'GWI'

Health

Let's get Queensland moving again

Queensland Labor

Waiting List Reduction Strategy

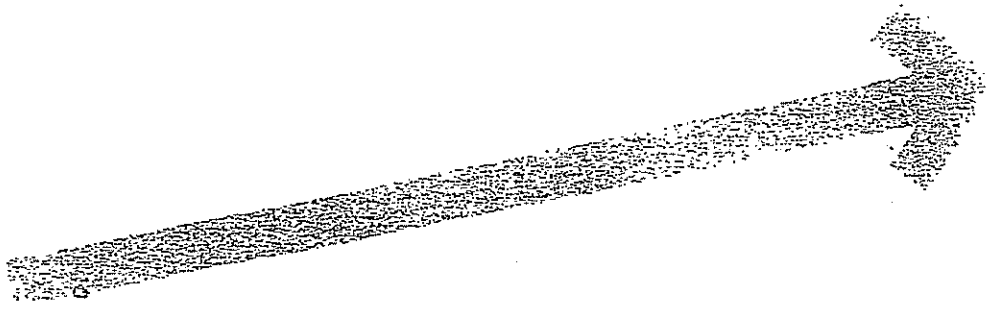
July 1998

LABOR'S WAITING LIST REDUCTION STRATEGY

PETER BEATTIE
Leader of the Opposition

Peter Beattie MLA Telephone 07 3406 7997 Facsimile 07 3229 4431
or Policy Hotline 1800 017 112

CONTENTS



WAITING LISTS

EXECUTIVE SUMMARY

The real state of Queensland's waiting lists has been manipulated and withheld from the general public. In Government, Labor will focus on bringing honesty back into the system and target funding to the people who are presently slipping through the system.

Our eight point plan to cut waiting lists will include a commitment to:

- publish the waiting list for each hospital every three months so that money can be channelled to where the real need is.
- supply general practitioners with quarterly briefings on waiting lists to help them when referring people for surgery
- even out waiting lists by moving people in appropriate cases to a hospital where their procedure can be performed more speedily
- provide additional funding of $6.8 million a year to finance extra surgery for complex procedures.
- work with the specialist colleges to expand training places for new specialists to meet the demand of the next century.
- use holiday times to keep operating theatres working for the benefit of those waiting for surgery
- benchmark waiting times for Accident and Emergency Departments to reduce excessive waits.
- increase levels of day surgery across the State to reduce the length of waiting times for elective surgery.

LABOR'S WAITING LIST REDUCTION STRATEGY

WAITING LISTS

Waiting lists are a source of anxiety and concern for many people. If you, or a family member or friend, is waiting for surgery, often in pain, each extra day can seem like a lifetime.

LABOR'S RECORD

Labor took a multi-pronged approach to reducing waiting lists while in Government. When Peter Beattie was Health Minister he developed and implemented the Strategy for Managing Elective Surgery in Queensland Public Hospitals which is still being used by the Coalition Government today.

This strategy was based on the principle of equal access for equal need with the aim of treating patients with similar conditions in a similar manner across the State. Labor's initiatives included:

- establishing an elective surgery strategy which included computerising waiting lists, developing the protocols for care, new pre-admission clinics and better discharge planning and appointing waiting list co-ordinators in hospitals.
- spending $64 million over three years to reduce the backlog in elective surgery
- attracting and keeping vital medical specialists within the public system with a $42.1 million package over three years
- accelerating the re-building of the major metropolitan hospitals as part of Labor's ten-year, billion dollar Hospital Rebuilding Program
- bringing Queensland's specialist medical equipment up to world standards by spending an extra $35 million over two years
- building dedicated day surgeries at major teaching and other hospitals funded by a $40 million 10-year program
- publishing the waiting lists for Queensland's major hospitals for the first time so that people were aware of the problems. Peter Beattie promised to continue releasing waiting lists.

THE SITUATION NOW

These sensible and open policies have been replaced by subterfuge and sleight of hand.

The Borbidge Government has made much play of reducing waiting lists over the past couple of years, while only releasing limited information on the real state of the lists. Queensland Health documents show that waiting lists have blown out in the semi-urgent and non-urgent categories - the lists where the vast majority of people are waiting. Government statistics show there are now 12,000 Queenslanders waiting too long for surgery in this State.

Compare our situation with New South Wales. They have 7,440 people listed as having waited for over a year for surgery. Queensland, a State with just over half the population of New South Wales, has 8,216 people waiting this long - and people in New South Wales think they have a waiting list problem!

LABOR'S WAITING LIST REDUCTION STRATEGY

The facts show a cruel fraud has been played on the Queensland people. Labor's Waiting List Hotline, started earlier this year, has exposed how this fraud has been executed.

Gate-keeping

Patients are placed on waiting lists from the time they see their specialist and are booked in for surgery. The Borbidge Government has tried to keep people off these lists by increasing the time it takes to see a specialist. Many people who spoke to us said they had already waited six months to see the specialist and had been told they may have to wait another six months.

These people face having to wait up to a year before they are even placed on the official "waiting list" or categorised.

Gate-keeping hides the true number of people waiting for surgery. By not facing up to what the true situation is, the Borbidge Government will never be able to address the unmet demand of people waiting for surgery

Re-categorising

Patients are categorised by the urgency of their operations into three categories of urgent, semi-urgent and non-urgent. The higher the category, the sooner surgery should be undertaken. Evidence has emerged of the Borbidge Government re-categorising patients. Patients have been taken off the lists on which they have been placed and re-categorised onto a less urgent list.

While this may reduce the number of patients on the relevant list it does nothing to help the patients concerned.

Easy Operations Only

The most heart-breaking stories from the Waiting List Hotline were from people waiting for more complicated surgery. This Government has concentrated on operating on the simple and straight foward cases in an effort to manipulate the waiting lists. This has left a growing and distressed group of people waiting for more complex surgery. Many of these people lead their daily lives in great pain and frustration as they see no end to their suffering.

The consignment of these patients to the end of waiting lists goes against the principles of the Medicare Agreement which states that people should be attended to on the basis of medical need. Obviously under this system, people with less need are being seen before those with greater need

What can Labor do?

What can Labor do to bring some decency and honesty back into our waiting list system?

A lot of money has been allocated to cutting waiting lists over the past five years by the Commonwealth and State Governments. We believe the base funding is in place for the on-going assault on reducing waiting lists

Though extra funding has been allocated for our waiting list policy, and we will bring honesty back into the system and targeting the existing money to the people with the real needs who are slipping through the system.

PUBLISHING WAITING LISTS

The last time full waiting lists were published in Queensland was in February when Peter Beattie was Health Minister. They have been hidden from the public ever since. The Borbidge Government has gone to great lengths to conceal the numbers of people waiting for surgery in Queensland. They have only released in the last couple of years selective, manipulated data.

In Government, Labor will again shine a light on the real state of waiting lists.

We will publish the waiting lists for each hospital every three months and the types of surgery people are waiting for. As well, we will publish the number of people waiting for surgery longer than the ideal time. This data will be released quarterly.

Labor will remove the tricks played by the National/Liberal Government and open the State's waiting lists to public scrutiny.

Labor's strategy will put the pressure on public hospitals to perform. It will be easy to check performances across hospitals and to see where there are deficiencies. Consumers and patients will then have information on the real state of waiting lists and it will allow a Labor Government to allocate resources to where the need really is.

BETTER INFORMATION FOR GENERAL PRACTITIONERS

It is important for general practitioners who are referring patients for surgery, to have an accurate picture of waiting lists. They often refer patients for surgery without knowing the length of wait at a particular hospital or the length of the list of the surgeon to whom they are referring.

Labor will supply quarterly briefings to Queensland's general practitioners to help them when referring people for surgery. By doing this we hope to even out the waiting lists across the State as people are referred to hospitals with shorter waiting times.

MOVING PATIENTS ONTO SHORTER LISTS

Waiting lists can change dramatically from area to area. Queensland is a growth State and sudden influxes in population can lead to increased waiting for people living in these areas. There will continue to be problems as the Government moves to get doctors and resources into these growing areas. In the meantime, Labor does not believe people should be left waiting at the end of lists because they live in an area without a high enough level of health services.

Labor will even out waiting lists by moving people, if they are agreeable, to a hospital where their procedure can be performed more speedily. We will organise and meet the cost of the transport to make this possible.

This initiative will be limited to a certain number of procedures where people are otherwise fit but are waiting a procedure. Many eye and skin procedures are a good example.

Moving people around will overcome the anguish for people who are permanently stuck on a list because of a shortage of medical specialists in their area. We will give them the option to have the operation performed elsewhere

Funding of $900,000 a year will be made available for this program.

ENHANCEMENT PROGRAM

As outlined earlier, many people in need of complex operations have been relegated to the bottom of waiting lists by this uncaring Government. Labor cannot let this situation continue. In Opposition, we have fought for these people to be operated on. In Government, we will make sure it happens.

One-off funding of $5.8 million was made available in 1997/98 for the Orthopaedic Enhancement Fund. Labor will continue this as on-going recurrent funding for an Enhancement Fund to finance extra surgery for complex procedures. Priorities for funding will be identified each financial year

This will give us the extra money we need to help those people needing complicated and necessary surgery.

Additional funding of $6 million a year will be allocated for our Enhancement Fund.

SHORTAGE OF MEDICAL SPECIALISTS

At the moment in Queensland there is a shortage of medical specialists in a number of key areas. These shortages are further exacerbated by some surgeons' reluctance to work within the public system. There is also a maldistribution of specialists, with few working outside the Southeast corner.

It is no co-incidence that the areas in which there are shortages of medical specialists - ear, nose and throat, orthopaedics, urology and ophthalmology - mirror exactly the areas where there are long waiting lists for surgery.

Labor will continue to work with the Specialist Colleges to make sure the expansion of training places for new specialists continues to meet the demand estimated for the 21st century. We will fund the extra traineeship positions required as outlined in the work undertaken by the Medical Training Review Panel.

QUIET TIMES

Patients are not consulted about when their elective surgery will be undertaken and it is assumed patients will not want to go to hospital during the traditional quiet times over the school Christmas holidays and Easter holidays. During this time the wards stay open and the hospital staff remain on duty but very few patients are booked in for operations

We believe we can make use of these valuable resources. We will use this quiet time to catch up on elective surgery. Many people on waiting lists, particularly those without school age children, would be more than happy to have their operation in a holiday period.

Labor will investigate keeping a core medical staff on-duty over these traditional quiet periods to keep the operating theatres working for the benefit of those waiting for surgery.

ACCIDENT AND EMERGENCY WAITING TIMES

As well as timely access to surgery, speedy attention in the event of an emergency is vital for a first class health system. The latter hinges on the efficient running of hospital accident and emergency departments in managing the most critical cases that come through a hospital. The two issues people are most concerned about in accident and emergency departments are waiting times for attention and, if being admitted, quick access to a bed in a ward

Labor's strategy will address both these issues. Labor will benchmark waiting times for the different triage categories across the State. We will introduce new systems so that the waiting times of the best performing Accident and emergency departments are replicated across the State. Computer systems will be introduced to all A and E Departments to ensure the use of recognised triage and acuity systems

We will also ensure each hospital has a plan to deal with the significant increased demands of the winter season and that services in accident and emergency can meet this demand.

Labor is concerned about stories of patients having to lie on trolleys for some time in Accident and Emergency before a bed can be found in a ward Labor will minimise this lack of bed availability, known as "access block", through better bed management strategies. We will take into account the predicability of bed utilisation to ensure the availability of general and special care beds

Additional funding of $5 million has been allocated for this program.

DAY SURGERY

Increases in Day surgery is one of the most powerful tools we have in reducing waiting times for elective surgery. Improvements in anaesthetics and new surgical procedures such as laparoscopy and key-hole surgery has meant many operations can be performed during the day with the patient sent home without overnight admission to the hospital.

The Labor Government had a ten year plan to increase day surgeries throughout Queensland. We still have relatively low levels compared to other States and overseas. In government, Labor will aim for internationally comparable levels of 45 to 50 percent of all surgical procedures being on a day basis.

Labor in office will develop a framework for continued development of day surgery, in consultation with clinicians, other service providers and patients. The transition to increased rates of day surgery will be integrated with special efforts to reduce the length of waiting lists and waiting time for elective surgery.

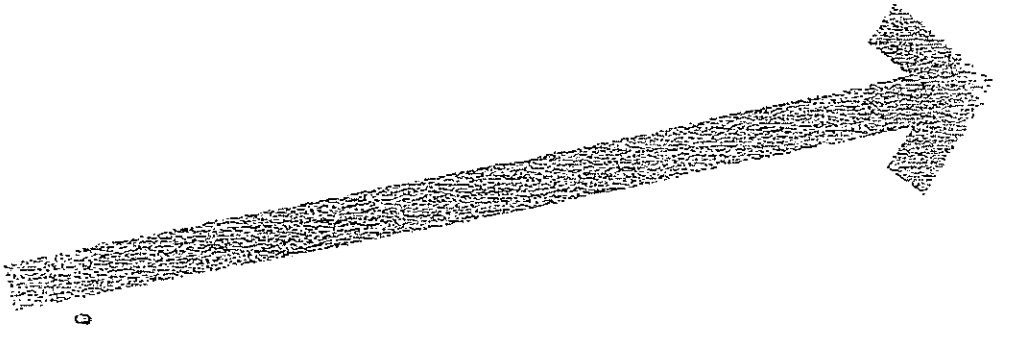
We will monitor the progress of day surgery across public hospitals and ensure our targets are met.

CONCLUSION

The length of the State's waiting lists is seen by those who wait as the major indicator of the health of the State's hospital system. Labor believes nothing is to be gained from hiding the true state of waiting lists. We believe by shining a light on where the delays are we can systematically work to remove those delays.

Operating on the waiting lists rather than the patients, as undertaken by the Borbidge Government, is counter-productive

Labor cannot promise miracles - rapid increase in population in some areas of the State will continue to put pressure on services for some time. We can promise an honest assessment of the challenges facing the health system and a thorough response to overcome those challenges.



'GW2' 'To immediate action' 8/25/9

QUEENSLAND HEALTH

RECEIVED
31 AUG 1998
MINISTERIAL/LIAISON UNIT

SB006372

RECEIVED
27 AUG 1998
3820
P.M.B.

Submission To:

- ☐ Minister
- ☑ Director-General
  - ☐ Deputy Director-General (Health Services)
  - ☑ Deputy Director-General (Planning & Systems)

RECEIVED
23 SEP 1998
DG'S OFFICE

Date: 20 August 1998

Prepared by: Gary Walker
Manager, Elective Surgery Team
Policy Coordination Unit
Performance Management Branch **Contact No:** (07) 3234 0500

GW 26.8.98

Submitted through Judith Robson
Director,
Performance Management Branch **Contact No:** (07) 3234 0825

JR 28/8

Subject: **Plan to achieve the Government's "Waiting List Reduction Strategy"**

---

(2). To be called Surgical Access ~~Team~~
- Staffing as per my notations.
- The specific Projects must reflect the Govt's priorities

(1) **RECOMMENDED**
22 SEP 1998
ROSS PITT
DEPUTY DIRECTOR GENERAL
(PLANNING & SYSTEMS)

RECOMMENDATIONS:

DB 23.9.98.

That the Director-General approve the Plan for achieving the Government's "Waiting List Reduction Strategy" including:

- the overall framework which presents an integrated approach to enhancing elective surgery, emergency surgery and specialist outpatient services.
- the staffing resources proposed to achieve the goals of the strategy.
- the funding arrangements associated with the proposal.
- the change of name from Elective Surgery Team to **Clinical Access Team** to better reflect the new direction

(3) Increase in 2 permanent positions approved.

DB 23.9.98.

(4) Minister concurs with same.

COI.0025.0006.00003

Elective Surgery ...12
Strategy Access Team
Unit
Surgical Access Unit

27

BACKGROUND:

The Government's *Waiting List Reduction Strategy* provides an eight-point plan to cut waiting times for surgery. The Strategy is a broader and much more comprehensive approach to enhancing the various components of the continuum of care and recognises the critical interrelationships between Emergency Surgery, Elective Surgery and Outpatient Departments and the impact of changes in these areas on the total health service continuum.

A plan has been developed to achieve the Government's policy initiatives in this area. It recognises that a new approach is required, not just an extension of the previous initiative. The opportunity exists to take a more comprehensive and integrated approach to the provision of acute services and to begin to utilise more fully the information available from systems such as the Operating Room Management Information System and the Clinical Benchmarking System.

In line with the broader strategy, a new team structure and a new team name are proposed to better represent the new expanded role. The recommended name for the new team is the **Clinical Access Team.**

ISSUES:

- **Staffing**
  The plan proposes 10 staff positions, 8 of which have been recommended to be permanent appointments. Position Numbers are available for the 10 positions. This strategy recognises the objective of the Performance Management Branch in mainstreaming the functions covered by the current Elective Surgery Team including the establishment of a Corporate Office "Clinical Benchmarking Team" in the Policy Coordination Unit to replace the current implementation team managing the installation of the Clinical Benchmarking System.

  The increase in permanent positions also addresses the ongoing problem of staff stability that has hampered the functioning of the former Elective Surgery Team.

- **Funding**
  Funding for the plan is available from unallocated **recurrent** elective surgery funds from 1997/98. Funds were used in 1997/98 to pay for the final two months of claims from the Hospital Access Bonus Pool (May and June) from 1996/97.

