.
Rostered ordinary hours	Means all of the hours a SMO is engaged to perform for that position.

What does the contract say?

In addition to the payments and benefits made by Queensland Health to the SMO pursuant to the Certified Agreement and the terms of the Option A Contract, Queensland Health and the SMO have agreed that, in consideration for the SMO working their ordinary hours of work through an Extended Hours arrangement in an emergency department, Queensland Health will pay the SMO the Emergency Department Extended Hours Benefit on the terms set out in this Contract.

Extended Hours means, with respect to the hours of operation of an emergency department, when Senior Medical Officers' rostered ordinary hours coverage is provided in accordance with the Certified Agreement at least from:
8.00am until 10.00pm Monday to Friday; and weekend coverage.

	Option	Issue / response
Option 1	Specify a minimum number of shifts in ED to attract the 25 percent benefit.	Unions view: - Minimum number not required Management response:- On 15/11 discussed 80 percent of shifts. Contract says where the SMO works in an emergency department providing coverage during Extended Hours and rostered ordinary hours include working of shifts where the majority of the shift is after 4.00pm Monday to Friday and/or on the weekend. The Macquarie dictionary definition of majority is the greater part or number. Extended hours are with respect to the hours of

		operation of an emergency department, when Senior Medical Officers' rostered ordinary hours coverage is provided in accordance with the Certified Agreement at least from 8.00am until 10.00pm Monday to Friday; and weekend coverage.
Option 2	Stipulate a minimum number of shifts after hours to attract the ED 25 percent. Such a benefit being in addition to the payments and benefits made by Queensland Health to the SMO pursuant to the terms of the Option A Contract	Unions view:- Not attracted to this idea. Query whether discriminatory? A minimum number would be smaller for a part timer. Management response:- This is contrary to the terms of the contract which refer to the benefit being payable where the SMO works in an emergency department providing coverage during Extended Hours and rostered ordinary hours include working of shifts where the majority of the shift is after 4.00pm Monday to Friday and/or on the weekend. Extended hours are with respect to the hours of operation of an emergency department, when Senior Medical Officers' rostered ordinary hours coverage is provided in accordance with the Certified Agreement at least from 8.00am until 10.00pm Monday to Friday; and

		weekend coverage. The Macquarie dictionary definition of majority is the greater part or number.
Option 3	No parameters. Any work performed in ED attracts ED.	Potential for abuse. All agree on this. Not designed for this. "Toe in the water" problem.
	Maintenance of ED 25 percent when SMO is out of ED for a period	Unions view Management response recognises need to work in ICU and anaesthetics. Need for degree of flexibility.

The Contracts

A The SMO is employed by Queensland Health as a **[**[insert job title]**.**

B The SMO and Queensland Health have entered into an Option A Contract dated [insert date] (**Option A Contract**).

C In addition to the payments and benefits made by Queensland Health to the SMO pursuant to the Certified Agreement and the terms of the Option A Contract, Queensland Health and the SMO have agreed that, in consideration for the SMO working their ordinary hours of work through an Extended Hours arrangement in an emergency department, Queensland Health will pay the SMO the Emergency Department Extended Hours Benefit on the terms set out in this Contract.

Agreed Terms

1 Definitions

For the purpose of this document:

Award means the *District Health Services - Senior Medical Officers' and Resident Medical Officers' Award – State 2003*.

Certified Agreement has the same meaning as in the Option A Contract.

Emergency Department Extended Hours Benefit has the meaning given by **clause 3.1** of this document.

Extended Hours means, with respect to the hours of operation of an emergency department, when Senior Medical Officers' rostered ordinary hours coverage is provided in accordance with the Certified Agreement at least from:

(a) 8.00am until 10.00pm Monday to Friday; and

(b) weekend coverage.

Senior Medical Officers (SMO) means Senior Medical Officers as classified under the Award working in an emergency department.

Supplementary Benefit has the same meaning as in the Option A Contract.

Supplementary Benefit Percentage has the same meaning as in the Option A Contract.

2 Term

This document will commence on [**insert date**] and terminate on [**insert date**] unless terminated earlier in accordance with this document.

3 Emergency Department Extended Hours Benefit

3.1 Where the SMO works in an emergency department providing Senior Medical Officers' coverage during Extended Hours as defined above and the SMO's rostered ordinary hours include working of shifts where the majority of the shift is after 4.00pm Monday to Friday and/or on the weekend, the SMO's entitlement to the Supplementary Benefit under the Option A Contract will be increased by adding a further 25% to the Supplementary Benefit Percentage as set out in **Item 5 of Schedule 1** to the Option A Contract (**Emergency Department Extended Hours Benefit**).

3.2 If the SMO is entitled to payment of the Emergency Department Extended Hours Benefit under **clause 3.1** then the Option A Contract will continue with full force and effect as if the Emergency Department Extended Hours Benefit forms part of the Supplementary Benefit in the Option A Contract.

3.3 In the event that Queensland Health decides to permanently close the emergency department, permanently cease to operate the emergency department during Extended Hours or suspend the operation of the emergency department during Extended Hours then the SMO's entitlement to the Emergency Department Extended Hours Benefit will continue until 26 consecutive weeks have expired since the emergency department ceased operating during Extended Hours.

3.4 In the event that the SMO decides to withdraw from participating in Extended Hours coverage then the SMO's entitlement to the Emergency Department Extended Hours Benefit will immediately cease.

4 Termination

4.1 The agreement evidenced by this document will automatically terminate in the event that the Option A Contract terminates for any reason.

000380 pg 6

BR027753 ME01827

05 JUN 2006

Queensland Health
BRIEFING NOTE FOR APPROVAL

..... OK
Dated / /
Approved / Not Approved
Further information required
M. Schnerlein
Dated 7/6/06

TO: **Director-General**

FROM: *Christine Axelby, A/Team Leader, Corporate Human Resource/Industrial Relations Policy & Strategy Centre*

SUBJECT: **Emergency Department Extended Hours Option A Payment**

PURPOSE
To seek the Director-General's approval of revised criteria to entitle medical officers working extended hours in Emergency Departments to the additional 25% Option A Allowance.

RECOMMENDATION
It is recommended that the Director-General approve the following revised criteria (as determined through broad agreement subsequent to further senior level negotiations) for Senior Medical Officers (SMOs) working in Emergency Departments to become eligible for the additional 25% private practice allowance:

Extended Hours means, with respect to the hours of operation of an Emergency Department, when Senior Medical Officers' rostered ordinary hours coverage is provided in accordance with the Certified Agreement at least from:

- *8.00am to 10.00pm Monday to Friday; and*
- *on weekends*

Where the SMO works in an emergency department providing SMO coverage during extended hours as defined above and the SMOs rostered ordinary hours include the working of shifts where the majority of the shift is after 4.00pm Monday to Friday and/or on the weekend, the SMOs entitlement to the Supplementary Benefit under the Option A Contract will be increased by adding a further 25% to the Supplementary Benefit Percentage.

In the event that Queensland Health decides to permanently close the Emergency Department, permanently cease to operate the Emergency Department during Extended Hours or suspend the operation of the Emergency Department during Extended Hours then the SMO's entitlement to the Emergency Department Extended Hours Benefit will continue until 26 consecutive weeks have expired since the Emergency Department ceased operating during Extended Hours.

In the event that the SMO decides to withdraw from participating in Extended Hours coverage then the SMO's entitlement to the Emergency Department Extended Hours Benefit will immediately cease.

FUNDING SOURCE

- Cabinet Budget Review Committee has approved this arrangement and its costings. Funding for this arrangement has been sought through the current State Budget process; however the outcome is under embargo until budget day.

RECEIVED RECORDS TEAM 13 JUN 2006 DEPT. OF HEALTH

Author's Name: Christine Axelby Position: A/Team Leader ~~Unit/Dist: CHRIRPSC~~ Tel No: (07) 3234 0003 Date: 24.05.06	Cleared by: Name: Michael Hawkins ~~Position: A/Director~~ Unit/District: CHRIRPSC Tel No: (07) 3234 1920 Date: 29.05.06

CURRENT ISSUES

- Further discussions at a senior level have occurred between unions and a number of the original negotiators of the February 2006 announcements. Considerable concern has been raised by the unions regarding the Department's intention to seek a minimum number of extended hours shifts per fortnight being worked by SMOs due to many Emergency Department SMOs working irregular shift patterns.
- Based on the discussions held, it is expected that the above recommendation would be acceptable to unions, allowing the payment of the Emergency Department Extended Hours 25% to occur.
- *Attachment 1* is the initial brief approved by the Director-General outlining criteria for the additional 25% allowance based on initial discussions with the parties.

PROPOSED ACTIONS

- That an Emergency Department Extended Hours Benefit Contract be finalised with the relevant unions and distributed to Health Service Districts to apply to eligible staff as a matter of urgency.

BACKGROUND

- On 3 February 2006, the Premier and Minister for Health announced a range of improvements to the entitlements of Queensland Health salaried doctors, including a range of improvements and extension of the private practice arrangements in place.

ATTACHMENTS:

Previous Brief: BR027236

COMMENTS

Author's Name: Christine Axelby Position: A/Team Leader ~~Unit/Dist: CHRIRPSC~~ Tel No: (07) 3234 0003 Date: 24.05.06	Cleared by: Name: Michael Hawkins ~~Position: A/Director~~ Unit/District: CHRIRPSC Tel No: (07) 3234 1920 Date: 29.05.06	

oc

000380 P6

BR027236

- 8 MAY 2006

Queensland Health
BRIEFING NOTE FOR APPROVAL

TO:	**Director-General**
FROM:	*Christine Axelby, A/Team Leader, Corporate Human Resource/Industrial Relations Policy and Strategy Centre*
SUBJECT:	**Criteria for payment of 25% Option A Allowance for Emergency Medicine doctors.**

..... OK
Dated / /
Noted /Approved / Not Approved
Further information required
M. Schaefer
Dated 5/5/06

RECEIVED RECORDS TEAM 16 MAY 2006 DEPT. OF HEALTH

PURPOSE
To seek approval of criteria required to be met to entitle medical officers working extended hours in Emergency Departments to the additional 25% Option A allowance.

RECOMMENDATION
It is recommended that the Director-General approve the following criteria as a means for Specialists and other Senior Medical Officers working in Emergency Departments to become eligible for the additional 25% private practice allowance:

1. The Emergency Department must be open at least from 8am to 10pm Monday to Friday and during the day on the weekend.
2. The relevant Emergency Department Senior Medical Officer (SMO) must be participating in and working shifts which result in the SMO performing ordinary hours during an afternoon shift and/or on the weekend. The shift arrangement performed by the Emergency Department SMOs should on an average provide for two afternoon shifts or one afternoon shift and one weekend shift in a week or pro rata for a part time Emergency Department SMOs.
3. When the extended hour's arrangements are either terminated or the individual doctor no longer participates in the extended hour's arrangements, the 25% allowance is no longer payable. However, when the extended hours arrangements are suspended it is proposed that the 25% private practice allowance is continued for a maximum period of 26 weeks.

FUNDING SOURCE

- Cabinet Budget Review Committee has approved this arrangement and its costings. Funding for this arrangement has been sought through the current State Budget process; however the outcome is under embargo until budget day.

CURRENT ISSUES

- As part of the package announced by the Premier and Minister for Health in February 2006 about private practice improvements and extensions available to all Senior Medical Officers, a specific entitlement of an additional 25% private practice arrangement was offered to Senior Medical Officers working extended ordinary hours arrangements in Emergency Departments. The criterion for eligibility was to be determined.
- Discussions with negotiators of the package indicated that the arrangement was subject to the Emergency Department working at least two shifts a day, Monday to Friday and providing weekend coverage.

Author's Name: Christine Axelby Position: A/Team Leader Unit/Dist: CHRIRPSC Tel No: (07) 3234 0003 Date: 21.04.06	Cleared by: Name: Barry Leahy Position: Executive Director Unit/District: Industrial Relations Tel No: (07) 3234 1865 Date: 5 May 2006

- General concerns within medical management in implementing this arrangement relate to:
  - Ensuring the payment is linked to emergency physicians only working in Emergency Departments and not employed in other roles i.e. as Medical Superintendents; and
  - Ensuring the payment is not flowed on to other work areas providing extended hours coverage.

PROPOSED ACTIONS

- The criteria for eligibility to the 25% allowance for Emergency Department SMOs need to be established urgently and agreement reached with the relevant unions to enable implementation and payment as soon as possible. General opinions have been ascertained from both management and union representatives on the Medical Interest Based Bargaining Group regarding how to determine the criteria, however further clarification is being sought from the Director-General in relation to Departmental requirements.
- General discussion with union and management representatives about eligibility criteria indicates a preference that the Emergency Departments must work at least two shifts (day and afternoon shift) on Monday to Friday and provide weekend coverage throughout the day. Current Emergency Departments performing extended hours provide service at least between 8am and 10pm Monday to Friday. Interest has been expressed by some management representatives in extending the hours to either 11pm or midnight, however this was not part of the negotiations and would be difficult to obtain the support of medical unions.
- General discussion with union and management representatives indicates that the Emergency Department SMOs need to be performing their ordinary hours within the afternoon shifts and weekend. Some management representatives have sought that on a weekly or fortnightly basis that the Emergency Department SMOs meet a minimum requirement of shift patterns.
- Discussions with Colin Page, Staff Specialist, Emergency Department, Princess Alexandra Hospital who was also involved in the negotiations, has indicated that emergency consultants do not regularly work regular shift patterns. Such inconsistency in roster patterning would make prescriptive criteria difficult to manage.
- As the 25% allowance is to be included as part of a private practice contract that is currently signed on an annual basis, it would not be practicable to strictly apply a set roster pattern to establish eligibility for the 25% allowance. However, it is critical that the Emergency Department SMO is performing some of their ordinary hours on the afternoon and weekend shifts on a fair and reasonable basis.
- The final outstanding matter relates to when an extended hours arrangement is either terminated or suspended. General discussion with union and management representatives indicates terminated extended hours arrangements should result in the termination of the 25% allowance; however differing opinions have been expressed regarding suspended arrangements.
- As the 25% allowance is determined by contract and it would be expected that suspension of extended hour's arrangements would be an aberrant affair, it is proposed that continuing the payment for a period of 26 weeks would be fair and reasonable to allow management to rectify any issues or determine that the extended hour's arrangements are to be terminated.

BACKGROUND

- On 3 February 2006, the Premier and Minister for Health announced a range of improvements to the entitlements of Queensland Health salaried doctors, including a range of improvements and extension of the private practice arrangements in place.

Author's Name: Christine Axelby Position: A/Team Leader Unit/Dist: CHRIRPSC Tel No: (07) 3234 0003 Date: 21.04.06	Cleared by: Name: Barry Leahy Position: Executive Director Unit/District: Industrial Relations Tel No: (07) 3234 1865 Date: 5 May 2006

Date	**18 August 2011**	Due date	**N/A**
Amendment	**No**	Due to	**DDGHRS**
Cleared by	**Rebecca Wells**	Critical due date?	**N/A**
Urgency	**Routine**		

Precis **An outline of arrangements which will form the basis for further consultation with the unions in the development of a draft policy on Emergency Department Extended Hours Benefit Contracts.**

Form 71 Version 1	Notice of Industrial Dispute Industrial Relations Act 1999, section 229 *(To be used for giving notice of an industrial dispute where the notifier wants the commission to call a compulsory conference)*	R.149.

QUEENSLAND INDUSTRIAL RELATIONS COMMISSION
Industrial Relations Act 1999 - *section 229*

NOTICE OF INDUSTRIAL DISPUTE

TO: The Industrial Registrar, Industrial Registry, Level 13, Central Plaza 2, 66 Eagle St, (Corner Creek and Elizabeth Streets), Brisbane 4000, GPO Box 373, Brisbane Q 4001
Phone: (07) 3227 8060, Fax: (07) 3221 6074]

NOTICE is hereby given under section 229 of the *Industrial Relations Act 1999* of an industrial dispute between

Together Queensland, Industrial Union of Employees
and
Queensland Health

and the notifier requests that the commission hold a compulsory conference of the parties to resolve the matter.

Particulars of party notifying dispute:

Name: Alex Scott
General Secretary
Together Queensland, Industrial Union of Employees
Address: 27 Peel Street
South Brisbane 4101
Contact person: Jenny Cannon, Industrial Advocate
Direct Telephone No: 30176129 Direct Fax No: 30176229
Mobile Telephone No: s.73
Email: jenny.cannon@together.org.au

Place where dispute exists: Statewide

Subject matter of dispute: Breach of no further claims clause of enterprise agreement

1. Over the past 18 months approximately Queensland Health has been redrafting a number of HR policies including policies on private practice for Senior Medical Officer employees.
2. The terms of the redrafted policies originally contained a number of references to eligibility for a supplementary benefit of 25% base salary for rostered hours in Emergency Departments with extended hours rosters
3. These criteria were not in the existing policy and depart significantly from the agreed application of the supplementary benefit.
4. The criteria for eligibility for the supplementary benefit were negotiated by the Unions in 2006 and were later clarified by the parties in 2007.
5. The documents which the parties have relied on to determine eligibility for the supplementary benefit are the agreed *Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A Contract Option A* (attached hereto and marked "Exhibit 1") and the email correspondence from Mary Kelaher, Snr Director Human Resources, Queensland Health to the unions dated 13 September 2007 (attached hereto and marked "Exhibit 2")
6. In November 2010, after reviewing the redrafted private practice policies, the union requested written confirmation from Queensland Health at the relevant EB consultative Committee that it did not propose to alter the agreed criteria as contained in the two documents mentioned above and Queensland Health agreed to provide the unions what they described as a 'letter of comfort' in this regard.

7. After several follow-up requests and meetings QH agreed to remove the clauses relating to the ED 25% from the policy however, due to concerns about Queensland Health's application of the entitlement the union continued to seek confirmation from Queensland Health of the agreed criteria.
8. A document (attached here and marked "Exhibit 3") was emailed to the union on 22nd September 2011 which contains similar and erroneous interpretations of the entitlement to those that were removed from the draft policy.
9. The persistence of the erroneous interpretation by Queensland Health and its ad hoc application of the entitlement is the source of ongoing friction and needs to be resolved
10. To the extent that Queensland Health claim their latest document details the eligible criteria for receiving the ED 25% the union submits it constitutes a breach of the no further claims clause of current enterprise agreement.
11. The union seeks the assistance of the Commission in recommending that QH confirm the status quo regarding eligibility criteria at the date of certification of Medical Officers' (Queensland Health) Certified *Agreement (N0.2) 2009* in terms of Exhibits 1 and 2.

Relevant industrial instrument:
Medical Officers' (Queensland Health) Certified Agreement (N0.2) 2009

Have dispute settling procedures, if any, been followed?
Yes. The Union has tried exhaustively for over 12 months to resolve the matter in various consultative committee meetings and separate meetings with industrial officers.

Particulars of other party/parties

Name: Dr Tony O'Connell
Acting Director-General
Queensland Health
Address: 147-163 Charlotte St
Brisbane 4000
Contact person: Greg Coonan
Medical Program Manager
Workplace Relations People and Culture Strategic Services
Direct Tel No: 32341440 Direct Fax: 3234-0314

Name: Nick Buckmaster
President
Salaried Doctors Queensland Industrial Organisation of Employees
Address: Room 8 Level 1
PO Box 807
The Green House
Spring Hill
173 Wickham Terrace
Brisbane Qld 4000
Contact person: Rupert Tidmarsh, Industrial Officer
Direct Tel No: 38392468 Direct Fax: 38392469
Mobile Telephone No: s.73
Email: rupert.sdq@internode.on.net

……..
Signature of person notifying the dispute

Pages 152 through 155 redacted for the following reasons:
- -
s.47(3)(f) - other access available - QIRC Transcript No D/2011/144 of Proceeings available for purchase from Auscript

Queensland Health Emergency Department Extended Hours Benefit Contract Arrangements.

13 December 2011

1. Applies to SMOs engaged under the District Health Services Senior Medical Officers' and Resident Medical Officers' Award – State 2003, who have entered into an Option A contract and who work in an emergency department with approved extended hours rosters as set out in this document.

2. Does not apply to:
   - VMOs
   - MSRPPS or MORPPs

3. These provisions are to be read in conjunction with other private practice policies, the SMO's Option A contract and the Emergency Department Extended Hours Benefit contract.

4. Reference documents:
   - *Medical Officers' (Queensland Health) Certified Agreement (No. 2) 2009*
   - *District Health Services Senior Medical Officers' and Resident Medical Officers' Award – State 2003*
   - *(Supplementary Benefit/Right to Private Practice Benefits Options – Senior Medical Officers – Specialists HR Policy B48)*
   - *(Supplementary Benefit/Right to Private Practice Benefits Options – Senior Medical Officers – Non-specialists HR Policy B49)*
   - *Op A Supplementary Benefit Contract – Staff Specialist contract*
   - *Op A Supplementary Benefit Contract – Senior Medical Officer contract.*

6. The Emergency Department Extended Hours Benefit contract for SMOs was introduced in 2007 to assist with:
   - Retention of SMOs employed at that time working in public hospital emergency departments with extended hours rosters as defined below; and
   - attraction of new medical staff to the practice area of emergency medicine with extended hours rosters as defined below.

7. Eligibility
   - Pursuant to clause 6.13 of the Medical Officers' (Queensland Health) Certified Agreement (No. 2) 2009, upon appointment an SMO will be offered a supplementary benefit/private practice benefits option.

   - The Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract is an extension of supplementary benefit/right to private practice benefits Option A Emergency Department Extended Hours Benefit contract for a SMO with an Option A contact must be offered to an SMO working in an emergency department with an extended hours roster as defined below.

8. Emergency Department Extended Hours Benefit contract criteria

   In determining whether an Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract is applicable, the MS and/or DMS is to ensure:

- The emergency department has an extended hours roster as defined below The SMO is rostered to work their ordinary hours or an agreed proportion of their ordinary hours in the emergency department.
- The SMO's rostered ordinary hours (or an agreed proportion of the SMOs ordinary hours) are worked in accordance with the extended hours arrangement.
- The SMO's rostered ordinary hours include the working of shifts where the majority of the shift is after 4.00pm Monday to Friday and / or the shift is worked on the weekend
- An Option A contract has already been signed.

9. Working ordinary hours in an Emergency Department as well as in another role within the public hospital facility
   - Where an SMO is not working full-time in an emergency department, the MS or DMS will determine what percentage of the SMO's ordinary working hours are required to be worked in the emergency department and shall document this.
   - Only those hours for which an SMO is rostered in the emergency department will attract the 25% payment
   - The ad hoc working hours in an emergency department does not qualify an SMO for the ED 25% payment
   - Time worked in an Acute Primary Care Clinic or other work area does not qualify an SMO to receive the payment of ED 25 percent on those hours worked in that area.

