

Department of Health

**Wait Times Strategy Statewide
Consultation Survey Analysis**

September 2015

Wait Times Strategy Statewide Consultation Survey Analysis

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Background

The publicly-funded health system in Queensland, as elsewhere, faces significant challenges in ensuring that patients receive timely access to services throughout their healthcare journey. Each patient journey consists of a series of clinical and non-clinical care processes, delivered by different providers and in different settings. Not all of these care processes will be delivered in a linear sequence. Nor will all care providers have real time information about the care processes that are planned (e.g. medical imaging/pathology test requests ordered by GPs or hospital specialists) and the outcomes from care processes that have already been delivered.

The Government is committed to developing a genuine, balanced and realistic approach to addressing the important issue of wait times at all points in the patient journey. With that in mind, the Minister for Health and Minister for Ambulance Services, the Honourable Cameron Dick, convened a Wait Times Summit on 29 April 2015. The Summit brought together expert clinical and executive healthcare professionals to commence discussions and build consensus on a strategy to improve performance in relation to wait times and service access. The event was attended by Chairs of Hospital and Health Boards, Chief Executives of Hospital and Health Services (HHSs), consumers, GPs, surgeons, specialist physicians, nurses and allied health workers.

The Wait Times Summit identified a number of principles and priority areas that should guide the development of a Wait Times Strategy. The Minister set a clear expectation that any proposals forming part of the Strategy would need to be genuine, balanced and realistic, and involve engagement of a broad cross-section of key stakeholders.

To deliver on this, the Department has undertaken a series of consultation workshops with staff from each HHS, and invited feedback through an online survey available to all Queensland Health employees, community practitioners and consumers. The consultation workshops provided participants with the opportunity to discuss proposed reforms and put forward their ideas on changes that would improve the efficiency and effectiveness of outpatient and elective surgery service provision.

Feedback from the consultation process has informed the development of a number of recommendations which will form the basis of discussion at the re-convened Wait Times Summit meeting on 7 October 2015.

Consultation topics

Consultation to inform the development of a Wait Times Strategy (referred to as a *Wait Times Policy* in the survey) for Queensland Health was organised around five priority areas, consistent with the principles and priorities identified at the April 2015 Wait Times Summit. The five priority areas are:

- Process and practice standards
- Communication between general practitioners (GPs), HHSs and patients
- Models of care, scope of practice and workforce development
- Performance frameworks and targets
- Investment priorities.

Summary of consultations

Prior to the distribution of the electronic survey, consultations were undertaken with each Hospital and Health Service, as well as Mater Health Services. These consultations targeted executive, management, clinical and operational-level staff responsible for outpatients and elective surgery, as well as business improvement officers, program managers, GP liaison officers and information management staff. The sessions were conducted both in person and via video conference, and participants were guided through a facilitated discussion of the priority areas outlined in the Wait Times Strategy Statewide Consultation Handbook.

There was broad support amongst participants for increased transparency and consistency of reporting and performance targets, as well as the need for contemporary information systems to support referral management, scheduling and activity monitoring. Participants highlighted the opportunity provided by the development of Clinical Prioritisation Criteria to improve the referral process, and the requirement for any new strategy to consider and align with these. Participants also emphasised the importance of considering and encouraging the use of telehealth services in the review and update of the Outpatient Services Implementation Standard (OSIS). In particular, participants from regional, rural and remote areas reported that effective use of telehealth for specialist appointments (where appropriate) significantly reduces costs, allows patients to remain in their local communities and enables more targeted use of visiting specialists when they are in attendance.

Finally, there was agreement amongst consultation participants that future efforts and investment should target not only additional activity, but also developing innovative models of care, overcoming workforce challenges and developing robust governance processes.

Despite feedback from participants generally aligning in relation to some topic areas, others elicited more diverse responses both within and between settings. Participants were encouraged to consider and discuss these areas further before providing their final responses via the electronic survey as outlined in the remainder of this document.

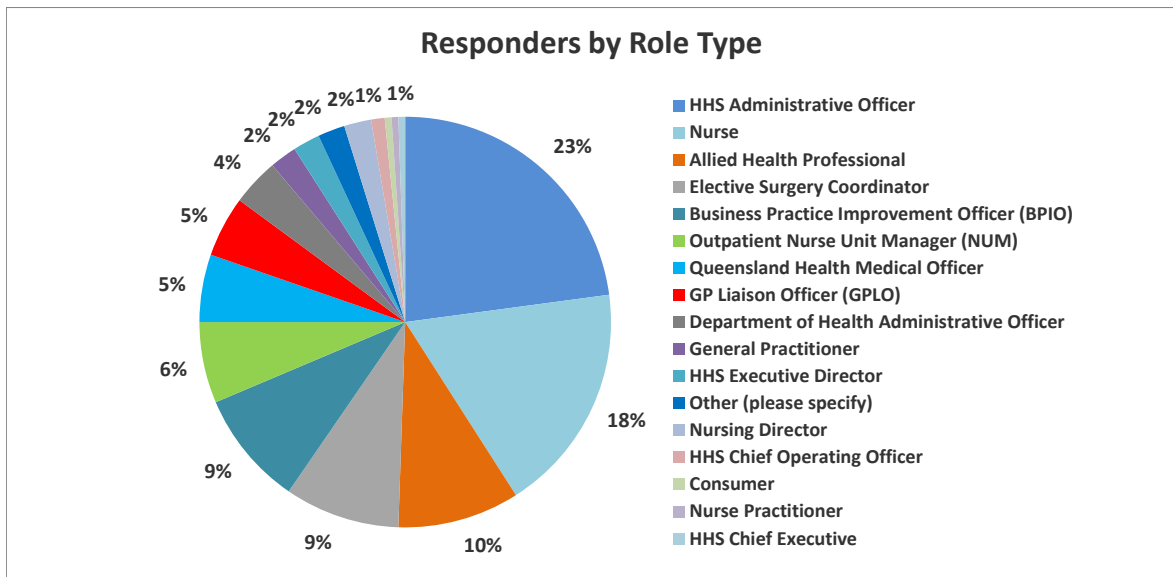
Survey Results

0. Demographics

0.1 Summary of responders

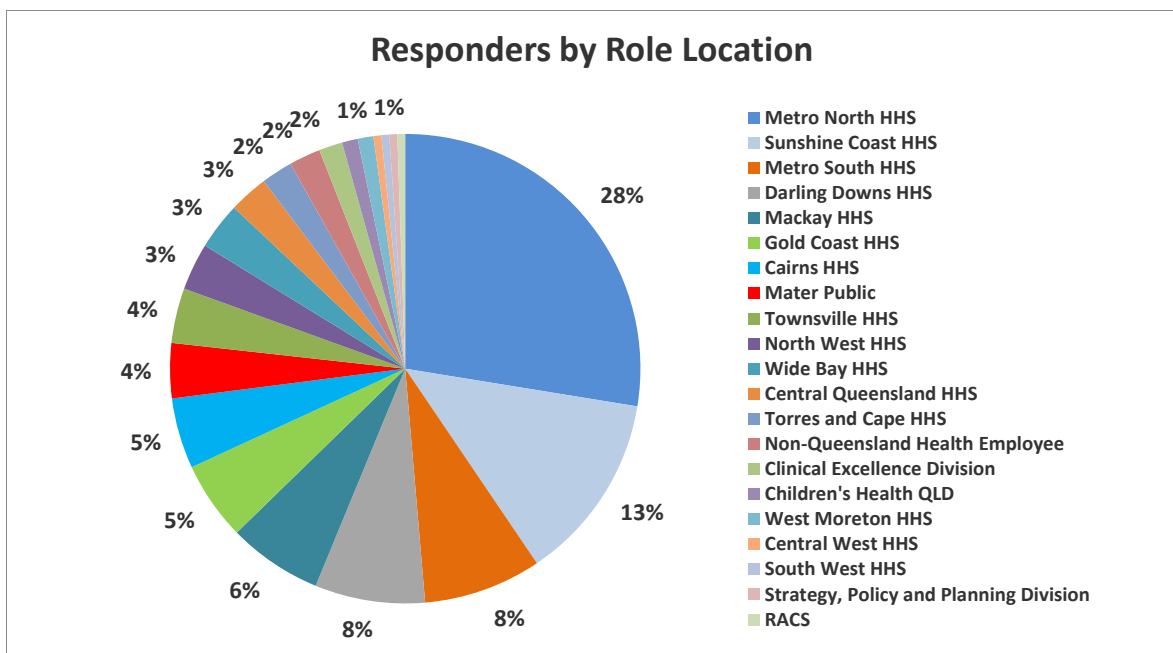
0.1.1 What is your role/position?

The survey was answered by a broad spectrum of healthcare professionals, executive leadership, administration and consumers. In total, there were 190 responders, representing the following role/position types:



0.1.2 What is your primary place of employment?

In all, 16 HHSs were represented, as well as multiple branches of the Department of Health and non-Queensland Health employees.



1. Priority area one: Process and practice standards

1.1 Wait times policy

1.1.1 Is a Wait Times Policy needed?

Responders were overwhelmingly in favour of the development of a Wait Times Policy, with 89% of responders supporting the development of a policy and only 1.4% indicating they did not think a Wait Times Policy was needed.

1.1.2 Which service types should be included?

This question provided responders with a free text form for their answers, limiting the ability to provide quantitative analysis, however specialist outpatients, elective surgery, diagnostic services, procedural services e.g. gastroenterology and emergency were the most commonly listed service types, with specialist outpatients and elective surgery the highest priority.

1.1.3 What principles should underpin a wait times policy?

Responders were asked to rank, in order of priority, the 6 principles that were developed at the first Wait Times Summit, with the following results (highest to lowest priority):

1. A patient focused approach
2. Care and treatment occurring at the most appropriate time in the most appropriate setting
3. Clear communication pathways between the Department of Health, Hospital and Health Services, General Practitioners (GPs) and patients themselves
4. Improved business intelligence about service demand, service supply, patient flow and individual patient journeys (including patient experience)
5. A long term commitment to an improvement agenda
6. An understanding that a one size fits all solution is not viable

1.1.4 What other principles (if any) should underpin a wait times policy?

There were more than 75 responders who contributed additional principles or comments. There were obvious themes among the commentary which will inform the development of the Wait Times Strategy and can be summarised in the following diagram:



1.1.5 If additional funding was made available, what services do you think are the highest priority for investment in a wait times improvement agenda?

There were 111 free text answers to this question, with responses closely reflecting the response to question 1.1.2. Additional services that were singled out for priority of investment include orthopaedics, paediatrics, gastroenterology and echo's.

1.1.6 Why should your chosen service type be prioritised?

There were 95 reasons provided, which can be summarised by the following categories:

- Inequity of patient access, longest waiting patients;
- Highest volume of activity;
- Greatest unmet need;
- Alignment with the Wait Times Policy proposed principles;
- Workforce challenges.

1.2 Outpatient Services Implementation Standard

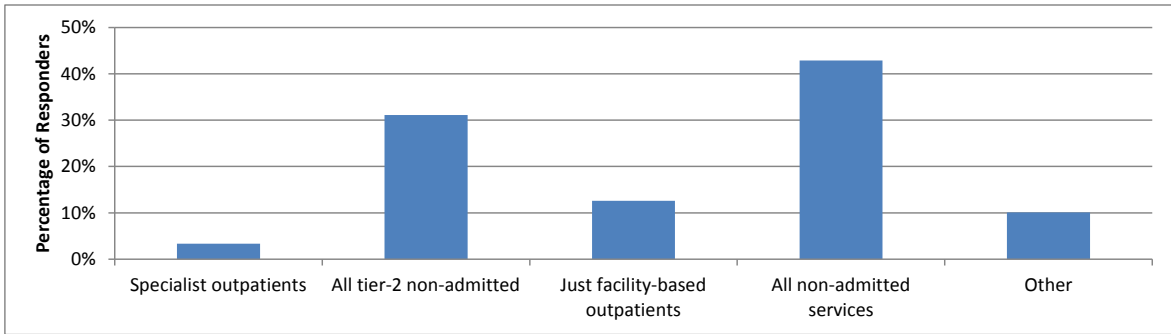
The Outpatient Services Implementation Standard is the set of 'business rules' that govern outpatient service provision in Queensland Health. It outlines best practice processes in relation to referral management, waitlist management and scheduling of outpatient services as well as providing guidance on minimum safety, quality and access service standards. The current version of the Outpatient Services Implementation Standard was published in November 2010 and has been due for review for a number of years.

When considering what services should be 'in-scope' for the Outpatient Services Implementation Standard, respondents should consider whether these service types involve referral management, waitlist management and scheduling and if similar safety, quality and access standards can be applied consistently in service delivery across the services. Respondents should also consider if 'in-scope' service types would conform to the minimum safety, quality and access service standards specified in the revised Outpatient Services Implementation Standard from an audit perspective from the date that it comes into effect.

1.3 Scope of Outpatient Services Implementation Standard

1.3.1 Which non-admitted services should be in-scope for the revised Outpatient Services Implementation Standard?

43% of responders indicated that all non-admitted service types should be in-scope for the revised Outpatient Services Implementation Standard, although there were many additional comments provided that the OSIS should not take a 'one size fits all' approach and many of the services would require their own section of the Standard to account for individualised business rules. It was noted that a phased approach to including various services may be the most appropriate to ensure the Standards enable best-practice models of care for all service types.



