

Department of Health

**Wait Times Strategy Statewide
Consultation Handbook**

September 2015

Wait Times Strategy Statewide Consultation Handbook

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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 National Partnership Agreement on Improving Public Hospital Services recognised some of these challenges and focused attention on improving patient access to elective surgery and emergency departments through the introduction of targets, specifically the National Elective Surgery Targets (NEST) and the National Emergency Access Target (NEAT). Queensland made significant progress towards achieving these targets, and as a result has significantly reduced the proportion of patients who wait longer than clinically recommended for care and treatment in these settings.

The National Partnership Agreement enabled this progress by providing 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 of Health ('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 in Queensland. As at 1 January 2015, only 290 ready-for-surgery patients were waiting longer than clinically recommended on the elective surgery waiting list. In contrast, there were more than 100,000 people waiting longer than clinically recommended on the specialist outpatient waiting list as at 1 January 2015.

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. These principles and priority areas are outlined in the 'Wait Times Summit Summary' at Appendix 1. 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. The Department is undertaking further consultation in relation to the issues raised, and the Summit will re-convene following the conclusion of the consultation.

To deliver on this, the Department is organising a series of consultation workshops with Summit invitees, as well as the Clinical Senate, Statewide Clinical Networks, and staff from each HHS. The consultation workshops will provide 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. HHSs will determine who should attend the consultation workshops in their HHS, however an electronic survey will provide all interested stakeholders with the opportunity to provide input into the Strategy. Feedback from the consultation process will inform development of a Wait Times Strategy for discussion at the next Wait Times Summit meeting.

Consultation topics

Consultation to inform the development of a Wait Times Strategy for Queensland Health will be organised around five priority areas, consistent with the principles and priorities identified at the Wait Times Summit as outlined in Appendix 1. 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.

1. Priority area one: Process and practice standards

1.1 Wait times policy

At present, there is no overarching policy on timely access to Queensland Health services covering all elements of the patient journey. Such a policy could guide the Department, HHSs and other sector stakeholders in strategically prioritising efforts to improve access to publicly funded services.

- If a wait times policy was developed, which service types should be included?
- What principles should underpin a wait times policy? See Appendix 1 – ‘Wait Times Summit Summary’ – for examples of principles.
- If additional funding was made available, what services do you think are the highest priority for investment in a wait times improvement agenda? Why should your chosen service type be prioritised?

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

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

- Just Tier 2 specialist outpatient clinics?
- All Tier 2 non-admitted clinics (this includes medical consultation clinics, mental health clinics, procedural clinics, diagnostic services, allied health and/or clinical nurse specialist intervention clinics and home based services such as home dialysis – see Appendix 2 for the full list of Tier 2 non-admitted clinic types)?

- Just facility-based outpatient clinics e.g. all public medical consultation clinics, allied health and nursing clinics delivered in a health facility but not community mental health or home based services?
- All non-admitted activity (including all Tier 2 clinics plus community health)?
- Should non-admitted cancer services and mental health services have their own business rules/implementation standards?

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.

- 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)?
- What timeframes should patients be seen within for each urgency category?
- Should the number of days a patient has waited be calculated in business days (excluding weekends and gazetted public holidays) or via continuous count?

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).

- 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?
- 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?
- Are there any circumstances where a HHS should have the right to not accept a referral? If so, what safeguards should be put in place to ensure that patient safety and Ryan's Rule are not compromised?

1.6 Not ready for care

- 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.
- 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? Are they currently assigned NRFC at any stage in their journey? If so, under which NRFC category (e.g. personal/clinical)?
- 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)?
- Should there be a maximum number of times a patient can be made NRFC for personal, clinical or administrative reasons?

1.7 Failure to attend

- How many times must a patient fail to attend before they should be removed from the waiting list?
- Should the patient's nominated GP be notified each time the patient fails to attend/cancels an appointment, or only after the maximum number has been reached and they have been removed from the waiting list?
- Should patients be reinstated to the waiting list if they appeal following removal, even if the correct notification and clinical review processes were followed?
- Should there be a maximum time period after which the patient should not be reinstated, even if they appeal?
- 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?
- What should constitute 'failure to attend' or a patient-initiated cancellation in a partial booking system? Should the patient need to have confirmed that they have accepted the appointment before they should be made NRFC for either reason?

