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QUEENSLAND HEALTH

# Surgery on Time

*A plan for enhancing elective surgery services in Queensland Public Hospitals*

*Elective Surgery Project*

*August 1996*

QUEENSLAND GOVERNMENT

# Foreword

*Surgery on Time* is a comprehensive Statewide initiative to enhance elective surgery services and reduce waiting times for elective surgery in Queensland public hospitals. The plan is a coordinated approach to managing the major elements that impact on elective surgery services. The developed strategies target increased throughput in conjunction with active management of waiting times rather than the size of the waiting list.

The 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 will result in :

- Better information and reporting to aid monitoring and performance management;
- Appropriately qualified and trained clinical staff in our hospitals;
- Enhanced capital infrastructure to support increased surgical throughput;
- Better utilisation of our operating theatres;
- Strategies to increase day surgery rates and reduce the need for hospitalisation;
- Improved transitional care in the community to promote reduced hospital lengths of stay;
- The development of better clinical practices; and
- Extra funding packages to ensure that our objectives are achieved.

To monitor and measure the success of the strategy, elective surgery targets have been set that, in the first six months, will focus on reducing the number of Category 1 patients waiting more than the recommended maximum of 30 days, to less than 5 per cent. Once this target is achieved, efforts and resources can be directed towards reducing the waiting times for patients requiring less urgent surgery while maintaining Category 1 achievements.

Queensland Health is committed to implementating strategies that will lead to real improvements in the delivery of surgical services and thereby reducing the time that Queenslanders wait for elective surgery. This plan is a significant step in that direction and I congratulate all those who were involved in its development. The hard work is just beginning however, and the implementation of the plan will require an ongoing commitment from all Queensland Health staff.

This initiative is one of the most challenging embarked on by Queensland Health in recent years. Our success in the effective management of elective surgery and in the reduction of waiting times will result in quality outcomes for both patients and health care providers.

(Dr) R L Stable
Director-General

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# 1. Background

Under Schedule E of the Medicare Agreement (1993-1998), Queensland has agreed to:

"6.1 (f) reform the management of elective surgery booking systems including :

(i) the regular clerical validation of waiting list numbers and waiting times;

(ii) the development and implementation of clinical validation protocols to ensure access to elective surgery is based on clinical need;

(iii) the regular collection and publication of nationally consistent and comparable data on waiting lists and waiting times and the provision of that data to the Australian Institute of Health and Welfare ("the AIHW") for publication at a national level; and

(iv) the development of comprehensive and co-ordinated elective surgery booking systems."

To this end, an audit and survey of waiting lists and waiting times was conducted at selected hospitals during October and November 1995. A second audit was undertaken during May 1996. The participating hospitals are: Cairns; Townsville; Rockhampton; Nambour; The Prince Charles; Royal Brisbane; Princess Alexandra; Gold Coast; Ipswich; and Toowoomba. The sample of 10 hospitals represent 55 per cent of elective surgical activity (approximately 70 per cent of occupied surgical bed days) for Queensland public hospitals.

In February 1996, the Government gave a commitment to significantly expand previous strategies to enhance elective surgery services in public hospitals in Queensland. A dedicated Project Team was formed in March 1996, headed by a senior clinician, to develop and implement an action plan for enhancing elective surgery services in Queensland's Public Hospitals.

On 25 March 1996, Queensland Cabinet considered an Information Paper outlining waiting times for elective surgery services in Queensland public hospitals and the planned approach to enhancing elective surgery.

The Information Paper included the following data from the 1995 survey:*

- The total number of people waiting for elective surgery in the participating hospitals as at 30 November 1995 was 22,505. There was a wide variation in numbers waiting across hospitals with 3,862 waiting at the Princess Alexandra Hospital, 3,109 waiting at the Royal Brisbane Hospital and 1,319 waiting at Cairns Base Hospital;
- There were 5,169 people in Category 2 who had waited longer than the maximum recommended 12 months and 492 patients in Category 1 waited longer than the maximum recommended 30 days;
- Approximately 24.2 per cent of Category 2 patients had waited longer than the optimal time for elective surgery. For Category 1 patients, approximately 43 per cent had waited longer than the recommended 30 days.

The data formed part of a national report published by the Australian Institute of Health and Welfare in April this year.

In the past, both the Commonwealth and individual States have investigated programs to decrease the size of waiting lists and reduce waiting times. Such programs have generally focussed on measures that increase hospital throughput, the popular perception being that waiting lists will decline as throughput increases.

* NOTE: For the purpose of the survey, patients were classified into one of two groups based on the clinical urgency of the awaited procedure. Category 1: admission desirable within 30 days.
Category 2: all other patients with no desirable time set for admission.

Time series analysis of a number of Victorian and South Australian hospitals does not support the hypothesis that increasing elective admissions at a hospital level will necessarily result in a corresponding decrease in the number of patients on the waiting list. The tendency seems to be for doctors' waiting lists to remain relatively unaltered, despite increases in the level of throughput. This finding is supported by similar studies in England. In some situations the waiting lists actually grew despite the increased throughput.

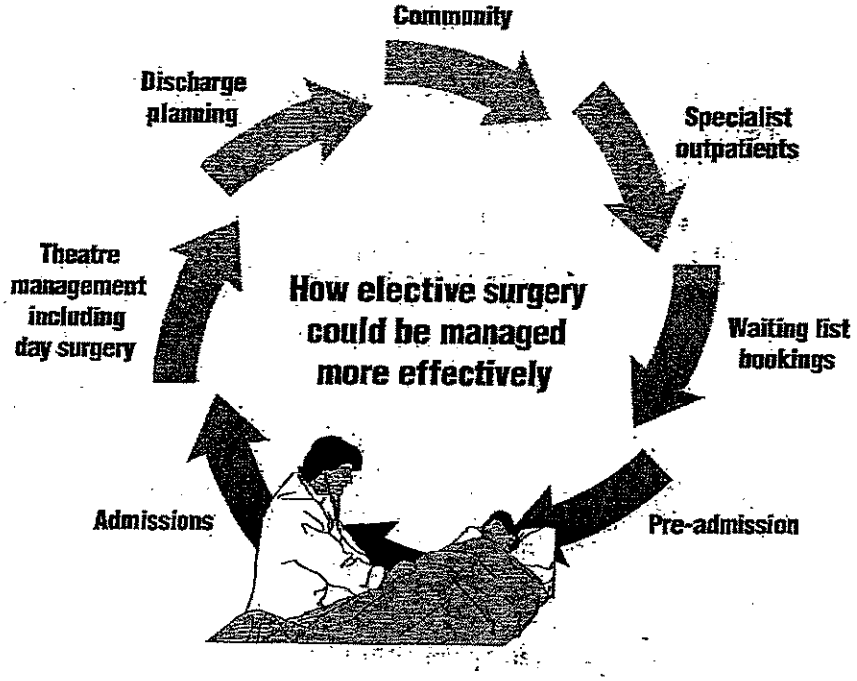
This reflects the commonly observed situation in health care where growth in supply can lead to increased demand and vice versa. It suggests that policy makers and funders should be cautious in interpreting waiting lists as an indicator of need and in pursuing patient throughput strategies in isolation to reducing waiting lists. It also suggests that when incentive funds are used to increase throughput, then these funds will need to be added to the hospital base level of funding if the status of the waiting list is to be maintained.

