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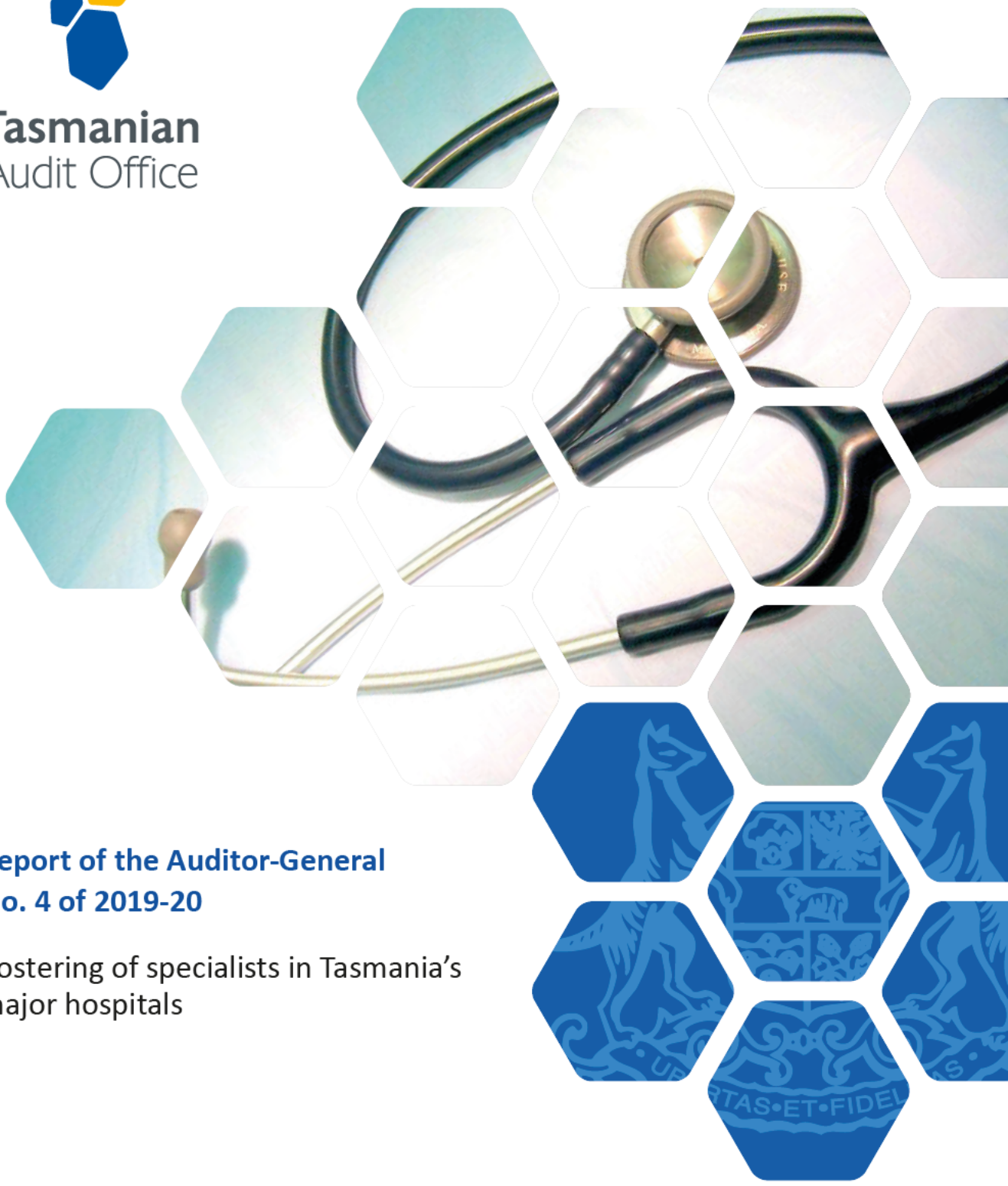

Report of the Auditor-General No. 4 of 2019-20

Rostering of specialists in Tasmania's major hospitals

November 2019

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Our primary responsibility is to conduct financial or 'attest' audits of the annual financial reports of State entities. State entities are defined in the Interpretation section of the Audit Act. We also audit those elements of the Treasurer's Annual Financial Report reporting on financial transactions in the Public Account, the General Government Sector and the Total State Sector.

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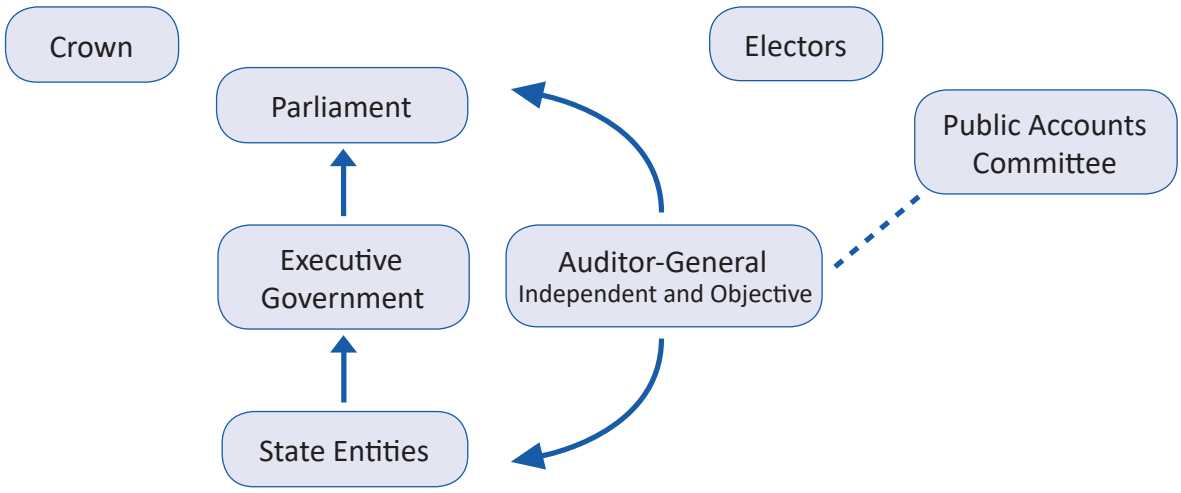

TASMANIA

2019
PARLIAMENT OF TASMANIA

Report of the Auditor-General
No. 4 of 2019-20

Rostering of specialists in Tasmania's major hospitals

November 2019

Presented to both Houses of Parliament pursuant to
Section 30(1) of the *Audit Act 2008*

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21 November 2019

President
Legislative Council
HOBART

Speaker
House of Assembly
HOBART

Dear Mr President
Dear Ms Speaker

REPORT OF THE AUDITOR-GENERAL
No. 4 of 2019-20: Rostering of specialists in Tasmania's major hospitals

This report has been prepared consequent to examinations conducted under section 23 of the *Audit Act 2008*. The objective of the review was to express a limited assurance opinion on the rostering of specialists in Tasmania's major hospitals.

Yours sincerely

Rod Whitehead
Auditor-General

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TABLE OF CONTENTS

AUDITOR-GENERAL'S INDEPENDENT ASSURANCE REPORT 1

EXECUTIVE SUMMARY 4

1. INTRODUCTION 8

2. ARE ROSTERS MANAGED IN A TRANSPARENT AND FAIR MANNER? 13

3. DO CULTURAL AND SYSTEMIC ISSUES IMPACT ON THE TRANSPARENT AND FAIR ROSTERING OF SPECIALISTS? 16

4. DO CURRENT ROSTERING PRACTICES INCREASE THE RISK EXPOSURE OF THS? 18

LIST OF ACRONYMS AND ABBREVIATIONS 20

APPENDIX 1: LIST OF MEDICAL SPECIALIST COLLEGES IN AUSTRALIA 22

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AUDITOR-GENERAL'S INDEPENDENT ASSURANCE REPORT

This independent assurance report is addressed to the President of the Legislative Council and the Speaker of the House of Assembly. It relates to my review of the rostering of specialists in Tasmania's major hospitals.

