

TASMANIA'S ELECTIVE SURGERY IMPROVEMENT PLAN

Getting our waiting
times down

NOVEMBER 2008

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Section I - Summary

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*.

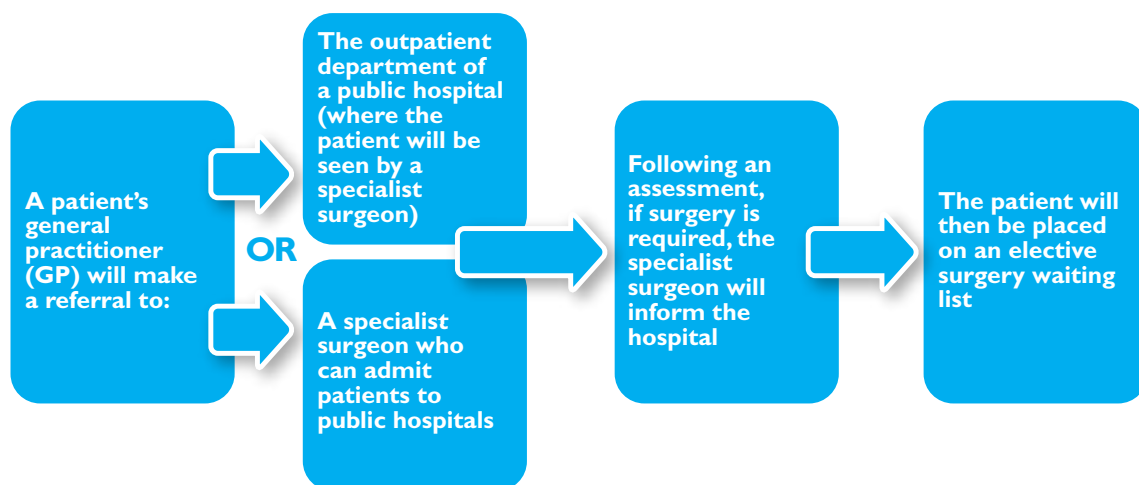
The overall waiting time of the waiting list queue depends in part on whether or not these criteria are adhered to. If a patient is treated out-of-turn it can lead to longer overall waits and increasingly inequitable access.

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.¹ 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.²
- 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.

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

² 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>	Commenced
<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>	Commenced

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>	Done
<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>	Commenced
	<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>	Commenced

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>	Jan 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>	Done
	<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.

Section 2

A. Background

Policy context

Tasmania's Elective Surgery Improvement Plan aligns with the following key Tasmanian and Commonwealth Government policy documents:

Tasmania's Health Plan

Published in May 2007, *Tasmania's Health Plan* sets the direction for a high quality sustainable, responsive and integrated health system to meet the future needs of the Tasmanian community. It addresses the challenges facing Tasmania's health care system in a systematic and sustainable manner.

The Plan has two major components – the *Primary Health Services Plan* and the *Clinical Services Plan* (CSP). The CSP, also released in May 2007, defines the roles, services and strategic direction for Tasmania's major public acute hospitals in accordance with key principles, which state that health services are to be:

- as close as possible to where people live, if services can be delivered safely, effectively and at an acceptable cost. (Where services cannot be delivered safely, effectively and at acceptable cost locally, access will be facilitated through service coordination, transport assistance and other appropriate support);
- appropriate to community needs – providing the right care at the right time;
- patient and family-focussed;
- integrated through effective service coordination and partnerships between providers; and
- designed for sustainability, including sufficient patient volume to support and maintain the competence of health professionals.

The Richardson Report

In 2004 the *Tasmanian Hospital System: Reforms for the 21st Century*, (known as the Richardson Report) detailed 34 recommendations for the operation of Tasmania's public and private tertiary hospital sector that included waiting times for elective surgery.

The report's recommendations were grouped under the following seven issues, the most relevant of which is Issue 1:

Issue 1 - Reduce waiting times for elective surgery.

Issue 2 - Accommodate the increasing demands for renal dialysis, endocrinology, medical oncology and haematology.

Issue 3 - Minimise the numbers of acute care beds being used by patients eligible for aged care placement.

Issue 4 - Maximise the use of limited, high cost technology, equipment and services.

Issue 5 - More effectively recruit, use and retain the hospital workforce.

Issue 6 - Further develop the capacity of the hospital sector to provide clinical education and training at undergraduate, post graduate and specialist levels.

Issue 7 - Ensure that effective co-operative arrangements are in place to deal with the demand for hospital services in the case of major emergencies.

The CSP further developed service design concepts introduced in the Richardson Report, particularly those relating to the sustainability of the health system that had not yet been implemented systemically.

The Elective Surgery Waiting List Reduction Plan

The Commonwealth Government's \$600 million Elective Surgery Waiting List Reduction Plan aims to reduce the number of patients waiting longer than the clinically recommended time for elective surgery. As noted earlier:

- Tasmania received \$8.1 million to treat 895 long waiting patients under Stage 1 of the plan;
- Under Stage 2 the state received \$3.1 million for the purchase of equipment; and
- Stage 3 of the plan will provide up to \$300 million to be shared by states and territories based on systemic improvements which result in an increase of the number of patients treated within the clinically recommended times.

As a condition of funding, the Commonwealth's plan requires all states and territories to commit to developing systems for managing waiting lists on a coordinated regional basis, to enable patients to move between hospitals to take advantage of available capacity for timely treatment. The Commonwealth considers the whole of Tasmania to be a region for this purpose.

The role of the Tasmanian DHHS

The Tasmanian Department of Health and Human Services (DHHS) is responsible for governance, policy, planning, funding and overseeing the quality of service delivery in the public health care system. Within the DHHS the Health Services Group is responsible for the delivery of high quality, efficient and patient-focussed hospital, ambulance and forensic medical services to the Tasmanian community.

The DHHS will take the lead role in implementation of the Plan, supported by an appropriate governance structure and effective elective surgery management structures within the hospitals.

The success of the Plan depends on the committed involvement of people who deliver and manage surgical services. The Plan will therefore be implemented by the DHHS in partnership with the major hospitals and clinicians.

The role of the DHHS will include; coordinating elective surgery policy development; supporting hospitals with implementation; and monitoring and evaluating implementation of the Plan to support its continuing development.

Tasmania's current elective surgery system

Tasmania has three major state-owned and operated public acute hospitals providing a range and mix of services - the Royal Hobart Hospital, the Launceston General Hospital and the North West Regional Hospital - Burnie. Public hospitals comprise the largest component of the state health budget.

The Mersey Community Hospital (MCH) is owned and funded by the Australian Government, but is operated on its behalf by the Tasmanian Government.

The major acute hospitals each serve their local community, with residents mainly accessing services in their geographic region. There are referrals for specialised services to the RHH, LGH and interstate.

Royal Hobart Hospital

The Royal Hobart Hospital (RHH) is a major teaching and research hospital with linkages to the University of Tasmania. It is the principal referral hospital for Tasmania and provides services primarily at role delineation levels 5 and 6 in medicine, surgery, critical care, rehabilitation, mental health, obstetrics and paediatrics.

It also provides the majority of statewide services, including cardiothoracic surgery, neurosurgery, vascular surgery, and complex paediatric surgery. The hospital operates a base of 540 beds, including 437 overnight and 103 day only beds. The RHH currently has a contract with the private sector for the provision of some public ophthalmology services.

Launceston General Hospital

The Launceston General Hospital (LGH) is a significant teaching and research hospital with linkages to the University of Tasmania. It is the major referral hospital for the residents of the North and North West of Tasmania and provides services primarily at role delineation levels 4 and 5 in medicine, surgery, critical care, aged care, rehabilitation, mental health, obstetrics and paediatrics.

The hospital operates from a base of 342 beds, including 296 overnight and 46 day only beds. The LGH contracts with the private sector for the provision of public services, including ophthalmology.

North West Regional Hospital – Burnie and Mersey Community Hospital

From December 2005 to November 2007 the North West Regional Hospital (NWRH) comprised campuses at Burnie and Latrobe (the latter known as the Mersey). In 2007 a commitment of the Howard Government resulted in ownership of the Mersey campus transferring to the Commonwealth and being renamed the Mersey Community Hospital (MCH). However, the Commonwealth Government was unable to identify a suitable private operator to run the hospital, resulting in it contracting operation of the hospital back to Tasmania in 2008.

