Ex 395

Queensland Government
Queensland Health

SUBMISSION TO:

☑ **General Manager (Health Services)**

☐ **Deputy Director-General, Policy and Outcomes**

(Please tick one box only)

DATE:	11 September, 2003		
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SUBMITTED THROUGH:	Glenn Cuffe, Manager Procurement Strategy Unit	**Contact No:**	52361
DEADLINE:	12th September 2003	**File Ref:**	1224-0023-016

SUBJECT: Retention of Quarantined Elective Surgery Funds

APPROVED/ NOT APPROVED

COMMENTS

(Dr) Steve Buckland
General Manager (Health Services)
/ / 2003

PURPOSE:

To present a series of options for endorsement by the General Manager (Health Services) designed to preserve quarantined elective surgery funding for the purchase of additional elective surgery activity.

BACKGROUND:

Earlier this year, the Surgical Access Service identified a number of hospitals actively reclassifying emergency surgical presentations as elective surgery. These cases were then claimed against funded activity targets.

This action contravenes the fundamental guiding principle of Surgical Access funding allocation, that funds are to be used to purchase additional elective surgery activity.

In most cases, these hospitals also reduced the amount of total surgery performed, while claiming elective surgery surpluses. In written advice to all District Managers, the General Manager (Health Services) reinforced the necessity to meet total surgery targets as well as those for elective surgery (Memorandum 24 March 2003).

In conjunction with Zonal management, the Surgical Access Service held discussions with District Managers from 8 hospitals representing 94.5% of reclassified emergency activity for the State. This document presents a summary of these discussions and common responses to the issues raised.

Three options for corrective action are then presented for consideration by the General Manager (Health Services).

DISCUSSIONS WITH DISTRICT MANAGERS:

Discussions focussed on the cohort of patients presenting at emergency department (ED), who were triaged, admitted, had a surgical procedure, and were reclassified as "elective" admissions. More detailed audits showed patients within this cohort fell into three groups;

1. Those already on waiting lists who presented to ED for booked surgery
2. Patients not on waiting lists, who were added by the hospital after admission or treatment
3. Patients transferred from other facilities after assessment, who had not been admitted as "Hospital Transfer" on presentation

Where the ED is regularly used as an entry point for patients booked for surgery the following day, some reclassification could be expected, as the status of the patient may not be known on admission. However some hospitals showed very high proportions of patients within the cohort who had not been previously assessed prior to ED presentation.

Common Responses

Summaries of each discussion are included in Attachment B. However there were some common views expressed by each of these 7 District Managers regarding reclassification practices. These views do not appear to be shared by District Managers responsible for the other 16 hospitals included within the audit.

Only 2 of the 8 hospitals selected for detailed audit met total surgery targets during 2002/03, yet all reported elective surgery surpluses and accessed full elective surgery funding allocations [1]. These elective surgery targets were achieved with the assistance of reclassified emergency presentations.

[1] Some activity funding was withheld from Nambour pending the outcomes of this audit

All District Managers interviewed stated that current reclassification practices would continue unless specifically prevented by criteria within the Elective Surgery Business Rules. All considered that the Queensland Health admission policy had been correctly interpreted. This belief was based on reclassification being legitimate provided the patient waited 24 hours or more for a surgical procedure. Patients not proceeding to theatre within 24 hours were routinely amended to elective status, and entered on the Elective Admissions Management module by the majority of hospitals reviewed.

This interpretation of the Queensland Health Admitted Patient Data Collection (QHAPDC) admission policy appears to have originated at the Princess Alexandra Hospital prior to 2000/01. This is the first time it has been formally challenged by the Surgical Access Service. Other Districts stated they had adopted this practice following contact and advice from PAH staff, after Zonal instructions to apply "consistent" classification practices, or following advice provided by SAS staff during site visits.

In order to meet qualifying elective surgery criteria, all hospitals added reclassified emergency surgery admissions to waiting lists on to the Elective Admissions Management module. Some hospitals (RBH, PAH, NBR) backdated these entries to between 1 and 2 days prior to ED presentation. These entries appear to be deliberately deceptive.

