QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

STATEMENT OF GARY WALKER

1. I, Gary Walker, Team Leader, Surgical Mortality Audit, Clinical Practice Improvement Centre, Innovation and Workforce Reform Directorate c/o Royal Brisbane and Women's Hospital, Brisbane in the State of Queensland acknowledge that this written statement by me is true to the best of my knowledge and belief.

2. This statement is made without prior knowledge of any evidence or information held by the Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

My employment with Queensland Health

3. I have been a Team Leader in the Clinical Practice Improvement Centre since January 2005. I am currently involved in a Surgical Practice Improvement initiative.

4. I joined the Elective Surgery Project ("ESP") in early 1996 as an officer in the project team. I became the Manager of the renamed Elective Surgery Team ("EST") in 1997 and continued in that role until January 2005.

5. My qualifications include a Bachelor and Masters Degree in Science and a Masters Degree in Business Administration.

6. The EST became the Surgical Access Team ("SAT") in 1998 and then the Surgical Access Service ("SAS") in 2001.

7. In this statement, a reference to the EST is a reference to the ESP, EST, SAT and the SAS.

8. The EST was disbanded in January 2005 and its management functions devolved to the Zonal Management Units. At this time, dedicated funding, previously managed by the EST, was

transferred to District budgets as a permanent addition to "base". Some data collection and reporting responsibilities were transferred to the Statewide Health and Community Services Branch.

Queensland Health's Elective Surgery Program

Introduction

9. Queensland Health's elective surgery program was introduced by the then Minister for Health, Peter Beattie, in November 1995 with the primary aim of increasing access to elective surgery services in public hospitals.

10. The program was expanded considerably after the election of the Coalition Government in 1996 and was termed "Surgery on Time". The "Surgery on Time" program was managed under the Elective Surgery Project.

11. The program has changed both name and functions over time as a result of the commitments of various Queensland Governments.

Waiting List Reduction Strategy

12. During the 1998 State election, the Labor Party unveiled its Waiting List Reduction Strategy ("WLRS"). **Attachment GW-1** is a copy of the WLRS which sets out the Labor Party's 8 point plan to reduce waiting lists. The Labor Government promised to reveal what it claimed was the true waiting time for elective surgery, including the waiting time for specialist outpatient appointments. The collection of specialist outpatient waiting time data essentially became the 9th element in the WLRS.

13. The WLRS, similarly to previous elective surgery strategies, was essentially about improving access to elective surgery services. Of the 8-point plan:

(a) 7 of the 8 points were strategies directed at elective surgery services.

(b) The other dot point involved a major strategy to improve waiting times in emergency departments. $5 million recurrent funding per annum was allocated for this strategy. Initial planning resulted in the Emergency Services Strategy which had three components:

(i) An information systems component to address the lack of an appropriate collection and reporting system for waiting times data;

(ii) A workforce strategy to assist with addressing the shortfall of clinicians in busy emergency departments;

(iii) A better practice component that focussed on ways to improve care and efficiency in emergency departments.

The Emergency Services Strategy was managed and enhanced by the SAS until the disbanding of the SAS in January 2005

(c) The ninth point of collecting specialist outpatient waiting list data was added to the WLRS after the new Government took office.

14. **Attachment GW-2** is the submission to the Director-General dated 20 August 1998 setting out the plan to achieve the Government's WLRS. The submission outlined a broad plan to implement the WLRS that the Government had provided as their enhancement to the former "Surgery on Time" program. The plan was comprehensive in nature and highlighted the critical linkages between outpatient departments, emergency departments, and operating theatres and their interdependence. This was considered a more realistic strategy than previous initiatives that treated elective surgery as a more isolated component of hospital service delivery.

15. This submission was the final result of a number of iterations to and from senior staff. Earlier proposals had included a greater staffing resource increase than was ultimately recommended in the final submission.

16. The result was the approval of only one additional full time equivalent (FTE) staff member. This position was to be dedicated to the management of the funding and activity monitoring role within the team, a role previously undertaken by myself as Manager. As Manager, I was then

required to distribute the considerable volume of additional work associated with the WLRS across existing team members, in addition to their current workloads.

