

Dental Health Program

Waiting Times Project Report

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Background

Statewide general and denture care average waiting times have been a key performance measure in the Dental Program. While this measure has been used to show progress it does not represent the variation of waiting times across the state.

Statewide waiting times have gone down since the injection of \$97.2 million in 2004-05. However, denture care waiting times are falling faster than general care and variation between agencies remains.

At March 2006 while the statewide average waiting time for general care was 26 months, the waiting times at individual clinics varied significantly:

- The longest general care waiting time was 68 months at Portland and District Hospital.
- The shortest wait of less than 1 month was at the Royal Dental Hospital of Melbourne, Omeo District Hospital Dental Clinic, East Wimmera Health Service (St Arnaud) and Mallee Track Health Service.
- One third of clinics had waiting times that were ten or more months above the state average.
- Almost ten per cent of clinics had waiting times that were more than double the state average.
- Around a quarter had waiting times less than half the state average.

Waiting Times Project

The waiting times project examined the drivers of waiting times in the public dental system and identified possible solutions to reduce and smooth waiting times at a local and statewide level.

While the project has looked specifically at waiting times, there are broader demand management issues within the public dental system. People who are seen from waiting lists account for around half of people receiving care. Children, youth, special needs, emergency and priority care clients are among the clients seen outside of waiting lists. This work looks at the demand of a specific group in the eligible population.

Existing data on waiting times, people seen, workforce numbers and demand was examined to identify possible drivers and links to long waiting times. To supplement the data analysis, two regions were selected for intensive consultation. All agencies in these regions were consulted about waiting times drivers and ways to address long waiting times.

Local and international approaches to waiting times management in a variety of health care settings were also examined to assess further options for the public dental system in Victoria.

The findings of this research, and recommendations are presented in this report.

Agency Consultations

Staff from agencies in the Southern Metropolitan and Gippsland regions were consulted to discuss waiting times drivers, issues relating to waiting lists and possible solutions to reducing waiting times. The staff consulted ranged from dental program managers, senior dentists, primary and/or community health managers and receptionists.

The Southern Metropolitan and Gippsland regions were chosen for the consultation to gain a metropolitan and rural perspective and for their differences in levels of variation and waiting times performance. Southern Metropolitan region is a relatively well performing region with only minor variation in waiting times from agency to agency while Gippsland region has a large variation in waiting times and significantly long waiting times at some clinics.

The agencies each identified different drivers ranging from client demographics, workforce levels and ability to meet demand. However, it was clear that most agencies had only thought of waiting times drivers at a superficial level without any action to address issues related to drivers. Most agencies were focussed on seeing the largest number of people as quickly as possible. However, agencies with workforce shortages as the main driver for waiting times were very much focussed on recruitment and retention.

The consultations identified a significant level of variance in the management of waiting lists and times, however all agencies reported that they follow program guidelines around waiting list management and triaging of patients. Some of the key findings relating to waiting list management include:

- Agencies differed in their approach to waiting list management and the importance they placed on it.
- Those agencies who were managed by a community and/or primary health manager tended to be more strategic in the approach to waiting list management and involved senior staff in both operational and strategic waiting list management.
- Some agencies prioritised certain groups or categories of patients outside of guidelines to meet local needs. This sometimes affected their ability to get through the waiting list.
- Agencies vary in their approach to scheduling appointments. Some focussed on finishing existing courses of care before taking new clients off the list, while others took new people off the list every day. Processes for filling broken or cancelled appointments also differed, and those who tended to experience more broken or cancelled appointments took more innovative approaches to the issue to maximise the use of clinicians time.

The consultations highlighted that there is opportunity to improve waiting times management across the system. All agencies work independently of each other in their waiting list management, and those that tended to share approaches only did so when they operated in the same community health service. Approaches to waiting list management depended on local interest, knowledge and need.

Because of this approach to waiting list management, most agencies had not thought of broad ways to address waiting times at a regional or statewide level. Some agencies were acutely aware of key local issues, such as their own workforce shortages, that could improve the situation if addressed. Most agencies also had a good understanding of how additional funding could impact their waiting times. Some agencies felt that nothing further could be done to improve waiting times in their clinic.