Others (MBO, HBY, QEII) entered the day of admission as the date the patient was added to the waiting list. BBG and TBA added the patient to the waiting list between the date of admission and date of operation.

CORRECTIVE MEASURES

Unless corrective measures are established, the volume of reclassified emergency surgery funded from elective surgery allocations will continue to increase, with less total surgery actually achieved each year. Elective waiting lists and waiting times for outpatient appointments will also increase.

Amendment of Qualification Rules

The simplest of these measures is to amend the Elective Surgery Business Rules to clarify which patients are eligible for elective surgery classification and funding. All Districts interviewed stated they would adhere to the qualifying criteria and guidelines within the Business Rules, but that these were currently ambiguous and open to a range of interpretations.

Financial Penalties for 2002/03 Re-classification

The Surgical Access Service believes financial penalties are appropriate for some hospitals, where reclassification has been deliberately adopted to maximise funding, Total Surgery targets have not been met, and no evidence of appropriate clinical review of these cases was presented.

Under the Elective Surgery Business Rules 2002/03, the General Manager (Health Services) has discretion to vary payments to any District.

In other Districts, reclassification has been undertaken in an open and transparent manner, with clinician review and certification, and detailed audit trails for each case. For these Districts, financial penalties for the previous financial year are not considered appropriate.

Target and Funding Adjustments for 2003/04

Where Districts have substantially reduced Total Surgery throughput, and accessed full elective surgery funding through reclassification, current year targets should be reduced by amounts equivalent to the volume of cases reclassified during 2002/03. These can be reviewed later in the financial year, after actual throughput and capacity have been established.

Assessments of Discussions and Recommendations for Corrective Action by District

Sunshine Coast

Fraser Coast have entered into a deliberate policy of reclassifying emergency presentations as elective surgery in order to maximise reported activity. The District Manager believes this is justified, and will continue the practice unless specific guidelines are added to the Elective Surgery Business Rules which prevent it.

Reclassification has resulted in significant elective surgery activity payments to Hervey Bay, however Maryborough funding has not been effected.

The SAS believes none of the reclassified activity should be recognised for funding purposes during 2002/03. No valid defence for the practice was presented by the District, and no evidence of clinical review provided. It is also considered appropriate that additional ESEI activity and funding offered to the District in 2003/04 be withdrawn, and re-evaluated after throughput capacity without reclassification is established.

Royal Brisbane

RBH have entered into a deliberate policy of reclassifying emergency presentations as elective surgery in order to maximise reported activity. The District Manager believes this is justified, and will continue the practice unless specific guidelines are added to the Elective Surgery Business Rules which prevent it. The District has recently adopted reclassification practices. PAH stated the RBH elective surgery team had travelled to PAH to learn and copy the admission processes in place, following appointment of a new District Manager in 2002.

Much of the information provided during the discussion was later shown to be unsupported by evidence in subsequent audits. Waiting List entries have been deliberately backdated to before emergency presentation to avoid discovery by simple audits. It is also likely that Urgency Category 2 has been assigned to these patients to help meet long wait targets for promised incentive payments.

Reclassification has not resulted in additional activity funding for RBH in 2002/03, however category 2 long wait percentage calculations (and eligibility for the incentive payment) will have been reduced due to increases in the fraction denominator.

The SAS believes reclassified activity during 2002/03 should not be recognised for funding purposes. However there would be no financial penalty involved. No evidence was provided of clinician review of the cases reclassified. Adjustment of activity targets and payments offered to the District for 2003/04 is not appropriate, as the District achieved total surgery and elective surgery targets in 2002/03 without use of reclassified activity.

Bundaberg

BBG have entered into a deliberate policy of reclassifying emergency presentations as elective surgery in order to maximise reported activity. These were presented as results of data quality and process failures. The statement that the majority of reclassified patients were on the waiting list prior to presentation was not supported by subsequent audits, with virtually all patients not present on the lists beforehand. The District Manager stated the volume of reclassified cases would not reduce in future years.

Reclassification has had a significant impact on elective surgery activity funding to the District in 2002/03.

The SAS believes reclassified cases should not be recognised for elective surgery funding purposes in 2002/03. No evidence of clinical review of these cases was presented, and statements made during the discussions were proven incorrect by subsequent audits. It is also

considered appropriate to reduce targets and funding offered to the District in 2003/04 by an amount equivalent to the volume of reclassified cases.

