ATTACHMENT AUGUST 03
DFM-5

? 15/8

Elective Surgery

(1)
Bundy
FC
Nambour
Tuba
QEII
PAH

ACTION
(1) Cary to write memo and send it out.
(2) FB to CMHS re relationship?

Give them data - be bland re data noticed shift between Emergency admission & Elective Surgery admission
don't put $ in memo under CMHS authority
Will be collected by 1 CW [illegible] to discuss
Δ's in Zonal rep's → numbers to them over phone
Shift of 4.5 m & will make decision on it

Business Rules
- stay same
- continue to monitor exchange of Emergency pts to Elective Surgery.

What should be given to Nambour this year.
- needs to be flagged at conversation & DM.

(2) ED's
Want latest data on RBH & Nambour.
- total presented
- Waiting times
- Access block.
- All performance across 2 YEARS

(3) # (3 HM) - increases in payments to Elective surgery
- look at areas with major exposure.
- e? eyes & orthop.
= Δing payment see if we can attract people into system
* focus on Speciality or sub

(4) $50 m - Access Elective Surgery.
Co paper for mid year review
do drill down base paper for
mid year re HSFDU.

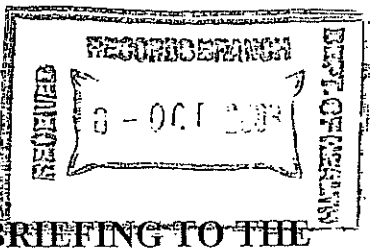
* ?. whether comment went into the
Cab Sub back to Premier re Report
being re submitted

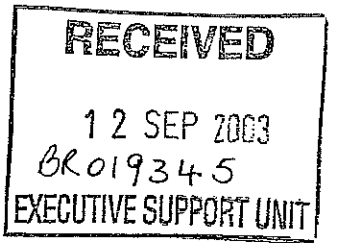
AT Attachment 1 – QFM-6

1930-0022-001

(21)

Queensland Government
Queensland Health





GMHS File

A BRIEFING TO THE GENERAL MANAGER, HEALTH SERVICES

BRIEFING NOTE NO:

REQUESTED BY: Gary Walker, Manager, Surgical Access Service, Procurement Strategy Unit.

DATE: 4 September 2003

PREPARED BY: Maree McKay, Manager, Organisation Development Unit, QEII Hospital Health Service District, 3275 6384.

CONSULTATION WITH: Lorraine Munn, NPC Operating Suite, Karin Matthews, Theatre Booking Clerk and Sylvia Siepka, Clinical Benchmarking Officer, QEII Jubilee Hospital.

CLEARED BY: Tracey Silvester, A/District Manager, QEII Hospital & Health Service District.

DEADLINE: 5 September 2003

SUBMITTED THROUGH: Karen Roach, Zonal Manager, Southern Zone

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

SUBJECT: Elective Surgery Cases admitted through Emergency Department – Chart Audit Submission– QEII Jubilee Hospital

---

GMHS'S COMMENTS:

Noted –

(Dr) S Buckland
General Manager Health Services
16 / OCT 2003

PURPOSE:

To provide the rationale used at the QEII Jubilee Hospital to classify patients admitted via the Emergency Department as elective surgery activity during the period of July 2002 to June 2003.

BACKGROUND:

In a memorandum from the General Manager (Health Services) dated 21st August 2003, it indicated that Surgical Access Service (SAS) had recently reviewed coded QEII Jubilee Hospital morbidity data. This review revealed a significant increase in patient reclassification from emergency to elective, where the patient was admitted and undergoes surgery. According to SAS, the effect of this reclassification is to maximise activity that can be claimed against specific surgical access funding and a reduction in the total volume of surgical work performed.

On 1 September 2003, a meeting was held with staff from SAS, Southern Zone Management Unit and QEII Jubilee Hospital. At that meeting SAS further outlined their concerns which were based on:

- An increasing number of elective surgery cases with an admission source 02 (i.e. from emergency) with approximately a 40% increase from FY2001/2002, and
- A decreasing number of emergency admissions – approx 14% decrease from FY2001/2002.

