



# **PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE**

**106<sup>TH</sup> REPORT TO THE PARLIAMENT**

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## **Review of the Auditor-General's Report on Access to Public Hospitals: Measuring Performance**

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**February 2012**

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Ordered to be  
printed

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By Authority  
Government Printer for the State of Victoria

No. 98  
Session 2010-12

# **PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE**

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**Parliament of Victoria  
Public Accounts and Estimates Committee**

*Review of the Auditor-General's Report on Access to Public Hospitals: Measuring  
Performance*

ISBN 978 0 9871550 2 3

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# **PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE MEMBERSHIP — 57<sup>TH</sup> PARLIAMENT**

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## DUTIES OF THE COMMITTEE

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The Public Accounts and Estimates Committee is a joint parliamentary committee constituted under the *Parliamentary Committees Act 2003*.

The Committee comprises seven members of Parliament drawn from both Houses of Parliament.

The Committee carries out investigations and reports to Parliament on matters associated with the financial management of the State. Its functions under the Act are to inquire into, consider and report to the Parliament on:

- any proposal, matter or thing concerned with public administration or public sector finances;
- the annual estimates or receipts and payments and other budget papers and any supplementary estimates of receipts or payments presented to the Assembly and the Council; and
- any proposal, matter or thing that is relevant to its functions and has been referred to the Committee by resolution of the Council or the Assembly or by order of the Governor in Council published in the Government Gazette.

The Committee also has a number of statutory responsibilities in relation to the Office of the Auditor-General. The Committee is required to:

- recommend the appointment of the Auditor-General and the independent performance and financial auditors to review the Victorian Auditor-General's Office;
- consider the budget estimates for the Victorian Auditor-General's Office;
- review the Auditor-General's draft annual plan and, if necessary, provide comments on the plan to the Auditor-General prior to its finalisation and tabling in Parliament;
- have a consultative role in determining the objectives and scope of performance audits by the Auditor-General and identifying any other particular issues that need to be addressed;
- have a consultative role in determining performance audit priorities; and
- exempt, if ever deemed necessary, the Auditor-General from legislative requirements applicable to government agencies on staff employment conditions and financial reporting practices.





## ACRONYMS AND ABBREVIATIONS

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ACEM	Australasian College of Emergency Medicine
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
COAG	Council of Australian Governments
the Department	Department of Health
DHS	Department of Human Services
EARC – ICT	Emergency Access Reference Committee – Information Communication Technology
ED	Emergency Department
ESIS	Elective Surgery Information System
ESTA	Emergency Services Telecommunications Authority
HEWS	Hospital Early Warning System
HIP	hospital initiated postponements
iPM	iPatient Manager
KPI	key performance indicator
MDS	minimum data set
NEHIPC	National E-Health Information Principal Committee
NHHRC	National Health and Hospital Reform Commission
NPA	National Partnership Agreement
PwC	PricewaterhouseCoopers
SOP	Statement of Priority
VAGO	Victorian Auditor-General's Office
VEMD	Victorian Emergency Minimum Dataset
VINAH	Victorian Integrated Non-Admitted Health



## CHAIRMAN'S FOREWORD

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Under its functions and powers set out in sections 14 and 33 of the *Parliamentary Committees Act 2003*, the Public Accounts and Estimates Committee follows up the status of findings and recommendations made in a selection of priority audit reports tabled in the Victorian Parliament by the Auditor-General.

In April 2009, the Auditor-General tabled a performance audit report entitled *Access to Public Hospitals: Measuring Performance*. This report of the Auditor-General examined the relevance, appropriateness and degree of fair representation of 12 access indicators in place for measuring the performance of public hospitals in providing to the community, whenever needed, timely access to emergency care and elective surgery. The report also evaluated the manner in which the then Department of Human Services managed the performance monitoring framework established for hospitals. This important monitoring function is now the responsibility of the Department of Health.

While the Auditor-General's report did not directly address the quality of emergency and elective surgery care, it recognised that the time taken to receive such care can significantly influence clinical outcomes for patients.

The Committee concurs with this viewpoint. To have unimpeded access to emergency care and elective surgery within hospitals, devoid of unwarranted delays, is a fundamental community expectation of elected governments. The coverage of the Auditor-General's report therefore involves a matter of high public interest. It was this direct nexus with patient welfare as a key community issue that prompted the Committee to earmark the report for its follow-up inquiry.

The Auditor-General conveyed to Parliament several significant findings including some disturbing messages of instances of admitted manipulation of data in one hospital to meet set performance targets. The findings also identified a lack of clarity in reporting rules and definitions which have given rise to inconsistent recording practices in hospitals visited during the audit. Such circumstances, if widespread across the hospital system, would mean that performance data had been developed on an inconsistent basis, leading to significant doubts on the accuracy and comparability across hospitals of published access performance material.

The Auditor-General also reported that there were a number of gaps in the access performance framework which required attention in order to better reflect a patient's journey through the hospital system. The advocated new performance information included the timeliness with which a hospital emergency department accepts patients arriving by ambulance and the extent of time spent by elective surgery patients waiting for a specialist outpatient appointment.

Added to these adverse audit findings were concerns expressed by the Auditor-General to the Committee during its inquiry on the design and implementation of integrity audits of data generated under the patient access management framework. These audits are conducted by the Department of Health's Office of Data Integrity.

After examining the Auditor-General's reported findings and recommendations, the Committee considered that substantial remedial action was required by the Department of Health to restore Parliament's and the community's confidence in the access performance data produced by hospitals. It was therefore pleasing to the Committee to find that a number of initiatives have been subsequently taken or commenced at state level to address the audit findings and recommendations.

Central to the actions taken at state level were the release by the Government of its *Health Priorities Framework 2012-22: Metropolitan Health Plan* in May 2011 and its introduction of a new and expanded quarterly performance report for hospitals and health services. Initiatives at departmental level in response to the audit recommendations have complemented these higher level Government actions.

The commentary in this report on the state initiatives also identifies the Committee's assessment of any further work that needs to be undertaken by the Department. Such work includes reinforcing the governance responsibilities of hospitals for the accuracy and reliability of recording and reporting practices, establishing clear milestones for its forward improvement plans and strengthening its own accountability obligations associated with the verification, through its integrity audits, of the extent of reliance that can be placed on published material. On this latter issue, the Committee has recommended the Department commission periodic external independent evaluations of the professional standing of its integrity audit methodologies.

There have also been some significant national developments in the subject area stemming principally from the signing of a new National Health Reform Agreement by the Commonwealth and all States and Territories in August 2011 and the adoption of a revised National Partnership Agreement on Improving Public Hospital Services. The Committee was informed during its inquiry that, under these national developments, there will be progressive application to Victoria of new and challenging performance indicators and targets for both emergency access and elective surgery access. These emerging national requirements, which will be fully operational by 2015, will address some of the Auditor-General's recommendations.

For both state and national developments since the Auditor-General's report, the Committee considers that time will be the key factor in determining the overall effectiveness, at both policy and operational levels, of all steps taken or in transit to strengthen the access performance management and reporting regime for Victorian public hospitals. In this regard, the Committee intends to monitor their progressive impact over the coming years. It has also recommended, in the light of the developments, that the next planned performance audit of the Auditor-General on patient access in public hospitals could incorporate, beyond the calibre of access indicators, an expanded focus on direct examination of access governance and reporting practices within hospitals, in addition to an updated assessment of the Department of Health's overseeing of such practices.

National initiatives are also underway to assess the quantum of statewide hospital performance data to be collected and reported under the new national framework. Through the Department of Health, Victoria is directly involved in this process. In this report, the Committee has advocated that the Department direct a commensurate level of attention to the magnitude of individual hospital reporting at state level. The aim of this work should be to ensure that, per medium of meaningful performance measures and targets, the accountability of hospitals to the Victorian Parliament and community can be strong while avoiding any potential adverse impact on the clinical treatment of patients.

The Committee has been assisted in its inquiry by significant evidentiary support from the Auditor-General and the Department of Health. On behalf of the Committee, I extend appreciation for their valuable cooperation and assistance.

I also wish to recognise the fine work of the Committee's Secretariat in the preparation of this report.



**Philip R. Davis MP**  
**Chairman**

# FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

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## CHAPTER 1 BACKGROUND TO THE COMMITTEE'S INQUIRY

### **Section 1.2.3** *Magnitude of published performance information*

<p><b>FINDING</b></p> <p>Against the backdrop of an expanding range of published performance information for hospitals, it is important that the Department of Health ensures, in seeking to improve the effectiveness of performance measures, that the cost of complying with reporting requirements does not come at the expense of delivering front line health services.</p>	<p>page 8</p>
<p><b>RECOMMENDATION 1</b></p> <p><b>The Department of Health continue to match national work underway to identify avenues for rationalising the collection and reporting by hospitals of performance data with its own initiatives at state level. The aim should be to ensure that the accountability of hospitals to the Victorian Parliament and community can be strong while avoiding any potential adverse impact on the clinical treatment of patients.</b></p>	<p>page 10</p>

### **Section 1.2.4** *Auditor-General's next planned performance audit for public hospitals*

<p><b>FINDING</b></p> <p>The Auditor-General's forward audit plans incorporate a performance audit revisit to the subject of access performance of hospitals.</p>	<p>page 10</p>
<p><b>FINDING</b></p> <p>Mindful of emerging state and national developments, the Committee would welcome further involvement by the Auditor-General over the next few years. Ideally, such involvement should have an expanded focus on direct audit examination and verification of management and reporting practices within hospitals.</p>	<p>page 10</p>
<p><b>RECOMMENDATION 2</b></p> <p><b>The Auditor-General's next planned performance audit relating to access management by public hospitals could incorporate an expanded scope for direct on site examination of access performance and associated public reporting.</b></p>	<p>page 10</p>

## CHAPTER 2 RELEVANCE OF ACCESS INDICATORS

### Section 2.2.1 Assessed relevance of the indicators

<p><b>FINDING</b></p> <p>The Auditor-General recommended implementation of a '<i>destination decision support system</i>' to manage ambulance arrivals at hospitals, thereby eliminating the need for bypass.</p>	<p>page 13</p>
<p><b>FINDING</b></p> <p>In late 2009, the Department of Health commenced a project to implement ambulance arrival boards in three emergency departments. Following some technical problems, a three month trial of ambulance arrival boards commenced in May 2011 with phase one planned for completion in August 2011.</p>	<p>page 13</p>
<p><b>FINDING</b></p> <p>The Department of Health should finalise the project at the earliest opportunity and systematically monitor its impact on the management by hospitals of ambulance patient arrivals, including whether there is a continuing need for the existing hospital bypass indicator.</p>	<p>page 13</p>
<p><b>RECOMMENDATION 3</b></p> <p><b>The Department of Health closely monitor the impact of its implementation of ambulance arrival boards on the management by hospitals of emergency patients arriving by ambulance, including the need or otherwise to continue with a hospital bypass indicator.</b></p>	<p>page 14</p>
<p><b>FINDING</b></p> <p>The Auditor-General advocated the Department of Health continue to monitor the total number of patients on the elective surgery waiting list as a measure of demand but remove this indicator from the performance monitoring framework.</p>	<p>page 14</p>
<p><b>FINDING</b></p> <p>The Department of Health is retaining the elective surgery waiting list measure as part of the performance framework as it reflects a net impact of patient demand and system capacity.</p>	<p>page 15</p>
<p><b>FINDING</b></p> <p>While recognising the links between the elective surgery waiting list measure and other access indicators as well as its value in informing decisions on system capacity, the Committee considers that hospitals should not be held directly accountable for patient numbers on the waiting list as they cannot control new patients registering for surgery.</p>	<p>pages 15-16</p>

