A4

Scanned and emailed to ZMS x 3 and MSAT 23/9/03

1224-0350-004

RECEIVED
12 SEP 2003
BR019346
EXECUTIVE SUPPORT UNIT

64

Ex 396

Queensland Government
Queensland Health

RECORDS BRANCH
RECEIVED
8 - OCT 2003
DEPT. OF HEALTH

GMHS File

A BRIEFING TO THE GENERAL MANAGER HEALTH SERVICES

BRIEFING NOTE NO:

REQUESTED BY: Gary Walker, Manager Surgical Access Services

DATE: Monday, 8 September 2003

PREPARED BY: Lee Hunter, Elective Surgery Coordinator

CONSULTATION WITH: Sandra Thomson, Acting District Manager Toowoomba Health

Dr Winton Barnes, Acting Exec Director Medical Services

Ken Morrissey, Manager Decision Support Unit

CLEARED BY: Sandra Thomson, Acting District Manager Toowoomba Health

DEADLINE: Monday, 8 September 2003

ES3 23/9/03.

SUBMITTED THROUGH: Karen Roach, Southern Zonal Manager

...../...../.....

SUBJECT: **Classification of Emergency and Elective Surgery**

GMHS'S COMMENTS:

Noted - NFA required
No change in funding base
or surgical payments

Copy to ZM(S)

(Dr) S Buckland
General Manager Health Services
21/8/2003

COPY TO ZM(S) + MSAT

PURPOSE:

- To respond to the Surgical Access Services report that Toowoomba Hospital has recorded emergency presentations as elective admissions.

BACKGROUND:

- Surgical Access Services identified 301 cases at Toowoomba Hospital in 2002/2003 that presented through the emergency department, yet were recorded as elective admissions. According to Surgical Access Services, these cases contributed 1,420 weighted separations to Toowoomba Hospital's elective surgery target of 10,292. (Phase 7)

- Surgical Access Services have stated that as Toowoomba Hospital's emergency activity has declined in the last two years, then these cases appear to represent emergency cases reclassified as elective surgery.

KEY ISSUES:

- In July 2000 Surgical Access Services provided the Elective Surgery Coordinator with a list of cases that had an emergency admission status. They advised that these cases might represent activity that could be claimed as elective surgery and recommended that Toowoomba Hospital implement a review process. As a result, the Hospital put into place the following process:
  - Review by a senior clinician of the operative theatre notes for patients booked onto a non-elective list.
  - Cases where surgical treatment could have been delayed for 24 hours, resulted in the admission status for that episode being amended.
  - Patient details were then added to the Elective Admissions Module if not already recorded.
- The reclassification process was undertaken in accordance with the interpretation of 'elective' as it appears in QHAPDC as per Business Rules at that time. If the patient did not meet the criteria for an 'emergency admission', they were reclassified as elective surgery.
- Confusion between the terms 'emergency surgery' and 'emergency admission,' due to lack of clarity in the Business Rules, seems to have resulted in the reclassification of cases where surgery could be delayed although in many cases admission was required.
- Trauma lists introduced at Toowoomba Hospital, allows for semi-urgent cases to be 'booked' onto a dedicated list. Typically fractures are treated on these lists and surgery may not occur until one or two days after admission. Similarly, Toowoomba Hospital has an all day emergency list, which provides an opportunity for semi-urgent cases to be accommodated in a more planned manner, than occurs with after hours surgery.