REVIEW OBJECTIVE

The objective of the review was to form a limited assurance conclusion on the efficiency and effectiveness of the rostering of specialists in Tasmania's major hospitals, with a focus on assessing whether the rostering of specialists was controlled and managed in a transparent and fair manner. The review covered transparency of rostering arrangements, fairness of rostering arrangements between specialists in a hospital department or unit and other potential risks; for example, specialist fatigue.

REVIEW SCOPE

In order to provide an informed insight to the rostering of specialists and manage the scope of the review, the following medical specialties at each of the four major hospitals were selected for review:

- anaesthetics and surgery
- general medicine.

The review examined rostering practices in place during the period from August 2018 to the date of this Report.

REVIEW APPROACH

The review was conducted in accordance with Australian Standard on Assurance Engagements ASAE 3500 *Performance Engagements* issued by the Auditing and Assurance Standards Board, to express a limited assurance conclusion.

The procedures performed in a limited assurance review vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement and consequently the level of assurance obtained in a limited assurance review is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

The review evaluated the following criteria:

1. Are rosters managed in a transparent and fair manner?
    - 1.1 Is the responsibility for establishing and managing changes to rosters clearly defined?
    - 1.2 Does technology assist in developing, managing and controlling rosters?
    - 1.3 Are timesheets used appropriately to assist in managing rostering of specialists?
2. Do cultural and systemic issues impact on the transparent and fair rostering of specialists?
    - 2.1 Is the Head of Department provided with the necessary skills and tools to manage rostering?
    - 2.2 Does the ability to successfully recruit and retain specialists impact on the transparent and fair rostering of specialists?
    - 2.3 Is transparency and fairness impacted by specialists practicing in private hospitals?
    - 2.4 Is non-clinical time managed in a transparent and fair manner?
3. Do current rostering practices increase the risk exposure of the Tasmanian Health Service (THS)?

I have conducted my limited assurance review by making such enquiries and performing such procedures I considered reasonable in the circumstances.

Evidence for the review was obtained primarily through discussions with relevant personnel and examining corroborative documentation.

Discussions were held with the relevant head of each department at each hospital as well as their Clinical Stream Directors, where relevant, and the Executive Directors of Operations and of Medical Services. Discussions were also held with staff from the Medical Workforce Unit (MWU) in the THS.

No review procedures were performed over the actual working patterns of specialists against rostered time. Sample rosters for each of the departments subject to the review were examined, but no procedures were undertaken to test for accuracy of the rosters against actual hours worked.

I believe that the evidence I have obtained is sufficient and appropriate to provide a basis for my conclusion.

MANAGEMENT RESPONSIBILITY

Ultimate responsibility for the strategic direction of Tasmania's major hospitals rests with the Secretary of DoH, who is also responsible for the performance of the THS and the THS Executive.

THS has responsibility and accountability for governing and delivering high quality, efficient and integrated healthcare services through the public hospital system and primary and community health services. THS was created on 1 July 2015 following the amalgamation of the three former Tasmanian Health Organisations (North, North West and South) which, prior to 2012, were themselves part of the former Department of Health and Human Services. Under the *Tasmanian Health Service Act 2018*, THS is accountable to the Secretary of DoH who in turn is responsible to the Minister for Health (Minister) for THS's performance.

The THS has an executive structure to oversee operations and clinical practice within the hospitals. Specific responsibility for rostering of medical specialists sits with the head of each department (HoD) or heads of unit within each hospital. For the purposes of this review, they are the HoDs of:

- anaesthetics and surgery
- general medicine.

Serious rostering issues can be escalated to, depending on the hospital, the Clinical Stream Director (or equivalent) or the Executive Director Medical Services.

AUDITOR-GENERAL'S RESPONSIBILITY

In the context of this review, my responsibility was to express a limited assurance conclusion on the efficiency and effectiveness of the rostering of specialists in Tasmania's major hospitals, as evaluated against the criteria.

INDEPENDENCE AND QUALITY CONTROL

I have complied with the independence and other relevant ethical requirements relating to assurance engagements, and apply Auditing Standard ASQC 1 *Quality Control for Firms that Perform Audits and Reviews of Financial Reports and Other Financial Information, and Other Assurance Engagements* in undertaking this assurance review.

AUDITOR-GENERAL'S CONCLUSION

Based on the procedures performed and evidence obtained, the following matters have come to my attention:

- while the process for establishing and managing rosters is generally defined, it is predominantly manually based and not usually reconciled to hours worked

- there is a system of trust, with few controls, that operates in monitoring specialist's time within the public system which means it is not possible to identify whether time allocated and worked is transparent or fair
- there is a heavy reliance on the HoD within hospitals to monitor the workload of the specialists within their Department. However, those Heads of Department are not always recruited to a set of expectations (through a Statement of Duties and designated managerial training) to assist them in fulfilling this important accountability role
- without transparency over hours worked, the risk profile of the THS is increased with greater exposure to the risks of specialist fatigue, loss of accreditation and cost to the health system.

These matters cause me to believe the rostering of specialists in Tasmania's major hospitals has not been performed to an optimal level with respect to efficiency and effectiveness as evaluated against the identified criteria, or the objective of the review, as a whole.

[redacted]

Rod Whitehead

Auditor-General

21 November 2019

EXECUTIVE SUMMARY

SUMMARY OF FINDINGS

Tasmanian hospitals require the clinical expertise and leadership of its most senior doctors as one critical element to run effectively and safely. However, this requirement must be balanced with accountability of senior medical staff as public hospital employees. While clinical outcomes are paramount, there needs to be demonstrated efficiency of time spent in the public system through transparency of rostering arrangements as well as demonstrated fairness to all staff in the medical department or unit.

We reviewed procedures in two departments (anaesthetics and surgery, and general medicine) across each of the state's major hospitals. We found that, generally, the rostering of specialists in Tasmania's hospitals is not effectively controlled.

The HoD for each medical unit within a hospital is accountable for rostering within their department. This position is the supervisor and manager of the other specialists in the department. Whilst this position is usually paid a management allowance (the percentage amount depends on the size and complexity of the department), for taking on the additional leadership responsibilities the role requires, we were informed by some HoDs that there was limited additional administrative time allocated to undertake these management tasks. This may be attributed to the fact that most HoDs have no specific statement of duties for this position.

We expected to find a training and development process for HoDs given their management skills are critical to transparent and fair operations. However, we were informed HoD learning and development tends to focus on clinical matters, and it is up to each individual HoD to self-select into more managerial-based training such as human resources, industrial relations and leadership.

Our enquiries and inspection of documentation identified a diversity of practice was evident in relation to rostering across departments and hospitals. In some instances HoDs delegated responsibility for the preparation and management of the roster to administrative support officers and in others to a registrar or specialist within the department. Whilst there appeared to be general acknowledgement as to where rostering responsibilities sat, there was a degree of informality around the allocation of responsibilities for roster management.

When we examined current procedures to develop and manage rosters, we found that practices are largely manually, rather than technology, based. Such practices means that it was difficult to track changes to rosters and provide transparency across all specialists in the department.

