

ACT Auditor-General's Office Performance Audit Report

**Gastroenterology and Hepatology Unit,
Canberra Hospital**

Health Directorate

June 2014

PA14/03

Mrs Vicki Dunne MLA
The Speaker
ACT Legislative Assembly
Civic Square, London Circuit
CANBERRA ACT 2601

Dear Mrs Dunne

I am pleased to forward to you a Performance Audit Report titled 'Gastroenterology and Hepatology Unit, Canberra Hospital' for tabling in the Legislative Assembly pursuant to Section 17(5) of the *Auditor-General Act 1996*.

Yours sincerely

Dr Maxine Cooper
Auditor-General
6 June 2014

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LIST OF ABBREVIATIONS AND GLOSSARY

ANU	Australian National University.
CACHS	Cancer, Ambulatory and Community Health Support Division.
CHHS	Canberra Hospital and Health Services.
Consultants	Term used in the report to describe Staff Specialists and VMOs.
Endoscopy	A procedure using an illuminated tubular instrument for visualising the interior of a hollow organ or part for diagnostic or therapeutic purposes. ¹
FTE	Full time equivalent.
Gastroenterology	The branch of medicine dealing with the structure and diseases of the digestive organs. ²
GEHU	Gastroenterology and Hepatology Unit.
Health Pathways	An integration initiative adopted by a number of Medicare Locals. This web-based information portal is developed for clinicians with a primary focus on general practice. It enhances collaboration between clinicians and across community, primary and secondary health sectors and develops online referral pathways. ³
Hepatology	The branch of medicine concerned with the liver. ⁴
Independent expert	A noted expert in the field who provides independent and objective analysis and advice.
KPI	Key Performance Indicator.
NBCSP	National Bowel Cancer Screening Program.
NTANS	Not to a Named Specialist (referral), also referred to as a generic referral.
SEA	Special Employment Arrangement: ‘...the authorisation of the payment of an allowance to a person ... payable where the position requires a person possessing knowledge, skills and experience which are: critical ... in high demand... normal package of salaries...is not sufficiently attractive to secure the services of such a person... it is desirable to secure the services...(as) and employee, rather than as a contractor.’ ⁵
Shared care	The sharing of the care of a patient between a GEHU consultant and the patient’s GP.

¹ Medline Plus medical dictionary - <http://www.merriam-webster.com/medlineplus/endoscopy> Accessed on 26 March 2014

² Macquarie Dictionary Accessed 28 March 2014

http://www.macquariedictionary.com.au/features/word/search/?word=gastroenterology&search_word_type=Dictionary

³ Australian Medicare Local Alliance, Medicare Locals in Australia, Response to the Medicare Local Review, submitted to Commonwealth Department of Health, 23 December 2013, p 48.

http://amlalliance.com.au/_data/assets/pdf_file/0009/52101/20131223_AML-Alliance-response.pdf Accessed 1 May 2014.

⁴ Medline Plus medical dictionary <http://www.merriam-webster.com/medlineplus/hepatology> Accessed 28 March 2014.

⁵ Guideline on Special Employment Arrangements for Salaried Medical Staff in Act Health, 17 June 2003.

List of Abbreviations

Staff Specialist	A registered medical practitioner, with not less than five years experience, with an appropriate higher medical qualification in their speciality acceptable to the employer. ⁶
Triage	The process of deciding which patients should be treated first based on how sick or seriously injured they are. ⁷
VMO	Visiting Medical Officer: A doctor...who is engaged, or who the Territory proposes to engage, under a service contract s100, <i>Health Act 1993</i> .

⁶ ACT Public Service Medical Practitioners Enterprise Agreement 2011–13, p 156.

⁷ Merriam-Webster online dictionary: <http://www.merriam-webster.com/dictionary/triage?show=0&t=1399419498>

1. REPORT SUMMARY AND CONCLUSIONS

INTRODUCTION

- 1.1 This report presents the results of a performance audit on the effectiveness of administrative and triaging practices of outpatient services provided by the Gastroenterology and Hepatology Unit (the GEHU) at Canberra Hospital.
- 1.2 A Public Interest Disclosure (PID) '*alleging prolonged maladministration of outpatient services provided by the GEHU since 2012*' was made to the Auditor-General on 27 September 2013. An investigation of the issues raised in the PID was undertaken by the Auditor-General from November 2013 through to February 2014. This investigation showed that there had been no maladministration, as defined by the *Public Interest Disclosure Act 2012* (the Act), of the GEHU.
- 1.3 Although the Audit Office concluded that there was no maladministration, some issues along similar themes to those presented in this report emerged from the investigation, which the Auditor-General decided were best considered through a performance audit.
- 1.4 The Audit Office did not examine the broader operations of the GEHU, Canberra Hospital or the Health Directorate that are not related to the provision of outpatient services by the GEHU. However, findings and recommendations from the audit may be applicable to other outpatient clinics.
- 1.5 The scope was defined as a result of the PID investigation conducted by the Audit Office and focused on governance and the delivery of services (management of the outpatient waiting list) by the GEHU.
- 1.6 Further background information on the audit objective, scope, criteria and approach is provided in Chapter 2.
- 1.7 Gastroenterology is the branch of medicine dealing with the structure and diseases of the digestive organs. Hepatology, a sub-speciality of gastroenterology, deals with the liver. Professor Paul Desmond, former Director of the Gastroenterology Department at St Vincent's Hospital, Melbourne provided independent expertise.
- 1.8 The GEHU provides a tertiary level of healthcare (or specialist service) as opposed to a primary healthcare service which, in the Australian Healthcare system, is provided by General Practitioners (GPs).
- 1.9 Private patients would usually access specialised treatment similar to that offered by the GEHU by obtaining a referral from their physician or GP to a specialist's private clinic (a clinic facility owned and operated by a private entity and funded on a fee-for-service basis). Public patients can access specialist treatment in the public system; and in this instance their referral is made out to

the outpatient unit at a public hospital or to a specific consultant in that outpatient unit (e.g. the GEHU or GEHU consultant).

- 1.10 Staff specialists within the GEHU are provided a Right of Private Practice. This offers them the ability to receive a portion of the Medicare Benefits Scheme claim for public outpatients they treat. This is in addition to their base salary provided by the Health Directorate. Private practice revenue is earned by a specialist only if the referral is made out to them by name.

CONCLUSIONS

- 1.11 Audit conclusions drawn against the audit criteria are set out below.

Governance

Governance of the GEHU is inadequate and this compromises its ability to align its activities with the strategic direction of the Health Directorate and to be held accountable.

Delivery of Services

The GEHU outpatient waiting list has not been managed effectively due to inadequate strategic management rather than a lack of resources. The GEHU's service delivery is likely to be improved through focusing actions on:

Triaging

Patients of the GEHU have not been receiving treatment within the timeframes recommended by the Health Directorate's triage categories. Addressing this will help the GEHU provide the best possible care to patients.

Clinic organisation

More initial (rather than review) appointments are needed in clinics to manage the waiting list. The process to establish new, or vary current, clinics needs to be more responsive to changes in demand.

Equitable Access

Access to GEHU consultants by patients does not occur according to a patient's medical need. A patient's symptoms (which determine their triage category) need to be the basis for their priority to see a consultant, rather than the referral type (i.e. to a named consultant (Specialist) or generic/Not to a Named Specialist) or the sub-speciality to which they were referred.

Referral processing and triage targets

Acceptance of patient referrals from GPs is not guided by referral criteria. Furthermore, the GEHU does not have defined triaging targets or guidelines. Referral

criteria, triaging targets and guidelines are needed to assist in managing the waiting list. Additionally, there is an opportunity for increased electronic processing of referrals within the GEHU and between the GEHU and GPs to reduce administration processing and the risk of referrals being lost or doubled up.

Scheduling

A patient on the GEHU waiting list, if an appointment is not booked immediately, is not informed of their probable waiting time to see a consultant or of alternative treatment options they could consider during this time. This information is particularly important for those who are likely to be on the waiting list for a lengthy period.

Tertiary health care

The GEHU is not being used effectively to provide tertiary healthcare as GPs are referring patients who require primary health care to the GEHU.

Furthermore, improving the way the GEHU and GPs work to provide 'shared care' could focus GEHU resources on the provision of tertiary health services, leaving primary services to be delivered, appropriately, by GPs.

'Open' endoscopy

Currently, other than patients referred through the National Bowel Cancer Screening Program, patients requiring an endoscopy are required to see a GEHU consultant first. An alternative is for GPs to request an endoscopy directly, after performing sufficient tests (primary healthcare) and a GEHU Senior Registered Nurse seeing patients prior to the procedure. While this 'open' endoscopy approach may have limitations, it merits further consideration.

Strategic use of data

Reporting to the Division of Medicine Executive does not include information on GEHU triaging categories and times, waiting times for appointments and whether patients attend appointments. (The majority of reporting is focused on endoscopy activity.) This level of reporting is needed so that the GEHU can be strategically managed to ensure that its resources are used to deliver services in a manner which reduces the waiting list and delivers the best possible patient care.

Incident reporting

Not all adverse events, that may be the result of poor referral, triage or scheduling practices, appear to be reported. This could be done using the centralised electronic Riskman system. This would provide information to assist in strategically managing the GEHU.

IT systems

There is a lack of integration between IT systems used in the GEHU which creates inefficiencies. Controls and logging in the e-Referral system over who can enter and change triage categories, booking and triage dates, and the status of the referral (open, triaged, booked, closed) are nonexistent. These are needed to control work flows.

KEY FINDINGS

1.12 The audit conclusions are supported by the below key findings.

Governance

- 1.13 There was no formal service level agreement or equivalent between the GEHU and Cancer, Ambulatory and Community Health Support (CACHS) for the services provided by the Medical Transcription⁸ and Outpatient Referral Processing and Scheduling Teams. However, during audit fieldwork a review of administration functions and service models across Ambulatory Care Services (part of CACHS) commenced. The GEHU is piloting an outpatient administration structure with administration staff and health professionals reporting to the same manager. (paragraph 3.7 and 3.8)
- 1.14 The Division of Medicine Executive Meeting and the meetings between the Executive and GEHU Director are not recorded. Action items are, however, maintained for the Division of Medicine Executive Meeting but not outcomes. The lack of a record of action items or outcomes of the Division of Medicine Executive Meeting and the meetings between the Executive and the GEHU Director has led to:
- a lack of accountability and transparency for decisions made by these groups; and
 - increased risk that key decisions, including actions required as a result of these decisions, such as initiatives to improve patient care would not be carried out and followed up accordingly. (paragraphs 3.14 and 3.15)
- 1.15 The Health Directorate reported that there was a lack of communication from the GEHU Director, to the Executive and to the GEHU, with information apparently not being passed up or down. (paragraph 3.11)
- 1.16 Despite it being clear in the Health Directorate Corporate Plan 2012-17 and the Division of Medicine Business Plan 2013-14 that 'partnering for better health outcomes' is a key focus area, there is no formal planning mechanism whereby

⁸ Note: Since fieldwork has been completed the GEHU transcription service has been outsourced.

the GEHU also adopts this focus and shows how its actions will provide the best possible patient care. In addition there is very limited regular communication of key strategic and operational messages from the Division of Medicine Executive, through the GEHU Director, to the GEHU business meetings. The inadequacies in the integration of the GEHU's actions with the strategic directions of the Division of Medicine could lead to doctors of the GEHU planning and directing their activities and allocating resources to areas that are not overall providing the best possible care to patients. (paragraphs 3.21 and 3.22)

1.17 The GEHU has not been using key performance indicators (KPIs) including setting targets to formally monitor or report on the majority of its operations. However, a number of KPIs were identified in March 2014. At the time of audit fieldwork, 'referrals waiting for triage' was the only new KPI that was being tracked. The lack of formal monitoring and reporting (including setting targets) through key performance indicators on the majority of the GEHU's operations could lead to:

- compromising the provision of the best possible patient care through 'partnering for better health outcomes' and other key strategies of the Health Directorate and the Division of Medicine;
- reduced control by those charged with governance of the GEHU;
- reduced transparency over how the doctors of the GEHU are planning, directing and allocating their activities and resources;
- the doctors of the GEHU not being held accountable through key performance indicators for their activities; and
- changes in demand for services and the need for re-allocation of resources not being identified in a timely manner. (paragraph 3.30 to 3.32)

1.18 No evidence was found of a GEHU risk management plan (risk register or report including a risk treatment plan). The GEHU is not regularly reviewing or reporting on risks and therefore not identifying, rating (assessing consequences and likelihood), prioritising and planning to treat significant risks specific to providing the best possible patient care. However, the Health Directorate advised that other units in the Division of Medicine do 'not have risk registers or risk management plans and there is currently no requirement for this'. The lack of risk management at a unit level needs to be considered further. Health professionals manage risk on a daily basis in the management of patients' care; the development of a risk management plan at the unit level is a logical extension of individual patient risk management.(paragraphs 3.36 and 3.37)

Delivery of Services

1.19 The GEHU has had a waiting list of around 1 500 patients during 2012 and 2013 and at the beginning of 2014; with the lowest number of patients being 621 in

March 2012, and the highest being 2 000 in May 2013. As of January 2014 the waiting list was just under 1 500. The waiting list reflects an imbalance between demand and supply, despite an increase of 100.3 per cent in outpatient services provided over the past seven years. (paragraph 4.4)

- 1.20 Given the number of outpatients on the waiting list, at current rates of processing (300 patients per month) it would take around 5 months to see these patients, without further patients being added to the waiting list. Some of those on the waiting list are unlikely to see a consultant at all, or at least not within a time determined by their medical condition. (paragraph 4.5)
- 1.21 It is considered that the GEHU has the capacity to see more outpatients. Therefore the issue of managing the GEHU waiting list is not due to a lack of resources but inadequate strategic management. (paragraph 4.6)
- 1.22 Patients waiting for treatment for longer periods than that recommended by their triage status are not receiving the best possible care. Strategic management is needed to reduce triaging, scheduling and appointment waiting times in order to reduce the GEHU outpatient waiting list. (paragraph 4.7)

Triaging outcomes

- 1.23 Analysis of data to determine the effectiveness of triaging with respect to the number of patients seen within the triage category timeframe shows poor results. Referrals categorised as urgent were the least likely to meet the timeframe. This is understandable in that it is only 48 hours; however, it is 48 hours in order to manage the risk to the patient of what have been judged by an experienced clinician as serious symptoms. (paragraph 4.22 and figure 4.5)

Clinic organisation

- 1.24 During 2013 the number of new referrals to the GEHU each month was significantly higher than the amount of initial appointments offered. This means that not only has the waiting list not reduced during 2013, but it has grown. If the rate of initial appointments is maintained at this level, and not increased significantly, the waiting list for GEHU will only continue to increase, despite an increase in the total number of clinics. Management of referrals, consultants, clinics and scheduling needs to actively address what is an ongoing problem. (paragraph 4.39)
- 1.25 The organisation of clinics is determined by each consultant. The current sign-off required for a new clinic, or for changes in the number of patients seen in a clinic, is lengthy. The current process, while providing oversight, may decrease flexibility to provide clinics to meet changes in demand. Health professionals reported to the Audit Office that it is an unwieldy process and hampers response to changing needs within the GEHU. (paragraphs 4.29 and 4.30)

Equitable Access

- 1.26 Referrals to the GEHU are either made to a specific consultant (named referrals), or as a generic/NTANS referral (Not to a Named Specialist). The distinction between named and generic/NTANS referrals is important as it effects the payment to staff specialists and to Canberra Hospital. (paragraphs 4.50 and 4.51)
- 1.27 On average, the total time taken for a referral to a named specialist was 52 days between when the referral was received and the date the appointment was booked; for a generic/NTANS it was 105 days, a difference of 53 days or 102%. This is evidence that those patients referred via generic/NTANS referrals were disadvantaged. However, the effect of the different referral types is not being monitored by the Health Directorate as this analysis had not been conducted prior to the Audit Office analysis. Currently staff specialists determine how many appointments they allocate for named versus generic/NTANS referrals. This allocation creates disadvantages for those patients with generic/NTANS referrals. (paragraph 4.59 and 4.60)
- 1.28 Referrals to the GEHU can be for general gastroenterology intervention, or for one of the sub-specialities, e.g. Inflammatory Bowel Disease, liver conditions and patients at high risk of gastrointestinal cancer. (paragraph 4.61)
- 1.29 Audit Office analysis of referrals in Figure 4.13, shows an average wait of 64 days for an appointment for general gastroenterology referrals and 45 days for sub-speciality referrals. This is evidence that general gastroenterology patients are being triaged and scheduled for appointments more slowly than those with sub-speciality referrals. (paragraph 4.62)

Referral processing and triage targets

- 1.30 Triage data from March 2012 – January 2013 shows that five consultants were up to date with triaging, with no referrals awaiting triage dated earlier than 4 February 2014. Of the other eight consultants assessed:
- four had referrals awaiting triage dated from July 2013 or later;
 - one had a referral awaiting triage dated from early 2013; and
 - two had referrals awaiting triage dated from 2012 (1 August and 4 October 2012).
- 1.31 Since it is possible that some of these referrals could be triaged at Category 1 or even urgent these delays are unacceptable. (paragraph 4.16)
- 1.32 Figure 4.3 which examines the percentage of referrals triaged to each category per consultant shows a variety in triaging practice among consultants. It shows a significant range in the percentage in each triage category for each consultant.

Category 1 ranges from zero to 57 per cent; Category 2 from 14 to 80 per cent; and Category 3 from 10 to 60 per cent. (paragraph 4.14)

- 1.33 The Audit Office made inquiries of GEHU staff as to the use of guidelines and targets for triaging referrals. These were not in use at the time of fieldwork. (paragraph 4.17)
- 1.34 When the e-Referral system was first introduced, there was significant uptake of it by GPs, as shown in Figure 4.14. However there has been a decrease in the number of GPs using the system. As it is estimated that 95% of GPs use an electronic practice management system, the low level of e-Referral use is surprising and may indicate a lack of confidence in this system by GPs. (paragraph 4.71)
- 1.35 Faxed referrals are collected by administration staff in the GEHU and are then scanned into the e-Referral system for triaging and scheduling of appointments. There are a number of concerns regarding faxed referrals, e.g. referrals can be lost, inadvertently disposed of, or caught up with other papers. (paragraph 4.72 and 4.73)
- 1.36 Letter and fax referrals mean that the referring GP does not receive any automatic updates as to the progress of the referral and that any further information required by the GEHU from the GP has to be sought by phone or letter. (paragraph 4.75)
- 1.37 The current referral processing options adopted by consultants places patients at risk due to the possibility of lost referrals, delays in processing referrals and subsequent delays in the delivery of treatment. It also results in poor use of administration staff time by creating unnecessary double handling of a number of steps in the process. These factors all contribute to an unnecessarily long waiting list. (paragraph 4.81)

Scheduling

- 1.38 A patient is booked for an appointment using the ACT Patient Administration System (ACTPAS) once a referral has been triaged. The way bookings are filled depends on the requirements of each consultant. Large numbers of patients have been triaged but not yet booked: 1 422 at 28 February 2014 (of those 763 were awaiting triage). This is due to the difficulties experienced in the scheduling area. Stakeholders reported significant frustration with trying to contact the scheduling area by phone. Based on feedback from stakeholders, this is particularly challenging with respect to patients with liver conditions. (paragraph 4.84 and 4.85)
- 1.39 The progression of only 39 per cent of Category 3 referrals to a booked appointment over 2012 and 2013 is evidence of the practice of not booking appointments for Category 3 referrals due to the number of Category 1 and 2 referrals already in the system. (paragraph 4.89)

- 1.40 Some stakeholders suggested to the Audit Office that an effective way to address the lack of appointments available for patients, including Category 3, would be to suggest to them that, if able, they could access the private health system for an initial appointment, and then return to the public system, the GEHU, for further treatment and investigations such as endoscopies. (paragraph 4.90)
- 1.41 Currently, a patient is notified they have an appointment by a phone call if the appointment is within the next two weeks, or a letter if the appointment is two weeks or more away. If a patient is on the waiting list and has not been scheduled an appointment they do not receive any communication from the GEHU. (paragraph 4.92)

Tertiary healthcare

- 1.42 In the Australian health care system primary care is provided through general practice, with GPs referring to specialists for tertiary care, as required for more complex health needs. It was reported by health professionals that a number of the patients accessing the GEHU do not require the level of specialist, tertiary care provided at Canberra Hospital and would be more appropriately treated by GPs, either solely or as part of a shared care model with GEHU consultants. Inappropriate GP referrals contribute to the waiting list for GEHU services. Health professionals reported that many referrals do not contain the required information, such as tests completed, prior to referring the patient to a tertiary health care facility. This results in some patients using GEHU resources when they could have been appropriately managed by their GP. (paragraph 4.105)
- 1.43 Some health professionals consulted during the audit suggested that inappropriate referrals should be returned to the referring GP with instructions for the appropriate tests to be performed, or primary treatment to be provided. The Health Directorate advised that there is a lack of agreement amongst GEHU specialists about returning referrals to the referring GP for more information. This needs to be addressed through the introduction of referral criteria which would provide a consistent message to GPs as to the standard of referral expected. (paragraph 4.107 and 4.108)
- 1.44 To ensure that Canberra Hospital is used as a tertiary and not a primary health care facility there is a need for referral criteria to be developed and implemented to guide which patients are scheduled an appointment. Such criteria may be warranted for other outpatient services. (paragraph 4.110)
- 1.45 Shared care, the sharing of the care of a patient between a GEHU consultant and a GP, may be an appropriate model for many patients treated through the GEHU. Shared care would involve a GP in the ongoing care of the patient, with periodic checks by the consultant, either scheduled by the GEHU consultant or when the GP and/or if the patient thought it necessary. This was suggested by a number of health professionals and has the advantage of including a GP in the patient's care in an ongoing relationship. (paragraph 4.113)

1.46 A commitment was made to conduct an extra 300 endoscopies in 2012–13 in order to address the endoscopy waiting list. As at May 2013, it was reported at the GEHU business meeting that 200 of the 300 extra endoscopies had been performed. It was stated at this meeting that the shortfall was due to the lack of progress on the refurbishment and new staff specialists commencing later than originally planned. From February 2013 to April 2013 an extra 59 endoscopes were being done each month. (paragraph 4.98)

'Open' endoscopies

1.47 A strategy for addressing the waiting list for the GEHU, including endoscopies, would be to formalise the use of 'open' endoscopies, as suggested by GEHU health professionals. Open endoscopy is when a GP refers a patient directly for an endoscopy when it is clear to the referring GP that an endoscopy is needed, following appropriate investigations. (paragraph 4.99)

Strategic use of data

1.48 The GEHU collects a large amount of data regarding referrals including clinic utilisation, triaging categories and times, waiting times for appointments and whether patients attend appointments. The Audit Office found that, although a number of reports are produced, other than endoscopy data, only a limited amount of data is reported to the Executive Director level. Currently the reporting focus is endoscopies. This level of reporting is not resulting in strategic management of the GEHU, its waiting lists and resources (current or required) and the means to address the waiting list and related risk to patients. (paragraph 4.138)

Incident reporting

1.49 Riskman is the incident reporting system used by Canberra Hospital. It is only used by one staff specialist in the GEHU. This is a missed opportunity as the reports generated by Riskman would provide information on adverse events that may be the result of poor referral, triage or scheduling practices and so provide information on how practices are impacting patient care and where to target improvements. (paragraph 4.121)

IT systems

1.50 There are a number of IT systems, with varying degrees of compatibility and communication, used in the referring, triaging and scheduling of patients in the GEHU. The lack of integration of the systems creates inefficiencies because they are time consuming for the administration staff. (paragraph 4.122)

1.51 The Audit Office identified that there are no automated controls in the e-Referral system to enforce restrictions on who can enter and change triage categories, booking and triage dates, and the status of the referral (open, triaged, booked, closed). While there is an audit log maintained, there is no monitoring of this log. (paragraph 4.129)

Review of Triaging and Patient Outcomes

- 1.52 The Independent expert commented that ‘the triage category was appropriate in the vast majority of patients. A small number of patients with the same referral symptoms were allocated to different categories.’ (paragraph 5.7)
- 1.53 Of the 35 patients who had been referred to GEHU two had also presented to the Emergency Department at Canberra Hospital around the time of their referral to GEHU. These cases were considered by the independent expert to assess if their presentation to the Emergency Department was related to their GEHU referral, particularly if they experienced any adverse outcome. The expert concluded for these patients that their histories ‘demonstrated that the patients were managed appropriately and in a timely manner’. (paragraph 5.11)
- 1.54 The conclusion from the independent expert only provides assurance in the two cases mentioned above, as data was available from the Health Directorate system for these cases but not for others. Data for other case study patients may be available from other sources or through contacting the patients, so the Audit Office cannot be sure that they did not experience any adverse outcomes. Given that the audit focus is systemic issues, individual patients were not contacted. (paragraph 5.12)

RECOMMENDATIONS AND RESPONSE TO THE REPORT

- 1.55 The audit made two recommendations to address the audit findings detailed in this report.
- 1.56 In accordance with Section 18 of the *Auditor-General Act 1996*, a final draft of this report was provided to the Director-General of the Health Directorate for consideration and comments. The Director-General’s overall response is shown below:

ACT Health welcomes this Performance Audit Report from the ACT Auditor-General and appreciates the opportunity to provide comment.

ACT Health also acknowledges the hard work of the staff involved in the delivery of services within the Gastroenterology and Hepatology Unit (GEHU). The GEHU delivers high levels of care for patients, and seeks to identify areas of change and improvement. The findings and recommendations of the Audit Report will assist to improve the services that the Unit provides.

As part of the Audit, an independent expert was commissioned to review the GEHU consultants’ triaging and outcomes of a selection of patients. This expert found that “the triage category was appropriate in the vast majority of cases” and for those cases where outcomes could be assessed “the patients were managed appropriately and in a timely manner”. While acknowledging the scope for improvement within the GEHU, ACT Health is reassured by the independent expert’s assessment.

Substantial work has been undertaken since the completion of the field work of the Auditor-General's Office for this audit. ACT Health has introduced changes to improve processes for acceptance and registration of referrals, and is focusing on increasing the Gastroenterology consultants' utilisation of IT systems to triage, in an effort to streamline referral processing and booking of patients into clinics.

