STANDING COMMITTEE ON PUBLIC ACCOUNTS

Review of Auditor-General's Report No. 1 of 2011: *Waiting Lists for Elective Surgery and Medical Treatment*

JULY 2012

Report 25

Committee Membership

Ms Caroline Le Couteur MLA	Chair
Mr John Hargreaves MLA	Deputy Chair from 5 August 2011
	Member from 20 November 2009 to 5 August 2011
Mr Brendan Smyth MLA	Member from 5 August 2011
	Deputy Chair to 5 August 2011
Ms Joy Burch MLA	Member to 19 November 2009

Secretariat

Secretary:	Dr Andréa Cullen
Senior Research Officer:	Dr Michael Sloane
Administration:	Ms Lydia Chung

Contact Information

Telephone:	(02) 6205 0142
Facsimile:	(02) 6205 0432
Email:	committees@parliament.act.gov.au
Post:	GPO Box 1020 Canberra ACT 2601
Website:	www.parliament.act.gov.au

Resolution of Appointment[1]

The ACT Legislative Assembly appointed the Standing Committee on Public Accounts on 9 December 2008 to:

(1) examine:

a) the accounts of the receipts and expenditure of the Australian Capital Territory and its authorities; and

b) all reports of the Auditor-General which have been presented to the Assembly;

(2) report to the Assembly any items or matters in those accounts, statements and reports, or any circumstances connected with them, to which the Committee is of the opinion that the attention of the Assembly should be directed;

(3) inquire into any question in connection with the public accounts which is referred to it by the Assembly and to report to the Assembly on that question; and

(4) examine matters relating to economic and business development, small business, tourism, market and regulatory reform, public sector management, taxation and revenue.

[1] Legislative Assembly for the ACT, *Minutes of proceedings,* No. 2, 9 December 2008, pp. 12–13.

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RECOMMENDATIONS

RECOMMENDATION 1

3.30 The Committee recommends that the ACT Auditor-General should program a follow-up audit to examine the management of access to elective surgery across the ACT's public hospitals at the midpoint of the 8th ACT Legislative Assembly term.

1 INTRODUCTION AND CONDUCT OF INQUIRY

1.1 On 23 June 2010, the Legislative Assembly for the ACT (the Legislative Assembly) passed a resolution that, in part, requested the Auditor-General to:

> …conduct an audit of 'Waiting Lists for Elective Surgery and Medical Treatment' and consider as part of that audit concerns raised about the management of the elective surgery waiting list.[2]

1.2 In response to this request the Auditor-General decided, in accordance with the *Auditor-General Act 1996*, to conduct a performance audit on patient waiting lists for elective surgery and medical treatment procedures.[3]

1.3 Auditor-General's Report No. 1 of 2011: *Waiting Lists for Elective Surgery and Medical Treatment* (the Audit report) was presented to the Speaker of the Legislative Assembly on 17 January 2011.[4]

1.4 In accordance with the resolution of appointment of the Standing Committee on Public Accounts (the Committee), the Audit report was referred to the Committee for examination.[5]

1.5 The Audit report presented the results of a performance audit that reviewed ACT Health's management of the waiting lists for elective surgery and medical treatment involving non-emergency medical procedures across the ACT's public hospitals.[6]

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[2] Legislative Assembly for the ACT, *Minutes of proceedings*, No. 64, 23 June 2010, p. 728.

[3] ACT Auditor-General's Office, Report No.1 of 2011: *Waiting lists for elective surgery and medical treatment*, January, p. 4.

[4] The Audit report was presented to the Legislative Assembly itself at the first available sitting day following its forwarding to the Speaker. This occurred on 15 February 2011.

[5] Legislative Assembly for the ACT, *Minutes of proceedings*, No. 2, 9 December 2008, pp. 12–13.

[6] ACT Auditor-General's Office, Report No.1 of 2011: *Waiting lists for elective surgery and medical treatment*, January, p. 3.

Terms of reference

1.6 The Committee's terms of reference were to examine the Audit report and report to the ACT Legislative Assembly.

Conduct of inquiry

1.7 On 24 February 2011 the Committee received a briefing from the Auditor-General on the Audit report.

1.8 The Committee received a submission from the Government in relation to the findings of the Audit report.[7] The Government submission is attached at **Appendix A** and can also be downloaded from the Committee's website.[8]

1.9 Under its resolution of appointment, the Committee examines all reports of the Auditor-General which have been presented to the Legislative Assembly. The Committee has established procedures for its examination of these reports.[9]

1.10 In accordance with these procedures, the Committee resolved on 12 October 2011 to inquire further into the Audit report. Pursuant to standing order 246A, this decision was reported to the Assembly on 27 October 2011.

1.11 The Committee held one public hearing to discuss the Audit report findings and recommendations on Thursday 15 March 2012. The Minister for Health, Ms Katy Gallagher MLA, appeared before the Committee accompanied by officials from the Health Directorate, the Canberra Hospital and Calvary Public Hospital. A list of all witnesses who appeared before the Committee is at **Appendix B**. The Committee's website contains the transcript of this hearing.[10]

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[7] ACT Government submission—dated 22 July 2011.

[8] http://www.parliament.act.gov.au/committees/index1.asp?committee=116

[9] Available at: http://www.parliament.act.gov.au/committees/AGReports.asp

[10] < http://www.parliament.act.gov.au/committees/index1.asp?committee=116>

1.12 The Committee met on 31 July 2012 to discuss the Chair's draft report. The Committee's draft report was adopted on 31 July 2012.

Structure of the report

1.13 The Committee's report is divided into four sections:

- Chapter 1—Introduction and conduct of inquiry
- Chapter 2—Audit background and findings
- Chapter 3—Committee comment
- Chapter 4—Conclusion

Acknowledgements

1.14 The Committee thanks the former Auditor-General, the Minister for Health and officials from the Health Directorate, the Canberra Hospital and Calvary Public Hospital who assisted the Committee during the course of its inquiry by appearing before it to give evidence and/or by providing additional information.