The QEII Jubilee Hospital was directed by SAS to seek clarification and show cause for these changes. The following was suggested:

1) Audit a reasonable sample of the cases identified as being reclassified from emergency to elective.
2) Provide reasons for reclassification and group patients into categories.
3) Define current admission processes and the rules applied for reclassification of such cases.
4) In cases where reclassification was not warranted, include recommendations for changes in protocols and procedures that will correct this situation.

KEY ISSUES:

This audit was undertaken based on a Crystal Report supplied by SAS. The audit identified 156 cases of patients classified as Elective Surgery who were admitted through Emergency Department, with 109 cases having a Triage Category of 1 to 5. Of these 156 cases, QEII Jubilee Hospital audited 107 cases. These cases have been grouped into two categories of previously on a waiting list or transfer from another hospital and emergency admission with a delayed theatre time.

Classification	Total	Percentage Splits
Waiting List	33	31%
Delayed theatre	74	69%
Grand Total	107	100%

For the thirty-three patients have been classified as waiting list the reasons and admission processes include:

The patient has presented to Emergency Department and admitted for an exacerbation of a condition for which they are already booked on a waiting list for elective surgery. Also elective surgery patients have been admitted after hours through the Emergency Department. Admission by this source is standard admitting practice where administration support is not available in the ward.

The process used by Operating Suites and the Booking Clerk is to reclassify all of these patients to Elective post operatively.

For the seventy-four patients that have been audited and classified into a group titled delayed theatre, the current rules and practices adopted by the QEII Jubilee Hospital Operating Suite are as follows:

If surgery is not undertaken as an emergency (ie attended surgery within 6 hours of admission from the Emergency Department), the case is classified retrospectively by Operating Suites and the Booking Clerk as Elective. This rule is also in force for any case that is booked after 2pm the previous day or overnight and private cases booked on the weekends as no weekend list is available. The audit identified that for these patients the wait to theatre time ranged between 0.13 hours to 400.20 hours with an average of 54.24 hours. There were only ten patients that fell under the 6 hour rule as nominated by Operating Suites.

ACTIONS TAKEN/ REQUIRED:

The QEII Jubilee Hospital will develop a procedure for all elective patients who are admitted as an emergency patient with an exacerbation of a condition for which they are already booked on a waiting list.

The QEII Jubilee Hospital will develop a procedure for all elective patients who arrive the day prior or after-hours in the Emergency Department for admission.

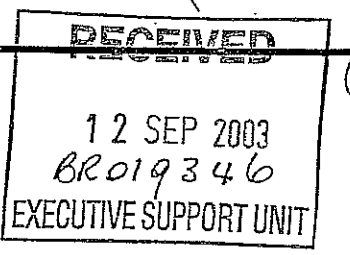
Based on the feedback provided by SAS, the QEII Jubilee Hospital will develop a procedure to correctly classify patients admitted through the Emergency Department, but subsequently are assessed by the speciality involved as not in fact requiring emergency surgery.

Without a permanent Elective Surgery Coordinator, the QEII Jubilee Hospital will need to consider options in order to monitor these cases and ensure standardised business rules and local procedures are applied accordingly.

Attachment QFM-7

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

1224-0350-004



64

Queensland Government
Queensland Health

GMHS file

A BRIEFING TO THE GENERAL MANAGER HEALTH SERVICES

BRIEFING NOTE NO:

REQUESTED BY: Gary Walker, Manager Surgical Access Services (323 40536)

DATE: Monday, 8 September 2003

PREPARED BY: Lee Hunter, Elective Surgery Coordinator (46166865)

CONSULTATION WITH: Sandra Thomson, Acting District Manager Toowoomba Health (4616 6179)

Dr Winton Barnes, Acting Exec Director Medical Services (4616 6011)

Ken Morrissey, Manager Decision Support Unit (46166155)

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 basis or surgical payments

Copy to ZM(S)

(Dr) S Buckland
General Manager Health Services
22/9/2003

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.