<b>RECOMMENDATION 4</b>  <b>The Department of Health categorise elective surgery waiting list patient numbers as a measure of demand for elective surgery, outside of the direct control of hospitals, in its periodic public reporting of the performance of Victoria's health services.</b>	page 16
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### **Section 2.2.2    *Gaps in the performance framework***

<b>FINDING</b>  The Auditor-General identified three gaps in the access performance framework in place for hospitals. These gaps concerned the absence of timeliness measures and targets for: <ul style="list-style-type: none"> <li>• acceptance by emergency departments of patients arriving by ambulance;</li> <li>• emergency departments seeing triage category 4 (semi-urgent) and 5 (non-urgent) patients; and</li> <li>• elective surgery patients waiting for a specialist outpatient appointment.</li> </ul>	page 16
<b>FINDING</b>  The Department of Health has introduced new performance measures to address emergency patients arriving by ambulance and elective surgery patients waiting for a specialist outpatient appointment. There needs to be maximum transparency in the Department's monitoring and public reporting of these measures.	page 17
<b>RECOMMENDATION 5</b>  <b>The Department of Health ensure there is maximum transparency in its monitoring and public reporting of the progressive impact of the new timeliness measure and target on patients arriving at emergency departments by ambulance.</b>	page 17
<b>FINDING</b>  While the Government's new quarterly performance report contains performance data for triage categories 4 and 5 patients, there is an absence of targeted performance levels for measuring the timeliness of access to care provided to these patients. A new national performance measure and target will progressively apply at the statewide level for all emergency patients before becoming fully operative in 2015. The Committee considers this new framework should automatically extend to measuring and reporting performance at individual hospital level.	page 19

**RECOMMENDATION 6**

**The Department of Health extend its performance monitoring and reporting framework on the timeliness of access to emergency care at individual hospital level to incorporate hospital performance against targets for triage categories 4 and 5 patients.**

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## **CHAPTER 3      APPROPRIATENESS OF ACCESS INDICATORS AND PUBLIC REPORTS**

### **Section 3.2.1      Adequacy of individual improvement targets for hospitals**

**FINDING**

Positive action has been taken by the Department of Health to address shortcomings in elective surgery access improvement targets set for individual hospitals.

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### **Section 3.2.2      Lack of evidence-based targets and benchmarks**

**FINDING**

The Auditor-General found that, excluding emergency care indicators developed by the Australasian College of Emergency Medicine, evidence of data analysis or research was not available to support the appropriateness of applying the other indicator targets and benchmarks to Victoria's public hospitals.

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**FINDING**

Significant developments are taking place at the national level on evidence-based targets for both emergency access and elective surgery access, with the Victorian Department of Health contributing to the research. Beyond this research, it is important that the Department ensures that there is an adequate evidential trail to support all state level access targets and benchmarks.

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**RECOMMENDATION 7**

**The Department of Health ensure that its adoption and use of all state level access targets and benchmarks can be supported by structured research and analysis to confirm their evidence based status.**

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### **Section 3.2.3    *Presentation of public reports***

<p><b>FINDING</b></p> <p>The Auditor-General's assessment of the reporting of hospital performance information identified:</p> <ul style="list-style-type: none"> <li>• for emergency access, information was reported against increasing demand for services and the resultant upward trends in numbers of patients treated creating an impression of progressive improvement when, in fact, if performance was presented as a percentage met within the established target, some statewide data would show that targeted performance had not been met over a nine year period; and</li> <li>• performance against the indicator measuring the number of patients who remain in the emergency department for more than 24 hours is not reported.</li> </ul> <p>The Department of Health has taken appropriate corrective action on these two matters.</p>	<p>pages 28-29</p>
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## **CHAPTER 4      FAIR REPRESENTATION OF PERFORMANCE AGAINST ACCESS INDICATORS**

### **Section 4.2.1    *Data capture and consistency***

<p><b>FINDING</b></p> <p>The Auditor-General found that captured data is recorded inconsistently because of varying interpretations of reporting rules and use of processes that are inconsistent and susceptible to error.</p>	<p>page 32</p>
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### **Section 4.2.2    *Data accuracy***

<p><b>FINDING</b></p> <p>On data accuracy, some quite serious findings were reached by the Auditor-General on the reporting of performance against emergency access indicators. The findings included deliberate manipulation of data at one visited hospital.</p>	<p>page 33</p>
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### **Section 4.3.1    Audit recommendations directed to the Department of Health**

<p><b>FINDING</b></p> <p>The Department of Health has taken a number of actions to clarify definitions and business rules to improve reporting of access indicator data.</p>	<p>page 35</p>
<p><b>FINDING</b></p> <p>It will be important for the Department of Health to systematically monitor the effectiveness of its improvement strategies for data clarity and consistency, including through the results of its data audits.</p>	<p>page 36</p>
<p><b>RECOMMENDATION 8</b></p> <p><b>The Department of Health regularly evaluate the effectiveness of its improvement strategies for enhancing consistency in the application by hospitals of definitions and rules for their reporting of performance against access indicators.</b></p>	<p>page 36</p>
<p><b>FINDING</b></p> <p>During the inquiry, a number of issues concerning the design and implementation of integrity audits of data including sample size and selection, audit programs and use of results were raised.</p>	<p>page 38</p>
<p><b>FINDING</b></p> <p>The emergence of new national health reporting obligations for Victoria, and the associated funding implications to the State, reinforces the imperative for quality reported information.</p>	<p>page 39</p>
<p><b>RECOMMENDATION 9</b></p> <p><b>The Department of Health commission periodic external independent evaluations of the professional standing of the methodologies employed by its Office of Data Integrity in periodic audits of hospital performance and include the results of such evaluations in its annual report to Parliament.</b></p>	<p>page 39</p>
<p><b>FINDING</b></p> <p>The Department of Health is in the process of supporting the implementation of new Emergency Department Information Systems in two metropolitan hospitals.</p>	<p>page 40</p>
<p><b>FINDING</b></p> <p>Meaningful progress is needed on the implementation of Emergency Department Information Systems across the hospital network aimed at overcoming delays and inconsistencies in data capture in emergency departments.</p>	<p>page 40</p>

<b>RECOMMENDATION 10</b>  <b>The Department of Health establish clear milestones for the implementation of Emergency Department information technology systems across the hospital network and inform Parliament in its annual report on the extent of achievement of the established milestones.</b>	page 41
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### **Section 4.3.2    *Audit recommendations for hospitals***

<b>FINDING</b>  The Auditor-General made three recommendations directed at hospitals regarding fair representation of access performance. These recommendations focused on the need for action to improve computer security controls; internal monitoring of compliance with reporting policies and staff training; and internal audits of data accuracy.	pages 41-42
<b>FINDING</b>  The Department of Health has initiated remedial action on these recommendations which, when finalised, should lead to improved governance practices across the hospital network.	page 43



# CHAPTER 1: BACKGROUND TO THE COMMITTEE'S INQUIRY

## 1.1 Scope and structure of the Auditor-General's report on *Access to Public Hospitals: Measuring Performance*

This follow-up inquiry of the Committee addresses the findings and recommendations of the Auditor-General set out in the performance audit report, *Access to Public Hospitals: Measuring Performance*, presented to Parliament in April 2009.

The Department of Health (the Department) was formed in August 2009 and given specific responsibility for hospitals, mental health, aged care and preventative health services.<sup>1</sup> The findings and recommendations of this follow-up report of the Committee are therefore principally directed to the Department as the entity now with overall responsibility for managing health services in Victoria.

### 1.1.1 Focus of Auditor-General's report on timeliness of access to care

The Auditor-General's report focussed specifically on access indicators in place for measuring the performance of public hospitals in providing timely emergency and elective access to care and of the then Department of Human Services (DHS) in managing the performance monitoring framework. Its emphasis was on the timeliness of access to care as one key dimension of health service performance. It did not directly address the quality of such care.

In its introductory paragraphs, the audit report identified the importance of timely access to hospital care and that the time taken to receive such care can significantly affect clinical outcomes.

### 1.1.2 The twelve access indicators examined by the Auditor-General

The audit objective was to determine whether the twelve access indicators used by the then DHS in 2008-09 to measure individual hospital performance were relevant and appropriate, and fairly represented performance.<sup>2</sup> Several of these indicators are also used to report against statewide performance measures.

In evaluating the relevance, appropriateness and fair representation of the twelve access indicators, the audit sought to determine the extent to which the indicators:<sup>3</sup>

- reflected the objective of providing timely and accessible health services;
- clearly demonstrated performance in providing timely access to hospital care through the use of appropriate targets and benchmarks as well as transparent public reporting; and

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1 Public Accounts and Estimates Committee, *Review of the Findings and Recommendations of the Auditor-General's Reports July-December 2008*, September 2010, p.63

2 Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p. 21

3 *ibid.*

- were consistently captured and reported accurately.

The twelve examined access indicators centred on timeliness of access to:<sup>4</sup>

- emergency care by ambulance – one indicator;
- care in the emergency department – three indicators;
- admission or discharge from the emergency department – three indicators; and
- elective surgery – five indicators.

Table 1.1 shows the twelve access indicators in the manner presented in the Auditor-General's report.

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4      *ibid.*, p.22

**Table 1.1: 2008-09 Access indicators**

Aspect of access	Hospital access indicators	Statewide indicators	Hospital benchmarks	Statewide benchmarks
Access to emergency care by ambulance	Operating time on hospital bypass (%)			3%
Access to care in the emergency department	Triage category 1 (resuscitation) patients seen immediately (%)			100%
	Triage category 2 (emergency) patients seen within 10 minutes (%)			80%
	Triage category 3 (urgent) patients seen within 30 minutes (%)			75%
Access to admission or discharge from the emergency department	Emergency patients transferred to an inpatient bed within eight hours (%)			80%
	Non-admitted emergency patients with a length of stay of less than four hours (%)			80%
	Patients with a length of stay in the emergency department greater than 24 hours (number)	Not included	0	Not included
Access to elective surgery	Category 1 elective surgery patients admitted within 30 days (%)		Individual hospital improvement targets determined	100%
	Category 2 elective surgery patients waiting less than 90 days (%)	Category 2 elective surgery patients admitted within 90 days (%)		80%
	Category 3 elective surgery patients waiting less than 365 days (%)	Category 3 elective surgery patients admitted within 365 days (%)		90%
	Patients on the elective surgery waiting list (number)	Not included	Individual hospital targets determined	Not included
	Hospital initiated postponements (HIPs) per 100 waiting list scheduled admissions (number)	Not included	8	Not included

Source: Victorian Auditor-General's Office, Access to Public Hospitals: Measuring Performance, April 2009, p.19

The agencies included in the audit were:

- the then Department of Human Services;
- a metropolitan tertiary hospital;
- a metropolitan specialist hospital;
- a metropolitan secondary hospital;
- a large regional hospital; and
- Ambulance Victoria.<sup>5</sup>

The names of the four hospitals were not identified in the audit report.

### **1.1.3 Structure of Auditor-General's report**

The audit report contains three substantive chapters. They assess the access indicators against the three identified requisite attributes of relevance, appropriateness and fair representation.

Each substantive chapter describes the desired characteristics of the subject attribute and documents the results of the audit examination in the four categories of access indicators.

Each chapter ends with the Auditor-General's conclusion on the findings of the audit work together with the consequential audit recommendations. The key audit findings, conclusions and audit recommendations are consolidated upfront in the report's audit summary and are followed by responses received by the Auditor-General from the DHS and two audited hospitals in accordance with section 16(3) of the *Audit Act 1994*.

The report includes three appendices on definitions and calculation methods for particular indicators and on audit statistical methodology.