17. An example of the significant additional responsibilities associated with the WLRS was the requirement to benchmark emergency department waiting times.

18. Monthly reports on progress on the implementation of the WLRS began with the first report produced for the month of September 1998. Copies of the report were distributed to the Minister for Health, Director-General, General Manager (Health Services) (GMHS) and Deputy Director-General, Policy and Outcomes. Outpatient waiting list data was included in this report from April 1999.

19. There were separate briefings to the Director-General dated 19 October 1998 and 12 November 1998 **(attachment GW-3)** containing status reports on progress with the implementation of the WLRS.

A. Elective Surgery

20. QH's elective surgery program has changed over time as a result of the commitments of various Queensland Governments. **Attachment GW-4** is a summary of the various Queensland Health elective surgery programmes between 1995 and 2005.

21. QH's elective surgery program is directed by the requirements imposed on it by Queensland and Commonwealth Governments. It must:

    (a) Enable QH to meet the reporting requirements in the Australian Health Care Agreement in relation to elective surgery.

    (b) Implement the Queensland Government's *"Waiting List Reduction Strategy"* (WLRS) (July 1998) which provides strategies to increase access to elective surgery services across the State. The Strategy is designed to:
        (i) Maintain or increase existing levels of elective surgical services and elective procedures;

(ii) Establish new programs to treat patients who are unable to access existing surgical services or elective procedures within a reasonable timeframe; and

(iii) Ensure that the treatment of patients from the elective surgery wait list is based on prioritisation according to clinical need.

22. An elective surgery patient in Queensland public hospitals is as defined in the National Health Data Dictionary. The clinical urgency categories are based on National Health Data Dictionary definitions:

- Category 1 (Urgent) – 30 days
  Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.

- Category 2 (Semi-urgent) – 90 days
  Admission within 90 days desirable for a condition causing some pain, dysfunction, or disability but which is not likely to deteriorate quickly or become an emergency.

- Category 3 (Non-urgent) – 365 day
  Admission some time in the future acceptable for a condition causing minimal pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.

23. In 1996, the Queensland Government set performance targets that no more than 5% of Category 1 patients (urgent) and no more than 5% of Category 2 patients (semi-urgent) should wait longer than clinically recommended. These targets were reaffirmed in July 1998 with the establishment of the WLRS. QH uses the performance targets as benchmarks for individual hospitals to strive towards.

24. QH has consistently met the 5% benchmark for the treatment of Category 1 patients. Recently, in the quarter ending 30 June 2005, QH did not meet the target in relation to Category 1 patients for the first time since 1996. In recent years, some 8-10% of Category 2 patients have waited longer for surgery than clinically recommended each quarter.

Data Collection and Reporting

25. Information systems were implemented from a very early date – 1995/6 - to ensure hospitals reporting elective surgery data had appropriate collection tools. The collection and reporting system is a module of HBCIS and is called the Elective Admissions Management system (EAM). Patients booked onto the waiting list are recorded through EAM. They are given an urgency category by the treating clinician, the date they are put on the waiting list is recorded, and the system is updated, commonly by the Elective Surgery Coordinator (ESC), to ensure that, at reporting times, numbers waiting are a true reflection of the actual waiting list at that time. In the last week of each month, ESCs ensure that waiting list details are as accurate as they can be. They make sure that patients who have been treated are removed from the system. After the "cleanup" is completed, data is transferred electronically to Corporate Office into a reporting database. Processes are highly automated, such that elective surgical waiting list reports can be generated promptly. At the beginning of each month (on the first working day) data is received from each hospital. The data is maintained in a data warehouse, such that comparative waiting list data can be generated for any time frame over the last ten years.

26. Since 1996, elective surgery waiting list data, both 'census' (i.e. the number of people waiting at a point in time) and 'throughput' data (i.e. the number of people treated in a period of time), has been collected and reported on a monthly basis. Data is collected from the 31 largest hospitals which provide approximately 95% of all elective surgery undertaken in all Queensland public hospitals. The remaining 5% is made up of small hospitals undertaking a small number of minor elective surgery procedures. Such reports, known as Elective Surgery Monthly Update Reports, have continued to be provided to the present time. Reports for the July 2002, September 2003 and November 2004 are attached by way of example only (**attachment GW-5**). If particular reports are required, they can be produced.