Attachment
DFM-8

Queensland Government
Queensland Health

A BRIEFING TO THE GENERAL MANAGER HEALTH SERVICES

MIN / DG / GMHS / DDG P&
FILE
EMAIL MIN
EMAIL SDLO
EMAIL EX DG
EMAIL MCM

BRIEFING NOTE NO:	
REQUESTED BY:	Zone Manager, Central Zone
DATE:	26 September 2003
PREPARED BY:	Quentin Clarke, Principal Project Officer, Central Zone Management Unit Anitra Mattiussi, Team Leader, Business Operations, Central Zone
CONSULTATION WITH:	District Managers, Sunshine Coast, Bundaberg, Fraser Coast and Royal Brisbane & Royal Women's Hospital.
CLEARED BY:	Dan Bergin, Zonal Manager Central Zone PH: 32340825
DEADLINE:	
SUBMITTED THROUGH:	...../...../.....
SUBJECT:	**Classification and retrospective reclassification of elective surgery patients with a source of referral code, Emergency Department**

ES3
30.9.03

GMHS'S COMMENTS:

→ Glenn Cuffe
Does the assertion that the business rules do not include Source of Referral Code have substance?
If it is true then SAS have

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

PURPOSE:

To detail the position in relation to classification or retrospective reclassification of elective surgery patients with a referral source code, emergency department.

BACKGROUND:

Elective surgery 2002/03 Business Rules outlined the following criteria for categorisation of surgery as elective surgery:

Elective Surgery:

- Elective Status of patient: 2 Elective
- DRG Type: S Surgical
- Urgency Category: 1, 2 or 3
- NMDS Speciality: Between 1 and 11
- Admission type: 01 Acute, 05 New born

NB This definition does not include Source of Referral Code.

Surgical Access Service identified increased the number of patients with a source of referral code, emergency department, being classified or retrospectively reclassified as elective surgery patients. The trend was higher in the 2002/03 financial year than in previous years.

KEY ISSUES:

The 2002/03 Elective Surgery Business Rules do not preclude patients with a referral source code, emergency department, being classified or retrospectively reclassified as elective surgery patients.

There are circumstances where this classification or retrospective reclassification is appropriate.

- For example when the condition of a patient already on the waiting list deteriorates requiring an emergency response. Bundaberg District indicated that a most of their reclassification of elective surgery patients with an emergency department source code fell into this category
- In other Central Zone Districts there is a high proportion of junior medical staff covering Departments of Emergency Medicine. The issues here are:
  - As a mechanism for safe practice junior staff tend to admit patients prior to review by more senior staff and scheduling for surgery.
  - Some of these patients are indeed true emergencies and fitted into the list within the next twenty-four hours.
  - Others following stabilisation and observation are deemed elective patients and are scheduled for surgery at the next available space in the elective surgery list.

- In many cases the patient remains in hospital while awaiting surgery. Issues that impact on the clinical decision to retain patients in hospital include:
    - Adequate support for patients returning home (RB &RWH, Sunshine Coast, Bundaberg and Fraser Coast) and,
    - Distance (Bundaberg and Fraser Coast, where the catchment extends into North and South Burnett Districts).
- In other Districts (RBH & RWH, Bundaberg and Sunshine Coast) the Department of Emergency Medicine acts as a transit lounge/admission portal, for patients awaiting admission or for admission outside normal working hours. Some forms are incorrectly coded with source of referral as emergency department. The retrospective reclassification of these records corrects a prior clerical error.
- Each of the Central Zone Districts where an increase in reclassification had occurred indicated that they were working with SAS in relation to the classification process and the explanations provide by the Districts appeared reasonable.

RELATED ISSUES:

The indemnity issue has focused undue attention on cautious medical practice. This has the effect of making junior medical staff more likely to admit patients for review by senior staff or consultants than in prior years.

ACTIONS TAKEN/ REQUIRED:

1. Recognised that the current rules are silent on the issue of source of referral code as part of the definition of elective surgery.
2. No action be taken in relation to classification or reclassification that occurred in 2002/03.
3. Although the District responses to the reclassification issue appeared reasonable action should be taken to:
    - 3.1. Modify the 2003/04 Elective Surgery Business Rules to clarify when reclassification is acceptable and within the rules, and
    - 3.2. Detail processes used to audit District results in the area of reclassification of elective surgery patients.