2 AUDIT BACKGROUND AND FINDINGS

2.1 This chapter presents an overview of the background to, and key findings of the Audit.

2.2 Subsequent to completion of the Audit and presentation of the Audit report, a new directorate structure for the ACT Public Service (ACTPS) was adopted by the Government on 24 March 2011 and took effect from 17 May 2011.[11] The directorate structure consists of a single department or agency, of nine directorates, oversighted by a new ACTPS Strategic Board. Under the new structure, references to ACT Health are now applicable to the Health Directorate.[12]

Audit background and objective

2.3 The objective of the Audit was to provide an independent opinion to the Legislative Assembly on whether:

- information on waiting lists published by ACT Health was complete, reliable and timely
- ACT Health effectively managed the elective surgery policy and related systems and procedures to promote clinically appropriate, consistent and equitable treatment of patients in public hospitals, and
- access to medical services (non-surgical) was effectively managed and timely.[13]

2.4 The scope of the Audit was confined to examining elective surgery and medical treatment procedures in the public hospitals of the ACT.[14] Elective

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[11] Gallagher, K. (2011) Media release: 'New ministerial arrangements', 17 May.

[12] On 3 September 2010, the former Chief Minister, Jon Stanhope, announced that Dr Allan Hawke AC had been appointed to review the structure and capacity of the ACTPS (Stanhope, J. (2010) Media release: 'Dr Allan Hawke AC to review ACT public-sector structures, capacity', 3 September). The proposal for a single department model was adopted by the Government on 24 March 2011 and took effect from 17 May 2011 (Gallagher, K. (2011) Media release: 'New ministerial arrangements', 17 May).

[13] ACT Auditor-General's Office, Report No. 1 of 2011: *Waiting lists for elective surgery and medical treatment*, January, p. 4.

surgery, in contrast to emergency surgery, is nationally defined as surgery that can be delayed for at least 24 hours.[15]

Audit conclusions

2.5 The Audit report contained the following audit conclusions drawn against the Audit objectives:

- Overall, elective surgery waiting lists are administered in the ACT within a sound framework of policies, guidelines and procedures. However, ACT Health's implementation and monitoring processes were not managed well to deliver the intended outcomes.
- Current practices in compiling the waiting lists have compromised the policy intention of promoting clinically appropriate, consistent and equitable management of elective surgery waiting lists. In particular, downgrades of patients' urgency category, often without documented clinical reasons, raised considerable doubts about the reliability and appropriateness of the clinical classifications for patients on the waiting lists.
- The strategies implemented by ACT Heath have not been adequate to address increased demand, and reduce the waiting lists for elective surgery. Recent reviews commissioned by the Department indicate significant issues concerning the delivery of surgical services and management of operating theatres, which have contributed to the long waiting lists.
- ACT Health is implementing the Elective Surgery Access Plan 2010–13 to meet the immediate needs of increasing demand for elective surgery, and introducing changes in elective surgery management. The success of this Plan depends on its effective implementation, which requires adequate resources, engagement of hospital staff and improved communication with, and cooperation from surgeons and other medical professions.

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[14] ACT Auditor-General's Office, Report No. 1 of 2011: *Waiting lists for elective surgery and medical treatment*, January, p. 4.

[15] Commonwealth Government—Department of Health and Ageing. (2010), *The state of our public hospitals*, June, p. 20.

- There were significant delays in assessing appointments in areas reviewed by Audit, namely the urology and gastroenterology units at the Central Outpatients Department (OPD) in the Canberra Hospital. There is scope to improve the effective management of waiting lists for medical treatment (non-surgical) by improving strategic management of the OPDs at the Canberra Hospital, and adopting consistent systems and operational procedures across the various units within the OPD.[16]

Audit findings

2.6 The Audit provided key findings to support its conclusions. The main elements of these findings—across five audit themes—are reproduced below.

Elective surgery processing systems, performance and accountability framework

2.7 The Canberra Hospital (TCH) and Calvary Public Hospital (CPH) manage waiting lists independently, largely because the hospitals use different electronic record systems to process patients' details.

2.8 The lack of an integrated database between TCH and the CPH and the absence of a single waiting list across the ACT have adversely impacted on the efficiency and effectiveness in the management of the waiting lists, including the transfer of patients between these two hospitals. ACT Health plans to implement the same electronic system (ACTPAS) currently used in TCH at the CPH within the next eighteen months.

2.9 There have been significant increases to base funding allocated to elective surgery in the ACT.

2.10 Notwithstanding increased funding by the Commonwealth and ACT Governments in recent years, the elective surgery waiting lists have not shown improvements, and the ACT compared unfavourably to other jurisdictions in 2008–09.

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[16] ACT Auditor-General's Office, Report No. 1 of 2011: *Waiting lists for elective surgery and medical treatment*, January, p. 5.

2.11 More recent statistics in 2009–10 indicated a general worsening situation compared to 2008–09.[17]

Reliability of elective surgery waiting list

2.12 ACT Health collected and compiled significant data on waiting lists for elective surgery, which are comprehensive and mostly accurate. However, the classification of clinical urgency categories did not always reflect ACT Health's policy and procedures, and therefore raised doubts on the reliability and appropriateness of the clinical classifications for patients within the waiting list.

2.13 In the absence of required documents, Audit was unable to form a view on the validity of the clinical reclassifications.

2.14 Currently, some surgeons managed their own waiting lists instead of using public hospitals' waiting lists. This, combined with the lack of documented clinical reasons for patient priority reclassifications, can compromise safeguards that ensure patients are treated in accordance with the priority order they presented and within the level of urgency of their respective case in public hospitals' waiting lists.

2.15 ACT Health's current policy does not require patients to be notified of any priority changes nor to be advised of the impact of the changes. It would appear that reclassifications often resulted from internal waiting list management procedures with no or limited involvement from patients.