10. Cessation of Extended Hours Benefit contract
    - In the event the SMO withdraws from participating in extended hours arrangements in the emergency department, ceases to have a current Option A contract, or terminates employment with Queensland Health, the SMO's entitlement to the emergency department extended hours benefit will immediately cease.
    - In the event that Queensland Health decides to permanently close the emergency department, permanently cease to operate the emergency department during Extended Hours or suspend the operation of the emergency department during Extended Hours then the SMO's entitlement to the Emergency Department Extended Hours Benefit will continue until 26 consecutive weeks have expired since the emergency department ceased operating during Extended Hours

11. Definitions

Emergency Department for the purpose of Queensland Health Emergency Department Extended Hours Benefit Contract Arrangements.	A dedicated area in a public hospital that is organised and administered to provide emergency care to those in the community who perceive the need for, or are in need of, acute or urgent care including hospital admission. Locations where the Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract as an extension of supplementary benefit/right to private practice benefits Option have been offered to an SMO with an Option A contact are listed in annexure 1
Extended hours roster	Means, with respect to the hours of operation of an emergency department, rostered ordinary hours coverage by medical officers provided in accordance with the medical officers' certified agreement from: 7.00am to 10.00pm Monday to Friday; and weekend cover.

Annexure 1*

Locations where the Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract as an extension of supplementary benefit/right to private practice benefits Option have been offered to an SMO with an Option A contact include the following:-

Bundaberg Hospital
Beaudesert Hospital
Caboolture Hospital
Cairns Base Hospital
Caloundra Hospital
Gladstone Hospital
Gold Coast Hospital
Gympie Hospital
Hervey Bay Hospital
Ipswich Hospital
Logan Hospital
Mackay Base Hospital
Maryborough Hospital
Mount Isa Hospital
Nambour Hospital
Princess Alexandra Hospital
Queen Elizabeth II Jubilee Hospital
Redcliffe Hospital
Redland Hospital
Robina Hospital
Rockhampton Base Hospital
Royal Brisbane & Women's Hospital
Royal Children's Hospital
The Prince Charles Hospital
Toowoomba Hospital
Townsville Hospital

* In the event that a District or a group of Doctors wished to implement new extended hours arrangements and roster in an Emergency Department not listed above the process under clause 6.3 of MOCA2 is to be followed including referring such a proposal to the MOCA2 Consultative Group for endorsement.

Queensland Health Emergency Department Extended Hours Benefit Contract Arrangements.

(1) SMOs engaged under the District Health Services Senior Medical Officers' and Resident Medical Officers' Award – State 2003, who have entered into an Option A contract and who work in an emergency department in particular circumstances.

(2) Does not apply to:

- Visiting Medical Officers (VMOs)
- Medical Superintendents or Medical Officers with Right of Private Practice (MS/MORPPs).

(3) Read in conjunction with other private practice policies, the SMO's Option A contract and the Emergency Department Extended Hours Benefit contract.

(4) Ref docs:

- Medical Officers' (Queensland Health) Certified Agreement (No. 2) 2009
- District Health Services Senior Medical Officers' and Resident Medical Officers' Award – State 2003
- *(Supplementary Benefit/Right to Private Practice Benefits Options – Senior Medical Officers – Specialists HR Policy B48)*
- *(Supplementary Benefit/Right to Private Practice Benefits Options – Senior Medical Officers – Non-specialists HR Policy B49)*

(5) The Emergency Department Extended Hours Benefit contract for SMOs was introduced in 2007 to assist with:

- retention of SMOs employed at that time working in public hospital emergency departments
- attraction of new medical staff to the practice area of emergency medicine.

(6) Eligibility

- Pursuant to clause 6.13 of the Medical Officers' (Queensland Health) Certified Agreement (No. 2) 2009, upon appointment an SMO will be offered a supplementary benefit/private practice benefits option.

- SMOs employed by Queensland Health in health service districts are eligible to participate in private practice arrangements. Supplementary benefit/right to private practice benefits options are only available after the SMO elects an option and signs the relevant option contract.

- The Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract is an extension of supplementary benefit/right to private practice benefits Option A and is only applicable to specific limited circumstances. Only SMOs who have an existing Option A contract are eligible to participate.

- To receive benefits under Option A it is a requirement the SMO make an election for the private practice Option A and comply with Queensland Health policy and arrangements applying to private practice Option A.

- The criteria set out in the standard Option A contract must be met before an offer of an additional Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract can be made to an SMO.

- It is not expected an Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract would ordinarily be offered to an SMO working part-time in an emergency department.

(7) Eligible emergency departments

- An emergency department is a dedicated unit within a public hospital. An Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract is not offered simply on the basis that a particular hospital may from time to time perform emergency services.

- An Emergency Department Extended Hours Benefit contract for a SMO with an Option A contact may be offered to an SMO working in an emergency department listed in the table below.

(8) Emergency Department Extended Hours Benefit contract offer criteria

- An Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract may be offered at the discretion of the medical superintendent (MS) and/or director of medical services (DMS). Such a contract is not an automatic entitlement.

- Before being offered an Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract, the SMO must have demonstrated their ability to meet the additional criteria listed below to the MS and/or DMS.

- In determining whether an Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract is to be offered, the MS and/or DMS is to ensure there is a realistic expectation the SMO will meet each of the following criteria:

    - Applicable only for work in an eligible emergency department
    - An extended hours arrangement is worked
    - The SMO's rostered ordinary hours are worked in accordance with the extended hours arrangement with a majority of shifts worked in the emergency department
    - The SMO's rostered ordinary hours include the working of shifts where the majority of the shift is after 4.00pm Monday to Friday or the shift is worked on the weekend
    - An Option A contract has already been signed.

(9) Termination of Department Extended Hours Benefit contract

- In the event the SMO withdraws from participating in extended hours arrangements in the emergency department, ceases to have a current Option A contract, or terminates employment with Queensland Health, the SMO's entitlement to the emergency department extended hours benefit will immediately cease.

(10) Definitions

Emergency Department	A dedicated area in certain hospitals that is organised and administered to provide a high standard of emergency care to those in the community who perceive the need for, or are in

	need of, acute or urgent care including hospital admission. Features of an emergency department are set out in the Emergency Department Terminology Document prepared by Emergency Department Clinical Networks. Refer http://qheps.health.qld.gov.au/ed/docs/ed_data_definitions.pdf
Extended hours arrangement	Means, with respect to the hours of operation of an emergency department, when rostered ordinary hours coverage by senior medical officers is provided in accordance with the medical officers' certified agreement at least from: 8.00am to 10.00pm Monday to Friday; and on weekends.

(12) Queensland Health emergency departments

Bundaberg Hospital
Caboolture Hospital
Cairns Base Hospital
Caloundra Hospital
Gladstone Hospital
Gold Coast Hospital
Gympie Hospital
Hervey Bay Hospital
Ipswich Hospital
Logan Hospital
Mackay Base Hospital
Maryborough Hospital
Mount Isa Hospital
Nambour Hospital
Princess Alexandra Hospital
Queen Elizabeth II Jubilee Hospital
Redcliffe Hospital
Redland Hospital
Robina Hospital
Rockhampton Base Hospital
Royal Brisbane & Women's Hospital
Royal Children's Hospital
The Prince Charles Hospital
Toowoomba Hospital
Townsville Hospital

Exhibit 3

Queensland Health Emergency Department Extended Hours Benefit Contract Arrangements.

(1) SMOs engaged under the District Health Services Senior Medical Officers' and Resident Medical Officers' Award – State 2003, who have entered into an Option A contract and who work in an emergency department in particular circumstances as set out in this document.

(2) Does not apply to:

- Visiting Medical Officers (VMOs)
- Medical Superintendents or Medical Officers with Right of Private Practice (MS/MORPPs).

(3) Read in conjunction with other private practice policies, the SMO's Option A contract and the Emergency Department Extended Hours Benefit contract.

(4) Ref docs:

- Medical Officers' (Queensland Health) Certified Agreement (No. 2) 2009
- District Health Services Senior Medical Officers' and Resident Medical Officers' Award – State 2003
- *(Supplementary Benefit/Right to Private Practice Benefits Options – Senior Medical Officers – Specialists HR Policy B48)*
- *(Supplementary Benefit/Right to Private Practice Benefits Options – Senior Medical Officers – Non-specialists HR Policy B49)*

(5) The Emergency Department Extended Hours Benefit contract for SMOs was introduced in 2007 to assist with:

- retention of SMOs employed at that time working in public hospital emergency departments
- attraction of new medical staff to the practice area of emergency medicine.

(6) Eligibility

- Pursuant to clause 6.13 of the Medical Officers' (Queensland Health) Certified Agreement (No. 2) 2009, upon appointment an SMO will be offered a supplementary benefit/private practice benefits option.

- SMOs employed by Queensland Health in health service districts are eligible to participate in private practice arrangements. Supplementary benefit/right to private practice benefits options are only available after the SMO elects an option and signs the relevant option contract.

- The Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract is an extension of supplementary benefit/right to private practice benefits Option A and is only applicable to specific limited circumstances. Only SMOs who have an existing Option A contract are eligible to participate.

- To receive benefits under Option A it is a requirement the SMO make an election for the private practice Option A and comply with Queensland Health policy and arrangements applying to private practice Option A.

- The criteria set out in the standard Option A contract must be met before an offer of an additional Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract can be made to an SMO.

- It is not expected an Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract would ordinarily be offered to an SMO working part-time in an emergency department.

(7) Eligible emergency departments

- An emergency department is a dedicated unit within a public hospital. An Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract is not offered simply on the basis that a particular hospital may from time to time perform emergency services.

- An Emergency Department Extended Hours Benefit contract for a SMO with an Option A contact may be offered to an SMO working in an emergency department listed in the table below.

(8) Emergency Department Extended Hours Benefit contract offer criteria

- An Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract may be offered at the discretion of the medical superintendent (MS) and/or director of medical services (DMS). Such a contract is not an automatic entitlement.

- Before being offered an Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract, the SMO must have demonstrated their ability to meet the additional criteria listed below to the MS and/or DMS.

- In determining whether an Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract is to be offered, the MS and/or DMS is to ensure there is a realistic expectation the SMO will meet each of the following criteria:

    - Applicable only for work in an eligible emergency department
    - An extended hours arrangement is worked
    - The SMO's rostered ordinary hours are worked in accordance with the extended hours arrangement.
    - The SMO's rostered ordinary hours include the working of shifts where the majority of the shift is after 4.00pm Monday to Friday or the shift is worked on the weekend
    - An Option A contract has already been signed.

(9) Cessation of Extended Hours Benefit contract

- In the event the SMO withdraws from participating in extended hours arrangements in the emergency department, ceases to have a current Option A contract, or terminates employment with Queensland Health, the SMO's entitlement to the emergency department extended hours benefit will immediately cease.

(10) Definitions

Emergency Department	A dedicated area in certain hospitals that is organised and administered to provide a high standard of emergency care to those in the community who perceive the need for, or are in need of, acute or urgent care including hospital admission.

	Features of an emergency department are set out in the Emergency Department Terminology Document prepared by Emergency Department Clinical Networks. Refer http://qheps.health.qld.gov.au/ed/docs/ed_data_definitions.pdf
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Ipswich Hospital
Logan Hospital
Mackay Base Hospital
Maryborough Hospital
Mount Isa Hospital
Nambour Hospital
Princess Alexandra Hospital
Queen Elizabeth II Jubilee Hospital
Redcliffe Hospital
Redland Hospital
Robina Hospital
Rockhampton Base Hospital
Royal Brisbane & Women's Hospital
Royal Children's Hospital
The Prince Charles Hospital
Toowoomba Hospital
Townsville Hospital

From: Greg Coonan
To: Scott Ponting
CC: David Farlow; Rebecca Wells
Date: 26/09/2011 2:31 pm
Subject: Fwd: MCG agenda item 5.1 - APCCs
Attachments: Acute Care Clinics.rtf; APCC QUESTIONS - Mackay.doc

Scott,

As you can see from unions's email below, we are long overdue in being able to respond MCG requests made at several meetings. It's becoming somewhat embarrassing that we are not able to provide a coherent QH outline to consult on APCCs (and not even provided a list of 'official' APCCs).

I know we had our hands tied because the draft policy and implementation standard had not yet been approved for distribution. Is there any way that we are able to move on these? Even in draft form? I don't believe we've even advised the union of their existence: if we can mention them and also commit to circulation/consultation, at least we can formally commence consultation.

It is QH position that the ED 25% should only apply to emergency departments - not APCCs.

Regards,

Greg Coonan
Program Manager
Workplace Relations Unit
Queensland Health

Ph: (07) 323 41440
Fax: (07) 323 40314

>>> "Jenny A. Cannon" <Jenny.Cannon@together.org.au> 26/09/2011 1:33 pm >>>

Greg

Just giving notice that tomorrow we will again and finally be asking QH for answers to the questions put by the Union regarding all APCCs (howsoever termed) in operation in the State

It is clear that at least one APCC has an extended hours arrangement in pl ace and an extended hours proposal should have been put to the Unions for consultation as per the EB. Is this being tabled tomorrow for our consideration?

We will also be seeking a satisfactory answer to the question of why QH is applying the ED25% to rostered hours in the APCCs – what is the authority or head of power for making these payment?.

Regards

Jenny Cannon
Industrial Advocate
Together Queensland
Ph: 30176129
Fax: 30176229
Mob: s.73

Email: Jenny.Cannon@together.org.au

Department RecFind No:	
Division/District	
File Ref No:	

Briefing Note

Deputy Director – General Human Resource Services

Requested by: **Date requested:** **Action required by:**

Action required
☐ For approval ☐ With correspondence
☐ For meeting ☒ For Information

Other attachments for consideration
☐ Speaking points ☐ Ministerial Statement
☐ Draft media release ☐ Question on Notice
☐ Cabinet related document

SUBJECT: Queensland Health Emergency Department Extended Hours Benefit Contract Arrangements

Proposal

That the Deputy Director – General Human Resource Services:

Note the contents of this Briefing Note and Attachments.

Urgency

1. Routine.

Background

That you note the unresolved nature of discussions with the Australian Municipal, Administrative, Clerical and Services Union, Central and Southern Queensland Clerical and Administrative Branch, Union of Employees (AMACSU) and the Salaried Doctors Queensland Industrial Organisation of Employees (SDQ) at the officer level with respect to defining the application of Emergency Department (ED) 25 % contracts.

That you note that the Workplace Relations Unit, Queensland Health consulted further on Wednesday 13 July 2011 with the unions on the circumstances in which an Emergency Department Extended Hours Benefit Contract may be offered to a Senior Medical Officers.

The object of the consultation was to confirm Queensland Health's understanding of arrangements before developing a draft policy.

2.

Key issues

On 5 June 2006 a brief for approval was signed by the then Director-General outlining the "revised" criteria for senior medical officers (SMOs) to be able to sign an Emergency Department Extended Hours Benefit Contract. The revised brief was required because the initial criteria nominated a certain number of shifts to be worked in an ED and this was subsequently decided to be too difficult due to irregularity of shifts (**Attachment 1**).

The revised brief notes that an ED 25% contract would be created to clarify the application of the payments. This did occur however the unions argued that it misrepresented the intent of the application of the ED 25%. Subsequent to this the then Senior Director, Human Resources wrote to the then QPSU on 13 September 2007 making an unauthorised assertion that part-time work in an ED would attract the ED 25% payment (**Attachment 2**).

Department RecFind No:	
Division/District	
File Ref No:	

Since that time Human Resource Services has advised the unions that the ED 25% contract is only applicable where all hours of work are performed in an ED on an extended hours roster and that any correspondence issued on 13 September 2007 was not authorised.

Human Resource Services most recently met with the unions on 13 July 2011 and confirmed our continuing position and committed to reducing this to writing.

Queensland Health believes that ED 25% was introduced to retain current doctors working in public hospital emergency departments and importantly to attract new medical staff to that area of practice to alleviate the then current crisis in emergency medicine service delivery. The rationale advanced for the extra remuneration was that emergency physicians who work extended hours and incur lifestyle impacts of that work pattern. A consequence of this work pattern is not only the inability to earn private practice income during what is normal working hours for most doctors, but also outside those hours due to the shift work commitment.

Attached is an outline of arrangements which will form the basis for further consultation with the unions before developing a draft policy (**Attachment 3)**.

3.

Consultation

AMACSU and SDQ at the officer level

Financial implications

Between 4 May 2011 and 1June 2011 there were 314 persons receiving payment for Emergency Department Extended Hours Benefit Contract.

4.

Legal implications

There is a legal obligation to honour Emergency Department Extended Hours Benefit Contracts.
5.

Elected representative Not applicable.

6.

Remedial action

No remedial action required.
7.

Attachmentsa. Attachment 1 –Brief note for approval BR027753 dated 7 June 2006.
b. Attachment 2 - Email from the then Senior Director, to the then QPSU dated 13 September 2007.
c. Attachment 3 Outline of arrangements which will form the basis for further consultation with the unions before developing a draft policy.

8.

Department RecFind No:	
Division/District	
File Ref No:	

Recommendation
That the Deputy Director – General Human Resource Services

Note the contents of this Briefing Note and Attachments.

APPROVED/NOT APPROVED **NOTED**

John Cairns
Deputy Director –General
Human Resource Services

/ /

Deputy Director – General Human Resource Services comments

Author	Cleared by:	Content verified by: (CEO/DDG/Div Head)
Edmund Lynch>	Greg Coonan>	Rebecca Wells
Senior Advisor>	Program Manager>	Senior Director
Workplace Relations Unit - Medical>	Workplace Relations Unit - Medical Unit>	Workplace Relations Unit
323 40003> 21 July 2011>	323 41440> July 2011> <>	<3006 4624> < July 2011 <>

Department RecFind No:	
Division/District	
File Ref No:	

Briefing Note

Deputy Director – General Human Resource Services

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Other attachments for consideration
☐ Speaking points ☐ Ministerial Statement
☐ Draft media release ☐ Question on Notice
☐ Cabinet related document

SUBJECT: Queensland Health Emergency Department Extended Hours Benefit Contract Arrangements

Proposal

That the Deputy Director – General Human Resource Services:

Note the contents of this Briefing Note and Attachments.

Urgency

1. Routine.

Background

That you note the unresolved nature of discussions with Together Queensland (TQ) which is from 9 August 2011 the new name of AMACSU and the Salaried Doctors Queensland Industrial Organisation of Employees (SDQ) at the officer level with respect to defining the application of Emergency Department (ED) 25 % contracts.

That you note that the Workplace Relations Unit, Queensland Health consulted further on Wednesday 13 July 2011 with the unions on the circumstances in which an Emergency Department Extended Hours Benefit Contract may be offered to a Senior Medical Officers.

The object of the consultation was to confirm Queensland Health's understanding of arrangements before developing a draft policy.

2.

Key issues

There is a need for clarity around the definition of the payment of the application of Emergency Department (ED) 25 % contracts due to a dearth of previous definition and differing opinions as to that which was intended.

On 5 June 2006 a brief for approval was signed by the then Director-General outlining the "revised" criteria for senior medical officers (SMOs) to be able to sign an Emergency Department Extended Hours Benefit Contract. The revised brief was required because the initial criteria nominated a certain number of shifts to be worked in an ED and this was subsequently decided to be too difficult due to irregularity of shifts (**Attachment 1**).

Department RecFind No:	
Division/District	
File Ref No:	

The revised brief notes that an ED 25% contract would be created to clarify the application of the payments. This did occur however the unions argued that it misrepresented the intent of the application of the ED 25%. Subsequent to this the then Senior Director, Human Resources wrote to the then QPSU on 13 September 2007 making an assertion that part-time work in an ED would attract the ED 25% payment (**Attachment 2**).

Since that time the Workplace Relations Unit (WRU) has advised the unions that the ED 25% contract is only applicable where all hours of work are performed in an ED on an extended hours roster. The current practice, however, appears, whilst not widespread that some part time employees and concurrent employees have been receiving the additional benefit. The contracts introduced in August 2009 are **not** specific in requiring all one's hours to be in an emergency department to attract the additional benefit.

The WRU most recently met with the unions on 13 July 2011 and confirmed our continuing position and on 16 August 2011 Together Queensland most recently corresponded. Queensland Heath has committed to reducing its continuing position to writing.

The WRU believes that ED 25% was introduced to retain current doctors working in public hospital emergency departments and importantly to attract new medical staff to that area of practice to alleviate the then current crisis in emergency medicine service delivery. The rationale advanced for the extra remuneration was that emergency physicians who work extended hours and incur lifestyle impacts of that work pattern. A consequence of this work pattern is not only the inability to earn private practice income during what is normal working hours for most doctors, but also outside those hours due to the shift work commitment.

Attached is a three page outline of arrangements which will form the basis for further consultation with the unions before developing a draft policy (**Attachment 3)**. The WRU will outline the criteria as follows to the unions to end continuing confusion:-

- Applicable only for work in an eligible emergency department
- An extended hours arrangement is worked
- The SMO's rostered ordinary hours are worked in accordance with the extended hours arrangement.
- The SMO's rostered ordinary hours include the working of shifts where the majority of the shift is after 4.00pm Monday to Friday or the shift is worked on the weekend
- An Option A contract has been signed.

It should also be noted that some SMO's work in Acute Care (or otherwise described) Clinics, which have been setting up in some locations, such as Mackay. The WRU do not regard such Clinics as satisfying the application of Emergency Department (ED) 25 % contracts
3.

Consultation

TQ and SDQ at the officer level

Financial implications

Between 4 May 2011 and 1June 2011 there were 314 persons receiving payment for Emergency Department Extended Hours Benefit Contract.

4.

Legal implications

Department RecFind No:	
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There is a legal obligation to honour Emergency Department Extended Hours Benefit Contracts.
5.

Elected representative Not applicable.

6.

Remedial action

No remedial action required.
7.

Attachmentsa. Attachment 1 –Brief note for approval BR027753 dated 7 June 2006.
b. Attachment 2 - Email from the then Senior Director, to the then QPSU dated 13 September 2007.
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Recommendation
That the Deputy Director – General Human Resource Services

Note the contents of this Briefing Note and Attachments.

APPROVED/NOT APPROVED **NOTED**

John Cairns
Deputy Director –General
Human Resource Services

/ /

Deputy Director – General Human Resource Services comments

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Workplace Relations Unit - Medical>	Workplace Relations Unit - Medical Unit>	Workplace Relations Unit
323 40003> 22 August 2011>	323 41440 August 2011	<3006 4624 August 2011

Together Medical Officers Portal

22 February meeting update

Posted by Alex Scott on February 23, 2012

It is pleasing to advise that MOCA 3 negotiations will not be suspended during the caretaker government period as has occurred in the past. The parties will continue to explore options for resolution of issues within interest areas in the Interest-based bargaining (IBB) format.

