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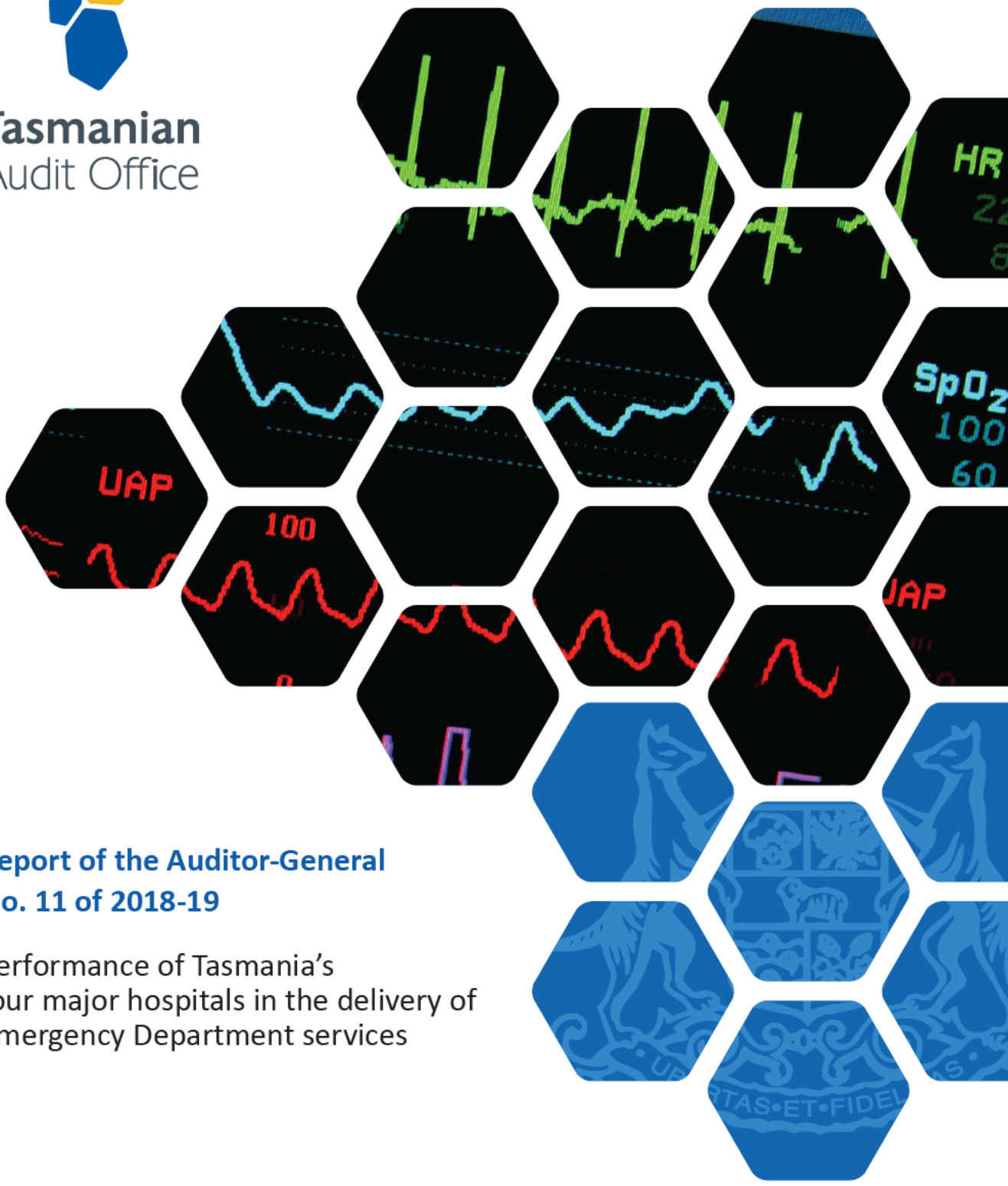



# Report of the Auditor-General No. 11 of 2018-19

## Performance of Tasmania's four major hospitals in the delivery of Emergency Department services

May 2019

## THE ROLE OF THE AUDITOR-GENERAL

The Auditor-General's roles and responsibilities, and therefore of the Tasmanian Audit Office, are set out in the *Audit Act 2008 (Audit Act).*

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.

Audits of financial reports are designed to add credibility to assertions made by accountable authorities in preparing their financial reports, enhancing their value to end users.

Following financial audits, we issue a variety of reports to State entities and we report periodically to the Parliament.

We also conduct performance audits and compliance audits. Performance audits examine whether a State entity is carrying out its activities effectively and doing so economically and efficiently. Audits may cover all or part of a State entity's operations, or consider particular issues across a number of State entities.

Compliance audits are aimed at ensuring compliance by State entities with directives, regulations and appropriate internal control procedures. Audits focus on selected systems (including information technology systems), account balances or projects.

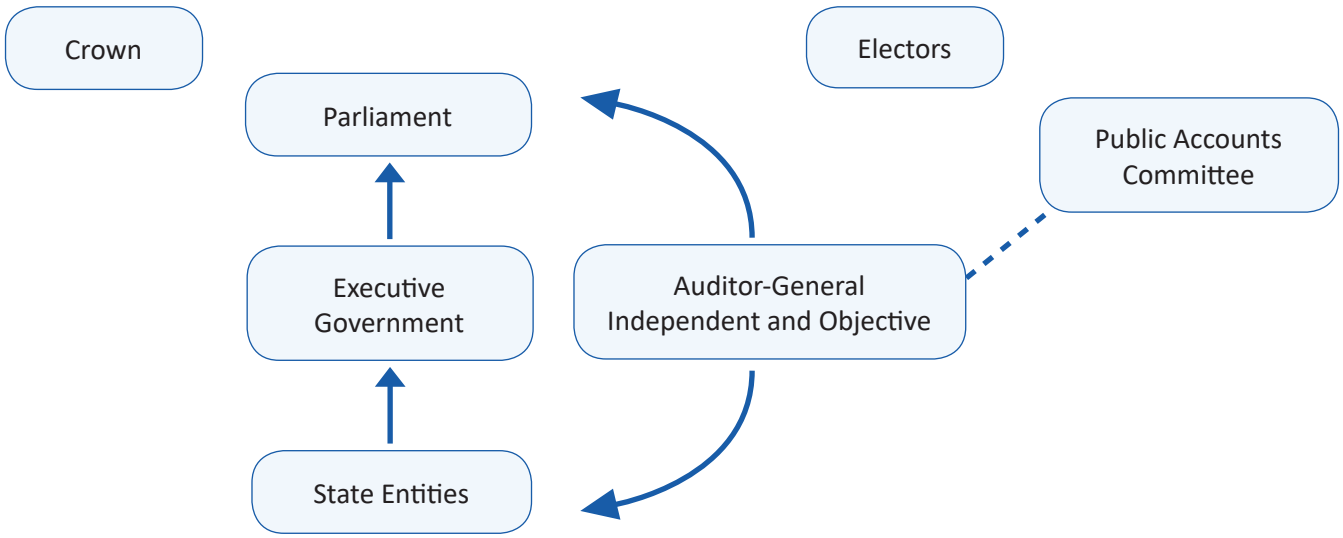
We can also carry out investigations but only relating to public money or to public property. In addition, the Auditor-General is now responsible for state service employer investigations.

Performance and compliance audits are reported separately and at different times of the year, whereas outcomes from financial statement audits are included in one of the regular volumes of the Auditor-General's reports to the Parliament normally tabled in May and November each year.

Where relevant, the Treasurer, a Minister or Ministers, other interested parties and accountable authorities are provided with opportunity to comment on any matters reported. Where they choose to do so, their responses, or summaries thereof, are detailed within the reports.

## THE AUDITOR-GENERAL'S RELATIONSHIP WITH THE PARLIAMENT AND STATE ENTITIES

The Auditor-General's role as Parliament's auditor is unique.




**2019**
**PARLIAMENT OF TASMANIA**

**Report of the Auditor-General**
**No. 11 of 2018-19**

# Performance of Tasmania's four major hospitals in the delivery of Emergency Department services

**May 2019**

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

Auditor-General's reports and other reports published by the Office can be accessed via the Office's website. For further information please contact:

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28 May 2019

President
Legislative Council
HOBART

Speaker
House of Assembly
HOBART

Dear President

Dear Ms Speaker

**REPORT OF THE AUDITOR-GENERAL**

**No.11 of 2018-19: Performance of Tasmania's four major hospitals in the delivery of Emergency Department services**

This report has been prepared consequent to examinations conducted under section 23 of the *Audit Act 2008*. The objective of the performance audit was to assess the efficiency and effectiveness of Emergency Departments in Tasmania's four major hospitals from the perspective of patients on their journey through an Emergency Department. The audit also assessed whether the Tasmanian Health Service was managing Emergency Departments effectively.

Yours sincerely

Rod Whitehead

**Auditor-General**

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# FOREWORD

The challenges facing Emergency Departments in Tasmania's four largest public hospitals are regularly publicised, highlighting increasing presentations to Emergency Departments, overcrowding, ambulance ramping, long patient wait times, adverse patient outcomes and the frequent presence of access block.

This audit examines the performance of the Emergency Departments at Tasmania's four largest public hospitals, from both a patient journey perspective and a governance and leadership perspective. It examines key performance measures related to Emergency Department performance and assesses whether initiatives identified to improve performance have been implemented and monitored.

Whilst the effective and efficient delivery of patient care in Emergency Departments depends on a variety of interrelated elements, such as prompt off-loading of ambulance patients, quick and accurate triage, timely and accurate diagnosis and appropriate clinical treatment, timely discharge or admission to an inpatient bed, the solution to fixing what is often perceived as 'an Emergency Department only problem' requires a whole-of-hospital and system-wide approach. Clinical and executive leadership is essential to this approach and senior management must ensure agreed upon changes are implemented and monitored and progress communicated. Hospital staff, including clinicians, managers and staff, must be involved in the clinical redesign process, both in designing and implementing solutions, whilst at the same time ensuring clinically appropriate patient care remains paramount.

Rod Whitehead

**Auditor-General**

28 May 2019

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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 performance audit (audit) on the Emergency Departments (EDs) in Tasmania's four major public hospitals.

## AUDIT OBJECTIVE

The objective of the audit was to assess the efficiency and effectiveness of the EDs from the perspective of patients on their journey through an ED and whether the Tasmanian Health Service was managing Emergency Departments effectively.

The Parliamentary Standing Committee of Public Accounts also requested that this audit consider:

- the occurrence and frequency of ambulance ramping[1] affecting access to ED services
- factors causing access block in inpatient areas.

## AUDIT SCOPE

The audit examined the operation of EDs and related performance data at the Royal Hobart Hospital (RHH), Launceston General Hospital (LGH), North West Regional Hospital (NWRH) and Mersey Community Hospital (MCH) over the period 1 July 2009 to 30 June 2018.

The following State entities (hereinafter collectively referred to as the agencies) were also included in the audit scope:

- Tasmanian Health Service (THS)
- Department of Health (DoH) and the former Department of Health and Human Services (DHHS)
- Ambulance Tasmania (AT).

## AUDIT APPROACH

The audit was conducted in accordance with Australian Standard on Assurance Engagements *ASAE 3500 Performance Engagements* issued by the Australian Auditing and Assurance Standards Board, for the purpose of expressing a reasonable assurance conclusion.

The audit assessed the performance of the agencies based on the following key questions a patient may ask during their journey through the three distinct phases of the ED care pathway — arrival at the ED, clinical treatment and discharge:

- What happens when I arrive at the ED?
- Will I get the care I need?
- What happens after I receive ED care?

The audit also assessed whether THS was managing EDs effectively.

## MANAGEMENT RESPONSIBILITY

THS is responsible for delivering integrated healthcare services through the public hospital system including 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 DHHS.

Under the *Tasmanian Health Service Act 2018* (THS Act), THS is accountable to the Secretary of DoH who in turn is responsible to the Minister for Health (Minister) for THS's performance.

## AUDITOR-GENERAL'S RESPONSIBILITY

In the context of this audit, my responsibility was to express a reasonable assurance conclusion on the extent to which EDs in Tasmania's four major public hospitals were performing efficiently and effectively.

1 Ambulance ramping occurs when ambulance officers and/or paramedics are unable to complete transfer of clinical care of their patient to the hospital ED within a clinically appropriate timeframe, specifically due to lack of an appropriate clinical space in the ED.

## FINDINGS AND RECOMMENDATIONS

Findings and recommendations for the audit criteria are summarised below. The recommendations highlight actions that THS and/or DoH should undertake. Appendix 1 contains further details regarding the audit criteria.

### Findings and recommendations

#### Criterion 1: What happens when I arrive at the Emergency Department?

**Summary of findings**

Demand for emergency care in Tasmanian public hospitals has steadily grown over the last nine years. The total number of presentations to EDs increased by 15% (or by almost 21 000) from 2009-10 to 2017-18, with most of this growth occurring at RHH.

Tasmania experienced the lowest growth in presentations compared to other Australian states but has some unique geographic and demographic characteristics that heighten the challenge of meeting demand. These include an older and more dependent population with lower rates of health literacy and a significant burden of chronic disease. The limited scope of private ED services across the State also adds to demand by reducing ED presentation bypass options for the State's already busy and geographically dispersed public hospitals.

These challenges are compounded by the growing complexity of presentations and by the limited number of bulk billing Tasmanian general practitioners (GPs) and extended care paramedics able to avoid unnecessary trips to the ED by providing alternative care to non-acute patients.

Collectively, these factors have contributed to the significant growth in demand for inpatient beds reflected in the 56% increase in the number of hospital admissions state-wide between 2009-10 and 2017-18.

The continued growth in demand for emergency care expected over the next decade, particularly from higher complexity patients, means there will be limited scope for diverting this to primary care[2] and the pressure on hospitals is likely to increase.

These circumstances highlight the need for effective and efficient hospital practices that optimise patient flow.

However increasingly, ED patients are not receiving timely care. Specifically:

- The incidence of ambulance ramping across Tasmania's four major hospitals increased significantly between 2012-13 and 2017-18, by around 149% and far exceeds the 20% growth in ambulance presentations to EDs over the same period.
- The duration of ramping similarly increased. Instances of ramp times in excess of the 15-minute offload target and instances where the offload delay exceeded 30 minutes grew by 197% and 239%, respectively, during the period.
- Patients are also now waiting longer for treatment in EDs. State-wide performance against most key performance indicators (KPIs) for triage waiting times (except for the most urgent Category 1 patients) deteriorated over the last five years, mainly due to worsening performance at RHH and LGH.

These delays reflect the combined impact of the growing number and complexity of ED presentations, ongoing access block[3] to inpatient beds and limited bed capacity particularly at the RHH.

Delays are also due to long-standing practices and behaviours within hospitals contributing to dysfunctional silos, poor coordination between inpatient areas and EDs, and the lack of a whole-of-hospital approach to improving patient flow.

2 Primary care can include general practice, allied health services, community health and community pharmacy.

3 Access block is the situation where patients who have been admitted to hospital and need a hospital bed are delayed from leaving the ED because of a lack of inpatient (admitted patient) bed capacity.

## Findings and recommendations

**Recommendation**

1. THS and DoH take urgent action to strengthen whole-of-health system leadership and coordination of initiatives designed to improve patient flow by, at a minimum:
   (a) clarifying the roles and responsibilities of all hospital Executive Directors of Operations, mental health services and primary and community care leadership teams, inpatient wards, department heads, clinicians, nurses and related administrative and support staff in prioritising and contributing to hospital and system-wide initiatives to improve patient flow
   (b) ensuring all hospital, mental health and community care leadership teams, department heads and their staff are fully empowered, sufficiently resourced and accountable for achieving sustained improvements in hospital and system-wide collaboration and performance on patient flow
   (c) taking immediate steps to review and, where relevant, strengthen the effectiveness of coordination mechanisms between all departments and staff within hospitals and with mental health, primary and community care services for optimising patient flow.

## Criterion 2: Will I get the care I need?

**Summary of findings**

The efficiency of hospital EDs state-wide has declined over the last nine years with a downward trend in the proportion of patients with a length of stay less than four hours evident since 2009-10. RHH and LGH exhibit the lowest performance against the four-hour target.

This has resulted in a significant increase in the total number of hours spent by patients in EDs beyond the State's four-hour target, which is up from an average of 8 845 days in 2009-10 to 14 255 days in 2017-18.

Despite this trend, the target for compliance with the four-hour rule was increased in 2018-19 from 80% to 90% to be achieved by 2022. There is currently little assurance the target will be met based on past performance.

The average length of stay of admitted patients across the four major EDs is around 9.5 hours driven mainly by historically very lengthy stays at LGH. This rate is significantly higher and more than double that of non-admitted patients (around three hours).

The excessive wait time by admitted patients within EDs for an inpatient bed, after the ED phase of care has finished, is limiting timely access to emergency care for other patients and contributing to ED overcrowding. Hospital staff highlighted that excessive waits by admitted patients for inpatient beds reflects the impact of longstanding cultural and process barriers within hospitals to freeing up existing bed capacity to improve patient flow.

Of concern is that the rate of ED adverse events[4] increased significantly from 2015 to 2018 across all four major hospitals, by around 60%. Most of these events occurred at RHH and LGH, with a sharp increase evident at RHH since 2016.

Hospital staff attributed this trend to the growing pressure on EDs from the rise in presentations and persistent access block issues, creating challenging conditions for both patients and ED staff.

**Recommendation**

2. THS and DoH urgently review the root causes of the growth in ED adverse events and implement targeted initiatives to mitigate the impacts and reduce future incidences.

4 Adverse event is any event or circumstance that could have or did lead to unintended or unexpected harm, loss or damage to any person receiving care or services from health services.

## Findings and recommendations

### Criterion 3: What happens after I have received Emergency Department care?

**Summary of findings**

Performance trends demonstrate patients admitted to Tasmanian hospitals through an ED are now waiting much longer in EDs for an inpatient bed. This is because of growing demand, capacity constraints and longstanding barriers to access, which means patients are now less likely to receive the treatment they need at the right time and place compared to almost a decade ago.

Consequently, a significant proportion of ED beds, estimated by hospital staff at around 50% of ED cubicles at times, are occupied by admitted patients awaiting a bed and for whom the ED phase of care has finished. This means that ED bed capacity has, in effect, declined in the face of the continual increase in admitted bed demand, which is reducing access to timely care for other patients presenting to the ED.

The solution to this problem is not simply more beds. There is an urgent need to improve the efficiency and effectiveness of hospital admission, bed management and discharge practices.

THS's Patient Flow Escalation Management Plan was established in August 2017 to address a gap in previous arrangements. It describes the actions and duties required by all staff to optimise patient flow, both during periods of normal activity and heightened demand.

THS analysis of the time spent by hospitals at varying levels of escalation between 29 June 2018 and 24 January 2019 demonstrated the framework and its implementation by THS and hospital staff has yet to deliver sustained improvements to patient flow and address the longstanding drivers of access block. Specifically, the analysis showed:

- LGH spent more than 70% of the time during the period at the highest possible level of escalation and in a state of almost constant 'gridlock'
- RHH was significantly bed blocked for almost 93% of the time, with patient safety severely and routinely compromised, on average, almost once every four days.

This concerning situation is reflected in THS's longstanding performance against the service agreement target relating to the length of stay for the 90$^{th}$ percentile of admitted patients. The time spent by this patient cohort in the ED waiting for an inpatient bed consistently exceeded the target of less than or equal to eight hours by a significant margin, particularly at LGH, which at times exceeded 40 hours.

These performance challenges have persisted state-wide despite successive past reviews and reform initiatives to improve patient flow over nearly a decade, demonstrating past reviews had little impact.

Although these initiatives consistently acknowledged the importance of an effective whole-of-hospital approach to improving patient flow, along with the need to address longstanding cultural and process barriers to change, these issues remain and have yet to be effectively addressed.

THS acknowledged it had experienced significant difficulty to date in resourcing the actions necessary to coordinate, monitor and drive effective implementation of past reforms. It also acknowledged most actions were either significantly behind schedule, had stalled, or had yet to be substantively addressed.

Agency and hospital staff consistently referred to the impacts of recent governance churn in the sector as a factor, but also to the absence of effective leadership and accountability as major impediments to tackling long-standing cultural barriers to change and the dysfunctional silo mentality within hospitals, contributing to bed block and ineffective discharge planning and bed management.

## Findings and recommendations

These significant cultural challenges were similarly noted in 2014 by the Australian Government's Commission on Delivery of Health Services in Tasmania which reported it had 'observed a deeply engrained culture of resistance to change, evidenced by the system's inertia in the face of several reviews recommending reform'.

A 2017 Clinical Utilisation Study by THS of 1 013 hospital admissions confirms significant scope exists across Tasmanian hospitals to free up existing bed capacity by improving bed management, including admission, patient management and discharge practices. THS estimates improvements to these practices alone could create an additional 3 000 bed days per year.

Both DoH and THS acknowledge there is a pressing need to overcome longstanding cultural barriers to change within Tasmania's health system impeding efficiency gains and the achievement of better patient outcomes. They also advised of a range of improvement initiatives currently underway to strengthen related hospital practices and to better engage with clinicians and hospital staff in solutions focused on improving patient flow.

These latest initiatives, like their predecessors, have considerable potential. However, their effectiveness will depend heavily on DoH's and THS's ability to overcome past governance, cultural and other challenges, which have impeded effective implementation of past reforms.

**Recommendations**

3. THS and DoH urgently implement a culture improvement program and initiatives with clearly defined goals, accountabilities and timeframes to:
   (a) eliminate the longstanding dysfunctional silos, attitudes and behaviours within the health system preventing sustained improvements to hospital admission, bed management and discharge practices
   (b) ensure that all THS departments and staff work collaboratively to prioritise the interests of patients by diligently supporting initiatives that seek to optimise patient flow.
4. THS and DoH develop an effective sector-wide consultation and engagement strategy to support sustained improvements in patient flow that, at a minimum, provides:
   (a) education to staff on the need for, and merits of, whole-of-hospital action to reduce access block through more effective and efficient admission, bed management and discharge practices and the benefits to patient care and safety that come from improved patient flow
   (b) genuine opportunities for THS staff to contribute to and influence the design, development and implementation of hospital and sector-wide patient flow reform initiatives.
5. THS and DoH expedite the development and implementation of proactive strategies that effectively leverage the insights of the 2017 Clinical Utilisation Study to both reduce and minimise the incidence of avoidable admissions and non-qualified continuing days of stay for admitted patients.
6. THS strengthen support to, and the accountability of, health system leadership teams for improving their performance in sustainably reducing the rate of avoidable admissions and non-qualified continuing days of stay for admitted patients.
7. THS and DoH review and strengthen the:
   (a) change management capability and skills of THS and hospitals to ensure future reform initiatives are adequately supported and deliver sustained behaviour change and impact
   (b) project management capability of THS and hospitals to ensure future reform initiatives are underpinned by effective implementation and delivery planning processes that are regularly monitored.
8. THS and DoH review and, where relevant, action outstanding recommendations from the Patients First, Staib Sullivan and Monaghan reviews.

## Findings and recommendations

### Criterion 4: Is the Tasmanian Health Service managing Emergency Departments effectively?

**Summary of findings**

The THS Performance Framework under the former *Tasmanian Health Organisations Act 2011* (THO Act) (the former Performance Framework) outlined reasonable procedures for performance monitoring, escalation and interventions to operationalise related provisions in the THO Act. Changes to the legislative framework in 2018 have rendered the former Performance Framework obsolete and removed explicit definitions and obligations for responding to unsatisfactory performance by THS.

Although DoH signalled an intent within the 2018-19 THS Service Plan to develop a more comprehensive monitoring framework for related KPIs, this had yet to occur more than six months after the plan was approved.