PLAN

to achieve the Government's

WAITING LIST REDUCTION STRATEGY

Turning information into action - knowledge into outcomes

August 1998

CONTENTS

1. OBJECTIVE

This document provides a plan for the implementation of the Government's "Waiting List Reduction Strategy". It examines the interrelationships between Elective Surgery, Emergency Services and Specialist Outpatients and provides a coordinated approach to the achievement of the Government's policy. It recognises that a new approach is required, not just an extension of the previous initiative. The opportunity exists to take a more comprehensive and integrated approach to the provision of acute services and to begin to utilise more fully the data being generated from systems such as the Operating Room Management Information and the Clinical Benchmarking System.

Resources are examined and a funding strategy is proposed including a source of funds

2. BACKGROUND

2.1 *Strategy for managing elective surgery in Queensland public hospitals*

The *Strategy for managing elective surgery in Queensland public hospitals* was released by the Minister for Health, Peter Beattie in November 1995. It provided a framework for improving access to elective surgery in Queensland public hospitals in conjunction with a number of funding strategies to reduce waiting times for elective surgery, eg. Casemix Incentives Strategy - $64 million over 3 years to reduce the elective surgery backlog.

2.2 *March 1996 – June 1998*

The Strategy has been further developed since that time involving focussed activity in each of eight areas – Information and Reporting; Workforce Issues; Capital Works; Theatre Management; Day Surgery; Post-Acute Care; Preferred Clinical Practice; and Financing and Incentives. A further $42.9 million ($17.7M recurrent) in 1997/98 was directed towards reducing the Category 2 backlog resulting in a reduction in Category 2 "long waits" from 42.1% to 12.6% and an increase of 7,047 in the number of operations performed over 1996/97 in the 10 core hospitals.

2.3 *Labor's Waiting List Reduction Strategy*

The strategy provides an eight-point plan to cut waiting lists for surgery:

- Publishing the waiting list for each hospital every three months so that money can be channeled to where the real need is.
- Supplying general practitioners with quarterly briefings on waiting lists to help them when referring people for surgery.
- Evening out waiting lists by moving people in appropriate cases to a hospital where their procedure can be performed more speedily.
- Providing additional funding of $6.8 million per year to finance extra surgery for complex procedures.
- Working with the specialist colleges to expand training places for new specialists to meet the demand of the next century.
- Using holiday times to keep operating theatres working for the benefit of those waiting for surgery.
- Benchmarking waiting times for Accident and Emergency Departments to reduce excessive waits.
- Increasing levels of day surgery across the State to reduce the length of waiting times for elective surgery.

The Strategy is a broader and much more comprehensive approach to enhancing the various components of the continuum of care and does not target one element eg. elective surgery. It recognises the critical interrelationships between Emergency Surgery, Elective Surgery and Outpatient Departments and the impact of changes in these areas on the total health service continuum.

5. INTEGRATING ACCESS TO ACUTE CARE

Two major challenges currently facing Queensland Health are to convert the Government's *Waiting List Reduction Strategy* into action and to develop strategies that allow the successes achieved in elective surgery to be applied in other areas. The broader approach of the Strategy acknowledges the relationships between ambulatory, surgical and inpatient services – implying an integrated approach to their management. This approach complements Commonwealth strategies and will facilitate continuing development of systems in areas that reflect the total continuum of care. The opportunity therefore exists to enhance service provision both through innovative strategies and through the extension of successful programs into related clinical areas.

Strong relationships and inter-dependencies exist between elective surgery, emergency surgery, outpatient services and bed management. Most patients pass through an outpatient clinic to access elective surgery. The emergency department also represents a critical access point for admitted patient services. The relationships between these service areas are represented in Figure 1. These links are also recognised in the Commonwealth Department of Health and Family Services document – *Development of Agreed Set of National Access Performance Indicators for Elective Surgery, Emergency Department and Outpatient Services* (Coopers & Lybrand Consultants 1997).

Moving towards integrated management of these related clinical areas has important implications for implementing and evaluating changes in health care. Focus on one aspect of service may lead to unintended consequences in other areas. Evaluation of services in context, with comparable, reliable performance indicators, assists in ensuring service enhancements have the desired effects in the area concerned, and do not have negative effects in related areas. This concept is supported by the Commonwealth Department of Health and Family Services document, which recommends that the implementation of performance indicators for elective surgery, emergency departments and outpatient services **must be undertaken as a package.**

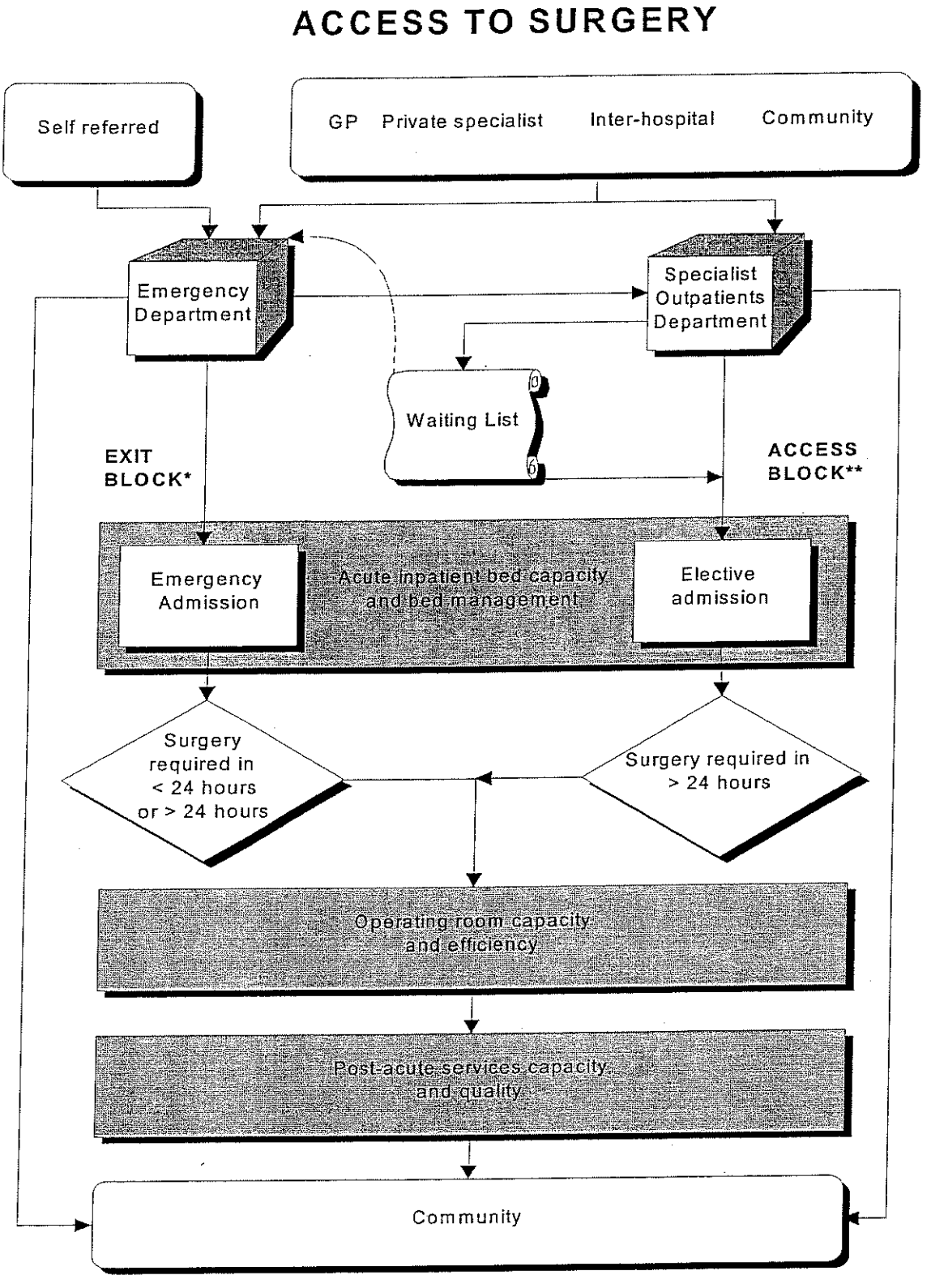
Considerable progress has been made in the development, enhancement and evaluation of elective surgery services over the past two years, and Queensland Health is therefore well placed to build on this base to provide extended benefits. Increased elective surgery throughput has been the focus of strategies to date and this has been achieved in conjunction with developments such as provision of pre-admission processes, improved discharge planning, provision of acute care in the community and development of models of care in specific targeted areas. The development and implementation of specific performance indicators have also enhanced evaluation of elective surgery. The information obtained has been used to purchase, monitor and review funding for elective surgery. Knowledge and experience in this area can now be applied on a broader scale to bring about improvements in patient management for areas other than elective surgery.

The links already established with districts and hospitals provide the ideal conduit through which continuing service developments and extension of existing programs can be implemented. On-going communication and cooperation through these networks will facilitate the successful achievement of corporate objectives.

An important element of applying knowledge to a broader clinical spectrum will be the development of systems to evaluate effectiveness and efficiency of health care services. A major requirement in this area will be the further development of information and reporting systems which will provide the basis on which decisions are made. Performance indicators that accurately reflect operational efficiency also require additional development, as do indicators of clinical outcome. Only by establishing valid, reliable measures of clinical outcome as well as measures of operational efficiency, will a balance be achievable in analysis and interpretation of information collected. These processes will also facilitate benchmarking of facilities and services across the State.

...it... ...rate, reliable information and evaluation systems, the benefits of benchmarking will be available on a clinical, business and operational level. The Clinical Benchmarking System allows collection and comparison of data relating to clinical, operational and financial aspects of service provision. Purchasing plans can be developed to ensure that operational and clinical outcomes will be achieved in an efficiency environment.

This plan outlines an integrated strategy that links **information** and **knowledge** to **action** and **outcomes**.

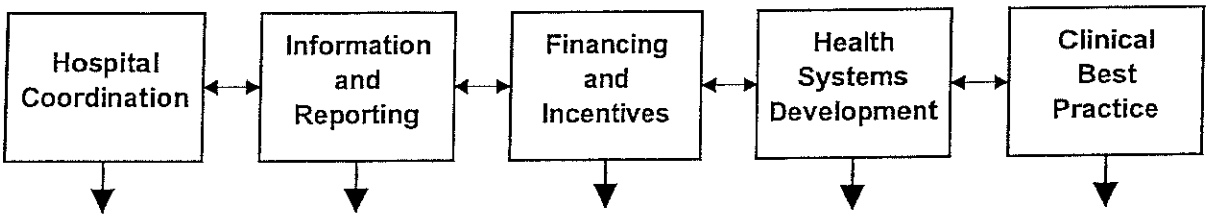


* Exit block refers to the delay in clearing patients from one clinical area due to insufficient resources in the next area.
** Access block refers to the delay in accessing services due to the lack of available resources.

Figure 1

4. FUNCTIONAL CONSIDERATIONS

To achieve the Government's surgery strategy, it is considered that five functional areas need to be resourced. These are:



Achievement of the Government's "*Waiting List Reduction Strategy*"

4.1 HOSPITAL COORDINATION

4.1.1 OVERVIEW

Elective Surgery Coordinators (ESCs) at the 10 core hospitals were appointed in early 1996 as a key management strategy of the then Labor government's *Strategy for managing elective surgery in Queensland public hospitals*. Elective Surgery Liaison Officers (ESLOs) have been nominated in a further 22 reporting hospitals. These ESLOs communicate regularly with the nearest ESCs who provide a mentoring function. The ESCs and ESLOs have provided a vital role in managing waiting lists in respective hospitals and developing strategies for the enhancement of elective surgery services. The ESCs have met monthly to develop such strategies and ensure a consistent approach to the managing of elective surgery waiting lists across the State.

The strategies developed and implemented by ESCs include:

- the identification of spare theatre capacity including extending theatre hours.
- non-metropolitan patients having procedures undertaken at local hospitals rather than being transferred to the metropolitan hospitals.
- the development of surgical profiles for the 10 core hospitals.

4.1.2 ROLES AND RESPONSIBILITIES

- Coordination of the activities of 32 Elective Surgery Coordinators (ESCs) and Elective Surgery Liaison Officers (ESLOs).
- Corporate Office coordination point for 32 Medical Superintendents.
- Management of the Medical Superintendents' Advisory Committee comprised of the Medical Superintendents from the 15 largest hospitals.
- Development of strategies that assist with the achievement of the Government's waiting list agenda and monitoring the success of those strategies.
- Directing the development and implementation of protocols and guidelines in accordance with the corporate direction in conjunction with ESCs and ESLOs.
- Assisting with the implementation of clinical best practice in hospitals through regular hospital visits.
- Addressing waiting list complaints specific to individual hospitals and individual patients.
- Undertaking regular site visits to ensure a statewide consistency of approach.

4.1.3 KEY RELATIONSHIPS

- Medical Superintendents
- Elective Surgery Coordinators and Elective Surgery Liaison Officers.

STAFF COMPLEMENT

Current	1 x AO7 Principal Project Officer (Hospital Support and Liaison) **T**
Future	1 x AO7 Principal Project Officer (Hospital Coordination) **P**

Recommendation:

Maintain and enhance the Hospital Coordination function to provide an operational arm to the surgery strategy so vital in ensuring that corporate policy is implemented.

4.2 INFORMATION AND REPORTING

4.2.1 OVERVIEW

The provision of accurate and timely management information is critical to the success of the future surgery strategy.

Waiting List and Elective Surgery Throughput

The *Elective Admissions System* (EAS) has been installed in 32 reporting hospitals and monthly census data and throughput volumes are reported to Corporate Office on the first working day of each month. This information is available at the specialty level and forms the basis of the Elective Surgery Waiting List Report which is published quarterly.

Theatre Utilisation Information

The *Operating Room Management Information System* (ORMIS) has been installed in 12 large hospitals and the *Theatre Management System* (TMS) in another 10 hospitals. Queensland Health is currently in the process of developing a corporate theatre utilisation reporting system that will allow benchmarking of the usage of operating theatres in 24 hospitals. The increased functionality of ORMIS and better integration with established systems such as EAS will facilitate this process.

Day Surgery Information

Extensive work has been recently undertaken to develop benchmarks for length of stay for potential day surgery procedures. A sophisticated collection and reporting system has been developed for day surgery based on the *Elective Admissions System* and the *Queensland Hospital Admitted Patient Data Collection*. A comprehensive report will be produced quarterly to allow the comparison of day surgery rates across the State.

Monitoring of Activity against Funding Provided

Through the *Queensland Hospital Admitted Patient Data Collection*, the Elective Surgery Team has developed a system that allows monitoring of actual activity performed (weighted separations) against funding provided. This is most important in ensuring that the funding provided is used to perform additional elective surgery activity.

4.2.2 ROLES AND RESPONSIBILITIES

- Develop and manage the Elective Admissions System collection from 32 reporting hospitals.
- Analyse information and preparation of reports to monitor State and national performance standards and benchmarks in the provision of elective surgery services.
- Establish and monitor the implementation of common standards in Queensland public hospitals in relation to terminology, data definition, data collection items and processing of elective surgery information in accordance with agreed State and national requirements.
- Develop quality assurance mechanisms to ensure information received from hospitals is accurate.
- Develop and organise protocols to report missing, incomplete or inconsistent data back to providers.
- Provide strategic advice to the Queensland Health executive on statistics and information relating to elective surgery.
- Represent Corporate Office and Queensland Health on State and National working parties in relation to the development of elective surgery collections in Queensland and Australia.
- Provide support to ORMIS users and facilitation of the ORMIS networks including secretariat duties to the ORMIS Strategic Management Group.

- ...ate the development of a Queensland Health Theatre Utilisation Reporting standard for 24 hospitals in consultation with key stakeholders.
- Ensure Queensland elective surgery data is reported to the Commonwealth government to meet reporting requirements specified by the AIHW and AHCA.

4.2.3 KEY RELATIONSHIPS

- Data Services Unit, Information Management Branch
- Corporate Information Systems Unit, Information Management Branch
- Elective Surgery Coordinators and Elective Surgery Liaison Officers

4.2.4 STAFFING COMPLEMENT

Current 1 x AO7 Principal Project Officer (Information and Systems Analysis) **T**
1 x AO5 Project Officer (Collections and Analysis) **P**
1 x AO6 Senior Project Officer (ORMIS Implementation) (CISU) **T**

Future 1 x AO7 Principal Project Officer (Information and Systems Analysis) **P**
1 x AO5 Project Officer (Collections and Analysis) **P**
1 x AO6 Senior Project Officer (ORMIS Development and Theatre Utilisation) **T**

Agreed AG DG 23.9.98

Recommendation:

That the collections, analysis and reporting function of the Elective Surgery Project be continued and extended to incorporate the reporting of theatre utilisation and related information from ORMIS.

4.3 FINANCING AND INCENTIVES

4.3.1 OVERVIEW

Within the planning context for elective surgery, the Elective Surgery Team has been responsible for the identification of surgical demand of the Queensland population, development of strategy to achieve government policy, and appropriate allocation of funds and the negotiation of agreements.