27. Elective surgery waiting list data has been collected and reported based on National Health Data Dictionary definitions for a period approaching ten years. During this period, this data has been analysed and reported back to individual hospitals and data quality processes continually monitored.

28. In addition to the elective surgery waiting list data having been provided to the Director-General and Minister for Health on a monthly basis since the inception of the program, it has also been

published on the QH internet site quarterly since July 1998. Cabinet is also provided with an update on the overall waiting list reduction strategy which includes the latest elective surgery data. Refer to the Cabinet submissions that are attached.

29. I believe that the elective surgery data as reported to the Director-General and Minister monthly and published on the QH internet quarterly, is an accurate reflection of the number of patients who have been examined by a surgeon, assessed as requiring an elective surgery procedure, booked for elective surgery and have yet to receive their surgery. It needs to be recognised that the accuracy of the data is dependent on the ongoing provision of accurate data from individual hospital sites. It is my belief that the elective surgery waiting list data continues to be collected with high degree of consistency and reliability.

Purposes of the data

30. There are many purposes for the collection and reporting of the elective surgery data. Firstly, the program is a major Government initiative with performance targets set by government. Collecting certain data and reporting against performance targets is a requirement of Government.

31. Secondly, it is worthwhile to consider the overall goal of the program which is to improve access to elective surgery services and to ensure people receive their surgery in a reasonable timeframe based on clinical need. The collection and analysis of relevant data is important in ensuring this goal is met. An example might be the monitoring of ENT services statewide. The analysis of data can determine the number of ENT cases treated by hospital over time and various trends established. Intervention strategies can then be instigated if, for example, the number of ENT patients waiting longer than clinically recommended, continues to grow.

32. Another example of the appropriate use of information would be an examination of where the "long waits" were occurring by specialty. Opportunities could be identified for transferring patients from one hospital waiting list to another reporting shorting waiting times in that specialty. SAS had a role in the past in initiating and managing this transfer process. That role diminished over time as the Zonal Management Units assumed more responsibility for the management of surgical services within their respective hospitals.

33. Data can also identify hospitals and particular procedures where day surgery rates and day of surgery admission rates can be improved.

Funding for Additional Elective Surgery

34. Funding provided by successive governments for additional elective surgery procedures has been substantial, totalling over $100 million in 2004/05. This funding was provided to purchase extra elective surgery, that is, elective surgery services over and above what has been traditionally supplied from the base budgets of public hospitals.

35. The allocation of funding and associated activity targets was conducted at the beginning of each financial year based on information regarding the capacity of individual hospitals to achieve a certain level of elective surgery activity in that year. The final allocation was the result of a negotiation process between the SAS and the Zonal Management Units. The additional funding is intended to cover the cost of performing the additional elective surgery, including labour and consumable costs. There is little scope for a hospital to do more surgery over and above that level negotiated at the beginning of the financial year and to be subsequently paid for it.

36. Monitoring of activity against targets was achieved through the Queensland Hospital Admitted Patient Data Collection (QHAPDC). This was based on coding of activity by the hospitals and reporting monthly to Corporate Office.

37. With the dissolution of the SAS the decision was taken to allocate the dedicated elective surgery funding into respective district budgets and it is now the responsibility of the Zonal Management Units to allocate activity targets associated with dedicated elective surgery funding. To a degree this has provided hospitals with some certainty in terms of what money they would receive each year, however, the reality is that hospitals were provided with the same amount of money year after year unless they were flagging a significant issue. For example, funding was reduced for Townsville in the financial year that the hospital moved into the new facility.

Current Arrangements

38. Currently, responsibility for the "WLRS" rests with the Senior Executive Director, Health Services Directorate ("SEDHSD") and Zonal Managers. The Executive Director of Statewide

Health and Community Services Branch has responsibility for data collection and reporting to the SEDHS against the Strategy, including the monthly waiting list reports.