Enhancements to the electronic referral system have also been identified and are being developed, which will improve the GEHU's visibility of their demand, enabling better management of appointment requirements.

The number of referrals waiting to be triaged has decreased, with a reduction of 60% since 1 March 2014⁹. An internal audit will be undertaken to review the existing clinic structure in order to maximise the number of new consultation appointments available.

ACT Health believes that this works as well as the response to the recommendations of the Audit will enable the service to continue to improve and provide high quality of services to the ACT community.

1.57 The Audit Office recommendations are shown on pages 13 and 14.

⁹ Refer to Figure 4.4 and paragraph 4.20.

Recommendation 1 (Chapter 3)

The Health Directorate should improve the governance of the GEHU by:

- (a) the three month outpatient administration structure pilot (commenced 17 March 2014) being evaluated to inform how best to provide medical transcriptions and outpatient referral processing and scheduling services;
- (b) recording action items and outcomes for the Division of Medicine Executive Meeting and the meetings between the Executive and GEHU. These should record decisions and actions agreed; be tabled and approved at subsequent meetings; and evidenced as such. Key messages from these meeting should be routinely communicated to staff and management.
- (c) the GEHU developing and implementing a business or action plan that prioritises strategies and allocates resources to *'partnering for better health outcomes'* and other key strategies in the Directorate and Divisional strategic plans. The GEHU business plan should include key performance indicators (refer to Recommendation 1(d)) and be regularly reviewed, at least annually, and findings from this reported to the Division of Medicine Executive Meeting.
- (d) the GEHU developing, monitoring and reporting on key performance indicators (including setting targets) that cover all of its activities:
 - endoscopy (already the subject of a key performance indicator and target);
 - care for inpatients with gastroenterological diseases;
 - medical services;
 - clinics for outpatients with viral hepatitis, liver disease, inflammatory bowel disease, gastrointestinal cancer and other complex gastrointestinal disorders; and
 - clinics for participants in the National Bowel Cancer Screening Program; and
- (e) the GEHU documenting its risks as part of its Business Plan, and reporting (at least annually) on any risk issues to the Division of Medicine Executive Meeting.

Recommendation 2 (Chapter 4)

The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (a) define targets (including specific ones for categories and the number of clients triaged per full time staff specialist) and adopt guidelines for GEHU triaging;
- (b) increase the use of electronic referrals to the GEHU by GPs;
- (c) require that all GEHU health professionals report incidents where patient care has the potential to be compromised because of an incident, and do this using Riskman;
- (d) investigate options to improve clinic organisation to be able to respond to varying patient demand;
- (e) specify initial appointments per clinic and the type of patients seen in each clinic (general or sub-speciality) to provide clear direction on the work they are expected to complete in a four week clinic cycle;
- (f) develop a process to guide clinic appointments being organised according to the urgency of a patient's symptoms (their triage category) and not according to referral type (named or generic/NTANS; or general gastroenterology or sub-speciality);
- (g) electronically perform referring, triaging and scheduling and if this is not possible, having as many steps as possible in this process performed electronically;
- (h) incorporate information on probable waiting times and alternative treatment options in letters provided to all registered GEHU patients by GEHU administration;
- (i) assess the merits and limitation of introducing 'open' endoscopy referrals in the GEHU;
- (j) develop and implement referral criteria that must be met before GEHU outpatients are scheduled an appointment;
- (k) affirm and/or expand the role of GPs (e.g. shared care) in supporting patients attending GEHU outpatients;
- (l) use Riskman data and reports to address areas of concerns identified through incident reporting; and
- (m) collect, analyse and report on GEHU data in order to strategically manage GEHU resources and demand for GEHU services.

ACKNOWLEDGEMENT OF THE HEALTH DIRECTORATE, IN PARTICULAR GEHU STAFF

The Health Directorate, in particular GEHU staff, are recognised for their involvement in this audit, particularly those health professionals who contributed to identifying possible solutions to address issues raised in this audit. These health professionals were able to relatively quickly identify the solutions which suggest that they had been thinking of ways to improve patient care and access prior to this audit.

2. BACKGROUND INFORMATION ON THE AUDIT AND THE GASTROENTEROLOGY AND HEPATOLOGY UNIT

- 2.1 This chapter provides background information on the audit and the Gastroenterology and Hepatology Unit (the GEHU) at Canberra Hospital.

THE AUDIT

- 2.2 A Public Interest Disclosure (PID) '*alleging prolonged maladministration of outpatient services provided by the GEHU since 2012*' was made to the Auditor-General on 27 September 2013.
- 2.3 The Auditor-General, after consulting with the PID discloser, formed the opinion that the PID should be referred to the Director-General, Health Directorate, for investigation in accordance with section 17 of the *Public Interest Disclosure Act 2012* (the PID Act). The PID was referred to the Director-General of the Health Directorate on 24 October 2013.
- 2.4 On 4 November 2013, the Director-General, Health Directorate, under section 19 of the PID Act, referred the matter back to the Audit Office for investigation. The Director-General stated that, due to:
- ... other management issues... which are underway in ACT Health, I request that the disclosure about prolonged maladministration of outpatient services by the Gastroenterology and Hepatology Unit at Canberra Hospital, be referred back to your office.
- 2.5 An investigation of the issues raised in the PID was undertaken by the Auditor-General under section 19(3) of the PID Act from November 2013 through to February 2014. This investigation showed that there had been no maladministration, as defined by the PID Act¹⁰, of the GEHU.
- 2.6 Although the Audit Office concluded that there was no maladministration, some issues along similar themes to those presented in Chapters 3 and 4 emerged from the investigation which the Auditor-General decided were best considered through a performance audit. Therefore, on 12 February 2014, the Auditor-General ceased the investigation of the PID under section 20(g) of the PID Act and a performance audit into GEHU outpatient services commenced under section 12 of the *Auditor-General Act 1996*.

¹⁰ The Audit Office confirmed this conclusion with independent legal advisors from the Office of the ACT Government Solicitor.

Audit Objective

- 2.7 To provide an independent audit opinion to the Legislative Assembly on the effectiveness of administrative and triaging practices of outpatient services provided by the GEHU at Canberra Hospital.

Audit Scope

- 2.8 The Audit Office focused on the administration of referrals and the triaging of outpatients by the GEHU from the period 1 January 2012 to 30 September 2013, with some data available up to 28 February 2014. The scope was defined as a result of a PID investigation conducted by the Audit Office (refer to paragraph 2.5).
- 2.9 The Audit Office did not examine the broader operations of the GEHU, Canberra Hospital or the Health Directorate that are not related to the provision of outpatient services by the GEHU. However, findings and recommendations from the audit may be applicable to other outpatient clinics.

Audit Criteria

- 2.10 The audit objective was addressed through examining two audit criteria; to determine if outpatient services provided by the GEHU are:
- accountable, transparent and appropriately controlled in terms of governance and management systems to provide the best possible patient care; and
 - meeting Government expectations and community needs by delivering timely, appropriate and value for money healthcare to patients.

Audit approach

- 2.11 The audit followed the Audit Office's Performance Audit Methods and Practices (PAMPr) and related policies, practice statements and guidance papers.
- 2.12 The audit approach and method consisted of:
- interviews and discussions with key Health Directorate staff, in particular those at Canberra Hospital in GEHU and a staff member in the Office of the ACT Health Services Commissioner;
 - the engagement of a specialist subject matter expert in the gastroenterology and hepatology field, Professor Paul Desmond, former Director of the Gastroenterology Department at St Vincent's Hospital Melbourne. This independent expert:
 - undertook a review of 35 patient referrals from General Practitioners (GPs) and the triaging of these by GEHU consultants

and the relevant Emergency Department records of those patients;
and

- provided an opinion as to whether the triaging of patient referrals to the GEHU delivered timely and appropriate healthcare to patients.
- interviews and discussions with key community stakeholders (e.g. Hepatitis ACT); and
- analysis of key statistical data for outpatient services provided by the Health Directorate.

The Audit Office followed all requirements of Australian Auditing Standards and relevant Australian professional ethical pronouncements in the conduct of this audit.

Previous Audits and Internal Reviews

- 2.13 In 2004 and 2011 the ACT Auditor-General reported on surgical and medical waiting lists, including references to the GEHU. The 2011 report found that wait times for the GEHU had improved during 2010, but were still outside guidelines. Recommendations included annual audits of data integrity for outpatients' waiting lists and the implementation of agreed recommendations from the outpatients redesign project, including consistent policies, practices and procedures for managing waiting lists for individual Units.
- 2.14 In February 2014 the Health Directorate commissioned a review of the administration of outpatient services (including the GEHU) at Canberra Hospital. The scope of the project is to review and evaluate the administrative support provided by Outpatient Services. The review covers:
- administration support for outpatient services across Canberra Hospital provided by Cancer, Ambulatory and Community Health Support (CACHS);
 - transcription services; and
 - administrative support provided internally through individual outpatient unit funding, from the Division of Medicine.
- 2.15 An internal audit on outpatient billing services concluded in November 2013. This identified inadequacies in the administration of medical services assessed as billable from Medicare. Although appropriate referrals existed, a high proportion of audited services were recorded and processed as non-billable, and therefore no associated revenue was collected by Canberra Hospital. The billing practices in Outpatient Services at Canberra Hospital have not been assessed by the Audit Office as they are outside the scope of this audit.

THE GASTROENTEROLOGY AND HEPATOLOGY UNIT (GEHU)

- 2.16 Gastroenterology is the branch of medicine dealing with the structure and diseases of the digestive organs.¹¹ Hepatology, a sub-speciality of gastroenterology, deals with the liver.¹²
- 2.17 The GEHU is part of the Division of Medicine in Canberra Hospital and Health Services Group, refer to Figure 2.1. The Division of Medicine is responsible for 16 outpatient units (including the GEHU) that provide services to the ACT community and neighbouring regions in NSW, particularly Queanbeyan and South Eastern NSW.
- 2.18 The majority of administrative support for outpatient services at Canberra Hospital (including the GEHU) is provided by Cancer, Ambulatory and Community Health Support (CACHS). Additional support is provided by officers in each outpatient unit (including the GEHU), managed by and responsible to the unit, not to CACHS.
- 2.19 The GEHU provides:
- inpatient¹³ care to patients with gastroenterological and hepatological diseases;
 - medical services (assessment, treatment and review of patients);
 - endoscopic procedures for inpatients and outpatients¹⁴;
 - clinics for public outpatients with viral hepatitis, liver disease, inflammatory bowel disease, gastrointestinal cancer and other complex gastrointestinal disorders; and
 - clinics for participants in the National Bowel Cancer Screening Program (the NBCSP).

¹¹ Macquarie Dictionary Accessed 28 March 2014

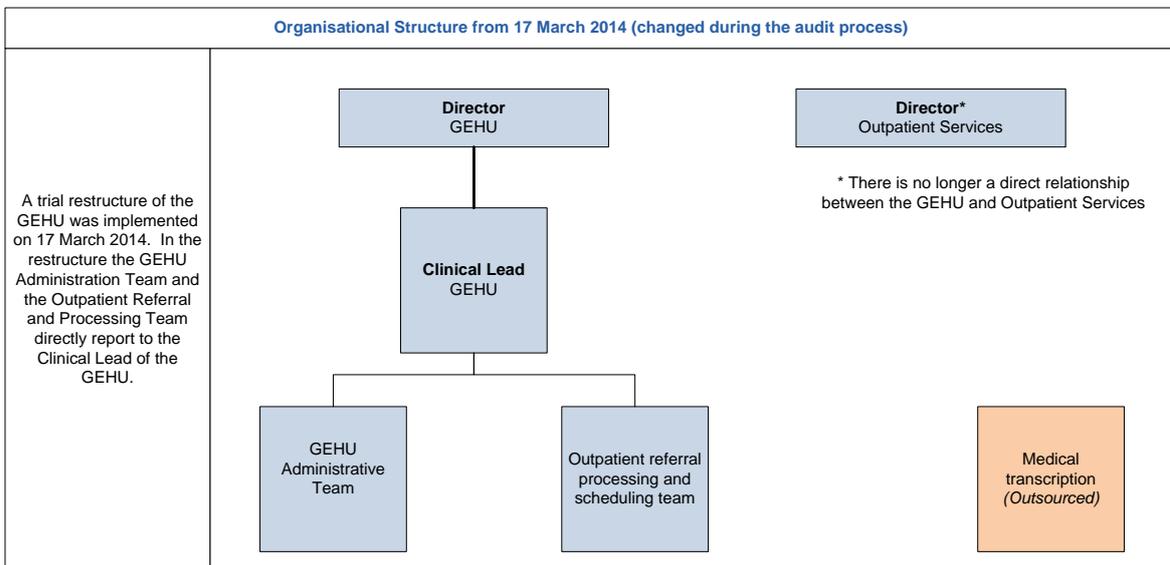
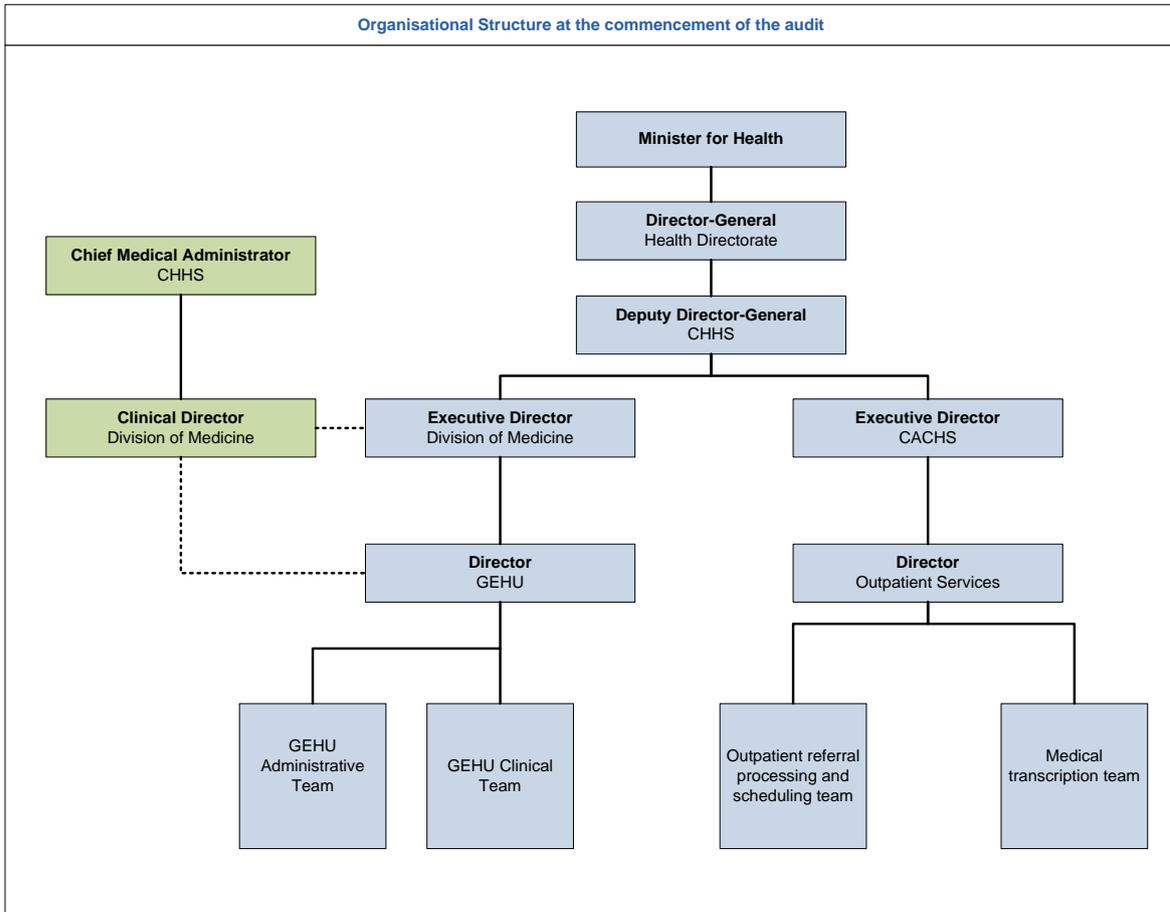
http://www.macquariedictionary.com.au/features/word/search/?word=gastroenterology&search_word_type=Dictionary

¹² Medline Plus medical dictionary <http://www.merriam-webster.com/medlineplus/hepatology> Accessed 28 March 2014.

¹³ The term 'inpatient' refers to where the patient is required to be admitted to the hospital.

¹⁴ The term 'outpatient' refers to where the patient receives treatment at a hospital but is not required to be admitted.

Figure 2.1: Health Directorate - GEHU Organisational Chart



Source: Audit Office

Outpatient services

- 2.20 Private patients would usually access specialised treatment similar to that offered by the GEHU by obtaining a referral from their physician or GP to a specialist's private clinic (a clinic facility owned and operated by a private entity and funded on a fee-for-service basis). Public patients can access specialist treatment in the public system; their referral is made out to the outpatient unit at a public hospital or to a specific consultant in that outpatient unit.
- 2.21 Once an appropriate referral¹⁵ is received by the public system (the GEHU in this instance) it cannot be refused under the *National Health Reform Agreement*. Following an appropriate referral, a patient will be seen at a clinic run by a consultant employed by the public hospital in clinic rooms provided by the hospital. Any medical procedures (usually endoscopies in the case of the GEHU), medication and follow-up appointments a patient requires, as a result of their clinic visit, can be provided using the resources of the public hospital.

Outpatient Billing

- 2.22 Outpatient services of the GEHU are bulk billed through Medicare. Bulk billing occurs when a patient assigns their right to a Medicare benefit to the service provider (consultant), allowing the fee to be paid by Medicare, under the Medicare Benefits Scheme, directly to the provider (consultant).
- 2.23 The consultant accepts the Medicare Benefits Scheme claim as full payment for services and cannot raise any additional charges.
- 2.24 In order for a Medicare Benefits Scheme claim to be made, there must be an appropriate referral¹⁶ from the patient's GP, physician or specialist to the GEHU consultant.

GEHU Employment

- 2.25 Most Health Directorate staff, including those in the GEHU, are employed under the *Public Sector Management Act 1994*. Employment conditions are specified in the enterprise agreements for each staff type:
- medical – ACT Public Service Medical Practitioners Enterprise Agreement 2011-13;
 - nursing – ACT Public Service Nursing and Midwifery Enterprise Agreement 2011-13; and

¹⁵ An appropriate referral is one for a patient that truly requires tertiary healthcare and where the primary healthcare provider (the GP) has performed all required tests and sufficient primary treatment. The issue of inappropriate referrals is discussed in paragraphs 4.105 to 4.110.

¹⁶ A valid referral, at minimum, includes the referring physician's name, their provider number or address, the date of the referral and the period of the valid referral as well as the patient's name, Medicare number, residential address, and date of birth.

- administrative – ACT Public Service Health Directorate Enterprise Agreement 2011-13.

2.26 However, Visiting Medical Officers (VMOs) are employed as contractors rather than staff members. The VMO contracts must follow the core conditions determined by the Minister for Health under section 102 of the *Health Act 1993* (notifiable instrument NI2013-381). A VMO is therefore not employed under the *Public Sector Management Act 1994*.

2.27 VMOs invoice the Health Directorate on a monthly basis for services rendered based on the hourly rates set out in the core conditions mentioned in paragraph 2.25. The scope of a VMO's services (amount of clinics provided, on-call duties, ward rounds, regular meetings and teaching and research) is specified in schedules in their contract. (The 'Right of Private Practice', discussed in paragraphs 2.29 and 2.30 does not apply to VMOs.)

2.28 The GEHU staff profile as at March 2014 is outlined in Table 2.1.

Table 2.1: GEHU Staff Profile

Staff Type/Position	Staff Number	Full Time Equivalency(FTE)
Medical		
Staff Specialist	9	6.7
Visiting Medical Officer (VMO)	6	6
Medical Staff Total	15	12.7
Nursing	17	15.4
Administrative (not including CACHS)	9	8.8
Grand Total	41	36.9

Source: Audit Office based on Health Directorate data

Right of Private Practice

- 2.29 In order to provide incentives for staff specialists to work in the public system financial rewards similar to those offered in private practice¹⁷ are included in their employment agreements. Section 154 of the Medical Practitioners Enterprise Agreement gives staff specialists in the GEHU the Right of Private Practice.¹⁸
- 2.30 The Right of Private Practice offers staff specialists, employed by the Health Directorate, the ability to receive a portion of the Medicare Benefits Scheme claim for public outpatients they treat. This is in addition to their base salary provided by the Health Directorate. Private practice revenue is earned by a specialist only if the referral is made out to them by name.
- 2.31 The GEHU receives two types of referrals from general practitioners:
- named referrals. A general practitioner refers a patient to a named VMO or staff specialist. GEHU staff specialists receive a portion of the Medicare Benefits Scheme claim for services rendered on a named referral and that portion of the fee is paid by Canberra Hospital into the staff specialist's private bank account; or
 - generic or 'not to a named specialist' (NTANS) referrals. This is where a general practitioner refers a patient to the GEHU generically (for example, by stating 'Dear Gastroenterologist' in the referral). There is no extra fee paid to Canberra Hospital for these referrals, accordingly, no extra fee is paid to the staff specialist who treats the patient above their base salary.
- 2.32 Canberra Hospital takes 20 per cent of the Medicare Benefits Scheme payment for each occasion of service provided by a named staff specialist as a facilities management fee. The remainder of the fee is provided to the staff specialist in accordance with the rules for the Right of Private Practice, with any remainder pooled in the staff specialists' Private Practice Trust Account.
- 2.33 The portion of the Medicare Benefits Scheme fee a staff specialist receives from Canberra Hospital for a named referral under the Right of Private Practice depends on which scheme they are under as defined by the Medical Practitioners Enterprise Agreement. The three schemes, A, B and C are detailed in Appendix A.

¹⁷ Such as the ability for a patient to assign their Medicare Benefits Scheme claim to a consultant in the public system.

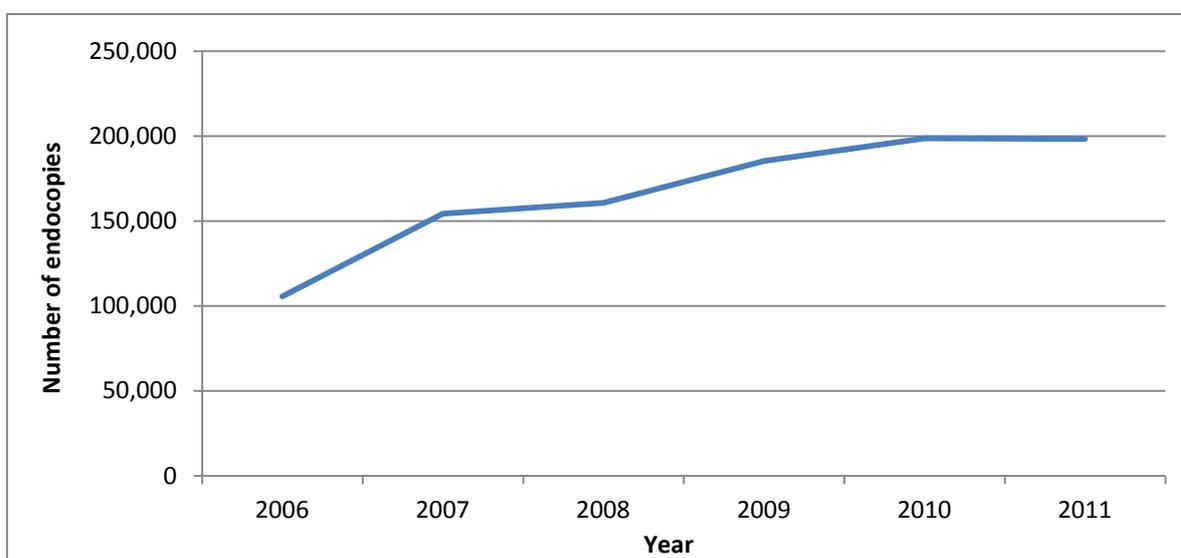
¹⁸ Staff specialists' Right of Private Practice should not be confused with their opportunity to have a second job approved, where they may work in a different, private, setting and see patients in a private context. If this is the case, it is expected that staff specialists will complete their private work in addition the hours of work for which they are employed, for example 40 hours per week for one FTE (full time equivalent).

- 2.34 Special Employment Arrangements (SEAs) can be negotiated by staff specialists, e.g. to increase the percentage of private practice revenue they are able to generate.
- 2.35 The options of Scheme A, B or C¹⁹ and SEAs result in a range of salaries among the staff specialists. In 2012–13 the total salaries paid to staff specialists ranged from \$190 000 (Band 1, Scheme A) to \$382 000 per annum (Senior Specialist, Scheme B, SEA).²⁰

GEHU DEMAND AND SUPPLY

- 2.36 There has been an increase of 100.3 per cent in outpatient services provided by the GEHU since 2006-07 with the total number of outpatient attendances increasing from 3 515 in 2006-07 to 7 040 in 2012-13. This increase is mostly due to:
- a national trend in the treatment and diagnosis of gastrointestinal problems; and
 - the implementation of the National Bowel Cancer Screening Program (NBCSP).