Neither THS nor DoH effectively implemented the former Performance Framework. DoH monitoring reports show THS consistently failed to meet its service delivery targets relating to ED access and care over the last three years.

The former DHHS initiated five Level 1 escalations during this period requiring THS to develop a Performance Improvement Plan for each affected KPI and to regularly report to DHHS on its progress. Although this occurred, neither DHHS interventions nor THS's related improvement actions were effective in improving the performance of hospitals against the KPIs.

DHHS monitoring reports during the period offered little insight into the root causes of THS performance issues including adequacy of its related improvement strategies. This rendered them ineffective from a performance monitoring perspective.

DoH advised that under the former agency structure and performance framework, responsibility for conducting in-depth analysis of performance issues, including root cause analysis rested with THS and that recent changes to bring THS under the authority of the Secretary provides DoH with an opportunity to address this deficiency.

Although it became evident to DHHS over successive quarters that THS previously initiated improvement strategies were not working, no evidence was found demonstrating DHHS fully explored the merits of alternative escalation options for addressing the evident and ongoing deterioration in THS performance.

DHHS advised it was concerned about THS's performance and held weekly meetings with the Minister, but that it did not regard further escalations under the former Performance Framework as an effective means of improving performance on an ongoing basis. Instead, DHHS believed that longer term sustainable performance improvements were best served by working closely with THS to support its operational staff to improve performance.

There is a risk changes to THS's governance arrangements introduced in 2018 have reduced DoH's independence in performance monitoring by virtue of the Secretary of DoH now also being directly responsible for THS's service delivery performance.

These circumstances create an inherent tension with DoH's 'system manager' role which previously and consistent with other Australian states, did not extend beyond governance, policy and planning, purchasing, and performance monitoring functions.

There is no evidence to indicate that this risk has materialised to date.

DoH noted that under the former THO Act, the role of DHHS, DoH and the Secretary in monitoring and managing THS performance was not explicit but instead articulated in supporting administrative documents such as the THS Performance Framework. It also advised this arrangement differed from other jurisdictions such as NSW where the Head of Department has a clearly articulated role within legislation for performance monitoring and issuing directions to Local Health Networks.

**Findings and recommendations**

DoH further stated the THS Act, in accordance with the Government's policy intention, provides a clearer articulation and codification of the role of the Secretary and DoH in monitoring and issuing instruction to address performance within THS.

Implementation of the new governance arrangements is at an early stage and to effectively implement the new legislative provisions and mitigate the risk to independence from occurring DoH should develop a transparent and effective framework for system management and performance monitoring.

**Recommendations**

9. DoH, in consultation with THS, expedite development of the revised THS Performance Framework.
10. DoH, in consultation with THS, strengthen performance monitoring and reporting processes to ensure they:
    (a) provide actionable insights into the root causes of performance issues affecting ED access and care
    (b) ensure related improvement actions address the root causes of performance issues and are likely to succeed
    (c) rigorously assess the merits of alternative escalation/improvement actions in circumstances of consistent underperformance.

## SUBMISSIONS AND COMMENTS RECEIVED

In accordance with section 30(2) of the *Audit Act 2008*, a summary of findings was provided to the Treasurer, Minister for Health and other persons who, in the opinion of the Auditor-General, had a special interest in the report, with a request for submissions or comments. Responses, or a fair summary of them, are included in Appendix 2.

## AUDITOR-GENERAL'S CONCLUSION

It is my conclusion that the Tasmanian hospital system is not working effectively to meet the growing demand for ED care, inpatient beds and its associated performance obligations for ED access and patient flow within the THS service plan.

This is partly due to capacity constraints, particularly at RHH, which is undergoing extensive redevelopment works, but also because of longstanding cultural and process weaknesses within hospitals that are impeding effective discharge planning, bed management and coordination between EDs and inpatient areas.

These challenges are heightening the risks for patients and staff and are preventing the EDs of Tasmania's four major hospitals from operating efficiently and effectively.

Successive reviews by the Tasmanian and Australian governments over the last decade have highlighted dysfunctional silos, behaviours, process barriers and resistance to change from some clinicians and administrators within hospitals as major drivers of inefficiencies.

These issues mainly lie outside of the EDs but are within the control of hospital leadership teams and have yet to be addressed. Consequently, the patient journey through Tasmania's four major EDs has deteriorated and become more challenging during the last decade for both patients and ED staff.

Recognising this, the Government introduced significant reforms to the institutional arrangements for Tasmania's health system in 2018 to improve governance and the performance of THS. These changes are in the early stages of implementation and cannot yet be reliably assessed.

Notwithstanding, urgent action is needed by DoH and THS to leverage these reforms and further strengthen whole-of-hospital and system–wide leadership, coordination and accountability for addressing the longstanding cultural and process barriers to improving patient flow.

Because of the significance of the matters described above, my conclusion is THS did not perform, in terms of efficiency and effectiveness, with respect to the audit criteria or the objective of the performance audit, as a whole.

Rod Whitehead

**Auditor-General**

28 May 2019

# CONTEXT

## CONTEXT INTRODUCTION

A hospital ED functions to assess, diagnose and treat patients who suffer from an acute serious illness or injury that would lead to severe complications if not treated promptly. It also functions to remove patients from further treatment in the ED or admission to the hospital as not every patient presenting or referred with potentially serious symptoms has an acute, serious condition or injury.

The health outcomes of patients presenting to EDs can depend heavily on the effectiveness and efficiency of their journey through the ED process.

However, EDs cannot achieve optimal patient outcomes in isolation. This requires a system-wide and whole-of-hospital approach underpinned by effective coordination between the ED, inpatient areas and the community. Such an approach is vital for managing growing demand and facilitating timely access to treatment in the right setting.

## GROWING DEMAND FOR EMERGENCY DEPARTMENT CARE

Demand for ED care has increased steadily over the past decade. In 2017–18, more than 162 000 people attended a public ED in Tasmania, an increase of 15% from 2009-10. In comparison, Tasmania's population increased by around 4.5% between 2009 and 2018.

The increase in demand is driven by an ageing and growing population, compounded by growth in complex and chronic conditions such as cancer and diabetes. Greater consumer awareness of health problems along with advances in medical technology have added to demand as people seek treatment for conditions previously considered untreatable.

The continued growth in demand for ED services expected over the next decade means efficient and effective emergency care will be vital for enabling Tasmanians to access high-quality treatment in public hospitals.

## ROLES AND RESPONSIBILITIES

### Tasmanian Health Services and Hospitals

THS is governed by the THS Act and is responsible for delivering integrated healthcare services through the public hospital system and primary and community health services. THS operates four major public hospitals:

- RHH – principal tertiary referral hospital for residents of Southern Tasmania that also provides a number of state-wide services
- LGH – principal referral hospital for the North and North-West of Tasmania that also provides a number of tertiary services for residents of those areas
- NWRH – provides acute general hospital services for residents in the North-West of Tasmania
- MCH – provides a mix of general hospital services for residents in the North-West of Tasmania.

ED care is provided at each of these hospitals.

Under the THS Act, THS is directly accountable to the Secretary of DoH, who has subsumed the key planning and oversight functions of the former THS Governing Council and is now responsible to the Minister for the performance of THS and its Executive.

### Minister for Health

The Minister is responsible for administering the THS Act. The Minister provides guidance and direction to DoH and THS through the:

- Ministerial Charter – sets out the broad policy expectations for the Secretary and THS. The THS and Secretary must comply with the Ministerial Charter.

- THS Service Plan – is a key accountability document setting out the services to be delivered by THS and the standards of performance expected by the Government. The Minister approves the THS Service Plan each financial year.

### The Secretary of Department of Health

Under the THS Act, the Secretary of DoH is responsible to the Minister for the performance of THS and THS Executive. He is assigned a number of functions and powers to guide, monitor and manage THS in undertaking its functions and powers, including:

- the ability to give direction to THS in relation to the performance of its functions and the exercise of its powers. This includes issuing policy or directing THS to undertake actions to improve performance
- responsibility for developing the Service Plan, including key performance indicators, service volumes and performance standards.

### Department of Health

As the health system manager, DoH is responsible for monitoring the performance of the wider health and human services system incorporating THS and public health services and for providing system-wide guidance, strategic planning and funding.

The term 'system manager' dates back to the Council of Australian Government (COAG) health policy changes in 2011 that recast the roles and responsibilities of the different stakeholders in the health system. These policy changes were established through the National Health Reform Agreement 2011 (NHRA), to which Tasmania is a signatory. This agreement tied all participating jurisdictions to establishing a Local Hospital Network or Networks (known in Tasmania as THS) and recognised the States and Territories as 'system managers' of the public hospital system.

## FUNDING AND PERFORMANCE MONITORING

### Funding

The THS funding model includes funding provided under a range of National Partnership Agreements, Commonwealth Own Purpose Expenditure payments and other agreements. It is based on the national Activity Based Funding (ABF) model developed by the Commonwealth Government's Independent Hospital Pricing Authority to fund public hospital services.

COAG reaffirmed its commitment to health system reform and the existing funding arrangements under the Heads of Agreement for public hospital finding endorsed by the Tasmanian Government in 2018.

Funding for ED patients follows the clinical pathway for that patient. Emergency patients who are subsequently admitted to an in-patient ward are funded as part of the ABF model and included in the associated National Weighted Activity Unit (NWAU) cost weighting. ED patients who are discharged home are funded via the Non-Admitted Emergency Department NWAU category.

On 1 July 2017 the Commonwealth Government, under a National Partnership Agreement, transferred the MCH to the Tasmanian Government, together with a $736.6m funding contribution. To ensure that Tasmania does not receive double funding for public hospital services, for the period from 2017-18 to 2026-27 inclusive, Tasmania will not be entitled to receive an ABF payment under the NHRA, or any subsequent agreement, for an agreed activity level under the Agreement, whether the agreed activity profile is provided at the MCH or elsewhere.

### Performance monitoring

The 2018-19 THS Service Plan outlines a suite of KPIs and related targets for THS. The ED-related indicators focus mainly on measuring compliance with targets for:

- waiting times for treatment in the ED by patients after being triaged
- ED length of stay for both admitted and non-admitted patients
- ambulance offload delay (i.e. ramping).

The THS Performance Framework underpins these KPIs and establishes the mechanisms used by DoH for monitoring THS's performance. The Service Plan states that these mechanisms include a range of monitoring activities underpinned by transparent criteria to ensure the services purchased are being delivered and that performance issues are appropriately identified and acted upon. The THS Performance Framework is discussed further in later sections of this Report.

## RECENT HEALTH SYSTEM REFORMS

In 2014, the Government initiated its long-term reform program for the Tasmanian Health System - One State, One Health System, Better Outcomes.

The Government's vision is for Tasmania to strive to have the healthiest population in Australia by 2025 and a world-class health care system. Similarly, its goal is to give Tasmanians a better health system: a complete, state-wide system that places the interests of patients at the forefront of every decision.

The four major components of the reform agenda were:

- the transition from the three former THOs to a single state-wide THO, known as THS
- a review and reform of the former DHHS, to enable it to better discharge its responsibilities as purchaser and system manager
- convening a Health Council of Tasmania, to provide strategic advice on the direction of Health Care in Tasmania, composed of clinicians, consumer and community representatives and other key stakeholders
- developing a White Paper to set the Government's agenda for better service planning, profiling and delivery in Tasmania (delivered in July 2015), with the first stage being the release of a Green Paper for public consultation in December 2014.

### White Paper

The White Paper outlined a series of proposals to deliver improved safety, quality of services, greater efficiency and improved patient support and access to services. Key proposals included:

- providing safer health services for patients through the development of a Tasmanian Role Delineation Framework, followed by mapping of services to determine a valid Tasmanian Clinical Service Profile
- building confidence in hospitals by defining their role in the system
- building better surgical service around the State by establishing an elective day surgery centre at MCH
- providing more health services across the North and North-West where there had been unacceptable service gaps like mental health and geriatrics
- building better, more sustainable services by ensuring adequate volumes for high quality, sustainable services.

### Green Paper

The Green Paper outlined the process for determining where and how services are provided, balancing safety with access, efficiency, suitability and equity. Supplement No. 4 to the Green Paper focused on Emergency Care in Tasmania including options for managing demand and related capacity issues.

The paper identified the functions of an ED, the implications of growing demand and access block and the need for options to reduce the associated pressure on EDs.

The paper acknowledged access block is not just an inconvenience for patients and staff and that it is associated with much greater waiting time for patients in the ED and a greater risk of adverse events including death as an inpatient.

It further acknowledged ED:

- capacity is reduced by access block with the flow on effect of reducing the ability for staff to assess and treat new patients
- overcrowding has been recognised as a major public health issue internationally, compromising patient safety and contributing to poor patient outcomes
- crowding is primarily a system issue, not merely an ED problem - its causes and solutions largely reside outside the ED.

### Review of Ambulance Tasmania

In June 2017, the Government released the findings of its review of AT clinical and operational services. The review identified reforms to increase AT's efficiency and to reduce demand on emergency services.

The review included an analysis of 210 000 ambulance responses and found:

- Use of ambulance services over the last seven years had grown 14 times faster than Tasmania's population.
- Increasingly, ambulances were responding to unexpected primary health care needs. While these patients may need urgent care, they do not usually require the acute capabilities of an ED.
- Over 40% of all transported patients in some areas of Tasmania were categorised as non-acute meaning they could be more appropriately directed to primary care instead of an ED.
- State-wide, only 2% of patients were categorised as acute and time critical once assessed by a paramedic indicating there was significant scope to reduce the number of unnecessary ambulance arrivals to hospital EDs.

The report recommended a range of initiatives. These including moving to secondary triage – where the triple zero call centre can, where appropriate, direct non-acute patients to other more suitable primary and/or community health providers.

The report also recommended exploring the use of Urgent Care Centres and better use of Extended Care Paramedics and Intensive Care Paramedics to increase treatment options for non-acute patients and reduce the need for unnecessary hospital transport. The status of key initiatives is discussed further in later sections of this Report.

## THE PATIENT JOURNEY THROUGH AN EMERGENCY DEPARTMENT

Patients presenting to an ED are assessed, treated and then either discharged home or admitted to hospital. The initial assessment is known as 'triage[5]' where those presenting are prioritised for treatment according to the clinical urgency of their presentation. EDs determine this using the Australasian Triage Scale, which consists of five categories. Category 1 indicates an immediate life threat where patients must be seen immediately, whereas Category 5 is for less urgent problems where the patient is deemed able to wait up to two hours to be seen.

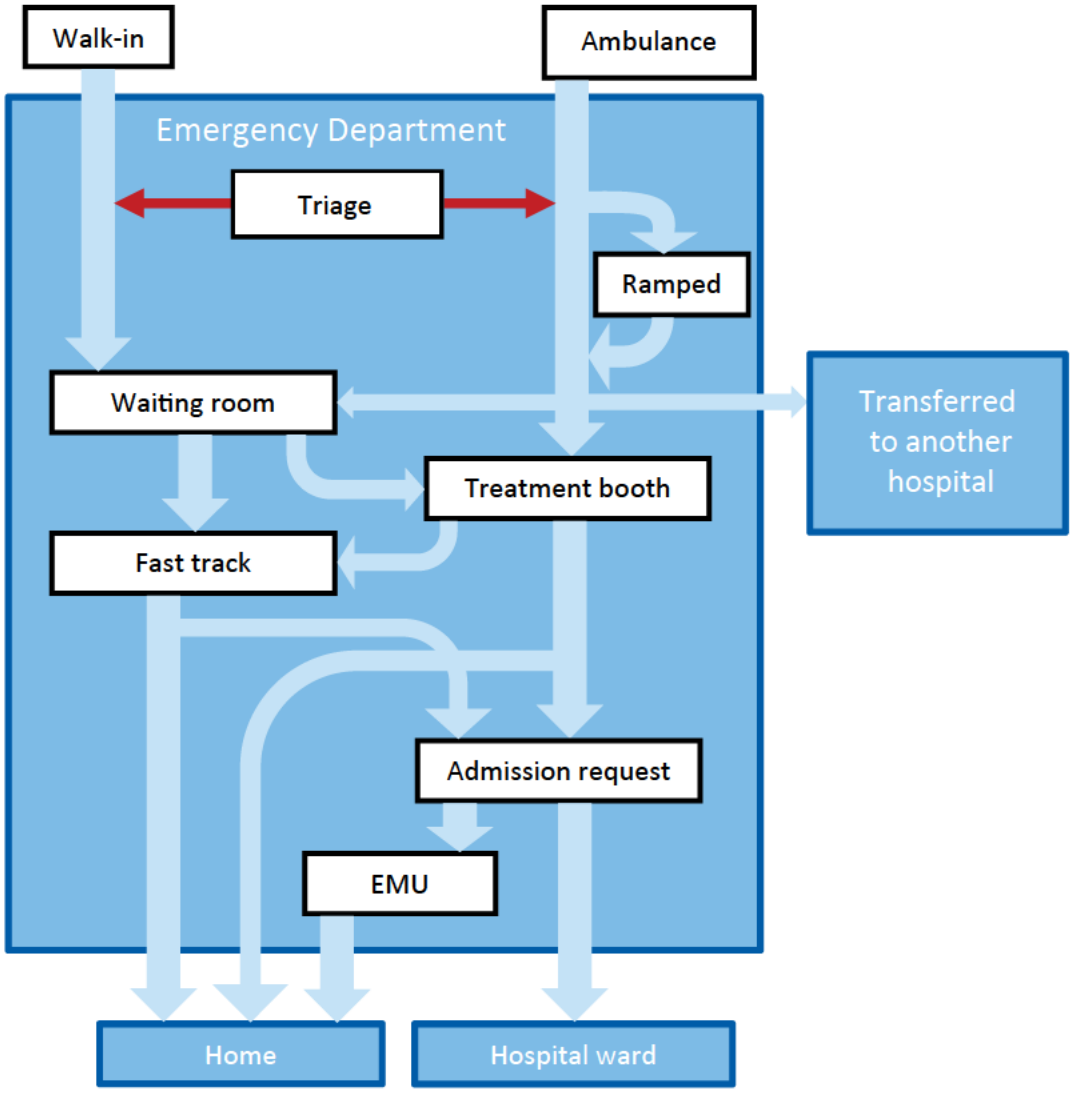
Emergency Medical Units (EMUs) are a type of observation unit, separate from the ED. They are designed for ED patients who, with proper assessment, treatment and planning, are likely to be discharged within 24 hours. ED patients who are likely to require observation or treatment for more than four hours, but less than 24 hours, are ideally admitted to an EMU following ED assessment and are classified as 'admitted' patients.

Fast-track services are designed to improve flow within an ED by providing the less seriously ill patients with access to timely assessment, treatment and discharge. These services may differ between hospitals, as EDs adopt slightly different practices and resource models.

5 The initial process of determining the priority of patients' treatments based on the clinical urgency of their condition.

Figure 1 graphically illustrates the patient's journey through an ED.

Figure 1: Patient journey through an emergency department




Source: TAO

# DETAILED FINDINGS

## 1. WHAT HAPPENS WHEN I ARRIVE AT THE EMERGENCY DEPARTMENT?

In evaluating this phase of the ED process, we examined:

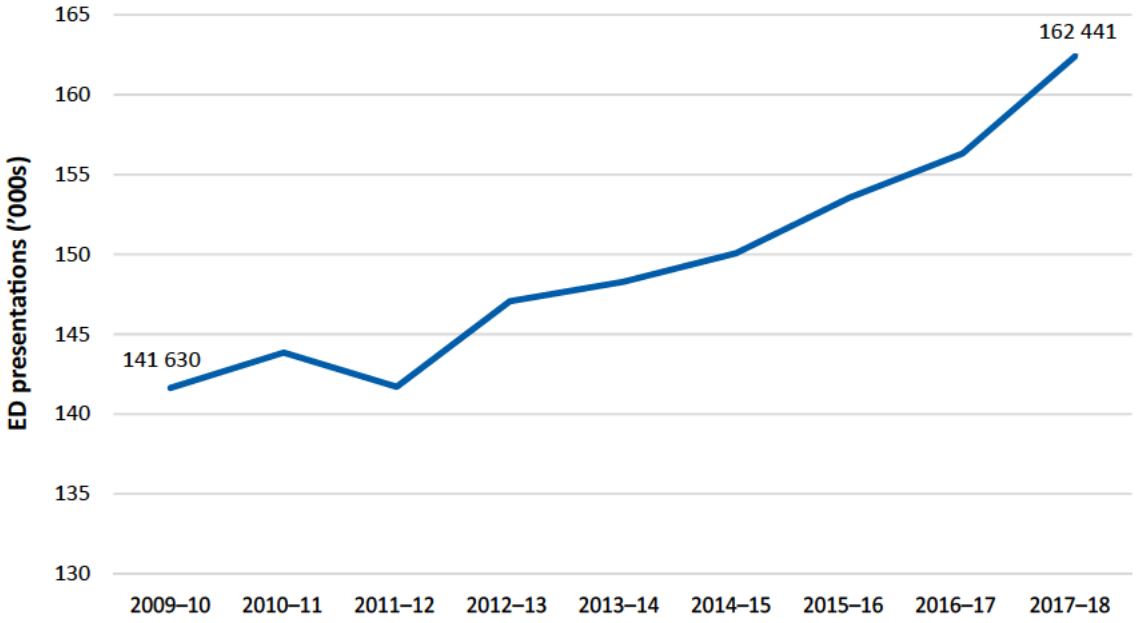
- the level and complexity of demand for emergency care and how this was impacting ED services
- ambulance presentations and extent of ramping
- if triaged patients were seen by clinicians within required timeframes
- the incidence of patients who leave the ED without being treated.

### Presentations are increasing

Demand for emergency care in Tasmanian public hospitals has steadily grown over the last nine years.

Figure 2 shows the number of ED presentations increased by 20 811 between 2009-10 and 2017-18, representing an increase of 14.7%.

Figure 2: Total number of presentations to EDs, 2009-10 to 2017-18




Source: TAO, AIHW

Most of the growth in presentations occurred at RHH which increased by 34.3% during the period and by more than twice the state-wide average.

Comparatively, there was much lower growth in presentations at the remaining Tasmanian hospitals during the period. Specifically, presentations increased by 5.4% and 9.9% at LGH and MCH, respectively, whereas they declined by 0.6% at NWRH.

Table 1 shows ED presentations by State and Territory 2009-10 to 2017-18.

Table 1: ED presentations by State and Territory 2009-10 to 2017-18

| | 2009–10 | 2010–11 | 2011–12 | 2012–13 | 2013–14 | 2014–15 | 2015–16 | 2016–17 | 2017-18 | Per cent growth since 2009-10 |
|---|---|---|---|---|---|---|---|---|---|---|
| New South Wales | 2 035 783 | 2 074 098 | 2 235 455 | 2 278 591 | 2 646 415 | 2 681 466 | 2 733 520 | 2 784 545 | 2 880 287 | 41.5% |
| Victoria | 1 432 745 | 1 483 159 | 1 509 065 | 1 528 609 | 1 572 787 | 1 610 623 | 1 679 886 | 1 731 040 | 1 792 906 | 25.1% |
| Queensland | 1 134 092 | 1 195 325 | 1 238 522 | 1 284 158 | 1 351 573 | 1 378 883 | 1 439 143 | 1 457 083 | 1 512 118 | 33.3% |
| Western Australia | 600 613 | 649 215 | 732 351 | 754 252 | 742 615 | 803 821 | 829 431 | 835 551 | 856 707 | 42.6% |
| South Australia | 373 700 | 383 992 | 427 011 | 455 220 | 463 171 | 469 368 | 481 889 | 493 268 | 506 494 | 35.5% |
| Tasmania | 141 630 | 143 848 | 141 700 | 147 064 | 148 278 | 150 076 | 153 541 | 156 323 | 162 441 | 14.7% |
| Australian Capital Territory | 106 815 | 112 232 | 118 396 | 118 931 | 125 888 | 129 961 | n.a. | 143 860 | 147 778 | 38.3% |
| Northern Territory | 132 583 | 141 419 | 144 842 | 145 532 | 145 176 | 142 244 | 148 459 | 153 936 | 158 761 | 19.7% |
| **Total** | **5 957 961** | **6 183 288** | **6 547 342** | **6 712 357** | **7 195 903** | **7 366 442** | **7 465 869** | **7 755 606** | **8 017 492** | **34.6%** |

Source: AIHW

Table 1 indicates the growth in total presentations was lower in Tasmania compared to all other Australian states. However, Tasmania's geographical and demographic characteristics create unique challenges for hospitals in meeting the growing demand for ED care. Specifically, compared to the national average, Tasmania has:

- an older and more rapidly ageing population
- the lowest average annual income levels
- a higher rate of dependency on social welfare
- lower rates of health literacy and a significant burden of chronic disease.