## **1.2 The Committee's approach to its inquiry**

### **1.2.1 Outline of the Committee's review program**

The Committee's program for its review of actions taken in response to the Auditor-General's report incorporated consideration of:

- a formal response from the Department to the Committee's questions and requests for specific information;
- correspondence from the Auditor-General on matters that might assist the Committee in addressing the core issues raised in the audit report;
- evidence obtained from the Department and the Auditor-General at public hearings; and
- the seeking of some additional information from the Department arising mainly from the public hearing.

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5      *ibid.*, p.22



The Committee has structured its report in line with the three substantive chapters presented in the Auditor-General's report, namely:

- relevance of access indicators;
- appropriateness of access indicators and public reports; and
- fair representation of access performance.

In his Foreword to the audit report, the Auditor-General provided a macro perspective to the audit findings. The Auditor-General used his Foreword to present an overarching audit conclusion on the matters addressed in the audit report by stating:<sup>6</sup>

*Focused and sustained action is clearly necessary to re-build trust and confidence in this important suite of performance information. This will require the attention of those responsible: DHS, together with hospital management, and all hospital staff who contribute to data collection. This task also includes re-examining the effectiveness of supervision, not just over the reporting of the data, but of the systems and processes that produce the data.*

*More positively, recent efforts by DHS to improve consistency of data collection, and to commence audits of data accuracy, are encouraging first steps. However, these efforts need to be sustained until a credible monitoring and accountability framework can be demonstrated.*

The Committee's deliberations during its review were aimed at determining whether the actions taken since the report, and particularly by the Department, have constituted meaningful progress towards establishing and sustaining a credible monitoring and accountability framework.

### **1.2.2 State and national developments since the Auditor-General's report**

During the course of its review, the Committee was informed of the many significant developments that have occurred or are underway at both state and national levels since the Auditor-General's report to widen and strengthen the performance management and reporting regime for public hospitals.

At the state level, developments since the audit report have been influenced by policy commitments articulated by the Coalition Government following the November 2010 election and by initiatives planned, in course of implementation or implemented by the Department.

In May 2011, the Minister released the Government's *Health Priorities Framework 2012-22: Metropolitan Health Plan*. This Plan outlines the following seven new priority areas:<sup>7</sup>

- developing a system that is responsive to people's needs;
- improving every Victorian's health status and experiences;

<sup>6</sup> *ibid.*, p.v

<sup>7</sup> Hon. T. Baillieu, Premier of Victoria, *Minister unveils landmark health plan*, media release, 3 May 2011

- expanding service, workforce and system capacity;
- increasing the system's financial sustainability and productivity;
- implementing continuous improvements and innovations;
- increasing accountability and transparency; and
- utilising e-health and communications technology.

These priority areas are directly related to the issues raised by the Auditor-General on the patient access performance of public hospitals. The Committee intends to monitor actions taken by the Government over coming years under its new Health Plan.

In June 2011, the Government introduced a new expanded performance report, the *Victorian Health Services Performance Report*, for hospitals which is published quarterly. The Minister stated that the release of this report '*represents an important first step in delivering a new and open system of publishing information on Victorian health services*'.<sup>8</sup>

As mentioned above, developments at state level have also been influenced by improvement initiatives for access management within hospitals planned, in course of implementation or implemented by the Department. Several of these improvement initiatives are identified by the Committee in this report.

The national developments include the signing of a new *National Health Reform Agreement* by the Commonwealth and all States and Territories on 2 August 2011. In addition, a revised *National Partnership Agreement on Improving Public Hospital Services* was also signed.

At the Committee's public hearing, the Department outlined a number of the national developments including the progressive introduction of new and challenging performance indicators and targets for both emergency access and elective surgery access under the revised national partnership agreement.

The Committee was informed that the new national emergency department measure and target will be:<sup>9</sup>

*90 per cent of all patients presenting to a public hospital emergency department will either physically leave the emergency department for admission to hospital, be referred to another hospital for treatment or be discharged within 4 hours.*

The Department stated that Victoria's 2010 calendar year baseline is 65.9 per cent, progressively increasing to 90 per cent in 2015.

For elective surgery access, the Committee was advised that the new national indicator and target will be:<sup>10</sup>

8 Hon. Ted Baillieu, Premier of Victoria, *Public gets to see how hospitals are performing*, media release, 1 June 2011

9 Ms F. Thorn, Secretary, Department of Health, transcript of evidence, 25 August 2011, p.4

10 *ibid.*

*100 per cent of all urgency category patients waiting for elective surgery are seen within the clinically recommended time.*

The Department further stated that Victoria's 2010 elective surgery baselines are:<sup>11</sup>

- Category 1 – 100 per cent (within clinically recommended time) to be maintained through to 2015;
- Category 2 – 72.5 per cent (within clinically recommended time) progressively increasing to 100 per cent by 2015; and
- Category 3 – 91.9 per cent (within clinically recommended time) progressively increasing to 100 per cent by 2015.

Another important aspect of the national developments is the creation of a new national body, the National Health Performance Authority, which will conduct independent monitoring and reporting of performance across the health system. Its functions also include:<sup>12</sup>

*Formulating performance indicators, collecting, analysing and interpreting performance information, and promoting, supporting, encouraging, conducting and evaluating research.*

The Committee determined to be cognisant of these major post-audit developments in its deliberations during its review in so far as they related to the findings and recommendations of the Auditor-General in his 2009 report.

The Committee has therefore not addressed in its review the full extent of initiatives and improvement actions that have been implemented, or are in course or planned, by the Government and the Department at both policy and operational levels, and nationally, regarding the monitoring and reporting of hospital performance.

### **1.2.3 Magnitude of published performance information**

As mentioned in an earlier paragraph (refer Section 1.2.2), the Government introduced a new and expanded performance report for hospitals during 2011. The new report is published quarterly and replaces the State's previous performance reporting which was on a six monthly basis. This new quarterly report, the *Victorian Health Services Performance Report*, encompasses, for the March 2011 quarter, 109 pages and includes performance data on a statewide basis and on individual hospitals and health services for:<sup>13</sup>

- patients treated;
- emergency care;
- elective surgery;
- dental care;

<sup>11</sup> *ibid.*

<sup>12</sup> House of Representatives Standing Committee on Health and Ageing, *Advisory Report on the National Health Reform Amendment (National Health Performance Authority) Act 2011*, March 2011, p.7

<sup>13</sup> Department of Health, *Victorian Health Services Performance Report — March 2011 Quarter*, 2011, p.4

- quality and safety; and
- mental health.

In the report's Foreword, the Minister stated that '*the range of data and information available will be expanded over time*'.<sup>14</sup>

The Auditor-General's report focusing on the first two patient access categories included recommendations for inclusion of some additional performance information in the Government's quarterly report. The Committee's commentary and conclusions on these recommendations are set out in later chapters of this report. The Committee generally endorses the relevant audit recommendations as addressing in a qualitative sense some existing performance reporting gaps.

The Auditor-General's report did not specifically address whether there was any potential for an overloading of performance reporting at hospital level to adversely impact on, or be at the expense of, clinical treatment of patients. The Auditor-General stated that:<sup>15</sup>

*Devoting time and resources to the collection and reporting of data on indicators that are not relevant is not productive.*

The Auditor-General also concluded that:<sup>16</sup>

*If hospitals and DHS are to contribute resources for reporting against access indicators, and judgements made about performance based on the indicators, then targets and benchmarks should be based on rationales that are supported by evidence.*

During its review, the Committee raised with the Department whether it had formed any view on the growth in compliance and auditing work and the associated reporting obligations at hospital level. In raising this issue, the Committee considered that, in seeking to improve the effectiveness of performance measures, it was important for the Department to ensure that the cost of complying with reporting and performance measurement requirements does not come at the expense of delivering front line health services.

The Department's Secretary provided the following response on this issue at the Committee's public hearing:<sup>17</sup>

*I think this is a perennial problem that we all grapple with. I have just come from a national committee that I chair – which actually is the committee that sets the standards for data collection – where we have said no to a couple because even though people want to collect them we do not think the cost-benefit analysis is sufficiently there yet for the collection, even though they are quite important issues. So your question is absolutely pertinent: if we spend our money collecting data, are we doing less clinical services? I do not think we have got to that stage yet, but there is a significant cost associated with reporting.*

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14    ibid.

15    Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p. 31

16    ibid., p.42

17    Ms F. Thorn, Secretary, Department of Health, transcript of evidence, 25 August 2011, p.11

*By and large we attempt to operate where we collect once or for what we call the national minimum datasets and extract out of that what we need for a broader set of measures, rather than having a separate collection for every measure. Or we consider other ways of collecting data: do we need to have an annual collection when a survey at a point in time will provide us with similar information? So we do look at the costs of collection, because it is an impost on hospitals and an impost for the department in the sense that it is something that we then have to do. It is certainly an issue we are raising in the national discussions about what appears to be a significant growth in data requirements nationally, all of which add to costs.*

*Can I say that it means that we are doing less clinical work? I could not categorically say that we are doing less clinical work as a by-product of our data collection; I do not think it has got to that stage. But I also think – because I think this is where your question is going – there is plenty of room for rationalisation. We are currently engaged in some work with New South Wales to look at rationalisation of data collections.*

In later correspondence to the Committee, the Department's Secretary provided an update on the data collection work currently underway with New South Wales. The Secretary advised that:<sup>18</sup>

*The reference to 'currently engaged in some work with New South Wales to look at rationalisation of data collections' relates to the escalation to the Australian Health Ministers' Conference (AHMC) of the issues, through a joint NSW/Vic sponsored AHMC paper, considered at the 4 August 2011 meeting. The outcome of this, as per the AHMC minutes was that Ministers:*

- (i) Noted previous discussion regarding the need to rationalise health data reporting required in the context of the national health reforms and the need for a review of the number of bodies that issue reports on various aspects of health system performance;*
- (ii) Agreed that a time limited Working Group be established under the auspices of the National E-Health Information Principal Committee (NEHIPC) of AHMAC [Australian Health Ministers' Advisory Council] to review opportunities for rationalisation of health data reporting; and*
- (iii) Agreed that an initial report be provided through AHMAC to Health Ministers for their meeting in November 2011.*

*The first meeting of the new NEHIPC working group (Working Group for Health Rationalisation of Data Collection and Reporting) has occurred, chaired by NSW, with secretariat functions being provided by Victoria. The Working Group will report through NEHIPC to AHMAC and AHMC.*

It is clear to the Committee from the above information presented by the Department that avenues to rationalise the quantum of hospital performance data collected and reported under new national requirements are currently under examination on behalf of the Australian Health Ministers. Through the work of the Department, Victoria is directly involved in this process.

<sup>18</sup> Ms F. Thorn, Secretary, Department of Health, letter to the Committee dated 11 October 2011, pp.3-4

The Committee welcomes the work that is underway in this area. It intends to progressively monitor the impact of any national initiatives on the recording and reporting obligations of Victoria's public hospitals and the Department's overseeing functions.

The Committee advocates that the Department direct a commensurate level of attention to the magnitude of individual hospital reporting at state level. The overall aim of all work focussed on data rationalisation should be to reinforce, through the use of meaningful measures and targets, the importance of transparent performance reporting by hospitals so that accountability to the Parliament and the community can be strong without any adverse implications for the clinical treatment of patients.

#### **RECOMMENDATION 1:**

**The Department of Health continue to match national work underway to identify avenues for rationalising the collection and reporting by hospitals of performance data with its own initiatives at state level. The aim should be to ensure that the accountability of hospitals to the Victorian Parliament and community can be strong while avoiding any potential adverse impact on the clinical treatment of patients.**

#### **1.2.4 Auditor-General's next planned performance audit for public hospitals**

The Committee was advised during the review that the Auditor-General's forward audit plans incorporate a performance audit revisit to the subject of access performance of hospitals.<sup>19</sup>

Mindful of the emerging state and national developments outlined above, the Committee would welcome further audit involvement in the subject area over the next few years. Ideally, this additional performance audit should have an expanded focus, beyond the specific calibre of access performance indicators, on direct audit examination and verification of management and reporting practices within hospitals as well as the Department's overseeing of such practices.