Figure 2.2: Total number of endoscopies in Australasia 2006 –2011



Source: Australasian Clinical Indicator Report 2004–2011²¹

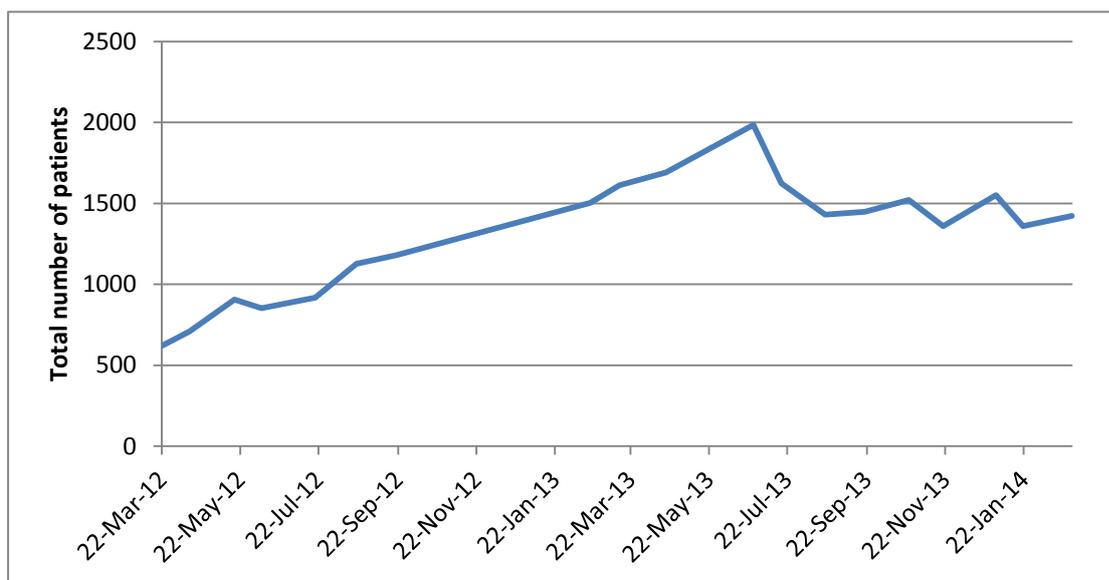
¹⁹ All staff specialists commence on Scheme A and can move to Scheme B or C after 12 months.

²⁰ These calculations are based on the 2011–13 ACT Government Medical Officers' Enterprise Agreement, and figures provided by the Health Directorate.

²¹ The Australian Council on Healthcare Standards, Gastrointestinal Endoscopy, version 1, Retrospective Data in Full.

- 2.37 While there has been an increase in outpatient services, demand has also increased and is currently greater than supply, as reflected by the outpatient waiting list. As at 28 February 2014 the GEHU had 1 422 outpatients awaiting triage or an appointment.
- 2.38 The current waiting list figure is an improvement of 81 patients (five per cent) from the same period in 2013. However, the waiting list at February 2013 was 1 503, which is an increase of 142 per cent on the March 2012 figure (621). Large increases in the GEHU outpatient waiting list have the potential to jeopardise the GEHU’s ability to provide the best possible patient care, discussed in paragraphs 4.4 to 4.8.
- 2.39 Recommendations made in this audit aim to assist the Health Directorate in reducing the GEHU waiting list, which while improved since its peak in June 2013 of 1 985, has been steady, approximately 1 500, since July 2013.
- 2.40 Figure 2.3 shows the change in the waiting list from March 2012 to January 2014.

Figure 2.3: Total number of patients awaiting an appointment



Source: Audit Office analysis of Health Directorate data.

3. GEHU GOVERNANCE

- 3.1 This chapter describes and reviews GEHU governance including accountability, transparency and controls for facilitating the delivery of the best possible patient care by the GEHU.

Conclusion

Governance of the GEHU is inadequate and this compromises its ability to align its activities with the strategic direction of the Health Directorate and to be held accountable.

Key Findings

- There was no formal service level agreement or equivalent between the GEHU and Cancer, Ambulatory and Community Health Support (CACHS) for the services provided by the Medical Transcription and Outpatient Referral Processing and Scheduling Teams. However, during audit fieldwork a review of administration functions and service models across Ambulatory Care Services (part of CACHS) commenced. The GEHU is piloting an outpatient administration structure with administration staff and health professionals reporting to the same manager. (paragraphs 3.7 and 3.8)
- The Division of Medicine Executive Meeting and the meetings between the Executive and GEHU Director are not recorded. Action items are, however, maintained for the Division of Medicine Executive Meeting but not outcomes. The lack of a record of action items and outcomes for the Division of Medicine Executive Meeting and the meetings between the Executive and the GEHU has led to:
 - a lack of accountability and transparency for decisions made by these groups; and
 - increased the risk that key decisions, including actions required as a result of these decisions, such as initiatives to improve patient care will not be carried out and followed up accordingly. (paragraphs 3.14 and 3.15)
- The Health Directorate reported that there was a lack of communication from the GEHU Director, to the Executive and to the GEHU, with information apparently not being passed up or down. (paragraph 3.11)
- Despite it being clear in the Health Directorate Corporate Plan 2012-17 and the Division of Medicine Business Plan 2013-14 that 'partnering for better health outcomes' is a key focus area, there is no formal planning mechanism whereby the GEHU also adopts this focus and shows how its actions will provide the best possible patient care. In addition there is very limited regular communication of key strategic and operational messages from the Division of Medicine Executive, through the GEHU Director, to the GEHU business meetings. The inadequacies in

the integration of the GEHU's actions with the strategic directions of the Division of Medicine could lead to doctors of the GEHU planning and directing their activities and allocating resources to areas that are not overall providing the best possible care to patients. (paragraphs 3.21 and 3.22)

- The GEHU has not been using key performance indicators (KPIs), including setting targets, to formally monitor or report on the majority of its operations. However, a number of KPIs were identified in March 2014. At the time of the audit fieldwork, 'referrals waiting for triage' was the only new KPI that was being tracked. The lack of formal monitoring and reporting (including setting targets) through key performance indicators on the majority of the GEHU's operations could lead to:
 - compromising the provision of the best possible patient care through 'partnering for better health outcomes' and other key strategies of the Health Directorate and the Division of Medicine;
 - reduced control by those charged with governance of the GEHU;
 - reduced transparency over how the doctors of the GEHU are planning, directing and allocating their activities and resources;
 - the doctors of the GEHU not being held accountable through key performance indicators for their activities; and
 - changes in demand for services and the need for re-allocation of resources not being identified in a timely manner. (paragraph 3.30 to 3.32)
- No evidence was found of a GEHU risk management plan (risk register or report including a risk treatment plan). The GEHU is not regularly reviewing or reporting on risks and therefore not identifying, rating (assessing consequences and likelihood), prioritising and planning to treat significant risks specific to providing the best possible patient care. However, the Health Directorate advised that other units in the Division of Medicine do 'not have risk registers or risk management plans and there is currently no requirement for this'. The lack of risk management at a unit level needs to be considered further. Health professionals manage risk on a daily basis in the management of patients' care; the development of a risk management plan at the unit level is a logical extension of individual patient risk management.(paragraphs 3.36 to 3.37)

GEHU WITHIN THE HEALTH DIRECTORATE

3.2 The GEHU is accountable to the Director-General of the Health Directorate through the Deputy Director-General of the Canberra Hospital and Health Services (CHHS) Group. The Director-General reports to the Minister for Health. Figure 2.1 illustrates the organisational structure of the GEHU within the Health Directorate.

- 3.3 Administrative and clinical issues and strategic and operational information are conveyed between staff and management within the structure through direct interaction and executive and management committees.
- 3.4 The Outpatient Services' Medical Transcription and Outpatient Referral Processing and Scheduling Teams are an integral component of the GEHU in providing the best possible patient care. If medical transcription and outpatient referral processing and scheduling services are not provided in a timely manner, or quality is compromised, delays in patient care can occur resulting in risks to patients. For example, if the Outpatient Referral and Processing Team does not enter a (hard copy) referral from a GP into the e-Referral system in a timely manner, triaging of the patient by the GEHU consultant is delayed. This may result in delaying the delivery of critical care. Further information on the delays and errors that can occur in the medical transcription and outpatient referral processing and scheduling services is provided in Chapter 4.
- 3.5 The GEHU had no direct control over the Medical Transcription and Outpatient Referral Processing and Scheduling Teams, refer to Figure 2.1. These teams provide a centralised service to all outpatient units in Canberra Hospital and report to the Executive Director of Outpatient Services in Cancer, Ambulatory and Community Health Support (CACHS).
- 3.6 Service level agreements, or their equivalent, can be used to formalise the arrangements for services to be provided, define responsibilities and agree terms and conditions between a customer and supplier. This provides a mechanism for accountability when direct reporting lines and control do not exist.
- 3.7 There was no formal service level agreement or equivalent between the GEHU and CACHS for the services provided by the Medical Transcription and Outpatient Referral Processing and Scheduling Teams. The lack of clear accountability in these arrangements risked a compromise to GEHU patient care. Poor quality medical transcriptions and outpatient referral processing and appointment scheduling may result in patients not being seen in a timely manner and not receiving the appropriate quality of care.
- 3.8 However, during audit fieldwork a review of administration functions and service models across Ambulatory Care Services (part of CACHS) commenced. It included 'all administration supporting outpatient services across Canberra Hospital and Health Services (CCHS) and transcription services'.²² The Audit Office met with the consultants conducting the review and they indicated that they had come to similar conclusions regarding the necessity of streamlining the organisation of administration staff within outpatient units such as the GEHU. The GEHU is piloting an outpatient administration structure with administration staff and health professionals reporting to the same manager. This took effect on 17 March 2014 for three months. This structure is shown in Figure 2.1

²² CCHS All Staff Email, 5 February 2014, Review of Administration Supporting Outpatient Services, Ian Thompson, DDG.

Recommendation 1 (Chapter 3)

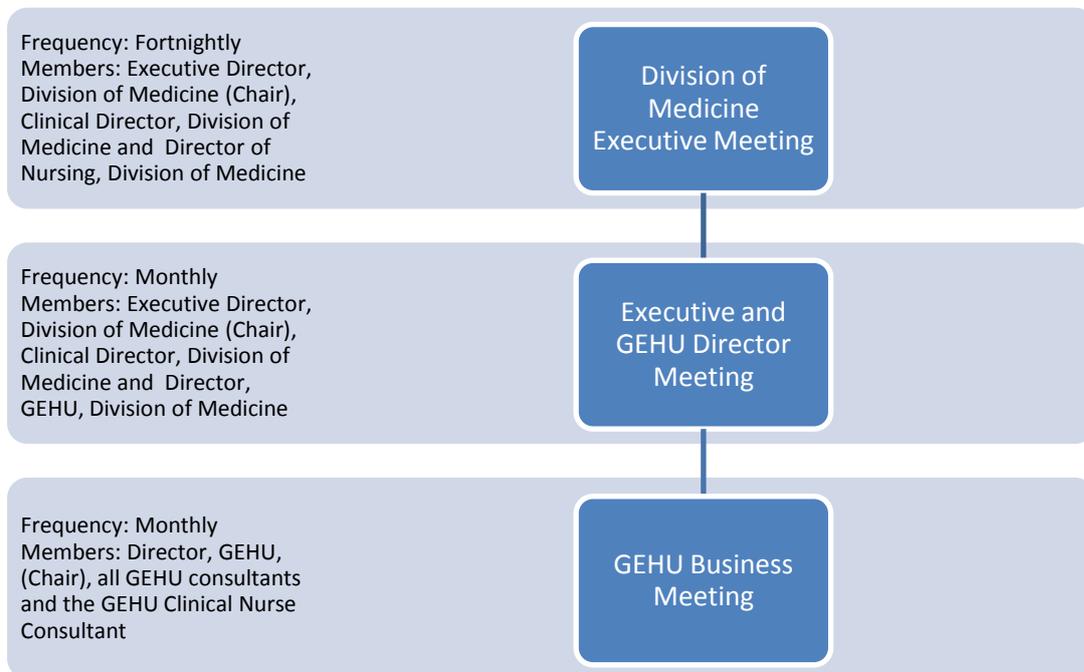
The Health Directorate should improve the governance of the GEHU by:

- (a) the three month outpatient administration structure pilot (commenced 17 March 2014) being evaluated to inform how best to provide medical transcriptions and outpatient referral processing and scheduling services;

OVERSIGHT OF GEHU

3.9 The formal arrangements for overseeing and guiding the GEHU’s operations are shown in Figure 3.1.

Figure 3.1: Oversight of GEHU



Source: Audit Office based on Health Directorate data

3.10 The Division of Medicine Executive, Executive and GEHU Director, and GEHU Business meetings are key decision-making committees and provide formal arrangements for overseeing and guiding the GEHU’s operations. It is important that information flows between these meetings in order to communicate issues and strategic planning to all levels.

3.11 The Health Directorate reported that there was a lack of communication from the GEHU Director to the Executive and to the GEHU, with information apparently not being passed up or down.

3.12 The agendas, minutes and action items (if available) for these three meetings were reviewed for the period of January 2012 to September 2013. The majority of the meetings included representation from all key stakeholders. However

there are inadequacies in the strategic direction, key performance indicators and risk management strategies for the GEHU, discussed later in this chapter.

- 3.13 Decision-making committees need to be transparent with respect to their decision-making processes so that they can be held accountable to stakeholders. Processes that should be adopted to ensure accountability and transparency of key decision-making committees include:
- documenting all decisions and any dissenting views; and
 - recording accurate meeting minutes or notes, including actions, responsibilities and dates for completion²³.
- 3.14 The Division of Medicine Executive Meeting and the meetings between the Executive and GEHU Director are not recorded. However action items are maintained for the Division of Medicine Executive Meeting but not outcomes.
- 3.15 The lack of a record of action items and outcomes of meetings between the Executive and GEHU has led to:
- a lack of accountability and transparency for decisions made at these meetings; and
 - an increased risk that key decisions, including actions required as a result of these decisions, such as initiatives to improve patient care, will not be carried out and followed up.

Recommendation 1 (Chapter 3)

The Health Directorate should improve the governance of the GEHU by:

- (b) recording action items and outcomes for the Division of Medicine Executive Meeting and the meetings between the Executive and GEHU. These should record decisions and actions agreed; be tabled and approved at subsequent meetings; and this recorded in the notes. Key messages from these meeting should be routinely communicated to staff and management.

GEHU DIRECTION

- 3.16 There have been several changes in the GEHU Director in recent years with the last person permanently appointed resigning in October 2013 after two years in the position. An appropriate replacement has not been identified despite attempts to recruit. An Interim Director has been appointed until a permanent appointment can be made. The Health Directorate advised that while these

²³ These processes are stipulated in the ACT Government's Boards and Committees Handbook which outlines the policy and best practice for conducting committee meetings, in particular the processes that can ensure effective decision making.

interim measures are in place the Division of Medicine Executive has been actively involved in GEHU management and meets weekly with the Interim Director.

- 3.17 The review of the GEHU business meeting agendas and minutes referred to in paragraph 3.113, identified a standing agenda item 'Brief report from meetings with the Executive Director of the Division of Medicine'. This was the only regular, formal way identified for the Division of Medicine Executive to communicate key strategic and operational messages to the GEHU. However, for this agenda item 'nothing to report' or 'nil' was noted for 13 (87 per cent) of the 15 meetings considered. Given that there is on average one meeting per month and that issues are likely to have emerged in this time, it seems questionable that for so many meetings there was nothing to communicate to the GEHU from the Executive.
- 3.18 In addition to regular, formal communication of key strategic and operational messages, business plans are another key communication tool for an entity to:
- define its direction;
 - detail actions, those responsible and completion dates; and
 - determine how resources are to be allocated to facilitate achieving its main objectives.
- 3.19 Business plans that include well developed key performance indicators and are regularly reviewed provide a form of oversight for those charged with governance. They also hold staff to account and provide transparency as to how an entity is managed.
- 3.20 Strategic plans exist for the Health Directorate (the Health Directorate Corporate Plan 2012-17) and the Division of Medicine (the Division of Medicine Business Plan 2013-14). These adequately outline the higher level vision, priorities, strategies and key performance indicators of the Directorate and Division. However, there is no supporting business plan for the GEHU.
- 3.21 Providing the best possible patient care is a key focus of the Health Directorate Corporate Plan 2012-17 and the Division of Medicine Business Plan 2013-14. In particular, '*partnering for better health outcomes*' is identified as a key focus area. However, there is no formal planning mechanism (a business plan) whereby the GEHU also adopts this focus and shows how its actions will provide the best possible patient care. In addition there is very limited regular communication of key strategic and operational messages from the Division of Medicine Executive, by the GEHU Director, to the GEHU business meetings.
- 3.22 The inadequacies in the integration of the GEHU actions with the strategic directions of the Division of Medicine could lead to GEHU consultants planning

and directing their activities and allocating resources to areas that are not providing the best possible care to patients. In particular:

- providing the best possible patient care through '*partnering for better health outcomes*' and other key strategies of the Health Directorate and the Division of Medicine will not be met;
- those charged with the governance, in particular the Director-General of the Health Directorate and Minister for Health, will have reduced oversight over how the GEHU consultants are planning, directing and allocating their activities and resources; and
- it will not be possible to hold the GEHU consultants accountable through key performance indicators for their collective activities.

Recommendation 1 (Chapter 3)

The Health Directorate should improve the governance of the GEHU by:

- (c) the GEHU developing and implementing a business plan that prioritises strategies and allocates resources to '*partnering for better health outcomes*' and other key strategies in the Directorate and Divisional strategic plans. The GEHU business plan should include key performance indicators (refer to Recommendation 1(d)) and be regularly reviewed, at least annually, and findings from this reported to the Division of Medicine Executive Meeting.

GEHU PERFORMANCE MANAGEMENT

3.23 Monitoring and reporting on the performance of an entity in key areas, through well developed strategic key performance indicators, provides:

- an effective and timely way to evaluate success in meeting strategic goals and indicate areas requiring improvement;
- oversight of the operations of an entity; and
- a framework for holding staff accountable for their actions and performance²⁴.

3.24 The evaluation of key performance indicators over time and against targets can also help to identify changes in demand for services and provide justification for the re-allocation of resources such as staff and/or capital and recurrent funding.

3.25 The Division of Medicine has developed a scorecard that includes national and agency specific key performance indicators. This scorecard is how the Division of

²⁴ Strengthening Performance and Accountability: A framework for the ACT Government provides further information on effective monitoring and reporting through strategic key performance indicators.

Medicine evaluates performance against its Business Plan. This is monitored on a monthly basis at the Division of Medicine Executive Meetings, refer to paragraph 3.10.

3.26 The key performance indicators in the Division of Medicine scorecard track 19 GEHU activities, nine of which are related to endoscopies²⁵ with eight related to general GEHU activities.²⁶ Key activities of the GEHU (refer to paragraph 2.19 for all activities of the GEHU) that are not covered by key performance indicators in the Division of Medicine scorecard include:

- medical services (assessment, treatment and review of patients);
- clinics for outpatients with viral hepatitis, liver disease, inflammatory bowel disease, gastrointestinal cancer and other complex gastrointestinal disorders; and
- pre-endoscopy clinics for participants in the National Bowel Cancer Screening Program.

3.27 However, the GEHU has developed a number of statistics which are tabled at the GEHU business meetings on a monthly basis. These statistics cover:

- total endoscopy procedures performed by doctors of the GEHU (inpatient and outpatient);
- total inpatient admissions;
- total outpatient attendances; and
- total outpatient 'did not attends' (DNA), cancellations and reschedules.

3.28 While these statistics are broader than the information that is collected in the Division of Medicine scorecard:

- there are only targets for three of the 19 activities for which data is collected. Targets allow an analysis of the information and determine if the desired service levels are being met. Accordingly, holding staff accountable for their actions and performance relative to these statistics is problematic, as is allocating resources according to overall need; and

²⁵ Two of the 19 relate to bronchoscopies which do not relate to GEHU patients although are preformed in the GEHU.

²⁶ Of these eight, 'Percentage of new referrals and Median waiting time for first Occasions of Service (days)' were not available on the reports examined. The other six are: 'Total GEHU Activity, Total National Weighted Activity Unit, Session Utilisation, New referrals, National Weighted Activity Unit, Average length of stay for gastro specialty and Ward separations'.

- these statistics are not regularly provided to the Division of Medicine Executive.

3.29 Outpatient Services also produces monthly statistics on referrals within the e-Referral system. These show the number of referrals which are awaiting triage; the number which have been triaged and are awaiting an appointment; and the next available appointment for each consultant. They are circulated to the managers of Outpatient Services and to the Unit Directors of each Outpatient Unit.²⁷ Again no targets have been set for these measures and the reports are not regularly provided to the Division of Medicine Executive.

3.30 The GEHU has not been using key performance indicators (KPIs) (including setting targets) to formally monitor or report on the majority of its operations. In particular, the following key performance indicators, specific to outpatient services, are not required to be reported to, and reviewed by, those charged with governance of the GEHU:

- average cost per outpatient appointment is within a set target (including corporate and administrative overhead);
- GEHU outpatient clinic occupancy rate (non-endoscopy) is within a set target. Information is collected on session utilisation, but this only measures if a doctor attends the scheduled clinic. No target has been set. Furthermore, a better measure of clinic occupancy would be to assess the total number of patients that could be seen at each clinic and then compare this with the total actually seen;
- average waiting time for GEHU outpatients (non-endoscopy) is within a set target;
- number of outpatients triaged by each GEHU consultant for the period is within a set target. A monthly report is provided by Outpatient Services to Unit Directors on total number of patients triaged which are awaiting an appointment. No target has been set. Furthermore, this information does not represent the number of outpatients triaged for the period (for example per month), it shows total patients that have been triaged and are awaiting an appointment since the doctor was allocated their first referral in the e-Referral system;
- number of outpatients treated by each GEHU consultant for the period (non-endoscopy) is within a set target. There is monitoring of this at the GEHU business meetings through the GEHU statistics report mentioned in paragraph 3.26. However again no target has been set; and

²⁷ There are a number of outpatient units – e.g. renal, neurology, cardiology, rheumatology.

- number of outpatients on the GEHU waiting list by doctor (non-endoscopy) is within a set target. A monthly report is provided by the Outpatient Services Unit to Unit Directors on the total outpatient waiting list by doctor. Again no target has been set.

3.31 However, a number of KPIs were identified in March 2014, some of which are similar to those above. At the time of audit field work, 'referrals waiting for triage' was the only new KPI that was being tracked.

3.32 The absence of formal monitoring and reporting (including setting targets) through key performance indicators on the majority of the GEHU's operations could lead to:

- compromising the provision of the best possible patient care through 'partnering for better health outcomes' and other key strategies of the Health Directorate and the Division of Medicine;
- reduced oversight by those charged with governance of the GEHU;
- reduced transparency of GEHU consultants' planning, direction and allocation of their activities and resources;
- lack of accountability of the GEHU consultants; and
- changes in demand for services and the need for re-allocation of resources not being identified in a timely manner.

Recommendation 1 (Chapter 3)

The Health Directorate should improve the governance of the GEHU by:

- (d) the GEHU developing, monitoring and reporting on key performance indicators (including setting targets) that cover all of its activities:
- endoscopy (already the subject of a key performance indicator and targets);
 - care for inpatients with gastroenterological diseases;
 - medical services (assessment, treatment and review of patients);
 - clinics for outpatients with viral hepatitis, liver disease, inflammatory bowel disease, gastrointestinal cancer and other complex gastrointestinal disorders; and
 - clinics for participants in the National Bowel Cancer Screening Program; and

GEHU RISK MANAGEMENT

- 3.33 Risk management plans are an important component of an entity's risk management strategy. Regularly reviewing and reporting on risks provides an entity with a systematic (controlled, accountable and transparent) approach to anticipating, managing and addressing significant risks relating to the entity's operations. Risk management plans often take the form of risk registers or reports that identify, rate (assess consequences and likelihood), prioritise and plan for the treatment of significant risks.
- 3.34 Similarly to the strategic planning mechanisms mentioned in paragraph 3.20, risk management in the Health Directorate is covered at the Directorate level (the Health Directorate Organisational Risk Register) and the Divisional level (the Division of Medicine Comprehensive Risk Report 2014). These registers include risk ratings, priority and treatment plans.
- 3.35 Under the Health Directorate's risk management policy and guidelines risks should be monitored at 3 tiers in the Directorate (Organisational – Tier 1, Divisional – Tier 2 and Team/Unit – Tier 3). Factors that should then be considered when escalating a risk to a higher tier are whether the risk:
- impacts several parts of the business at the current tier;
 - cannot be effectively managed at the current tier; and/or
 - will affect core objectives at the higher tier.

- 3.36 Risks should also be identified, reviewed, monitored and reported on at the GEHU level (Tier 3) but are not. No evidence was found of a GEHU risk management plan (risk register or report including a risk treatment plan). The GEHU is not regularly reviewing or reporting on risks and therefore not identifying, rating (assessing consequences and likelihood), prioritising and planning to treat significant risks specific to providing the best possible patient care.
- 3.37 The Health Directorate advised that other units in the Division of Medicine do 'not have risk registers or risk management plans and there is currently no requirement for this'. The lack of risk management at a unit level needs to be considered further. Health professionals manage risk on a daily basis in the management of patients' care; the development of a risk management plan at the unit level is a logical extension of individual patient risk management.
- 3.38 While there are risks that are specific to the GEHU in the Division of Medicine Comprehensive Risk Report 2014 (two of the six risks identified relate to the GEHU), these were identified by the Executive of the Division. This top down approach to risk management is inconsistent with the Health Directorate's policy and could lead to significant risks being overlooked.
- 3.39 Without risks being documented by the GEHU there is an increased risk the GEHU will be unable to meet outpatient demand effectively and deliver the best possible patient care. Documentation of risks could be achieved through including these in the unit's Business Plan.

Recommendation 1 (Chapter 3)

The Health Directorate should improve the governance of the GEHU by:

- (e) the GEHU documenting its risks as part of its Business Plan, and reporting (at least annually) on any risk issues to the Division of Medicine Executive Meeting.

4. DELIVERY OF SERVICES

- 4.1 This chapter examines the efficiency and effectiveness of services provided by the Gastroenterology and Hepatology Unit (GEHU). It considers two major issues: the extent to which resources are efficiently deployed to deliver gastroenterology and hepatology services; and the extent to which patients receive timely and appropriate treatment according to their triage category.
- 4.2 As mentioned in paragraph 2.8 the period of time over which these issues are assessed is from 1 January 2012 to 30 September 2013, with some data available up to 28 February 2014.
- 4.3 As mentioned in paragraph 2.12, an independent gastroenterology expert provided medical advice on the quality of triaging of GEHU outpatients. Some of the expert's considerations are presented in this chapter with those on the quality of triaging presented in Chapter 5.

Conclusion

Delivery of Services

The GEHU outpatient waiting list has not been managed effectively due to inadequate strategic management rather than a lack of resources. The GEHU's service delivery is likely to be improved through focusing actions on:

Triaging

Patients of the GEHU have not been receiving treatment within the timeframes recommended by the Health Directorate's triage categories. Addressing this will help the GEHU provide the best possible care to patients.