A plan for enhancing elective surgery, *Surgery on Time*, has been developed by Queensland Health as a statewide approach to boosting elective surgery services and reducing waiting times for elective surgery. The plan takes a coordinated and comprehensive approach to managing the major elements that impact on elective surgery services in Queensland public hospitals. Based on the available evidence, the developed strategies target increased throughput in conjunction with active management of waiting times rather than the size of the waiting list.

## 2. Elements of the Plan

The *Surgery on Time* plan focuses on the major elements that impact on elective surgery services in Queensland public hospitals. It involves both short and long term strategies that target the reduction of waiting times and increasing the number of people receiving care.

A "continuum of care" approach has been adopted with strategies having been developed to improve service delivery at all stages of the clinical cycle including waiting list bookings, pre-admission, admission, theatre management and discharge planning.




The elements of the plan are:

- Information and Reporting;
- Workforce Issues (including staff development and training);
- Capital Works;
- Theatre Management;
- Preferred Clinical Practice;
- Day Surgery;
- Post-Acute Care;
- Financing and Incentives.

Information and reporting systems will be progressively implemented in Queensland public hospitals during 1996, dramatically improving the capability of Queensland Health to set elective surgery goals and monitor progress towards these goals. Attachment 1 includes the minimum achievements that Queensland Health expects of hospitals participating in the Elective Surgery Project.

## 2.1 Information and Reporting

The provision of timely and accurate information is of critical importance in the management and monitoring of waiting lists and waiting times for elective surgery in Queensland public hospitals. Obtaining and maintaining this information corporately is regarded as the key to the success of the project. In the past, hospitals have not been able to accurately monitor and audit their elective surgery lists or provide information on a routine basis to Corporate Office.

The monitoring of each hospital's performance and trends in the area of elective surgery has critical links to the development of hospital budgets and service agreements.

The 10 participating hospitals have installed the Elective Admissions System (EAS) module of the McDonnell Information Systems *Hospital-Based Corporate Information System* (HBCIS) to manage and monitor their waiting lists for elective surgery. In the past, the EAS module has been limited in functionality and reporting ability. It has been recently enhanced to alleviate many shortcomings.

The hospitals now have the ability to report on a monthly basis:

- National Minimum Dataset (NMDS) information which is necessary to access Commonwealth Pool B funding under the Medicare Agreement;
- Unit record (patient level) waiting list data;
- Waiting list status reports on the previous month's activities.

Performance reports will be provided on a monthly basis to the Minister, senior management and the hospitals. These reports will contain detailed information on hospital activity including the type and complexity of procedures, the specialities covered by these procedures in addition to comprehensive information on waiting times for elective surgery. Case complexity will be measured using the casemix index which weights resource intensive procedures accordingly and allows comparison of surgical workloads between hospitals.

At present, only the 10 hospitals participating in the elective surgery project are required to report on the status of their waiting lists. These hospitals account for approximately 55% of elective surgery activity (by number of procedures) in Queenslands public hospitals. In order to properly monitor waiting times in Queensland and benchmark against other States and national indicators, it is necessary to extend reporting requirements to other major public hospitals in Queensland.

To achieve a coverage of 95 per cent of elective surgery activity in Queensland, it is estimated that the 32 largest hospitals will be required to routinely report on the state of their waiting lists. Twenty-five of the 32 hospitals have implemented EAS.

Project implementation will ensure that the installation of EAS in the remaining seven hospitals will completed by February 1997. Access to special purpose funding for elective surgery will be made conditional on the supply of information from the EAS module by individual hospitals on a monthly basis from this date.

Further enhancements to the EAS module are planned and these will allow more accurate reporting and monitoring of elective surgery services in Queensland.

The net effect of the activities will be the development and implementation of a Statewide waiting list monitoring system which can be used to minimise geographic and intra-hospital variations.

## 2.2 Workforce Issues

### Medical Workforce

The availability of a medical workforce for elective surgery services is affected by a combination of many factors.

#### Medical Graduates

Except for Western Australia, Queensland graduates the lowest number of doctors per capita. In 1995 there were 6.59 final year medical students in Queensland per 100,000 population compared to the national average of 7.14. NSW had 7.19, Victoria 6.86, South Australia 10.44 and Tasmania 8.03. The only State to have less final year students per capita was Western Australia with 5.71 students per 100,000 population.

Women make up approximately 50 per cent of medical graduates from the University of Queensland, however, they total only 26 per cent of the total medical workforce in Queensland. Women are considerably under represented in specialist disciplines making up only 12.8 per cent of specialists.

Approximately, one third (35 per cent) of General Practitioners (GPs) are women and 51.3 per cent of the female medical workforce is in general practice.

#### Resident Medical Officers

In all States there is an acute shortage of Resident Medical Officers (RMOs). This has resulted from a combination of decreased hours of work and a move by employing hospitals to a shift system employing increasing numbers of RMOs. This is to avoid high overtime payments. The high number of female graduates has lead to greater part-time employment linked with changing lifestyles for all doctors reflected by a desire to work shorter hours. Many hospitals are experiencing increasing difficulties recruiting adequate numbers of RMOs with consequent effects on the ability to rapidly process surgical patients.

In Queensland this has been compounded by the rapid population growth and expansion of hospital services requiring large numbers of RMO staff. In 1993/94, Queensland accounted for over 43 per cent of the nation's population growth, with much of this growth occurring in the south east corner of the State. Queensland's population continues to grow faster than the rest of Australia, with growth for the 1995/96 period forecast at 2.2 per cent, compared with 0.6 per cent for the rest of Australia.

Queensland Health is implementing a range of incentives to attract and retain junior medical officers in Queensland public hospitals. The following initiatives are an indication of this commitment:-

*Junior Doctor Training Program*

The Clinical Policy Unit has provided funding for the development of a two year Junior Doctor Clinical Training Program for the junior non-specialist medical workforce. This formal postgraduate hospital training program is being developed to address the gap in structured training identified between the intern year and entering general practice/ specialty training. The program focuses on clinical skills, in particular to prepare doctors for rural relieving. It is anticipated that introducing a formal curriculum for second years may increase the likelihood of keeping them in the public system longer.

