PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

2009-10 AND 2010-11 FINANCIAL AND PERFORMANCE OUTCOMES QUESTIONNAIRE — PART TWO

DEPARTMENT OF HEALTH

Question 1

Department of Health response

For the following performance measures in the Ambulance Emergency Services output, there were no explanations given for the variance between the actual result and the target for 2009-10 (*Annual Report 2009-10*, p.156):

- Portion of emergency (Code 1) incidents responded to within 15 minutes – statewide
- Portion of emergency (Code 1) incidents responded to within 15 minutes in centres with more than 7,500 population

(a) What were the reasons for which the targets were not achieved in 2009-10?

The Auditor General reported in 2010 that: "Ambulance Victoria (AV) has achieved much since amalgamation, including improvements to call taking and dispatch for the whole state, and strategic planning for rural regions. However, some expected efficiencies have not been realised and the trend of deteriorating ambulance response times evident prior to amalgamation has not been arrested. Ambulances are taking longer to respond to Code 1 emergencies, with the lowest performance since 2004–05 recorded in 2009–10. Response times have worsened more in rural regions than in the metropolitan area and are worst in population centres less than 7 500" (Access to Ambulance Services).

There are complex inter-related factors contributing to the decline in response times, including increasing demand and increasing case time. There was a 4% increase in cases from 2008-09 to 2009-10

(b) What were the implications on health outcomes?

Determining the impact of ambulance response times on the health outcomes of patients is difficult in the absence of a unique patient identifier and causative analysis.

In 2009-10 Ambulance Victoria achieved and exceeded all quality and safety targets: cases meeting clinical practice standards, pain reduction in patients experiencing severe cardiac and traumatic pain, patient satisfaction with quality of care provided, cardiac arrest patients with vital signs to hospital and surviving to hospital discharge.

In 2009-10 Victoria had the highest cardiac arrest survived event rate in Australia (Report on Government Services 2011).

(c) What action is planned to improve performance in these areas?

There are a range of strategies in place to address ambulance response time performance:

- The $151 million investment to recruit an additional 310 paramedics and 30 patient transport officers across Victoria.
- Transferring state-wide ambulance call taking and dispatch to the Emergency Services Telecommunications Authority to optimise use of ambulance resources. The transition for emergency ambulance services was completed on 16 August 2011.
- Ambulance Victoria is reviewing their rostering arrangements to better align services to peak demand times.
- On 30 June 2011 a new Health Services Performance website was launched, which for the first time reports data on the transfer of ambulance patients to emergency departments. The website will increase transparency, accountability and integrity.
- The Baillieu government announced a new board for Ambulance Victoria in August 2011. The board is charged with the task of improving Ambulance Victoria's performance across the state.

Question 2

Department of Health response

For the output performance measure 'Emergency patients transferred to ward within eight hours', the annual report for 2010-11 reveals that 71 per cent of emergency patients were transferred within this timeframe in 2010-11 compared to the target of 80 per cent.[1] The budget papers for 2011-12 state that the expected outcome for 2010-11 of 67 per cent reflects health services experiencing higher acuity presentations.[2] The annual report for 2010-11 indicates that the number of patients admitted to a hospital bed within eight hours increased by 9 per cent compared to 2009-10.[3]

(a) How many emergency patients were not transferred to a ward within eight hours in 2010-11?

105,718

(b) Please provide a break-down of this measure by health service.

Hospital	Number of patients transferred from the emergency department to hospital beds	Number of patients transferred from the emergency department to hospital beds within eight hours	Number of patients transferred from the emergency department to hospital beds, not within 8 hours
Albury Hospital	5,197	3,145	2,052
Alfred Hospital	24,151	18,677	5,474
Angliss Hospital	6,390	5,385	1,005
Austin Hospital	20,728	13,047	7,681
Bairnsdale Hospital	2,697	2,491	206
Ballarat Base Hospital	7,676	5,724	1,952
Bendigo Hospital	10,056	7,247	2,809
Box Hill Hospital	18,552	13,776	4,776
Casey Hospital	6,890	5,119	1,771
Dandenong Hospital	18,366	11,631	6,735
Echuca Hospital	2,162	1,897	265
Frankston Hospital	23,099	11,799	11,300
Geelong Hospital (Barwon Health)	18,015	12,939	5,076
Hamilton Hospital	1,763	1,712	51