2.16 There were deficiencies in processing patients on to the elective surgery waiting list.

2.17 The Surgical Booking team at TCH and the CPH did not routinely review waiting list transactions on a monthly basis as required by the Waiting List Policy. This non-compliance increases the risk of the hospitals not detecting

[17] ACT Auditor-General's Office, Report No. 1 of 2011: *Waiting lists for elective surgery and medical treatment*, January, pp. 5–6.

and correcting processing errors on patient information in a timely manner, which may in turn compromise the accuracy of the waiting lists.[18]

Analysis of elective surgery waiting times

2.18 Analysis of the waiting lists of four specialties selected for review and of selected surgeons for these specialties indicated that the estimated waiting times for all patients, except most Category 1 patients, would continue to be well beyond the recommended timeframe and target set by ACT Health and, where relevant, the Commonwealth Government for each category.[19]

Management of elective surgery waiting lists

2.19 There was a strong consistent view expressed by key stakeholders consulted by Audit, including various medical professions, that the management of waiting lists by the hospitals was not effective in ensuring patients receive surgery within their clinical urgency timeframes. Overall inadequate resources, such as beds, equipment and operating theatre times and some current inefficient practices, had impacted on the effectiveness of patient throughput, and contributed to the delays experienced by patients.

2.20 Implementation of strategies by ACT Health to improve the waiting list to-date has been slow. Other than progress made in the outsourcing of various surgical procedures to private providers in the 2010–11 financial year, there has been limited progress or improvements on other options such as: transfer of patients to other doctors with a shorter waiting list; transfer of patients to another hospital; and increases in theatre utilisation.

2.21 Clinical review of long-wait patients was not conducted within the recommended timeframes. Patients or their general practitioner (GPs) often needed to request the hospitals to review their cases after long waits.

2.22 There was a high level of postponement and cancellation of elective surgery (335 in 2009–10 for four selected specialities in TCH), due to various reasons, some avoidable. The main reasons included substitutions of surgical

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[18] ACT Auditor-General's Office, Report No. 1 of 2011: *Waiting lists for elective surgery and medical treatment*, January, pp. 6–7.

[19] *Ibid.*, pp. 7–8.

sessions by higher priority Category 1 and 2 patients and emergency surgery. Other postponements or cancellations that could have been avoided by better planning and management by TCH were due to doctors' leave (with or without sufficient notice) and the unavailability of equipment.

2.23 Many leave applications from doctors (about 32 percent in TCH and 14 percent in CPH) did not comply with the existing policy to provide a minimum of four weeks' notice. Insufficient notice to hospitals makes reallocation of available surgical sessions to other surgeons difficult and sometimes impractical. There were no records of patients' management plans being developed and implemented to minimise the impact on the patients affected by the treating surgeons who took leave.

2.24 Consultants commissioned by ACT Health recently to review surgical services in the ACT (April 2010) and the operations of TCH operating theatres (June 2010) identified many deficiencies in the management of TCH operating theatres that require immediate attention and rectification. ACT Health has commenced actions to address the matters identified, but needs to formalise implementation plans and an appropriate governance and accountability framework to monitor progress and report on outcomes.

2.25 ACT Health has also commenced implementing a new Elective Surgery Access Plan 2010–13 to meet the immediate needs of increasing demand for access to elective surgery and improve elective surgery management. The new plan has set a performance target for each public hospital and an overall target of 10 711 admissions for 2010–11.[20]

Management of medical treatment waiting lists

2.26 The OPDs in TCH provided almost 118 000 services in 2009–10, an increase of 13 percent from 2008–09 and about 13 000 over target. Funding for the OPDs in public hospitals in 2009-10 totalled $79.8 million, an increase of 3.4 percent over the previous year.

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[20] ACT Auditor-General's Office, Report No. 1 of 2011: *Waiting lists for elective surgery and medical treatment*, January, pp. 8–9.

2.27 ACT Health conducted an internal review of the outpatient services at TCH and a draft report in October 2010 found deficiencies in strategic planning, inconsistent application of policies and procedures across the OPDs, ad hoc processes for managing the waiting lists, and poor and inefficient communications with clinicians, consumers and staff. The review report included 35 recommendations to address strategic and immediate operational needs.

2.28 Audit examination of a selection of patient records on the urology unit waiting list at TCH showed that more than 85 percent failed to meet the timeframes for referral, triaging and booking processes included in the relevant policy.

2.29 Audit examination of a selection of patient records on the gastroenterology unit's waiting list at TCH showed that although the average wait for Category 1 patients fell from 48 days in February 2010 to 39 days in July 2010, the waiting time for only one month in the reviewed period (February 2010 to July 2010) was within the clinical target of 30 days.

2.30 An internal audit of the gastroenterology unit's waiting list, which commenced in February 2010 (reported in July 2010), identified numerous data errors including multiple request for admission (RFAs) for the same patient, unregistered RFAs, registrations under the incorrect specialist, and registrations for deceased patients.

2.31 Most referrals tested by Audit were complete and accurately entered onto the waiting list. Only half of the selected entries were processed within the required timeframe and several instances were noted where the specialist doctor had not assigned a clinical urgency category, or the assigned category was varied by staff at the clinic.

2.32 The Canberra Hospital has been implementing improvement strategies in all TCH clinics and this is expected to improve the waiting list over time.[21]

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[21] ACT Auditor-General's Office, Report No. 1 of 2011: *Waiting lists for elective surgery and medical treatment*, January, pp. 9–10.

Audit recommendations

2.33 The Auditor-General made **11** recommendations, which are reproduced in full at **Appendix C**. The following table provides a summary of the recommendations across three of the five audit themes:

Audit theme	Recommendation coverage
1. Reliability of elective surgery waiting lists	R1—Development of a single waiting list across the ACT
	R2—Request for admission forms
	R3—Regular clerical reviews to mitigate risks of processing errors
	R4—Development of procedural manual for surgical bookings and associated training
	R5—Procedures for reclassifying the clinical urgency categories of patients
2. Management of elective surgery waiting lists	R6—Clinical reviews of patients on elective surgery waiting lists
	R7—Strategies to avoid elective surgery patients waiting longer than their clinical urgency timeframes
	R8—Doctors' leave and patient management plans
	R9—Minimising postponements and cancellations of surgery initiated by hospitals
3. Management of medical treatment waiting lists	R10—Data integrity audits for outpatient department waiting lists at TCH
	R11—Implementation strategy for recommendations arising from the *Review of The Canberra Hospital outpatients service redesign project*.