Funding for elective surgery ($33.5 million per annum) over and above what is expected to be performed in base budgets has been provided to 36 public hospitals in Queensland since 1995/96 – Casemix Incentives Strategy. In 1997/98, an additional $42.9 million ($17.7 recurrent) was provided to address the Category 2 backlog. Commonwealth funding of $3 million per annum for Transitional Care and $2.6 million per annum for enhanced Day Surgery has been managed through the Elective Surgery Team. Cabinet Budget Review Committee deliberations in early August 1998, has resulted in additional recurrent funding of $14.04 million ($17.59 million in out years) and $6.06 million in one-off funds to be targeted on elective surgery activity in 1998/99. In addition, $2.5 million ($5.0 million in out years) is available for the benchmarking of waiting times for Accident and Emergency Departments to reduce excessive waits.

4.3.2 ROLES AND RESPONSIBILITIES

- Develop formal consultation processes with Zonal Health Units in identifying demand for clinical services and the achievement of activity targets.
- Establish close relationships with Districts to ensure targets are achieved.
- Develop a process for the targeting of the new funding for additional elective surgery activity.
- Manage the monitoring of expenditure of funding against activity targets for the Elective Surgery Maintenance Fund, Elective Surgery Performance Fund and new funding for elective surgery activity.

- Develop a funding and monitoring strategy for the enhancement of capital infrastructure to support the elective surgery strategy.
- Identify strategies to shift funding to meet demand in association with spare capacity.
- Develop a funding and monitoring strategy for the targeting of dedicated funding to the benchmarking of waiting times for Accident and Emergency Departments and to reduce excessive waits.
- Develop a funding and monitoring strategy for the targeting of dedicated day surgery funding in 1998/99 to achieve a day surgery rate of 50% of total elective surgery activity.
- Develop and implement specific funding strategies to target elective procedures in particular specialties, particular in relation to complex procedures.

Continue the development and implementation of the Elective Surgery Funding Model.

4.3.3 KEY RELATIONSHIPS

- Zonal Health Units
- Pricing Policy Team
- Finance Unit
- District Managers

4.3.4 STAFFING COMPLEMENT

Current nil
Future 1 x AO7 Principal Project Officer (Financing and Incentives) **T**

Agreed
NJ
DL
23.9.99

Recommendation:

That the Financing and Incentives function be resourced appropriately to reflect the responsibilities of managing and monitoring a funding and incentives strategy that amounts to $84.6 million in 1998/99. The position should be temporary for 12 months and be subsumed within the Zonal Health Units at this time.

4.4 HEALTH SYSTEMS DEVELOPMENT

4.4.1 OVERVIEW

A number of strategies of the government refer to major development projects and extend the traditional boundaries of the elective surgery initiative. These projects include the development and implementation of a collection and reporting system for specialist outpatients departments. In addition, the *Waiting List Reduction Strategy* includes the development and implementation of a strategy to benchmark waiting times for accident and emergency departments with the aim of reducing waiting times. Other strategies to be developed by this functional area include the better seasonal utilisation of operating theatres, procedures for the transfer of patients between facilities and the inclusion of substitutable DRGs (eg, cystoscopies) in the DRGs claimable as elective surgery.

4.4.2 ROLES AND RESPONSIBILITIES

- Development and implementation of a collection and reporting system for specialist outpatient departments.
- Development and implementation of a collection and reporting system to benchmark waiting times for specialist outpatients departments.
- Development and implementation of a strategy to allow the better seasonal utilisation of operating theatres.
- Development and implementation of a strategy to allow for the transfer of patients to facilities where waiting times for particular procedures is appreciably reduced.
- Determination of a basket of medical DRGs that are substitutable for surgical DRGs and negotiate with the Commonwealth for the inclusion in the National Data Dictionary.

4.4.3 KEY RELATIONSHIPS

- Medical Superintendents
- Elective Surgery Coordinators and Elective Surgery Liaison Officers.
- Clinical Nurse Consultants – Specialist Outpatients Departments

4.4.4 STAFFING COMPLEMENT

Current 1 x AO7 Principal Project Officer (Transitional Care and Day Surgery) **T**
1 x AO6 Senior Project Officer (Transitional Care and Day Surgery) **T**

Future 1 x AO7 Principal Project Officer (Health System Development) **P**
1 x AO6 Senior Project Officer (Health System Development) **P**

Not agreed Clinical Policy Team should undertake this role longer term

Recommendation:

That a Health Systems Development function of the team be established to develop and implement major projects included in the Government's "Waiting List Reduction Strategy".

4.5 CLINICAL BEST PRACTICE

4.5.1 OVERVIEW

Clinical systems change related to surgery has been successfully progressed over the past 2 years. For example, all 32 reporting hospitals now having formal pre-admission processes in place. The change process has been managed corporately by firstly, keeping abreast of clinical innovations nationally and internationally through literature review and conference participation. Secondly, consultation with key stakeholders has been a critical driving factor, ensuring "buy in" from those responsible for delivering the changes. The Clinical Advisory Committee, made up of professional associations and service providers, has met monthly and has managed focussed working party activity in targeted areas such as pre-admission processes, day surgery, theatre utilisation, transitional care, and discharge planning. Thirdly, the promotion of alternative practices has occurred through pilot projects with the wide dissemination of information from the projects. Fourthly, education has been an important element of the function in promoting better models of care through the hosting of seminars and workshops and through the distribution of summary reports.

The opportunity now exists to extend the Preferred Clinical Practice function beyond surgical boundaries to include innovative clinical practices in the medical area. Within Performance Management Branch, the Clinical Policy Team (Policy Coordination Unit) is the appropriate area to provide leadership and a coordination role for all clinical policy directions for Queensland Health. This should include an oversight role to the establishment and coordination of a clinical benchmarking function. The implementation of the Clinical Benchmarking System in the first five of 24 potential sites provides an incentive to establish the Team and progress the development of clinical outcome measures for specific clinical areas.

However, there is a need to continue a "clinical best practice" function within the proposed ***Clinical Access Team***. The Elective Surgery Team has initiated significant innovative clinical changes by providing leadership in establishing "Hospital in the Home" models and progressing the credentialling of acute out-of-hospital care to allow inclusion in activity targets for District Health Services. In addition, a number of excellent "models of care" developed through the Transitional Care program must now be implemented in other public hospitals. A District collaboration model is proposed in similar vein to the National Demonstration Hospitals Program by establishing lead hospitals and collaborating hospitals to implement these system changes.

...ication of the quarterly *Elective Surgery Waiting List Report* and the Minister's requirement to collect waiting times for specialist outpatients appointments, has introduced the need for a significant increase in liaison and communication with general practitioners. The enhancement of this liaison role will commence on 27 August 1998 with the meeting of the General Practice Liaison Council where such issues as referral protocols and processes, access to outpatient appointments, hospital contact officers and assistance to patients will be covered.

This position in the proposed Clinical Access Team is considered pivotal to the identification and integration of best practice across the total continuum from general practitioner referral to specialist outpatient appointment through to post admission processes. It provides the innovative clinical expertise in the Team and manages the important interface with the Clinical Advisory Committee. It would operate in close concert and take strategic direction from the Clinical Policy Team and the Clinical Benchmarking Team in the new arrangements.

4.5.2 ROLES AND RESPONSIBILITIES

- Establishment of formal policy direction mechanisms from the Clinical Policy Team and Clinical Benchmarking Team.
- Manage the rollout of preferred models of care developed through the Transitional Care program through a district collaboration model.
- Manage the enhancement of the general practitioner liaison role in conjunction with the 25 Divisions of General Practice in consultation with the Health Outcomes Unit.
- Scanning of clinical practice developments related to the scope of the proposed Clinical Access Team both nationally and internationally.
- Consultation with major stakeholders including professional associations and service providers either through the Clinical Policy Team or directly – Specialist Advisory Panels, Clinical Advisory Committee, Medical Superintendents Advisory Committee.
- Engage in regular consultation with the Organisational Improvement Team to provide education programs for major stakeholders & service providers.

4.5.3 KEY RELATIONSHIPS

- Clinical Policy Team.
- Clinical Benchmarking Team.
- Clinical Advisory Committee.
- Health Outcomes Unit
- Divisions of General Practice

As this is a priority for the Govt, these teams should be concentrating on this issue now (with current resources).

4.5.4 STAFFING COMPLEMENT

Current 1 x AO7 Principal Project Officer (Preferred Clinical Practice) **T** ✓

Future 1 x AO7 Principal Project Officer (Clinical Best Practice) **P** ✗ Not Agreed

23.9.98

Recommendation:

That the Preferred Clinical Practice function be expanded beyond surgical boundaries and be informed by strong links with the Clinical Policy Team and Clinical Benchmarking Team. In line with the mainstreaming objective, this position will transfer to the Clinical Policy Team or Clinical Benchmarking Team in 12 months.

5. BUDGET

5.1 Staff/Administrative Expenses

- Funding has been identified in the Corporate Office budget workup for the following positions:

Manager AO8		HT5169	$64,973
Principle Project Officer (Hospital Coordination) AO7		HT5174	$59,199
Principle Project Officer (Information and Systems Analysis) AO7		HT5173	$59,199
Principle Project Officer (Clinical Best Practice) AO7	H11273		$59,199
Project Officer (Collections and Analysis) AO5		H11565	$46,535
Administrative Officer (Communications and Office Support) AO3		HT5177	$34,573
Administrative Support @ $6,800 per FTE			$40,800
TOTAL			**$364,478**

- Funding is required for the following positions:

Principle Project Officer (Funding and Incentives) AO7	HT5172	$59,199
Principle Project Officer (Systems Development) AO7	H11272	$59,199
Senior Project Officer (Systems Development) AO6	H11274	$52,826
Senior Project Officer (ORMIS Development and Theatre Utilisation) AO6		$52,826
Administrative Support @ $6,800 per FTE		$34,000
TOTAL		**$251,250**

5.2 Travel

The proposed unit structure allows for a significant consultion role for the Manager and other more senior staff. This role is considered critical in ensuring Districts remain motivated in achieving the Government's policy directives in this area and for the promotion of achievements. To this end, additional travel funds are required to support this expanded role.

$50,000

5.3 Systems Development

A number of enhancements are planned for the information systems that provide the data for the strategy in 1998/99.

Description of Enhancement	Amount	Payment to
EAS Module enhancements in EAS 1997/98	$33,000	Data Services Unit
Cost sharing for enhancements to EAS 1997/98	$70,000	CISU
Ad hoc reporting requirements including the $5,500 for "Removals Report"	$20,000	CSC
Implementation of unit record level EAS data monthly reporting	$200,000	CISU/CSC
Development and construction of database for new QHAPDC extract	$15,000	Programmer/software
Theatre Utilisation Corporate Reporting	$100,000	
Estimated Total	**$438,000**	

5.4 Source of Funds

Uncommitted recurrent elective surgery funds from 1997/98.

6. FORMAL CONSULTATION MECHANISMS

6.1 Elective Surgery Taskforce

A Special Ministerial Task Force, chaired by the Deputy Director-General (Health Services), was formed to investigate and make recommendations on appropriate changes to the health care delivery system. The Task Force has met on a six monthly basis and has provided a forum for discussion of the achievement and directions of the *Surgery on Time* initiative. It has not been successful in setting strategic direction.

Recommendation:

That the Elective Surgery Task Force be discontinued.

6.2 Clinical Advisory Committee

A Clinical Advisory Committee was formed specifically to review and make recommendations on preferred clinical practice. The committee has met on a monthly basis and has been most active in progressing initiatives in five targeted areas – pre-admission processes, day surgery, transitional care, theatre utilisation and discharge planning.

Recommendation:

The Clinical Advisory Committee continue to meet on a monthly basis.

6.3 Medical Superintendents Advisory Committee

A Medical Superintendents Advisory Committee chaired by the District Manager, West Moreton District Health Service was formed to provide a direct operational link to the participating hospitals. It comprised the Medical Superintendents from the 10 participating hospitals. The Committee has been very active and the committee has received the support of the Deputy Director-General (Health Services) to expand membership to include representation from Redcliffe, Logan and QE II Hospitals and continue to provide operational support and feedback to the surgery strategy.

Recommendation:

The Medical Superintendents Advisory Committee continue to meet on a monthly basis.

6.4 Elective Surgery Coordinators Committee

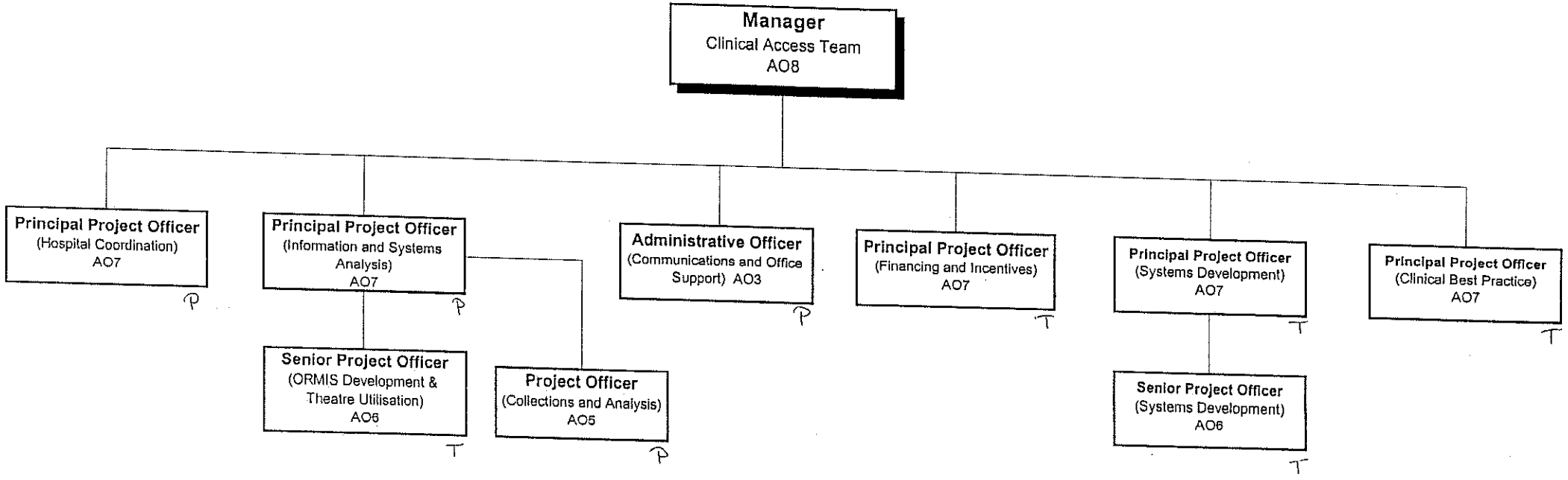
Elective Surgery Coordinators have been employed at all participating hospitals and funding for these positions has now been made a permanent addition to the base budgets of relevant hospitals. The coordinators are the pivotal link between the corporate initiative and the hospitals. The roles and responsibilities include the management of the waiting lists in the respective hospitals and developing and implementing hospital-based strategies to enhance elective surgery services.

Recommendation:

The Elective Surgery Coordinators continue to meet on a monthly basis.

Proposed Organisational Structure

CLINICAL ACCESS TEAM - Proposed Structure



VERSION 27 August 1998

Major Projects

Overview

PROJECT OUTLINE
Specialist Outpatient Information and Reporting

Background

One of the major barriers to accurately assessing the demand for elective surgical services in Queensland hospitals is the lack of timely, accurate and comparable outpatient information. At present there are no corporate reporting requirements for hospitals in relation to specialist outpatient services apart from the occasions of service reports. This absence of specialist outpatient reporting allows the true demand for surgery to be masked if access to specialist outpatients is limited.

The lack of useful information relating to specialist outpatient services is due to the absence of:

- definitions relating to outpatient services
- consistent information recording
- an appropriate data collection system.

The key element in establishing a system for reporting of specialist outpatient services is the development of an appropriate data collection system. The HBCIS Appointment Scheduling system is a computerised system operational in 12 hospitals. This system has not been used to facilitate the generation of management information. The remaining hospitals maintain manual systems to manage their outpatient clinics. Any form of reporting from the hospitals will therefore be resource intensive.

Objectives

1. To develop and implement a corporate standard for the regular collection of surgical specialist outpatients information from the 32 Queensland elective surgery reporting hospitals. The corporate standard will define the minimum data set required of reporting hospitals.

2. To profile the demand for surgical services and availability of these services across the State.

Methodology

1. Develop performance indicators for specialist outpatient services.

2. Establish the minimum data set required for corporate reporting.

3. Identify the information systems and data collection processes in use at the 32 elective surgery reporting hospitals.

4. Investigate the feasibility of implementing HBCIS Appointment Scheduling, or an alternative information system, across all hospitals.

5. Establish a system for collection and reporting of the minimum data set (either manually or electronically as determined in point 3 above).

6. Implement the system, ensuring consistency across the 32 hospitals and that the accurate identification of all demand for surgical services is facilitated.

7. Develop a profile of the specialist surgical services available in the 32 reporting hospitals.

8. Identify the demand for specialist outpatient services and where waiting lists exist.

9. Relate waiting lists and waiting times in specialist outpatient services to those for surgical waiting lists.

PROJECT OUTLINE
Targeting Integrated Bed Management

Background

Integrated bed management is a process of maximising bed utilisation while taking into account the finite resources, the predictable variations in demand, and the need to prioritize patient admissions on the basis of clinical need. Access to inpatient beds within hospitals is determined by the total number of beds, the availability of beds and the demand for emergency and booked admissions. The number of hospital beds is finite. Within the demand for admissions, there are several categories of patients competing for the available beds – a fact which has the potential to cause access blocks. Beds must be available for emergency admissions, but this need must be balanced against the beds required for elective admissions, both medical and surgical.