The NWRH - Burnie and the MCH are the regional public acute hospitals for residents of the North West. They provide services primarily at role delineation levels 3 and 4 in medicine, surgery, critical care, obstetrics, paediatrics, mental health, drug and alcohol, and aged care and rehabilitation. They are teaching and research hospitals with linkages to the University of Tasmania.

NWRH – Burnie operates from a bed base of 179 beds, including 146 overnight and 33 day. Mersey operates from a maximum of 115 beds including 96 acute overnight. The NWRH - Burnie contracts with the private sector for the provision of public patient services including ophthalmology and obstetrics.

Private elective surgical services

The public hospital system is complemented by a number of private hospital and day surgery services.

Calvary Health Care Tasmania

Calvary Health Care Tasmania has four hospital campuses that offer elective surgery:

- Lenah Valley – provides surgery in a range of specialties
- St John's (South Hobart) – provides day surgery
- St Vincent's Hospital (Launceston) - provides surgery in a range of specialties; and
- St Luke's (Launceston) – provides surgery in a range of specialties.

Healthscope Tasmania

Healthscope Tasmania operates Hobart Private, which is co-located with the RHH and provides surgery in a range of specialties.

The North West Private Hospital

The North West Private Hospital is co-located with NWRH - Burnie and provides services in general surgery, orthopaedic surgery, ophthalmology, gynaecology, and obstetrics.

The Eye Hospital at Launceston

The Eye Hospital at Launceston is a private hospital dedicated to medical and surgical ophthalmology. It offers an extensive range of day surgery procedures.

Hobart Day Surgery

Hobart Day Surgery is a private day facility offering ear, nose and throat, ophthalmology, dental and plastic surgery.

Hobart Eye Surgeons

Hobart Eye Surgeons is a private day facility offering cataract, glaucoma and squint surgery.

B. Elective surgery in Tasmania – key challenges and a case for change

A number of factors pose significant challenges to the delivery of elective surgical care in Tasmania and give a clear indication of the need for changed elective surgery practices, a better focus on patients and greater theatre and operational efficiency to tackle increasing demand. These are discussed in detail below.

Population characteristics

Tasmania (with South Australia) has the oldest and one of the fastest ageing populations in Australia with a median age of 39 years. The proportion of Tasmanians aged 70 years and above is predicted to increase from 10.6% in 2006 to 16.6% in 2021.

The prevalence of chronic disease in Tasmania is above the national average, this issue coupled with a greater need for health and community care associated with ageing, places increased pressure on health services.

As noted previously, Tasmanians are generally poorer, less well educated and more disadvantaged than the general Australian population. The Australian Bureau of Statistics economic index of disadvantage places Tasmania as the second most disadvantaged state or territory, behind the Northern Territory.

A report recently released by the Australian Institute of Health and Welfare (AIHW), *Elective Surgery in Australia New Measures of Access*, found that 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 socioeconomic disadvantage.

The AIHW report, which presents elective surgery separations by quintile of socioeconomic advantage/disadvantage across Australia, found that during 2004-05:

- public elective surgery admissions per 1000 persons were highest in the most disadvantaged socioeconomic group (41.1 per 1000) and lowest for those in the most advantaged socioeconomic group (17.7 per 1000)
- the rate of private elective surgery was highest for people in the most advantaged socioeconomic group (62.4 per 1,000 persons) and decreased with socio-economic advantage to 35.6 per 1000 persons for the most disadvantaged group; and
- 27% of admissions from public hospital waiting lists were for patients from the most disadvantaged socioeconomic group, decreasing to 14% in the most advantaged socioeconomic group.

NB Rates of admissions for people in the most and second most disadvantaged groups may have been understated by about 25%, and for the most advantaged group by about 5%, due to variation in coverage of linked data by socioeconomic status.

Growth in demand for services

In Tasmania, demand for health services is increasing rapidly driven by community ageing and a high prevalence of chronic disease.

Between 2000-01 and 2004-05 total public hospital usage by Tasmanian residents increased by 20.2% for separations and 7.8% for bed days. Between 2004-05 and 2021-22, demand for public acute services is predicted to increase by 55% for separations and 42% for bed days with significant growth across all regions. Two thirds of separations are projected to take place in the public sector in 2021-22, a greater share than in 2004-05.

A significant component of the demand for healthcare services is from people aged 70 years and older, with this group accounting for approximately 10% of the total Tasmanian population. However, in 2004-05 this group accounted for approximately 26% of total separations and 39% of bed days (a growth of 17% in this group since 2000-01). The three major public hospitals currently experience lack of or delayed access to sub-acute and nursing home beds. This means that patients who no longer require acute care continue to occupy expensive hospital beds and prevent patients requiring surgery from being admitted.

Workforce

The availability of a competent workforce in sufficient numbers and distributed according to service delivery needs is critical to the development and success of Tasmania's health care system. There is a national and international shortage of health care professionals. There are shortages in and/or mal-distribution of the health workforce in Tasmania. This is a major factor affecting sustainability of Tasmania's health system.

The CSP identified the recruitment and retention of a highly skilled multidisciplinary surgical workforce and highly skilled surgical staff as key challenges for the provision of all surgical specialities in Tasmania.

A fuller discussion of Workforce Development issues is set out in Section C – Enablers.

Key indicators of the health of elective surgery management – waiting times³

The size of a waiting list is often used to gauge whether access to elective surgery is improving or declining. However, at a national level this is no longer used due to recognition that the size of a list:

- depends on the level of demand for public elective surgery and can be influenced by levels of supply of public and private surgery and other factors;
- does not provide information on how much elective surgery is being provided; and
- is not necessarily related to how long people wait for surgery.

The key question for patients requiring surgery is how long they will have to wait, so the number of people listed is less important than the time taken to receive treatment.

One important issue relating to elective surgery performance is understanding the way that waiting times for surgery are measured. This is explained further later in the section.

³ The DHHS collects a range of surgical activity and performance data through the:

- Elective Surgery Management Information System (ESMIS): The central collection of elective surgery waiting list information for the major state-owned and operated public acute hospitals
- Clinical Costing Collection: Collects morbidity, activity and utilisation (e.g. theatre, pathology and imaging) data on admitted patients.

With the exception of day surgery rates and DOSA data, the performance data presented in this section of the plan are from the ESMIS. Data is derived in accordance with the definition of elective surgery set out in the *National Health Data Dictionary Version 1.3.3*.

Day surgery and DOSA data are derived by hospitals and provided to DHHS.

National data

The comparison of elective surgery waiting times across states and territories and individual hospitals is not straightforward because of the variation in the assignment of clinical urgency categories.

Nationally, elective surgery data is collected by the AIHW. The latest AIHW publication, *Australian Hospital Statistics 2006-07*, shows that nationally, there were 26.7 elective surgery waiting list admissions per 1,000 population. AIHW data shows Tasmania is the second highest provider of elective surgery, delivering 28.8 admissions per 1,000 population. Only NSW with 29.4 admissions per 1,000 population is ahead of Tasmania in providing elective surgery.

Despite, or perhaps because of, this relatively high supply, Tasmanian patients do wait longer than the national average and Tasmania has some of the longest waiting patients in Australia.

This Elective Surgery Improvement Plan will monitor Tasmania's success in reducing long waiting times; because long waiting times can adversely impact on medical outcomes and the quality of patients' lives.

The AIHW report shows the following for three key indicators:

- nationally, the median waiting time for patients admitted from waiting lists was 32 days, with Tasmanian patients experiencing a median waiting time of 38 days. This was the third longest median waiting time;
- 90% of patients were admitted within 343 days in Tasmania, compared to 226 days nationally. Tasmania had the third longest waiting time for this indicator; and
- the proportion of admitted patients who waited more than 365 days for their surgery was 9.2% in Tasmania, significantly more than the national average of 3.1%. Tasmania had the third highest proportion of patients waiting longer than 1 year.

Tasmanian public hospital performance⁴

Tasmanian public hospitals provide a comprehensive range of services across a range of medical, surgical and women's and children's specialties. Recent trends in separation rates (see p20) across the three public hospitals considered in this section clearly demonstrate the increased demand experience mentioned above.