Government response to recommendations

2.35 In its submission, the Government stated:

> Notwithstanding the general endorsement of the recommendations, and the recognition that a number of systems need to be improved in relation to documentation relative to elective surgery, the Government is concerned that the Audit Report failed to give sufficient weight to the need by our public hospitals to balance the demand for elective and emergency surgery, as well as failing to note the considerable increase in access to elective surgery and reductions in waiting times being achieved in the 2010-11 financial year.[22]

[22] ACT Government submission—dated 22 July 2011, p. 3.

2.36 The Government commented that the resources required to deliver elective surgery, including doctors, nurses and operating theatres, are the same resources required to deliver emergency surgery. As such, growth in demand for emergency surgery can limit the capacity of public hospitals to meet growth in demand for elective surgery, despite the provision of increased resources.[23]

2.37 The Government indicated that it agreed fully with the Audit's recommendations, except for recommendation 1, to which it agreed in principle, and recommendation 6, to which it agreed in part.[24]

2.38 Regarding recommendation 1, the Government stated that the Health Directorate was working to establish a single waiting list for public elective surgery in the ACT and that this work should be finalised by October 2012. However, the establishment of a single ACT waiting list will:

> …remove some control of access to elective surgery at the Calvary site from Calvary Public Hospital, by placing that control within the Health Directorate. Accordingly, any agreement will require changes to the operation of Calvary Public Hospital and agreement from the Little Company of Mary Health Care.[25]

2.39 In evidence, the Committee inquired about the integration of the two hospital databases that will underpin the establishment of a single waiting list for public elective surgery in the ACT. The Deputy Director-General of Strategy and Corporate explained:

> The key to achieving that is the implementation of the patient administration system that we currently have at the Canberra Hospital at Calvary. Work is progressing very well on that. We have an October completion date for that. We expect, once we have what is called ACTPAS—the ACT patient administration system—in Calvary, that will enable us to establish a consolidated list.[26]

2.40 The Committee confirmed that whilst the two databases are currently being managed as two separate systems, a central coordination unit monitors the

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[23] ACT Government submission—dated 22 July 2011, p. 3.

[24] *Ibid.*, pp. 7–15.

[25] *Ibid.*, p. 7.

[26] Mr Ian Thompson, *Transcript of evidence*, 15 March 2012, p. 6.

capacity across both systems and provides scope to transfer patients between the waiting lists at CPH and TCH.[27]

2.41 The Committee was interested to know whether the functionality of the database management system enabled access to patient records between the two hospitals. A Health Directorate official explained that it was a patient administration system not a full electronic health record.[28]

2.42 Regarding recommendation 6, the Government agreed that there are times when it is appropriate for the hospital to initiate a clinical review of patients and that clear guidance on when this should occur will be included in the revised *ACT Elective Surgery Access Policy*. However, the Government did not agree that all patients who wait longer than the recommended time should be clinically reviewed:

> If all patients were reviewed it would mean diverting the Health Directorate resources from caring for other patients to provide reviews for patients for whom the review may provide no benefit.[29]

2.43 Recommendation 5 concerns the processes by which the urgency categories assigned to patients are changed. The Government agreed with the Audit recommendations concerning proper documentation of reclassifications, enhanced controls and procedures for recording reclassifications and improved accountability and transparency. However, the Government commented in its submission:

> …it is important to note that audit found no evidence that surgical booking clerks or any other administrative officer made any changes to the reclassification of patient without the direction of the treating surgeon. The principal issue relates to adequate documentation -not deliberate manipulation of data to achieve a required result.[30]

2.44 Regarding this issue, the Audit noted:

> As part of the review of ACT Health's 2009-10 Statement of Performance, Audit reviewed all Category 1 patients from all specialties whose clinical urgency

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[27] *Transcript of evidence*, 15 March 2012, p. 6.

[28] Mr Ian Thompson, *Transcript of evidence*, 15 March 2012, p. 6.

[29] ACT Government submission—dated 22 July 2011, p. 11.

[30] *Ibid.*, p. 10.

category had been reclassified from Category 1 to Category 2 during 2009-10. In all, 259 Category 1 patients' reclassifications were examined. Audit found that:

- nearly all patients' priority changes (252 out of 259 patients' records examined or 97 percent) were not supported by any documented reasons; and
- only 177 reclassifications (or 68 percent) were evidenced as having been approved by a doctor (i.e. 55 reclassifications – or 32 percent - had no evidence of having been approved by a doctor).[31]

2.45 The Committee notes that it received the Government's submission approximately six months[32] after the Audit report was presented to the Legislative Assembly[33]—three months longer than the three-month time frame set out for Government submissions to be provided to the Committee in response to reports of the Auditor-General.[34]

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[31] ACT Auditor-General's Office, Report No. 1 of 2011: *Waiting lists for elective surgery and medical treatment*, January 2011, p. 47.

[32] Dated 22 July 2011.

[33] 17 January 2011.

[34] A Government submission is to be provided to the Public Accounts Committee three months from the date an Auditor-General's report is presented in the ACT Legislative Assembly. Refer ACT Government, *Guidelines for responding to reports by the Auditor-General*, November 2009, p. 3.

3 COMMITTEE COMMENT

3.1 The Audit report presents the results of a performance audit that reviewed ACT Health's management of waiting lists for elective surgery and medical treatment involving non-emergency medical procedures at TCH and CPH.

3.2 The Committee is of the view that the elective surgery system is itself complex and its functioning is also determined by the wider system in which it operates. The Committee acknowledges that maintaining an appropriate focus on elective surgery in the context of growing hospital demand is a challenge for all health services.

3.3 However, the Committee notes that the Audit report observed that notwithstanding increased funding by the Commonwealth and the ACT Governments, elective surgery waiting lists had not shown improvements, and the ACT compared unfavourably to other jurisdictions in 2008–09. Furthermore, statistics in 2009–10 indicated a general worsening of the situation compared to 2008–09.[35]

3.4 In considering the Audit report and its findings, the Committee is of the view that four areas warrant further comment—(i) progress on implementation of recommendations; (ii) Expert Panel review of elective surgery under the National Health Partnership Agreement; (iii) previous performance audit on waiting lists for elective and medical treatment; and (iv) whole systems thinking as it applies to the delivery of hospital services. Comment against each of these areas is set out below.