Additionally, the fewer and more geographically dispersed public hospitals within the Tasmanian health care system means ED presentation bypass options are not normally available.

Further, DoH identified the low number of Tasmanian GPs who bulk bill coupled with AT's limited numbers of extended care paramedics capable of providing care on site to lower acuity patients as additional factors contributing to the growth in presentations.

DoH also advised that public hospital EDs are impacted by the limited availability of emergency services at private hospitals. Specifically, it noted that as the two private EDs in Hobart managed a substantial number of lower acuity presentations (estimated at around 30 000 presentations per year), their frequent last-minute closure to public patients often placed significant burden on the public system.

## Patients are presenting with more complex conditions

Table 2 shows the complexity of ED presentations also increased over the last nine years with the incidence of the more urgent triage Categories 1 to 3 experiencing the greatest increase. This, along with the general increase in total presentations, is contributing to the growing challenge faced by hospitals.

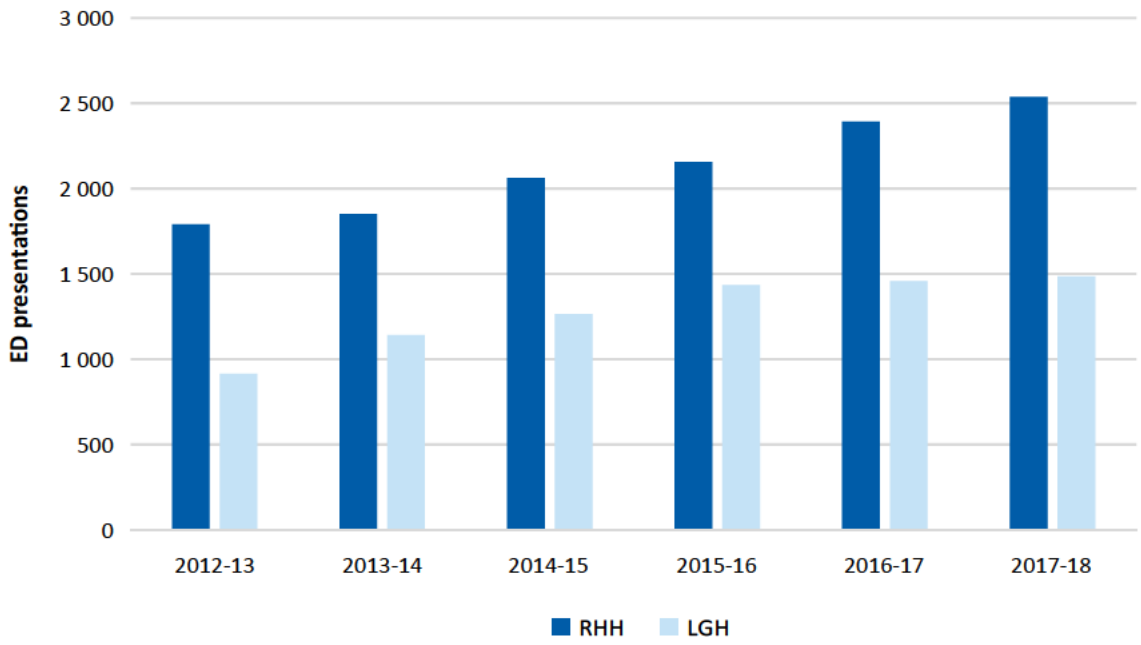
Table 2: Growth in presentations by triage category 2017-18

| Triage category | Description | Treatment time | Per cent growth since 2009-10 |
|---|---|---|---|
| Category 1 | Imminently life threatening, requiring aggressive intervention | 0 min | 32.6% |
| Category 2 | Life-threatening, time critical treatment and/ or very severe pain | 10 min | 50.0% |
| Category 3 | Potentially life-threatening, situational urgency and/or severe discomfort or distress | 30 min | 18.7% |
| Category 4 | Potentially serious, complex or severe | 60 min | 7.4% |
| Category 5 | Less urgent | 120 min | 7.0% |

Source: TAO, THS

The DoH July 2018 analysis of ED demand factors also forecasted an increasingly more complex and older cohort of presentations reflecting the growing acuity of ED presentations, ageing of Tasmania's population and evident increase in the rate of mental health ED presentations as shown in Figure 3 below.

Figure 3: Mental health presentations to RHH and LGH EDs, 2012-13 to 2017-18




Source: TAO, DoH

Note: Data shows nine months per year

DoH concluded from its analysis there was a steady rising presenting demand for ED care, with drivers that remained poorly understood with little likelihood of change to this trajectory.

We further noted the growing acuity of ED presentations also indicated there was limited and diminishing scope to mitigate the impact of this growth on ED demand by diverting lower acuity presentations to GPs or primary care.

## Patients are not receiving timely access to emergency care

We examined the performance of hospitals and THS in meeting targets relating to ED access over the period 2015–16 to 2018–19. As shown in Table 3, aside from some minor changes and additions to some KPIs since 2015-16, the ED-related indicators remained largely consistent within THS service agreements during this period and focus mainly on measuring compliance with targets for:

- waiting times for treatment in the ED by patients after being triaged
- ED length of stay for both admitted and non-admitted patients
- ambulance offload delay (i.e. ramping).

Table 3: ED KPIs contained within the THS Service Agreement/Plan – 2015-16 to 2018-19

| 2015-16 Service Agreement: ED related KPIs (targets shown in brackets) | 2016-17 to 2018-19 Service Agreements/ Plan: ED related KPIs (targets shown in brackets) |
|---|---|
| • AEC 1: Triage 1 ED patients seen within recommended time (100%)<br>• AEC 2: Triage 2 ED patients seen within recommended time (80%)[1]<br>• AEC 3: ED did not wait presentation (<=5%)<br>• AEC 4: Time until most (i.e. 90%) admitted patients departed the ED (<=8 hours)<br>• AEC 5: Ambulance offload delay (part 1) – (85% within 15 mins)<br>• AEC 6: Ambulance offload delay (part 2) – (100% within 30 mins) | • ACC 1: Triage 1 ED patients seen within recommended time (100%)<br>• ACC 2: Percent all ED patients seen within recommended time (80% - i.e. covers all triage categories 1-5)<br>• ACC 3: Percent of ED patients that did not wait (<=5%)<br>• ACC4: Percent all ED patients with LoS < 4hrs (80%)[2]<br>• ACC 5: Percent admitted patients with LoS < 8 hrs (90%)<br>• ACC 6: Percent all ED patients with LoS < 24 hrs (100%)[2]<br>• EFF3: Ambulance offload delay (part 1) – (85% within 15 mins)<br>• EFF4: Ambulance offload delay (part 2) – (100% within 30 mins) |

**Notes:**

1. the 2015-16 KPI AEC2 was replaced by ACC2 in the Service agreement from 2016-17
2. new KPIs added to the Service Agreement from 2016-17

KPI abbreviations:

- ACC = Accessibility
- AEC = Access to Emergency Care
- LoS = Length of Stay
- EFF = Efficiency

THS's performance against each of the above performance indicators is discussed in the following sections of this Report.

## The incidence and duration of ambulance ramping is increasing

Hospitals achieved the ambulance offload target of 85% of presentations within 15 minutes between 2012-13 and 2016-17, but fell short of the target in 2017-18. They also consistently failed to achieve the more challenging target of 100% of presentations offloaded within 30 minutes during the same period.

DoH advised it measures the duration of ramping from the point in time a patient waits longer than 15 minutes to be offloaded from an ambulance, thereby experiencing offload delay. Table 4 shows the incidence of ramping across all hospitals increased significantly – by around 149% between 2012-13 and 2017-18 and substantially exceeds the growth in ambulance presentations which only went up by pproximately 20% over the same period.

Although hospitals mostly met the 15-minute offload target, instances of ramping with times in excess of the 15 minute offload target and instances where the offload delay exceeded 30 minutes increased by 197% and 239%, respectively, during the period.

Table 4: Ambulance ramping, all hospitals

| | 2012-13 | 2013-14 | 2014-15 | 2015-16 | 2016-17 | 2017-18 |
|---|---|---|---|---|---|---|
| **Total Presentations** | 147 059 | 148 392 | 150 243 | 153 676 | 156 586 | 162 673 |
| **Ambulance Presentations** | 37 995 | 39 452 | 40 529 | 42 467 | 43 340 | 45 540 |
| **Ambulances Ramped[1]** | 5 386 | 6 085 | 4 342 | 5 895 | 7 598 | 13 415 |
| **Transfer of Care >15 min[2]** | 3 372 | 3 900 | 2 801 | 3 831 | 5 125 | 10 026 |
| **Transfer of Care >30 min[3]** | 2 249 | 2 642 | 1 796 | 2 414 | 3 360 | 7 644 |

Source: DoH

**Notes:**

1. does not = Note 2 + Note 3 as Note 2 counts all patients waiting longer than 15 minutes and includes those shown at Note 3 waiting longer than 30 minutes
2. includes patients ramped for 1 minute or more in excess of the 15-minute offload target
3. includes patients ramped for 15 minutes or more in excess of the 15-minute offload target – as such this figure is a subset of Note 2

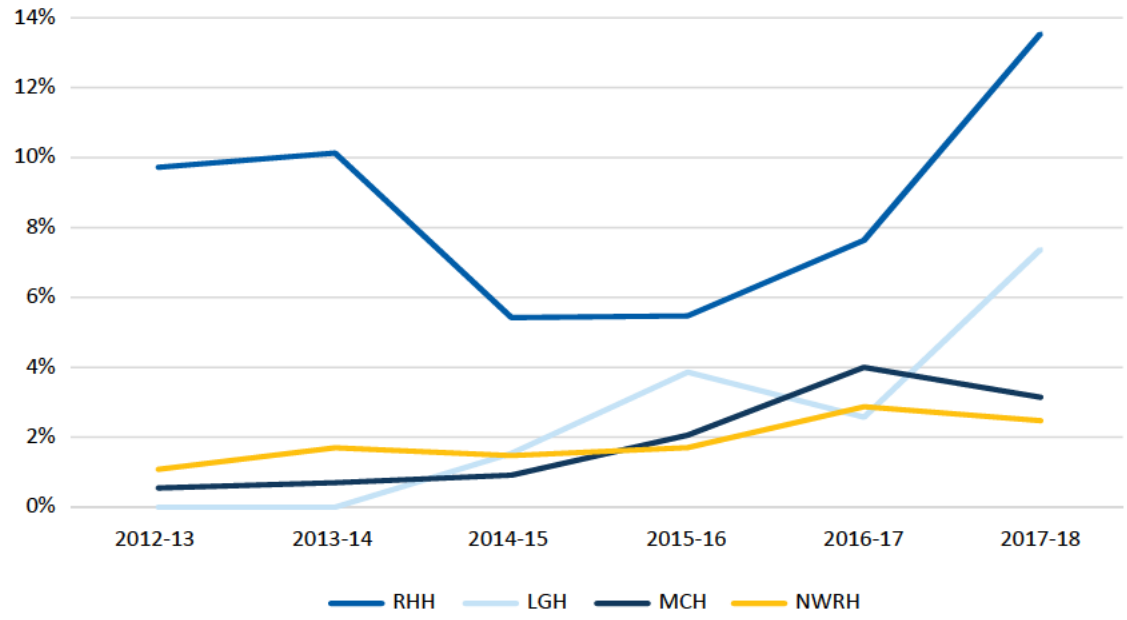
Ramping across the system is now occurring a lot more frequently and there are more patients presenting by ambulance that are waiting excessively on a ramp within a hospital ED.

AT acknowledged ramping was a significant issue impacting both patient flow and its capacity to respond to other emergencies. AT also acknowledged the significant growth in ramping illustrated by Table 4 but stated the data was most likely an under-estimate of the actual incidence and duration of ramping.

AT noted this was because hospitals measure ramping from a point in time after initial triage and when the ED nurse determines a patient needs to be ramped, rather from when the ambulance crew enters the ED and notifies ED staff their patient needs to be triaged consistent with the definition of ramping used by the Australasian College for Emergency Medicine. AT stated this meant the time spent by ambulance crews with ramped patients before triage and the nurse's decision is not currently captured in a hospital's measurement of ramping. Data supplied by AT for the period January 2018 to March 2019 indicates ambulance crews waited, on average, between 5.9 and 7.6 minutes until triage and between 50.6 and 63.6 minutes in total with ramped patients at the RHH.

Figure 4 shows a significant and sharp increase in ramping across the system since 2015-16 with RHH having the highest incidence of ramping as a percentage of all presentations, 13.5%, followed by LGH, 7.4%.

Figure 4: Incidence of ambulance ramping by hospital (% of total presentations)




Source: TAO, THS

## Causes of ramping and implications

In July 2018, DoH analysed ramping data covering the two-year period between June 2016 and July 2018. This showed that both older patients and Category 3 patients were more likely to be ramped and for longer periods than other ambulance arrivals. DoH's analysis of data covering the wider period 2014-15 to 2017-18 also showed:

- The absolute number of presentations and ambulance arrivals at RHH rose steadily, with the proportion of presentations via ambulance noted as stable. Our examination of DoH data affirmed these trends revealing the proportion of ambulance arrivals was consistently around 35% during the period.
- The proportion of ambulance arrivals at LGH, whilst previously stable, grew steadily between 2013-14 and 2017-18. We similarly found a steady increase in the proportion of ambulance arrivals from around 26% in 2013-14 to just over 29% of all arrival modes in 2017-18 from our analysis of DoH data.

DoH projected continuous growth in presentations over the next decade, with the rate of growth at RHH expected to rise faster than that at LGH.

The analysis further showed that 80% of ramped cases ended up as admitted patients, compared to around 50-60% of all ambulance presentations. Ramping was also more likely to occur at the beginning of the week and during the afternoon and early evening.

The analysis also showed a correlation between ramping and bed availability at midnight the previous day. DoH concluded this signalled a clear association between ramping incidence and bed capacity, admissions and discharges. THS advised that peak occupancy mid-morning is a more precise indicator. Particularly, when new patients are admitted and discharges have yet to come through. It also noted that general measures of bed availability can sometimes be a misleading indicator of capacity as the type of available beds may not meet the need. For example, children's beds may be available at a point in time when adult medical or mental health beds are required.

However, DoH also observed ramping still occurred at RHH even when bed occupancy was at its lowest suggesting this was indicative of a cultural and practice problem at RHH rather than just a capacity issue.

Our discussions with hospitals and THS revealed a consensus that ramping and ED access issues were largely caused by longstanding capacity challenges that in many cases could be addressed through a more effective whole-of-hospital approach to improving discharge and admission practices, bed management and patient flow. At RHH, the physical capacity limits of inpatient wards and the ED were compounding these challenges.

Hospital staff described a range of longstanding cultural and governance challenges as the main factors contributing to poor coordination between EDs and inpatient areas. These included the ongoing presence of dysfunctional silos between most EDs and inpatient wards, the lack of effective whole-of-hospital leadership and action for driving necessary change and the residual impacts of disruptive governance churn at senior executive levels throughout the health service.

These issues, along with perceived inadequate planning, governance and resources for implementing past state-wide reforms were commonly cited as major drivers of the lack of traction for past initiatives to improve patient flow.

The lack of accountability for the failure of some hospital staff to prioritise the interests of patients over that of their own department, was also consistently raised by staff across all the agencies as a key barrier to implementing practical improvements that would enhance the patient journey and related outcomes. These issues are discussed further in later sections of this Report.

## Impact of ramping on Ambulance Tasmania

Senior AT officials emphasised the level of ramping in Tasmania was symptomatic of a system that was not yet optimally configured towards prioritising higher acuity patients. During our discussions, officials highlighted real-time data showing ramping mainly occurred in relation to lower acuity patients that, in effect, prevented ambulance crews from responding to other patients with more urgent needs.

Real-time dashboards showed instances of several ambulance ramped, mostly at RHH, attending to low acuity patients, in some cases for over one hour. This had resulted in instances of no ambulance vehicles available in Southern Tasmania for similar periods able to respond to other patients waiting in the queue for an ambulance rated by AT staff as more urgent.

Officials stated the implications of ramping for AT were that it often reduced its capacity to respond to those most in need of ambulance services.

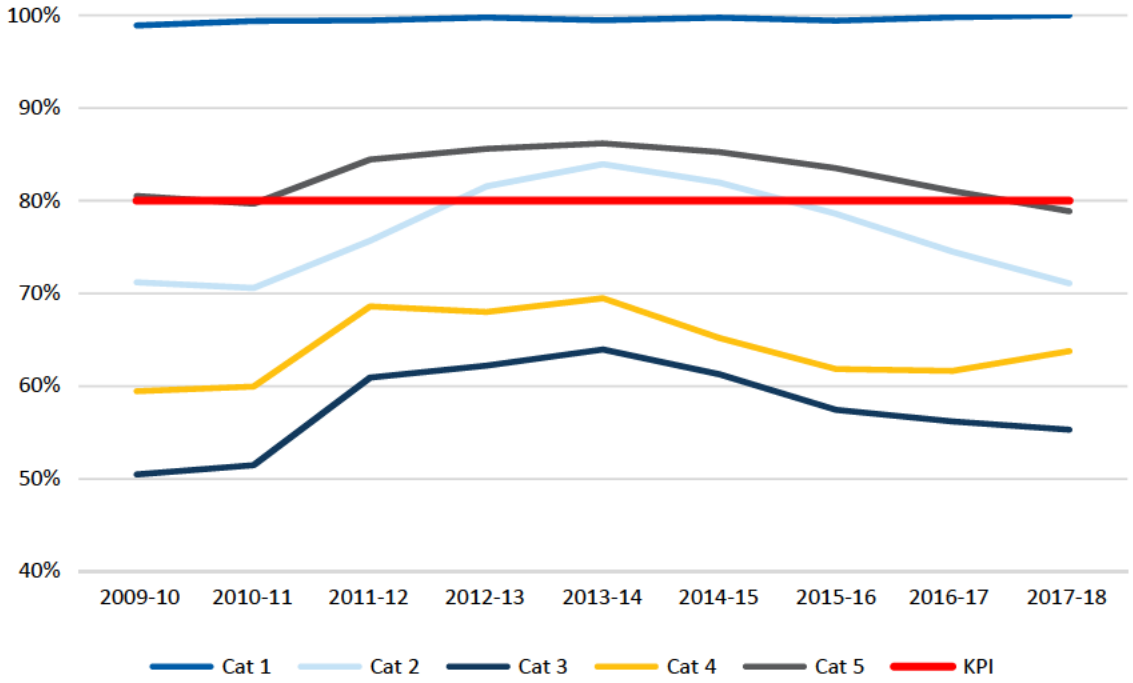
AT developed a surge escalation plan in December 2018 to mitigate these impacts. The plan sets out a series of pre-determined actions designed to provide the Tasmanian public with the safest and best quality service during periods of heightened demand while using its resources in the most efficient manner. Officials advised the plan is currently in the early stages of implementation and AT will review and adjust the actions as needed in future to maximise their impact.

## Patients are waiting longer for treatment in the ED

Performance data and monitoring reports from DoH indicated hospital EDs are under pressure to meet target waiting times for treatment.

Figure 5 shows a general downward trend in performance since 2013-14 across all triage categories (except for Category 1 patients), with Category 2 performance below target since 2015. Except for Category 1, none of the target waiting times for all other triage categories were achieved by THS and hospitals in 2017-18.

Figure 5: Tasmanian EDs compliance with waiting time KPIs




Source: TAO, THS

Tasmanian EDs consistently achieved targets for the most urgent triage Category 1 patients over the last nine years (i.e. 100% patients seen immediately). However, state-wide performance consistently fell short of target for triage Categories 3 and 4 by a significant margin (approximately 20%) over the same period.

This adverse state-wide trend is largely due to deteriorating compliance levels at RHH and LGH. Compliance rates are higher and closer to target at MCH and NWRH with both hospitals exhibiting improvements in compliance rates since 2016-17.

Our discussions with hospitals identified delays in access to treatment in EDs were driven by the combined impact of the growing number and complexity of ED presentations, ongoing access block, and capacity shortages particularly at RHH that were resulting in increased ramping, higher admissions and lengthier stays by admitted patients within EDs.

These issues were perceived as comprising a 'vicious circle' that served to perpetuate the access issues already contributing to ED overcrowding and delays.

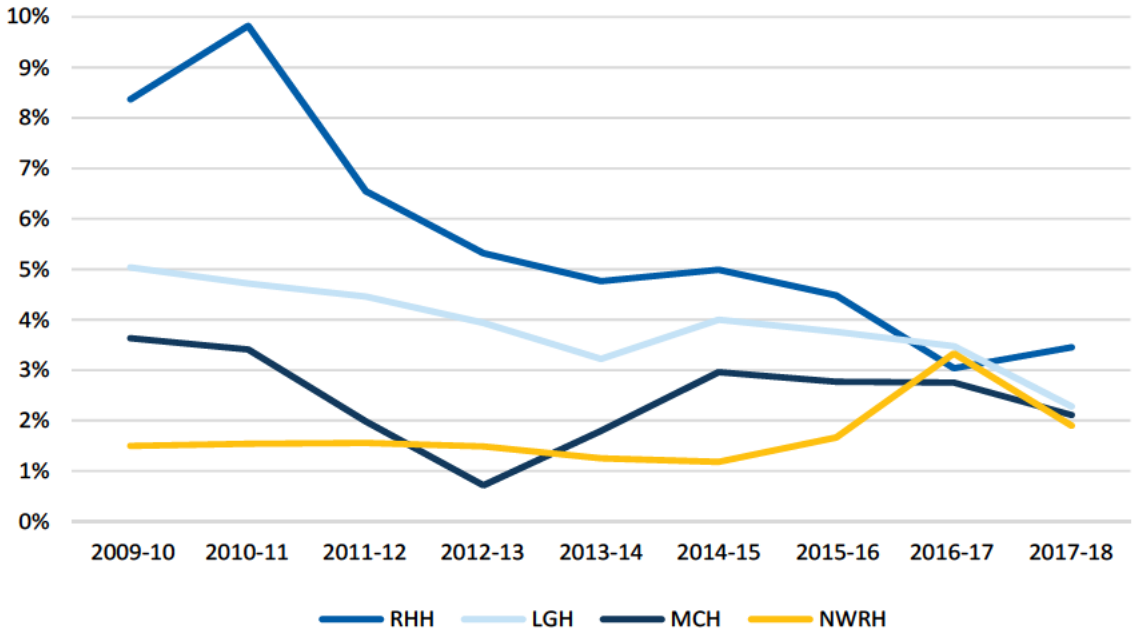
Staff also referred to the paucity of real-time data for managing and improving patient flow and the longstanding resistance from some clinicians and inpatient areas to reforming inefficient discharge practices that were preventing timely access to inpatient beds.