39. QH's current policy in relation to elective surgery is set out in the *"Policy Framework for Elective Surgery Services"* released in March 2005 ("the Policy Framework") (**attachment GW-6**). The Policy replaced previous QH policies such as the *"Guidelines for the Management of Waiting Lists"* and the *"Guidelines for Pre-admission processes, Discharge planning and Transitional Care"*.

40. The Policy Framework has been developed according to national data definitions and following extensive consultation with clinicians. It is designed to:

    (a) Provide instruction, information and guidance to QH employees and other practitioners involved in the provision of elective surgery services.

    (b) Be the definitive source of information for the implementation and maintenance of elective surgery systems and management processes within QH.

    (c) Articulate individual policies dealing with clinical and administrative processes which guide facilities in developing protocols and procedures within local settings.

    (d) Provide specific guidance around clinical urgency categories, prioritising elective surgery, the elective surgery waiting list systems, the roles and responsibilities of key stakeholders, additions, removals and audit of the waiting list.

41. The Policy Framework was developed as part of the 2001 election commitment. It took approximately 3 years to develop because of the limited resources able to be devoted to the exercise. As well, a significant consultation exercise was necessary before finalisation.

Documentation

42. In July 1998 there was a request from the new Minister for the development of a press statement to accompany the release of the elective surgery waiting list report as at 1 July 1998 (**attachment GW-7**).

43. In a memorandum from the Deputy Director-General Health Services dated 26 November 1998 **(attachment GW-8)** District Managers were requested to provide information on the proposed closure of operating theatres in holiday periods between now and the end of the financial year. This is consistent with statements in the Cabinet Submissions that he was monitoring this situation.

44. The memorandum from the Minister for Health to the Director-General dated 8 February 1999 **(attachment GW-9)** asks for information on the following issues:-

- Establishing a high level action team to conduct visits to underperforming hospitals;
- The immediate transfer of funds and patients from underperforming hospitals;
- The effective quarantining of elective surgery funds;
- The development of an appropriate communication strategy.

45. The memorandum to the Minister for Health from the Director-General dated 10 February 1999 **(attachment GW-10)** reveals a number of strategies to address each of these issues.

46. Briefing to Minister dated 7 April 1999 regarding meeting with medical colleges on 7 April 1999 **(attachment GW-11)**. SAT provided advice to the Minister concerning a meeting with representatives of the major medical colleges and associations. A surgical profile of a number of major Queensland public hospitals was provided to the Minister. Such meetings were considered constructive and participants invited to speak frankly about issues of concern. The meeting of 7 April 1999 was informal. I attended the meeting with the Director-General.

B. SPECIALIST OUTPATIENTS

47. In memorandum dated 27 April 1998 **(attachment GW-12)** from the Clinical Advisory Committee (CAC), requested the Elective Surgery Team (**EST**) to collect current waiting times on outpatient clinics. This request was approved on 30 April 1998 by Dr John Youngman, the then Deputy Director-General, Health Services.

48. During the 1998 State Government election (the Labor Party unveiled the WLRS (attached at **GW-1**).

49. The Clinical Advisory Committee (CAC) had a major oversight role in the implementation of WLRS including the specialist outpatient initiative. I understand that the Terms of Reference and minutes of the CAC for the period August 1998 to October 2000 have been supplied to the Commission.

50. In a memorandum from the Director-General dated 15 July 1998 (**attachment GW-13**) to the Director of Performance Management Branch, the EST was directed to provide an urgent report of waiting times for specialist outpatient clinic appointments for each specialty at each hospital by 29 July 1998. To achieve this, the EST was required to contact each hospital and request a manual count be conducted.

51. The Minister for Health, Ms Wendy Edmond, was provided with a briefing on the status of specialist outpatient waiting lists on 29 July 1998 (**attachment GW-14**). It highlighted poor data quality, significant variation in management practices across hospitals, the fact that there were no standard national definitions of urgency of classification of patients for prioritisation for access to outpatient appointments and the lack of information systems within hospitals to record outpatient activity. It recommended that the EST develop a standard proforma document for the regular collection of specialist outpatient information. This was agreed to by the Director-General.