Excessive waiting times for admission from Emergency Departments and Admission Waiting Rooms can occur during periods of increased demand for emergency admissions and high bed occupancy. Bed availability may then be further compromised as patients become backlogged in emergency departments. One strategy used to alleviate this pressure is to cancel elective surgical patients. While this strategy may make beds available, it also results in anxiety for patients, increased pressure in terms of treating patients within the desired time frame and sub-optimal use of hospital resources accessed prior to admission.

Other factors such as seasonal variations also impact on the demand for beds and bed availability. During winter months hospitals experience an increase in emergency admissions, as well as booked medical admissions. Detailed analysis of bed utilisation by specialty, identifying trends in seasonal variations could assist in predicting bed availability for elective admissions. This would be particularly useful in planning for the purpose of maximising elective surgery.

Strategies initiated over the past two years have made some attempt to improve bed availability and increase bed utilisation rates. Improved pre-admission processes, discharge planning and out-of-hospital care can reduce the demand for inpatient beds. Further development is required to integrate these strategies with bed management policy to reduce pressure on hospital resources.

Clinical practice guidelines may also assist in achieving equity of access for patients with similar clinical need.

Objectives

1. To develop an integrated bed management strategy which facilitates maximal utilisation of resources.
2. To develop clinical practice guidelines which will assist in prioritisation of patients for admission.

Methodology

1. Undertake a detailed bed utilisation analysis, including identification of capacity for emergency and booked admissions within the 32 reporting hospitals.
2. Examine existing bed management strategies.
3. Examine models of integrated bed management implemented in other States appropriate for application within Queensland hospitals.
4. In consultation with key stakeholders, develop appropriate strategies for prioritisation of emergency and booked cases within hospitals.
5. Implement data collection system and reporting process in the 32 Elective Surgery reporting hospitals for reasons for cancellation, and waiting times on admission for emergency and booked admissions.
6. Review data and identify target areas for modification of services and procedures.

PROJECT OUTLINE
Development of Corporate Reporting
Using the Clinical Benchmarking System

Background

The Clinical Benchmarking System (CBS) is a computerised system that will allow data collection on an operational, business and clinical level. Clinical benchmarking is strongly related to monitoring of service quality and service enhancement. Ultimately, purchasing plans will ensure that operational and clinical outcomes will be achieved in an efficiency environment; that is services can be clinically, operationally and financially benchmarked. The CBS is being implemented in 24 sites over a 3-year period. Implementation is nearing completion at 3 sites – Princess Alexandra Hospital, Gold Coast Hospital, and Royal Brisbane, Royal Women's and Royal Children's Hospital.

In addition to the implementation of the CBS, considerable progress has been made in the use of performance indicators which focus on access and efficiency. Waiting times for elective surgery and within Emergency Departments as well as theatre utilisation rates, clinical throughput by specialty and DRG are currently collected and reported. Measuring quality of service using outcome-based measures is more difficult than measuring operational performance since these measures involve education and training of staff and can be specific for particular conditions or procedures.

Further developing corporate reporting and effective clinical benchmarking will require definition of valid, reliable clinical outcome measures; refinement of operational performance indicators; and the broad application of appropriate data collection systems. The importance of quality and outcome indicators in this process has been identified in the Commonwealth Department of Health and Family Services publication - *Quality and Outcome Indicators for Acute Healthcare Services*.

Objectives

1. To develop the outputs from the Clinical Benchmarking System to allow benchmarking of clinical and operational measures. The strategy to develop the output should provide the link between policy, clinical and operational outcomes and costings.

2. To develop the Clinical Benchmarking System reporting system to assist managers and clinicians within Queensland hospitals and to allow performance monitoring by corporate office.

Methodology

1. Identify target procedures and conditions for collection and reporting of clinical outcome and operational performance indicators.

2. Investigate the availability of validated, reliable clinical outcome measures for use in the targeted areas and facilitate their implementation.

3. Continue development of performance indicators for assessment of access, efficiency, safety, effectiveness, continuity, acceptability, technical proficiency and appropriateness.

4. Establish collection and reporting systems for clinical outcome measures and key performance indicators utilising the Clinical Benchmarking System.

5. Identify and describe current practice for the target procedures in each site including details, profiles or credentialling of services. This will include the identification of demographics and trends of service need.

PROJECT OUTLINE
Controlling Demand for Elective Surgery

Background

Any considered effort to reduce waiting lists for elective surgery must include elements which address the demand for surgery. Successful measures which have been used to manage elective surgery waiting lists have concentrated on the supply of services, without attempting to influence demand. While many of these strategies continue to be effective, it seems clear that the long-term strategy to manage waiting lists must include some effort to control the demand for surgery.

Limiting demand for surgery by reducing the incidence of preventable conditions and effective early management of chronic conditions has to date received little consideration as a means of managing waiting lists for surgery. There is evidence that for certain conditions, the need for surgery can be delayed or prevented, reducing the clinical need for surgery. However, funding for preventive and non-medical management is limited, making effective options of this type underutilised. This strategy would require changes to the funding for non-surgical services.

Another relevant issue is that the demand for elective surgery is closely linked to the demand for specialist outpatient services and is therefore influenced by referral practices to specialist outpatient services. There is lack of clearly defined criteria or guidelines to assist general practitioners in making decisions about when to refer to specialist outpatient services. This may be resulting in referral to surgical services when treatments other than surgery are most appropriate.

Demand for elective surgery is also influenced by clinical practises within surgical specialties. There is considerable variation in the types of surgery offered in public hospitals throughout the State. Corporate policies can be developed to define which procedures will not be publicly funded. Decisions about when patients are placed on a surgical list are also inconsistent. While many of these variations will be due to legitimate differences in patient needs, there is scope for more consistency in establishing when patients require surgery. Collaboration with surgical colleges to develop criteria for access to surgery is one possible means of addressing this issue.

Objectives

1. To investigate the potential for reducing need for surgery by effective prevention and early management.
2. To develop a system that assists medical practitioners in determining which patients are suitable for referral to specialist outpatient services.
3. To develop systems that ensure patients are ready for surgery when placed on surgical waiting lists, and that effective non-surgical options for treatment have been accessed where appropriate.

Methodology

1. Identify surgical conditions for which preventive and early management programmes are effective in reducing the need for surgery.
2. Consult with relevant colleges, associations and consumer advocate groups to define procedures which can be provided in public hospitals.
3. Examine relationships between referral to specialist surgical outpatients and placement on waiting lists for surgery.
4. Identify any source of sub-optimal or inappropriate referral practises and investigate systems to minimize these practises.
5. Investigate existing systems which incorporate criteria for access to surgery and examine the feasibility of implementing criteria in Queensland public hospitals.
6. Examine alternative funding models for the provision of surgical services, which remove incentives for performing surgery in preference to other effective treatments.
7. Facilitate modification of existing systems to minimize inappropriate referrals, incorporate criteria for access, and provision of appropriate funding for effective alternatives to surgery.

PROJECT OUTLINE
Day Surgery - Purchasing and Reporting

Background
For the past two years, the provision of incentive funding has initiated changes that have increased day surgery rates through the promotion of infrastructure and process changes such as improved discharge planning and pre-admission processes. This has facilitated an improvement in the proportion of elective surgery being performed as day surgery to 42.8% (6 months July 1997 to December 1997). However, to enable further improvements in the proportion of elective surgery performed as day surgery, a purchasing and reporting strategy is recommended.

Objective
1. To develop a policy to identify purchasing and reporting strategies that will increase the day surgery rate to 52.8% by July 1999 and 60% by July 2000 for elective surgery reporting hospitals. Specific targets will be incorporated into Health Service District Agreements.

The policy will promote the delivery of day surgery services based on the principles of quality, effectiveness, best practice and client focussed outcomes.

Methodology
1. Identify agreed day surgery target rates as a percentage of overall elective surgery for each reporting facility.

2. Identify target procedures for each speciality that will be performed as day cases unless specifically contraindicated.

3. Identify and monitor
- admission policies and procedures to ensure equity of access for all people
- pre-operative patient screening and selection processes ensure that targets are achieved
- surgical equipment requirements that includes laser and endoscopic surgery equipment
- recovery and discharge criteria to promote optimal patient outcomes
- post-surgical community support that includes the General Practitioner and other community service providers.

4. Establish lead facilities that will increase day surgery caseload by undertaking more complex day surgery procedures, refining minimal access surgery and introducing advanced anaesthetic and intravenous sedation technology.

5. Provide timely census and activity data to support decision making for funding allocation, to identify problem areas, to identify achievement of targets. The Day Surgery Report will provide information by facility, by specialty, by category and by procedures.

PROJECT OUTLINE
Targeted Long-Wait Patients

Background

The management of patients waiting longer than the ideal times on surgical waiting lists has important implications for clinical outcome, equity of access and operational efficiency. There is currently considerable variation in the manner in which waiting lists are managed across the State and within individual hospitals. This is resulting in inequitable access to surgical services and may be adversely affecting clinical outcomes.

Responsibility for clinical review while patients are on a surgical waiting list has been outlined, but must now be specifically defined. Clinical review of patients is an important part of providing quality specialist outpatient services. In some cases, specialist outpatient review is carried out to monitor deterioration of condition, or on the basis that surgery will be needed in the future. These practices increase demand for specialist surgical outpatient services, and may limit the availability of services for new cases. Review of such patients could be carried out by general practitioners, with re-referral when the patient's condition warrants. Formal review of patients on waiting lists by general practitioners will ensure clinical needs are met, but requires good communication between specialist and general medical practitioners.

The order in which patients are selected from waiting lists also has implications for clinical outcome and operational efficiency. Patients with similar clinical needs are currently experiencing markedly different waiting times for surgery when comparison is made between surgeons within a service and even within individual surgeons' lists. This practice results in preferential treatment of some patients and delayed treatment for others whose needs are similar.

Objectives

1. To define responsibility for review of patients on waiting lists for surgery, ensuring issues relating to patient care and efficient utilisation of resources are addressed.

2. To establish a system which ensures equitable selection of patients from surgical waiting lists.

Methodology

1. Identify clinical groups or services with long waiting times to be targeted.

2. Examine current practice relating to review of 'long-wait' patients on surgical waiting lists.

3. Investigate alternative models for clinical review processes (including consultation with relevant colleges).

4. Define the professionals responsible for clinical review of patients on surgical waiting lists.

5. Establish a system for appropriate review of patients on waiting lists and for monitoring of the review process.

6. Examine current practice relating to selection of patients from Category 3 waiting lists.

7. Investigate systems for facilitating equitable selection of patients from the waiting list and develop models appropriate for local needs.

8. Implement systems for review of patients and for selection from waiting lists throughout the 32 elective surgery reporting hospitals.

PROJECT OUTLINE
Enhancing Out-of-Hospital Services

Background

Services directed at improving management of patients in the community have been shown to improve overall efficiency of the health service while maintaining clinical outcomes. Successful programmes initiated over the last two years have demonstrated that specific groups of patients can be safely and appropriately managed out of the acute hospital environment. Provision of out-of-hospital care may also have a significant influence on the needs for capital expenditure in the future.

A number of facilities throughout Queensland have developed successful models for the provision of out-of-hospital services and the benefits demonstrated can be passed on to other facilities. Guidelines for inclusion of patients, data collection, corporate reporting and credentialling of services are currently being established.

Initiatives which provide specific post-acute services and hospital-in-the-home type services have resulted in decreased length of stay in hospital, with improved patient satisfaction and maintenance of clinical outcome. The observed reductions in inpatient length of stay suggest a decrease in hospital resource utilisation. However, further work is required to ensure quality of care is maintained across the State.

Objectives

1. To continue the establishment and refinement of guidelines to assist clinicians in determining which patients are suitable for out-of-hospital care.

2. To investigate funding systems which appropriately support the use of out-of-hospital care for appropriate patients.

3. To provide incentives to assist hospitals in establishing the infrastructure and service agreements to support out-of-hospital care.

Methodology

1. Continue identification of out-of-hospital services available across the State and the capabilities of services in each locality.

2. Examine successful models for out-of-hospital care which have been initiated to date and establish a framework to facilitate implementation across the State.

3. Establish lead facilities that will assist other hospitals and facilities in the continuing development of out-of-hospital care.

4. Investigate possibilities for State-wide service agreements with service providers.

5. Examine the application of discharge criteria for in-hospital and out-of-hospital episodes.

PROJECT OUTLINE
Targeted Seasonal Utilisation of Facilities

Background

Seasonal variations occur in elective and emergency admissions to hospital for a number of reasons, resulting in marked differences in the amount of surgery performed at various times of the year. Traditionally, hospitals use times around Christmas and Easter as a budget saving strategy by closing beds and having staff take holidays. This results in reduced elective surgery throughput at these times. Increased emergency admissions during the winter months also impacts indirectly on surgical throughput as more beds are taken up by these emergency admissions – allowing fewer elective admissions.

The Government's *Waiting List Reduction Strategy* identifies the reduction in elective surgery during holiday periods as a potential opportunity for increasing surgical throughput. Increasing surgical throughput during traditionally quiet times will make better use of physical resources such as operating theatres and wards. However, there will be significant human resource and cost implications for hospitals if this method of budgetary control is removed.

Objectives

To provide incentives for increased surgical throughput during holiday periods.

Methodology

1. Identify periods to be targeted for increased surgical throughput.

2. Establish criteria for accessing funds for increasing surgery in the designated periods.

3. Request submissions from District Health Services for appropriate programmes to meet criteria and objectives.

4. Provide funding to districts on the basis of submissions received.

5. Measure the activity provided against the allocated funds and facilitate achievement of objectives by District Health Services.

PROJECT OUTLINE
Targeted Complex Procedures

Background

The *Waiting List Reduction Strategy* presented by the Government included a commitment to provide funds for extra surgery for complex procedures. This commitment was made on the basis that targeting day surgery in isolation results in hospitals increasing throughput only in that area. Therefore, targeting day surgery alone does not provide benefits for patients awaiting surgery which cannot be performed on a day-only basis, and may even encourage day surgery at the expense of patients in need of more complex procedures.

Complex procedures which have been identified are those which require high levels of resource utilisation (eg hip replacement). The weighted separation assigned to a DRG is thus an indicator of the complexity of the procedure.

The commitment to funding extra surgery for complex procedures includes a pledge of recurrent funds with priorities for funding to be established each year. It is anticipated that in the 1998-1999 financial year, $3.55 million will be directed toward complex procedures. Recurrent funding of $7.1 million will then be provided from the 1998-1999 financial year.

Objectives

To establish an enhancement fund which will support extra surgery for complex surgical cases.

Methodology

1. Identify complex procedures to be targeted.

2. Establish criteria for accessing funds for complicated surgery.

3. Request submissions from District Health Services for appropriate programmes to meet criteria and objectives.

4. Provide funding to districts on the basis of submissions received.

5. Measure the activity provided against the allocated funds and facilitate achievement of objectives by District Health Services.

'GW2' To immediate action Mrs R25/9

QUEENSLAND HEALTH

RECEIVED
31 AUG 1998
MINISTERIAL/LIAISON UNIT

SB006372

RECEIVED
27 AUG 1998
3820
P.M.B.

Submission To:

- ☐ Minister
- ☑ Director-General
  - ☐ Deputy Director-General (Health Services)
  - ☑ Deputy Director-General (Planning & Systems)

RECEIVED
23 SEP 1998
DG'S OFFICE

Date: 20 August 1998

Prepared by: Gary Walker
Manager, Elective Surgery Team
Policy Coordination Unit
Performance Management Branch **Contact No:** (07) 3234 0500

GW 26.8.98 JRobson 27/8/98

Submitted through Judith Robson
Director, JR 28/8
Performance Management Branch **Contact No:** (07) 3234 0825

Subject: **Plan to achieve the Government's "Waiting List Reduction Strategy"**

---

(2). To be called Surgical Access ~~Elective~~ Team
- Staffing as per my notations.
- The specific Projects must reflect the Govt's priorities

(1) RECOMMENDED
22 SEP 1998
ROSS PITT
DEPUTY DIRECTOR GENERAL
(PLANNING & SYSTEMS)

RECOMMENDATIONS:

DB 23.9.98.

That the Director-General approve the Plan for achieving the Government's "Waiting List Reduction Strategy" including:

- the overall framework which presents an integrated approach to enhancing elective surgery, emergency surgery and specialist outpatient services.
- the staffing resources proposed to achieve the goals of the strategy.
- the funding arrangements associated with the proposal.
- the change of name from Elective Surgery Team to **Clinical Access Team** to better reflect the new direction

COI.0025.0006.00003

(3) Increase in 2 permanent positions approved.

Executive Surgical ...12
Services Access Team
Unit

DB 23.9.98.

(4) Minister concurs with same.

Surgical Access Team

BACKGROUND:

The Government's *Waiting List Reduction Strategy* provides an eight-point plan to cut waiting times for surgery. The Strategy is a broader and much more comprehensive approach to enhancing the various components of the continuum of care and recognises the critical interrelationships between Emergency Surgery, Elective Surgery and Outpatient Departments and the impact of changes in these areas on the total health service continuum.