A further performance audit would give the Victorian Parliament and community a valuable independent perspective on the effectiveness of actions that have been taken since the 2009 audit report. It would also provide an independent assessment of the state and national developments and their impact on the standard of hospitals' performance in patient access management and of the public reporting of such performance.

#### **RECOMMENDATION 2:**

**The Auditor-General's next planned performance audit relating to access management by public hospitals could incorporate an expanded scope for direct on-site examination of access performance and associated public reporting.**

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<sup>19</sup> Mr A. Greaves, Assistant Auditor-General, Performance Audit, transcript of evidence, 25 August 2011, p.7



## CHAPTER 2: RELEVANCE OF ACCESS INDICATORS

### 2.1 Introduction

In the initial paragraphs of each substantive chapter, the Auditor-General's report outlines the requisite characteristics of performance indicators in order for them to be deemed relevant, appropriate or fairly representative of actual performance. The Committee considers this approach is particularly useful to readers of the report.

Chapter four of the Auditor-General's report examined the relevance of the hospital access indicators.

The Auditor-General considered that performance indicators are relevant when:<sup>20</sup>

- *they have a logical relationship to their objectives, e.g. they do measure the objectives of timeliness of access to health services*
- *the agency whose performance is assessed against the indicators is properly accountable for its achievement, i.e. performance against the indicator is within the control of the hospital*
- *the indicators do not produce inappropriate outcomes, e.g. they do not create perverse incentives.*

The audit report then presents the results of the audit examination of the emergency access indicators and the elective surgery access indicators against these three required attributes of relevant indicators.

### 2.2 Conclusions and recommendations of the Auditor-General on relevance

The emergency access indicators in place at the time of audit measured access to the following:<sup>21</sup>

- *emergency care by ambulance*
- *care within the emergency department*
- *admission or discharge from the emergency department.*

The elective surgery access indicators in place were:<sup>22</sup>

- *the percentage of category 1 (urgent) patients admitted within 30 days*
- *the percentage of category 2 (semi-urgent) patients waiting less than 90 days*

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20 Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.24

21 *ibid.*

22 *ibid.*, p.29

- *the percentage of category 3 (non-urgent) patients waiting less than 365 days*
- *the number of patients on the elective surgery waiting list*
- *the number of hospital initiated postponements (HIPs) of surgery per 100 waiting list scheduled admissions.*

### 2.2.1 Assessed relevance of the indicators

The Auditor-General found that:<sup>23</sup>

*The majority of the access indicators used are relevant – they relate to the objective of timely access to health services and hospitals are properly accountable for performance against the indicators.*

*Two indicators, however, are not considered relevant. Those indicators are:*

- *percentage of time spent on bypass – as hospitals are not solely accountable for performance*
- *total numbers of patients on the elective surgery waiting list – as this is a measure of demand, not access.*

*Devoting time and resources to the collection and reporting of data on indicators that are not relevant is not productive.*

### Percentage of time spent on bypass – Statewide benchmark of 3 per cent

In reaching the above conclusion on the bypass indicator (there is just one indicator), the Auditor-General drew attention to the ‘knock on’ effect of one hospital using bypass on other hospitals and stated:<sup>24</sup>

*Hospitals use bypass to manage demand on emergency departments. However, bypass itself can lead to increased pressure on emergency department capacity. When a hospital uses bypass, one less hospital is available for the delivery of patients by ambulances. The increased arrivals to the remaining hospitals may cause another to commence bypass and this process can continue. Time hospitals spend on bypass due to this ‘knock on’ effect reflects a failure of bypass to manage arrivals effectively, rather than hospital performance. Individual hospitals, therefore, cannot entirely control their performance against this indicator.*

The Auditor-General also identified the potential for an inappropriate outcome from the use of bypass:<sup>25</sup>

*Hospitals may, to meet the 3 per cent target, avoid calling for bypass despite need, resulting in ambulances waiting at the door. Anecdotally, this is reported to occur.*

<sup>23</sup> *ibid.*, p.31

<sup>24</sup> *ibid.*, p.26

<sup>25</sup> *ibid.*



### Audit recommendation 4.1 (first element) as per Auditor-General's report

In the first element of this audit recommendation, the Auditor-General recommended that the Department of Health (the Department) needs to:<sup>26</sup>

*Improve the measurement of access to emergency care by ambulance by:*

- *implementing a 'destination decision support system' to manage ambulance arrivals thereby eliminating the need for bypass.*

The formal response to this recommendation of the then Department of Human Services (DHS) published in the Auditor-General's report stated that:<sup>27</sup>

*There is currently national work to develop an agreed set of key performance indicators. This recommendation would be considered as part of this process.*

The Department of Health subsequently advised the Committee of the status of a 2008 DHS study which had advocated a destination decision support system. The Department stated that:<sup>28</sup>

*In late 2009, a project to implement ambulance arrival boards in three EDs [Emergency Departments] was commenced. This will provide 'real time' notification of impending and actual ambulance arrivals. Hospitals can use this information to prepare and plan for ambulance arrivals within the context of overall ED workload.*

*Technical issues with the Emergency Services Telecommunications Authority (ESTA) and Oracle software significantly delayed the establishment of the live feed to the three EDs. This led to extensive challenges during the testing phase.*

*In May 2011, a three month trial of ambulance arrival boards commenced. Completion of phase one is expected in August 2011.*

The Committee looks forward to completion by the Department of this positive action. It considers it will be important for the Department to finalise the project at the earliest opportunity and to systematically monitor the impact of its implementation on the management by hospitals of ambulance arrivals, including if there is a continuing need for, or otherwise, of the existing hospital bypass indicator.

On the hospital bypass indicator, the Department informed the Committee that:<sup>29</sup>

*...The Government has set a target for the thirteen major metropolitan hospitals which requires them to spend no more than 3 per cent of operating time on bypass. In both 2009-10 and 2010-11, the result for this measure has been 1.9 per cent.*

26 *ibid.*, p.31

27 *ibid.*, p.11

28 Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, p.6

29 Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 11 October 2011, p.7

*The target of 3 per cent is applied to both the 13 hospitals as a group as well as individual hospitals as an annual target. It is important to note that there is a seasonality impact upon the performance against this measure, and while the target has not been exceeded (a favourable result) for the 13 hospitals as a group for the past two years, individual hospitals have exceeded the target on occasions within or over a year.*

These comments reinforce the need for the Department to closely monitor the relationship between the bypass indicator and the impending implementation of ambulance arrival boards and particularly for individual hospitals that have experienced difficulty in meeting the bypass indicator.

### **RECOMMENDATION 3:**

**The Department of Health closely monitor the impact of its implementation of ambulance arrival boards on the management by hospitals of emergency patients arriving by ambulance, including the need or otherwise to continue with a hospital bypass indicator.**

### ***Patients on the elective surgery waiting list (number)***

The Auditor-General's analysis underpinning the second conclusion on relevance, concerning the elective surgery access indicator "Patients on the elective surgery waiting list (number)", identified that the indicator fell short of all three relevance criteria in that:<sup>30</sup>

- waiting list numbers are a measure of demand and '*do not provide information about the objective of timely access to health services*';
- while hospitals '*can control the number of patients removed from their waiting list, they cannot prevent new patients registering for surgery*'; and
- there is potential for an inappropriate outcome as '*where waiting list numbers are measured and access to specialist outpatient appointments is not, hospitals may be encouraged to limit access to outpatient clinics to reduce the number of new patients registered on the waiting list and meet the set target. Measuring access to specialist outpatient appointments would likely identify this and may mitigate the likelihood of its occurrence*'.

### **Audit recommendation 4.3 as per Auditor-General's report**

Based on the above analysis, the Auditor-General recommended that the Department needs to:<sup>31</sup>

*Continue to monitor total numbers of patients on the elective surgery waiting list as a measure of demand but remove this indicator from the performance monitoring framework.*

<sup>30</sup> Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, pp.30-1

<sup>31</sup> *ibid.*, p.32

This audit recommendation was not accepted by the then DHS. Its formal response included in the Auditor-General's report stated that:<sup>32</sup>

*The performance monitoring framework is a critical component of the health system governance framework, and includes a wide range of indicators that contribute to health system financial and service delivery performance. This includes the elective surgery waiting list indicator, which reflects the net impact of patient demand and system capacity and supports the monitoring of other access performance indicators which measure time to treatment.*

In correspondence to the Committee, the Department reiterated the above response. It added that '*the indicator is also of significant public interest*'.<sup>33</sup>

The Department's Secretary also reiterated this policy position at the Committee's public hearing and stated:<sup>34</sup>

*The elective surgery waiting list is still monitored, as it supports the monitoring of other access performance indicators. So we are continuing to retain that as a form of measurement for the system, and it will continue to be part of the performance framework as it reflects a net impact of patient demand and system capacity.*

The Department's Secretary further expanded on the reporting of the elective surgery patient waiting list at the public hearing in the following manner:<sup>35</sup>

*The question of the actual waiting list is a matter of policy for any government, about whether they report on a waiting list. What the waiting list provides is essentially a measure of the stock and flow of what happens in elective surgery over a period of time. Because it is a number – and, yes, one could say it is a bit too simplistic – you do not automatically take into account contextual factors. The waiting list in fact has been reasonably similar for quite some time. The contextual factor is that the population of Victoria has grown considerably at the same time... in the context of the size of the population the waiting list is as small as it has ever been. But it is still a measure that is popularly understood to tell people something about what is happening – that is, are we moving people appropriately through elective surgery in a timely fashion.*

The findings of the Auditor-General leading up to audit recommendation 4.3 centred on the conceptual status of the elective surgery waiting list. The findings recognised the waiting list's proper purpose as a measure of demand but questioned its inclusion within a performance monitoring framework which assigns a degree of control and accountability at individual hospital level for the quantum of the waiting list.

The Committee concurs with the findings of the Auditor-General. The Committee recognises the views expressed by the Department on the links between the waiting list measure and other access indicators and its value in informing decisions on system capacity. In effect, these

32 *ibid.*, p.12

33 Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, p.8

34 Ms F. Thorn, Secretary, Department of Health, transcript of evidence, 25 August 2011, p.4

35 *ibid.*, p.10

views reinforce the key purpose of the elective surgery waiting list as an important measure of public demand for elective surgery services.

The Committee considers that hospitals should not be held accountable for the indicator on the total numbers of patients on the elective surgery waiting list. The public reporting of such numbers should categorise the information as reflecting the level of public demand for elective surgery services, a matter outside the direct control of individual hospitals.