52. In a memorandum from the Minister for Health to the Director-General dated 31 July 1998 (**attachment GW-15**), the Minister requested advice on the proposal to develop a standard proforma for the collection of specialist outpatient information.

53. The Minutes of the CAC dated 20 October 1998 (**attachment GW-16**) refers to the Minister for Health attending the meeting. Discussions included an explanation that it was not possible to reduce elective surgery waiting lists and outpatient waiting lists at the same time because there not enough clinicians to spread their time to provide services for both. It was revealed that the same specialists provide both services. The point was also raised that any increase in the

proportion of outpatient clinics (to reduce waiting times) would necessarily result in increased waiting times on elective surgery waiting lists.

Collection of Outpatient Data

54. Prior to Ms Edmond becoming the Minister for Health, EST only collected waiting list data in relation to elective surgery. Prior to Ms Edmond becoming the Minister for Health, specialist outpatient waiting list data was not collected and was not available corporately.

55. After the initial pro-forma collection undertaken in August 1998, SAT was requested to continue to collect outpatient waiting list data. As part of this process, SAT examined current arrangements and found that there were a number of problems in collecting Outpatient Data:-

- It found that there were almost 200 separate clinic types (services) described in outpatient departments.

- Different hospitals defined the same clinic differently. For example, a thoracic clinic could be a surgical or medical clinic. To make the data meaningful, SAT had to determine how these descriptions of clinic types aligned with the common clinical specialties. As a result a major 'mapping' exercise of these clinics to individual specialities was conducted by SAT.

- It was revealed that a significant number of specialists were storing non-urgent referrals in draws or filing cabinets rather than having them recorded in the hospital system.

- Early investigations in July/August 1998 revealed significant differences across hospitals in the management of specialist outpatient clinics. For example some hospitals were allocating outpatient appointments up to 3 years in advance with the resultant problems of high non-attendance rates.

- Hospital outpatient departments kept hard copy outpatient records, and in many cases simply kept the referrals in a folder (until the actual appointment date). As such, outpatient data had to be collected manually. This was a very time consuming exercise for outpatient

department staff. For example, it took one staff member in a large metropolitan hospital, a full week to collect the data required for the monthly corporate manual collection.

56. As a result of the problems and particularly the variance in procedures, SAT undertook to develop guidelines to assist hospitals with a consistent approach for the management of specialist outpatients departments.

57. Within SAT, completed pro-formas were received either by email or fax. A good deal of follow-up contact with hospitals was required before a "final" report for the month was delivered. This data was then manually transcribed by SAT staff into a data repository which would allow the generation of reports. The source documents, comprising the information fax sheets or emails, are not available as these were discarded once the data was transcribed into the data repository.

58. To the best of my recollection, SAT was not given any direction from the Office of the Director-General (ODG) or the Minister to explore resource options for moving from manual to electronic collection.

What data was collected?

59. The initial pro-forma collection of outpatient waiting list data was undertaken in August 1998. The data requested was for two measures:-

- The time to the next available specialist outpatient appointment for each clinical specialty eg: a week or a month etc;

- The number of patients with and without appointments for each clinical specialty.

60. From 1999, hospitals were requested to provide the data monthly.

Press Release by the Minister dated 16 October 1998

61. To the best of my knowledge, SAT did not have any input into the preparation of Ms Edmond's press release dated 16 October 1998 other than to supply the figures referred to in the press release. To the best of my knowledge, the figures that Ms Edmond is referring to in the press release are the result of the first proforma collection of outpatient waiting list data collected by Queensland Health.

Guidelines for the Management of Specialist Outpatient Departments

62. Between October 1998 and April 1999, SAT developed the *Guidelines for the Management of Specialist Outpatient Departments* (the Guidelines). This was an initiative of SAT under the guidance of the CAC. The Clinical Best Practice Outpatient Working Party (CBPOWP) was formed from senior Specialist Outpatient Department nurses from hospitals in Southern Queensland for this purpose. The CAC provided advice and direction to the CBPOWP during the development of the *Guidelines.* The CAC invited a representative of the CBPOWP to attend meetings of the CAC during the development of the Guidelines. The CAC endorsed the Guidelines prior to approval.