QEII

QEII have reclassified just over a quarter of emergency presentations as elective surgery from the cohort audited. It is possible that these were legitimate data entry errors. The majority of cases were presentations on the day prior to booked admissions. While this indicates a significant number of patients are being admitted prior to the day of surgery, there is little evidence of deliberate reclassification in order to maximise reported activity.

The A/District Manager believed the admission criteria had been interpreted correctly, but requested clarification within the Elective Surgery Business Rules this year.

The SAS believes no financial penalty should be applied to the District for activity claimed within 2002/03. We believe this District is at the first stages of testing reclassification as a procedural option, and will desist if qualification criteria within the Business Rules are tightened.

Nambour

NBR have entered into a deliberate policy of reclassifying emergency presentations as elective surgery in order to maximise reported activity. Furthermore the amount of activity claimed has been extreme, and accompanied by a deficit in Total Surgery achieved of 4,590 w/seps. Although the District was under severe budgetary pressure and impact from industrial action and medical workforce issues, the action adopted was intended to obtain elective surgery activity funding to which the District was not entitled.

The Surgical Access Service believes none of the reclassified cases at Nambour Hospital should be recognised for funding purposes in 2002/03, and that activity targets and funding should be reduced by an amount equivalent to the volume of emergency records reclassified for 2003/04.

PAH

There is little doubt that reclassification of emergency presentations has been undertaken to maximise funded activity, however the practice is long standing and has not been formally challenged previously. The majority of cases audited were inter-hospital transfers not entered correctly on HBCIS.

PAH will adhere to the elective surgery classification policy of Queensland Health. However this needs to be explicitly stated to ensure the same interpretations are applied by all hospitals. The hospital has kept a thorough audit trail, and provided detailed advice on the cohort of patients identified.

The SAS believes financial penalties are not defensible, given the transparency with which the District has responded to the audit process and the stated willingness to amend practice in line with more specific qualification criteria. Adjustment of targets and funding for 2003/04 are not considered appropriate as the District met total surgery activity for 2002/03, and the majority of reclassified w/seps were from inter-hospital transfers.

Toowoomba

TBA have entered into a deliberate policy of reclassifying emergency presentations as elective surgery in order to maximise reported activity. Furthermore the amount of activity claimed is very high in proportion to the surgical throughput of the hospital. Each of these cases had been reviewed by a senior clinician. The District believes the interpretation of admission criteria within QHAPDC

used has been defensible, and stated that more specific criteria would be adopted if included within the Elective Surgery Business Rules.

Reclassification has had a significant impact on elective surgery activity payments made to TBA in 2002/03. None of these changes have been attributed to data errors by the District, and interpretation of the admission criteria appears very broad indeed. However the hospital has substantially improved the management of elective surgery patients over the last 2 years.

The SAS believes financial penalties for activity reclassified during 2002/03 are not appropriate, given the pro-active approach by the District in improving elective surgery management practices and evidence of clinical review. However activity targets and funding offered to the hospital in 2003/04 should be reduced an amount equivalent to reclassified cases until actual capacity without reclassification has been established.

More detail on discussions held are given in **Attachment B.** Additionally, all Districts were invited to submit written explanations of reclassified patients for your review. Where received, these are appended as **Attachment C.**

BENEFITS AND COSTS:

Financial adjustments for 2002/03 recommended above would recoup the following funds for re-allocation to other Districts. These amounts are approximate, and will be reviewed following finalisation of morbidity coding by Data Services Unit.