*Project Residency*

Project Residency is being undertaken by the Medical Superintendents Association of Queensland with assistance from the Medical Workforce section of the Clinical Policy Unit. The project aims to address the current shortage of RMOs in Queensland public hospitals with a view to Resident Medical Workforce planning for the future. The Taskforce has begun to work on defining of the purpose of RMO Workforce; defining feasible models for medical service and education/training for RMOs; defining the role of RMOs in preferred models of integrated medical service and education.

A discussion paper, resulting from this initial work on the projects objectives, will be circulated to the major stakeholders for comment, prior to addressing the following additional objectives: to quantify productivity of the average RMO in terms of health service delivery in the context of service/ education models; to define education/ training requirements for RMOs in context of the service/ education models; to benchmark RMO productivity across Queensland hospitals; to benchmark RMO education opportunities across Queensland hospitals; and to consolidate a redesign of the RMO workforce in terms of its purpose and service and education functions.

**Rural Co-ordination Networks**

The Clinical Policy Unit in consultation with relevant stakeholders, is in the process of establishing two Rural Co-ordination Networks, Northern and Southern to decentralise the delivery of rural relieving and locum services from Corporate Office to public hospitals. These Networks will facilitate a coordinated approach for providing rural relieving medical officers to hospitals. This service can be more responsive to local needs and one which ensures training and education requirements for junior practitioners are met. The Networks will oversee the training and placement requirements of non-specialist medical officers and an integrated program of mentorship initially targeted toward Medical Scholarship Holders.

**Overseas Trained Doctors (OTDs)**

Clinical Policy Unit has provided funding for the development of a pre-MCQ Bridging Course to assist OTDs with Australian residency prepare for the Australian Medical Council examinations which are prerequisites for registration. In return for the educational assistance, OTDs will be bonded for a period to Queensland public hospitals. Many rural areas receive temporary assistance provided by Overseas Trained Doctors, or Visiting Medical Officers, as these areas are unable to recruit sufficient locally trained staff. Overseas trained doctors represent a valuable resource which would otherwise be lost to Queensland public hospitals should their medical qualifications not be utilised.

**Anaesthetics**

A significant limiting factor for elective surgery is the availability of anaesthetic specialists. Anaesthetists are involved not only in the actual operative anaesthetic but also in preoperative patient risk assessment and increasingly in post operative pain management.

Per capita, Queensland has the lowest number of anaesthetists of any State or Territory in Australia. The Australian Medical Workforce Advisory Committee (AMWAC) Medical Workforce Benchmarks Report released in February 1996 records Queensland as having 9.7 Anaesthetists per 100,000 population (1993/94 figures) compared to a national average of 10.59. In New South Wales/Australian Capital Territory, the figure was 10.36; Victoria 11.15; South Australia/Northern Territory 11.58 and Western Australia 10.58.

The number of vacancies in anaesthetics in Queensland has improved considerably with the introduction of improved specialist remuneration packages in July 1995. Anaesthetic vacancies have to an estimated 5 positions in June 1996 following an active recruitment drive. However, this reflects the vacancies in funded positions. Most hospitals could readily argue that, to provide a fully efficient anaesthetic service, additional positions are required.

There are currently 82 accredited anaesthetic training posts in Queensland public hospitals including three additional positions funded in the 1994/95 budget.

### Surgical Specialists

Queensland also has, according to the AMWAC Report, low overall numbers of surgeons at 23.53 per 100,000 population compared to the national average of 24.92. The other major States have higher ratios of surgeons with New South Wales 25.18 and Victoria 26.16 by comparison.

The major disciplines with significant shortages in the public sector are Anaesthetics, Ear/Nose/Throat, Orthopaedics and Urology.

Queensland Health will be offering scholarships to the value of $20,000 to registrars to undertake advanced training overseas in 1997. This amount would be in addition to any salary earned while working in the overseas post and would assist with the cost of travel and accommodation. On their return to Queensland, scholarship holders would be required to provide two years contractual service in a Queensland provincial city hospital along the lines of the Queensland Health Scholarship Scheme.

Expressions of interest will be sought from final year registrars, targeting those disciplines in which the need is greatest — Anaesthetics, Obstetrics and Gynaecology, Psychiatry, Emergency Medicine, and Radiology.

### Geographical Distribution

South East Queensland contains 71.1 per cent of GPs and 78.3 per cent of specialists together with 67.2 per cent of non-specialist hospital doctors and 95 per cent of trainee specialists. This distribution means lower availability of specialists in provincial cities and rural areas.

### Ageing Population

By the year 2011, it is estimated that 19 per cent of Queensland's population will be more than 60 years of age, and by 2031 this will increase to 27 per cent. Within four decades, one in every four Queenslanders will be more than 60 years of age. In the years to 2001, the number of persons aged 75 years or more will increase more rapidly than those aged 65 – 74 years. This has major implications for surgical demand and available medical workforce.

The specific issues identified in the elective surgery project will be addressed as part of a Statewide approach to health workforce planning issues in conjunction with the new Health Workforce Planning Unit.

## Nursing Workforce

The difficulty of attracting and retaining nurses to work in Queensland hospital operating rooms (perioperative nurses) is well documented. The perioperative nursing workforce in Queensland is currently some 40 full-time equivalent nurses under establishment. It is recognised that a lack of hospital support, in-service training and the availability of perioperative nursing courses offered by the Queensland tertiary education sector are contributing factors.

Based on an analysis of the status of perioperative nursing education in Queensland, a dual approach is proposed to achieve positive short and long term outcomes.

In the short term, the following are required:

- *transition support programs* for all registered nurses entering the perioperative sphere;
- *skills acquisition programs* for perioperative nurses already in the workforce.

For the long term, the following are required:

- access to continuing education; and
- articulation of learning between the clinical practice environment and the tertiary education setting by the linking of hospital-based *transition support programs* to continuing education.

*Transition support programs* use the preceptorship or "buddy" model to facilitate learning and skills acquisition. This model builds upon knowledge and skills carried into the position by the entering nurse with the expert "buddies" being the linchpins to the successful integration of new staff.

The elements of the program are:

- the establishment of a formal *transition support program* by each perioperative nurse employing hospital; and
- the development of "Guidelines to Perioperative Nurse Transition" which will include performance indicators and program evaluation criteria.

*Skills acquisition programs* for perioperative nurses facilitates ongoing education and provides an avenue for perioperative nurses to learn new skills, update previously learnt skills and gain new knowledge.

The creation of a dedicated full time "Nurse Educator — Perioperative" position in each participating hospital is required to facilitate the *transition support programs* and *skills acquisition programs*. The establishment of a communication infrastructure to facilitate the sharing of knowledge, clinical practice issues and research is essential.

These initiatives will reduce the number of perioperative nursing vacancies and enhance the quality and effect of operating theatres in Queensland public hospitals.