A plan has been developed to achieve the Government's policy initiatives in this area. It recognises that a new approach is required, not just an extension of the previous initiative. The opportunity exists to take a more comprehensive and integrated approach to the provision of acute services and to begin to utilise more fully the information available from systems such as the Operating Room Management Information System and the Clinical Benchmarking System.

In line with the broader strategy, a new team structure and a new team name are proposed to better represent the new expanded role. The recommended name for the new team is the **Clinical Access Team.**

ISSUES:

- **Staffing**
  The plan proposes 10 staff positions, 8 of which have been recommended to be permanent appointments. Position Numbers are available for the 10 positions. This strategy recognises the objective of the Performance Management Branch in mainstreaming the functions covered by the current Elective Surgery Team including the establishment of a Corporate Office "Clinical Benchmarking Team" in the Policy Coordination Unit to replace the current implementation team managing the installation of the Clinical Benchmarking System.

  The increase in permanent positions also addresses the ongoing problem of staff stability that has hampered the functioning of the former Elective Surgery Team.

- **Funding**
  Funding for the plan is available from unallocated **recurrent** elective surgery funds from 1997/98. Funds were used in 1997/98 to pay for the final two months of claims from the Hospital Access Bonus Pool (May and June) from 1996/97.

PLAN

to achieve the Government's

WAITING LIST REDUCTION STRATEGY

Turning information into action - knowledge into outcomes

August 1998

CONTENTS

1. OBJECTIVE

This document provides a plan for the implementation of the Government's "Waiting List Reduction Strategy". It examines the interrelationships between Elective Surgery, Emergency Services and Specialist Outpatients and provides a coordinated approach to the achievement of the Government's policy. It recognises that a new approach is required, not just an extension of the previous initiative. The opportunity exists to take a more comprehensive and integrated approach to the provision of acute services and to begin to utilise more fully the data being generated from systems such as the Operating Room Management Information and the Clinical Benchmarking System.

Resources are examined and a funding strategy is proposed including a source of funds

2. BACKGROUND

2.1 *Strategy for managing elective surgery in Queensland public hospitals*

The *Strategy for managing elective surgery in Queensland public hospitals* was released by the Minister for Health, Peter Beattie in November 1995. It provided a framework for improving access to elective surgery in Queensland public hospitals in conjunction with a number of funding strategies to reduce waiting times for elective surgery, eg. Casemix Incentives Strategy - $64 million over 3 years to reduce the elective surgery backlog.

2.2 *March 1996 – June 1998*

The Strategy has been further developed since that time involving focussed activity in each of eight areas – Information and Reporting; Workforce Issues; Capital Works; Theatre Management; Day Surgery; Post-Acute Care; Preferred Clinical Practice; and Financing and Incentives. A further $42.9 million ($17.7M recurrent) in 1997/98 was directed towards reducing the Category 2 backlog resulting in a reduction in Category 2 "long waits" from 42.1% to 12.6% and an increase of 7,047 in the number of operations performed over 1996/97 in the 10 core hospitals.

2.3 *Labor's Waiting List Reduction Strategy*

The strategy provides an eight-point plan to cut waiting lists for surgery:

- Publishing the waiting list for each hospital every three months so that money can be channeled to where the real need is.
- Supplying general practitioners with quarterly briefings on waiting lists to help them when referring people for surgery.
- Evening out waiting lists by moving people in appropriate cases to a hospital where their procedure can be performed more speedily.
- Providing additional funding of $6.8 million per year to finance extra surgery for complex procedures.
- Working with the specialist colleges to expand training places for new specialists to meet the demand of the next century.
- Using holiday times to keep operating theatres working for the benefit of those waiting for surgery.
- Benchmarking waiting times for Accident and Emergency Departments to reduce excessive waits.
- Increasing levels of day surgery across the State to reduce the length of waiting times for elective surgery.

The Strategy is a broader and much more comprehensive approach to enhancing the various components of the continuum of care and does not target one element eg. elective surgery. It recognises the critical interrelationships between Emergency Surgery, Elective Surgery and Outpatient Departments and the impact of changes in these areas on the total health service continuum.

5. INTEGRATING ACCESS TO ACUTE CARE

Two major challenges currently facing Queensland Health are to convert the Government's *Waiting List Reduction Strategy* into action and to develop strategies that allow the successes achieved in elective surgery to be applied in other areas. The broader approach of the Strategy acknowledges the relationships between ambulatory, surgical and inpatient services – implying an integrated approach to their management. This approach complements Commonwealth strategies and will facilitate continuing development of systems in areas that reflect the total continuum of care. The opportunity therefore exists to enhance service provision both through innovative strategies and through the extension of successful programs into related clinical areas.

Strong relationships and inter-dependencies exist between elective surgery, emergency surgery, outpatient services and bed management. Most patients pass through an outpatient clinic to access elective surgery. The emergency department also represents a critical access point for admitted patient services. The relationships between these service areas are represented in Figure 1. These links are also recognised in the Commonwealth Department of Health and Family Services document – *Development of Agreed Set of National Access Performance Indicators for Elective Surgery, Emergency Department and Outpatient Services* (Coopers & Lybrand Consultants 1997).

Moving towards integrated management of these related clinical areas has important implications for implementing and evaluating changes in health care. Focus on one aspect of service may lead to unintended consequences in other areas. Evaluation of services in context, with comparable, reliable performance indicators, assists in ensuring service enhancements have the desired effects in the area concerned, and do not have negative effects in related areas. This concept is supported by the Commonwealth Department of Health and Family Services document, which recommends that the implementation of performance indicators for elective surgery, emergency departments and outpatient services **must be undertaken as a package**.

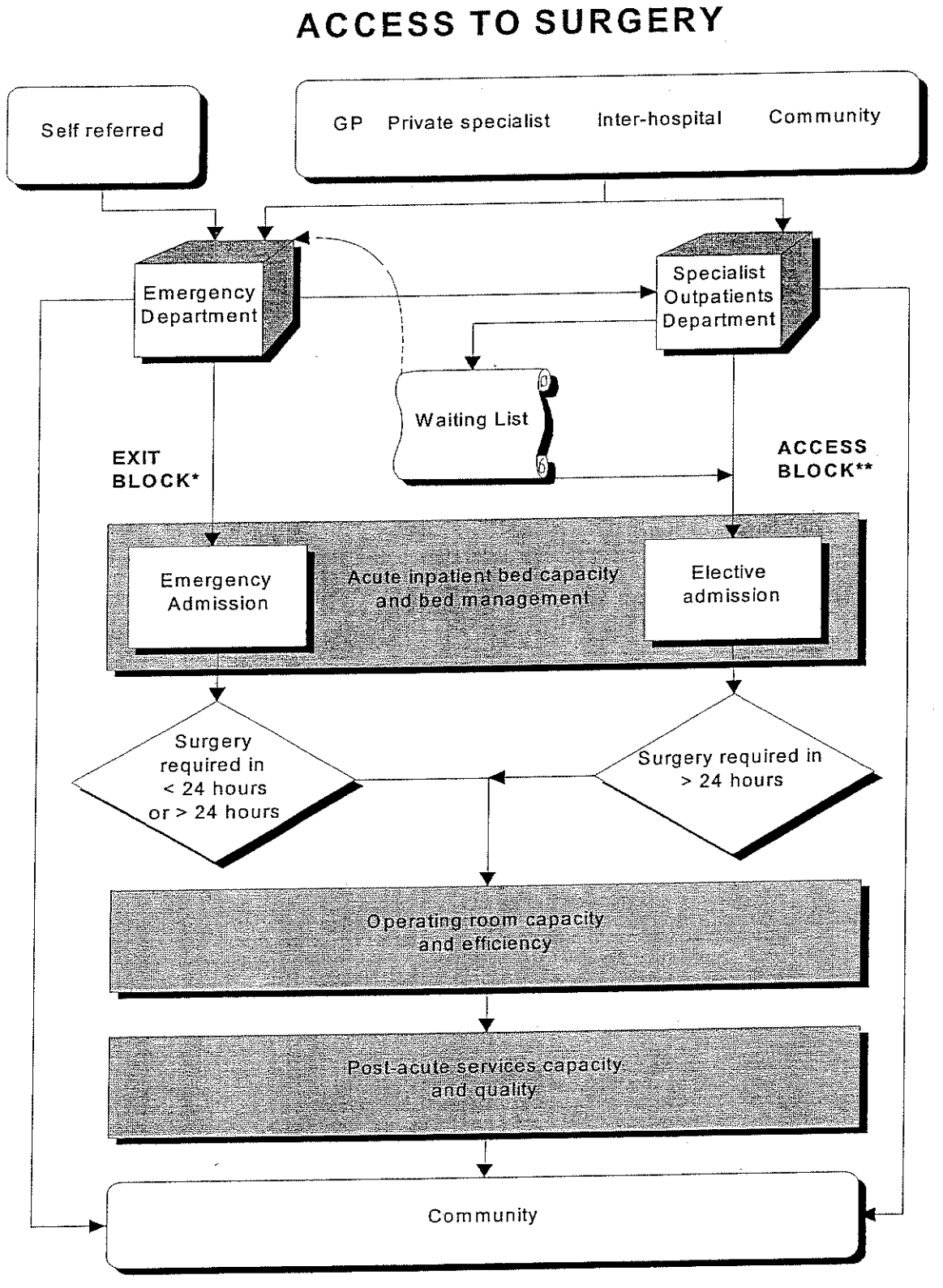
Considerable progress has been made in the development, enhancement and evaluation of elective surgery services over the past two years, and Queensland Health is therefore well placed to build on this base to provide extended benefits. Increased elective surgery throughput has been the focus of strategies to date and this has been achieved in conjunction with developments such as provision of pre-admission processes, improved discharge planning, provision of acute care in the community and development of models of care in specific targeted areas. The development and implementation of specific performance indicators have also enhanced evaluation of elective surgery. The information obtained has been used to purchase, monitor and review funding for elective surgery. Knowledge and experience in this area can now be applied on a broader scale to bring about improvements in patient management for areas other than elective surgery.

The links already established with districts and hospitals provide the ideal conduit through which continuing service developments and extension of existing programs can be implemented. On-going communication and cooperation through these networks will facilitate the successful achievement of corporate objectives.

An important element of applying knowledge to a broader clinical spectrum will be the development of systems to evaluate effectiveness and efficiency of health care services. A major requirement in this area will be the further development of information and reporting systems which will provide the basis on which decisions are made. Performance indicators that accurately reflect operational efficiency also require additional development, as do indicators of clinical outcome. Only by establishing valid, reliable measures of clinical outcome as well as measures of operational efficiency, will a balance be achievable in analysis and interpretation of information collected. These processes will also facilitate benchmarking of facilities and services across the State.

With accurate, reliable information and evaluation systems, the benefits of benchmarking will be available on a clinical, business and operational level. The Clinical Benchmarking System allows collection and comparison of data relating to clinical, operational and financial aspects of service provision. Purchasing plans can be developed to ensure that operational and clinical outcomes will be achieved in an efficiency environment.

This plan outlines an integrated strategy that links **information** and **knowledge** to **action** and **outcomes.**

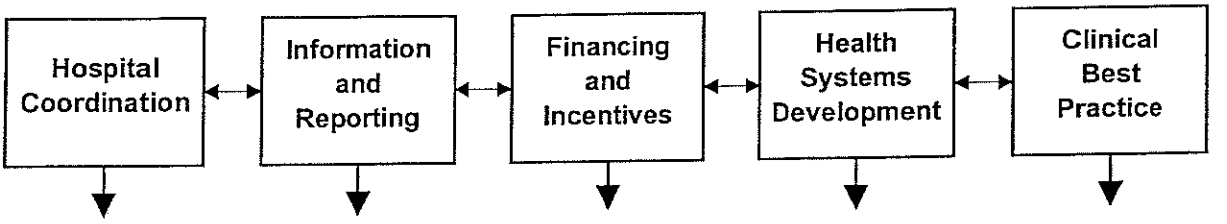


* Exit block refers to the delay in clearing patients from one clinical area due to insufficient resources in the next area.
** Access block refers to the delay in accessing services due to the lack of available resources.

Figure 1

FUNCTIONAL CONSIDERATIONS

To achieve the Government's surgery strategy, it is considered that five functional areas need to be resourced. These are:



Achievement of the Government's "*Waiting List Reduction Strategy*"

4.1 HOSPITAL COORDINATION

4.1.1 OVERVIEW

Elective Surgery Coordinators (ESCs) at the 10 core hospitals were appointed in early 1996 as a key management strategy of the then Labor government's *Strategy for managing elective surgery in Queensland public hospitals*. Elective Surgery Liaison Officers (ESLOs) have been nominated in a further 22 reporting hospitals. These ESLOs communicate regularly with the nearest ESCs who provide a mentoring function. The ESCs and ESLOs have provided a vital role in managing waiting lists in respective hospitals and developing strategies for the enhancement of elective surgery services. The ESCs have met monthly to develop such strategies and ensure a consistent approach to the managing of elective surgery waiting lists across the State.

The strategies developed and implemented by ESCs include:

- the identification of spare theatre capacity including extending theatre hours.
- non-metropolitan patients having procedures undertaken at local hospitals rather than being transferred to the metropolitan hospitals.
- the development of surgical profiles for the 10 core hospitals.

4.1.2 ROLES AND RESPONSIBILITIES

- Coordination of the activities of 32 Elective Surgery Coordinators (ESCs) and Elective Surgery Liaison Officers (ESLOs).
- Corporate Office coordination point for 32 Medical Superintendents.
- Management of the Medical Superintendents' Advisory Committee comprised of the Medical Superintendents from the 15 largest hospitals.
- Development of strategies that assist with the achievement of the Government's waiting list agenda and monitoring the success of those strategies.
- Directing the development and implementation of protocols and guidelines in accordance with the corporate direction in conjunction with ESCs and ESLOs.
- Assisting with the implementation of clinical best practice in hospitals through regular hospital visits.
- Addressing waiting list complaints specific to individual hospitals and individual patients.
- Undertaking regular site visits to ensure a statewide consistency of approach.

4.1.3 KEY RELATIONSHIPS

- Medical Superintendents
- Elective Surgery Coordinators and Elective Surgery Liaison Officers.

STAFF COMPLEMENT

Current	1 x AO7 Principal Project Officer (Hospital Support and Liaison) **T**
Future	1 x AO7 Principal Project Officer (Hospital Coordination) **P**

Recommendation:

Maintain and enhance the Hospital Coordination function to provide an operational arm to the surgery strategy so vital in ensuring that corporate policy is implemented.

4.2 INFORMATION AND REPORTING

4.2.1 OVERVIEW

The provision of accurate and timely management information is critical to the success of the future surgery strategy.

Waiting List and Elective Surgery Throughput

The *Elective Admissions System* (EAS) has been installed in 32 reporting hospitals and monthly census data and throughput volumes are reported to Corporate Office on the first working day of each month. This information is available at the specialty level and forms the basis of the Elective Surgery Waiting List Report which is published quarterly.

Theatre Utilisation Information

The *Operating Room Management Information System* (ORMIS) has been installed in 12 large hospitals and the *Theatre Management System* (TMS) in another 10 hospitals. Queensland Health is currently in the process of developing a corporate theatre utilisation reporting system that will allow benchmarking of the usage of operating theatres in 24 hospitals. The increased functionality of ORMIS and better integration with established systems such as EAS will facilitate this process.

Day Surgery Information

Extensive work has been recently undertaken to develop benchmarks for length of stay for potential day surgery procedures. A sophisticated collection and reporting system has been developed for day surgery based on the *Elective Admissions System* and the *Queensland Hospital Admitted Patient Data Collection*. A comprehensive report will be produced quarterly to allow the comparison of day surgery rates across the State.

Monitoring of Activity against Funding Provided

Through the *Queensland Hospital Admitted Patient Data Collection*, the Elective Surgery Team has developed a system that allows monitoring of actual activity performed (weighted separations) against funding provided. This is most important in ensuring that the funding provided is used to perform additional elective surgery activity.

4.2.2 ROLES AND RESPONSIBILITIES

- Develop and manage the Elective Admissions System collection from 32 reporting hospitals.
- Analyse information and preparation of reports to monitor State and national performance standards and benchmarks in the provision of elective surgery services.
- Establish and monitor the implementation of common standards in Queensland public hospitals in relation to terminology, data definition, data collection items and processing of elective surgery information in accordance with agreed State and national requirements.
- Develop quality assurance mechanisms to ensure information received from hospitals is accurate.
- Develop and organise protocols to report missing, incomplete or inconsistent data back to providers.
- Provide strategic advice to the Queensland Health executive on statistics and information relating to elective surgery.
- Represent Corporate Office and Queensland Health on State and National working parties in relation to the development of elective surgery collections in Queensland and Australia.
- Provide support to ORMIS users and facilitation of the ORMIS networks including secretariat duties to the ORMIS Strategic Management Group.

- ...ate the development of a Queensland Health Theatre Utilisation Reporting standard for 24 hospitals in consultation with key stakeholders.
- Ensure Queensland elective surgery data is reported to the Commonwealth government to meet reporting requirements specified by the AIHW and AHCA.

