

# TASMANIA'S ELECTIVE SURGERY IMPROVEMENT PLAN

Getting our waiting  
times down

Summary

NOVEMBER 2008

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# Introduction

Each year more than 12,000 Tasmanians have elective surgery as patients of the public hospital system. It is an increasing challenge for hospitals to maintain a focus on elective surgery in the face of rising demand for emergency surgery and urgent and emergency medical care.

Elective surgery in public hospital systems is provided through the use of waiting lists, which are registers of patients who are waiting for elective care. These enable hospitals and clinicians to manage the demand for surgery based on the level of clinical need and the availability of appropriate facilities and clinical staff.

One of the key concerns for all hospitals is how waiting lists should be used to manage the flow of elective surgery efficiently, safely and equitably in order to maximise health outcomes for all patients accessing the health system.

Waiting lists do not simply function on a *first come, first served* basis. It is essential that hospitals actively and transparently manage elective surgery waiting lists to provide timely and appropriate access based on clinical urgency, while also providing a range of other medical and emergency surgery services.

The community also requires open accountability of its health services when dealing with valuable public resources. Effective planning will help ensure that our elective surgery system develops in an equitable and consistent way, with resources used efficiently to improve access for all Tasmanians to these services.

## Purpose and aims of this Plan

The purpose of Tasmania's Elective Surgery Improvement Plan (the Plan) is to address issues facing the delivery of elective surgery in Tasmania. In so doing, it sets out the policy direction and key principles for elective surgery, consistent with the reforms of the health system established in 2007 in *Tasmania's Health Plan and the Clinical Services Plan (CSP)*.

The Plan will enable the health system to best meet the elective surgery care needs of the community in the future. The aims of the Plan are to:

- Deliver shorter waiting times for elective surgery, including targeting procedures such as cataract removal
- Improve categorisation of patients across the state to manage access to surgery fairly
- Better inform patients and their doctors about elective surgery, waiting lists and waiting times
- Promote a structured, consistent and sustainable approach to managing elective surgery waiting lists
- Promote better partnerships and elective surgery referrals between hospitals
- Ensure that elective surgery services are appropriate
- Enhance the efficient use of hospital resources; and
- Ensure that we are measuring the performance of and improvements to the elective surgery system.

This Plan recognises that demand for acute health care is growing and that an appropriate balance needs to be maintained to meet the demand for both emergency and elective surgery and medical services.

Responsible planning in this area will develop the system in a systematic, sustainable and integrated manner, so that valuable health resources are used efficiently.

### What is elective surgery?

Elective surgery is surgery that, in the opinion of the treating clinician is necessary, and for which admission can be delayed for at least 24 hours.

Examples of elective surgery include cataract removal, gall bladder removal, some coronary artery surgery, inguinal hernia repair, total hip replacement and total knee replacement.

# Why an elective surgery improvement plan now?

The capacity of the public health system to provide elective surgery is governed by a number of crucial factors. These include the demand for emergency surgery, demand for hospital beds due to emergency and urgent medical care, the supply of surgeons, anaesthetists and nursing staff, theatre capacity, scheduling and management practices, and effective planning of patient discharge from hospital.

Demand for elective surgery in public hospitals is affected by a number of factors, including the rate at which clinicians refer patients for surgery, the types of surgical treatment for which patients are referred, the accessibility of surgery in the private hospital sector, and the availability of appropriate non-surgical services, such as physiotherapy.

Tasmania's health system also has a number of features that affect our ability to provide elective surgery as well as we would like.

Most importantly, elective surgery services in Tasmania have not been managed as a coordinated system. Waiting list management practices vary considerably from hospital to hospital, and are affected by decisions of individual clinicians and hospital management.

Another feature is the relatively high number of patients on elective surgery waiting lists, partly due to the comparatively low rate of private health insurance in Tasmania, and the inability of the private hospital system to offer a comprehensive range of surgical procedures.

