ACT AUDITOR–GENERAL'S
PERFORMANCE AUDIT REPORT

# MANAGEMENT OF OPERATION REBOOT (OUTPATIENTS)

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AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

PA 22/06

The Speaker
ACT Legislative Assembly
Civic Square, London Circuit
CANBERRA ACT 2601

Dear Madam Speaker

I am pleased to forward to you a Performance Audit Report titled 'Management of Operation Reboot (Outpatients)' for tabling in the Legislative Assembly pursuant to Subsection 17(5) of the *Auditor-General Act 1996*.

The audit has been conducted in accordance with the requirements of the *Auditor-General Act 1996* and relevant professional standards including *ASAE 3500 – Performance Engagements*.

Yours sincerely

Michael Harris
Auditor-General
14 June 2023

*The ACT Audit Office acknowledges the Ngunnawal people as traditional custodians of the ACT and recognises any other people or families with connection to the lands of the ACT and region. The Office acknowledges and respects their continuing culture and the contribution they make to the life of this city and this region.*

# CONTENTS

# SUMMARY

Patients referred for diagnostic and treatment services from specialists, who may not need to be admitted to hospital but require hospital services, are known as outpatients.

In 2020 the ACT Government provided $3.5 million to Canberra Health Services (CHS) for an additional 14,000 specialist outpatient appointments as part of 'Operation Reboot'. Operation Reboot aimed to help address the impact of COVID-19 on the public health system.

The audit considered the effectiveness of CHS' management of the outpatient services component of Operation Reboot, including its planning, implementation and monitoring and reporting arrangements.

## Conclusions

### PLANNING FOR REBOOT (OUTPATIENTS)

Planning for Reboot (Outpatients) was ineffective. The target of 14,000 additional specialist outpatient appointments was derived from pre-COVID-19 data analysis that did not account for the impact of the early public health response to the pandemic, which was ostensibly the purpose of Operation Reboot.

### MANAGEMENT AND ADMINISTRATION OF REBOOT (OUTPATIENTS)

The prioritisation of rapid rollout over forward planning compromised the effectiveness of the implementation of Reboot (Outpatients). Reboot (Outpatients) was primarily predicated on the provision of additional appointments as the mechanism to address the wait lists, rather than potentially more sustainable measures to improve efficiency.

A high-level approach to implementation was detailed in a draft Budget Concept Brief (which did not proceed to Cabinet). Once the initiative commenced, however, no project management plan or risk management plan was developed. In the early stages of implementation, some aspects of how the initiative was to be delivered were addressed in papers approved by the Outpatient Transformation Steering Committee.

This approach provided little scope for CHS to effectively manage risks to successful delivery of additional outpatient appointments. Several known risks, including limited access to clinic space, staffing, and COVID-19 transmissions, ultimately affected the rollout.

### DELIVERY OF REBOOT (OUTPATIENTS)

CHS achieved 6,132 additional outpatient appointments for Reboot (Outpatients), which was only 43.8 percent of the 14,000 appointment target. Significant effort was expended on engaging

external providers, for very little return. Only 585 patients (9.5 percent of the additional appointments) were seen by external providers, compared with 5,547 patients (90.5 percent) seen by internal providers.

The process to identify internal medical skills and resources had some strengths—clinics were successfully engaged in the development of new approaches to reduce wait lists. Clinicians undertook additional work during a time of substantial pressure on the public health system. However, the application process was not used consistently throughout the initiative, and even when used, lacked robust capacity planning (i.e. the approved targets did not have a clear basis).

There were significant limitations in the procurement approach to source external providers. This included: a lack of documented assessment of expressions of interest; the engagement of providers without written expressions of interest; and (in one instance) the delivery of services without an agreed contract. This compromises the integrity of patient service delivery arrangements.

### MONITORING AND REPORTING OF REBOOT (OUTPATIENTS)

Monitoring and reporting arrangements for Reboot (Outpatients) were partially effective. The Outpatient Transformation Steering Committee and Outpatient Transformation Working Group, which took responsibility for internal oversight, benefited from access to a bespoke Reboot Dashboard which provided clear insights regarding the approximate number and source of additional appointments delivered. These bodies were well-positioned to share information across clinical divisions, and did so in relation to early planning, implementation challenges and lessons learned. However, these oversight bodies were large, with many members, and not suited to rapid project-related decision-making.

## Key findings

### PLANNING FOR REBOOT (OUTPATIENTS)

Paragraph

#### Wait list management

Restricted access to hospital services from March 2020 to May 2020, due to the COVID-19 pandemic, exacerbated an existing mismatch between the number of patient referrals received by CHS, and the initial appointments provided. The number of initial outpatient appointments provided by CHS declined more rapidly than patient referrals from February 2020 to April 2020 and recovered more slowly in May. In the four months to May 2020, the percentage of patients waiting beyond clinically recommended timeframes increased from 67 percent to 75 percent. 2.24

#### The Reboot (Outpatients) target

Reboot (Outpatients) sought to provide 14,000 additional specialist outpatient appointments. CHS' efforts to address outpatient wait lists was predicated on the 2.39

provision of additional appointments and not by redesigning or providing services more efficiently. The target of 14,000 appointments was identified in a June 2020 ACT Health Directorate 2020-21 ACT Budget Submission. The inclusion of '14,000 specialist appointments' in the Submission was based on a draft Budget Concept Brief developed by CHS in early 2020. The two-page Concept Brief was characterised by:

- analysis of service need from pre-COVID-19 data, as at January 2020; and
- analysis of service need in specialities with long waits in categories 1 and 2, rather than categories 2 and 3, where appointments had been rescheduled as part of the public health response to the pandemic.

Neither of these methods of analysis yielded the target of 14,000. The target of 14,000 was based on analysis of service need from pre-COVID-19 data and did not account for the increasing proportion of patients waiting outside clinically recommended timeframes due to the early public health response to the pandemic, which was ostensibly the purpose of Operation Reboot. 2.40

## MANAGEMENT AND ADMINISTRATION OF REBOOT (OUTPATIENTS)

Paragraph

### Planning for Reboot (Outpatients)

Detailed implementation planning was not undertaken for Reboot (Outpatients). There was no agreed project plan that set out: a budget and schedule of activities aligned to the desired outcomes of the initiative; or roles and responsibilities for the initiative. 3.14

CHS advised that consideration was given to risks to its capacity to deliver 14,000 additional appointments. CHS asserted that risks were identified with respect to: the potential impact of COVID-19 on the achievement of the initiative's stated targets; and known limitations to business-as-usual outpatient activity, including clinic space and staffing. However, CHS' consideration of these issues was not documented, and no risk management plan was developed to mitigate the likely effects of these issues. These risks subsequently eventuated and impacted on the implementation of Reboot (Outpatients). 3.15

Although there was a lack of project planning, the early 2020 draft Budget Concept Brief provided broad guidance on how the additional 14,000 outpatient appointments were to be delivered under Reboot (Outpatients). It provided high level, summary details about staffing and intended activities. The draft Budget Concept Brief was supplemented by two papers, which were approved by the Outpatient Transformation Steering Committee; *Operation Reboot Arrangements Paper* and *Reboot (Outpatients) project report*. The papers addressed some aspects of how the initiative was to be implemented, including: 3.23

- governance and oversight of the initiative would be provided by the Steering Committee, a large existing body rather than a specifically convened group for the purposes of Reboot (Outpatients);

- processes for attracting and evaluating proposals from internal and external providers; and
- processes for measuring and funding the additional appointments to be delivered.

### Resourcing for Reboot (Outpatients)

Reboot (Outpatients) was led by a Senior Manager, with the following support: an Administrative Support Officer; 12 weeks support from a Registered Nurse; and a Project Officer, Outpatient Support (who was not a dedicated Reboot (Outpatients) resource). This was much lower than the support staffing level proposed in the draft Budget Concept Brief, which had estimated the initiative would require: 3.36

- three FTE nurses to provide additional in clinic support and referral screening;
- three administrative staff to audit the wait list, confirm referrals, and book appointments; and
- one data entry officer to cope with additional load through transcription.

COVID-19 transmissions contributed to an inability to retain support staff on the project. By the end of the initiative in June 2021, only $192,192 of the planned $500,000 had been spent on administrative and nursing costs. 3.37

## DELIVERY OF REBOOT (OUTPATIENTS) Paragraph

### Appointments delivered by internal clinical divisions

On 20 July 2020 a call for applications was circulated to CHS clinical divisions. The call for applications included the *Operation Reboot Outpatient Guidance* document (the Guidance), which set out the background to Reboot (Outpatients) funding and the application process. No evaluation plan or selection criteria was documented. 4.8

Twenty applications were received and considered by a sub-group of the Outpatient Transformation Steering Committee. Thirteen were approved, but only twelve proceeded because one application was withdrawn. Applications were assessed by a panel drawn from the Outpatient Transformation Steering Committee, based on their alignment to the purpose of Reboot (Outpatients), namely: 4.16

- total number of long waits by category;
- proposed approach to reducing long waits;
- projected number of additional appointments; and
- strategy to manage capacity/demand going forward.

This approach relied on clinics to judge their capacity to deliver the additional appointments. Through this process, the Steering Committee approved applications for a total of 8,584 appointments (61.3 percent of the 14,000 target). However, there 4.17

was no clear basis for the targets nominated by the clinics, or Steering Committee oversight of the internal processes to develop and deliver on these targets.

After the application and approval processes had concluded additional activity was approved for some specialties. The additional activity was not referred to the Steering Committee sub-group for assessment. Approximately 1,000 additional appointments were approved through this process, but this is not clear because for some additional activity no targets were identified. For some of the additional activity there was no documentation associated with its approval i.e. no evidence of how the activity was applied for and no evidence of how it was approved. 4.18

The delivery of internal Reboot (Outpatients) appointments was managed in accordance with business-as-usual processes within clinical divisions. This included using existing processes for estimating the volume of additional activity that could be delivered by specialties, as well as supervision, risk management and financial management. This approach was a means to engage specialties in Reboot (Outpatients) and surface ideas to improve service delivery based on the clinical expertise within divisions. Notwithstanding these aspirations, there was significant variability in the targets set by specialties, and the percentage of projected appointments achieved (from 2.7 percent to 668.6 percent) by the end of June 2021. Only five of the fifteen specialty-level targets were met or exceeded. A further three specialties did not nominate a target in the first instance. Speciality and subspeciality planning is required for any wait list initiative (including buy-in from senior clinicians in each speciality and subspeciality), but this was not apparent in this instance. 4.25

## Appointments delivered by external providers

On 5 August 2020, CHS issued a request for Expressions of Interest (EOIs) to potential external providers. The request for EOIs asked providers for proposals to support CHS in the removal of 14,000 referrals from the medical specialist outpatient wait list but did not identify, or otherwise detail, any specifications for how this was to occur. The request for EOIs did not specify the funding arrangements. 4.34

No specifications regarding the form or level of detail required of EOIs was provided. CHS advised that going to market without a clearly set out scope was intentional and the aim was for prospective providers to come up with ideas to address the backlog, rather than CHS dictating how this would be done. Eight written EOIs from external providers were received by the due date of 24 August. The proposed approaches varied considerably, as did the format of the EOIs, their level of detail and demonstrated relevance to the removal of 14,000 referrals from the medical specialist outpatient wait list. 4.35

An *Operation Reboot Application Evaluation Form* was developed and finalised on 5 August 2020 for the purpose of assessing EOIs. Five of the eight EOIs were provided to the relevant CHS division for preliminary consideration and feedback. There is no documentation or information as to why the other three applications were not circulated for comment and feedback. None of the EOIs were supported by the clinical divisions. Because of the lack of divisional endorsement of the EOIs no formal assessment panel was convened and no further assessment was undertaken. The 4.46

*Operation Reboot Application Evaluation Form* was not used for the assessment of applications.

Notwithstanding that the EOIs were not formally assessed, and there was a lack of support from the relevant clinical divisions for the EOIs, CHS progressed negotiations with two providers: Top Health Trust; and My Emergency Doctor. While Top Health Trust had submitted an EOI, My Emergency Doctor had only provided verbal advice of its interest in participating in Reboot (Outpatients) and did not submit an EOI. CHS advised that it progressed negotiations with these providers because testing the market for outpatient services was part of the aim of Reboot (Outpatients) and these providers were considered capable of delivering required outpatient appointments. However, CHS did not formally document an assessment of the service offerings of the two providers. 4.47

On 22 October 2020 (almost two months after the request for EOIs closed) the Senior Manager Outpatient Support sought the CHS Procurement Committee's endorsement for a Select Tender process to contract external providers to undertake outpatient appointments. The Procurement Committee Request form noted that a Request for EOIs had been distributed 'through the networks of Territory Wide Surgical Services, General Practice Liaison Unit, Capital Health Network and posted on the ACT Health website for external parties to submit proposals to undertake this work'. The CHS Procurement Committee endorsed the request on 30 October 2020 and in doing so noted that 'while this procurement has not gone through the usual process, the advertisement process was targeted to the appropriate audience'. 4.62

On 5 November 2020, a minute from the Executive Director, Cancer and Ambulatory Support Division was provided through the CHS Procurement Committee to the CEO for approval. The minute incorrectly identified that two EOIs had been received; only one EOI had been received. The minute advised the two potential providers 'were considered appropriate for further negotiation. These negotiations are ongoing, and we are now at a point of entering into a contract with these [two suitable] providers'. The CEO approved the approach on 25 November 2020, but requested it be forwarded to the Executive Director Medical Services (EDMS) for review and endorsement. On 17 December, the procurement approach was endorsed by the Executive Director Medical Services with 'some reservations'. The Executive Director requested to be included in the tender selection panel, but was advised that the two providers had already been engaged and contracts executed. 4.63

Contracts were entered into with Top Health Trust and My Emergency Doctor for the provision of services. However, in January 2021, CHS was notified that Top Health Trust had withdrawn its proposal. The specific timing and reason for this was not documented. CHS sent 788 referrals to My Emergency Doctor. Of the 788 referrals to My Emergency Doctor, 538 patients were marked as seen and 250 patients were not seen for various reasons. A total of $95,310 (GST ex) was paid to My Emergency Doctor for Reboot (Outpatients) services. 4.84

A third provider, the Yarralumla GP Clinic, was also engaged to provide services for the purpose of Reboot (Outpatients). This was despite the fact it did not submit an EOI. No contract was executed for the Yarralumla GP Clinic services. 4.96

The engagement of the Yarralumla GP Clinic followed an approach it made in March 2020, to collaborate with CHS to see Category 2 and 3 Aboriginal and Torres Strait Islander children waiting to be seen in the CHS Ear, Nose and Throat clinic. A November 2020 paper to the Steering Committee reported that a clinic was run for this purpose on 24 October 2020 (a Saturday) and recommended the development of 'a sustainable model to run more clinics such as these …'. In total, however, there were eight bookings to see Ear, Nose and Throat specialists via the Yarralumla GP Clinic. Five of the patients identified as Aboriginal and Torres Strait Islander, but two of these patients did not arrive for their scheduled appointment. A total of 55 patients were recorded by CHS as removed from the initial wait list via Yarralumla GP Clinic activity. In addition to the Ear, Nose and Throat patients, Dermatology and Urology patients were also seen. A total of $8,930 (GST ex) was paid for these services. 4.97

## MONITORING AND REPORTING OF REBOOT (OUTPATIENTS) Paragraph

### Internal oversight

Existing governance arrangements for outpatient services (the Outpatient Transformation Steering Committee and Outpatient Transformation Working Group) were used for monitoring and reporting of the implementation of Reboot (Outpatients). The large membership of both the Steering Committee (21 members plus the Chair) and Working Group (47 members plus the Chair) was suited to information sharing across clinical divisions, but not best suited to project-related decision-making for Reboot (Outpatients). 5.9

A 'Reboot Dashboard' was developed by data specialists within CHS specifically for monitoring Reboot (Outpatients). The Reboot Dashboard presented data based on the measurement approach approved by the Steering Committee in August 2020. The Reboot Dashboard provided a clear overview of progress, but it had a number of key limitations: 5.24

- the measurement approach was based on a crude measure of additionality. It did not account for factors that would otherwise result in additional appointments being provided, such as higher staffing levels, or additional clinic days; and
- any recorded wait list removals were subject to a high risk of reporting error due to:
  - the complexity of the outpatient care journey;
  - variations in clinic record keeping between outpatient services within CHS; and
  - the age/useability of the patient information system, ACTPAS.

### Learnings from Reboot (Outpatients)

At the end of Reboot (Outpatients), the Division of Cancer and Ambulatory Support provided a paper, *Operation Reboot - Outpatients Project Report* (Project Report), to the Working Group and Steering Committee for noting and discussion. The paper provided a detailed overview of Reboot (Outpatients) activity and learnings, 5.41

including best available data on the number of wait list removals achieved by all areas of activity. The paper reflected a range of important operational lessons, but did not identify broader strategic learnings from Reboot (Outpatients), or how these may shape the work of CHS in relation to outpatient care going forward.

Some services developed their own analyses, and shared these findings through professional publications and presentations. This critical reflection is of significant value to improve CHS' management of access to outpatient care. It provides an evidence base for improved practice. However, this demonstrated a relatively autonomous clinician-driven approach, which is unlikely to contribute to public administration improvements within CHS more broadly. 5.42

# Recommendations

**RECOMMENDATION 1 IMPLEMENTATION PLANNING**

Canberra Health Services should ensure the lessons from Reboot (Outpatients) inform planning for future emergency response scenarios. This should include the development and circulation of short checklists and templates to support project owners needing to develop effective implementation and risk management plans within short timeframes.

**RECOMMENDATION 2 PROCUREMENT**

Canberra Health Services should review its procurement practices to ensure that future procurement activity is supported by evaluation of responses that is supported by:

a) consistent treatment of all prospective suppliers with respect to written submission requirements;

b) rigorous evaluation of each supplier's response against specified criteria, with the results of the evaluation informing decision-making;

c) detailed record-keeping, so that accurate information exists regarding how decisions are made and value for money is achieved; and

d) consistent treatment of all suppliers regarding the development and implementation of contracts for the delivery and payment for services.

# Entities' responses

In accordance with subsection 18(2) of the *Auditor-General Act 1996*, Canberra Health Services was provided with the draft proposed report for comment. All comments were considered and required changes were reflected in the final proposed report.

In accordance with subsection 18(2) of the *Auditor-General Act 1996*, Canberra Health Services was provided with the final proposed report for comment. All comments were considered and required changes were reflected in the final report.

In accordance with subsection 18(3) of the *Auditor-General Act 1996* other entities considered to have a direct interest in the report were also provided with extracts of the draft proposed and final proposed reports for comment. All comments were considered and required changes made.

# 1 INTRODUCTION

## Outpatient services

1.1 Patients referred for diagnostic and treatment services from specialists, who may not need to be admitted to hospital but require hospital services, are known as outpatients.

1.2 Access to outpatient services is usually prompted by either a referral from a General Practitioner (GP), or an emergency or admitted patient episode, for which diagnostic or follow-up care is required.[1] Services are delivered by a medical or nurse practitioner, sometimes with input from allied health personnel and/or clinical nurse specialists.

1.3 Outpatient services comprise:

- procedures—minor surgical and non-surgical procedures by a surgeon or other medical specialist, where hospital admission is not required (11 percent of all outpatient services nationally in 2020-21);
- consultations—services by a medical or nurse practitioner, sometimes with input from allied health personnel and/or clinical nurse specialists (26 percent of all outpatient services nationally in 2020-21);
- diagnostics—stand-alone diagnostic services such as imaging, screening, clinical measurement and pathology which support outpatient clinics (19 percent of all outpatient services nationally in 2020-21); and
- allied health and/or clinical nurse specialist interventions—services led or primarily provided by an allied health professional or clinical nurse specialist (44 percent of all outpatient services nationally in 2020-21).[2]

[1] Australian Institute of Health and Welfare (AIHW), *Non-admitted patient activity*, available from https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/nap [accessed 21 March 2023].