To ensure the provision of long term access to continuing education for perioperative nurses, Queensland Health will be instrumental in generating communication and positive outcomes between key stakeholders.

It is proposed to:

- commence formal discussion with key stakeholders to address curriculum development and the linking of clinical practice issues to the theory elements of continuing education;
- seek expressions of interest for the development of curriculum and the implementation of continuing education for perioperative nurses. The intention is for the course to be offered in both attendance and external modes and link with the Transition Support Program; and
- negotiate the development of perioperative nurse education to the Graduate Diploma level with a consortium of Queensland universities.

These issues will be addressed as part of a Statewide approach to health workforce planning issues in conjunction with the new Health Workforce Planning Unit.

## 2.3 Capital Works

The Capital Works component of the plan has three elements:

- a $35 million equipment replacement program for hospitals;
- a $1 million minor works program specifically targeting elective surgery services; and
- an analysis of major projects on the Queensland Health Capital Works Program.

The $35 million for replacement of equipment has been approved and totally committed. A total of $11.5 million had been expended to 30 June 1996.

The $1 million minor works program was developed to provide a direct impact on elective surgery services in Queenslands public hospitals. Acting District Managers from the 10 participating hospitals provided a list of minor capital works projects including equipment purchase/replacement that, if implemented, would have a direct effect on elective surgery services. The list of minor works has been approved by the Capital Works Task Force.

The analysis of major projects on the Capital Works Program will identify those projects that will have an impact on Elective Surgery Services in Queensland public hospitals. Prioritising and fast tracking of some of the projects may be possible in order to influence elective surgery services at an earlier time. An example of a recent initiative in this area is the upgrading of the airconditioning system in the operating theatres at Toowoomba Hospital.

## 2.4 Theatre Management

The effective utilisation of operating theatres is critical to improvements in waiting times for elective surgery. Poor theatre utilisation disrupts admission planning, and creates bottlenecks in the hospital that can result in longer than optimal lengths of stay. There are also adverse impacts on the use of equipment and other capital items. Poor utilisation of operating rooms has human resource costs, in terms of inefficient staff rostering and sub-optimal scheduling of medical staff for theatre sessions.

Studies in Queensland at the Townsville General Hospital, Princess Alexandra Hospital and Royal Brisbane Hospital have identified opportunities for increased efficiency in many of these areas. A range of strategies for workplace reform have been developed to improve theatre utilisation.

The studies have also identified the fundamental role of management information systems in operating rooms to realise or optimise efficiencies gained across the hospitals. Queensland Health has undertaken the development of a business case for the implementation of theatre information systems in 10 major hospitals. These hospitals collectively represent more than 70 per cent of occupied surgical bed days for Queensland public hospitals.

This business case indicates that the cost of implementation would be approximately $2.4 million and would be central to significant improvements in efficiency. Funds for such an implementation are available within the Capital Works budget, and commitment to implementation has been made, subject to finalisation of the business case.

## 2.5 Preferred Clinical Practice

During the past five years, a number of isolated special projects affecting the management of elective surgery waiting times have been established around the State, funded via State and/or Commonwealth funds.

A Clinical Advisory Committee has been formed specifically to review preferred clinical practice locally, nationally, and internationally in the continuum of patient care associated with elective surgery. Through review of the literature nationally and internationally, and analyses of the outcomes of projects instigated to date, the Clinical Advisory Committee will recommend strategies to pursue elements of the patient care continuum such as pre-admission assessments, the use of day surgery, theatre utilisation, hospital bed management, and discharge planning.

The membership of the Clinical Advisory Committee has been designed to offer professional Colleges and associations representation to ensure their assistance in the development of, and their ultimate endorsement of, preferred clinical practice.

All of the elements of care listed above have been established in various combinations throughout Queensland public hospitals. Coordination of these elements and guiding principles for their establishment and/or enhancement will be developed within Queensland Health. The expected outcome is the recognition and promotion of preferred clinical practice in the area of elective surgery.

The promotion of these successful approaches in the management of elective surgery services, for example, in the form of workshops attended by clinical and administrative staff, will be critical. Where possible, the outcomes of local and national programs, such as the Ambulatory Care Program, will be promoted through staged presentations. Commonwealth funds have been allocated within that Program to arrange these promotions of preferred clinical practice.

The "Access to Surgery" symposium on the planning and management of health care programs under Medicare held in Townsville on 23 – 25 May 1996, is an example of the type of approach required to report on, encourage debate, and promote recent national initiatives to improve access to elective surgery. Outcomes of the Theatre Utilisation Project at Townsville Hospital, Princess Alexandra Hospital and Royal Brisbane Hospital were presented at this symposium. A further seminar is planned for November of 1996.

## 2.6 Day Surgery

The Commonwealth Government provides financial incentives towards increasing day surgery through the *Day Only Procedures Program* (DOPP) under Schedule G of the Medicare Agreement (1993 – 98). Funding of $2.73 million is available in 1996/97.

DOPP funds have been distributed in the past on a modified Regional Allocation Formula and based on defined targets. Recent initiatives in the *Day Only Procedures Program* include the benchmarking of Queensland's day surgery rates for selected surgical procedures against other Australian States and against international rates. Benchmarking for each of the participating hospitals will also be undertaken.

A funding distribution system is currently being developed, in conjunction with the Casemix Unit, which will encourage and reward demonstrated shifts to same day admission and discharge in targeted surgical procedures.

## 2.7 Community-Based Post-Acute Care and Acute Care

The *Post-Acute Program* (PAP) is a Commonwealth program funded under Schedule G of the Medicare Agreement (1993 – 1998). Funding of $2.7 million is available in 1996/97 to enhance hospital efficiency and reduce length of stay while maintaining continuity of care. The program focuses on the appropriateness of the site of care and supports a shift of care

to the community. Funding may also be utilised to prevent admission by providing community-based care as an alternative to hospitalisation.

Increases in elective surgery throughput will necessitate enhanced community-based support both prior to admission and post-discharge. This will ensure that access to elective surgery beds is maximized, continuity of care is enhanced and re-admission risk is minimised. In the long term, system-wide strategies need to be implemented to support a decrease in hospital-based activity and an increase in community-based care in the acute and post-acute care areas.

To date, PAP funding has been used mainly to purchase post acute care services from the non-government and private sectors on a fee-for-service basis. Other Commonwealth funding programs such as the *Hospital Access Program* (HAP) have also been utilised to establish elements of a coordinated approach to providing health care. However, substantial system change has yet to be achieved and a comprehensive and integrated 'episode of care' approach is yet to be developed. Increasing demand and hospital throughput have highlighted the limitations of the current system.