The data presented in this section reveals the rise in demand for elective surgery experienced within Tasmanian public hospitals. The performance of our public hospitals in the face of this increasing demand is not surprising. The data demonstrates that elective surgery in Tasmania is in clear need of a coordinated and implemented range of strategies that will address the issues in elective surgery across the state and allow the three hospitals to manage this increasing demand. The case for change is obvious.

Patients on waiting lists

As at 30 June 2008 there were 8,620 patients on public hospital waiting lists, representing approximately 1.74% of the Tasmanian population. The waiting list comprised:

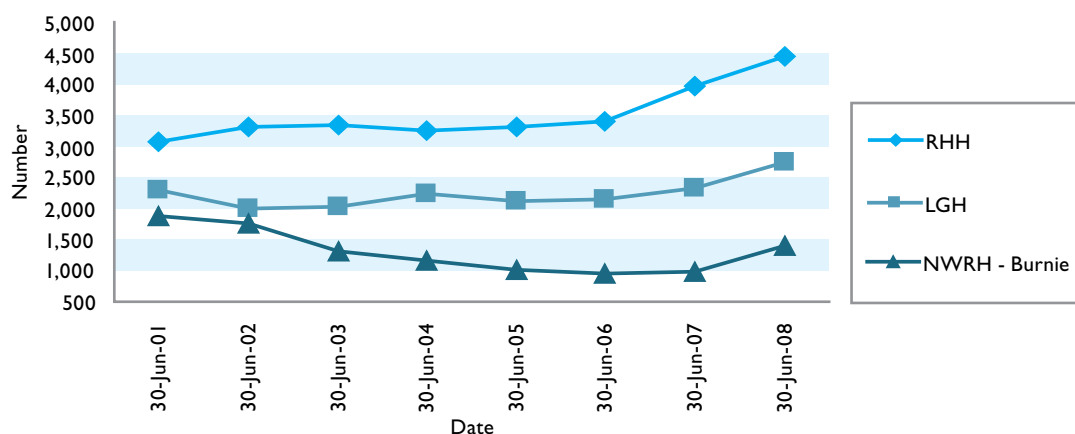
- 579 Category 1 patients
- 4,174 Category 2 patients; and
- 3,867 Category 3 patients.

Over half (51.9%) of the patients were waiting at the RHH, 31.8% were waiting at LGH and 16.3% were waiting at the NWRH - Burnie.

The graph below shows the size of the waiting list at each of the public hospitals between 30 June 2001 and 30 June 2008. During this time, the waiting list increased by 44.6% at the RHH and by 19.3% at the LGH. At the NWRH - Burnie there was a 25.1% decrease in the size of the waiting list. During this period, the overall waiting list increased by 19.1%.

A marked increase in the waiting list is particularly evident in 2007-08, in part due to an alteration, in waiting list management practices at the NWRH – Burnie. These facts relate to key priorities within the Plan; Priority 1 - a better approach to managing elective surgery and Priority 6 - promoting appropriate elective surgery. These priorities focus on overall waiting list coordination and ensuring appropriate surgery is provided within the public system.

Number of patients on waiting lists



⁴ The analysis presented in this section does not include elective surgery performance data for the MCH. Since 2000-01 this hospital has undergone several changes of ownership. The hospital was privately owned until December 2004 and subsequently operated by the Tasmanian and Commonwealth Governments.

Data on elective surgery activity was not reported to the DHHS during periods when the hospital was either privately owned or operated by the Commonwealth. Therefore, MCH data has been omitted from elective surgery data from 2000-01 onwards to enable meaningful comparison of performance over time.

The key categories that increased between 30 June 2006 and 30 June 2007 are Category 2 (semi-urgent) patients on the waiting list for RHH and Category 3 (non-urgent) patients on the waiting list for LGH. Between 30 June 2007 and 30 June 2008, the major increases were in Category 2 patients on the waiting lists of both RHH and LGH.

At 30 June 2008 categorisation of waiting lists varied markedly across the three hospitals, as detailed in the table below. Overall, waiting list patients at the RHH were more highly prioritised than those at the other hospitals, with Category 1 and 2 comprising over two thirds of the hospital's waiting list. Further detail relating to categorisation is set out in the following table.

Categorisation of waiting lists as at 30 June 2008

Category	RHH – waiting list		LGH – waiting list		NWRH Burnie – waiting list	
	No. on list	% of list	No. on list	% of list	No. on list	% of list
1	456	10.2	68	2.5	55	3.9
2	2,991	66.9	857	31.3	326	23.1
3	1,026	22.9	1,814	66.2	1027	73.0
Total	4,473	100	2,739	100	1408	100

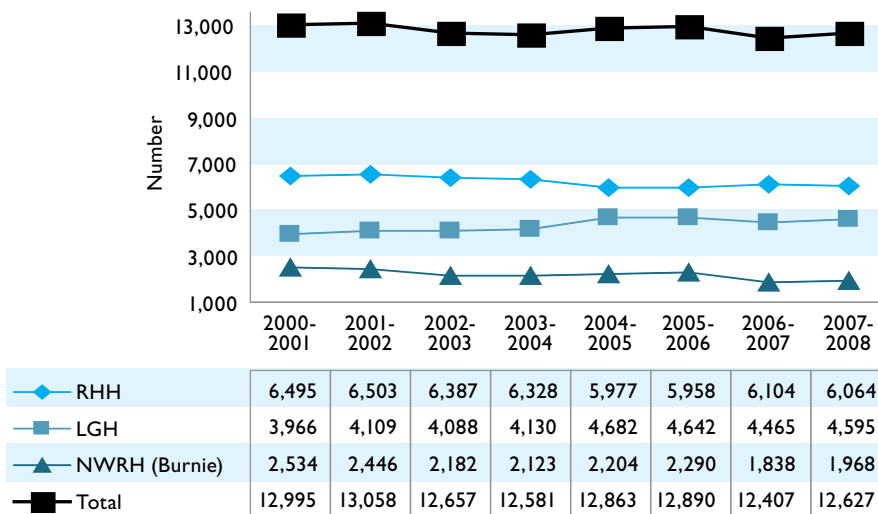
Waiting list admissions

The CSP reported that adult surgical separations in public and private hospitals in Tasmania increased by 2.8% between 2000-01 and 2004-05, with an increase in day only separations and a decrease in overnight separations. The private sector experienced 3.4% growth in separations and the public sector 2.1%. However, this issue is made more complex when considering the impact of the emergency and urgent medical and surgical load on the public hospital system. Overall, day only and overnight separations increased in the public system between 2000-01 and 2004-05 (by 38.3% and 3.5% respectively). In comparison the private sector separations for day only procedures increased and overnight stays fell for the same period (15.1% and -7.5%). The increased separations in the public system in this period are therefore largely non-surgical in nature.

The proportion of adult surgical separations undertaken in the public sector during these years remained stable, at approximately 47% (26,153 in 2000-01 and 26,695 in 2004-05). During this period, elective surgery waiting list admissions decreased by 1% (from 12,995 in 2000-01 to 12,863 in 2004-05).

The graph below shows elective surgery waiting list admissions by year. Between 2000-01 and 2007-08 the LGH was the only hospital to achieve an increase in waiting list admissions (by 15.9%), with the RHH experiencing a 6.6% decrease in admissions and the NWRH - Burnie experiencing a 22.3 % decrease. Overall, waiting list admissions were 2.8% lower in 2007-08 than in 2000-01, decreasing from 12,995 to 12,627.

Admissions from Waiting Lists



This decrease in waiting list admissions points to a clear need for increased operational capacity, particularly in the management of theatre time. Priority 3 - Enhancing the patient experience of elective surgery through system and process redesign in hospitals, and Priority 5 - implementing models for better elective surgery - address the issue of elective surgery capacity and will increase the capacity of the three hospitals to improve elective surgery throughput.

Percentage of patients admitted within clinically recommended times

The fluctuation in performance and inconsistencies in categorising patients across the three hospitals requires management. Improvement of these elements will assist to improve the proportion of people who are seen within the clinically recommended time.

Across the three hospitals in 2007-08, 75% of Category 1 patients, 47% of Category 2 patients and 69% of Category 3 patients were admitted within the clinically recommended times. Performance however varied markedly across the three hospitals, as illustrated in the table below.