63. No separate resources were available to develop the Guidelines and SAT had to fund this work from within its existing budget.

64. On 22 September 1999, the GMHS approved the publication and distribution of the Guidelines for the Management of Specialist Outpatient Clinic Waiting Lists. The Guidelines are attached (**attachment GW-17**).

Enhancements to the HBCIS appointment scheduling module

65. Approval was received on 14 March 2000 from the GMHS to proceed with enhancements to the HBCIS appointment scheduling module. Attached is a copy of submission dated 10 March 2000 (**attachment GW-18**).

66. These were significant enhancements to the current system and most benefited those working in outpatient departments in hospitals.

Reporting of Outpatient Data

67. Briefings to the Director-General dated 14 October 1998, 9 December 1998, 8 January 1999, 9 March 1999, 16 April 1999 (**attachment GW-19**) provided information on waiting times for specialist outpatient clinics, the initial pro-forma collection undertaken in August 1998, problems with the data and the latest profile of waiting times for outpatients in the reporting hospitals. These were provided in response to specific requests by the Director-General and were in addition to the monthly reports referred to in paragraph 68. I have no recollection or knowledge to explain why these briefings to the Director-General concerning the waiting times for specialist outpatient clinics ceased after 16 April 1999.

68. Monthly outpatient waiting list data was provided by SAT to the GMHS, the Director-General and the Minister for Health through the monthly report from the Surgical Access Team on the WLRS. The reporting of outpatient waiting list data within this report began in April 1999 (although as referred to in paragraph 18, the WLRS monthly reports actually commenced in September 1998). By October 1999, the report contained the number waiting by clinical specialty (Medical, Surgical, Obstetrics/Gynaecology, Paediatric and Psychiatric), both with and without an appointment. The individual surgical specialties with the largest number of patients was also provided with numbers waiting as well as a graphical representation of total patients waiting by month.

69. Outpatient waiting list data was also provided periodically to Cabinet in Cabinet Submissions. Those Cabinet Submissions included information on waiting lists for elective surgery and, for a period of time, outpatient waiting list data, day surgery and emergency services data. This information was prepared by officers within SAT/SAS. There was other information within those submissions that dealt with other topics such as workforce issues and funding. Those topics were provided by other areas within Queensland Health.

70. The SAT received a direction from the ODG in October 2000 that summary information only would be required to be reported in future on a zonal basis as opposed to the more

comprehensive reporting described above in paragraph 69. This was the first indication to scale back the reporting of outpatient waiting list data.

71. A further incident occurred when the SAT was seeking approval to fund the enhancements for the HBCIS appointment scheduling system. In about October 2000 advice was received that the Minister's office was not supportive of the expenditure on the enhancements to the HBCIS appointment scheduling system. My recollection is that the then Director-General, Dr Stable intervened in suggesting that, as Director-General, he needed to provide enhanced tools for staff in the management of specialist outpatient departments. This was in response to the briefing to the Minister dated 10 October 2000 (**attachments GW-20**) which provides a comprehensive summary of the background and progress with the Specialist Outpatient Initiative.

72. Early in 2003, I received instructions from the Office of the GMHS for SAS to cease the monthly report from the Surgical Access Team on the WLRS to the GMHS/Director-General/Minister. This was the only internal report that contained the outpatient department waiting list data. I do not recall the actual mode of communication of this instruction. Normally such decisions were communicated from the Office of the GMHS via email or directly by telephone. Communications from the GMHS commonly came through the Manager of the then Procurement Strategy Unit, Dr Glenn Cuffe. I do not know if the instructions originated with the GMHS or with the Director-General or Minister.

73. I believe that no other substituted form of briefing for the monthly reports of outpatient waiting list data was subsequently used (such as briefings).

74. While monthly reporting of outpatient waiting list data inter alia to the GMHS/ Director-General /Minister ceased in 2003, the reporting of outpatient waiting list data by the hospitals to SAS did not cease. Along with elective surgery and emergency department data, an extract of outpatient data was developed and automatic electronic transfer began in 2001. With no dedicated resources in SAS, a continuing strong focus on elective surgery and emergency department waiting times and little incentive for the hospitals to seriously look at OPD data quality, the development of this collection has been neglected. Data that is being received automatically is variable across sites and incomplete. I am informed that a significant investment of resources would be required to establish a quality outpatient data waiting list collection. The HBCIS system that supplies the data has been mooted for replacement for the past 3 years.