Across all hospitals, there exists a high degree of trust in specialists. This trust was demonstrated in a number of ways including the take-up of autopay arrangements (available through relevant industrial agreements) and sporadic use of timesheets to demonstrate actual hours worked.

In addition, there is little oversight of any time worked in private hospitals and non-clinical time. Lack of transparency in these areas has the potential to lead to an increased risk profile of the THS. These risks include potential for misuse of rostered non-clinical time, safety risks from fatigue and potential for an increased cost profile.

Our review identified the inability to successfully recruit and retain specialists places increased pressure on the management of rosters. This has the potential to increase operational risks through increased hours worked by each specialist, less flexibility to take time off and more work undertaken by more junior doctors and locums and possible loss or downgrading of accreditation.

RECOMMENDATIONS

We recommend DoH:

1. Conduct a detailed review of how specialists account for their time in order to develop a range of improvements to this process, consequently reducing risks to the THS through tighter controls. This review should consider whether rosters be managed within departments or at a more centralised level and whether they be prepared by specialists or administrative staff.
2. Consider planning and executing a rollout of a rostering and time management system across all medical departments within all major hospitals and train each hospital department in using the software to manage and account for specialists' time. This system should have consistent access controls, monitoring and reporting.
3. Consider mandating the use of timesheets in all hospital departments, either electronically (preferred), or manually for submission within the following month. This would enable specialist hours to be more transparent, providing evidence of fairness to the Tasmanian Health Service and specialists themselves.
4. Develop a Statement of Duties for all HoD and invest in transitional and ongoing managerial and leadership development for these roles.
5. Consider recording time scheduled for private practice on other premises in specialist rosters to increase transparency, assess fairness and better manage specialist fatigue.
6. Assess whether departments need to factor in appropriate levels of non-clinical time to rosters to enable specialists to better structure their working days.

SUBMISSIONS AND COMMENTS RECEIVED

In accordance with section 30(2) of the *Audit Act 2008* (Audit Act) a summary of observations was provided to DoH and THS, the Treasurer, Minister for Health, with a request for submissions or comments.

Submissions and comments that we receive are not subject to the audit nor the evidentiary standards required in reaching an audit conclusion. Responsibility for the accuracy, fairness and balance of these comments rests solely with those who provided the response. However, views expressed by DoH and THS were considered in reaching our conclusions.

Section 30(3) of the Audit Act requires that this Report include any submissions or comments made under section 30(2) or a fair summary of them. Submissions received are included in full below.

Thank you for the opportunity to respond to the draft independent assurance report - Rostering of specialists in Tasmania's major hospitals.

The Tasmanian Government welcomes the Auditor-General's report into this important aspect of our State's health system. The recommendations and findings contained within the report outline several opportunities to improve safety, transparency, fairness and accountability through enhanced workforce management processes and investment in our senior clinical leaders.

It is pleasing to note that this report highlights the high level of trust in our senior clinicians and the important role that they play across the public and private hospital systems in Tasmania. The Government is keen to examine the recommendations closely to ensure that, consistent with good governance of our public sector, this trust is balanced with evidence that objectives are achieved, risks are managed effectively, and finite public resources are used responsibly and with accountability.

The safety of our patients and staff is paramount. The link between potential impact of specialist fatigue and the need to monitor and manage clinical hours across the public and private system is noted.

The Government remains committed to looking at how our system is operating and what we can do better as part of an ongoing process of improvement. Over the past five years, the Government has brought in reforms to clarify and strengthen accountability in Tasmania's health system, with the Secretary of the Department of Health now the single point of accountability for the planning, management and delivery of healthcare in this state, and stronger local leadership for our hospitals. The findings of this report are consistent with the need to invest in local leadership for our hospitals, recognising the important role of Heads of Department as leaders within our system.

To this end, the Department and the Tasmanian Health Service (THS) must leverage these reforms to address the issues and risks raised in this report. Specifically, Tasmania's Health System Access Solutions includes clinical risk management, cultural improvement and process improvement strategies at the Royal Hobart Hospital. Transition to statewide rollout of these initiatives should include consideration of synergies with the recommendations of this report.

This report provides some strategies and solutions to enhance workforce management processes at the THS. The proposed changes are likely to require some cultural change. This must be undertaken in collaboration with clinicians and their relevant professional bodies to ensure that we do not impose unnecessary administrative burden on staff, or introduce barriers to attraction and retention of senior clinicians in the public hospital system.

Hon Sarah Courtney MP
Minister for Health

Thank you for your Report. I am pleased that it provides a comprehensive situational analysis of current rostering practices and constructive recommendations on the management of the associated issues and risks.

The Department of Health is currently working very closely with the Tasmanian Health Service (THS) to plan and implement a range of governance and improvement initiatives that intersect with the recommendations of this Report, including investments in strengthening local leadership.

The THS continues to work to improve service delivery and support statewide coordination and the local management of health services. The implementation of a clinical stream structure in each region and the appointment of Clinical Stream Directors will ensure the strengthening of local leadership and empowering decision making at the local level. Clinical Directors hold responsibility for managing the performance of all services within their clinical stream including to operationally manage all personnel within the clinical stream. The Clinical Directors are tasked with improving rostering practices, ensuring there is transparency and accountability in regard to the efficient and effective use of allocated resources.

It is acknowledged that an electronic rostering and time management system is recommended. Such a system must be interoperable with existing and emerging Human Resources and payroll IT systems. The Business Systems Unit of the Department will work with the THS to investigate the options available and provide me with advice on implementation risks, strategies and options.

I note that the Government's recently announced review of the public service's draft terms of reference includes identifying opportunities to deliver government services and other initiatives more efficiently or effectively, including information technology platforms. The review of options for rostering systems will consider any opportunities in this regard.

I encourage all clinical leaders and aspiring leaders to consider enhancing their leadership and management credentials through investment in self education and training. The Department provides a range of training opportunities through the Agency's Learning Management System. Our online Manager Essentials package also provides information and resources needed to manage staff in the Department of Health.

In addition, State Government has partnered with the University of Tasmania to provide access to a range of HECS scholarship eligible diploma and postgraduate qualifications in health to eligible employees of the Department of Health and the THS, including a postgraduate leadership program.

Kathrine Morgan-Wicks
Secretary
Department of Health

1. INTRODUCTION

1.1 In a 2017 Australian survey[1] on the 'Image of Professions', the most highly regarded professionals are nurses (94% of respondents rated them highly or very highly), followed by doctors (89%). The Australian experience is mirrored overseas where the most recent annual Gallup poll[2] in the United States ranked nurses and doctors at positions one and two of most trusted professionals. Thus, medical doctors occupy a privileged position in the community, being a trusted and highly regarded profession.

1.2 Specialists are the most senior types of doctor in the hospital system. As Fellows of their respective Medical Colleges, they are able to access private practice and can choose to operate within the public or private sector or across both systems in their chosen specialties.

1.3 While specialists employed in the public system receive a base salary, they also have access to a range of allowances and other benefits. Nevertheless, it can be challenging to recruit and retain specialists, particularly in the three major hospitals located across the North and North West of Tasmania.

1.4 This combination of a high degree of public trust, coupled with the expenditure of significant public funds, means that specialists are expected to show a measure of accountability and transparency in the way in which they perform their duties.

1.5 This review focused on one aspect of that accountability, that being, specialists' time, as represented through rostering and time recording arrangements in the State's four major hospitals.