Clinic organisation

More initial (rather than review) appointments are needed in clinics to manage the waiting list. The process to establish new, or vary current, clinics needs to be more responsive to changes in demand.

Equitable Access

Access to GEHU consultants by patients does not occur according to a patient's medical need. A patient's symptoms (which determine their triage category) need to be the basis for their priority to see a consultant, rather than the referral type (i.e. to a named consultant (Specialist) or generic/Not to a Named Specialist) or the sub-speciality to which they were referred.

Referral processing and triage targets

Acceptance of patient referrals from GPs is not guided by referral criteria.

Furthermore, the GEHU does not have defined triaging targets or guidelines. Referral criteria, triaging targets and guidelines are needed to assist in managing the waiting list. Additionally, there is an opportunity for increased electronic processing of referrals within the GEHU and between the GEHU and GPs to reduce administration processing and the risk of referrals being lost or doubled up.

Scheduling

A patient on the GEHU waiting list, if an appointment is not booked immediately, is not informed of their probable waiting time to see a consultant or of alternative treatment options they could consider during this time. This information is particularly important for those who are likely to be on the waiting list for a lengthy period.

Tertiary health care

The GEHU is not being used effectively to provide tertiary healthcare as GPs are referring patients who require primary health care to the GEHU.

Furthermore, improving the way the GEHU and GPs work to provide 'shared care' could focus GEHU resources on the provision of tertiary health services, leaving primary services to be delivered, appropriately, by GPs.

'Open' endoscopy

Currently, other than patients referred through the National Bowel Cancer Screening Program, patients requiring an endoscopy are required to see a GEHU consultant first. An alternative is for GPs to request an endoscopy directly, after performing sufficient tests (primary healthcare) and a GEHU Senior Registered Nurse seeing patients prior to the procedure. While this 'open' endoscopy approach may have limitations, it merits further consideration.

Strategic use of data

Reporting to the Division of Medicine Executive does not include information on GEHU triaging categories and times, waiting times for appointments and whether patients attend appointments. (The majority of reporting is focused on endoscopy activity.) This level of reporting is needed so that the GEHU can be strategically managed to ensure that its resources are used to deliver services in a manner which reduces the waiting list and delivers the best possible patient care.

Incident reporting

Not all adverse events, that may be the result of poor referral, triage or scheduling practices, appear to be reported. This could be done using the centralised electronic Riskman system. This would provide information to assist in strategically managing the GEHU.

IT systems

There is a lack of integration between IT systems used in the GEHU which creates inefficiencies. Controls and logging in the e-Referral system over who can enter and change triage categories, booking and triage dates, and the status of the referral (open, triaged, booked, closed) are nonexistent. These are needed to control work flows.

Key Findings

Delivery of Services

- The GEHU has had a waiting list of around 1 500 patients during 2012 and 2013 and at the beginning of 2014; with the lowest number of patients being 621 in March 2012, and the highest being 2 000 in May 2013. As of January 2014 the waiting list was just under 1 500. The waiting list reflects an imbalance between demand and supply, despite an increase of 100.3 per cent in outpatient services provided over the past seven years. (paragraph 4.4)
- Given the number of outpatients on the waiting list, at current rates of processing (300 patients per month) it would take around 5 months to see these patients, without further patients being added to the waiting list. Some of those on the waiting list are unlikely to see a consultant at all, or at least not within a time determined by their medical condition. (paragraph 4.5)
- It is considered that the GEHU has the capacity to see more outpatients. Therefore the issue of managing the GEHU waiting list is not due to a lack of resources but inadequate strategic management. (paragraph 4.6)
- Patients waiting for treatment for longer periods than that recommended by their triage status are not receiving the best possible care. Strategic management is needed to reduce triaging, scheduling and appointment waiting times in order to reduce the GEHU outpatient waiting list. (paragraph 4.7)

Triaging outcomes

- Analysis of data to determine the effectiveness of triaging with respect to the number of patients seen within the triage category timeframe shows poor results. Referrals categorised as urgent were the least likely to meet the timeframe. This is understandable in that it is only 48 hours; however, it is 48 hours in order to manage the risk to the patient of what have been judged by an experienced clinician as serious symptoms. (paragraph 4.22 and figure 4.5)

Clinic organisation

- During 2013 the number of new referrals to the GEHU each month was significantly higher than the amount of initial appointments offered. This means that not only has the waiting list not reduced during 2013, but it has grown. If

the rate of initial appointments is maintained at this level, and not increased significantly, the waiting list for GEHU will only continue to increase, despite an increase in the total number of clinics. Management of referrals, consultants, clinics and scheduling needs to actively address what is an ongoing problem. (paragraph 4.39)

- The organisation of clinics is determined by each consultant. The current sign-off required for a new clinic, or for changes in the number of patients seen in a clinic is lengthy. The current process, while providing oversight, may decrease flexibility to provide clinics to meet changes in demand. Health professionals reported to the Audit Office that it is an unwieldy process and hampers response to changing needs within the GEHU. (paragraphs 4.29 to 4.30)

Equitable Access

- Referrals to the GEHU are either made to a specific consultant (named referrals), or as a generic/NTANS referral (Not to a Named Specialist). The distinction between named and generic/NTANS referrals is important as it effects the payment to staff specialists and to Canberra Hospital. (paragraphs 4.50 and 4.51)
- On average, the total time taken for a referral to a named specialist was 52 days between when the referral was received and the date the appointment was booked; for a generic/NTANS it was 105 days, a difference of 53 days or 102%. This is evidence that those patients referred via generic/NTANS referrals were disadvantaged. However, the effect of the different referral types is not being monitored by the Health Directorate as this analysis had not been conducted prior to the Audit Office analysis. Currently staff specialists determine how many appointments they allocate for named versus generic/NTANS referrals. This allocation creates disadvantages for those patients with generic/NTANS referrals. (paragraph 4.59 and 4.60)
- Referrals to the GEHU can be for general gastroenterology intervention, or for one of the sub-specialities, e.g. Inflammatory Bowel Disease, liver conditions and patients at high risk of gastrointestinal cancer. (paragraph 4.61)
- Audit Office analysis of referrals in Figure 4.13, shows an average wait of 64 days for an appointment for general gastroenterology referrals and 45 days for sub-speciality referrals. This is evidence that general gastroenterology patients are being triaged and scheduled for appointments more slowly than those with sub-speciality referrals. (paragraph 4.62)

Referral processing and triage targets

- Triage data from March 2012 – January 2013 shows that five consultants were up to date with triaging, with no referrals awaiting triage dated earlier than 4 February 2014. Of the other eight consultants assessed:
 - four had referrals awaiting triage dated from July 2013 or later;

- one had a referral awaiting triage dated from early 2013; and
 - two had referrals awaiting triage dated from 2012 (1 August and 4 October 2012).
- Since it is possible that some of these referrals could be triaged at Category 1 or even urgent these delays are unacceptable. (paragraph 4.16)
 - Figure 4.3 which examines the percentage of referrals triaged to each category per consultant shows a variety in triaging practice among consultants. It shows a significant range in the percentage in each triage category for each consultant. Category 1 ranges from zero to 57 per cent; Category 2 from 14 to 80 per cent; and Category 3 from 10 to 60 per cent. (paragraph 4.14)
 - The Audit Office made inquires of GEHU staff as to the use of guidelines and targets for triaging referrals. These were not in use at the time of fieldwork. (paragraph 4.17)
 - When the e-Referral system was first introduced, there was significant uptake of it by GPs, as shown in Figure 4.14. However there has been a decrease in the number of GPs using the system. As it is estimated that 95% of GPs use an electronic practice management system, the low level of e-Referral use is surprising and may indicate a lack of confidence in this system by GPs. (paragraph 4.71)
 - Faxed referrals are collected by administration staff in the GEHU and are then scanned into the e-Referral system for triaging and scheduling of appointments. There are a number of concerns regarding faxed referrals, e.g. referrals can be lost, inadvertently disposed of, or caught up with other papers. (paragraph 4.72 and 4.73)
 - Letter and fax referrals mean that the referring GP does not receive any automatic updates as to the progress of the referral and that any further information required by the GEHU from the GP has to be sought by phone or letter. (paragraph 4.75)
 - The current referral processing options adopted by consultants places patients at risk due to the possibility of lost referrals, delays in processing referrals and subsequent delays in the delivery of treatment. It also results in poor use of administration staff time by creating unnecessary double handling of a number of steps in the process. These factors all contribute to an unnecessarily long waiting list. (paragraph 4.81)

Scheduling

- A patient is booked for an appointment using the ACT Patient Administration System (ACTPAS) once a referral has been triaged. The way bookings are filled depends on the requirements of each consultant. Large numbers of patients

have been triaged but not yet booked: 1 422 at 28 February 2014 (of those 763 were awaiting triage). This is due to the difficulties experienced in the scheduling area. Stakeholders reported significant frustration with trying to contact the scheduling area by phone. Based on feedback from stakeholders, this is particularly challenging with respect to patients with liver conditions. (paragraph 4.84 and 4.85)

- The progression of only 39 per cent of Category 3 referrals to a booked appointment over 2012 and 2013 is evidence of the practice of not booking appointments for Category 3 referrals due to the number of Category 1 and 2 referrals already in the system. (paragraph 4.89)
- Some stakeholders suggested to the Audit Office that an effective way to address the lack of appointments available for patients, including Category 3, would be to suggest to them that, if able, they could access the private health system for an initial appointment, and then return to the public system, the GEHU, for further treatment and investigations such as endoscopies. (paragraph 4.90)
- Currently, a patient is notified they have an appointment by a phone call if the appointment is within the next two weeks, or a letter if the appointment is two weeks or more away. If a patient is on the waiting list and has not been scheduled an appointment they do not receive any communication from the GEHU. (paragraph 4.92)

Tertiary healthcare

- In the Australian health care system primary care is provided through general practice, with GPs referring to specialists for tertiary care, as required for more complex health needs. It was reported by health professionals that a number of the patients accessing the GEHU do not require the level of specialist, tertiary care provided at Canberra Hospital and would be more appropriately treated by GPs, either solely or as part of a shared care model with GEHU consultants. Inappropriate GP referrals contribute to the waiting list for GEHU services. Health professionals reported that many referrals do not contain the required information, such as tests completed, prior to referring the patient to a tertiary health care facility. This results in some patients using GEHU resources when they could have been appropriately managed by their GP. (paragraph 4.105)
- Some health professionals consulted during the audit suggested that inappropriate referrals should be returned to the referring GP with instructions for the appropriate tests to be performed, or primary treatment to be provided. The Health Directorate advised that there is a lack of agreement amongst GEHU specialists about returning referrals to the referring GP for more information. This needs to be addressed through the introduction of referral criteria which would provide a consistent message to GPs as to the standard of referral expected. (paragraph 4.107 and 4.108)
- To ensure that Canberra Hospital is used as a tertiary and not a primary health

care facility there is a need for referral criteria to be developed and implemented to guide which patients are scheduled an appointment. Such criteria may be warranted for other outpatient services. (paragraph 4.110)

- Shared care, the sharing of the care of a patient between a GEHU consultant and a GP, may be an appropriate model for many patients treated through the GEHU. Shared care would involve a GP in the ongoing care of the patient, with periodic checks by the consultant, either scheduled by the GEHU consultant or when the GP and/or if the patient thought it necessary. This was suggested by a number of health professionals and has the advantage of including a GP in the patient's care in an ongoing relationship. (paragraph 4.113)
- A commitment was made to conduct an extra 300 endoscopies in 2012–13 in order to address the endoscopy waiting list. As at May 2013, it was reported at the GEHU business meeting that 200 of the 300 extra endoscopies had been performed. It was stated at this meeting that the shortfall was due to the lack of progress on the refurbishment and new staff specialists commencing later than originally planned. From February 2013 to April 2013 an extra 59 endoscopes were being done each month. (paragraph 4.98)

'Open' endoscopy

- A strategy for addressing the waiting list for the GEHU, including endoscopies, would be to formalise the use of 'open' endoscopies, as suggested by GEHU health professionals. Open endoscopy is when a GP refers a patient directly for an endoscopy when it is clear to the referring GP that an endoscopy is needed, following appropriate investigations. (paragraph 4.99)

Strategic use of data

- The GEHU collects a large amount of data regarding referrals including clinic utilisation, triaging categories and times, waiting times for appointments and whether patients attend appointments. The Audit Office found that, although a number of reports are produced, other than endoscopy data, only a limited amount of this data is reported to the Executive Director level. Currently the reporting focus is endoscopies. This level of reporting is not resulting in strategic management of the GEHU, its waiting lists and resources (current or required) and the means to address the waiting list and related risk to patients. (paragraph 4.138)

Incident reporting

- Riskman is the incident reporting system used by Canberra Hospital. It is only used by one staff specialist in the GEHU. This is a missed opportunity as the reports generated by Riskman would provide information on adverse events that may be the result of poor referral, triage or scheduling practices and so provide information on how practices are impacting patient care and where to target improvements. (paragraph 4.121)

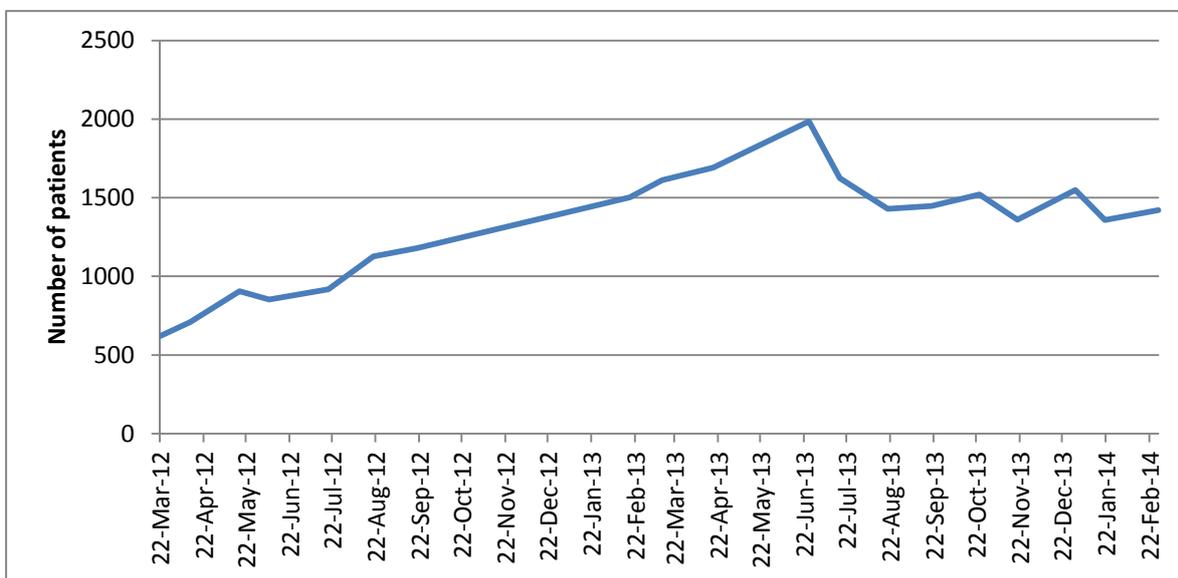
IT systems

- There are a number of IT systems, with varying degrees of compatibility and communication, used in the referring, triaging and scheduling of patients in the GEHU. The lack of integration of the systems creates inefficiencies because they are time consuming for the administration staff. (paragraph 4.122)
- The Audit Office identified that there are no automated controls in the e-Referral system to enforce restrictions on who can enter and change triage categories, booking and triage dates, and the status of the referral (open, triaged, booked, closed). While there is an audit log maintained, there is no monitoring of these logs. (paragraph 4.129)

GEHU OUTPATIENT WAITING LIST

4.4 As shown in Figure 4.1 the GEHU has had a waiting list of around 1 500 patients during 2012 and 2013 and at the beginning of 2014; with the lowest number of patients being 621 in March 2012, and the highest being 2 000 in May 2013. As of January 2014 the waiting list was just under 1 500. It reflects an imbalance between demand and supply, despite an increase of 100.3 per cent in outpatient services provided over the past seven years.

Figure 4.1: Waiting list: number of patients waiting for triage and appointment (March 2012 – January 2014)



Source: Audit Office analysis of Health Directorate data.

- 4.5 Given the number of outpatients on the waiting list, at current rates of processing (300 patients per month)²⁸ it would take around 5 months²⁹ to see these patients, without further patients being added to the waiting list. Some of those on the waiting list are unlikely to see a consultant at all, or at least not within a time determined by their medical condition.³⁰
- 4.6 However, it is estimated that, based on more strategic management to improve work practices, it may be possible to clear the current waiting list (1 422 as at 28 February 2014) in around three and half months and also see all new referrals; refer to the scenario outlined in Table 4.1. Accordingly, it is considered that the GEHU has the capacity to see more outpatients. Therefore, the issue of managing the GEHU waiting list is not a lack of resources but strategic management.

Table 4.1: Analysis of figures for addressing the GEHU waiting list – scenario

Over a four week period, and based on a conservative estimate of 140 clinics³¹, scheduling five initial (71 per cent) appointments and two review (29 per cent) appointments each clinic, this means that, in a four week clinic cycle the following patients could be seen:

- 700 initial appointment; and
- 280 review appointment.

The average rate of new referrals per four week period is 300.

On the basis of scheduling 700 initial appointments per four week period, the 300 new referrals could be accommodated with 400 initial appointments available to address initial appointments on the waiting list. (Of the 1 422 patients on the waiting list as at 28 February 2014 a breakdown of initial and review appointments was not known by the Audit Office.)

On the assumption that all patients on the waiting list are initial appointments, it would take around three and a half months (3.5 x four week cycles) to see all those patients, while continuing to see all new initial appointments and review appointments (29 per cent of clinic time).

²⁸ This is based on the Audit Office analysis of Health Directorate data and is worked out for VMOs and staff specialists only/ It does not include RN and registrar clinics.

²⁹ This is on the basis of 300 appointments per month, and a waiting list of 1 422. An initial / review appointment breakdown is not possible as the clinics vary (although 50% initial would be the highest on average) and the initial / review status of the waiting list is not known.

³⁰ It was reported to the Audit Office that Category 3 referrals are not often scheduled for appointments as the number of Category Urgent, 1 and 2 patients take all available appointments.

³¹ This is half of what is available on a clinic room basis, and less than what is available on the basis of staff specialist FTEs and so is a very conservative estimate. However, it allows for staff leave, a difference in the estimate of possible initial appointments, and DNAs. Average DNAs for July 2013 to March 2014 is 215 per month, noting no records available for September, October and November 2013. DNAs are discussed in paragraph 4.82.

Source: Audit Office analysis of Health Directorate data.

- 4.7 Patients who are waiting for treatment for longer periods than that recommended by their triage status are not receiving the best possible care. Strategic management is needed to reduce triaging, scheduling and appointment waiting times in order to reduce the GEHU outpatient waiting list.
- 4.8 Reducing the waiting list is likely to be achieved through strategically managing the GEHU and in so doing implementing a suite of actions to improve service delivery. Accordingly, this audit identified, based on a significant contribution from GEHU health professionals, some remedial actions. These are discussed in this chapter and included in Recommendation 2.

TRIAGING

- 4.9 Referrals require triaging when there is a waiting list with priority being given to those patients whose symptoms indicate the most urgent need for intervention. Once a referral is triaged, an appointment can be made, based on the triage Category: Urgent, 1, 2 or 3. Refer to Table 4.2 for triage categories and timeframes.

Triaging referrals

- 4.10 Triaging prioritises non-emergency patients' access to services based on priority of need, determined by the risk posed by the patient's symptoms. The more serious the presenting signs and symptoms, the earlier a patient should be seen. Table 4.2 shows the four triage categories and recommended time frames to be used in GEHU.

Table 4.2: Triage categories and time frames

Triage category	Time until treatment (days)
Urgent	Within 48 hours
1	Within 30 days
2	Between 30 and 90 days
3	Between 90 and 365 days

Source: Health Directorate

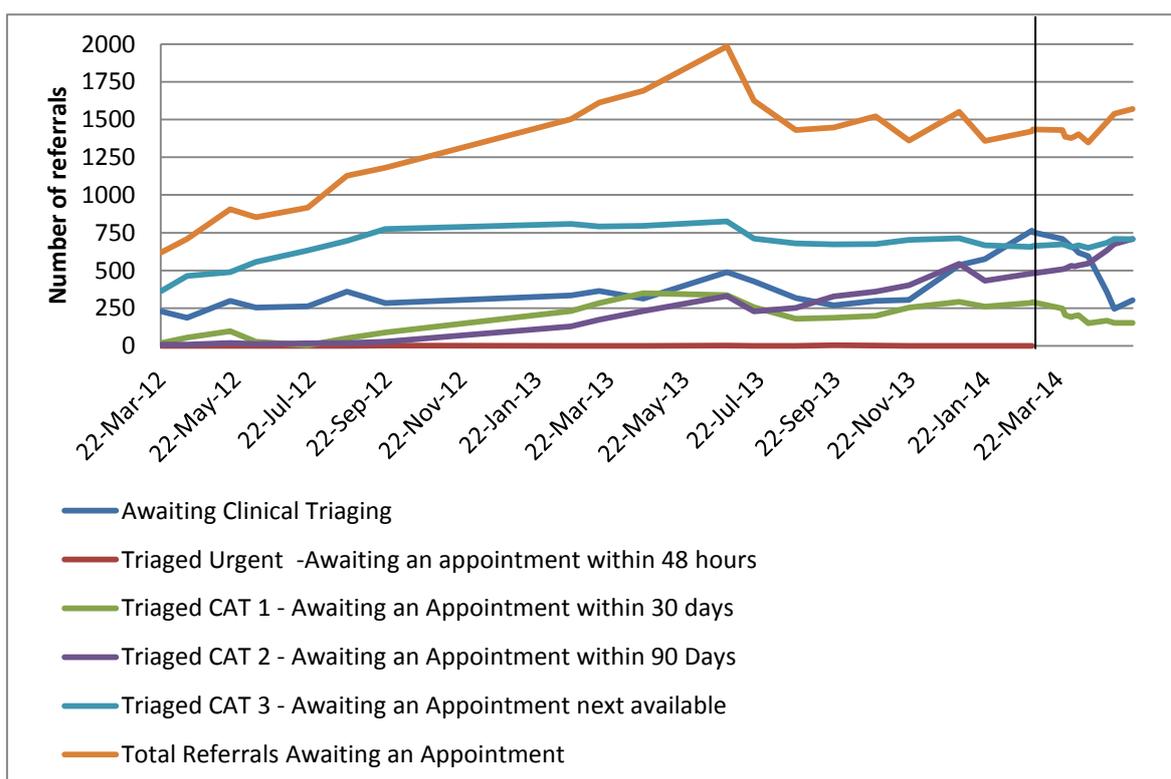
- 4.11 As at 28 February 2014, 763 referrals were awaiting clinical triage, over one half (763/1 422) of the total patients already triaged and awaiting an appointment. Referrals awaiting appointments included:
- Nil Urgent;
 - 286 Category 1;
 - 480 Category 2; and

- 655 Category 3.

4.12 Analysis of the triaging data from March 2012 to February 2014 (and more recent data to May 2014) showed a significant change in the triaging outcomes over this time, refer to Figure 4.2. The, expectedly, low percentage of referrals triaged as urgent remains consistent. However, the percentage of referrals triaged as Category 1 and 2 rose consistently over the time, while the percentage triaged as Category 3 fell consistently. This aligns with health professionals' feedback that, in order to increase patients' access to appointments, consultants triage at a more urgent level.

4.13 The independent expert stated that some cases reviewed were triaged at a higher level than expected; however, some were triaged at a lower level. It is not possible to draw conclusions about any move to triage at a higher level in order to increase a patient's access to treatment without a full analysis of referrals over that time by a gastroenterology expert.

Figure 4.2: Number of referrals awaiting clinical triage; triaged urgent, Category 1, 2 and 3, and total referrals awaiting an appointment for 22 March 2012 to 21 May 2014

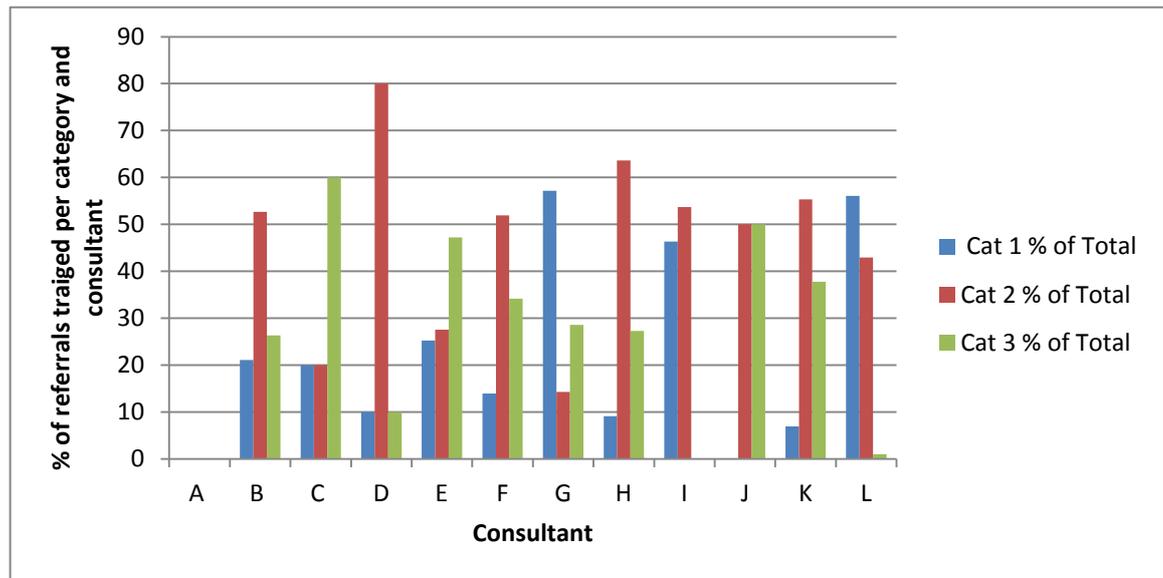


Note: Data for the 'Urgent' triage category is not available past 28 February 2014
 Note: The vertical line at February 2014 indicates the provision of new data by the Health Directorate after the completion of audit fieldwork.
 Source: Audit Office analysis of Health Directorate data

4.14 Figure 4.3 which examines the percentage of referrals triaged to each category per consultant shows a variety in triaging practice among consultants. It shows a

significant range in the percentage in each triage category for each consultant. Category 1 ranges from zero to 57 per cent; Category 2 from 14 to 80 per cent; and Category 3 from 10 to 60 per cent. These variations could be due to a range of factors including: consultant’s speciality associated with more urgent conditions and the desire of consultant for their patient to receive earlier appointment.