Regional Profile – Southern Metropolitan Region

- Eligible population per chair: 6,534

Agency	General Care Wait Time (Jul 06)	Denture Care Waiting Time (Jul 06)	EFT (Vacancy Rate) 05/06	Chairs (at Dec 05)	Emergency vs General Care (05/06)	No. Individuals Treated (internal) (05/06)
Bentleigh Bayside Community Health Service	15.31	43.56	4.56 (0%)	5 (plus 2 SDS)	44:56	4,640
Cardinia/Casey Community Health Service – Berwick Site						
Cardinia/Casey Community Health Service - Cranbourne Site	32.66	25.17	5.44 (9%)	6 (plus 4 SDS)	54:46	5,899
Greater Dandenong Community Health Service – Kingston Dental Clinic				1		
Greater Dandenong Community Health Service – Dandenong Dental Clinic				4		
Greater Dandenong Community Health Service - Springvale Dental Clinic	15.74	41.49	9.25 (0%)	3 (plus 2 SDS)	57:43	10,442
Central Bayside Community Health Services	17.71	28.02	3.24 (19%)	4 (plus 4 SDS)	46:54	3,398
Inner South Community Health Service	13.93	35.65	4.50 (0%)	4	40:60	4,203
Peninsula Community Health Service	37.22	13.9	2.67 (11%)	3	49:51	2,332
Peninsula Health - Frankston Dental Clinic	32.82	33.58	4.73 (0%)	5 (plus 4 SDS)	59:41	4,718
Southern Total/Average	27.31	27.94	34.41 (5%)	35 (plus 16 SDS)	52:48	35,632

Regional Profile – Gippsland region

- Eligible population per chair: 4,195

Agency	General Care Wait Time (Jul 06)	Denture Care Waiting Time (Jul 06)	EFT (Vacancy Rate) 05/06	Chairs (at Dec 05)	Emergency vs General Care (05/06)	No. Individuals Treated (internal) (05/06)
Bairnsdale Regional Health Service	32.62	18.83	2.31 (23%)	3 (plus 1 SDS)	49:51	1,749
Latrobe Community Health Service (Churchill)						
Latrobe Community Health Service (Moe)	65.77	39.56	2.73 (45%)	5 (plus 2 SDS)	57:43	3,139
Omeo District Health	0	0	0.21 (0%)	1	0	166
Orbost Regional Health – Community Health Centre	46.92	6.6	0.30 (40%)	1	46:54	403
Central Gippsland Health Service	60.94	30.49	1.2 (40%)	2	67:33	1,291
Bass Coast Regional Health	24.97	34.4	1.85 (8%)	2 (plus 2 SDS)	52:48	2,021
Gippsland Total/Average	38.54	21.65	8.59 (32%)	14 (plus 5 SDS)	55:45	8,769

Waiting Times Drivers

The agency consultations identified a range of waiting times drivers however, most drivers could only be addressed in the long term or were significant problems that would require a substantial coordinated effort to address. The consultation did not identify consistent drivers that could readily be addressed on a statewide or regional level.

Most agencies were aware of their client demographics and had adapted their service delivery to best meet this driver. An example is Bentleigh Bayside Community Health where a prosthetist has been employed to provide in-house denture care as the majority of clients are over the age of 65. Drivers such as these appear best responded to at a local level.

In the Southern Metropolitan region, the need for additional infrastructure was cited as a driver for waiting times. Southern Health agencies (clinics at Berwick, Cranbourne, Dandenong, Springvale and Kingston) in particular, noted that the demand in the area is growing at a rate that the current infrastructure cannot support. Waiting times have remained relatively stable for 15 years while chairs have expanded rapidly to meet demand.

In the Gippsland region, workforce was the main driver for waiting times at all clinics. Fully staffed agencies also identified workforce shortages as a significant driver, as they are concerned about how to find a replacement clinician if a staff member was to leave their organisation or be absent for an extended period of time. Private sector shortages in this region compound public sector shortages, as there is no capacity to supplement in-house care through private sector voucher schemes.

Agencies who maintained consistent waiting times also tended to place a high priority on managing the waiting list and appointment schedules. These agencies focused on filling cancelled appointments, seeing new clients each day and ensuring courses of care were completed as quickly as possible. However, these agencies tended to be larger and have more administrative support, which allowed more time to be spent on management of waiting lists and schedules.

Local Solutions

In the short term, agencies with local support from the private sector felt that more funding could help reduce waiting times through the provision of vouchers. In the longer term, additional infrastructure would reduce waiting times in areas where workforce shortages are not a significant issue, allowing additional services to be provided in-house.

Several agencies saw the potential for regional or local area partnerships to reduce waiting times at those clinics with longer waiting times. In the Southern Metropolitan region, Central Bayside Community Health which has waiting times below that state average expressed interest in seeing patients from other clinics at a designated time such as a Saturday clinic. In the Gippsland region, Bairnsdale Regional Health expressed interest in recruiting a pool of dentists who would travel to other clinics in a region or area and subcontract these staff on a needs basis. The current structures, particularly funding arrangements, do not support such initiatives.

Four Gippsland agencies were involved in a group consultation that inadvertently allowed agencies to share ideas and knowledge about waiting list management. The agencies agreed that while they differed in their approaches and level of knowledge, all felt that the meeting allowed them to understand different approaches and share ideas.