1 Department of Health, *Annual Report 2010-11*, October 2011, pp.186 and 188

2 Budget Paper No.3, *2011-12 Service Delivery*, May 2011, p.193

3 Department of Health, *Annual Report 2010-11*, October 2011, p.188

Latrobe Regional Hospital	6,112	4,195	1,917
Maroondah Hospital	12,920	10,075	2,845
Mercy Hospital for Women	2,882	2,362	520
Mercy Werribee Hospital	4,058	2,892	1,166
Mildura Base Hospital	5,570	4,919	651
Monash Medical Centre (Clayton)	28,402	19,060	9,342
Northern Hospital	18,322	10,839	7,483
Royal Children's Hospital	11,024	8,320	2,704
Royal Melbourne Hospital	20,716	13,973	6,743
Rosebud Hospital	1,434	1,234	200
Royal Women's Hospital	7,578	7,433	145
Royal Victorian Eye & Ear Hospital	1,182	1,139	43
Sale Hospital (Central Gippsland Health Service)	2,368	1,964	404
Sandringham Hospital	3,783	3,079	704
Shepparton Hospital (Goulburn Valley Health)	8,017	6,484	1,533
St Vincent's Hospital	13,050	8,968	4,082
Sunshine Hospital	12,090	8,060	4,030
Swan Hill Hospital	2,360	2,171	189
Wangaratta Hospital	3,689	2,760	929
Warrnambool Hospital (South West Healthcare)	7,152	5,792	1,360
West Gippsland Healthcare Group	3,121	2,166	955
Western Hospital	15,052	9,597	5,455
Williamstown Hospital	6	5	1
Wimmera Health Care Group (Horsham)	3,016	2,868	148
Wodonga Hospital	2,668	1,652	1,016
Statewide	**362,314**	**256,596**	105,718

(c) Please provide information to support the contention that '*health services experienced higher acuity presentations in 2010-11*' and information that demonstrates the impact of this on increasing the length of stays in emergency.

Patients presenting to an Emergency Department are triaged by a clinician according to their urgency. There are five triage categories (1) Resuscitation, (2) Emergency, (3) Urgent, (4) Semi-Urgent, and (5) Non-Urgent. In 2010-11, there were over 45,000 more patients in triage categories 1-3 presenting to Emergency Departments, an increase of 8 per cent compared with 2009-10. Categories 1 to 3 are often described as urgent and often present with more acute conditions.

Patient acuity is a function of factors such as age, disease condition, co-morbidity, procedures required, and processes involved in delivering care and are important determinants of ED length of stay. The time and resource intensiveness of treating higher acuity conditions is a key factor impacting on longer lengths of stay in emergency departments.

(d) What factors contributed to the 9 per cent increase in the number of patients admitted to a hospital bed within eight hours during 2010-11 compared to 2009-10?

The increase in the number of patients admitted to hospital within eight hours during 2010-11 is largely due to population growth and demographic change (specifically ageing of the population). There was no real change in the propensity to admit patients from ED among those triaged as urgent presentations.

(e) For those emergency patients not transferred to a ward within eight hours, what was the impact on health outcomes?

Patients waiting to be transferred to a ward receive high quality care within the ED. On occasion these patients stay in the ED in order to continue diagnosis of their clinical condition and acuity.

Question 3

Department of Health response

In relation to emergency mental health patients, 70 per cent were admitted to a mental health bed within 8 hours in 2010-11 (73 per cent in 2009-10) compared to the target of 80 per cent.[4] The Department indicated that this was due to high demand and significantly lower access rates to mental health beds in three specific metropolitan health services.[5]

(a) What were the three metropolitan health services that had the lowest access rates?

1. Melbourne Health mental health response to Western Health ED at Sunshine
2. Werribee Mercy Health
3. Melbourne Health mental health response to Northern Health

(b) What were the implications on health outcomes, particularly in the three metropolitan health services with the lowest access rates?