A bargaining plan has been agreed to by all parties and is now being circulated to principals for their signature. QH and ASMOFQ are still to finalise their list of participants and when the document is complete we will be able to post it to our website. This document will give members a better idea of the nature of the IBB process being engaged in.

Eligibility for 4/5 weeks leave and 5/6 weeks leave

Recreation leave entitlements appear in the Award however there is inconsistent application of the Award and all parties agreed they share an interest in clearly defining the entitlements to ensure consistent application.

The parties noted that the Award is written with 5 weeks as the default with one week being in lieu of penalty rates on public holidays because most employees would be part of a roster that would require work to be done on public holidays (including on-call). However where there is no requirement for service to be provided on public holidays and MOs are not rostered to cover the holidays 4 weeks leave is applicable.

Together raised a concern that employees who have 5 weeks leave and who take recreation leave on public holidays do not have those public holiday credited to their leave balance. Our members consider there should be an option to choose either 5 weeks leave in lieu of penalty rates or 4 weeks leave with penalty rates to avoid being penalised for agreeing to working on public holidays.

Together also raised concerns about inconsistent application of the additional weeks leave (the 6th week) for RMOs who do continuous shift work. The Union has dealt with issues in the past where RMOs are rostered for night shifts in blocks and because individuals do not do night shifts throughout the whole year they are only given a pro rata entitlement of the additional weeks leave. This is not appropriate where an individual is part of a roster that has shifts covering days, evenings, nights, week days and weekends.

QH has undertaken to scope the practices occurring before working on options to resolve the issue and also to clarify the appropriate application of the Award.

Eligibility for ED extended hours allowance

When the ED 25% allowance was introduced in 2006 it was stated to apply only to work in an extended hours arrangement in EDs (which were the only units working those extended hours at the time).

Recently, a number of Acute Primary Care Clinics have been established drawing staff from EDs and the question arose as to whether work in an APCC attracted the 25% allowance also. It has been clarified that it does not however where an employee of an ED is required to work on an ad hoc (not rostered) basis in an APCC they will not lose their entitlement to the allowance for those hours worked on an ad hoc basis.

Regional Development Incentive Scheme (RDIS)

Both QH and the Unions identified an interest in finding better ways to recruit and retain MOs to specific regional areas with recruitment problems. The

RDIS in the past two agreements has caused many problems that the parties would like to avoid in future. Options will be discussed at a future meeting

Part-timers entitlements to Motor Vehicle Allowance

A major area of interest identified by the parties was recruitment and retention of Medical Officers and equity.

Together raised the first item in the equity category – part-time entitlements to the Motor Vehicle Allowance. Currently a .5FTE SMO will receive about 25% (not 50%) of the allowance received by a FTE and those with less than a .5 FTE appointment receive no allowance.

Three years ago in negotiation of MOCA2 QH was prepared to rectify this inequity; however delays attributable to another participant at the time took the negotiations well into the period of the global financial crisis and the offer was taken off the table.

QH undertook to revisit this matter – having an interest in reviewing entitlements for part-time employees taking account of parity, retention and the future trends for workforce mix.

Next week Together will continue to outline a number of issues and options for resolution under the heading of recruitment and retention and equity.

We hope you continue to follow our blogs and give us your feedback as we go. The blog is an innovation to the union's bargaining plan and represents an unprecedented opportunity for Medical Officers to participate in real-time in the negotiations by emailing your comments to jenny.cannon@together.org.au . It is important too that you are talking to other members in your workplace about the negotiations and encouraging non-member colleagues to join. The more involvement from grass roots membership the better outcomes we will achieve together.

Authorised Alex Scott, Secretary, Together.

MINIMUM REQUIREMENTS: ACCREDITATION OF ADULT AND MIXED EMERGENCY DEPARTMENTS

Guideline No: AC01

1. PURPOSE AND SCOPE

This document provides information on the minimum requirements necessary for an emergency department to be considered for accreditation by ACEM for advanced training. Detail relating to periods of 6, 12 or 24 months accreditation is included.

The guidelines will assist ACEM non-accredited emergency departments to ascertain their possible status prior to making an application for an inspection to the College. It will also assist ACEM accredited departments; and other key stakeholders, by providing clear references to the current requirements.

The Board of Education (BOE) and Council recognises that emergency departments across Australia and New Zealand are a complex mix of factors, and therefore, *some discretion may be applied when making decisions regarding accreditation*. As a result, the meeting of these requirements does not provide a guarantee of ACEM accreditation for the training periods outlined. Similarly a department may not meet all these requirements but may offer other elements that would help it gain accreditation for one of the training periods outlined. The inspection visit and, the DEMT and trainee feedback received by the College, are considered the most important parts of the accreditation process and issues identified by those mechanisms will clearly play an important role in the final decision regarding accreditation.

2. DEFINITIONS

Definitions pertaining to full-time equivalence (FTE):

Total FTE FACEM

The cumulative total of paid FTE FACEM (ordinary time plus all paid leave), overtime FTE FACEM, and approved, funded but short term vacant FTE FACEM positions. (The total FTE FACEM figure should be provided by the hospital HR/Finance Service).

Total clinical FTE FACEM

That cumulative FTE of FACEMs that refers to clinical on-floor duties only.

FTE position

One full-time equivalent position; pertains to one or more FACEMs or staff members being employed in positions equivalent to one FT or one full-time position.

FTE trainees

One full-time equivalent of either advanced and/or provisional trainees.

Other definitions in order of appearance in the document:

Clinical support time

With regard to FACEMs / DEMTs or DEMs, see 5.2(a) to 5.2.(d); 6.2(a) to 6.2(d) 9; 7.2(a) to 7.2(d) – that time which is other than that for direct on-floor clinical duties and is designated for approved teaching, research or administrative duties.

FACEM hours exclusively rostered to clinical duties

See 5.2(e); 6.2(e); 7.2(e)
Example:
An eight hour shift covered by two or more FACEMs would count as eight hours only; not as a multiple of eight hours. Thus five shifts such as this per week would equate to 40 hours of FACEM hours rostered exclusively to clinical duties.

Direct clinical supervision

See 5.2(f); 6.2(f); 7.3(f)
Rostered trainee clinical time that is associated with one or more FACEMs rostered on the floor clinically at the same time.

Protected teaching time

With regard to trainees, see 5.3(b); 6.3(b); 7.3(b) – time which is paid protected clinical support time and is available for the trainee to engage in approved educational activities. It would be envisaged that part of this would involve the presence of a FACEM tutor or facilitator in a "programmed fashion" as outlined in item 4(h), while part could be individually organized self-directed learning and/or research projects.

Additional clinical support time

With regard to trainees, see 5.3(b); 6.3(b); 7.3(b) – that time which is other than for direct on-floor clinical duties and is designated for approved educational, research, quality management or administrative duties.

3. MANDATORY CRITERIA FOR ALL LEVELS

All emergency departments seeking accreditation for Emergency Medicine Training must have:

(a) Appropriate and acceptable standards of patient care.

(b) Documented management, admission, discharge and referral policies.

(c) A functional electronic patient information management system.

(d) A formal system of quality management. Trainees are expected to participate in these activities.

(e) A formal orientation program for new staff.

(f) Educational programs for all grades of medical and nursing staff.

(g) Adequate emergency medicine textbooks, journals, management guidelines and protocols available on site. There should also be access to electronic sources of medical information.

(h) Access to advice or information, which facilitates trainees seeking mentorship if they wish to do so.

4. EMERGENCY DEPARTMENT EVALUATION

The evaluation of an emergency department as suitable for advanced training will include consideration of the following:

(a) The level and numbers of emergency physicians and senior staff capable of providing adequate and appropriate supervision for trainees of all levels of experience and at all times.

(b) An appropriate number and casemix of emergency patients to provide adequate clinical experience and with trainees having an adequate and appropriate level of involvement at an assessment, procedural and management level.

(c) There will be an adequate specialist workforce. In considering the adequacy of the specialist workforce, regard will be given to the appropriateness of rosters, safe hours, access to leave, overall department performance and benchmarks.

(d) Compliance with the ACEM Continuing Professional Development (CPD) Program by the FACEM staff.

(e) Appropriate levels of staffing with respect to medical, nursing, secretarial and other personnel.

(f) Design and equipment of the department appropriate to the provision of emergency care and training.

(g) An appropriate range and level of support services.

(h) An appropriate education program, including lectures, case presentations, mortality and morbidity review, discussions, audit and review. There should be a strong emphasis on activities that encourage adult learning, reflection, self-evaluation, discussion and collaborative learning. There should be emphasis placed on interactive teaching. There should be appropriate provisions in the education program to meet the needs of trainees sitting the primary or fellowship examination.

(i) The opportunity for trainee research and the infrastructure supporting this.

(j) Accreditation of an appropriate range of specialties within the hospital by their respective colleges and the opportunity for rotations, which will provide relevant clinical experience for emergency medicine.

(k) Evaluation of emergency department function and level of access block so as to determine how this may impact on training and registrar wellbeing.

(l) The ACEM Statement document - Emergency Department Role Delineation.

5. 24-MONTH ACCREDITATION

5.1 Minimum Criteria

With respect to hospitals seeking accreditation for 24 months of Emergency Medicine Advanced Training:

(a) There should be at least 30,000 presentations per year to the emergency department, which are primarily attended to by emergency department staff.

(b) The emergency department should have a comprehensive casemix, which may include major trauma, critically ill patients, a broad range of complex patients and acute cardiology. It is important to ensure that with increasing experience trainees are able to provide immediate care and assume increased responsibility for these patients, while at the same time receiving appropriate levels of supervision.

(c) The emergency department should have an admission rate of >25%.

(d) The emergency department should have one FTE Nurse Unit Manager, or equivalent, who is supernumerary to the clinical staffing needs of the department.

(e) The emergency department should have at least one FTE Nurse Educator.

(f) The emergency department should display a willingness and capacity to host or co-host the fellowship clinical examinations and to contribute invigilators for the primary and fellowship examinations.

5.2 Level of Supervision of Trainees

With respect to the level of supervision of trainees, the emergency department requires:

(a) One (1) FTE FACEM as Director of Emergency Medicine who should ideally be supernumerary to the clinical staffing needs of the department. If this is not possible, the Director of Emergency Medicine should be provided with at least 50% clinical support time.

(b) A Director(s) of Emergency Medicine Training (DEMT). The DEMT will be a FACEM who is required to be employed at a minimum of 0.5 FTE and undertake clinical work within the emergency department. The DEMT should be at least 3 years post-fellowship (within a Co-DEMT model, this is mandatory for at least one of the DEMT).

(c) With reference to provisional and advanced trainees within an emergency department roster, the following should be approximated with respect to the amount of clinical support time required within an emergency department for DEMT duties:

- 1 hour DEMT clinical support time / trainee / week

With the following minimum also applying:

- 20 hours / week

The clinical support time required within an emergency department for DEMT duties can be utilised by a single DEMT or by a co-DEMT model. A maximum of two DEMTs may be appointed within a co-DEMT model. The division of an emergency department's clinical support time for DEMT duties between the two co-DEMTs may occur in any ratio.

(d) A minimum of eight (8) FTE FACEMs within the department (inclusive of the DEM and DEMT positions). Each FACEM (exclusive of the DEM and DEMT positions) should ideally be provided with at least 25% clinical support time for approved teaching, research or administrative activities.

(e) The presence of a FACEM exclusively rostered to clinical duties for at least 98 hours of every week.

(f) A minimum of 60% of trainee time to be under the direct clinical supervision of a FACEM.

5.3 Structure of Training Program

With respect to the structure of the training program, the emergency department requires:

(a) An educational program, which includes access to teaching for both the primary and fellowship examination. For emergency departments seeking a continuation of accreditation, there should be demonstrated proven performance in a) assisting trainees to pass both the primary and fellowship examination and b) the development of highly regarded emergency physicians who practise good clinical care.

(b) There must be protected teaching time for trainees of four (4) hours per week. Additional clinical support time should be provided to allow trainees to complete other non-clinical duties specified by the department.

(c) Formal arrangements for the rotation of trainees to other specialty areas. Adult only departments should be able to demonstrate that they can offer assistance to trainees wishing to access appropriate paediatric terms, either emergency or ward based.

(d) There should be at least one FACEM formally responsible for the provision of advice, supervision and support of trainees undertaking the research component of their training (i.e. a trainee research project or approved university subjects). If applicable, they should also be responsible for providing critical review of the trainee's final manuscript to ensure it is suitable for adjudication by the Trainee Research Committee.

6. 12-MONTH ACCREDITATION

6.1 Minimum Criteria

With respect to hospitals seeking accreditation for 12 months of Emergency Medicine Advanced Training:

(a) There should be at least 25,000 presentations per year to the emergency department, which are primarily attended to by emergency department staff.

(b) The emergency department should have a broad casemix. This may include major trauma, critically ill patients, a broad range of complex patients and acute cardiology. However, it is acknowledged that there may be some limitations with regard to the number of these patients. It is important to ensure that with increasing experience trainees are able to provide immediate care and assume increased responsibility for these patients, while at the same time receiving appropriate levels of supervision.

(c) The emergency department should have an admission rate of >20%.

(d) The emergency department should have one FTE Nurse Unit Manager or equivalent, who is supernumerary to the clinical staffing needs of the department.

(e) The emergency department should have at least one FTE Nurse Educator.

(g) The emergency department should display a willingness and capacity to contribute invigilators for the primary and fellowship examinations. The department may display a willingness and capacity to co-host the fellowship clinical examinations.

6.2 Level of Supervision of Trainees

With respect to the level of supervision of trainees, the emergency department requires:

(a) One (1) FTE FACEM as Director of Emergency Medicine who should ideally be supernumerary to the clinical staffing needs of the department. If this is not possible, the Director of Emergency Medicine should be provided with at least 50% clinical support time.

(b) A Director (s) of Emergency Medicine Training (DEMT). The DEMT will be a FACEM who is required to be employed at a minimum of 0.5 FTE and undertake clinical work within the emergency department. The DEMT should be at least 3 years post-fellowship (within a Co-DEMT model, this is mandatory for at least one of the DEMT).

(c) With reference to provisional and advanced trainees within an emergency department roster, the following should be approximated with respect to the amount of clinical support time required within an emergency department for DEMT duties:

- 1 hour DEMT clinical support time / trainee / week

With the following minimum also applying:

- 10 hours / week

The clinical support time required within an emergency department for DEMT duties can be utilised by a single DEMT or by a Co-DEMT model. A maximum of two DEMT may be appointed within a Co-DEMT

model. The division of an emergency department's clinical support time for DEMT duties between the two Co-DEMT may occur in any ratio.

(d) A minimum of a five (5) FTE FACEMs within the department (inclusive of the DEM and DEMT (positions). Each FACEM (exclusive of the DEM and DEMT positions) should ideally be provided with at least 25% clinical support time for approved teaching, research or administrative activities.

(e) The presence of a FACEM exclusively rostered to clinical duties for at least 80 hours of every week.

(f) A minimum of 40% of trainee time to be under the direct clinical supervision of a FACEM.

6.3 Structure of Training Program

With respect to the structure of the training program, the emergency department requires:

(a) An educational program, which includes access to teaching for both the primary and fellowship examination.

(b) There must be protected teaching time for trainees of at least two (2) hours per week. Additional clinical support time should be provided to allow trainees to complete other non-clinical duties specified by the department.

(c) Formal arrangements for the rotation of trainees to other specialty areas are recommended. However, it is recognised that there may be some limitations in this regard. If possible arrangements should include access to appropriate paediatric terms, either emergency or ward based.

(d) Opportunities for trainee research should be possible but it is recognised that the infrastructure to support this may be limited compared to an academic and/or 24 month accredited department.

7. 6-MONTH ACCREDITATION

7.1 Minimum Criteria

With respect to hospitals seeking accreditation for six months Emergency Medicine Advanced Training:

(a) There should be at least 15,000 presentations per year to the emergency department, which are primarily attended to by emergency department staff.

(b) It is recognised that the emergency department may have a limited casemix. It is possible that the department may be bypassed for conditions that involve trauma or other complex patients. However, the casemix may be such that it provides adequate exposure to critically ill patients and other emergencies to support training. It is important to ensure that with increasing experience trainees are able to provide immediate care and assume increased responsibility for these patients, while at the same time receiving appropriate levels of supervision.

(c) It is recognised that the emergency department may have an admission rate of <20% and that participation in transfers to major centers may also need to be considered.

(d) The emergency department should have one FTE Nurse Unit Manager or equivalent. Ideally this person should be supernumerary to the clinical staffing needs of the department. However, it is recognised that this may not be possible due to rostering constraints.

(e) The emergency department should have access to a Nurse Educator.

(f) The emergency department will not be expected to host or co-host a fellowship examination, but may be requested to provide invigilators for the primary or fellowship examination where possible.

7.2 Level of Supervision of Trainees

With respect to the level of supervision of trainees, the emergency department requires:

(a) One (1) FTE FACEM as Director of Emergency Medicine who should ideally be supernumerary to the clinical staffing needs of the department. If this is not possible, the Director of Emergency Medicine should be provided with at least 30% clinical support time. [A part time FACEM DEM may be considered acceptable for a 6 month department at the discretion of Council and if there is a minimum of 2.5 total FTE of FACEM and criteria 7(c) is met.]

(b) A Director(s) of Emergency Medicine Training (DEMT). The DEMT will be a FACEM who is required to be employed at a minimum of 0.5 FTE and undertake clinical work within the emergency department. The DEMT should be at least three years post-fellowship (within a Co-DEMT model, this is mandatory for at least one of the DEMT).

(c) With reference to provisional and advanced trainees within an emergency department roster, the following should be approximated with respect to the amount of clinical support time required within an emergency department for DEMT duties:

- 1 hour DEMT clinical support time / trainee / week

With the following minimum also applying:

- 10 hours / week

The clinical support time required within an emergency department for DEMT duties can be utilised by a single DEMT or by a Co-DEMT model. A maximum of two DEMT may be appointed within a Co-DEMT model. The division of an emergency department's clinical support time for DEMT duties between the two Co-DEMTs may occur in any ratio.

(d) A minimum of two-and-a half (2.5) FTE FACEMs within the department (inclusive of the DEM and DEMT positions). Each FACEM (exclusive of the DEM and DEMT positions) should ideally be provided with at least 25% clinical support time for approved teaching, research or administrative activities.

(e) The presence of a FACEM exclusively rostered to clinical duties for at least 50 hours of every week.

(f) A minimum of 30% of trainee time to be under the direct clinical supervision of a FACEM.

7.3 Structure of Training Program

With respect to the structure of the training program, the emergency department requires:

(a) An educational program, which includes access to teaching for both the primary and fellowship examination.

(b) There must be protected teaching time for trainees of at least two (2) hours per week. Additional clinical support time should be provided to allow trainees to complete other non-clinical duties specified by the department.

(c) Formal arrangements for the rotation of trainees to other specialty areas are recommended. However, it is recognised that there may be significant limitations in this regard.

(d) Infrastructure to support research would be encouraged but may not be well developed.

8. EMERGENCY MEDICINE TRAINING NETWORK

8.1 Minimum Criteria

With respect to hospitals seeking accreditation within an Emergency Medicine Training Network:

(a) An Emergency Medicine Training Network is defined as a group of hospitals that have formally agreed to a coordinated education and training program for Emergency Medicine trainees.

(b) An Emergency Medicine Training Network will ideally consist of hospitals of differing sizes, case-mix and emergency department accreditation levels.

(c) An Emergency Medicine Training Network will have a Network Director(s) of Emergency Medicine Training. This person(s) may also hold the position of DEMT within their own facility. The Network DEMT(s), with support from each department's DEMT(s), will be responsible for the coordination of the network education and training program. This position will be supported with appropriate clinical support time to perform the required duties.

(d) All emergency medicine trainees within a network will have equal access to the education programs and training resources provided by the network.

(e) Each hospital within the network must individually satisfy the mandatory criteria for accreditation [3(a) to 3(h)] and the accreditation criteria for 24-months, 12-months or 6-months with respect to the following:

- Presentations per year
- Case-mix
- Admission rate
- Nurse Unit Manager, or equivalent, FTE
- Nurse Educator, FTE
- Contributions to Primary and Fellowship Exams
- DEM FTE
- DEMT FTE and DEMT Clinical Support Time for DEMT duties
- Total FACEM FTE
- FACEM hours of clinical coverage
- Percentage of trainee time under the direct clinical supervision of a FACEM

8.2 Structure of Training Program

With respect to the structure of the training program, the emergency medicine training network requires:

(a) An educational program, which includes access to teaching for both the primary and fellowship examination. For networks seeking a continuation of accreditation, there should be demonstrated proven performance in a) assisting trainees to pass both the primary and fellowship examination and b) the development of highly regarded emergency physicians who practise good clinical care.

(b) There must be protected teaching time for trainees of four (4) hours per week. Additional clinical support time should be provided to allow trainees to complete other non-clinical duties specified by the network or individual department.

(c) Formal arrangements for the rotation of trainees within and outside of the network to emergency departments and to other specialty areas. The ACEM designated minimum term lengths for a training rotation, ED or non-ED, must be adhered to within the individual hospital of the network. Trainees will be able to move between networks and rotations dependant on their preferences.

(d) There should be at least one FACEM formally responsible for the provision of advice, supervision and support of trainees undertaking the research component of their training (i.e. a trainee research project or approved university subjects). If applicable, they should also be responsible for providing critical review of the trainee's final manuscript to ensure it is suitable for adjudication by the Trainee Research Committee.

8.3 Accreditation Inspection of an EM Training Network

With respect to the accreditation inspection of an emergency medicine training network:

(a) The Accreditation Committee will require a Hospital Information Questionnaire to be completed by each Emergency Department within the network. With respect to the sections concerning the educational program, training rotations and research support, a single submission covering the network programs in these areas will be required.

(b) The Accreditation Committee will determine, based on the submitted Hospital Information Questionnaires and recent Trainee Feedback Forms from the networked emergency departments, the size of the accreditation inspection team and the extent of the inspection to be undertaken within each hospital of the network.

(c) The accreditation inspection team will determine the accreditation status of each emergency department within the network, including approval of the training program within the network. Withdrawal of accreditation (e.g. due to FACEM staff number) for an emergency department automatically excludes them from the network. Failure of the network's training program to meet accreditation criteria will result in outcomes that may include, but are not limited to, withdrawal of recognition as an Emergency Medicine Training Network; and withdrawal, or reduction of, accreditation status for departments within the network.