Hospital	Category 1	Category 2	Category 3
RHH	63	40	52
LGH	98	58	70
NWRH – Burnie	80	44	84
<i>Total</i>	75	47	69

Between 2000-01 and 2007-08, the performance of individual hospitals against categories of elective surgery patients admitted in time was as follows:

- at the RHH, despite some fluctuations, there was an overall decline in performance for all categories of patients;
- at the LGH, from a low in 2003-04, access to surgery has improved for Category 1 patients, remained relatively constant for Category 2 patients, and fluctuated for Category 3 patients, with a deterioration again since 2005-06; and
- at NWRH - Burnie access for Category 1 patients improved until 2003-04, but dropped in 2004-05 and has remained relatively constant since, fluctuated but trended down for Category 2 patients, and steadily improved for Category 3 patients from 2003-04.

Comparing 2000-01 to 2007-08, overall, access for Category 1 patients improved from 72% to 75%. Access to surgery decreased for Category 2 and Category 3 patients, with a 9% reduction in Category 2 patients admitted within the clinically recommended time and a 10% reduction in Category 3 patients admitted within the clinically recommended time.

Waiting times

Waiting times for elective surgery can be measured for admitted patients (that is, the time patients who have had their surgical procedure had to wait) or for patients who are still waiting for their surgery. Results for these two measures can differ significantly, and both are important indicators of performance. For example an average or median waiting time for admitted patients may be relatively low because of the treatment of significant volumes of patients who have waited less than average/median time. The average or median waiting time for patients still waiting for surgery may be relatively high as it includes the waiting times of those patients on the list for extended periods.

The average time that people on the list wait for their surgery depends in part on whether patients from within the same clinical urgency category are treated “in turn.” If a patient is treated “out of turn” this inevitably leads to longer overall waiting times and decreased access. A range of factors contribute to patients being treated “out of turn” including waiting list management practices, bed availability (e.g. multi-day stay or same day which can impact on the cases scheduled for surgery), a change in patient condition and case selection for teaching purposes.

Indicators used to assess waiting times for elective surgery include the:

- percentage of patients from each clinical urgency category admitted within clinically recommended times;
- average waiting times of admitted or waiting patients;
- median or 90th percentile waiting times of waiting patients;
- median or 90th percentile waiting times of admitted patients;*
- proportion of patients waiting more than 365 days.*

* Used by the AIHW to report the elective surgery performance of states and territories.

Median waiting times by year

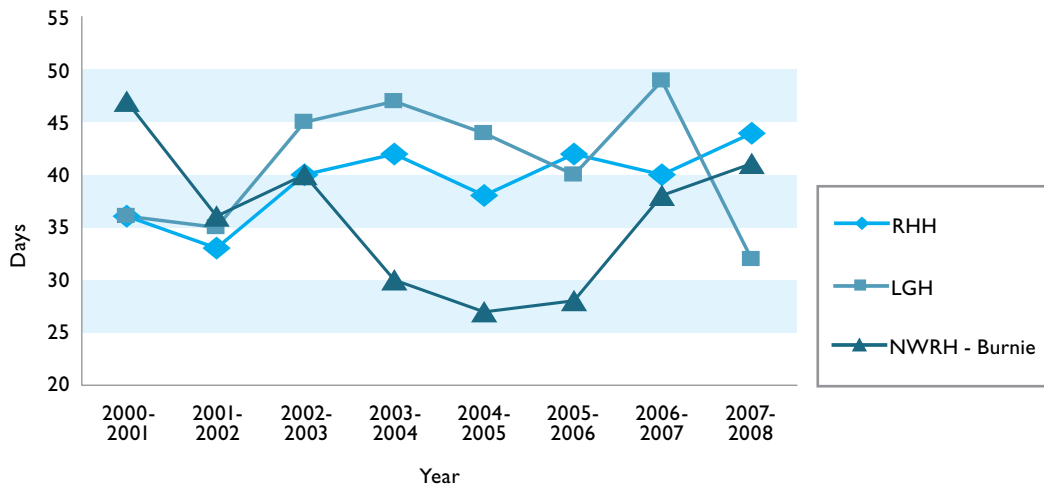
The two graphs below show the median waiting times of admitted and waiting patients at each hospital between 2000-01 and 2007-08.

Waiting times for admitted patients at the LGH, have fluctuated over the period. Within the last year waiting times for admitted patients have improved, while the waiting time for those on the waiting list has increased.

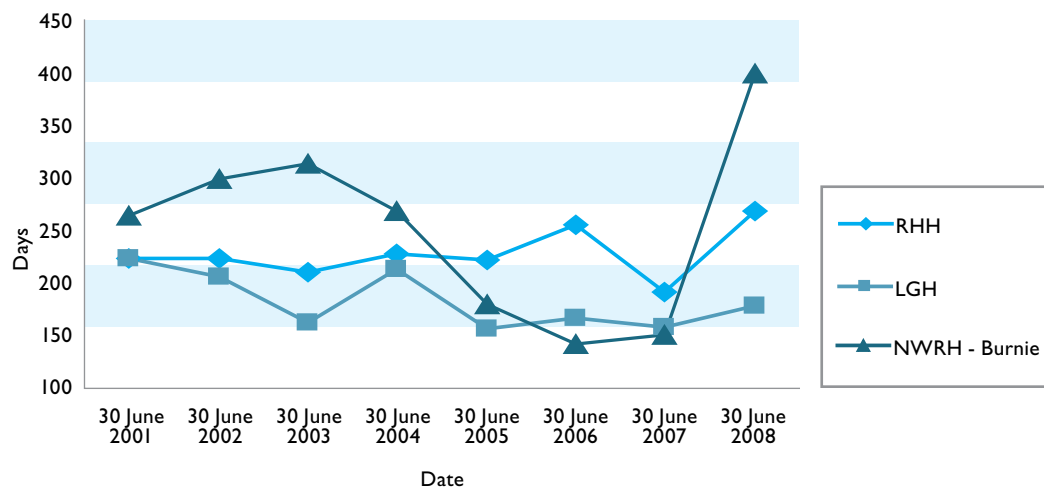
From an increase in waiting times for those patients on the waiting list, peaking in 2003, the NWRH - Burnie improved elective surgery access for both admitted and waiting patients. However, since June 2006 the hospital has experienced a marked increase in elective surgery waiting times. The rapid increase in the waiting time of patients on the list in 2007-08 can be attributed to the implementation in June 2008, of a significant change to waiting list management practices.

The median waiting time of patients on the waiting list at the RHH was relatively stable between 2001 and 2006, with a marked improvement in the waiting time in 2007. However, waiting times of admitted and waiting elective surgery patients have increased in the last year.

Median waiting time (days) of patients admitted from the waiting list by year



Median waiting time (days) of patients on the waiting list



The median waiting time of admitted patients varied considerably across specialities. In 2007-08 patients waited longest for:

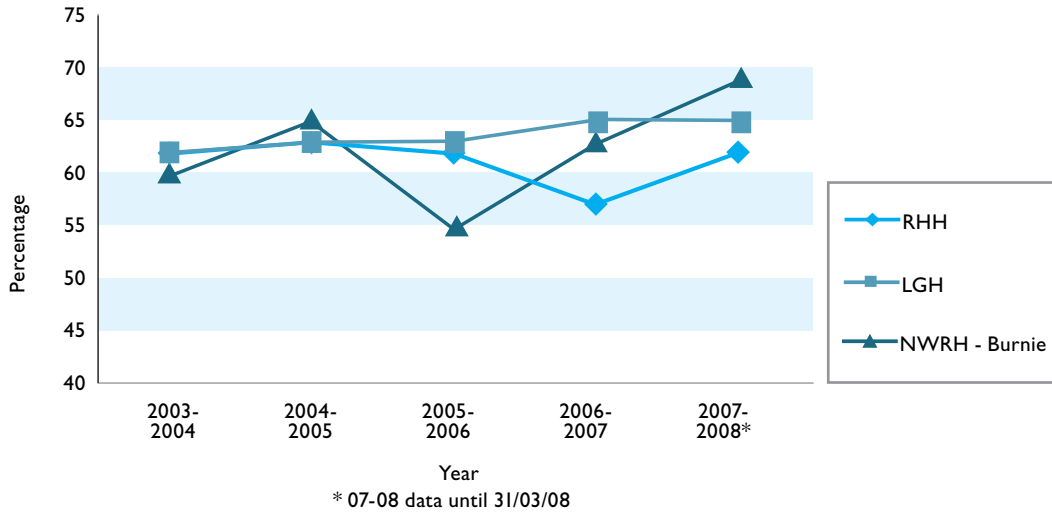
- general surgery, ENT and ophthalmology surgery at the RHH
- plastic and orthopaedic surgery at LGH; and
- ophthalmology, gynaecology and orthopaedic surgery at NWRH - Burnie

Under Priority 3 of the Plan - Improving the patient experience, a website will be developed to provide patients and GPs with information detailing the waiting times for elective surgery.