1.3.2 *Should non-admitted cancer services and mental health services have their own business rules/implementation standards?*

Responders were generally in favour of separate implementation standards for cancer and mental health services, with a weighted average score between 'Neutral' and 'Probably' for both service types. Additional service types that responders submitted as candidates for either separate implementation standards, or their own section within the Outpatient Services Implementation Standard were:

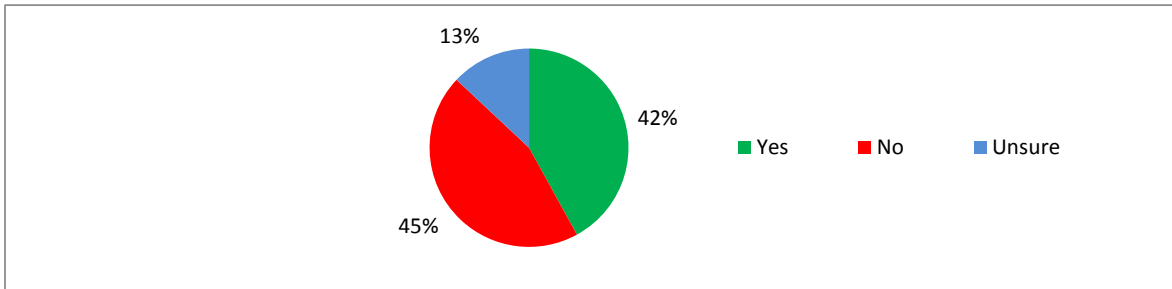
- Allied Health;
- Community Services (Allied Health, Diagnostics, Maternity Services);
- Diagnostic Clinical Investigation Laboratory Services; and
- Diabetic Services

1.4 Outpatient prioritisation system

There is currently no national prioritisation system for specialist outpatient services. Queensland has adopted the national prioritisation system used in elective surgery and applied it to outpatient services. The number of days a patient has waited is calculated using a continuous count (which includes weekends and gazetted public holidays), although specialist outpatient services typically operate Monday to Friday. Queuing theory (the mathematical study of queues) supports having a lesser number of queues (urgency categories) in specialist outpatient services to improve the ability of HHSs to see patients within clinically recommended timeframes.

1.4.1 *Should Queensland change from three urgency categories (Category 1 – urgent, Category 2 – semi-urgent, and Category 3 – non-urgent) to two urgency categories (urgent and routine)?*

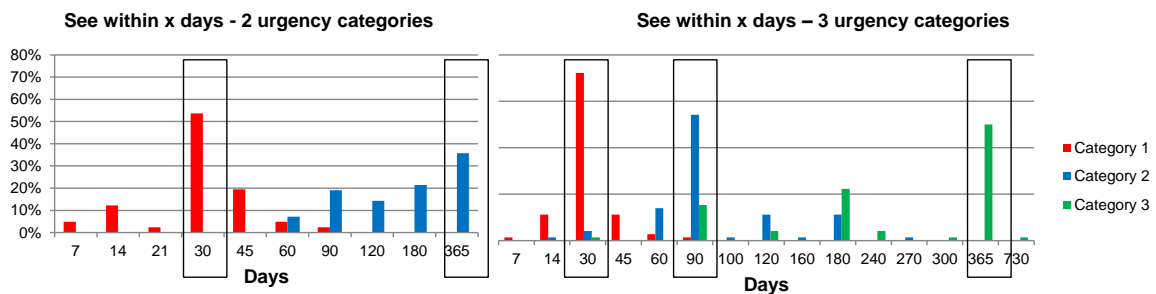
Opinion was divided on whether or not Queensland should change from three urgency categories to two. Further discussion and consultation is necessary and the Wait Times Summit will provide an opportunity to discuss the implications of a potential change in more detail.



1.4.2 What timeframes should patients be seen within for each urgency category?

The results for this question were split based on whether responders indicated they thought Queensland should change to two urgency categories or not. For those that believed two categories was more appropriate, the most popular timeframes chosen were 30 days for category 1 and 365 days for category 2. For those who thought three categories was appropriate, the most popular timeframes reflect the current practice of 30, 90 and 365 days for categories 1-3 respectively.

Contrastingly, during the face to face consultations there was a high level of support for extending the category two timeframe to 182 days (six months) amongst those in favour of maintaining three urgency categories. A number of participants also highlighted that different categorisation systems may be more or less appropriate depending on the particular population or specialty e.g. paediatrics, maternity.



1.4.3 Should the number of days a patient has waited be calculated in business days (excluding weekends and gazetted public holidays) or via continuous count?

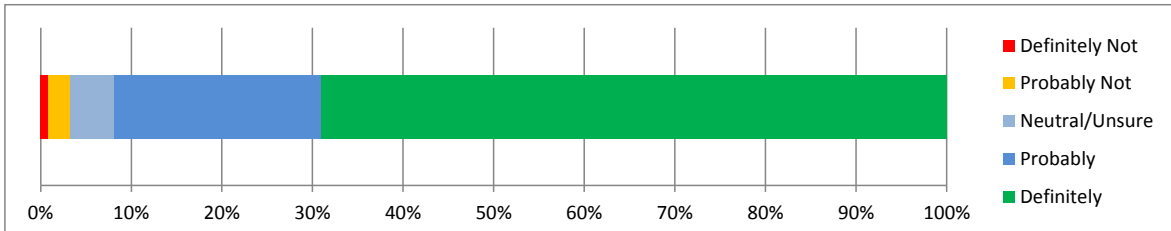
55% of responders indicated that the number of days a patient has waited should be calculated via continuous count, with only 38% indicating that business days would be more appropriate.

1.5 Reason for referral

Currently, outpatient waitlist information systems do not record information about the patient's condition/diagnosis upon referral or the reason for referral. Information about the 'reason for referral' is recorded in the referral letter in free text, with no standardised taxonomy (classification system) to enable efficient data collection and analysis. It has been suggested that capturing information on the patient's condition/diagnosis and reason for referral in the waitlist management system would be beneficial in ensuring that referrals are correctly allocated/routed to healthcare providers, as well as for service planning (including load sharing across providers, analysing case-mix, detecting potential duplicate referrals, costing 'unmet demand' and outsourcing).

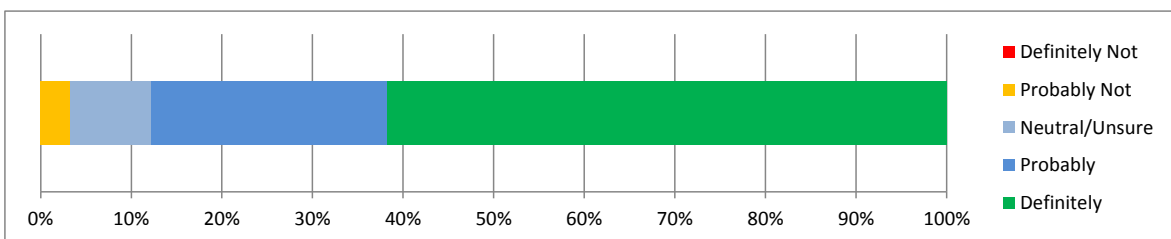
1.5.1 *Should information about the patient’s primary ‘presenting condition/diagnosis/referring condition’ be included in the minimum data set for outpatients and in the minimum referral requirements for Clinical Prioritisation Criteria?*

Responders overwhelmingly agreed that the ‘presenting condition/diagnosis/referring condition’ be included in the minimum data set for outpatients and in the minimum referral requirements for Clinical Prioritisation Criteria, with 92% of responders choosing ‘Probably’ or ‘Definitely’.



1.5.2 *Should a taxonomy of ‘referral reasons’ be developed and included in the minimum data set for outpatients and in the minimum referral requirements for Clinical Prioritisation Criteria?*

Similarly, there was great interest in developing a taxonomy of referral reasons with 88% of responders choosing ‘Probably’ or ‘Definitely’.



1.5.3 *Are there any circumstances where a HHS should have the right to not accept a referral?*

85% of responders indicated that a HHS should have the right to not accept a referral. The most common circumstances given were:

- Where a patient resides outside of the HHSs catchment area and the HHS where the patient resides offers the required service(s);
- Where the referral does not meet the minimum required data set;
- Where the service is not offered; and
- Where alternative services are more applicable for the presenting condition, including GP care in the community.

1.5.4 *What safeguards should be put in place to ensure that patient safety and Ryan’s Rule are not compromised?*

There were 92 free text answers to this question which can be summarised by the following categories:

- Standardised guidelines for referral;
- Clinical review of referrals deemed not appropriate; and

- Communication with Primary Health Networks regarding service availability and alternatives for each specialty and sub-specialty.

1.6 Not ready for care

1.6.1 Under which circumstances should a person be assigned 'not ready for care' (NRFC) for clinical, personal and administrative reasons? An example would be assigning a patient 'NRFC – administrative' from the date a patient fails to attend or cancels an appointment until the date of the next appointment. This has been suggested as both situations arise from circumstances that are beyond the control of the HHS but impact on performance in treating patients within clinically recommended timeframes.

Free text answers were given for each of the three categories with the following common responses –

- Clinical
 - The patient has a clear plan for optimisation or investigation prior to a procedure;
 - The patient is ill, or has a medical condition, and cannot attend an appointment.
- Personal
 - The patient needs to travel, or goes on holiday;
 - The patient chooses to be 'not ready for care' at their own discretion, or for undisclosed reasons;
 - The patient fails to attend an appointment or cancels on the day of the appointment (these responders did not believe the separate category, Administrative, was necessary).
- Administrative
 - The patient fails to attend an appointment or cancels on the day of the appointment. This should apply until the date of the next available appointment;
 - A patient should never be listed as 'not ready for care' for administrative purposes.

1.6.2 Some patients may be waitlisted in more than one outpatient clinic because they require a 'sequence of care/assessments' to be undertaken. What business rules should be applied in these circumstances?

The most common business rules referenced in the responses include:

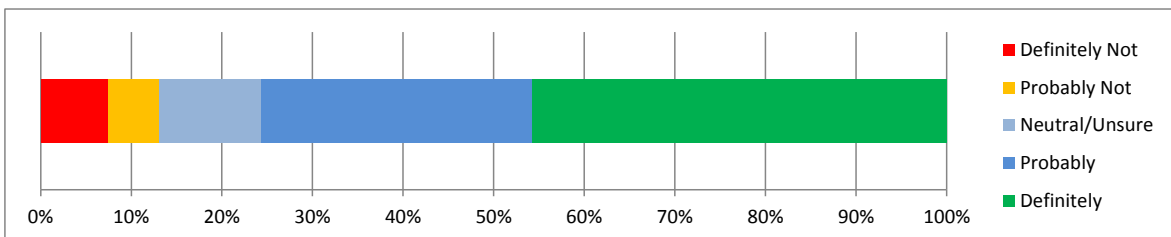
- Patients should be added to the waitlist but are able to be identified as 'not ready for care – staged' while they undergo the sequence of assessments;
- There should be guidelines regarding the maximum wait time allowable between various appointments in a sequence of care; and
- Multiple appointments should be scheduled for the same day, where clinically appropriate.

1.6.3 Are the patients referred to in the previous question currently assigned NRFC at any stage in their journey? If yes, under which NRFC category (e.g. personal/clinical)?

55% of responders indicated that patients who require a sequence of care/assessments are currently assigned as NRFC – Clinical at some stage during their journey.

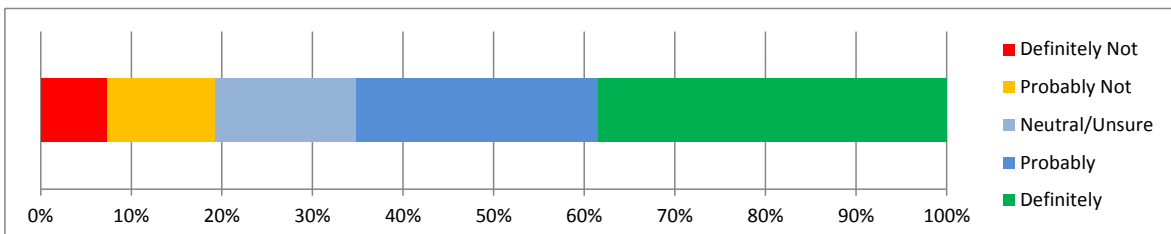
1.6.4 Should there be maximum time periods for NRFC categories linked to the urgency category of the patient (e.g. Category 1 patients can only be made NRFC for a maximum of 30 days)?

76% of responders indicated that there should be maximum time periods for NRFC categories linked to the urgency category of the patient, with 32% responding there ‘Probably’ should be and 46% indicating there ‘Definitely’ should be.