Progress on implementation of recommendations

3.5 The follow up of performance audits to assess whether agencies have addressed recommendations and findings arising from specific audits is an important exercise to inform the Legislative Assembly on progress towards implementation of accepted recommendations.

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[35] ACT Auditor-General's Office, Report No. 1 of 2011: *Waiting lists for elective surgery and medical treatment*, January, pp. 5–6.

3.6 The Committee emphasises that it is the action taken by applicable agencies to implement audit recommendations that is all important in helping achieve better efficiency and improving accountability of the Government, not the recommendations *per se*.

3.7 In evidence, the Minister for Health informed the Committee that much work had been done to progress the Auditor-General's recommendations alongside targeted initiatives to improve access to elective surgery. The Minister for Health commented:

> A lot of work has been done and we are very pleased to appear before you today to discuss the Auditor-General's report into waiting times for elective surgery and medical treatment. Running alongside the Auditor-General's report, as members would know, there has been a lot of work done around improving access to elective surgery, which is probably something that the Auditor-General's report did not actually address. It was more around how we manage the list and report against our processes.
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> A significant part of the effort of the Health Directorate has been going into improving access overall to elective surgery for patients getting their operations faster, and that is bearing fruit. We will deliver record amounts of elective surgery this year. We are seeing already in the first five months of this year that we are ahead of where we were this time last year. We are also seeing improvements in the reductions of people waiting too long for care and we are seeing commensurate reductions in the median wait time, even though I have, as you know, a number of concerns about median wait time being an accurate measure of the performance of the elective surgery system.
> ...
> I think from my point of view the Auditor-General's report was useful. I do not believe that it will necessarily deliver one extra operation—the actual Auditor-General's report. But we are doing that alongside this work with significant extra resources going in. I think the usefulness of the Auditor-General's report was to look at our processes and identify ways that we could improve them. We have been implementing those.[36]

3.8 The Committee notes that the Minister for Health also instructed the Health Directorate to develop an action plan to ensure that each of the Auditor-General's recommendations was addressed.[37] The Committee notes that, since presentation of the Audit report, the Minister for Health has tabled two

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[36] Ms Katy Gallagher MLA, *Transcript of evidence*, 15 March 2012, pp. 1–2.

[37] ACT Government submission—dated 22 July 2012, p. 6.

reports[38] in the Assembly detailing progress with regard to implementation of recommendations.[39] The Committee commends the approach taken by the Health Directorate.

3.9 The Committee welcomes the public commitment as demonstrated by the Minister for Health and the Health Directorate to follow up implementation activity. This action signals a Directorate level of commitment to ensure implementation and a willingness to be publicly accountable for its progress. The Committee commends the Minister for her leadership on this matter. This is an approach that other agencies may wish to consider adopting.

3.10 In evidence, the Committee was told that all of the agreed recommendations bar one had been implemented. The Deputy Director-General—Strategy and Corporate explained:

> The consolidated waiting list is the primary one, and we have just discussed that. Associated with that there was a recommendation for a single request for admission form across the two hospitals. We have worked to get consistency between the two hospitals, but some of the local management arrangements mean that it is actually quite difficult and it would be disruptive to try to have the same form at both hospitals. It has the same core information with some local adaptations. We believe we have addressed the core issue associated with that recommendation but it has not addressed fully the exact recommendation.[40]

3.11 The Committee inquired about progress with regard to implementation of recommendations and the Minister for Health explained:

> We are continuing to work with our doctors, nurses and staff at the hospital to implement the recommendations of the Auditor-General's report, including audits against our process. I think I have reported against that work to the Assembly. That work is being implemented to a very high standard as well.[41]

3.12 The Committee has considered the submission received from the Government, evidence received at the public hearing of 15 March 2012, and the two progress reports as tabled by the Minister for Health, and assessed whether the Health Directorate has responded appropriately to the Auditor-General's findings.

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[38] October 2011 and March 2012.

[39] *Transcript of evidence*, 15 March 2012, pp. 6–7.

[40] Mr Ian Thompson, *Transcript of evidence*, 15 March 2012, p. 7.

[41] Ms Katy Gallagher MLA, *Transcript of evidence*, 15 March 2012, pp. 1–2.

3.13 The Committee is of the view that the submission and related evidence demonstrate that the Health Directorate has acted upon its initial response as set out in the Audit report. Further, where action is pending, the Committee believes the Directorate has signalled a credible intention to follow through with implementation.

3.14 The Committee is generally satisfied that the Health Directorate has either addressed, or is in the process of addressing, those matters identified by the Audit as requiring attention.

Review of Elective Surgery under National Partnership Agreement

3.15 The Committee notes that subsequent to the tabling of the Audit report, the Expert Panel reviewing elective surgery and emergency access targets under the *National Partnership Agreement on Improving Public Hospital Services* released its report to the Council of Australian Governments (COAG) in June 2011.[42]

3.16 On 13 February 2011 Australia's First Ministers signed the *National Partnership Agreement on Improving Public Hospital Services* (the Agreement). The Agreement is focused on enhancing public patient access to elective surgery, emergency departments and subacute care services. The primary means by which the Agreement seeks to achieve this is through improving efficiency and capacity in public hospitals. The Agreement provides:

> ...up to $1.55 billion to assist meeting elective surgery and emergency department targets, $1.6 billion for new subacute beds and a $200 million flexible funding pool for capital and recurrent projects across elective surgery, emergency department and subacute care.[43]

3.17 In parallel to the formation of the Agreement, an Expert Panel (the Expert Panel) was established on 10 May 2011:

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[42] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency success Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June 2011.

[43] *Ibid*., p. xi.