[2] AIHW, *Australia's hospitals at a glance*, 7 December 2022, available from https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance/contents/hospital-activity [accessed 21 March 2023]; Independent Health and Aged Care Pricing Authority (IHACPA), *Tier 2 Non-Admitted Services Classification*, available from https://www.ihacpa.gov.au/health-care/classification/non-admitted-care/tier-2-non-admitted-services-classification [accessed 21 march 2023]; IHACPA, *Tier 2 Non-Admitted Services Definitions Manual 2022–23*, Version 7.0, April 2022, available from https://www.ihacpa.gov.au/sites/default/files/2022-08/Tier%202%20Non-Admitted%20Services%20Definition%20Manual%202022-23.pdf

1.4 In 2020–21, the specialties receiving the largest number of outpatient referrals nationally were cardiology, dermatology, gynaecology, neurology, obstetrics, oncology, paediatrics and rheumatology.[3]

## Public health response to COVID-19

1.5 The first case of COVID-19 in the ACT was confirmed on 12 March 2020. The Territory declared a public health emergency the following week on 16 March. To manage the risk of COVID-19 in the public hospital system, visitor restrictions were introduced on 19 March. This was followed by an announcement on 25 March that all elective surgery other than Category 1 (urgent) and urgent Category 2 (semi-elective) cases would be suspended. At the same time, the ACT Government announced it would reduce non-urgent and non-essential outpatient activity as part of the health response to the COVID-19 pandemic. A timeline of key milestones is provided at Appendix A to this report.

1.6 On 2 April 2020, funding of $126 million for the Territory's public health response to COVID-19 was announced. The funding comprised:

- $63 million from the ACT Government, appropriated via an amendment to the *Appropriation Bill 2019-2020 (No 2)*, which had accompanied the Mid-Year review in February;[4] and
- an equal amount from the Commonwealth, which had committed to reimburse states and territories for 50 percent of eligible COVID-19 related costs under the *National Partnership on COVID-19 Response*.[5]

1.7 Efforts to re-establish access to hospital services were then introduced. On 22 April 2020, telehealth appointments for CHS outpatients were announced. This was followed on 24 April by the announcement that elective surgery Category 2 and 3 procedures would resume (Category 1 had not been affected by COVID-19 restrictions). The following month, on 29 May, an easing of COVID-19 restrictions was announced, and hospital visitor access restrictions were eased from 4 June to allow patients to have up to two visitors per day.

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[3] AIHW, *Referred medical specialist attendances*, 7 July 2022, available from: https://www.aihw.gov.au/reports/medical-specialists/referred-medical-specialist-attendances [accessed 21 March 2023].

[4] Appropriation Bill 2019-2020 (No 2); *Appropriation Act 2019-20 (No. 2)*; Legislative Assembly for the ACT, *Debates*, Thursday, 13 February 2020, p. 281; ACT Government, Supplementary Budget Papers 2019-2020, February 2020, available from https://apps.treasury.act.gov.au/__data/assets/pdf_file/0007/1479976/2019-20-supplementary-budget-papers.pdf; Legislative Assembly for the ACT, *Debates*, 2 April 2020, pp. 815-819.

[5] This commitment was for the duration of the Australian Health Sector Emergency Response Plan for Novel Coronavirus 2019 (COVID-19 plan). The COVID-19 plan was declared by the Australian Health Protection Principal Committee (AHPPC). See *National Partnership on COVID-19 Response*, clause 10, as in effect in 2020; Eligible costs included public hospital elective surgeries that had been delayed in response to the COVID-19 outbreak (additionality was measured against the number of surgeries performed in 2018-19). See *National Partnership on COVID-19 Response*, clause 33.b and 37.c, as in effect in 2020.

# Operation Reboot

1.8 'Operation Reboot' was announced on 1 July 2020.[6] It aimed to provide additional support for the recovery of public health services impacted by COVID-19. The media release stated:

> … while the pandemic is certainly not over, we are now in a good position to re-open many services and procedures that were postponed due to COVID-19 and fast track recovery in our public health system.[7]

1.9 Under the Operation Reboot initiative, $30 million was allocated in 2020-21 for:

- 2,000 elective surgeries;
- 14,000 additional specialist outpatient appointments (Reboot (Outpatients));
- up to 679 additional endoscopy procedures;
- targeted school checks for kindergarten children focusing on hearing and vision;
- 2,600 child development checks through the Maternal and Child Health Clinic; and
- up to 1,900 dental appointments targeting people with special needs, children and vulnerable community groups.[8]

1.10 $3.5 million was allocated for the specialist outpatient component of this initiative; Reboot (Outpatients). At the end of the initiative in June 2021, only $1,304,592 had been spent on Reboot (Outpatients). Of this, $1,112,400 was for appointment activity and $192,192 was for administration. A total of $2,195,408 remained unspent due to the lower than intended number of appointments being delivered.

1.11 Canberra Health Services (CHS) advised that the unspent funding was reallocated within CHS to other elements of Operation Reboot or to the broader COVID-19 public health response. Reboot (Outpatients) activity is summarised in Table 1-1.

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[6] Appropriation Bill 2019-2020 (No 2); Legislative Assembly for the ACT, *Debates*, Thursday, 13 February 2020, p. 281; ACT Government, Supplementary Budget Papers 2019-2020, February 2020, available from https://apps.treasury.act.gov.au/__data/assets/pdf_file/0007/1479976/2019-20-supplementary-budget-papers.pdf.

[7] Barr, A (Chief Minister) and Stephen-Smith, R, *Boosting elective surgery and specialist outpatient clinics*, media release, 1 July 2020, available from https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/barr/2020/boosting-elective-surgery-and-specialist-outpatient-clinics

[8] Ibid.

### Table 1-1 Reboot (Outpatients) activity

| Activity | Outcome | Expenditure |
|---|---|---|
| **Internal outpatient clinics** | 5,547 additional appointments | $1,112,400 |
| **External providers** | 585 additional appointments | $104,240 |
| **Administrative support** | 299 wait list removals* and support and coordination of internal and external activities | $192,192<br>($500,000 had been included in the total cost for admin support) |
| **Total** | 6,132 appointments<br>(43.8% of target of 14,000 appointments) | $1,314,751<br>(37.6% of budgeted $3.5 million) |

Source: ACT Audit Office, based on information supplied by CHS. These counts are approximate only.

Note: Measurement limitations associated with Reboot (Outpatients) are discussed in Chapter 4 of this report.

* Removals were the result of several different streams of work: 250 while consenting for My Emergency Doctor; two while consenting for Yarralumla GP Clinic; 47 as part of the nurse review of patients waiting 2000 to 4000 days.

## Wait list initiatives

1.12 Wait list initiatives like Reboot (Outpatients) are not uncommon in the public health system. They typically provide funding for additional clinical capacity for a finite time. Done well, they can provide a one-off benefit, but have demonstrated to be ineffective in addressing structural issues within a health system:

> In general, short-term funding targeted at waiting lists and waiting times has proved unsuccessful. This may be because it fails to address the structural issues that determine waiting times, leads to a subsequent increase in demand, or is targeted at a specific waiting list.[9]

1.13 Effective wait list initiatives require clear objectives, detailed demand and capacity planning, achievable workforce plans and realistic budgets. Operationally, lists need to be validated, cases screened to ensure supporting information is available and staff recruitment and rostering completed in good time.

1.14 In *Strategies to reduce waiting times for elective care* the Kings Fund investigated factors that, in combination, enabled the National Health Service in England to significantly and sustainably reduce elective waiting times in the 2000s. The Kings Fund highlight:

- hospitals that improved fastest tended to have accurate wait list and clinic capacity data at speciality and consultant level to pinpoint bottlenecks and identify opportunities;
- the use of a clear national 18-week waiting time standard (from referral from a GP to commencement of treatment) provided the basis for performance management;

[9] Siciliani, L., Moran, V. and Borowitz, M., 'What works? Waiting time policies in the health sector', *Eurohealth*, 21(4), 2015, p. 16.

- the importance of central visibility of performance and implementation progress so areas requiring additional support or intervention were clearly seen;
- waiting times were made a top tier priority for managers and that they were held to account to deliver against the 18-week standard; and
- a narrative that communicates the purpose of reducing waiting times improvement, in a way that responds to values shared among clinicians and managers, is needed to galvanise the workforce.[10]

## Roles and responsibilities

1.15 Canberra Health Services (CHS) was the agency responsible for the development and delivery of Reboot (Outpatients). CHS is the ACT Government directorate responsible for the delivery of health services and facilities that are owned and operated by the ACT Government, primarily via the Canberra Hospital.[11]

1.16 Within CHS, responsibility for outpatient care is distributed across a number of different divisions. The Division of Cancer and Ambulatory Support (CAS) has overarching responsibility for outpatient care strategic direction, reform projects, facilities management and health intake.[12]

1.17 Outpatient services are delivered by clinics in the Division of Cancer and Ambulatory Support, as well as clinics in five other divisions:

- Medicine;
- Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS);
- Rehabilitation, Aged and Community Services (RACS);
- Surgery; and
- Women, Youth and Children (WYC).[13]

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[10] Blythe, N. and Ross, S., *Strategies to reduce waiting times for elective care*, The Kings Fund, 2022, available from https://www.kingsfund.org.uk/sites/default/files/2022-12/Strategies%20to%20reduce%20waiting%20times%202022.pdf

[11] In addition to CHS-run services, public hospital services in the Territory are also delivered by Calvary Health Care ACT Ltd. (Calvary), a subsidiary of Little Company of Mary Health Care Ltd., a not-for-profit Catholic health care organisation. Calvary delivers most of its ACT-based public hospital services via Calvary Public Hospital. Calvary Public Hospital was engaged in the early stages of Reboot (Outpatients) but did not ultimately deliver any appointments as part of the initiative.

[12] CHS, *Ambulatory Care Operations Manual*, issued 18 August 2021, p. 15, available from https://www.canberrahealthservices.act.gov.au/__data/assets/word_doc/0010/1981117/Ambulatory-Care-Operations-Manual.docx

[13] CHS, *Canberra Health Services Organisational Chart*, available from https://www.health.act.gov.au/sites/default/files/2021-11/CHS%20Organisational%20Chart%2020200821%20%281%29.pdf [accessed 21 March 2023].

1.18 Each of these divisions reports to the Chief Operating Officer (COO).

1.19 Oversight of outpatient care within CHS is provided by the Outpatient Transformation Steering Committee, which is supported by the Outpatient Transformation Working Group. These bodies have members from across the divisions delivering outpatient services. The activities of these committees in monitoring the implementation of Reboot (Outpatients) are discussed in detail in Chapter 5. The governance arrangements for outpatient care are shown in Figure 1-1.

**Figure 1-1 CHS outpatient care governance arrangements**


Source: CHS, *Ambulatory Care Operations Manual*, issued 18 August 2021, p. 12.

# Audit objective and scope

## Audit objective

1.20 The objective of the audit was to assess the effectiveness of CHS' administration of Reboot (Outpatients).

## Audit scope

1.21 The audit considered CHS' activities to plan for, and implement, Reboot (Outpatients).

1.22 The audit focused on CHS' activities in 2020-21, following the ACT Government's July 2020 announcement of Operation Reboot. CHS' earlier planning activities were considered as necessary, as well as subsequent reporting relevant to these activities. The audit considered:

- the effectiveness of CHS' planning for Reboot (Outpatients), including needs identification and analysis, objective setting, and implementation planning;

- sourcing and allocation of resources across the three areas of activity CHS planned to contribute to Reboot (Outpatients), including:
  - proposals from CHS specialist clinics to provide additional appointments to people on the wait list;
  - expressions of interest from external medical providers to deliver appointments via external clinics;
  - allocation of administrative staff to review and update the wait list and provide other administrative support to the initiative; and
- arrangements to manage the implementation of Reboot (Outpatients), including monitoring and reporting.

1.23 In addition to outpatient services, Operation Reboot provided funding for a range of other services to assist with the public health system's recovery from COVID-19 disruptions. These included elective surgeries and child development checks. The audit did not consider these aspects of Operation Reboot.

1.24 The audit also did not consider CHS':

- planning for, and implementation of, the Digital Health Record;
- administration of referral, triage and wait list processes or the effectiveness of the IT systems used for this purpose; and
- demand management measures, such as diverting patients to other non-hospital health services.

1.25 The audit also did not consider broader funding arrangements for outpatient (and hospital) services including:

- hospital funding arrangements relating to outpatient care, such as funding and billing of outpatients through Medicare or GP provider; and
- levels of funding by the Commonwealth and ACT Government.

# Audit criteria, approach and method

## Audit criteria

1.26 To form a conclusion against the objective, the following criteria were used:

- Criterion 1: Did CHS effectively plan for Reboot (Outpatients)?
  - The target of 14,000 removals from the wait list was based on appropriate analysis of service need and capacity.
  - CHS had an effective plan for implementing Reboot (Outpatients).
- Criterion 2: Did CHS effectively source and allocate resources to Reboot (Outpatients)?

  - CHS effectively identified internal medical skills and resources.
  - CHS developed and implemented an effective procurement plan for external medical providers and considered value for money when assessing procurement options.
  - CHS effectively identified and allocated internal administrative skills and resources to review and update the wait list and provide other administrative support.
- Criterion 3: Did CHS effectively manage, monitor and report on the implementation of Reboot (Outpatients)?
  - CHS effectively managed the resources necessary to support Reboot (Outpatients) implementation.
  - CHS effectively monitored and reported on progress during implementation.
  - CHS identified and documented learnings from Reboot (Outpatients).

## Audit approach and method

1.27 The audit approach and method consisted of analysis of documentation, and discussions with key CHS officials, including the:

- Executive Director, Cancer and Ambulatory Support;
- Executive Director, Medical Services;
- Senior Manager, Outpatient Support;
- Senior Director, External Reporting and Budgets;
- Manager, Financial Support Unit;
- Manager, Business Intelligence;
- Executive Director, Rehabilitation, Aged and Community Services; and
- Medical Director GP Liaison Unit.

1.28 Fieldwork involved:

- recovering the documentary trail for decisions and supporting advice sufficient to form a view on the effectiveness of CHS' implementation of Reboot (Outpatients); and
- discussions with CHS officials, to build an understanding of events, improve the efficiency of searching for documentation, and as a secondary means to corroborate events.

1.29 The Australian Healthcare and Hospitals Association (AHHA) was engaged to assist with the conduct of the audit. An AHHA consultant provided subject matter expertise with respect to the management and administration of outpatient services in a hospital context.

1.30 Auditing Standard ASAE 3500 requires that an audit consider events up to the date of the report. To achieve this, when seeking comments on the draft report, the audit team asked the agency to inform the team of any significant events affecting audit findings since fieldwork ceased.

1.31 The audit was performed in accordance with *ASAE 3500 – Performance Engagements.* The audit adopted the policy and practice statements outlined in the Audit Office's *Performance Audit Methods and Practices* (PAMPr) which is designed to comply with the requirements of the *Auditor-General Act 1996* and *ASAE 3500 – Performance Engagements*.

1.32 In the conduct of this performance audit the ACT Audit Office complied with the independence and other relevant ethical requirements related to assurance engagements.

## Disclosure of deliberative information

1.33 Section 20 of the *Auditor-General Act 1996* (the Act) relates to the disclosure of 'deliberative information' in Audit Office reports. Section 20 provides that the Auditor-General may only include 'deliberative information' in a report:

- if the Auditor-General considers that it is in the 'public interest' to do so; and
- after consulting with the Chief Minister.

1.34 'Deliberative information' is defined in the Act as 'information that discloses a deliberation or decision of the Executive'.

### Report references to Cabinet material

1.35 The audit report refers to, and includes information from, Cabinet material. The material is included to provide information on the advice provided to Cabinet with regard to the outpatient waitlist, the impact of the pandemic on outpatient services and progress of Operation Reboot.

### Consultation with the Chief Minister

1.36 The Chief Minister was consulted regarding information to be included in the report. On 8 May 2023, the Chief Minister was provided with the extracts of the draft proposed report that included the Cabinet material.

1.37 On 1 June 2023 the Head of Service, on behalf of the Chief Minister, advised that they did not have any specific concerns or objections in relation to the use of the material in the audit report.

# 2 PLANNING FOR REBOOT (OUTPATIENTS)

2.1 This chapter discusses the development and approval of the Reboot (Outpatients) concept. It discusses key contextual factors that shaped its development.

## Summary

### Conclusions

Planning for Reboot (Outpatients) was ineffective. The target of 14,000 additional specialist outpatient appointments was derived from pre-COVID-19 data analysis that did not account for the impact of the early public health response to the pandemic, which was ostensibly the purpose of Operation Reboot.

### Key findings

| | Paragraph |
|---|---|
| **Wait list management** | |
| Restricted access to hospital services from March 2020 to May 2020, due to the COVID-19 pandemic, exacerbated an existing mismatch between the number of patient referrals received by CHS, and the initial appointments provided. The number of initial outpatient appointments provided by CHS declined more rapidly than patient referrals from February 2020 to April 2020 and recovered more slowly in May. In the four months to May 2020, the percentage of patients waiting beyond clinically recommended timeframes increased from 67 percent to 75 percent. | 2.24 |
| **The Reboot (Outpatients) target** | |
| Reboot (Outpatients) sought to provide 14,000 additional specialist outpatient appointments. CHS' efforts to address outpatient wait lists was predicated on the provision of additional appointments and not by redesigning or providing services more efficiently. The target of 14,000 appointments was identified in a June 2020 ACT Health Directorate 2020-21 ACT Budget Submission. The inclusion of '14,000 specialist appointments' in the Submission was based on a draft Budget Concept Brief developed by CHS in early 2020. The two-page Concept Brief was characterised by:<br>• analysis of service need from pre-COVID-19 data, as at January 2020; and<br>• analysis of service need in specialities with long waits in categories 1 and 2, rather than categories 2 and 3, where appointments had been rescheduled as part of the public health response to the pandemic. | 2.39 |

Neither of these methods of analysis yielded the target of 14,000. The target of 14,000 was based on analysis of service need from pre-COVID-19 data and did not account for the increasing proportion of patients waiting outside clinically recommended timeframes due to the early public health response to the pandemic, which was ostensibly the purpose of Operation Reboot. 2.40

## Wait list management

2.2 Outpatient services in the ACT (and other jurisdictions) usually receive more patient referrals than they have appointments available for new patients. A reason for this is that outpatient appointments are typically taken for follow up appointments rather than initial appointments (up to 80 percent of appointments in 2019). As a consequence, long waits for initial consultation with a specialist ('initial long waits') are a persistent problem in outpatient care, both in the ACT and other jurisdictions.[14]

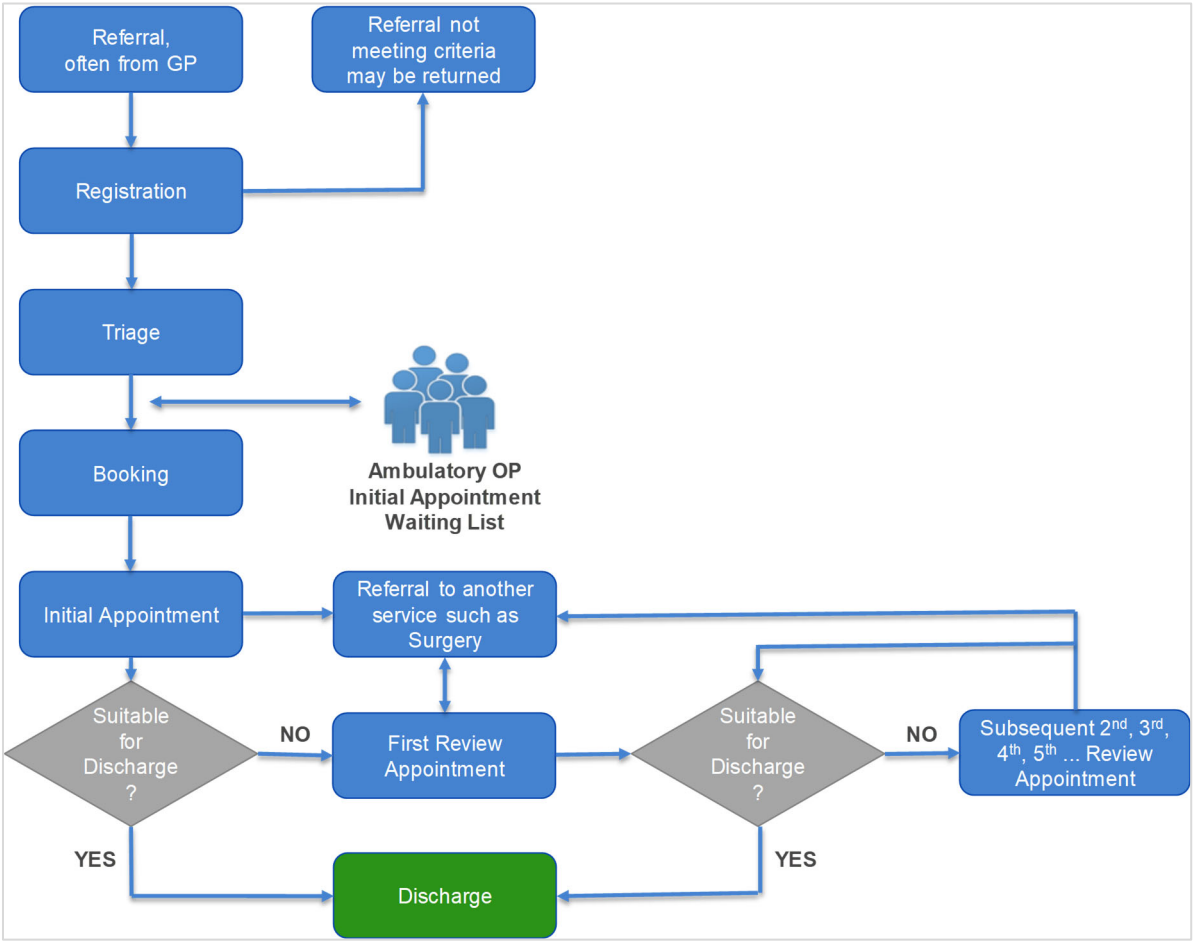
2.3 CHS attempts to minimise the impact of this mismatch between referrals and initial appointments through its administration of wait lists. CHS' *Ambulatory Care Operations Manual* sets out the process for wait list management:

> Wait lists are used to ensure consumers are treated equitably within clinically appropriate timeframes, promoting the most effective use of available resources. All ambulatory activity should reflect a genuine clinical need in addition to other eligibility criteria as determined by the service.
>
> Services able to book all appointments within the six-month horizon do not need to use a wait list but may elect to do so.
>
> …
>
> A client's referral is placed on to the Wait List once it has been triaged (for initial), post discharge from CHS ward, or a continuing/following/review appointment is required ...