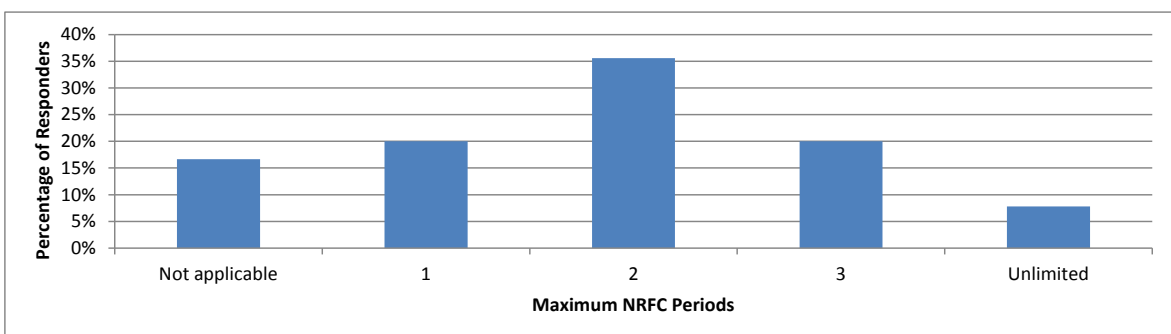
1.6.5 Should there be a maximum number of times a patient can be made NRFC for personal, clinical or administrative reasons?

66% of responders indicated that there should be a maximum number of times a patient can be made NRFC for personal, clinical or administrative reasons, with 27% responding there ‘Probably’ should be and 39% indicating there ‘Definitely’ should be.



1.6.6 If yes, how many times?

Responses to this question were spread more evenly across the possible answers than any other question so far, with the slight majority (36%) indicating that the maximum amount of times a patient can be made NRFC for personal, clinical or administrative reasons should be 2.

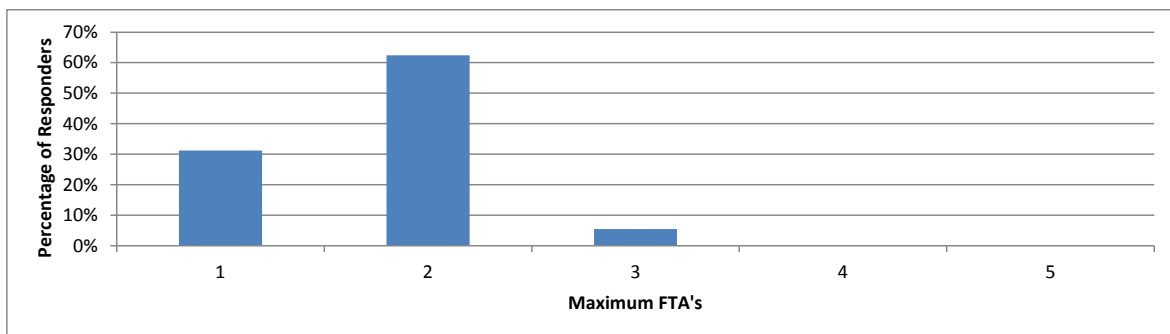


1.7 Failure to attend

1.7.1 How many times must a patient fail to attend before they should be removed from the waiting list?

The overwhelming majority of responses indicated that a patient should be removed from the waitlist after either 1 FTA (31%) or 2 FTA's (62%).

During the face to face consultations, diverse opinions were expressed regarding the number of times a patient may fail to attend before being removed from the waiting list. In particular, consultation participants voiced challenges regarding how this issue should be managed in relation to 'at risk' populations e.g. paediatrics, people from non-English speaking backgrounds and Aboriginal and Torres Strait Islander people. Participants commented that allowing for clinical judgement to be exercised in certain cases will be important to ensure patient safety.

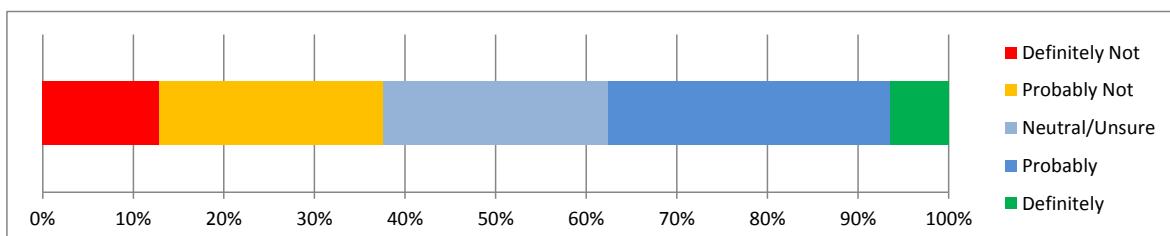


1.7.2 When should the patient's nominated GP be notified of the failure to attend (FTA)?

67% of responders indicated that the patient's nominated GP should be notified of the FTA each time the patient fails to attend/cancels the appointment, while 30% believed the GP should only be notified once the maximum number has been reached and the patient has been removed from the waitlist.

1.7.3 Should patients be reinstated to the waiting list if they appeal following removal, even if the correct notification and clinical review processes were followed?

Opinion was divided on whether or not a patient should be reinstated to the waiting list if they appeal following removal, with 38% of responders indicated that patients should not be reinstated and 37% responding they 'Probably' or 'Definitely' should.



1.7.4 Should there be a maximum time period after which the patient should not be reinstated, even if they appeal?

60% of responders indicated that there should be a maximum time period. The time periods suggested range from one week to twelve months, with the most common suggestion being 30 days.

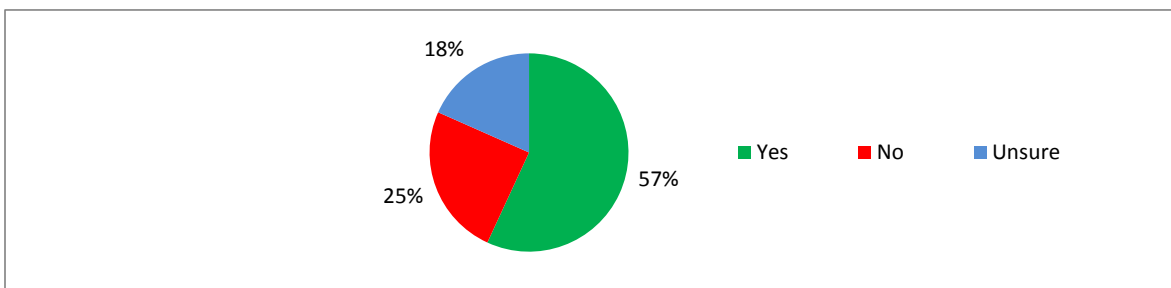
1.7.5 Should there be a clinical review for all urgency categories (or just the most urgent category – Category 1) when a patient is going to be removed from the waiting list because the maximum number of ‘failure to attend’ has been reached?

Opinion was largely split for this question, with 49% believing there should be a clinical review for all urgency categories and 45% suggesting a clinical review is necessary for only the most urgent category.

1.7.6 Should the patient need to have confirmed that they have accepted the appointment before they should be made NRFC due to failure to attend or a patient-initiated cancellation?

The majority of responders (57%) indicated that a patient should need to have confirmed that they have accepted the appointment before they should be made NRFC due to failure to attend or a patient-initiated cancellation. Additional commentary was also provided that appointments should be made in conjunction with the patient and that we should design our business rules to promote and enable patients to take responsibility for their healthcare.

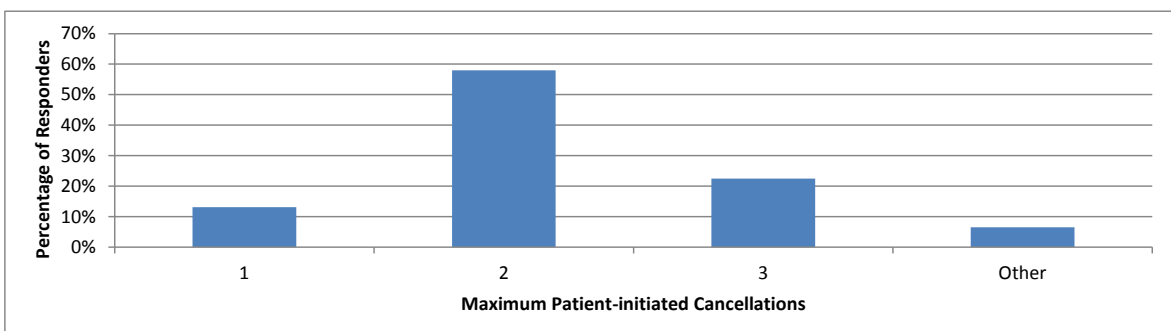
During the face to face consultations this issue was discussed at length. While participants agreed in principle with active patient participation in the scheduling of appointments, a number of sites voiced concerns about the resulting increase in administrative resources required to enable this to occur.



1.8 Cancellations

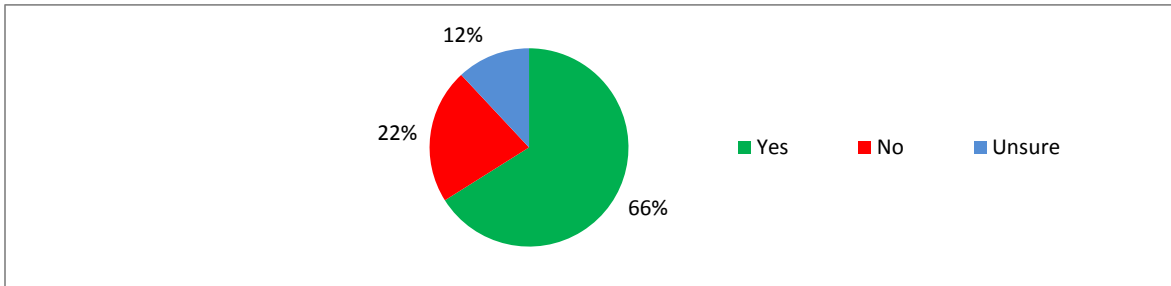
1.8.1 How many times must a patient cancel their appointment before they should be removed from the waiting list?

58% of responders indicated that a patient should be removed from the waiting list after cancelling their appointment twice.



1.8.2 Should there be a maximum number of times that the hospital can cancel the patient's appointment?

The majority of responders believed that there should be a maximum number of times that the hospital can cancel the patient's appointment, with 66% for a maximum and 22% against a maximum.



1.8.3 If yes, what should happen if the maximum number of hospital-initiated cancellations is reached?

An overarching principal of the responses was that the HHS hold itself to the same standards we hold patients to, in other words, if the HHS were to remove the patient from the waitlist after one FTA, then the HHS should be willing to offer alternatives to the patient after one hospital-initiated cancellation. The most commonly provided suggestions were:

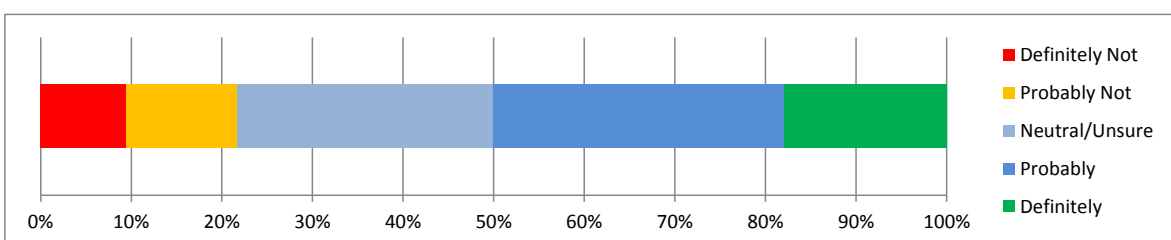
- The patient is offered next available appointment;
- The patient should be offered to be seen at another hospital within the HHS; and
- The patient should be offered to be seen privately at the HHSs expense.

1.9 Transfer of patients between waiting lists

Patients who are registered on Queensland Health outpatient waiting lists can permanently relocate across HHS boundaries and may request that their waitlist information be transferred to a facility closer to where they now reside. Transfers between HHS/facility waiting lists can obviously only occur in situations where the facility: (a) provides the service; and (b) has the capability to safely provide the service that the patient needs.

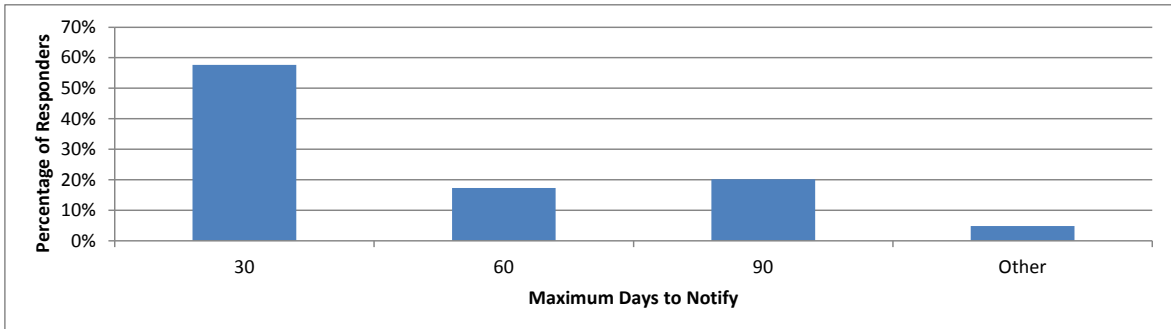
1.9.1 Should a patient have to relocate at least 50kms away from the hospital with which they are waitlisted before a request for transfer is accepted?

There was a moderately positive response to setting the 50km rule for patient transfers, with a combined 50% responding 'Probably' or 'Definitely'.