9. TRAINEE NUMBERS

With respect to trainee numbers in emergency departments:

(a) BOE & Council will make a recommendation on the maximum number of trainees (includes advanced and provisional) within an emergency department. [Note there may be more on rotation to non-ED terms and other networked emergency departments.] This is a recommendation only. The department may choose to employ more trainees than the recommendation if they feel this is required and will not lead to any impairment in training conditions. However, if failure to adhere to these recommendations clearly leads to a documented impairment of training conditions this may lead to a reduction of accreditation status.

(b) The recommended overall ratio for trainees will be no more than three (3) trainees per 1.0 FTE FACEM.

(c) The number of trainees within an emergency department will reconcile with the amount of clinical support time required within an emergency department for DEMT duties – see 5.2(c); 6.2(c) or 7.2(c).

(d) The trainee's degree of access to an adequate, appropriately supervised clinical experience will be taken into account in the final recommendation. It is important to ensure that trainees have an appropriate level of involvement at an assessment, procedural and management level.

(e) The proven success of that department in training emergency physicians will be taken into account in the final recommendation.

(f) When considering a recommendation of the number of trainees that a department can support, the following factors will be amongst those taken into account by the Board of Education & Council:
- The overall number and casemix of patients presenting to the emergency department.
- The total FTE FACEM working in the emergency department.

- The total clinical FTE FACEM working in the emergency department.
- The level of access a trainee would have to the casemix of patients and procedural requirements of emergency medicine training.
- Success rates of trainees at both the primary and fellowship examination.
- Success rates of trainees satisfying the trainee research requirement.
- Feedback from DEMT surveys and interviews.
- Feedback from trainee surveys and interviews.
- Feedback from the DEM, DEMT and FACEMs in the department with regard to how many trainees they feel they can adequately train.

10. AMWAC RECOMMENDATIONS

Relation of this document to the AMWAC workforce recommendations:-

It should be noted that the FACEM numbers mentioned in this guideline are not a direct reflection of AMWAC workforce recommendations; they are minimum requirements for ACEM training accreditation and as such they should not be taken as optimal staffing requirements for all departments. The AMWAC workforce recommendations were based on the following:

> *The number of emergency physicians estimated to be required for major referral emergency departments ranged from 11-16 per department, and for urban district and major rural/regional hospital emergency departments, the range was from 6-8 per department.* [1]

oOo

Reference:
1. Australian Medical Workforce Advisory Committee. The Specialist Emergency Medicine Workforce in Australia 2002-2012. AMWAC Report 2003.6 September 2003.

See also Companion Documents:

G05	Guidelines for Accreditation of Paediatric Emergency Departments: Minimum Requirements
A01	Administrative process - Accreditation Inspection
R4.19	College Regulation *Accreditation of Emergency Departments*
HIQ	Hospital Information Questionnaire

LATEST DEVELOPMENTS IN QIRC - Acute Primary Care Clinics (APCCs)

Dear Medical Officer Members

At the latest compulsory conference in the Queensland Industrial Relations Commission (QIRC) on 22 December three matters were discussed

1. The establishment of new bulk-billing APCCs without consultation
2. The appropriate remuneration for ordinary hours worked in an APCC
3. The ability of Doctors to decline requests from their employer to work in APCCs

The outcomes of the conference were

1. Qld Health confirmed that no new bulk billing clinic will be established without consultation and it will suspend bulk billing at a Wynnum clinic which was established without consultation after the parties reached agreement on the process to be followed
2. Commissioner Brown formally recommended that Qld Health provide the Commission and Union with written advice on the eligibility for the ED 25% payments particularly where an employee works part of their ordinary hours in an ED and part in an APCC. Follow this link to documentation on this subject filed recently in the QIRC in relation to a separate but related dispute. Commissioner Brown also recommended that QH (and, because of ongoing payroll problems, that all employees also) keep accurate records of hours worked in EDs and APCCs to support legislative obligations for financial accountability. It should be noted that in our view work in an APCC does not legitimately attract the ED extended hours 25% loading and Medical Officers should be aware that such payments may legitimately be recoverable as overpayments.
3. By mid-January Qld Health is to provide the Union with a definitive answer to its question about whether individuals will be allowed to decline any request to move from a role in an ED to a role in an APCC. To this point in time QH has claimed it can deploy its staff to APCCs without their agreement. The Union disagrees with this view and will provide advice and representation to all members who currently have an Option A contract and Emergency Department Extended Hours benefit (25%) contract

For advice or assistance on this matter members are invited to contact

Jenny Cannon
Industrial Advocate | **Together**
Phone 30176129 |Fax 31076229 |Mob s.73
Email: Jenny.Cannon@together.org.au

Authorised by Alex Scott, Secretary

The State of Queensland acting through Queensland Health

[Insert name of Senior Medical Officer]

Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A Contract

Date

Parties

The State of Queensland acting through Queensland Health of 147-163 Charlotte Street, Brisbane in the State of Queensland (**Queensland Health**)

[Insert name of Senior Medical Officer] of [insert address] (**SMO**)

Background

A The SMO is employed by Queensland Health as a [insert job title]**.**

B The SMO and Queensland Health have entered into an Option A Contract dated [insert date] (**Option A Contract**).

C In addition to the payments and benefits made by Queensland Health to the SMO pursuant to the Certified Agreement and the terms of the Option A Contract, Queensland Health and the SMO have agreed that, in consideration for the SMO working their ordinary hours of work through an Extended Hours arrangement in an emergency department, Queensland Health will pay the SMO the Emergency Department Extended Hours Benefit on the terms set out in this Contract.

Agreed Terms

1 Definitions

For the purpose of this document:

Award means the *District Health Services - Senior Medical Officers' and Resident Medical Officers' Award – State 2003*.

Certified Agreement has the same meaning as in the Option A Contract.

Emergency Department Extended Hours Benefit has the meaning given by **clause 3.1** of this document.

Extended Hours means, with respect to the hours of operation of an emergency department, when Senior Medical Officers' rostered ordinary hours coverage is provided in accordance with the Certified Agreement at least from:

(a) 8.00am until 10.00pm Monday to Friday; and

(b) weekend coverage.

Senior Medical Officers (SMO) means Senior Medical Officers as classified

under the Award working in an emergency department.

Supplementary Benefit has the same meaning as in the Option A Contract.

Supplementary Benefit Percentage has the same meaning as in the Option A Contract.

2 Term

This document will commence on [**insert date**] and terminate on [**insert date**] unless terminated earlier in accordance with this document.

3 Emergency Department Extended Hours Benefit

3.1 Where the SMO works in an emergency department providing Senior Medical Officers' coverage during Extended Hours as defined above and the SMO's rostered ordinary hours include working of shifts where the majority of the shift is after 4.00pm Monday to Friday and/or on the weekend, the SMO's entitlement to the Supplementary Benefit under the Option A Contract will be increased by adding a further 25% to the Supplementary Benefit Percentage as set out in **Item 5 of Schedule 1** to the Option A Contract (**Emergency Department Extended Hours Benefit**).

3.2 If the SMO is entitled to payment of the Emergency Department Extended Hours Benefit under **clause 3.1** then the Option A Contract will continue with full force and effect as if the Emergency Department Extended Hours Benefit forms part of the Supplementary Benefit in the Option A Contract.

3.3 In the event that Queensland Health decides to permanently close the emergency department, permanently cease to operate the emergency department during Extended Hours or suspend the operation of the emergency department during Extended Hours then the SMO's entitlement to the Emergency Department Extended Hours Benefit will continue until 26 consecutive weeks have expired since the emergency department ceased operating during Extended Hours

3.4 In the event that the SMO decides to withdraw from participating in Extended Hours coverage then the SMO's entitlement to the Emergency Department Extended Hours Benefit will immediately cease.

4 Termination

4.1 The agreement evidenced by this document will automatically terminate in the event that the Option A Contract terminates for any reason.

Executed as an agreement.

Signed for and on behalf of	)	
Queensland Health by	)	
	)	.....
.....	)	
(print name) District Manager, a duly	)	
authorised person in the presence of:	)	

.....
Witness

.....
Name of Witness (print)

Signed sealed and delivered	)	
by [**insert name of Senior Medical**	)	
Officer] in the presence of:	)	.....

.....
Witness

.....
Name of Witness (print)

The State of Queensland acting through Queensland Health

Name:

Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A Contract

Date:

Parties

The State of Queensland acting through Queensland Health of 147-163 Charlotte Street, Brisbane in the State of Queensland (**Queensland Health**)

of

(**SMO**)

Background

A The SMO is employed by Queensland Health as a .

B The SMO and Queensland Health have entered into an Option A Contract dated (**Option A Contract**).

C In addition to the payments and benefits made by Queensland Health to the SMO pursuant to the Certified Agreement and the terms of the Option A Contract, Queensland Health and the SMO have agreed that, in consideration for the SMO working their ordinary hours of work through an Extended Hours arrangement in an emergency department, Queensland Health will pay the SMO the Emergency Department Extended Hours Benefit on the terms set out in this Contract.

Agreed Terms

1 Definitions

For the purpose of this document:

Award means the *District Health Services - Senior Medical Officers' and Resident Medical Officers' Award – State 2003*.

Certified Agreement has the same meaning as in the Option A Contract.

Emergency Department Extended Hours Benefit has the meaning given by **clause 3.1** of this document.

Extended Hours means, with respect to the hours of operation of an emergency department, when Senior Medical Officers' rostered ordinary hours coverage is provided in accordance with the Certified Agreement at least from:

(a) 8.00am until 10.00pm Monday to Friday; and

(b) weekend coverage.

Senior Medical Officers (SMO) means Senior Medical Officers as classified

under the Award working in an emergency department.

Supplementary Benefit has the same meaning as in the Option A Contract.

Supplementary Benefit Percentage has the same meaning as in the Option A Contract.

2 Term

This document will commence on and terminate on unless terminated earlier in accordance with this document.

3 Emergency Department Extended Hours Benefit

3.1 Where the SMO works in an emergency department providing Senior Medical Officers' coverage during Extended Hours as defined above and the SMO's rostered ordinary hours include working of shifts where the majority of the shift is after 4.00pm Monday to Friday and/or on the weekend, the SMO's entitlement to the Supplementary Benefit under the Option A Contract will be increased by adding a further 25% to the Supplementary Benefit Percentage as set out in **Item 5 of Schedule 1** to the Option A Contract (**Emergency Department Extended Hours Benefit**).

3.2 If the SMO is entitled to payment of the Emergency Department Extended Hours Benefit under **clause 3.1** then the Option A Contract will continue with full force and effect as if the Emergency Department Extended Hours Benefit forms part of the Supplementary Benefit in the Option A Contract.

3.3 In the event that Queensland Health decides to permanently close the emergency department, permanently cease to operate the emergency department during Extended Hours or suspend the operation of the emergency department during Extended Hours then the SMO's entitlement to the Emergency Department Extended Hours Benefit will continue until 26 consecutive weeks have expired since the emergency department ceased operating during Extended Hours

3.4 In the event that the SMO decides to withdraw from participating in Extended Hours coverage then the SMO's entitlement to the Emergency Department Extended Hours Benefit will immediately cease.

4 Termination

4.1 The agreement evidenced by this document will automatically terminate in the event that the Option A Contract terminates for any reason.

Executed as an agreement.

Signed for and on behalf of)
Queensland Health by)
) .....
.....)
(print name) Local Health and)
Hospital Network Manager, a duly)
authorised person in the presence of:

.....
Witness

.....
Name of Witness (print)

Signed sealed and delivered)
by)
in the presence of:) .....

.....
Witness

.....
Name of Witness (print)

Queensland Government
Queensland Health

Private Patients and Emergency Departments

Medicare and Healthcare Agreement requirements

Commonwealth Funding Unit
Funding and Resourcing Branch

April 2009

Introduction

This document summarises the arrangements for the referral, admission, treatment and billing of private patients in Queensland public hospitals as expressed in Commonwealth legislation, national health care agreements and the Medicare Benefits Schedule. It replaces previous Queensland Health policy guidance on this topic.

Public hospitals and private patients

The primary purpose of public hospitals is to provide healthcare without charge to eligible patients and secondarily to provide a place for clinical education and research. Although the principal funding source for these 'public hospital services' is the Queensland Government, the Commonwealth also provides contributions under the 2003-09 Australian Health Care Agreement (AHCA). The current AHCA expires on 30 June 2009 and will be replaced by the new National Healthcare Agreement (NHA).

The following Medicare Principles apply to both of these agreements:

(a) Eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals
(b) Access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period
(c) Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographical location.

In short, these principles preserve the right of Australian residents to access public hospital services free of charge according to clinical need and urgency. As a consequence of these principles and the following provision of the *Health Insurance Act 1973* 'public hospital services' cannot be billed to Medicare.

Section 19 (2) of the *Health Insurance Act 1973* precludes the payment of a Medicare benefit for a professional service that has been funded directly or indirectly by a government (either State or Commonwealth). This includes services to public patients provided by or on behalf of Queensland Health.

The only exceptions to this rule are Magnetic Resonance Imaging (MRI) services provided to non-admitted patients and non-referred services provided to non-admitted patients of Queensland Health facilities granted an exemption from section 19(2) of the *Health Insurance Act 1973* by the Commonwealth.

Treatment of private patients in public hospitals

As in other States and Territories, Queensland Health's salaried doctors working in public hospitals are offered a right of private practice under contracts of employment. This allows salaried doctors to earn additional income above their base salary and enables public hospitals to compete with the private sector in recruiting and retaining doctors. It also means that additional services can be provided to patients in Queensland Health facilities, over and above public patient services. Queensland Health supports the expansion of this form of service provision.

The Commonwealth recognises that States have 'right of private practice' arrangements for their medical staff and accepts that these private patient services can be claimed against Medicare. For example, MediGuide (issued as an official document issued by the Commonwealth) states that services by a salaried practitioner in a public hospital do not attract Medicare benefits '*except when the practitioner is in private practice*', and that '*salaried practitioners in public hospitals may have a "right of private practice" which allows them to treat private patients outside their salaried employment and charge for their services. When*

this occurs, a Medicare benefit is payable'. For these purposes '*outside their salaried employment*' means when doctors are treating patients while exercising their right of private practice.

It is a requirement under Commonwealth/State funding agreements that services provided to private patients in public hospitals must also be made available to public patients. This means that existing public outpatient services cannot be withdrawn and replaced exclusively with private outpatient services. New specialist outpatient services not previously offered by a public hospital cannot be provided exclusively to private patients; however clinical service names do not need to be the same.

Who are private patients?

A private patient is described in the health care agreements as an eligible person who elects to be treated as a private patient and to be responsible for paying fees for these hospital services as determined by the State. A patient must make an informed choice to be treated as a private patient (eg. the patient must be made aware of financial consequences of his or her choice).

An election by an eligible patient to receive **admitted** public hospital services as a private patient has to be made in writing before, at the time of, or as soon as practicable after admission. This is achieved by the completion of a Patient Election Form (PEF)[*]. Districts must ascertain whether patients, presenting for admission through the emergency department, have private insurance and whether or not they wish to be treated as private patients.

Private **non-admitted** patients are seen in Queensland Health facilities in the following circumstances:

1. *For specialist medical outpatient services.* These patients must hold a valid referral to a named public hospital medical specialist who is exercising a right of private practice.
2. *For urgent care.* These patients may have presented at an emergency department but advised of alternative service provision options to ensure speedier ambulatory care.
3. *For diagnostic services.* Patients can either be referred directly from outside medical practitioners for diagnostic services (in which case arrangements are similar to those applying to patients referred for specialist medical outpatient services) or following urgent or general practice care as outlined above. Doctors who do not have a provider number allowing billing for attendance items, may be able to order tests privately or to refer the patient for further specialist care[†].

Private non-admitted patients do not have to make a written election but the patient must have chosen to be treated as a private patient.

Non-admitted private patients are not considered to be patients of the public hospital rather they are patients of the practitioner who is using the facilities of the public hospital under arrangement with Queensland Health.

[*] Copies of Queensland Health Patient Election Forms can also be viewed and downloaded from QHEPS via the following link: http://www.health.qld.gov.au/publications/aust_hlth_care_agreement/Queensland.pdf

[†] A patient can still elect to be a private patient of a specific doctor even if that doctor is not eligible to claim services against Medicare, as the doctor will usually have a Medicare provider number that enables them to request diagnostic imaging and pathology tests, prescribe pharmaceuticals and refer patients for tertiary care.

PRIVATE PATIENTS AND EMERGENCY DEPARTMENTS

Eligible patients presenting at a public hospital emergency department must be treated as public patients, regardless of whether they subsequently become admitted private patients. If a patient of an emergency department is subsequently admitted as a private patient, only those services provided post admission are private patient services. (Note: the term emergency department should only be used for services designated level 2 and above in the Clinical Services Capability Framework, http://qheps.health.qld.gov.au/pcb/cscfv2_home.htm. Other services should be labelled as 'Urgent care' or the like. Guidelines about private patients in those services are included below).

If it is clinically appropriate, patients in an emergency department can be provided with information about alternative service providers. However, hospital staff should not direct patients toward a particular choice and patients should not be denied treatment as a public patient if they choose to be treated at the emergency department.

The establishment of private primary care clinics at the hospital is one way that public hospitals can offer alternative treatment options to ambulatory patients presenting at emergency departments for non-urgent care (eg many triage category 4 and 5 patients).

ESTABLISHING A PRIMARY CARE CLINIC	
1	The Primary Care Clinic (PCC) should be physically and administratively separate from the Department of Emergency Medicine (DEM).
2	The services of the PCC must not be, nor appear to be, provided by an existing hospital service such as the DEM or an outpatient department.
3	The signage and general information should clearly identify the PCC as a separate service and should refer to itself as a 'Primary Care Clinic' or like term.
4	The PCC may be staffed by salaried medical practitioners exercising a right of private practice or contracted out to General Practitioners.
5	Patients should preferably be aware of the option of attending a private PCC before they have been registered as patients of the DEM. This can happen via signage and general information that provides information about options for treatment at the PCC, as well as other general practice clinics in the local area. Hospital staff, including DEM staff, can register patients for a private PCC but they must ensure that patients are aware they will be treated privately.
6	Clear protocols for DEM staff should be developed for providing information to patients that are registered with the DEM containing the following information: a. Patients categorised as triage category 4 or 5 who did not arrive by ambulance should be provided with an information sheet setting out their options for treatment including being seen in the DEM or in the PCC. b. DEM staff should not direct or encourage patients towards any particular choice. c. DEM staff must ensure that they clearly document in the patient record that the patient has elected to seek treatment from the PCC or an alternative GP service.

INFORMATION FOR PATIENTS PRESENTING TO THE EMERGENCY DEPARTMENT FOR MEDICAL TREATMENT WITH LESS URGENT CARE NEEDS

Emergency Departments must give priority to emergency patients.

You have been identified as a patient who could expect a longer wait in the Emergency Department or who could be appropriately seen in general practice or in the Primary Care Clinic, which is located on site and nearby, rather than waiting to be seen in the Emergency Department.

If you are entitled to Medicare, doctors at the Primary Care Clinic will bulk bill Medicare for your treatment, meaning that there is no out of pocket fee payable by you if you elect to obtain treatment at the Clinic.

In the event that further investigations or tests are provided at the hospital, unless otherwise indicated, your Medicare benefit will be accepted as full payment ie there will be no out of pocket fee payable for these investigations.

Alternatively, you may wish to access medical treatment via a local general practitioner. The local general practitioners within a 1 km radius of the hospital include:

- [insert details].

We are unable to advise you of their billing arrangements and whether they bulk bill or charge patients a fee.

You may, of course, elect to remain and wait to be seen in the Emergency Department.

The reason for offering you the option of being seen in the Primary Care Clinic is based upon an assessment of your relative priority for acute emergency services offered by the Emergency Department

Given your need for care is assessed to be non-urgent, taking up the option to attend the Primary Care Clinic means that you can be seen more quickly.

You may have to wait some considerable period of time to see a doctor in the Emergency Department, and people who arrive after you with more urgent presentations will be given priority.

If you decide to wait here and there is any change or worsening of your condition, you should immediately bring this to our attention.

Please let us know if you decide to attend the Primary Care Clinic or visit a general practitioner.

SUPPORTING DOCUMENTATION

AUSTRALIAN HEALTH CARE AGREEMENT (AHCA)

Although the 2003-2009 Australian Health Care Agreement (AHCA) between Queensland and the Australian Government is the agreement covering the provision of public hospital services, it also provides direction on the admission, treatment and billing of private patients in public hospitals. Similar agreements exist between other jurisdictions and the Australian Government. The full Agreement can be found on the Australian Government Department of Health and Ageing web site or at:

http://www.health.qld.gov.au/publications/aust_hlth_care_agreement/Queensland.pdf

Note that from 1 July 2009 this agreement will be replaced by the National Healthcare Agreement.

MEDICARE BENEFITS SCHEDULE (MBS)

The chief source of operational policy, guidelines and rules relating to medical services to private patients from the Australian Government's perspective is the legislation providing for Medicare Benefits incorporating the MBS. Details are available in the MBS book, which is updated yearly and available at:
http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1

FURTHER INFORMATION

This document provides general advice and answers to some specific questions. However, it does not endeavour to cover all questions that may arise. If a question cannot be answered by the application of the guidelines, please contact the Director, Commonwealth Funding Unit, Funding and Resourcing Branch by telephone (07 323 41309), facsimile (07 323 41174) or e-mail commonwealth_funding_unit@health.qld.gov.au .

From: Greg Coonan
To: Jenny A. Cannon
CC: Edmund Lynch; Rebecca Wells
Date: 23/01/2012 8:23 am
Subject: Re: Innisfail ED extended hours arrangement

Jenny,

Queensland Health does not consider that the circumstances currently exist such that the *Emergency Department Extended Hours Benefit (ED 25%) would be applicable to Innisfail.*

For over 12 months the Workplace Relations Unit has been in discussion with Together and ASMOFQ on QH's understanding of the application of ED25%. *Despite our best efforts, and notwithstanding the development of the document of 13 December 2011, it would appear that the definition of a emergency department for the purposes of this payment remains deficient.*

The possible devaluing of a payment that recognises the commitment of and demands placed on trained SMOs within an ED is of particular concern to QH.

In the circumstances, QH proposes that further discussions occur to arrive at a more robust definition of an Emergency Department for the purposes of properly applying the ED 25% payment.

Regards,

Greg Coonan
Program Manager
Workplace Relations Unit
Queensland Health

Ph: (07) 323 41440
Fax: (07) 323 40314

>>> "Jenny A. Cannon" <Jenny.Cannon@together.org.au> 13/01/2012 12:05 pm >>>

Greg

We have received advice from SMO members at Innisfail about the extended hours of work required of them in the ED Monday to Sunday.