Figure 4.3: Percentage of referrals triaged to each category per consultant



Source: Audit Office analysis of Health Directorate data

4.15 Triage data from March 2012 – January 2013 shows that five consultants were up to date with triaging, with no referrals awaiting triage dated earlier than 4 February 2014. Of the other eight consultants assessed:

- four had referrals awaiting triage dated from July 2013 or later;
- one had a referral awaiting triage dated from early 2013; and
- two had referrals awaiting triage dated from 2012 (1 August and 4 October 2012).

4.16 Since it is possible that some of these referrals could be triaged at Category 1 or even urgent these delays are unacceptable. Case studies 1, 2 and 3 illustrate inappropriate triaging.

Case Study 1

A patient with psoriasis, on methotrexate, was referred to the GEHU having developed an abnormal liver function test. They were triaged as Category 2 and seen four months later.

The independent expert commented that they 'should possibly have been a Category 1 patient and seen earlier'.

Case Study 2

A 73 year old patient was referred to the GEHU with a positive faecal occult blood test. The patient was triaged as Category 3 (triaging took two months). An appointment was provided three months after triaging. The patient cancelled the appointment.

The independent expert commented that the patient should have been triaged as a Category 1 or possibly 2 and the five month wait for an appointment was inappropriate.

Case Study 3

A 71 year old patient, with a past history of lymphoma, was referred to the GEHU with iron-deficiency anaemia. They were triaged as Category 2 and waited three months for a clinic appointment and then had an endoscopy within one month.

The independent expert commented that the patient 'probably should have been triaged as Category 1 and seen earlier.'

- 4.17 The Audit Office made inquires of GEHU staff as to the use of guidelines and targets for triaging referrals. These were not in use at the time of fieldwork. Guidelines are readily available and have been implemented in some Australian and New Zealand hospitals. Through an internet search the Audit Office obtained a number of guidelines including from St Vincent's Gastroenterology and Liver Clinic, Melbourne, and from South Australia Health.
- 4.18 The development or adoption of guidelines for defining what indicates Urgent, Category 1, 2 or 3 could alleviate what appear to be discrepancies in triaging practices. The current practices, highlighted through the case studies above, could place patients at risk.

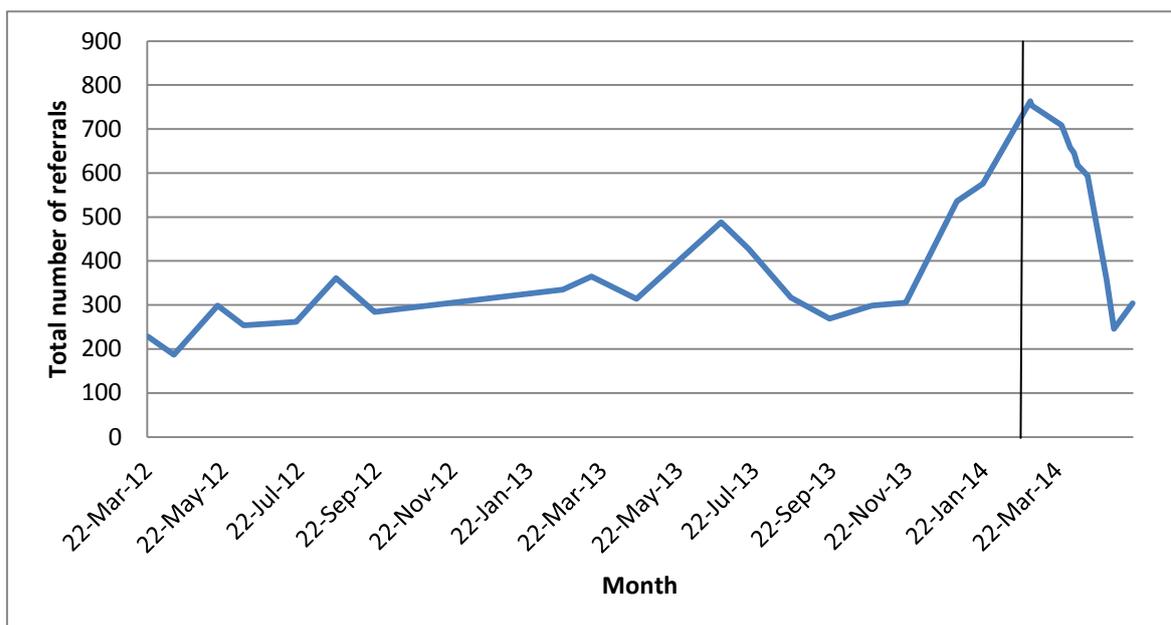
Recommendation 2 (Chapter 4)

The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (a) define targets (including specific ones for categories and the number of clients triaged per full time staff specialist) and adopt guidelines for GEHU triaging;

- 4.19 At the commencement of this audit there were no triage targets that GEHU consultants were required to meet. This is discussed under *GEHU performance management*, page 34, Chapter 2. Since the appointment of a Clinical Lead in March 2014 Key Performance Indicators (KPIs) have been introduced which include: number of outstanding referrals: to triage; to book – Category 1; to book – Category 2; to book – Category 3; percentage of Category 1 patients waiting more than one month; percentage of Category 2 patients waiting more than 3 months, and percentage of Category 3 patients waiting more than 12 months. The effective use of these KPIs, including accurate measuring, monitoring, evaluation and the implementation of any remedial action required, should assist in ensuring patients are scheduled for appointments in a timely manner, that takes into account the risk of their symptoms. This has not been the case to date.
- 4.20 There was an overall increase in referrals awaiting clinical triage from March 2012 to February 2014. However, there was a decline after February 2014 with a subsequent increase as of 21 May 2014, refer to Figure 4.4. The decrease in March and April 2014 correlates with changes in practices which were introduced in March 2014 which are discussed in paragraph 4.56.

Figure 4.4: Number of referrals awaiting clinical triage – 22 March 2012 to 21 May 2014



Source: Audit Office analysis of Health Directorate data

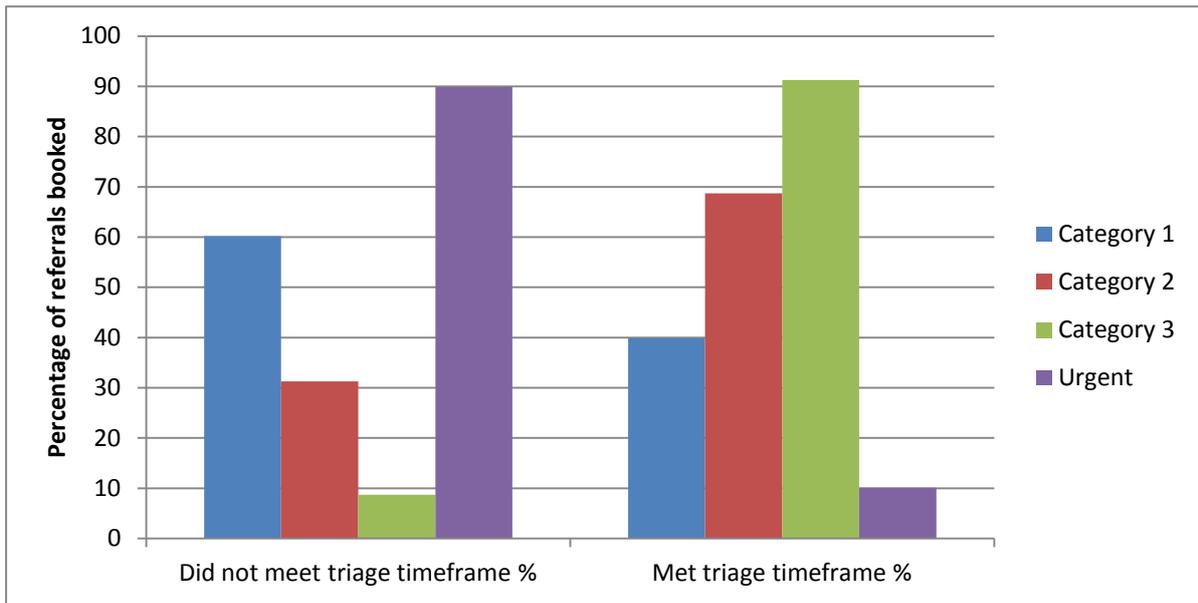
Note: The vertical line at February 2014 indicates the provision of new data by the Health Directorate after the completion of audit fieldwork.

4.21 Figure 4.4 indicates a risk to clients if Urgent and Category 1 referrals, particularly, are not being triaged. It is currently dependent on GPs to highlight and/or the Clinical Nurse Consultant (CNC) to interpret and/or the administration staff to identify urgent appointments to ensure they are triaged and an appointment scheduled within 48 hours. The systems in place should operate to remove this responsibility, especially from administration staff with no medical training who are expected to carry a much lower level of responsibility. This responsibility rests, appropriately, with the GEHU consultants. Furthermore, the lower risk, Category 3 referrals were not being scheduled for appointments and this indicates poor functioning of the systems in place in the GEHU.

Percentage of triaged patients seen within category timeframes

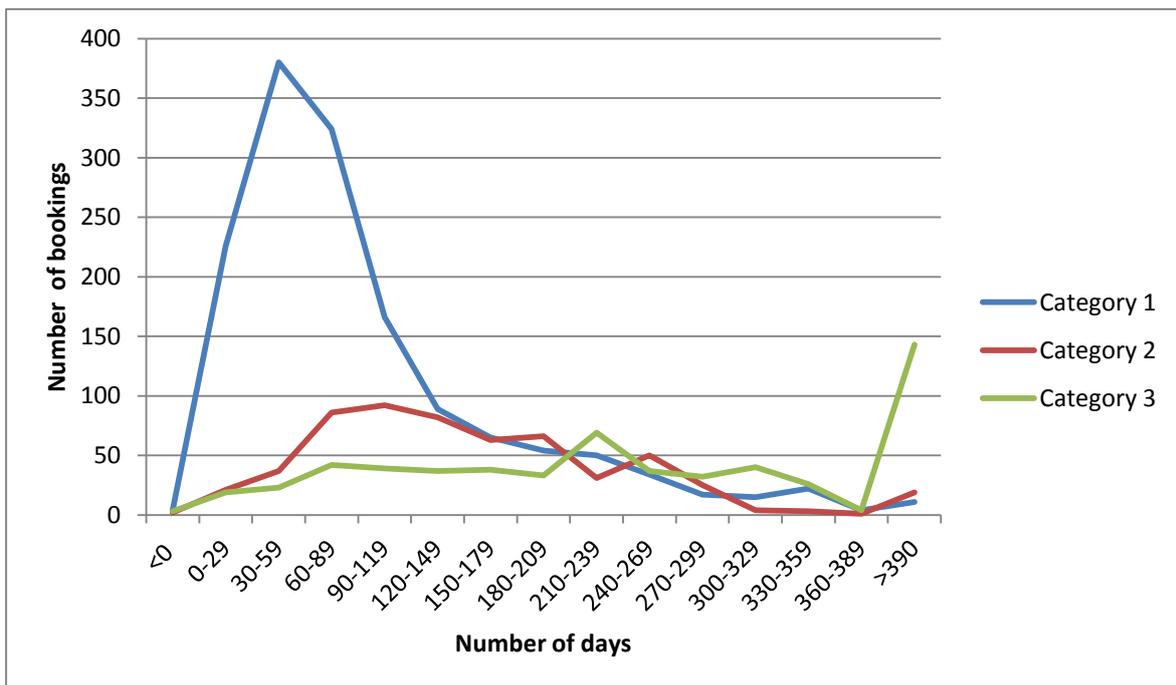
4.22 Analysis of data to determine the effectiveness of triaging with respect to the number of patients seen within the triage category timeframe shows poor results. Figure 4.5 shows referrals categorised as urgent are the least likely to meet the timeframe. This is understandable in that it is only 48 hours; however, it is 48 hours in order to manage the risk to the patient of what have been judged by an experienced clinician as serious symptoms.

Figure 4.5: Percentage of referrals booked within the triage category timeframe



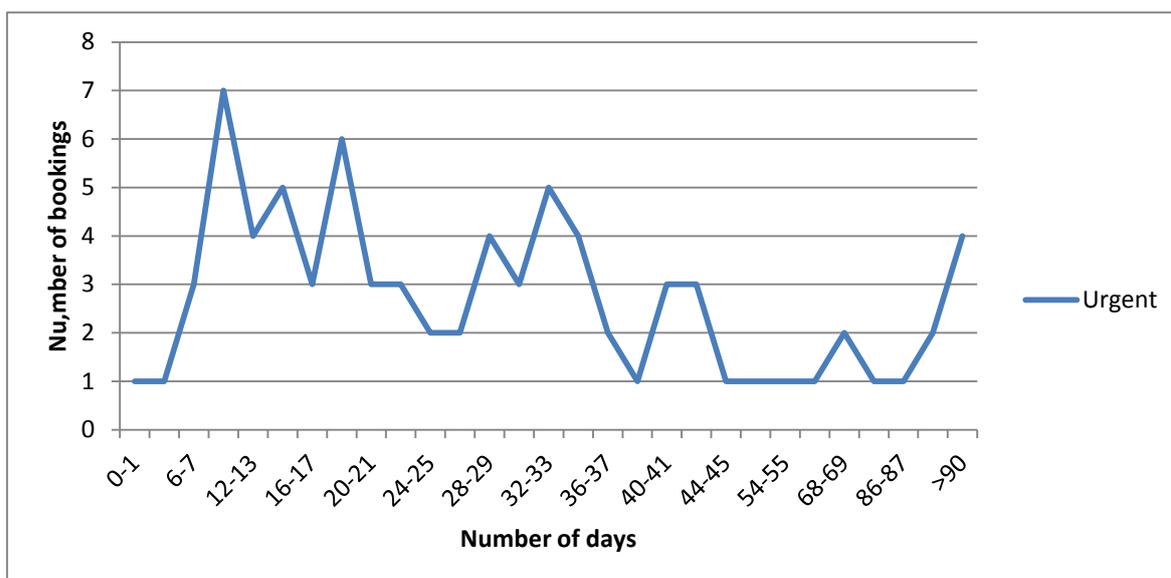
Source: Audit Office analysis of Health Directorate data 1 January 2012 – 31 January 2014

Figure 4.6: Range of days for booking referrals triaged 1, 2 and 3.*



Source: Audit Office analysis of Health Directorate data

*Urgent category was not included due to the short timeframe in which they should be seen, see Figure 4.8.

Figure 4.7: Range of days for booking referrals triaged as Urgent.

Source: Audit Office analysis of Health Directorate data

4.23 As is evident from Figures 4.6 and 4.7 the system for triaging and scheduling appointments is not meeting the timeframes determined by the seriousness of the patients' presenting symptoms. Figure 4.4 indicates that the March 2014 changes to triaging introduced by the GEHU Clinical Lead for named and generic/NTANS referrals may have addressed this to some extent, but these changes, while addressing the need for generic/NTANS referrals to be triaged, do not address the:

- hard copy triaging practiced by all VMOs and one staff specialist;
- difference in appointment scheduling for general gastroenterology and sub-speciality referrals; and
- difference in scheduling between named and generic/NTANS referrals.

4.24 Audit Office analysis found that of 3 919 individual referrals triaged since 1 January 2012, 663 (17 per cent) were triaged more than once, but only 89 (2 per cent) had their triage category changed: 63 were upgraded and 26 downgraded. This does not indicate large-scale re-triaging. Changes were made on average 55 days after the initial triage.

Risks in current referral and triaging system

4.25 A number of issues were identified that pose risks to patients in the current referral and triaging system:

- timeframes recommended for the triage category are not being met;

- there are inconsistencies in triaging named versus generic/NTANS referrals and general gastroenterology versus sub-speciality referrals;
- hard copy referrals, letters, faxes, print outs of e-Referrals, can be lost between the administration area, the consultants, and being returned to the administration area following triage;
- printing of faxed referrals can be delayed on receipt in GEHU or lost; and
- in the minutes of the GEHU Business Meeting, 14 May 2013, p 2, it was stated that, in one staff specialist's absence, his referrals waiting for triage were being returned to GPs requesting amendment to two other staff specialists.³²

4.26 Some of these risks are likely to be alleviated to a large extent through the increased use of the e-Referral system for all referrals. To achieve this, the GEHU will need to address GPs reluctance to refer electronically. GPs will have to be confident that e-Referrals are an effective way to refer patients and all consultants will have to use the e-Referral system to triage, and not continue to use hard copy referrals.

4.27 There has been some recent changes in practices with the Clinical Lead distributing all the generic/NTANS referrals among the eight staff specialists that use the e-Referral system, while the Clinical Lead is triaging those generic/NTANS referrals held over from previous arrangements. However, while some consultants continue to insist on hard copy referrals and GPs continue to fax referrals, the risk management and feedback features of the e-Referral system will not be fully utilised.

³² This is contrary to the National Health Reform Agreement. Instead of being returned to the GPs these referrals should have been distributed for triage among the other consultants as for generic referrals. This improved practice has been implemented during the time of this audit.

Recommendation 2 (Chapter 4)

The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (b) increase the use of electronic referrals to the GEHU by GPs;
- (c) require that all GEHU health professionals report incidents where patient care has the potential to be compromised because of an incident, and do this using Riskman³³;

GEHU CLINICS

4.28 The organisation of clinics is determined by each consultant. When organising clinics the consultant specifies the:

- start and finish time;
- number of appointments and their duration;
- number of review and initial appointments;
- if any appointments may be double booked or changed from review to initial;
- what conditions the clinic is for, eg Inflammatory Bowel Disease only; and
- the billing acceptable, eg public funded or Medicare Shared (bulkbilled).

4.29 The current sign-off required for a new clinic, or for changes in the number of patients seen in a clinic, includes: the Director of Outpatients, the Clinician in Charge of the Clinic and the Division of Medicine Executive Director³⁴ with final approval from the Capital Region Cancer Service (CRCS) Executive Director.

4.30 As well as the consultant involved, each clinic requires administration support and may require nursing support. An ad hoc system for new clinics, without sign off by those managers responsible for the required resources, would be unsustainable and could result in a decrease in patients seen. However the current process, while providing oversight, may decrease flexibility to provide clinics to meet changes in demand. Health professionals reported to the Audit Office that it is an unwieldy process and hampers response to changing needs within the GEHU.

³³ Riskman discussed at paragraph 4.120 and 4.121.

³⁴ Ambulatory Care Clinic Establishment Amendment Application June 2011

Recommendation 2 (Chapter 4)

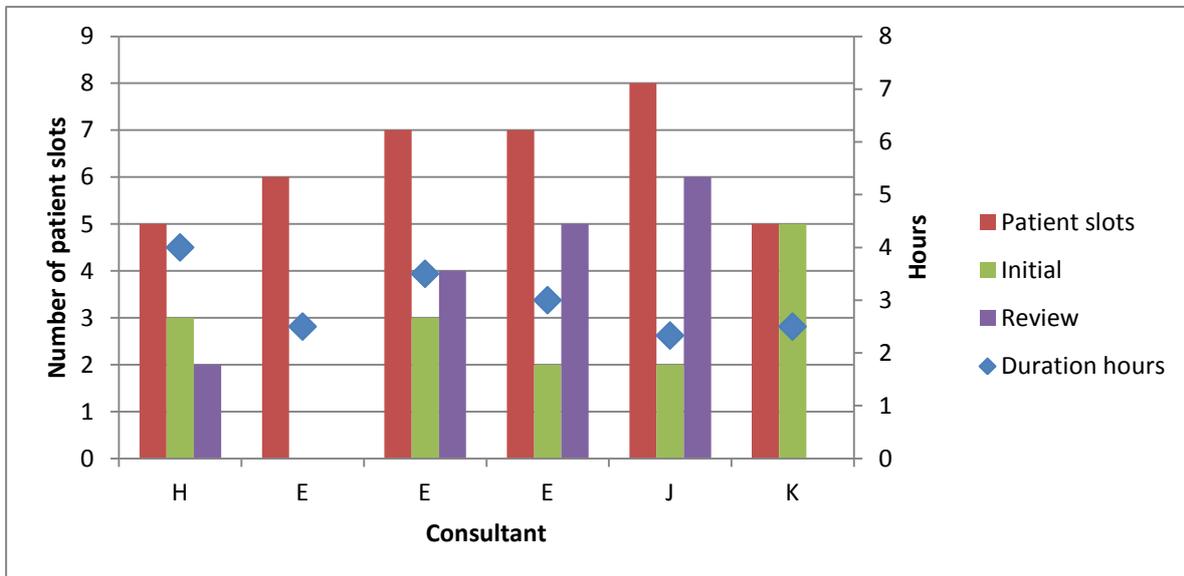
The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (d) investigate options to improve clinic organisation to be able to respond to varying patient demand;

Clinic Organisation

4.31 Figure 4.8 shows examples of five clinics for three different doctors and the proportion of initial and review appointments alongside the duration, in hours, of the clinic.

Figure 4.8: Set up of six clinics for four consultants – H, E, J and K.



Source: ACT Audit Office analysis of ACT Health data
 Note: Consultants H, E, J and K are all full time (1 FTE) staff specialists

4.32 This shows a significant difference between the approach taken by four staff specialists (no VMOs are included in this sample). A large number of patient slots does not correlate with a longer clinic but with a greater number of review appointment and a lesser number of initial appointments.

Table 4.3: Staffing of the GEHU as at March 2014, showing FTEs and possible clinics

Staff Specialists FTEs	Total Hours per week (FTE x 40)	Clinics per Week
2 x 0.2 = 0.4	16	2 clinics per week
1 x 0.5 = 0.5	20	3 clinics per week
1 x 0.8 = 0.8	32	4 clinics per week
5 x 1.0 = 5.0	200	30 clinics per week
Total: 6.7¹	268	39 per week, 78 per fortnight

Source: Audit Office analysis of Health Directorate information

Note: The six VMOs are not included in the table as they do not equate to FTEs. These numbers are based on clinics of 3- 4 hours.

Note 1: This was .5 less in 2013, for a total of 6.2 FTEs

4.33 Based on Table 4.3, with 70 clinics per fortnight³⁵, providing appointments for 5 initial patients and 2 review patients each session would result in a total of 700 initial and 280 review patient appointments for each four week period. The average referral rate per month from 1 January 2012 until 30 January 2014 was 303 (so slightly less per four week period). If sessions were organised to maximise initial appointments as calculated here, new referrals could be managed quite easily. (VMO, registrar and registered nurse clinics have not been included in this analysis which is based on the number of rooms available.³⁶) The approximately 400 extra initial appointment slots could be used to address the waiting list, 1 422 as at February 2014. Waiting lists are discussed in paragraphs 4.4 to 4.6.

Clinic Utilisation

4.34 GEHU reporting on clinic utilisation is done on the basis of four clinics per day, five days a week, over a four week period. However, utilisation is only assessed on what clinics are booked in that time, not on what clinics *could* be booked in that time.

4.35 The Health Directorate assessment of utilisation rates for March 2014 (a four week cycle) is based on 56 sessions as full utilisation³⁷, vacant sessions are listed

³⁵ This is on the basis of 7 consulting rooms, with 2 clinics in each per day, 5 days per week.

³⁶ VMOs generally provide one to two clinics per four week cycle. Registrars and registered nurses provide a number of clinics per week.

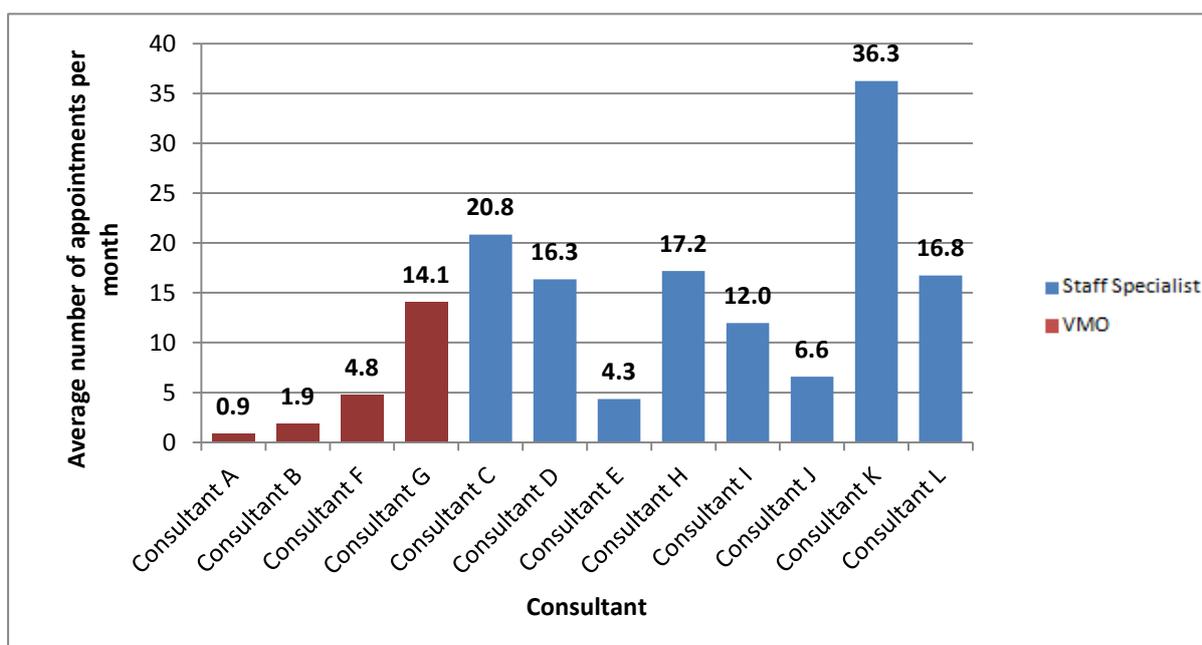
³⁷ This would be 70 according to Audit Office calculations.

as seven (it is not clear how this number is reached) and total number of possible sessions is 60, with three lost due to a public holiday. These figures result in 93.3 per cent of lists utilised.