1.9.2 What is the maximum time that a patient should have to notify the hospital where they are currently waitlisted that they have moved (number of days)?

The majority of responders (58%) indicated that 30 days should be the maximum time that a patient should have to notify the hospital where they are currently waitlisted that they have moved.

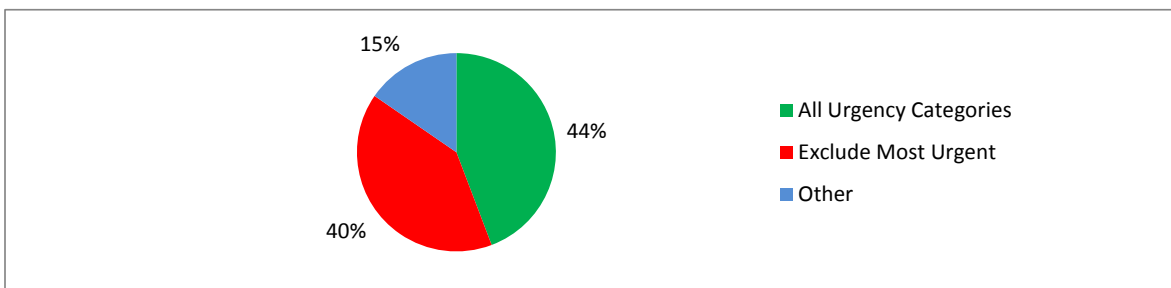


1.9.3 Who should be responsible for organising the patient's transfer to a new list?

While 61% of responders indicated that it should be the responsibility of the existing hospital to organise the patients' transfer to the new hospital, as opposed to the new hospital, there were many additional comments echoing the sentiment that hospitals should be jointly responsible to ensure the continuity of the patients' care.

1.9.4 Should requests for transfers be accepted for all urgency categories or should it exclude the most urgent category (Category 1) due to the short timeframes required for scheduling of the initial appointment to meet Key Performance Indicators (KPIs) in the Performance Management Framework?

Opinion was largely divided on whether requests for transfers be accepted for all urgency categories or exclude the most urgent category, with a 44% to 40% split respectively. Additional commentary provided raised the notion that KPI's should not restrict patient care and business rules should not be made that are not in the best interests of the patient.



1.9.5 How should transfers of long wait patients be managed to minimise any disadvantage to either the patient or the HHS that accepts them?

The overwhelming sentiment from the free text responses to this question is that patients' days waiting should not be reset and that the potential for a hospital to receive a transferred patient who they cannot treat within the clinically recommended time should be built into the performance target.

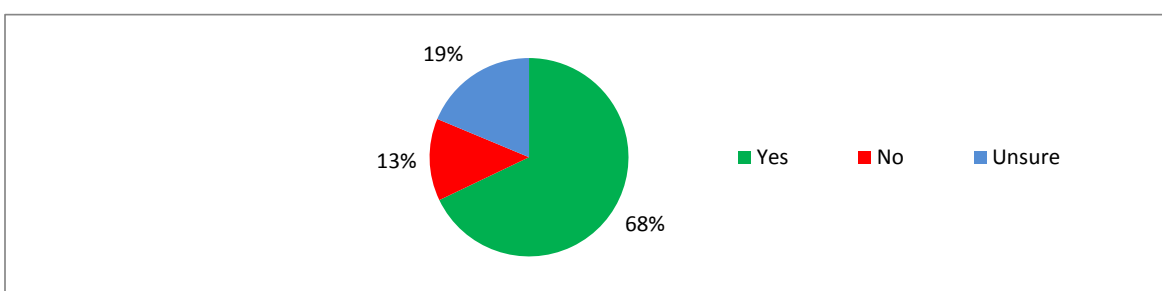
1.10 Reviews

The Western Australia Department of Health has a business rule which states:

'To assist in decision-making, patients may be reviewed by a registrar (or junior medical officer) for two consecutive follow-up appointments. If the registrar (or junior medical officer) is not able to discharge the patient, a third follow-up appointment (i.e. fourth appointment) must be undertaken by the treating specialist or authorised delegate. This process will ensure that a standardised and more active approach is applied to the discharge of patients.'

1.10.1 Should there be automatic booking with the treating specialist if a registrar/junior medical officer has reviewed a patient two times and a third review appointment has been requested?

There was a high level of support (68%) for automatic booking with a consultant for a third review appointment after two review appointments with a registrar/junior medical officer.



1.10.2 How could this be implemented in Queensland Health given that all clinics are mapped to consultants and there is currently no data collection on whether a registrar or consultant sees the patient?

There were few responses to this question that contained specifics beyond 'data should be recorded at the time of consultation as to whether the patient was seen by a registrar or consultant.'

Two of the more specific ideas/answers were:

- "This can be achieved by having Registrar Only clinics and identifying these by means of the Provider Type (will require additional Provider Type codes for Registrars)"; and
- "Registrars at our facility must complete a review request audit form if not discharging patients following review appointment. Consultant & CN review all forms and manage future appointment scheduling with the Consultant or patient discharge if Consultant is satisfied with Reg consult."

The Monthly Activity Collection currently defines a 'Review non-admitted patient service event' as:

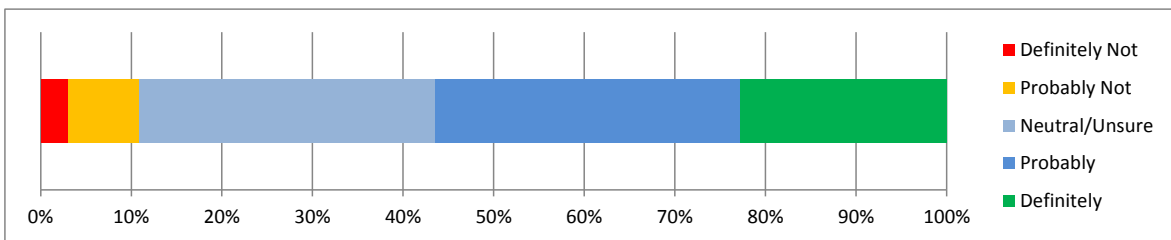
'Any subsequent service event in that given clinic (i.e. Corporate Clinic Code) required for the continuing management/treatment of that condition, up to the stage where the patient is discharged from that given clinic.'

'Includes post-discharge review associated with an admitted patient episode.'

'Where the patient requires ongoing review for the same condition at that given clinic after the referral has expired, an updated referral confirming the need for continued management (refer to Section 5.4 Appointment Management of the Implementation Standard, of the Outpatient Service Implementation Standard) is required and will not initiate a new course of treatment, and the next service event will be a review.'

1.10.3 Should this definition be included in the revised implementation standard?

More than 50% of responders indicated that the definition 'Probably' or 'Definitely' should be included in the revised implementation standard.

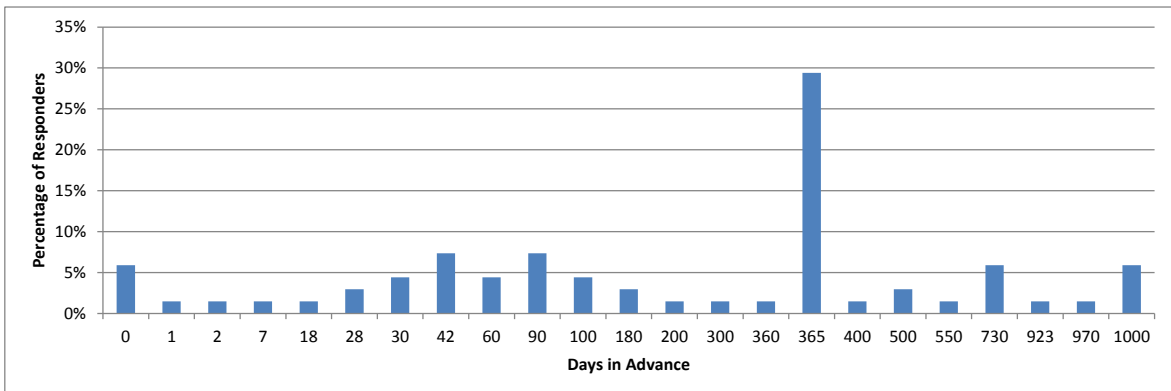


1.10.4 Considering the above definition, how does your service currently manage post-discharge reviews – as initial service events or reviews?

Only 9% of responders indicated that their service currently manages post-discharge reviews as initial service events, while 62% manage them as review appointments. All other responders were unsure.

1.10.5 Currently, how far in advance are review appointments scheduled in the system (number of days)?

The responses to this question indicate a large variation in practice, with answers ranging from 0 days to 1000 days (3 years). The most common answer was 365 days, although it should be noted that the current Outpatient Services Implementation Standard states that "Patients will be offered an appointment date no more than thirty (30) days in advance of the offered date."



1.10.6 Do you keep a separate excel spreadsheet or database to track patients who require review appointments?

Only 13% of responders indicated that they keep a separate database for review appointments, with those that do providing reasons such as:

- Used to ascertain review demand for future planning;
- Used for internal quality assurance (QA) and external verification;
- Used to book more patients than what fits on the OSIM template.

1.11 Internal referrals

Whilst the majority of referrals to outpatient services are initiated by GPs, staff from Queensland Health emergency departments, inpatient wards and other Queensland

Health outpatient clinics may also initiate referrals to clinics. Outpatient referrals initiated by other Queensland Health services are classified as 'internal referrals', as they occur between parts of the Queensland Health business. It should be noted that the intended scope of the Clinical Prioritisation Criteria is that they will also apply to internal referrals.

1.11.1 Should semi-urgent (Category 2) and non-urgent (Category 3) internal referrals be accepted from emergency departments and inpatient areas or only urgent (Category 1) internal referrals?

62% of responders indicated that only Category 1 internal referrals should be accepted from emergency department and inpatient areas compared to 30% who believed Category 2 and Category 3 referrals should also be accepted.

1.11.2 Are there any other business processes/rules that should be specified in relation to internal referrals?

The suggestions for business processes/rules can be grouped into the following categories:

- Only allow ED to make Category 1 referrals and Inpatient departments to make referrals for all categories;
- Internal referrals should only be made by Senior Medical Officers;
- All non-urgent referrals should be managed by GP's;
- Certain clinic's e.g. Fracture Clinic should be an exception to the rule;
- All internal referrals must be compliant with the CPC.

1.12 Reviewing and registering referrals

The current Outpatient Services Implementation Standard includes a requirement for:

'Review of referrals by a delegated nurse within twenty-four (24) hours of receipt in the Outpatient Service to determine the suitability of the referral for acceptance and streaming into the correct specialty. The nurse may undertake action to reroute or expedite care in consultation with the medical officer as required;

Categorisation of referrals by a medical officer within five (5) days of receipt of the referral;

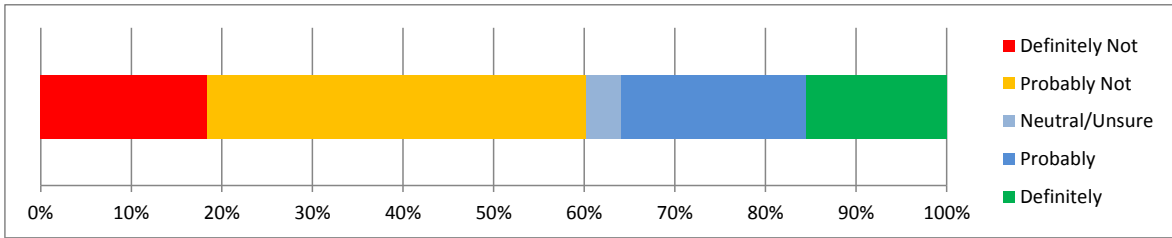
Registration of all referrals on the waitlist within two (2) days of receipt;

Updating the waitlist register occurs once categorisation has taken place.'

1.12.1 Is the requirement to review referrals within 24 hours appropriate given that outpatient clinics are a non-emergency service and do not operate 24/7?

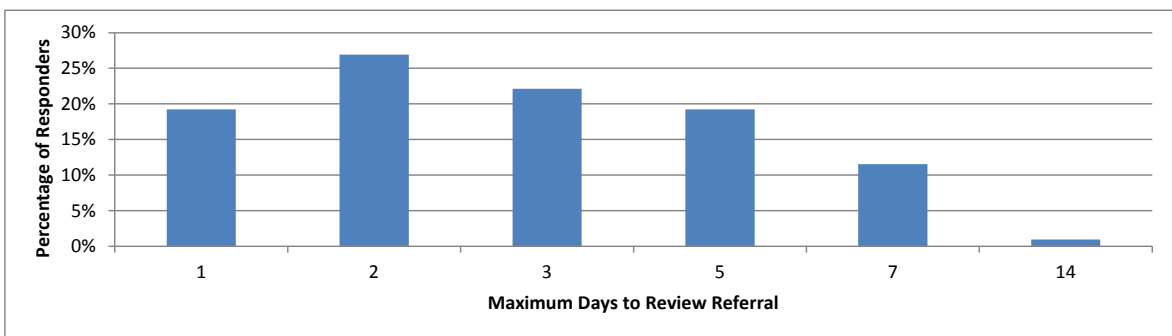
There was general agreement that the requirement to review referrals within 24 hours is not appropriate, with 60% of responders indicating that it is "Probably Not" or "Definitely Not" appropriate. It is suggested that the requirement be changed to '...within one (1) business day of receipt...'