None of the SMOs is receiving the ED 25% where, in our view, ED 25% contracts should apply.

We now draw this to your attention for inclusion of Innisfail on the list in the attachéd document and implementation of the supplementary payment.

We look forward to a response at your early convenience.

Regards

Jenny Cannon

Industrial Advocate | **Together**
Phone 30176129 |Fax 31076229 |Mob s.73
Email: Jenny.Cannon@together.org.au

Together Medical Officers Portal

22 February meeting update

Posted by Alex Scott on February 23, 2012

It is pleasing to advise that MOCA 3 negotiations will not be suspended during the caretaker government period as has occurred in the past. The parties will continue to explore options for resolution of issues within interest areas in the Interest-based bargaining (IBB) format.

A bargaining plan has been agreed to by all parties and is now being circulated to principals for their signature. QH and ASMOFQ are still to finalise their list of participants and when the document is complete we will be able to post it to our website. This document will give members a better idea of the nature of the IBB process being engaged in.

Eligibility for 4/5 weeks leave and 5/6 weeks leave

Recreation leave entitlements appear in the Award however there is inconsistent application of the Award and all parties agreed they share an interest in clearly defining the entitlements to ensure consistent application.

The parties noted that the Award is written with 5 weeks as the default with one week being in lieu of penalty rates on public holidays because most employees would be part of a roster that would require work to be done on public holidays (including on-call). However where there is no requirement for service to be provided on public holidays and MOs are not rostered to cover the holidays 4 weeks leave is applicable.

Together raised a concern that employees who have 5 weeks leave and who take recreation leave on public holidays do not have those public holiday credited to their leave balance. Our members consider there should be an option to choose either 5 weeks leave in lieu of penalty rates or 4 weeks leave with penalty rates to avoid being penalised for agreeing to working on public holidays.

Together also raised concerns about inconsistent application of the additional weeks leave (the 6th week) for RMOs who do continuous shift work. The Union has dealt with issues in the past where RMOs are rostered for night shifts in blocks and because individuals do not do night shifts throughout the whole year they are only given a pro rata entitlement of the additional weeks leave. This is not appropriate where an individual is part of a roster that has shifts covering days, evenings, nights, week days and weekends.

QH has undertaken to scope the practices occurring before working on options to resolve the issue and also to clarify the appropriate application of the Award.

Eligibility for ED extended hours allowance

When the ED 25% allowance was introduced in 2006 it was stated to apply only to work in an extended hours arrangement in EDs (which were the only units working those extended hours at the time).

Recently, a number of Acute Primary Care Clinics have been established drawing staff from EDs and the question arose as to whether work in an APCC attracted the 25% allowance also. It has been clarified that it does not however where an employee of an ED is required to work on an ad hoc (not rostered) basis in an APCC they will not lose their entitlement to the allowance for those hours worked on an ad hoc basis.

Regional Development Incentive Scheme (RDIS)

Both QH and the Unions identified an interest in finding better ways to recruit and retain MOs to specific regional areas with recruitment problems. The

RDIS in the past two agreements has caused many problems that the parties would like to avoid in future. Options will be discussed at a future meeting

Part-timers entitlements to Motor Vehicle Allowance

A major area of interest identified by the parties was recruitment and retention of Medical Officers and equity.

Together raised the first item in the equity category – part-time entitlements to the Motor Vehicle Allowance. Currently a .5FTE SMO will receive about 25% (not 50%) of the allowance received by a FTE and those with less than a .5 FTE appointment receive no allowance.

Three years ago in negotiation of MOCA2 QH was prepared to rectify this inequity; however delays attributable to another participant at the time took the negotiations well into the period of the global financial crisis and the offer was taken off the table.

QH undertook to revisit this matter – having an interest in reviewing entitlements for part-time employees taking account of parity, retention and the future trends for workforce mix.

Next week Together will continue to outline a number of issues and options for resolution under the heading of recruitment and retention and equity.

We hope you continue to follow our blogs and give us your feedback as we go. The blog is an innovation to the union's bargaining plan and represents an unprecedented opportunity for Medical Officers to participate in real-time in the negotiations by emailing your comments to jenny.cannon@together.org.au **. It is important too that you are talking to other members in your workplace about the negotiations and encouraging non-member colleagues to join. The more involvement from grass roots membership the better outcomes we will achieve together.**

Authorised Alex Scott, Secretary, Together.

20 Feb 2012 Update re Medical Team Work

Hi Greg

Welcome back!!!!

Some quick salient points. Carl has scheduled our Team meeting for tomorrow.

ED 25 PERCENT

This is now agenda item now at MOCA3 for the Wednesday 22 Feb meeting. We are maintaining our defendable position.

Acute Primary Care Clinics

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After the better part of two hours, with the benefit of the Commission's time, there was resolution of the dispute with the parties were on the same page. Namely, that that working in an APCC does not qualify an SMO to receive the payment of ED 25% on those hours worked in that area. However, if an SMO meets the eligibility criteria for the ED 25 per cent payment, and that SMO who usually works in an ED is required to work in an APCC on an ad hoc basis that SMO should continue to receive the ED25% payment as specified in their current contract.

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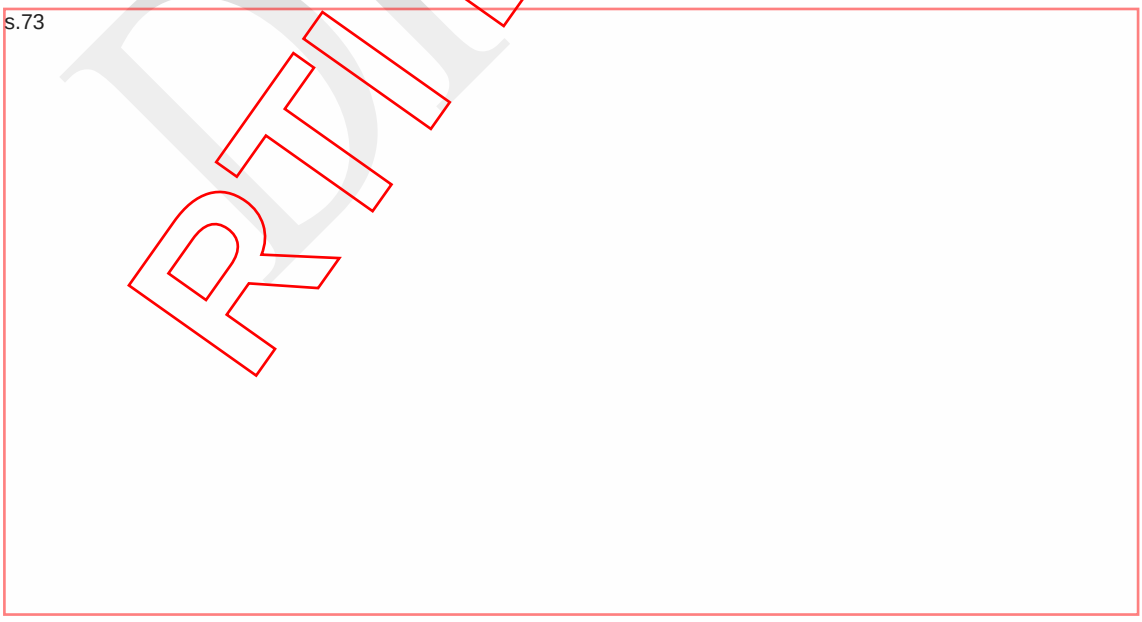

MOCA 3 (towards a replacement agreement)

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Extended Hours – SMO (Carl Blunck)

3. How many SMOs receiving shift penalties?
4. How many receiving ED 25%?
5. How much does the ED 25% cost?

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Kind regards Edmund Lynch

Senior Health Employee Contracts

Contract governance

Introduction

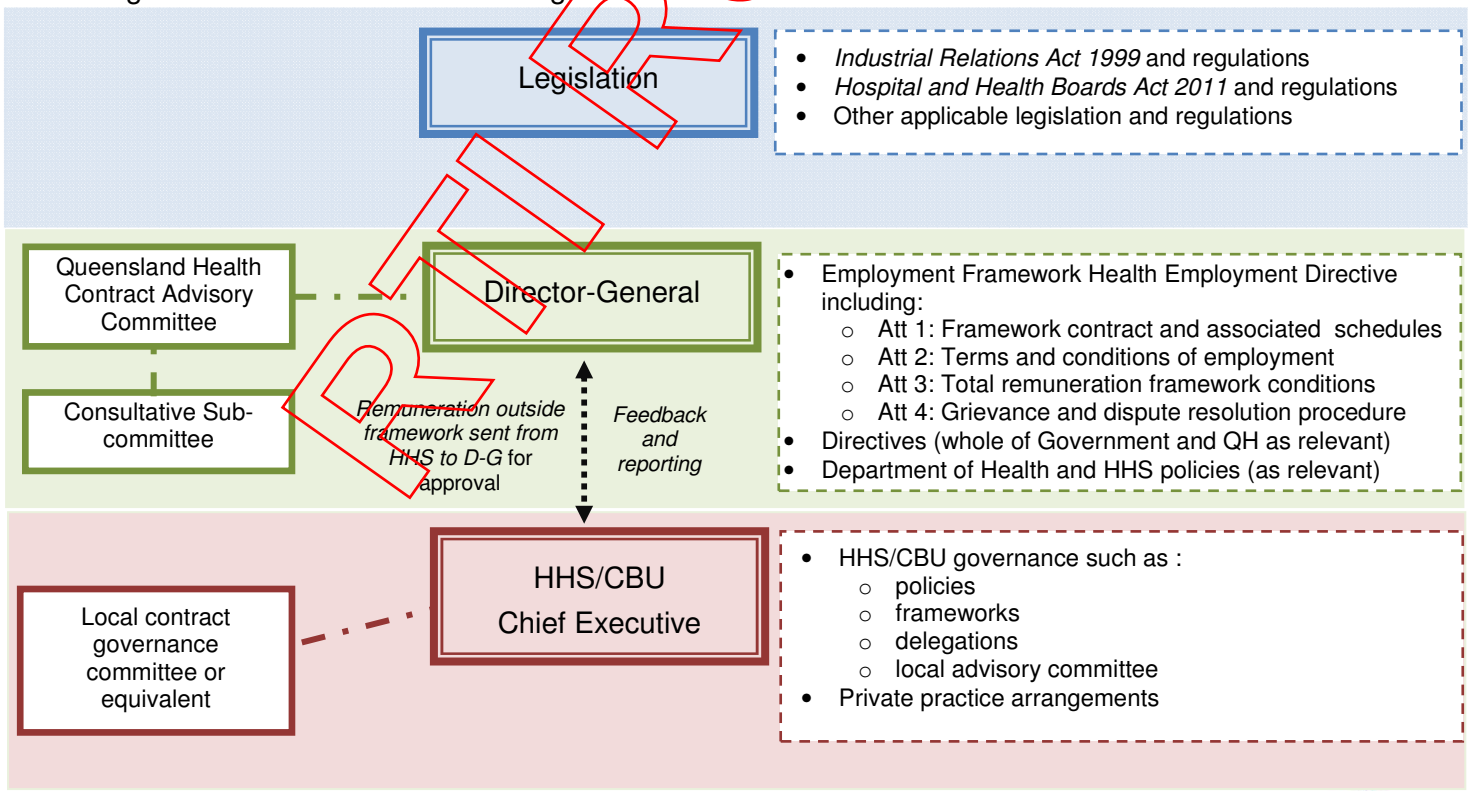
On 1 December 2013, it was prescribed by regulation that certain Queensland Health employees holding senior positions are 'senior health service employees' for the purposes of s74A of the *Hospital and Health Boards Act 2011*.

This document summarises the governance arrangements for senior health service employees (including those within Hospital and Health Services (HHSs) and the Department of Health), employed under the *Hospital and Health Boards Act 2011* **and** through the mechanism of health employment directives (excluding chief executives). It incorporates three sections:

1. Governance of the employment contract for senior health service employees, including:
   a) roles and responsibilities
   b) Queensland Health Contract Advisory Committee
2. Governance of total remuneration framework conditions
3. Attachment 1 Senior Medical Officer (SMO) remuneration governance requirements, Attachment 2 Visiting Medical Officer (VMO) remuneration governance requirements, and Attachment 3 Business case to remunerate outside of the provisions of the Employment Framework Health Employment Directive.

Governance of the employment contract for senior health service employees

This diagram outlines the three levels of governance



Roles and responsibilities

Detail regarding the specific roles of the three levels of governance, are provided in the table below.

Legislation	• Provides the relevant legislative framework governing the employment of senior health service employees.
Director-General	• Determines the parameters for the terms and conditions of employment for all senior health service employees. • Issues health employment directives about specific employment conditions or arrangements for senior health service employees, including the framework contract, terms and conditions of employment and remuneration rules. • Approves remuneration arrangements outside the discretion of the governance of the HHS/commercialised business unit (CBU). • Is advised by the Queensland Health Contracts Advisory Committee regarding the implementation and strategic review of contracts for SMOs and VMOs.

Hospital and Health Services (HHSs) and commercialised business units (CBUs) chief executive	• Manage negotiation of the following Schedules to the framework contract within the prescribed parameters:
	  ○ Schedule 1 - duties
	  ○ Schedule 2 - employment details
	  ○ Schedule 3 - private practice.
	• Execute, administer and manage individual employment contracts in line with HHS/CBU frameworks and local governance requirements.
	• Confirm private practice approach for HHS/CBU (if no alternative arrangement is in place).
	• Ensure workforce aligns with service planning or alternative as appropriate.
	• Provide oversight to ensure business practices reflect best practice contract management.
	• Escalate remuneration arrangements outside the discretion of HHS/CBU governance to the Director-General.
	• Monitor outputs and report to Queensland Health Remuneration Advisory Board as specified in the terms of reference.
	• Monitor labour budget as appropriate.
	• Set framework for remuneration allocation specific to the HHS/CBU within the state-wide framework including the development of remuneration distribution parameters if appropriate.
	• Determine, implement and maintain performance review framework including associated KPIs.
	• Review role descriptions for inclusion in Schedule 1 to the framework contract – duties.

Queensland Health Contract Advisory Committee

Purpose of the Queensland Health Contract Advisory Committee

The purpose of the Queensland Health Contract Advisory Committee (the Committee) is to provide expert advice and recommendations to the Director-General with regard to matters relating to the implementation and strategic review of contracts for SMOs and VMOs.

The principal functions of the Committee are to:

- provide rigorous and consistent assessment of matters relating to the implementation, operation and ongoing management of contracts for senior health service employees
- bring their experience and skill from their specialist areas to provide authoritative advice and solutions to resolve implementation matters and acknowledge that at times these may not align with their corporate interests
- critically analyse all material that is provided for review of the Committee
- consider the independent reviewer's findings in relation to contract arrangements alignment with the clinical, business, training and research needs of the HHSs
- commit to the provision of impartial advice
- make recommendations about any required actions to the Chair
- provide and/or receive reports on the progress of the implementation of contracts for senior health service employees.

Governance of remuneration framework conditions

Governance of remuneration for senior medical officers and visiting medical officers employed pursuant to the framework contracts

The SMO Employment Framework Health Employment Directive and the VMO Employment Framework Health Employment Directive each contain the framework contract, including the remuneration framework, under which SMOs and VMOs respectively can be employed by a HHS or the Department of Health from 4 August 2014.

Attachment 1 to this document outlines the governance requirements applicable to the remuneration of SMOs employed by a HHS or the Department of Health (including commercialised business units) pursuant to the framework contract attached to the SMO Employment Framework Health Employment Directive.

Attachment 2 to this document outlines the governance requirements applicable to the remuneration of VMOs employed by a HHS or the Department of Health (including commercialised business units) pursuant to the framework contract attached to the VMO Employment Framework Health Employment Directive.

Approval from the Director-General will be required for any employment arrangements outside those prescribed in the SMO or VMO employment framework. A business case will need to be submitted by the relevant HHS/CBU chief executive or their delegate to the Director-General, as per the format provided in Attachment 3.

Attachment 1: Senior Medical Officer remuneration governance requirements

The following information outlines the governance requirements for the remuneration of SMOs employed by a HHS or the Department of Health (including CBUs) pursuant to the framework contract attached to the SMO Employment Framework Health Employment Directive.

The provision of any benefits not contained in the SMO Employment Framework Health Employment Directive that have not been approved by the Director-General is not permitted.

Base

Base salary amounts are fixed. The rates to be applied are outlined in the SMO terms and conditions of employment document.

Payment of base rate salary levels other than at those rates set out in the classification structure (SMO levels 13 to 29, and medical superintendents and medical officers with private practice) within the SMO terms and conditions of employment document is not permitted.

Increases to base rate salary levels (other than incremental progression) will be in accordance with the Government Wages Policy and applied to SMOs following the Director-General's approval.

Tier 1 – Standard allowances

Standard allowances prescribed in the SMO total remuneration framework conditions document are fixed based on the SMO's classification level. The payment of allowances other than the fixed allowances prescribed in the SMO total remuneration framework conditions document is not permitted.

Changes to the amounts paid for standard allowances will be governed as follows:

- Motor Vehicle Allowance – as approved by the Director-General in consideration of Public Service Commission changes, and
- Professional Development Allowance – as approved by the Director-General.

Tier 2/2s – Clinically required additional hours

Tier 2 relates to the remuneration for SMOs working non-standard core hours within contracted hours (Tier 2S) and additional hours worked beyond base core hours (Tier 2).

Local governance arrangements must provide for local reporting and approval of Tier 2/2S (combined) amounts greater than 30 per cent of a SMO's base salary.

Attendance variation and allowance claim (MedAVAC) forms must be submitted to receive payments for:

- recall
- overtime for staff on an arrangement where overtime (comprised of hours in excess of core hours of work) is paid by exception.

Local HHSs/CBUs must continue to maintain time and attendance records for each SMO whom they employ.

For staff on an annualised Tier 2/2S package (i.e. not paid by exception), AVAC forms for overtime will not be paid.

Tier 3 – Productivity and performance

Payment for productivity and performance not provided for within the Tier 3 rules specified in the SMO total remuneration framework conditions document is not permitted.

Local governance arrangements must provide for consistent governance of Tier 3 via a HHS/CBU performance framework (or equivalent) that has been approved at the local level (within the prescribed local governance).

Tier 4a – Rural and remote incentives

The payment of rural and remote incentives must be consistently applied for all eligible recipients, as per the rules outlined in the SMO terms and conditions of employment document and the SMO total remuneration framework conditions document.

Approval from the Director-General will be required for any Tier 4a amount not provided for within the parameters specified in the SMO terms and conditions of employment document and the SMO total remuneration framework conditions document.

For SMOs translating onto a contract, if approval from the Director-General (or other authorised delegate) has previously been sought and received for amounts or benefits outside the SMO total remuneration framework conditions document, a second approval from the Director-General is not required, provided supporting documentation is available and retained to substantiate the original approval of the arrangement.

Tier 4b – Management and leadership

Payments for management and leadership must be consistently applied for all eligible recipients, as per the rules outlined in the SMO total remuneration framework conditions document.

Approval from the Director-General will be required for Tier 4b amounts not provided for within this framework.

Tier 4c – Speciality recruitment

Translating emergency doctors

For SMOs translating to employment contracts that were employed as an SMO by Queensland Health as at 3 August 2014 **and** receiving the emergency department incentive (ED25%), payment in Tier 4c is fixed at 25 per cent of base salary.

All other SMOs (including SMOs appointed after 4 August 2014)

Approval from the Director-General is required for:

- any Tier 4c payment greater than 25 per cent of base salary for an individual, and
- any Tier 4c payments for groups of two or more doctors in the same specialty (for example, anaesthetics) in the HHS/CBU, within any six month period. This excludes SMOs who are employed in the emergency department.

This governance arrangement is intended to reduce the possibility of specialty-based wage escalation precedents being set across the Queensland public healthcare sector.

Tier 4d – Medical attraction

Option A or Option P doctors translating to the revenue assignment private practice model

For translating SMOs employed as an SMO by Queensland Health as at 3 August 2014 **and** receiving an Option A or Option P supplementary benefit, payment in Tier 4d is determined as the balance of their historical option payment (the residual amount that has not been accounted for in Tier 3) up to 25 per cent of base salary.

This Tier 4d payment for these SMOs is fixed in perpetuity.

Approval from the Director-General is required for any Tier 4d payments greater than 25 per cent of base salary.

SMOs appointed after 4 August 2014, under the revenue assignment private practice model

Approval from the Director-General is required for any Tier 4d payments greater than 25 per cent of base salary.

SMOs under the revenue retention model

No Tier 4d payments are applicable.

Attachment 2: Visiting Medical Officer remuneration governance requirements

The following information outlines the governance requirements for the remuneration of VMOs employed by a HHS or the Department of Health (including CBUs) pursuant to the framework contract attached to the VMO Employment Framework Health Employment Directive.

The provision of any benefits not contained in the VMO Employment Framework Health Employment Directive that has not been approved by the Director-General is not permitted. No doctor can be appointed as a VMO unless the incur private practice costs.

Base

Base salary amounts are fixed. The rates to be applied are outlined in the VMO terms and conditions of employment document.

Payment of base salary rates other than at those rates set out in the classification structure within the VMO terms and conditions of employment document is not permitted.

Increases to base rate salary levels (other than incremental progression) will be in accordance with the government wages policy and applied to VMOs following the Director-General's approval.

Tier 1 – Standard allowances

Standard allowances prescribed in the VMO total remuneration framework conditions document are fixed. The payment of allowances other than the fixed allowances prescribed in the model is not permitted.

Changes to the amounts paid for standard allowances will be governed as follows:

- Fuel Allowance – as approved by the Director-General in consideration of Public Service Commission changes
- Professional Development Allowance – as approved by the Director-General.

Tier 2 – Clinically required additional hours

Tier 2 relates to the remuneration payable to VMOs for working additional hours beyond their contracted Core Hours.

Local governance arrangements must provide for reporting and approval of Tier 2 amounts greater than 30 per cent of base salary.

Attendance variation and allowance claim (AVAC) forms must be submitted to receive payments for:

- recall (call back)
- overtime (continuation of duty) – comprised of hours in excess of core hours of work – for staff on an arrangement where overtime is paid by exception.

Local HHSs/CBUs must continue to maintain time and attendance records for each VMO whom they employ.

For staff on an annualised Tier 2 package, AVAC forms for overtime will not be paid.