## Fewer patients are refusing to wait for treatment despite growing delays

The state-wide incidence of 'did not waits' declined since 2010-11 and THS consistently achieved or exceeded the target of less than or equal to 5% when averaged across all hospitals.

Figure 6 shows RHH experienced the most significant improvement reducing its rate to under 4% in 2017-18 after a peak of almost 10% in 2009-10 but was again exhibiting an upward trend.

Figure 6: Percentage of patients that leave before being treated




Source: TAO, THS

The decline in 'did not waits' in the face of increased presentations and access delays is a positive albeit counter-intuitive result.

Hospital staff we spoke to consistently referred to the growth in acuity of patients and the limited availability of alternative services as a key driver of the observed trend suggesting many of those presenting to EDs had limited options meaning they were more inclined to sit it out and wait.

### Section 1 Summary of findings

Demand for emergency care in Tasmanian public hospitals has steadily grown over the last nine years. The total number of presentations to EDs increased by 15% (or by almost 21 000) from 2009-10 to 2017-18, with most of this growth occurring at RHH.

Tasmania experienced the lowest growth in presentations compared to other Australian states but has some unique geographic and demographic characteristics that heighten the challenge of meeting demand. These include an older and more dependent population with lower rates of health literacy and a significant burden of chronic disease. The limited scope of private ED services across the State also adds to demand by reducing ED presentation bypass options for the State's already busy and geographically dispersed public hospitals.

These challenges are compounded by the growing complexity of presentations and by the limited number of bulk billing Tasmanian GPs and extended care paramedics able to avoid unnecessary trips to the ED by providing alternative care to non-acute patients.

Collectively, these factors have contributed to the significant growth in demand for inpatient beds reflected in the 56% increase in the number of hospital admissions state-wide between 2009-10 and 2017-18.

The continued growth in demand for emergency care expected over the next decade, particularly from higher complexity patients, means there will be limited scope for diverting this to primary care and the pressure on hospitals is likely to increase.

These circumstances highlight the need for effective and efficient hospital practices that optimise patient flow.

However increasingly, ED patients are not receiving timely care. Specifically:

- The incidence of ambulance ramping across Tasmania's four major hospitals increased significantly between 2012-13 and 2017-18, by around 149% and far exceeds the 20% growth in ambulance presentations to EDs over the same period.
- The duration of ramping similarly increased. Instances of ramp times in excess of the 15-minute offload target and where instances the offload delay exceeded 30 minutes grew by 197% and 239%, respectively, during the period.
- Patients are also now waiting longer for treatment in EDs. State-wide performance against most key performance indicators (KPIs) for triage waiting times (except for the most urgent Category 1 patients) deteriorated over the last five years, mainly due to worsening performance at RHH and LGH.

These delays reflect the combined impact of the growing number and complexity of ED presentations, ongoing access block to inpatient beds and limited bed capacity particularly at the RHH.

Delays are also due to long-standing practices and behaviours within hospitals contributing to dysfunctional silos, poor coordination between inpatient areas and EDs, and the lack of a whole-of-hospital approach to improving patient flow.

### Recommendation

1. THS and DoH take urgent action to strengthen whole-of-health system leadership and coordination of initiatives designed to improve patient flow by, at a minimum:
   (a) clarifying the roles and responsibilities of all hospital Executive Directors of Operations, mental health services and primary and community care leadership teams, inpatient wards, department heads, clinicians, nurses and related administrative and support staff in prioritising and contributing to hospital and system-wide initiatives to improve patient flow
   (b) ensuring all hospital, mental health and community care leadership teams, department heads and their staff are fully empowered, sufficiently resourced and accountable for achieving sustained improvements in hospital and system-wide collaboration and performance on patient flow
   (c) taking immediate steps to review and, where relevant, strengthen the effectiveness of coordination mechanisms between all departments and staff within hospitals and with mental health, primary and community care services for optimising patient flow.

## 2. WILL I GET THE CARE I NEED?

In evaluating this phase of the ED process, we examined the efficiency of Tasmania's four major hospitals in responding to ED demand to deliver clinical care at the right place and time. Specifically, we examined hospital's performance against key service agreement targets relating to the 'length of stay' of patients within the ED.

### The National Emergency Access Target – 'the four hour rule'

The National Emergency Access Target (NEAT) was introduced in 2011 as part of the National Health Reform Agreement (NHRA) and was agreed to by COAG. Its purpose was to increase the proportion of patients presenting to EDs who were discharged, admitted or transferred to another hospital within four hours. The target was intended to drive whole-of-hospital reform and improve patient flow, allowing patients to access an appropriate hospital bed and receive care in a timely manner.

Targets that varied from state to state were set for all Australian EDs. The original aim was to incrementally increase the target to 90% in all jurisdictions by 2015, in line with the 'four-hour rule' target set in the United Kingdom in 2010.

The NEAT target was discontinued in 2015, as part of the change to hospital funding arrangements announced in the 2014-15 Commonwealth Budget. Despite this, it is still a useful measure for how the EDs are performing and remains in use across several jurisdictions.

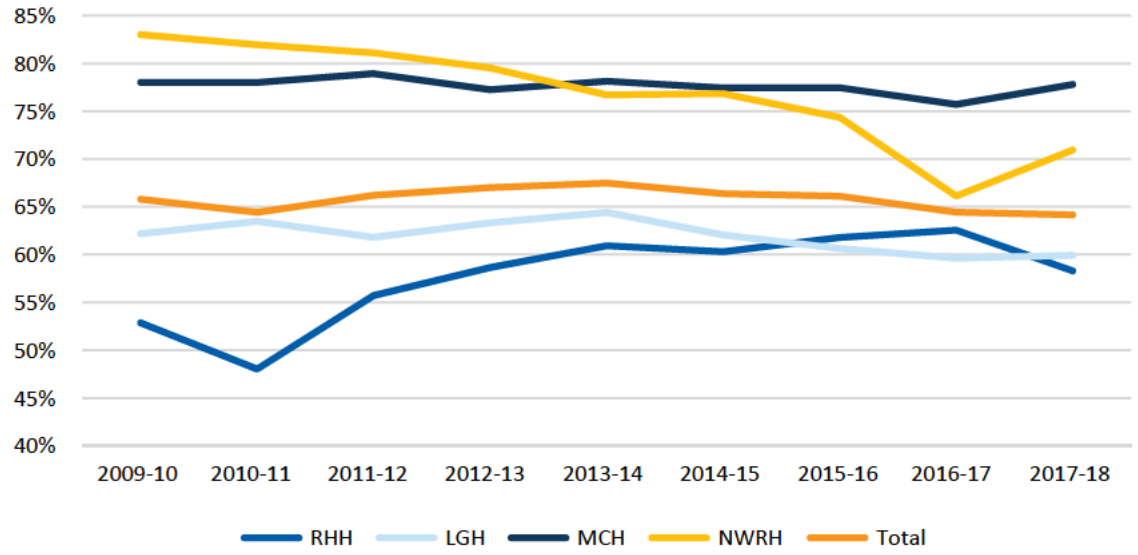
### Hospital efficiency has deteriorated resulting in longer waits in the ED

Since 2013-14, none of the hospital EDs met the service agreement target of 80% of patients with an ED length of stay of less than four hours.

State-wide, the efficiency of hospital EDs declined over the last nine years with a downward trend in the proportion of patients with length of stay less than four hours evident since 2009-10. A more pronounced deterioration in the state-wide trend is particularly evident since 2013-14.

Figure 7 shows RHH and LGH exhibit the lowest performance against the four-hour target and consistently performed below the state-wide average since 2009-10. RHH's performance deteriorated markedly since 2016-17.

Figure 7: Proportion of patients with an ED length of stay less than 4 hours by hospital.




Source: TAO, THS

Despite hospitals' longstanding inability to meet the target of discharging 80% of patients within four-hours, the target was increased under the 2018-19 service plan to 'not less than 90% of patients' to be achieved by 2022 through quarterly staged targets.

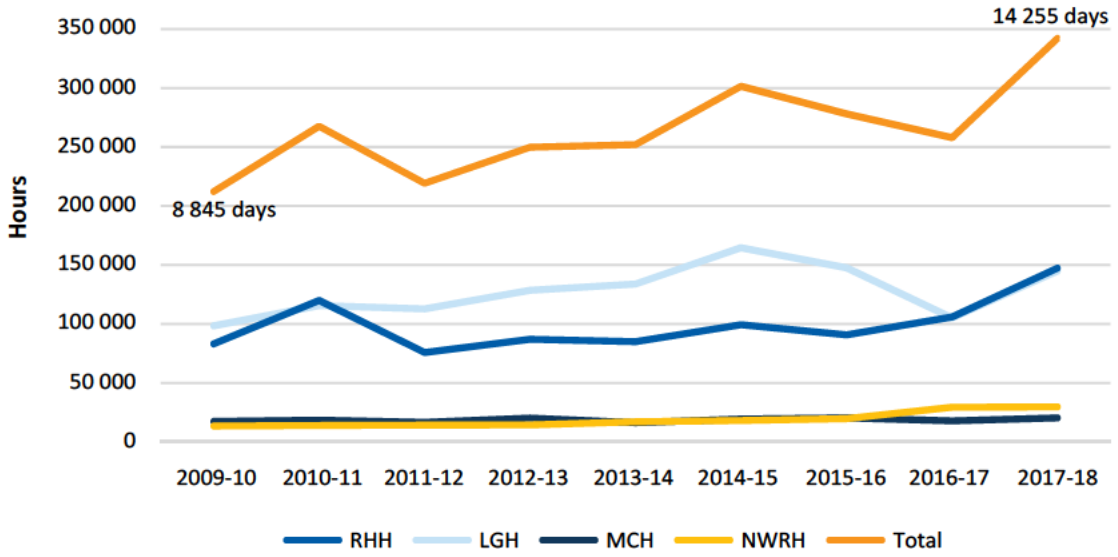
The increase in the target is based on an election commitment and it is currently unclear what resources DoH has directed to support THS and hospitals address the drivers of longstanding performance issues to achieve the higher target by 2022.

The 2018-19 Budget provides funding for a range of capacity building initiatives that include an additional 298 beds, more doctors, nurses and other recurrent funds and capital upgrades. However, the ongoing presence of dysfunctional silos, cultural and process barriers to improving patient flow within hospitals will, if unaddressed, likely limit the impact of these initiatives on reducing access block.

The historical underperformance of hospitals against less stringent trajectory targets also means that, in the absence of resource or process changes or a reduction in presentations, there is little assurance the 2022 target will be achieved.

Figure 8 shows the deterioration in performance noted above resulted in a significant increase in the total number of hours spent by patients beyond the four-hour target in Tasmanian EDs.

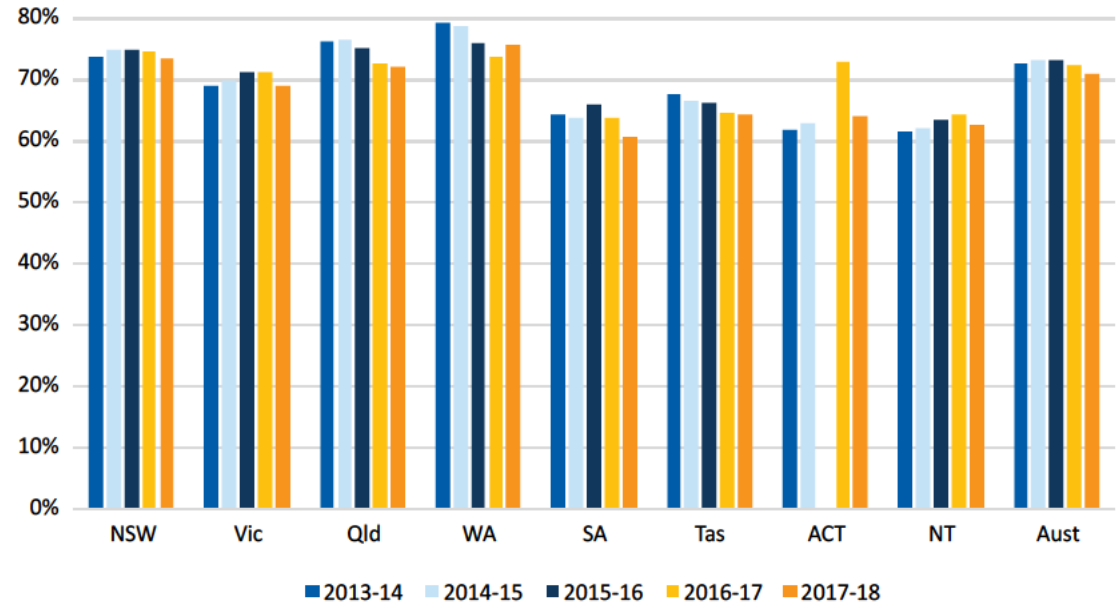
Figure 8: Total number of hours patients spent in EDs beyond the target of four hours, 2009-10 to 2017-18




Source: TAO, THS

Figure 9 further shows Tasmania's declining performance against the four-hour target was consistently below that of most other Australian states and the national average but remains marginally higher than that of South Australia, the Northern Territory and the Australian Capital Territory (with the exception of 2016-17).

Figure 9: Trend in the percentage of patients with a length of stay less than four hours by Australian State/Territory, 2013-14 to 2017-18




Source: Productivity Commission

**Note:** Data was not available for the ACT in 2015-16

## Admitted patients are waiting longer in EDs for an inpatient bed

The average ED length of stay of admitted patients is significantly higher and more than double than that of non-admitted patients.

Figure 10 shows the average length of time admitted patients spent in EDs increased to just over 9.5 hours during the period 2009-10 and 2014-15. This was mainly driven by excessive average stays at LGH for admitted patients, which grew by almost 49% during the period.

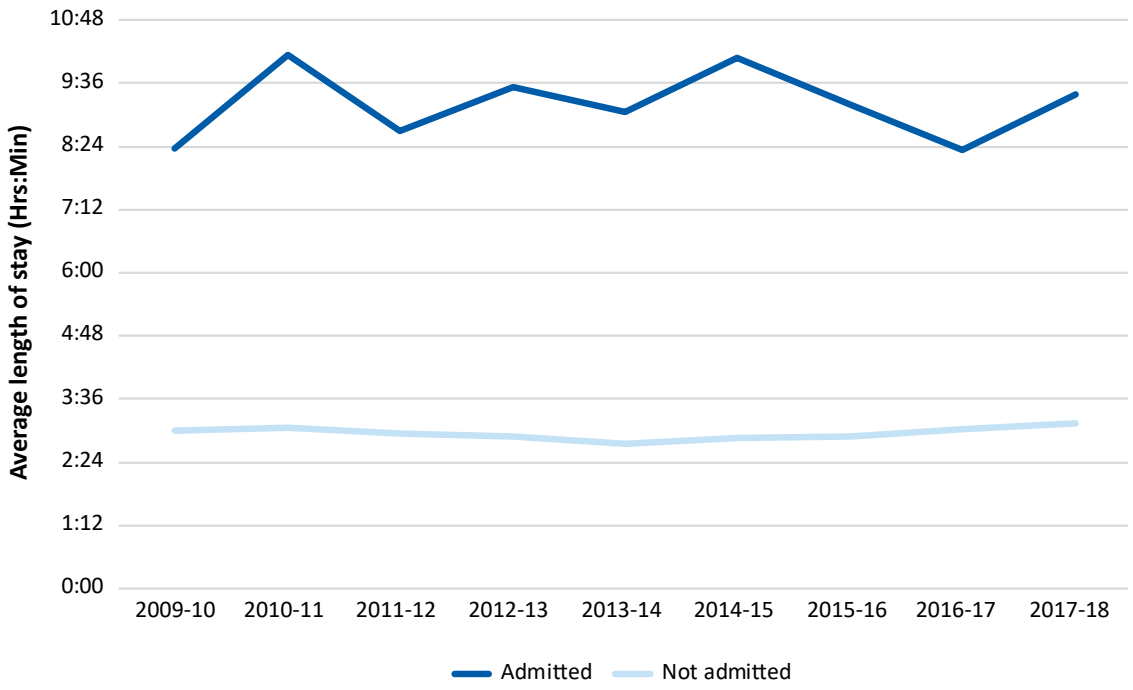
The state-wide average improved in the subsequent period until 2016-17 but has since exhibited an upward trend. However, as discussed later, we found there is a risk the observed improvement masks ongoing poor performance, particularly at LGH, as it is correlated with significantly higher admissions to inpatient wards from the LGH Emergency Medical Unit (EMUs) during this time indicating the EMU has been used as an overflow mechanism for the ED contrary to state-wide policy.

The average length of stay for admitted patients nevertheless remained well above that of non-admitted patients and significantly higher than the four-hour target during the period.

The long wait times experienced by admitted patients within EDs contributes to ED overcrowding and restricts timely access to emergency care for patients who are ramped or awaiting treatment. Most hospital staff we spoke to noted it further demonstrated the impact of the significant longstanding internal cultural challenges and process barriers they faced to free up or effectively leverage existing capacity to meet the growing demand for inpatient beds.

In discussing recent improvements in length of stay evident at MCH and NWRH the ED Director highlighted a positive recent state-wide initiative by THS in conjunction with AT to develop an acuity-based transfer and redirection policy released in September 2018. This state-wide policy diverts higher acuity patients with more complex conditions from the smaller EDs at NWRH and MCH to LGH and RHH. The ED Director advised this policy along with the proactive efforts of key staff had resulted in more timely interventions in the patient journey that ensured more patients were treated at the right time and place.

Figure 10: Average length of stay – admitted vs non-admitted patients




Source: TAO, THS

## Adverse events in EDs have increased significantly state-wide

DoH defines an adverse event as 'any event or circumstance that could have or did lead to unintended or unexpected harm, loss or damage to any person receiving care or services from health services'. Such events include near misses, close calls and process failures.

Table 5 summarises the number and type of adverse events within the EDs of Tasmania's four major hospitals between 2015 and 2018. It shows an upward trend with the total number of ED adverse events across the four hospitals increasing significantly during the period, by around 60%.

Table 5: Total ED adverse events, January 2015 to November 2018

| Event type | 2015 | 2016 | 2017 | 2018 | Total |
|---|---|---|---|---|---|
| Behaviour | 108 | 194 | 145 | 99 | 546 |
| Blood/Blood Products | 37 | 42 | 47 | 51 | 177 |
| Care Management Process | 117 | 97 | 146 | 182 | 542 |
| Clinical Process/Procedure | 89 | 90 | 191 | 166 | 536 |
| Documentation | 58 | 52 | 69 | 41 | 220 |
| Equipment/Medical Device | 10 | 16 | 17 | 40 | 83 |
| Falls | 55 | 62 | 81 | 78 | 276 |
| Healthcare Associated Infection | 1 | 7 | 2 | 5 | 15 |
| Medication/IV Fluids | 93 | 99 | 130 | 165 | 487 |
| Nutrition | 1 | 1 | 6 | 4 | 12 |
| Skin-tissue | 13 | 40 | 90 | 100 | 243 |
| **Total** | **582** | **700** | **924** | **931** | **3 137** |

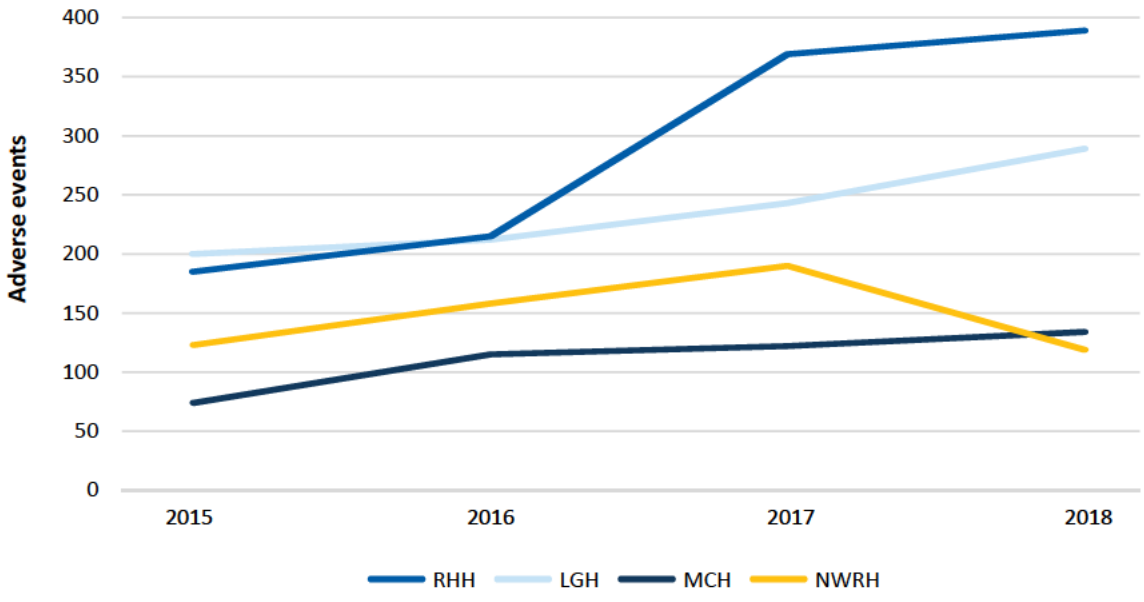
Source: DoH

Note: Data for 2018 calendar year only covers 11 months meaning the actual number of adverse events may be higher than shown

This upward trend is also evident after taking into account the increase in the number of presentations as the rate of ED adverse events per 1 000 presentations increased by 50% between 2015 and 2018.

Figure 11 shows most adverse events occurred at the State's busiest EDs – RHH and LGH.

Figure 11: Number of adverse events by hospital, 2015 to 2018.




Source: TAO, THS

ED directors advised the results reflected the growing pressure on EDs from the rise in presentations and persistent access block issues that contributed to ED overcrowding, longer wait times and more challenging conditions for both patients and ED staff.

### Section 2 Summary of findings

The efficiency of hospital EDs state-wide has declined over the last nine years with a downward trend in the proportion of patients with a length of stay less than four hours evident since 2009-10. RHH and LGH exhibit the lowest performance against the four-hour target.

This has resulted in a significant increase in the total number of hours spent by patients in EDs beyond the State's four-hour target, which is up from an average of 8 845 days in 2009-10 to 14 255 days in 2017-18.

Despite this trend, the target for compliance with the four-hour rule was increased in 2018-19 from 80% to 90% to be achieved by 2022. There is currently little assurance the target will be met based on past performance.

The average length of stay of admitted patients across the four major EDs is around 9.5 hours driven mainly by historically very lengthy stays at LGH. This rate is significantly higher and more than double that of non-admitted patients (around three hours).

The excessive wait time by admitted patients within EDs for an inpatient bed, after the ED phase of care has finished, is limiting timely access to emergency care for other patients and contributing to ED overcrowding. Hospital staff highlighted that excessive waits by admitted patients for inpatient beds reflects the impact of longstanding cultural and process barriers within hospitals to freeing up existing bed capacity to improve patient flow.

Of concern is that the rate of ED adverse events increased significantly between 2014 to 2018 across all four major hospitals, by around 60%. Most of these events occurred at RHH and LGH, with a sharp increase evident at RHH since 2016.

Hospital staff attributed this trend to the growing pressure on EDs from the rise in presentations and persistent access block issues, creating challenging conditions for both patients and ED staff.

### Recommendation

2. THS and DoH urgently review the root causes of the growth in ED adverse events and implement targeted initiatives to mitigate the impacts and reduce future incidences.