Day surgery rates

Day surgery occurs when a patient is admitted and separated from a hospital on the same day. Since 2003-04 day surgery rates have improved in Tasmanian hospitals. For the first three quarters of 2007-08 the rates were: 62.4% at RHH; 64.8% at LGH; and 69.1% at NWRH - Burnie.

Day Surgery Rates

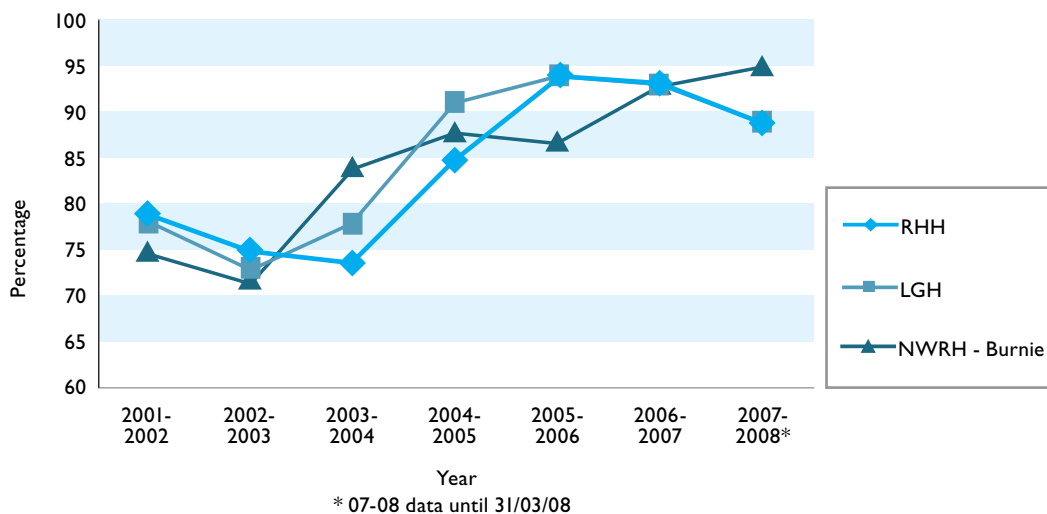


Day of surgery admissions

Day of surgery admissions (DOSAs) occur when patients are admitted and undergo surgery on the same day. All same day patients are DOSAs. The indicator is a useful measure for multi-day stay patients – that is for measuring what proportion of patients, admitted for surgery over several days, went into hospital on the day of surgery, instead of spending an unnecessary day in hospital.

Since 2001-02, DOSA rates have improved markedly. For the first three quarters of 2007-08 the rates were 89.4% at the RHH and at LGH and 94.9% at NWRH - Burnie.

DOSA Rates



The data detailed in this section clearly identifies that elective surgery in Tasmanian public hospitals is under pressure and presents a comprehensive argument for change and action in this area. The following sections identify the enablers and the priorities through which reform in elective surgery in Tasmania will be undertaken.

C. Enablers to move forward

A number of enablers provide direction for reform of the health system to improve elective surgical care and access in Tasmania's public hospitals.

Project governance and implementation

As noted earlier in this document, consultation on Tasmania's Elective Surgery Improvement Plan is currently underway and will be finalised by mid December 2008. This may result in further refinements to the priority actions.

Implementation of appropriate components of the Plan will continue to progress during the finalisation of consultation with any refinements incorporated into a revised 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 also inform the development of a state-wide 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.

Funding policy reform

Activity Based Funding (ABF) is being implemented in Tasmania. This is consistent with the principle of sustainability articulated in the CSP, which requires public acute hospital services to have transparent and predictable funding allocations.

ABF defines the services provided and provides an objective means of funding. It allows resources to be allocated according to the activity undertaken (patient treatments provided), as distinct from the current incremental budget changes, where hospital funding is based on previous allocations plus growth.

This approach provides incentives to hospitals to minimise costs through efficiency gains, provides measurements of performance, benchmarking and reporting, enables a clearer picture of demand and the service responses to that demand, and supports the rational use of hospital resources.

A shadow ABF budget is being used in 2008-09. Full ABF will be implemented in 2009-10.

Workforce development

The CSP makes a number of commitments in the areas of education, training, recruitment and retention that are designed to strengthen Tasmania's health care workforce.

The DHHS continues to work with the University of Tasmania and other tertiary and further education providers to develop a long term strategic plan that links Tasmania's health care education and workforce needs. The strategic plan will be consistent with and aid implementation of the CSP.

Clear targets for workforce numbers will be established in each health care professional category. The strategy will also identify key workforce risks and the need to redesign care pathways.

The National Health Workforce Taskforce (NHWT) has released its 2008-2009 Work Program, which encompasses planning for the professional groups required for surgical services. The Taskforce will be undertaking a substantial program of national health workforce planning and research projects over a three-year period. This will provide valuable information to progress workforce reforms.

Supply and demand projections for priority medical specialties, where demand is not properly accounted for in a national supply and demand model, will include anaesthetists and intensive care physicians, nursing in acute hospitals (including peri-operative services) and the development of a workforce demand measure for priority allied health disciplines.

Performance monitoring

A range of indicators can be used to monitor access to elective surgery, including:

- *admissions from the waiting list**
- *percentage of patients admitted within/waiting longer than clinically recommended times**
- *average waiting times**
- *median and 90th percentile waiting times**
- *hospital-initiated postponements (HIPs) of surgery**
- the size of a waiting list
- population rates of elective surgery provision (as an indicator of the amount of surgery being provided)
- day surgery rates; and
- day of surgery (DOSA) admission rates.

* Generally considered the most useful and informative indicators.

Resource and Performance Agreements will be established between the DHHS and each hospital which will contain specific targets to be met by each hospital, and monitored and overseen by DHHS in regular performance meetings (see Priority 4).

IT and data management solutions

Patient Administration System (PAS)

A major statewide project is currently underway to replace the current PAS. The new PAS (iPM - isoft patient manager) is a statewide, integrated, windows-based system that will improve the patient journey by reducing the time and effort required of patients to provide, and of staff to collect, core patient administrative information.

The iPM system enables clinical and administrative staff to work collaboratively to improve the management of key patient areas such as elective surgery waiting lists, outpatient clinics, theatre management and bed and ward management. The new PAS is scheduled for implementation during 2009.

Key outcomes from the project include:

- Improved efficiency and effectiveness through standardised core patient administration and information collection;
- Improved capacity to identify and manage quality, risk and performance indicators through access to accurate and relevant patient administrative information; and
- Improved capacity to comply with hospital, State and Commonwealth reporting requirements.

Checklist

Checklist is a software package used to model waiting list activity and plan capacity. It has been purchased by the DHHS and introduced in the three hospitals.

It shows how waiting lists are being managed and how they could be managed better without compromising clinical priorities. It assists in optimising waiting list management based on good clinical practice.

Checklist calculates future activity requirements and shows the recurring activity needed to keep up with demand. It also enables users to run different future demand scenarios and plan for months or even several years into the future. Checklist works out the bed, theatre and clinic capacity needed for any proposed activity plan.

Patient transport and accommodation support

Patients may face significant difficulties in accessing health services because of age, mobility, long distances and lack of family or carer support.

The DHHS operates the Patient Travel Assistance Scheme, which helps to ensure equity of access for Tasmanian residents to specialist medical services. The scheme is targeted to Tasmanians who have to travel long distances (intrastate or interstate) to access specialised medical services, and face high travel costs in accessing these services. The DHHS contributes to the cost of patients and their carer for travel and accommodation.

The DHHS has undertaken a comprehensive review of methods of transport that patients use to attend medical appointments, including community transport, non-urgent patient transport, doctor escorted medical retrievals and the Patient Transport Assistance Scheme.

These have resulted in significant reforms to the patient travel and accommodation support system announced in November 2008.

A statewide service for central coordination of the Patient Transport Service for community transport is also being investigated. Other forms of transportation between health services, for example the potential for regular health transport between acute hospital sites, are also being considered.