Table 1 : 2002/03 Funding Adjustments

Hospital	Re-classified Cases Not On WL (Ph7)	Funding Adjustment
Nambour	2,723	$ 1,446,718
Hervey Bay	933	$ 405,739
Bundaberg	552	$ 365,266
Total		**$2,217,723**

CONSULTATION:

Consultation and discussions were undertaken with the following staff, as well as numerous other Zonal and District staff in the preparation of this submission;

Dr Steve Buckland, General Manager (Health Services)
Karen Roach, Zonal Manager, Southern Zone
Dan Bergin, Zonal Manager, Central Zone
Mike Allsopp, District Manager, Fraser Coast HSD
Richard Olley, District Manager, Royal Brisbane & Women's Hospitals HSD
Peter Leck, District Manager, Bundaberg HSD
Tracey Silvester, A/District Manager, Queen Elizabeth II Jubilee Hospital HSD
Martin Jarman, District Manager, Sunshine Coast HSD
Dr Richard Ashby, A/District Manager, Princess Alexandra Hospital HSD
Sandra Thomson, A/District Manager, Toowoomba HSD
Gary Walker, Manager, Surgical Access Service

ATTACHMENT(S):

Attachment A: Emergency presentations reclassified as elective surgery @25/8/2003
Attachment B: Summary of discussions by District
Attachment C: District responses to issues raised during discussions

RECOMMENDATION(S):

It is recommended that the General Manager (Health Services) endorse the following recommendations;

1. Elective Surgery Business Rules be amended from 2003/04 to clarify qualification criteria for patients presenting through emergency department for elective surgery.
2. Financial adjustments be applied to Nambour, Hervey Bay, and Bundaberg for emergency presentations claimed as elective surgery during 2002/03 as shown in Table 1 totalling approximately $2,217,723 after morbidity data for 2002/03 is finalised by Data Services Unit.
3. Elective surgery activity targets and funding for 2003/04 be reduced for Nambour, Hervey Bay, Maryborough, Bundaberg, and Toowoomba hospitals by amounts equivalent to the volume of weighted separations reclassified during 2002/03.

Emergency presentations reclassified as Elective Surgery @25/8/2003

Hospital	w/Seps (P17)			% Not on WL (1)	Ineligable w/seps	Potential Funding Adjustment
	2000/01	2001/02	2002/03			
Nambour	30	112	2,830	96%	2,723	-1,446,718
PAH	1,088	1,134	2,056	81%	1,657	-473,646
Toowoomba	317	1,228	1,420	98%	1,395	-1,058,383
Hervey Bay	0	11	945	99%	933	-405,739
Royal Brisbane	19	80	803	95%	765	0
QE2	172	259	640	37%	239	-157,866
Bundaberg	28	607	563	98%	552	-365,266
Maryborough	0	0	118	93%	110	0
Sub-Total	1,654	3,431	9,375		8,374	-3,907,620

EOY Surgery Variance against Target by component @25/8/2003

Hospital	III EOY Variance (w/seps)				Adjusted Variance (w/seps)			
	ES	Emer	Other	Total	ES	Emer	Other	Total
Nambour	300	-3,918	-972	-4,590	-2,423	-1,195	-972	-4,590
PAH	7	81	128	216	-1,650	1,738	128	216
Toowoomba	96	-54	-335	-293	-1,299	1,341	-335	-293
Hervey Bay	511	-442	-115	-46	-422	491	-115	-46
Royal Brisbane	1,529	155	-1,066	618	764	920	-1,066	618
QE2	91	-836	-733	-1,478	-148	-597	-733	-1,478
Bundaberg	175	-456	-210	-491	-377	96	-210	-491
Maryborough	126	-685	-270	-829	16	-575	-270	-829
Sub-Total	2,835	-6,155	-3,573	-6,893	-5,339	2,719	-3,573	-6,893

Elective Surgery Funding by FY

Hospital	97/98	98/99	99/00	00/01	01/02	02/03
Bundaberg	1,596,595	1,476,236	1,201,236	1,501,701	1,301,701	1,301,701
Hervey Bay	0	0	0	0	0	696,200
Maryborough	518,845	518,845	518,845	819,000	819,000	760,800
Nambour	5,825,796	4,937,831	4,287,831	5,162,386	5,862,386	5,362,386
PAH	6,008,725	6,408,792	6,538,792	8,138,460	11,207,460	11,665,658
QE2	1,602,034	725,000	725,000	1,900,000	2,885,000	2,344,336
Royal Brisbane	9,088,349	8,413,236	7,713,236	4,709,204	6,409,204	6,802,490
Toowoomba	3,701,572	1,300,209	2,800,209	3,000,412	3,179,412	3,413,122
	28,341,916	23,780,149	23,785,149	25,231,163	31,664,163	32,346,693