Face to face consultation participants also voiced strong support for reviewing, categorising and registering referrals to be reported in business days as opposed to calendar days.



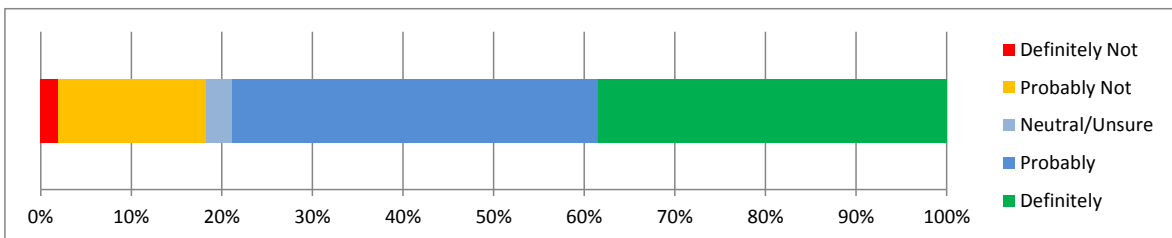
1.12.2 What should be the maximum timeframe to review a referral? (Number of working days)

There was no consensus on the maximum timeframe to review a referral, with answers ranging from 1 to 14 days. The most popular response was 2 days, with 27% of the vote. It should be noted that this timeframe could significantly impact the services’ ability to see Category 1 patients in time.



1.12.3 Is the requirement to register all referrals within two days of receipt appropriate?

Similar to question 1.12.1, responders tended to indicate that the requirement to register all referrals within two days of receipt was appropriate, with 78% choosing either “Probably” or “Definitely” appropriate. Again, the potential to move to business days for this requirement would solve the issue of the service not being offered 24/7.



1.12.4 Currently, are referrals that do not contain appropriate content (as specified in the Outpatient Services Implementation Standard) registered on the waitlist system, even if they are returned to the referring practitioner with a request for further information?

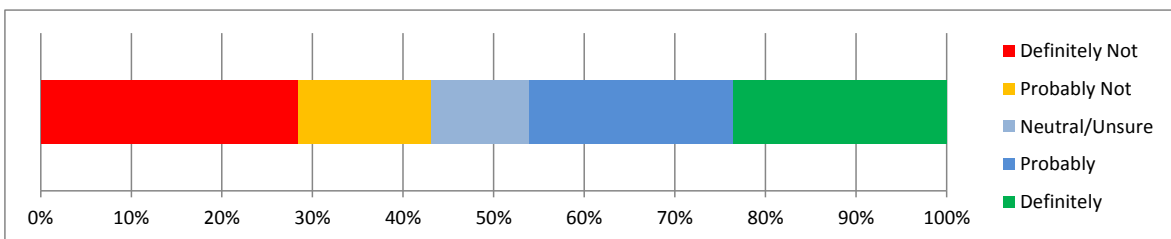
A large proportion of responders indicated that they were unsure of current practice (as they were likely not involved in this process). Of those who answered the question either “Yes” or “No”, 67% said they do register referrals that contain inappropriate information and provided the following commentary:

- “Registering is essential to track and to send correspondence with GP’s”;
- “The referral, once corrected, should be re-dated for the purpose of meeting the referral criteria”;

- “They are registered on the 'unclassified' waiting list and if at clinical review there appears no indication of urgency, the referral is returned to the GP by mail with advise of non-acceptance”;
- “They should be but frequently are not”;
- “Entered as 'Awaiting Information' unless there is insufficient information to register the patient in HBCIS.”

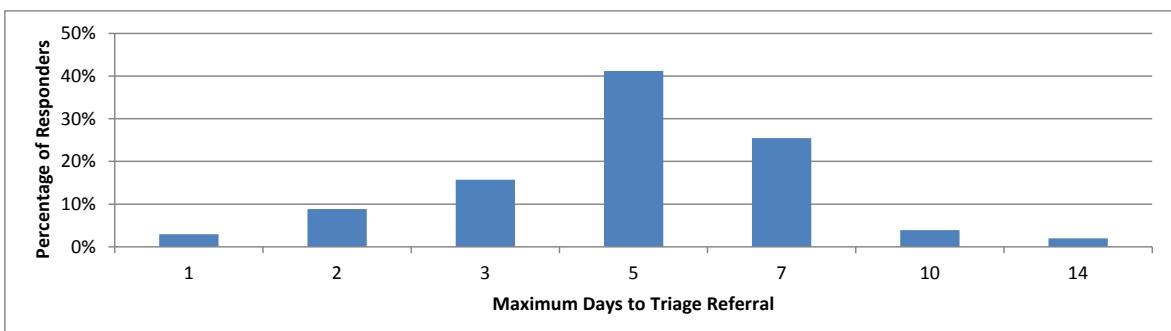
1.12.5 Should the business rule requiring HHSs to return the original referral to the referring practitioner if a patient fails to confirm an appointment and is removed from the waitlist be discontinued?

There was a somewhat even spread of responses to this question, with a weighted average of “Neutral/Unsure”. This may indicate a misunderstanding of the question, which was intended to have the emphasis on returning the *original* referral, as opposed to a copy of the referral, not whether the referral should be returned at all. Although it is difficult to ascertain a consensus from this result, it would be reasonable to conclude that the majority of responders would be satisfied with a copy of the referral being returned to the referring practitioner if a patient fails to confirm an appointment and is removed from the waitlist.



1.12.6 What should be the maximum timeframe to triage/categorise a referral? (Number of working days)

Similarly to question 1.12.2, there was a wide range of responses from 1 to 14 working days. The most popular response was 5 working days, with 41% of the vote. It should be noted that this is the same as the current requirement.



1.12.7 Should 'time waited' be counted from the date of triage, rather than the date that the referral was received?

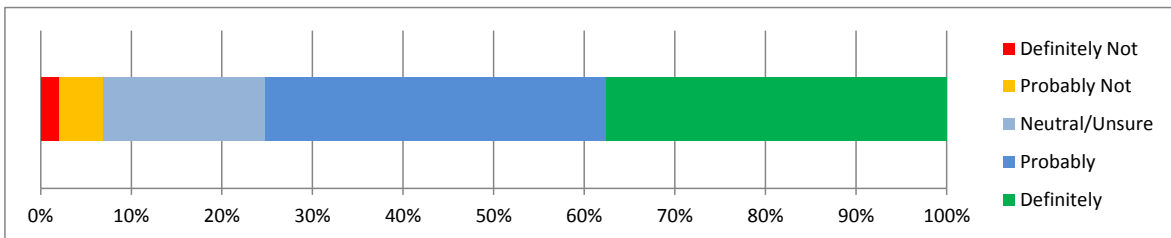
A majority (64%) indicated that the time waited should be counted from the date the referral was received. It should be noted that this is the current practice.

1.13 Book in turn

Queuing theory demonstrates that treating patients in the order that they are waitlisted ('treat in turn') shortens the queue. Elective surgery performance has improved using a business rule which requires a minimum of 60% of patients in Categories 2 and 3 to be 'treated in turn'.

1.13.1 Should the Outpatient Services Implementation Standard include a similar requirement for outpatients?

There was a high level of consensus that the OSIS should include a similar requirement to the 'treat-in-turn' model for elective surgery, with a weighted average response between "Probably" and "Definitely".



1.13.2 Are there any risks/issues that would need to be managed if this business rule was implemented?

The responders flagged a variety of potential risks/issues which can be summarised by the following points:

- As not all medical officers within a speciality can perform all procedures, the treat-in-turn KPI should be measured at a Consultant-level, not a Speciality level;
- Facilities that depend on Visiting Medical Officers and can only schedule appointments around their visiting dates may struggle to achieve the target;
- Reporting on this metric may be difficult without additional resources or technology to support it;
- Patients are frequently sub-categorised e.g. 'high-priority Category 2' which, if followed, would affect performance against this metric;
- Outpatient waitlists are more specialty-specific and many specialties have specialised clinics with limited capacity.

1.14 Appointment confirmation

The current Outpatient Services Implementation Standard specifies:

5.4.40 The partial booking system applies to both new and repeat case appointment scheduling.

5.4.41 Patients will be offered an appointment date no more than thirty (30) days in advance of the offered date.

5.4.42 All patients will confirm the offer of appointment within fourteen (14) days of the offer being made.

5.4.43 A letter of confirmation of the booked appointment will be sent to the patient and referring practitioner.

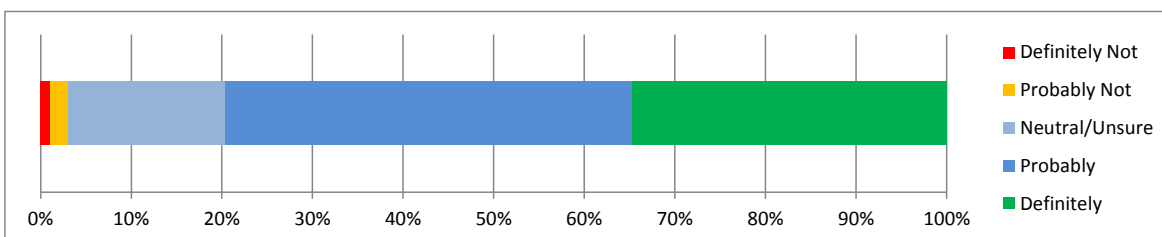
5.4.44 Appointment offers that are not confirmed within the specified timeframe will be offered to other patients.

5.4.45 The appointment scheduling or booking system will facilitate the immediate booking of Category 1 patients within the accepted timeframe (30 days) from when they are placed on the wait list.

5.4.46 A partial booking system that allocates appointments no more than thirty (30) days in advance of the offered appointment date will be utilised for Category 2 and Category 3 patients.

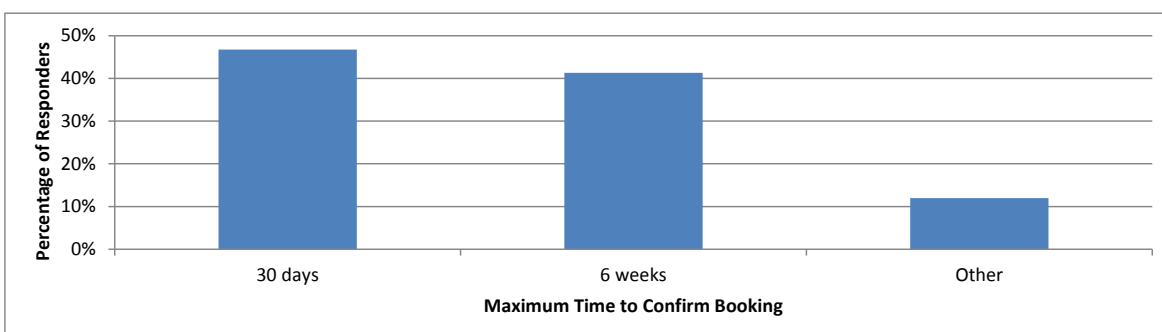
1.14.1 It has been suggested that the revised implementation standard should specify only 'what' processes need to be followed, not 'how' they are implemented (e.g. sending letters). In line with this principle, should the statement that 'A letter of confirmation of the booked appointment will be sent to the patient and referring practitioner' be modified to 'The referring practitioner and patient will be formally notified of the urgency category, and recommended timeframes for treatment, for all referrals that are accepted'?

There was a definite consensus that the revised implementation standard specify only 'what' processes need to be followed, not 'how' they are implemented, with 80% of responders in favour and virtually all the remainder unsure.



1.14.2 What timeframes, if any, should be specified to guide partial booking processes in the revised implementation standard?

Opinion was divided on the timeframe for partial booking of a patient. The current implementation standard specifies that “patients will be offered an appointment date no more than thirty (30) days in advance of their appointment.” While there was support to maintain this timeframe, almost the same number of responders believed this should be changed to 6 weeks, in line with many leave notice requirements for HHSs. Additional commentary provided raised issues regarding patients indicating they require more notice to arrange time off work or childcare, and consideration must be given to the length of time to deliver mail in areas where Australia Post has reduced in service.



2. Priority area two: Communication between GPs, HHSs and patients

At the Wait Times Summit meeting, it was agreed that any future work program would need to be patient-focussed and involve clear communication pathways between the Department, HHSs, referring practitioners and patients themselves.