Tasmania's Elective Surgery Improvement Plan recognises that significant changes need to be made in order to cope with the increasing demand for elective surgery. We recognise that we cannot keep going on as we have been. Unless we dramatically improve the elective surgery system, the situation will only worsen with the rising demand for all health services.

## Our investment in elective surgery

Rising demand for elective surgery was one of the key issues recognised in Tasmania's Health Plan, which focussed on the sustainability of all health services across the state. That is why the Tasmanian Government is investing \$8.4 million to enhance elective surgery.

Maintaining and developing elective surgery services is key to the health and well being of Tasmanians. The Tasmanian Government funding over the next two years will enable us to undertake this essential level of reform.

Elective surgery is also a priority issue for the Commonwealth Government. The Commonwealth's Elective Surgery Waiting List Reduction Plan aims to reduce the number of patients waiting longer than the clinically recommended times for elective surgery.

Under Stage 1 of the Commonwealth's plan, Tasmania received a further \$8.1 million to treat 895 long waiting patients by 31 December 2008. This is happening now. Under Stage 2 of the plan, Tasmania received \$3.1 million for the purchase of equipment. This has enabled us to buy the following items listed in the table below.

| Elective surgery equipment  | Estimated cost |
|---|----------------|
| Three sterilisation systems   | \$240,000      |
| Twenty beds and chairs  | \$170,000      |
| Gynaecological equipment  | \$50,000       |
| Seven monitors for recovery and operating rooms                                   | \$177,000      |
| Various orthopaedic surgery equipment   | \$43,000       |
| A patient lifter  | \$32,000       |
| An ultrasound machine   | \$100,000      |
| Two diathermy machines (equipment used in the operating room to control bleeding) | \$68,000       |

We are also in the process of purchasing another 17 major pieces of equipment for elective surgery.

Stage 3 of the Commonwealth plan will provide a total of \$300 million to be shared by states and territories that have improved their performance by dramatically increasing the number of patients treated within the clinically recommended times. As a condition of funding, states and territories must commit to developing systems for managing waiting lists on a coordinated regional basis. For this purpose, the Commonwealth considers the whole of Tasmania to be a region. This provides us with an additional financial incentive to re-design elective surgery in our state.

# Elective surgery waiting lists – how do they work?

Elective surgery waiting lists are prioritised, first-in, first-out queues. In Tasmania, the queues have three categories that are consistent with national definitions – urgent, semi-urgent and non-urgent – the priority of each varying according to the clinical urgency of the surgery patients require.

## Elective surgery waiting lists – priority categories

- **Category 1 – Urgent:** admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency, or for diagnostic procedures requiring urgent answers, or for urgent treatment of neoplastic conditions (tumours, cancers or related growths);
- **Category 2 – Semi-urgent:** admission within 90 days is desirable for a condition causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency; and
- **Category 3 – Non-urgent:** admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and does not have the potential to become an emergency. There is no national standard for desirable treatment time, but 365 days is used as a guide.

The purpose of categorising elective surgery by levels of priority is to manage access equitably, with priority given to those who are assessed as having the greatest clinical need. Patients from the same clinical urgency category are, where practicable, treated in turn – hence *first-in, first-out*.