Statewide Solutions

Most agencies focused their ideas on solutions at a local level, by agency, network or region. Some of the ideas raised by agencies include:

- Better use of and stronger relationships with private sector.
- Systems to ensure clients are only on one waiting list and not being seen at one or more clinics. eg: central waiting lists, catchment areas.
- Sterilisation nurse for all medium to large clinics to increase productivity.

- Central recruitment and employment of clinicians, perhaps through large hub and spoke type partnerships.

Agencies also proposed general ideas for reducing demand across the public dental system, mostly in the long term, including:

- Better information provided to clients about managing their own oral health when they join the waiting list, and or health promotion initiatives to support those already on waiting lists.
- Extension of fluoridation.
- Focusing on prevention through integrated health promotion and targeting effort to children.

Many of the statewide solutions identified by agencies could be managed at a local level through an agency or regional lead, but a larger statewide approach could be adopted. In order for these mostly long-term solutions to progress, both policy and funding support would be needed.

Data and Further Research

This project has focussed mainly on qualitative research through consultation, as well as research about approaches to waiting times management in other jurisdictions and areas of health. Only basic data was used to identify where waiting times are the longest and shortest, and where waiting times do not reflect actual demand and/or workforce supply.

Existing Data

The Department holds dental data, in report format, on waiting times, workforce EFT, service mix and service throughput at an agency and statewide level. The data has been used in this project to give a general picture of waiting times across the state and some indicators for demand at agency level.

In preparation for the project, data was collated to show the number of people waiting and the waiting time in months for general care at each agency from July 2002 to June 2006. This data gave a general picture of which clinics could not meet demand. However it is important to note that the data did not show a consistent relationship between large numbers of people waiting and long waiting times or small numbers of people waiting and short waiting times.

The data was used to identify two regions to be consulted, the first with stable and relatively low waiting times and the second with larger variation and longer waiting times. Basic data was then collated to profile agencies in these regions, including waiting times, workforce EFT, number of chairs, number of people seen and the rates of emergency compared to general care. This data was supplemented by consultation, which gave further detail on the supply and demand patterns in the area, in addition to how waiting lists are managed at that clinic.

Neither the data analysis or consultation with agencies identified a general trend or consistent explanation for long waiting times. However, a link between workforce shortages and waiting times was relatively clear.

Data issues

Using Dental Program data to look at waiting times and demand is problematic for several reasons not limited to but including that:

- Statewide waiting times are presented as an average without taking into consideration the relative size of a clinic or the number of patients seen at that clinic.
- Waiting times are counted differently in the dental program to many other areas of health. The waiting time for a clinic is taken as the time the person at the top of the list has waited to receive an offer of care.
- The number of people waiting means something different at each clinic, as the take up rates for care and the proportion of priority clients compared to general care clients varies between clinics.
- The types of patients waiting also vary, for example due to the complexity of care levels, numbers of special needs clients and the mix of denture and general care.

Further Use of Existing Data

For the purposes of this project, the data was consulted to identify general trends. There is opportunity to look closer at the relationship between demand for services, the types of clients presenting and the waiting times at each clinic. In particular, the correlation between workforce and waiting times, and demand and waiting times could be examined further.

Other Approaches

Waiting time management is a topical area, and many jurisdictions are looking at ways to better monitor and manage waiting times in various areas of health care. Three examples of work that are relevant to the Victorian public dental program are presented below:

National Health Service Cancer Plan, UK

In September 2000, the NHS Cancer Plan was launched with “the drive to end waiting” central to the plan. While the need for timely diagnosis, referral and care is more crucial to cancer treatment than dental care, the plan has trialled and evaluated some interesting approaches that have the potential for use in the public dental system including:

- National and local level targets for waiting times, including interim targets as part of a medium term plan.
- A national cancer waits project established to monitor progress and ensure that cancer plan promises are met. The project has been given a high profile to ensure high-level ownership through for example, conferences/workshops attended by the Minister.
- A cancer waiting times implementation group established to set up effective monitoring systems including data systems and analysis.
- Guidelines for implementing and monitoring waiting times initiatives distributed to the sector, assisting trusts (agencies) to meet national and local Cancer Plan targets. (See examples at Appendix).
- Best practice and change management guides distributed to the sector to provide guidance on the organisational changes required to achieve the targets. (See examples at www.cancerimprovement.nhs.uk and www.doh.gov.uk/cancer).
- Demonstrators established at regional level to learn and share best practice approaches, plus an Intensive Support Team was formed to reduce the “performance gap” between trusts and assist those with a large number of “breaches” ie: a number of patient waiting times falling outside of targets.
- Categorising trusts in three categories based on progress and providing support to those not yet at the desired top level:
 1. Trusts that demonstrate a month-on-month achievement of targets. These trusts have short intervals between the key milestones (ie: diagnosis, referral and treatment) and clear, effective patient pathways.
 2. Trusts which have achieved targets, but in an inefficient and unsustainable way eg: decisions about care are made close to target date, extra operating lists at short notice to meet need, variance in performance etc.
 3. Trusts which are struggling to achieve targets.