75. With the development of the Policy Framework for Specialist Outpatient Services in 2001 - 2003, it was intended to reconsider the issue of the regular collection of outpatient waiting list data during the implementation phase.

Cabinet Briefings

76. The Cabinet Submission in April 1999 (**attachment GW-21**):

- Identifies that it was intended to introduce a more coordinated approach to appointment scheduling and data collection in outpatient departments as a result of SAT identifying that the management and data handling processes varied considerably across hospitals.

77. Cabinet Submission in September 1999 (**attachment GW-22**):-

- Identifies that the waiting time until the next available appointment by specialty varies throughout the State between both hospitals and specialties.

- Identifies that a major source of inefficiency in outpatient clinics has been the non-attendance by patients at scheduled appointments. Initial data suggested non-attendance rates of up to 30% of new and review cases. Page 5 of the Guidelines details a variety of strategies that have been utilised or should be utilised to decrease non-attendance, including telephone and mail reminders and audits, patient-initiated confirmation and removal from waiting lists following non-attendance.

78. In regard to the Cabinet Submission dated 4 March 2000 (**attachment GW-23**) I was not in the position of Manager, SAT from October 1999 to July 2000 as I was Acting District Manager of the Bowen HSD. Therefore I cannot provide any specific comment on this submission.

79. The Cabinet Submission in October 2000 (**attachment GW-24**) highlights that the elective surgery program was always focussed on better access by patients to surgical services. It states that with the Guidelines it enabled more accurate assessment of demand and waiting times of outpatient services.

80. The Cabinet Submission in May 2001 **(attachment GW-25)** refers to the enhancements to the HBCIS appointment scheduling system (having commenced rollout in March 2001). This was the first Cabinet decision that identified 4 new instructions from Government in relation to the WLRS program. The document identified that the January 2001 Government election commitments provided for the enhancement of surgical services in public hospitals including:-

- Injecting an additional $20 million over 2 years into funding for elective surgery so that more people can have operations faster.

- Continuing to work towards a target of 50% of elective surgery performed as day surgery and setting a target of 80% for day surgery admissions within 2 years.

- Establishing a central elective surgical booking bureau that will be more patient focussed and more responsive to providing services to people where they live.

- Strengthening clinical protocol to ensure appropriate and timely treatment of patients based on clinical need.

81. Discussions between SAT and officers from the Office of the Minister for Health revealed the final dot point under paragraph 80 involved a requirement to develop policy frameworks in the areas of elective surgery, specialist outpatients departments and emergency departments. An issue worth highlighting was the intention to mandate the policy frameworks as opposed to the Guidelines whose adoption was considered to be voluntary by a number of hospitals.

82. The Cabinet Submission in October 2001 (**attachment GW-26**) refers to the enhancement for better communication with GPs with the aim of reducing inappropriate referrals to public hospital outpatients.

83. The Cabinet Submission in February 2002 (**attachment GW-27**) refers to the development of the *Policy Framework for Specialist Outpatient Services.* The Specialist Outpatient Advisory Committee was established to provide advice to SAT in this regard.

84. The Cabinet Submission in August 2002 (**attachment GW-28**). On a date I cannot recall, but may have been about this time, Ros Walker from the Department of Premier and Cabinet met with me and a number of other team members from SAT. She advised that the Cabinet Submissions were to be reformatted to include action statements or individual strategies to address problems identified. She said this was the desire of the Premier.

85. **Attachment GW-29** is the Cabinet Submission for December 2002 providing a Progress Report on the WLRS.

86. The Cabinet Submission in October 2003 (**attachment GW-30**) was the last occasion that Cabinet was briefed on outpatient data.

87. The Cabinet Submission in August 2004 (**attachment GW-31**) does not include outpatient waiting list data. I do not recall the reason for not including this data. It was likely related to an increased concern of the unreliability of the data and the opportunity of adopting a revised reporting format to Cabinet inclusive of the 2004 election commitments. Paragraph 5 lists the 10 election commitments related to elective surgery. Responsibility for the management of 4 of these initiatives rested with SAS. This was additional work over and above the current responsibilities of the SAS.