2.4 Figure 2-1 shows CHS' wait list management process.

[14] Australian Medical Association, *Shining a light on the elective surgery 'hidden' waiting list*, 30 September 2022, available from https://www.ama.com.au/elective-surgery-hidden-waiting-list

## Figure 2-1 CHS wait list management process




Source: ACT Audit Office, based on information provided by CHS.

2.5 Figure 2-1 shows that after initial referral, registration and triage takes place, the patient will usually be placed on the 'ambulatory initial wait list' before being booked for a consultation with a CHS specialist. It is this initial wait list that Reboot (Outpatients) targeted.

2.6 Reboot (Outpatients) was particularly focused on reducing the number of patients waiting outside clinically recommended timeframes for an initial appointment. At the time Reboot (Outpatients) commenced, these timeframes were determined using three priority categories. These are summarised in Table 2-1.

## Table 2-1 Outpatient priority categories

| Category | Definition |
|---|---|
| **1** | (urgent)—Appointment within 0 to 30 days. |
| **2** | (semi-elective)—Appointment within 90 days. |
| **3** | (elective)—Appointment within 365 days. |

Source: CHS, *Ambulatory Care Operations Manual*, issued 18 August 2021, p. 43.

2.7 An additional higher urgency category with a recommended timeframe of two weeks has since been added, but no change has been made to the 30, 90 and 365 day waiting times outlined in Table 2-1. The AHHA consultant advised that it is better practice to have fewer categories (e.g. Urgent and Routine). Adding a fourth category is not consistent with this.

2.8 Depending on the outcome of the initial appointment, a patient may be referred to another CHS service within the hospital and/or placed on a further CHS wait list, before being booked for a follow-up appointment to review their condition. CHS data shows that, on average, approximately 80 percent of appointments are to review existing patients.

## Performance targets

2.9 Several jurisdictions have moved to improve access to outpatient care through performance improvement targets and the publication of outpatient wait list data. However, there are no nationally agreed reporting standards or performance targets for outpatient care.[15]

2.10 The Territory does not currently publish outpatient waiting times and, prior to 2020, CHS did not set performance targets for outpatient services through its strategic planning framework. Nevertheless, data presented to the first meeting of the Outpatient Transformation Steering Committee showed CHS delivered 127,026 outpatient appointments in 2019 (an average of 10,586 per month). Because a high proportion of these were follow-up reviews (80.3 percent), the number of new referrals (36,462) significantly outstripped the number of new appointments that were provided (25,045). As such, between 2018 and 2019, the initial wait list grew from 19,884 to 23,642.

2.11 As a consequence, in February 2020, the Outpatient Transformation Steering Committee considered the introduction of two key performance indicators:

- raising new appointments to 50 percent (from around 20 percent in 2019); and
- seeing all Category 1 patients within the clinically recommended timeframe of 30 days.

2.12 However, these indicators have not been formally agreed to or implemented.

2.13 In relation to outpatient waiting times, CHS' *Clinical Services Plan 2021-2031*, which was under consultation from August 2020 during the implementation of Operation Reboot, committed to:

> … support improved patient flow, prioritisation, provision of care in the community and / or at home (through virtual care models), and continue our improvement in management of long wait patients on the waiting list. In addition, we will explore the potential for Territory-wide waiting lists.

[15] Australian Medical Association, *Shining a light on the elective surgery 'hidden' waiting list*, 30 September 2022, available from https://www.ama.com.au/elective-surgery-hidden-waiting-list

2.14 A revised target of 35 percent new consultations by June 2023 is currently in place under the *Canberra Health Services Corporate Plan (Our strategic priorities for July 2022 – June 2023)*. Meeting this target would involve reducing the proportion of outpatient appointments that are used to review existing patients (currently around 80 percent) to increase the number of new patients that can be seen. If this can be achieved, it will allow capacity to exceed demand and bring CHS outpatients into line with better practice nationally and internationally.

2.15 The *ACT Health Services Plan 2022-2030*, led by the ACT Health Directorate (ACTHD), also commits to further related actions including:

- a focus on 'transitions of care' through health services, including between outpatient services and other parts of the health system;
- investing in alternative models to better-manage demand for outpatient care, such as telehealth and community-based facilities;
- working with GPs and nurse practitioners to support transitions from specialist to primary care; and
- better forecasting outpatient demand by the ACTHD.[16]

## The impact of COVID-19

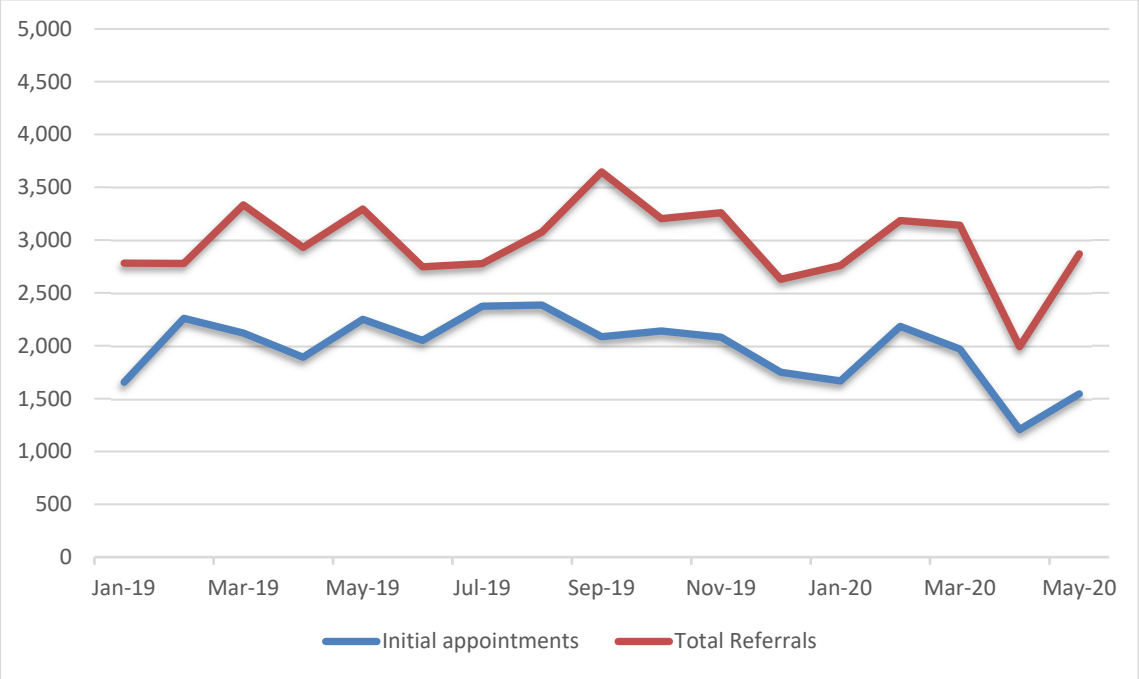
2.16 The Outpatient Transformation Steering Committee was established in February 2020. It was established in response to an identified lack of ownership and formal strategic direction for outpatient care within CHS, including a lack of accountability for outcomes, unclear governance and a siloed approach. It sought to provide a means to address the lack of strategic direction, as well as issues related to patient-centred care, relationships with GPs, resourcing and IT.

2.17 The Steering Committee's initial discussions of possible performance targets and strategies to achieve these issues were soon overtaken by the COVID-19 pandemic. Restricted access to hospital services from March to May 2020 exacerbated an existing mismatch between the number of patient referrals received by CHS, and the initial appointments provided.

2.18 Figure 2-3 shows the number of outpatient referrals and initial appointments between January 2019 and May 2020.

[16] ACT Health Directorate (ACTHD), *ACT Health Services Plan 2022-2030*, 2022, pp. 38, 45, and 54, available from https://health.act.gov.au/about-our-health-system/planning-future/act-health-services-plan-2022-2030

### Figure 2-3 Total outpatient referrals and initial appointments (January 2019 to May 2020)

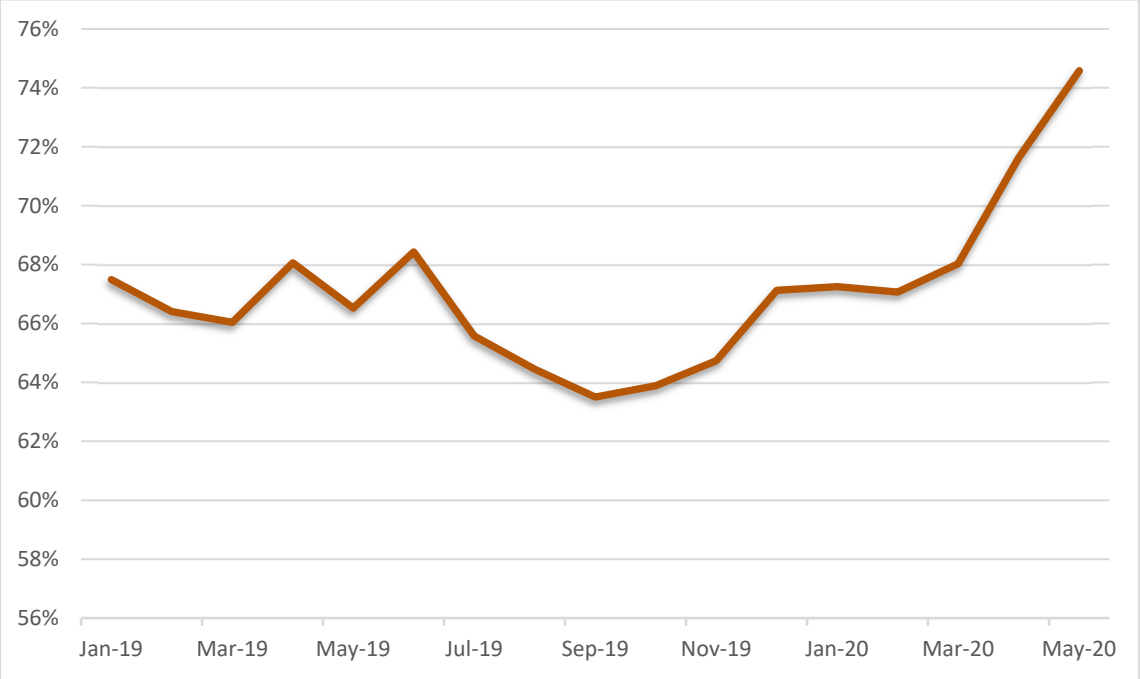



Source: ACT Audit Office, based on CHS data.

2.19 The number of initial outpatient appointments provided by CHS declined more rapidly than referrals from February to April 2020 and recovered more slowly in May. Appointments declined by 10 percent in March and 39 percent in April, compared with declines in referrals of 1 percent in March and 37 percent in April. In May, referrals rapidly increased (by 44 percent) compared with a slower recovery in appointments (28 percent).

2.20 Figure 2-4 shows the percentage of patients across all specialties waiting beyond clinically-recommended timeframes for an initial appointment between January 2019 and May 2020, averaged across specialties.

**Figure 2-4 Average percentage of patients waiting beyond clinically recommended timeframes for an initial appointment (January 2019 to May 2020)**

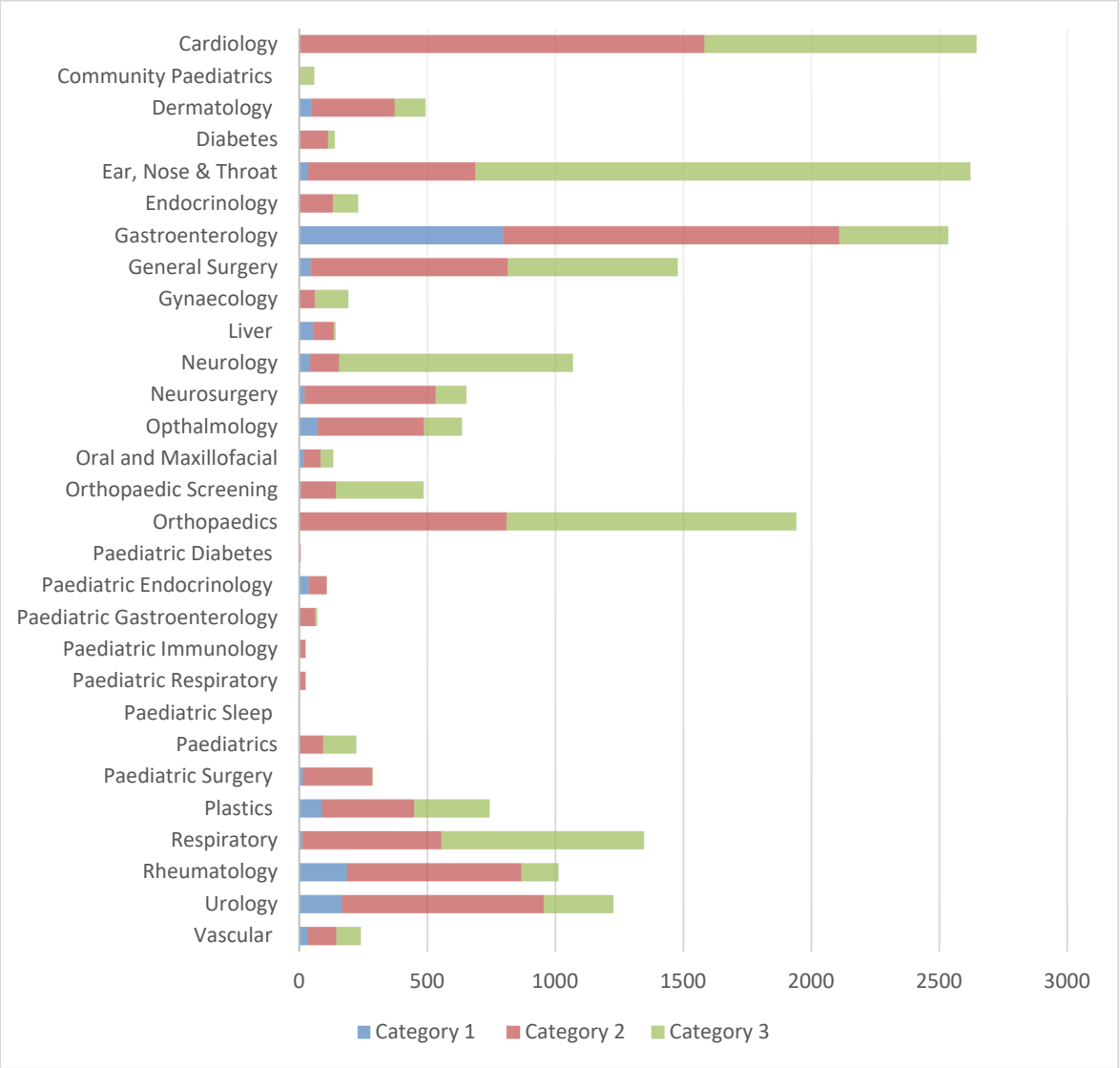



Source: ACT Audit Office, based on CHS data.

2.21 In the four months to May 2020, the percentage of patients waiting beyond clinically recommended timeframes for an initial appointment, as per the priority categories shown in Table 2-1, increased from 67 percent to 75 percent.

2.22 However, initial long waits are more common in some specialties than others. Figure 2-5 shows initial long wait lists by specialty in May 2020.

## Figure 2-5 Initial long waits by specialty (May 2020)




Source: ACT Audit Office, based on CHS data.

2.23 A review of initial long wait lists by specialty in May 2020 shows significant variations between specialties in the number of patients waiting outside clinically recommended timeframes:

- the five specialties with the largest number of long waits, together accounting for 54 percent of all long waits, were: Cardiology (2,646); Ear, Nose and Throat (2,622); Gastroenterology (2,536); Orthopaedics (1,942); and General Surgery (1,479);
- paediatric services generally have few long wait patients, with the lowest number of long waits in Paediatric Sleep (1); Paediatric Diabetes (7); Paediatric Respiratory (26); Paediatric Immunology (26) and Community Paediatrics (60); and
- non-Paediatrics specialties with low numbers of long waits were: Oral and Maxillofacial (134); Diabetes (140); Liver (143); Gynaecology (198); and Endocrinology (231).

2.24 Restricted access to hospital services from March 2020 to May 2020, due to the COVID-19 pandemic, exacerbated an existing mismatch between the number of patient referrals received by CHS, and the initial appointments provided. The number of initial outpatient appointments provided by CHS declined more rapidly than patient referrals from February 2020 to April 2020 and recovered more slowly in May. In the four months to May 2020, the percentage of patients waiting beyond clinically recommended timeframes increased from 67 percent to 75 percent.

# The Reboot (Outpatients) target

2.25 Reboot (Outpatients) sought to provide 14,000 additional specialist outpatient appointments.

## Health Directorate Budget Submission (June 2020)

2.26 Increases in referrals and initial appointments in May 2020 (as shown in Figure 2-3) showed outpatient services were beginning to recover from the initial impact of the COVID-19 pandemic. However, the effects were still evident in the increasing proportion of long waits (as shown in Figure 2-4).

2.27 On 23 June 2020 the ACT Health Directorate made a 2020-21 ACT Budget Submission for Cabinet consideration. The Submission was made partly in response to the impact of the pandemic on outpatient services. The Submission sought agreement to roll over a 2019-20 underspend of $29.95 million to 2020-21 'to meet forecast costs associated with COVID-19 suppression, impact and ongoing recovery'. The Submission noted:

> Decisions taken both nationally and locally restricted many elective and non-essential health care services for a number of months. Restrictions created capacity within hospitals, preserved PPE, as well as protected the workforce, patients and families – by avoiding crowded waiting rooms and treatment spaces. But it resulted in thousands of Canberrans not receiving the care they need in a timely way.
>
> Both ACT public hospitals experienced some reduction in (non-COVID-19) activity over April 2020. At the end of April, total activity as measured by National Weighted Activity Units (NWAU) was approximately 3.7 per cent below the pro-rata year to date (YTD) target, or approximately 4,800 NWAU, excluding COVID-19 activity.
>
> Patients and their conditions are now deteriorating. In some areas, restrictions created marked backlogs, which added to already existing waitlists. The backlog generated was significant. The most clinically urgent include:
>
> …
>
> 14,000 specialist appointments …
>
> …
>
> With the health system returning to normal, existing capacity cannot handle both normal activity and extended wait lists. Tens of thousands of Canberrans are now waiting longer than is safe for their care.
>
> Although these patients are not strictly COVID-19 patients, the impact on their care has been a direct result of COVID-19.

2.28 The Budget Submission was developed in consultation and with the support of CHS. In respect of outpatient care, the inclusion of '14,000 specialist appointments' in the Submission was based on a draft Budget Concept Brief developed in early 2020.

## Draft Budget Concept Brief (early 2020)

2.29 The draft Budget Concept Brief sought an additional $3.5 million funding to achieve the following outcomes:

> Remove 14,000 referrals from the waiting list. 100% of Cat 1 seen in 30 days. 90% of Cat 2 seen in 90 days. Long wait Cat 3 referrals reduced by 40%.