1.8 Cancellations

- How many times must a patient cancel their appointment before they should be removed from the waiting list?
- Should there be a maximum number of times that the hospital can cancel the patient's appointment? If so, what should happen if the maximum number of hospital-initiated cancellations is reached?

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.

- 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?
- What is the maximum time that a patient should have to notify the hospital where they are currently waitlisted that they have moved?
- Who should be responsible for organising the patient's transfer to a new list – the existing hospital or the new hospital?
- 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?
- How should transfers of long wait patients be managed to minimise any disadvantage to either the patient or the HHS that accepts them?

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.'

- 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?
- 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?

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.'

- Should this definition be included in the revised implementation standard?
- Considering the above definition, how does your service currently manage post-discharge reviews – as initial service events or reviews?
- How does your service co-ordinate/schedule/manage review appointments? How far in advance are they scheduled in the system? Do you keep a separate excel spreadsheet or database to track patients who require review appointments?

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.

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

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.'

- 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?
- What should be the maximum timeframe to review a referral?
- Is the requirement to register all referrals within two days of receipt appropriate?
- What business rules/processes does your facility implement for referrals that do not contain appropriate content (as specified in the Outpatient Services Implementation Standard)? Are they registered on the waitlist system, even if they are returned to the referring practitioner with a request for further information?

- 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?
- What should be the maximum timeframe to triage/categorise a referral?
- Should 'time waited' be counted from the date of triage, rather than the date that the referral was received?

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'.

- Should the Outpatient Services Implementation Standard include a similar requirement for outpatients?
- Are there any risks/issues that would need to be managed if this business rule was implemented?

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.

- 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'?

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

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

- Should Queensland Health consider procuring 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).
- Should Queensland Health consider procuring 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?
- 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?
- What else should be done to improve connectivity, communication and service integration between the Department, HHSs, referring practitioners and patients?

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:

- Should Queensland Health develop a policy framework to drive and systematise improvement in patient experience in Queensland Health?
- Should a suite of patient experience KPIs be developed and systematically analysed to inform improvement initiatives? If so, should these KPIs be included in the service agreements and the Queensland Health Performance Management Framework?

- Should Queensland Health procure technology to ensure that all HHSs have the capability to collect data on patient experience or should funding 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?
- Should training and development in patient experience be included in leadership development programs?

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:

- Should Queensland Health invest in innovative beacon practice models to assist GPs to practice to the top of their scope of practice? If so, how should this happen? For example, should 'Special Interest' GPs be 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?
- What should be done to improve public sector supply of specialist services?

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:

- 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? What would be required to support safe and sustainable implementation of this model?
- 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? What would be required to support safe and sustainable implementation of this model?

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:

- Are the interim elective surgery targets appropriate in the longer term? If no, what should the targets be?

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.

- Should outpatient performance targets initially focus on reducing the current number of long waits for specialist outpatient services? If so, over what timeframe should all HHSs have achieved a significant reduction in the number of long waits for specialist outpatient services?
- 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)?
- 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?
- What should be the performance target for HHSs once they have significantly reduced their backlog of long waits:

- 100% of patients ‘seen-in-time’ for each urgency category with no tolerance margin
 - 100% of patients ‘seen-in-time’ for each urgency category with performance management linked to a pre-determined tolerance margin
 - 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.
- What mechanisms should be put in place to ensure that HHSs do not achieve performance targets by restricting supply? For example, 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?

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:

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

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?

- 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)?
- Should the investment be targeted to provide additional activity for 'high demand specialties' with more than 50% long waits across all urgency categories?
- Should a proportion of the funding be withheld and used as 'reward funding' for those who achieve annual performance targets?
- 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.
- Should recurrent funding growth in future years be targeted at those specialties where additional activity is required to sustain improvement?

Appendix 1: Wait Times Summit Summary

1. Presentations

The Wait Times Summit included presentations by Philip Davies, Deputy Director-General, Health Commissioning Queensland, and Michael Zanco, Executive Director, Clinical Access and Redesign Unit. These presentations provided the context for the event and a background synopsis of current issues. Key issues highlighted by the presenters included:

- There are clear benefits in developing targets for improved performance, however, as with the Wait Time Guarantee, targets that are poorly defined or too onerous can lead to unintended consequences and create the risk of 'gaming'.
- A target should not just focus on one part of the patient journey such as elective surgery, but the whole patient journey, from GP referral, to an outpatient or diagnostic appointment, then on to surgery or other treatment and recovery, where appropriate.
- Targets also need to be comprehensive in scope since an undue focus on a particular patient cohort (e.g. those requiring elective surgery) may have adverse impacts on others (e.g. mental health and medical patients).
- There is no nationally defined prioritisation system for specialist outpatient services. Queensland has adopted the national prioritisation system used for elective surgery services and applied it to outpatient services. Under this system, patients are categorised as either Category 1, 2 or 3. Category 1 patients are clinically recommended to be seen within 30 days, Category 2 patients within 90 days, and Category 3 patients within 365 days.
- The overwhelming majority of patients who have not received a specialist outpatient appointment within the clinically recommended timeframe are Category 2 and 3 patients.
- Queensland is the only state which publicly reports on outpatient wait times.
- System challenges are broad and complex but include:
 - Supply-induced demand
 - Poor communication and connectivity with referring practitioners
 - Unclear and setting-specific funding signals (activity based funding vs. population-based funding vs. bulk billing)
 - Specialist workforce distribution
 - Low levels of public sector participation in some specialties
 - Impacts of sub-specialisation on access
 - Public sector training obligations
 - Competing health service priorities (NEAT vs. NEST vs. outpatient wait time performance) with known inter-dependencies and impacts on workforce, budget integrity and bed capacity.

2. Principles to guide future work

As the Summit progressed, participants identified that a future work program should encompass, as a minimum:

- A patient-focused approach
- Care and treatment occurring at the most appropriate time in the most appropriate setting
- Improved business intelligence about service demand, service supply, patient flow and individual patient journeys (including patient experience)
- A long-term commitment to an improvement agenda
- An understanding that patients often require non-sequential, episodic care by multiple providers and do not all follow sequential, linear pathways
- Clear communication pathways between the Department, HHSs, GPs and patients themselves.

Discussion of the above at the Summit led to the development of the following draft policy objective to guide future work on wait times:

‘People in Queensland will be treated by the appropriate clinical professional in the appropriate setting and in the appropriate time (as defined by the clinician and patient). Policy success would be achieved if patients do not experience any deterioration in health whilst waiting.’

The Summit then established that, in order to achieve that policy objective, the following principles should be adhered to:

- The approach to wait times will be patient-driven with the patient having access to valid and transparent data and being empowered to make informed choices about their pathway of care.
- Strategies and targets to reduce wait times across emergency department, outpatient and elective surgery services will consider inter-dependencies between the service settings, as well as the potential to create perverse incentives and/or generate unintended consequences.
- Performance targets will be developed that work to avoid both inappropriate wait times and preventable adverse outcomes.
- The system will prioritise those patients with the greatest need (taking account of both clinical and other relevant factors) and will ensure they are seen in the appropriate setting by the appropriate clinician.
- Queensland will have transparent, auditable waiting list and activity data for all services which publicly report on performance (emergency department, outpatient, elective surgery, oral health, hospital activity, breast screening, and immunisation services).
- Approaches to managing wait times will recognise and reflect the fact that GPs are best placed to fully understand the needs of their patients, can make reliable referral decisions using agreed criteria, and can manage the ongoing care of their patients once specialist assessment and/or treatment has concluded.

3. Priority areas for future work

Following a wide-ranging discussion, the Summit identified a number of areas where work is needed to inform and develop a sustainable response to wait times in line with the agreed principles. These areas of work have been grouped into five different priority areas.

Priority area one: Process and practice standards

- Develop statewide policy and practice standards, to ensure that care is delivered across the patient journey in line with minimum safety, quality and access service standards.
- Develop and implement statewide Clinical Prioritisation Criteria to ensure consistent and appropriate access to specialist services.
- Enhance existing data collections to ensure they provide comprehensive, valid and timely information on service demand (referral rates and waiting lists) and service supply (activity and capacity).

Priority area two: Communication between GPs, HHSs and patients

- Implement systems and processes to ensure that the necessary data are available to patients and GPs to enable them to make informed referral decisions (including a directory of public specialist services in each HHS) and to understand each patient's progress in the queue.
- Improve interfaces between GP and specialist care to diffuse the skills and knowledge needed to ensure patients are seen in the right setting at the right time by the right clinician. This includes developing capacity at the GP level and having opportunities for real time exchanges between specialist and GP providers on care plans and management strategies.

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

- Support the establishment and sustained implementation of models of care that allow medical and non-medical clinicians to work at the top of their scope of practice, in order to bring additional capacity to the system and improve patient experience.