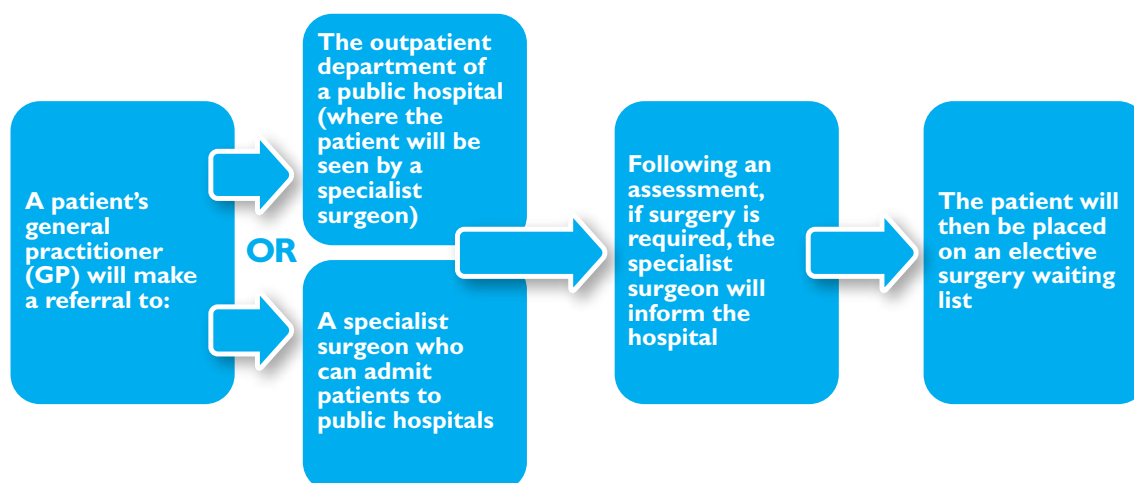
The overall waiting time of the waiting list queue depends in part on whether or not these criteria are adhered to. If a patient is treated out-of-turn it can lead to longer overall waits and increasingly inequitable access.

A range of factors contribute to patients being treated out-of-turn. These include bed availability (e.g. the availability of same day beds or beds for patients requiring multi-day stays can affect the cases scheduled for surgery), and case selection for teaching purposes. Waiting list management practices can also affect equity of access.

Over-prioritising patients to a higher urgency category is another problem that commonly occurs when difficulties are confronted in accessing timely elective surgery. This leads to an increase in more urgent cases, which inevitably means longer waits for more routine cases.

While in some cases over-prioritisation may occur due to patients' or clinicians' frustration with long waiting times, it is an inequitable practice that unfairly affects those who are correctly prioritised, and could ultimately jeopardise the entire categorisation process.

## How do patients get placed on an elective surgery waiting list?



## Factors contributing to longer wait times

Many factors influence elective surgery waiting times. These include demand, financial resources, theatre capacity, staffing, service coordination and bed availability. Factors which contribute to long waiting times in Tasmania include the following:

- Tasmania (with South Australia) has the oldest population in Australia with a median age of 39 years. It also has one of the fastest ageing populations in Australia. Ageing is associated with increasing prevalence of chronic disease and a greater need for health and community care, including elective surgery.
- The prevalence of obesity in Tasmania is increasing. Obesity is a risk factor for a range of diseases, and in Australia accounts for an estimated 7.5% of the total burden of disease.
- There has been a relatively recent increase in demand for bariatric (surgery to treat obesity). Bariatric surgery is the most rapidly growing type of surgery in Australia, and is mostly provided within the private hospital system. In Tasmania this surgery is also provided in the public hospital system.
- Tasmanians are generally poorer, less well educated and more disadvantaged than the general Australian population.<sup>1</sup> Access to elective surgery varies markedly by socio-economic status. Access to private elective surgery generally decreases, and access to public elective surgery generally increases, with remoteness and socio-economic disadvantage.<sup>2</sup>
- Lower per capita rates of private health insurance in Tasmania result in a greater reliance on the public system. The national average private health insurance rate is 44.7%. The Tasmanian rate is 42.9%, the third lowest rate of private health insurance coverage in Australia.

<sup>1</sup> Tasmanian Department of Health & Human Services 2007, *Tasmania's Health Plan; Clinical Services Plan*.

<sup>2</sup> Australian Institute of Health and Welfare, 2008, *Elective Surgery in Australia: New Measures of Access*.