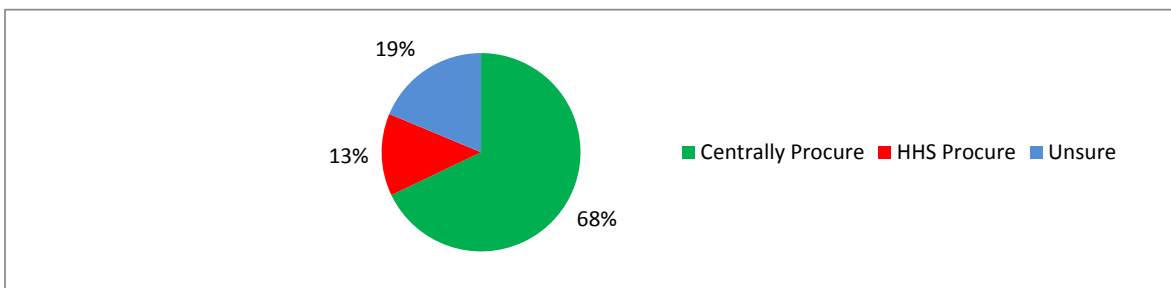
2.1 Information and communications technology (ICT) systems

2.1.1 *Should Queensland Health centrally procure a referral management system for outpatients with the following core functionality, or should each HHS procure their own within a specified timeframe:*

- *Ability to integrate with the Queensland Health Patient Administration System and associated clinical and administrative information management systems*
- *Electronic referrals (incorporating Clinical Prioritisation Criteria where appropriate) with deep integration with GP software programs*
- *Referral receipt and lodgement to track referrals status and progress*
- *Electronic directory/catalogue of outpatient services for each HHS*
- *Patient and referring practitioner portals (providing access to waitlist, appointment scheduling and care plan information)?*

The majority of responders (65%) preferred a referral management system to be centrally procured. Those in favour of central procurement commented that it would assist with standardisation which is potentially crucial for integration with GP systems, and that fragmented medical record systems have already caused many of the issues we face today.

Those opposed to a centrally procured system commented that central procurement could delay the implementation of the system by years and it would be difficult to integrate with HHS digital hospital programs.



2.1.2 *Should Queensland Health centrally procure contemporary scheduling systems for outpatient services (e.g. scheduling systems, next generation queue management systems, SMS reply and interactive smartphone technology) or should each HHS procure their own within a specified timeframe?*

Like the previous question, the majority of responders (62%) preferred contemporary scheduling systems to be centrally procured. The additional commentary provided reflected the same sentiment as the previous question.

2.1.3 *Should Queensland Health enable referring practitioners to have access to diagnostic results through The Viewer (and other integrated Electronic Medical Record or 'ieMR' information) to support timely and comprehensive access to supporting clinical information and improve care coordination?*

There was overwhelming agreement that QH enable referring practitioner's access to diagnostic results through The Viewer, with 92% of responders in favour and only 4% not in favour. A caveat was provided that referring practitioners would have to have their access limited to only their patients.

2.1.4 *What else should be done to improve connectivity, communication and service integration between the Department, HHSs, referring practitioners and patients?*

There were 52 suggestions provided which can be summarised by the following:

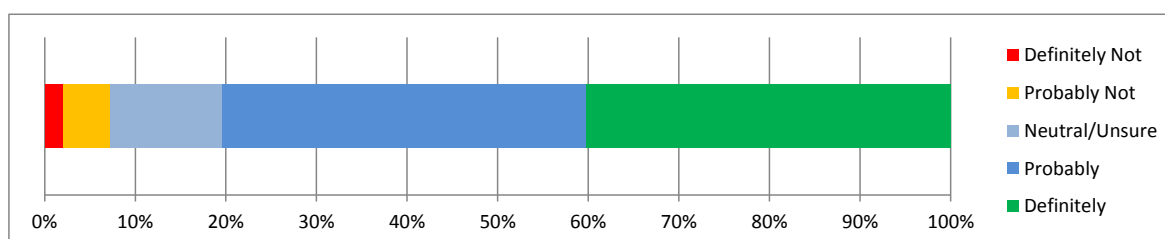
- Transparency and publication of meaningful wait list information e.g. CPC and corresponding category, actual days waiting of longest wait for each category;
- Access for GP's to discharge summaries through The Viewer;
- Continual education of GPs through GPLO's to identify the information required in referrals and what alternative services or care plans can be provided prior to the need to refer;
- Replacement of HBCIS with a PAS system that is integrated with ieMR;
- Electronic transmission of letters e.g. FTAs and Discharge letters to referrers.

2.2 Patient experience

Patient experience is a crucial part of quality health care; in fact, research from other health jurisdictions indicates that it is as highly valued by patients as the clinical effectiveness and quality of care provided by healthcare professionals. With this in mind:

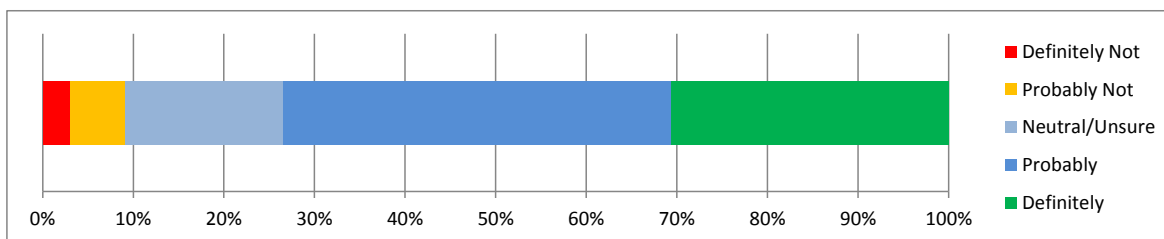
2.2.1 *Should Queensland Health develop a policy framework to drive and systematise improvement in patient experience in Queensland Health?*

Responders were generally in favour of a policy framework for improvement in patient experience, with a weighted average response of "Probably". Overall, 80% of responders indicated there "Probably" or "Definitely" should be a policy framework.



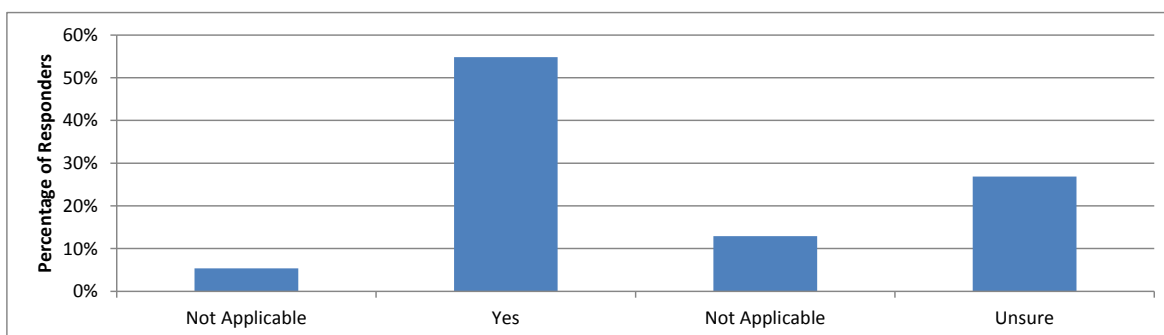
2.2.2 Should a suite of patient experience KPIs be developed and systematically analysed to inform improvement initiatives?

Responders were similarly in favour of a suite of patient experience KPI's, with 74% of responders indicating they "Probably" or "Definitely" should be developed.



2.2.3 If yes, should these KPIs be included in the service agreements and the Queensland Health Performance Management Framework?

More than half of the responders agreed that the patient experience KPI's should be included in service agreements and the Queensland Health Performance Management Framework while only 13% were against the inclusion.

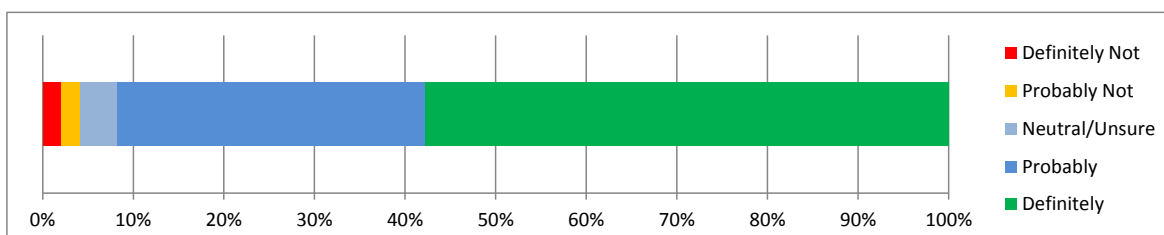


2.2.4 How should Queensland Health support Hospital and Health Services to ensure that they all have the same capability to collect data on patient experience?

The majority of responders (62%) were in favour of Queensland Health centrally procuring technology to enable collection of patient experience data, with 20% suggesting that funding should be devolved to each HHS to procure their own technology (provided the data can be reliably and efficiently exported to the Department for central collation) within a specified timeframe. It should be noted that multiple HHS executives voiced their concern that Department-led procurement could be construed as a return to the centralised model.

2.2.5 Should training and development in patient experience be included in leadership development programs?

There was a strong consensus that training and development in patient experience be included in leadership development programs, with 92% in favour of the inclusion and only 4% against the inclusion.



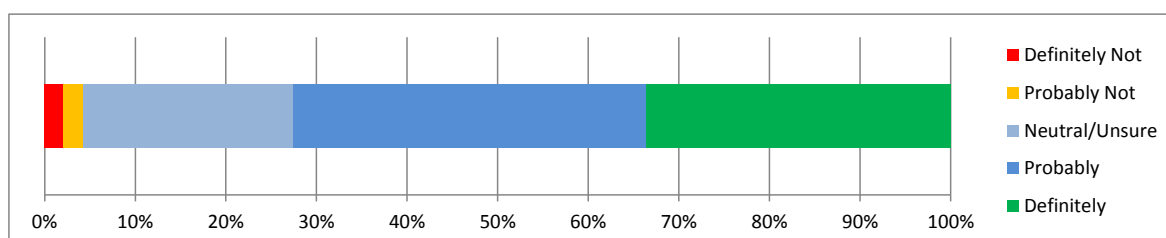
3. Priority area three: Models of care, scope of practice and workforce development

A 'model of care' broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to bring about improvements in service delivery through effecting change, with the ultimate goal of ensuring that people get the right care, at the right time, by the right team and in the right place. Developing, or changing, a model of care requires consideration of any clinical, technical, legislative or financial factors that may impact on successful implementation.

A critical success factor in model of care design is the scope of practice of the health practitioners who will be expected to implement the model. 'Scope of practice' refers to the procedures, actions, and processes that a healthcare practitioner is permitted to undertake in keeping with the terms of their professional license. Scope of practice and public sector specialist workforce supply were both raised as issues integral to outpatient and elective surgery wait time performance, requiring innovative solutions to position Queensland to meet growing demand for health care into the future. With this in mind:

3.1.1 *Should Queensland Health invest in innovative beacon practice models to assist GPs to practice to the top of their scope of practice?*

There were a high proportion of responders to this question who indicated they were "Neutral/Unsure". Excluding those, the vast majority (95%) were in favour of investment in innovative beacon practice models to assist GP's.



3.1.2 *If so, how should this happen?*

Many responders (79%) were in favour of the suggested model, that 'Special Interest' GPs are funded to work for set time periods in 'embedded' beacon clinics within the hospital to allow up-skilling/close connection with specialists, before returning to their community practices to allow more GPs with a special interest to have access to up-skilling/capability development opportunities.

One innovative model which is to be trialled at Logan Hospital in early 2016 was suggested. The model involves offering two ENT training registrar positions for a period of six months for General Practice trainees. The purpose of the training is for participants to learn interventions that could be provided in a GP setting, but are often referred to public outpatient departments. The model is self-sustainable in terms of cost due to the eligibility for Medicare billing of patients seen by the trainees. The outcomes of this model are anticipated to include reduced inappropriate referrals and reduced waiting times for specialist ENT services.

Additionally, throughout the face to face consultations, a number of innovative models of service delivery currently being used across Queensland were discussed. These included:

- General Practitioners spending approximately half their time running clinics within the hospital in Central West Hospital and Health Service, with each General Practitioner having nominated areas of interest.
- Special interest General Practitioners running clinics for Mater Health Services, particularly in the areas of plastics, orthopaedics and community-based diabetes services.
- Darling Downs Hospital and Health Service currently using beacon practice models for special interest General Practitioners.

3.1.3 *What should be done to improve public sector supply of specialist services?*

There were 45 free text responses to this question, which can be summarised by the following points:

- Partner with colleges to include a period of service within the public sector post attaining staff specialist qualifications;
- Use demand profiling and modelling to improve workforce planning/recruitment;
- Use trained GPs in specialist clinics to take over certain tasks e.g. determining suitability for surgery;
- Improve non-financial incentives for specialists e.g. involvement in innovation programs and access to teaching and leadership programs;
- Develop resources for patients regarding private alternatives, including intermediate private options for surgery & financial assistance programs to encourage participation in low-cost private options;
- Engage with the colleges to promote training for specialties that reflect growing demand or current shortage of specialists across the State;
- Support the capability development of the primary health sector to deliver increased treatment and management within the general practice/community care setting.

At present the Elective Surgery Implementation Standard states that:

‘Only specialists with admitting and operating rights for the hospital can request registration of a patient on the hospital’s elective surgery waiting list’.