STRUCTURE OF TASMANIA'S MAJOR HOSPITALS

1.6 Tasmania's major hospitals are part of the THS. The THS Executive (comprising the Chief Operating Officer, Chief People and Culture Officer and Chief Corporate Officer) oversees the operations of, and clinical practice within, the hospitals. The Executive ultimately reports to the Secretary of DoH.

1.7 Tasmania four major hospitals are:

- Royal Hobart Hospital (RHH) – located in Hobart
- Launceston General Hospital (LGH) – located in Launceston
- North West Regional Hospital (NWRH) – located in Burnie
- Mersey Community Hospital (MCH) – located in Latrobe.

1.8 There are other components to the THS that were outside the scope of this review.

WHAT IS A SPECIALIST?

1.9 Doctors within major hospitals are referred to by a number of titles. A key differentiation is between those classified as 'junior doctors' and those classified as 'senior doctors'. Within each of those classifications there are different categories and terminologies, as follows:

Junior doctors

- Intern – once a student has graduated, they can apply for a hospital internship, which is a period of mandatory supervised clinical experience. To meet the requirements for full registration, an intern must satisfactorily complete a minimum of 47 weeks full-time equivalent service, including core terms in emergency medicine, medicine and surgery.

1 http://www.roymorgan.com/findings/7244-roy-morgan-image-of-professions-may-2017-201706051543
2 https://news.gallup.com/home.aspx?g_source=logo

- Resident Medical Officer (RMO) – following internship, an RMO may spend a further one or two years working in the hospital across a range of different clinical areas to gain more experience. They will have a higher general level of responsibility than an intern.
- Registrar and Senior Registrar – a junior doctor who is usually working towards a vocational speciality (meeting the pre-requisites of the relevant speciality College, such as the Royal Australasian College of Surgeons – see Appendix 1 for a full list of Colleges). Some Registrars are employed as 'Service Registrars' who are working at the same level as other Registrars, but not towards the College program. Registrars have a much greater level of responsibility than RMOs and this increases with years of experience.
- Senior Registrars have successfully completed all fellowship examinations relevant to their training program and employment, and are within one year of obtaining specialist fellowship (or dual fellowship). Senior Registrars are sometimes also referred to as senior doctors.

Senior doctors

- A doctor that has been awarded a Fellowship of one of the medical Colleges and is eligible to register and be recognised as a registered specialist with the Medical Board of Australia.
- Some of the titles used for senior doctors include:
    - an abbreviation of their College speciality, for example, FACEM (Fellow of the Australasian College for Emergency Medicine)
    - consultant
    - managerial title, for example, Clinical Director
    - medical specialist
    - senior medical officer
    - senior specialist
    - specialist
    - specialist clinician
    - staff specialist
    - the title of their specialty, for example, Endocrinologist, Paediatrician, Oncologist or Orthopaedic Surgeon
    - visiting medical officer (VMO)
    - visiting medical specialist.

1.10 While the focus is on specialist rostering, it should be acknowledged that there is a grade of senior practitioners – Career Medical Officers or CMOs – who work semi-independently in a chosen field and are not pursuing specialist qualification. A CMO is a medical practitioner with general medical registration who is beyond internship, does not possess a specialist qualification, is not a trainee of a medical specialist college, is employed by a hospital employing entity and it not seeking a specialist qualification at the time of their employment. CMOs often participate in the senior roster, alongside specialists.

Locums

1.11 A locum is a doctor temporarily contracted through a private agency, who is engaged to assist when there are shortfalls in particular specialties within a hospital.

1.12 For the purposes of this Report, we will use the collective term – specialists – to refer to all senior doctors. Where it is necessary to make a particular distinguishing point, we will additionally use the terms Senior Registrar, VMO or locum.

INDUSTRIAL ENVIRONMENT FOR SPECIALISTS

1.13 The regulator of all medical practitioners is the Australian Health Practitioner Regulation Agency (AHPRA). Specialists can operate in private practice and/or as salaried employees in public hospitals. Specialists in public hospitals are employed under state-based industrial agreements.

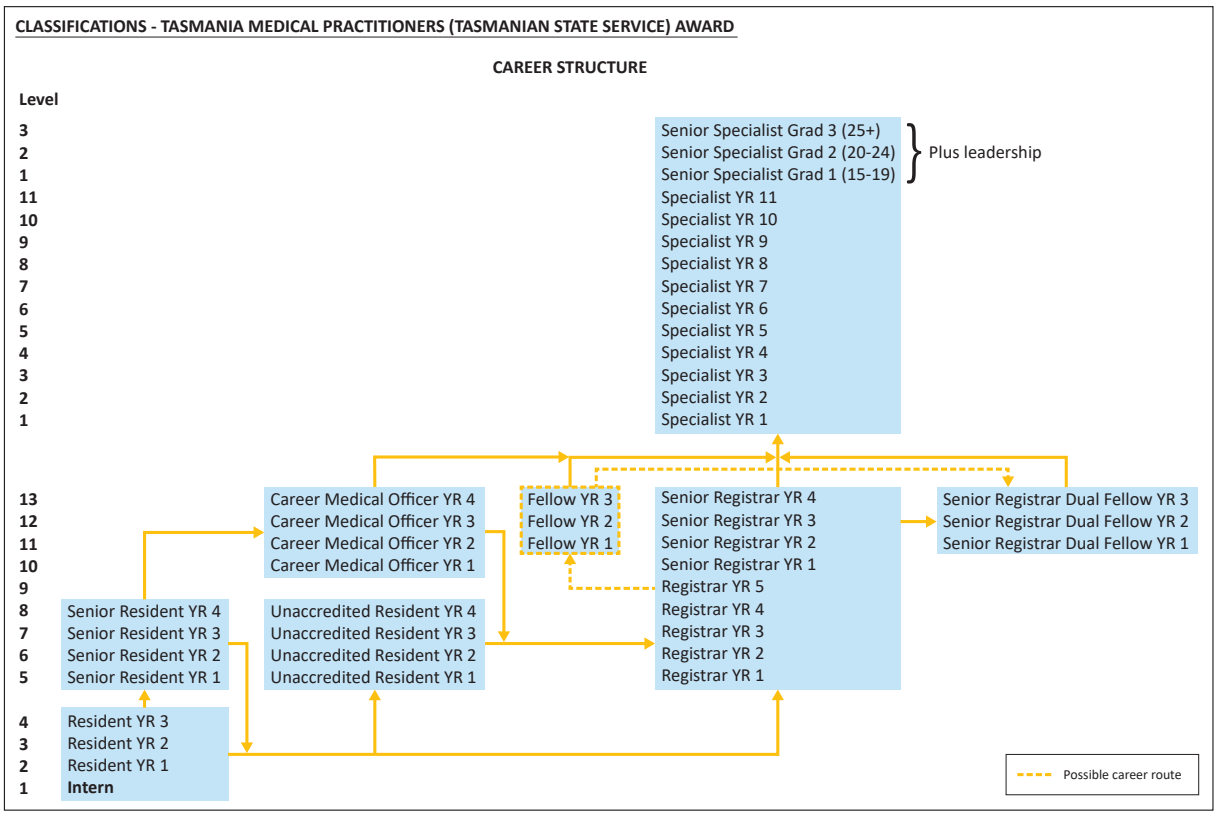
Specialists employed in the public system

1.14 The main industrial instruments for specialists (not including VMOs and locums) in Tasmania's major hospitals are:

- *Salaried Medical Practitioners (Tasmanian State Service) Agreement 2017*[3] (the Agreement)
- *Medical Practitioners (Tasmanian State Service) Award 2018*[4] (The Award).