4.36 This high rate of utilisation is misleading as the clinic timetable (procedures and consultations) used for utilisation assessment only schedules four clinics each day, with two rooms used at any time.³⁸ Since the GEHU refurbishment there are seven consulting rooms and three procedure rooms.³⁹

4.37 The current clinic timetable, provided in April 2014, shows an increased timetabling of clinics per week, with 23.5 provided by consultants, 16.5 by registered nurses and seven by registrars. If this clinic timetable is maintained, there is a greater opportunity to address the waiting lists for GEHU, although it is essential that the number of initial appointments for each clinic is high enough to make a difference.

Figure 4.9: Number of initial appointments per month, adjusted for FTE and employment commencement date, per consultant in 2013.



Source: Audit Office analysis of data provided by Health Directorate.

Note: Consultant A, B, F and G are VMOs, the remainder are staff specialists.

4.38 Figure 4.9 shows a significant variation in the number of patients seen for initial appointments by each consultant. Consultants A, B, F and G are VMOs and so you would expect a lower number of consultations overall as VMOs provide less clinics per week. However, consultants E, J and I are all staff specialists⁴⁰ and

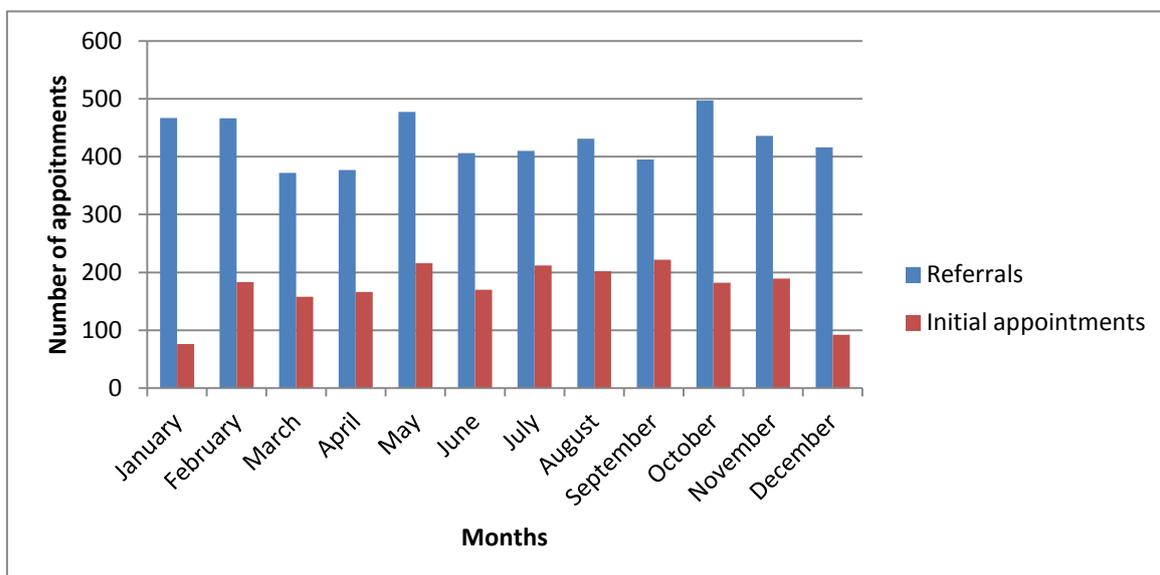
³⁸ This is a low usage rate, given the available number of consultants, particularly when 20 available clinic slots are free.

³⁹ The procedure rooms are sometimes used for respiratory procedures, however, some GEHU procedures are done in Medical Imaging.

⁴⁰ Consultants C and D are staff specialists employed at .2 FTE.

have similarly low numbers of initial appointments. The Audit Office was not able to examine the reasons for this variation as staff specialists do not keep diaries or account for their time on a regular basis.

Figure 4.10: Referrals against initial appointments for GEHU for 2013



Source: Audit Office analysis of data provided by Health Directorate.

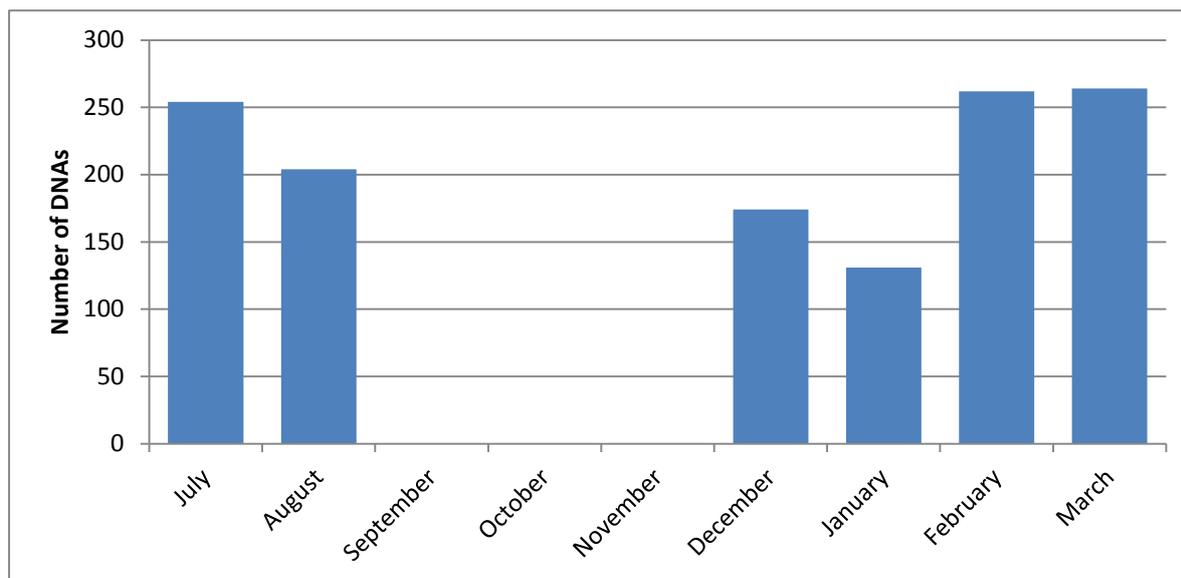
4.39 Figure 4.10 shows referrals compared to initial appointments in the GEHU for 2013. It is evident that referrals are significantly higher than initial appointments each month⁴¹, meaning that not only would the waiting list not have been addressed during 2013, but it would have grown. If the rate of initial appointments is maintained at this level, and not increased significantly, the waiting list for GEHU will only continue to increase, despite the increase in clinics. Management of referrals, consultants, clinics and scheduling needs to actively address what is an ongoing problem.

Non-attendance at Clinics (DNAs)

4.40 A concern expressed by a number of GEHU staff was the number of people who did not attend (DNA) appointments at the GEHU. This leads to a lack of utilisation of resources when there are a significant number of patients waiting for appointments. The rate of DNAs for the GEHU for July 2013 – March 2014 is shown in Figure 4.11.

⁴¹ Not all referrals are for initial appointments as some patients referrals expire before they are due for a review appointment.

Figure 4.11: Number of DNAs in GEHU from July 2013 to March 2014⁴²



Source: ACT Health – Gastro Monthly Stats (2013–14) March 2014

Note: There was no data available from the Health Directorate for September, October and November 2013.

Note: The average DNA rate over the six months for which there is data is 215 per month. If January is removed (holidays may skew the data) it is 231.

4.41 Some outpatient clinics avoid DNAs through calling or sending an SMS to patients the day prior to their appointment. This is common practice in the private health system. The new *clinic set up forms* ask if the clinic is ‘taking part in SMS Reminders?’. It appears that this continues to be at the discretion of the consultant, and it was reported to the Audit Office that patients also have to opt-in to receive these SMS reminders.

4.42 GEHU staff reported that another factor that contributes to the high DNA rate is the length of time between a patient being referred and being allocated an appointment. This results in some patients:

- seeking care in the private system;
- deciding they no longer need an appointment;
- experiencing an increase in their symptoms and so being treated earlier; or
- moving from the address they were at when the referral was made, and so not knowing they have an appointment.

4.43 The current practice of only calling patients if they are allocated an appointment within two weeks of referral, and sending letters to other patients to inform

⁴² Note: data was not available from the GEHU for September, October and November 2013.

them of their appointment⁴³ will not address that part of the DNA rate due to patients no longer living at the same address as when referred.

- 4.44 This issue could be addressed, at least in part, through: letters to all registered patients which include anticipated waiting times and alternative treatment options; and the increased use of the e-Referral system by GPs and consultants.
- 4.45 Another factor in the DNA rate is the number of multiple referrals in the system. This is the result of GPs re-referring when they do not receive feedback as to the progress of their referral; and inadvertent doubling up in the scheduling system by administration staff. An internal audit was conducted in 2013 to check for multiple referrals in the system, and to remove them, and this decreased the number on the waiting list. There is now an annual program of audits to check data integrity across outpatients units and the GEHU will be audited on an annual basis.

Specialist clinics

- 4.46 A number of specialist clinics are available within the GEHU. This should result in enhanced care for patients whose symptoms place them within those clinics. This is not always the situation in the GEHU as shown by the Case Study 4.

Case Study 4

A 49 year old patient with chronic hepatitis C and liver function tests showed a moderately elevated enzyme. They were triaged as Category 2 and an appointment was made for eight months later.

The independent expert commented that while the triaging was appropriate the wait was too long.

- 4.47 The independent expert's comment that the wait was too long for this patient raises concerns as liver clinics, one of the subspecialties of the GEHU, are scheduled frequently. The timetable for GEHU outpatient clinics in 2013 lists 18 liver clinics each week. This includes junior medical officer clinics (4), registered nurse clinics (7), and consultant clinics (7). Assuming the patient above needed to see a consultant and each consultant clinic was to see two initial referral patients, this would result in a wait of eight months if there were already 448 patients, triaged at category 1 or 2, requiring an initial appointment ahead of this patient. However, in 2013, two of the staff specialists specialising in liver patients saw more than 1 500 patients between them in total, however, less than 300 were initial appointments. This would explain why this patient's wait was assessed as too long by the independent expert.

⁴³ This may be some months after the referral was made and so the patient's contact details may have changed.

- 4.48 No guidelines or directions have been developed to inform GEHU consultants as to how to structure their clinics, so consultants have complete autonomy in this area. For example, consultants have control over the amount of clinics offered to treat named or generic referrals, initial consultations versus reviews and appointments for sub-specialities such as dedicated liver or inflammatory bowel disease (IBD) clinics. Consultants also control the number of appointments they offer in a particular clinic and pass this guidance to the administration services unit for booking patients. More initial appointments need to be allocated by consultants in order to address the waiting list.
- 4.49 It is evident from the current clinic timetable that most of the clinics are provided for sub-specialities and not general gastroenterology patients. This has resulted in a decreasing number of general gastroenterology patients being seen, and a decrease in available appointments for general gastroenterology patients. If a general gastroenterology referral was also a generic/NTANS referral, the patient referred would have experienced a delay in their initial appointment due to both these factors, neither of which have anything to do with the seriousness of their condition. It is important that clinics in the GEHU are structured to address the lack of initial and general gastroenterology appointments. The current situation does not provide equitable treatment for all GEHU patients.

Recommendation 2 (Chapter 4)

The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (e) specify initial appointments per clinic and the type of patients seen in each clinic (general or sub-speciality) to provide clear direction on the work they are expected to complete in a four week clinic cycle;

Named and generic (NTANS) referrals

- 4.50 Referrals to the GEHU are either made to a specific consultant, named referrals, or as a generic/NTANS (not to a named specialist) referral.

Named referrals

- 4.51 Named referrals are, automatically or manually, assigned to the named consultant for triaging. The distinction between named and generic / NTANS referrals is important as it effects the payment to staff specialists and to Canberra Hospital. GEHU staff specialists earn income in two ways: their salary and an 'allowance in lieu of private practice', commonly termed their 'Right of Private Practice'. The amount of the allowance depends on which scheme the staff specialist is in, A, B or C⁴⁴ or if they have a Special Employment Agreement

⁴⁴ Part of the ACT Public Service Medical Practitioners Enterprise Agreement 2011–13. A new agreement is currently being finalised. This is discussed at paragraph 2.34 and the Schemes are shown in Appendix A.

(SEA) (discussed in detail in paragraphs 2.34 to 2.36). The amount paid as the 'allowance in lieu of private practice' depends on the number of patients they see that are referred directly to them, i.e. a named referral. Generic/NTANS referrals do not attract the additional, 'Right to Private Practice' allowance.

- 4.52 Payments for patients who are treated by the GEHU following a named referral are paid by the Medicare Benefits Scheme to Canberra Hospital. Canberra Hospital retains 20 per cent of the funds (facility fee) with the remainder being paid to the staff specialist or pooled in the staff specialists' education fund (Private Practice Trust Account). The way in which the payment to the staff specialist is calculated varies according to the Scheme (A, B or C) or the SEA of which the particular staff specialist is a member.⁴⁵

Generic / (NTANS) referrals

- 4.53 Generic/NTANS referrals are written out to the GEHU generally with no consultant named. They may be made by a GP: (perhaps new to the area) who is not familiar with the consultants available; or who does not trust the waiting list information, for each consultant, available on the ACT Health website⁴⁶, and so makes a general referral in the hope of obtaining the earliest available appointment.

- 4.54 Generic/NTANS referrals do not attract a fee from the Medicare Benefits Scheme for the treating doctor, or for Canberra Hospital. In the past they have been treated differently to named referrals with some consultants refusing to accept generic referrals, and asking that they be returned to the GP. The document, *GP advice re referral to GEHU, 2013*, includes:

Referral of new patients: Please address to a specific named consultant and mail or fax to the GEHU. Our fax number is 6281 5179. We do not accept "no named referrals". All referrals must be addressed to one of the specialists who will triage the referral.

- 4.55 Rejection of referrals on this basis is contrary to the current National Health Reform Agreement (NHRA) in which the ACT is a partner.
- 4.56 In the past generic/NTANS referrals were being distributed to the GEHU Director (a VMO) for triage, where they accumulated, with their triage category not yet determined.⁴⁷ The GEHU Clinical Lead, appointed in March 2014, is now distributing all generic/NTANS referrals to the eight staff specialists that triage on the e-Referral system.

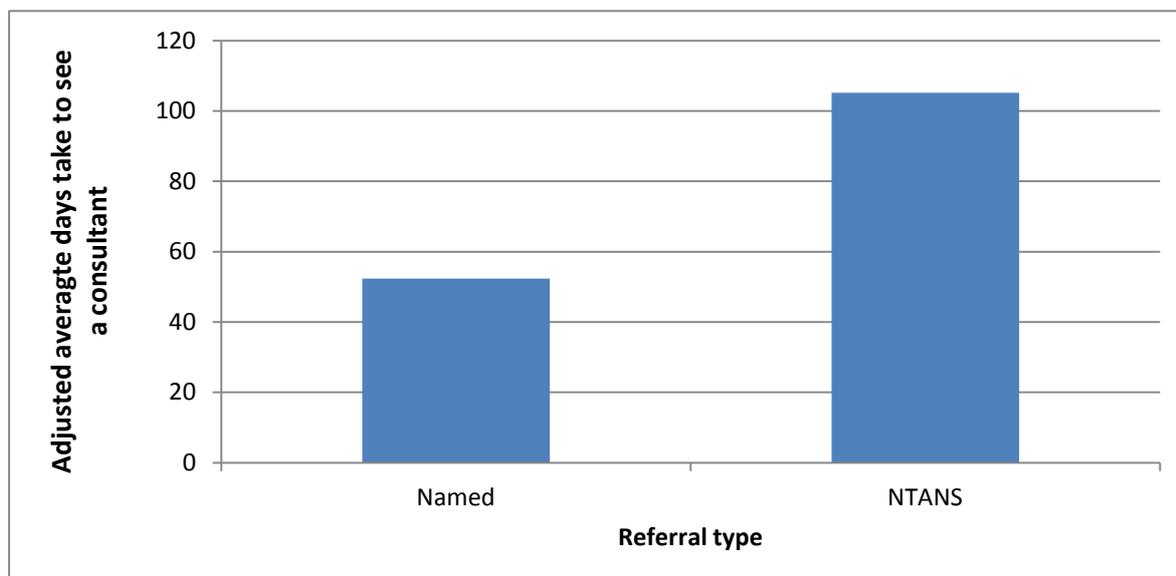
⁴⁵ Staff specialists' Right of Private Practice should not be confused with their opportunity to have a second job approved, where they may work in a different, private, setting and see patients in a private context. If this is the case, it is expected that staff specialists will complete their private work in addition the hours of work for which they are employed, for example 40 for one FTE (full time equivalent).

⁴⁶ When the audit office checked this web site in March 2014 the information was out of date.

⁴⁷ This is particularly problematic if the Director is a VMO and so mostly working off-site.

- 4.57 The earlier practice of all generic/NTANS referrals being distributed to the GEHU Director presented a risk to patients. This was a higher risk for patients who may have been triaged as an Urgent or Category 1 patient, and their treatment was delayed as a result of having a generic referral. At the commencement of this audit there was not a practice in place to address generic referrals in a strategic way; the practice was ad hoc, may have put patients at risk, and depended on the willingness of certain consultants to take responsibility for these referrals and forgo the income they could earn treating patients with named referrals.
- 4.58 The Clinical Lead is also electronically triaging those generic referrals not triaged to date. This will decrease a number of the current risks involved in hard copy referrals with only five consultants continuing to triage using hard copy referrals. Electronic triage will also provide ongoing feedback to those GPs who refer electronically.

Figure 4.12: Comparison of average days taken to see a consultant based on named or NTANS referral



Source: Audit Office analysis of Health Directorate data.

- 4.59 As shown in Figure 4.12, on average, the total time taken for a referral to a named specialist was 52 days between when the referral was received and the date the appointment was booked; for a generic/NTANS it was 105 days, a difference of 53 days or 102%. This is evidence that those patients referred via NTANS/generic referrals were disadvantaged. However, the effect of the different referral types is not being monitored by the Health Directorate as this analysis had not been conducted prior to the Audit Office analysis.
- 4.60 Currently staff specialists determine how many appointments they allocate for named versus generic/NTANS referrals. Figure 4.13 shows that the current allocation disadvantages for those patients with NTANS/generic referrals.

General and sub-speciality referrals

4.61 Referrals to the GEHU are either for general gastroenterology intervention, or for one of the sub-specialities. The sub-specialities provided in GEHU include:

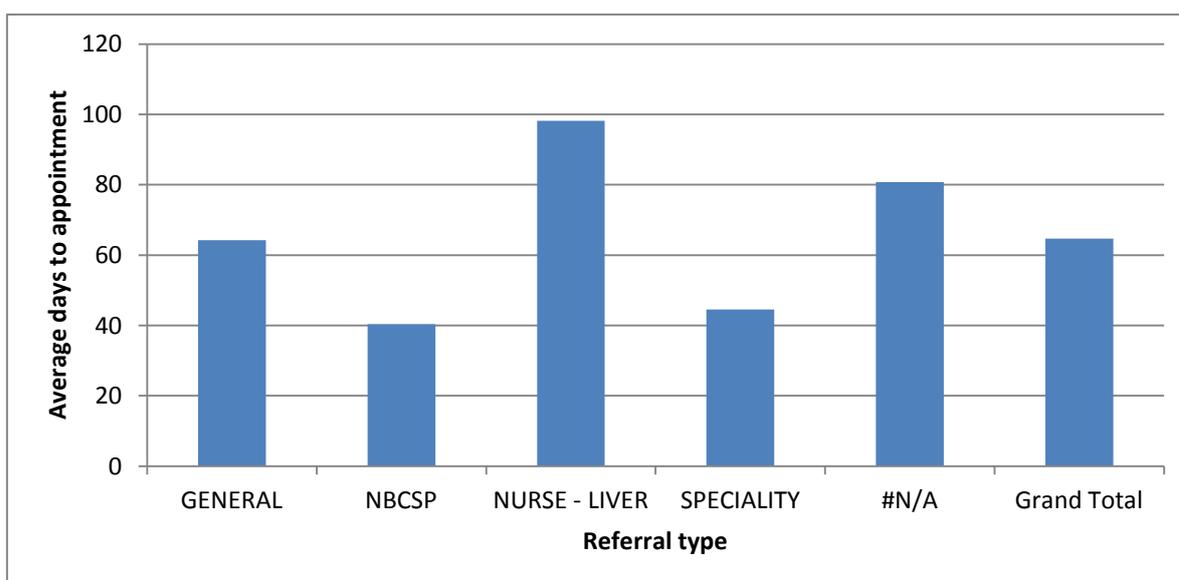
- Inflammatory Bowel Disease (IBD);
- Liver conditions including patients post transplant, with tumours, Hepatitis and Fatty Liver; and
- Patients at High Risk for Gastrointestinal Cancer.

Referrals for general gastroenterology (non-specialist)

4.62 Health professionals reported that some consultants refuse to see general gastroenterology referrals, choosing to treat only patients with conditions in their area of sub-speciality. This has resulted in patients requiring general gastroenterology treatment waiting longer than those whose symptoms fit one of the current sub-specialities available at GEHU. Audit Office analysis of referrals in 2013, shown in Figure 4.13, showed an average wait of 64 days for an appointment for general gastroenterology referrals and 45 days for sub-speciality referrals.

4.63 Figure 4.15 shows a comparison of days to appointment booked for general and sub-speciality referrals.

Figure 4.13: Comparison of days to appointment booked for general and specialist referrals



Source: Audit Office analysis of Health Directorate data

Note: #NA refers to those referrals in the sample not matched with an appointment due to data difference.

Note: Patients seeing registered nurses in the liver clinic wait a long time, nearly 100 days. The organisation of the liver clinics was not examined in detail; however, stakeholders reported concerns about these clinics in particular.

- 4.64 The following case study, examined by the independent expert, illustrates this difference between patients referred to sub-specialities available in the GEHU, and those who have a general referral.

Case Study 5

A 35 year old patient with a change in bowel habits, and queried Irritable Bowel Syndrome, was triaged as Category 2, seen within one month and a procedure was then performed quickly.

The independent expert commented that the patient was ‘seen very quickly’.

(There are Inflammatory Bowel Disease Clinics offered by the GEHU and this is likely to be why this patient was ‘seen very quickly’.)

- 4.65 Analysis of 2013 GEHU Outpatient clinics, Table 4.4, shows the low number of general gastroenterology clinics per week, particularly compared to those assigned to treating patients with liver conditions.

Table 4.4: Types and numbers of different GEHU clinics per week.

Clinic	Consultant Clinic	Registered Nurse Clinic	Junior Medical Officer Clinic	Other Clinic	Total
Liver	7	7	4		18
Gastro	7	2	4		13
IBD*	5	4	1	2 (Trial)	12
High Risk	1				1

*IBD: Inflammatory Bowel Disease

Source: Audit Office Analysis of Health Directorate Data

- 4.66 The emphasis on sub-speciality clinics with 31 sub-speciality clinics (70 per cent and only 13 general gastroenterology clinics (30 per cent), may pose a risk to patients with a general gastroenterology referral, and is not an effective and efficient use of GEHU resources. Audit Office analysis, not done by the Health Directorate, shows evidence that general gastroenterology patients are being triaged and scheduled for appointments more slowly than those with sub-speciality referrals. Figure 4.15 shows this comparison. To ensure effective and efficient use of GEHU resources, clinic type (general or sub-speciality) should be based on demand resulting from referrals, not on the preference of GEHU consultants.

- 4.67 The situation presented by the named and generic/NTANS referrals, created an inequitable system for patients, as the timeliness of their appointments depended on whether or not they had a named referral or were referred to a sub-speciality of gastroenterology, not solely on the urgency of their symptoms. As of March 2014, after this audit had commenced, the named/generic referral practice was changed. These changes need to be monitored to ensure their ongoing implementation.

Recommendation 2 (Chapter 4)

The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (f) develop a process to guide clinic appointments being organised according to the urgency of a patient's symptoms (their triage category) and not according to referral type (named or generic/NTANS; or general gastroenterology or sub-speciality);

Referrals to GEHU

- 4.68 Most referrals to the GEHU are made by GPs, electronically, by fax or by letter, to either a specific consultant (named referral) or to the GEHU (a generic or Not to a Named Specialist (NTANS) referral). Some referrals are received from Canberra Hospital Accident and Emergency Department, when the referring registered medical officer visits the GEHU, books the appointment and informs the patient.⁴⁸

Electronic referrals

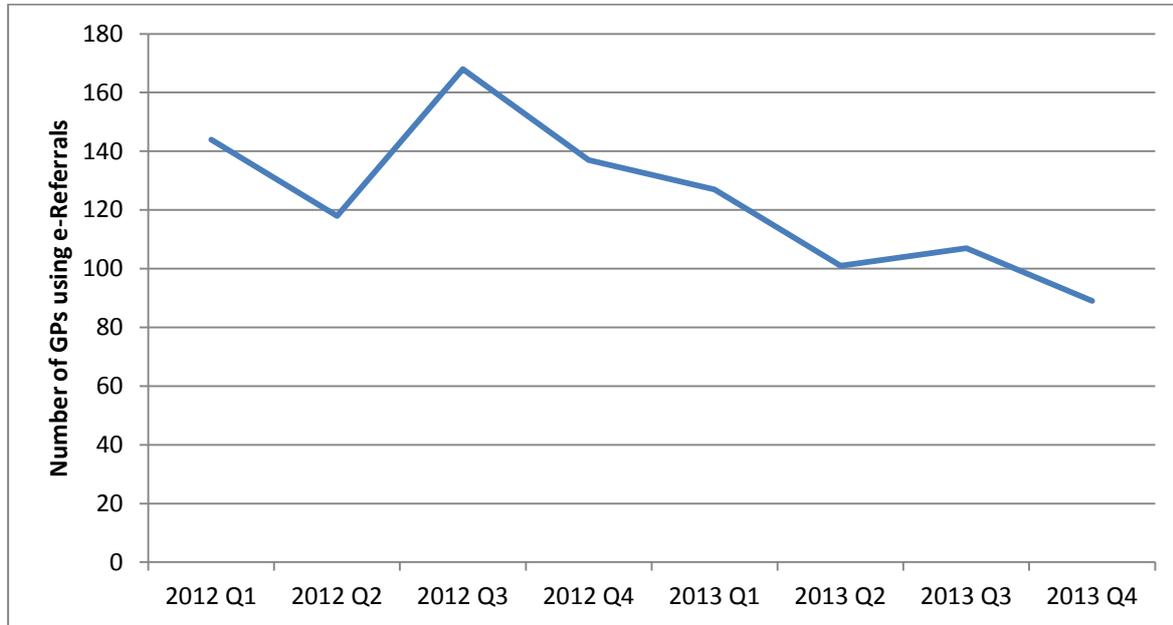
- 4.69 Electronic referrals, through the Health Directorate's e-Referral system, are done from a GP's rooms and rely on that GP using a complementary electronic practice support system. The system automatically populates many of the required fields in the referral. While ever the referral continues to be processed in the e-Referral system the GP will be informed of its progress, for example: referral triaged, appointment made, appointment attended. Feedback can also be provided to the GP electronically if more information is required in the referral before it can be accepted and triaged.⁴⁹
- 4.70 Those consultants who triage referrals in the e-Referral system maintain the feedback loop to the GP and eliminate any risk of (hard copy) referrals being misplaced. While it was reported to the Audit Office by some health professionals that it takes longer to triage patients in the e-Referral system than

⁴⁸ This was previously done through patient discharge summaries requesting a clinic.