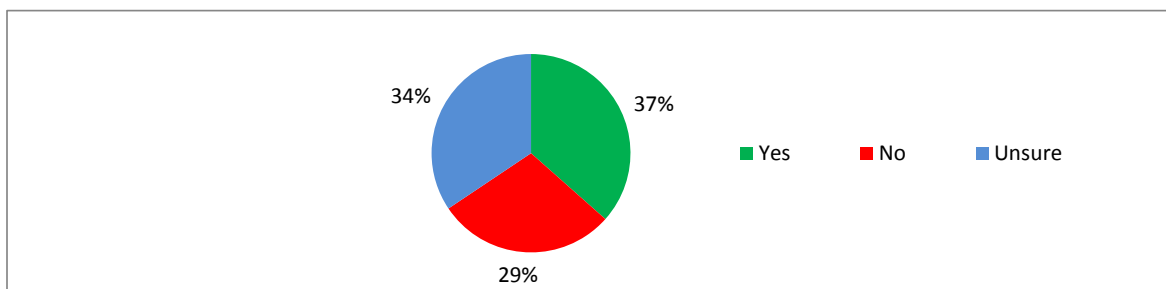
With this in mind:

3.1.4 *Should other private specialists be able to refer directly to public elective surgery waiting lists and/or diagnostic and interventional waiting lists in line with Clinical Prioritisation Criteria to streamline access for some services? For example, should private specialists employed in federally-funded outreach programs (e.g. Rural Health Outreach Fund and the Medical Outreach Indigenous Chronic Disease Program) be able to request registration of a patient onto a hospital’s elective surgery waiting list for defined procedures?*

There was a very even distribution of responses to this question which reflects the high level of contention experienced during the workshops. While there was no quantitative

consensus on whether or not other private specialists should be able to refer directly to public waiting lists, additional commentary provided suggested that if it was to be included in the updated implementation standard, then there would need to be strict guidelines applied, including:

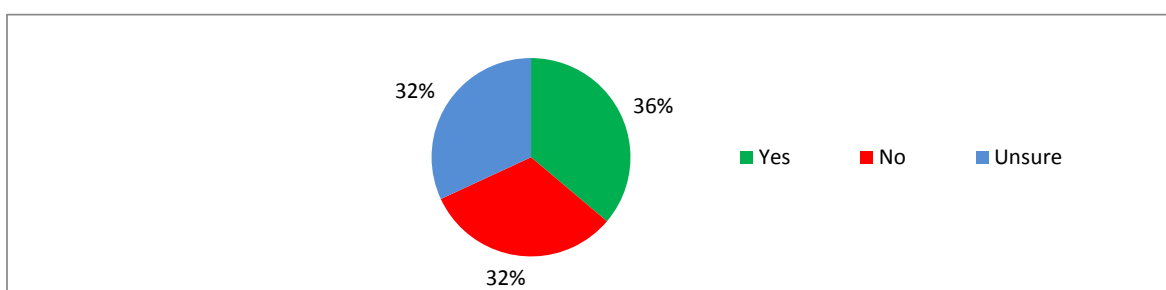
- The referral meets the Clinical Prioritisation Criteria and can be audited;
- Only applicable to a defined set of procedures;
- There should be some formal arrangement between the federally funded private specialists and the HHS they are referring to.



3.1.5 *Should accredited GPs be able to request direct registration of a patient onto a hospital's waiting list in line with Clinical Prioritisation Criteria for selected interventional procedures and/or diagnostic procedures?*

Consistent with the previous question, opinion was divided on whether accredited GP's should be able to request direct registration of a patient onto public waiting lists. Suggestions for guidelines if the provision for direct registration was included in the updated implementation standard include:

- Accredited GP's should be able to request public MRI's to assist Neurosurgery and Orthopaedics;
- The referral must meet all Clinical Prioritisation Criteria for the clinical condition;
- Consideration must be given to ensure access is not compromised for those patients who cannot access the 'accredited GPs' for referral to these services;
- The specialist clinician must have the power of veto based on expert knowledge.



3.1.6 *What would be required to support safe and sustainable implementation of direct referral by private specialists and/or GPs to surgical, interventional and diagnostic services?*

There were 46 free text responses to this question, which can be summarised by the following points:

- An integrated, end to end 'smart' e-referral system;

-
- Training, accreditation and auditing of referrers;
 - Coding of diagnoses to allow for accurate data extraction and evaluation of referrals/outcomes for patients;
 - Clinical Prioritisation Criteria that are well defined and rigorously enforced.

4. Priority area four: Performance frameworks and targets

4.1 Performance management framework

The Hospital and Health Service Performance Management Framework sets out the systems and processes that the Department will employ to fulfil its responsibility as the overall manager of public health system performance. The Performance Management Framework applies to the 16 HHSs in Queensland and to public health services provided by the Mater Health Services, South Brisbane. The aim of the Performance Management Framework is to ensure delivery of services in line with the service agreement between the Department and each HHS.

Both the Department and HHSs have a role to play in ensuring that performance expectations are met and that services meet the needs of the population. It is the Department's role to undertake KPI governance, including reviewing the KPIs, setting targets, and tracking the key drivers for better health care. A key aspect in establishing the targets is to consult with the HHSs to ensure that the target is operationally appropriate and adequately supported by funding in order to deliver the required performance.

4.2 Performance targets

The objective of the Government is to reduce wait times across all elements of the patient journey. The Government supports the implementation of performance targets that are 'genuine and realistic' and do not create perverse incentives or generate unintended consequences. It is also important to ensure that the safety and quality of care provided is not compromised in the pursuit of performance targets.

The Performance Management Framework states that targets must meet the following criteria:

- Clear and unambiguous – it must be clear what is to be achieved and within what timeframe.
- Relevant – the target should reflect what the public health system is trying to achieve and should be aligned where possible to targets set in higher level documents (e.g. National Performance and Accountability Framework).
- Attributable – the targets must be capable of being influenced by actions which can be attributed to the HHS; it should be clear who has accountability for achieving the target, and what the consequences are if the target is not met.
- Achievable – the target should be challenging but achievable within available resources.

4.3 Elective surgery

The National Partnership Agreement on Improving Public Hospital Services focused attention on improving patient access to elective surgery through the introduction of the National Elective Surgery Targets (NEST). The National Partnership Agreement provided

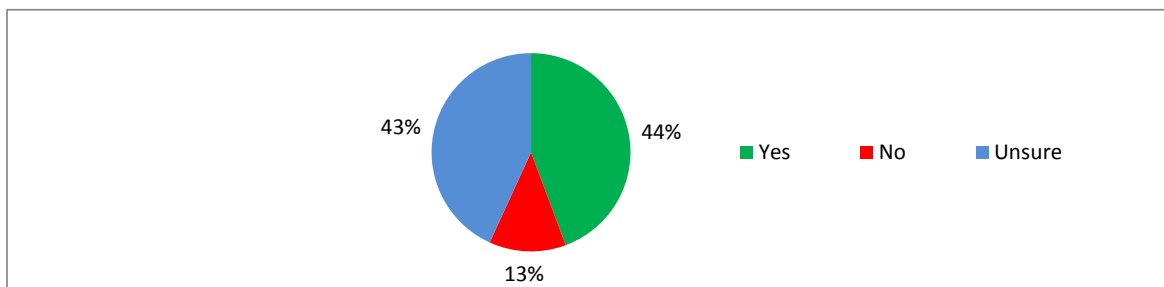
facilitation funding for improvement activities and reward funding for achievement of incremental targets, both of which have now ceased. Between 1 July 2010 and 31 December 2014, the Department spent \$133.1 million of funding provided by the Commonwealth Government under this National Partnership Agreement on initiatives to reduce the number of people waiting longer than clinically recommended for elective surgery. The Department also implemented a range of clinical and process improvements in relation to elective surgery services in response to this National Partnership Agreement.

These actions resulted in a significant reduction in the number of people waiting longer than clinically recommended for elective surgery. As at 1 January 2015, only 290 ready-for-surgery patients were waiting longer than clinically recommended on the elective surgery waiting list.

On 10 March 2015, the Government announced the introduction of interim elective surgery targets, effective from 1 April 2015, with the intention to undertake broad consultation to review the appropriateness of these targets in the longer term. The interim elective surgery targets require that 98% of Category 1 patients, 95% of Category 2 patients, and 95% of Category 3 patients receive their elective surgery within the clinically recommended timeframe. With this in mind:

4.3.1 Are the interim elective surgery targets appropriate in the longer term?

A large proportion (43%) of responders indicated that they were unsure of the appropriateness of the interim elective surgery targets. Of those who responded yes or no, 78% believed the interim targets were appropriate compared with 22% who believed they were not.



4.3.2 If no, what should the targets be?

Given the limited number of responders who believed the interim targets were not appropriate, the sample size of 12 responders for this question was too small for the answers to be statistically significant.

4.4 Outpatient services

As at 1 January 2015, more than 100,000 people were waiting longer than clinically recommended for a specialist outpatient appointment. That was almost half of the 229,737 people who were on the specialist outpatient waiting list as at 1 January 2015.

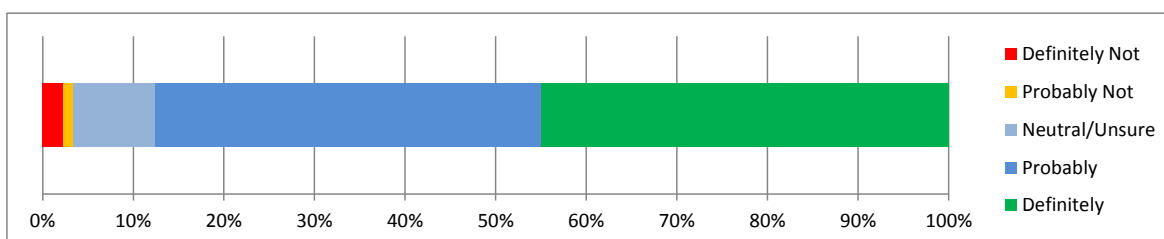
The current outpatient KPI in the Performance Management Framework is the ‘% of unseen specialist outpatients waiting more than the clinically recommended timeframe for their urgency category (Category 1: 30 days, Category 2: 90 days, Category 3: 365 days)’ with each HHS supplying their own improvement trajectory. These HHS-specific targets are not published externally.

4.4.1 Should outpatient performance targets initially focus on reducing the current number of long waits for specialist outpatient services?

There was a high level of agreement that outpatient performance targets initially focus on reducing the current number of long waits for specialist outpatient services, with 87% choosing either “Probably” or “Definitely”.

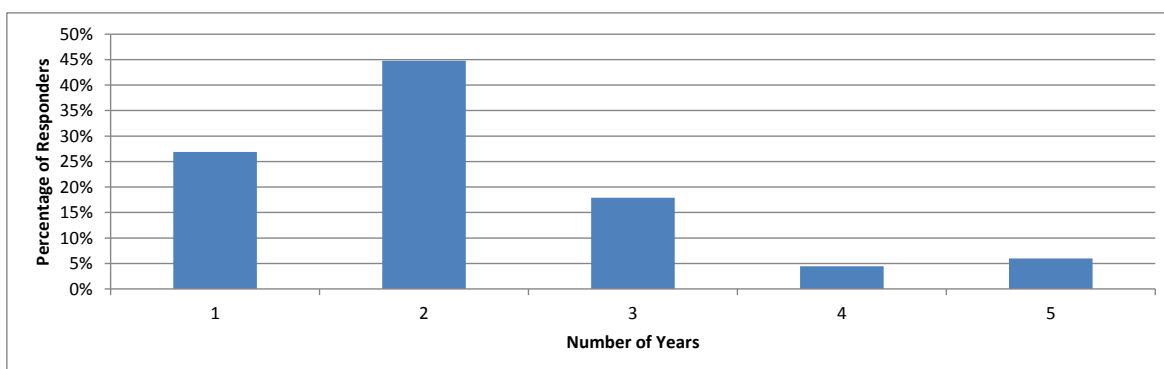
Participants in the face to face consultations also reported that the current measure used (‘% of unseen specialist outpatients waiting more than the clinically recommended timeframe,,,’) disadvantages smaller services who have a small number of patients, and also those who rely on the schedules of visiting specialists. Participants from these areas suggested that reporting the following measures may deliver a more accurate understanding of performance:

- Total number of patients listed as waiting.
- Total number of patients waiting longer than clinically recommended timeframes minus those who have an appointment booked for the near future (to be determined).
- Current maximum wait time.



4.4.2 If so, over what timeframe should all HHSs have achieved a significant reduction in the number of long waits for specialist outpatient services? (Number of years)

Responses ranged from 1 to 5 years, the most popular being 2 years with 45% of the vote.



4.4.3 Should the initial target be associated with a specific cohort of patients? For example, surgical or medical outpatients, those waiting more than 2 years, or 'high demand' specialties (e.g. those with more than 50% long waits)?

A large proportion (34%) of responders indicated that they were unsure if the initial target should be associated with a specific cohort of patients. For those that chose yes or no, 60% believed the target should be associated with a specific patient cohort, and only 40% believed it shouldn't. The longest waiting patients and high-demand specialities were the most commonly specified cohorts.