Patients waiting to be transferred to a ward receive high quality care from the ED. Psychiatric assessment

[4] Department of Health, *Annual Report 2010-11*, October 2011, p.191

[5] Department of Health, *Annual Report 2010-11*, October 2011, p.192

and treatment planning can be undertaken during this time and some treatments can also commence for example in the form of administration of medication.

(c) What action is planned to improve performance in these areas?

Significant action has occurred in relation to the three metropolitan health services:

A total of 60 additional beds were opened in 2010-11. An additional 28 Adult Beds, 2 Aged and 30 new Prevention And Recovery (subacute) beds. Access to beds is affected by a number of factors including availability of alternative community based responses. The Government has committed to funding 44 additional clinical positions in mental health clinical community settings in metropolitan growth areas to directly support people in staying at home and not needing admission. There has also been additional funding announced for the specialist non-clinical sector to better respond to people's recovery needs in the community by building alternative and better home-based responses.

Question 4

Department of Health response

One of the achievements for 2009-10 as outlined by the Department relates to '*improving patient safety and quality of care across six major health services and agencies through the implementation of the Victorian Health Incident Management System*' (*Annual Report2009-10*, p.8).

Please quantify the impact that implementing the Victorian Health Incident Management System (as distinct from other factors) has had on improving patient safety and the quality of care across major health services and agencies during 2009-10 and 2010-11.

The statewide roll out of the Victorian health incident management system (VHIMS) was completed in February 2011. There are 42 instances (health service incident management systems) utilising the VHIMS data set specification across 135 health services and agencies. These health services (and agencies) are now transmitting de-identified clinical incident data to the department for collation into statewide aggregate reports. The first round of health service reports were disseminated to health services in December 2011. These reports, apart from summarising the incidents unique to the reporting health service, will provide them with an overview of the incident type, incident severity and classification of clinical incidents across the state. Health services will then be able to compare their incident profile to the state profile.

The statewide roll out has been supported by the provision of three e-learning modules accessed via the department's clinical risk management website http://www.health.vic.gov.au/clinrisk/vhims/

The first of these is a best practice model of the incident management process from identification through to feedback to staff on the lessons learned from incident review. The second outlines the open disclosure process and how open disclosure fits within the incident management process. The third module, in-depth case review is designed to provide users with a comprehensive methodology for the review of clinical incidents in order to identify system gaps and opportunities for improvement.

The *Victorian health incident management policy* and policy guide released in June 2011 also provides guidance and clarification on roles and responsibilities of staff, health services and the department in relation to incident management. http://www.health.vic.gov.au/clinrisk/vhims/.

The policy and education resources provide a framework for health services to identify and manage patient safety incidents. In the past the department has provided a framework for a small cohort of clinical incidents only through the sentinel event program and serious transfusion (blood) incidents only.

One of the themes from health service feedback has been the increase in transparency of incidents, and the management of incidents at the health service level. The workflows and alert mechanisms included in VHIMS have helped illustrate the importance of patient safety incidents. The introduction of VHIMS has contributed to accountability of incident management across public funded health services.

In the absence of baseline data it is difficult to statistically determine whether the introduction of VHIMS has improved patient safety in Victoria. Incident management is one part of a multi factorial framework of management of adverse events and patient safety issues. The department hope to undertake this work in the 2012-2013 period.

Question 5

Department of Health response

For the output performance measure 'Public hospitals meeting cleaning standards, as assessed by external audit', 88 per cent of health facilities passed in 2010-11 compared to the target of 100 per cent. The annual report also notes that '*one facility failed to achieve the AQR [acceptable quality level] and the remainder had not yet complied with the internal auditing requirements.*'[6]

(a) How many health facilities had not yet complied with the internal auditing requirements as at 30 June 2011?

Two health services had not yet achieved the requirements needed to reach full compliance with the internal auditing requirements by the end of the 2010-11 year. Five achieved in the first and second audit but then failed to reach full compliance in the final audit for the year.

(b) In each case, what were the reasons why each health facility had not introduced an internal auditing process?