> ...to examine safety and quality issues and practical impediments to the timing and phasing of the elective surgery and emergency department targets.[44]

3.18 The Committee is of the view that the Report of the Expert Panel warrants further consideration following presentation of the Audit report. The Committee wishes to highlight a number of findings and recommendations as detailed in the Report of the Expert Panel that are pertinent to its consideration of the Audit report and management of elective surgery *per se*. In particular, the report of the Expert Panel notes that:

Whole-of-system reform

3.19 The national elective surgery access targets are accompanied by associated reward payments. The challenge for all hospitals is to improve patient access without impacting on the quality of other aspects of health care service provision.[45]

3.20 Meeting the specified targets cannot be solely the responsibility of emergency or surgery departments. Whole-of-hospital engagement will be needed to successfully achieve these targets to ensure that all obstacles to effective patient flow are addressed.[46]

Sharing best practice

3.21 Some jurisdictions have established surgical taskforces to facilitate information sharing with regard to elective surgery. The Expert Panel recommended that a surgical taskforce, as already exists in some jurisdictions, be established in all jurisdictions and linked nationally as a means of sharing information on best-practice elective surgery waiting list management.[47]

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[44] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency success Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June 2011, p. xi.

[45] *Ibid.*

[46] *Ibid.* pp. 9–14.

[47] *Ibid.*, p. 14.

Monitoring impact of targets on demand

3.22 Concerns were expressed that achievement of the targets might increase demand for emergency department and elective surgery services. The Expert Panel was of the view that this needs to be monitored and early strategies developed to respond to any increasing demand pressures that might arise and which could potentially compromise service safety or quality.

Linking of reward funding

3.23 Reward funding for elective surgery should be linked to maintaining volume levels and treating those patients who have waited longest beyond the clinically recommended time for treatment.[48]

Consistency in elective surgery categories and practices

3.24 Inconsistency in practices for recording waiting times for patients waiting for specialist appointments between jurisdictions was cited as a barrier to establishing true demand for elective surgery and total waiting times for elective surgery procedures, from the time of referral by a GP to the procedure taking place. The Expert Panel recommended that a nationally consistent measure of surgical access be developed for the purposes of future agreements. The Panel emphasised that such a measure would be of particular importance if, as has been suggested, demand for public surgical procedures increases as a result of improvement in access.[49]

Review and evaluation of implementation of targets

3.25 In relation to ongoing review, that a process be established to review and evaluate the targets. This process should include: (i) evaluation of implementation and progress; (ii) identification of any safety and quality

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[48] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency success Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June 2011, p. xi.

[49] *Ibid.*, p. 53.

issues; and (iii) recommended revisions to the targets and establishment of a framework to support learning for continuous improvement.[50]

Previous performance audit on waiting lists for elective surgery and medical treatment

3.26 The Committee notes that a performance audit on waiting lists for elective surgery and medical treatment was previously conducted by the Auditor-General in 2004 coinciding with the 6th Assembly.[51] Subsequent to the presentation of that Audit report, the 6th Legislative Assembly's Standing Committee on Public Accounts inquired further into Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery and Medical Treatment*. That Public Accounts Committee examined elective surgery waiting lists in the context of whole systems theory, and supply and demand issues associated with delivery of elective surgery, including short-term and sustainable reductions in waiting times.

3.27 The ACT community places great value on the quality of public health care services in the Territory. Improving the access of public patients to elective surgery is not only a matter of significant public interest but also a core aspect of delivery of high quality health care.

3.28 The Committee recognises that no aspect of health service delivery should be immune from critical examination at any time and it would be unrealistic to accept that the administrative and service delivery facets of hospital services are free of inefficiencies or, as is the case with other areas of public administration and service delivery, are incapable of continuous improvement.

3.29 The Committee is therefore of the view that the Auditor-General should program a follow-up audit to examine the management of access to elective surgery across the ACT's public hospitals at the midpoint of the next Legislative Assembly term. This follow-up audit should be scheduled to

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[50] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency success Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June 2011, p. 58.

[51] Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery and Medical Treatment*.

permit it to consider, at a minimum, at least two years of operation of the *National Partnership Agreement on Improving Public Hospital Services* as it relates to improving public patient access to elective surgery, emergency departments and subacute care services.

RECOMMENDATION 1

3.30 **The Committee recommends that the ACT Auditor-General should program a follow-up audit to examine the management of access to elective surgery across the ACT's public hospitals at the midpoint of the 8th ACT Legislative Assembly term.**

Whole systems thinking

3.31 The Committee notes that, notwithstanding the Government's endorsement of the recommendations and acknowledgement that some of the systems in relation to the documentation of elective surgery needed to be improved, the Government was concerned that the Audit report failed to give sufficient weight to the requirement that public hospitals have to balance the demand for elective and emergency surgery. This was coupled with a failure to acknowledge that a considerable increase in access to elective surgery and reductions in waiting times have been achieved in the 2010–11 financial year.[52]

3.32 The Minister for Health commented that:

> Running alongside the Auditor-General's report, as members would know, there has been a lot of work done around improving access to elective surgery, which is probably something that the Auditor-General's report did not actually address. It was more around how we manage the list and report against our processes.[53]

3.33 The Committee notes that the Expert Panel reviewing elective surgery and emergency access targets under the *National Partnership Agreement on Improving Public Hospital Services* was of the view that meeting the specified elective surgery access targets cannot be solely the responsibility of surgery departments. It emphasised that whole-of-hospital engagement will be

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[52] ACT Government submission—dated 22 July 2011, p. 3.

[53] Ms Katy Gallagher MLA, *Transcript of evidence*, 15 March 2012, p. 1.

needed to successfully achieve these targets to ensure that all obstacles to effective patient flow are addressed.[54]

3.34 The Committee is of the view that the elective surgery system is itself complex, and its functioning is also determined by the wider system in which it operates. Any strategies to improve its performance must take into account the way the elective surgery system responds to changes in waiting times, the way in which other demands on the hospital system are dealt with, and the whole system within which the hospital operates.[55]

3.35 In evidence, the Minister for Health illustrated the practical complexity of delivering access to elective surgery within the wider hospital system and in a climate of increasing demand:

> Nothing went wrong. What happened was that the demand for elective surgery grew at a faster rate than it could be provided at. That is not just operations; that is around staff and their availability, and growing our medical and nursing staff. It is around extra operating theatres. It is around extra intensive care beds. It is about extra beds in the hospital. You cannot just open a theatre for eight hours extra a day and not have intensivists, the beds on the ward, to actually deal with the throughput. When you see in a budget line $2½ million for elective surgery, that buys about 200 operations. You then look to the lines below it—extra intensive care beds, extra acute care beds, that have to match that, and you have to grow that. I think you need to look at the adequacy of the hospital system dating back to the late 90s, and it has taken years to catch up. It is not a problem that you can just fix like that.[56]

Improving access to elective surgery

3.36 Improving access to elective surgery must consider the wider hospital system in which it operates. In a practical sense it must consider the: (i) factors that influence demand for elective surgery; (ii) capacity of the system; and (iii) concepts of short term and sustainable reductions of waiting times.