2.30 The draft Budget Concept Brief stated:

> CHS currently has 20,000 referrals waiting outside clinically recommended timeframes for outpatient appointments. This initiative will target specialties with long wait Cat 1 and 2 patients (as per below table) with additional clinic sessions through a combination of locums, extra registrar and VMO [visiting medical officer] sessions. Where possible other approaches to care such as referral review, allied health assessment, telehealth, referral to alternate service and partnering with local GPs to host specialist clinics will be implemented. Whilst backlog is cleared, continue to work with services to increase clinic capacity and reduce demand to ensure sustainability.

2.31 The figures referenced in the draft Budget Concept Brief are shown in Table 2-1.

### Table 2-1 Number of outpatients waiting outside clinically recommended timeframes in specialties with Category 1 and 2 long waits (January 2020)

| Speciality | Category 1 | Category 2 | Category 3 |
|---|---|---|---|
| Ear Nose and Throat (ENT) | 19 | 549 | 1,761 |
| General Surgery | 73 | 658 | 538 |
| Urology | 107 | 668 | 229 |
| Orthopaedics | 13 | 740 | 1,514 |
| Orthopaedics Screening | 11 | 49 | 596 |
| Neurosurgery | 30 | 474 | 99 |
| Ophthalmology | 95 | 400 | 106 |
| Oral and Maxillofacial | 19 | 47 | 39 |
| Plastics | 113 | 264 | 334 |
| Vascular | 37 | 118 | 64 |
| Dermatology | 59 | 324 | 120 |
| Endocrinology | 3 | 129 | 101 |
| Gastroenterology | 883 | 698 | 352 |
| Rheumatology | 369 | 675 | 125 |
| Respiratory | 6 | 429 | 663 |
| Paediatric Surgery | 21 | 184 | 1 |
| **TOTAL** | **1,858** | **6,406** | **6,642** |

Source: ACT Audit Office, based on information provided by CHS.

2.32 The number of outpatients waiting outside clinically recommended timeframes in all specialties and categories was 14,906 as at January 2020. This formed the basis for the objective to remove 14,000 referrals from the wait list. The data pre-dates the impact of COVID-19 and associated increase in the proportion of patients waiting outside clinically recommended timeframes.

2.33 Additionally, the draft Budget Concept Brief used data for specialities with long waits in categories 1 and 2, rather than 2 and 3, which were the categories where appointments had been rescheduled as part of the public health response to the pandemic.

2.34 More specifically, however, if the goal was to reduce the Category 1 waitlist by 100 percent, the Category 2 waitlist by 90 percent and the Category 3 waitlist by 40 percent (as per the draft Budget Concept Brief) then the planned number for Reboot should have been in the order of 10,280. Overall, this shows a lack of macro planning and general confusion around the 14,000 figure.

## Development of Concept Brief

2.35 CHS was unable to provide details relating to the timing, development, and approval of the draft Budget Concept Brief. However, there is evidence that the Concept Brief was initially developed in early 2020 for the purpose of the 2020-21 ACT Budget, but that it did not proceed because of the COVID-19 pandemic.

2.36 In December 2019, Treasury had issued 2020-21 Budget guidance, stating:

> For the 2020 21 Budget, Concept Briefs are being considered via the Initiatives Review Process, which will involve the Chief Minister and the Deputy Chief Minister meeting directly with individual Ministers to discuss their respective new initiatives. The Chief Minister and Deputy Chief Minister will then advise, via correspondence, which items are able to proceed to the Business Case Stage.
>
> Full Business Cases will then be considered by the Budget Committee of Cabinet (BCC) for potential inclusion in the 2020-21 Budget.

2.37 Cabinet consideration was anticipated to take place between March and May 2020, following the Initiatives Review Process. This would have included consideration of the draft Budget Concept Brief prepared by CHS. However, the development of concept briefs and business cases did not occur as anticipated in 2020 because of the advent of the COVID-19 pandemic.

2.38 CHS advised that consultation with internal and external stakeholders was not undertaken as part of developing the draft Budget Concept Brief.

2.39 Reboot (Outpatients) sought to provide 14,000 additional specialist outpatient appointments. CHS' efforts to address outpatient wait lists was predicated on the provision of additional appointments and not by redesigning or providing services more efficiently. The target of 14,000 appointments was identified in a June 2020 ACT Health Directorate 2020-21 ACT Budget Submission. The inclusion of '14,000 specialist appointments' in the Submission was based on a draft Budget Concept Brief developed by CHS in early 2020. The two-page Concept Brief was characterised by:

- analysis of service need from pre-COVID-19 data, as at January 2020; and
- analysis of service need in specialities with long waits in categories 1 and 2, rather than categories 2 and 3, where appointments had been rescheduled as part of the public health response to the pandemic.

2.40 Neither of these methods of analysis yielded the target of 14,000. The target of 14,000 was based on analysis of service need from pre-COVID-19 data and did not account for the increasing proportion of patients waiting outside clinically recommended timeframes due to the early public health response to the pandemic, which was ostensibly the purpose of Operation Reboot.

# 3 MANAGEMENT AND ADMINISTRATION OF REBOOT (OUTPATIENTS)

3.1 This chapter considers the effectiveness of Canberra Health Services' (CHS) management and administration of Reboot (Outpatients).

## Summary

### Conclusion

The prioritisation of rapid rollout over forward planning compromised the effectiveness of the implementation of Reboot (Outpatients). Reboot (Outpatients) was primarily predicated on the provision of additional appointments as the mechanism to address the wait lists, rather than potentially more sustainable measures to improve efficiency.

A high-level approach to implementation was detailed in a draft Budget Concept Brief (which did not proceed to Cabinet). Once the initiative commenced, however, no project management plan or risk management plan was developed. In the early stages of implementation, some aspects of how the initiative was to be delivered were addressed in papers approved by the Outpatient Transformation Steering Committee.

This approach provided little scope for CHS to effectively manage risks to successful delivery of additional outpatient appointments. Several known risks, including limited access to clinic space, staffing, and COVID-19 transmissions, ultimately affected the rollout.

### Key findings

| | Paragraph |
|---|---|
| **Planning for Reboot (Outpatients)** | |
| Detailed implementation planning was not undertaken for Reboot (Outpatients). There was no agreed project plan that set out: a budget and schedule of activities aligned to the desired outcomes of the initiative; or roles and responsibilities for the initiative. | 3.14 |
| CHS advised that consideration was given to risks to its capacity to deliver 14,000 additional appointments. CHS asserted that risks were identified with respect to: the potential impact of COVID-19 on the achievement of the initiative's stated targets; and known limitations to business-as-usual outpatient activity, including clinic space and staffing. However, CHS' consideration of these issues was not documented, and no risk management plan was developed to mitigate the likely effects of these issues. | 3.15 |

These risks subsequently eventuated and impacted on the implementation of Reboot (Outpatients).

Although there was a lack of project planning, the early 2020 draft Budget Concept Brief provided broad guidance on how the additional 14,000 outpatient appointments were to be delivered under Reboot (Outpatients). It provided high level, summary details about staffing and intended activities. The draft Budget Concept Brief was supplemented by two papers, which were approved by the Outpatient Transformation Steering Committee; *Operation Reboot Arrangements Paper* and *Reboot (Outpatients) project report*. The papers addressed some aspects of how the initiative was to be implemented, including: 3.23

- governance and oversight of the initiative would be provided by the Steering Committee, a large existing body rather than a specifically convened group for the purposes of Reboot (Outpatients);
- processes for attracting and evaluating proposals from internal and external providers; and
- processes for measuring and funding the additional appointments to be delivered.

### Resourcing for Reboot (Outpatients)

Reboot (Outpatients) was led by a Senior Manager, with the following support: an Administrative Support Officer; 12 weeks support from a Registered Nurse; and a Project Officer, Outpatient Support (who was not a dedicated Reboot (Outpatients) resource). This was much lower than the support staffing level proposed in the draft Budget Concept Brief, which had estimated the initiative would require: 3.36

- three FTE nurses to provide additional in clinic support and referral screening;
- three administrative staff to audit the wait list, confirm referrals, and book appointments; and
- one data entry officer to cope with additional load through transcription.

COVID-19 transmissions contributed to an inability to retain support staff on the project. By the end of the initiative in June 2021, only $192,192 of the planned $500,000 had been spent on administrative and nursing costs. 3.37

# Planning for Reboot (Outpatients)

## Project planning

3.2 The Senior Manager, Outpatient Support was responsible for project managing Reboot (Outpatients). To do this, the Senior Manager took direction from the Outpatient Transformation Steering Committee, building on the approach, resourcing and risks set out in the draft Budget Concept Brief.

3.3 No detailed implementation planning was undertaken for Reboot (Outpatients). There was no project plan.

3.4 Currently, CHS provides project managers with a large number of project planning and management resources, including project management guidance and plans, governance guidelines and timeline templates. However, these were not in place when Reboot (Outpatients) commenced. CHS advised that it has tried to adopt a centralised project management approach several times over the years, and previously had a resource available to provide guidance to project managers, but widespread adoption of this assistance has proven challenging.

## The draft Budget Concept Brief

3.5 The draft Budget Concept Brief detailed the following planned activity:

> This initiative will target specialties with long wait Cat 1 and 2 patients … with additional clinic sessions through a combination of locums, extra registrar and VMO [visiting medical officer] sessions. Where possible other approaches to care such as referral review, allied health assessment, telehealth, referral to alternate service and partnering with local GPs to host specialist clinics will be implemented. Whilst backlog is cleared, continue to work with services to increase clinic capacity and reduce demand to ensure sustainability.

3.6 According to the draft Budget Concept Brief, the provision of additional appointments, rather than measures to improve efficiency, was identified as the mechanism for reducing the waitlists. The additional appointments would be provided by:

- additional staff working within CHS services (locums, extra registrar);
- other approaches to care (telehealth);
- in partnership with external providers (local GPs to host specialist clinics); and
- via external providers (referral to alternate service).

3.7 The draft Budget Concept Brief proposed the following resourcing for CHS to deliver the initiative:

> 5 FTE Staff Specialist (will be used to pay additional sessions, locums, VMOs across specialties).
>
> 3 FTE nurse to provide additional in clinic support and referral screening.
>
> 3 admin staff to audit wait list, confirm referrals, to book appointments.
>
> 1 typist to cope with additional load through transcription.
>
> Project management will be provided through existing [Ambulatory] Care Resources.
>
> Additional consumables and on costs.

3.8 The proposed resourcing for the initiative was not based on a detailed capacity analysis. Instead, the main focus of Operation Reboot was to address the surgical backlog, and the outpatients proposal was designed to make use of the funding available for outpatient care alongside the larger surgical effort.

3.9 Two key risks were identified in the Concept Brief:

> There may be considerable pushback by specialists who may not wish to participate in surge clinics or want locums to see patients referred to them.
>
> Increasing throughput in surgical specialties will increase the numbers of the surgical wait list.

3.10 CHS advised that consideration was given to risks to its capacity to deliver 14,000 additional appointments. CHS asserted that risks were identified with respect to:

- the potential impact of COVID-19 on the achievement of the initiative's stated targets; and
- known limitations to business-as-usual outpatient activity, including clinic space and staffing.

3.11 However, CHS' consideration of these issues was not documented, and no risk management plan was developed to mitigate the likely effects of these issues. In practice, these issues arose at several points throughout the implementation of Reboot (Outpatients), as discussed in Chapters 4 and 5.

### The Steering Committee—*Operation Reboot Arrangements Paper*

3.12 Early implementation issues outside the scope of the draft Budget Concept Brief were dealt with by the Outpatient Transformation Steering Committee at its 17 July 2020 meeting. The Executive Director, Division of Cancer and Ambulatory Support presented an *Operation Reboot Arrangements Paper*. The paper set out a proposed process to manage the outpatients-related Operation Reboot investment. The Steering Committee agreed to the Paper's proposals, one of which was that the Steering Committee would be the governance body to oversee the program. The Steering Committee also agreed to a process for seeking internal interest within CHS for the implementation of Reboot (Outpatients):

- a proposal template would be distributed to CHS outpatient services (clinics) for completion and return by 4 August 2020;
- proposals must include structural changes that are proposed to be implemented to address the capacity demand mismatch; and
- a small sub-group would meet to assess proposals from providers out of session.

3.13 The effectiveness of these arrangements is discussed in Chapters 4 and 5.

3.14 Detailed implementation planning was not undertaken for Reboot (Outpatients). There was no agreed project plan that set out: a budget and schedule of activities aligned to the desired outcomes of the initiative; or roles and responsibilities for the initiative.

3.15 CHS advised that consideration was given to risks to its capacity to deliver 14,000 additional appointments. CHS asserted that risks were identified with respect to: the potential impact of COVID-19 on the achievement of the initiative's stated targets; and known limitations to business-as-usual outpatient activity, including clinic space and staffing. However, CHS' consideration of these issues was not documented, and no risk management plan was

developed to mitigate the likely effects of these issues. These risks subsequently eventuated and impacted on the implementation of Reboot (Outpatients).

## Financial and performance planning

### Draft Budget Concept Brief

3.16 As discussed in the previous section, the draft Budget Concept Brief set out a proposed approach to delivering 14,000 outpatient appointments using one-off additional funding, and drawing (in part) on external medical providers. Both features of the initiative were new for CHS outpatient services.

3.17 CHS advised that these new features were central to the proposal outlined in the draft Budget Concept Brief. CHS intended to use the Reboot (Outpatients) funding to trial new approaches to addressing the backlog of long waits in outpatient services. This necessitated the creation of bespoke financial and performance monitoring arrangements that were outside the existing arrangements for outpatient services.

3.18 Ordinarily, government financial support for outpatient services is provided via one of the following:

- rebates for patients to access specialists working in a private capacity through the Australian Government Medicare Benefits Scheme (MBS);
- funding for public hospital patients from Commonwealth and Territory governments under the *National Health Reform Agreement* (NHRA), which requires funded services to be provided 'free of charge' (that is, no charge to public patients or the MBS); or
- targeted veterans' health services and workers compensation schemes.[17]

3.19 In contrast to this, there were two sources of funding for the additional appointments undertaken for Reboot (Outpatients):

- $200 per appointment went to the responsible clinic/service from the Reboot funding; and
- services also charged to the Commonwealth using MBS billing.

[17] A person is generally eligible to access hospital services at no cost if they have a Medicare card or Department of Veterans Affairs (DVA) card, or if they are an asylum seeker. See *National Health Reform Agreement (NHRA) 2020-25 Addendum*, Schedule G; AIHW, *Non-admitted patient care 2020-21 tables*, 29 Jul 2022; Australian Government Department of Health and Aged Care, *Medicare billing in public hospitals – overview*, fact sheet, 20 March 2023, available from https://www.health.gov.au/resources/publications/medicare-billing-in-public-hospitals-overview?language=en

## Steering Committee—*Reboot (Outpatients) project report*

3.20 In order for Reboot (Outpatients) funding to be allocated to internal providers for additional appointments that would not otherwise have taken place, a new measurement approach was developed and approved through the Steering Committee.

3.21 On 21 August 2020 the Steering Committee considered a paper titled *Reboot (Outpatients) project report*, which included an overview of proposed financial and performance monitoring arrangements:

> The method to measure performance against committed activity is to first determine a baseline activity. This will include:
>
> • monthly average of removals of new referrals from the waitlist over twelve months prior
>
> • Monthly average of long wait removals
>
> • Total appointment volume
>
> • % new appointments
>
> Funding will be provided on a monthly basis based on any removals above baseline at $200 per removal. The cost will be transferred into a central operation reboot cost centre, with corresponding revenue to the cost centre.
>
> For example, ENT have average of monthly wait list removals from June 2019-June 2020= 146 appointments on average. 146 appointment will be calculated as baseline for ENT. Removals in excess of 146 will be counted towards additional investment towards outpatient clinic activity. Triangulation of the above data points will be undertaken to ensure that the overall objectives of the program are being met: namely a reduction in total long waits.

3.22 The implementation of these arrangements is discussed later in Chapter 5.

3.23 Although there was a lack of project planning, the early 2020 draft Budget Concept Brief provided broad guidance on how the additional 14,000 outpatient appointments were to be delivered under Reboot (Outpatients). It provided high level, summary details about staffing and intended activities. The draft Budget Concept Brief was supplemented by two papers, which were approved by the Outpatient Transformation Steering Committee; *Operation Reboot Arrangements Paper* and *Reboot (Outpatients) project report*. The papers addressed some aspects of how the initiative was to be implemented, including:

- governance and oversight of the initiative would be provided by the Steering Committee, a large existing body rather than a specifically convened group for the purposes of Reboot (Outpatients);
- processes for attracting and evaluating proposals from internal and external providers; and
- processes for measuring and funding the additional appointments to be delivered.

# Resourcing for Reboot (Outpatients)

## Administrative activity

3.24 $500,000 of the total funding for Reboot (Outpatients) was allocated to administer the program. The draft Budget Concept Brief estimated the initiative would require:

- three FTE nurse to provide additional in-clinic support and referral screening;
- three administrative staff to audit the wait list, confirm referrals, and book appointments; and
- one typist to cope with additional need for transcription.

3.25 However, the COVID-19 pandemic made it difficult to retain support staff on the project.

3.26 In practice, in addition to the Senior Manager Outpatient Support, Reboot (Outpatients) was supported by:

- an Administrative Support Officer;
- 12 weeks support from a Registered Nurse; and
- a Project Officer, Outpatient Support (who, like the Senior Manager, was not a dedicated Reboot (Outpatients) resource).

3.27 By the end of the initiative in June 2021, only $192,192 of the planned $500,000 had been spent on administrative and nursing costs across three areas of work:

- administrative action to reduce the wait list;
- administrative support to external providers; and
- nurse actions to support external providers.

### Role of the Senior Manager, Outpatient Support

3.28 The administrative component of Reboot (Outpatients) was undertaken by the Senior Manager, Outpatient Support who led the following work:

- securing the support of outpatient clinics to undertake work above their usual load;
- procuring the services of external providers to make up the shortfall between the 14,000 appointment target and the intended activity level of internal specialists;
- developing and monitoring protocols for patient transitions between CHS and external providers;
- managing and coordinating the work of administrative and nursing support;
- developing, monitoring and reporting on a measurement approach to monitor the performance of services undertaking additional appointments;
- managing updates to existing systems to support the measurement approach; and

- developing financial arrangements to ensure services were paid appropriately for additional activity in line with the objectives of Reboot (Outpatients).

3.29 At the commencement of Reboot (Outpatients), a cost centre was created to manage the funding.[18] The Senior Manager, Outpatient Support was responsible for receiving invoices from external providers certifying that activity had taken place and forwarding the invoice to CHS finance for payment. For internal providers, the transfer of funds was undertaken directly by CHS' finance team.

## Wait list review

3.30 To allocate patients to medical specialist appointments, administrative and nursing staff were required to review referrals to determine patient suitability for a telehealth appointment and whether the patient still required an appointment.

3.31 CHS advised that by 2020 the ACT Patient Administration System (ACTPAS) being used for these tasks was outdated. Its use created significant administrative burden for CAS and outpatient clinics, and a risk of inaccurate data.

3.32 To allocate a patient to Reboot (Outpatients), there was a need to manually read each referral, move suitable patients onto the Reboot wait list and then (if required) back into their original place in the CHS ambulatory initial wait list. Once an appointment had been completed, administrative staff in each service were required to remove the patient from the wait list by selecting an 'outcome' from the relevant drop-down menu in ACTPAS.

3.33 In summary, the following administrative actions were taken for the purpose of reviewing existing outpatient wait lists and arranging for patients to be seen as part of Reboot (Outpatients):

- review of approximately 6,500 referral reasons;
- obtaining patient consent to refer them to Reboot (Outpatient) appointments, which could be via an external provider and/or telehealth;
- removing patients from the wait list who had been seen by private specialists and no longer needed an appointment;
- calling patients a second and third time when they could not be contacted, and sending 'unable to contact' letters where needed (after three attempts);
- sending 'did not attend' (DNA) letter to patients who scheduled an appointment but did not attend; and
- compilation of information into Objective Connect (a secure document sharing system), for access by external providers.

[18] This did not distinguish between outpatient appointments and other areas of Reboot activity (such as surgery).

## Nurse wait list review

3.34 A nursing resource funded by Reboot (Outpatients) undertook an audit of the waitlist that focused on 323 patients marked as waiting for between 2000 and 4000 days. All patients were contacted by the nurse and advised to visit their GP if their condition was deteriorating. If the referral was missing information, the nurse would follow up with the GP to facilitate the appointment. As a result of this activity, 47 patients were removed from the wait list for administrative reasons.