- A shortage of nursing staff to optimise hospital bed capacity; there are also shortages in and mal-distribution of the wider health workforce in Tasmania.
- The major public hospitals cannot easily share the patient workload as, unlike large metropolitan hospitals in mainland cities, ambulances cannot bypass public hospitals under extreme demand pressures and spread the workload more evenly.
- Limited or delayed access to sub-acute and nursing home beds, which means that patients who no longer require acute care continue to occupy expensive hospital beds, and prevent patients requiring surgery from being admitted.
- Elective surgery waiting list management is inconsistent across Tasmanian hospitals. This means that there is considerable variability in the implementation of best practice elective surgery management practices.
- There is significant variation in the way surgeons across the state prioritise surgical patients and determine the length of time their patients can wait for surgery.
- Demand levels in some surgical specialties are insufficient for the development of a viable second service in the same specialty within the private sector. Because the private hospital system is less able to provide some services, an extra burden is placed on the public hospital system.

# The way forward – a summary of the priorities

The plan proposes a range of strategies to address the challenges with elective surgery faced by the public hospital system. These strategies are summarised below.

## **1. A better approach to managing elective surgery**

In Tasmania elective surgery is currently managed at an individual hospital level, with significant differences in the length of time patients wait for their surgery.

Providing equitable and efficient elective surgery waiting list management is a key priority for the Tasmanian Government, the Department of Health and Human Services (DHHS) and our hospitals.

It is essential that we implement a structured, consistent and sustainable approach to the management of elective surgery waiting lists across the state.

This will enable us to better capitalise on our current elective surgery capacity, including, where appropriate and necessary, using our ability to redirect patients for elective surgery to another surgeon within the same hospital, to an alternative public hospital with capacity in the specialty, or to an appropriate private hospital. However, the use of private hospital services needs to be carefully considered.

The Tasmanian private hospital system treats some public patients requiring cataract surgery under contractual arrangements. However, 13% of the State's total elective surgery waiting list comprises patients waiting for cataract surgery. The DHHS will therefore target this procedure to reduce waiting times.

| Actions – Priority 1   | When            |
|--|-----------------|
| Establish an Elective Surgery Coordination Unit (ESCU) that will implement a statewide approach to elective surgery management, and will -           | By March 2009   |
| <i>Facilitate the movement of long-waiting patients to hospitals and surgeons with shorter wait times</i>  | During 2009     |
| <i>Identify ways to better use the private hospital sector</i>   | During 2009     |
| <i>Develop and implement elective surgery policies in liaison with clinicians, hospitals and other stakeholders, starting with an Access Policy</i>  | From early 2009 |
| <i>Develop and implement strategies and arrangements to better inform patients, hospitals and clinicians about elective surgery arrangements and</i> | From early 2009 |
| <i>Monitor and report on elective surgery performance across the system, including capacity and resource utilisation.</i>                            | During 2009/10  |

## 2. Improving elective surgery categorisation

Treating the right patient at the right time is a key priority for our health services. Access to elective surgery should be provided in an equitable manner; judged against consistently applied criteria, with priority for those who have the greatest clinical need. Clinical need is determined by the treating clinician at the time a patient is placed on a waiting list. In Tasmania there are significant inconsistencies in categorisation across the three hospitals, which results in inequitable access to surgery.

| Actions – Priority 2  | When        |
|---|-------------|
| Implement three clinical urgency categories – urgent, semi-urgent and non-urgent – statewide, and –                                   | Early 2009  |
| <i>Develop guidelines for assigning urgency categories for each surgical specialty</i>  | During 2009 |
| <i>Consider tools to improve prioritisation of patients with certain conditions (eg those waiting for joint replacement surgery).</i> | 2009/10     |

## 3. Improving the patient experience of elective surgery

We will tackle four key factors that affect the patient experience:

**Provide timely and relevant information** – It is important that patients, carers and GPs have ready access to timely information that is easily understood, and which gives details about elective surgery waiting lists, including waiting times. This assists in meeting patient expectations about surgery and helps alleviate any stress or uncertainty they may experience while waiting.

**Redesign the patient journey to reduce waits and delays** – The patient journey is the process or steps taken by a patient as they receive health care. These journeys can be brief, or can occur over a prolonged period for people with chronic illnesses. Redesign is about managing to meet changing demand by improving the way we do some things. Improving systems and processes means that we look to identify the things that patients define as important in the health care service they receive (patient focussed), map the patient journey, eliminate waste steps, reduce errors and duplication and deliver patient defined value.