⁴⁹ This feedback is usually provided by the triaging GEHU consultant, and so a referral lacking in information may delay the scheduling of an appointment.

using hard copies, there is time saved in not having to contact GPs for more information or to notify them of progress. There is also likely to be a decreased risk of poor and untimely communication between the consultant and the GP using electronic triaging⁵⁰; and a significant time saving for administration staff when the e-Referral system is used throughout the entire process.

Figure 4.14: Number of GPs using e-Referrals



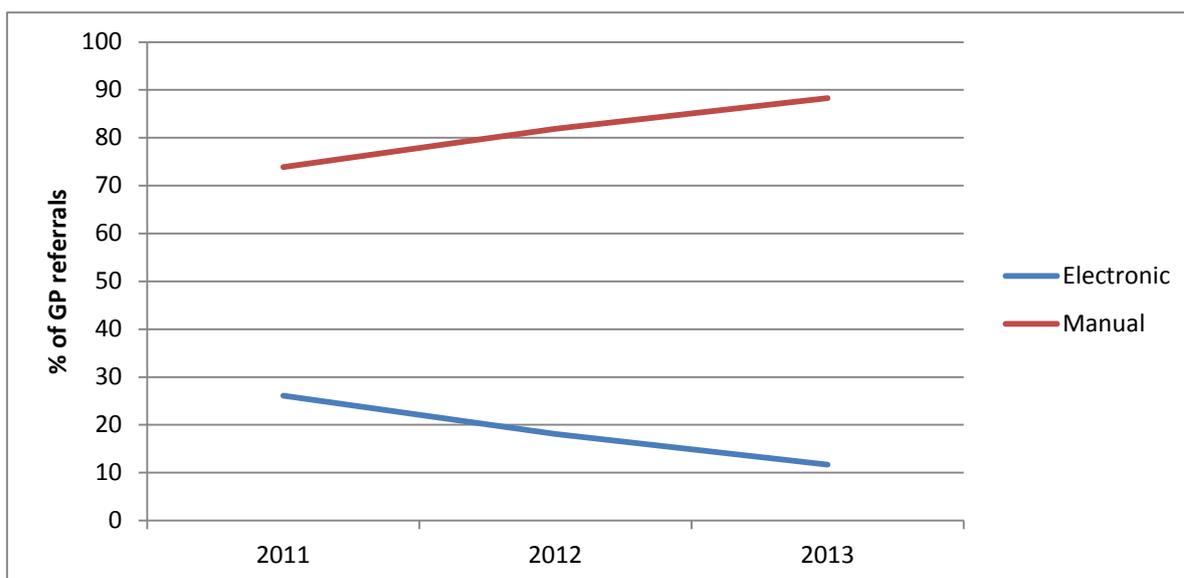
Source: GP Liaison Unit, Canberra Hospital

4.71 When the e-Referral system was first introduced, there was significant uptake of it by GPs, as shown in Figure 4.14. However there has been a decrease in the number of GPs using the system. As it is estimated that 95% of GPs use an electronic practice management system⁵¹, the low level of e-Referral is surprising and may indicate a lack of confidence in this system by GPs.⁵² Figure 4.15 shows the decrease in e-Referrals by GPs associated with an increase in manual referrals.

⁵⁰ Risks include loss of hard copy referral, delay in consultant receiving and returning hard copy referral. Risks as discussed in more detail at paragraph 4.73.

⁵¹ Figure provided by GP Liaison Unit.

⁵² The Audit Office did not seek this information from GPs.

Figure 4.15: Percentage of GPs using electronic or manual referrals 2011 - 2013

Source: GP Liaison Unit, Canberra Hospital

Faxed and letter referrals

4.72 Faxed referrals are collected by administration staff in the GEHU and are then scanned into the e-Referral system for triaging and scheduling of appointments.

4.73 There are a number of concerns regarding faxed referrals:

- referrals can be lost, inadvertently disposed of, or caught up with other papers. It was reported to the audit team that at one time a number of hard copy referrals was found in a bottom draw in the administration area following a change in staffing. Some of these referrals were six months old and had not been triaged;
- printing of faxed referrals can be delayed on receipt in GEHU due to the large number being transmitted, or the fax / printer being used for other activities, resulting in referrals 'dropping out' of the system. There is nothing to warn the administration staff that this has occurred until the GP or patient follows up when there is no progress on their referral; and
- the fax number for GEHU was changed and that this was not communicated effectively to GPs, resulting in referrals being made to the incorrect fax until the GP Liaison Unit (GPLU) was made aware of the problem.

4.74 Referral letters are sent to GEHU by the GP or presented in person by the patient when seeking an appointment. They are then scanned into the e-Referral system by administration staff.

- 4.75 Letter and fax referrals mean that the referring GP does not receive any automatic updates as to the progress of the referral and that any further information required by the GEHU from the GP has to be sought by phone or letter.

Processing referrals

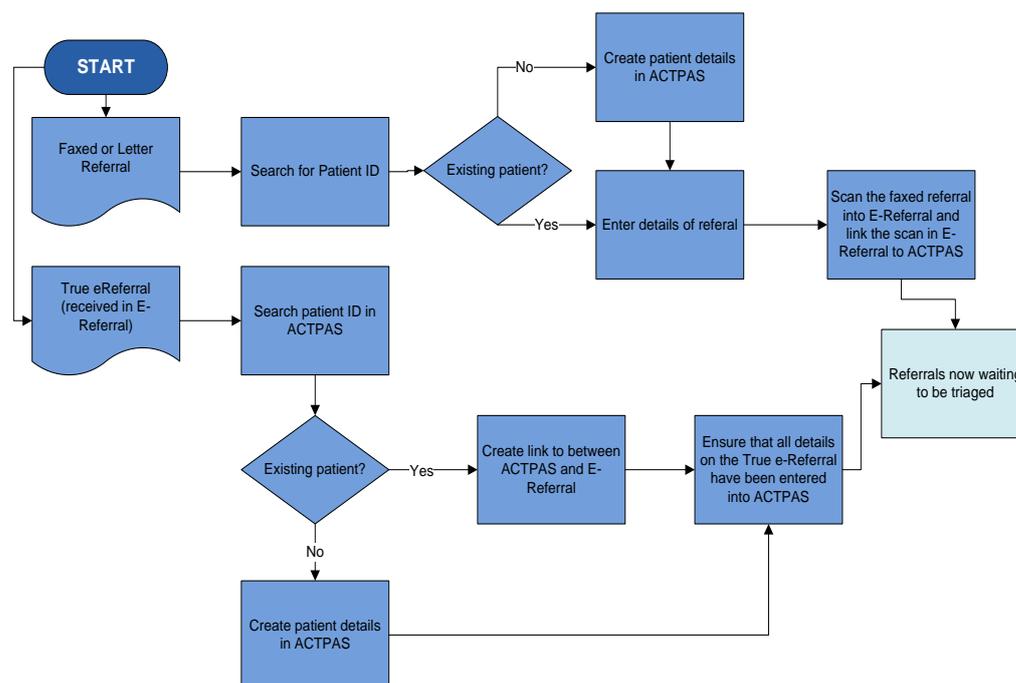
- 4.76 Consultants in the GEHU triage referrals through the e-Referral system, electronically, or on hard copy. If the referral has been made using the e-Referral system and the consultant requires a hard copy to triage, the administration staff print out the referral for the consultant and place it in their pigeon hole in the GEHU. If faxed, they provide that copy to the consultant once they have entered it into the e-Referral system, and then the administration staff manually enter the triage category into the e-Referral system when they received the triaged hard copy from the consultant. Once referrals' triage categories are entered into the e-Referral system appointments can be scheduled.
- 4.77 This variation in practices for processing referrals and triaging patients means that administrative staff need to know how each consultant prefers to receive referrals and triage their patients. In the past this has largely depended on word of mouth, with little written guidance available to new staff.
- 4.78 Most of this information was recently included in Business Rules which cover Referral Registration Guidelines, Booking Guidelines and Billing Guidelines. This sets out which way consultants prefer to triage patients – electronic or hardcopy⁵³, the type of clinics available for each consultant – urgent initials, general gastro, Inflammatory Bowel Disease (IBD) clinic⁵⁴, and whether the billing is Medicare Shared or Outpatient Bulk Billed.⁵⁵

⁵³ Of the 13 consultants listed, 5 prefer hardcopy triage and 8 electronic.

⁵⁴ There are clinics for: general gastro – 11; urgent initials – 1; High Risk GI Cancer Clinic – 4; IBD Clinic – 14; Quarterly Liver Transplant – 2; Liver Clinic – 5; Fatty Liver Clinic – 1; Liver Tumour Clinic – 1; Trainee / Registrar Clinics – 6; General Gastro / IBD Clinic – 1; Fibroscan Clinic (liver) – 1; and a number of RN clinics, including NBCSP.

⁵⁵ All VMOs are Medicare Shared and all staff specialists are Outpatient Bulk Billed.

Figure 4.16: The referral process to the point of triage



Source: Audit Office analysis of information provided by the Health Directorate

- 4.79 Due to consultants' varied weekly timetables, it is possible for paper referrals to sit in pigeon holes for up to a week before being picked up by the consultant. Currently all VMOs and one staff specialist triage on hard copy with all other staff specialists triaging electronically.⁵⁶ As VMOs are not based in the GEHU, unlike the staff specialists, this makes time delays in processing hard copy referrals more likely.
- 4.80 Further delays can then occur while the consultant is triaging referrals, and hard copy referrals have been lost during this process. There is a risk that an urgent referral, recommended to be seen within 48 hours, not identified by administrative staff (and it is not their role to do this) or highlighted by the referring GP, could sit with a consultant for longer than 48 hours and so be seen outside recommended guidelines, designed to manage the risk to patients. This is also possible with e-Referrals if consultants do not access the system to triage on a daily basis, but is less likely. Once triaged in the system, the administration staff are then able to react to the urgent category and make an appointment as quickly as possible.
- 4.81 The current referral processing options adopted by consultants places patients at risk due to the possibility of lost referrals⁵⁷, delays in processing referrals and subsequent delays in the delivery of treatment. It also results in poor use of

⁵⁶ CHHS Ambulatory Care Referral Registration Guidelines, Draft

⁵⁷ Faxed referrals can also be lost if the system overloads and referrals 'drop out' of the printing queue.

administration staff's time by creating unnecessary double handling of a number of steps in the process. These factors all contribute to an unnecessarily long waiting list.

Recommendation 2 (Chapter 4)

The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (g) electronically perform referring, triaging and scheduling and if this is not possible, having as many steps as possible in this process performed electronically;

Scheduling

- 4.82 A patient is booked for an appointment using ACT Patient Administration System (ACTPAS) once a referral has been triaged. The way bookings are filled depends on the requirements of each consultant, as outlined in their clinic organisation forms. The forms detail: clinic speciality; location; frequency; day(s) of week / month; start time; end time; how many initial appointments; how many review; the duration of each appointment; last appointment time; and the maximum number of patients per time slot. (January 2014 version of the New Clinic Profile Set Up Form at Appendix 2)
- 4.83 There are several Standard Operating Procedures (SOP) and Policies that outline steps to be taken by the Unit to receive referrals, triage and allocate patients to clinics. These SOPs and policies explain how to enter data and use the systems; however, they do not provide guidance as to how to manage patients' appointments based on their triage category. This is left to the administration officer, usually an Administrative Services Officer level 3, to decide as they work through the waiting list. One strategy that is used is booking Category 1 patients until the appointment would be more than six months away, then booking Category 2s from the waiting list. Category 3s are rarely booked due to the numbers of 1s and 2s already in the system.
- 4.84 Large numbers of patients have been triaged but not yet booked: 1 422 were to be booked at 28 February 2014 (of these 763 were awaiting triage). This is due to the difficulties experienced in the scheduling area:
- time spent checking the system to see if it is a new referral or a repeat;
 - checking if the patient is in the system and entering them if they are not (information only flows one way between two of the systems);
 - entering hard copies into the e-Referral system (faxed referrals, triaged hard copies);
 - collecting faxed referrals from, and distributing to, consultants;

- constant phone calls as the person responsible for these processes is also answering the main reception phone for GEHU;
- calling all patients who are scheduled for appointments within two weeks to notify them and see if they are available;
- calling patients whose contact details are out of date in the system; and
- attending to requests from consultants and nursing staff.

4.85 Stakeholders reported significant frustration with trying to contact the scheduling area by phone in order to change, confirm or make appointments.⁵⁸ Based on feedback from stakeholders, this is particularly challenging with respect to patients with liver conditions when trying to access services as illustrated in Case Study 6.

Case Study 6

A couple called the Liver Clinic 80 times over the course of one week and their calls were not answered. They left numerous phone messages which were not returned. They were only able to obtain an appointment when they were given the then GEHU Director's (unpublished) email address, provided to them by a support group for people in the ACT with hepatitis.

A referral for this patient had been made by the GP on 14 November 2013. They now have an appointment for June 2014.

- 4.86 Stakeholders reported a number of concerns regarding the operation of the liver clinics. As the concerns expressed to the Audit Office were more appropriately addressed through the Health Services Commissioner, the Audit Office referred the stakeholders to the Commissioner. The Commissioner is currently scoping a Commissioner Initiated Investigation.
- 4.87 Audit Office analysis shows a wide variation in the progression of referrals to appointments. This is set out in Table 4.5.

⁵⁸ The administration officer responsible for these duties related to the Audit Office that when away on a day's sick leave the person brought in to relieve them in GEHU did not answer the phone all day and there were 70 voice messages to be returned as a result.

Table 4.5: Number of patients registered, triaged and with an appointment scheduled from 1 January 2012 – 31 December 2013

Referral Status	TOTAL	TOTAL (by Triage Category)
Registered	7,570	
Triaged	4,562	
Category 1		1,966
Category 2		1,103
Category 3		1,304
Urgent		98
NULL		91
Booked (Initial Appt)	5,144	
Category 1		1,577
Category 2		625
Category 3		592
Urgent		89
NULL		2,261
Booked (Follow-up Appt)	1,423	
Category 1		365
Category 2		145
Category 3		137
Urgent		20
NULL		756
Did Not Attend	613	
Category 1		192
Category 2		52
Category 3		93
Urgent		8
NULL		268

Source: Audit Office analysis of Health Directorate Data.

4.88 Table 4.5 shows referrals that progressed to a booked appointment in the two years examined:

- 91 per cent of referrals (89 of 98) triaged as Urgent ;
- 80 per cent (1,577 of 1,966) triaged as Category 1;

- 57 per cent (625 of 1,103) triaged as Category 2; and
- 39 per cent (592 of 1,304) triaged as Category 3.

- 4.89 The progression of only 39 per cent of Category 3 referrals to a booked appointment over 2012 and 2013 is evidence of the practice (paragraph 4.77) of not booking appointments for Category 3 referrals due to the number of Category 1 and 2 referrals already in the system.
- 4.90 Some stakeholders suggested to the Audit Office that an effective way to address the lack of appointments available for patients, including Category 3, would be to suggest to them that, if able, they could access the private health system for an initial appointment, and then return to the public system, the GEHU, for further treatment and investigations such as endoscopies.
- 4.91 If consultants were to be involved in providing this information, or referring patients to the private health system, this would present a conflict of interest for those working in private practice outside the GEHU. This includes all VMOs and eight out of nine staff specialists. This does not mean information should not be provided to patients about their option to seek treatment in the private health system, it does mean that that information should be provided by the GEHU administration area with no reference to any consultant.
- 4.92 Currently, a patient is notified they have an appointment by a phone call if the appointment is within the next two weeks, or a letter if the appointment is two weeks or more away. If a patient is on the waiting list and has not been scheduled an appointment they do not receive any communication from the GEHU. The introduction of a practice where every referred patient receives a letter notifying them of the probable wait time could include information on the possibility of seeking private care, and asking the patient to notify the GEHU if they do. This letter could also check that their contact details are correct and ask the patient to notify the GEHU if they change.

Recommendation 2 (Chapter 4)

The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (h) incorporate information on probable waiting times and alternative treatment options in letters provided to all registered GEHU patients by GEHU administration;

Endoscopies and the National Bowel Cancer Screening Program

- 4.93 The National Bowel Cancer Screening Program (NBCSP) is funded by the Australian Government, through the states and territories, to reduce the incidence of, and death from, bowel cancer. It offers people turning 50, 55, 60

and 65 years of age screening with a faecal occult blood test (FOBT) in the privacy of their own home.⁵⁹ As part of the 2012–13 Federal Budget the Australian Government announced that the Program would be expanded to include Australians turning 60 years of age from 2013 and those turning 70 years of age from 2015⁶⁰, with biennial screening for 50 – 70 year olds in 2017–18.⁶¹

4.94 Patients accessing the NBCSP do so through the NBCSP manager, a registered nurse (RN) who manages the NBCSP in the GEHU. The NBCSP takes referrals directly for endoscopies on the basis of the patient's positive faecal occult blood test (FOBT).

4.95 From January 2012 to December 2013, 93 patients were seen by the NBCSP Manager, with 79 (85 per cent) of these progressing to endoscopies. This is significantly faster progress⁶² than for patients who access endoscopies through:

- using alternative bowel cancer screening and seeking follow-up from their GP; or
- referral by their GP either specifically for an endoscopy or for diagnosis and treatment that may include an endoscopy.

4.96 Figure 4.17 shows the percentage of Category 1, 2 and 3 endoscopies seen within triage category time frames by the GEHU from January 2012 to December 2013. This includes those done as part of the NBCSP, which would increase timeliness due to the NBCSP's faster throughput. This analysis shows that:

- the best results for seeing patients triaged as Category 1, to be seen within 30 days, were achieved in the first half of 2012, with a significant decrease in the second half of 2012 which then improved but had not reached early 2012 rates by November 2013;
- the best results for seeing patients triaged as Category 2, to be seen within 90 days, were achieved at the end of 2012, experienced a significant decrease in early 2013 and improved significantly from March 2013 to the end of 2013; and
- during 2012 patients triaged as Category 3, to be seen between 90 and 365 days, met this time frame, 38 – 81 per cent of the time, however, the timeliness level was inconsistent across the year. In 2013 timeliness was achieved for 30 to 70 per cent of the time, with a general improvement in timeliness through the year, although with a slight decrease in November 2013.

⁵⁹ <http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/home> Accessed 24 March 2014.

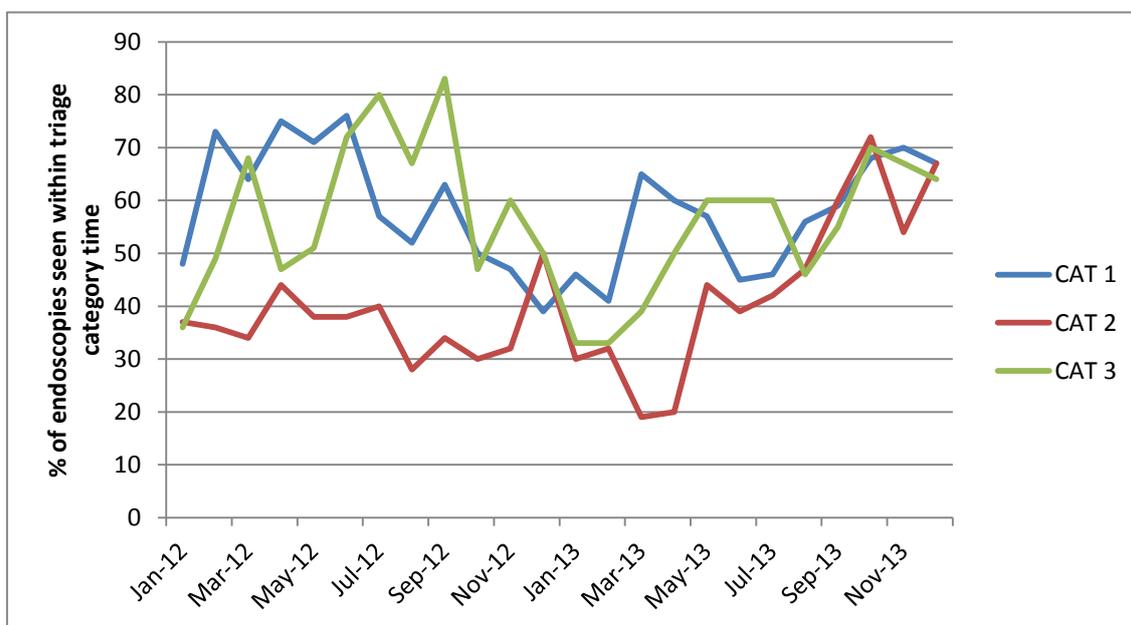
⁶⁰ <http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/bowel-about> Accessed 24 March 2014.

⁶¹ AIHW, National Bowel Cancer Screening Program (NBCSP)

⁶² NBCSP patients aren't required to wait for an initial GEHU consultant appointment, and then for an endoscopy

4.97 While still less than 70 per cent in November 2013, all three categories had improved on early 2013 levels and, for the first time in this time period, were all trending positively.

Figure 4.17: The percentage of Category 1, 2 and 3 endoscopies seen within triage category time: January 2012 – December 2013



Source: Audit Office analysis of Health Directorate data

4.98 A commitment was made to conduct an extra 300 endoscopies in 2012–13 in order to address the endoscopy waiting list. As at May 2013 it was reported at the GEHU business meeting that 200 of the 300 extra endoscopies had been performed. It was stated at this meeting that the shortfall was due to the lack of progress on the refurbishment and new staff specialists commencing later than originally planned. From February 2013 to April 2013 an extra 59 endoscopes were being done each month.⁶³

4.99 A strategy for addressing the waiting list for the GEHU, including endoscopies, would be to formalise the use of ‘open’ endoscopies⁶⁴, as suggested by GEHU health professionals. Open endoscopy is when a GP refers a patient directly for an endoscopy when it is clear to the referring GP that an endoscopy is needed, following appropriate investigations. The patient would not have to wait to see a GEHU consultant⁶⁵ prior to being scheduled for an endoscopy. ‘Open’ endoscopy would assist in clearing a number of patients from the GEHU waiting list, provide more timely intervention for endoscopy patients, and comply with the tertiary

⁶³ The refurbishment of the GEHU commenced in November 2013. Stage 1 was completed on 19 March 2014, Stage 2a) in late March 2014 and Stage 2b) in early April 2014.

⁶⁴ It was reported to the Audit Office that open endoscopy referrals currently occur, on an ad hoc basis, with no formal guidelines.

⁶⁵ Consultant is used throughout to refer to GEHU staff specialists and VMOs.

status of Canberra Hospital while maintaining primary care with the GP. The GEHU Case Study 7 supports the formalisation of 'open' endoscopy referrals.

Case Study 7

A 64 year old patient who had a history of surgery for bowel cancer in 2009 and had one follow-up colonoscopy in 2011 was referred to GEHU. They were triaged as Category 3 and seen in the clinic ten months later with a colonoscopy five months after their clinic appointment.

The independent expert⁶⁶ stated that there was a long delay and that it had not jeopardised the patients care. However, they also stated that this case 'highlights the need for protocols for follow-up after bowel cancer surgery, possibly without necessarily needing to be seen in the clinic prior to follow-up colonoscopy. The colonoscopy was performed within the appropriate timeframe'.

- 4.100 If the patient in Case Study 7 had been referred as an 'open' endoscopy, as part of a bowel cancer follow-up protocol, they would have had their post cancer endoscopy 5 months earlier.⁶⁷ This case study illustrates the advantage of 'open' endoscopy and the need for the development of bowel cancer follow-up protocols in GEHU.
- 4.101 'Open' endoscopy has the potential advantage of patients not needing to meet with a consultant prior to the scheduling of their endoscopy, only attending the usual pre-endoscopy clinic, provided by a registered nurse. This would assist in reducing the overall waiting time for a patient to have an endoscopy and reduce waiting list times as fewer patients would be waiting for consultation appointments prior to endoscopy. If introduced, any associated increase in endoscopies would need to be managed, perhaps by scheduling extra clinics for a defined period.
- 4.102 One GEHU health professional expressed concern about 'open' endoscopy referrals, stating that the observation and history taking of a patient that occurs during a consultation should not be omitted from the process. This could be addressed through each patient being assessed as part of the pre-clinic process by an experienced registered nurse.
- 4.103 While it is recognised that 'open' endoscopy may have limitations, the potential benefits of providing a patient with a timelier endoscopy and reducing the GEHU outpatient waiting lists, suggests that this merits consideration.

⁶⁶ The Audit Office sought the advice of an expert in gastroenterology on a number of referrals. This is discussed in more detail in Chapter 5.

⁶⁷ This assumes the patient would have waited no longer for an endoscopy than they waited for their consultant appointment.