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[54] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency success Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June 2011, pp. 9–14.

[55] Appleby, J., Boyle, S., Devlin, N., et al., 'Sustaining Reductions in Waiting Times: Identifying Successful Strategies', *King's Fund*, January 2005, pp. 19–20.

[56] Ms Katy Gallagher MLA, *Transcript of evidence*, 15 March 2012, p. 3.

Factors influencing demand for elective surgery

3.37 A number of factors influence demand for elective surgery treatment in Australia. Demand for elective surgery is determined by the health status of the population and state of medical technology, which determines the range of conditions that are treatable and patients' expectations. Various financial incentives, such as the extent of cost sharing by public patients, the proportion of the population with private health insurance and the price of private surgery, are also likely to be factors influencing demand.[57] In the case of the ACT some of the factors contributing to an increasing demand for elective surgery include:

- ageing of the population
- burden of chronic disease
- increased consumer knowledge and health expectations
- advances in technology, and
- cross border health service provision.

Capacity of the system

3.38 The outflow (supply) of elective surgery depends on the surgical capacity of the system and the productivity with which this capacity is used.[58]

3.39 The supply of elective surgery is primarily determined by budget allocations, but is also influenced by practical factors such as the availability of surgeons, operating theatres, beds and nurses, and also by the efficiency with which these factors are brought together to provide elective surgery.[59]

3.40 The Committee is of the view that the challenge to policy makers and health providers is to find the right balance of resources to the system and waiting list management procedures that produce both optimal surgery rates and optimal waiting times.

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[57] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[58] *Ibid.*

[59] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery and Medical Treatment*, p. 16.

3.41 Fundamentally this requires policy makers and health providers to be clear about the level of capacity of elective service provision that is potentially available, and the factors affecting this capacity.

3.42 The Committee acknowledges that the Health Directorate, in conjunction with TCH and CPH, have done a lot of work on improving access to elective surgery.

3.43 As an example of strategies being undertaken to increase supply, the Committee inquired about work underway to provide access to Queanbeyan hospital as a means of increasing capacity and thus supply of elective surgery. The Minister for Health told the Committee:

> Discussions are ongoing with New South Wales around using Queanbeyan hospital. I know that to everybody from the outside it sounds like a very easy thing to do but—
>
> ...there are issues about working out what kind of procedures could be done, the funding arrangements for those procedures—who pays, what patients might be the right ones to use, a system got up and running, what doctors should be used? If they are ACT doctors, what credentialling process needs to happen to be able to use a New South Wales facility? Then there is the equipment that the doctors use and whether that equipment is available at the hospital.
>
> So there has been considerable work done in this area and I am hopeful that we will have progress soon. You need to make sure that the patient safety issues are completely addressed and the professional issues for the doctors before you can embark on something. It is not like I can just run a little pilot and see how it goes. There is also the post-care of the surgical patients. All of these matters have to be looked at and it takes time. We want to make sure we get it right and have it as a success from the word go.[60]

Short-term and sustainable reduction of waiting times

3.44 It is important to emphasise that strategies to reduce waiting times are not always the same (or of the same importance or scale) as those needed to sustain reductions. For example, the need to protect resources used for elective activity, or to manage demand, for example, by referral protocols, is less relevant once waiting times are low. As a consequence, once optimum

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[60] *Transcript of evidence*, 15 March 2012, pp. 7–8.

demand and supply management is in place, it would be reasonable to conclude that referrals can be processed more quickly.[61]

3.45 Several governments have tried to address high waiting times by providing extra funds to existing hospitals to perform extra activity (for a given capacity), raising the productivity of the hospitals (in terms of the number of treatments per surgeon or per bed).[62] This policy making approach depends upon the premise that a waiting list is a backlog of patients that can be eliminated through the one-off introduction of temporary dedicated funding. However, such a perspective ignores the dynamic nature of waiting times and waiting lists and the continuous nature of technological change. That is, waiting time is affected not only by the number of patients on the list at one point in time but also by the number of patients that are continuously added to the list.[63]

3.46 Temporary increases in capacity are essential as a short-term strategy to meet targets; however, research has shown that they are often wasteful and expensive in the long term, and prevent the same money being invested in a permanent capacity. Further, research has shown that such strategies do not lead to sustainable reductions in waiting times.[64]

3.47 Short-term initiatives or temporary policies for reducing waiting lists run the risk of providing only temporary relief and do not address the underlying problem of ensuring that waiting lists operate as an efficient and equitable price rationing mechanism.[65]

3.48 In contrast, research has shown that scrutinising the logistics of hospital care processes is more effective in reducing waiting lists. This involves looking at patients' routes through different interventions and attempting to simplify and shorten them; identifying bottlenecks for patients, and then using the whole

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[61] Appleby, J., 'Cutting NHS Waiting Times', *King's Fund*, February 2005, p. 5.

[62] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[63] Worthington, D.J., 'Hospital waiting list management models', *Journal of Operational Research Society*, 1991, 42(10), pp. 833–843; Worthington, D.J., ' Queuing models for hospital waiting list', *Journal of Operational Research Society*, 1987, 38(5), pp. 413–422.

[64] Appleby, J., 'Cutting NHS Waiting Times', *King's Fund*, February 2005, p. 7.