Other international and Australian jurisdictions have developed a range of patient and carer accommodation models. Examples include medi-hotel type arrangements. A new low-cost patient accommodation facility in Hobart operated by the Fight Cancer Foundation opened in November 2008 and provides hostel style accommodation for up to 20 patients, their family and carers. DHHS will continue to review services for patients and their family/carers near the state's other public hospitals.

D. Priorities of the Improvement Plan

This section expands on the summary of the priorities presented in Section I (The way forward) and provides further detail of the seven priorities, related strategies and actions.

Priority I - A better approach to managing elective surgery

In Tasmania elective surgery is currently managed at an individual hospital level. A patient is placed on a waiting list at the RHH, LGH or the NWRH - Burnie and remains on that hospital's list, regardless of the length of their waiting time, until they receive treatment or are removed for other reasons (e.g. the patient no longer requires surgery).

As discussed above, the length of time a patient waits for their surgery varies markedly across the three hospitals, resulting in significant inequities in access to treatment.

Providing consistent and efficient elective surgery waiting list management is a key priority that recognises all Tasmanians should have equitable access to high quality hospital treatment within clinically appropriate timeframes.

In order to improve the capacity of our public hospitals to respond to the increasing demand for elective surgery, it is essential that we take a structured and sustainable approach to the management of elective surgery waiting lists across Tasmania. This includes developing the role of the Elective Surgery Coordination Unit (ESCU) in relation to the management of the waiting list to respond to systemic or individual hospital issues. This unit will work in consultation with the three hospitals and be responsible for implementing a statewide waiting list approach.

A role of the ESCU will be to facilitate the redirection of appropriate patients for elective surgery to another surgeon within the same hospital, 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.

Appropriate support arrangements for patients and their carers when transferring patients to another location will require consideration. The transfer of patients to alternative public hospitals in Tasmania for surgery will depend on their willingness to travel significant distances and on sufficient capacity being available at receiving hospitals.

The Commonwealth Government's Elective Surgery Waiting List Reduction Plan requires states and territories to develop systems for better managing elective surgery waiting lists on a coordinated regional basis. This is consistent with the Australian Healthcare Agreement between Tasmania and the Commonwealth Government, which obliges all public hospitals to offer their services to all eligible patients equitably and on the basis of clinical need (rather than the patient's place of residence).

Accordingly, we are taking the following key actions:

Key action 1.1 – 1.6

Establish an Elective Surgery Coordination Unit (ESCU) that will implement a statewide approach to elective surgery management, and will -

Facilitate the movement of long-waiting patients to hospitals and surgeons with shorter wait times

Identify ways to better use the private hospital sector

Develop and implement elective surgery policies in liaison with clinicians, hospitals and other stakeholders, starting with an Access Policy

Develop and implement strategies and arrangements to better inform patients, hospitals and clinicians about elective surgery arrangements; and

Monitor and report on elective surgery performance across the system, including capacity and resource utilisation.

Priority 2 - Improving elective surgery categorisation

Treating the right patient at the right time is a key priority for health systems. Access to elective surgery should be provided in an equitable manner with priority for those who have the greatest clinical need.

Clinical need - the clinical assessment of the immediacy of the patient's need for surgery - is determined by the treating clinician at the time a patient is placed on a waiting list, with patients allocated one of three clinical categories: urgent, semi-urgent or non-urgent.

The AIHW reports that, in 2005-06, the proportion of patients admitted from waiting lists that were Category 1 (urgent) varied considerably – with 44.5% in Tasmania and 22.4% in Victoria – and with similar variations occurring in all urgency categories. (NB There is some question about the comparability of urgency category data across states and territories, which may be influenced by different approaches to categorisation.)

The AIHW also reports that there were differences in the categorisation of specialties and procedures. For example, the proportion of patients admitted from elective surgery waiting lists for plastic surgery who were Category 1 varied from 79.2% in Tasmania to 31.0% in the ACT.

The AIHW considers that, at the procedural level, the patient mix is likely to be relatively uniform. This therefore suggests that other factors influence variation. These could include differing financial arrangements (e.g. incentives to admit patients within clinically recommended times) or differing interpretation of urgency categories by clinicians, clinician groups or hospitals.

Within Tasmania, there is also evidence of difficulties with consistent categorisation. There are significant inconsistencies across the three hospitals, even at procedural level (see tables below). The RHH has the highest proportions of patients in Categories 1 and 2 and the NWRH - Burnie has the lowest proportion of patients in these categories.

Categorisation of waiting lists as at 30 June 2008

Category	RHH – waiting list		LGH – waiting list		NWRH Burnie – waiting list	
	No. on list	% of list	No. on list	% of list	No. on list	% of list
1	456	10.2	68	2.5	55	3.9
2	2,991	66.9	857	31.3	326	23.2
3	1,026	22.9	1,814	66.2	1,027	72.9
Total	4,473	100	2,739	100	1,408	100

Categorisation of patients admitted for hip replacement or inguinal hernia surgery (as at 30 June 2008)

Procedure	Category	RHH	LGH	NWRH – Burnie
Total hip replacement % per assigned category	1	12.66	6.85	3.92
	2	89.34	41.10	52.94
	3	0	52.05	43.14
Inguinal hernia % per assigned category	1	26.72	4.65	54.87
	2	62.93	79.07	16.81
	3	10.34	16.28	28.32

One factor contributing to this inconsistency in Tasmania is the use of four urgency categories at the LGH, where Category 3 has been split into 3A and 3B. This was introduced in response to concerns that some patients were inappropriately being allocated to Category 2, due to an indeterminate timeframe for treatment of Category 3 patients. This categorisation should cease with consistent policy across Tasmania.

Inconsistencies in categorisation are problematic because they result in inequity of access to services. As noted earlier, over-prioritisation of patients, so that there are more and more urgent cases, leads to longer waits for routine cases and risks the proper functioning of the entire categorisation system. It is therefore important that the use of the clinical urgency categories is regularly monitored and evaluated to determine its accuracy.

Internationally and within Australia, work has been undertaken on developing more refined approaches to prioritising waiting list patients. The impetus for this was recognition that urgency categorisation is effective for the management of patients with life-threatening illnesses, such as malignancy and potentially fatal cardiac conditions, but less effective for the prioritisation of patients with chronic conditions. This is because the treatment of chronic conditions, routinely classified as Category 2 (or more commonly, Category 3), is based solely on their length of wait, as evidence of the disease burden is not available.

In Australia, work has focussed on developing a tool to prioritise patients waiting for joint replacement surgery. At least one state has developed a reference list of recommended clinical priority categories to ensure that patients with similar conditions are prioritised in a similar way. And one hospital has also examined the prioritisation of patients with particular conditions such as Dupuytren's contracture.

The AIHW is also examining elective surgery categorisation, including prioritisation tools and considering options to improve consistency.

Key actions 2.1 to 2.5

Implement three clinical urgency categories.

Analyse the use of clinical urgency categories.

Develop guidelines for assigning urgency category.

Consider tools that assist in better prioritisation of patients with certain conditions (e.g. those waiting for joint replacement or surgery).

Continue to contribute to the AIHW process.

As individual categorisation of patients for elective surgery is a clinical decision, actions will be progressed with appropriate clinical input.

Priority 3 - Improving the patient experience

Redesign the patient journey to reduce waits and delays

Long waiting patients represent only a small proportion of total patient journeys. To reduce waits and delays for the majority of patients it is important to focus on redesigning the journey for patients.

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 wasteful steps, and reduce errors and duplication to deliver a better patient experience.

The patient journey is the process or steps taken by a patient as they receive health care. These journeys can be brief, in the event of a one-off acute illness or surgical procedure, or can occur over a prolonged period for people with chronic illnesses that require protracted management.

A clinical pathway is a document that describes and defines a whole patient journey. It details what happens when and where to the patient and how they are expected to flow along the path. A pathway is designed as a tool that can be reviewed and updated as part of a continual process of service improvement.

Redesigning clinical pathways can provide a range of benefits, including improving coordination and consistency of care, better patient outcomes and better use of resources by eliminating inefficiencies and reducing length of stay.

Key action 3.1

Include elective surgery within the scope of patient flow (pathway redesign) initiatives through business cases submitted to DHHS from hospitals.