Funding % variance to 1997/98

Hospital	97/98	98/99	99/00	00/01	01/02	02/03
Bundaberg		-8%	-25%	-6%	-18%	-18%
Hervey Bay						
Maryborough		0%	0%	58%	58%	47%
Nambour		-15%	-26%	-11%	1%	-8%
PAH		7%	9%	35%	87%	94%
QE2		-55%	-55%	19%	80%	46%
Royal Brisbane		-7%	-15%	-48%	-29%	-25%
Toowoomba		-65%	-24%	-19%	-14%	-8%
	0	-16%	-16%	-11%	12%	14%

Source: Transition II COR database 25/8/2003, DSU Data Collection 16/8/2003

Selection: Admission Source 02-Emergency, Care Type 01 or 05, Elective Status 2-Elective, NMDS Specialty 1 to 11, Urgency Category 1 to 3, DRG Type S-Surgical, Discharge Fiscal Year 2003, Discharged and Coded cases only.

Notes:

(1) Percentage not on waiting list drawn from coded and discharged DSU data
Totals will increase until 30 Sep 2003 as morbidity coding is finalised for 2002/03.
Mount Isa was not included in audits, as not interfaced to Transition II

Attachment B

Fraser Coast

Date:
29th August 2003

Present:
Dan Bergin, Mike Allsopp, Quentin Clarke, Anitra Mattiussi, Gary Walker, Col Roberts

SAS Assessment:

Fraser Coast have entered into a deliberate policy of reclassifying emergency presentations as elective surgery in order to maximise reported activity. The District Manager believes this is justified, and will continue the practice unless specific guidelines are added to the Elective Surgery Business Rules which prevent it.

Reclassification has resulted in significant elective surgery activity payments to Hervey Bay, however Maryborough funding has not been effected.

The SAS believes none of the reclassified activity should be recognised for funding purposes during 2002/03. No valid defence for the practice was presented by the District, and no evidence of clinical review provided. It is also considered appropriate that additional ESEI activity and funding offered to the District in 2003/04 be withdrawn, and re-evaluated after throughput capacity without reclassification is established.

Summary:

- FC have restructured clinical services to shift all emergency presentations to Hervey Bay. In part this was to prevent VMOs instructing their patients to present to emergency after private hospitals operating lists are full.
- Emergency presentations at Maryborough are triaged at both hospitals.
- Community expects to be able to receive surgery after presentation at Emergency. This WL queue jumping is considered acceptable by the DM.
- Possible cause of queue jumping is restriction of access to OP Appointments.
- Practice is continuing.
- Zonal Manager requested DMs to review ED presentations and reclassify if appropriate.
- An SAS member reviewed procedures prior to the bye-election (March 2003) and was aware of current practices

Key Statements by DM:

1. Patients were not on WL prior to admission
2. Patients were triaged to determine severity
3. Admitted patients were reclassified if they waited more than 24 hours for surgery
4. Patients were booked in next available theatre session, emergency or elective
5. Surgery performed was directly related to reason for ED presentation

Subsequent Audits show:

Hervey Bay: 99% of reclassified emergency patients were not present on Elective Admissions Management module waiting lists prior to admission.
Maryborough: 93% of reclassified emergency patients were not present on Elective Admissions Management module waiting lists prior to admission.
"Queue jumping" not supported by data, as very few patients have presented to OPD and been placed on waiting lists.

Royal Brisbane

Date:
29th August 2003

Present:
Richard Olley, Mary Montgomery, Michael Kalimnios, Kerry Mason, Quentin Clarke, Anitra Mattiussi, Gary Walker, Col Roberts

SAS Assessment:

RBH have entered into a deliberate policy of reclassifying emergency presentations as elective surgery in order to maximise reported activity. The District Manager believes this is justified, and will continue the practice unless specific guidelines are added to the Elective Surgery Business Rules which prevent it. The District has recently adopted reclassification practices. PAH stated the RBH elective surgery team had travelled to PAH to learn and copy the admission processes in place, following appointment of a new District Manager in 2002.