Recommendation 2 (Chapter 4)

The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (i) assess the merits and limitation of introducing 'open' endoscopy referrals in the GEHU;⁶⁸

GP primary care

4.104 In the Australian health care system primary care is provided through general practice, with GPs referring to specialists for tertiary care, as required for more complex health needs. Effective treatment (with respect to cost and health) by GPs includes ensuring referrals are made appropriately, and not before primary care interventions have been explored and the appropriate speciality for referral determined. Inappropriate referrals unnecessarily add to waiting lists in specialist units.

GP Referrals

4.105 It was reported by health professionals that a number of the patients accessing the GEHU do not require the level of specialist, tertiary care provided at Canberra Hospital and would be more appropriately treated by GPs, either solely or as part of a shared care model⁶⁹ with GEHU consultants. Referrals from GPs, prior to the exploration and/or completion of primary care treatments and tests, contribute to inappropriate utilisation of the GEHU. Examples of GPs referring to the GEHU for primary care treatment are presented in the following case studies, which include comments from the independent expert. The independent expert reported that 'the quality of the referral letters from the GPs in general was very poor, making the decisions about categorisation difficult.'⁷⁰

⁶⁸ This occurs when the GP refers directly to GEHU for an endoscopy, having completed appropriate investigations and met specific criteria required for an 'open' referral, e.g. an acceptable BMI. It was reported to the Audit Office that 'open' endoscopy referrals occur currently, on an ad hoc basis.

⁶⁹ This aligns with 'Health Pathways' – an integration initiative adopted by a number of Medicare Locals. This web-based information portal is developed for clinicians with a primary focus on general practice. It enhances collaboration between clinicians and across community, primary and secondary health sectors and develops online referral pathways.

⁷⁰ Independent expert report, Dr Paul Desmond.

Case Study 8

A 27 year old was referred to the GEHU with heartburn, triaged as Category 2 and seen five months later with no follow-up or procedure preformed.

The independent expert questioned the appropriateness of the referral, although commented that the patient was seen within the appropriate time for the triage category.

Case Study 9

A 60 year old was referred with fatty liver, presumably diagnosed on ultrasound, but with normal liver function tests. The patient was triaged as Category 3, and seen 11 months later.

The independent expert stated that: the triage category was appropriate; an 11 months wait was long; and the patient probably did not need a specialist appointment.

- 4.106 Inappropriate GP referrals contribute to the waiting list for GEHU services. Health professionals reported that many referrals do not contain the required information, such as tests completed, prior to referring the patient to a tertiary health care facility. This results in some patients using GEHU resources when they could have been appropriately managed by their GP.
- 4.107 Some health professionals consulted during the audit suggested that inappropriate referrals should be returned to the referring GP with instructions for the appropriate tests to be performed, or primary treatment to be provided. For example, patients with ongoing reflux being provided with appropriate medication and, if applicable, supported to lose weight. Some outpatient clinics at Canberra Hospital have referral criteria that must be met before patients are scheduled an appointment. This was not the case in the GEHU during the course of this audit.
- 4.108 The Health Directorate advised that 'there is a lack of agreement amongst GEHU specialists about referring back to the referring GP for more information'. Introducing referral criteria would provide a consistent message to GPs as to the standard of referral expected.
- 4.109 Some Canberra Hospital outpatient clinics hold information sessions for GPs to inform them of what is required in referrals. It was suggested to the Audit Office that educating GPs who refer to the GEHU would help in addressing inappropriate referrals; alternatively it was argued that the most effective way to manage inappropriate referrals is through strict referral criteria described in paragraph 4.106, which would have the benefit of educating GPs. Some attempts have been made to educate GPs: the GP Liaison Unit, Canberra Hospital, provides regular updates to GPs through a fortnightly newsletter; and

one staff specialist reported he had held an information session but the GPs did not seem very interested.

- 4.110 To ensure that the Canberra Hospital is used as a tertiary and not a primary health care facility there is a need for referral criteria to be developed and implemented to guide which patients are scheduled an appointment. Such criteria may be warranted for other outpatient services.

Recommendation 2 (Chapter 4)

The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (j) develop and implement referral criteria that must be met before GEHU outpatients are scheduled an appointment;

GP Satisfaction with outpatient services

- 4.111 The GP Liaison Unit (GPLU) at Canberra Hospital conducts an annual survey of GPs. In 2013 there were 92 respondents. In 2013 various questions related to perceptions of the Outpatients Department referral and appointment processes. At Canberra Hospital only 11 per cent rated the Outpatients Department and referral processes as above average or excellent (down from 18 per cent) and 49 per cent felt they were below average or poor (57 per cent in 2012).
- 4.112 Questions about the timeliness of reports and letters from the Outpatients Department found that 58 per cent rated this as below average or poor. When asked if the delay in receiving reports or letters had clinical consequences to patients the response was that 33% of respondents said mostly or always with an additional 36% saying often. Consultants' dissatisfaction with the transcription service, which supports the GPs' response, is discussed in paragraph 4.135)

Shared care

- 4.113 Shared care, the sharing of the care of a patient between a GEHU consultant and a GP, may be an appropriate model for many patients treated through the GEHU. Shared care would involve a GP in the ongoing care of the patient, with periodic checks by the consultant, either scheduled by the GEHU consultant or when the GP and/or if the patient thought it necessary. This was suggested by a number of health professionals and has the advantage of including a GP in the patient's care in an ongoing relationship. This may present challenges for those patients who do not have a regular GP and this would need to be addressed. However, shared care would have the advantage of moving the patient out of the GEHU more quickly, and providing them with an appropriate level of care that may be more accessible. Managing discharge from the GEHU would be as important as managing referrals, as a number of health professionals felt that patients are brought back to the GEHU for unnecessary reviews.

4.114 The current development of Health Directorate's Health Pathways⁷¹ would contribute to the shared care model and was suggested in this context by a number of Health Directorate staff.

4.115 A shared care model has the potential to:

- provide more appropriate and effective care to patients;
- provide more effective use of Canberra Hospital's tertiary health care facilities;
- decrease waiting time for patients who need specialist care; and
- enhance the role of GPs in their patients' care.

Recommendation 2 (Chapter 4)

The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (k) affirm and/or expand the role of GPs (e.g. shared care) in supporting patients attending GEHU outpatients;

COST

4.116 Funding for health care is based on historical need and, to date, hasn't been based on an analysis of expected procedures / clinics costing a certain amount per patient. This is changing through the introduction of Activity Based Funding.⁷² The lack of data currently available limited the Audit Office's assessment of the effectiveness of the administration of GEHU on a cost basis and the associated value for money. However, as the ongoing waiting list at the GEHU cannot be attributed to a lack of capacity, value for money healthcare is not being provided to the ACT community by the GEHU.

4.117 Background information on costs provided by the Health Directorate had the following inadequacies for being able to determine the cost effectiveness of the GEHU:

- there is no differentiation in cost between an initial and review

⁷¹ Australian Medicare Local Alliance, Medicare Locals in Australia, Response to the Medicare Local Review, submitted to Commonwealth Department of Health, 23 December 2013, p 48 *An integration initiative adopted by a number of Medicare Locals. This web-based information portal is developed for clinicians with a primary focus on general practice. It enhances collaboration between clinicians and across community, primary and secondary health sectors and develops online referral pathways.*

⁷² Activity Based Funding (ABF) is a way of funding hospitals whereby they get paid for the number and mix of patients they treat. If a hospital treats more patients, it receives more funding. Because some patients are more complicated to treat than others, ABF also takes this in to account. <http://ihpa.gov.au/internet/ihpa/publishing.nsf/Content/funding> Accessed 10 April 2014. The National Health Reform Agreement, signed by all Australian governments in August 2011, commits to funding public hospitals using ABF where practicable. <http://ihpa.gov.au/internet/ihpa/publishing.nsf/Content/funding> Accessed 10 April 2014.

appointment (they are both recorded as a service event);

- the average cost for a one gastroenterology service event is \$807.28, based on 2011–12 analysis. However, there is no differentiation between a gastroenterologist performing an endoscopy or conducting a regular clinic;
- VMOs bill the Health Directorate for procedures performed at Canberra Hospital but not for their time;
- registered nurses costs are identified as an ‘intermediate cost’ to delivering a non-admitted service event and are not captured nor costed as a service event; and
- if a registrar conducts a consultant’s clinic it is recorded as if the consultant conducted the clinic and therefore there is no difference recorded in the cost data.

Table 4.6: GEHU Net Costs 2012–13

Area	Cost (\$)
GEHU	5 198 845
GEHU Nursing	3 002 273
GEHU Outpatient Administration	246 429
Total Expenditure	8 447 547

Source: Health Directorate

4.118 The GEHU costs are largely staffing, particularly for employing the staff specialists. In order to gain the most from the cost of employing nine staff specialists⁷³ it is necessary that their time be allocated in the most effective way to provide gastroenterology and hepatology services to the ACT and surrounding area and to provide the best possible care to patients. Given the previously low clinic rate and the current low rate of initial appointments, more strategic management of the staff specialists and their time would assist in addressing the ongoing waiting list and the risk that poses to patients.

⁷³ Staff specialists’ salaries are discussed in Chapter 2.

STRATEGIC USE OF DATA

4.119 The GEHU currently collects a variety of data, some of which is used to report on its operations. However, this data is not currently being used to assist in strategically managing the GEHU.

Riskman

4.120 Riskman⁷⁴ is the incident reporting system used by Canberra Hospital.

‘The Riskman Risk Register enables ACT Health to track risks that have been identified as either a threat or as limiting our ability to achieve or exceed delivery of our objectives and our ability to fulfil individual responsibilities.’⁷⁵

4.121 Riskman should be used by all health professionals in the GEHU to register incidents and near misses that result, or could result, in an adverse patient outcome. It is only used by one staff specialist in the GEHU. This is a missed opportunity as the reports generated by Riskman would provide information on adverse events that may be the result of poor referral, triage or scheduling practices and so provide information on how practices are impacting patient care and where to target improvements. For example, a referral that does not meet its triaging timeframe should be recorded on Riskman, particularly if it was triaged as an Urgent or Category 1, due to the possible negative outcome for the patient. The lack of use of Riskman by health professionals in the GEHU parallels the:

- lack of use of the e-Referral system (refer to paragraph 4.70); and
- lack of accountability of consultants (discussed in Chapter 3).

Recommendation 2 (Chapter 4)

The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (l) use Riskman data and reports to address areas of concerns identified through incident reporting; and

IT Systems and their role in referring, triaging and scheduling

4.122 There are a number of IT systems, with varying degrees of compatibility and communication, used in the referring, triaging and scheduling of patients in the

⁷⁴ Riskman is the licensed software product managed by the Quality and Safety Unit (QSU) on behalf of the ACT Health Directorate as the centralised integrated Incident and Risk Management system.
<http://acthealth/c/HealthIntranet?a=da&did=5365758&pid=1305683402> Accessed 6 May 2014.

⁷⁵ Health Directorate intranet: <http://acthealth/c/HealthIntranet?a=da&did=5365758&pid=1305683402> Accessed 6 May 2014.

GEHU. The lack of integration of the systems creates inefficiencies by being time consuming for the administration staff.

ACT Patient Administration System (ACTPAS).

- 4.123 ACTPAS is a patient administration system used across the Health Directorate for the registration of patient information, including personal details and referral information including the referring GP and outpatient clinic required. ACTPAS is also used for scheduling and booking clinic appointments for outpatient clinics.
- 4.124 ACTPAS can receive information from the e-Referral system, but ACTPAS cannot send information to it. This creates problems for administration staff when managing referrals and scheduling appointments for patients in GEHU.

E-Referral system - Concerto.

- 4.125 The e-Referral system used by the GEHU (commonly referred to as Concerto) is a clinical portal application that hosts a suite of applications including discharge summaries and electronic referrals. This system is used by those consultants in the GEHU who triage referrals electronically.
- 4.126 The e-Referral system receives referrals electronically from GP practice management software. Paper and faxed referrals are scanned into the e-Referral system and those consultants who electronically triage referrals use this system.

Booking appointments

- 4.127 Clinic appointments, scheduled in ACTPAS, are allocated based on a waiting list produced by the e-Referral system which shows all referrals that have been triaged and waiting for appointments. Once an appointment has been booked in ACTPAS, ACTPAS should inform the e-Referral system that the appointment has been booked and that the e-Referral system should remove it from the waiting list. The removal process does not always occur and therefore referrals are left on the waiting list. This contributes to an inaccurate waiting list and creates inefficiencies as administration staff perform unnecessary processing.⁷⁶
- 4.128 The current system can also lead to referrals having more than one appointment booked which unnecessarily increases the workload of the administration staff and could lead to some referrals waiting longer for an appointment than is recommended. Although there is a monthly audit of the e-Referral system waiting lists, this is an additional and unnecessary step and is consuming resources better used elsewhere.

⁷⁶ This error occurs when three unique fields that need to link ACTPAS and the e-Referral system do not match exactly. This means that ACTPAS will not inform the e-Referral system that an appointment has been booked for a referral and the e-Referral system will not remove it from the waiting list.

- 4.129 The Audit Office identified that there are no automated controls in the e-Referral system to enforce restrictions on who can enter and change triage categories, booking and triage dates, and the status of the referral (open, triaged, booked, closed). While there is an audit log maintained, there is no monitoring of these logs.
- 4.130 As outline in paragraph 3.29, there is some limited reporting produced by Cancer and Ambulatory Care (responsible for most administration staff in the GEHU) in relation to the number of referrals that are waiting for an appointment and referrals that are waiting to be triaged.
- 4.131 To produce these reports data has to be manually extracted and manipulated from the e-Referral system as there are no reporting functions built into the application. The lack of a reporting function results in reports not being easily produced and not produced often. Closer or more frequent monitoring of the waiting lists would be possible if there was a reporting tool built into the application.
- 4.132 There is no flagging in ACTPAS to indicate that a patient has been waiting for an appointment beyond their triage category. While there continues to be significant waiting lists and poor management of waiting lists, flagging is unlikely to make any difference to the management of appointments. However, flagging of overdue appointment allocation would be useful if waiting lists were to be more effectively managed.

Other IT systems used by the GEHU to support clinical outcomes

CRIS (Clinical Research Information System)

- 4.133 CRIS is a standalone electronic document management system which has held all records at Canberra Hospital since 1994. The medical records of patients attending the GEHU are stored on CRIS.

Scribes

- 4.134 Scribes is a clinical support system for endoscopies which stores all clinical information including copies of images, diagnosis information and pathology information.

Transcription Services

- 4.135 Transcription is the electronic system used by staff specialists to dictate letters (done through the telephone system) which are then typed by the transcription service. There was a high level of dissatisfaction amongst the staff specialists interviewed with the transcription service which included delays and errors in letters being typed. Test results are not attached to the letters by the transcription service, and the consultant is often not aware of the letter having been sent until they receive a response from the GP. Delays of six weeks in letters being sent to GPs following an appointment with a patient can place the

patient at risk, particularly if important follow up information and advice are included.

- 4.136 Since the audit commenced the GEHU transcription services have been outsourced in an attempt to address these concerns.
- 4.137 Funding of \$90 million has been provided to the Health Directorate for the Healthy Futures Program and this includes funds for modernising the IT systems for clinical services. A challenge in providing an effective IT service for the whole Canberra Hospital is to integrate the systems of individual units without compromising functionality within the unit.
- 4.138 The GEHU collects a large amount of data⁷⁷ regarding referrals including clinic utilisation, triaging categories and times, waiting times for appointments and whether patients attend appointments. The Audit Office found that, although a number of reports are produced reporting to the Executive Director level is focused on endoscopies – those performed and waiting lists. Other data reported in the monthly Scorecard Report includes: total GEHU activity – inpatient and outpatient; session utilisation; average length of stay; and ward separations. This level of reporting is not resulting in strategic management of the GEHU, particularly outpatient services, including its waiting lists, resources – current or required, and the means to address the waiting list and related risk to patients. Refer to Table 4.7 for report distribution.

Table 4.7: Reports produced using GEHU data

Report	Distribution List
Gastroenterology monthly stats (includes: HCV, IBD and outpatient clinic utilisation, attendance, cancellation and DNAs.)	Director, GEHU; Administrative Support Officer, GEHU; CNC, GEHU; Administration Team Leader, GEHU; Senior Data Analyst, Health Performance; Office Manager, GEHU; Business Support Officer, Division of Medicine; Information Officer, Business Intelligence, Health Performance; Clinical Lead, GEHU.
Division of Medicine Scorecard.	Director, GEHU; CNC, GEHU; Manager, Health Performance Unit; Administrative Support Officer, GEHU; Office Manager, GEHU; Clinical Lead, GEHU; ED, Division of Medicine; DON, Division of medicine; Senior Data Analyst, Health Performance; Business Support Officer, Division of Medicine; Information Officer, Business Intelligence, Health Performance.

Source: Health Directorate Business Information Branch

- 4.139 The Health Directorate staff in the Business Intelligence Unit (BIU), Performance Information Branch, who collect and analyse GEHU data advised that there have

⁷⁷ Some data that would be helpful in monitoring effectiveness of the GEHU administration such as general or sub-speciality referral is not collected.

been changes in the staffing and structure of BIU. These changes are designed to use GEHU data to provide reports to GEHU and Health Directorate management on the effectiveness of GEHU's service in providing the best possible patient care.

Recommendation 2 (Chapter 4)

The Health Directorate should develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care. This plan should include actions to:

- (m) collect, analyse and report on GEHU data in order to strategically manage GEHU resources and demand for GEHU services.

5. REVIEW OF TRIAGING AND PATIENT OUTCOMES

- 5.1 This chapter presents the findings of the independent expert's review of GEHU consultants' triaging of a selection of 35 patients⁷⁸ and these patients' health outcomes. The triaging reviewed by the independent expert occurred in the period from 1 January 2012 to 30 September 2013.
- 5.2 The Audit Office screened the 35 patients to identify if any had presented to Canberra Hospital Emergency Department (Emergency) around the time of their presentation to the GEHU with related symptoms. Two patients were identified which the independent reviewer assessed to determine if their presentation to Emergency was a result of poor practices within the GEHU. These cases are discussed in paragraph 5.11.
- 5.3 GEHU triaging is discussed in Chapter 4, paragraphs 4.9 to 4.27. As mentioned in paragraphs 4.17 to 4.18 the GEHU has no triage guidelines. Recommendation 2 (a) addresses this issue.
- 5.4 The independent expert referred to St Vincent's Gastroenterology and Liver Clinic, Melbourne, triaging guidelines, referred to in Chapter 4, paragraph 4.17

Key findings

- The Independent expert commented that 'the triage category was appropriate in the vast majority of patients. A small number of patients with the same referral symptoms were allocated to different categories.' (paragraph 5.7)
- Of the 35 patients who had been referred to GEHU two had also presented to the Emergency Department at Canberra Hospital around the time of their referral to GEHU. These cases were considered by the independent expert to assess if their presentation to the Emergency Department was related to their GEHU referral, particularly if they experienced any adverse outcome. The expert concluded for these patients that their histories 'demonstrated that the patients were managed appropriately and in a timely manner'. (paragraph 5.11)
- The conclusion from the independent expert only provides assurance in the two cases mentioned above, as data was available from the Health Directorate system for these cases but not for others. Data for other case study patients may be available from other sources or through contacting the patients, so the Audit Office cannot be sure that they did not experience any adverse outcomes. Given that the audit focus is systemic issues, individual patients were not contacted. (paragraph 5.12)

⁷⁸ The 35 patients were randomly selected based on professional judgement to obtain a moderate level of confidence that the selection was indicative of the characteristics of the population.

5.5 Triage Review results The results from the independent review are presented in Tables 5.1 and 5.2:

Table 5.1: Triage categories for selected cases

Triage categories	
Category 1	12
Category 2	11
Category 3	12

Source: Independent expert report

Table 5.2: Time to clinic appointment in months for selected cases

Category (with timeframe)	Mean (months)	Range (months)
1 (within 30 days)	1	1-3
2 (between 30 and 90 days)	4.2	3 -8
3 (between 90 and 365 days)	6.7	3-10

Source: Independent expert report

5.6 The independent expert analysis, presented in Tables 5.1 and 5.2, shows that:

- the triage categories were spread evenly across the referrals selected;
- the time to clinic appointments was particularly poor for Category 2 referrals, with the range and mean both outside the required timeframe for Category 2;
- those selected cases triaged as Category 1 (timeframe within one month) had a mean of one month (the outer limit) and a range that extended from one to three months (outside the timeframe for Category 1); and
- for those selected cases triaged as Category 3 (timeframe between one and twelve months) were within the triage timeframe.

5.7 The independent expert commented that:

‘in general the triage was performed within an appropriate and short time frame. There were a small number of cases in which there was a significant delay before triage occurred.

The triage category was appropriate in the vast majority of patients. A small number of patients with the same referral symptoms were allocated to different categories (Cat 1/2 or Cat 2/3).

Overall patients in Category 1 were seen within an appropriate timeframe in the clinic.

Patients in Category 2 have variable wait time to be seen in the clinic and in some instances it was quite long.

The wait time for patients in Category 3 was long and in many situations they were not seen for 10 months after the initial referral.’

5.8 This opinion generally correlates with the analysis provided in paragraph 5.6. However, the audit analysis in Chapter 4 found more issues with triaging timeliness than identified by the independent expert. This difference is likely to be due to the relatively small number of referrals examined by the expert compared with the large amount of data analysed by the Audit Office.

5.9 The independent expert commented that three of the patient records examined should have been triaged as a 1 and not a 2, and seen earlier; and that another patient ‘should possibly’ have been a Category 1, not 2, and seen earlier.

5.10 The inconsistency in triaging identified by the expert, and by Audit Office analysis, is of concern as it presents a risk for patients’ care, and adds to other risks patients face, identified by the Audit Office, including inconsistency of:

- treatment of GP referrals, depending on whether they are electronic, faxed or hard copy, to a named specialist or generic/NTANS⁷⁹, or for a sub-speciality or general gastroenterology (refer to paragraph 4.25);
- triaging practice – electronic or hard copy, with associated delays (refer to paragraphs 4.68 to 4.75); and
- scheduling of patients, particularly Category 3 (refer to paragraphs 4.82 to 4.92).

⁷⁹ This concern has been addressed since the commencement of the audit.

PATIENT OUTCOMES WHILE ON THE OUTPATIENT WAITING LIST

- 5.11 In order to assess if patients experienced an adverse outcome related to their symptoms while on the outpatient waiting list the Audit Office examined the records of the sample of 35 patients whose referrals were provided to the independent expert. Of the 35 patients who had been referred to the GEHU two had also presented to the Emergency Department at Canberra Hospital around the time of their referral to GEHU. These cases were considered by the independent expert to assess if their presentation to the Emergency Department was related to their GEHU referral, particularly if they experienced any adverse outcome. The expert concluded for these patients that their histories 'demonstrated that the patients were managed appropriately and in a timely manner'.
- 5.12 The conclusion from the independent expert only provides assurance in the two cases mentioned above, as data was available from the Health Directorate system for these cases but not for others. Data for other case study patients may be available from other sources or through contacting the patients, so the Audit Office cannot be sure that they did not experience any adverse outcomes. Given that the audit is focus on system issues, individual patients were not contacted.

APPENDIX A: STAFF SPECIALIST SCHEME

Staff Specialist Scheme, part of the Medical Practitioners Enterprise Agreement, options for payment

The rules for each scheme are as follows:

Scheme A.

- Specialists will be paid a private practice payment equal to 20% of the Specialist's base salary including allowances (pro rated for part-time Specialists).
- The Specialist will also be entitled to an additional payment of \$0.50 for every dollar of private practice revenue generated by the Specialist exceeding an amount equivalent to 10% but not exceeding 30% of the Specialist's base salary.

Scheme B.

- Specialists will be paid a private practice payment of \$1.00 for every dollar of private practice revenue generated by the Specialist exceeding the threshold applicable to the Specialist's speciality but not exceeding an amount equivalent to 50% of the Specialist's base salary.
- If the Specialist does not generate private practice fees in excess of 20% of his or her salary, the Specialist will still be entitled to a payment equivalent to the amount of fees generated under Scheme A.

Scheme C.

- This Scheme is available to Specialists who have been granted leave without pay for 25% of the time worked by full-time specialist medical officers. For the purposes of this Scheme those Specialists will be regarded as full time.
- Specialists will be paid a private practice payment of \$1.00 for every dollar of private practice revenue generated by the Specialist exceeding the threshold applicable to the Specialist's speciality but not exceeding an amount equivalent to 133% of the Specialist's base salary.

APPENDIX B: NEW CLINIC PROFILE SET UP FORM



NEW CLINIC PROFILE SET UP FORM

OFFICE USE ONLY:
Job:

Please refer to information provided regarding clinic set-up

ACTION REQUESTED					
New Clinic	<input type="checkbox"/>	Custom (1 off)	<input type="checkbox"/>	Permanent (ongoing)	<input type="checkbox"/>

CLINIC DETAILS	
Clinic Name:	
Clinic Description: <i>If the clinic is taking part in the SMS Reminder, this is sent to the patient (maximum 30 characters including spaces)</i>	
PLEASE NOTE: Both Clinic Name and Description cannot include: Clinician Name, Location, Day/Time	
Session Description: <i>(maximum 30 characters including spaces):</i>	
Clinician in Charge	
Other clinicians linked to clinic*	
Speciality	
Location <i>(Please include full address, phone and fax)*</i>	
Frequency <i>(not applicable for Custom)</i>	
Day(s) of Week/ Day(s) of month	
'Active from' date (date of change)	
Start time – i.e. first appointment time	
End time – i.e. time last consultation ends	
Related clinics* <i>(Please provide clinic code)</i>	
Do this clinic's appointments have to go to CRIS (Clinical Record Information System) or other interfaces with external applications?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does this clinic run on public holidays?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is this clinic taking part in SMS Reminders?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please provide Lead Time for SMS <i>(currently only available for BCHC, TBCHC, TCHC @ TTCHC):</i>	

Please record the individual appointment characteristics over the page.

Form last updated: 06/01/2014

New clinic profile set up form

INDIVIDUAL APPOINTMENT SLOT INFORMATION						
	Apt Time	Maxi # per slot	Duration (in minutes)	Priority	Appointment Type	Rules/Instructions
1						
2						
3						
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Form last updated: 06/01/2014

Audit Reports

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Report No. 3/2013	ACT Government Parking Operations
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