#### **RECOMMENDATION 4:**

**The Department of Health categorise elective surgery waiting list patient numbers as a measure of demand for elective surgery, outside of the direct control of hospitals, in its periodic public reporting of the performance of Victoria's health services.**

### **2.2.2 Gaps in the performance framework**

The remaining conclusions of the Auditor-General in chapter four of the audit report concerned three gaps in the access monitoring framework identified during the audit analysis on the relevance criterion. The Auditor-General stated:<sup>36</sup>

*The access indicators also miss out some key patient groups and aspects of timely access to health services. These are the timeliness:*

- *with which a hospital emergency department accepts patients arrived by ambulance*
- *of access to emergency department care for triage category 4 and 5 patients*
- *of access to a specialist outpatient appointment.*

*Measuring hospital performance in these aspects of timely access to health services will result in a more balanced performance monitoring framework that better reflects access along a patient's journey through the hospital system and assists in limiting potential for inappropriate outcomes.*

#### **Need to measure timeliness of emergency departments in accepting patients arrived by ambulance**

The Auditor-General reinforced his conclusion on this identified performance gap, the absence of a measure for the timeliness with which a hospital's emergency department accepts patients arrived by ambulance, with a tabular comparison of the bypass performance of hospitals with transfer times from the ambulance to the emergency department.<sup>37</sup> This comparison identified that good performance against the bypass indicator does not necessarily mean good transfer times from the ambulance to the emergency department. Four of the 13 examined hospitals had good performance against the bypass indicator of three per cent, but high percentages for cases that the ambulance service had recorded '*as taking more than 40 minutes from arrival to completion of transfer of care*'.<sup>38</sup> The audit report stated that such delays '*can negatively*

<sup>36</sup> Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.31

<sup>37</sup> *ibid.*, p.25

<sup>38</sup> *ibid.*

*affect patient outcomes and prevent ambulances from attending their next call’.*<sup>39</sup>

#### **Audit recommendation 4.1 (second element) as per Auditor-General’s report**

The Auditor-General recommended that the Department needs to improve the measurement of access to emergency care by ambulance by:<sup>40</sup>

*Addressing the need to measure hospital performance in both their ability to be available to ambulance arrivals, as well as the timeliness with which they accept patients arrived by ambulance.*

The Committee was pleased to hear from the Department that Victoria introduced in May 2011 the following three new performance measures relating ‘*to the ability of hospitals to be available to ambulance arrivals and the timeliness with which they accept arrivals by ambulance*’.<sup>41</sup>

- number of occasions on Hospital Early Warning System (HEWS) – a quality output measure in the 2011-12 budget papers with a target for 2011-12 of 11,388 occasions);
- operating time on HEWS – also a quality output measure in the 2011-12 budget papers with a target for 2011-12 of 10 per cent; and
- proportion of ambulance patient transfers within 40 minutes – a timeliness output measure in the 2011-12 budget papers with a target for 2011-12 of 90 per cent.

The 2011-12 budget papers state that these new measures ‘*reflect the Government’s commitment to increased transparency, quality and safety*’.<sup>42</sup>

The Committee is pleased to note these new developments. The timeliness measure and associated target on ambulance patient transfers fills the performance reporting gap identified by the Auditor-General.

The Committee considers it is now important for the Department to ensure there is maximum transparency in its monitoring of the performance of hospitals in response to this new measure. The aim of the Department’s action should be to provide Parliament and the community with clear information on the extent to which the introduction of the new measure and target has reduced waiting times for patients arriving at emergency departments by ambulance and has, in turn, contributed positively to their clinical outcomes.

#### **RECOMMENDATION 5:**

**The Department of Health ensure there is maximum transparency in its monitoring and public reporting of the progressive impact of the new timeliness measure and target on patients arriving at emergency departments by ambulance.**

39     ibid.

40     ibid., p.31

41     Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, p.5

42     Budget Paper No.3, *2011-12 Service Delivery*, May 2011, pp.194-5

## **Absence of a timeliness measure at hospital level for emergency access by triage category 4 and 5 patients**

The second identified gap in performance measurement involved the absence of a timeliness measure for triage category 4 (semi-urgent) and 5 (non-urgent) patients. As indicated in the audit report, these patient categories are included within the Australasian College of Emergency Medicine's (ACEM) Australasian Triage Scale. The Auditor-General pointed out that patients within these two categories in 2007-08 represented more than half of all emergency department presentations and that the National Health and Hospital Reform Commission (NHHRC) had recommended in 2008 their inclusion in future Australian Healthcare Agreements. The Auditor-General acknowledged that public reports include the statewide percentage of category 4 and 5 patients treated within desired timeframes but these indicators are not utilised for measuring individual hospital performance for purposes of determining levels of performance monitoring or bonus funding.<sup>43</sup>

### **Audit recommendation 4.2 as per Auditor-General's report**

The Auditor-General recommended that the Department needs to:<sup>44</sup>

*Include indicators and targets for emergency patients in triage categories four and five, reflecting the Australasian College of Emergency Medicine's (ACEM) and National Health and Hospital Reform Commission (NHHRC) recommendation.*

The formal response to this recommendation of the then DHS published in the Auditor-General's report stated that 'there is currently national work to develop an agreed set of key performance indicators. This recommendation would be considered as part of this process'.<sup>45</sup>

During the Committee's review, the Department advised that:<sup>46</sup>

*The Victorian Government is committed to quarterly performance reporting. A new report, the Victorian Health Services Performance Report December Quarter 2010, released during June, contains performance data on the number and proportion of category 4 and 5 patients who are treated within clinically recommended times (according to the Australasian College of Emergency Medicine guidelines).*

*As part of the National Partnership Agreement on Hospital and Health Workforce Reform, a key performance benchmark is:*

*By 2012-13, 80 per cent of ED presentations are seen within clinically recommended triage times as recommended by the Australasian College of Emergency Medicine (Schedule D – Taking Pressure off Public Hospitals).*

*This performance measure will apply to all emergency department patients.*

43 Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.27

44 *ibid.*, p.32

45 *ibid.*, p.11

46 Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, pp.7-8



While the Government's new quarterly performance report contains performance data on categories 4 and 5 patients, the absence of targeted percentage levels for measuring the timeliness of access to care by such patients means the reporting position is unchanged from that raised by the Auditor-General in 2009. This situation was confirmed by the Department's Secretary at the Committee's public hearing. The Committee was informed that '*whilst there are no targets for emergency department triage category 4 and 5 patients, the department continues to monitor performance in this area*'.<sup>47</sup>

The Committee considers that the Government's performance reporting regime for hospitals should include information, at both statewide and individual hospital level, on the extent to which targeted numbers of triage category four and five patients have been treated within clinically-recommended times.

In terms of developments at statewide level, the Department's website includes summary information on National Health Reforms. In addition to outlining the key highlights of the August 2011 *National Health Reform Agreement*, the website identifies that a revised *National Partnership Agreement on Improving Public Hospital Services* has also been signed. This Agreement incorporates the recommendations made by an Expert Panel of doctors, health professionals and administrators established by The Council of Australian Governments (COAG) to provide advice on the appropriate implementation of targets. The website states that new arrangements for targets will include '*a new emergency department four hour access target for patients in all triage categories from January 2012*'.<sup>48</sup>

At the Committee's public hearing, the Department elaborated on this new target and advised that it will require that:<sup>49</sup>

*90 per cent of all patients presenting to a public hospital emergency department will either physically leave the emergency department for admission to hospital, be referred to another hospital for treatment or be discharged within 4 hours.*

The Committee was also informed that '*the baseline 2010 calendar year is 65.9 per cent, progressively increasing to 90 per cent in 2015*'<sup>50</sup> in Victoria.

While the new national reporting regime will disclose statewide performance against the new target, the Committee considers the Department will need to establish a performance reporting framework for triage categories 4 and 5 patients at individual hospital level similar to that in place for measuring and reporting on the timeliness of access to emergency care provided to triage categories 1, 2 and 3 patients. With this action, the Department's access indicator suite would encompass all triage patient categories and there would be a uniform approach to the application of the Department's performance monitoring and reporting strategies, and of bonus funding for individual hospitals.

47 Ms F. Thorn, Secretary, Department of Health, transcript of evidence, 25 August 2011, p.4

48 Department of Health, 'National Health Reform – Victoria's Approach', <[www.health.vic.gov.au/healthreform/index.htm](http://www.health.vic.gov.au/healthreform/index.htm)>, accessed 14 November 2011

49 Ms F. Thorn, Secretary, Department of Health, transcript of evidence, 25 August 2011, p.4

50 *ibid.*

## RECOMMENDATION 6:

**The Department of Health extend its performance monitoring and reporting framework on the timeliness of access to emergency care at individual hospital level to incorporate hospital performance against targets for triage categories 4 and 5 patients.**

### ***Need to measure time spent by elective surgery patients waiting for a specialist outpatient appointment***

The third performance gap identified by the Auditor-General concerned the absence of time spent by elective surgery patients waiting for a specialist outpatient appointment, '*the source of the surgery referral*', and of the time the surgeon may take to forward on the referral.<sup>51</sup>

In commenting on this gap, the Auditor-General recognised that, under national reporting rules, waiting time is measured from the date the patient is registered on the waiting list. The Auditor-General also recognised that the number of patients treated in specialist outpatient clinics is monitored but the absence of information on timeliness of access to specialist outpatient services meant that current indicators provide only a partial measure of timeliness of access.<sup>52</sup>

### **Audit recommendation 4.4 as per Auditor-General's report**

The Auditor-General recommended that the Department needs to:<sup>53</sup>

*Address the need to measure hospital performance in providing access to specialist outpatient appointments.*

The formal response of the then DHS published in the Auditor-General's report stated that:<sup>54</sup>

*There is currently national work to develop an agreed set of key performance indicators. This recommendation will be considered as part of this process.*

During the Committee's review, the Department of Health advised the Committee that the Government was committed to releasing public information about access to specialist outpatient services. This commitment is set out in the Government's *Victorian Health Priorities Framework 2012-22: Metropolitan Health Plan* which was released by the Minister on 3 May 2011. This new health planning initiative identifies, as an immediate action, to:<sup>55</sup>

*Provide, by the end of 2011, public reporting of outpatient waiting lists for public hospital specialist clinics, including the time patients wait to get an appointment.*

More detailed information provided to the Committee by the Department's Secretary on the status of its action to implement the above Government commitment identified that:<sup>56</sup>

51 *ibid.*, p.29

52 *ibid.*, pp.29-30

53 Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.32

54 *ibid.*, p.12

55 *Victorian Health Priorities Framework 2012-22: Metropolitan Health Plan*, p.37

56 Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, p.9



*Consultation with the health sector on proposed KPIs [key performance indicators] is anticipated to commence in June 2011.*

*Reporting of the KPIs will initially be based on aggregate data provided by the health services. However, a patient level minimum data set (MDS) has been developed for non-emergency non-admitted hospital services, including specialist clinics, and will be collected through the VINAH (Victorian Integrated Non-Admitted Health) data collection... It is expected that the VINAH data collection will be operational by 2012-13.*

*Once established, the VINAH MDS for specialist clinics will allow the department to calculate and report access performance information, including the number of patients waiting for specialist clinic appointments and their waiting times.*

The Committee welcomes the action in course under the Government's policy commitment to introduce periodic reporting on the timeliness of access to specialist outpatient clinics. Such action will remove the performance gap identified by the Auditor-General in 2009 and result in more complete performance information to enable assessments of the timeliness of access by elective surgery patients to specialist outpatient services.



## CHAPTER 3: APPROPRIATENESS OF ACCESS INDICATORS AND PUBLIC REPORTS

### 3.1 Introduction

Chapter five of the Auditor-General's report examined the appropriateness of the hospital access indicators and the associated reporting of the indicators.

The Auditor-General considered that performance indicators are appropriate when:<sup>57</sup>

- they set realistic goals so there is motivation for improvement; and
- they are evidence-based, showing that the target or benchmark represents reasonable expectations.

The Auditor-General also addressed the importance of appropriate public reporting of performance. The audit report indicated that public reporting of performance against indicators, their targets and benchmarks allows users to understand the health care system and to assess levels of achievement. The audit report added that '*accurate assessment relies on comprehensive, transparent and timely presentation of information.*'<sup>58</sup>

The Auditor-General's report presents the results of the audit assessment of the appropriateness of access indicators and of the public reporting of performance against the indicators.

### 3.2 Appropriateness of targets and benchmarks

In line with the above appropriateness criteria, the Auditor-General's report initially identified the basis established at the time for the targets and benchmarks relating to Victoria's twelve indicators that comprised the access indicator suite.