It should be noted that all health services introduced internal auditing programs; the issue was health services not achieving the program to the level prescribed in the Cleaning Standards.

Albury Wodonga Health – insufficient trained staff

Barwon Health – insufficient rooms internally audited

Calvary Health Care – issues with electronic software used to record internal audits – now resolved

Cohuna District Hospital – staffing issues

Eastern Health – problems with external auditor losing data

Inglewood & District Health Service – insufficient frequency of internal auditing

Southern Health – resource allocation issues

(c) What health facility failed to achieve the acceptable quality level of cleaning and in what areas?

Heywood Rural Health failed to meet AQL in the external audit undertaken in August 2010. They have passed AQL in subsequent non external audits.

(d) What was the impact of not achieving the acceptable quality level of cleaning?

This is difficult to measure. Good cleaning outcomes reduce the risk of transmission of disease causing organisms among patient populations, as well as increasing public confidence. Unless there is an outbreak of disease, or a complaint, the impact cannot be measured.

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6 Department of Health, *Annual Report 2010-11*, October 2011, p.186-8

Question 6

Department of Health response

In relation to the Residential Aged Care output, 893,948 bed days in high-care places were provided in 2010-11 compared to the target (and 2010-11 expected outcome in the 2011-12 the budget papers) of 924,000.[7]

(a) What were the factors that resulted in the actual outcome for 2010-11 being below the target and expected outcome for the year?

Reported performance represents a 96.8% outcome for the output. In bed vacancy terms it represents some 82 vacant beds in a portfolio of some 2,531 beds, or 3.2% vacancy rate.

The actual performance is the result of:

- A small number of high-care places being taken out of operation to be used for an alternative service type at Horsham (8 places used as Transition Care) and Swan Hill (6 places used as Transition Care).

Softening demand for high-care, particularly in some small rural towns such as Koroit, Dimboola, Maffra, Dunolly, Avoca, Eildon where catchments are limited and hence between 2 and 6 beds were vacant at each site.

(b) How was the 2010-11 expected outcome in the 2011-12 budget papers determined?

The expected outcome is based on quarter two year to date (YTD) performance, which indicated that the 2010-11 target would be met.

(c) Given that 30,052 targeted bed days in high-care places were not provided in 2010-11, what impact has this had on the achievement of key government outcomes?

No impact. The key Government objective in this case is to provide access to RACS in rural Victoria which is achieved through the presence of these services. While some fluctuation in service demand is expected to continue, the cost of operating services is largely fixed with few if any savings being achieved through small reductions in service size.

Question 7

Department of Health response

In relation to the Aged Care Assessment output, 56,413 aged care assessments were provided in 2010-11 compared to the target (and 2010-11 expected outcome in the 2011-12 the budget papers) outcome of 59,000.[8]

(a) What were the factors that resulted in the actual outcome for 2010-11 being below the target and expected outcome for the year?

In 2010-11 the capacity of ACAS teams to meet assessment targets was affected by a significant level of

[7] Department of Health, *Annual Report 2010-11*, October 2011, p.193

[8] Department of Health, *Annual Report 2010-11*, October 2011, p.193

serious illness, high staff turnover and difficulties in recruiting to vacancies in a competitive environment.

(b) How was the 2010-11 expected outcome in the 2011-12 budget papers determined?

The expected outcome in the 2011-12 budget papers was based on quarter 2 YTD performance which indicated an upward trend in assessments. Performance in quarters 3 & 4 was impacted by the staffing issues outlined in part (a).

(c) Given that 2,587 fewer aged care assessments were provided in 2010-11 than planned, what impact has this result had on the achievement of key government outcomes?

Despite the shortfall in the number of assessments, indicators do not show a negative impact on clients. In 2010-11 assessments increased by 6% from the previous year and average waiting times for assessment in a community setting decreased from 19.6 to 18.5 days.

Question 8

Department of Health response

The 2009-10 annual report discloses particular significant milestones met in 2009-10 relating to the Health*SMART* program. (*Annual Report 2009-10*, p.13). How has the Health*SMART* program tracked against key milestones in 2010-11?