1.15 Salary classifications for specialists are based on 'years of experience', which accrue each anniversary starting one calendar year from the date of Fellowship of a recognised Australian College. Once a specialist exceeds 15 years' experience they can apply to attain 'senior specialist' status. Progression is by assessment of suitability, including such issues as level of responsibility and leadership roles.

Figure 1: Extract from the Award showing classifications of doctor in the THS



3 https://www.tic.tas.gov.au/__data/assets/pdf_file/0017/402335/T14573-of-2017-Salaried-Medical-Practitioners-TSS-Agreement-2017.pdf

4 https://www.tic.tas.gov.au/__data/assets/pdf_file/0004/407686/T14572-Medical-Practitioners-Public-Sector-S099.pdf

1.16 The industrial instruments for specialists contain a range of built-in allowances and benefits in addition to those included in other State Service Awards, including, *inter alia*:

- allowance in lieu of Private Practice Scheme (PPS) – for specialists that cannot access the PPS
- market allowance – case-by-case basis (must be approved by the Employer, through the State Service Management Office)
- on-call allowance – amount determined by the number of nights (for example 1:4, 1:1 etc) that a specialist is on call
- sabbatical leave
- communication allowance – fixed annual amount
- managerial allowance – for specialists who head up a Department/Division of the hospital, with the level determined by the relevant delegate
- North West Tasmania recruitment and retention allowance
- professional development – fixed annual amount, not included in calculation of other entitlements, and Continuous Professional Development leave
- full time specialists may choose between provision of a fully maintained motor vehicle with designated parking, or an annual allowance in lieu of the fully maintained motor vehicle and parking. Part time specialists are entitled to the motor vehicle allowance on a pro rata basis
- salary aggregation – for regular patterns of work. For example, an allowance in lieu of call-back overtime or out-of-hours penalty rates
- travel and meal allowances – similar to other industrial arrangements.

Visiting specialists

1.17 VMOs are already in private practice, and are on-boarded to assist with a specific type of service in public hospitals, for example, orthopaedic surgery. The main industrial instrument for VMOs in Tasmania's major hospitals is the *Tasmanian Visiting Medical Practitioners (Tasmanian State Service) Agreement 2016*[5] (VMO Agreement). Conditions include:

- committee leave for a national or international professional appointment
- flat hourly rate on-call allowances
- market allowance may apply on a case-by-case basis – approved by Employer
- no extra claims of salary or conditions
- only fixed-term – commonly three years, not ongoing appointments
- paid more base salary on an hourly rate than SMOs but few other entitlements
- restricted to work a maximum of 18 hours per week, other than in exceptional circumstances
- sabbatical leave
- salaries either at a 'rolled-up' rate with no leave entitlements or with paid leave benefits
- salary aggregation allowed
- teaching and research responsibilities considered a normal part of working hours.

5 https://www.tic.tas.gov.au/__data/assets/pdf_file/0008/360458/Tasmanian_Visiting_Medical_Practitioners_Tasmania_State_Service_Agreement_2016_-_T14440_of_2016.pdf

Locums

1.18 Locums are paid as contractors. A contract managed by the THS is in place for provision of Locum Medical Practitioners. At present the contract provides for a provision of a preferred provider.

ROSTERING INDUSTRIAL ENVIRONMENT

1.19 The hours of work for specialists are 38 hours per week or not less than an average of 76 hours per fortnight comprised of roster periods of between four and not more than ten hours, exclusive of a meal break. Ordinary hours are 7am-7pm (Monday-Friday). By mutual agreement, work outside these hours can still be considered as ordinary hours if the total is below 76 hours a fortnight.

1.20 Specialists have flexibility in how they deliver their 76 hours per fortnight in the public system. For example, a doctor may work 86 hours in one fortnight and 66 hours in the next fortnight. To compensate for these variations, timesheets for doctors are usually posted in arrears. Specialists can also "consolidate" their hours to essentially achieve their 76 hours per fortnight in a small number of working days. This would provide them with 'spare' working days to undertake private practice work, research projects or other relevant activities.

1.21 The Agreement states that rostering should be done four weeks in advance and should not be changed without four weeks' notice, except where there is a genuine emergency.

On-call and call-backs

1.22 An allowance is paid for a specialist to be on-call. The amount of allowance is variable depending upon the ratio of specialists in the particular department. When called back, a specialist is entitled to a minimum of three hours (including travelling time) paid at double time, with anything over three hours paid to the nearest half hour at double time. Additional hours worked that are not call-backs accrue excess time (commonly referred to as time off in lieu - TOIL).

1.23 Junior doctors (up to and including senior registrars) are paid penalty rates for all additional time worked.

Safe working hours

1.24 Where a specialist is working more than 88 hours per fortnight, the THS has an obligation to monitor the clinical workload and rostering practices to ensure:

- rostering is appropriate for the specialist's training requirements and in accordance with the *National Code of Practice – Hours of Work, Shiftwork and Rostering of Hospital Doctors*[6]
- clinical supervision is appropriate for the level of training
- teaching and feedback opportunities are appropriate
- measures to monitor and minimise fatigue are in place.

6 Australian Medical Association *National Code of Practice: Hours of Work, Shiftwork and Rostering for Hospital Doctors* (revised 2016), found at: https://ama.com.au/article/national-code-practice-hours-work-shiftwork-and-rostering-hospital-doctors

2. ARE ROSTERS MANAGED IN A TRANSPARENT AND FAIR MANNER?

2.1 We assessed whether the THS managed rosters in a transparent and fair manner by determining whether:

- the responsibility for establishing and managing changes to specialist rosters was clearly defined
- technology assisted in developing, managing and controlling rosters
- timesheets were used appropriately to assist in managing rostering of specialists.

RESPONSIBILITY FOR ESTABLISHING AND MANAGING CHANGES TO SPECIALIST ROSTERS IS GENERALLY DEFINED

2.2 The HoD for each medical unit within a hospital is accountable for rostering within their department. Our enquiries and inspection of documentation identified a diversity of practice was evident in relation to rostering across departments and hospitals. In some instances HoDs delegated responsibility for the preparation and management of the roster to administrative support officers and in others to a registrar or specialist within the department.

2.3 We asked each department how changes to rosters are managed. Most stated that roster 'swaps' are done by mutual agreement between specialists and only emergencies or illness necessitated short-notice intervention by roster managers. Where there is a disagreement or conflict with regard to the roster, the HoD arbitrates, with an escalation to the Stream Leader or Executive Director Medical Services, if necessary.

2.4 We noted a degree of informality around the allocation of responsibilities for roster management. However, given the size of the departments within hospitals, there appeared to be general acknowledgement as to where rostering responsibilities sat.

TECHNOLOGY IS NOT USED EFFECTIVELY TO DEVELOP, MANAGE AND CONTROL ROSTERS

2.5 We expected to find technology used by hospital departments to control and track who has access to create rostering documentation and to make changes. Such a system would provide an audit trail to alleviate any allegations of roster manipulation and unfairness in the distribution of shifts between specialists.

Manual rosters

2.6 We observed that most rosters are prepared using manual techniques, typically Microsoft Excel. Controls used included:

- creation by administrative support officer and/or a designated registrar/specialist, and sign-off by HoD
- publication of rosters on the intranet or printed out in departmental offices. For example, RHH publishes on its intranet a daily on-call roster that lists all hospital departments
- changes by reciprocal agreement only, except in the cases of emergency or illness.

2.7 There was limited information available regarding how changes are tracked or approved. One department in one hospital that we reviewed was able to show reports that aggregated each specialist's time over a three month period to demonstrate equity in the number of working hours.