The audit report included at the start of its evaluative narrative the following tabular presentation of the basis underpinning the various targets and benchmarks established for respective indicators.<sup>59</sup>

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57 Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.34

58 *ibid.*

59 *ibid.*, p.35

**Table 3.1: Basis of access indicator targets and benchmarks**

Access indicator	Method for target / benchmark setting
<b>EMERGENCY ACCESS INDICATORS</b>	
Operating time on hospital bypass (%)	Benchmark of 3% set by the Department
Triage category 1 emergency patients seen immediately	Time limit and benchmark of 100% based on the Australasian Triage Scale
Triage category 2 emergency patients seen within 10 minutes	Time limit and benchmark of 80% based on the Australasian Triage Scale
Triage category 3 emergency patients seen within 30 minutes	Time limit and benchmark of 75% based on the Australasian Triage Scale
Non-admitted emergency patients with a length of stay of less than four hours (%)	Limit of four hours adopted by the Department from the UK National Health Service. Benchmark of 80% determined by the Department.
Emergency patients transferred to an inpatient bed within eight hours (%)	Limit of eight hours and benchmark of 80% determined by the Department
Patients with a length of stay in the emergency department greater than 24 hours (number)	Limit of 24 hours and benchmark of 0 determined by the Department
<b>ELECTIVE ACCESS INDICATORS</b>	
Category 1 patients admitted within 30 days (%)	Limit of 30 days determined by the Department and adopted nationally, benchmark of 100% set by the Department
Category 2 patients waiting less than 90 days (%)	Limit of 90 days determined by the Department and adopted nationally, hospital improvement targets set by the Department
Category 3 patients waiting less than 365 days (%)	Limit of 365 days and hospital improvement targets set by the Department
Patients on the waiting list (number)	Individual hospital targets determined by the Department
Hospital initiated postponements (HIP) per 100 waiting list scheduled admissions (number)	Benchmark of 8 set by the Department

Source: Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.34

### 3.2.1 Adequacy of individual improvement targets for hospitals

At the time of the Auditor-General's report, the then Department of Human Services (DHS) set individual improvement targets for hospitals to measure elective surgery access for category 2 and 3 patients.

The Auditor-General concluded that these individual hospital improvement targets were not achieving improvement in access at the hospitals where it was needed most. This conclusion followed an audit analysis of the extent of variances in hospital targets which ranged from 53 to 100 per cent of category 2 patients treated within time and 75 to 100 per cent of category 3 patients. Further analysis showed that 16 of the 26 hospitals reporting the percentage of category 2 patients admitted within 90 days did not meet the 80 per cent statewide benchmark and 14 of these hospitals showed poorer performance in 2008 than in 2004.<sup>60</sup>

<sup>60</sup> *ibid.*, pp.37, 43

From these reported findings, it was very evident to the Committee that corrective action needed to be taken, particularly as the audit report stated that the individual improvement targets set for hospitals were not accompanied by clear timelines or directions for how and when better performance would be achieved.

### **Audit recommendation 5.1**

Based on the above conclusion, the Auditor-General recommended that the Department of Health (the Department) needs to:<sup>61</sup>

*Review the use of improvement targets for elective surgery indicators and set specific action plans and timelines for when poor performing hospitals should achieve improved performance.*

### **Response by the Department of Health**

The formal response of the then DHS published in the Auditor-General's report accepted this recommendation. It included a brief description of the collaborative process in place with hospitals for the review of performance against improvement targets. The response concluded that 'DHS will continue to review the appropriateness of improvement targets.'<sup>62</sup>

During the Committee's review, the Department of Health furnished more substantive information on action taken in response to this audit recommendation. The Department advised the Committee that:<sup>63</sup>

*The improvement targets were replaced by benchmark targets in 2009 to set consistent expectations around the performance of health services. Statements of Priorities (SOPs) are the key accountability agreements between Health Services and the Minister for Health. The annual agreement ensures delivery or substantial progress towards the key shared objectives of financial stability, improved access and waiting times, and quality of service provision. The department monitors all Statement of priorities KPIs, including elective surgery indicators on a monthly basis.*

*The Council of Australian Governments (COAG) released the National Partnership Agreement (NPA) for Improving Public Hospital Services in February 2011, which includes the introduction of national elective surgery targets. Victoria is committed to meeting the new national targets and is leading a number of implementation activities under this NPA.*

The benchmark targets referred to in the above response are 80 per cent for the proportion of category two patients waiting less than the recommended time, and 90 per cent for category three patients waiting less than the recommended time.

The Committee welcomes the positive nature of the above actions taken by the Department. It considers these actions satisfactorily address the Auditor-General's recommendation.

61 *ibid.*, p.43

62 *ibid.*, p.12

63 Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, p.10

### 3.2.2 **Lack of evidence-based targets and benchmarks**

The Auditor-General found that, excluding the indicators measuring time to emergency department care developed and reviewed by the Australasian College of Emergency Medicine (ACEM), the then DHS was unable to provide evidence of data analysis or research to support the appropriateness of applying the other indicator targets and benchmarks to Victorian public hospitals.<sup>64</sup>

From this finding, the Auditor-General concluded the lack of evidence meant it was not possible to make an informed appraisal of whether access to hospital services is good or bad depending on indicator performance. The Auditor-General added that, if hospitals and the Department are to contribute resources for reporting against the indicators and judgements are to be made about performance, targets and benchmarks should be based on rationales that are supported by evidence.<sup>65</sup>

#### **Audit recommendation 5.2**

The Auditor-General recommended the Department needs to:<sup>66</sup>

*Conduct research and analysis to determine evidence-based targets and benchmarks for access indicators.*

#### **Response by the Department of Health**

The formal response by the then DHS published in the Auditor-General's report accepted this recommendation. The response indicated that:<sup>67</sup>

*DHS will continue to strengthen the evidence base to inform decisions about the appropriate balance of resources, clinical risk and patient wellbeing when determining access indicators and targets. DHS does involve appropriately qualified clinicians in the establishment of measures and benchmarks. However, in the absence of definitive research anywhere in the world, challenging targets have been set and performance reported publicly for indicators that Victoria has implemented to improve patient access.*

During its review, the Committee sought information from the Department of Health on the nature of action it has taken in response to this audit recommendation. The Department advised the Committee as follows:<sup>68</sup>

*The department continues to support this recommendation and has been actively involved in work being done at the national level to determine evidence-based targets.*

<sup>64</sup> Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.36

<sup>65</sup> *ibid.*, p.42

<sup>66</sup> *ibid.*, p.43

<sup>67</sup> *ibid.*, p.13

<sup>68</sup> Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, p.12

*For example, in October 2009, a sub-committee of the Australian Health Ministers Advisory Committee (AHMAC) engaged PricewaterhouseCoopers (PwC) to develop options for a model for nationally consistent elective surgery listing practices, data collection and reporting. This involved an extensive review of published literature and international practice, as well as consultation with all jurisdictions, including Victoria. The final report was tabled at the October 2010 meeting of AHMAC. Findings from that report highlighted a lack of consensus internationally on the absence of evidence-based targets.*

*In relation to Emergency Department access, the department has commissioned a project to inform the implementation of the National 4 hour access target, consulting with stakeholders to define criteria for clinically appropriate exceptions to ED departure within 4 hours. This includes analysis of medical record audit data.*

*The report is pending finalisation.*

At the Committee's public hearing, the Department's Secretary further commented on the above important national developments, including the new 90 per cent target for emergency department departures within four hours by 2015, and advised that exceptions will be subject to clinical judgement within the remaining 10 per cent.<sup>69</sup>

At the public hearing, the Department's Secretary also commented more broadly on the lack of consensus internationally on the existence of evidence-based targets. The Secretary stated that:<sup>70</sup>

*Health is one of those areas where, over time, knowledge changes and therefore your knowledge of what are reasonable or challenging targets to set yourself also changes. We would reasonably want to regularly look at what new evidence is telling us about performance and whether that performance is the right measure. You need to balance that, however, against the idea of measuring something consistently over time as well. Trends over time are often just as important or provide more information about performance than getting the absolutely precise measure. I should say about health that people have been arguing for years over what the right measures are in health. That might be an explanation for why we have so many, however if you look at all the many items that we report on. Both nationally and at the state level, there are a lot of measures. I think that will continue to be the case, but I would hope that we would always be open to what the evidence told us was, at a given point in time, the right thing to be looking at.*

It is clear to the Committee that significant developments are taking place at the national level on evidence-based targets for emergency department access and elective surgery access, with the Victorian Department contributing to the research underpinning such developments.

The Committee considers it is important for the Department to ensure that, for all other state-level access targets and benchmarks, there is an adequate evidential trail to support their use.

<sup>69</sup> Ms F. Thorn, Secretary, Department of Health, transcript of evidence, 25 August 2011, p.4

<sup>70</sup> *ibid.*, p.8

**RECOMMENDATION 7:**

**The Department of Health ensure that its adoption and use of all state-level access targets and benchmarks can be supported by structured research and analysis to confirm their evidence-based status.**

**3.2.3 Presentation of public reports**

The Auditor-General's assessment of the reporting of performance in emergency care identified that, unlike the approach adopted for performance against elective surgery access indicators, the then DHS presented information on the increasing demand for emergency services and reported performance within that context.<sup>71</sup>

Through a series of manual calculations, the Auditor-General disclosed in the audit report that reported upward trends in numbers of patients treated and the number treated within specified timelines created an impression of improvement when statewide performance had actually declined if access times had been calculated as a percentage. Of particular note was the revelation that, for the measure of emergency patients admitted within eight hours, the 80 per cent target had not been achieved over the nine year period examined during the audit.<sup>72</sup>

The Auditor-General's examination in this area also disclosed that performance against the indicator measuring the number of patients who remain in the emergency department for more than 24 hours is not reported.<sup>73</sup>

The Auditor-General made two recommendations, 5.3 and 5.4 arising from the audit work on the presentation of public reports.

**Audit recommendation 5.3**

The Auditor-General recommended the Department needs to:<sup>74</sup>

*Present emergency access performance over time as the percentage of patients seen, admitted or discharged within time.*

**Response by the Department of Health**

The formal response of the DHS to this recommendation published in the Auditor-General's report referred to the national developments and stated:<sup>75</sup>

*There is currently national work to develop an agreed set of key performance indicators. This recommendation will be considered as part of this process.*

71 Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.40

72 *ibid.*, pp.41-2

73 *ibid.*, p.42

74 *ibid.*, p.43

75 *ibid.*, p.13



Information provided to the Committee during its review by the Department of Health indicated that the method of reporting of emergency access performance as a time series was adopted in 2009. The Government's new quarterly report, the *Victorian Health Services Performance Report*, presents the performance data in line with the approach recommended by the Auditor-General.

The Committee understands that reporting of performance data on the basis of the percentage of patients seen, admitted or discharged within time is likely to be a requirement under the new national emergency access indicator and target.

#### **Audit recommendation 5.4**

The Auditor-General recommended the Department needs to:<sup>76</sup>

*Include performance against access indicators measuring the number of patients with emergency department stays of more than 24 hours, and rates of HIPs [hospital initiated postponements] of surgery.*

#### **Response by the Department of Health**

The formal response of DHS to this recommendation published in the Auditor-General's report also referred to the national developments, mirroring its response to the previous recommendation.

During its inquiry, the Committee was advised by the Department that the Government's new quarterly performance reports includes, from June 2011, the number of patients that stay in hospital emergency departments for more than 24 hours. In Addition, the rates and numbers of HIPs became publicly available on the Department's website from early May 2011.<sup>77</sup>

The Committee was pleased to hear from the Department that the two matters raised by the Auditor-General in recommendations 5.3 and 5.4 have been satisfactorily addressed.