Provide timely relevant information to stakeholders

It is important that patients have ready access to useful, timely information that is easily understood, and which gives details about elective surgery waiting lists (including waiting times) as well as patient rights and responsibilities.

This assists in meeting patient expectations about surgery and helps alleviate any stress or uncertainty they may experience while waiting. It is also important that patients understand their responsibilities in relation to elective surgery, such as what to do if their condition deteriorates while waiting.

General practitioners (GPs) are the first point of contact for patients who may need surgery or who have concerns about changes in their condition while waiting for surgery. Ready access to elective surgery information, particularly waiting times, helps GPs and their patients make informed decisions, and enables GPs to better plan a patient's care.

Key action 3.2

Develop a range of new material to provide patients, GPs and surgeons with more comprehensive information about elective surgery, treatment options and patient's rights and responsibilities. These will include the following:

- ***Patient Information Brochure***

We will review and update the patient information brochure and provide it both online and in printed form to patients when they are registered on a waiting list.

- ***Telephone Service***

We will establish a telephone service to enable patients and clinicians to access information about elective surgery, including how to receive treatment at a hospital with shorter waiting times. This service will be managed by the ESCU.

- ***Waiting times website***

We will develop a website to provide patients and their GPs with information about elective surgery waiting times at each of the three public hospitals. This will show waiting times for high volume procedures.

Data on patients whose elective surgery is complete will be used, as this is widely considered to be the most valuable for assessing hospital performance. Consideration will also be given to providing this data at surgeon level.

The information will be able to be used by patients and their GPs to give you them an indication of the likely time to access surgery. It will help them to make informed decisions and enable GPs to better plan their patients' care.

This is consistent with the Commonwealth Government's Elective Surgery Plan, which requires states and territories to inform patients where waiting times are shorter.

- ***Enhance the DHHS website***

We will revise the DHHS website so that includes information about elective surgery policy, strategy, targets and performance trends, as well as international and interstate comparisons.

Improve management of long waiting patients

Hospitals' endeavours to provide timely treatment for their patients are affected by many factors. These include: clinical capacity (staff, equipment, facilities); coordination of the transition through different types of care; blockages in access to and delivery of complex care; differing views about the benefits of surgery and its alternatives; and problems in ensuring waiting lists are up-to-date and accurately show patients who are ready for and want treatment. Postponements of surgery and out-of-turn treatment, where hospitals treat patients who have shorter waiting times than patients of equivalent need, also contribute to delays experienced by long-waiting patients.

Long waiting patients are those who have waited longer than clinically desirable, as recommended by their assigned clinical urgency category. Long waiting times for surgery are associated with adverse impacts on health outcomes. For example, hip and knee joint replacement surgery can reduce pain and disability and improve health-related quality of life; however, extensive delays for surgery can result in the deterioration of both physical function and overall wellbeing of the patient and significantly impair the outcomes of surgery.

Key action 3.3

Develop strategies to identify long waiting patients and facilitate their treatment. These will include clinical reviews, case management to coordinate care in order to facilitate access to surgery, transfer for more timely treatment (as part of the statewide waiting list) and unit based waiting lists to reduce waiting times across a specialty.

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. Hospital initiated postponements (HIPs) of elective surgery can result in significant distress and inconvenience to patients (particularly those who have travelled long distances to the hospital or taken time off work).

HIPs occur for a variety of reasons:

- operating theatres may become unavailable because emergency surgery needs to be performed or scheduled surgery has taken longer than anticipated
- more urgent elective patients may need to be admitted
- a surgeon or other staff member may be unavailable
- an intensive care bed may be required post-surgery and intensive care beds may all be occupied; or
- the hospital may be fully occupied.

Hospitals with higher separation rates also tend to have higher numbers of elective surgery postponements.

Key action 3.4

Develop new strategies to minimise the number of postponements that occur, and the inconvenience associated with them, including:

- reviewing current postponement guidelines
- considering the introduction of a hospital-initiated postponement indicator and targets, and
- monitoring and reporting hospital-initiated postponement performance.

Priority 4 – Improving accountability of the elective surgery system

Under the Australian Health Care Agreement, all states are accountable to the Commonwealth Government for public hospital services. The Agreement requires that access to services is to be provided on the basis of clinical need and within a clinically appropriate period. At the national level, waiting times for elective surgery are counted as indicators of effectiveness of access to public hospitals.

Improved governance and accountability are key components of the CSP, with the DHHS aiming to maintain and improve accountability of hospitals for their efficient operation. To achieve this, the DHHS will work with the CEOs of each public hospital to define explicit performance agreements that incorporate targets for clinical activity within agreed budgets, and require that the CEOs prepare a clinical engagement strategy.

The CSP also focuses on distributed governance as an enabler of a sustainable service system. This requires clinicians and managers who have local decision making authority to assume corresponding accountability for working within agreed budgets and in accordance with system-wide policies and strategies.

A range of other strategies will also be considered to ensure an appropriate level of governance and accountability for public hospital elective surgery services.

Elective surgery performance indicators and targets will be introduced for each hospital to enable the DHHS to monitor, analyse and evaluate a hospital's performance. Elective surgery performance indicators implemented in other states and internationally are listed on page 30.

Indicators used in performance agreements between the DHHS and hospitals may vary from year to year in response to issues that arise within the public system.

Key actions 4.1 to 4.4

Develop elective surgery performance indicators for incorporation into hospital resource and performance agreements.

Report benchmarking and performance results to public hospitals on a regular basis.

Publish elective surgery performance data on a website to provide greater transparency about how the system is working.

Hold regular performance meetings between the DHHS and hospitals, and reward hospitals for elective surgery performance that meets or exceeds expectations.

Priority 5 – Exploring models for better care

A range of models has been shown to improve both access to elective surgery and the patient experience. Successful innovations adopted internationally and in other states that have improved the capacity of the system to respond to elective surgery demand include the following:

- day surgery
- short stay, 23-hour surgery beds
- medi-hotels
- day of surgery admissions
- hospital-in-the-home
- beds quarantined for elective surgery; and
- staged admission procedures.

Tasmania's Health Plan and the CSP discussed some of these models and made specific recommendations about further development or implementation in Tasmania. This Plan focuses on three key initiatives: day surgery; short stay 23-hour surgery; and medi-hotels.

Day surgery

There are no nationally reported data on day surgery rates. Australian Hospital Statistics 2006-07 reports aggregated data on day rates for both medical and surgical patients in public hospitals. These continue to improve across Australia, with 50.0% of separations occurring on a same day basis in 2006-07. The Tasmanian rate was 50.2%, with some states reporting rates as high as 60.6%.

The Australian Day Surgery Council report cited that up to 60% of operative procedures were undertaken as day patient procedures in Australia in 2004. At that time in the United States the rate was up to 80%, and is likely to be as high as 85% by the end of the decade.

As outlined earlier, in 2007-08 Tasmanian day surgery rates ranged from 62.4% at the RHH to 69.1% at the NWRH – Burnie. While this is an encouraging rate, opportunities for continued improvement in the same day surgical rate need to be explored.

One opportunity is the implementation of the recommendation in the CSP that the Mersey Community Hospital (MCH) become a referral centre for same day surgery, and provide 23 hour elective surgical services for general surgery, gynaecology, orthopaedics, ENT, ophthalmology and procedural diagnostic GI endoscopies.

This would improve regional self-sufficiency - the extent to which patients who require health services are able to access them in their own regions - for the Northwest. It will also provide patients with access to elective surgery services that are not competing with emergency demand, and are therefore less likely to be postponed.

It is proposed that the MCH provide same day surgery services for 40% of same day patients from the NWRH - Burnie referral area, 90% of same day patients from the Mersey area, and 15% of same day patients from the LGH referral area. There may also be a potential for some patients from the RHH referral area to receive their same day surgery at the Mersey.

A scoping study will be undertaken to determine the best means of implementing this approach.

Short stay/23 hour surgery

The use of short stay units and 23-hour surgery units are major strategies for delivering responsive surgery services. This is based on the premise that the majority of surgical care can be administered within a 24-hour period.

Patients can be admitted, prepared for their surgical procedure and then monitored and appropriate pain relief given post surgery before protocol-based discharge occurs within 24 hours. We propose clarifying how the MCH can provide 23-hour elective surgical services for general surgery, gynaecology, orthopaedics, ENT, ophthalmology and procedural diagnostic GI endoscopies.