Attachment 3: Business case to remunerate outside of the employment framework

This business case is to be completed by HHSs / CBUs who wish to apply to the Director-General to remunerate an individual or a group of individuals outside of the SMO or VMO Employment Framework Health Employment Directive and/or outside the discretion of local governance.

Note: if the application is in relation to a group – i.e., more than one employee in a speciality – a separate form must be completed for each recipient.

Individual particulars

This section should include information relevant to the individuals being considered for remuneration outside of the SMO or VMO Employment Framework Health Employment Directive or outside the discretion of local governance and must include the following details:

- relevant HHS/CBU
- speciality
- facility/area
- name (s) of employee(s)/ potential employee(s)
- employee personal identification number(s) (if the employee is a current employee)
- length of time remuneration outside of the employment framework is requested
- if this affects a group of two or more SMOs or VMOs in the same speciality.

Proposed remuneration

This section outlines the format by which an HHS/CBU can propose to remunerate outside of the Employment Framework Health Employment Directive.

	Remuneration framework value $ and %	Proposed value $ and %	Rationale
Base	Fixed	Fixed	
Tier 1	Fixed	Fixed	
Tier 2	Variable	Variable	
Tier 3	0-25%		
Tier 4a	0-20%		
Tier 4b	0-25%		
Tier 4c	0-25%		
Total			

Rationale

This section includes the rationale for remunerating an individual or a group outside of the SMO or VMO Employment Framework Health Employment Directive or outside the discretion of local governance, such as:

- location is difficult to recruit to
- speciality is difficult to recruit to
- failure to remunerate outside of the framework may result in critical loss of talent

The statement of rationale should describe the benefits of remunerating the individual or group and how that aligns with the best use of taxpayers' money.

Alternative solutions

Information regarding alternative options that have been considered and action taken prior to making application to remunerate outside of the employment framework or outside the discretion of local governance is to be included in this section.

For each alternative, describe:

- time frame
- resources
- costs
- benefits
- any constraints and major assumptions that are critical in deciding between the alternatives considered.

Mitigation strategies and future planning

Describe what activities will be undertaken to mitigate against prolonged payment outside of the SMO or VMO Employment Framework Health Employment Directive, such as recruitment campaigns, teaching and training plans, alternative solutions etc.

Sensitivities and risks

Identify key sensitivities and risks that exist in either remunerating or not remunerating individuals or groups of individuals. Present potential contingent actions that could mitigate the risks.

Recommendations

Describe the way forward, detailing any specific recommendations and outcomes.

Senior medical workforce contracts

Overview

November 2013

Privileged and confidential – not Government policy

Today's agenda

- Employment framework
  - Contract
  - Remuneration model
  - Private practice arrangements
- Questions

Modern and relevant employment arrangements for senior health employees, which will:

- ensure that **terms and conditions** of employees engaged as high income senior employees **are regulated by contracts** with simple and easy to understand terms and conditions, with a focus on achieving local productivity
- provide senior employees with the ability to **negotiate flexible employment arrangements**
- support **service delivery** and clinical **innovation** goals
- provide **consistent fortnightly remuneration** based on an annualised package
- provide a mechanism for **reformed private practice arrangements**
- provide **continuity of already accrued entitlements**
- provide a **line-of-sight** between their work and the clinical performance of their Hospital and Health Services (HHS) through key performance indicators (**KPIs)**.

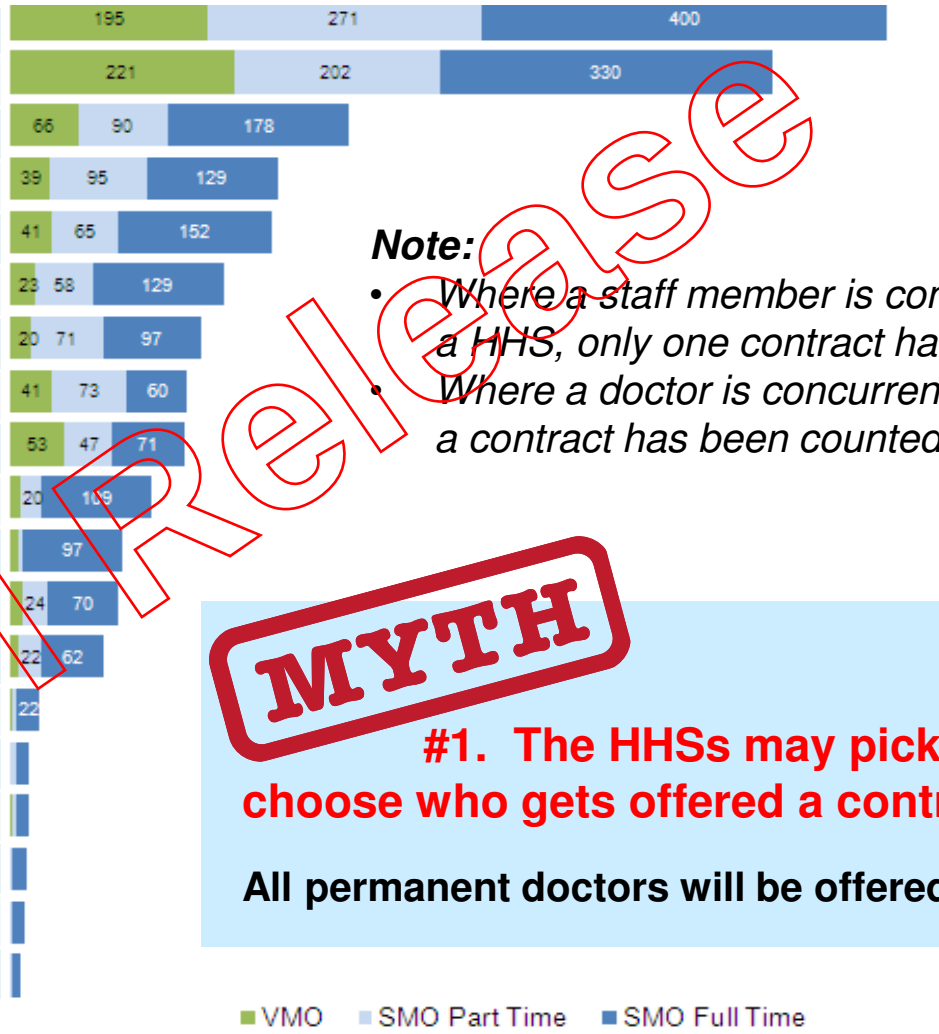
Who is a ‘senior health service employee’?

- A ‘senior health service employee’ is someone whose **total remuneration** package is **over $129,300** and is **prescribed by a regulation.**

- At the expiry of current agreements, the following senior health employees will be covered by individual contracts, not by a replacement certified agreement:
  - Senior officers (SOs) / district senior officers (DSOs)
  - Senior nurses
  - Senior health practitioners
  - Senior dentists
  - Visiting medical officers (VMOs)
  - Senior medical officers (SMOs) (with early ‘opt-in’ to individual contracts available from 1 July 2014).

Number of SMO and VMO contracts by HHS (as at Nov 2013)

HHS/CBU	Total contracts
Metro North HHS	866
Metro South HHS	753
Gold Coast HHS	334
Sunshine Coast HHS	263
Townsville HHS	258
Cairns and Hinterland HHS	210
Darling Downs HHS	188
CHQ HHS	174
West Moreton HHS	171
Wide Bay HHS	139
HSSA	109
Central Queensland HHS	106
Mackay HHS	92
North West HHS	27
HSCI	17
Cape York HHS	17
South West HHS	15
Torres Strait / Nth Peninsula HHS	14
Central West HHS	9



Note:

- *Where a staff member is concurrent **within** a HHS, only one contract has been counted*
- *Where a doctor is concurrent **across** HHSs, a contract has been counted for each HHS.*

MYTH

#1. The HHSs may pick and choose who gets offered a contract.

All permanent doctors will be offered a contract.

Reducing complexity through the new arrangement

Current arrangement

- IR Act / HHB Act / PSA
- Public sector and Queensland Health directives
- 189 HR policies
- Awards, MOCA3 / VMO Unregistered Agreement
- Right of private practice contract
- Letter of offer (including terms and conditions)

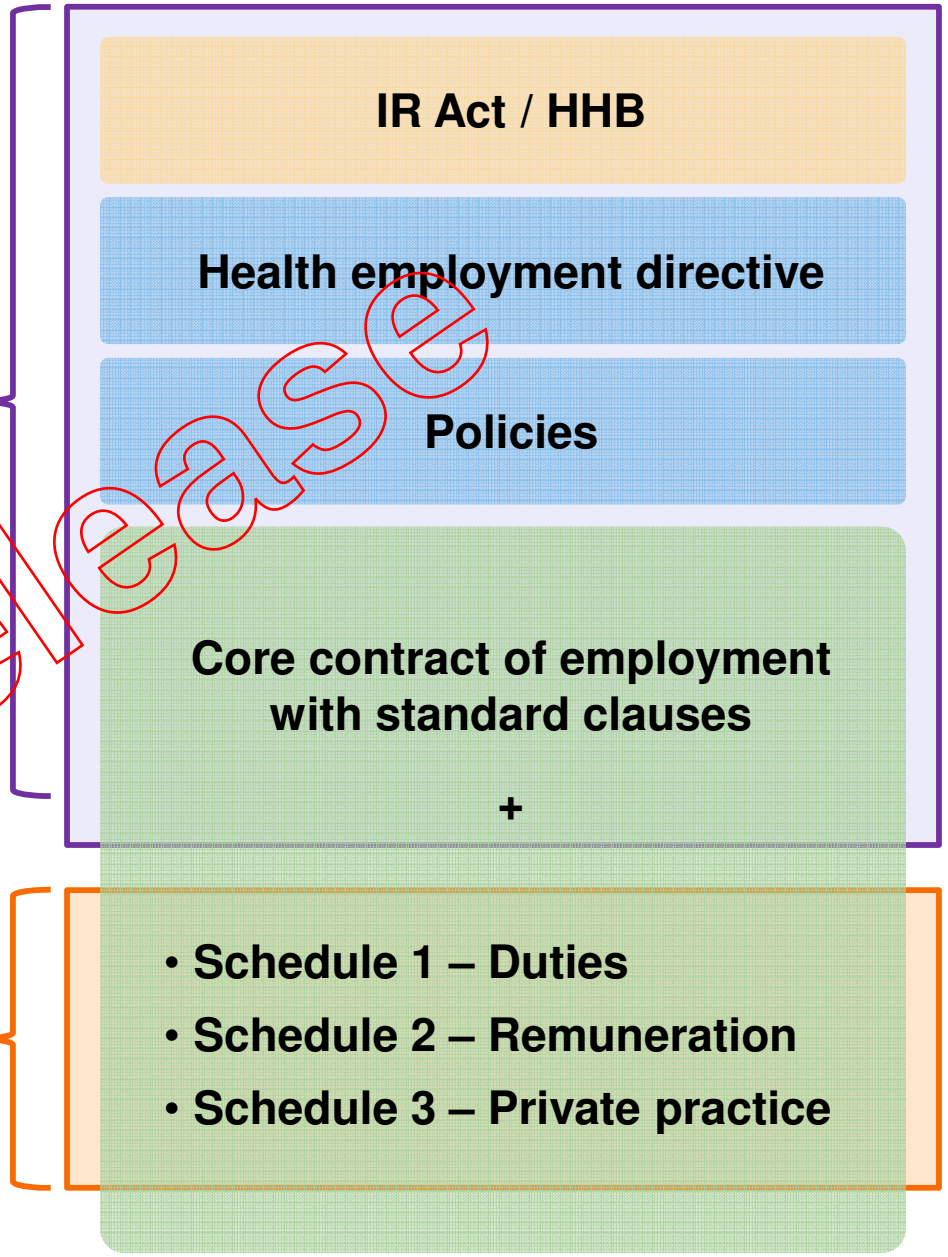
New arrangement

- IR Act / HHB Act
- Public sector and Queensland Health directives
- Greater flexibility with HR policies
- Contract of employment (incl. private practice)

The employment framework

Consistent statewide framework →

Local flexibility →



The core contract has five sections

1. Working with us
2. Your benefits
3. Your time at work
4. Medical officer specific conditions
5. Formal provisions

Key contract clauses

Section 1 - Working with us

- **Contracts will have no fixed end date ('perpetual').** Fixed term contracts can be issued for temporary appointments.
- **Mandated grievance policy** (E12) applies.

Section 2 - Your benefits

- **Superannuation and salary sacrifice provisions are a continuation of current arrangements** (under MOCA3 for SMOs)
- The remuneration and benefits outlined in the contract **and terms and conditions handbook** are the full benefits payable.

MYTH

#2. The contract will be a fixed length and may not be renewed, thus ending my employment.

This is not the case.

Key contract clauses (cont'd)

Section 3 - Your time at work

- Core hours
  - **SMOs** – core hours are 80 per fortnight for full time staff and up to 80 hours per fortnight for part-time staff
  - **VMOs** – contracted core hours of work to be determined between the employer and the employee.
- Performance review against KPIs to occur at least annually.
- Mandated Fatigue Risk Management Policy specified in the contract and **continues** to apply.

- **The Medical Fatigue Risk Management Policy and its associated standard and protocol will continue to apply across Queensland Health.**
- **All HHSs are required to have a documented fatigue risk management system** that ensures a co-operative approach with doctors.
- Further, the core hours of employment remain at 80 hours per fortnight for fulltime staff, the same as it is now.

#3. The contract does not contain fatigue management provisions. Doctors will be forced to work longer hours and compromise clinical standards.

This is not the case.

Key contract clauses (cont'd)

Section 3 - Your time at work (cont'd)

1. **'No cause' termination** – similar provision to executive contracts
   - Any use of this clause would be accompanied by a **significant period** of notice:
     - **up to 12 months' service – 4 weeks**
     - **1-5 years service – 3 months**
     - **>5 years service – 6 months**
   - Opportunity to provide written submission for consideration prior to final decision.

2. **Termination without notice may occur following <u>serious misconduct</u>.**

MYTH

#4. The termination clause in the contract means that I could be dismissed at a moment's notice for no reason.

This is not the case.

Compare this to…

- ***QIRC*** *– maximum is 6 months payment in lieu*
- ***Current award for SMOs*** *– notice is 3 months*
- ***Current notice period for VMOs*** *is 3 months*

Key contract clauses (cont'd)

Section 4 – Medical officer specific conditions

- **Indemnity policy (I2) continues to apply**
  - For VMOs – amendments to occur prior to 1 July 2014 to include private practice.
- **Commitment to clinical support time** (this includes education, training and research).
- For **SMOs**, professional development assistance remains unchanged.
- For **VMOs**, professional development leave can be accessed during non-contracted time by agreement.

Section 5 – Formal provisions

- States that amendments may be made in writing.
- Definitions section.

A **tiered** approach to remuneration (Schedule 2 of your contract)

- Annual remuneration packages under the contract will be structured in **tiers**:
  - current remuneration elements can be logically grouped into several key areas (e.g. base, additional hours, allowances etc.) and annualised
  - existing entitlements (such as leave and superannuation) remain largely unchanged as a result of the transfer to contracts
  - gives HHSs and doctors greater flexibility around work practice.

Annual increases and increments

MYTH

#5. I won't get increments any more.

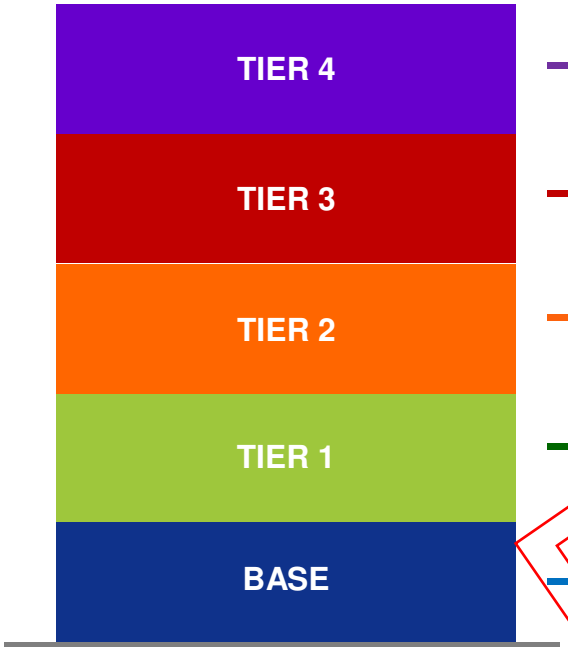
- The **current classification structure (from your existing agreement) will continue to apply,** as will incremental advancement based on successful annual review.

MYTH

#6. I will no longer get an annual pay rise.

- Base rates in the SMO contract will be the **MOCA3 rate** as at **1 July 2014** (which **includes the 2.5% pay rise**).
- Base rates in the VMO contract will be the current loaded rates as per the VMO unregistered agreement (2011).
- **Government Wages Policy** will apply to future wage increases.

An annualised remuneration package



Elements of the annual remuneration package

Recruitment and retention enhancements — Variable

Productivity and activity payment tied to measureable and meaningful outcomes — Fixed % of base

Compensation for *clinically required* additional hours — Variable

Standard allowances – i.e. professional development and motor vehicle allowances (based on previous eligibility) — Fixed

Annualised base (at MOCA3 rate) — Fixed

Proposed arrangement for existing SMOs

Draft

Package component		How to determine the amount for a contract offer (subject to review by HHS and adjustment to suit new working arrangements)	Notes/Comments
Base	**(Fixed amount)**	• Your **annual base amount** will be calculated using the base fortnightly rate relevant to your position from 1 July 2014. These rates will be aligned to MOCA3 base rates as at 1 July 2014.	• Contracted SMO annual base amount = fortnightly base rate x 26.0893 fortnights.
Tier 1 – Standard allowances	**(Fixed amount)**	• Your Tier 1 amount will be determined based on existing entitlements which include: o **Professional development allowance** of $20,000 per annum (pro rata for part-time SMOs). o **Motor vehicle allowance** of $21,000 or $25,500 per annum, depending on your classification level.	• In most cases this will be a direct translation of your existing entitlements. • If you still have a motor vehicle lease at 1 July 2014, the motor vehicle allowance will apply pro-rata when the lease expires.
Tier 2 – Clinically required additional hours	**(Variable % of base)**	• Your Tier 2 amount will be determined based on anticipated additional hours (**overtime, on-call, shift penalties**). • For translating SMOs, it will be translated based on additional hours worked in the year FY12-13. This amount will provide a like-for-like translation of your current arrangements. • The translated amount can be adjusted prior to signing the contract by agreement with your health service to reflect intended working arrangements if these have changed since June 2013. • It also be adjusted periodically at the initiation of either the SMO or their health service in response to a significant change in work patterns.	• Following consistent feedback from industrial and professional bodies, and Directors of Medical Services throughout the State, it is proposed that **recall** be **excluded** from the annualised package and instead paid fortnightly after it is worked.
Tier 2 (S) – Clinically required additional hours with OTE/Super	**(Variable % of base)**	• As per above (Tier 2), applied to shift penalties (evenings and Saturdays).	• This tier has been specially developed to retain your OTE/Super entitlements.
Tier 3 – Productivity and performance	**(Fixed % of base)**	• Your Tier 3 amount will contain a payment equivalent to 25% of your base annual amount that is linked to ongoing performance. • For **Option A and P doctors**, this reflects approximately half of the value of your current supplementary benefit payment. • For **Option B and R doctors**, this is a new payment. This payment is intended to provide a consistent approach to including an at-risk performance-based component. It may also offset a reduction in billings retained as a result of increased fees associated with private practice.	• This performance will be evaluated through annual review of key performance indicators (KPIs) that are agreed between you and your health service and included in Schedule 2 of your individual employment contract. • This tier will apply to all SMOs (excluding MORPPs and MSRPPs).
Tier 4 – Recruitment and retention incentives	**(Variable amounts)**	Your Tier 4 amount will be determined based on eligibility in four categories as outlined below.	
	4a. Rural and remote	• Translation of your relevant existing **rural and remote allowances** if any. • **Option A (rural and remote):** The value of the rural and remote component of your current. Option A supplementary benefit will be redistributed here.	• Rural and remote allowances will continue to be paid at their current intervals (typically 6 – 12 months).
	4b. Management and leadership	• Translation of your existing **clinical managers allowance** or **medical managers allowance** if any.	• Will continue to be calculated for the purposes of superannuation for translating employees.
	4c. Specialty recruitment	• **Emergency doctors:** translation of your existing **ED25%** benefit. • Speciality recruitment may be available to improve recruitment and retention of key specialties.	• A strict governance model will be implemented to manage the use of this incentive for translating doctors.
	4d. Medical attraction	• **Option A and P:** balance of your supplementary benefit value .	• A strict governance model will be implemented to manage the use of this incentive for translating doctors.

Tier 4 – recruitment and retention incentives

Employee group	Existing SMOs (translation)	New SMOs
4a Rural and remote	• Translates your existing rural and remote allowances. • Translates your portion of historical Option A or P payments (associated with the area loading).	• Minimal change to rural and remote incentives: ○ rural and remote attraction (additional amount – **up to** 15% of base – based on existing area definitions) ○ inaccessibility incentive – fixed amount based on location and paid on completion.
4b Management and leadership	• Translates your existing clinical manager or medical manager allowance.	• Clinical manager or medical manager allowance – **between** 0-10% of base (additional amount).
4c Specialty recruitment	• Translates the existing emergency department extended hours benefit (ED 25%). • HHSs have the ability to offer an additional amount – up to 25% of base – to retain existing specialist staff, subject to specific governance arrangements (including business case).	• HHSs have the ability to offer an additional amount – **up to** 25% of base – to attract new specialist staff (subject to specific governance arrangements, including business case).
4d Medical attraction	• Translates the reminder of your historical Option A or P payments supplementary benefit. • HHSs have the ability to offer an additional amount – up to 25% of base – to doctors on the private practice revenue retention model, subject to specific governance arrangements.	• HHSs have the ability to offer an additional amount – **up to** 25% of base – to attract new doctors (subject to specific governance arrangements).