## 3. WHAT HAPPENS AFTER I RECEIVE EMERGENCY DEPARTMENT CARE?

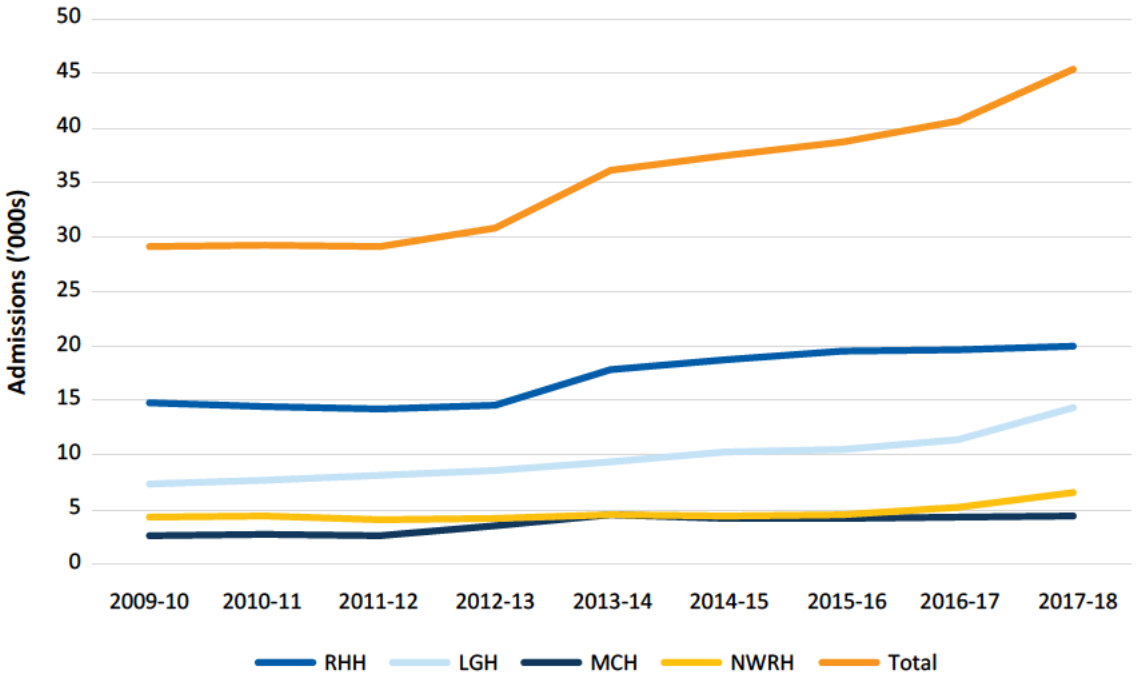
Following ED assessment and treatment, patients are usually either discharged or admitted to hospital.

In examining this phase of the patient journey, we assessed the effectiveness and efficiency of hospitals in facilitating timely access to inpatient beds for those requiring hospital admission.

### The demand for inpatient beds is growing

Figure 12 indicates the growth in presentations to EDs from higher acuity patients contributed to a significant increase in the number of ED patients admitted to hospitals state-wide since 2009-10. Specifically, the annual number of admitted patients grew by around 56% from just over 29 000 in 2009-10 to more than 45 000 patients in 2017-18.

Figure 12: Total number of admissions to inpatient wards, 2009-10 to 2017-18




Source: TAO, THS

RHH and LGH account for the vast majority of admitted patients, around 75% in 2017-18. The largest growth in hospital admissions since 2009-10 occurred at LGH, which increased by approximately 94.8%. RHH and LGH experienced sharp increases in admissions in 2013-14 and 2017-18, respectively.

The significant and steady growth in admissions signals the Tasmanian hospital system is under increasing pressure to meet the demand for inpatient beds. It also highlights the need for effective and efficient hospital practices that optimise the flow of patients through the system together with timely discharge from the hospital as clinically appropriate.

## Implications of performance trends for the patient journey

The performance trends examined in the preceding two sections show the patient journey through Tasmanian EDs has generally deteriorated and become increasingly more challenging over the last nine years.

The data shows there are now greater numbers of patients than ever presenting to EDs, which are more likely to be busier and overcrowded places. It also shows those presenting are now more likely to be waiting for longer periods for treatment by an ED physician (except for Category 1 patients that are seen immediately) and/or on an ambulance ramp which increases their likelihood of being admitted and of experiencing poorer health outcomes and adverse events.

Patients admitted to hospitals through the ED are also now waiting much longer in the ED for an inpatient bed because of growing demand, capacity constraints and longstanding barriers to access. It also means they are now less likely to receive the treatment they need at the right time and place compared to almost a decade ago. Consequently, a significant proportion of ED beds, estimated by hospital staff at around 50% of ED cubicles at times, are occupied by admitted patients awaiting a bed and for whom the ED phase of care has finished. This means ED bed capacity has declined in the face of the continual increase in demand, which is reducing access to timely care for other patients presenting to the ED.

The following section further examines the impact and causes of longstanding access block issues and the adequacy of action taken to-date by THS and hospitals to address them and improve patient flow.

## THS's Patient Flow Escalation Management Plan has yet to deliver sustained improvements to patient flow

The significant and steady growth in demand for inpatient beds evident in recent years highlights the importance of effective and efficient hospital practices that optimise the flow of patients through the system.

THS's Patient Flow Escalation Management Plan was established in August 2017 and describes the actions and duties required by all staff to optimise patient flow, both during periods of normal activity and heightened demand. It addresses the lack of such a plan in previous arrangements and provides a useful framework for hospitals designed to promote a co-ordinated, patient focused approach to patient flow that aims to ensure:

- consistent, effective organisational management responses to surge, overcrowding and access block
- safe, clinically appropriate care for patients regardless of escalation level
- timely communication to relevant staff about increasing activity and surge, including when senior management will be informed of and, where required, are to be involved in activities associated with increased demand.

It describes the varying management responses required at an organisational level to maintain continuous patient flow in circumstances of changing demand and occupancy as defined by Levels 1-3 in the framework and described in Table 6. The goal of management responses triggered by escalation Levels 2 and above, is to return the system to a normal state as defined by Level 1.

Escalation to Level 4 applies to RHH and can only be approved by the Chief Operating Officer, THS. It invokes significant incident and mandatory actions across the hospital to create capacity and prioritise ED admissions.

Table 6: Escalation levels in THS Patient Flow Escalation Management Plan

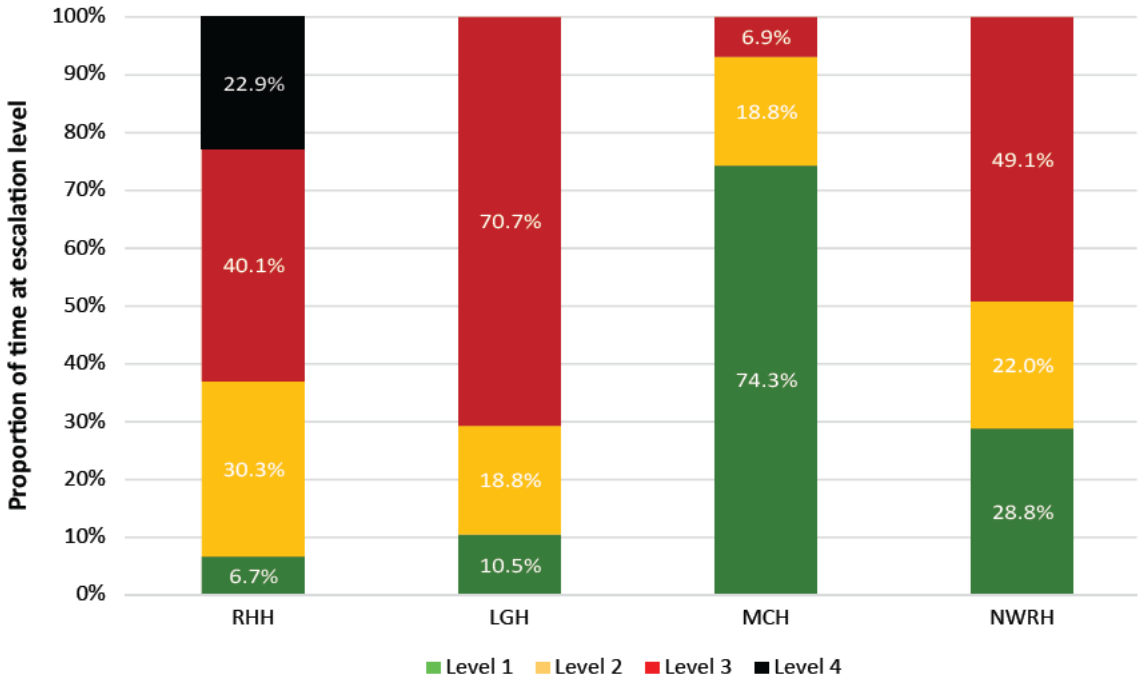
| Escalation level | Definition |
|---|---|
| **LEVEL 1 Green – Normal Operating Activity** | Capacity is such that the campus is able to maintain patient flow and is able to meet anticipated demand within available resources. |
| **LEVEL 2 Amber – Increased Pressure on Flow Activity** | The campus and systems are starting to show signs of pressure. Focused actions are required to mitigate further escalation. Enhanced coordination will alert the campus to take action to return to green status as quickly as possible. |
| **LEVEL 3 Red – Severe effect on Flow Activity** | Actions taken in amber have failed to return the system to green and pressure is worsening. The campus and local health care systems are experiencing major pressures compromising patient flow to bed block. Further urgent actions are required across the system by all areas. |
| **LEVEL 4 Black – System severely compromised in relation to delivery of safe patient care** | All actions initiated have failed to contain service pressures within agreed timeframes, and local health care systems are unable to deliver comprehensive emergency care. There is a high potential for patient care to be compromised. Decisive action and decision making must be instituted to recover capacity using a health system-wide approach. |

Source: THS

Figure 13 shows the results of a THS analysis of the proportion of time hospitals spent at each of the four escalation levels during the period 29 June 2018 and 24 January 2019.

Although THS acknowledged some limitations in the data, the analysis is concerning, which we found accords with the experience of staff on the ground. Specifically, it shows RHH, LGH and NWRH experienced significant access block issues for most of the time during this seven-month period.

Figure 13: Proportion of time at escalation level by hospital, 29 June 2018 to 24 January 2019




Source: THS

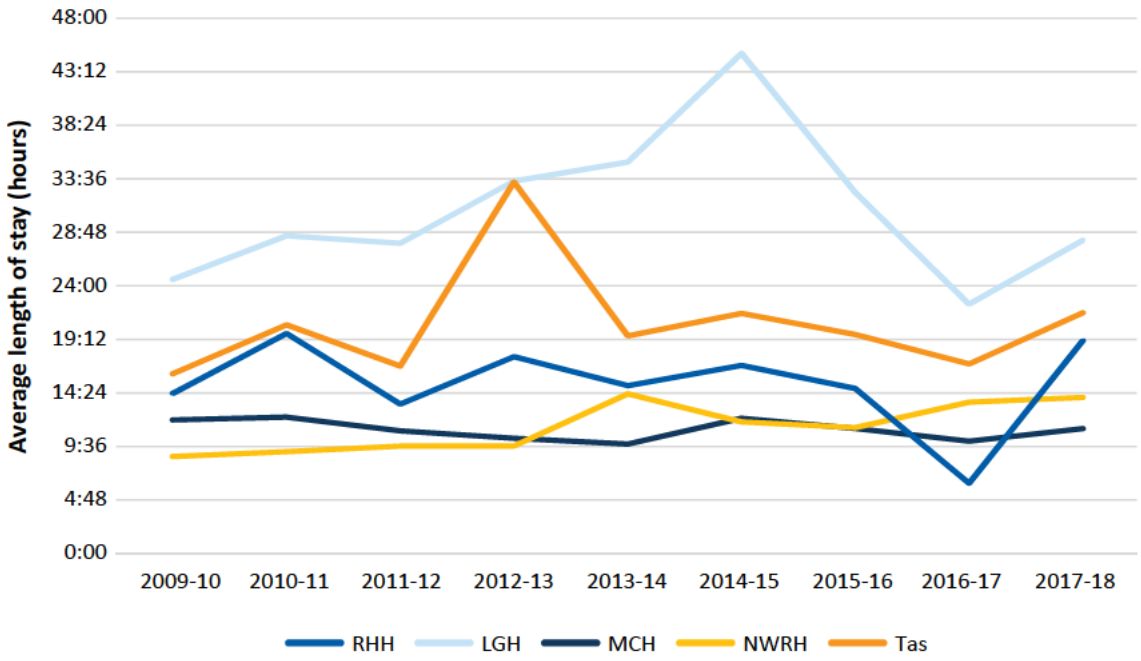
THS's analysis noted escalation Level 4 exists for RHH only meaning, in effect, LGH had spent more than 70% of the time during the period at the highest possible level of escalation and in a state of almost constant 'gridlock'.

A further concern is the results show RHH was bed-blocked for almost 93% of the time, with the delivery of safe patient care being severely and routinely compromised, on average, almost once every four days.

The challenges indicated by the above analysis are also reflected in THS's longstanding performance results against the service agreement target relating to the length of stay for the 90th percentile of admitted patients.

As shown in Figure 14, the state-wide result for this metric consistently exceeded the target of less than or equal to eight hours by a significant margin, with LGH being an obvious outlier. In 2015-16, DHHS triggered a performance escalation for this measure requiring THS to develop improvement strategies against this KPI. This requirement remains in place as THS's performance has yet to sufficiently improve.

Figure 14: Average length of stay for the 90th percentile of admitted patients by hospital, 2009-10 to 2017-18




Source: TAO, THS

The results discussed above confirm the hospital system in Tasmania is under significant pressure to meet the growing demand for inpatient beds and it is currently failing to do so.

They also demonstrate the escalation framework and its implementation by THS and hospital staff to date has yet to deliver sustained improvements to patient flow and address the longstanding drivers of access block.

## Past state-wide initiatives to improve whole-of-hospital patient flow have had little impact

THS has been responsible for implementing recommendations and actions arising from a number of recent reform initiatives directed at improving patient flow at RHH and LGH. Key initiatives have included the:

- May 2012 review of RHH ED Patient Flow Processes by Dr Mark Monaghan (Monaghan Review)
- May 2016 Patients First Initiative – a suite of 19 urgent actions directed by the Minister to manage ED demand and to improve whole-of-hospital patient flow across all hospitals with a particular focus on RHH and LGH

- 2016 Review of Access to Emergency Care at LGH and RHH by Dr Andrew Staib, Dr Clair Sullivan and Ms Jo Timms (Staib Sullivan Review) – this review was also directed by the Minister under the Government's Patients First initiative.

The following sections briefly summarise each of these initiatives.

## Monaghan Review

This review was commissioned by RHH and based on two days of interviews with staff from various disciplines. It examined ED processes relating to patient flow, the interface of ED with the greater hospital and ambulance ramping practices. The reviewers highlighted several issues relating to whole-of-hospital processes including bed management, ED processes, the medical and surgical patient journey, pathology and radiology and ramping. The key findings are briefly summarised in Table 7.

Table 7: Summary of selected key findings from the Monaghan Review

The review found although there were some examples of staff working collaboratively on reforms there was a 'palpable lack of engagement' in emergency access reform throughout the inpatient areas. It further noted there 'is very clearly a divide between the ED and the inpatient hospital, with this negative and unhealthy relationship presenting a very real barrier to patient care'.

There was a clear view among inpatient areas that initiatives focused on improving ED length of stay primarily benefited the ED and they would result in increased workload for their areas. The reviewers noted there was a fundamental lack of understanding by inpatient teams of the link between access block, mortality and the need for whole-of-hospital reform. The reviewers indicated these were concerning misconceptions that required a change in mindset.

They also found there was a perception among staff that the hospital executive was not visible in driving reform.

The hospital's admission practices were similarly found to be outdated and problematic because of their heavy reliance on the registrar's availability to review patients requiring admission. This often resulted in delays because of the registrar's alternative commitments throughout the day. Additionally, processes for bed allocation were inefficient as they relied heavily on manual processes and staff diligence in ensuring effective communication between the ED and inpatient areas.

Discharge planning was not seen as a priority, particularly at a senior medical level. The reviewers noted anecdotal evidence of long delays from when a patient is identified as ready for discharge to when they leave the ward. The reviewers found there was no formal or practical whole-of-hospital response to ED overcrowding or any discernible mechanism for alerting inpatient teams to ED overcrowding.

Other key findings included:

- Initiatives giving ED physicians the 'decision to admit' before inpatient review were viewed by staff as 'aggressive' and were very rarely used, with wards previously refusing to accept these patients.
- There was a tremendous willingness by the ED director to improve current process. However, the lack of data and KPIs around the ED work practice were a major obstacle to reform and measuring improvements.
- Efforts to create a consistent 'pull' model were restricted by the lack of availability of beds, which typically did not become available until early afternoon on any given day. This was contributing significantly to access block.
- There were no clear processes or policies for reviewing if ramped patients can move from trolleys to the waiting room to create capacity. There were also anecdotal reports of ramping occurring with empty beds in the ED with one such occasion observed during the review.

The report made 51 recommendations directed at addressing these issues.

The last available progress reports were produced in 2016 and show most recommendations were expected to be completed by early 2013. Although the ED had addressed the vast majority of those directed to it at that time, most remaining recommendations directed at the wider hospital for improving bed management, discharge planning, and coordination with the ED had yet to be satisfactorily addressed. These recommendations were experiencing significant delays more than four years after the Monaghan Review was completed. We found no evidence to demonstrate these recommendations have since been effectively implemented.

## Patients First Initiative

In 2016, the Tasmanian Government announced its Patients First initiative, which comprised a range of urgent actions to ensure patients were able to access more timely care in EDs, particularly at RHH and LGH.

In May 2016, the Minister directed THS to convene an Emergency Services Management Committee, co-chaired by DHHS Secretary and the THS Chief Executive Officer to:

- advise on issues affecting access to emergency care
- oversee implementation of specific immediate actions
- to commission a wider review into patient flow through all major hospitals (which later became known as the Staib Sullivan Review).

Stage 1 of the Patients First initiative was announced in April 2016 and included 19 specific actions aimed at improving patient flow issues across LGH and RHH and, where beneficial, other hospitals state-wide. The areas of focus included timely movement of patients to the right place at the right time, staff training and recruitment, developing a state-wide clinical handover framework, better supporting long stay patients, use of rural facilities and more efficient discharge.

Although the 19 actions were deemed urgent and intended for completion by 2016, 17 of these actions have yet to be satisfactorily addressed. THS acknowledged it has experienced significant delays and challenges in implementing these reforms. These issues are discussed in later sections of this Report.

Stage 2 of the Patients First initiative was announced by the Government in February 2017 in recognition of continuing demand pressures in EDs across the State. DoH advised the 2017-18 budget included additional recurrent funds for 106 new beds across the State.

On 6 June 2017, the Government established a New Beds Implementation Team (NBIT) to ensure timely opening of the new beds at RHH. The NBIT Steering Committee comprised the Secretary, Department of Premier and Cabinet (DPAC), the Secretary, DHHS and the THS Chief Executive Officer.

NBIT had responsibility for monitoring and reporting on the opening of 127 beds (including treatment recliners) across Tasmania and THS's progress in implementing the 19 Patients First actions. DoH advised 105 new beds had been opened as at 28 June 2018, with a further 22 delivered by July 2018. NBIT became inactive from November 2017 following the resignation of the previous Secretary of DPAC.

## Staib Sullivan Review

This review assessed the arrangements for operational management at LGH and RHH, particularly the systems, processes and accountabilities in place to support safe, efficient and effective emergency care and patient flow.

The August 2016 report noted the review was prompted by negative media attention of long delays for treatment at RHH and LGH and was to focus on impediments to:

- delivering a timely response to patients attending the ED
- timely transfer of admitted patients to the wards
- timely discharge from the hospital as clinically appropriate
- addressing structural, cultural and process-related barriers to flow across the wider hospital.

The reviewers noted delays in accessing emergency care are often the manifestation of broader system issues, with reduced patient flow across the hospital and out into the community resulting in limited access to inpatient beds for those requiring admission from the ED. They similarly observed poor access to primary care and aged care facilities can also influence demand on acute hospital facilities and contribute to access block.

The reviewers highlighted it was important to consider the issues with access to emergency care as the end result of system-wide issues rather than simply an 'ED problem'.

The report synthesised the results of document reviews and interviews with THS staff and open forums with staff at RHH and LGH. Table 8 summarises key findings from the review.

Table 8: Summary of selected key findings from the Staib Sullivan Review

The reviewers found RHH had been performing below its peers with respect to Health Roundtable data in 'emergency access to inpatient beds for admission' noting this had manifested as long stays in the ED after emergency care was completed (i.e. access block).

They also noted feedback from RHH clinicians suggesting the resulting ED overcrowding was contributing significantly to the lack of access to treatment for other ED patients.

The most notable feature at LGH was the very long length of stay for admitted patients. The majority of this time was found to occur after the decision to admit had been made. The reviewers also found a significant delay in accessing beds with an average of 6.04 hrs from bed request to bed allocation.

LGH staff reported a lack of acute treatment cubicles due to them being occupied by high numbers of admitted patients (sometimes half of the available cubicle spaces). This was seen as impacting their ability to provide timely/appropriate care and to meet performance targets relating to ED care and access. They also advised of difficulties in providing appropriate inpatient care to admitted patients unable to leave the ED due to the lack of inpatient beds.

The reviewers found both RHH and LGH reported significant issues with access block and it was common for their EDs to be more than 50% occupied by admitted patients waiting for inpatient beds. The reviewers noted this was strongly associated with decreased performance on length of stay measures.

Although it was evident both hospitals had taken steps to reduce 'very long waits' for inpatient beds, ED overcrowding due to access block remained the number one issue at both sites and performance at both sites was found to be below that of other peers.

The reviewers observed ED physicians did not have admission rights to the inpatient wards, and previous attempts to afford them with such rights were met with opposition from inpatient teams. The reasons for this reluctance was unclear.

The report acknowledged direct admission of suitable patients from the ED to inpatient wards prior to inpatient team review was part of most contemporary emergency admission systems.

However, it further acknowledged it was unlikely the unilateral 'right to admit' would make a significant impact in the absence of inpatient bed availability and bilateral agreement from ED and inpatient clinicians.

The report further noted staff at both hospitals reported some improvements were occurring but these were being overcome by the growth in presentations and subsequent admissions resulting in little change to ED overcrowding. It also noted hospital staff reported of having to compromise timeliness and quality of care because of ED overcrowding and the lack of access to treatment areas.

The report further summarised the issues by noting:

- the main impediment to timely care appears to be the delay in accessing inpatient beds due to a 'difficult ED-inpatient interface' and delayed discharges that are reducing access to inpatient beds
- the lack of clearly defined organisational structures and accountabilities was seen as a 'structural barrier to clinical redesign to facilitate improved patient flow'

- there are cultural barriers to improving patient flow, with ED clinicians frustrated and some inpatient teams disengaged
- process barriers to improving flow included the:
    - lack of a clear target for 'timely' care
    - inability to monitor patient outcomes during clinical redesign which impairs clinical engagement
    - lack alignment between accountability for performance and the authority to act. That is, although clinicians are accountable for performance, they did not feel authorised to facilitate system change.

The reviewers made 16 recommendations focused on addressing the process, structural and cultural barriers to patient flow. Progress reports supplied by DoH show none of the recommendations except for one (i.e. establishing a Short Stay Unit at LGH) have been implemented. THS progress reports show the outstanding recommendations have consistently been rated as 'delayed' and 'slow to progress'.

## Significant delays in implementation

Various actions by the agencies in response to the above reforms since at least 2012 means the Tasmanian health system has been engaged in broad-ranging initiatives to improve patient flow for nearly a decade.

However, the deterioration in the patient journey over the last nine years clearly demonstrates these initiatives have not been effective.