Medi-hotels

Other states have implemented medi-hotels as a strategy to manage demand for acute beds. These facilities are used for patients before their procedure, and for those who are not ready to go home and still require access to hospital services, but do not need an acute hospital bed.

A variety of service models have been established in response to local demands, and to meet differing needs of various target groups, including on-site facilities and provision off-site by third party providers.

While medi-hotels have not as yet been implemented in Tasmania, we are also examining opportunities for medi-hotels in major hospital locations.

Key actions 5.1 to 5.2

Further develop and implement models for better elective surgery care at RHH, LGH and NWRH – Burnie.

Strengthen the elective surgery capacity at the MCH to accept referrals from the rest of Tasmania.

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.

Priority 6 - Promoting appropriate surgery

Appropriate for patients

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 which there is clear evidence demonstrating that treatment of a particular condition risks causing more harm than good to the patient. An example of this is varicose veins, where evidence shows that for certain patients surgery is not warranted.

There is also evidence that, for some conditions (eg 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.

Key actions 6.1 & 6.2

Develop a policy so that Tasmania has a consistent statewide approach to ensuring that surgery is based on the application of best possible evidence.

Develop protocols to identify patients for whom non-surgical alternatives may be more appropriate and facilitate their access to this treatment.

Appropriate surgery for the health system

There is also a range of elective surgical procedures that do not solve a health issue, including some cosmetic procedures where there is no clinical reason for surgery. Increasingly, attention is focusing on how public hospital resources should be used and on what is appropriate for the public health system to provide.

At least three other Australian states have introduced policies limiting access to cosmetic and discretionary procedures within their public hospital systems, in order to promote the appropriate use of public hospital elective surgery services.

Key action 6.3

Develop guidelines to ensure that public hospital elective surgery services are only provided to patients with a clinical need for surgery to improve their health.

Priority 7 - Strengthening management of elective surgery in hospitals

The success of the implementation of the plan will depend on the involvement of people who deliver and manage surgical services in collaboration with DHHS. It will also depend on appropriate and adequate staff resources being in place within hospitals to improve both strategic management and operational delivery of elective surgery.

Management of elective surgery waiting lists

At present, models used to manage elective surgery waiting lists vary across our hospitals:

- At the LGH, there is a dedicated Elective Surgery Waiting List Access Co-ordinator, managed by the Nursing Director of Surgery, who is responsible for the day-to-day administrative management of the waiting list.
- The RHH has a Nurse Co-Director for Clinical Services Surgery, who manages a Nurse Unit Manager with responsibility for the elective surgery waiting list.
- At the NWRH - Burnie the Director of Corporate and Support Services is responsible for the management of the elective surgery waiting list, and reports to the CEO.

One strategy used interstate to strengthen management and coordination of elective surgery within hospitals is the appointment of Elective Surgery Access Co-ordinators (ESACs).

Experience shows that these positions work best if they are strategic, rather than operational, with responsibility for establishing and reviewing protocols and processes, including pre-admission, and educating nurses and clinical staff.

The ESAC role is designed to work in partnership with Directors of Surgery, and works best in conjunction with an Access Manager – a senior position, reporting directly to the hospital CEO or Operations Manager, which manages all patient flows throughout the hospital.

Processes also need to be established to strengthen management and coordination of elective surgery. Hospitals are responsible for developing and implementing some of these internally. However, there is also a need to enhance co-operation and information sharing across hospitals and to strengthen collaboration and partnering between the DHHS and hospitals. This will be essential to implementing a systemic approach to the management of elective surgery.

To successfully implement this Plan, hospitals will need effective management structures that support and facilitate designated staff to:

- work collaboratively with the ESCU and each other on elective surgery policy and associated matters leading to the implementation of strategic changes in the management of waiting lists;
- work collaboratively with the ESCU, each other and private hospital staff to facilitate the transfer of patients to hospitals or surgeons with shorter waiting times;
- maintain effective clinical and administrative structures that actively and effectively manage waiting lists within hospitals and across the state;
- work collaboratively with the DHHS on elective surgery data issues, to ensure valid, reliable and timely data; and
- participate on reference and advisory groups to encourage best practice in managing elective surgery patients.

Key actions 7.1 and 7.2

Support collaboration and partnering between hospitals and the DHHS, including a nursing special interest group to foster information sharing across hospitals and the DHHS.

Investigate and implement new arrangements to strengthen the management and coordination of elective surgery within hospitals.

Checklist

As discussed in Section C - Enablers, Checklist is a software package used to model waiting list activity and plan capacity. It has already been purchased by the DHHS and introduced in the three hospitals.

Key actions 7.3

Implement Checklist in the major public hospitals.

Elective surgery data

Waiting list management is a dynamic and complex process requiring input from and coordination by a multidisciplinary team in each facility and across the state. Accurate and complete information is essential to make decisions about elective surgery and to ensure that waiting list data are a valid measure of demand. As noted above, hospitals and the ESCU will work collaboratively on elective surgery data issues, to ensure valid, reliable and timely data.

Key actions 7.4

Improve the quality and availability of meaningful data to hospital to better inform decisions about waiting list management.

Operational policy

Tasmania currently has two documents that detail operational policies for the delivery of elective surgery. These are:

- *Management of Admission for Elective Surgery in Tasmanian Public Hospitals*; and
- *Management of Admission for Elective Surgery in Tasmanian Public Hospitals - Operational Guidelines*.

The implementation of the Plan provides a timely opportunity to revise and combine the two documents into a new Elective Surgery Access Policy.

Key actions 7.5 to 7.7

Review operational policies to ensure they reflect best practice elective surgery waiting list management. This will be undertaken by ESCU in consultation with hospitals.

Combine operational policies into one Elective Surgery Access Policy.

Establish a timeframe in which to evaluate the revised access policy.

E. Other Issues

While an important part of the work undertaken by our public hospitals, elective surgery is also affected by a range of issues listed below that lie outside of the scope of this Plan, but nevertheless have an impact on elective surgery access and throughput:

- hospital activities such as bed management, theatre utilisation and scheduling, and discharge policies;
- patient lengths of stay - Tasmania's average length of stay is high compared to the national average;
- capacity issues – e.g. equipment, and multi-day versus same day capacity, which can impact on the patients scheduled for surgery;
- access to step down facilities such as nursing home beds;
- access and availability of appropriate services in the community to support discharge of patients from hospitals;
- demand from emergency, medical and other elective surgery patients not reported through the waiting list;
- seasonality of demand – experience shows increases in presentations during the winter illness period for illnesses such as influenza, which impact on hospital performance; and, finally;
- maximising access to elective surgery is contingent on a whole of hospital approach to demand management.

Many of these important issues also affect overall hospital services and other areas of the public health service. Although approaches to redesign can assist in addressing some of the internal issues within the hospital setting, such as hospital length of stay, external service factors continue to have their impact.

As a result, these issues need to inform the debate around current and future health service provision and planning at both State and Commonwealth levels.

F. Glossary

Day of Surgery Admission (DOSA)

Day of surgery admission (DOSA) occurs when a patient is admitted and undergoes surgery on the same day. Same day surgery patients are by definition DOSA.

Day Surgery

Day surgery occurs when a patient is admitted, undergoes surgery and is discharged on the same day.

Median waiting time

50th percentile waiting time. The median or middle value in a group of data arranged from lowest to highest value for days waited. It represents the number of days within which 50% of patients were admitted - half the waiting times are shorter, and half the waiting times longer, than the median.

Medi-hotel

Medi-hotels are a model of care designed to assist in managing demand for acute beds. These facilities provide care for patients who are not ready to go home and still require access to hospital services, but do not need access to an acute hospital bed. Medi-hotels can cater for the needs of a range of target groups, including medical patients requiring multiple treatments over several days, and hospitals needing to improve peri-operative patient flows.

90th percentile

90th percentile waiting time represents the number of days within which 90% of patients were admitted; 10% of waiting times are longer than the 90th percentile waiting time.

23-Hour service model

A model of care for elective surgery patients who require no more than one overnight stay. The 23-hour care model recognises that selected procedures, not otherwise suitable for day surgery, can be provided within a 23-hour period in a non-inpatient environment. In these units, patients can be monitored post-operatively and discharged within 23-hours. The model is not an alternative or substitute for day surgery, but an extension of services for patients unsuitable for day surgery.

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