Priority area four: Performance frameworks and targets

- Develop performance frameworks for each part of the patient journey to enable the Department to benchmark and monitor compliance with safety, quality and access service standards.
- Establish short- and medium-term performance targets to deliver measureable and sustainable improvements in wait time performance metrics.
- Undertake statewide analysis, building on detailed work at HHS level, to understand current system productivity and potential capacity.

Priority area five: Investment priorities

- Ensure that investment decisions are guided by evidence and support care coordination between and across, service providers and service settings, with due consideration of statewide access to services.
- Ensure that investment decisions take account of the system's potential capacity and productivity at both whole-of-state and HHS levels.

Appendix 2: Tier 2 non-admitted services

Procedure clinics

- Hyperbaric Medicine
- Interventional Imaging
- Minor Surgical
- Dental
- Angioplasty/Angiography
- Endoscopy – Gastrointestinal
- Endoscopy – Urological/Gynaecological
- Endoscopy – Orthopaedic
- Endoscopy – Respiratory/ENT
- Renal Dialysis – Hospital Delivered
- Medical Oncology (Treatment)
- Radiation Oncology (Treatment)
- Minor Medical Procedures
- Pain Management Interventions
- Renal Dialysis – Haemodialysis – Home Delivered
- Renal Dialysis – Peritoneal Dialysis – Home Delivered
- Total Parenteral Nutrition – Home Delivered
- Enteral Nutrition – Home Delivered

Medical consultation clinics

- Transplants
- Anaesthetics
- Pain Management
- Developmental Disabilities
- General Medicine
- General Practice and Primary Care
- General Surgery
- Genetics
- Geriatric Medicine
- Haematology
- Paediatric Medicine

- Paediatric Surgery
- Palliative Care
- Epilepsy
- Neurology
- Neurosurgery
- Ophthalmology
- Ear, Nose and Throat (ENT)
- Respiratory
- Respiratory – Cystic Fibrosis
- Anti-coagulant Screening and Management
- Cardiology
- Cardiothoracic
- Vascular Surgery
- Gastroenterology
- Hepatobiliary
- Craniofacial
- Metabolic Bone
- Orthopaedics
- Rheumatology
- Spinal
- Breast
- Dermatology
- Endocrinology
- Nephrology
- Urology
- Assisted Reproductive Technology
- Gynaecology
- Gynaecology Oncology
- Obstetrics
- Immunology
- Medical Oncology (Consultation)
- Radiation Oncology (Consultation)
- Infectious Diseases
- Psychiatry
- Plastic and Reconstructive Surgery

- Rehabilitation
- Multidisciplinary Burns Clinic
- Geriatric Evaluation and Management (GEM)
- Psychogeriatric
- Sleep Disorders

Stand-alone diagnostic clinics

- General Imaging
- Medical Resonance Imaging (MRI)
- Computerised Tomography (CT)
- Nuclear Medicine
- Pathology (Microbiology, Haematology, Biochemistry)
- Positron Emission Tomography (PET)
- Mammography Screening
- Clinical Measurement

Allied health and/or clinical nurse specialist interventions clinics

- Aboriginal and Torres Strait Islander Health Clinic
- Aged Care Assessment
- Aids and Appliances
- Clinical Pharmacy
- Hydrotherapy
- Occupational Therapy
- Pre-Admission and Pre-Anaesthesia
- Primary Health Care
- Physiotherapy
- Sexual Health
- Social Work
- Rehabilitation
- Wound Management
- Neuropsychology
- Optometry
- Orthoptics
- Audiology

- Speech Pathology
- Cardiac Rehabilitation
- Stomal Therapy
- Nutrition/Dietetics
- Orthotics
- Podiatry
- Family Planning
- Midwifery and Maternity
- Psychology
- Alcohol and Other Drugs
- Burns
- Continence
- General Counselling
- Specialist Mental Health
- Palliative Care
- Geriatric Evaluation and Management (GEM)
- Psychogeriatric
- Infectious Diseases
- Neurology
- Respiratory
- Gastroenterology
- Circulatory
- Hepatobiliary
- Orthopaedics
- Dermatology
- Endocrinology
- Nephrology
- Haematology and Immunology
- Gynaecology
- Urology
- Breast
- Oncology
- General Medicine
- General Surgery
- Paediatrics

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- Falls Prevention
 - Cognition and Memory
 - Hospital Avoidance Programs
 - Post-Acute Care