3.35 The Reboot (Outpatients) nursing resource also undertook a review of more than 400 Plastics service Category 3 referrals to identify any potential acceptance of referrals for cosmetic reasons.[19] As a result of this activity, approximately 145 referrals were identified for the Plastics service to review and action.

3.36 Reboot (Outpatients) was led by a Senior Manager, with the following support: an Administrative Support Officer; 12 weeks support from a Registered Nurse; and a Project Officer, Outpatient Support (who was not a dedicated Reboot (Outpatients) resource). This was much lower than the support staffing level proposed in the draft Budget Concept Brief, which had estimated the initiative would require:

- three FTE nurses to provide additional in clinic support and referral screening;
- three administrative staff to audit the wait list, confirm referrals, and book appointments; and
- one data entry officer to cope with additional load through transcription.

3.37 COVID-19 transmissions contributed to an inability to retain support staff on the project. By the end of the initiative in June 2021, only $192,192 of the planned $500,000 had been spent on administrative and nursing costs.

**RECOMMENDATION 1 IMPLEMENTATION PLANNING**

Canberra Health Services should ensure the lessons from Reboot (Outpatients) inform planning for future emergency response scenarios. This should include the development and circulation of short checklists and templates to support project owners needing to develop effective implementation and risk management plans within short timeframes.

[1919] Referrals for cosmetic purposes are not eligible for public health funding, and as such, cosmetic consultations are not provided by public CHS services. The purpose of this activity was to identify any inappropriate referrals, which should not have been accepted by CHS.

# 4 DELIVERY OF REBOOT (OUTPATIENTS)

4.1 This chapter considers the effectiveness of arrangements to deliver outpatient appointments through Reboot (Outpatients) and remove patients from the wait list. Appointments were delivered by both internal CHS clinics and external providers. Both service delivery mechanisms are considered in this chapter.

## Summary

### Conclusion

CHS achieved 6,132 additional outpatient appointments for Reboot (Outpatients), which was only 43.8 percent of the 14,000 appointment target. Significant effort was expended on engaging external providers, for very little return. Only 585 patients (9.5 percent of the additional appointments) were seen by external providers, compared with 5,547 patients (90.5 percent) seen by internal providers.

The process to identify internal medical skills and resources had some strengths—clinics were successfully engaged in the development of new approaches to reduce wait lists. Clinicians undertook additional work during a time of substantial pressure on the public health system. However, the application process was not used consistently throughout the initiative, and even when used, lacked robust capacity planning (i.e. the approved targets did not have a clear basis).

There were significant limitations in the procurement approach to source external providers. This included: a lack of documented assessment of expressions of interest; the engagement of providers without written expressions of interest; and (in one instance) the delivery of services without an agreed contract. This compromises the integrity of patient service delivery arrangements.

### Key findings

| | Paragraph |
|---|---|
| **Appointments delivered by internal clinical divisions** | |
| On 20 July 2020 a call for applications was circulated to CHS clinical divisions. The call for applications included the *Operation Reboot Outpatient Guidance* document (the Guidance), which set out the background to Reboot (Outpatients) funding and the application process. No evaluation plan or selection criteria was documented. | 4.8 |
| Twenty applications were received and considered by a sub-group of the Outpatient Transformation Steering Committee. Thirteen were approved, but only twelve proceeded because one application was withdrawn. Applications were assessed by a panel drawn from the Outpatient Transformation Steering Committee, based on their alignment to the purpose of Reboot (Outpatients), namely: | 4.16 |

- total number of long waits by category;
- proposed approach to reducing long waits;
- projected number of additional appointments; and
- strategy to manage capacity/demand going forward.

This approach relied on clinics to judge their capacity to deliver the additional appointments. Through this process, the Steering Committee approved applications for a total of 8,584 appointments (61.3 percent of the 14,000 target). However, there was no clear basis for the targets nominated by the clinics, or Steering Committee oversight of the internal processes to develop and deliver on these targets. 4.17

After the application and approval processes had concluded additional activity was approved for some specialties. The additional activity was not referred to the Steering Committee sub-group for assessment. Approximately 1,000 additional appointments were approved through this process, but this is not clear because for some additional activity no targets were identified. For some of the additional activity there was no documentation associated with its approval i.e. no evidence of how the activity was applied for and no evidence of how it was approved. 4.18

The delivery of internal Reboot (Outpatients) appointments was managed in accordance with business-as-usual processes within clinical divisions. This included using existing processes for estimating the volume of additional activity that could be delivered by specialties, as well as supervision, risk management and financial management. This approach was a means to engage specialties in Reboot (Outpatients) and surface ideas to improve service delivery based on the clinical expertise within divisions. Notwithstanding these aspirations, there was significant variability in the targets set by specialties, and the percentage of projected appointments achieved (from 2.7 percent to 668.6 percent) by the end of June 2021. Only five of the fifteen specialty-level targets were met or exceeded. A further three specialties did not nominate a target in the first instance. Speciality and subspeciality planning is required for any wait list initiative (including buy-in from senior clinicians in each speciality and subspeciality), but this was not apparent in this instance. 4.25

## Appointments delivered by external providers

On 5 August 2020, CHS issued a request for Expressions of Interest (EOIs) to potential external providers. The request for EOIs asked providers for proposals to support CHS in the removal of 14,000 referrals from the medical specialist outpatient wait list but did not identify, or otherwise detail, any specifications for how this was to occur. The request for EOIs did not specify the funding arrangements. 4.34

No specifications regarding the form or level of detail required of EOIs was provided. CHS advised that going to market without a clearly set out scope was intentional and the aim was for prospective providers to come up with ideas to address the backlog, rather than CHS dictating how this would be done. Eight written EOIs from external providers were received by the due date of 24 August. The proposed approaches varied considerably, as did the format of the EOIs, their level of detail and 4.35

demonstrated relevance to the removal of 14,000 referrals from the medical specialist outpatient wait list.

An *Operation Reboot Application Evaluation Form* was developed and finalised on 5 August 2020 for the purpose of assessing EOIs. Five of the eight EOIs were provided to the relevant CHS division for preliminary consideration and feedback. There is no documentation or information as to why the other three applications were not circulated for comment and feedback. None of the EOIs were supported by the clinical divisions. Because of the lack of divisional endorsement of the EOIs no formal assessment panel was convened and no further assessment was undertaken. The *Operation Reboot Application Evaluation Form* was not used for the assessment of applications. 4.46

Notwithstanding that the EOIs were not formally assessed, and there was a lack of support from the relevant clinical divisions for the EOIs, CHS progressed negotiations with two providers: Top Health Trust; and My Emergency Doctor. While Top Health Trust had submitted an EOI, My Emergency Doctor had only provided verbal advice of its interest in participating in Reboot (Outpatients) and did not submit an EOI. CHS advised that it progressed negotiations with these providers because testing the market for outpatient services was part of the aim of Reboot (Outpatients) and these providers were considered capable of delivering required outpatient appointments. However, CHS did not formally document an assessment of the service offerings of the two providers. 4.47

On 22 October 2020 (almost two months after the request for EOIs closed) the Senior Manager Outpatient Support sought the CHS Procurement Committee's endorsement for a Select Tender process to contract external providers to undertake outpatient appointments. The Procurement Committee Request form noted that a Request for EOIs had been distributed 'through the networks of Territory Wide Surgical Services, General Practice Liaison Unit, Capital Health Network and posted on the ACT Health website for external parties to submit proposals to undertake this work'. The CHS Procurement Committee endorsed the request on 30 October 2020 and in doing so noted that 'while this procurement has not gone through the usual process, the advertisement process was targeted to the appropriate audience'. 4.62

On 5 November 2020, a minute from the Executive Director, Cancer and Ambulatory Support Division was provided through the CHS Procurement Committee to the CEO for approval. The minute incorrectly identified that two EOIs had been received; only one EOI had been received. The minute advised the two potential providers 'were considered appropriate for further negotiation. These negotiations are ongoing, and we are now at a point of entering into a contract with these [two suitable] providers'. The CEO approved the approach on 25 November 2020, but requested it be forwarded to the Executive Director Medical Services (EDMS) for review and endorsement. On 17 December, the procurement approach was endorsed by the Executive Director Medical Services with 'some reservations'. The Executive Director requested to be included in the tender selection panel, but was advised that the two providers had already been engaged and contracts executed. 4.63

Contracts were entered into with Top Health Trust and My Emergency Doctor for the provision of services. However, in January 2021, CHS was notified that Top Health Trust had withdrawn its proposal. The specific timing and reason for this was not documented. CHS sent 788 referrals to My Emergency Doctor. Of the 788 referrals to My Emergency Doctor, 538 patients were marked as seen and 250 patients were not seen for various reasons. A total of $95,310 (GST ex) was paid to My Emergency Doctor for Reboot (Outpatients) services. 4.84

A third provider, the Yarralumla GP Clinic, was also engaged to provide services for the purpose of Reboot (Outpatients). This was despite the fact it did not submit an EOI. No contract was executed for the Yarralumla GP Clinic services. 4.96

The engagement of the Yarralumla GP Clinic followed an approach it made in March 2020, to collaborate with CHS to see Category 2 and 3 Aboriginal and Torres Strait Islander children waiting to be seen in the CHS Ear, Nose and Throat clinic. A November 2020 paper to the Steering Committee reported that a clinic was run for this purpose on 24 October 2020 (a Saturday) and recommended the development of 'a sustainable model to run more clinics such as these …'. In total, however, there were eight bookings to see Ear, Nose and Throat specialists via the Yarralumla GP Clinic. Five of the patients identified as Aboriginal and Torres Strait Islander, but two of these patients did not arrive for their scheduled appointment. A total of 55 patients were recorded by CHS as removed from the initial wait list via Yarralumla GP Clinic activity. In addition to the Ear, Nose and Throat patients, Dermatology and Urology patients were also seen. A total of $8,930 (GST ex) was paid for these services. 4.97

# Appointments delivered by internal clinical divisions

## Call for applications

4.2 On 20 July 2020, following the Outpatient Transformation Steering Committee's approval of the *Operation Reboot Arrangements Paper* on 17 July, a call for applications was circulated to CHS clinical divisions. Applications were due by 4 August 2020. The call for applications was circulated to divisions involved in delivering outpatient services: Cancer and Ambulatory Support; Medicine; Rehabilitation, Aged and Community Services; Women, Youth and Children; and Calvary Public.

4.3 The call for applications was emailed to Executive Directors, Operations Managers, Clinical Unit Directors, Business Managers and Administration Managers. The email included the *Operation Reboot Outpatient Guidance* document (the Guidance). The Guidance set out the background to Reboot (Outpatients) funding and the application process. It identified that funding of $200 per additional appointment was available and that payments would be based on completed activity. The Guidance included an application form.

4.4 The Guidance sought information from the clinical divisions as to whether they could provide appointments through a range of different mechanisms such as:

- locum telehealth clinics;
- going to market for private assistance;
- additional surge clinics;
- extending current session times;
- utilising pre-screening approaches; and
- restructuring current clinics to increase the number of new patients seen.

4.5 The application form asked divisions to specify:

- their total number of long wait referrals by category as at 30 June 2020;
- a proposed approach to reduce long waits in each category;
- a projected number of additional appointments by category; and
- a strategy to manage capacity/ demand going forward.

4.6 Proposals were required to clearly identify strategies to ensure that the mismatch between capacity and demand would be addressed. A reduction of follow-up appointments was identified as a key component of these efforts. In this respect the Guidance stated:

> Currently only 19% of appointments are for new referrals. This needs to reach an average of 50% across services.[20]

4.7 No evaluation plan or selection criteria was documented.

4.8 On 20 July 2020 a call for applications was circulated to CHS clinical divisions. The call for applications included the *Operation Reboot Outpatient Guidance* document (the Guidance), which set out the background to Reboot (Outpatients) funding and the application process. No evaluation plan or selection criteria was documented.

## Assessment process

4.9 A sub-group of the Steering Committee was formed to assess applications. The sub-group consisted of:

- Executive Director, Division of Cancer and Ambulatory Support;
- Executive Director, Division of Medicine;
- Executive Branch Manager, Strategy, Planning and Policy;
- Project Manager;
- Senior Manager Outpatient Support; and

[20] This target was ultimately not formally adopted across CHS. The current target is 35 percent.

- Executive Director of Medical Services, Calvary Public Hospital Bruce.

4.10 An assessment of applications occurred on two occasions: 5 August 2020 and 17 August. The outcomes of this assessment were summarised in the 21 August *Reboot (Outpatients) project report* to the Steering Committee. This paper documented the decisions of the sub-group and the comments that were provided back to the applicant Division.

4.11 Table 4-1 shows the outcomes of the internal Reboot (Operations) process.

### Table 4-1 Internal Reboot (Outpatients) application outcomes

| Date applications received by | Date of sub-group meeting to consider applications | Number of applications received | Number approved | Number not approved |
|---|---|---|---|---|
| 4 August | 5 August | 14 | 11* | 3 |
| 14 August | 17 August | 6 | 2 | 4 |

Source: ACT Audit Office, based on CHS documentation.

Note: * 1 later withdrawn by Calvary Public Hospital

4.12 Twenty applications were considered by the sub-group. Thirteen were approved, but only twelve proceeded because one was later withdrawn. A total of seven applications were not approved. For two applications, the reason given was that the proposal was not focused on removals from the current wait list. For the other applications, the reasons were not documented in the *Reboot (Outpatients) project report* to the Steering Committee.

4.13 The divisions and specialties with successful proposals, along with the target number of appointments, are shown in Table 4-2. Clinics themselves estimated the number of additional appointments they could deliver. The basis for the clinics' estimates were not documented by the clinics, or the Steering Committee sub-group responsible for the assessments.

### Table 4-2 Initial internal Reboot (Outpatients) approved activity

| Division | Speciality | Date of approval | Number of appointments to be delivered |
|---|---|---|---|
| Allied Health | Physiotherapy-led orthopaedics triage | 5 August | 487 |
| Medicine | Respiratory | 5 August | 822 |
| Medicine | Cardiology | 5 August | 1,855 |
| Medicine | Gastroenterology | 5 August | 2,232 |
| Medicine | Vascular<br>podiatry | 5 August | 242 |

| Division | Speciality | Date of approval | Number of appointments to be delivered |
|---|---|---|---|
| Medicine | Rheumatology | 5 August | 856 |
| Medicine | Diabetes | 5 August | 524 |
| Women, Youth and Children &<br>Cancer and Ambulatory Support | Immunology | 5 August | 718 |
| Women, Youth and Children | Paediatrics (includes two applications—General Paediatrics and Paediatric Immunology and Allergy) | 5 August | 500 |
| Women, Youth and Children | Community Paediatrics | 17 August | 120 |
| Women, Youth and Children | Gynae and Colposcopy | 17 August | 192 |
| **Total** | | | **8,584** |

Source: ACT Audit Office, based on CHS documentation.

4.14 After the application and approval processes had concluded additional activity was approved for some specialties. The additional activity was not referred to the Steering Committee sub-group for assessment. Table 4-3 shows the additional Reboot (Outpatients) activity that was approved and the processes for application and approval.

### Table 4-3 Additional internal Reboot (Outpatients) approved activity

| Division | Speciality | Method of approval | Date of approval | Number of appointments to be delivered |
|---|---|---|---|---|
| Cancer and Ambulatory Support | Haematology | None documented | None documented | None documented |
| Medicine | Neurology | Email to ED, CAS | 25 May 2021 | None documented |
| Women, Youth and Children | Genetics | Application form | April 2021 | 19 per month |
| Surgery | Orthopaedics | Application form | None documented | 120 |
| Surgery | Urology | Application form | February 2021 | 250 |
| Surgery | General Surgery | None documented | None documented | None documented |
| Women, Youth and Children | Gynaecology and Physiotherapy | Application form | None documented | 140 |
| Women, Youth and Children | Gynae and Colposcopy | Minute to ED, CAS | 26 February 2021 | 500 |

Source: ACT Audit Office, based on CHS documentation.

4.15 For some of the additional activity there was no documentation associated with its approval, i.e. no evidence of how the activity was applied for and no evidence of how it was approved. Some of the additional activity was approved via a minute provided to the Executive Director, Cancer and Ambulatory Support. For some of the additional activity no specific targets were identified.

4.16 Twenty applications were received and considered by a sub-group of the Outpatient Transformation Steering Committee. Thirteen were approved, but only twelve proceeded because one application was withdrawn. Applications were assessed by a panel drawn from the Outpatient Transformation Steering Committee, based on their alignment to the purpose of Reboot (Outpatients), namely:

- total number of long waits by category;
- proposed approach to reducing long waits;
- projected number of additional appointments; and
- strategy to manage capacity/demand going forward.

4.17 This approach relied on clinics to judge their capacity to deliver the additional appointments. Through this process, the Steering Committee approved applications for a total of 8,584 appointments (61.3 percent of the 14,000 target). However, there was no clear basis for the targets nominated by the clinics, or Steering Committee oversight of the internal processes to develop and deliver on these targets.

4.18 After the application and approval processes had concluded additional activity was approved for some specialties. The additional activity was not referred to the Steering Committee sub-group for assessment. Approximately 1,000 additional appointments were approved through this process, but this is not clear because for some additional activity no targets were identified. For some of the additional activity there was no documentation associated with its approval i.e. no evidence of how the activity was applied for and no evidence of how it was approved.

## Delivery of appointments

4.19 Reboot (Outpatients) appointments were provided through established outpatient clinics under business-as-usual clinical supervision, governance and risk management arrangements.

4.20 Table 4-4 shows internal Reboot (Outpatients) activity, including achievements against targets. The total number of appointments achieved are as reported in July 2021 and are only approximate due to measurement limitations which are discussed in Chapter 5 of this report.

## Table 4-4 Internal Reboot (Outpatients) activity

| Division | Speciality | Approved target | Total Achieved | Difference | % of target achieved |
|---|---|---|---|---|---|
| Allied Health | Physiotherapy-led orthopaedics triage | 487 | 168 | -319 | 34.5 |
| Cancer and Ambulatory Support | Haematology | None specified* | 234 | - | - |
| Medicine | Respiratory | 822 | 22 | -800 | 2.7 |
| Medicine | Cardiology | 1,855 | 357 | -1,498 | 19.2 |
| Medicine | Gastroenterology | 2,232 | 419 | -1,813 | 18.8 |
| Medicine | Vascular podiatry | 242 | 41 | -201 | 16.9 |
| Medicine | Rheumatology | 856 | 464 | -392 | 54.2 |
| Medicine | Diabetes | 524 | 58 | -466 | 11.1 |
| Medicine | Neurology | None specified* | 451 | 451 | - |
| Women, Youth and Children & Cancer and Ambulatory Support | Immunology | 718 | 147 | -571 | 20.5 |
| Women, Youth and Children | Paediatrics | 432* | 237 | -195 | 54.9 |
| Women, Youth and Children | Community Paediatrics | 120 | 99 | -21 | 82.5 |
| Women, Youth and Children | Gynae and Colposcopy | 1,017* | 1,045 | 28 | 102.8 |
| Women, Youth and Children | Gynaecology and Physiotherapy | 140* | 936 | 796 | 668.6 |
| Women, Youth and Children | Genetics | 85* | 193 | 108 | 227.1 |
| Surgery | Orthopaedics | 120* | 234 | 114 | 195.0 |
| Surgery | Urology | 250* | 258 | 8 | 103.2 |
| Surgery | General Surgery | None specified* | 184 | - | - |

| Division | Speciality | Approved target | Total Achieved | Difference | % of target achieved |
|---|---|---|---|---|---|
| **Total** | | **9,990** | **5,547** | **(4,353)** | |

Source: ACT Audit Office, based on information from CHS.

Notes: * Totals marked with an asterisk have targets which vary between the approved applications approved in August 2020 and the final paper about the initiative, which summarised the number of appointments achieved by specialty in July 2021.

4.21 A review of internal Reboot (Outpatients) activity shows activity and outcome levels varied considerably. For example, only 2.7 percent of approved respiratory appointments were achieved (22 appointments from a target of 822), while 227 percent of genetics appointments were achieved (193 appointments against a target of 85).

4.22 The AHHA consultant advised that a speciality and subspeciality planning process is required for any wait list initiative (including buy-in from senior clinicians in each speciality and subspeciality). This was not apparent in this instance.