Proposed arrangement for existing VMOs translating to individual employment contracts

Package component		How to determine the amount for contract offer (subject to review by HHS and adjustment to suit new working arrangements)	Notes/Comments
		Visiting Medical Officer contracts on 1 July 2014	
Base	**(Fixed amount)**	• Your annual base amount will be calculated using the base rate relevant to your position from 1 July 2014. These rates will be consistent with *VMO Unregistered Agreement (2011)*.	• Your VMO base amount = base hourly rate (including 24% or 48% loading based on current eligibility) x fortnightly base hours x 26.0893 fortnights.
Tier 1 – Standard allowances	**(Fixed amount)**	• Your Tier 1 amount will be determined based on existing entitlements which include: ○ **Professional development allowance** of $5,000 per annum, or $6,000 per annum for country medical practitioners. ○ **Fuel payment** of $580, $1,150, $1,700 or $2,350 per annum, depending on the number of contracted hours per fortnight.	• In most cases this will be a direct translation of your existing entitlements.
Tier 2 – Clinically required additional hours	**(Variable % of base)**	• Your Tier 2 amount will be determined based on anticipated additional hours (**overtime, on-call, re-call**). • For translating VMOs, it will be translated based on additional hours worked in the year FY12-13. This amount will provide a like-for-like translation of your current arrangements. • The translated amount can be adjusted prior to signing the contract by agreement with your health service to reflect intended working arrangements if these have changed since June 2013. • It also be adjusted periodically at the initiation of either the VMO or their health service in response to a significant change in work patterns.	
Tier 2 (S) – Clinically required additional hours with OTE/Super	**(Variable % of base)**	• As per above (Tier 2), applied to shift penalties (evenings and Saturdays).	• This tier has been specially developed to retain your OTE/Super entitlements.
Tier 3 – Productivity and performance	**(Fixed % of base)**	• May be available in the future at the discretion of the HHS	

Superannuation

MYTH

#7. The move to contracts will affect my superannuation and salary sacrifice arrangements.

No.

- The tiers have been developed to ensure **minimal disruption to superannuation payments**.
- Superannuation payments for both the defined benefits and accumulation funds will be paid on the same payments as they are currently:
  - For the **defined benefit fund** – 12.75% paid on base rate and Tier 4b (CMA / MMA)
  - For the **accumulation fund** – the greater of **either** the above **or** 9.25% of ordinary time earnings, paid on the base rate, Tier 2S, Tier 3 and Tier 4 (with the exception of the lump sum inaccessibility allowance payment in Tier 4a).
- This has been discussed and confirmed with QSuper.
- The federal level (currently 9.25%) of ordinary time earnings (OTE) will continue to apply in accordance with the federal legislation.

Other common myths…

MYTH

#8. Individual contracts are intended to reduce my pay.

- The remuneration model has been developed to translate your existing pay into an annual structure (including specific remuneration for additional hours, evening and weekend work). Recall will still be paid for every instance that it is worked as it is now.

MYTH

#9. Under the contract, I will have no right of recourse if I disagree with my employer.

- The **grievance resolution policy** that currently applies to your employment (E12) will continue to apply.
- This is specifically incorporated into the contract in **clause 9**.

MYTH

#10. Key performance indicators in my contract will be set centrally and will be impossible for me to achieve or irrelevant to my work.

- **KPIs will be set by each health service**, not by the Department of Health.
- It is generally acknowledged (in both the public and private sector) that in order to be effective, agreed KPIs for any individual need to be **s**pecific, **m**easurable, **a**chievable by the individual, **r**elevant and **t**argeted.
- Many HHSs have indicated they plan to develop KPIs **in consultation with senior clinical staff** based on local requirements.

Other common myths… (cont'd)

MYTH

#11. Under the new arrangement for SMOs, my HHS can force me to work anywhere it likes – including overseas – for extended periods of time.

- For SMOs, this clause is still to be negotiated.
- The contract can require you to work anywhere within your HHS, as is **currently the case**. In regards to travel throughout Australia and overseas, it states that it may be required. However, such arrangements would have to be discussed and agreed according to both HHS and personal circumstances.
- In cases of major disagreement, the grievance policy would apply (as stated in clause 9).

MYTH

#12. Research and teaching will be diminished under individual contracts.

- The move to contracts will **not interfere with the research and teaching commitments** of an HHS.
- The commitment to research and teaching is and will remain a matter for the HHS and, where agreed, may form a key performance indicator (KPI).
- Fixed term contracts are available if necessary to employ staff where research grants may be time or financially limited.

The National Health Reform Agreement **changes** private practice funding arrangements

National Health Reform

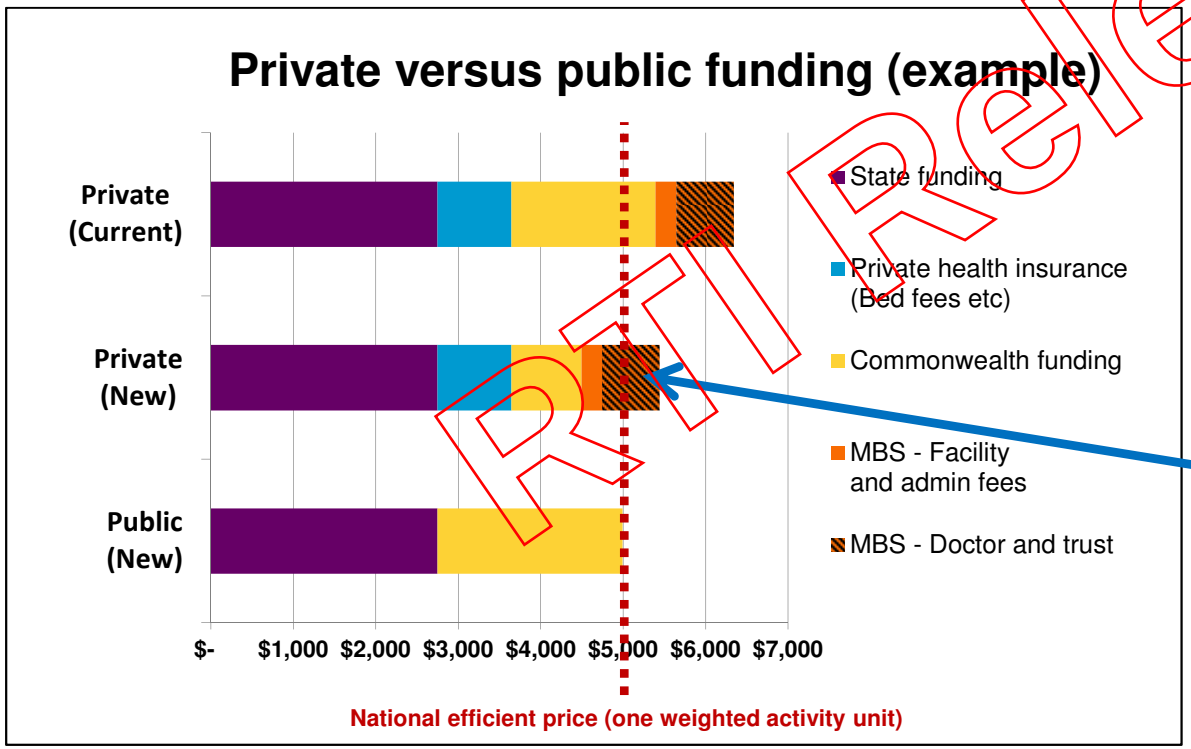
Key NHRA objective

Achieve **revenue neutrality** for both public and private services

- From July 2014, the Commonwealth will fund 45% of efficient growth in eligible activity at a National Efficient Price.
- The Commonwealth will **reduce** its activity based funding (ABF) contribution for private patient activity to compensate for funding it provides through Medicare Benefits Scheme (MBS) and private health insurance.
- **The reductions mean that on average the Commonwealth will contribute 30% less for private patients compared to public patients.**

The National Health Reform Agreement **changes** private practice funding arrangements (cont'd)

National Health Reform



Either

A private patient will receive less funding compared to a public patient

OR

Model needs to realign in response to these reductions to ensure ongoing financial viability.

Key changes

1. 'Option A' supplementary benefit **ceases**

- Option A benefit will cease.
- **Monetary value** of these payments will be reinvested in:
  - Tier 3 subject to performance targets
  - Tier 4 for recruitment/retention.

2. **Simplified** private practice options will be available during employed time

- RoPP Options A/B/P and R will be discontinued.
- One Granted Retention model.
- One Granted Assignment model.

3. **Rebased** fees for retention participants

- In response to QAO and two external reviews, facility and administration fees will be replaced with a single service fee for each applicable MBS category.
- Better aligns with costs drivers.
- Aims to ensures financial viability with respect to NHRA changes.

New service fees levied to granted retention participants
Recovering reasonable costs

83 facility and administration fees will be rebased into **9** item categories.

Clinical Area / Item Category	Medical Specialist	Clinical & Other Supplies	Practice Staff / Resources	Infrastructure	Minor Capital	Major Capital	Service Fee as % of Gross Billings
Pathology							75%
Medical Imaging							70%
Radiation Oncology							70%
Nuclear Medicine							70%
Diagnostic Procedures							60%
Surgical Procedures							60%
Svcs not contained in the MBS							60%
Misc. Svcs							55%
Therapeutic Procedures (Exc Rad Onc)							55%
Professional Attendances							40%

Higher service fee

Lower service fee

Note - Service fees and the annual earnings ceiling (threshold) will be set annually and gazetted in the DoH Fees and Charges Register.

Low cost drivers ⟷ High cost drivers

What happens for translation?

Old option	No. SMOs	New option	Impact
A P	90%	**Assignment** revenue to HHS	A – no impact provided no change to work patterns P – still working through translation options
B	10%	**Retention** revenue by clinician/ Partnership	For majority, minimal impact due to new Tier 3 amount paid Some may experience reductions / gains in net billings
R			

Retention arrangement

- Fees for professional services can be set by the individual clinician however the default fee rates are those contained in the MBS.

- The employment contract provides the ability for a clinician to direct their net earnings to a third party. This means that individual clinicians can still enter into partnership agreements with colleagues i.e. radiologist group practice.

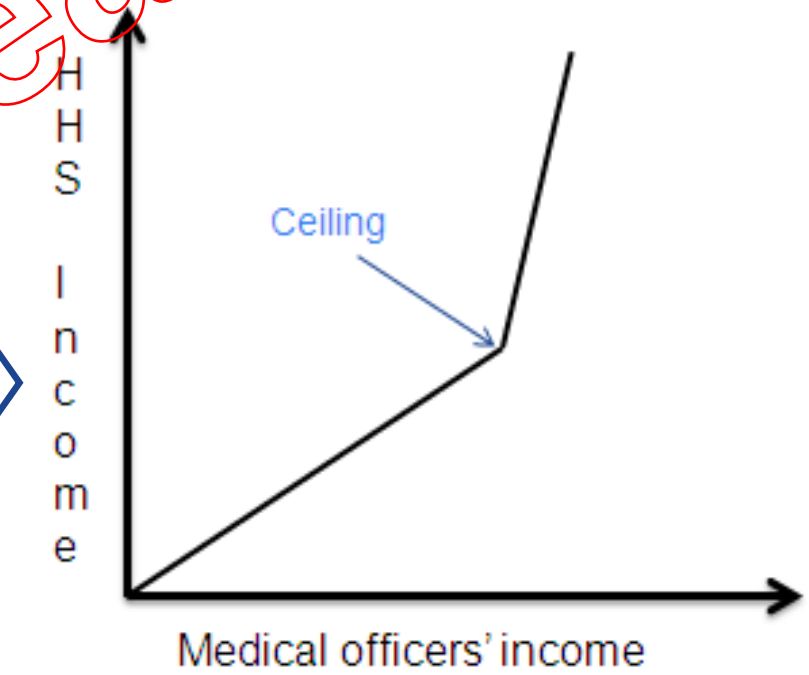
- GST is payable on service fees and will be deducted from gross billings prior to disbursement to individual (as like current Option B arrangement).

Retention arrangement

- Participants retain revenue after payment of service fees and GST, up to an earnings ceiling equivalent to 100% of the base salary as defined in schedule 2 of the employment contract.

- Once this ceiling is reached only $1 in $3, net of service fees and GST is retained by the clinician for the remainder of the financial year.

- Disbursement of fees to operating or trust accounts at HHS discretion.



Private practice policy instruments

Policies / directives

- Private Practice in the Qld Public Health Sector **Policy – Health Service Directive.**

  (Mandatory requirements)

Supporting documents

- Private Practice in the Qld Public Health Sector **Framework** (key policy principles).
- Private Practice in the Qld Public Health Sector **Guideline** (regulatory guidance).

Private practice myths

MYTH

#13. Under the new employment arrangements, I will be 'forced' to do private practice even if I work in a specialty where I cannot bill privately.

- The SMO contract contains a clause committing employees to cooperate with their health service to source alternative revenue. In some cases, this may include billing private patients during your employed time, provided the patient elects to be treated as a private patient.

- Not every clinician has capacity to bill privately or works in a specialty with a direct relationship with patients - and you would not be reasonably expected to do so under the new contract. Ultimately, your performance will be evaluated against achievable KPIs that will be set periodically and relevant to your work.

MYTH

#14. Under the new Commonwealth funding model, doctors won't be able to bill privately anymore.

We are still developing the QABF model, however:

- **Queensland will continue to support private patients under the State funding model.**
- Private practice is relied upon as **a key source of income for some specialties**, which has been an important consideration in reforming private practice arrangements.
- Modelling suggests that the increased service fees go a significant way to closing the potential funding gap between public and private options under ABF.
  - The majority of inpatients remain financially viable as private patients.
  - Where outpatients have a diagnostic examination or procedure, the majority will remain viable as private patients.
  - Stand alone clinics with no subsequent procedures or diagnostics will need to be assessed at the local level.

Next steps for private practice

- Comprehensive guideline, framework and schedule was provided on 18 November 2013 for two weeks consultation.
- A **tool** to assist in ABF decision-making will be available to HHSs in mid-December 2013 to assist with contract negotiations.

More information

For more information on medical contracts

- www.health.qld.gov.au/medical/medical-contracts

For more information on private practice reform

- www.health.qld.gov.au/news/pp

Shirelle M Wolfe

From: Mark Uzelin
Sent: Wednesday, 7 May 2014 2:19 PM
To: Damon Atzeni
Cc: Shirelle Wolfe
Subject: RE: Definition of emergency department and ED extended hours benefit contract for SMOs with and option A contract
Attachments: CORRSDMS-#8699916-v1-Final_-_SMO_Extended_Hours.DOC; Clin Svcs Capy Fmwk.pdf

Hi Damon,

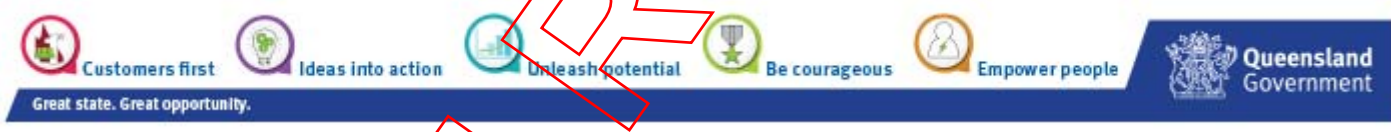
Please find the copy of the contract attached.

There is no industrial definition of an emergency department. The Clinical Services Capability Framework (attached) is used to determine eligibility. Level 4 and above qualify. Level 3 may qualify and level 2 and below do not qualify.

I hope this assists.

Kind Regards,

Mark Uzelin
A/Principal Advisor
Employee Relations Unit | Human Resource Services | System Support Services
Department of Health | Queensland Government
Queensland Health Building, 147-163 Charlotte St, Brisbane QLD 4000
t. 07 323 41369
e. Mark.Uzelin@health.qld.gov.au | www.health.qld.gov.au



From: Damon Atzeni
Sent: Wednesday, 7 May 2014 1:42 PM
To: Mark Uzelin
Subject: Definition of emergency department and ED extended hours benefit contract for SMOs with and option A contract

Hi Mark

Could you please send me a copy of the latest Emergency Department extended hours benefit contract for SMOs with and option A contract. And do you have a definition of what constitutes an emergency department for the purpose of receiving the ED extended hours benefit for SMOs.

Your urgent assistance would be greatly appreciated.

Kind regards

Damon Atzeni
Director, Business Change
Medical Contracts Implementation Project

Human Resource Services|Department of Health

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160 Mary Street
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P: (07) 3006 2873
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Shirelle M Wolfe

From: Mark Brady
Sent: Thursday, 15 May 2014 1:46 PM
To: Dave Waters; Shirelle M Wolfe; Dominic Lian
Subject: Fw: SMO Contract issue - Kingaroy Hospital

Importance: High
Sensitivity: Confidential

We need to discuss and resolve

From: Chris Curran
Sent: Thursday, May 15, 2014 01:40 PM
To: Mark Brady
Cc: Peter Gillies
Subject: SMO Contract issue - Kingaroy Hospital

Clinical Services Capability Framework
Good afternoon Mark,

Dr Gillies and I visited Kingaroy Hospital last week to discuss SMO contracts with a number of the doctors.

They raised the issue of why they are not entitled to the Emergency Department Extended Hours Benefit.

You may be aware that the allowance had previously been paid at Kingaroy and was withdrawn when the facility became part of our HHS.

Whilst we verbally confirmed that they were ineligible the doctors have requested a written response.

I have been unable to find one document that provides a definitive answer but I believe the following elements need to be in place:

1. The SMO works in an emergency department under Extended Hours and the SMO's rostered ordinary hours include working shifts where the majority of the shift is after 4.00pm Monday to Friday and/or on the weekend.
2. The SMO is a Specialist - A medical practitioner who is registered as a specialist with the Medical Board of Australia under the Health Practitioner Registration National Law Act 2009 and who is employed as such.
3. And, The Clinical Services Capability Framework is used to determine eligibility. Level 4 and above qualify. Level 3 may qualify. Kingaroy is Level 3.

The doctors at Kingaroy meet the requirements of (1) above, don't meet the definition of (2) above and may meet the definition of (3) above.

Can you please confirm my analysis so we can provide a written response to the doctors concerned?

Thanks
Chris Curran
Program Manager – Medical Contracts
Darling Downs Hospital and Health Service
Ph 4616 5918

Emergency Services

Module overview

Please note: This module must be read in conjunction with the Fundamentals of the Framework (including the glossary and acronym list), the Preamble to Children's Services and the Children's Emergency Services module.

Emergency services are the front door of the health facility and, for many people, form their primary contact with the health care system, providing an important interface between the community and the health facility.[1] Emergency services are responsible for the reception, triage, initial assessment, stabilisation and management of patients of all age groups presenting with acute and urgent aspects of illness and injury.[2]

The role and level of function of a hospital-based emergency service depends on various factors, including the type of facility in which it is located, geographical location, location in the public or private sector, and the place of the facility within a health system network.[3] The level of emergency service provided will also vary depending on availability of support services, staffing expertise, physical design, activity and acuity. Rapid access to operating rooms, intensive care and coronary care units (if present) is highly desirable to minimise transfer times of critically ill patients.[4]

Emergency departments are not stand-alone facilities. To provide safe and effective service delivery, emergency departments rely on a suite of support services from both within and external to the service. The scope of the Framework does not permit the inclusion of all services necessary to support the adequate function of emergency departments. Therefore, this module concentrates on those support services that have a direct impact on the ability of emergency departments to deliver safe and high-quality care, and ensure patient flow.

The term *emergency department* is generally used to describe facilities ranging from high-level departments with emergency medicine specialists and trainees employed 24 hours a day, through to rooms in small rural and remote hospitals staffed by rostered local general practitioners and generalist nursing staff.[5] For the purposes of this module, Level 1 to Level 3 services will be referred to as *emergency care centres*, while higher level services will be known as emergency departments.

The use of the term *emergency department* to describe such a broad range of settings can lead to misunderstandings of service capabilities and delivery. A hospital-based emergency service must have amenities and functions greater than the minimum standard for Rural Emergency Service role delineation to be considered an emergency department.[3]

Children have specific needs in health services—please refer to the relevant children's services modules.

Service networks

In addition to the requirements outlined in the Fundamentals of the Framework, specific service network requirements include:

- each emergency service is supported by Queensland Health and Smart Service Queensland Health Contact Centre – 13HEALTH (134325)
- documented processes for all non-admitted patients to be sent to a nominated primary health care medical practitioner.

Service requirements

In addition to the requirements outlined in the Fundamentals of the Framework, specific service requirements include:

- must have a dedicated clinical and management information system, which records both presentation details and recognised clinical indicators (refer to the Australian College of Emergency Medicine's [ACEM] Policy on Standard Terminology)
- the amount and type of space required for individual emergency units is dependent on a combination of activity, acuity and access to inpatient beds and alternative services[4]
- risk management strategies are developed, implemented and evaluated by qualified and registered health professionals in consultation with higher level health services where possible, and in accordance with established algorithms for specific clinical services
- documented processes guide assessment and management of mental health clients, which includes suicide risk and relevant referrals
- formal quality improvement programs include review of morbidity, mortality and recognised emergency medicine clinical indicators
- quality improvement data are submitted to a recognised facility quality program such as the Australian Council on Healthcare Standards (ACHS) Evaluation and Quality Improvement Program (EQuIP).[6]

Workforce requirements

In addition to the requirements outlined in the Fundamentals of the Framework, specific workforce requirements include:

- where possible, medical, nursing and allied health staff are provided with the opportunity to participate in a variety of identified emergency courses, which may include:
  - Advanced Life Support
  - Acute and Complex Medical Emergencies
  - Clinical Rural Skills Enhancement
  - Early Management of Severe Trauma Course
  - Emergency Crisis Resource Management
  - Emergency Events Management
  - Emergency Technical Skills Course for Doctors
  - Pre-Hospital Trauma Life Support
  - Trauma Nursing Core Course
  - Trauma Nursing Program
  - Advanced Paediatric Life Support Course
  - Emergency Nurses Paediatric Course
  - Paediatric Emergency Crisis Resource Management
  - Paediatric Life Support.

Note: There is no one model of emergency services staffing that will suit all needs due to the wide variability of roles and work practices between services.[7] Staffing numbers are dependent on throughput, casemix and capacity. Standards and guidelines from the ACEM[3,7] detail desired staffing requirements for the delivery of emergency services and should be taken into consideration.

Level 1 Emergency Service

Service description

A Level 1 service, also known as a Level 1 emergency care centre, is primarily a nurse-run clinic with a registered nurse available 24 hours for emergency presentations and 24-hour access to a registered medical practitioner.

The service is capable of providing limited treatment for minor injuries and illnesses, basic resuscitation and limited stabilisation prior to transfer. There is no access to inpatient services at this level. However, short, inpatient-style service to children may be provided (for example, intravenous rehydration of a child or intravenous delivery of antibiotics and subsequent observation of a child for up to 4 hours). This level service may provide ongoing observation for up to 8 hours in consultation with a higher level service. Services that do not provide a 24-hour service (i.e. primary care centres) are not regarded as emergency care centres.

Service requirements

As per module overview, plus:

- documented processes with another health facility to review and report on all x-rays
- equipment to provide initial resuscitation measures for both adults and children.