<sup>76</sup> *ibid.*, p.43

<sup>77</sup> Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, p.13



## CHAPTER 4: FAIR REPRESENTATION OF PERFORMANCE AGAINST ACCESS INDICATORS

### 4.1 Introduction

Chapter six of the Auditor-General's report examined the extent to which reports of performance against access indicators fairly represented actual performance.

The Auditor-General considered that performance data fairly represented actual performance if it is:<sup>78</sup>

- captured consistently; and
- accurate.

The Auditor-General examined performance data for access indicators against the above criteria at four selected hospitals covering the period January-June 2007.

### 4.2 Findings, conclusions and recommendations of the Auditor-General

#### 4.2.1 *Data capture and consistency*

The Auditor-General's report presented under separate headings the results of the audit examination of data capture and consistency for emergency access indicators and elective surgery indicators.

#### ***Emergency access indicators***

For emergency access indicators, the audit examination found that captured data is recorded inconsistently because of:<sup>79</sup>

- *varying interpretations of reporting rules*
- *data capture processes that are inconsistent and susceptible to error.*

The exception to this finding related to data used for reporting against the bypass indicator where data was consistently collected across hospitals and independently recorded by Ambulance Victoria.

In presenting the findings on varying interpretations of reporting rules, the Auditor-General identified that, for triage categories 1, 2 and 3 patients, data was recorded inconsistently across the four audited hospitals. Each hospital had recorded differently 'time to be seen' including conditions that determine the start of treatment and ceasing of waiting time for reporting purposes.<sup>80</sup>

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78 Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.46

79 *ibid.*

80 *ibid.*, p.47

The Auditor-General pointed out a quite serious implication of these circumstances in that:<sup>81</sup>

*Hospitals taking the earliest opportunity to 'stop the clock' may be seen to have better performance than those waiting longer, regardless of the actual time that ongoing assessment care is provided to patients.*

For the second element of the Auditor-General's findings, the audit examination detected that processes for recording the time a patient is first seen in the emergency department, or the time they leave, were also variable and susceptible to error. The Auditor-General expressed the view that, as a result, '*reported waiting times to be seen, and times to admission or discharge for some patients are likely to be inaccurate*'.<sup>82</sup>

The audit examination further found that none of the audited hospitals had documented instructions for relevant staff about how to correctly record data. The Auditor-General conveyed a telling message in the audit report that:<sup>83</sup>

*Requiring clinicians, whose immediate priority is patient care, rather than data entry, to complete forms or leave the patient to find a computer, is unlikely to produce accurate data.*

### **Elective access indicators**

The audit narrative on data capture centred on difficulties experienced at one of the audited hospitals following implementation of the new *HealthSMART* patient administration system, iPatient Manager (iPM), and concerned the ability to generate accurate reporting from that system to the Elective Surgery Information System (ESIS).

The Auditor-General considered that, because of these circumstances, '*DHS's [the Department of Human Services] ability to accurately measure and monitor performance against the elective access indicators as the iPM system is rolled out across the state is in doubt*'.<sup>84</sup>

The audit examination also found that consistency of data for reporting elective surgery access is limited because of:<sup>85</sup>

- Variable interpretations of urgency categories assigned to patients – potentially meaning that patients may not access surgery in order of priority, and where surgeons list patients as more urgent than necessary, hospitals will have an artificially higher proportion of patients to treat in shorter times, impacting on their ability to perform to targets.
- Inappropriate recording of patients as 'not ready for care' – any days spent as 'not ready for care' are removed from the total time calculated for that patient so any inconsistent recording will affect reported waiting times and numbers.

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81     ibid.

82     ibid., p.48

83     ibid.

84     ibid., p.54

85     ibid., pp.55-6

### 4.2.2 Data accuracy

The work of the Auditor-General on accuracy of data recorded for access indicators involved the checking of available source documentation with information held in DHS databases.

#### **Emergency access indicators**

Some quite serious findings were reached by the Auditor-General in this area. The presentation in the Auditor-General's report of the results of audit work was detailed and preceded by the following summary of the key findings:<sup>86</sup>

*For emergency access indicators, data used for reporting performance was:*

- *accurate for the indicator measuring the percentage spent on bypass;*
- *unable to be verified for accuracy for the indicators measuring:*
  - *the time to be seen for triage category 1, 2 and 3 patients*
  - *the percentage of non-admitted patients discharged from the emergency department in less than four hours*
- *inaccurate for indicators measuring time to admission from the emergency department due to:*
  - *inconsistent data capture processes previously discussed*
  - *errors in recording departure destination*
  - *deliberate changes to data at one of the hospitals.*

The latter findings on inaccuracy of reported performance data were described in the Auditor-General's report as derived from the recording at hospitals of three categories of data, namely:<sup>87</sup>

- patient departure time;
- patient destination; and
- whether the patient is actually admitted to an inpatient bed.

For patient departure time, the audit methodology was complex and statistically-based with details set out in an Appendix to the Auditor-General's report. The audit examination revealed that substantial levels of error of data accuracy in the patient departure time at three hospitals, after comparison of information in the patient's medical record with that recorded in the Victorian Emergency Minimum Dataset (VEMD), were caused by poor data capture processes.<sup>88</sup>

More disturbing to the Committee was the audit finding that errors at the other audited hospital were due to data manipulation.<sup>89</sup>

<sup>86</sup> *ibid.*, p.48

<sup>87</sup> *ibid.*, p.49

<sup>88</sup> *ibid.*, p.50

<sup>89</sup> *ibid.*, pp.50-1

The Auditor-General made the following two significant points in the audit report on the errors detected in this particular hospital.<sup>90</sup>

*The errors and recording practices were facilitated by poor security controls of data and lack of an audit log within this hospital's emergency department computer system. Poor data security and lack of audit logs was common among the audited hospitals and this finding was also previously made in our report Managing Emergency Demand in Public Hospitals (Report No. 71. 2004) and the follow-up to that report (Report No. 17. 2007).*

*Our finding of deliberate changes to data echoes findings of data manipulation in other jurisdictions. In our example, and others, data changes were intended to improve reported performance. It is important, therefore, that performance against access indicators is used and understood as a way to drive continual improvement of the hospital system, and not associated with the success or failure of individuals.*

On patient destination and admittance of patients, the Auditor-General found recording errors at three hospitals relating to patients who, under Commonwealth admission guidelines, receive their care entirely within the Emergency Department and are 'discharged home' from this setting. At these three hospitals, 'these patients were recorded in the VEMD as having transferred to a ward or short stay unit, though this did not occur'.<sup>91</sup>

The final audit point on accuracy of data concerning patient movement related to compliance with conditions for short stay units where three of the audited hospitals recorded patients as having transferred to an inpatient bed when they actually continued their care on hospital trolleys.

The audit analysis of data accuracy concluded with an overarching comment that:<sup>92</sup>

*Without effective quality control regimes, at both hospitals and DHS, the risk of inaccurate data being reported and subsequent misleading representation of access performance is real. To date, DHS has not undertaken an audit of the VEMD. However, before this audit, DHS started work to develop and implement an audit program that will begin in 2009.*

## **Elective surgery access indicators**

While the areas examined by audit for these access indicators detected some data errors at hospitals relating to the recording of receipt of referrals for elective surgery patients, the Auditor-General's report identified that these errors had no effect on the overall performance of two hospitals where the majority of examined referrals did not show the date they were received.

90     ibid., p.51

91     ibid.

92     ibid., p.53

### 4.2.3 Important overall audit conclusion

The Auditor-General conveyed an important message to Parliament in his final paragraph on fair representation of access performance data where he stated:<sup>93</sup>

*Due to current inconsistencies and errors, the extent to which the majority of access indicators fairly represent performance at these hospitals is questionable. There is no reason to suggest that the findings of this audit of four hospitals are not representative of problems with data capture across hospitals. The current level of effort and control directed towards accurate data capture does not match the importance placed on the role of the access indicators. These circumstances preclude the provision of reasonable assurance that data on performance published in Your Hospitals is reliable.*

## 4.3 Auditor-General's recommendations and responses by the Department of Health and hospitals

Drawing on the above audit findings and related audit conclusions, the Auditor-General made seven recommendations, four directed to DHS and three to hospitals.

### 4.3.1 Audit recommendations directed to the Department of Health

#### Audit recommendation 6.1

The Auditor-General recommended that the Department of Health (the Department) should:<sup>94</sup>

*Review and clarify rules and definitions for reporting against access indicator data.*

#### Response by the Department of Health

The Auditor-General's report identified in its commentary on varying interpretations of reported data that DHS had recognised this issue before the audit and had begun work to clarify reporting rule definitions with the aim to improve consistency of reporting.

During its review, the Committee sought information from the Department on the action it had taken concerning rules and definitions since the Auditor-General's report.

The Department informed the Committee it had taken a number of actions to clarify definitions and business rules to improve reporting of access indicator data. These actions have included:<sup>95</sup>

- the issue of a revised *Elective Surgery Access Policy*, effective from 1 October 2009, providing clearer direction to hospitals on a range of practices such as the referring and registering of patients and their removal from waiting lists, clinical prioritisation, scheduling patients for surgery, postponement of surgery and validation and record keeping;

93 *ibid.*, p.58

94 *ibid.*

95 Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, pp.15-16

- implementation of a new definition of patient management from July 2009 covering emergency department time to treatment indicators – this definition was subsequently accepted nationally;
- development by a widely-representative Technical Reference Group, including clinicians and hospital management, of a definition of registration which was implemented in September 2009;
- confirmation by Victoria's reference committee of the definition of physical departure as the end of an Emergency Department stay to support transfer and length of stay indicators; and
- submission by Victoria's reference committee of a proposed definition of triage time for consideration as part of a national review of emergency department triage categories expected to be completed in 2011.

The Committee recognises the significance of the above departmental initiatives. It considers the reported findings of the Auditor-General in 2009 on the inconsistent interpretation of reporting rules at hospital level and their adverse impact on fair representation of reported performance warranted such a response.

The Government has included the following two actions within its seven priority areas identified under its *Health Priorities Framework 2012-22: Metropolitan Health Plan*:<sup>96</sup>

- implementing continuous improvements and innovations; and
- increasing accountability and transparency.

These two priority areas are particularly relevant to the responsibility of the Department to ensure there is ongoing maximum clarity and consistency in the application of rules and definitions for the reporting by hospitals against access indicators. Optimal decision making by the various users of reported performance data is dependent on such clarity and consistency.

The Committee therefore encourages the Department to continue its improvement efforts to support hospitals in their understanding and use of reporting rules and definitions for access indicators. A measure of the effectiveness of its achievements in this area should be progressively evident in the results of its periodic audits of compliance by hospitals with reporting rules.

The Committee considers it will be important for the Department to systematically monitor the effectiveness of its improvement strategies for data clarity and consistency, including through the results of its data audits, and implement any necessary further remedial action.

#### **RECOMMENDATION 8:**

**The Department of Health regularly evaluate the effectiveness of its improvement strategies for enhancing consistency in the application by hospitals of definitions and rules for their reporting of performance against access indicators.**

96 Hon. T. Baillieu, Premier of Victoria, *Minister unveils landmark health plan*, media release, 3 May 2011



## Audit recommendation 6.2

The Auditor-General recommended the Department should:<sup>97</sup>

*Routinely audit both the Victorian Emergency Minimum Dataset (VEMD) and the Elective Surgery Information System (ESIS) for compliance with reporting rules and accuracy.*

### Response by the Department of Health

As mentioned in an earlier paragraph, the Auditor-General recognised in his report that DHS had, before the audit had taken place, commenced work to develop and implement a program for an audit of the VEMD.