The major milestones for HealthSMART during 2010-2011 were:

- The deployment of Release 1b (outpatient prescribing) at Eastern Health and Royal Victorian Eye & Ear Hospital (RVEEH)
- The implementation of the Common Technical Infrastructure (CTI) at Austin Health and Peninsula Health; CTI is directed at improving clinician productivity by introducing functionality such as single sign-on and workstation roaming plus smartcard and secure remote access; CTI is a pre-requisite for implementing Release 2 of the HealthSMART Clinical System
- The deployment of Release 2b (outpatient prescribing plus order/results) at Austin Health and Peninsula Health.

However, in November 2011 the Victorian Ombudsman reported that: "Health*SMART*, originally budgeted at $323 million, will require an additional $243 million to complete (Own motion investigation into ICT-enabled projects).

The Ombudsman also reported that "The Health*SMART* had no business case, despite seeking over $300 million in funding. Instead the funding submission was based on a high-level strategy document and a 14-page implementation plan".

"By the end of 2011-12, the Health*SMART* program will have been running for nine years and will only have delivered the clinical application into four of the ten planned health services".

Question 10

Department of Health response

What efficiency and service effectiveness gains were achieved by the Department in 2010-11 as a result of centralisation of IT services through the use of CenITex (please quantify gains where possible)?

The Memorandum of Understanding (MOU) for the transition of Information Technology (IT) Services from the Department to CenITex was signed effective 1 April 2010. This coincided with the Department of Human Services (DHS) transfer and consisted of Tranche 1, which was the transfer of infrastructure assets, people and policy as set out at that time. Not all IT services were transferred to CenITex.

Tranche 2, which involved the transfer of some of the functions and staff of the department's Desktop Support unit, was completed on 1 February 2011. The completion of the Machinery of Government processes associated with the transfer is still pending; this had been expected to take place from 1 July 2011.

To date, the department is unable to identify efficiency and service effectiveness gains as a result of centralisation of IT services through the use of CenITex. The department has raised its concerns with the new CEO of CenITex, particularly in the areas of continuous improvement and the transition to the Whole of Victorian Government service catalogue and agreed service levels. The department has also requested CenITex for greater visibility of decisions and/or actions that might affect it.

Question 11

Department of Health response

The Department, in its 2010-11 annual report, indicated that 31 hospitals and Ambulance Victoria participated in the *Redesigning Hospital Care* program, which is designed to improve the efficiency and effectiveness of the delivery of healthcare services, and increase the quality of care in Victorian hospitals.

To date, the Department has funded 105 individual projects under the program and health services have also funded their own projects. All of the 48 projects that have reported outcomes have shown measurable improvement against at least one key objective (e.g. reduced length of stay, improved throughput and bed days saved). Financial benefits from the program are measured by a return-on-investment model, which is based on three areas: wards, theatres and emergency departments.[9]

(a) Please provide a summary of the reported outcomes for each project funded by the *Redesigning Hospital Care* program that were achieved in 2009-10 and 2010-11.

To date a total of 107 projects have been supported within health services by the Redesigning Hospital Care Program. Projects have been spread across the years 2008–09 to 2010–11 in four waves. In 2009–10, 27 projects were supported with a further 52 projects supported in 2010–11. The majority of projects have submitted final reports however 11 projects included in wave four are due to complete final reports by end of December 2011.

In collating results from projects the redesign program identifies a key overarching indicator for each project such as Length of Stay (LOS) reduction, standard emergency indicators, elective surgery indicators or patient experience measures. These overarching indicators provide a key measure upon which the project can demonstrate project outcomes. Each project however includes multiple other measures which may include system and process performance, and patient and staff experience for example.

For the purpose of this response project outcomes have been collated into key focus areas and demonstrate outcomes against the key measure for each project. Further details of project outcomes are included in the attached appendix.

In 2009–10, 27 projects primarily focused on improving patient access to surgical services, in-patient care,

[9] Department of Health, *Annual Report 2010-11*, October 2011, p.17

and emergency care and specialist clinics. The outcomes are summarised below.