Much of the information provided during the discussion was later shown to be unsupported by evidence in subsequent audits. Waiting List entries have been deliberately backdated to before emergency presentation to avoid discovery by simple audits. It is also likely that Urgency Category 2 has been assigned to these patients to help meet long wait targets for promised incentive payments.

Reclassification has not resulted in additional activity funding for RBH in 2002/03, however category 2 long wait percentage calculations (and eligibility for the incentive payment) will have been reduced due to increases in the fraction denominator.

The SAS believes reclassified activity during 2002/03 should not be recognised for funding purposes. However there would be no financial penalty involved. No evidence was provided of clinician review of the cases reclassified. Adjustment of activity targets and payments offered to the District for 2003/04 is not appropriate, as the District achieved total surgery and elective surgery targets in 2002/03 without use of reclassified activity.

Summary:

- These patients are "Emergent" rather than "Emergency" (RO)
- Predominantly orthopaedic or vascular presentations from Redcliffe (RO)
- Require surgery within 7 days, but can wait 24 hours (RO)
- Placed in next available theatre slot, either emergency or elective, based on clinical need (MM)
- RO believed cases would all be Cat 1, but defended Cat 2 as "Category not relevant" and doesn't want to send wrong message to clinicians about joint categorisation
- Redcliffe ceased ortho services in December (RO)
- Obs ward off emergency opened in new building from January. Emergency clinicians admit to obs as precaution (RO)
- These patients had not attended RBH or RDC OP clinics and were not queue jumping (KM, RO)
- Any emergency presentation who can wait up to 7 days for surgery is Elective (RO)

Key Statements by DM & others:

1. These patients are not on the WL at Redcliffe (KM)
2. They are brought to RBH when no services are available at Redcliffe, between Wednesday night and Monday morning (RO)

3. Cases are added to the WL after admission, with an urgency category assigned by Kerry Mason (KM)
4. The QHAPDC definitions are clinically meaningless and should be changed (RO)
5. The practice will continue at RBH, and are a result of better data, not gaming (RO)
6. #NOF following a fall, presenting to ED is Elective (RO)

Subsequent Audits show:

4 of the 110 reclassified patients come from Redcliffe-Caboolture (18 w/seps). 1 of these (4 w/seps) was an orthopaedic case.

There were no vascular presentations from areas other than North Brisbane.

95% of reclassified emergency patients were not present on Elective Admissions Management module waiting lists prior to admission.

When added retrospectively, the date used when placing patients on a waiting list was 2 days prior to initial presentation.

Bundaberg

Date:
29th August 2003

Present:
Peter Leck, Darren Keating, Jenny Kirby, Quentin Clarke, Anitra Mattiussi, Gary Walker, Col Roberts

SAS Assessment:

BBG have entered into a deliberate policy of reclassifying emergency presentations as elective surgery in order to maximise reported activity. These were presented as results of data quality and process failures. The statement that the majority of reclassified patients were on the waiting list prior to presentation was not supported by subsequent audits, with virtually all patients not present on the lists beforehand. The District Manager stated the volume of reclassified cases would not reduce in future years.

Reclassification has had a significant impact on elective surgery activity funding to the District in 2002/03.

The SAS believes reclassified cases should not be recognised for elective surgery funding purposes in 2002/03. No evidence of clinical review of these cases was presented, and statements made during the discussions were proven incorrect by subsequent audits. It is also considered appropriate to reduce targets and funding offered to the District in 2003/04 by an amount equivalent to the volume of reclassified cases.

Summary:

- An audit of classification processes was established after Mike Zanco visiting 2 years ago.
- ED is a common entry point for planned surgery
- Elective surgery patients admitted through ED are treated on an elective surgical list
- Junior medical staff within ED are typically from overseas, and don't understand Queensland Health practice
- Admitting staff in A&E may routinely admit all patients as emergency, even if they are presenting for planned procedures

Key Statements by DM:

1. The majority of patients in this category are already on the waiting list, but are not picked up by admin staff as "elective" until after presentation and admission.
2. The practice will continue during 2003/04 and subsequent years, as it is a part of regular system audit

Subsequent Audits show:

98% of reclassified emergency patients were not present on Elective Admissions Management module waiting lists prior to admission.