With the cessation of Commonwealth PAP funding approaching, available funds in 1996/97 need to be used in a manner which will continue in the short term to support shortened hospital length of stays. However, funds also need to be directed towards the establishment of a model of care which is integrated across the whole hospital/community system, has the potential for mainstreaming, and has the capacity to meet long-term goals of reducing demand upon hospital beds. It is therefore proposed to establish a number of community-based acute care and post-acute care services which will be targeted at elective surgery with the possibility of replication across other care streams in the future.

There are a number of interstate models such as Adelaide's Queen Elizabeth II Hospital, which established an acute care stream in the community through hospital outreach. As well, some excellent progress has been made in developing programs in Queensland such as the work undertaken by the Mackay Base Hospital.

A funding distribution system is currently being developed, in conjunction with the Casemix Incentives Strategy, which will target projects that encourage the establishment of models of care which are integrated across the whole hospital/community system, have the potential for mainstreaming, and has the capacity to meet long-term goals of reducing demand upon hospital beds.

It is proposed that available funding will be directed towards developing and implementing a model of care where hospital and community staff are jointly appointed to provide a comprehensive service targeted towards:

- provision of pre-admission clinics;
- development of documentation, critical pathways and patient information/education in conjunction with elective surgery ward staff;
- provision of post-acute services (nursing and allied health) to reduce length of stay following surgery; and
- provision of "Hospital in the Home" services for patients selected according to agreed criteria requiring therapeutic treatment which would otherwise be given in hospital following elective surgery (eg. intravenous antibiotics in selected cases).

The net effect of such initiatives will be to reduce the length of time patients spend in hospital freeing up beds and allowing additional patients to be treated.

## 2.8 Financing and Incentives

The financing of enhanced elective surgery services in Queensland public hospitals is focussed on the primary aim of significantly reducing the number of patients who have waited longer than is clinically desirable in conjunction with increasing elective surgery throughput in public hospitals.

Specific funds are provided to Queensland Health aimed at reducing waiting times for elective surgery. The **Casemix Incentives Strategy** is a three year Queensland Government funded new initiative which will provide $13.8 million in 1996/97 for the waiting list reduction in two pools, the Waiting List Backlog Program and the Hospital Access Bonus Pool. $1.3 million is available to specifically address the issue of Cardiac Surgery at Townsville Hospital and The Prince Charles Hospital.

The **Waiting List Backlog Program** is the first component of the Casemix Incentives Strategy which is designed to deal with the current backlog of patients in particular surgical specialties. Under this arrangement, hospitals are required to enter into agreements which define a predetermined price and agreed volume of patients which is to be treated throughout the year in targeted service areas. In turn, funds from this pool are paid to hospitals in advance so the necessary resources are available to ensure the most urgent patients on hospital waiting lists (Category 1 patients) are treated in a timely manner. Where the agreed number of patients are not treated in the specified time period, the grant amount is adjusted and funds reallocated to other priority service areas within this Program.

The **Hospital Access Bonus Pool**, the second initiative under the Casemix Incentives Strategy, provides incentives for hospitals to reduce the number of semi-urgent patients in all surgical specialities on public hospital waiting lists.

In addition, funding is provided under the **Home Support Scheme**, which addresses the issues of additional pressure on the community health sector as a consequence of decreases in length of stay and increased demand on post-acute services arising from increases in hospital surgical activity.

A summary of these funding arrangements, provided as a new initiative in 1995/96, is as follows:

| Funding Pool | 1995/96 | 1996/97 (Indicative) | 1997/98 (Indicative) |
|---|---|---|---|
| Waiting List Backlog Program* | $5.0 million | — | — |
| Hospital Access Bonus Pool | $10.0 million | $12.5 million | $12.5 million |
| Home Support Scheme | $5.0 million | $7.5 million | $7.5 million |
| TOTAL | $20.0 million | $20.0 million | $20.0 million |

* An additional $1.3 million is available in all three years under the Waiting List Backlog Program to specifically address the issue of Cardiac Surgery at The Prince Charles Hospital and Townsville Hospital.

In order to provide adequate incentives to reduce the number of patients on the waiting lists who have waited longer than is clinically desirable to a minimum, *additional* funding in each of the 1996/97 and 1997/98 financial years is required. In the first year, this additional funding would only be available to the 10 hospitals participating in the Elective Surgery Project. In future years the scope of application of funds may be extended to include other hospitals.

However, it is clear that ongoing funding must be provided for hospitals not participating in the Elective Surgery Project, to support extra elective surgery activity generated by the Casemix Incentives Strategy in 1995/96. To this end, funds will be transferred from the Hospital Access Bonus Pool and Home Support Scheme to the Waiting List Backlog Program to ensure that the most urgent cases continue to be addressed in a timely manner.

Under the Waiting List Backlog Program, hospitals will be required to submit bids to undertake an agreed volume of services in selected clinical specialities which will be funded in accordance with the State-wide benchmark prices. As is currently the case, hospitals will be funded in advance based on agreed activity with retrospective budget adjustments being made if agreed volumes are not met.

A team will travel to participating hospitals to jointly negotiate performance targets that will be met with funding dedicated to extra throughput. Both district managers and hospital clinicians will be parties to the resulting service agreements which will provide a guarantee for the achievement of the agreed target and which specify that hospital resources (staff and capital) are available to support the agreed increased activity at the specified prices.

Hospital activity including throughput and waiting list data will be monitored on a monthly basis through the EAS module and Casemix reporting arrangements.

# 3. Mechanisms for Project Management

## 3.1 Special Ministerial Task Force

A Special Ministerial Task Force, chaired by the Deputy Director-General (Health Services), has been formed to investigate and make recommendations on appropriate changes to the health care delivery system. The Task Force is comprised of representatives from the Australian Medical Association, Royal College of Surgeons, Australian and New Zealand College of Anaesthetists, Royal Australian College of General Practitioners, Royal Australian College of Ophthalmologists, Queensland Nurses Union, Perioperative Nurses Association, Directors of Nursing Association, Australian Orthopaedics Association, Medical Superintendents Association, Queensland College of Allied Health Professionals, the Under-Treasurer and senior managers from within Queensland Health including the Chief Health Officer, Director, Capital Works Branch and the Principal Nurse Adviser.

## 3.2 Clinical Practice Advisory Committee

A Clinical Practice Advisory Committee, chaired by Dr Steve Buckland, Manager, Redcliffe-Caboolture Health District Health Service, has been formed to review preferred clinical practice locally, nationally, and internationally in the continuum of patient care associated with elective surgery. The Advisory Committee is comprised of representatives of Queensland State Committee — Royal Australasian College of Surgeons, General Practitioner Liaison Council, Royal Australian College of Medical Administrators, Royal College of Nursing, Perioperative Nursing Association, Community Nursing Groups, Division of Public Health Services — Queensland Health, Operational Services within healthcare facilities, Queensland Branch of the Royal Australian College of Ophthalmologists and the Queensland Regional Committee — Australian and New Zealand College of Anaesthetists. The Committee reports to and takes direction from the Special Ministerial Task Force.

