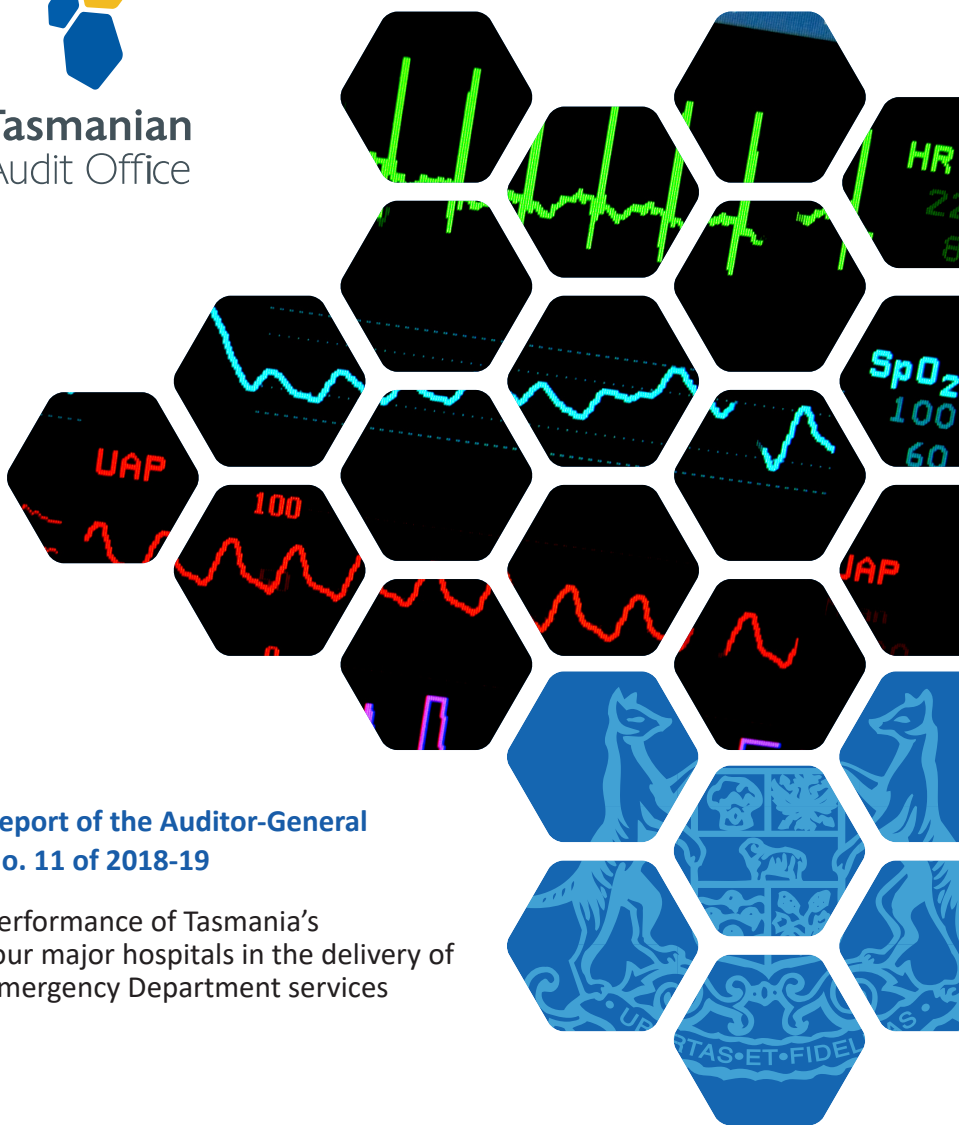




Tasmanian
Audit Office



**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

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 ramping¹ 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.

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.

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.

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 of the full report 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

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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 care² 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 block³ 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.

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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

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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 events⁴ 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.

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

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.

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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 90th 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

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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

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- (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.

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.

Findings and recommendations

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.
-

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 of the full report.

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

For the full report go to:

<https://www.audit.tas.gov.au/publication-category/performance-audit>



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