QEII

Date:
1st September 2003

Present:
Karen Roach, Tracey Silvester, Maree McKay, Joanne Meldrum, Brett Bricknell, Gary Walker, Col Roberts

SAS Assessment:

QEII have reclassified just over a quarter of emergency presentations as elective surgery from the cohort audited. It is possible that these were legitimate data entry errors. The majority of cases were presentations on the day prior to booked admissions. While this indicates a significant number of patients are being admitted prior to the day of surgery, there is little evidence of deliberate reclassification in order to maximise reported activity.

The A/District Manager believed the admission criteria had been interpreted correctly, but requested clarification within the Elective Surgery Business Rules this year.

The SAS believes no financial penalty should be applied to the District for activity claimed within 2002/03. We believe this District is at the first stages of testing reclassification as a procedural option, and will desist if qualification criteria within the Business Rules are tightened.

Summary:

- A random chart audit had been performed on the 156 cases identified as elective surgery presenting through ED. Of the 57 charts reviewed 33% (19 cases) were patients on the WL presenting for treatment on the following day. Another 4% (2 cases) were patients booked for elective surgery, who were advanced in the queue after emergency presentation. The balance of cases (63%, 36 cases) were reclassified after waiting more than 24 hours for surgery.
- ED does not handle many urgent presentations, as most are taken to PAH.

Key Statements by DM:

1. Audit will be time consuming with no clear benefit. However a comprehensive chart audit will be undertaken if SAS can provide a list of contentious cases.
2. Guidelines as to what can be legitimately claimed as elective surgery are not clear
3. Presentation to ED prior to admission for elective surgery is common

Subsequent Audits show:

Only 37% of reclassified emergency patients were not present on Elective Admissions Management module waiting lists prior to admission.

Sunshine Coast

Date:
2nd September 2003

Present:
Martin Jarman, Quentin Clarke, Anitra Mattiussi, Gary Walker, Col Roberts

SAS Assessment:

NBR have entered into a deliberate policy of reclassifying emergency presentations as elective surgery in order to maximise reported activity. Furthermore the amount of activity claimed has been extreme, and accompanied by a deficit in Total Surgery achieved of 4,590 w/seps. Although the District was under severe budgetary pressure and impact from industrial action and medical workforce issues, the action adopted was intended to obtain elective surgery activity funding to which the District was not entitled.

The Surgical Access Service believes none of the reclassified cases at Nambour Hospital should be recognised for funding purposes in 2002/03, and that activity targets and funding should be reduced by an amount equivalent to the volume of emergency records reclassified for 2003/04.

Summary:

- The ESBRs do no prevent reclassifying emergency patients as elective
- Sunshine Coast was under severe financial pressure last year
- The Zonal Manager advised all Districts to code consistently
- Advice was sought from Mike Allsopp and Dr. John Wakefield on appropriate classification practice
- The principle applied was "If the patient can wait 24 hours for surgery they are elective"

Key Statements by DM:

1. This practice will continue unless there is a specific change to the ESBR to prevent it

Subsequent Audits show:

96% of reclassified emergency patients were not present on Elective Admissions Management module waiting lists prior to admission.

Princess Alexandra Hospital

Date:
4th September 2003

Present:
Dr Richard Ashby, Dr John Wakefield, Karen Roach, Joanne Meldrum, Brooke Anderson, Gary Walker, Col Roberts

SAS Assessment:

There is little doubt that reclassification of emergency presentations has been undertaken to maximise funded activity, however the practice is long standing and has not been formally challenged previously. The majority of cases audited were inter-hospital transfers not entered correctly on HBCIS.

PAH will adhere to the elective surgery classification policy of Queensland Health. However this needs to be explicitly stated to ensure the same interpretations are applied by all hospitals. The hospital has kept a thorough audit trail, and provided detailed advice on the cohort of patients identified.

The SAS believes financial penalties are not defensible, given the transparency with which the District has responded to the audit process and the stated willingness to amend practice in line with more specific qualification criteria. Adjustment of targets and funding for 2003/04 are not considered appropriate as the District met total surgery activity for 2002/03, and the majority of reclassified w/seps were from inter-hospital transfers.