ProAct

2.8 The primary system used in THS is ProAct. ProAct is a rostering and tracking system used in a number of Australian hospitals and also internationally. It has been in place across Tasmanian hospitals for nursing roster management for many years.

2.9 We were told that ProAct has not been successfully rolled out for doctor rostering in the major Tasmanian hospitals as there had been limited buy-in across departments. Currently, a version of the software is used:

- for junior doctors only (not specialists)
- in the South only (some limited engagement has begun in the North West)
- not as a time and attendance system (timesheet generation generally not used)
- in some departments of the hospital only.

2.10 Even in the areas currently using ProAct, it has not been rolled out in a way that accesses or optimises available and potential functionality. Rosters are still prepared manually and then sent to the MWU in the THS where they are re-entered in the system for viewing more broadly. From our enquiries, we identified the roster information input into ProAct is not generally used for reviewing rosters for specialists for the departments reviewed.

2.11 The THS showed us that they are using the system to track currency of key credentialing of doctors that, if not in place, would prevent a doctor working. These include any relevant visa requirements, working with children registration and AHPRA registration and renewals. The THS stated that, as the ProAct system does not interface well with other systems, much of this information is re-input by the MWU, such as accreditation currency, working hours, etc.

2.12 We were told there is much more scope to invest in and use the system in a more powerful manner. Examples were given of hospitals interstate where ProAct was linked to a phone application to provide up to date and transparent rostering information to doctors.

AMiON

2.13 One department we spoke to at NWRH was using a dedicated rostering system called AMiON. A specialist within that department personally funded the software licence because they had used it at a previous workplace.

2.14 An administrative support officer constructed the roster and processed changes into the system. Approvals were done through the Co-Directors of the Department. The system uploaded automatically into doctors' Outlook calendars and all specialists in the department could log in and view the entire roster a month out. Only the Co-Directors, one specialist and the administrative support officer could makes changes in the system but all specialists had view access, meaning it was relatively well-controlled and transparent.

2.15 The system could also produce longer-term reports that showed aggregate hours worked, including call-backs and extra time. This enhanced the fairness of the rosters as specialists could compare their overall patterns of work with their peers.

2.16 AMiON is not used more broadly by the THS.

TIMESHEETS ARE NOT CONSISTENTLY USED TO MANAGE ROSTERING OF SPECIALISTS

2.17 In our interviews with departments, we were told there was widespread use of autopay salary arrangements[7] for specialists. In consultation with their HoD, specialists can opt in or out of the use of timesheets by agreeing to a standard set of hours inclusive of any callbacks or overtime. The inclusion of call backs or overtime, as a regular fortnightly allowance, can be arranged through salary aggregation and should be reflective of the 'true' work commitment over a 12 month period. A consistent fortnightly salary is paid regardless of the actual hours worked each fortnight. We were told that a high proportion of specialists utilise this arrangement. This is in contrast to registrars, all of whom must use timesheets to record all additional time above their 80 hours a fortnight[8]. We were told that registrar time was closely monitored by the hospitals, the Australian Medical Association and the Colleges.

2.18 One HoD that we spoke to insisted all their specialists must fill in a timesheet because it promoted accountability and made the process more transparent. However, he stated that some of those specialists regularly wrote 'usual hours' on their timesheet, effectively negating the process.

2.19 Almost none of the departments we spoke to indicated they regularly reviewed actual hours worked against rostered hours. One of the HoDs tracked each specialist's accumulation of TOIL through a spreadsheet that recorded: submission of timesheets, additional hours worked and when the time off was taken. Although manually intensive, the system was more accountable than others observed.

2.20 ProAct has the potential to produce electronic timesheets, but we were advised this functionality was not currently used.

2.21 We were told by multiple interviewees that specialists are trusted professionals who voluntarily worked more than the hours for which they were remunerated. There was a perception that timesheets were therefore unnecessary and could result in adverse financial implications for THS where specialists built up large TOIL balances. However, given the absence of timesheet evidence we could not substantiate the claims of specialists working more hours than what they were remunerated for or claims specialists were unable to take hours worked in lieu of overtime.

7 Autopay pays a standard fortnightly rate on the assumption that employees work standard hours each fortnight. There is no need for reconciliation or timesheets for overs or unders in hours worked. In a rostered environment, this is essentially a system of trust.

8 Under the Medical Practitioners (Tasmanian State Service) Award, cl. 35, the ordinary hours for Medical Practitioners levels 5-13 is 40 hours per week (https://www.tic.tas.gov.au/__data/assets/pdf_file/0004/407686/T14572-Medical-Practitioners-Public-Sector-S099.pdf).

3. DO CULTURAL AND SYSTEMIC ISSUES IMPACT ON THE TRANSPARENT AND FAIR ROSTERING OF SPECIALISTS?

3.1 We assessed whether cultural and systemic issues impacted the transparent and fair rostering of specialists by determining whether:

- the HoD was provided with the necessary skills and tools to manage rostering
- the ability to successfully recruit and retain specialists impacted on the transparent and fair rostering of specialists
- transparency and fairness was impacted by specialists also practicing in private hospitals
- non-clinical time was managed in a transparent and fair manner.

THE HEAD OF DEPARTMENT IS NOT CONSISTENTLY PROVIDED WITH THE NECESSARY SKILLS AND TOOLS TO MANAGE ROSTERING

3.2 Specialists are respected and trusted individuals who are well advanced in their chosen career. This workforce cohort was described to us as highly intelligent, complicated to manage and challenging to recruit and retain.

3.3 A key role in the accountability of specialists within a hospital is the HoD. This position is the supervisor and manager of the other specialists in the department. The position is also paid a management allowance (the percentage amount depends on the size and complexity of the department), for taking on the additional leadership responsibilities the role requires. There is also limited additional administrative time allocated to undertake these management tasks.

3.4 We expected to find a robust recruitment, training and development process for HoDs. Their management skills are critical to transparent and fair operations.

3.5 We found that HoD positions were not considered separate positions from other specialist positions in the department. They had no specific statement of duties. Positions were usually filled by an expression of interest process and there was no appointment time limit. Anecdotally, some HoDs told us that they were appointed for their 'seniority and respect within the discipline' but that such positions could actually be difficult to fill as many specialists did not want the management and administrative responsibilities that came with the role. Others informed us they were appointed as they nominated for the position without any formal recruitment or appointment process.

3.6 Perhaps the most complex HoD we observed was for the General Medicine department at RHH. This department had the highest in-patient workload in the THS with a specialist complement of 7.0 FTE (plus an additional temporary 0.5 FTE at time of review) made up of 13 people, most of whom worked a fractional load. The HoD was also fractional (0.5 FTE) in the role and had a complex rostering arrangement to maintain and monitor.

3.7 We were told HoDs tend to focus on clinical matters in their learning and development. It is up to the individual HoD to self-select into more managerial-based training such as human resources, industrial relations and leadership.

THE ABILITY TO SUCCESSFULLY RECRUIT AND RETAIN SPECIALISTS HAS AN IMPACT ON THE TRANSPARENT AND FAIR ROSTERING OF SPECIALISTS

3.8 We were told that in major hospitals outside of Hobart, it was more difficult to attract and retain specialists. While there were shortage issues at LGH, particularly in the ability to staff theatres at capacity, the North West in particular was carrying multiple longer-term vacancies

in a number of departments. These specialist shortages at the NWRH and MCH, occur despite an employment agreement that provides an additional salary loading of 25% paid to those choosing to work in the North West of Tasmania (two-year 25% NW Tasmanian Recruitment and Retention Allowance Trial).