Workforce requirements

As per module overview, plus:

Medical

- registered medical practitioner available 24 hours
- access—24 hours—to a registered medical practitioner with credentials in critical care (intensive care or emergency)

Nursing

- registered nurse with relevant clinical knowledge, demonstrated evidence of ongoing clinical competency and experience appropriate to the service being provided available 24 hours
- access to a registered nurse with or working towards Rural and Isolated Practice Registered Nurse (RIPRN) accreditation

Allied health

- limited medication service by a pharmacist (or an approved registered nurse)

Other

- Aboriginal and Torres Strait Islander health worker available 24 hours.

Support service requirements

A Level 1 service requires:

Service	On-site	Accessible
intensive care		4
medical imaging		1
medication		1
pathology		2

Level 2 Emergency Service

Service description

A Level 2 service, also known as a Level 2 emergency care centre, has on-site, 24-hour access to nursing staff and triage of all presentations. This level service is capable of providing treatment for all minor injuries and illnesses and limited treatment of acute illnesses and injuries. This service provides basic resuscitation and limited stabilization, including short-term assisted ventilation prior to transfer to a higher level service.

Service requirements

Refer to Level 1 service for details.

Workforce requirements

As per Level 1, plus:

Medical

- registered medical practitioner available on-site within 30 minutes in normal circumstances—24 hours

Nursing

- access to a registered nurse who is competent in providing adult advanced life support and paediatric life support
- access—24 hours—to a registered nurse who has successfully completed the Emergency Triage Education Kit (ETEK)

Allied health

- access to a pharmacist (or an approved registered nurse) on weekdays for medication services
- access to allied health professionals, as required

Other

- access to patient support staff and security personnel.

Support service requirements

A Level 2 service requires:

Service	On-site	Accessible
intensive care		4
medical		2
medical imaging		1
medication		2
pathology		2
surgical		2

Level 3 Emergency Service

Service description

A Level 3 service, also known as a Level 3 emergency care centre, provides on-site, 24-hour access to designated emergency nursing staff and triage of all presentations. This level service is capable of providing initial treatment and care for all presentations, and advanced resuscitation and stabilisation, including short-term assisted ventilation prior to transfer to a higher-level service. This service has the ability to assist in the care of minor trauma and enable the rapid transfer of major trauma.

Service requirements

As per Level 2, plus:

- access to a pathway for direct admission of children to a paediatric inpatient unit.

Workforce requirements

As per Level 2, plus:

Medical

- designated registered medical practitioner in charge of the service
- designated medical officer available 24 hours to enact a *Care and Treatment Order for a Child*
- registered medical practitioner who is competent in providing advanced adult life support and paediatric life support (or may be competent in advanced paediatric life support) on-site or available within 30 minutes in normal circumstances—24 hours
- all registered medical practitioners providing emergency care must provide evidence of training in, or progression towards training in, the assessment and management of critically ill patients

Nursing

- designated clinical nurse/nurse manager (however titled) in charge of service with relevant clinical knowledge, demonstrated evidence of ongoing clinical competency and relevant clinical experience appropriate to the service being provided
- a registered nurse who is competent in providing advanced adult life support—on-site 24 hours
- registered nurse with successful completion of ETEK available on-site 24 hours

Allied health

- as per Level 2 service

Other

- as per Level 2 service.

Support service requirements

A Level 3 service requires:

Service	On-site	Accessible
anaesthetic	3	
intensive care		4
medical		3
medical imaging		1
medication	3	
mental health (relevant section/s)		4
pathology		3
surgical		3

Level 4 Emergency Service

Service description

A Level 4 emergency department provides a 24-hour service, which includes triage by qualified emergency staff and advanced care for all presentations. Depending on the medical staffing, a Level 4 service may be recognised as an emergency department under ACEM standards.[2] This level service has the ability to provide high-quality trauma care to medium and minor level trauma patients and is capable of stabilising trauma patients until transfer. A Level 4 service may provide a short-stay unit or equivalent functional area.

Service requirements

A Level 4 service requires:

- a purpose-designed area with separate resuscitation facilities
- short-term assisted ventilation capacity
- invasive monitoring capacity.

Workforce requirements

A Level 4 service requires:

Medical

- lead clinician responsible for clinical governance of the service who is, preferably, a Fellow of the Australasian College for Emergency Medicine (FACEM), or a registered medical specialist with credentials in emergency medicine with oversight provided by a FACEM
- at least one additional registered medical practitioner with credentials in emergency medicine to support the department director
- one FACEM or registered medical specialist with credentials and/or extensive experience in emergency medicine, or a senior registered medical practitioner with credentials and/or extensive experience in emergency medicine, on-site 8 hours a day, 7 days a week
- one registered medical practitioner with experience in emergency medicine exclusively rostered to the unit 24 hours
- immediate, 24-hour access to a second registered medical practitioner
- where relevant, designated short-stay unit medical staff, in addition to emergency service medical staff

Nursing

- designated senior registered nurse or nurse manager (however titled) in charge of each shift
- minimum of two registered nurses with experience in emergency medicine present in the department at all times
- one of the two or more registered nurses is a dedicated triage nurse 24 hours
- access to a registered nurse who is competent in providing advanced life support—on-site 24 hours a day
- registered nurse with successful completion of ETEK available on-site 24 hours

- access to additional registered nurses within the facility, as required
- where relevant, designated short-stay unit nursing staff in addition to emergency service nursing staff

Allied health

- access to allied health professionals, as required
- access to a specialised clinical social worker or health practitioner with competencies in case management and counselling, as required

Other

- as per Level 2 service.

Support service requirements

A Level 4 service requires:

Service	On-site	Accessible
anaesthetic	4	
cardiac (cardiac care unit)		4
cardiac (cardiac diagnostic and interventional)		4
intensive care	4	
medical	4	
medical imaging	4	
medication	4	
mental health (relevant section/s)		4
pathology		4
surgical	4	

Level 5 Emergency Service

Service description

A Level 5 service, also known as a Level 5 emergency department, provides comprehensive trauma care and stabilisation of all trauma patients until transfer. A Level 5 emergency department should provide a short-stay unit/area to define patient diagnosis and determine continued hospitalisation or discharge plan and destination for acutely ill patients, if required.[7]

Service requirements

As per Level 4, plus:

- a structured nursing education program
- evidence of all senior registered nurses progressing towards an emergency qualification.

Workforce requirements

As per Level 4, plus:

Medical

- a minimum 0.5 full-time equivalent designated lead clinician with responsibility for clinical governance of the service, who is a FACEM and is a registered medical specialist with credentials in emergency medicine on-site
- at least one FACEM or registered medical specialist with credentials in emergency medicine or senior registered medical practitioner with credentials in emergency medicine on-site 16 hours a day, 7 days a week
- at least one FACEM or registered medical specialist with credentials in emergency medicine or senior registered medical practitioner with credentials in emergency medicine available for the remaining 8 hours a day, 7 days a week
- in addition to the above, at least three registered medical practitioners exclusively rostered to the department 16 hours a day, 7 days a week, and at least one registered medical practitioner exclusively rostered to the department for the remaining 8 hours a day, 7 days a week, with immediate, 24-hour access to additional registered medical practitioners, as required
- where relevant, there must be designated short-stay unit medical staff directly responsible for the short-stay unit, in addition to emergency service medical staff

Nursing

- designated nurse manager (however titled) with or working towards management and/or postgraduate qualifications in emergency nursing who has relevant clinical nursing experience commensurate with the position
- designated senior registered nurse/nurse manager in charge of each shift with relevant clinical knowledge, demonstrated evidence of ongoing clinical competency and relevant clinical experience appropriate to the service being provided
- registered nurse competent in providing advanced life support on-site 24 hours
- at least three experienced registered nurses present in the department at all times with access to additional acute care registered nurses, as required

- where relevant, there must be designated short-stay unit nursing staff, in addition to emergency service nursing staff

Allied health

- as per Level 4 service

Other

- as per Level 2 service.

Support service requirements

A Level 5 service requires:

Service	On-site	Accessible
anaesthetic	5	
cardiac (cardiac care unit)	5	
cardiac (cardiac diagnostic and interventional)	5	
cardiac (cardiac medicine)	5	
intensive care	5	
medical	5	
medical imaging	5	
medication	5	
mental health (relevant section/s)		5
nuclear medicine		4
pathology	4	
surgical	5	

Level 6 Emergency Service

Service description

A Level 6 service, also known as a Level 6 emergency department, provides initial treatment and advanced care for all emergency presentations, and the full spectrum of trauma care for all critically ill and injured patients. This service has established documented processes and collaborative partnerships between the emergency department and integrated mental health services.

Service requirements

As per Level 5 service.

Workforce requirements

As per Level 5, plus:

Medical

- one full-time equivalent medical director/chair who is a FACEM and is a registered medical specialist with credentials in emergency medicine
- at least two FACEMs on-site during the day and one FACEM on-site during the evening, to provide 16 hours of cover a day, 7 days a week, commensurate with workload
- one FACEM accessible for the remaining 8 hours a day, 7 days a week
- sufficient registered medical specialists with credentials in emergency medicine to provide two FACEM shifts (day and evening) per weekend on a 1:4 weekend rotation
- at least one ACEM advanced training registrar on-site 24 hours
- one additional advanced training registrar on-site during the day and evening Monday to Friday to provide at least 16 hours of cover
- in addition to the FACEM, no fewer than five registered medical practitioners exclusively rostered to the department 24 hours

Nursing

- dedicated clinical nurse leader (however titled) with qualifications in emergency nursing
- at least six experienced registered nurses present in the unit at all times
- dedicated nurse leader (however titled) of critical care

Allied health

- specialised clinical social worker or health practitioner with competencies in case management and counselling on-site 16 hours a day during the week
- access to designated short-stay unit physiotherapist and occupational therapist and other allied health staff

Other

- as per Level 2 service.

Support service requirements

A Level 6 service requires:

Service	On-site	Accessible
anaesthetic	5	
cardiac (cardiac care unit)	5	
cardiac (cardiac diagnostic and interventional)	5	
cardiac (cardiac medicine)	5	
cardiac (cardiac surgery)		6
intensive care	6	
medical	5	
medical imaging	5	
medication	5	
mental health (relevant section/s)	5	
nuclear medicine	5	
pathology	5	
surgical	5	

Legislation, regulations and legislative standards

Refer to the Fundamentals of the Framework for details.

Non-legislative standards, guidelines, benchmarks, policies and frameworks

In addition to what is outlined in the Fundamentals of the Framework, the following are relevant to emergency services:

- Australasian College for Emergency Medicine. All relevant emergency clinical guidelines and benchmarks. www.acem.org.au/
- Australasian College for Emergency Medicine. Guidelines on quality and safety. ACEM; nd. www.acem.org.au
- Australian and New Zealand College of Anaesthetists, Joint Faculty of Intensive Care Medicine, Australasian College for Emergency Medicine. Minimum Standards for Intrahospital Transport of Critically Ill Patients. ANZCA, JFICM, ACEM; 2003. www.acem.org.au/media/policies_and_guidelines/min_stand_intrahosp_crit_ill.pdf
- Australian and New Zealand College of Anaesthetists. Professional Standard PS9: Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures. ANZCA; 2008.
- Australian College of Critical Care Nurses. ACCCN Resuscitation Position Statement (2006): Adult and Paediatric Resuscitation by Nurses. ACCCN; 2006. www.acccn.com.au/images/stories/downloads/adult__paediatric_resus.pdf
- Australian College of Paediatrics, Australasian College for Emergency Medicine. Policy on hospital emergency department services for children. ACEM; nd. www.acem.org.au/media/policies_and_guidelines/P11_Hosp_ED_Services_for_Children.pdf
- Queensland Government, Royal Australasian College of Surgeons. A Trauma Plan for Queensland. Queensland Health, Department of Emergency Services, RACS; 2006. www.surgeons.org/Content/NavigationMenu/WhoWeAre/Regions/QLD/QLD_Trauma_plan_final_prac.pdf
- Queensland Government. Queensland Blood Management Program. Queensland Health; 2009. www.health.qld.gov.au/qhcss/qbmp
- Queensland Government. Queensland Blood Management Program: Rural and Remote Blood Supply in Queensland. Queensland Health; 2009. www.health.qld.gov.au/qhcss/qbmp/rural.asp
- Royal Australasian College of Surgeons. Trauma Verification: Model Resource Criteria for Level I, II, III & IV Trauma Services in Australasia. RACS; 2009.
- The Australian Council on Healthcare Standards. Emergency Medicine Indicators. www.achs.org.au

Reference list

1. Australasian College for Emergency Medicine. Policy Document: Standard Terminology. ACEM; 2001. www.acem.org.au/media/policies_and_guidelines/standard_terminology.pdf
2. Australasian College for Emergency Medicine. Statement on Emergency Department Role Delineation. ACEM; 2004. www.acem.org.au/media/policies_and_guidelines/S12_Role_delineation_formatted_August_2004.pdf
3. Australasian College for Emergency Medicine. Guidelines on Emergency Department Design. ACEM; 2007. www.acem.org.au/media/policies_and_guidelines/G15_ED_Design.pdf
4. NSW Department of Health. Emergency Department Services Plan. NSW Health; 2001. www.health.nsw.gov.au/pubs/2001/pdf/edplan.pdf
5. The Australian Council on Healthcare Standards. www.achs.org.au/EQUIP4/
6. Australasian College for Emergency Medicine. Guidelines on Constructing an Emergency Medicine Medical Workforce. ACEM; 2008. www.acem.org.au/media/policies_and_guidelines/G23_Constr_Workforce.pdf
7. Australasian College for Emergency Medicine. Guidelines on the implementation of the Australasian triage scale in emergency departments. ACEM; 2005.

The State of Queensland acting through Queensland Health

Insert name of SMO

Emergency Department Extended Hours Benefit Contract for a Senior Medical Officer with an Option A Contract

Date:

Parties

The State of Queensland acting through Queensland Health of 147-163 Charlotte Street, Brisbane in the State of Queensland (**Queensland Health**)

[Insert name of SMO] of [insert address] (SMO)

Background

A The SMO is employed by Queensland Health.

B The SMO and Queensland Health have entered into an Option A Contract.

C By this Contract, Queensland Health and the SMO have agreed that, in respect of the Right of Private Practice granted under the Option A Contract, and given the SMO works their ordinary hours of work through an Extended Hours arrangement in an emergency department, Queensland Health will pay the SMO the Emergency Department Extended Hours Benefit on the terms set out in this Contract.

Agreed Terms

1 Definitions

For the purpose of this document:

Commencement Date means [insert date].

Emergency Department Extended Hours Benefit has the meaning given by **clause 3.1** of this Contract.

End Date means [insert date].

Extended Hours means, with respect to the hours of operation of an emergency department, when the SMO's rostered ordinary hours are implemented under an extended span of hours arrangement in accordance with the *Medical Officers' (Queensland Health) Certified Agreement (No. 3) 2012*.

Novation Notice means the notice given by Queensland Health under **clause 5** of this Contract.

Option A Contract means the Option A contract entered into between Queensland Health and the SMO dated [insert date].

Supplementary Benefit has the same meaning as in the Option A Contract.

Supplementary Benefit Percentage has the same meaning as in the Option A Contract.

2 Term

This Contract will commence on the Commencement Date and terminate on the End Date unless:

(a) Queensland Health extends the Option A Contract, in which case this Contract is automatically extended until the revised date of expiry nominated by Queensland Health in respect of the Option A Contract; or

(b) it is terminated earlier in accordance with this Contract.

3 Emergency Department Extended Hours Benefit

3.1 Where the SMO works in an emergency department under Extended Hours and the SMO's rostered ordinary hours include working shifts where the majority of the shift is after 4.00pm Monday to Friday and/or on the weekend, the SMO's entitlement to the Supplementary Benefit under the Option A Contract will be increased by adding a further 25% to the Supplementary Benefit Percentage as set out in **Item 5** of **Schedule 1** to the Option A Contract (**Emergency Department Extended Hours Benefit**).

3.2 If the SMO is entitled to payment of the Emergency Department Extended Hours Benefit under **clause 3.1** then the Option A Contract will continue with full force and effect as if the Emergency Department Extended Hours Benefit forms part of the Supplementary Benefit in the Option A Contract.

3.3 In the event that Queensland Health decides to:

(a) permanently close the emergency department;

(b) permanently cease to operate the emergency department during Extended Hours; or

(c) suspend the operation of the emergency department during Extended Hours

the SMO's entitlement to the Emergency Department Extended Hours Benefit will continue until 26 consecutive weeks have expired since the emergency department ceased operating under Extended Hours.

4 Termination

4.1 This Contract will automatically terminate if:

(a) the Option A Contract terminates for any reason; or

(b) the SMO decides to withdraw from participating in Extended Hours coverage.

5 Novation

5.1 The SMO agrees that Queensland Health may novate this Contract to the HHS under the Option A Contract by giving notice to the SMO (**Novation Notice**) that this Contract is novated to that HHS.

5.2 Novation of this Contract takes effect from the date specified in the Novation Notice.

5.3 On the date of Novation:

(a) this Contract will be novated so that the HHS takes the place of Queensland Health under this Contract as though the HHS has always been a party to this Contract instead of Queensland Health;

(b) the HHS will be liable to the SMO for the performance of all of Queensland Health's obligations under this Contract, whether those obligations arose before or after the date of Novation; and

(c) Queensland Health will have no further liability under this Contract.

5.4 Queensland Health and the SMO must prepare and enter into such documents necessary or required to give effect to any novation under this **clause 5**.

Executed as an agreement.

Signed for and on behalf of	)	
Queensland Health by	)	
	)	.....
.....	)	
(print name), a duly authorised person	)	
in the presence of:	)	

.....
Witness

.....
Name of Witness (print)

.....
Date

Signed sealed and delivered	)	
by	)	
in the presence of:	)	.....

.....
Witness

.....
Name of Witness (print)

.....
Date

Shirelle M Wolfe

From: Shirelle Wolfe
Sent: Monday, 28 September 2015 3:52 PM
To: Lauren Mellifont; Mitchell Innes
Cc: Mark Uzelin
Subject: RE: MOCA4 Question

Hi,

The ancient history is probably irrelevant now – what's used in the contract framework? If this is maintaining that status quo then that is what is relevant now.

Shirelle

From: Lauren Mellifont
Sent: Monday, 28 September 2015 3:23 PM
To: Mitchell Innes
Cc: Shirelle Wolfe
Subject: RE: MOCA4 Question

Mitch

My view is this allowance is the old ED25% allowance and therefore the same classification as was applied previously should be used to determine what an ED is for the purposes of attracting the allowance.

In the past at one stage, ED25% was to be included in the previous private practice policy B48. The file notes indicate advice was to remove it from the draft back in August 2010.

Following this there was a request to draft an ED25% HR policy mid 2011. The policy included a definition and a schedule of identified eligible EDs as below. The draft policy was prepared and then put on hold pending National Health Reform. It is then noted that the new policy was not required as the provisions were to be included in MOCA3. Not sure if the arrangements were part of an exchange of letters at the time?

Shirelle
In the absence of Edmund and other prior Medical Team members, are you able to advise on any other history re ED 25% and the clarification of determining eligible ED sites?

Emergency Department	A dedicated area in certain hospitals that is organised and administered to provide a high standard of emergency care to those in the community who perceive the need for, or are in need of, acute or urgent care including hospital admission. Features of an emergency department are set out in the Emergency Department Terminology Document prepared by Emergency Department Clinical Networks. Refer http://qheps.health.qld.gov.au/ed/docs/ed_data_definitions.pdf

http://qheps.health.qld.gov.au/caru/networks/docs/ed-terminology.pdf **note the link above is out of date here is the link to the current ED Ref Doc**

Annexure 1* - note this table is from December 2011 so likely out of date???

Locations where the Emergency Department Extended Hours Benefit contract for a SMO with an Option A contract as an extension of supplementary benefit/right to private practice benefits Option have been offered to an SMO with an Option A contact include the following:-

Bundaberg Hospital
Beaudesert Hospital
Caboolture Hospital
Cairns Base Hospital
Caloundra Hospital
Gladstone Hospital
Gold Coast Hospital
Gympie Hospital
Hervey Bay Hospital
Ipswich Hospital
Logan Hospital
Mackay Base Hospital
Maryborough Hospital
Mount Isa Hospital
Nambour Hospital
Princess Alexandra Hospital
Queen Elizabeth II Jubilee Hospital
Redcliffe Hospital
Redland Hospital
Robina Hospital
Rockhampton Base Hospital
Royal Brisbane & Women's Hospital
Royal Children's Hospital
The Prince Charles Hospital
Toowoomba Hospital
Townsville Hospital

Regards
Lauren

From: Mitchell Innes
Sent: Monday, 28 September 2015 12:15 PM
To: Lauren Mellifont
Subject: FW: MOCA4 Question

Hi Lauren,

Can you have a look at the query below and advise?

M

Mitchell Innes
Director, Stakeholder Engagement and Communications
Human Resources Branch | Corporate Services Division
Department of Health | Queensland Government
t. s.73
e. Mitchell.innes@health.qld.gov.au | www.health.qld.gov.au

From: MOCARProject
Sent: Monday, 28 September 2015 11:36 AM
To: Mitchell Innes
Subject: FW: MOCA4 Question

Tania Moore
Project Support Officer
Medical Officer Collective Arrangement Reversion Project | Human Resource Services | Systems Support Division
Department of Health | Queensland Government
Queensland Health Building, Level 15, 147-163 Charlotte Street, Brisbane
t. 07 3006 2899
E Tania.Moore@health.qld.gov.au |www.health.qld.gov.au

From: Chris Curran
Sent: Monday, 28 September 2015 11:03 AM
To: MOCARProject
Subject: MOCA4 Question

4.14.3 Emergency Department specialty allowance
Where a SMO works in an Emergency Department under a rostering arrangement in accordance with Clause 4.3, and the medical officer's rostered hours include working evening shifts Monday to Friday, and/or shifts anytime on the weekend, an allowance of 25% of base salary is paid in addition to amounts in Clause 4.14.1 and 4.14.2.

Good morning,

We have had a question about the above clause. The question is – what is the definition of an Emergency Department? This was previously covered under B48, but that policy is now revoked. I believe we use the same definition as the Clinical Services Capability Framework wherein a CSCF of 4 or above is an **emergency department** while 3 and below are **emergency care centres**.

Can you please advise.

Chris Curran
Manager | Medical Workforce Unit
Darling Downs Hospital and Health Service

Toowoomba Hospital
Level 2 Cossart House
Pechey Street
Toowoomba QLD 4350

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M: s.73
E: chris.curran@health.qld.gov.au

Web: http://www.health.qld.gov.au/darlingdowns/

Pages 277 through 290 redacted for the following reasons:
- -
s.47(3)(f) - other access available - QIRC Transcript No D/2011/144 of Proceeings available for purchase from Auscript