## 3.3 Medical Superintendents Advisory Committee

A Medical Superintendents Advisory Committee chaired by Dr Mark Waters Manager, Ipswich District Health Service has been formed comprised of the Medical Superintendents from the 10 participating hospitals. The role of the Committee is to inform the project from the perspective of the hospitals in developing strategies to enhance the delivery of elective surgery services and identifying ways to meet the goals and targets identified by the Special Ministerial Task Force.

## 3.4 Corporate Office Reference Group

A Corporate Office Reference Group has been formed to provide expertise to the project team on a regular basis. The composition of the Reference Group includes representatives with corporate knowledge in the following areas: Health Policy, Health Services Planning, Health Financing and Incentives, Casemix, Medical Workforce, Nursing Workforce, Information Systems and the Capital Works Program.

## 3.5 Elective Surgery Coordinators

Elective Surgery Coordinators have been employed at all participating hospitals. The coordinators are the pivotal link between the corporate project and the hospitals. The roles and responsibilities include assessing the management of elective surgery in the hospital and developing and implementing hospital-based strategies to enhance elective

surgery services. The critical nature of accurate and timely information in this plan has been emphasised and the coordinators have an oversight role in ensuring the provision of reliable, consistent and comparable data. Regular clerical auditing and liaising with clinicians to ensure regular clinical audits is an important and related role.

A graphical representation of the mechanisms established for project management is included at Attachment 2.

## 4. Consultation

Consultation has occurred with District Managers and key medical and nursing personnel from the participating hospitals on the approach to enhancing elective surgery services. Such consultation has included a visit to each of the participating hospitals.

An initial framework for the action plan for enhancing elective surgery has been circulated across a wide cross section of health care providers for comment. The comments received were used to enhance the framework within which the plan was developed.

Consultation has occurred widely with medical and nursing colleges, societies and organisations and briefings have been completed with the Royal Australian College of Surgeons, the Queensland Nursing Union, the Queensland Nursing Council, the Royal Australian College of Medical Administrators, the Health Rights Commission, the Australian and New Zealand College of Anaesthetists, the Australian Medical Association, the General Practitioners Liaison Council, the Queensland Council of Allied Health Professions, the Royal Australian College of Ophthalmologists and the Royal Australian College of General Practitioners.

The Minister for Health has met personally with a majority of these stakeholders to emphasise the commitment of the Government to the Elective Surgery Project.

# 5. Financial Considerations

## 5.1 Commonwealth Funding

Health services in Queensland are funded from Queensland's own source revenue and through Commonwealth payments. For the current year, 1995/96, the Queensland Health budget is $2.75 billion of which $1.71 billion (62 per cent) is from Queensland's own sources and $1.04 billion (38 per cent) from the Commonwealth.

### Hospital Funding Grant

The bulk of the Commonwealth funding is in the form of the Hospital Funding Grant (HFG) under the Medicare Agreement ($864.9 million in 1995/96). The remainder of the Commonwealth funding ($176.1 million) consists of other Specific Purpose Payments for health services such as Magnetic Resonance Imaging.

The HFG is composed of a number of separate elements, including the Base Grant, Bonus Pools A and B, Incentives Package, Mental Health, and Other Health Services. Yearly increases in the Base Grant are indexed against the Consumer Price Index, movements in award wages, and population increases. Increases in other areas reflect a variety of factors, such as public sector performance, scheduled projects, and numbers of particular patients.

Each State's share of the total Hospital Funding Grant pool is generally determined by its population share. There are some components of the HFG based on other factors apart from population such as approved projects. Overall, Queensland's weighted population share of 17.8 per cent at December 1995 is reflected in its HFG of 18.5 per cent of the total pool.

### Bonus Pool B

Within the HFG there has been, until recently, only one pool of funding tied to a measure of performance for the public hospital sector. This is Bonus Pool B ($169 million nationally in 1995/96). In this Pool, States were rewarded for increases in public hospital activity above an agreed threshold level. All States shared in the Pool and were, in effect, competing with each other.

In Queensland, the funding received from Bonus Pool B has been directed to specific activity purchased at benchmark prices. In 1993/94 and 1994/95, the inpatient activity purchased was either medical or surgical bed days. However, in 1995/96 with the implementation of casemix, Bonus Pool B funds were specifically directed to procuring increased elective surgery throughput under the Waiting List Backlog Program. In all, $16.8 million of combined State and Commonwealth funding has been directed to this Program in 1995/96. Overpayment by the Commonwealth in previous years will require a repayment of $9.6 million by the end of the 1995/96 financial year.

The operation of the Bonus Pool B has been the cause of concern at both Commonwealth and State levels. Payments from the Pool have been difficult to predict, varying significantly from year to year and being difficult to finalise for particular years. For example, the Commonwealth initially predicted Queensland would receive $27 million in 1993/94, while the actual entitlement is $6.3 million for 1993/94. The actual entitlement for 1994/95 is $2.2 million.

In 1995/96, agreement was reached between the Commonwealth and all States to replace Pool B with the 'Performance Pool'. Under the new arrangements, each State will gain access to an agreed amount of funding contingent only on public sector performance within the State. The level of achievement against the performance targets will determine the amount of funding received. States will no longer compete with each other for funding.

Performance targets in the Performance Pool relate to four principal areas: inpatient activity; non-inpatient activity; elective surgery waiting times data; and emergency department waiting times data. Targets in the four areas have been recently agreed with the Commonwealth for all States for 1995/96, and the funding tied to these areas is $8.4 million.

The Commonwealth has also agreed to roll up other specified funding under the Medicare Agreement, along with Pool B funds, into the Performance Pool. Funding for Day Surgery, Post Acute Care, Private Hospital Contracts, and certain other uncommitted funds have been included in this arrangement. These additional components add $12.6 million in 1995/96 to Queensland's total Performance Pool.

However, it remains the case that these are not new funds, and are on the whole committed to particular services to the end of the Agreement. The Commonwealth has undertaken to quarantine these additional funds from any risk of reduction should a State fail to reach performance outcomes and targets. Only the Pool B share of the new Performance Pool would be reduced.

Thus the total Commonwealth-funded Performance Pool for Queensland for 1995/96 is $21.0 million consisting of $8.4 million old Pool B funding, and $12.6 million in rolled up Specific Purpose Payments. In future years, the Performance Pool is estimated to total $22.0 million in 1996/97, and $17.6 million in 1997/98.