4.23 At the outset of the initiative, each clinic had a different capacity to address long waits. For example, some clinical teams may have had new team members while others may have been short staffed. The 'bottom up' approach taken to planning and managing the internal activity sought to ensure clinics were making their own judgments about the extra work they were taking on. It would not have been possible for the Senior Manager, Outpatient Support, or Executive Director, Division of Cancer and Ambulatory Support to direct clinics to undertake extra commitments to do additional appointments.

4.24 One head of a clinical division advised the Audit Office that the internal application process was:

- an effective means to distribute limited funding between the large number of specialties; and
- a mechanism to surface good ideas about improving the management of the outpatient wait list, as those in central positions likely didn't have a detailed insight into which specialties were best placed to address long waits.

4.25 The delivery of internal Reboot (Outpatients) appointments was managed in accordance with business-as-usual processes within clinical divisions. This included using existing processes for estimating the volume of additional activity that could be delivered by specialties, as well as supervision, risk management and financial management. This approach was a means to engage specialties in Reboot (Outpatients) and surface ideas to improve service delivery based on the clinical expertise within divisions. Notwithstanding these aspirations, there was significant variability in the targets set by specialties, and the percentage of projected appointments achieved (from 2.7 percent to 668.6 percent) by the end of June 2021. Only five of the fifteen specialty-level targets were met or exceeded. A further three specialties did not nominate a target in the first instance. Speciality and subspeciality planning is required for any wait list initiative (including buy-in from senior clinicians in each speciality and subspeciality), but this was not apparent in this instance.

# Appointments delivered by external providers

## Call for applications

4.26 On 5 August 2020, CHS issued a request for Expressions of Interest (EOI) to potential external providers. EOIs were due by 24 August. The timing allowed EOIs to be received after the assessment of internal applications on 5 and 17 August. According to a minute later provided to the CEO (refer to paragraph 4.50) the external call for applications sought to supplement the approved internal activity '… in order to ensure [CHS had] sufficient capacity to undertake the 14,000 appointments …'

4.27 The request for EOIs was issued through existing networks (Territory Wide Surgical Services, General Practice Liaison Unit and Capital Health Network) and posted publicly on the ACT Health website.

4.28 The request for EOIs asked providers for proposals to support CHS in the removal of 14,000 referrals from the medical specialist outpatient wait list. The request for EOIs did not identify, or otherwise detail, any specifications for how this was to occur. The request for EOIs also did not specify the funding arrangements. Providers were asked to consider how the removals could be achieved as part of their response. The following information was requested:

- specialty and scope of proposal, including specialty areas, any exclusions or specific conditions being targeted, acuity category, type of health professional providing services, and whether appointments would be screening, treatment, diagnostics, minor procedures, planning or a combination of these;
- whether the services would be provided via CHS facilities, private facilities or virtually via telehealth;
- method of service delivery, including processes for referral review, communication and patient agreement, pre-appointment readiness, options for follow-up care and record keeping;
- governance arrangements; and
- logistics, including lead time to establish the service, proposed volume of appointments and timeframe, and preference for contractual arrangements.

4.29 However, no specifications regarding the form or level of detail required of EOIs was provided.

4.30 Providers were also asked to propose a funding model for the services. In this respect, the $200 that was to be provided to internal applicants for each appointment was not specified.

4.31 CHS advised that going to market without a clearly set out scope was intentional. The aim was for prospective providers to come up with ideas to address the backlog, rather than CHS dictating how this would be done.

4.32 The call for EOIs stated:

> EOIs will be assessed and feedback provided within 14 days of the closing date. Successful proposals will then enter discussions with CHS to refine proposals and determine contractual arrangements. During these negotiations evidence of insurance, credentialing and other requirements will be detailed and sought.

4.33 Eight written EOIs from external providers were received by the due date of 24 August 2020. The EOIs varied considerably in both form and substance. The proposed approaches varied considerably, as did the format of the EOIs, their level of detail and demonstrated relevance to the removal of 14,000 referrals from the medical specialist outpatient wait list (refer to Table 4-4).

4.34 On 5 August 2020, CHS issued a request for Expressions of Interest (EOIs) to potential external providers. The request for EOIs asked providers for proposals to support CHS in the removal of 14,000 referrals from the medical specialist outpatient wait list but did not identify, or otherwise detail, any specifications for how this was to occur. The request for EOIs did not specify the funding arrangements.

4.35 No specifications regarding the form or level of detail required of EOIs was provided. CHS advised that going to market without a clearly set out scope was intentional and the aim was for prospective providers to come up with ideas to address the backlog, rather than CHS dictating how this would be done. Eight written EOIs from external providers were received by the due date of 24 August. The proposed approaches varied considerably, as did the format of the EOIs, their level of detail and demonstrated relevance to the removal of 14,000 referrals from the medical specialist outpatient wait list.

## Assessment of applications

### *Initial assessment*

4.36 An *Operation Reboot Application Evaluation Form* was developed and finalised on 5 August 2020. It provided space for comment on EOIs with respect to:

- current long wait list for the specialty;
- the proposal to remove wait list entries (how many would be removed);
- the proposed strategy to address the demand-capacity mismatch;
- whether the strategy was achievable;
- value for money;
- alignment with the Divisional Plan; and
- the percentage of new (rather than follow-up) appointments (current and forecast).

4.37 Five of the eight EOIs were provided to the relevant CHS division for preliminary consideration and feedback. For example, an EOI proposing to provide appointments for dermatology was provided to the Executive Director, Division of Medicine, who delegated

consideration to a Dermatologist. There is no documentation or information as to why the other three applications were not circulated for comment and feedback.

4.38 Two specialties were involved in both submitting an internal application for Reboot (Outpatients) and advising on prospective external providers:

- the Ear Nose and Throat unit considered and advised on an EOI after making an *unsuccessful* internal application; and
- the Diabetes unit considered the application relating to clinic space after making a *successful* internal application.

4.39 Table 4-5 summarises the EOIs that were received and their cost, as well as the initial response from the relevant CHS Division.

### Table 4-5 Summary of external provider Reboot (Outpatients) EOIs

| Name | Offering | Cost | Initial Divisional Response |
|---|---|---|---|
| Respondent 1 | Dermatology clinic staffed by General Practitioner with Post Graduate Diploma in Skin Cancer Medicine and Registered Nurse as needed, Category 2 or 3 patients. | Sessional Rates of $800 negotiable funded per 4-hour session, along with GP MBS billing per patient. | Advised not to progress further with the EOI based on a number of concerns, including appropriateness of redirecting specialist referral to a GP, and mismatch between categories of interest (2 and 3) expertise (skin cancer) and reality of wait lists (not dominated by skin cancer, and skin cancer generally triaged as a Category 1). |
| Respondent 2 | Optometrist service for ophthalmology outpatient appointments. | Upfront cost of $174,965.00 plus GST for equipment, with MBS billing for appointments. No ongoing costs to CHS except for Telehealth appointments, which would be billed to CHS at $80.00 plus GST. | Advised not to progress further based on existing access to optometrists. |
| Respondent 3 | Telehealth Clinic for patients with chronic and complex non-cancer pain, provided by a specialist in Rehabilitation Medicine. | MBS billing only. | Advised not to progress further, no reason documented. |

| Name | Offering | Cost | Initial Divisional Response |
|---|---|---|---|
| Respondent 4 | Ear Nose and Throat appointments to be delivered by GP with specialist interest and some experience in ENT. | Fee for service or visiting medical officer rates, to be negotiated. | Advised not to progress further, with concerns about GP undertaking the appointments without specialist supervision, and accepting referrals for surgery without awareness of the practitioner's standards. |
| Top Health Trust | GP Specialists (i.e. Fellows of the Royal Australian College of General Practitioners (FRACGP), or Fellows of the Australian College of Rural and Remote Medicine (FACCRM)) to assess and manage out-of-timeframe Category 3 referrals within the primary care setting, in a range of specialties including Orthopaedics, Rheumatology, Paediatrics, Gastroenterology, General Surgery, Ear Nose and Throat surgery, Cardiology, Respiratory, Diabetes and Endocrinology, and Dermatology. | Fee for service plus MBS billing: $50 for referral review; 273 for initial patient assessment; $297 for procedure.<br>Additional funding for governance committee. | None documented. |
| Respondent 5 | Clinic space only. | Cost per room underdetermined but potentially $140.00 per session. | Advised not to progress further following site visit. A range of issues were identified including possible patient confusion about location, lack of public transport access, need to fit out rooms, IT access, need to transport specialist equipment. |
| Respondent 6 | GP with specialist interest and some experience in Emergency Medicine seeking employment to assist with referral review. | None specified. | None documented. |
| Respondent 7 | Orthopaedics/Reconstructive Hand Surgery Waiting List referrals to be handled by GP with special interest in sport and exercise medicine. | No bulk billing. A range of fee-for-service and sessional rates to be charged to CHS, ranging from $60 to $360 depending on service. | None documented. |

Source: ACTAO, summarised from CHS documents.

4.40 None of the responses received from external providers were supported by the relevant clinical division.

4.41 Because of the lack of divisional endorsement of the EOIs no formal assessment panel was convened and no further assessment was undertaken. The *Operation Reboot Application Evaluation Form* was not used for the assessment of applications.

*Subsequent consideration*

4.42 Notwithstanding that the eight EOIs were not formally assessed through the use of the *Operation Reboot Application Evaluation Form* and there was a lack of clinical division support for the EOIs, CHS progressed negotiations with two providers:

- Top Health Trust; and
- My Emergency Doctor.

4.43 My Emergency Doctor provided verbal advice of its interest in participating in Reboot (Outpatients) but did not submit an EOI. Nevertheless, it was included in subsequent procurement approvals and contract negotiations alongside Top Health Trust.

4.44 CHS advised that it progressed negotiations with these providers because testing the market for outpatient services was part of the aim of Reboot (Outpatients). CHS advised that they were the only interested providers capable of delivering the services sought and that:

- the EOI from Top Health Trust was preferred, because it proposed to bring together General Practitioners with special interests in a range of specialties. This was identified as an appealing approach that had not been used previously in the Territory; and
- the My Emergency Doctor proposal was considered acceptable as the provider could deliver appointments in a range of specialties, for which the market had already been tested.

4.45 Nevertheless, CHS did not formally document an assessment of the service offerings of the two providers.

4.46 An *Operation Reboot Application Evaluation Form* was developed and finalised on 5 August 2020 for the purpose of assessing EOIs. Five of the eight EOIs were provided to the relevant CHS division for preliminary consideration and feedback. There is no documentation or information as to why the other three applications were not circulated for comment and feedback. None of the EOIs were supported by the clinical divisions. Because of the lack of divisional endorsement of the EOIs no formal assessment panel was convened and no further assessment was undertaken. The *Operation Reboot Application Evaluation Form* was not used for the assessment of applications.

4.47 Notwithstanding that the EOIs were not formally assessed, and there was a lack of support from the relevant clinical divisions for the EOIs, CHS progressed negotiations with two

providers: Top Health Trust; and My Emergency Doctor. While Top Health Trust had submitted an EOI, My Emergency Doctor had only provided verbal advice of its interest in participating in Reboot (Outpatients) and did not submit an EOI. CHS advised that it progressed negotiations with these providers because testing the market for outpatient services was part of the aim of Reboot (Outpatients) and these providers were considered capable of delivering required outpatient appointments. However, CHS did not formally document an assessment of the service offerings of the two providers.

## Procurement for services

4.48 In 2020 the *ACT Health Procurement Policy Statement* (the Procurement Policy) was in operation. It was initially developed by the former Health Directorate and was in use across the Health Directorate and CHS in 2020. The Procurement Policy stated:

> All ACT Health employees undertaking procurement and/or disposal activities on behalf of the Directorate are required to ensure the following principles are met:
>
> 1. Value for money;
>
> 2. Probity and ethical behaviour;
>
> 3. Management of risk;
>
> 4. Open and effective competition;
>
> 5. Optimising whole of life costs;
>
> 6. Confidentiality and conflict of interest; and
>
> 7. Anything else prescribes by legislation.

4.49 Under the Procurement Policy, CHS managed its own procurements, which were overseen by the CHS Procurement Committee (CHSPC). According to its Terms of Reference the CHS Procurement Committee is responsible for:

- ensuring that due diligence is being applied to all CHS procurement activities by:
  - approving all requests within the delegation limits of the committee members present at the meeting;
  - endorsing all requests that exceed the delegation limits of the committee members present at the meeting, prior to financial delegation approval;
  - endorsing all exemption requests to the Government Procurement Regulations 2007 e.g. Single Select prior to CEO approval;
- providing advice to the Our Infrastructure and Technology Committee regarding procurement priorities, including CHS procurement risks and issues unable to be adequately resolved or funded;
- reviewing a CHS procurement register;
- when reviewing procurement requests, the CHSPC will consider the following:
  - whether the procurement can be deferred;
  - whether a value for money exercise has been undertaken to ensure CHS is receiving either the best priced items or services at the standard required; and
  - alternate strategies to procure the goods/services to reduce expenditure; and,

• overseeing of CHS Procurement Policy governance, including capacity to request, modify and endorse policy changes.

### *Procurement approval process*

4.50 On 22 October 2020 (almost two months after the request for EOIs closed) the Senior Manager Outpatient Support provided a Procurement Committee Request form to the CHS Procurement Committee. The CHS Procurement Committee's endorsement was sought for a Select Tender process to contract external providers to undertake outpatient appointments.

4.51 According to the guidance on the form, such a request is required for all new procurement activities over $100,000 in total value, and/or those procurement activities that require exemption from the *Government Procurement Regulation 2007*.

4.52 According to the Procurement Committee Request Form, estimated spending of up to $1 million on contracted services was envisaged before the end of the 2020-21 financial year. The Procurement Committee Request Form stated:

> The ACT Government has committed $3.5 million to undertake up to 14,000 long wait outpatient appointments this financial year. An internal process of applications has committed to up to 8,800 appointments. In order to ensure we have sufficient capacity to undertake the 14,000 appointments, an expression of interest was distributed through the networks of Territory Wide Surgical Services, General Practice Liaison Unit, Capital Health Network and posted on the ACT Health website for external parties to submit proposals to undertake this work.

4.53 It did not provide any further details about the approach to market but indicated that the impact of not undertaking the procurement would be 'failure to deliver on organisational targets'.

4.54 The CHS Procurement Committee endorsed the request for CEO consideration on 30 October 2020. In doing so it noted that 'while this procurement has not gone through the usual process, the advertisement process was targeted to the appropriate audience'.

4.55 On 5 November 2020, a minute from the Executive Director, Cancer and Ambulatory Support Division (*Select Tender Procurement of External Providers for Operation Reboot*) was provided through the CHS Procurement Committee to the CEO for approval. The minute sought an exemption from the requirement to call for public tenders as 'the time within which this procurement activity must be completed prevents public tenders being called'. It indicated that two EOIs were received and:

> … were considered appropriate for further negotiation. These negotiations are ongoing, and we are now at a point of entering into a contract with these [two suitable] providers.
>
> Proposals include only seeing patients once, providing detailed letter back to referrer and to Canberra Health Services (CHS). CHS will make contact with patients and determine if an appointment is still required and that they consent to their referral being passed on to external provider. Payments will be based on actual volume.

4.56 The minute referred to two EOIs having been received. This is incorrect, as an EOI was not received from My Emergency Doctor.

4.57 The minute briefly outlined the service offerings and costs of the two providers:

- (Top Health Trust:

  IMPACT model – 'to work across a range of General Practitioners (GP) and GP practices where GPs have been identified as being specialist GPs with extended skills or specialist interest' to see category 3 and some category 2 patients, requiring definitive diagnosis and care planning. The proposal was costed at $200 per initial appointment, $250 for subsequent minor procedures, and $3500, for governance activities, and was endorsed as having the potential to 'enhance the GP – GP referral approach moving forward'.

- My Emergency Doctor

  'FACEMS providing telehealth consultations to confirm diagnosis and care planning for GP to provide ongoing management' and was costed at $200 per initial appointment.

4.58 The minute cautioned that there was:

> … a reluctance on the part of some specialists to endorse this approach. However as there is insufficient capacity within CHS to see an additional 14,000 appointments the Outpatient Transformation Steering Committee has supported the use of external providers.

4.59 The minute further stated there was a risk that:

> Some GPs may not like that their referrals to a specialist have been referred to another GP. However, GP to GP referrals are now becoming more common place. In addition, tightening of referral acceptance criteria will see a reduction in the number of these lower acuity referrals moving forward. This proposed approach is to manage the backlog that has built up over time.

4.60 The CEO approved the approach on 25 November 2020, and in doing so noted the minute should be forwarded to the Executive Director Medical Services (EDMS) for review and endorsement of approach. The minute was provided to the Executive Director for review on 27 November.

4.61 On 17 December, the procurement approach was endorsed by the Executive Director Medical Services with 'some reservations'. The Executive Director requested to be included in the tender selection panel, but was advised that the two providers had already been engaged and contracts executed.

4.62 On 22 October 2020 (almost two months after the request for EOIs closed) the Senior Manager Outpatient Support sought the CHS Procurement Committee's endorsement for a Select Tender process to contract external providers to undertake outpatient appointments. The Procurement Committee Request form noted that a Request for EOIs had been distributed 'through the networks of Territory Wide Surgical Services, General Practice Liaison Unit, Capital Health Network and posted on the ACT Health website for external parties to submit proposals to undertake this work'. The CHS Procurement Committee endorsed the request on 30 October 2020 and in doing so noted that 'while this procurement has not gone through the usual process, the advertisement process was targeted to the appropriate audience'.

4.63 On 5 November 2020, a minute from the Executive Director, Cancer and Ambulatory Support Division was provided through the CHS Procurement Committee to the CEO for approval. The minute incorrectly identified that two EOIs had been received; only one EOI had been received. The minute advised the two potential providers 'were considered appropriate for further negotiation. These negotiations are ongoing, and we are now at a point of entering into a contract with these [two suitable] providers'. The CEO approved the approach on 25 November 2020, but requested it be forwarded to the Executive Director Medical Services (EDMS) for review and endorsement. On 17 December, the procurement approach was endorsed by the Executive Director Medical Services with 'some reservations'. The Executive Director requested to be included in the tender selection panel, but was advised that the two providers had already been engaged and contracts executed.

## Delivery of appointments

4.64 The Senior Manager, Outpatient Support oversaw external providers and internal administrative effort. The Senior Manager reported to the Steering Committee and chaired the Working Group.

### Administrative and nurse support to external providers

4.65 Administrative actions to support external providers involved:

- downloading referrals to be transferred to external providers and saving with agreed naming conventions; and
- uploading referrals to secured network for transferring referrals.

4.66 Nurse actions to support external providers involved:

- review of referrals and referral reasons for approximately 6,100 referrals;
- approximately 1,800 referrals deemed suitable for telehealth (meeting the telehealth doctor's requested conditions and clinical review of the nurse).

### Top Health Trust

4.67 Top Health Trust (a Canberra-based group of GPs who had specialist interests and specialist qualifications) was the only provider that provided a written EOI that was considered suitable. However, despite entering into a contract, Top Health Trust did not deliver any appointments.

#### *Contract for services*

4.68 The contract to engage Top Health Trust was signed on 9 December 2020 by the Deputy CEO. This followed the provision of a minute seeking agreement and signature for a short form contract (for services between $25,000 and $200,000), which was provided on 8 December.

4.69 Top Health Trust proposed to review Category 3 long waits. According to the EOI:

> The reduction of out-of-timeframe Category 3 referrals will be achieved by providing an initial appointment to consenting consumers by a GP Specialist who has appropriate skills in the subspecialty required for appropriate assessment and management of the referral. The IMPACT project [Integrated Management of Patient Assessment with Category Three Referrals, the name of the Top Health Trust proposal] has the capacity to be upscaled in the future. Opportunities to upscale include:
>
> • To process additional Category 3 referrals
>
> • To expand the project to appropriate Category 2 referrals
>
> • To include referrals from additional non-GP specialties
>
> • To identify consumers that are currently seen in the Outpatient Department that can be safely handed back to their usual GP for ongoing management. This will free up capacity for non-GP specialists to see appropriate new referrals.
>
> • To run the Program on a permanent basis to ensure all referrals to the CHS Outpatient Department are seen on a timely manner in the future.

### *Service provision*

4.70 CHS undertook preparatory work to identify conditions suitable for referral to Top Health Trust However, in January 2021, CHS was notified that Top Health Trust had withdrawn its proposal. The specific timing and reason for this was not documented. In response to the draft proposed report, Top Health Trust advised that it withdrew its proposal because of the COVID-19 pandemic and the need for GP specialists to respond to the increased demand for health services.