Surgery Projects

Seven (7) projects focused on improving access to surgical services and/or improving the patient experience with the following outcomes:

- 3 projects demonstrated a reduction in patient length of stay.
- 2 projects demonstrated reductions in waiting periods for category 2 and 3 patients.
- 1 project focused in reducing the reducing the number of surgery cancellations.
- 1 project demonstrated an improvement in the time taken to book patient appointments.

Ward Projects

A total of nine (9) projects focused on improving access to in-patient services and increasing staff capability for redesign and improvement, with the following outcomes:

- 7 projects demonstrated reductions in patient length of stay.
- 1 project demonstrated an improvement in patient safety e.g. reductions in the number of falls, medication errors and pressure areas.
- 1 project resulted in a substantial increase in the number of staff trained in the lean thinking/ process improvement processes.

Emergency Projects

Six (6) projects focused on improving patient access to emergency care. All six projects demonstrated improvements in performance with:

- 4 projects increasing the number of patients admitted within 8 hours.
- 2 projects increasing the percentage of patients discharged from ED within 4 hours.

Specialist Clinics

Three (3) projects were funded focusing on improving patient access to specialist clinics. The following outcomes were identified:

- 2 projects demonstrated a decrease in the amount of time patients spent waiting to be seen at clinics.
- 1 project resulted in reductions in the waiting period for an appointment to a specialist clinic.

Other Projects

An additional two projects were funded with the following outcomes:

- 1 project resulted in an increase in the time spent by nurses at the bed side.
- 1 project resulted in reduced waiting times for both urgent and non-urgent echocardiograms.

In 2010–11, 41 projects were supported which focused on either emergency access targets (38 projects across 18 health services) or elective surgery access targets (3 projects across 3 health services). Projects were developed and implemented from January to June 2011.

Of the 18 health services who focused redesign projects on improving emergency access targets 16 health services demonstrated significant improvement against the indicator - percentage of patients treated and discharged within four hours in the emergency department, one health service maintained performance and one demonstrated a slight decrease in performance. As the projects were of a short duration, health services may continue to demonstrate improved performance as redesigned processes and models of care are implemented.

Three health services implemented redesign projects focused on improving elective surgery performance. All projects demonstrated improved performance against their chosen elective surgery measure.

The final wave of health services undertaking 11 redesign projects in 2010-11 will submit final reports by the end of 2011.

(b) What financial benefits have been derived from the program in 2009-10 and 2010-11 as measured by the return-on-investment model for each of the three areas – wards, theatres and emergency departments?

Generally, health services see the return from redesign projects as released value (more patients treated with the same resource) rather than as a budgetary or cash flow improvement. An ROI methodology has been developed as a trial to test if it is possible to measure ROI from these types of redesign projects.

A small sample of projects was used to develop the ROI methodology and as such there are some limitations with the ROI calculation. To date the sample provides only an early indication of project success demonstrating positive ROI. The return on investment is calculated in two ways: dollar value released (efficiency gains) and additional patients treated. The ROI methodology is yet to be further tested against all projects completed to date; this is planned in the near future.

(c) Is the Department satisfied with the level of measurable improvement and financial benefits that have flowed from the program to 30 June 2011? What criteria have been used to base this assessment?

Measurable improvement from the Redesign program is defined in multiple ways and includes financial benefits (released value), improved patient and staff experience, process improvements, and increased capability in health services for redesign and improvement. The department is satisfied at this point in time with the outcomes reviewed to date, however is still collating project results as they report. Further testing of the ROI methodology and commissioning of an external evaluation to further understand the impact on the program on the system are currently being undertaken.

(d) When does the Department consider that all projects will report on the achievement of outcomes?

All currently funded projects are due to be completed and provide final reports by end of December 2011.

Question 12

Department of Health response

Please outline the factors that contributed to the Department's annual report being tabled on 26 October 2011, rather than in a more timely manner.

In line with the government's commitment for transparency, annual reports were tabled over a period of time rather than on one day. The Department of Health's Annual Report was tabled in a timely manner.