RELATED ISSUES:

- Significant improvements have been made in waiting times for surgery including:
- Dramatic improvements for ENT surgery from greater than three years in 1999/2000 to less than 3 months in 2002/2003 for all surgery including FESS and septoplasty
- Waits of less than 3 months now for general and gynaecological surgery, for most types of surgery including sterilisation and varicose veins. Two years ago, patients waited more than 12 months for non-urgent elective surgery.
- Dramatic improvements for ophthalmology surgery. In November 2002, patients waited up to 1200 days on the waiting list for surgery. The longest waiting time now is 800 days and further improvements are expected as the rate of treatment has more than doubled. Similar improvements are occurring in waiting times for an ophthalmology appointment.
- Waiting times for urology surgery is now less than 3 months at Toowoomba Hospital, although the full range of procedures is not done. Mater Hospital program established to bridge the gap.
- Most joint replacement surgery is now performed in 18 months of going on waiting list. All other types of orthopaedic surgery usually are booked within three months. Two years ago, waiting times for most patients was in excess of 12 months and two years for joint surgery. Further improvements can be expected with the addition of an orthopaedic specialist to the team next year.
- Improvements in waiting times for outpatient appointments are occurring as additional clinics are being held to see more new patients in General Surgery, ENT and Orthopaedics.

BENEFITS AND COSTS:

- It is anticipated that in the financial year 2003/2004, with the proposed changes to the Elective Surgery Business Rules and auditing requirements, the result could be a reduction in the amount of activity claimed as elective surgery and subsequent increase in emergency surgery.
- To estimate the impact of the new audit criteria, 111 cases from the 301 cases identified by SAS as questionable elective activity in 2002/2003, have been analysed. Within this sample three broad groups were identified. These are listed in the attachment.
- From a sample of the total 301 cases, identified in the report by Surgical Access Team, it is estimated that between fifty and sixty percent of the total cases, may not meet the new audit criteria. Many of the cases involved large weighted separation values. The resultant shift from elective to emergency surgery under the new audit criteria is estimated to be between sixty and seventy percent of the total weighted separations.
- The Surgical Access Services Report also identified 38 cases recorded as 'emergency admissions' with the 'Outpatient Department' as the referral source. These cases may represent legitimate unclaimed elective activity, to the value of 199 weighted separations. This could help offset the above changes.

ACTIONS TAKEN/ REQUIRED:

- Teleconference to discuss issues with Surgical Access Service and Southern Zone Management on 4 September 2003.
- Meeting planned 9 September with Senior Clinicians from Surgery and Emergency Department, as well as the Health Information Manager, to resolve data entry issues.
- No further reclassification from Emergency to Elective admission without endorsement of Executive Director of Medical Services.
- Further analysis to be undertaken on impact on targets and budgets for 2003/2004 and strategies developed to determine how Toowoomba Hospital will meet the targets for elective surgery within the framework of the Business Rules.

ATTACHMENTS:

- To estimate the impact of the new audit criteria, 110 cases from the 300 cases identified by SAS as questionable elective activity in 2002/2003, have been analysed. Within this sample three broad groups were identified. These are listed in the table below along with an estimate of the number of cases in each group:

Table 1 Summary of Cases Identified as 'Reclassified' Emergencies

No. Cases	Description of Cases
50	• Mixture of emergency and elective admissions. • Classified at the time of presentation as an elective admission by administrative officer in Emergency Department, without any clinical input.
30	• Reclassified as an elective admission, • Patient admitted due to pain management issues, lack of support at home, mobility difficulties or inability to travel where distance involved. Examples include: Fractured lower leg; Fractured neck of femur; Fracture, wound or tendon damage to upper limb; Injury to foot.
115	• Reclassified as an elective admission as surgery deemed not necessary within 24 hours of presentation. • It was known for some time prior to admission that these patients would present for surgery, but they were not added to the Elective Admission Module. Many patients in this group had numerous outpatient appointments prior to admission. Admission may have occurred due to the exacerbation of a chronic condition where conservative treatment had failed or where a malignancy was suspected and investigations prior to surgical intervention were required. Examples include: Diabetic Foot; Gall bladder calculus; Ovarian cyst; Malignancy of colon and Abdominal adhesions.
	• These patients were on the Elective Admission Module prior to admission, but were probably admitted via the Emergency Department. Emergency Department staff appear to have entered "emergency department" as the referral source and provided a triage category.