The approach is now also being used in elective surgery and emergency waiting times. After six years, key factors to success in the cancer plan, and in shared knowledge of other waiting time plans, were determined as:

- Raising the profile of the work early.
- Engaging senior clinicians and managers so they will champion benefits.
- Establishing managerial leaders for all trusts and a clinical lead for the first 18 weeks.
- Determining a clear baseline for performance.
- Establishing an ongoing monitoring approach as soon as possible.
- Providing support for service improvement initiatives.
- Providing support to pioneer sites and assist them to share knowledge
- Providing intensive support teams.
- Ensuring synergy between service improvement and performance management.

Canadian Waiting Times Projects

Canadian experts, program managers and clinicians have been drawn together at three "Taming of the Queue" conferences, which have provided an opportunity to share the outcomes of waiting times projects and debate next steps for Canada. Some of the key directions and issues from each of the conferences are presented below.

The first conference was held in 2004 and identified the need for a more organised approach to waiting lists, performance indicators and better data collection. Many Canadian projects were in their infancy, and were developing tools to prioritise patients requiring care in particular areas of the health system. Presenters agreed that the next steps to support waiting time management included:

- Data consistency.
- Standardised systems and codes.
- Urgency ratings and thresholds.
- Balancing demand with clinical appropriateness of care.
- Adequate financial resources.
- Ongoing political support.
- Engaging clinicians.
- Helping patients understand waiting times and lists.
- Developing networks or communities of interest.
- Ensuring the system is patient centred.

At the second conference in 2005, progress and support for waiting times management was clear with each Province presenting their current status in regard to waiting times. The conference highlighted that waiting list issues cannot be tackled in isolation and need to include support for human resources, information technology and primary care reform issues. By 2005, five priority areas had been established – cardiac surgery, cancer, diagnostic imaging, joint replacement and sight restoration. Following on from progress since the first conference, the future agenda included:

- Patient focussed research:
 - Choice vs shortest wait.
 - Expectations.
- Waitlist management research:
 - Refining tools.
 - Coordination of services.
 - Impact on patients for different approaches.
- HR research:
 - Integration/coordination of HR.
 - Modelling impact of changed staff roles or increased numbers of staff.
 - Projecting future HR needs.
- Governance and accountability.
- Fixing the whole system ie: waiting times are a symptom of other system issues.
- Possible rationing.

The final conference to date was held in 2006 and looked at future directions for waiting times management following recent significant changes. In 2005 a Supreme Court decision ruled that timely access to health care is a legitimate expectation of Canadians. Soon after a Federal Adviser on wait times was appointed and a Waiting Times Alliance was established to provide a national response to waiting times. The Alliance has developed the "4M tool box" as a framework for waiting times improvement, which includes mitigating, measuring, managing and monitoring benchmarks.

This conference identified factors for success learned from several years of effort to manage waiting times including:

- Infrastructure that supports change.
- Commitment from clinicians and managers.
- Leadership.
- Change management.
- Inter-jurisdictional learning and cooperation.
- Partnerships and inclusion.

The final conference identified the next challenges for Canada, many of which are relevant to Victoria's public dental system, including:

- Managing "care guarantees" or committed benchmarks.
- Sustainable funding.
- Demand management.
- Appropriateness of care.
- Expanding scope beyond the 5 current priority areas.
- Data and research issues (eg: comparability of data, connecting research to action, outcomes and measures).
- Communication and public education.
- Management strategies.
- HR planning.

Elective Surgery - Victoria

The *Elective Surgery Access Policy* was launched in June 2005 to assist Victorian hospitals to manage elective surgery patients and treatment times in a consistent and equitable manner. The policy outlines the three priority categories of patients according to clinical need – urgent, semi-urgent and non-urgent, and how patients in each category are managed.

Only patients deemed 'ready for care' are included on waiting lists, yet all patients requiring elective surgery are actively managed to ensure they are in the right category for their readiness and clinical need. Patients can only be reassessed by a clinician, but other methods such as health surveys are used to screen and identify patients who may require further follow up. Health services are expected to implement active management strategies to reduce the number of long waiting patients.

The department collects data on all elective surgery waiting lists, and provides health services with status reports that identify long waiting patients and highlight anomalies in offers of care. Health services unable to provide elective surgery within recommended time frames are required to investigate whether other opportunities for more timely treatment at other hospitals exists.

The department also supports elective surgery access coordinators and managers, by hosting a bi-monthly Managing Elective Surgery Special Interest Group that assist coordinators and managers to develop strategies to manage long-waiting elective surgery patients.

Recommendations

The department is considering a series of recommendations. They include interim projects and long-term initiatives to support better waiting times management, accountability and monitoring measures.