4.2.3 KEY RELATIONSHIPS

- Data Services Unit, Information Management Branch
- Corporate Information Systems Unit, Information Management Branch
- Elective Surgery Coordinators and Elective Surgery Liaison Officers

4.2.4 STAFFING COMPLEMENT

Current
1 x AO7 Principal Project Officer (Information and Systems Analysis) **T**
1 x AO5 Project Officer (Collections and Analysis) **P**
1 x AO6 Senior Project Officer (ORMIS Implementation) (CISU) **T**

Future
1 x AO7 Principal Project Officer (Information and Systems Analysis) **P**
1 x AO5 Project Officer (Collections and Analysis) **P**
1 x AO6 Senior Project Officer (ORMIS Development and Theatre Utilisation) **T**

Agreed NG DG 23.9.98

Recommendation:

That the collections, analysis and reporting function of the Elective Surgery Project be continued and extended to incorporate the reporting of theatre utilisation and related information from ORMIS.

4.3 FINANCING AND INCENTIVES

4.3.1 OVERVIEW

Within the planning context for elective surgery, the Elective Surgery Team has been responsible for the identification of surgical demand of the Queensland population, development of strategy to achieve government policy, and appropriate allocation of funds and the negotiation of agreements.

Funding for elective surgery ($33.5 million per annum) over and above what is expected to be performed in base budgets has been provided to 36 public hospitals in Queensland since 1995/96 – Casemix Incentives Strategy. In 1997/98, an additional $42.9 million ($17.7 recurrent) was provided to address the Category 2 backlog. Commonwealth funding of $3 million per annum for Transitional Care and $2.6 million per annum for enhanced Day Surgery has been managed through the Elective Surgery Team. Cabinet Budget Review Committee deliberations in early August 1998, has resulted in additional recurrent funding of $14.04 million ($17.59 million in out years) and $6.06 million in one-off funds to be targeted on elective surgery activity in 1998/99. In addition, $2.5 million ($5.0 million in out years) is available for the benchmarking of waiting times for Accident and Emergency Departments to reduce excessive waits.

4.3.2 ROLES AND RESPONSIBILITIES

- Develop formal consultation processes with Zonal Health Units in identifying demand for clinical services and the achievement of activity targets.
- Establish close relationships with Districts to ensure targets are achieved.
- Develop a process for the targeting of the new funding for additional elective surgery activity.
- Manage the monitoring of expenditure of funding against activity targets for the Elective Surgery Maintenance Fund, Elective Surgery Performance Fund and new funding for elective surgery activity.

- Develop a funding and monitoring strategy for the enhancement of capital infrastructure to support the elective surgery strategy.
- Identify strategies to shift funding to meet demand in association with spare capacity.
- Develop a funding and monitoring strategy for the targeting of dedicated funding to the benchmarking of waiting times for Accident and Emergency Departments and to reduce excessive waits.
- Develop a funding and monitoring strategy for the targeting of dedicated day surgery funding in 1998/99 to achieve a day surgery rate of 50% of total elective surgery activity.
- Develop and implement specific funding strategies to target elective procedures in particular specialties, particular in relation to complex procedures.

Continue the development and implementation of the Elective Surgery Funding Model.

4.3.3 KEY RELATIONSHIPS

- Zonal Health Units
- Pricing Policy Team
- Finance Unit
- District Managers

4.3.4 STAFFING COMPLEMENT

Current nil
Future 1 x AO7 Principal Project Officer (Financing and Incentives) **T**

Agreed
NJ
23.9.99

Recommendation:

That the Financing and Incentives function be resourced appropriately to reflect the responsibilities of managing and monitoring a funding and incentives strategy that amounts to $84.6 million in 1998/99. The position should be temporary for 12 months and be subsumed within the Zonal Health Units at this time.

4.4 HEALTH SYSTEMS DEVELOPMENT

4.4.1 OVERVIEW

A number of strategies of the government refer to major development projects and extend the traditional boundaries of the elective surgery initiative. These projects include the development and implementation of a collection and reporting system for specialist outpatients departments. In addition, the *Waiting List Reduction Strategy* includes the development and implementation of a strategy to benchmark waiting times for accident and emergency departments with the aim of reducing waiting times. Other strategies to be developed by this functional area include the better seasonal utilisation of operating theatres, procedures for the transfer of patients between facilities and the inclusion of substitutable DRGs (eg, cystoscopies) in the DRGs claimable as elective surgery.

4.4.2 ROLES AND RESPONSIBILITIES

- Development and implementation of a collection and reporting system for specialist outpatient departments.
- Development and implementation of a collection and reporting system to benchmark waiting times for specialist outpatients departments.
- Development and implementation of a strategy to allow the better seasonal utilisation of operating theatres.
- Development and implementation of a strategy to allow for the transfer of patients to facilities where waiting times for particular procedures is appreciably reduced.
- Determination of a basket of medical DRGs that are substitutable for surgical DRGs and negotiate with the Commonwealth for the inclusion in the National Data Dictionary.

4.4.3 KEY RELATIONSHIPS

- Medical Superintendents
- Elective Surgery Coordinators and Elective Surgery Liaison Officers.
- Clinical Nurse Consultants – Specialist Outpatients Departments

4.4.4 STAFFING COMPLEMENT

Current	1 x AO7 Principal Project Officer (Transitional Care and Day Surgery)	**T**
	1 x AO6 Senior Project Officer (Transitional Care and Day Surgery)	**T**
Future	1 x AO7 Principal Project Officer (Health System Development)	**P**
	1 x AO6 Senior Project Officer (Health System Development)	**P**

Not agreed Clinical Policy Team should undertake this role longer term

Recommendation:

That a Health Systems Development function of the team be established to develop and implement major projects included in the Government's "Waiting List Reduction Strategy".

4.5 CLINICAL BEST PRACTICE

4.5.1 OVERVIEW

Clinical systems change related to surgery has been successfully progressed over the past 2 years. For example, all 32 reporting hospitals now having formal pre-admission processes in place. The change process has been managed corporately by firstly, keeping abreast of clinical innovations nationally and internationally through literature review and conference participation. Secondly, consultation with key stakeholders has been a critical driving factor, ensuring "buy in" from those responsible for delivering the changes. The Clinical Advisory Committee, made up of professional associations and service providers, has met monthly and has managed focussed working party activity in targeted areas such as pre-admission processes, day surgery, theatre utilisation, transitional care, and discharge planning. Thirdly, the promotion of alternative practices has occurred through pilot projects with the wide dissemination of information from the projects. Fourthly, education has been an important element of the function in promoting better models of care through the hosting of seminars and workshops and through the distribution of summary reports.

The opportunity now exists to extend the Preferred Clinical Practice function beyond surgical boundaries to include innovative clinical practices in the medical area. Within Performance Management Branch, the Clinical Policy Team (Policy Coordination Unit) is the appropriate area to provide leadership and a coordination role for all clinical policy directions for Queensland Health. This should include an oversight role to the establishment and coordination of a clinical benchmarking function. The implementation of the Clinical Benchmarking System in the first five of 24 potential sites provides an incentive to establish the Team and progress the development of clinical outcome measures for specific clinical areas.

However, there is a need to continue a "clinical best practice" function within the proposed ***Clinical Access Team***. The Elective Surgery Team has initiated significant innovative clinical changes by providing leadership in establishing "Hospital in the Home" models and progressing the credentialling of acute out-of-hospital care to allow inclusion in activity targets for District Health Services. In addition, a number of excellent "models of care" developed through the Transitional Care program must now be implemented in other public hospitals. A District collaboration model is proposed in similar vein to the National Demonstration Hospitals Program by establishing lead hospitals and collaborating hospitals to implement these system changes.

...ication of the quarterly *Elective Surgery Waiting List Report* and the Minister's requirement to collect waiting times for specialist outpatients appointments, has introduced the need for a significant increase in liaison and communication with general practitioners. The enhancement of this liaison role will commence on 27 August 1998 with the meeting of the General Practice Liaison Council where such issues as referral protocols and processes, access to outpatient appointments, hospital contact officers and assistance to patients will be covered.

This position in the proposed Clinical Access Team is considered pivotal to the identification and integration of best practice across the total continuum from general practitioner referral to specialist outpatient appointment through to post admission processes. It provides the innovative clinical expertise in the Team and manages the important interface with the Clinical Advisory Committee. It would operate in close concert and take strategic direction from the Clinical Policy Team and the Clinical Benchmarking Team in the new arrangements.

4.5.2 ROLES AND RESPONSIBILITIES

- Establishment of formal policy direction mechanisms from the Clinical Policy Team and Clinical Benchmarking Team.
- Manage the rollout of preferred models of care developed through the Transitional Care program through a district collaboration model.
- Manage the enhancement of the general practitioner liaison role in conjunction with the 25 Divisions of General Practice in consultation with the Health Outcomes Unit.
- Scanning of clinical practice developments related to the scope of the proposed Clinical Access Team both nationally and internationally.
- Consultation with major stakeholders including professional associations and service providers either through the Clinical Policy Team or directly – Specialist Advisory Panels, Clinical Advisory Committee, Medical Superintendents Advisory Committee.
- Engage in regular consultation with the Organisational Improvement Team to provide education programs for major stakeholders & service providers.

4.5.3 KEY RELATIONSHIPS

- Clinical Policy Team.
- Clinical Benchmarking Team.
- Clinical Advisory Committee.
- Health Outcomes Unit
- Divisions of General Practice

As this is a priority for the Govt, these teams should be concentrating on this issue now (with current resources).

4.5.4 STAFFING COMPLEMENT

Current 1 x AO7 Principal Project Officer (Preferred Clinical Practice) **T** ✓

Future 1 x AO7 Principal Project Officer (Clinical Best Practice) **P** ✗ Not Agreed

23.9.98

Recommendation:

That the Preferred Clinical Practice function be expanded beyond surgical boundaries and be informed by strong links with the Clinical Policy Team and Clinical Benchmarking Team. In line with the mainstreaming objective, this position will transfer to the Clinical Policy Team or Clinical Benchmarking Team in 12 months.

5. BUDGET

5.1 Staff/Administrative Expenses

- Funding has been identified in the Corporate Office budget workup for the following positions:

Manager AO8		HT5169	$64,973
Principle Project Officer (Hospital Coordination) AO7		HT5174	$59,199
Principle Project Officer (Information and Systems Analysis) AO7		HT5173	$59,199
Principle Project Officer (Clinical Best Practice) AO7	H11273		$59,199
Project Officer (Collections and Analysis) AO5		H11565	$46,535
Administrative Officer (Communications and Office Support) AO3		HT5177	$34,573
Administrative Support @ $6,800 per FTE			$40,800
TOTAL			**$364,478**

- Funding is required for the following positions:

Principle Project Officer (Funding and Incentives) AO7	HT5172	$59,199
Principle Project Officer (Systems Development) AO7	H11272	$59,199
Senior Project Officer (Systems Development) AO6	H11274	$52,826
Senior Project Officer (ORMIS Development and Theatre Utilisation) AO6		$52,826
Administrative Support @ $6,800 per FTE		$34,000
TOTAL		**$251,250**

5.2 Travel

The proposed unit structure allows for a significant consultion role for the Manager and other more senior staff. This role is considered critical in ensuring Districts remain motivated in achieving the Government's policy directives in this area and for the promotion of achievements. To this end, additional travel funds are required to support this expanded role.

$50,000

5.3 Systems Development

A number of enhancements are planned for the information systems that provide the data for the strategy in 1998/99.

Description of Enhancement	Amount	Payment to
EAS Module enhancements in EAS 1997/98	$33,000	Data Services Unit
Cost sharing for enhancements to EAS 1997/98	$70,000	CISU
Ad hoc reporting requirements including the $5,500 for "Removals Report"	$20,000	CSC
Implementation of unit record level EAS data monthly reporting	$200,000	CISU/CSC
Development and construction of database for new QHAPDC extract	$15,000	Programmer/software
Theatre Utilisation Corporate Reporting	$100,000	
Estimated Total	**$438,000**	

5.4 Source of Funds

Uncommitted recurrent elective surgery funds from 1997/98.

6. FORMAL CONSULTATION MECHANISMS

6.1 Elective Surgery Taskforce

A Special Ministerial Task Force, chaired by the Deputy Director-General (Health Services), was formed to investigate and make recommendations on appropriate changes to the health care delivery system. The Task Force has met on a six monthly basis and has provided a forum for discussion of the achievement and directions of the *Surgery on Time* initiative. It has not been successful in setting strategic direction.

? needed

Recommendation:

That the Elective Surgery Task Force be discontinued.

6.2 Clinical Advisory Committee

A Clinical Advisory Committee was formed specifically to review and make recommendations on preferred clinical practice. The committee has met on a monthly basis and has been most active in progressing initiatives in five targeted areas – pre-admission processes, day surgery, transitional care, theatre utilisation and discharge planning.

? needed

Recommendation:

The Clinical Advisory Committee continue to meet on a monthly basis.

6.3 Medical Superintendents Advisory Committee

A Medical Superintendents Advisory Committee chaired by the District Manager, West Moreton District Health Service was formed to provide a direct operational link to the participating hospitals. It comprised the Medical Superintendents from the 10 participating hospitals. The Committee has been very active and the committee has received the support of the Deputy Director-General (Health Services) to expand membership to include representation from Redcliffe, Logan and QE II Hospitals and continue to provide operational support and feedback to the surgery strategy.

Recommendation:

The Medical Superintendents Advisory Committee continue to meet on a monthly basis.

Agreed.

6.4 Elective Surgery Coordinators Committee

Elective Surgery Coordinators have been employed at all participating hospitals and funding for these positions has now been made a permanent addition to the base budgets of relevant hospitals. The coordinators are the pivotal link between the corporate initiative and the hospitals. The roles and responsibilities include the management of the waiting lists in the respective hospitals and developing and implementing hospital-based strategies to enhance elective surgery services.

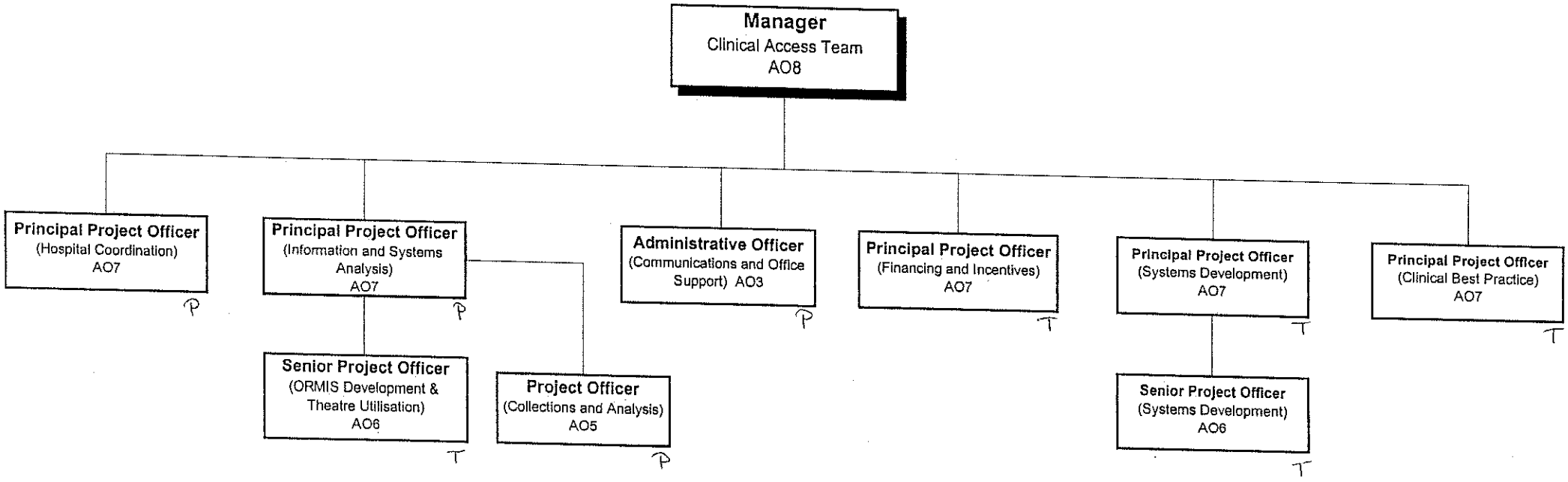
Recommendation:

The Elective Surgery Coordinators continue to meet on a monthly basis.

- Face to Face – quarterly
- Teleconference at other times – suggest 4 ie. 8 meetings per year unless special reason for additional meetings.

Proposed Organisational Structure

CLINICAL ACCESS TEAM - Proposed Structure



VERSION 27 August 1998

Major Projects

Overview

PROJECT OUTLINE
Specialist Outpatient Information and Reporting

Background

One of the major barriers to accurately assessing the demand for elective surgical services in Queensland hospitals is the lack of timely, accurate and comparable outpatient information. At present there are no corporate reporting requirements for hospitals in relation to specialist outpatient services apart from the occasions of service reports. This absence of specialist outpatient reporting allows the true demand for surgery to be masked if access to specialist outpatients is limited.

The lack of useful information relating to specialist outpatient services is due to the absence of:

- definitions relating to outpatient services
- consistent information recording
- an appropriate data collection system.

The key element in establishing a system for reporting of specialist outpatient services is the development of an appropriate data collection system. The HBCIS Appointment Scheduling system is a computerised system operational in 12 hospitals. This system has not been used to facilitate the generation of management information. The remaining hospitals maintain manual systems to manage their outpatient clinics. Any form of reporting from the hospitals will therefore be resource intensive.

Objectives

1. To develop and implement a corporate standard for the regular collection of surgical specialist outpatients information from the 32 Queensland elective surgery reporting hospitals. The corporate standard will define the minimum data set required of reporting hospitals.