The Minister for Health was responsible for tabling 104 hospital and health service annual reports, including the Department of Health. The Office for the Minister of Health scheduled annual reports to be tabled in a staged approach and in line with the Financial Management Act, s46 (1) which requires the Minister to table the report by the 4th month after the end of financial year (31 October 2011) or by the next sitting day after this date (8 November 2011).

Question 13

Department of Health response

As outlined by the Department in its 2010-11 annual report, as at 31 December 2010, Victoria recorded its lowest number of long-waiting patients since reporting commenced in 1999.[10]

(a) What is the definition of 'long-waiting patients'?

Patients who have waited longer than the desirable waiting time for their assigned clinical urgency category, which for Category 1 is longer than 30 days, for Category 2 longer than 90 days, and for Category 3 longer than 365 days.

(b) Please outline the number of long-waiting patients as at 30 June each year to 2011, commencing 30 June 1999 (as well as the position at 31 December 2010), for each surgical category.

Category	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	30/6/2010	31/12/2010	2011
All Cardiothoracic surgery	33	106	136	41	35	46	91	67	35	110	130	46	44	35
Coronary artery bypass graft	14	75	104	21	19	39	64	34	20	74	67	12	12	10
All ear, nose and throat surgery	1,492	2,062	1,744	1,358	1,047	865	740	456	320	374	421	576	577	616
Myringoplasty	77	107	84	114	70	56	37	23	18	22	15	16	19	19
Myringotomy	37	62	54	45	25	24	32	11	20	20	26	35	37	56
Septoplasty	579	683	619	555	487	381	241	120	71	83	99	147	121	127
Tonsillectomy	281	362	320	217	126	103	177	122	73	99	116	174	184	209

[10] Department of Health, *Annual Report 2010-11*, October 2011, p.20

Category	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	30/6/2010	31/12/2010	2011
Ophthalmology	571	856	987	869	416	151	91	51	46	129	161	36	23	23
Cataract extraction	373	691	747	740	324	101	51	20	23	100	109	23	18	11
All general surgery	1,967	3,256	3,405	2,938	2,710	2,800	2,223	1,615	1,492	1,864	1,483	1,245	965	877
Cholecystectomy	246	430	676	492	473	554	400	205	221	277	185	145	120	90
Haemorrhoidectomy	74	153	196	164	157	130	130	111	85	115	110	100	48	50
Inguinal herniorrhaphy	0	240	459	392	356	431	368	199	206	270	164	131	100	82
All Gynaecology	273	497	470	477	386	558	596	323	353	269	264	229	98	144
Hysterectomy	34	109	122	98	73	108	111	56	57	42	44	38	19	32
All Neurosurgery	171	113	135	244	200	208	256	185	192	278	291	283	260	161
All Orthopaedics	1,822	2,570	3,898	4,116	3,903	4,754	4,505	3,326	2,779	2,663	3,022	2,443	1,884	1,669
Total hip replacement	186	258	481	537	479	544	566	390	416	399	406	312	207	169
Total knee replacement	193	288	582	584	622	724	744	662	639	577	686	469	346	322
All Plastic surgery	1,004	1,104	1,311	1,430	1,219	1,529	1,708	1,213	1,126	889	795	549	594	978
All Urology	629	851	1,198	1,467	1,497	1,743	1,653	1,096	1,272	1,063	719	664	677	629
Cyctoscopy	163	265	490	706	792	843	791	507	606	481	276	216	229	170
Prostatectomy	128	164	216	300	305	408	362	274	345	292	214	189	201	156
All vascular surgery	306	468	717	679	717	690	527	251	221	282	381	244	265	202
Varicose veins stripping and ligation	614	889	1,110	1,082	1,082	767	509	203	173	213	263	102	145	133

Category	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	30/6/2010	31/12/2010	2011
Total	11,267	16,659	20,261	19,666	17,520	18,557	16,973	11,520	10,809	10,985	10,447	8,424	7,193	6,970

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The completed questionnaire must be returned by no later than COB, Tuesday, 13 December 2011.

Please return the response (including an electronic version) of the questionnaire to:

Valerie Cheong
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For inquiries on this questionnaire, please contact the Executive Officer or:

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