Summary of Discussions:

- All surgical targets were met
- Thorough audit undertaken
- Audit trail of all reclassified patients kept
- The majority (94) of the 173 reclassified cases found were inpatient transfers from other hospitals, not correctly recorded on presentation to ED.
- A further 32 cases were "planned" by clinicians, but had not been entered on EAM prior to presentation
- ED replaces 28 points of presentation available during business hours. Poor communication between these areas and ED may result in after hours presentation of planned admissions
- PAH staff instructed RBH staff on classification and admission policy after Dr Waters moved to RBH. All RBH staff involved travelled to PAH for this instruction.

Key Statements by DM:

1. Majority of cases listed were the result of systemic process errors. These have not previously been given priority as data integrity was not considered critical. There is a large variation in the competency of ED clerical staff
2. District believes all reclassified cases meet the definitions within QHAPDC
3. Clear definitions within the Elective Surgery Business Rules are required to ensure cases are classified consistently by all hospitals

Subsequent Audits show:

81% of reclassified emergency patients were not present on Elective Admissions Management module waiting lists prior to admission.

Only 3 of the 173 patients were reclassified in May and June (following receipt of the Total Surgery Memo)

Toowoomba Hospital

Date:
4th September 2003

Present:
Sandra Thomson, Lee Hunter, Ken Morrissey, Winton Barnes, Karen Roach, Brett Bricknell, Joanne Meldrum, Gary Walker, Col Roberts

SAS Assessment:

TBA have entered into a deliberate policy of reclassifying emergency presentations as elective surgery in order to maximise reported activity. Furthermore the amount of activity claimed is very high in proportion to the surgical throughput of the hospital. Each of these cases had been reviewed by a senior clinician. The District believes the interpretation of admission criteria within QHAPDC used has been defensible, and stated that more specific criteria would be adopted if included within the Elective Surgery Business Rules.

Reclassification has had a significant impact on elective surgery activity payments made to TBA in 2002/03. None of these changes have been attributed to data errors by the District, and interpretation of the admission criteria appears very broad indeed. However the hospital has substantially improved the management of elective surgery patients over the last 2 years.

The SAS believes financial penalties for activity reclassified during 2002/03 are not appropriate, given the pro-active approach by the District in improving elective surgery management practices and evidence of clinical review. However activity targets and funding offered to the hospital in 2003/04 should be reduced an amount equivalent to reclassified cases until actual capacity without reclassification has been established.

Summary:

- Administrative staff in ED are not all equally competent
- There is poor communication between consultant OPD clinics and the Elective Surgery Coordinator when future surgery is considered essential for a patient. Ie. They are not placed on a waiting list.
- Patients where future surgery is considered necessary are not placed on the waiting list and flagged as "Not Ready For Care" if they state they are not ready for surgery yet.
- The QHAPDC admission criteria were reinterpreted after advice from an SAS member on a site visit 2 years ago

Key Statements by DM:

1. Real waiting times for surgery have been reduced substantially by the hospital over the previous 2 years
2. Admission criteria within the draft Elective Surgery Business Rules 2003/04 are clear, as are guidelines provided by Surgical Access Service during this audit process. These would be adopted if published, and the volume of reclassified cases would reduce in future years.

Subsequent Audits show:

98% of reclassified emergency patients were not present on Elective Admissions Management module waiting lists prior to admission.

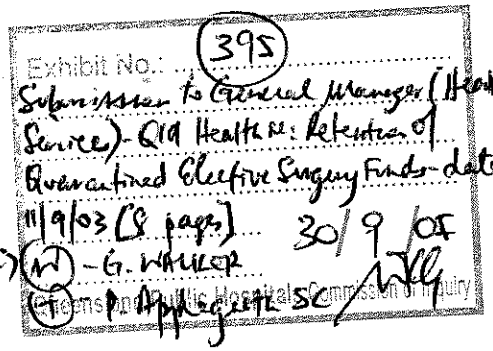
Exhibit No.: 395
Submission to General Manager (Health Service) - Q19 Health re: Retention of Quarantined Elective Surgery Funds - dated 11/9/03 [8 pages]
30/9/04
(M) - G. WALKER
Commission of Inquiry