The Plan provides resources for hospitals to undertake initiatives to tackle local obstacles and develop alternatives, including new models of care that will assist hospitals to provide more surgery. This strategy also includes resources for the provision of support staff to improve surgical systems within the hospitals on a sustainable basis by better using hospital resources, eliminating duplication and improving coordination of patient care.

**Improve management of long waiting patients** – Long waiting patients are those who have waited longer than clinically desirable. Long waiting times for surgery can result in the deterioration of a patient's health and impair the outcomes of their surgery.

**Minimise postponements of elective surgery** – Postponements of elective surgery occur for a number of reasons, and can be initiated either by the patient or the hospital providing the surgery. Elective surgery postponements by hospitals can result in significant distress and inconvenience to patients (particularly those who have travelled long distances to the hospital or taken time off work).

| Actions – Priority 3  | When            |
|---|-----------------|
| Develop new material to provide patients, GPs and surgeons with up-to-date information about elective surgery. These will include –                 | From early 2009 |
| <i>A new Patient Information Brochure, a Telephone Service, a new elective surgery website, and enhancement of the DHHS website; plus we will –</i> | From early 2009 |
| <i>Include elective surgery within the scope of patient flow (pathway redesign) initiatives through business cases from hospitals</i>               | Commence 2009   |
| <i>Develop strategies to identify long waiting patients and facilitate their treatment; and</i>   | From early 2009 |
| <i>Develop strategies to minimise the number of postponements that occur.</i>   | 2009            |

#### 4. Improving accountability of the elective surgery system

The CSP focuses on better governance as crucial to a sustainable health system, with the DHHS aiming to maintain and improve accountability of hospitals for their efficient and effective operation through specific performance agreements.

A range of elective surgery performance indicators and targets will also be introduced for each hospital to enable the DHHS to better monitor, analyse and evaluate a hospital's performance. Key elective surgery performance indicators include:

- percentage of patients admitted within clinically recommended times by clinical urgency category
- average waiting times of patients; and
- admissions from the waiting list.

| Actions – Priority 4   | When               |
|--|--------------------|
| Develop elective surgery performance indicators for incorporation into hospital resource and performance agreements; and -                 | From July 2009     |
| <i>Report benchmarking and performance results to public hospitals on a regular basis</i>  | <b>Commenced</b>   |
| <i>Publish elective surgery performance data on the DHHS website to provide greater transparency about how the system is working; and</i>  | From 2nd half 2009 |
| <i>Regularly review performance of hospitals and reward hospitals for elective surgery performance that meets or exceeds expectations.</i> | <b>Commenced</b>   |

#### 5. Exploring models for better care

A number of models have been shown to improve both access to elective surgery and the patient experience by enhancing the capacity of the system to respond to elective surgery demand. These include:

**Day surgery** – Continued improvement in the rate of same day surgery need to be delivered. This includes the CSP's recommendation that the Mersey Community Hospital (MCH) become a referral centre for same day surgery.

**23 hour surgery units** – Major strategies for surgical services across the state include the use of short stay units and 23-hour surgery units.

**Day of surgery admission** – Opportunities for continued improvement in the rate of day of surgery admission need to be explored.

**Medi-hotels** – The introduction of medi-hotels is a strategy to assist to manage the demand for acute beds. These facilities are used for patients before their procedure, and for those who may not be ready to go home and still require access to hospitals services, but do not require an acute hospital bed.

| Actions – Priority 5   | When         |
|--|--------------|
| Further develop and implement models for better elective surgery care at RHH, LGH and NWRH – Burnie; as well as –  | 2009/10      |
| <i>Strengthen the elective surgery capacity at the MCH to accept referrals from the rest of Tasmania.</i>  | January 2009 |
| <i>Undertake a scoping study to clarify how the planned elective surgery at MCH will complement statewide surgical services; and implement a dedicated 23-hour same day surgery centre at the MCH.</i> | March 2009   |

## 6. Promoting appropriate elective surgery

Increasingly, attention is being focussed on how public hospital resources should be used and on what is appropriate for the public health system to provide.