## 5.2 State Funding

### Previous Funding Allocations

On 4 March 1996, Cabinet approved the allocation of $1.945 million of additional part year funding to implement strategies at Royal Brisbane Hospital, Gold Coast Hospital and Cairns Hospital. All strategies have been targeted at alleviating pressure on elective surgery at these hospitals.

On 18 March 1996, Cabinet approved the allocation of $0.540 million of additional part year funding to implement strategies at Prince Charles Hospital and Cairns Hospital. All strategies have been targeted at alleviating pressure on elective surgery at these hospitals.

The full year costs of the strategies total $10,085,700 (new initiative funding 1996/97 to 1998/99 committed by Queensland Treasury in the context of the 1996/97 budget).

### 1996/97 Funding Arrangements

The following table details the actual expenditure from the Casemix Incentives Strategy in 1995/96 together with the allocations approved by Cabinet for 1996/97.

| Funding Pool | 1995/96 (Actual Expenditure) | 1996/97 (Cabinet Decision) |
|---|---|---|
| Waiting List Backlog Program (WLBP)* | $8.6 million | $11.1 million |
| Hospital Access Bonus Pool (HABP) | $9.8 million | $10.5 million |
| Home Support Scheme (HSS) | $1.6 million | $4.0 million |
| TOTAL | $20.0 million | $25.6 million |

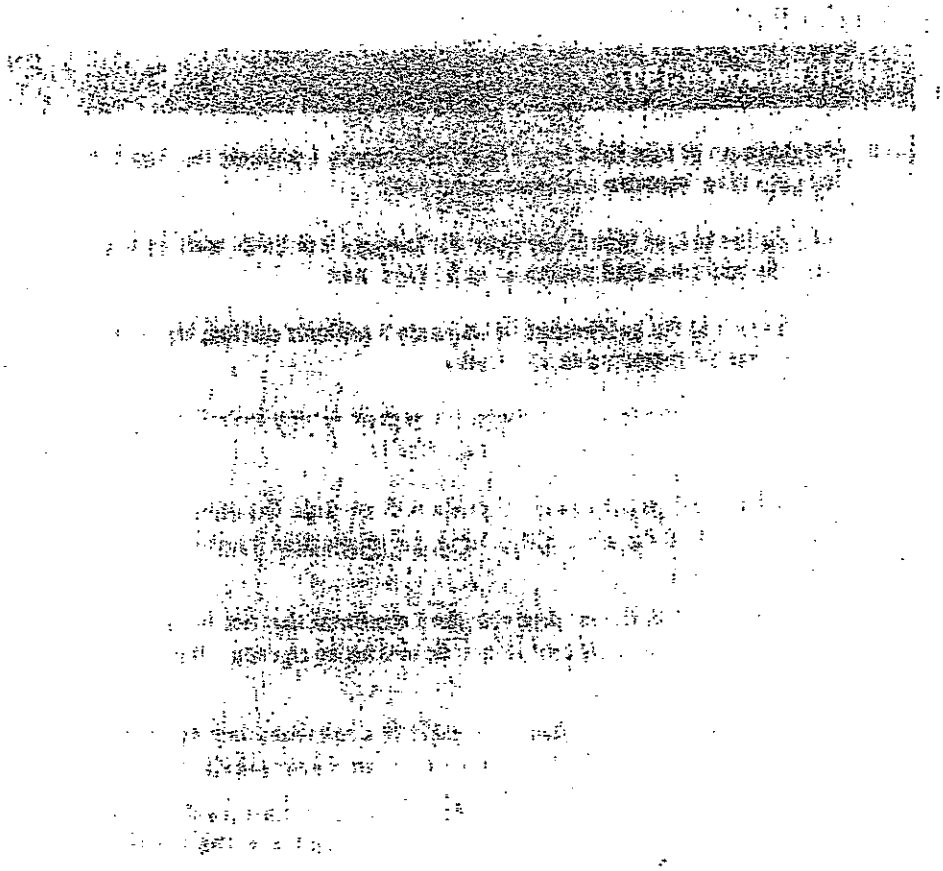
* Includes an additional $1.3 million which is available under the Waiting List Backlog Program to specifically address the issue of Cardiac Surgery at The Prince Charles Hospital and Townsville Hospital.

Full year funding of $520,000 has been provided for the continued employment of Elective Surgery Coordinators in the 10 participating hospitals.

Full year funding of $550,000 has been provided for the employment of perioperative nurse educators in each of the 10 participating hospitals.

## 6. Timing

The establishment phase of the Project will be completed by 30 June 1996 and the major implementation phase will be completed by 31 December 1996. Implementation of longer term initiatives will continue through 1997 and the project will conclude on 31 December 1997. The major reporting dates to Cabinet are 31 December 1996 and 31 December 1997.



# Attachment 1

## Elective Surgery Goals

### By 31 December 1996

- **A reduction to less than 5 per cent of Category 1 patients waiting longer than the recommended maximum of 30 days;**
- **A reduction of the percentage of Category 2 patients waiting longer than the recommended maximum of 90 days; and**
- **Maintenance of the percentage of Category 3 patients waiting longer than the recommended maximum of 12 months.**

### By 31 December 1997

- **Maintenance of less than 5 per cent of Category 1 patients waiting longer than the recommended maximum of 30 days;**
- **A reduction to less than 5 per cent of Category 2 patients waiting longer than the recommended maximum of 90 days; and**
- **A reduction of the percentage of Category 3 patients waiting longer than the recommended maximum of 12 months.**

Future census data and performance reports will include the three categories that have been adopted for use in defining waiting times for all elective surgery undertaken in public hospitals in Queensland.