4.71 Patients consented to be seen by Top Health Trust were subsequently transferred to a third external provider, Yarralumla GP Clinic (discussed further below).

## My Emergency Doctor

4.72 CHS engaged My Emergency Doctor, a telehealth provider to see Category 3 (low acuity) patients on CHS long wait lists, based on verbal advice of its interest in participating.

### *Contract for services*

4.73 The contract to engage My Emergency Doctor was signed on 2 December 2020 by the Deputy CEO. This followed the provision of a minute seeking agreement and signature for a short form contract (for services between $25,000 and $200,000), which was provided on 1 December.

4.74 The specialities selected for My Emergency Doctor were specialities that did not have an internal (CHS) Reboot (Outpatients) process or were not likely to meet the target set. My Emergency Doctor also provided a list of specialities and conditions that were telehealth suitable.

4.75 The My Emergency Doctor contract provided for payment of $200 per appointment undertaken, and three deliverables:

- establishment of a governance committee, within 30 days of contract signing;
- monthly schedule of volume of appointments for the remainder of the year, within 30 days of contract signing; and
- a project completion report detailing outputs, lessons and recommendations for potential future approach to collaborating with GPs in the provision of specialist services, by 31 July 2021.

*Service provision*

4.76 For the purpose of providing the services, My Emergency Doctor: retrieved information compiled by CHS from Objective Connect; called the patient; booked their appointment; and produced an outcome letter on a template letter provided by CHS. This outcome letter was uploaded to the patient's My Health record and sent to the patient (if requested).

4.77 In total CHS sent 788 referrals to My Emergency Doctor. The outcome of these referrals is summarised in Table 4-6. The services were provided from December 2020 to June 2021 and were billed in April, May, and June 2021.

**Table 4-6 Outcomes for patients referred to My Emergency Doctor**

| | | |
|---|---|---|
| **Patients seen** | Discharged back to GP | 317 |
| | Required further hospital services from CHS | 221 |
| | **TOTAL** | **538** |
| **Patients not seen** | Did not require an appointment | 181 |
| | Deemed not suitable for telehealth | 40 |
| | Did not arrive for their scheduled appointment | 17 |
| | Cancelled their scheduled appointment | 7 |
| | Preferred face-to-face to telehealth | 1 |
| | Uncontactable due to a disconnected phone number | 4 |
| | **TOTAL** | **250** |

Source: ACT Audit Office based on information provided by CHS.

4.78 Of the 788 referrals to My Emergency Doctor:

- 538 patients were marked as seen;
  - 317 of these were discharged back to their GP;
  - 221 were identified as requiring further hospital services; and

- 250 patients were not seen for various reasons, including:
  - 181 being identified as not requiring an appointment; and
  - 40 being identified as not suitable for telehealth services.

4.79 In respect of the remaining contracted deliverables CHS provided advice as to the extent to which these were delivered as per the contract.

4.80 In respect of the governance committee, CHS advised that this was not established as agreed, but that alternative governance arrangements were established:

> Governance Committee – Project governance was provided through an agreed working relationship between each party's project leads. For CHS this was the Senior Manager Outpatients Support … and for My Emergency Doctor this was the Director of Strategy and Expansion ... This governance arrangement was supported through regular communication and liaison on processes and any issues that arose … Issues were resolved in these communications and, if needed, meetings were held between relevant CHS and My Emergency Doctor representatives to discuss and resolve more complex issues.

4.81 In respect of the schedule of appointments, CHS advised that this was not implemented as agreed, but that an alternative arrangement was established for scheduling:

> Schedule of appointments - As the project began we realised the monthly schedule was not the most efficient way to manage the volume of activity. We agreed to work with batches depending how many patients we had consented and deemed suitable for telehealth appointment.

4.82 In respect of the project completion report, CHS advised that this was not delivered as agreed:

> Project completion report – At the end of the project, CHS and My Emergency Doctor reconciled the final spreadsheet together ensuring all patients allocated to My Emergency Doctor were seen and that there was accurate recording of activity status and handover. A report on lessons and recommendations from My Emergency Doctor was deemed to be unhelpful as they had a number of staffing changes throughout the project. CHS instead undertook their own review of learnings as document in the final project report dated 16 July 2021.

4.83 A total of $95,310 (GST ex) was paid to My Emergency Doctor for Reboot (Outpatients) services.

4.84 Contracts were entered into with Top Health Trust and My Emergency Doctor for the provision of services. However, in January 2021, CHS was notified that Top Health Trust had withdrawn its proposal. The specific timing and reason for this was not documented. CHS sent 788 referrals to My Emergency Doctor. Of the 788 referrals to My Emergency Doctor, 538 patients were marked as seen and 250 patients were not seen for various reasons. A total of $95,310 (GST ex) was paid to My Emergency Doctor for Reboot (Outpatients) services.

## Yarralumla GP Clinic

4.85 The Yarralumla GP Clinic was also engaged to provide services for the purpose of Reboot (Outpatients). This was despite the fact it did not submit an EOI.

### *Engagement of services*

4.86 In March 2020, prior to the development of Reboot (Outpatients), the Yarralumla GP Clinic had approached CHS about collaborating to see Category 2 and 3 Aboriginal and Torres Strait Islander children waiting to be seen in the CHS Ear, Nose and Throat clinic. Subsequent to this, the Yarralumla GP Clinic reported to the Steering Committee on 20 November 2020 that a clinic was run for this purpose on Saturday 24 October 2020.

4.87 The November 2020 paper to the Steering Committee recommended the development of 'a sustainable model to run more clinics such as these to improve access to CHS Medical Specialist Outpatient clinics, especially for Aboriginal and Torres Strait Islander children'. This recommendation was approved by the Committee.

4.88 CHS advised that, based on this earlier work, discussions were underway with the Yarralumla GP Clinic at the time the request for EOIs was circulated for Reboot (Outpatients), but the Clinic was unable to submit an EOI in the time available.

### *Contract for services*

4.89 No contract was proposed or executed for the Yarralumla GP Clinic services.

### *Service provision*

4.90 In March 2021, CHS consultants in the field of Ear, Nose and Throat (ENT), Urology and Dermatology planned to establish a Charitable Trust in collaboration with the Yarralumla GP Clinic, for the purpose of undertaking Reboot (Outpatients) work outside their CHS contracts at Saturday clinics at Yarralumla GP Clinic. The intent of this work was to review patients consented to be seen by Top Health Trust for Dermatology and ENT. The Yarralumla GP Clinic advised that, in practice, the services were billed by the Yarralumla GP Clinic and, following the receipt of payments from CHS, the funds were distributed in their entirety to the Charitable Trust.

4.91 Three Saturday clinics were held as part of this work:

- Saturday 22 May: Dermatology and Urology patients;
- Saturday 12 June: Ear, Nose and Throat patients; and
- Saturday 19 June: Urology patients.

4.92 CHS advised that Aboriginal and Torres Strait Islander patients were prioritised during this work. In total, however, three Ear, Nose and Throat patients who identified as Aboriginal and Torres Strait Islander received services. There were eight bookings to see Ear, Nose and Throat specialists via the Yarralumla GP Clinic, of which five patients identified as Aboriginal and Torres Strait Islander, but two of these patients did not arrive for their scheduled appointment.

4.93 A total of 55 patients were recorded by CHS as removed from the initial wait list via Yarralumla GP Clinic activity. Outcomes are summarised in Table 4-7 below.

### Table 4-7 Outcomes for patients referred to Yarralumla GP Clinic

| | | |
|---|---|---|
| **Patients seen** | Discharged back to GP | 19 |
| | Required further hospital services from CHS | 28 |
| | **TOTAL** | **47** |
| **Patients not seen** | Did not require an appointment | 2 |
| | Did not arrive for scheduled appointment | 6 |
| | **TOTAL** | **8** |

Source: ACT Audit Office based on information provided by CHS.

4.94 Of the 55 referrals to Yarralumla GP Clinic:

- 47 were marked as seen;
  - 19 of these were discharged back to their GP;
  - 28 were identified as requiring further hospital services; and
- eight patients were not seen for various reasons.

4.95 A total of $8,930 (GST ex) was paid for the Reboot (Outpatients) services delivered through the Yarralumla GP Clinic.

4.96 A third provider, the Yarralumla GP Clinic, was also engaged to provide services for the purpose of Reboot (Outpatients). This was despite the fact it did not submit an EOI. No contract was executed for the Yarralumla GP Clinic services.

4.97 The engagement of the Yarralumla GP Clinic followed an approach it made in March 2020, to collaborate with CHS to see Category 2 and 3 Aboriginal and Torres Strait Islander children waiting to be seen in the CHS Ear, Nose and Throat clinic. A November 2020 paper to the Steering Committee reported that a clinic was run for this purpose on 24 October 2020 (a Saturday) and recommended the development of 'a sustainable model to run more clinics such as these …'. In total, however, there were eight bookings to see Ear, Nose and Throat specialists via the Yarralumla GP Clinic. Five of the patients identified as Aboriginal and Torres Strait Islander, but two of these patients did not arrive for their scheduled appointment. A total of 55 patients were recorded by CHS as removed from the initial wait list via Yarralumla GP Clinic activity. In addition to the Ear, Nose and Throat patients, Dermatology and Urology patients were also seen. A total of $8,930 (GST ex) was paid for these services.

## Summary of external service provision

4.98 Table 4-8 provides a summary of the selection process for external services provider, procurement and contracting of external service providers and the delivery of services through the external service providers.

### Table 4-8 Assessment of prospective providers

| Name | Written EOI | Assessed by clinical division | Supported by clinical division | Recommended to Procurement Committee and CEO | Contract for services | Delivered appointments |
|---|---|---|---|---|---|---|
| Respondent 1 | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Respondent 2 | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Respondent 3 | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Respondent 4 | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Top Health Trust | ✓ | ✗ | Not provided for assessment | ✓ | ✓ | ✗ |
| Respondent 5 | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Respondent 6 | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Respondent 7 | ✓ | ✗ | Not provided for assessment | ✗ | ✗ | ✗ |
| My Emergency Doctor | ✗ | ✗ | Not provided for assessment | ✓ | ✓ | ✓ |
| Yarralumla GP Clinic | ✗ | ✗ | Not provided for assessment | ✗ | ✗ | ✓ |

Source: ACT Audit Office, based on information provided by CHS.

**RECOMMENDATION 2 PROCUREMENT**

Canberra Health Services should review its procurement practices to ensure that future procurement activity is supported by evaluation of responses that is supported by:

a) consistent treatment of all prospective suppliers with respect to written submission requirements;

b) rigorous evaluation of each supplier's response against specified criteria, with the results of the evaluation informing decision-making;

c) detailed record-keeping, so that accurate information exists regarding how decisions are made and value for money is achieved; and

d) consistent treatment of all suppliers regarding the development and implementation of contracts for the delivery and payment for services.

# 5 MONITORING AND REPORTING OF REBOOT (OUTPATIENTS)

5.1 This chapter considers the effectiveness of Canberra Health Services' (CHS) monitoring and reporting of the implementation of Reboot (Outpatients).

## Summary

### Conclusion

Monitoring and reporting arrangements for Reboot (Outpatients) were partially effective. The Outpatient Transformation Steering Committee and Outpatient Transformation Working Group, which took responsibility for internal oversight, benefited from access to a bespoke Reboot Dashboard which provided clear insights regarding the approximate number and source of additional appointments delivered. These bodies were well-positioned to share information across clinical divisions, and did so in relation to early planning, implementation challenges and lessons learned. However, these oversight bodies were large, with many members, and not suited to rapid project-related decision-making.

### Key findings

| | Paragraph |
|---|---|
| **Internal oversight** | |
| Existing governance arrangements for outpatient services (the Outpatient Transformation Steering Committee and Outpatient Transformation Working Group) were used for monitoring and reporting of the implementation of Reboot (Outpatients). The large membership of both the Steering Committee (21 members plus the Chair) and Working Group (47 members plus the Chair) was suited to information sharing across clinical divisions, but not best suited to project-related decision-making for Reboot (Outpatients). | 5.9 |
| A 'Reboot Dashboard' was developed by data specialists within CHS specifically for monitoring Reboot (Outpatients). The Reboot Dashboard presented data based on the measurement approach approved by the Steering Committee in August 2020. The Reboot Dashboard provided a clear overview of progress, but it had a number of key limitations:<br>• the measurement approach was based on a crude measure of additionality. It did not account for factors that would otherwise result in additional appointments being provided, such as higher staffing levels, or additional clinic days; and | 5.24 |

- any recorded wait list removals were subject to a high risk of reporting error due to:
  - the complexity of the outpatient care journey;
  - variations in clinic record keeping between outpatient services within CHS; and
  - the age/useability of the patient information system, ACTPAS.

### Learnings from Reboot (Outpatients)

At the end of Reboot (Outpatients), the Division of Cancer and Ambulatory Support provided a paper, *Operation Reboot - Outpatients Project Report* (Project Report), to the Working Group and Steering Committee for noting and discussion. The paper provided a detailed overview of Reboot (Outpatients) activity and learnings, including best available data on the number of wait list removals achieved by all areas of activity. The paper reflected a range of important operational lessons, but did not identify broader strategic learnings from Reboot (Outpatients), or how these may shape the work of CHS in relation to outpatient care going forward. 5.41

Some services developed their own analyses, and shared these findings through professional publications and presentations. This critical reflection is of significant value to improve CHS' management of access to outpatient care. It provides an evidence base for improved practice. However, this demonstrated a relatively autonomous clinician-driven approach, which is unlikely to contribute to public administration improvements within CHS more broadly. 5.42

# Internal oversight

## Project governance

5.2 Oversight of Reboot (Outpatients) was provided by existing governance structures:

- the Outpatient Transformation Steering Committee; and
- the Outpatient Transformation Working Group.

### Outpatient Transformation Steering Committee

5.3 The Outpatient Transformation Steering Committee is Chaired by the Chief Operating Officer, with secretariat support provided by the Senior Manager, Outpatient Support, Division of Cancer and Ambulatory Services. The Committee is made up of 21 other members:

- the Deputy Chief Executive Officer;
- Executive Directors of relevant divisions;
- Clinical Directors of relevant services;

- other key CHS stakeholders including: the Chief Information Officer; a Senior Business Intelligence representative; the Director of Integrated Care; the Executive Group Manager, People and Culture; Executive Branch Manager, Planning, Analysis and Insights; and two members from Finance and Business Intelligence; and
- key external stakeholders including: Calvary representative; Health Care Consumers' Association representative; Capital Health Network representative; Territory Wide Support Services representative; and ACT Health Directorate representative.

5.4 Steering Committee meetings are scheduled to occur monthly. Between July 2020 and June 2021 (when Operation Reboot was being delivered) the Steering Committee met three times (July, August and October 2020) and considered items out of session twice (September and November 2020). The first meeting of 2021 was held in July.

5.5 The purpose of the Steering Committee is to drive improvements by providing strategic guidance and direction on medical specialist outpatients to achieve:

- key performance indicator targets in the outpatient setting across all Divisions;
- necessary support systems to ensure compliance with the National Safety and Quality Health Service (NSQHS) standards;
- improved collaboration with external stakeholders;
- reduced variation in outpatient care;
- improved patient experience;
- a fully implemented and optimised Single Intake Model; and
- provide policy advice to the Executive Committee and the CEO on balancing supply and demand for outpatient services.

### Outpatient Transformation Working Group

5.6 The Outpatient Transformation Working Group is Chaired by the Senior Manager, Outpatient Support, with secretariat support provided by the Project Officer, Outpatient Support. The Working Group is made up of 47 others with responsibilities for operational management and support of outpatient services across CHS.

5.7 Working Group meetings are scheduled to occur monthly. Between July 2020 and June 2021 (when Operation Reboot was being delivered) the Working Group met eleven times. It discussed barriers to implementing Reboot (Outpatients) at five of those meetings.

5.8 The purpose of the Working Group is:

- to implement the strategic direction of the Outpatient Transformation Steering Committee;
- escalate issues to the Steering Committee that need strategic guidance and support;

- to support individual outpatient areas to identify areas of improvement and develop, implement and evaluate plans of action;
- share best practice and expertise amongst peers; and
- ensure consistent application of agreed standards and processes for the support of outpatients across CHS.

5.9 Existing governance arrangements for outpatient services (the Outpatient Transformation Steering Committee and Outpatient Transformation Working Group) were used for monitoring and reporting of the implementation of Reboot (Outpatients). The large membership of both the Steering Committee (21 members plus the Chair) and Working Group (47 members plus the Chair) was suited to information sharing across clinical divisions, but not best suited to project-related decision-making for Reboot (Outpatients).

## Monitoring arrangements

### Appointment recording

5.10 Appointments delivered by CHS clinics were recorded using ACTPAS. However, the risk of inaccurate information management was a recurring issue throughout Reboot (Outpatients). At its 16 October 2020 meeting the Steering Committee noted the importance of the Working Group reminding administrative staff to remove the patient from the wait list when they were seen.

5.11 For external providers, scrutiny was provided by the Senior Manager, Outpatient Support, using a manually compiled spreadsheet for each provider. The spreadsheet recorded: the names of patients referred to each provider; whether they attended the appointment; when they had been seen; and the outcome of the appointment. The spreadsheets also recorded additional administrative actions required by CHS, such as following up with any patient who did not attend a scheduled appointment. The outcome of appointments was also recorded in ACTPAS.

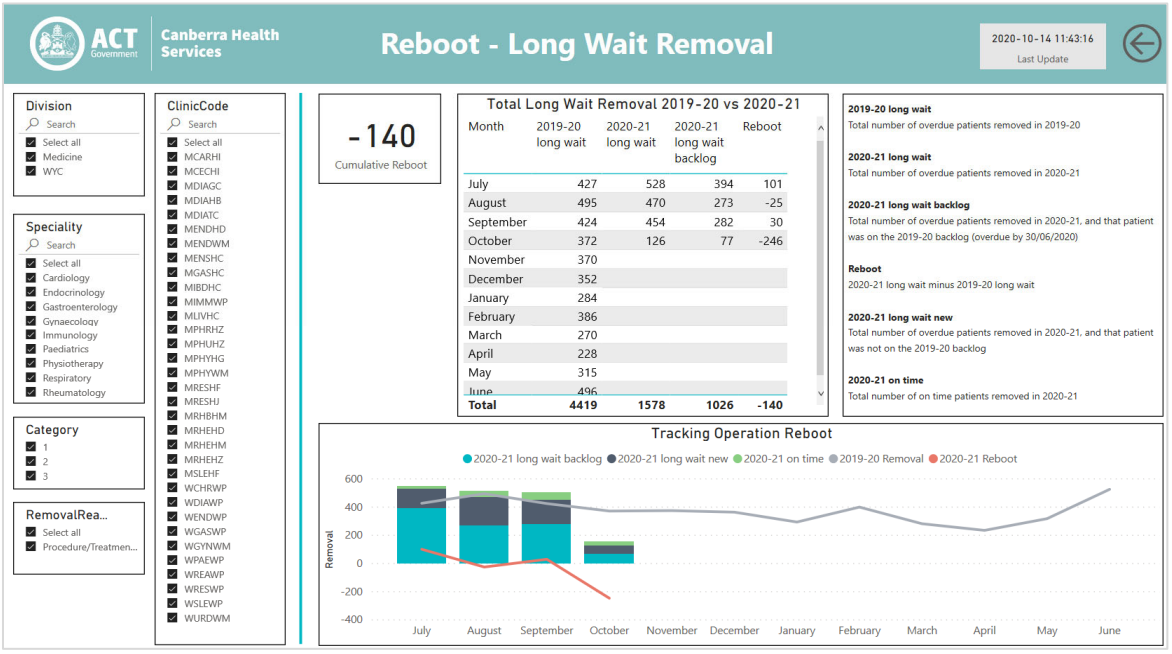
### Appointment reporting: the Reboot Dashboard

5.12 A 'Reboot Dashboard' was developed by data specialists within CHS specifically for Reboot (Outpatients). It was based on an existing outpatient services reporting dashboard and was informed by ACTPAS data.

5.13 The Reboot Dashboard presented data based on the measurement approach approved by the Steering Committee in August 2020. It compared the difference between 2019-20 and 2020-21 overdue removals (i.e. those patients waiting beyond clinically recommended timeframes) for each month. It enabled users to view total Operation Reboot long wait removals, removals by month, or isolate particular divisions, clinics, specialties or urgency categories.

5.14 Figure 5-1 shows the Reboot Dashboard as at October 2020.

## Figure 5-1 Operation Reboot Dashboard (October 2020)




Source: CHS.