3.9 Lack of specialists in a discipline has the potential to impact College accreditation to teach junior doctors within a hospital. Each College has defined criteria for accreditation, including the number of junior doctors to each specialist in their respective department. There have been well documented[9] cases in all major Tasmanian hospitals where particular specialities have been disaccredited, downgraded or threatened to be disaccredited by their Colleges.

3.10 Shortages have necessitated the use of locums to help ease service delivery pressures and workforce management issues. However, staff we spoke to expressed a level of frustration with the changes to the locum engagement process.

3.11 Previously, individual hospitals engaged locums directly. The engagement of locums is now performed centrally by the THS using a preferred provider model in accordance with a contract put in place for the provision of locum medical practitioners. THS advised that, at present, there is a panel of 29 providers, with the preferred provider having the first right of reply for a period of 24 hours. All business case requests for locums are sent centrally for approval.

3.12 THS stated that its intention was to ensure the engagement of locum medical practitioners was legal, in accordance with Treasurer's Instructions, and to eliminate any risk in regard to medical indemnity, employer superannuation and taxation obligations. The THS also wanted to ensure all alternative solutions for filling a vacancy were exhausted before a locum was sought (locum reduction strategy). While these aims appear to have been met, staff at hospitals expressed concerns regarding:

- delays in approval to engage locums despite a clearly identified business need
- inability to use some previously engaged locums because the individual was not registered with the preferred agency.

3.13 We were told that, to run a hospital of NWRH's size, the number of specialists required in general medicine needed to be five or six to enable the department to allow staff to take leave without the use of locums. At the date of our visits to NWRH and MCH the number of specialists in the general medicine department were below complement at four and three respectively.

3.14 The inability to successfully recruit and retain specialists places increased pressure on the management of rosters. This has the potential to increase operational risks through increased hours worked by each specialist, less flexibility to take time off and more work undertaken by more junior doctors and locums.

9 http://www.parliament.tas.gov.au/ctee/Council/GovAdminA_HealthServices.htm

TRANSPARENCY AND FAIRNESS CAN BE IMPACTED BY SPECIALISTS PRACTICING IN PRIVATE HOSPITALS

3.15 VMOs are private medical specialists that work a capped number of sessions/hours in the public system each fortnight. However, public specialists can also provide services in private hospitals. In these circumstances, the specialists' availability and accountability for hours worked in the public system is critical to ensuring the system is transparent and fair.

3.16 In Tasmania, both the RHH and NWRH have private hospitals co-located with their respective public hospital. The LGH has a private hospital in relatively close proximity. The greater Hobart area also has a further three private hospitals a short driving distance from the RHH.

3.17 This convenience can produce efficiencies for both doctors and patients (and the hospital itself, as they can source additional beds from the private hospital in times of operational over-capacity), by reducing travel time between clinical sessions. However, co-located private hospitals increase the importance of accountability for doctors' time when being remunerated by the public system.

3.18 We did not test specialist's actual work patterns as part of this review. However, we were told by multiple interviewees, that many specialists do incorporate private practice into their work week in the public system. This is facilitated by 'rolling up' work hours to, for example, fit ten days of work in the public system into nine days in order to spend the tenth day undertaking work in the private system. But we were also told of informal arrangements that could be difficult to identify and track, particularly for VMOs who are expected to move between systems.

3.19 The lack of reconciling hours worked by specialists (through the use of timesheets and/or electronic systems such as ProAct) means the issue of operating privately during public time is one that is spoken about quite openly, but largely untested and uncontrolled. There is no visibility over the scale of the issue.

3.20 There are a number of risks arising from this lack of visibility. Being unable to adequately account for hours worked, across both the public and private system, impacts on the ability to manage fatigue and therefore presents a potential risk to patient safety. If public specialists are not working the hours for which they are paid within the public system (instead spending some of that time in private practice), this would not only result in adverse financial impact but also adversely impact on waiting times for public patients.

3.21 More generally, limited accountability for hours spent in private practice as opposed to the public sector leads to a risk of fraudulent activity or misconduct.

THERE IS LITTLE ACCOUNTABILITY FOR NON-CLINICAL TIME

3.22 The Award and Agreement are both silent as to expectations or entitlements regarding non-clinical time.

3.23 When we asked specifically about non-clinical time, defining it to mean administrative duties, teaching and research activities or attendance at training or development, answers provided were that it was up to the individual specialist to manage their time appropriately within the 76 hour fortnight. It is noted that many of the Colleges define recommended clinical support time for specialists.

3.24 Transparency and fairness can be compromised where rosters do not adequately reflect the level of clinical and non-clinical work required in specialist roles and where there is no accountability for clinical and non-clinical time worked.

3.25 At each of the departments we visited, we reviewed copies of rosters to form a view on the level of detail of information recorded. We found practices varied from department to department and from hospital to hospital. In general, rosters were kept at a high level – that is, who was on duty and for what amount of time.

3.26 There was one department that divided each specialist's week into ten morning and afternoon 'sessions' that identified ward rounds, clinics and other clinical activities. However, we found more generally across hospitals, unless a specialist is booked into a specific location, such as a theatre or clinic, the identification of rostered clinical and non-clinical time is largely absent.

3.27 Specialists in leadership roles (HoDs and above) we spoke to invariably stated they were always aware of who is on-duty in their area, and what they are doing, on any given day. The language used by those we interviewed indicated a high degree of trust in specialists and how they chose to manage their time. For example, 'as long as they are available to public patients as and when we need them, how they structure their day is up to them'.

3.28 Overall, non-clinical time is not separately rostered or monitored.

4. DO CURRENT ROSTERING PRACTICES INCREASE THE RISK EXPOSURE OF THS?

4.1 A number of potential risks do arise from rostering management practices for specialists.

4.2 Without exception, all interviewees said that, in general, specialists work longer hours than they are paid for. However, we could not identify any sources of information to substantiate their claim. As was stated previously, specialist's cumulative work hours may also include time spent in private practice at private hospitals.

4.3 The large number of specialists on 'autopay' means there is no official reconciliation of actual hours worked for those staff. Even where timesheets are used to claim for extra hours, we were told that practice varies widely: specialists either do not claim the extra time at all or only claim it sporadically. In addition, shortages of specialists in certain areas means that it is not practical to accumulate extra TOIL, as they know it will not be possible to take it.

4.4 Some timesheets were not filled out other than to say 'usual hours worked' meaning again, there were no audit trails of time worked.

4.5 There were limited controls in place in regard to call-backs. We were told that when specialists in particular areas (such as a surgeon or anaesthetist) are called in overnight, they must take the following day off. However, how that specialist chooses to spend their day off is up to them. If they elect to work in the private system while not at the public hospital, that is their right, but it increases overall clinical hours worked without a visible means of assessing potential fatigue.

RISK OF FATIGUE

4.6 It is difficult for HoDs to manage potential fatigue in specialist staff when the hours worked are only understood at an anecdotal level. When we asked how they know one of their staff is fatigued, answers centred on knowing they had done some long shifts recently and were showing physical signs of fatigue. The HoD would then ask that specialist to take some time off.

4.7 The absence of information relating to hours worked in the private sector also inhibits the appropriate management of fatigue. We were told that this was in contrast to junior doctors where hours worked are carefully scrutinised to ensure they are not overworked.

RISK OF INCREASED COST TO THE HEALTH SYSTEM

4.8 The number of specialists on autopay may not represent accurately the hours worked and therefore the true cost to the Tasmanian health system. In addition, the risk of specialists working in private hospitals when they should be in the public hospital may mean that they are paid for time not worked.