2. To profile the demand for surgical services and availability of these services across the State.

Methodology

1. Develop performance indicators for specialist outpatient services.

2. Establish the minimum data set required for corporate reporting.

3. Identify the information systems and data collection processes in use at the 32 elective surgery reporting hospitals.

4. Investigate the feasibility of implementing HBCIS Appointment Scheduling, or an alternative information system, across all hospitals.

5. Establish a system for collection and reporting of the minimum data set (either manually or electronically as determined in point 3 above).

6. Implement the system, ensuring consistency across the 32 hospitals and that the accurate identification of all demand for surgical services is facilitated.

7. Develop a profile of the specialist surgical services available in the 32 reporting hospitals.

8. Identify the demand for specialist outpatient services and where waiting lists exist.

9. Relate waiting lists and waiting times in specialist outpatient services to those for surgical waiting lists.

PROJECT OUTLINE
Targeting Integrated Bed Management

Background

Integrated bed management is a process of maximising bed utilisation while taking into account the finite resources, the predictable variations in demand, and the need to prioritize patient admissions on the basis of clinical need. Access to inpatient beds within hospitals is determined by the total number of beds, the availability of beds and the demand for emergency and booked admissions. The number of hospital beds is finite. Within the demand for admissions, there are several categories of patients competing for the available beds – a fact which has the potential to cause access blocks. Beds must be available for emergency admissions, but this need must be balanced against the beds required for elective admissions, both medical and surgical.

Excessive waiting times for admission from Emergency Departments and Admission Waiting Rooms can occur during periods of increased demand for emergency admissions and high bed occupancy. Bed availability may then be further compromised as patients become backlogged in emergency departments. One strategy used to alleviate this pressure is to cancel elective surgical patients. While this strategy may make beds available, it also results in anxiety for patients, increased pressure in terms of treating patients within the desired time frame and sub-optimal use of hospital resources accessed prior to admission.

Other factors such as seasonal variations also impact on the demand for beds and bed availability. During winter months hospitals experience an increase in emergency admissions, as well as booked medical admissions. Detailed analysis of bed utilisation by specialty, identifying trends in seasonal variations could assist in predicting bed availability for elective admissions. This would be particularly useful in planning for the purpose of maximising elective surgery.

Strategies initiated over the past two years have made some attempt to improve bed availability and increase bed utilisation rates. Improved pre-admission processes, discharge planning and out-of-hospital care can reduce the demand for inpatient beds. Further development is required to integrate these strategies with bed management policy to reduce pressure on hospital resources.

Clinical practice guidelines may also assist in achieving equity of access for patients with similar clinical need.

Objectives

1. To develop an integrated bed management strategy which facilitates maximal utilisation of resources.
2. To develop clinical practice guidelines which will assist in prioritisation of patients for admission.

Methodology

1. Undertake a detailed bed utilisation analysis, including identification of capacity for emergency and booked admissions within the 32 reporting hospitals.
2. Examine existing bed management strategies.
3. Examine models of integrated bed management implemented in other States appropriate for application within Queensland hospitals.
4. In consultation with key stakeholders, develop appropriate strategies for prioritisation of emergency and booked cases within hospitals.
5. Implement data collection system and reporting process in the 32 Elective Surgery reporting hospitals for reasons for cancellation, and waiting times on admission for emergency and booked admissions.
6. Review data and identify target areas for modification of services and procedures.

PROJECT OUTLINE
Development of Corporate Reporting
Using the Clinical Benchmarking System

Background

The Clinical Benchmarking System (CBS) is a computerised system that will allow data collection on an operational, business and clinical level. Clinical benchmarking is strongly related to monitoring of service quality and service enhancement. Ultimately, purchasing plans will ensure that operational and clinical outcomes will be achieved in an efficiency environment; that is services can be clinically, operationally and financially benchmarked. The CBS is being implemented in 24 sites over a 3-year period. Implementation is nearing completion at 3 sites – Princess Alexandra Hospital, Gold Coast Hospital, and Royal Brisbane, Royal Women's and Royal Children's Hospital.

In addition to the implementation of the CBS, considerable progress has been made in the use of performance indicators which focus on access and efficiency. Waiting times for elective surgery and within Emergency Departments as well as theatre utilisation rates, clinical throughput by specialty and DRG are currently collected and reported. Measuring quality of service using outcome-based measures is more difficult than measuring operational performance since these measures involve education and training of staff and can be specific for particular conditions or procedures.

Further developing corporate reporting and effective clinical benchmarking will require definition of valid, reliable clinical outcome measures; refinement of operational performance indicators; and the broad application of appropriate data collection systems. The importance of quality and outcome indicators in this process has been identified in the Commonwealth Department of Health and Family Services publication - *Quality and Outcome Indicators for Acute Healthcare Services*.

Objectives

1. To develop the outputs from the Clinical Benchmarking System to allow benchmarking of clinical and operational measures. The strategy to develop the output should provide the link between policy, clinical and operational outcomes and costings.

2. To develop the Clinical Benchmarking System reporting system to assist managers and clinicians within Queensland hospitals and to allow performance monitoring by corporate office.

Methodology

1. Identify target procedures and conditions for collection and reporting of clinical outcome and operational performance indicators.

2. Investigate the availability of validated, reliable clinical outcome measures for use in the targeted areas and facilitate their implementation.

3. Continue development of performance indicators for assessment of access, efficiency, safety, effectiveness, continuity, acceptability, technical proficiency and appropriateness.

4. Establish collection and reporting systems for clinical outcome measures and key performance indicators utilising the Clinical Benchmarking System.

5. Identify and describe current practice for the target procedures in each site including details, profiles or credentialling of services. This will include the identification of demographics and trends of service need.

PROJECT OUTLINE
Controlling Demand for Elective Surgery

Background

Any considered effort to reduce waiting lists for elective surgery must include elements which address the demand for surgery. Successful measures which have been used to manage elective surgery waiting lists have concentrated on the supply of services, without attempting to influence demand. While many of these strategies continue to be effective, it seems clear that the long-term strategy to manage waiting lists must include some effort to control the demand for surgery.

Limiting demand for surgery by reducing the incidence of preventable conditions and effective early management of chronic conditions has to date received little consideration as a means of managing waiting lists for surgery. There is evidence that for certain conditions, the need for surgery can be delayed or prevented, reducing the clinical need for surgery. However, funding for preventive and non-medical management is limited, making effective options of this type underutilised. This strategy would require changes to the funding for non-surgical services.

Another relevant issue is that the demand for elective surgery is closely linked to the demand for specialist outpatient services and is therefore influenced by referral practices to specialist outpatient services. There is lack of clearly defined criteria or guidelines to assist general practitioners in making decisions about when to refer to specialist outpatient services. This may be resulting in referral to surgical services when treatments other than surgery are most appropriate.

Demand for elective surgery is also influenced by clinical practises within surgical specialties. There is considerable variation in the types of surgery offered in public hospitals throughout the State. Corporate policies can be developed to define which procedures will not be publicly funded. Decisions about when patients are placed on a surgical list are also inconsistent. While many of these variations will be due to legitimate differences in patient needs, there is scope for more consistency in establishing when patients require surgery. Collaboration with surgical colleges to develop criteria for access to surgery is one possible means of addressing this issue.

Objectives

1. To investigate the potential for reducing need for surgery by effective prevention and early management.
2. To develop a system that assists medical practitioners in determining which patients are suitable for referral to specialist outpatient services.
3. To develop systems that ensure patients are ready for surgery when placed on surgical waiting lists, and that effective non-surgical options for treatment have been accessed where appropriate.

Methodology

1. Identify surgical conditions for which preventive and early management programmes are effective in reducing the need for surgery.
2. Consult with relevant colleges, associations and consumer advocate groups to define procedures which can be provided in public hospitals.
3. Examine relationships between referral to specialist surgical outpatients and placement on waiting lists for surgery.
4. Identify any source of sub-optimal or inappropriate referral practises and investigate systems to minimize these practises.
5. Investigate existing systems which incorporate criteria for access to surgery and examine the feasibility of implementing criteria in Queensland public hospitals.
6. Examine alternative funding models for the provision of surgical services, which remove incentives for performing surgery in preference to other effective treatments.
7. Facilitate modification of existing systems to minimize inappropriate referrals, incorporate criteria for access, and provision of appropriate funding for effective alternatives to surgery.

PROJECT OUTLINE
Day Surgery - Purchasing and Reporting

Background
For the past two years, the provision of incentive funding has initiated changes that have increased day surgery rates through the promotion of infrastructure and process changes such as improved discharge planning and pre-admission processes. This has facilitated an improvement in the proportion of elective surgery being performed as day surgery to 42.8% (6 months July 1997 to December 1997). However, to enable further improvements in the proportion of elective surgery performed as day surgery, a purchasing and reporting strategy is recommended.

Objective
1. To develop a policy to identify purchasing and reporting strategies that will increase the day surgery rate to 52.8% by July 1999 and 60% by July 2000 for elective surgery reporting hospitals. Specific targets will be incorporated into Health Service District Agreements.

The policy will promote the delivery of day surgery services based on the principles of quality, effectiveness, best practice and client focussed outcomes.

Methodology
1. Identify agreed day surgery target rates as a percentage of overall elective surgery for each reporting facility.

2. Identify target procedures for each speciality that will be performed as day cases unless specifically contraindicated.

3. Identify and monitor
- admission policies and procedures to ensure equity of access for all people
- pre-operative patient screening and selection processes ensure that targets are achieved
- surgical equipment requirements that includes laser and endoscopic surgery equipment
- recovery and discharge criteria to promote optimal patient outcomes
- post-surgical community support that includes the General Practitioner and other community service providers.

4. Establish lead facilities that will increase day surgery caseload by undertaking more complex day surgery procedures, refining minimal access surgery and introducing advanced anaesthetic and intravenous sedation technology.

5. Provide timely census and activity data to support decision making for funding allocation, to identify problem areas, to identify achievement of targets. The Day Surgery Report will provide information by facility, by specialty, by category and by procedures.

PROJECT OUTLINE
Targeted Long-Wait Patients

Background

The management of patients waiting longer than the ideal times on surgical waiting lists has important implications for clinical outcome, equity of access and operational efficiency. There is currently considerable variation in the manner in which waiting lists are managed across the State and within individual hospitals. This is resulting in inequitable access to surgical services and may be adversely affecting clinical outcomes.

Responsibility for clinical review while patients are on a surgical waiting list has been outlined, but must now be specifically defined. Clinical review of patients is an important part of providing quality specialist outpatient services. In some cases, specialist outpatient review is carried out to monitor deterioration of condition, or on the basis that surgery will be needed in the future. These practices increase demand for specialist surgical outpatient services, and may limit the availability of services for new cases. Review of such patients could be carried out by general practitioners, with re-referral when the patient's condition warrants. Formal review of patients on waiting lists by general practitioners will ensure clinical needs are met, but requires good communication between specialist and general medical practitioners.

The order in which patients are selected from waiting lists also has implications for clinical outcome and operational efficiency. Patients with similar clinical needs are currently experiencing markedly different waiting times for surgery when comparison is made between surgeons within a service and even within individual surgeons' lists. This practice results in preferential treatment of some patients and delayed treatment for others whose needs are similar.

Objectives

1. To define responsibility for review of patients on waiting lists for surgery, ensuring issues relating to patient care and efficient utilisation of resources are addressed.

2. To establish a system which ensures equitable selection of patients from surgical waiting lists.

Methodology

1. Identify clinical groups or services with long waiting times to be targeted.

2. Examine current practice relating to review of 'long-wait' patients on surgical waiting lists.

3. Investigate alternative models for clinical review processes (including consultation with relevant colleges).

4. Define the professionals responsible for clinical review of patients on surgical waiting lists.

5. Establish a system for appropriate review of patients on waiting lists and for monitoring of the review process.

6. Examine current practice relating to selection of patients from Category 3 waiting lists.

7. Investigate systems for facilitating equitable selection of patients from the waiting list and develop models appropriate for local needs.

8. Implement systems for review of patients and for selection from waiting lists throughout the 32 elective surgery reporting hospitals.

PROJECT OUTLINE
Enhancing Out-of-Hospital Services

Background

Services directed at improving management of patients in the community have been shown to improve overall efficiency of the health service while maintaining clinical outcomes. Successful programmes initiated over the last two years have demonstrated that specific groups of patients can be safely and appropriately managed out of the acute hospital environment. Provision of out-of-hospital care may also have a significant influence on the needs for capital expenditure in the future.

A number of facilities throughout Queensland have developed successful models for the provision of out-of-hospital services and the benefits demonstrated can be passed on to other facilities. Guidelines for inclusion of patients, data collection, corporate reporting and credentialling of services are currently being established.

Initiatives which provide specific post-acute services and hospital-in-the-home type services have resulted in decreased length of stay in hospital, with improved patient satisfaction and maintenance of clinical outcome. The observed reductions in inpatient length of stay suggest a decrease in hospital resource utilisation. However, further work is required to ensure quality of care is maintained across the State.

Objectives

1. To continue the establishment and refinement of guidelines to assist clinicians in determining which patients are suitable for out-of-hospital care.

2. To investigate funding systems which appropriately support the use of out-of-hospital care for appropriate patients.

3. To provide incentives to assist hospitals in establishing the infrastructure and service agreements to support out-of-hospital care.

Methodology

1. Continue identification of out-of-hospital services available across the State and the capabilities of services in each locality.

2. Examine successful models for out-of-hospital care which have been initiated to date and establish a framework to facilitate implementation across the State.

3. Establish lead facilities that will assist other hospitals and facilities in the continuing development of out-of-hospital care.

4. Investigate possibilities for State-wide service agreements with service providers.

5. Examine the application of discharge criteria for in-hospital and out-of-hospital episodes.

PROJECT OUTLINE
Targeted Seasonal Utilisation of Facilities

Background

Seasonal variations occur in elective and emergency admissions to hospital for a number of reasons, resulting in marked differences in the amount of surgery performed at various times of the year. Traditionally, hospitals use times around Christmas and Easter as a budget saving strategy by closing beds and having staff take holidays. This results in reduced elective surgery throughput at these times. Increased emergency admissions during the winter months also impacts indirectly on surgical throughput as more beds are taken up by these emergency admissions – allowing fewer elective admissions.

The Government's *Waiting List Reduction Strategy* identifies the reduction in elective surgery during holiday periods as a potential opportunity for increasing surgical throughput. Increasing surgical throughput during traditionally quiet times will make better use of physical resources such as operating theatres and wards. However, there will be significant human resource and cost implications for hospitals if this method of budgetary control is removed.

Objectives

To provide incentives for increased surgical throughput during holiday periods.

Methodology

1. Identify periods to be targeted for increased surgical throughput.

2. Establish criteria for accessing funds for increasing surgery in the designated periods.

3. Request submissions from District Health Services for appropriate programmes to meet criteria and objectives.

4. Provide funding to districts on the basis of submissions received.

5. Measure the activity provided against the allocated funds and facilitate achievement of objectives by District Health Services.

PROJECT OUTLINE
Targeted Complex Procedures

Background

The *Waiting List Reduction Strategy* presented by the Government included a commitment to provide funds for extra surgery for complex procedures. This commitment was made on the basis that targeting day surgery in isolation results in hospitals increasing throughput only in that area. Therefore, targeting day surgery alone does not provide benefits for patients awaiting surgery which cannot be performed on a day-only basis, and may even encourage day surgery at the expense of patients in need of more complex procedures.

Complex procedures which have been identified are those which require high levels of resource utilisation (eg hip replacement). The weighted separation assigned to a DRG is thus an indicator of the complexity of the procedure.

The commitment to funding extra surgery for complex procedures includes a pledge of recurrent funds with priorities for funding to be established each year. It is anticipated that in the 1998-1999 financial year, $3.55 million will be directed toward complex procedures. Recurrent funding of $7.1 million will then be provided from the 1998-1999 financial year.

Objectives

To establish an enhancement fund which will support extra surgery for complex surgical cases.

Methodology

1. Identify complex procedures to be targeted.

2. Establish criteria for accessing funds for complicated surgery.

3. Request submissions from District Health Services for appropriate programmes to meet criteria and objectives.

4. Provide funding to districts on the basis of submissions received.

5. Measure the activity provided against the allocated funds and facilitate achievement of objectives by District Health Services.

GW3

SAT4

QUEENSLAND HEALTH

BRIEFING TO THE DIRECTOR-GENERAL

SUBJECT: Status of the *Waiting List Reduction Strategy*

BACKGROUND:

At a meeting between the Minister for Health, the Director-General and members of the Surgical Access Team on 15 October 1998, the Director-General requested a status report on the progress of the *Waiting List Reduction Strategy*.

ISSUES:

Staffing

- Approval for the plan to achieve the Government's *Waiting List Reduction Strategy* was received at the end of September. The plan approves the renaming of the Elective Surgery Team to the *Surgical Access Team*. The following positions have been approved, some permanent (P), some temporary (T). The positions that have been filled on a temporary basis are indicated by (t) after the name of the incumbent.