ATTACHEMENTS:

NIL

1224-0023-01

Queensland Government
Queensland Health

A BRIEFING TO THE GENERAL MANAGER HEALTH SERVICES

MIN / DG / GMHS / DDG P&C
FILE
EMAIL MIN
EMAIL SDLO
EMAIL EX DG
EMAIL MCM

BRIEFING NOTE NO:	
REQUESTED BY:	Zone Manager, Central Zone
DATE:	26 September 2003
PREPARED BY:	Quentin Clarke, Principal Project Officer, Central Zone Management Unit Anitra Mattiussi, Team Leader, Business Operations, Central Zone
CONSULTATION WITH:	District Managers, Sunshine Coast, Bundaberg, Fraser Coast and Royal Brisbane & Royal Women's Hospital.
CLEARED BY:	Dan Bergin, Zonal Manager Central Zone PH: 32340825
DEADLINE:	
SUBMITTED THROUGH:	...../...../.....
SUBJECT:	**Classification and retrospective reclassification of elective surgery patients with a source of referral code, Emergency Department**

ES 30/9/03

GMHS'S COMMENTS:

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

PURPOSE:

To detail the position in relation to classification or retrospective reclassification of elective surgery patients with a referral source code, emergency department.

BACKGROUND:

Elective surgery 2002/03 Business Rules outlined the following criteria for categorisation of surgery as elective surgery:

Elective Surgery:

- Elective Status of patient: 2 Elective
- DRG Type: S Surgical
- Urgency Category: 1, 2 or 3
- NMDS Speciality: Between 1 and 11
- Admission type: 01 Acute, 05 New born

NB This definition does not include Source of Referral Code.

Surgical Access Service identified increased the number of patients with a source of referral code, emergency department, being classified or retrospectively reclassified as elective surgery patients. The trend was higher in the 2002/03 financial year than in previous years.

KEY ISSUES:

The 2002/03 Elective Surgery Business Rules do not preclude patients with a referral source code, emergency department, being classified or retrospectively reclassified as elective surgery patients.

There are circumstances where this classification or retrospective reclassification is appropriate.

- For example when the condition of a patient already on the waiting list deteriorates requiring an emergency response. Bundaberg District indicated that a most of their reclassification of elective surgery patients with an emergency department source code fell into this category
- In other Central Zone Districts there is a high proportion of junior medical staff covering Departments of Emergency Medicine. The issues here are:
  - As a mechanism for safe practice junior staff tend to admit patients prior to review by more senior staff and scheduling for surgery.
  - Some of these patients are indeed true emergencies and fitted into the list within the next twenty-four hours.
  - Others following stabilisation and observation are deemed elective patients and are scheduled for surgery at the next available space in the elective surgery list.

In many cases the patient remains in hospital while awaiting surgery. Issues that impact on the clinical decision to retain patients in hospital include:

- Adequate support for patients returning home (RB &RWH, Sunshine Coast, Bundaberg and Fraser Coast) and,
- Distance (Bundaberg and Fraser Coast, where the catchment extends into North and South Burnett Districts).

- In other Districts (RBH & RWH, Bundaberg and Sunshine Coast) the Department of Emergency Medicine acts as a transit lounge/admission portal, for patients awaiting admission or for admission outside normal working hours. Some forms are incorrectly coded with source of referral as emergency department. The retrospective reclassification of these records corrects a prior clerical error.
- Each of the Central Zone Districts where an increase in reclassification had occurred indicated that they were working with SAS in relation to the classification process and the explanations provide by the Districts appeared reasonable.

RELATED ISSUES:

The indemnity issue has focused undue attention on cautious medical practice. This has the effect of making junior medical staff more likely to admit patients for review by senior staff or consultants than in prior years.