RISK OF LOSS OF ACCREDITATION FOR THE DEPARTMENT

4.9 The inability to recruit and retain adequate specialists, in order to provide adequate coverage for training of junior doctors can increase the risk of deaccreditation or downgrading of accreditation.

LIST OF ACRONYMS AND ABBREVIATIONS

AHPRA	Australian Health Practitioner Regulation Agency
DoH	Department of Health
FTE	Full-time equivalent (staff)
HoD	Head of Department
LGH	Launceston General Hospital
MCH	Mersey Community Hospital
MWU	Medical Workforce Unit
NWRH	North West Regional Hospital
RHH	Royal Hobart Hospital
RMO	Resident Medical Officer
THS	Tasmanian Health Service
TOIL	Time off in lieu
TSS	Tasmanian State Service
VMO	Visiting Medical Officer

APPENDIX 1: LIST OF MEDICAL SPECIALIST COLLEGES IN AUSTRALIA

Organisation	Speciality	Fellowship Awarded
Royal Australasian College of Physicians (RACP) https://www.racp.edu.au/ Paediatric: • cardiology • clinical pharmacology • emergency medicine • endocrinology • gastroenterology and hepatology • haematology • immunology and allergy • infectious diseases • intensive care medicine • medical oncology • nephrology • neurology • nuclear medicine • palliative medicine • rehabilitation medicine • respiratory and sleep medicine • rheumatology Community child health General paediatrics Neonatal and perinatal medicine Sexual health medicine Occupational and environmental medicine Public health medicine Addiction medicine	Cardiology Clinical pharmacology Endocrinology Gastroenterology General medicine Geriatric medicine Haematology Immunology and allergy Infectious diseases Medical oncology Nephrology Neurology Nuclear medicine Palliative care Respiratory and sleep medicine Rheumatology Clinical genetics	Fellowship of the Royal Australasian College of Physicians (FRACP) Fellowship of the Australasian Chapter of Palliative Medicine, Royal Australasian College of Physicians (FAChPM) Fellowship of the Australasian Chapter of Addiction Medicine, Royal Australasian College of Physicians (FAChAM) Fellowship of the Australasian Chapter of Sexual Health Medicine, Royal Australasian College of Physicians (FAChSHM) Fellowship of the Australasian Faculty of Occupational and Environmental Medicine (FAFOEM) Fellowship of the Australasian Faculty of Public Health Medicine (FAFPHM) Fellowship of the Australasian Faculty of Rehabilitation Medicine (FAFRM)

Organisation	Speciality	Fellowship Awarded
Royal Australasian College of Surgeons (RACS) https://www.surgeons.org/	Cardio-thoracic surgery General surgery Neurosurgery Orthopaedic surgery Otolaryngology & Head and Neck surgery Paediatric surgery Plastic & Reconstructive surgery Urology Vascular surgery	Fellowship of the Royal Australasian College of Surgeons (FRACS)
Australian and New Zealand College of Anaesthetists (ANZCA) http://www.anzca.edu.au/	Anaesthesia Pain Medicine	Fellowship of the Australian and New Zealand College of Anaesthetists (FANZCA) Fellowship of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (FFPMANZCA)
Australasian College of Sport and Exercise Physicians (ACSEP) https://www.acsep.org.au/	Sports & Exercise Medicine	Fellowship of the Australasian College of Sport and Exercise Physicians (FACSEP)
Australasian College of Dermatologists (ACD) https://www.dermcoll.edu.au/	Dermatology	Fellowship of the Australasian College of Dermatologists (FACD)
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) https://www.ranzcog.edu.au/	Obstetrics & Gynaecology Gynaecological oncology Maternal-fetal medicine Obstetrics and gynaecological ultrasound Reproductive endocrinology and infertility Urogynaecology	Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (FRANZCOG)

Organisation	Speciality	Fellowship Awarded
Royal College of Pathologists of Australasia (RCPA) https://www.rcpa.edu.au/	Anatomical pathology Chemical pathology Forensic pathology General pathology Haematology Immunology Microbiology	Fellowship of the Royal College of Pathologists of Australasia (FRCPA)
Royal Australian and New Zealand College of Psychiatrists (RANZCP) https://www.ranzcp.org/	Psychiatry	Fellowship of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP)
Australasian College for Emergency Medicine (ACEM) https://acem.org.au/	Emergency Medicine	Fellowship of the Australasian College for Emergency Medicine (FACEM)
Royal Australian and New Zealand College of Radiologists (RANZCR) https://www.ranzcr.com/	Diagnostic radiology Diagnostic ultrasound Radiation oncology Nuclear medicine	Fellowship of the Royal Australian and New Zealand College of Radiologists (FRANZCR)
Royal Australian and New Zealand College of Ophthalmologists (RANZCO) https://ranzco.edu/	Ophthalmology	Fellowship of the Royal Australian and New Zealand College of Ophthalmologists (FRANZCO)
Royal Australian College of General Practitioners (RACGP) https://www.racgp.org.au/	General Practice	Fellowship of the Royal Australian College of General Practitioners (FRACGP)
Australian College of Rural and Remote Medicine (ACRRM) https://www.acrrm.org.au/	General Practice	Fellowship of the Australian College of Rural and Remote Medicine (FACRRM)
College of Intensive Care Medicine of Australia and New Zealand (CICM) https://www.cicm.org.au/	Intensive Care Medicine	Fellowship of the College of Intensive Care Medicine of Australia and New Zealand (FCICM)
Royal Australasian College of Dental Surgeons (RACDS) https://www.racds.org/	Oral & Maxillofacial Surgery	Fellowship of the Royal Australasian College of Dental Surgeons (Oral Maxillofacial Surgery) (FRACDS (OMS))
Royal Australasian College of Medical Administrators (RACMA) https://www.racma.edu.au/	Medical Administration	Fellowship of the Royal Australasian College of Medical Administrators (FRACMA)

AUDIT MANDATE AND STANDARDS APPLIED

Mandate

Section 23 of the *Audit Act 2008* states that:

(1) The Auditor-General may at any time carry out an examination or investigation for one or more of the following purposes:

- (a) examining the accounting and financial management information systems of the Treasurer, a State entity or a subsidiary of a State entity to determine their effectiveness in achieving or monitoring program results;
- (b) investigating any matter relating to the accounts of the Treasurer, a State entity or a subsidiary of a State entity;
- (c) investigating any matter relating to public money or other money, or to public property or other property;
- (d) examining the compliance of a State entity or a subsidiary of a State entity with written laws or its own internal policies;
- (e) examining the efficiency, effectiveness and economy of a State entity, a number of State entities, a part of a State entity or a subsidiary of a State entity;
- (f) examining the efficiency, effectiveness and economy with which a related entity of a State entity performs functions –
  - (i) on behalf of the State entity; or
  - (ii) in partnership or jointly with the State entity; or
  - (iii) as the delegate or agent of the State entity;
- (g) examining the performance and exercise of the Employer's functions and powers under the *State Service Act 2000*.

(2) Any examination or investigation carried out by the Auditor-General under subsection (1) is to be carried out in accordance with the powers of this Act.

Standards Applied

Section 31 specifies that:

'The Auditor-General is to perform the audits required by this or any other Act in such a manner as the Auditor-General thinks fit having regard to -

- (a) the character and effectiveness of the internal control and internal audit of the relevant State entity or audited subsidiary of a State entity; and
- (b) the Australian Auditing and Assurance Standards.'

The auditing standards referred to are Australian Auditing and Assurance Standards as issued by the Australian Auditing and Assurance Standards Board.

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