Policy Framework for Specialist Outpatient Services

88. In January 2001, a Government election commitment included the development of the *Policy Framework for the Specialist Outpatient Services* (the Policy Framework). The Specialist Outpatient Advisory Committee had a major role in developing the Policy Framework.

89. Around late 2003, the GMHS approved the content of the Policy Framework for Specialist Outpatient Services (the Policy Framework) (**attachment GW-32**).

90. The Policy Framework has been developed to provide a consistent, structured approach to assist Queensland Health staff in the coordination and management of specialist outpatient services and waiting lists and following extensive consultation with clinicians. It is designed to:

(a) Provide instruction, information and guidance to QH employees and other practitioners involved in the provision of specialist outpatient services.

(b) Be the definitive source of information for the implementation and maintenance of specialist outpatient systems and management processes within QH.

(c) Articulate individual policies dealing with systems and processes which guide facilities in developing protocols and procedures within local settings.

(d) Provide specific guidance around clinical urgency categories, prioritising specialist outpatients, specialist outpatient waiting list systems, additions, removals and audit of the specialist outpatient waiting list.

91. The Policy Framework was developed as part of the 2001 election commitment. It supercedes the Guidelines for the Management of Specialist Outpatient Clinic Waiting lists. It took approximately 3 years to develop because of the limited resources able to be devoted to the exercise. As well, a significant consultation exercise was necessary before finalisation.

92. On 5 April 2004, the Acting GMHS approved the Project Plan for the implementation of the Policy Framework including the appointment of a Project Officer for a period of 12 months (**attachment GW-33**).

93. The beginning of the implementation process involved the development of a profile document of the current arrangements within specialist outpatient departments of public hospitals including outpatient department waiting list data. It was considered that a clear understanding of the extent of adoption of the former Guidelines that had occurred across the hospitals was required for the purposes of implementing the Policy Framework. To achieve this a profile survey document was developed by the project officer, John Stibbard which included a requirement to identify the number of patients waiting by surgical speciality both with and without an outpatient appointment, as at 1 July 2004. The data collected through the proforma was provided back to individual hospitals for comment. A copy of the pro-forma is attached (**attachment GW-34**).

94. Preliminary findings from this one-off profile survey included:-

- 116 outpatient departments were identified by the Districts;

- Over 106,000 patients were waiting for a new case appointment of which some 37,800 had been offered an appointment as at 1 July 2004;

- The non-attendance rate statewide was 11% and ranged from 1% to 33%;

- Work practices for appointment scheduling varied significantly between facilities and also between outpatient areas within the same facility.

95. The implementation process continued through 2004/05 with individual visits by members of the SAS. This implementation process was continued after the dissolution of the SAS in January 2005. The implementation process was to involve personal visits to all elective surgery reporting hospitals. The visits were to include a full discussion of the issues surrounding policy implementation at that particular site including impediments.

96. It is my understanding that Queensland Health completed implementation of the *Policy Framework for Specialist Outpatient Services* in June 2005. Under the Policy Framework, QH's specialist outpatient clinics are required to operate as follows:

(a) All referrals received are required to be prioritised according to a clinical urgency category, a system similar to that used in elective surgery. The categorisation of referrals is designed to facilitate equitable and timely access to appropriate services according to urgency of need.

(b) Ensure their specialist outpatient waiting list contains details about all patients who require an outpatient appointment, from the time that the facility accepts the referral until the initial appointment has been allocated, or the patient has been removed from the waiting list. The system to register patients on the specialist outpatient waiting list may be manual or electronic. The type of system is usually dependent upon the size of the facility and the demand for specialist outpatient services.

(c) Following the initial consultation, the patient may be returned to the referring practitioner with recommendations for ongoing management; admitted to the facility; placed on an elective surgery waiting list; or followed-up in specialist outpatient clinics.

Signed at Brisbane on fourteenth September 2005.

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GARY WALKER
Queensland Health