ACTIONS TAKEN/ REQUIRED:

1. Recognised that the current rules are silent on the issue of source of referral code as part of the definition of elective surgery.
2. No action be taken in relation to classification or reclassification that occurred in 2002/03.
3. Although the District responses to the reclassification issue appeared reasonable action should be taken to:

   3.1. Modify the 2003/04 Elective Surgery Business Rules to clarify when reclassification is acceptable and within the rules, and

   3.2. Detail processes used to audit District results in the area of reclassification of elective surgery patients.

ATTACHEMENTS:

NIL

Date: 13/10/2003	Time: 10.00am	Venue: 19th Floor QHB	Present: S Buckland, Dan Bergin, T Mehan, Tracey Silvester, Linda Dawson, Richard Olley, Deb Poduby, Deb Miller and Cheryl Brennan,

Zonal and Statewide Managers Meeting 13 October 2003

Item Discussed	Discussion Points	ACTION (To do)	Outcome of Action
	Townsville Radiation Therapy – 7.2 under establishment, shifts to drop to 1.4 by the end of the month. GMHS questioned if patients should be moved out of Townsville for treatment.	Zonal Manager, Northern to seek feedback from DM, Townsville on numbers. GMHS to discuss with Zonal Manager, Northern to establish a proactive way forward	Completed.
	Kooralbyn – GMHS to deliver DG's presentation which will be a wash-up of 2002/2003.	All direct reports to prepare 5-10 slides "Year in Review" for incorporation into presentation. There should be 2 to 3 achievements highlighted by each area.	Slides to Deb Miller.
	Presentation of a gift to DG at Kooralbyn.	GMHS' office to action.	Completed.
	Placement of Scholarship Holders. Working party consists of Manager, Rural Health, Principal Medical Advisor and Zonal Coordinators. Concerns were raised with regard to: • the criteria used to place scholarship holders; • the misinformation that there would be free accommodation; • possible funding difficulties for those Districts who allocated more than one scholarship holder.	Information to be sought from Dr Suzanne Huxley	Completed
	MASS – Review of MASS underway. Draft report due early November.		For information.
	3/11/2003 – John Scott to be A/GMHS. Business Rules for A/DG will be prepared.		For information.
	Presentation by Danielle Stowasser on Recurrent Funding for Queensland Health Pharmacy Information Management Systems	Sub to be revised and resubmitted for sign off.	Completed.

DFM-9

NOTED. FILE. TRL 29/10.

Zonal Managers Meeting

Date:	Time:	Venue:	Present:
13/10/2003	10.00am	19th Floor QHB	S Buckland, Dan Bergin, T Mehan, Tracey Silvester, Linda Dawson, Richard Olley, Deb Poduby, Deb Miller and Cheryl Brennan.

Zonal and Statewide Managers Meeting 13 October 2003

Item Discussed	Discussion Points	ACTION (To do)	Outcome of Action
1. GMHS Issues	Elective Surgery – Glenn Cuffe and Members of Surgical Access Team attended meeting to discuss changes to the business rules. Concern raised that adequate consultation not undertaken. It was reiterated that all submissions with a financial focus needed to be signed off by the operational arm of the organisation before being presented to GMHS for approval. It was acknowledged that $10 million needed to be rolled out as soon as possible. Additional $3million would not be released at this stage. Original intent of $3 million was for distribution into areas where it was thought there was a shortfall. Further concern was raised at the direct reporting relationship between the Surgical Access Team and Elective Surgery Coordinators – there should be no dual reporting line.	Surgical Access Team to meet with all Zonal Managers and Glenn Cuffe to return to GMHS' meeting on 27 October 2003 with revised submission for approval. GMHS suggested that Zonal Manager give thought to the roll-out of $3 million.	To be raised at 27/10/2003 meeting To be raised at 27/10/2003 meeting.
	IBNR – No further information has been made available by either HIC or Commonwealth.	GMHS to feedback to meeting on any future developments.	Updated at 27/10/2003 meeting.
	ENT in the north		Completed. Feedback direct to GMHS.
	Urological Surgical Trainees – GMHS recently met with Urological Society and College of Surgeons to discuss the issue of national placements. Currently everyone is ranked 1 through to 60. Commitment made that banding would be sorted out be December with a suggestion that top ten would have option on location and that the geographic factor would come into play after their placements.		For information.
	Pathology – GMHS met with College re alternative training programs.		For information
	CIS – Independent review completed.		For information

ATTACHMENT
DFM-10

Zonal Managers Meeting 13 oct.