Referrals to the elective surgery waiting list should be clinically appropriate and represent the most suitable treatment for a patient's condition.

There are some procedures, for example treatment of varicose veins, where evidence shows that for certain patients surgical treatment is not warranted.

There is also evidence demonstrating that, for some conditions (e.g. patients waiting for some orthopaedic surgery or with carpal tunnel syndrome), non-surgical alternatives such as physiotherapy may be a more appropriate form of treatment.

There is also a range of elective surgical procedures that, in the absence of a clinical reason for surgery, do not solve a health problem. These include a number of cosmetic procedures.

| Actions – Priority 6  | When             |
|---|------------------|
| Develop and implement a consistent statewide policy so we can ensure surgery is based on the application of best possible evidence; as well as –        | To commence 2009 |
| <i>Develop guidelines to ensure public elective surgery is provided only to patients with a clinical need for surgery to improve their health; and</i>  | 2009             |
| <i>Develop protocols to identify patients for whom non-surgical alternatives may be more appropriate and facilitate their access to this treatment.</i> | From early 2010  |

## 7. Strengthening management and coordination of elective surgery within hospitals

Implementation of this Plan will be a collaborative effort between hospitals and the DHHS, and will depend on the involvement of people who deliver and manage surgical services.

It will also depend on appropriate and adequate staff resources being in place within hospitals to improve both management and delivery of elective surgery.

Introduction of specific elective surgery access management roles in each hospital, together with enhanced co-operation and information sharing between hospitals with the new Elective Surgery Coordination Unit (ESCU) in the DHHS, will assist in management of elective surgery waiting lists.

Accurate and complete information is essential to make decisions about elective surgery and to ensure that waiting list data are valid. Work will be undertaken to improve the quality and availability of meaningful data to hospitals to better inform decisions about waiting list management.

Checklist, an elective surgery software package, has been implemented in hospitals and will be used to model waiting list activity and plan capacity.

| Actions – Priority 7   | When                  |
|--|-----------------------|
| Support collaboration between hospitals and the DHHS, and establish a nursing group to foster information sharing across hospitals; as well as – | Feb-March 2009        |
| <i>Implement the Checklist software package in the major public hospitals</i>  | <b>Done</b>           |
| <i>Investigate and implement new arrangements to strengthen the management and coordination of elective surgery within hospitals; and</i>        | 2009                  |
| <i>Improve the quality and availability of meaningful data to hospitals to better inform decisions about waiting list management.</i>            | Commencing early 2009 |

# What we are doing – a timetable of actions

Starting immediately, we will undertake the following:

| Priority | Actions   | When                           |
|----------|---|--------------------------------|
|          | Undertake consultations with hospitals, clinicians and non-government organisations, including the Royal Australasian College of Surgeons, The Australian Medical Association, The Australian and New Zealand College of Anaesthetists, The Australian Nursing Federation, Tasmanian Operating Room Nurses and General Practice Tasmania. | Completed by mid December 2008 |
| 1        | Establish an Elective Surgery Coordination Unit (ESCU) that will implement a statewide approach to elective surgery management, and will –  | By March 2009                  |
|          | <i>Facilitate the movement of long-waiting patients to hospitals and surgeons with shorter wait times</i>   | During 2009                    |
|          | <i>Identify ways to better use the private hospital sector</i>  | During 2009                    |
|          | <i>Develop and implement elective surgery policies in liaison with clinicians, hospitals and other stakeholders, starting with an Access Policy</i>   | From early 2009                |
|          | <i>Develop and implement strategies and arrangements to better inform patients, hospitals and clinicians about elective surgery arrangements and</i>  | From early 2009                |
|          | <i>Monitor and report on elective surgery performance across the system, including capacity and resource utilisation</i>  | During 2009/10                 |
| 2        | Implement three clinical urgency categories – urgent, semi-urgent and non-urgent – statewide, and –   | Early 2009                     |
|          | <i>Develop guidelines for assigning urgency categories for each surgical specialty</i>  | During 2009                    |
|          | <i>Consider tools to improve prioritisation of patients with certain conditions (eg those waiting for joint replacement surgery)</i>  | 2009/10                        |
| 3        | Develop new material to provide patients, GPs and surgeons with up-to-date information about elective surgery. These will include –   | From early 2009                |
|          | <i>A new Patient Information Brochure, a Telephone Service, a new elective surgery website, and enhancement of the DHHS website; plus we will –</i>   | From early 2009                |
|          | <i>Include elective surgery within the scope of patient flow (pathway redesign) initiatives through business cases from hospitals</i>   | Commence 2009                  |
|          | <i>Develop strategies to identify long waiting patients and facilitate their treatment; and</i>   | From early 2009                |
|          | <i>Develop strategies to minimise the number of postponements that occur</i>  | 2009                           |
| 4        | Develop elective surgery performance indicators for incorporation into hospital performance agreements; and –   | From July 2009                 |
|          | <i>Report benchmarking and performance results to public hospitals on a regular basis</i>   | <b>Commenced</b>               |
|          | <i>Publish elective surgery performance data on the DHHS website to provide greater transparency about how the system is working; and</i>   | From 2nd half 2009             |
|          | <i>Regularly review performance of hospitals and reward hospitals for elective surgery performance that meets or exceeds expectations.</i>  | <b>Commenced</b>               |

| Priority | Actions  | When                  |
|----------|--|-----------------------|
| 5        | Further develop and implement models for better elective surgery care at RHH, LGH and NWRH – Burnie; as well as –  | 2009/10               |
|          | <i>Strengthen the elective surgery capacity at the MCH to accept referrals from the rest of Tasmania.</i>  | January 2009          |
|          | <i>Undertake a scoping study to clarify how the planned elective surgery at Mersey Community Hospital will complement statewide surgical services; and implement a dedicated 23-hour same day surgery centre at the MCH.</i> | March 2009            |
| 6        | Develop and implement a consistent statewide policy so we can ensure surgery is based on the application of best possible evidence; as well as –   | To commence 2009      |
|          | <i>Develop guidelines to ensure public elective surgery is provided only to patients with a clinical need for surgery to improve their health; and</i>   | 2009                  |
|          | <i>Develop protocols to identify patients for whom non-surgical alternatives may be more appropriate and facilitate their access to this treatment</i>   | From early 2010       |
| 7        | Support collaboration between hospitals and the DHHS, and establish a nursing group to foster information sharing across hospitals; as well as –   | Feb-March 2009        |
|          | <i>Implement the Checklist software package in the major public hospitals</i>  | <b>Done</b>           |
|          | <i>Investigate and implement new arrangements to strengthen the management and coordination of elective surgery within hospitals; and</i>  | 2009                  |
|          | <i>Improve the quality and availability of meaningful data to hospitals to better inform decisions about waiting list management</i>   | Commencing early 2009 |

## How are we going about this?

Consultation on Tasmania's Elective Surgery Improvement Plan is currently underway and will be finalised by mid December 2008. This could result in further refinements to the priority actions.

Implementation which is reflected in the table above, will continue to progress while consultation is finalised and any refinements incorporated into the Plan.

The Plan will be implemented through the existing clinical meeting framework which includes the North/Northwest Surgical Services Committee and a similar committee for the South.

These committees will provide a clinical consultative function in the early implementation of the actions required to deliver the outcomes of the Plan. The committees will inform the development of a statewide oversight group to continue the progression of specific elements of the Plan, reporting through to the Secretary of the DHHS.

The committees will liaise closely with the relevant executive and clinical management of the three major hospitals, and will be supported by the ESCU.