Neither DoH nor THS could demonstrate key reform initiatives had either been satisfactorily completed, or effectively and efficiently implemented to date. Instead, both acknowledged the actions taken to date have had no effect on improving patient flow.

Although DoH and the former DHHS had been receiving monthly reports from THS on the status of the above reform actions in some cases for years, it is evident to us that there was no clear understanding or reliable picture of the precise status of these initiatives.

Status reports supplied by DoH contained little useful information. We observed the information within these reports was either conflicting or inordinately focused on describing low-level activities that offered little insight into the adequacy of progress by THS and hospitals in delivering key reforms.

Our examinations and discussions with THS confirmed these initiatives were either significantly behind schedule, had stalled, or had yet to be substantively addressed. THS acknowledged it had experienced significant difficulty to date in resourcing the actions necessary to coordinate, monitor and drive effective implementation of these reforms.

## Causes of barriers to progress

We identified the following common perceptions regarding the key causal barriers to progress from our discussions with DoH and THS:

- Staff on the ground spoke of the need to be more involved in developing solutions rather than having them imposed on them.
- Lack of buy-in to initiatives had resulted in governance structures being ignored and direct lobbying to the Minister, which was viewed as disruptive and not constructive.
- The significant churn in governance arrangements and leadership positions across the health system in recent years was regarded as a major barrier to achieving progress, follow-through and coordination.
- The Patients First actions were viewed as well intentioned, but ill-conceived initiatives that in effect comprised 19 siloed projects that were imposed on the health system with little, if any, consultation.
- Reform actions and initiatives were often announced with insufficient regard for planning, change management, or the governance architecture needed to assure effective delivery and oversight.

Consequently, there was a consensus among those we spoke to, that the health system has been busily engaged for several years in implementing a range of related, but often disjointed and overlapping activities that have neither been pursued nor managed as part of a coordinated and integrated program of reform.

Staff consistently referred to the absence of effective leadership both within hospitals, THS and the wider health system as the major impediments to tackling longstanding cultural barriers to change and the dysfunctional silo mentality, which they universally acknowledged still existed within hospitals contributing to bed block, ineffective discharge planning and bed management and the ongoing lack of coordination between EDs, inpatient wards and the community.

These issues are longstanding challenges that have impeded the progress of successive reform initiatives within the Tasmanian health system for many years.

In 2014, cultural barriers were similarly noted by the Australian Government's Commission on Delivery of Health Services in Tasmania which reported it had 'observed a deeply engrained culture of resistance to change, evidenced by the system's inertia in the face of several reviews recommending reform'. Our discussions with stakeholders confirmed that the significant cultural barriers to progress identified in the Commission's 2014 report largely remain in place within Tasmania's health system and have yet to be addressed.

Table 9 provides an extract from the Commission's 2014 report summarising the longstanding cultural challenges.

Table 9: Extract from the 2014 report by the Commission on Delivery of Health Services in Tasmania

### The Tasmanian context

The Tasmanian health system has long been a subject of concern, both in terms of excessive costs and inadequate delivery of health services. It has been reviewed, reported upon and debated. Mixed responses to implementation of these various reform processes have polarised organisational culture in the Tasmanian health system. While there are many individuals whose enthusiasm and willingness to embrace change has been encouraged by the understanding that there are still opportunities for improvement, and who remain strongly committed to achieving system improvements, others are experiencing reform fatigue.

We observed a deeply engrained culture of resistance to change, evidenced by the system's inertia in the face of several reviews recommending reform. There is also intra-system discord within both administrative and clinical elements of the health system, as well as a level of defensiveness in response to either explicit or implicit criticism of current practices. This culture of resistance, although not universal, includes varying degrees of denial about problems with the health system; or, in other cases, a resigned cynicism about the ability of health system leaders to act successfully on initiatives to increase efficiency and sustainability.

The influence of local political interests on health system decisions has been a consistent source of frustration. Reforms, particularly with regard to overarching issues of governance, cannot be enacted where opportunistic political interference can intrude into the reform process. Health care is a political issue, but political concerns must not interfere with the implementation of reforms once those reforms have been accepted at a governmental level. There can be no effective governance, and therefore no genuine and sustainable reform, if clinicians or administrators believe that they can circumvent or redirect reform by making use of political connections and short-term political tactics. Such tactics are the product of a culture in which too many decisions are made on the basis of what is politically convenient and one where self-interest is placed before the interests of patients.

Against this environment, there are a number of longstanding cultural attitudes and behaviours that remain unaddressed and are undermining the realisation of a functional governance system in Tasmania. We have observed a lack of respect among key stakeholders, competition and a lack of cooperation and resistance to routine performance measures. While there are capable and committed individuals within the health system, there are administrators and clinicians in leadership positions who behave in an unduly territorial manner. Personal

animosities appear to override professional considerations and what should be universally accepted codes of conduct.

The move to three Tasmanian Health Organisations (THOs) appears to have acted, in effect, to further legitimise dangerous and undisciplined behaviour within the system, particularly with regard to collaborative practice and collaboration. A measure of scrutiny provided by the daily realities of working within a state-wide system has been lost and some poor work practices have been shielded within the THOs. Those who do have the authority to address and eliminate poor behaviour, the THO Governing Councils, do not appear to exercise it.

Throughout our stakeholder consultations, we heard many reports of disillusionment based upon immediate, first hand observation of poor behaviour that has gone unchecked. Every system, every jurisdiction will encounter individual instances of misdeeds and inappropriate actions and relationships. Tasmania lacks the mechanisms to ensure the consequences of such behaviour are swift and widely understood and thereby creates a culture where behaviour that falls far outside acceptable professional conduct is tolerated and able to thrive.

The absence of clear accountability mechanisms and lack of strong leadership to enforce them have fostered an environment where there are few, if any, sanctions for unacceptable behaviour. This is not lost on those working within the system, with direct and indirect calls from respondents to our (i.e. the Commission's) governance survey for improved accountability within Tasmania's health system.

There are several problems of leadership at all levels of Tasmania's health system that must be addressed if the necessary improvements are to be realised. The ability and willingness to stridently defend one's own institution and interests does not constitute leadership, and in Tasmania, it appears such combativeness is confused with strong leadership. A well-led health system is one characterised by mutual respect, a willingness to listen and a shared common purpose. Tasmania's health system leaders need to cooperate in forging this common path, with a leadership culture that is collaborative, inclusive and united around the aim of improving patient outcomes.

Source: Commission on Delivery of Health Services In Tasmania – April 2014

It should be noted that the State recently introduced significant changes to the institutional arrangements for Tasmania's health system in 2018 designed to improve governance including the effectiveness and efficiency of THS.

These changes, discussed in later sections of this Report, are in the early stages of implementation meaning it is not yet possible to reliably assess their impact on addressing the longstanding cultural challenges identified by this audit and the Commission's 2014 report.

## Significant opportunities remain for improving hospital practices

### Bed capacity within hospitals is being underutilised

THS commissioned a clinical utilisation study in August 2017 of 1 013 patient admissions to obtain a system-wide understanding of the following factors affecting patient flow:

- demographics and acuity of patients utilising/healthcare services
- blockages and pockets of restricted capacity across the care continuum
- gaps in the current provision of healthcare services
- options for addressing blockages, shortages and gaps
- a baseline against which the impact of future improvements can be measured.

Consultants used a proprietary survey tool to assess the sample of admissions and identify:

- patients whose admission to the facility was not necessary for the care they received
- patients who no longer require inpatient care
- opportunities for admissions avoidance and length of stay reduction based on the survey outcomes.

The results were presented to THS management in September 2017 and highlighted that there was extensive scope to enhance bed management and availability by improving hospital admission, patient management and discharge practices.

The key findings from the study were:

- 15% of major hospital admissions were found to be 'non-qualified' meaning they were avoidable, and 42% of continuing days of stay were similarly non-qualified. THS advised this was equivalent to freeing up around 3 000 bed days per year
- 69% of patients were older than 70 years of age and 73% of patients had significant risk factors
- 50% of patients were admitted through the ED
- 11% of admissions were readmissions and 42% of these were readmissions within seven days
- that only 28% of patient charts had some discharge planning information and only 22% of them had an estimated date of discharge in the paper record. THS advised that discharge dates were populated in the Patient Flow Manager[6] software albeit with some inconsistencies
- 45% of the non-qualified days were due to alternate care issues. However, almost half of these, around 46% of all issues, were within the control of the facilities and included consultant, discharge and test/treatment issues
- 42% of non-qualified days could have been avoided by providing a variety of services at home or by arranging for GP follow-up. Around 22% of non-qualified days required supported living settings such as nursing home and assisted living.

In respect of the above-noted 'alternate care issues' relating to the 45% of non-qualified days, the consultants noted these issues involved services that were either present but unavailable, services that may not exist, or services that are too distant or difficult to make available on a practical basis.

The consultants concluded THS should develop a strategy for each facility to reduce unwarranted admissions and shorten length of stay. They also noted there was a need to improve discharge planning processes and this should start at the point of admission for all patients using risk factors as a guide to anticipate their post-acute care needs.

The above results clearly demonstrate there is significant scope for hospitals to improve access to inpatient beds through more efficient and proactive discharge and bed management practices.

It also indicated to us a pressing need for the system to prioritise improvements in these areas over simply adding additional bed capacity to ensure existing bed stock is being used optimally and managed efficiently.

### Improving real-time data for managing patient flow

ED directors advised current data systems within hospitals did not support real-time management of patient flow bottlenecks. They also advised of significant quality issues with some existing data as a result of poor compliance by clinicians with the recording of accurate estimated discharge dates for admitted patients.

They noted a major limitation of the state-wide ED information system was it only captured information about the patient journey within the ED. Once a patient is discharged to the ward the patient's information is automatically downloaded to their digital medical record. However, because inpatient wards still use paper notes, the ED has to print off the documentation about the patient and hand it over to inpatient teams, which creates another barrier in the flow of information. Although the state-wide ED information system measures the time at key points between triage and admission/discharge, there is no facility to capture the time a person spends in a waiting room before being triaged. ED directors advised such data would assist hospitals to more fully understand the patient journey.

6 Patient Flow Manager is the software the hospitals use to track patients while in the ED.

They further noted the absence of real-time data accessible to inpatient areas meant a lot of decisions often had to be made based on perception rather than evidence. It also meant timely action to address blockages usually relied heavily on the goodwill and cooperation of areas outside the ED, which was often lacking. THS advised it was in the process of developing an ED dashboard for use by hospital Integrated Operations Centres (IOCs) to aid patient flow and safety decisions.

Although hospitals require the systematic recording of an estimated discharge date at the point of admission to aid discharge planning and management, staff we spoke to advised clinicians rarely complied with this requirement. Consequently, it was often very difficult to hold clinicians and inpatient teams to account for patients that exceeded their estimated length of stay.

We also found neither THS nor DoH systematically audited and assured the quality of information contained within hospital systems. Consequently, DoH had little assurance the data it used to assess THS' performance could be fully relied upon.

### Addressing longstanding issues affecting timely discharge

THS emphasised there was a need to maintain a focus on creating capacity on the wards through encouraging early discharge where possible and timely cleaning of beds so they are available when needed. It also noted there has been resistance from some clinicians to discharge patients who come in late in the day suggesting this was more of a cultural issue.

Stakeholders identified the lack of timely discharge and bed turnover as longstanding issues that in some cases reflected clinicians' rigidity in the way they approach ward rounds that do not facilitate timely discharges.

They stated part of the problem was processes tended to be organised around the doctors rather than patients. They also referred to anecdotal examples of inefficiencies in hospitals where patients that could be discharged were not, either because the necessary blood tests were not arranged in time before the doctor's round, or because in some cases there were no daily rounds meaning some patients who were able to go home had to stay until the next round occurred, which may be in a couple of days.

THS noted rounds usually occurred daily for general medical wards, but specialist teams often only undertook rounds twice a week.

### Appropriate use of Emergency Medicine Units (EMU)

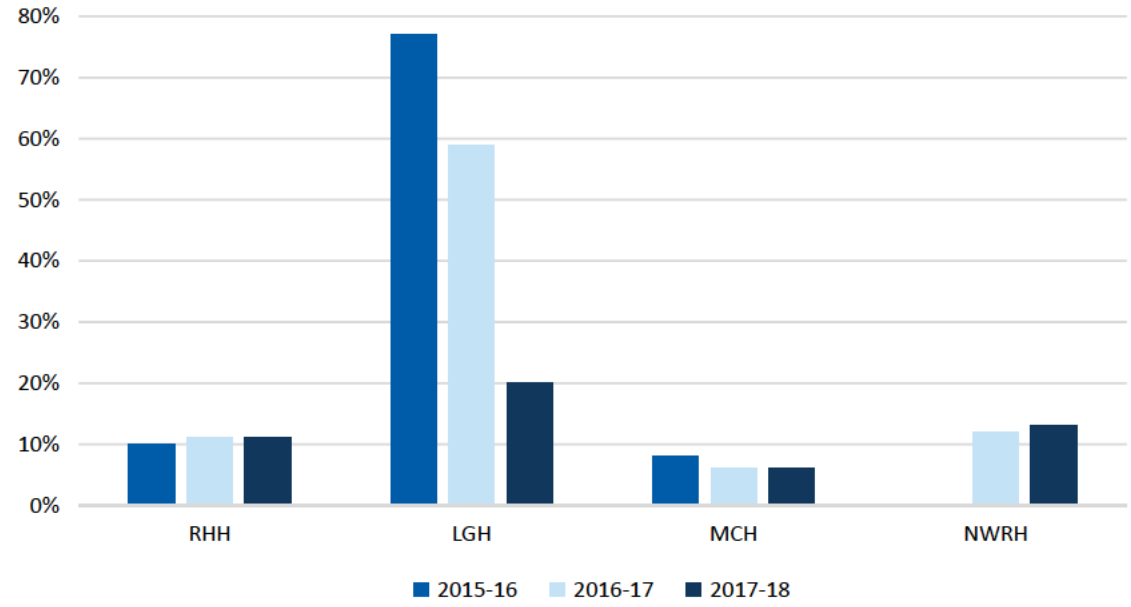
ED staff can admit ED patients requiring longer observation to an EMU. THS policy establishes that the purpose of EMUs is to enable short stay admission, observation or further assessment of ED patients with a predicted length of stay of less than 24 hours.

The process aims to optimise early treatment and discharge, where appropriate and to reduce the overall length of time patients stay in hospital.

However, we found EMUs were not used consistently by all hospitals and, in some cases, there was a risk their use was masking poor performance against KPIs relating to length of stay.

This risk was primarily evident at LGH. As noted earlier, we observed that, historically, the ED length of stay for the 90$^{th}$ percentile of admitted patients at LGH had, at times, averaged around 40 hours significantly exceeding the state-wide target of eight hours. Figure 14 earlier showed LGH's performance against this measure improved during the period 2014-15 to 2016-17. However, as shown in Figure 15, this improvement corresponds with a significant proportion of EMU patients admitted to the hospital during the same period indicating the hospital had used the EMU as a de-facto holding bay for admitted patients awaiting a bed contrary to THS policy.

Figure 15: EMU patients admitted to hospital by year, 2015-16 to 2017-18




Source: TAO, DoH

## Recent and planned initiatives

THS, DoH and AT have undertaken a range of initiatives in recent years to improve the monitoring and management of patient flow. Key initiatives are outlined below. These initiatives are in the early stages of implementation and cannot yet be reliably assessed.

### Patient flow managers and related data tools

THS has led the development of a patient flow software tool, known as Patient Flow Manager used by hospitals since July 2017 to collate data from the ED and wards to monitor demand and project the number of available beds based on anticipated and actual discharges. Patient Flow Managers at each hospital use the information to coordinate with the ED and inpatient teams to match patients, wherever possible, with available bed capacity.

THS advised these initiatives improved access to information for hospital staff, which provided better visibility of bed capacity issues and of the opportunities to take more timely action. THS noted a key improvement arising from the initiative to date was the ability to identify unoccupied beds that could not be used due to the lack of timely cleaning. This enabled hospitals and THS to focus attention on addressing these barriers. THS further acknowledged key remaining challenges included improving data quality on bed availability that, for example, took account of the bed cleaning issue and obtaining more accurate data from clinicians on estimated discharge dates. There was also a need to ensure hospitals consistently used the information effectively to identify and address patient flow bottlenecks.

### Integrated Operations Centres and the use of data analytics

THS acknowledged some clinicians and nurses found the Patient Flow Manager software tool difficult to use. THS responded by working to establish IOCs to further assist and facilitate the monitoring and coordination of patient flow initiatives.

THS advised building works had been completed at NWRH and LGH to establish IOCs, with the aim of bringing all people involved in making decisions on patient flow, and the related systems that support decision-making, into one area to improve efficiency.

THS has been using IOCs together with data analytics to extract information and develop dashboards for end users to assist with monitoring when the hospital and system goes out of control. It is also working with AT to integrate more timely data on ambulance arrivals to aid patient flow and improve the interface between AT and EDs.

This work has been challenged due to a couple of failed recruitment rounds spanning around 12 months that delayed acquiring the data analytics expertise to produce the dashboards.

THS advised the positions were eventually filled after 12 months in October 2018 and work on developing the dashboards is now progressing.

### Transit lounges

THS advised it had developed a transit lounge at LGH that has been working successfully since July 2018 to create a 'pull model' that facilitates earlier movement of people awaiting discharge out of wards to free up bed capacity. It also advised RHH was currently reviewing the potential use of transit lounges with a view to similarly establish a pull model.

### Criteria led discharge

THS advised it was in the early planning stages of an initiative that aimed to use a multidisciplinary team involving nursing, medical and allied health to determine the criteria a patient needs to meet in order to be discharged from the hospital. THS advised the intent was to enable a junior clinician, nurse or allied health professional to be able to decide to discharge a patient early in the patient journey, where appropriate, based on assessment against clearly defined criteria.

### Bed Utilisation Review Tool

THS stated it was working to leverage the insights and methodology from the August 2017 clinical utilisation study to establish a Bed Utilisation Review Tool. It noted it had experienced significant delays with progressing the tender for developing the tool due to protracted legal issues relating to the contract. THS advised the tool was based on the approach made mandatory in the UK to help rebalance the health system. It emphasised this work was similarly important for ensuring that existing beds within Tasmanian hospitals were being used optimally for those in need rather than for those who did not need to be in acute care.

### Patient Risk Identification and Management Project

An intended outcome of THS's IOC project is achieving early identification of vulnerable and complex care patients and at-risk patients to ensure their treatment is optimised and their length of stay managed effectively. The Patient Risk Identification and Management Project aims to implement an electronic nursing assessment tool that will assist with meeting this objective by August 2019.

The system will provide timely and ongoing patient risk assessments at key points in their journey such as presentation to the ED, admission and discharge from admitted care and community nursing visits. This information will be available to caregivers at the point of care for real time updates to reflect changes in the patient's status. It will also convert clinical observations into full problems lists, diagnostic screeners, risk assessments, severity measures and quality indicators.

The tool's ability to facilitate a full risk assessment for vulnerable and complex care patients is expected to help reduce adverse patient events in the hospital through the availability of real-time data and assessments that may trigger a timelier change in the patients care plan.

### Community Nursing Enhanced Connections Service

DoH has similarly worked to improve ED performance by establishing the Community Nursing Enhanced Connections Service (CoNECs) and the Community Rapid Response Service (CommRS). DoH advised these initiatives have embedded ED diversionary strategies state-wide through close collaboration between community nurses and local GPs.

CoNECs is a non-admitted alternative for clinical care following ED presentation, assessment and initial treatment that provides enhanced access from hospital EDs to Community Nursing Services. It seeks to provide a person centred, coordinated approach to the delivery of clinical care following ED presentation to maximise both patient and organisational outcomes across the care continuum.

Services are provided seven days a week, 365 days a year predominately in Community Nursing Clinics. However, people unable to attend due to their condition, may be seen within their usual place of residence, including home, supported accommodation, or residential facility.

### Community Rapid Response Service

CommRS was established in 2016 to provide quality care in the community for people with chronic and complex illnesses and help to keep them out of hospital.

The service was piloted during 2016-17 and is being rolled out to all practices across the greater Launceston area. While the pilot program in Launceston finished on 30 June 2017, DHHS decided to continue the program in the North in 2017-18 and DoH is undertaking further work to roll out of the program in the North-West and the South of the State in close consultation with GPs and other key stakeholders.

The new service provides treatment for people who need short-term intermediate care that can be safely delivered in the community or in the home.

CommRS is available to people with acute illness or injury and to people whose chronic and/or complex condition has deteriorated in a way that would otherwise see them present at an ED and possibly be admitted to hospital. The service works on the principle that a patient's care is shared between their GP and community nursing and other health professionals. Treatment is being provided wherever it best meets the patient's needs, which might be in their home, in a residential aged care facility, or in a community health centre.

### Urgent Care Centres

DoH advised it was working on a feasibility study for Urgent Care Centres which would divert demand from Category 3 and 4 presentations away from EDs. This work was initiated in response to the May 2017 *Review of Ambulance Tasmania Clinical and Operational Service* (May 2017 Review), which recommended the State assess the merits of Urgent Care Centres and whether there is any benefit to introducing them in larger urban centres in Tasmania.

The recommendation was based on an innovative initiative by St John Ambulance in Western Australia that had purchased several Urgent Care Centres to provide both an alternative destination for ambulances carrying lower acuity patients and to encourage individuals to self-present to Urgent Care Centres rather than EDs.

The May 2017 Review noted these urgent care centres were staffed by a combination of medical, nursing and paramedic staff. They were configured in a way that is not dissimilar to an ED, with open bays monitored and serviced from a central coordination hub. The centres were also co-located with GP consulting rooms, dental consulting rooms, radiology (x-rays), pathology and a pharmacy.

In assessing the feasibility of introducing Urgent Care Centres in Tasmania, the May 2017 Review suggested the State examine the impact of Urgent Care Centres in Western Australia on reducing demand for ED services.

### Secondary Triage – Ambulance Tasmania

AT is currently establishing a 'Secondary Triage' system, also in response to the May 2017 Review, wherein callers who do not need ambulance transport but do need immediate or urgent care can be directed along alternate pathways.

The May 2017 review noted a significant proportion of patients that call triple zero do not require an ambulance response or transport to an ED. Often patients are looking for reassurance and advice or help to resolve an unexpected primary health-related event (like a minor cut, nausea or a closed fracture). Over half (53%) of patients assessed by a paramedic either do not require transport because they can be treated on site or are non-acute. A further 45% are assessed as acute, but not time critical.

Secondary triage is a strategy for reducing the inappropriate use of emergency ambulance services and delivering better outcomes for patients. Related services employ officers that have the skills, systems and support to diagnose the needs of low-acuity patients over the phone and divert them to alternative services that are suited to the patient's needs.

The May 2017 Review identified Ambulance Victoria as having the most effective model nationally for reducing demand on paramedic services, and recommended Tasmania develop, as a priority, a secondary triaging service by leveraging the experience of Ambulance Victoria.

AT stated that many of the needed alternative services to EDs were not yet fully available and that initially the focus would be on a telephone referral service, with other services coming on line over time. AT advised the telephone referral services was expected to commence early in 2019-20.

### Redesign of Hospital Discharge Project

In 2018, THS commenced work on a hospital discharge referral pathways project under the National Partnership Agreement on Improving Health Services in Tasmania. The initiative, known as the Redesign of Hospital Discharge project, aims to deliver a standardised, effective state-wide discharge model by:

- building sub-acute related skills, knowledge and capacity among the clinical workforce
- strengthening networks between acute, sub-acute and the primary care sector to improve the integration and coordination of care for patients.

The project aims to ensure uniformity, consistency and best practice with respect to the discharge of patients from Tasmanian public hospitals. In doing so, it will engage with private and community sector providers and Primary Health Tasmania to make appropriate links with the primary care sector.