During its review, the Committee requested from the Department advice on the results of the audit of the VEMD and of the ESIS as well as information on the nature of follow-up action it had taken on the results of the audits, and its plans for future periodic audits.

The Department advised the Committee on these issues in the following terms:<sup>98</sup>

*In general terms, the audits involved a random sample of patient record data as provided to the department by each health service. These records were validated by the auditors, against the records maintained by the health services with any discrepancies noted. Tolerance levels established in the preceding VAGO [Victorian Auditor-General's Office] audit at four health services were also applied in the DH [Department of Health] audits; these are explained in the audit reports. Business processes and controls associated with data recording for both VEMD and ESIS data were also reviewed by the auditors, principally by interviews and observation. Finally, IT systems security and controls were reviewed and reported upon. The audits were focused on identifying opportunities for improvement and the auditors provided recommendations based on that approach.*

*As a reasonable period of time has now passed since health services received the recommendations from the audits, the department is in the process of writing to health service CEOs requesting advice as to progress with implementation of recommendations. The department has provided advice to health services in response to requests for information about audit recommendation implementation.*

*Contractors have been engaged by the department for the next three year comprehensive round of data integrity audits of VEMD and ESIS reporting by health services.*

The Department's Office of Data Integrity is responsible for the selection of audit contractors and overseeing the management of the audits.

<sup>97</sup> Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.58

<sup>98</sup> Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, p.16

The subject of the Department's integrity audits received substantial attention in the evidence requested by the Committee from both the Department and the Auditor-General at its public hearings.

At the public hearings, the Auditor-General and his representatives raised a number of issues concerning the design and implementation of the integrity audits including sample size and sample selection, whether the audit program provides an adequate level of assurance about the integrity of data, the cost effectiveness of the audit program and how audit results are being used to improve data accuracy and strengthen the internal assurance mechanism.<sup>99</sup>

These issues were extensively pursued by the Committee with the Department at the public hearing. Subsequent to the public hearing, the Committee requested further information from the Department on the concerns that had been raised by the Auditor-General relating particularly to:

- sample sizes; and
- justification for the data accuracy/reliability checks to be categorised as audits providing an equivalent level of assurance to that professionally recognised as attributable to that description.

On sample sizes, the Department provided the following information to the Committee:<sup>100</sup>

*The department has given consideration to the matter of sample sizes for the audits it commissions, with particular attention to the number of records required to meet audit objectives and the cost and dislocation associated with large sample sizes and the benefits that may be realised. The department has typically used sample sizes of 10, 30 or 60 records, with the objective to report on the processes, controls, IT systems, management oversight and governance (including internal audit) associated with data recording and reporting. The department is satisfied that samples of this size are sufficient to monitor compliance and identify positive practices and areas for improvement at each health service.*

*The department conducted one series of spot audits using larger statistical samples. The results achieved were not considered any more informative in terms of examining data collection and reporting systems, processes, controls and governance, and informing continuous improvement in hospitals.*

*The department will continue to review the issue of sample sizes and sampling methodologies in conjunction with auditors, to balance audit objectives and the level of assurance required with the costs of larger sample sizes and the dislocation caused for health services.*

On categorisation of its integrity reviews as audits, the Department stated:<sup>101</sup>

*Auditors engaged by the department comply with standards made by the Auditing and Assurance Standards Board.*

99 Mr D. Pearson, Auditor-General, transcript of evidence, 25 August 2011, p.9

100 Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 11 October 2011, p.4

101 *ibid.*, pp.4-5

*Some engagements have been undertaken in accordance with the standards applicable to an agreed procedure. In these cases, factual findings and recommendations were provided by the auditor, without a formal audit opinion. Because the term audit has a wide range of uses, the Auditing and Assurance Standards Board has more recently required assurance practitioners to distinguish between assurance engagements and agreed upon procedure engagements.*

*Reports provided by the department have been made available to the public. In each case, the auditor has identified the work as either a “review” or an “audit”, and has clearly identified the scope, approach and limits of their work.*

The Committee has considered the important reservations on sample sizes and other core aspects of the Department’s integrity audit program conveyed to it in quite direct terms by the Auditor-General.

The Committee has also assessed the above views and supporting information provided by the Department on these matters.

While recognising the Department’s stated position and its commitment to continuous review, the Committee sees the overriding issue as the responsibility of the Department to be able to demonstrate that its integrity audit methodologies are always professionally defensible. Adherence to this criterion is considered by the Committee to be fundamental to ensuring that the various users of performance information for hospitals, such as the Parliament, the Government, the Department itself, hospital management, hospital patients and the taxpaying community etc., can have complete confidence in the accuracy and reliability of reported data. In other words, the data must always be of optimum quality in order to support key decision making by these users.

The emergence of new national health reporting obligations for Victoria, and the associated funding implications to the State, reinforces the imperative for quality reported information.

The Committee therefore considers that the Department needs to incorporate within its governance practices provision for periodic external independent assessments of its audit practices, including sampling methodologies, against professional yardsticks. The results of these independent assessments of the professional standing of audit practices, which could occur every three to five years, would constitute important input into the Department’s continuous improvement strategies.

#### **RECOMMENDATION 9:**

**The Department of Health commission periodic external independent evaluations of the professional standing of the methodologies employed by its Office of Data Integrity in periodic audits of hospital performance and include the results of such evaluations in its annual report to Parliament.**

### Audit recommendation 6.3

The Auditor-General recommended that the Department needs to:<sup>102</sup>

*Facilitate implementation of information technology systems that support simple, real-time data capture within hospital emergency departments.*

While the Auditor-General's report did not extensively canvass information technology issues, it was evident to the Committee that implementation of this audit recommendation would help to overcome the delays and inconsistencies in data capture for patient access to emergency departments that were identified in the audit report.

### Response by the Department of Health

The Department advised the Committee on its actions taken in response to this audit recommendation in the following terms:<sup>103</sup>

*As part of the Emergency Access Reference Committee – ICT [Information Communication Technology] subcommittee (EARC – ICT), work was undertaken including stakeholder forums in 2010 to develop a list of functional requirements for ED ICT.*

*Functional requirements have been developed to inform the long-term ICT strategy for ED services, within the context of the broader health service systems...*

*A departmental business case was prepared to implement comprehensive ED ICT systems in two lead agencies integrated with existing HealthSMART systems.*

*Discussions are continuing within the department regarding the development and costs of ED ICT.*

*The department is in the process of supporting implementation of new emergency department information systems (EDIS) at the Austin Hospital and the Frankston Hospital.*

The Committee has assessed the above brief high-level information provided by the Department and notes the directions proposed for implementation of EDIS. The Committee welcomes the specific EDIS actions underway at the Austin and Frankston hospitals. The other actions emanating from the work of a sub-committee of the Emergency Access Reference Committee also appear to be positive.

From the Committee's perspective, what is important now is that meaningful progress is made on the implementation of EDIS across the hospital network. For this to occur, such implementation needs to be categorised as a strategic priority, with clear milestones linked to available funding. These milestones would support the Department's monitoring and reporting of progress to achieve, without excessive delay, its intended objective for EDIS across hospitals.

<sup>102</sup> Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.58

<sup>103</sup> Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, p.17

**RECOMMENDATION 10:**

**The Department of Health establish clear milestones for the implementation of Emergency Department information technology systems across the hospital network and inform Parliament in its annual report on the extent of achievement of the established milestones.**

**Audit recommendation 6.4**

The Auditor-General recommended that the Department needs to:<sup>104</sup>

*Review the reporting capability of the iPM waiting list module and facilitate improvements as required.*

This audit recommendation arose from the Auditor-General's revelation that one audited hospital had expressed serious concern regarding the accuracy of data submitted to DHS from the iPM waiting list module. The Auditor-General pointed out that, given the issues experienced at this hospital, '*DHS's ability to accurately measure and monitor performance against the elective access indicators as the iPM is rolled out across the state is in doubt*'.<sup>105</sup>

**Response by the Department of Health**

The Department responded as follows to the Committee on this audit recommendation:<sup>106</sup>

*At the time of the VAGO audit, the Department ascertained that other health services that had implemented iPM were successfully submitting elective surgery data extracts to the Department. As outlined in the department's response to the VAGO audit, the Department worked collaboratively with [the health service] to resolve the difficulties encountered.*

*Subsequent to that, detailed examination of elective surgery data reported by other iPM sites identified some complex data migration and business process issues, which had the effect of overstating the size of the waiting list and individual waiting times. The department (including the HealthSMART team) again worked collaboratively with those health services to resolve these issues, and as at May 2011, the department is working to resolve minor outstanding issues at only one iPM site.*

On the basis of the material provided by the Department, the Committee considers that appropriate action has been taken in response to this audit recommendation.

**4.3.2 Audit recommendations for hospitals**

The Auditor-General's report included three recommendations for hospitals in the chapter dealing with fair representation of access performance. The Auditor-General recommended that hospitals need to:<sup>107</sup>

104 Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.58

105 *ibid.*, p.54

106 Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, p.18

107 Victorian Auditor-General's Office, *Access to Public Hospitals: Measuring Performance*, April 2009, p.58

- *improve security controls on computer systems used for recording VEMD data and utilise audit log systems* [audit recommendation 6.5]
- *internally monitor compliance with policy regarding reporting of access indicators and provide appropriate instruction and training to staff submitting data* [audit recommendation 6.6]
- *conduct internal audits of accuracy of VEMD and ESIS data* [audit recommendation 6.7].

The formal response by DHS to these recommendations published in the Auditor-General's report indicated acceptance of the recommendations and stated that '*they constitute good data management practice*'.<sup>108</sup>

While this is not an inaccurate description, the Committee also considers that the recommendations represent fundamental requirements for effective governance within hospitals.

### **Response by the Department of Health**

The Department provided quite positive responses to the Committee on the actions that have been taken since the Auditor-General's report.<sup>109</sup>

On improved security controls, the Department pointed out that all health services have been instructed to implement improved security controls within their information technology systems. These instructions specifically related to unique user identification and passwords and transaction logging of key data fields. The Department added that at this stage implementation of transaction logging was not universal as some systems require significant change. The Department's coming three year audit program will monitor this facet of the control environment.

With regard to the monitoring of hospital compliance with access policies, the Department advised it has implemented a range of data integrity initiatives to ensure hospitals are in full compliance with policies related to access indicator reporting. It indicated that comprehensive definitions, standards and collection instructions are provided in manuals so that stakeholders have the one, consistent suite of guidelines and requirements. Recognising that data integrity is a prime responsibility of health service boards, the Department identified that it was currently developing data integrity guidelines for health services. In response to a Committee request for an update on the status of these guidelines, the Department indicated they will be finalised after the 2011 audits have concluded to ensure that new audit recommendations are addressed in the guidelines.

On the final audit recommendation concerning a need for internal audits of the accuracy of VEMD and ESIS data, the Committee welcomed information furnished by the Department that it had directed that Chairs of health service boards of management ensure data accuracy is included in the terms of reference of their audit committee and that regular internal audits are undertaken. In addition, responsible officers of each health service must now provide a data accuracy attestation in annual reports and the Minister for Finance has issued a new Standing Order addressing data integrity issues which encompasses health services in its coverage.

<sup>108</sup> *ibid.*, p.14

<sup>109</sup> Ms F. Thorn, Secretary, Department of Health, letter to the Committee, 2 June 2011, pp.18-21



Finally, the Department mentioned that the new three year data integrity audit program will also report upon health service internal audit activity with respect to data integrity.

The Committee welcomes the information presented by the Department in response to the three audit recommendations directed at hospitals. The advised actions, when finalised, should lead to improved governance practices on the issues identified by the Auditor-General across the hospital network.