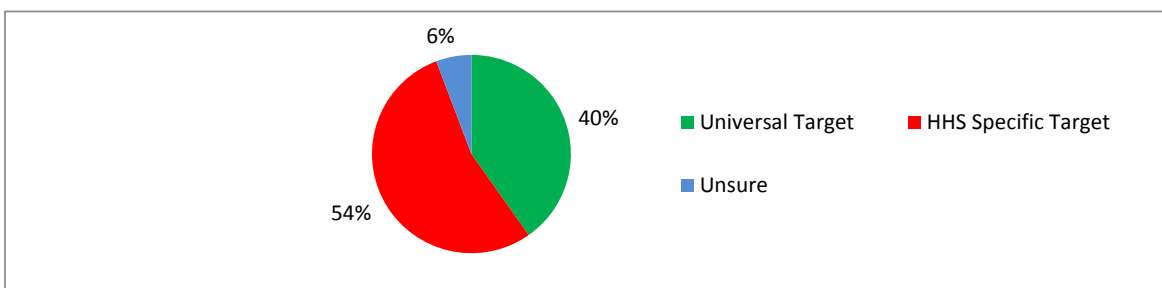
4.4.4 Please rank in order of priority, which of the following long wait cohorts should be cleared first.

Responders were asked to rank, in order of priority, 6 patient cohorts with the following results (highest to lowest priority):

1. Category 1 long wait patients (all specialties)
2. Those waiting longer than 2 years (all categories and specialties)
3. Long waits across all urgency categories¹
4. 'High-demand' specialties (those with >50% long waits across all categories)¹
5. Long wait surgical outpatients (all categories)
6. Long wait medical outpatients (all categories)

4.4.5 Recognising the current variability in HHS performance in relation to long waits for specialist outpatient services, should the same targets apply to all HHSs or should they be HHS-specific? For example, should HHSs with a significant proportion of long waits be assigned a percentage reduction in long waits each year, and other HHSs with a low proportion of long waits be assigned a KPI requiring them to maintain current performance?

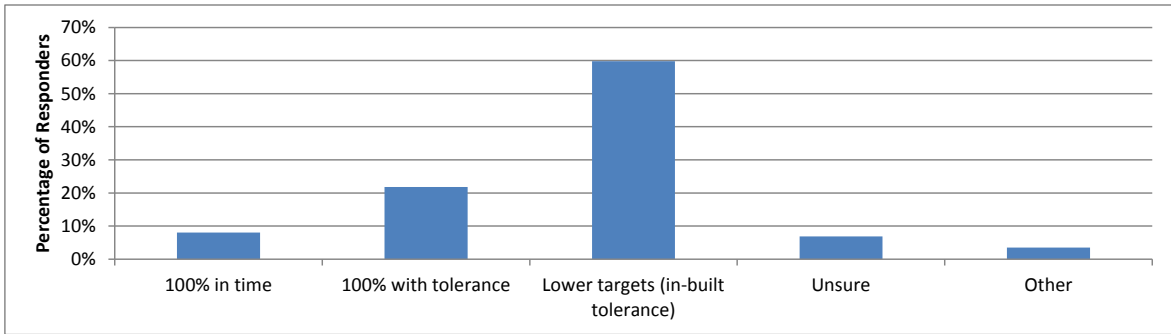
Opinion was fairly evenly split on whether targets should be HHS-specific or statewide, which reflects the high level of contention experienced during the workshops. Given the divide in opinion, one solution would be to set an end-goal statewide target, with HHS-specific interim targets designed to set an achievable improvement trajectory based on current performance.



4.4.6 What should be the performance target for HHSs once they have significantly reduced their backlog of long waits?

The majority of responders (60%) indicated that the performance targets should be lower 'seen-in-time' targets for each urgency category, similar to the interim elective surgery targets (e.g. 98% of Category 1, 95% of Category 2 and 3 patients seen in time), that incorporate a tolerance margin. This was clearly preferred over the second option of 100% of patients 'seen-in-time' for each urgency category with performance management linked to a pre-determined tolerance margin, which only 22% of responders chose.

¹ Priority 3 and Priority 4 were ranked equally



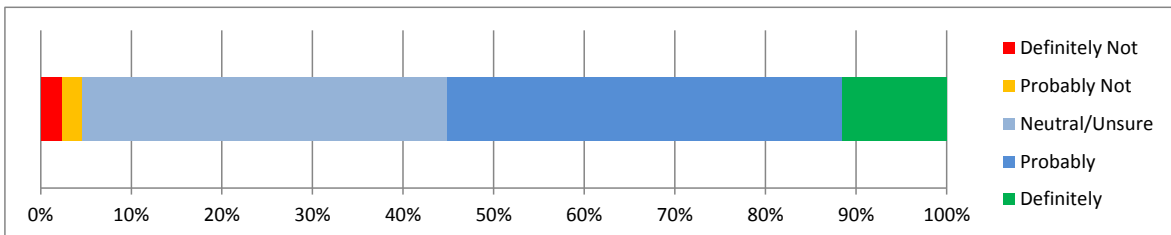
4.4.7 What mechanisms should be put in place to ensure that HHSs do not achieve performance targets by restricting supply?

There were 42 free text responses to this question, which can be summarised by the following points:

- A robust external complaints/concerns mechanism which both GPs and patients can access;
- Monitoring of patient volumes as well as ‘seen in time’ KPI’s;
- Alternative funding models e.g. population-based funding;
- Advanced modelling of population demand to inform Weighted Activity Unit targets, as opposed to historical throughput with a set growth factor applied.

4.4.8 Should ‘maintenance of effort clauses’ be added to service agreements to ensure that HHSs continue to deliver volumes of activity above baseline, year on year, which take account of growth funding?

Responders were mostly in favour of ‘maintenance of effort’ clauses being added to service agreements, with a weighted average response between “Neutral” and “Probably”. Overall, 55% of responders indicated that maintenance of effort clauses either “Probably” or “Definitely” should be added to service agreements.



4.5 Performance in relation to targets

The Performance Management Framework provides an integrated process for the assessment, reporting and review of performance across the 16 HHSs and the Mater. It is based on six overarching principles:

- Transparent – the Performance Management Framework is target based with clear pre-determined measures of performance which are easy to understand.
- Consistent – the Performance Management Framework is consistent with the objectives set out within the *National Health Reform Agreement 2011* and enacted in the *Hospital and Health Boards Act 2011* and applied consistently across all HHSs.

- Proactive – the Department and HHSs each have a role to play in identifying performance issues early and working collaboratively to address the performance issues in a timely manner.
- Responsibility – the Department and HHSs each have a role to play in ensuring that performance expectations are met and that services meet the needs of the population. Accountability for performance needs to be understood and agreed at all levels.
- Balanced – a view of HHS performance across a number of key areas of performance including safety and quality, access to services and efficiency is considered when determining performance assessments.
- Proportionate – intensive HHS support is based on the level of risk and takes into account local circumstances and trajectory of individual HHS performance.

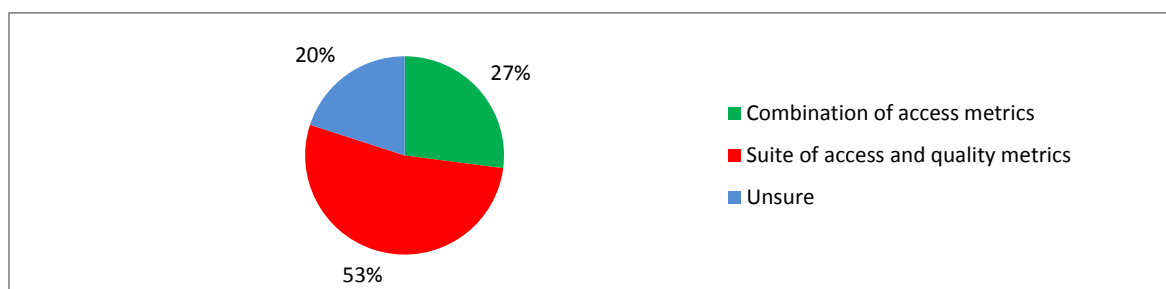
With this in mind:

4.5.1 *Should HHS performance be measured in relation to a single KPI or a suite of inter-related KPIs?*

There was a very high level of support for a suite of inter-related KPI's; with 85% of responders indicating that a suite of KPI's is preferred to a single KPI to measure HHS performance.

4.5.2 *If performance in relation to a suite of KPIs was chosen, should the KPI suite consist of a combination of different access metrics (e.g. maintenance of baseline activity, plus percentage of outpatients seen within clinically recommended timeframes for their clinical urgency category), or involve a suite of access and quality metrics (e.g. percentage of outpatients seen within clinically recommended timeframes for their clinical urgency category, plus performance in relation to patient experience data).*

Responders favoured a suite of access and quality metrics over a combination of different access metrics, with 53% of the vote compared to 27% respectively. Additional commentary provided suggested the potential to focus on access metrics initially in order to reduce the number of long wait patients, before integrating quality metrics into the suite of KPI's.



5. Priority area five: Investment priorities

It is well documented that funding mechanisms drive behaviour in healthcare delivery. With this in mind, it is important to ensure that investment decisions to address wait times support performance improvement, without unintended consequences.

Supporting the Government's commitment to address the needs of patients across the entire patient journey, the 2015-16 Budget allocated \$361.2 million over four years (including \$71.3 million in 2015-16) to reduce the number of people waiting longer than clinically recommended for a specialist outpatient appointment.

Allocation of this additional funding will need to consider the initial specialist outpatient activity required to deliver a long wait reduction, as well as the follow-on inpatient impact of any conversions to elective surgery and the associated outpatient reviews.

Given additional funding will be invested in HHSs to support improved wait time performance, how should this money be invested?

- 5.1.1 *Should it all be invested directly into additional activity to deliver more outpatient services across all clinic types (global growth in outpatient/elective surgery/inpatient activity)?*
- 5.1.2 *Should the investment be targeted to provide additional activity for 'high demand specialties' with more than 50% long waits across all urgency categories?*
- 5.1.3 *Should a proportion of the funding be withheld and used as 'reward funding' for those who achieve annual performance targets?*
- 5.1.4 *Should a proportion of funding be invested non-recurrently in activities that will support performance improvement but are not directly related to service provision – for example:*
 - *Equipment/technology procurement*
 - *Additional general practice liaison officer hours*
 - *Additional business practice improvement officers/project management positions*
 - *Seed funding to pilot innovative models of service delivery*
 - *Embedded beacon practice models or clinical redesign programs/initiatives.*
- 5.1.5 *Should recurrent funding growth in future years be targeted at those specialties where additional activity is required to sustain improvement?*

Responders were asked to indicate their level of support for each of the previous five questions, on a scale ranging from "Definitely Not" – "Probably Not" – "Unsure/Neutral" – "Probably" – "Definitely". Each option was assigned a weighting from 1-5 and the weighted average results were as follows, in order of highest level of support to lowest:

1. Recurrent funding growth in future years should be targeted at those specialties where additional activity is required to sustain improvement (4.10/5);
2. A proportion of funding should be invested non-recurrently in activities that will support performance improvement but are not directly related to service provision (4.05/5);

3. Investment should be targeted to provide additional activity for 'high demand specialties' with more than 50% long waits across all urgency categories (3.75/5);
4. Funding should be invested directly into additional activity to deliver more outpatient services across all clinic types (3.43/5);
5. A proportion of the funding should be withheld and used as 'reward funding' for those who achieve annual performance targets (3.11/5).

Participants across the face to face consultations also expressed strong support for investing in hospital avoidance initiatives, General Practice Liaison Officers and early intervention programs to reduce the burden on outpatient services.

6. Additional comments

6.1.1 Do you have any other comments you would like to add?

Responders were given the opportunity to provide additional comments. A sample of those relevant to the development of the Wait Times Strategy is provided below.

‘The waitlist strategy needs to invest in the establishment and sustained implementation of models of care that allow all clinicians to work at the top of their scope of practice to bring additional capacity to the system and improve patient experience.’ – Allied Health Professional

‘Invest in relation building between HHS's and primary care.’ – General Practitioner

‘Local needs and access varies significantly. Whilst standards of care are often set based on State, National or International Guidelines, they need to be ‘intelligently’ implemented by informed clinicians that have the training to critique those KPI's against their local need.’ - Allied Health Professional

‘Funding mechanisms must be designed to promote *good* behaviour and highly efficient services, and avoid the potential for conflicts of interest or adverse effects on performance.’ – Department of Health Administration Officer

‘Funding must be recurrent. Withholding funds deters HHSs from expending the required funds to ensure a good outcome.’ – HHS Administrative Officer

‘Nothing will change if the culture doesn't change.’ – GP Liaison Officer

‘Provide funding for innovative, cost effective, advanced scope Allied Health non-operative models of care to reduce long waits. This is already proving successful with the Musculoskeletal Pathway of Care implemented over the past 18 months which has reduced long waits - with only 18% converting to surgery.’ – Allied Health Professional

‘Most importantly, a substantive improvement needs to be rapidly implemented in the way we share clinical information in this digital healthcare age.’ - Allied Health Professional

‘There needs to be more guidance from Outpatient Standards to ensure Public patients are not being disadvantaged by the fact they do not have a named referral. We do not have enough information in the current OSIS covering private clinics or named referrals management.’ – Nurse Unit Manager

‘While a heavy emphasis on investment in hospital/HHS ‘activity’ is understandable, consideration should be given to investment outside these settings (such as in primary and community health) that may assist in removing barriers or blocks to delivering a timely and/or efficient patient journey.’ – Executive, Department of Health

‘Changing the models of care, i.e. involving GPs in the OPD clinics, pre assessment clinics, greater use of telehealth solutions and greater shared care, is integral to successfully reducing wait times.’ – General Practitioner