Manager (P)	Gary Walker (p)
Principal Project Officer, Hospital Coordination (P)	Michael Zanco (t)
Principal Project Officer, Information and Systems Analysis (P)	Ann Maguire (t)
Principal Project Officer, Clinical Best Practice (T)	**To be filled**
Principal Project Officer, Funding and Incentives (T)	Dorothy Vicenzino (t)
Principal Project Officer, Health Systems Development (T)	**To be filled**
Senior Project Officer, ORMIS Development and Theatre Utilisation (T)	Karen Scott (t)
Senior Project Officer, Health Systems Development (T)	**To be filled**
Project Officer, Collections and Analysis (P)	**To be filled**
Administrative Officer (P)	Linda Johns (t)

- Several people have been interviewed so that positions may be filled promptly and developmental work can proceed. Permanent positions will be advertised when created.

STATUS:

All of the elements of the 8 point plan have been progressed. The status of each of the elements is as follows:

1. **Publication of the *Elective Surgery Waiting List Report* and General Practitioner Briefings.**
   - The first report was launched by the Minister for Health on 30 July 1998.
   - The second report is due to be published and distributed on 30 October 1998.
   - Letters have been sent to Divisions of General Practice requesting feedback on the report and whether or not the Divisional newsletters are suitable for publishing information. Six replies have been received from the nineteen letters sent. All of the replies provided support for the use of the newsletters for dissemination of information.
   - Memoranda have been sent to all District Managers of the 32 reporting hospitals requesting information regarding any increase in queries since the publication of the report. District Managers report no increase in the number of queries.
   - A letter has been drafted to be distributed with the second *Report* requesting that, if hard copies of the *Report* are required in the future, then a form will need to be completed and returned to the Surgical Access Team. This will encourage greater access to the report via the Queensland Health Internet and Intranet sites and potentially save publishing and postage costs.

2. **Transfer of Patients to even out Waiting Lists.**
This item has been discussed at the Clinical Advisory Committee, the Medical Superintendents Advisory Committee and the Elective Surgery Coordinators Meeting. A detail briefing has been prepared for consideration which recommends the transfer of patients once they have been assessed by a surgeon and are on a waiting list.

3. **Funding and Incentives**
   - The funding allocation for each of the Districts was approved on 30 September 1998. Districts have been notified of the allocations. Post Budget Adjustments are currently being prepared to transfer the funds, identify reporting requirements and identify baseline targets. Approval has been received to review activity against targets quarterly. Elective surgery funding will be transferred from facilities where targets are not achieved to facilities with the capacity and commitment to perform additional activity.
   - Funding associated with Complex Procedures has also been allocated. A briefing is being prepared recommending that this funding be directed towards DRGs with a weight greater than 5. The funding associated with Complex Procedures forms approximately 25% of the recurrent allocation. Subsequently 25% of the new activity purchased will be associated with highly weighted DRGs.

4. **Specialists Colleges to expand Training Places**
Communication with the Office of the Principal Medical Adviser has indicated that a project has been funded by the Commonwealth to review the medical workforce. The Office of the Principal Medical Adviser has prepared a briefing for the Minister.

5. **Working through Holiday Times**
   - This issue has been discussed in depth at the Clinical Advisory Committee, the Medical Superintendents Advisory Committee and the Elective Surgery Coordinators Meeting. Several issues were raised such as: extra funding required to open theatres over holiday periods, slow periods used by facilities to maintain budget integrity, surgeons and specialists needing to take holidays at some time. These issues were briefly discussed with the Minister at the meeting on 15 October 1998. The Minister clarified that holiday times do not refer to public holidays but to slow period leading up to and following the Christmas holidays. This issue will be progressed with those hospitals that are not achieving activity targets.
   - The Corporate Theatre Utilisation Report is being progressed. A workshop was held in September to clarify issues related to the first report. This report will identify efficient utilisation of operating theatres so that 'down' periods can be identified and utilised.

6. **Benchmarking Waiting Times for Accident and Emergency Departments**
A draft plan has been developed. It was discussed at the *Credentialling Committee Meeting for Acute Services Provided Out of Hospital* which is composed mainly of emergency physicians. Further discussions have taken place with the Principal Nursing Adviser regarding the needs for nursing and other staff in Emergency Departments. A meeting with the Deputy Director-General (Health Services) is planned for 20 October 1998 to discuss the strategy.

7. **Day Surgery Targets**

The Surgical Access Team has had an initial planning meeting to advance the Day Surgery strategy. The outcomes of this planning meeting included:

- The need for the development of a policy for day surgery for Queensland public hospitals;
- The identification of targets for each speciality for reporting facilities;
- The need for facilities to identify ways of fulfilling the policy conditions and achieve the targets established;
- The quarterly day surgery report is due at the end of October and will include procedures that have been targeted as potential day cases.
- It is proposed that targeted funding will be directed to "Lead Hospitals" that will develop advanced day surgery techniques, can be used as training facilities and will work with other facilities to improve day surgery rates.

8. **Specialist Outpatients Collection**

Manual collections of next new case appointment times and total number of new cases with and without an appointment time has been established. A plan is being developed for the long term collection and reporting of Specialist Outpatients data. This is a complex area and an initial meeting with Clinical Nurse Consultants from Outpatients is planned for the end of October. This meeting will review the draft plan and identify needs related to the establishment of *Guidelines for the Management of Outpatient Waiting Lists.*

PREPARED BY: Dorothy Vicenzino
Principal Project Officer
Surgical Access Team
Policy Coordination Unit
Performance Management Branch

19.10.98

Contact No.: 40500

CLEARED BY: Judith Robson
Director, Performance Management Branch

20/10/98

Contact No.: 40500

DATE: 19 October 1998

QUEENSLAND HEALTH

COPY

18.11.98

BRIEFING TO THE DIRECTOR-GENERAL

SUBJECT: Status of the *Waiting List Reduction Strategy*, November 1998

BACKGROUND:

- A status report on the progress of the *Waiting List Reduction Strategy* has been prepared for a meeting with the Minister for Health and the Director-General on Thursday 12 November 1998.

ISSUES:

- Three additional project staff will join the Surgical Access Team in November 1998 to provide much needed resources to progress, in particular, the Emergency Services and Specialist Outpatients Strategies.

STATUS:

All of the elements of the 8-point plan have been progressed. The status of each of the elements is as follows.

1. **Publication of the *Elective Surgery Waiting List Report* and General Practitioner quarterly briefings**
   - The second report was published and distributed on 30 October 1998.
   - A letter has been sent to all recipients requesting notification as to whether or not they require future hard copies of the report, considering that the entire report is published on the Queensland Health Information Network and the Internet.
   - Responses continue to be received from the Divisions of General Practice regarding feedback on the report and if the Divisional newsletters are suitable for publishing information. Nine replies have been received and follow-up contact will be made with the other 10 Divisions. It is intended that the Divisional Newsletters be used to improve communication between hospitals and general practitioners and to improve the understanding of the quarterly report.

2. **Transfer of Patients to even out waiting lists**
   - A detail briefing that recommends the transfer of patients once they have been assessed by a surgeon and are on a waiting list has been prepared for the Minister for Health for consideration.

3. **Funding and Incentives**
   - The District allocations for elective surgery in 1998/99 have been finalised and Districts notified. A document *Elective Surgery Funding Arrangements in 1998/99* has been supported by the Deputy Director-General (Health Services). This document details the reporting arrangements for elective surgery in 1998/99 including the setting of a total elective surgery target and the reporting of monthly elective surgery activity against this target.
   - Funding of $3.1M for complex procedures has been included in the allocations to Districts. Complex procedures with a cost weight greater than four are eligible for claims under this funding.

4. **Specialists Colleges to expand training places**
   - Communication continues with the Principal Medical Adviser, Health Advisory Unit regarding the review of the medical workforce. The Adviser has indicated that the project officer for the Medical Workforce Project will commence in the new year.
   - A proforma developed for the review of the current staffing of Emergency Departments was reviewed by the Principal Medical Adviser. It was agreed that the Principal Medical Adviser be part of the group that reviews the information collected in the proforma.

5. **Working through holiday time**
   - A memorandum to Districts has been drafted for the signature of the Deputy Director-General (Health Services) requesting information on closure times of theatres during holiday periods between now and the end of the financial year.
   - The Corporate Theatre Utilisation Report is being progressed. A workshop was held in September to clarify issues related to the first report. The recommendations from the workshop are being reviewed in respect to progress in Theatre Utilisation Definitions used by other states. This report will identify efficient utilisation of operating theatres so that 'down' periods can be identified and utilised.

6. **Benchmark waiting times for Accident and Emergency Departments**
   - The Surgical Access Team met with the Deputy Director-General (Health Services) to review the status of the Emergency Department Strategy on 20 October 1998. Several elements of the strategy were discussed and agreed to.
   - To review emergency department staffing needs, a proforma was developed and distributed to facilities with a role delineation of four and above. This proforma includes requests for information regarding current staffing levels, other services that are provided within emergency departments and retrieval and transfer information. Completed proformas are to be returned by 13 November 1998.
   - Occasions of service for Emergency Departments, by triage category and disposition for the last two financial years for have been received from the Data Services Unit. This information is currently collected via the Monthly Activity Collection. Initial analysis is being undertaken and will form part of the staffing review.
   - The Surgical Access Team met with the Queensland Emergency Nurses Association on 26 October 1998. This meeting discussed issues that the Association had raised with the Minister for Health on 15 October 1998. The group agreed to continue to provide information to the Surgical Access Team regarding education requirements and best practice innovations in emergency departments. The group has since met on 9 November 1998 and continues to provide input into the strategy.
   - The Emergency Services Project Plan was presented to the Emergency Services Specialist Advisory Panel on 3 November 1998. The panel recommended that further information be collected regarding the needs for equipment in emergency departments. A sub-group was also formed to review and advise the Surgical Access Team on the results collected in the proforma. This group will include the Principal Medical Adviser.
   - A comparison of emergency department information systems (EDIS and HBCIS Emergency Module) has been undertaken. The outcome of this comparison will be a recommendation as to the best system to meet information needs for corporate reporting and emergency department management.
   - Two project outlines have been received regarding mathematical algorithms and bed simulations for predicting bed usage from emergency and elective admissions. These outlines are being assessed for inclusion in recommendations for funding in the Emergency Department Plan.

- A meeting with Dr Richard Ashby on 11 November provided information regarding the analysis of occasions of service by triage category. This included analysis by hospital emergency departments, by attendance by triage, and admission rates by triage. There are National benchmarks for these measures. Analysis will provide indications of data integrity and consistency.

7. Day Surgery Targets

- The minimum day surgery target of 50% has been identified in the *Elective Surgery Funding Arrangements in 1998/99.* Districts that do not demonstrate progress towards this target will be requested to provided details of their plans on how this target will be met.

8. Outpatient Collection

- Manual collection of next new case appointment times and total number of new cases with and without an appointment time continues.
- Clinical Nurse Consultants from outpatient departments met with the Surgical Access Team on 4 November 1998. They agreed to form the Outpatient Clinical Best Practice Working Party and are currently reviewing current practice and management of outpatient waiting lists and appointments. A primary objective of the Working Party is to develop business rules for outpatient departments in the form of *Guidelines for the Management of Outpatient Waiting Lists.*
- A communication strategy for the inclusion of other key stakeholders from the outpatients' area was discussed in depth at the Clinical Advisory Committee on 10 November 1998. This committee agreed to provide the input required from General Practitioners and from medical officers.

PREPARED BY: Dorothy Vicenzino
Principal Project Officer
Surgical Access Team
Policy Coordination Unit
Performance Management Branch **Contact No.:** 40500

CLEARED BY: Judith Robson
Director, Performance Management Branch **Contact No.:** 40825

DATE: 12 November 1998

GW4

History of the Elective Surgery Program 1995-2005

Name *Strategy for managing elective surgery in Queensland public hospitals*
Period *November 1995 – February 1996*
Party *Labor Government*

The *Strategy for managing elective surgery in Queensland public hospitals* was released by the Minister for Health, Peter Beattie in November 1995. It provided a framework for improving access to elective surgery in Queensland public hospitals in conjunction with a number of funding strategies to reduce waiting times for elective surgery.

The Strategy complemented a range of other initiatives introduced by the State Government to reduce the times that patients in public hospitals wait for elective surgery. These initiatives included:

- Investment to reduce the backlog in elective surgery ($64 million over three years);
- Incentives to attract and retain specialized personnel ($42.1 million over three years);
- Accelerated rebuilding of the major metropolitan hospitals so that they can be used to their full potential (an additional $40 million over two years); and
- A specialist equipment program to ensure that our specialist areas maintain world class standards (an additional $35 million over two years).

Name *Surgery on Time*
Period *February 1996 – June 1998*
Party *Coalition Government*
Team *Elective Surgery Project*

In February 1996, the Government gave a commitment to significantly expand previous strategies to enhance elective surgery services in public hospitals in Queensland through the *Surgery on Time* plan. The plan involved a coordinated approach to managing the major elements that impact on elective surgery services, with strategies to target increased throughput in conjunction with active management of waiting times (rather than the size of the waiting list).

A dedicated Project Team was formed in March 1996 to develop and implement an action plan for enhancing elective surgery services in Queensland's public hospitals. The team was known as the Elective Surgery Project and was headed by a senior clinician. The action plan was developed after extensive consultation with medical and nursing colleges, societies and associations as well as with District Managers and key medical and nursing personnel from the participating hospitals.

The implementation of the *Surgery on Time* plan aimed to achieve:

1. Better information and reporting to aid monitoring and performance management;
2. Appropriately qualified and trained clinical staff in our hospitals;

3. Enhanced capital infrastructure to support increased surgical throughput;
4. Better utilisation of our operating theatres;
5. Strategies to increase day surgery rates and reduce the need for hospitalisation;
6. Improved transitional care in the community to promote reduced hospital lengths of stay;
7. The development of better clinical practices; and
8. Extra funding packages to ensure that our objectives are achieved.

Name *Waiting List Reduction Strategy*
Period *July 1998 – January 2005*
Party *Labor Government*
Team *Surgical Access Team (changed to Surgical Access Service in 2002)*

In 1998, the Government gave a commitment to significantly expand previous strategies to reduce waiting times in public hospitals in Queensland. The Waiting List Reduction Strategy involves an eight-point plan to cut waiting lists and includes a commitment to:

i) publish the waiting list for each hospital every three months so that money can be channelled to where the real need is;
ii) supply general practitioners with quarterly briefings on waiting lists to help them when referring people for surgery;
iii) even out waiting lists by moving people in appropriate cases to a hospital where their procedure can be performed more speedily;
iv) provide additional funding of $6.0 million per year to finance extra surgery for complex procedures;
v) work with the specialist colleges to expand training places for new specialists to meet the demand of the next century;
vi) use holiday times to keep operating theatres working for the benefit of those waiting for surgery;
vii) benchmark waiting times for accident and emergency departments to reduce excessive waits; and
viii) increase levels of day surgery across the State to reduce the length of waiting times for elective surgery.

A further element was added to the eight-point plan, being the collection of waiting times for specialist outpatient appointments to assist in clinical prioritisation for surgery and appointments.

In achieving these elements, the Surgical Access Team's objectives were to:

- Develop policy directions to inform the effective delivery of services into the future;
- Develop and implement systems to improve efficiency, appropriate practice and equity of access to emergency department, specialist outpatient and elective surgery services on a statewide basis;
- Provide information, both at a strategic and operational level, to guide the forward planning and ongoing management and of emergency department, specialist outpatient and elective surgery services across Queensland public hospitals;
- Benchmark performance of emergency department, specialist outpatient and elective surgery services in Queensland public hospitals;

- Provide expert advice and analysis relating to emergency department, specialist outpatient and elective surgery services; and
- Consult and communicate with key stakeholders including the major medical and nursing colleges and associations.

In 2001, the Government's election commitments provided for the enhancement of surgical services in public hospitals, including:

- injecting an additional $20 million over two years, into funding for elective surgery so that more people can have their 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 of surgery admissions within two years;
- establishing a central elective surgery booking bureau that will be more patient-focused and more responsive to providing services to people where they live; and
- strengthening clinical protocols to ensure appropriate and timely treatment of patients based on clinical need.

In 2004, the Government's election commitments included a $110 million program aimed at reducing waiting lists throughout the State, with funding for areas with the highest need and longest waiting lists over three and a half years. The Government has also committed significant funding to support initiatives to ease the pressure on public hospital emergency departments.

Name *Waiting List Reduction Strategy*
Period *February 2005 - current*
Party *Labor Government*
Team *Zonal Management Units and Health Systems Development Unit (SH&CSB)*

In February 2005, the Surgical Access Service was mainstreamed and the responsibility for overseeing the *Waiting List Reduction Strategy* was given to the Zonal Management Units. The responsibility for reporting against the *Strategy* was given to the Health Systems Development Unit (within Statewide Health and Community Services Branch).

In March 2005, the Elective Procedures Program Steering Committee was activated comprising membership from Statewide Health and Community Services Branch, Zonal Management Units, and the Health Services Directorate office. The role of the Elective Procedures Program Steering Committee is to oversee the Elective Procedures Program in line with the Government's *Waiting List Reduction Strategy*. This includes:

- Developing the business rules for the Elective Procedures Program;
- Providing recommendations to the Senior Executive Director, Health Services Directorate (SEDHSD) regarding the allocation of funding and activity targets to Districts for the Elective Procedures Program;
- Monitoring performance against agreed funding and target allocations;
- Developing the methodology for incorporating elective procedures and elective surgery into the Elective Procedures Program; and
- Governance of the Policy Framework and Management Guidelines for the Elective Surgery Program