Information supplied by THS shows the project will map existing hospital discharge transfer of care processes, policies and procedures, as well as research and develop an agreed standardised state-wide discharge framework. The major outputs of the project will be an agreed framework and an implementation plan by December 2019.

### Next stage of Royal Hobart Hospital redevelopment

In March 2019, the Government announced its intention to allocate $91.0m for Stage 2 of the RHH K-Block redevelopment in the 2019-20 Budget.

The announced three-year project includes:

- a new second dedicated patient lift that would connect the ED, medical imaging and J-Block
- an expansion of the ED
- a refurbishment of A-Block
- an expansion of the intensive care unit in its current location
- a refit of the existing J-Block, which would be vacated for other services.

The released masterplan also indicates a future Stage 3 of the RHH project proposes to redevelop the Repatriation Hospital as a subacute and mental health campus of the broader hospital facility that will require funding from future budgets.

The expanded ED is expected to assist with mitigating the growing pressure on the RHH ED from the continued rise in ED presentations projected over the next decade.

### Emergency Management Clinical Network

THS acknowledged there was an urgent and pressing need to overcome longstanding cultural barriers to change to reform the system and achieve sustainable improvements to patient flow and outcomes.

THS advised of a pending initiative it was developing in conjunction with DoH and the State Health Service Joint Executive (SHSJE) to engage more effectively with the sector in a process of collaborative reform using the expertise of an emergency management clinical network (EMCN).

THS emphasised this initiative was action oriented and not intended as another review as it acknowledged there was little appetite within the sector for yet another review.

THS advised the intent of the EMCN was to provide an important governance framework to engage with clinicians in identifying solutions and to support the embedding of clinical reform initiatives across hospitals.

THS also confirmed a key focus of the initiative will be on addressing the reasons why the system has yet to improve. In this context, THS noted the focus will be on the drivers of root causes such as structural issues, required model of care changes, along with accountability and cultural challenges it acknowledged still needed to be addressed despite past reviews identifying these issues.

This initiative has significant potential. However, its effectiveness will depend heavily on THS's ability to overcome past governance, cultural and other challenges that have impeded effective implementation of past reforms.

## Section 3 Summary of findings

The above-noted performance trends demonstrate patients admitted to Tasmanian hospitals through an ED are now waiting much longer in EDs for an inpatient bed. This is because of growing demand, capacity constraints and longstanding barriers to access, which means patients are now less likely to receive the treatment they need at the right time and place compared to almost a decade ago.

Consequently, a significant proportion of ED beds, estimated by hospital staff at around 50% of ED cubicles at times, are occupied by admitted patients awaiting a bed and for whom the ED phase of care has finished. This means that ED bed capacity has, in effect, declined in the face of the continual increase in admitted bed demand, which is reducing access to timely care for other patients presenting to the ED.

The solution to this problem is not simply more beds. There is an urgent need to improve the efficiency and effectiveness of hospital admission, bed management and discharge practices.

THS's Patient Flow Escalation Management Plan was established in August 2017 to address a gap in previous arrangements. It describes the actions and duties required by all staff to optimise patient flow, both during periods of normal activity and heightened demand.

THS analysis of the time spent by hospitals at varying levels of escalation between 29 June 2018 and 24 January 2019 demonstrated the framework and its implementation by THS and hospital staff has yet to deliver sustained improvements to patient flow and address the longstanding drivers of access block. Specifically, the analysis showed:

- LGH spent more than 70% of the time during the period at the highest possible level of escalation and in a state of almost constant 'gridlock'
- RHH was significantly bed blocked for almost 93% of the time, with patient safety severely and routinely compromised, on average, almost once every four days.

This concerning situation is reflected in THS's longstanding performance against the service agreement target relating to the length of stay for the 90$^{th}$ percentile of admitted patients. The time spent by this patient cohort in the ED waiting for an inpatient bed consistently exceeded the target of less than or equal to eight hours by a significant margin, particularly at LGH, which at times exceeded 40 hours.

These performance challenges have persisted state-wide despite successive past reviews and reform initiatives to improve patient flow over nearly a decade, demonstrating past reviews had little impact.

Although these initiatives consistently acknowledged the importance of an effective whole-of-hospital approach to improving patient flow, along with the need to address longstanding cultural and process barriers to change, these issues remain and have yet to be effectively addressed.

THS acknowledged it had experienced significant difficulty to date in resourcing the actions necessary to coordinate, monitor and drive effective implementation of past reforms. It also acknowledged most actions were either significantly behind schedule, had stalled, or had yet to be substantively addressed.

Agency and hospital staff consistently referred to the impacts of recent governance churn in the sector as a factor, but also to the absence of effective leadership and accountability as major impediments to tackling long-standing cultural barriers to change and the dysfunctional silo mentality within hospitals, contributing to bed block and ineffective discharge planning and bed management.

These significant cultural challenges were similarly noted in 2014 by the Australian Government's Commission on Delivery of Health Services in Tasmania which reported it had 'observed a deeply engrained culture of resistance to change, evidenced by the system's inertia in the face of several reviews recommending reform'.

A 2017 Clinical Utilisation Study by THS of 1 013 hospital admissions confirms significant scope exists across Tasmanian hospitals to free up existing bed capacity by improving bed management, including admission, patient management and discharge practices. THS estimates improvements to these practices alone could create an additional 3 000 bed days per year.

Both DoH and THS acknowledge there is a pressing need to overcome longstanding cultural barriers to change within Tasmania's health system impeding efficiency gains and the achievement of better patient outcomes. They also advised of a range of improvement initiatives currently underway to strengthen related hospital practices and to better engage with clinicians and hospital staff in solutions focused on improving patient flow.

These latest initiatives, like their predecessors, have considerable potential. However, their effectiveness will depend heavily on DoH's and THS's ability to overcome past governance, cultural and other challenges, which have impeded effective implementation of past reforms.

### Recommendations

3. THS and DoH urgently implement a culture improvement program and initiatives with clearly defined goals, accountabilities and timeframes to:
   (a) eliminate the longstanding dysfunctional silos, attitudes and behaviours within the health system preventing sustained improvements to hospital admission, bed management and discharge practices
   (b) ensure that all THS departments and staff work collaboratively to prioritise the interests of patients by diligently supporting initiatives that seek to optimise patient flow.
4. THS and DoH develop an effective sector-wide consultation and engagement strategy to support sustained improvements in patient flow that, at a minimum, provides:
   (a) education to staff on the need for, and merits of, whole-of-hospital action to reduce access block through more effective and efficient admission, bed management and discharge practices and the benefits to patient care and safety that come from improved patient flow
   (b) genuine opportunities for THS staff to contribute to and influence the design, development and implementation of hospital and sector-wide patient flow reform initiatives.
5. THS and DoH expedite the development and implementation of proactive strategies that effectively leverage the insights of the 2017 Clinical Utilisation Study to both reduce and minimise the incidence of avoidable admissions and non-qualified continuing days of stay for admitted patients.
6. THS strengthen support to, and the accountability of, health system leadership teams for improving their performance in sustainably reducing the rate of avoidable admissions and non-qualified continuing days of stay for admitted patients.
7. THS and DoH review and strengthen the:
   (a) change management capability and skills of THS and hospitals to ensure future reform initiatives are adequately supported and deliver sustained behaviour change and impact
   (b) project management capability of THS and hospitals to ensure future reform initiatives are underpinned by effective implementation and delivery planning processes that are regularly monitored.
8. THS and DoH review and, where relevant, action outstanding recommendations from the Patients First, Staib Sullivan and Monaghan reviews.

## 4. IS THE TASMANIAN HEALTH SERVICE MANAGING EMERGENCY DEPARTMENTS EFFECTIVELY?

The former Performance Framework established under the former THO Act outlined reasonable procedures for performance monitoring, escalation and interventions to operationalise related provisions in the THO Act. However, the 2018 changes to the legislative framework have rendered the former Performance Framework obsolete and there has been no fully functioning performance framework or active monitoring of THS's performance improvement obligations since that date.

The removal of explicit definitions and obligations for responding to unsatisfactory performance from the legislation governing THS has reduced clarity on the standards and obligations for triggering interventions in response to poor performance by THS.

Although DoH has signalled an intent to develop a more comprehensive monitoring approach that addresses these issues and extends beyond Service Plan KPIs to better support THS meet its obligations, this has yet to be developed more than six months after the new 2018-19 Service Plan was approved.

This means DoH does not currently have a robust system in place for monitoring the quality of ED services provided by THS and for taking timely action in response to emerging performance issues.

### Performance monitoring under the former THO Act

Part 7 of the former THO Act established the statutory mechanisms for managing the performance of THOs. These mechanisms formed the basis of the May 2017 THS Performance Framework, a DHHS document that codified the administrative process that put into effect the legislative framework for identifying, monitoring and managing THS's performance.

The purpose of the Performance Framework was to provide THS with certainty regarding the approach for responding to identified performance issues and to establish a structure around the legislative performance interventions available to the Minister. Specifically, the framework described how the statutory performance management mechanisms would be applied to escalate and de-escalate identified performance issues and the obligations of THS for responding to these issues. These mechanisms and related obligations mirrored the key performance management procedures, governance roles and requirements set out in the THO Act as follows:

- The Minister could authorise a review or audit of any aspect of THS's operations or performance to identify whether THS's performance was satisfactory, or unsatisfactory within the meaning of section 59 of the former THO Act (s. 58).
- If the Minister was of the opinion THS was performing unsatisfactorily there were a range of actions that could be taken, such as the Minister:
    - requiring the Governing Council to produce a Performance Improvement Plan (PiP) (s. 60) – defined as a Level 1 escalation under the Performance Framework
    - appointing ministerial representatives to the Governing Council (s. 63), or could declare that a Performance Improvement Team has been appointed (s. 67) – defined as a Level 2 escalation under the Performance Framework.
    - dissolving the Governing Council (s. 69) – defined as a Level 3 escalation under the Performance Framework.

Most of the above actions were to be informed by quarterly review meetings between THS and DHHS and designed to provide temporary assistance and/or resources to the Governing Council and/or THS rather than being punitive. They were also designed to allow for the application of graduated interventions, rather than the Minister having the sole option of dissolving the Governing Council.

DHHS initiated five Level 1 escalations over the last three financial years for poor performance by THS in meeting Service Agreement targets for five ED-related KPIs. THS was required to develop a PiP for each of these KPIs and to regularly report to DHHS on its progress in implementing the actions. It is evident to us that this occurred in the examined three-year period between 2015-16 and 2017-18.

However, our review of DHHS's performance monitoring activities during this period shows neither DHHS interventions nor THS related improvement actions were effective in improving the performance of hospitals against the five ED-related KPIs. DHHS repeatedly observed during this period that THS's performance remained unsatisfactory and it continued to deteriorate against the KPIs. Despite this, DHHS did not activate any further escalations under the Performance Framework. These issues are discussed further later sections.

### Neither THS nor DHHS effectively implemented the framework

We examined THS's performance over the three-year period 2015-16 to 2017-18 and found it consistently failed to meet service delivery targets relating to ED access and care. As noted earlier, DHHS initiated several performance escalations under the THS Performance Framework to address these issues. However, it was not evident to us that it was sufficiently proactive in working with THS to gain assurance the underlying causes of poor performance were being adequately addressed, or in providing robust advice to the Minister on these issues and on the merits of alternative options for addressing them.

As noted in earlier sections of this Report:

- THS consistently did not meet its core service agreement KPIs for ED performance and patient flow and its performance deteriorated over the period.
- No significant and/or sustained improvements in ED performance and patient flow were achieved by THS as a result of any implemented reforms, or improvement actions requested by DHHS under the Performance Framework.

We found DHHS did not use all the interventions available to it under the Performance Framework and had little assurance THS was effectively addressing the root causes of its longstanding performance issues. This is discussed further below.

### Lack of sustained impact from improvement actions

Our review of DHHS quarterly monitoring briefings to the Minister during the period show it raised concerns about THS's performance against Service Agreement targets in the first quarter of 2015-16. This resulted in a Level 1 performance escalation against KPI AEC4: 90% of admitted patients depart the ED in less than eight hours, triggering a requirement for THS to develop a PiP to achieve compliance with the KPI target. This escalation was maintained in 2016-17 for the corresponding Service Agreement KPI ACC5: Percentage of patients admitted through the ED with ED length of stay less than eight hours (90%).

A further four Level 1 escalations were triggered by DHHS in the second quarter of 2016-17 for Service Agreement KPIs whose targets were consistently unmet by THS.

The five affected 2016-17 KPIs and the associated improvement strategies developed by THS are shown in Table 11.

Table 11: ED related KPIs within the THS Service Agreement/Plan – 2015-16 to 2017-18 and associated THS improvement actions.

| 2016-17 Service Agreement KPI | PiP Strategies |
|---|---|
| **ACC2: Percentage of all emergency patients seen within recommended time (80%)** | • ED Clinical workforce to fulfil full time equivalent (FTE) and meet clinical demand:<br>o increase triage capacity by implementing a second ED triage nurse at RHH<br>o introduce Clinical Initiatives nurse<br>o Medical Workforce review at RHH<br>o Nursing Workforce review at RHH<br>o Fellow of the Australasian College for Emergency Medicine recruitment to meet fulltime equivalent at LGH and NWRH. |

| 2016-17 Service Agreement KPI | PiP Strategies |
|---|---|
| **ACC4: Percentage of all ED patients with an ED LoS less than four hours (80%)** | • Remove barriers to access and improve patient flow:<br>o Deliver a state-wide electronic tool to manage patient flow through and between all THS facilities, which will automate manual workflows, and enable transparency and access of all patient flow activities across the whole State:<br>▪ Target outcomes for this project include reduced waiting times, in particular relevant for this KPI is reduced waiting times for admission from ED. |
| **ACC5: Percentage of patients admitted through the ED with ED LoS < eight hours (90%)** | • Patients First 2 – increased access to beds:<br>o Work continuing to implement further bed availability as per patients two actions:<br>▪ 19 permanently funded beds – LGH Ward 4D – 22 inpatients as at 29 June 2017<br>▪ 10 beds State Mental Health Service – Jasmine Unit – opened 5th June<br>▪ four short stay and four Surgical beds – NWRH – already open<br>▪ funding approved to maintain John L Grove Unit – Launceston.<br>o Short to medium term strategies to address RHH bed availability include: two additional Intensive Care Unit beds, increased accessibility to 10 Hobart Private beds, planned Mental Health Short stay observation unit, increased Mental health stepdown beds in the community. |
| **ACC6: Percentage of all ED patients with an ED LoS less than 24 hours (100%)** | • Integrated Operations Command Centres:<br>o Develop central Operations and Capacity Command Centre, with regional hubs, that ensures effective communication and allows for safe, efficient and effective management of THS hospitals, with outcomes to include:<br>▪ Preparedness at all levels of the organisation to manage and anticipate exceptional circumstances and surges in demand whilst continuing business as usual.<br>▪ To develop a culture that is more anticipatory and predictive and less reactive through the use of integrated data provided in a timely (real time where possible) and structured format.<br>▪ To improve clinical oversight and governance regarding resource utilisation and allocation, to ensure the right service is responding in the right and timely manner to minimise negative impact across the organisation and for patient care. |

| 2016-17 Service Agreement KPI | PiP Strategies |
|---|---|
| | ▪ To facilitate the organisational response in maintaining patient safety and to maximise the care being provided to at risk patients by:<br>– allowing clear identification of where patients are in THS facilities and services<br>– systems to highlight patients at risk and facilitating appropriate services being delivered by the most appropriate personnel in a timely way. |
| **EFF4: Ambulance offload delay – 30 mins (100%)** | • Collaborative working groups between ED and AT are in place with local procedures streamlined, and it has been agreed there will be a state-wide ambulance Offload delay policy which will include localised procedures.<br>• Integrated Operations Centre – ambulance ramping project – identified potential for inclusion of AT data within THS operations centres to enhance decision making, flow, allocation of resources. |

DHHS monitored the impact of the above five escalations and progress of PiP actions on at least a monthly basis over the period 2015-16 to 2017-18. Successive quarterly performance reports and associated briefings to the Minister from DHHS during this period show THS's performance continued to deteriorate, and no sustained improvement was achieved from the above actions. Although it was evident DHHS required THS to provide it with updated improvement actions and trajectory targets for some KPIs during this period, neither hospitals nor THS consistently achieved them.

### Internal challenges impacting THS's performance

A 14 June 2017 briefing to the Minister from DHHS noted THS's performance against KPIs had shown little improvement at that time, with performance deteriorating for various indicators relating to treatment waiting times, length-of-stay in EDs and ramping. The briefing further notes THS acknowledged it had experienced significant internal challenges in ensuring PiPs were developed, owned and managed at an appropriate level within the organisation. It further notes THS recognised that the PiPs were deficient and it needed time to develop and resubmit more robust PiPs that outlined real plans for delivering sustained improvements. The briefing offered no further detail on the nature of the deficiencies.

In December 2017, the Minister released a report prepared by DHHS providing an update of work undertaken by the NBIT including feedback from interviews and a survey of leaders and managers across the health system to gather individual perspectives on how they were working as one health system to achieve their strategic objectives. The interviews and survey also looked at leadership, the clarity of roles and authority, direction and focus, governance and service planning across THS. The findings from the interviews and survey responses indicated:

- a need to clarify roles and responsibilities across THS, so all members of the organisation understand structures at the local and state-wide level and to ensure there is clear accountability for decision making at each level
- the THS Executive was not seen to be operating effectively, with a need to improve:
    - Communication – particularly with clinical leaders to improve relationships and also to the broader organisation to impart the THS vision and strategy
    - Consultation – both internally within the Executive and externally on proposed change and reforms

    - Process – core processes fundamental to the successful and sustained performance of an executive, in the form of an established approach to problem solving, decision making and a culture of collaboration, are not seen to be operating effectively
    - Culture – to ensure that the THS Executive can perform their duties collaboratively and cohesively as a team.
    - Accountability – roles and responsibilities within the Executive are unclear and members need clarity on their individual and collective responsibility
    - Relationships – the THS Executive need to build foundational elements of trust, conflict resolution and a collective responsibility for leadership
- the perceived lack of unity of the THS Executive was impacting the broader organisation, with the potential to undermine the effectiveness of the leadership group
- improvements needed to be made to collect and analyse operational performance data and make this widely available so that robust decision making can occur to improve patient outcomes.

The Government subsequently introduced significant changes to THS's institutional arrangements that included repealing the former THO Act, replacing it with the THS Act and, in the process, disbanding the THS Governing Council and Chief Executive Officer roles bringing THS under the control of the Secretary, DoH. These developments are discussed in later sections of this report.

We found the PiPs were subsequently amended and resubmitted by THS. However, there was insufficient detail within these plans to enable assessment of the nature and adequacy of remedial actions taken against both the previously identified PiP deficiencies and THS's internal challenges. Notwithstanding, the lack of any sustained improvements against the affected KPIs since indicates they had little, if any, impact.

The above-noted PiPs lapsed with the transition to the new THS Act in July 2018 and all associated reporting from THS to DoH on the status of PiP actions similarly ceased at this time. Performance monitoring by DoH against the 2018-19 service Plan KPIs resumed on 3 September 2018.

The SHSJE was established in July 2018 to provide strategic direction for the State health service, and to monitor THS's service delivery performance. Its membership comprises the Secretary, nominated Deputy Secretaries and Chief Medical Officer of DoH, the Chief Executive Officer of AT and members of the THS Executive.

On 13 September 2018, the SHSJE resolved strategies to manage underperformance were still required in 2018-19 and DoH requested updated trajectory targets from THS at this time. These targets had yet to be finalised as at January 2019, more than six months after the commencement of the 2018-19 Service Plan. This means DoH has not been in a position during this period to transparently assess THS's service delivery performance, or to identify and promptly respond to underperformance.

THS acknowledged work on the updated targets had been delayed due to the lack of dedicated staff resources but advised it had since developed the targets and forwarded them to DoH for approval in February 2019. There is no evidence to indicate DoH or SHSJE can be confident the requested updated trajectory targets will not be adversely affected by any residual ongoing challenges contributing to past PiP deficiencies and hospitals' poor performance as these issues were neither noted nor discussed by SHSJE at the time it resolved to request the updated targets. Consequently, there is little assurance the updated targets will be soundly based, sufficiently challenging and reliable. These circumstances mean there is a risk of continued poor performance.

A January 2019 THS briefing shows the proposed updated targets have been moderated following consultation with DoH to align more closely with THS's current levels of underperformance. Specifically, all five KPIs under performance escalation at RHH and LGH had trajectory targets that in most cases matched current performance levels that were substantially below the 2018-19 Service Plan KPI target but were projected to increase gradually over time. However, there is no evidence to demonstrate that lowering performance expectations is justified and consistent with the longstanding goal of driving performance improvement, or that it supports greater transparency and accountability for performance.

### Weaknesses in DHHS performance monitoring and oversight

Quarterly performance reports and related ministerial briefings during the period do not demonstrate DHHS understood the key drivers of the hospitals ongoing failure to meet service delivery targets for emergency care and access. Instead, they indicate an over-reliance by DHHS on THS to identify solutions and related improvement actions without gaining sufficient assurance that these actions were either appropriate, well targeted or likely to succeed.

We found DHHS's monitoring reports and related ministerial briefings contained gaps, which rendered them ineffective from a performance monitoring perspective.

Specifically, the reports and ministerial briefings focused narrowly on describing THS's ongoing failure to achieve KPI targets and the ongoing deterioration in performance against KPIs. They offered no analysis of the root causes of the observed performance issues, or any insights into the adequacy of previously initiated improvement strategies and of any factors impeding THS's effectiveness in implementing related actions.

DoH advised that under the former agency structure and performance framework, responsibility for conducting in-depth analysis of performance issues, including root cause analysis rested with THS and that recent changes to bring THS under the authority of the Secretary provides DoH with an opportunity to address this deficiency.

Although it became clearly evident to DHHS over successive quarters that previously initiated improvement strategies were not working, none of its ministerial briefings analysed the merits of alternative options for addressing the evident and ongoing deterioration in THS's performance. In particular, it is not evident from these reports DHHS either fully explored, assessed or advised the Minister on the merits of:

- initiating a higher level (i.e. Level 2 or 3) performance escalation as was available to it under the former THO Act and related THS Performance Framework
- alternative performance improvement strategies to those that were being pursued by THS at the time and which were obviously having little impact
- providing additional support or resources to THS, where needed, to help it overcome any identified barriers to effective implementation of improvement actions.

Instead, DHHS reports during this period primarily focused on observing and describing the problem to the Minister.

DHHS stated weekly meetings were held between the Minister and the Secretary and other staff during this period, in which verbal and written accounts of THS's performance and related issues were provided and discussed.

DHHS also advised it was concerned about the unfolding performance trends but did not regard further performance escalation under the Performance Framework as an effective means of improving performance on an ongoing basis. It pointed to the ultimate removal of the former THS Governing Council and similar interventions at the former THOs between 2012 and 2016 due to financial concerns as equivalent to escalations, even though it acknowledged that these were not done under the auspices of the Performance Framework at the time.

Prior to this, DHHS held the view that longer term sustainable performance improvements were best served by working closely with THS to support their operational staff to improve their performance, rather than adding individuals at the level of the Governing Council or sending in an external Performance Improvement Team (i.e. Level 2 escalation options available to the State under the former Performance Framework), as it believed this could exacerbate cultural problems and would not necessarily result in the capacity building of existing staff.

Because of the significant cultural change required in hospitals, as identified by this Report, DoH considers it unlikely additional resources to support alternative performance improvement strategies in the circumstances would have had an impact as it believes the success of any such strategy would depend on cultural change.

However, it is not evident this view was rigorously tested against defined alternative escalation options. The issues impeding further escalations and the feasibility of specific escalation options were never discussed or analysed within performance reports and documented briefings to the Minister.