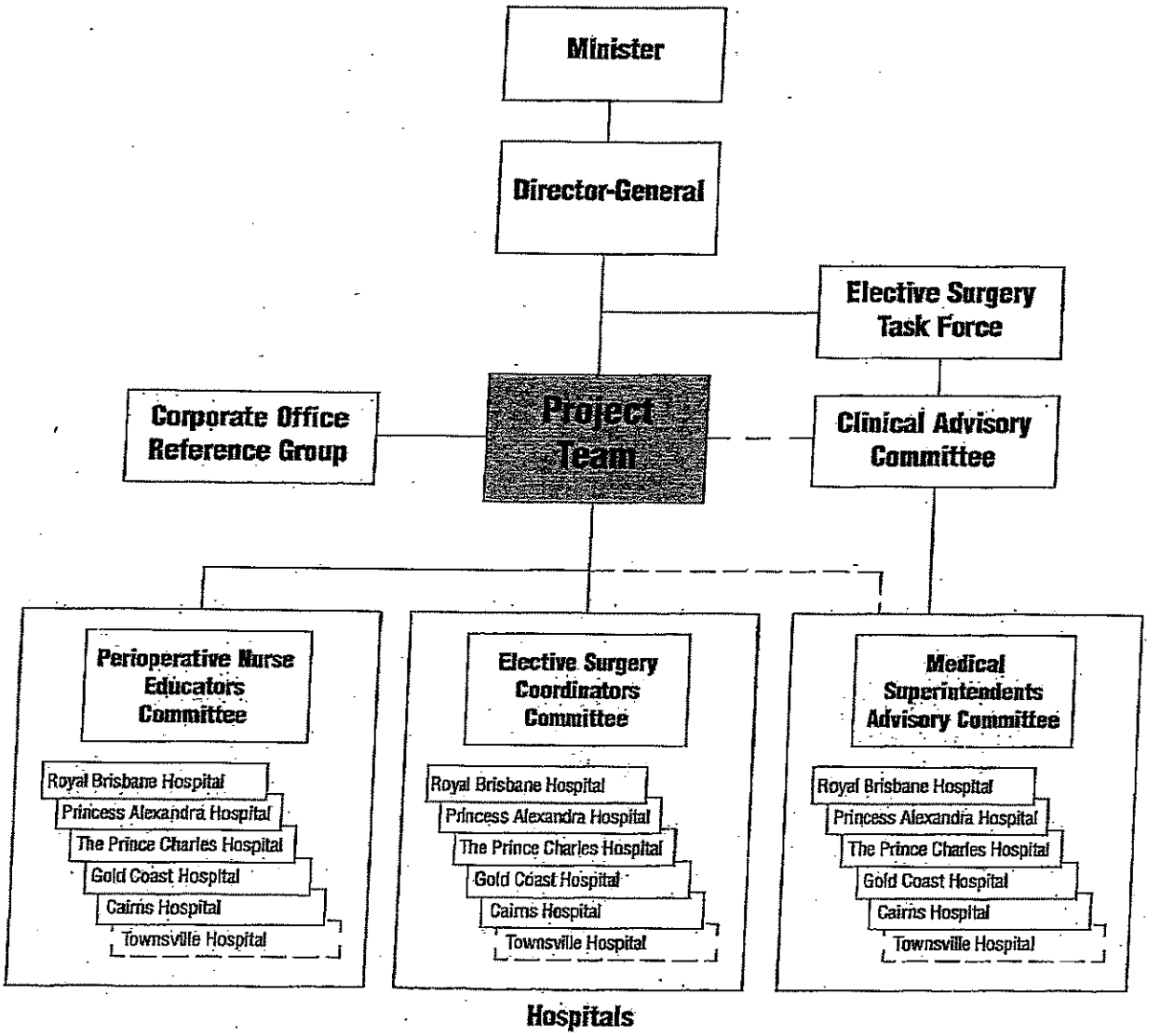
*Category 1:* *Very early admission desirable for a condition that has the potential to deteriorate quickly, to the point that it may become an emergency. Admission within 30 days desirable.*

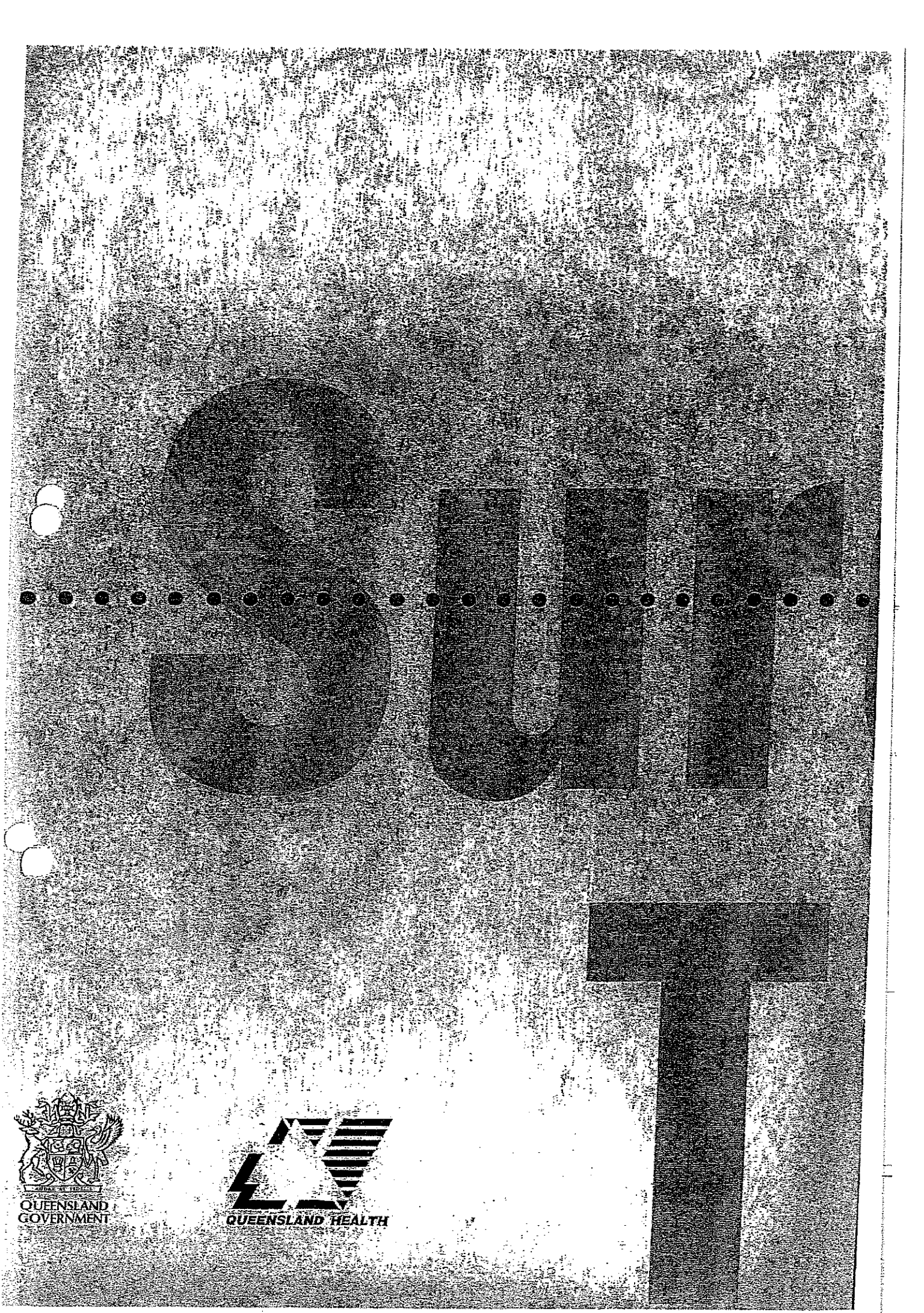
*Category 2:* *Admission within 90 days acceptable for a condition causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency.*

*Category 3:* *Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.*

## Attachment 2

### Mechanisms for Consultation





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