5.15 The Reboot Dashboard was presented to the Steering Committee at its 16 October 2020 meeting. The Committee noted 'it is evident the surge work has begun with the increase in initial appointments, and wait list removals for actual activity undertaken'. The Dashboard was not subsequently circulated to the Steering Committee again, but it was accessible to its members.

5.16 The Reboot Dashboard was presented to the Working Group twice:

- in October 2020, at the same time as it was introduced to the Steering Committee; and
- in June 2021 to show outcomes near completion.

5.17 The Reboot Dashboard provided a clear overview of progress, but it had a number of key limitations:

- the measurement approach was based on a crude measure of additionality. It did not account for factors that would otherwise result in additional appointments being provided, such as higher staffing levels, or additional clinic days;
- any recorded long wait removals were subject to a high risk of reporting error due to:
  - the complexity of the outpatient care journey;
  - variations in clinic record keeping between outpatient services within CHS; and
  - the age/useability of the patient information system, ACTPAS, which has since been replaced by the Digital Health Record. For example, if a clinic saw a patient, but did not record an outcome (such as whether the patient was referred back to their GP, or for surgery), the patient would remain on the wait list, and the

appointment would not be recorded as Reboot (Outpatients) activity for that month.

## Financial reporting

5.18 Funding for Reboot (Outpatients) was provided to divisions and external providers based on recorded activity:

- internal appointments were monitored using the Reboot Dashboard and payments processed by the CHS finance area on this basis; and
- external appointments were monitored by the Senior Manager, Outpatient Support, who received invoices and confirmed satisfactory provision of services for CHS' finance area to process payment.

5.19 In two cases, discrepancies were found between activity recorded by the Reboot Dashboard and by CHS clinics providing appointments. In these cases, additional checking was undertaken by the Division of Cancer and Ambulatory Services, and payments adjusted in line with accurate appointment numbers.

## Reporting implementation barriers

5.20 The Steering Committee minutes record only one discussion of barriers to achieving the target of 14,000 removals. On 16 October 2020, the Committee discussed '[t]he desire to hold surge clinic but the lack of space to complete this task in addition to business as usual operations'.

5.21 More regular reporting from Divisions that had committed to delivering additional appointments was undertaken through the Working Group. Table 5-1 shows meetings of the Working Group where barriers to the implementation of Reboot (Outpatients) were discussed.

### Table 5-1 Reported resourcing challenges for Reboot (Outpatients)

| Meeting | Issues raised |
|---|---|
| Working Group meeting, 22 September 2020 | • Clinic space—lack of space to undertake increased outpatient activity for Operation Reboot.<br>• Lack of clear visibility of space availability.<br>• Unavailability of registrars—sessions are being cancelled due to unavailability, and there is a lack of information on when registrars are on planned study leave or annual leave. |
| Working Group meeting, 23 February 2021 | • Significant staffing shortages in Respiratory and Cardiology. |
| Working Group meeting, 20 April 2021 | • Clinic space—very limited options for additional space to run Reboot activity.<br>• Rates of patients not arriving for scheduled appointments still too high (7.7 percent), although improvements have been made in recent years. |

| Meeting | Issues raised |
|---|---|
| Working Group meeting, 25 May 2021 | • Space has been an issue and limiting factor on additional Reboot activity, even in areas otherwise doing well against targets. |
| Working Group meeting, 22 June 2021 | • Space—another issue is space being booked but not occupied. |

Source: ACT Audit Office, based on information provided by CHS.

5.22 A review of Working Group meeting minutes shows the availability of space to deliver additional appointments and the availability of specialists were recurring barriers to the successful delivery of Reboot (Outpatients).

### Executive committee oversight

5.23 The executive committee at the time, the Corporate Plan Review Committee, was the internal escalation point for executive briefing on risks of not achieving the targeted Reboot (Outpatients) appointments. The Committee was not briefed on risks associated with not achieving the targeted appointments.

5.24 A 'Reboot Dashboard' was developed by data specialists within CHS specifically for monitoring Reboot (Outpatients). The Reboot Dashboard presented data based on the measurement approach approved by the Steering Committee in August 2020. The Reboot Dashboard provided a clear overview of progress, but it had a number of key limitations:

- the measurement approach was based on a crude measure of additionality. It did not account for factors that would otherwise result in additional appointments being provided, such as higher staffing levels, or additional clinic days; and
- any recorded wait list removals were subject to a high risk of reporting error due to:
  - the complexity of the outpatient care journey;
  - variations in clinic record keeping between outpatient services within CHS; and
  - the age/useability of the patient information system, ACTPAS.

## External oversight

5.25 Cabinet was a key external oversight body for Operation Reboot activity overall. From 15 December 2020 the Health Directorate commenced reporting to Cabinet on Operation Reboot activity as part of broader COVID-19 pandemic reporting. The December 2020 report provided July to September year to date expenditure for the total Operation Reboot effort, as well as details of surgery and dental activity. Specific information about outpatients, such as the number of outpatient appointments delivered or expenditure on this part of the initiative, was not provided at this stage. The report identified risks to service delivery, but the identified risks focused on the elective surgery wait list. No outpatient-specific risks, or risk management activities, were identified.

5.26 The next report, on 16 February 2021, took the same approach. It provided activity and expenditure data for July to November 2020.

5.27 On 29 March 2021 the Health Directorate (with CHS input), provided the first detailed outpatient activity reporting to Cabinet. The report included year to date expenditure and appointment numbers (to December 2020). A total of 664 of 14,000 appointments were reported as having taken place. Gradually, increasing expenditure and appointments were reported throughout the remainder of the year, until it covered the entirety of Operation Reboot implementation:

- on 19 April 2,310 appointments are reported as having taken place to end February 2021;
- on 25 May 2,981 appointments are reported as having taken place to end March 2021;
- on 29 July 3,990 appointments are reported as having taken place to end May 2021; and
- on 24 August 5,336 appointments are reported as having taken place to end June 2021.

5.28 This material was provided to Cabinet for noting. No outpatients-related decisions or actions arising from these reports were documented.

# Learnings from Reboot (Outpatients)

5.29 CHS did not plan for, or undertake, an evaluation of Operation Reboot as a whole. Nevertheless, the Division of Cancer and Ambulatory Support identified and documented learnings from Reboot (Outpatients). Certain specialties also undertook analysis of the outcomes of their work on Reboot (Outpatients).

## Operation Reboot – Outpatients Project Report

5.30 At the end of Reboot (Outpatients), the Division of Cancer and Ambulatory Support provided a paper, *Operation Reboot - Outpatients Project Report* (Project Report), to the Working Group and Steering Committee for noting and discussion. The paper provided a detailed overview of Reboot (Outpatients) activity and learnings, including best available data on the number of wait list removals achieved by all areas of activity. This paper was discussed at the Steering Committee's 16 July 2021 meeting. The paper analysed both the internal and external parts of the initiative, from an operational perspective.

## The provision of internal appointments

5.31 In relation to appointments provided by CHS clinics, the Project Report summarised the following lessons:

- Availability Clinic room space was vital in supporting internal reboot. Consideration was given to hiring external space however, it was not deemed cost effective or logistically suitable. The lack of central view of clinic room availability, its utilisation, and untrustworthiness of lending out clinic rooms managed by services negatively affected Outpatient Reboot.
- There was a lack of communication between clinical directors and senior staff specialists were not aware of the funding available through Operation Reboot, resulting in only a few internal reboot applications. This may have been a missed opportunity.
- One service did not record all its activity in ACTPAS. Referrals were not waitlisted and hence activity corresponding to that referral was not counted as Operation Reboot activity. This was highlighted to the service and their Executive Director.
- The administrative review has identified deviation from standardised outpatient processes which are being actioned.

5.32 This analysis identified key operational barriers to achieving better outcomes in relation to internal appointments. However, there was a lack of reflection on the strategic drivers of poor outcomes in the Project Report, including for example:

- the relative infancy of outpatient services governance and planning functions (the Steering Committee and Working Group, established in February 2020), and the possible impact of this on the quality of the proposal outlined in the Concept Brief;
- the prioritisation of clinical functions and the prioritisation of rolling out the additional appointments without adequate implementation planning; and
- the limited capacity of CAS to direct services in relation to the additional work, and the possible contribution of this to limited oversight of internal appointments as they occurred.

## The provision of external appointments

5.33 In relation to appointments provided by external providers, the Project Report summarised the following lessons:

- GP Hub did not go ahead. CHS had invested time and effort to collate appropriate referrals as per their requirement.
- Some services were not keen on using telehealth for the patients on their long waitlists. It may have been rightly inappropriate for some specialities while some specialities were risk averse.
- My Emergency Doctors' outcomes letters in the earlier period were not to the expected quality which meant if the patients were returned to CHS, the review did not add information for the CHS clinician to triage. It was reiterated that if a patient was being returned to CHS a clear reason for the return is required with a management plan (if possible) and advice to the patient until they were seen by the CHS specialist. Inadequate quality of initial outcome letters reduced confidence in the use of telehealth as a value add for patients on long waiting lists.

- Feedback from the administrative team who spoke to patients was that patients seemed to be genuinely thankful and appreciative of the initiative being undertaken by CHS. Some patients had started to believe they would never be offered any sort of treatment or that their referral had been completely lost, and so they could now feel reassured that a focus had been directed by CHS to patients on long waitlists.
- There were staffing changes which impacted the flow and continuity of the project.
- The dedicated administration staff was based in the Central Outpatient Intake team. To provide consistent support (sickness/ staffing issues) to the project it was elected that 1 ASO2/3 administration employee would be used out of a pool of Operation Reboot trained staff members for a daily rotating roster. However, this seemed to disrupt efficiency because priorities and processes needed to be receptive to the external factors. This led to some small intricacies not being adequately communicated due to Central Outpatient Intake's workload intensity for the first half of 2021. The smaller instructions that may not have been fully passed along could result in inaccurate reporting. The inaccuracies have been fixed resulting in additional workload.

External and Internal Operation Reboot was a novel project for CHS. There were times when unpredictability created inefficiencies, but these were dealt with within the team. The team have reported feeling supported through task-oriented weekly meetings and continuous discussion to support morale (post bush fires and COVID pandemic fatigue).

5.34 CHS advised that the challenges associated with ACTPAS have since been recognised as part of CHS' work on the Digital Health Record. (The Digital Health Record was launched on 12 November 2022, replacing ACTPAS and a number of other systems.) In this respect the management of referrals and wait lists now occurs within the Digital Health Record (rather than two separate systems). This reduces the need for administrative staff to manually coordinate between different systems.

5.35 As with the analysis of internal appointments, observations on external appointments were focused on operational lessons. The Project Report did not draw out broader lessons such as:

- whether the market approach (My Emergency Doctor) or collaboration with external providers (Yarralumla GP Clinic) is endorsed as a worthwhile component of outpatient services going forward;
- the importance of improving project management and procurement practices to allow for more successful engagement of external providers, should this option be adopted again in future; or
- the need for standardised processes within CHS, including formally agreed clinical guidelines for referral to external outpatient service providers, to reduce administrative burden and increase oversight, should this option be adopted again in future.

## Learnings at specialty level

5.36 The documentation and dissemination of learnings at a speciality level was varied, based on the level of engagement of clinics with Operation Reboot. Allied Health, for example, produced a range of materials reflecting on clinical practice lessons and ongoing improvements that could be drawn from participation in Reboot (Outpatients). The material produced in relation to Physiotherapy work on the Gynaecological Wait list is presented below.

### Operation Reboot Gynaecological Wait list and Physiotherapy

5.37 Women's health physiotherapists working with Gynaecologists designed a new pathway. It commenced in September 2020 with a view to:

> Provide timely, evidence-based care to women referred to CHS gynaecology and to reduce the gynaecology waiting time by offering women with stress urinary continence and pelvic organ prolapse, the opportunity to be seen by a physiotherapist as initial assessment and treatment option.
>
> …
>
> The Gynaecologists triages referrals and forwards appropriate referrals to physiotherapy for woman assessed as likely to benefit from conservative management by physiotherapy (women referred for pelvic organ prolapse or urinary incontinence).
>
> These women were contacted and offered physiotherapy prior to planned consultation with a gynaecologist. These women are either managed and discharged by physiotherapy or referred back to gynaecology waitlist.

5.38 Allied Health identified the following outcomes from this new pathway:

- 166 patients have attended Physiotherapy through this change in service. Approximately 45 percent completed their treatment by physiotherapy alone.
- Patients referred back for gynaecology input following a physiotherapy assessment wait no longer than 1 month for a gynaecology appointment as they have already trialled conservative management.
- Because they were able to access earlier treatment, patients' conditions did not deteriorate whist waiting for an appointment on an extensive wait list.
- CHS surveyed participating patients and found:
  - 85 percent felt that the service met their needs;
  - 80 percent felt they had increased ability to manage activities/concerns;
  - 100 percent found the information helpful;
  - 80 percent preferred physiotherapy as first option;
  - 95 percent felt women's physiotherapy helped them manage concerns;
  - 95 percent would recommend women's health physiotherapy to others; and
  - 95 percent of patients were happy with the service they were provided.

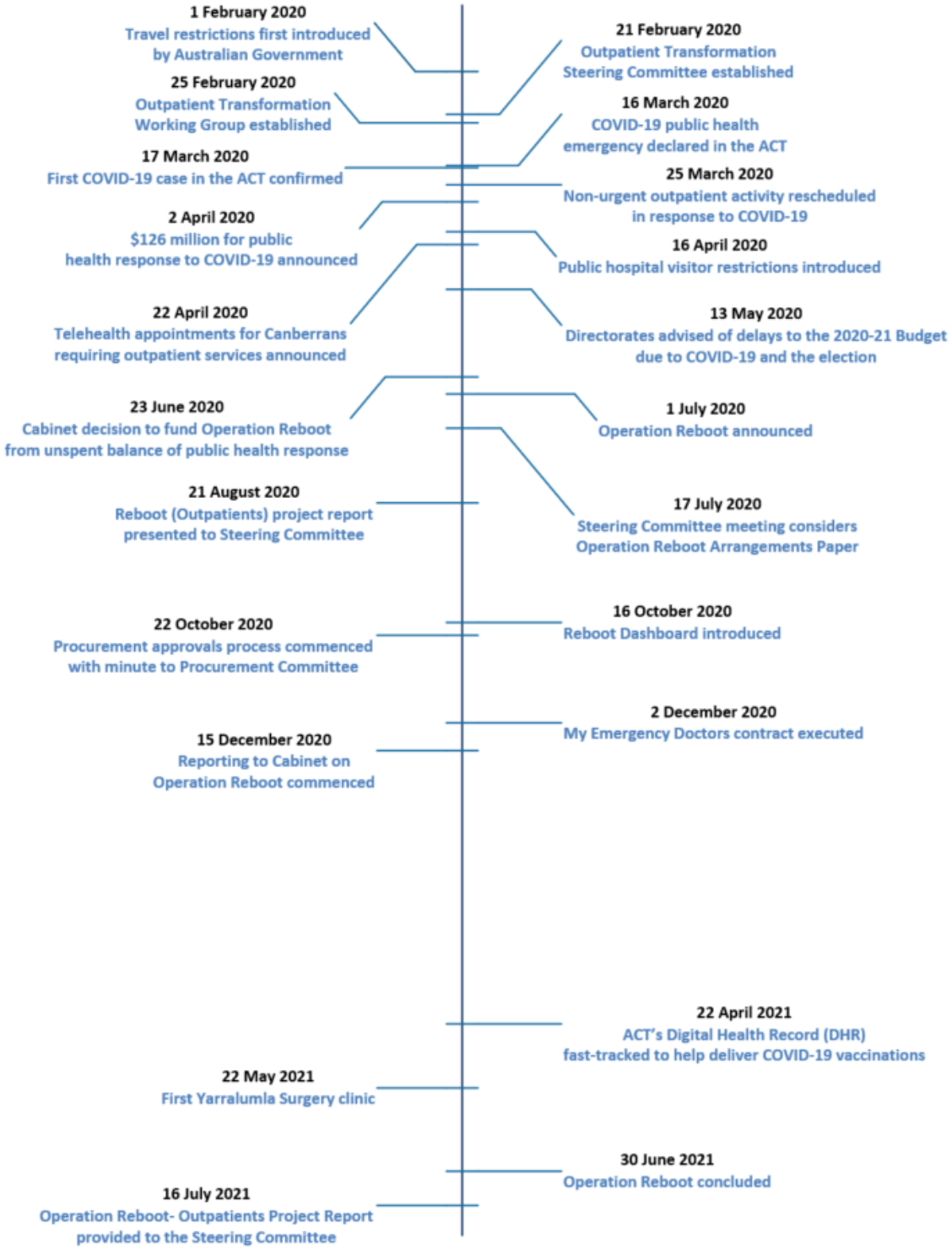
5.39 At the completion of Operation Reboot in June 2021, the wait time for physiotherapy-appropriate patients was seven months. Prior to this initiative it was 17 months or greater.

5.40 This critical reflection is of significant value to improve CHS' management of access to outpatient care. It provides an evidence base for improved practice. However, this is a relatively autonomous clinician-driven approach, which is unlikely to contribute to public administration improvements within CHS more broadly.

5.41 At the end of Reboot (Outpatients), the Division of Cancer and Ambulatory Support provided a paper, *Operation Reboot - Outpatients Project Report* (Project Report), to the Working Group and Steering Committee for noting and discussion. The paper provided a detailed overview of Reboot (Outpatients) activity and learnings, including best available data on the number of wait list removals achieved by all areas of activity. The paper reflected a range of important operational lessons, but did not identify broader strategic learnings from Reboot (Outpatients), or how these may shape the work of CHS in relation to outpatient care going forward.

5.42 Some services developed their own analyses, and shared these findings through professional publications and presentations. This critical reflection is of significant value to improve CHS' management of access to outpatient care. It provides an evidence base for improved practice. However, this demonstrated a relatively autonomous clinician-driven approach, which is unlikely to contribute to public administration improvements within CHS more broadly.

# APPENDIX A: OPERATION REBOOT (OUTPATIENTS) KEY MILESTONES




Source: ACTAO, based on publicly available information and information supplied by CHS.

## Audit reports

| | |
|---|---|
| **Reports Published in 2022-23** | |
| Report No. 01 – 2023 | Construction Occupations Licensing |
| Report No. 10 – 2022 | 2021-22 Financial Audits Financial Results and Audit Findings |
| Report No. 09 – 2022 | ACT Emergency Services Agency cleaning services arrangement |
| Report No. 08 – 2022 | 2021-22 Financial Audits – Overview |
| Report No. 07 – 2022 | ACT Childhood Healthy Eating and Active Living Programs |
| Report No. 06 – 2022 | Annual Report 2021-22 |
| Report No. 05 – 2022 | Procurement and contracting activities for the Acton Waterfront Project |
| **Reports Published in 2021-22** | |
| Report No. 04 – 2022 | Governance arrangements for the planning of services for Parkwood, Ginninderry |
| Report No. 03 – 2022 | Taxi Subsidy Scheme |
| Report No. 02 – 2022 | Fraud Prevention |
| Report No. 01 – 2022 | Management of Detainee mental health services in the AMC |
| Report No. 13 – 2021 | Campbell Primary School Modernisation Project Procurement |
| Report No. 12 – 2021 | 2020-21 Financial Audits – Financial Results and Audit Findings |
| Report No. 11 – 2021 | Digital Records Management |
| Report No. 10 – 2021 | 2020-21 Financial Audits Overview |
| Report No. 09 – 2021 | Annual Report 2020-21 |
| Report No. 08 – 2021 | Canberra Light Rail Stage 2a: Economic Analysis |
| **Reports Published in 2020-21** | |
| Report No. 07 – 2021 | Procurement Exemptions and Value for Money |
| Report No. 06 – 2021 | Teaching Quality in ACT Public Schools |
| Report No. 05 – 2021 | Management of Closed-Circuit Television Systems |
| Report No. 04 – 2021 | ACT Government's vehicle emissions reduction activities |
| Report No. 03 – 2021 | Court Transport Unit Vehicle – Romeo 5 |
| Report No. 02 – 2021 | Total Facilities Management Contract Implementation |
| Report No. 01 – 2021 | Land Management Agreements |
| Report No. 10 – 2020 | 2019-20 Financial Audit – Financial Results and Audit Findings |
| Report No. 09 – 2020 | 2019-20 Financial Audits Overview |
| Report No. 08 – 2020 | Annual Report 2019-20 |
| Report No. 07 – 2020 | Management of care of people living with serious and continuing illness |

These and earlier reports can be obtained from the ACT Audit Office's website at http://www.audit.act.gov.au.