It is reasonable to expect DHHS to have done so and transparently assessed the merits of further performance escalations given this was its core role under the Performance Framework and they were statutory options that were clearly available to the State and relevant to the circumstances in question.

## Performance monitoring under the THS Act

In June 2018, the former THO Act was repealed and replaced with the THS Act. The THS Act established the continuation of THS as a separate legal entity but introduced significant changes to both THS governance and performance management arrangements. Specifically, under the THS Act:

- the Secretary has subsumed the key planning and oversight functions of the former THS Governing Council and is responsible to the Minister for the performance of THS and the THS Executive
- the THS Executive have been conferred with the responsibilities and functions to administer and manage THS formerly vested in the CEO and are accountable to the Secretary
- all former provisions relating to performance management of THOs and THS, including procedures for escalation/de-escalation in relation to unsatisfactory performance, were repealed.

As noted above, DoH had yet to produce an updated THS Performance Management Framework to clarify the procedures and obligations for performance management and improvement now applicable under the THS Act and the 2018-19 Service Plan.

Consequently, these obligations are currently not clearly defined.

Reporting by THS to DoH against the five PiPs ceased on 1 July 2018 with the transition to the new THS Act and new 2018-19 THS Service Plan. DoH advised this was because the PiPs lapsed as they no longer had a legislative basis under the new THS Act and because it had formed the view the former approach to performance monitoring had not worked. It also stated THS's performance against the service plan is now actively monitored on a monthly basis by the recently formed SHSJE. Although still in an establishment stage, DoH noted the new arrangements are enabling ongoing dialogue between members of the SHSJE and THS Executive Directors of Operations and their staff on a range of matters including the performance of ED and a closer and more constructive working relationship between DoH and THS.

DoH further advised the new arrangements have led to substantial improvements in performance monitoring by removing unnecessary duplication in data collection and reporting between DoH and THS. This has resulted in a 'single source of truth' for performance information that has allowed the parties to focus more constructively and collaboratively on addressing issues highlighted by the data and which has significantly reduced the former unproductive disputes over the accuracy of different data sources and related definitions.

SHSJE has also taken action to review the implementation of Patient First initiatives and progress of initiatives recommended under the Staib Sullivan Review. DoH expects this will provide a basis for assessing the progress made under the previous governance arrangements and for developing a targeted action plan to implement outstanding initiatives.

DoH acknowledged the change in legislation from 1 July 2018 meant the former Performance Framework was now outdated and needed to be replaced with new arrangements. It also advised in January 2019 it was still in the process of developing the new Performance Framework.

### Overview of the current Performance framework

Part D of the 2018-19 Service Plan establishes that both the Service Plan and the associated 'Performance Framework' are instruments that assist DoH in undertaking its role as system manager.

It further acknowledges a robust system must be in place for monitoring and reporting on the quality of services to ensure:

- the services purchased under the Service Plan are being delivered and they are safe and of high quality
- performance issues are identified and appropriate action can be taken and direction provided to ensure THS meets its performance obligations.

The Service Plan notes the 2018-19 Performance Framework 'will' provide a holistic and more comprehensive approach to performance monitoring and analysis that will no longer focus solely on KPIs contained within Part F of the Service Plan. Specifically, it will also include an increased focus on:

- safety and quality
- achievement of government priorities and funded initiatives
- achievement of purchased volumes and targets
- celebrating successful strategies and enabling shared learning throughout the system.

To achieve this, the Service Plan states the suite of Service Plan KPIs will be underpinned by a range of monitoring activities and indicators coupled with regular system scanning to identify areas of improvement, significant concern, clinical risk or sentinel events that will inform performance discussions. These activities will be underpinned by transparent performance criteria that will guide determination regarding escalation and de-escalation.

However, as noted above, an updated 2018-19 Performance Framework has yet to be developed by DoH more than six months after the 2018-19 Service Plan commenced operation.

### Risks inherent in current governance arrangements

There is a risk the significant change to the governance arrangements introduced in 2018 have reduced DoH's independence in performance monitoring by virtue of the Secretary now also being directly responsible for THS's service delivery performance.

These circumstances create an inherent tension with DoH's 'system manager' role, which previously (under the former THO Act), and consistent with other Australian states, did not extended beyond governance, policy and planning, purchasing and performance monitoring functions.

DoH noted that under the former THO Act, the role of DHHS, DoH and the Secretary in monitoring and managing THS performance was not explicit but instead articulated in supporting administrative documents such as the THS Performance Framework. It also advised this arrangement differed from other jurisdictions such as NSW where the Head of Department has a clearly articulated role within legislation for performance monitoring and issuing directions to Local Health Networks.

DoH further stated the THS Act, in accordance with the Government's policy intention, provides a clearer articulation and codification of the role of the Secretary and DoH in monitoring and issuing instruction to address performance within THS.

The State's longstanding 'system manager' role emanates out of the NHRA to which Tasmania is a signatory. The NHRA underpins Commonwealth funding to public hospitals through a national framework in which hospitals are coordinated via local health networks in each Australian State and where the States and Territories operate as 'system mangers' with a primary role in planning, policy, purchasing, and performance monitoring and management.

The Government reaffirmed its commitment to the NHRA and the State's role as a system manager in 2018 when it became a signatory to the Heads of Agreement forming the basis of negotiations for a new five year National Health Agreement from 1 July 2020. The Minister in his second reading speech for the new THS Act similarly recognised the importance of retaining THS as a separate legal entity noting that this 'is a key feature of the Commonwealth funding for what are known as local hospital networks'.

The expansion of the Secretary's role to now encompass direct responsibility for THS's service delivery performance has therefore blurred DoH's system manager role.

It also creates an inherent disincentive for DoH to both report on and escalate THS performance issues that may ultimately be used to hold the Secretary and DoH to account. There is a consequential risk this situation may lead to less scrutiny and lower standards of performance being applied to THS by DoH for addressing longstanding performance challenges, although there is no evidence to indicate this risk has materialised to date.

However, implementation of the new governance arrangements is at an early stage and to effectively mitigate this risk from occurring DoH needs a transparent and effective framework for system management. In September 2015 the former DHHS noted such a framework must at a minimum outline:

- the approach to managing system performance and quality assurance
- how the system will be monitored
- how performance will be reported
- how the system will be improved
- how the instruments of the system manager will work collaboratively to achieve the above and relate to the activities of service delivery providers.

The present absence of a codified Performance Framework underpinning the new THS Act and 2018-19 Service Plan means there is currently little assurance the above-noted risks have been satisfactorily mitigated or that DoH has an effective framework in place for system management.

### Section 4 Summary of findings

The THS Performance Framework under the former THO Act outlined reasonable procedures for performance monitoring, escalation and interventions to operationalise related provisions in the THO Act. Changes to the legislative framework in 2018 have rendered the former Performance Framework obsolete and removed explicit definitions and obligations for responding to unsatisfactory performance by THS.

Although DoH signalled an intent within the 2018-19 THS Service Plan to develop a more comprehensive monitoring framework for related KPIs, this had yet to occur more than six months after the plan was approved.

Neither THS nor DoH effectively implemented the former Performance Framework. DoH monitoring reports show THS consistently failed to meet its service delivery targets relating to ED access and care over the last three years.

The former DHHS initiated five Level 1 escalations during this period requiring THS to develop a Performance Improvement Plan for each affected KPI and to regularly report to DHHS on its progress. Although this occurred, neither DHHS interventions nor THS's related improvement actions were effective in improving the performance of hospitals against the KPIs.

DHHS monitoring reports during the period offered little insight into the root causes of THS performance issues including adequacy of its related improvement strategies. This rendered them ineffective from a performance monitoring perspective.

DoH advised that under the former agency structure and performance framework, responsibility for conducting in-depth analysis of performance issues, including root cause analysis rested with THS and that recent changes to bring THS under the authority of the Secretary provides DoH with an opportunity to address this deficiency.

Although it became evident to DoH over successive quarters that THS previously initiated improvement strategies were not working, no evidence was found demonstrating DHHS fully explored the merits of alternative escalation options for addressing the evident and ongoing deterioration in THS performance.

DHHS advised it was concerned about THS's performance and held weekly meetings with the Minister, but that it did not regard further escalations under the former Performance Framework as an effective means of improving performance on an ongoing basis. Instead, DHHS believed that longer term sustainable performance improvements were best served by working closely with THS to support its operational staff to improve performance.

There is a risk changes to THS's governance arrangements introduced in 2018 have reduced DoH's independence in performance monitoring by virtue of the Secretary of DoH now also being directly responsible for THS's service delivery performance.

These circumstances create an inherent tension with DoH's 'system manager' role which previously and consistent with other Australian states, did not extend beyond governance, policy and planning, purchasing, and performance monitoring functions.

There is no evidence to indicate that this risk has materialised to date.

DoH noted that under the former THO Act, the role of DHHS, DoH and the Secretary in monitoring and managing THS performance was not explicit but instead articulated in supporting administrative documents such as the THS Performance Framework. It also advised this arrangement differed from other jurisdictions such as NSW where the Head of Department has a clearly articulated role within legislation for performance monitoring and issuing directions to Local Health Networks.

DoH further stated the THS Act, in accordance with the Government's policy intention, provides a clearer articulation and codification of the role of the Secretary and DoH in monitoring and issuing instruction to address performance within THS.

Implementation of the new governance arrangements is at an early stage and to effectively implement the new legislative provisions and mitigate the risk to independence from occurring DoH should develop a transparent and effective framework for system management and performance monitoring.

### Recommendations

9. DoH, in consultation with THS, expedite development of the revised THS Performance Framework.
10. DoH, in consultation with THS, strengthen performance monitoring and reporting processes to ensure they:
    (a) provide actionable insights into the root causes of performance issues affecting ED access and care
    (b) ensure related improvement actions address the root causes of performance issues and are likely to succeed
    (c) rigorously assess the merits of alternative escalation/improvement actions in circumstances of consistent underperformance.

# ACRONYMS AND ABBREVIATIONS

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| **ABF** | Activity Based Funding |
| **AT** | Ambulance Tasmania |
| **COAG** | The Council of Australian Governments |
| **CommRS** | Community Rapid Response Service |
| **CoNECS** | Community Nursing Enhanced Connection Service |
| **DHHS** | Department of Health and Human Services |
| **DoH** | Department of Health |
| **DPAC** | Department of Premier and Cabinet |
| **ED** | Emergency Department |
| **EMCN** | Emergency Management Clinical Network |
| **EMU** | Emergency Medical Unit |
| **GP(s)** | General Practitioner(s) |
| **IOC** | Integrated Operations Centre |
| **KPI(s)** | Key Performance Indicator(s) |
| **LGH** | Launceston General Hospital |
| **LoS** | Length of Stay |
| **MCH** | Mersey Community Hospital |
| **Minister** | Minister for Health |
| **NBIT** | New Beds Implementation Team |
| **NEAT** | National Emergency Access Target |
| **NHRA** | National Health Reform Agreement |
| **NWAU** | National Weighted Activity Unit |
| **NWRH** | North West Regional Hospital |
| **PiP** | Performance Improvement Plan |
| **RHH** | Royal Hobart Hospital |
| **SHSJE** | State Health Service Joint Executive |
| **THO** | Tasmanian Health Organisation |
| **THO Act** | *Tasmanian Health Organisations Act 2011* |
| **THS** | Tasmanian Health Service |
| **THS Act** | *Tasmanian Health Service Act 2018* |

# GLOSSARY OF TERMS

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| **Access block** | The situation where patients who have been admitted to hospital and need a hospital bed are delayed from leaving the ED because of lack of inpatient (admitted patient) bed capacity. |
| **Activity based funding** | A way of funding hospitals under which they are paid for the volume and type of services provided. For example, if a hospital provides more services or provides care to more complicated patients, it receives more funding. |
| **Acute** | A medical condition that comes on suddenly and lasts for a limited time. |
| **Acute care** | Care in which the intent is to perform surgery, diagnostic or therapeutic procedures in the treatment of illness or injury. |
| **Admission** | The administrative process by which a hospital records the commencement of a new episode of care. |
| **Admitted patient** | A patient who undergoes a hospital's formal admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time, and can occur in hospital and/or in the person's home (for hospital in the home patients). |
| **Adverse event** | Any event or circumstance that could have or did lead to unintended or unexpected harm, loss or damage to any person receiving care or services from health services. |
| **Ambulance ramping** | Occurs when ambulance officers and/or paramedics are unable to complete transfer of clinical care of their patient to the hospital ED within a clinically appropriate timeframe, specifically due to lack of an appropriate clinical space in the ED. In some jurisdictions, ambulance ramping is also referred to as off-stretcher time delays or ambulance turnaround delays. |
| **Block funding** | A method of funding public hospitals, used for hospitals deemed too small for Activity Based Funding to operate effectively and in some other instances. |
| **Emergency department (ED)** | The ED is the dedicated area in a hospital that is organised and administered to provide a high standard of emergency care to those in the community who perceive the need for or are in need of acute or urgent care, including hospital admission. |
| **Emergency department overcrowding** | Refers to the situation where ED function is impeded because the number of patients exceeds either the physical or staffing capacity of the ED, whether patients are waiting to be seen, undergoing assessment and treatment, or waiting for departure. |
| **Episode (of care)** | A period of care in a hospital. |
| **Fellowship of Australasian College of Emergency Medicine** | Fellowship of Australasian College of Emergency Medicine is granted to doctors who have demonstrated that they have reached the standard required for specialist emergency medical practice in Australia. |

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| **General Practitioner (GP)** | A family physician who holds fellowship of Royal Australian College of General Practitioners or Australian College of Rural and Remote Medicine or, is otherwise so credentialed by the appointing health service or, recognised as such by Australian Health Practitioner Regulation Agency and/or Health Insurance Commission for Medicare payment purposes. |
| **Incident** | An event or circumstance that resulted, or could have resulted, in unintended and/or unnecessary harm to a person, and/or complaint, loss, damage or claim for compensation. |
| **Inpatient** | See admitted patient. |
| **Inpatient area or unit** | The term used to describe both the physical space where hospital beds are, such as the general medical ward, as well as a specialist unit such as the intensive care unit or an assessment and diagnostic unit. |
| **Length of stay (LoS)** | The length of stay of an overnight patient is calculated by subtracting the date the patient is admitted from the date of separation and deducting days the patient was on leave. A same-day patient is allocated a length of stay of one day. |
| **Non-admitted** | Care provided to a patient who has not undergone a hospital's formal admission process. Non-admitted care may include outpatient visits and ED services. |
| **Number of beds** | The average number of beds available to be used by an admitted patient or resident, or if an average is not available for a given hospital, the number of beds available at 30 June. Equivalent to the statistical measure 'average available beds'. 'Available' means that the bed is staffed and not in a closed ward; it does not necessarily mean that the bed is unoccupied. |
| **Offload** | Refers to an agreed process between ambulance services and ED staff when transferring patients from the ambulance stretcher into an appropriate area within the ED. |
| **Outpatient** | A non-admitted patient. |
| **Outpatient service** | A hospital service in which patients receive treatment without being admitted. Classification of certain services as 'outpatient' varies between hospitals as similar treatments may require admission in some hospitals but not others. |
| **Overcrowding** | See Emergency Department overcrowding. |
| **Patient** | A person receiving health care. |
| **Patient flow** | This term describes the movement of patients through the specific health system, for example an ED or a hospital. With respect to an ED, patient flow includes patient access to the ED, flow through the ED and departure via admission, transfer or discharge from the ED. |
| **Performance indicator** | A statistic or other unit of information that directly or indirectly, reflect either the extent to which an expected outcome is achieved or the quality of processes leading to that outcome. |
| **Presentation** | When a patient arrives at an ED for treatment. As a person may visit an ED in a hospital more than once in a year, the number of presentations is not the same as the number of people seen by the ED. |

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| **Ramping** | See ambulance ramping. |
| **Separation** | A technical term for the end of an episode of care. |
| **Triage** | The initial process of determining the priority of patients' treatments based on the clinical urgency of their condition. |
| **Triage category** | A category used in the emergency departments of hospitals to indicate the urgency of the patient's need for medical and nursing care. |

# APPENDIX 1: AUDIT CRITERIA

The audit addressed the objectives through the following criteria.

| Criteria | Issues considered |
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| 1. **What happens when I arrive at the Emergency Department?** | • Presentations (sources of referral)<br>• Triage<br>• Ambulance arrivals and ramping<br>• Waiting times<br>• Routine and demand (surge) management<br>o Performance measures, such as:<br>o time from arrival to the commencement of triage<br>o time from the start to the end of triage<br>o time to treatment by triage category<br>o ambulance offload delays<br>o number of occasions when ED and hospital escalation plans were activated to support peak periods of demand<br>o analysis to understand the underlying causes of escalation plan activation (for example, growth in ED presentations, downstream system delays)<br>o numbers of patients who leave the ED without being treated. |
| 2. **Will I get the care I need?** | • Factors impacting on patient care<br>• Measures of performance, including:<br>o waiting time for treatment by triage category<br>o ED patient total length of stay<br>o National Emergency Access Target (4 hour)<br>o other length of stay targets for admitted and non-admitted patients<br>o adverse events in the ED. |
| 3. **What happens after I have received Emergency Department care?** | • Discharge from ED<br>• Admission to an appropriate ward/unit<br>• Short stay units<br>• Bed management, patient flow and the impact of access block on the function of the ED<br>• Measures of performance, such as:<br>o delays in discharge process<br>o bed availability<br>• Progress made on implementing the recommendations of previous reviews/reforms. |
| 4. **Is the Tasmanian Health Service managing Emergency Departments effectively?** | • Governance (culture, leadership)<br>• Accountability for performance<br>• Escalation processes<br>• Monitoring and management reporting systems |

# APPENDIX 2: SUBMISSIONS AND COMMENTS RECEIVED

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 the Minister for Health and the Secretary for the Department of Health, were considered in reaching audit conclusions.

Section 30(3) of the 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.

### MINISTER FOR HEALTH

The Tasmanian Government welcomes the Auditor-General's report into this important part of our State's health system.

The recommendations and findings contained within the report outline several opportunities to provide better care for more Tasmanians, informed largely by existing data provided via the Department of Health. The Government is keen to examine these closely as part of the upcoming Access Solutions Meeting in June, and will be providing a copy of the report to attendees to help inform discussions and further sharpen the meeting's focus.

Physical capacity constraints are observed within the report, and the Tasmanian Government is working to address these through the completion of the Royal Hobart Hospital Redevelopment, which will be followed by the commissioning of additional beds.

Similarly, the Launceston General Hospital is undergoing major capital investment to allow for more beds to be opened, and new beds have also been recently opened at both the North West Regional hospital and Mersey Community Hospital, as well as capital works to provide more and better clinical spaces.

The Report also notes longstanding cultural and process challenges across our hospitals. If these issues can be resolved, it is clear that improved discharge planning, bed management and coordination within our hospitals will enable better care to be provided with greatly improved patient outcomes. In particular, the Government wants to fully explore the claimed potential of 3,000 bed days per annum which could be unlocked.

These issues have combined with growing demand and complexity of patients, meaning than despite more than 1,000 additional staff being added to our health system over the past five years, and significant bed openings across the state, we have not seen the improved performance and bed access for our patients that would otherwise ordinarily be expected. Without these new beds that the Government has opened, our health system's ability to meet our patients' needs would clearly be poorer.

The Report recognises that many long-term issues have been subject to a number of reviews going back a decade, and indeed some even further. These complex challenges persist despite the dedicated medical, nursing paramedic and administrative staff that work across our State.

The Government acknowledges all of these challenges, exacerbated by growing demand for services, but we remain committed to looking 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 management and delivery of healthcare in this state, and stronger local leadership for our hospitals. The Government acknowledges the Report's finding that is too early to assess the success of the 2018 legislative changes, and the Department and THS must leverage these reforms and further strengthen whole-of-hospital and system-wide leadership, coordination and accountability for addressing the longstanding cultural and process barriers to improving patient flow.

There are no silver bullets to these long-term problems, but as a Government we are Committed to working with expert health administrators, clinicians and consumers in addressing these challenge to improve the way we provide health services.

Thank you for providing the opportunity to make comment.

The Honourable Michael Ferguson MP
**Minister for Health**

### SECRETARY FOR THE DEPARTMENT OF HEALTH

Thank you for your report. I am pleased it provides a comprehensive view of the factors affecting Emergency Department performance and offers constructive suggestions for ways in which improvements in all areas of our hospitals can have lasting, positive impacts on care provided at EDs.

I am grateful that the Report acknowledges the expertise and diligence of clinicians working in the EDs. It is important that Tasmanians understand that the expertise and commitment of our doctors, nurses, allied health professionals, paramedics and administrative staff is not in question. The recommendations of the report will ensure that patient wellbeing is at the centre of everything that we do, in the changes we make in response to this report, and that everything we do is aimed at supporting and improving the health and wellbeing of Tasmanians.

The Department of Health (DoH) is currently working very closely with the Tasmanian Health Service (THS) to plan and implement a range of strategies that will improve performance across the whole THS, including:

- close engagement by Executive with patients and staff across all levels of the THS, to build a broad culture of caring based on empathy and solidarity with the experiences and aspirations of patients and staff;
- a patient experience survey that will allow our patients to provide timely and quality feedback about their experiences of our services, and which will be used to drive patient-centred care and values-based practices;
- a comprehensive program to recognise, reward and encourage individuals and teams of staff who exemplify values-based practice and patient centred care;
- professional networks that will focus on management and planning expertise to embed skills and shared learning across different areas of the THS;
- information technology solutions to;
    - ensure the timely and effective transfer of patient information between clinical areas to facilitate patient flow through the hospital system, from the ED to discharge home; and
    - that make it easier for our clinicians to undertake discharge planning, which will ensure that when patients go home from hospital, their GPs and other health providers have the information they need to provide safe and appropriate care outside of the hospital;
- a comprehensive performance framework that will monitor and report the performance of the Tasmanian Health Service, and which will include regular reviews of underlying risk factors and risk management practices.

In addition, the Minister will be co-convening with the Australian College of Emergency Medicine an Access Solutions meeting to focus specifically on improving hospital flow at the Royal Hobart Hospital in June 2019. It is anticipated that the findings and recommendations in this report will assist agreeing on a set of actions to improve patient's timely access to care.

While some of these activities will need time to embed in clinical practice, we are also addressing project management and change management capability within the THS, to ensure that clinical and management expertise is backed up by effective logistical and planning support. I am committed to making the THS and the DoH places that doctors, nurses, allied health professionals, managers and administrators from all over Australia aspire to work because it is a place that recognises and rewards patient-centred excellence.

Michael Pervan
**Secretary**
**Department of Health**

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# AUDIT MANDATE AND STANDARDS APPLIED

## Mandate

Section 17(1) of the *Audit Act 2008* states that:

> 'An accountable authority other than the Auditor-General, as soon as possible and within 45 days after the end of each financial year, is to prepare and forward to the Auditor-General a copy of the financial statements for that financial year which are complete in all material respects.'

Under the provisions of section 18, the Auditor-General:

> '(1) is to audit the financial statements and any other information submitted by a State entity or an audited subsidiary of a State entity under section 17(1).'

Under the provisions of section 19, the Auditor-General:

> '(1) is to prepare and sign an opinion on an audit carried out under section 18(1) in accordance with requirements determined by the Australian Auditing and Assurance Standards
>
> (2) is to provide the opinion prepared and signed under subsection (1), and any formal communication of audit findings that is required to be prepared in accordance with the Australian Auditing and Assurance Standards, to the State entity's appropriate Minister and provide a copy to the relevant accountable authority.'

## 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 Standards as issued by the Australian Auditing and Assurance Standards Board.

Tasmanian
Audit Office


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