① Elective Surgery

* Business rules
* — Met with Zones re reclassificat
  e coding issues
* Business rules:
  - made one change which will effect E.S funded any case claimdde must be "planed" otherwise simila to previous years
  - met with elective surgery co-ord.
    - overall impact will be insignificant
  - Questioned about Elective Surgery Co-ord are the right people to talk to
    - should be DM's, Directors of surgery
  - SAS must come through the DM's so they can understand whats going on
  - Medical Sup's meeting Friday to conduct

Cuffe to be involved once a month.

* Business Rules to go back for further work involving the Zones & other key Stakeholders Richard Olley & Deb Padley → action by end of Octobe
⇒ SAS process was flawed and could have resulted in significat exposure → Sig - exposure failure of System.

Surgical Co-ordinatn report to DM's

Intent needs to be stated
& DM needs to get out

SAS transfer have to monitor not buy or negotiate
- Business rules need to state how SAS do business with the Districts/Zones

IBNR
- Cuth will rewrite the legislat
- Still falls short of what's required.
- Move back to staff specialist path in GH

AMAS
- roadshows - moving around the state
  - PAH this week.
- advertised top IR adviser

Urological Society 9/11-/03
- College of Surgeons flew David Scott up from Melbourne
- They don't know what they doing
  ACEC has created significant concern
- 04 will happen but by Dec need plan for how we appoint trainees into the future
- Ranking system for all surgical Specialists
  - SB has discussed banding
  - Geographical determinant
- 1st jurisdiction to go & discuss issues
- should get good outcome

College of Radiologists
- Could be done at University

Body of work done by Ramsay in Tasmania

Check re Sue Huxley emailed — See request.

C.I.S. - been advised inappropriately done 2004
- costs at options - PAS wrapped up with Clinicals

Attachment DFM-11

Zonal Managers Meeting

1) Business Rules.
- all negotiation before going to CMHS
- no more behind door bidding will be thru DM's
- i

(i) - Issue how deal c growth funds
- base target.

(ii) fundout of activity 02/03
- Nambour 1.4
- Bundy 365,000.
- HB/MB 400,000

Nambour needs to know CMHS is not prepared to settle it needs to be sorted
- Strong message no more consideration if can't get it right
→ corporate rules.

(iii) data must be cleansed at point of entry

Redcliffe = opthalmology. sorted
Sth Burnett 200,000 } off top
Nth " " 120,000
Mackay knocked off 200,000 + sep's

$3m still not sure what we will buy discussion c ZM's
Sub to be sent up to CMHS

Steve to be involved?

DISTRICT MANAGER POSITIONS
- IPCH interviewed before Kooralbyn. mid next week — Nov 7
- CMHS must sit on all DM panels.

~~[illegible]~~
~~[illegible] paid.~~
~~[illegible]~~

Bowen - closed 1-1.
Mt Isa. -
[illegible] on 7 November

S.S.1
→ transitional map/plan
→ problems re troubleshooting transactional issues.
→ ?. business rules Cairns/Tville.
have to wait till Exec Director
→ risk mgt of SS1 was not focused on business continuity

Call Tony

Cheryl re: CGMS was followed up of Exec Director position wed next wk. SS.1

BUDGET
figures ordinary
= independent review of whats happened at the park
= in corporate policy for oncosts for new services/projects
= Rules → new funding must be signed off by ZM's to ensure all costs

→ ?. do need to establish corporate policy re business rules.

~~Standard~~ costing methodology for all new service programs.

HEALTHY HEARING
- not new $
- gone CBRC
- business case
- incidents based on international figures
= must measure/evaluation
- do not want people to ask $
① Govt sign off ✓
② Next process needs to be undertaken
→ those places that can put up b/case for → within existing staff will get up first
built in agreed methodology

ED Physicians — consultant ↓
- have resolved & orians will not take place in transfer
- BAN on MO going in aircraft.

↓ 7% pathology] zonal manager will be meeting a Pathology & SS
↑ 17% in price]

Training course Security

→ brief from Bayer & all Districts ? cheryl.
inconsistency in policy across the state

Capital Works Plan.

→ access plan so know what's on the play.

Jennifer Wagner.

---

① Bennett.

② Cheryl
Mark Farley
= Job training onesth.
at Tville.

② Emerald
Anae 1-2 ext to Emerald SA
Ven Hydeige.
Accepted Anaesthetist
forms not

See Huxley will follow up