[65] Edwards, 'Points for pain: waiting list priority scoring systems', *British Medical Journal*, 1999, 13 February, 318 (7181), pp. 412–414.

hospital system perspective to work out, for example, the best way of handling the interaction between elective and emergency flows.[66]

3.49 Further, a range of smaller measures to improve efficiency, including the careful management of beds, maximising day-case activity, ensuring the full use of theatres, and effective discharge planning, including investment in step-down facilities to free up beds for elective cases have also been effective in reducing waiting lists.[67]

3.50 The Committee is of the view that short-term supply and demand policies to reduce waiting times are essential[68]; however, this needs to be combined with supply and demand policies that lead to sustainable reductions in waiting times.

3.51 The Committee acknowledges that initiatives being undertaken as part of the *National Partnership Agreement on Improving Public Hospital Services* are focused on, amongst other things, improving the efficiency and capacity of the hospital system to enhance access to elective surgery. As the Territory became a signatory to the Agreement on 13 February 2011, it will be a matter of time before the effectiveness of measures under the Agreement can be assessed with regard to improving access to elective surgery and contribution to the short term and sustainable reduction of waiting times.

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[66] Appleby, J., 'Cutting NHS Waiting Times', *King's Fund*, February 2005, p. 8.

[67] *Ibid.*, p. 8.

[68] Research has shown that the use of short-term initiatives such as weekend working to reduce waiting lists were unsustainable in the long run and expensive in terms of cost per case (Appleby, J., 'Cutting NHS Waiting Times', *King's Fund*, February 2005, p. 8).

4 CONCLUSION

4.1 The Committee believes the Audit to have been both timely and of benefit to TCH, CPH and the Health Directorate.

4.2 The Committee is of the view that the elective surgery system is itself complex, and its functioning is also determined by the wider system in which it operates. Any strategies to improve its performance must take into account the way the elective surgery system responds to changes in waiting times, the way in which other demands on the hospital system are dealt with, and the whole system within which the hospital operates.[69]

4.3 The Committee acknowledges that maintaining an appropriate focus on elective surgery in the context of growing hospital demand is a challenge for all health services.

4.4 The Committee has made **one** recommendations in relation to its report inquiring into Auditor-General's Report No. 1 of 2011: *Waiting Lists for Elective Surgery*.

Caroline Le Couteur MLA

Chair

31 July 2012

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[69] Appleby, J., Boyle, S., Devlin, N., et al., 'Sustaining Reductions in Waiting Times: Identifying Successful Strategies', *King's Fund*, January 2005, pp. 19–20.

APPENDIX A: ACT Government submission

Attached is a copy of the Government submission to the Standing Committee on Public Accounts in response to the Audit report.

ACT Government

GOVERNMENT SUBMISSION TO THE
Standing Committee on Public Accounts

Auditor-General's Report No. 1 of 2011
Waiting times for elective surgery and medical treatment

Authorised for publication
12·10·11

Submission by:
Katy Gallagher MLA
Minister for Health
July 2011

1 Overview

1.1 On 23 June 2010, the Legislative Assembly passed a resolution that requested the Auditor General to:

> " conduct an audit of 'Waiting Lists for Elective Surgery and Medical Treatment' and consider, as part of the audit, concerns raised about the management of the elective surgery waiting list."

1.2 In response to the request, the Auditor General decided to conduct a performance audit on waiting lists for elective surgery and medical treatment.

1.3 The Auditor General provided the Speaker of the ACT Legislative Assembly with her completed report, Auditor General's Report No.1 of 2011, *Waiting Lists for Elective Surgery and Medical Treatment* (the Audit Report) on 17 January 2011.

1.4 The Audit Report contains 11 recommendations in relation to improvements to the management of the elective surgery waiting list.

1.5 This Submission to the Standing Committee on Public Accounts provides the Government Response to the Audit Report.

2 General Comments

2.1 The Government agrees fully to nine of the 11 recommendations; agrees in-principle to one recommendation; and agrees in-part to one recommendation. The ACT Government's position is provided at Paragraph 3 of this submission.

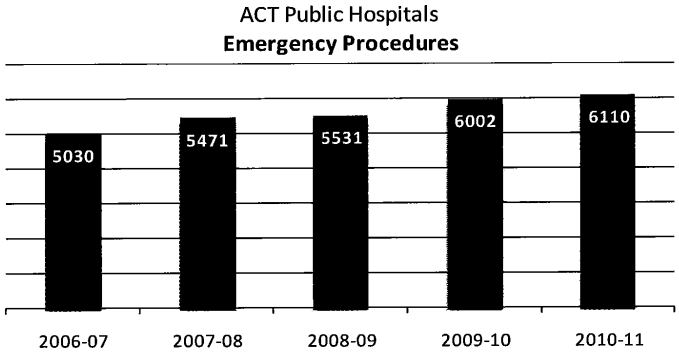
2.2 Notwithstanding the general endorsement of the recommendations, and the recognition that a number of systems need to be improved in relation to documentation relative to elective surgery, the Government is concerned that the Audit Report failed to give sufficient weight to the need by our public hospitals to balance the demand for elective and emergency surgery, as well as failing to note the considerable increase in access to elective surgery and reductions in waiting times being achieved in the 2010-11 financial year.

2.3 Elective surgery is not provided in a vacuum. The resources required to provide elective surgery (including doctors, nurses and operating theatres) are the same resources required to provide emergency surgery services.

2.4 Significant growth in demand for emergency surgery can hamper the capacity of our public hospitals to meet growing demand for elective surgery, despite the provision of additional resources by Government.

2.5 Over the four-year period of the Audit Report (from 2006-07 to 2010-11), our public hospitals reported a 21 percent increase in demand for emergency surgery. This unprecedented increase in demand for emergency surgery reduced the capacity of our public hospitals to meet growing demand for elective surgery. This increase is continuing into 2010-11, with an increase in demand reported over the first eleven months of this year compared with last financial year (Fig 1).

Fig 1



Source: Admitted Patient Care published Data

2.6 Despite this considerable increase in emergency surgery, our public hospitals did manage to provide a 5.1 percent increase in elective surgery in 2009-10 compared with 2006-07. However, the Government accepts that this level of growth is not sufficient to meet growing demand for elective surgery and address the number of people on the waiting list with longer than recommended waiting times.

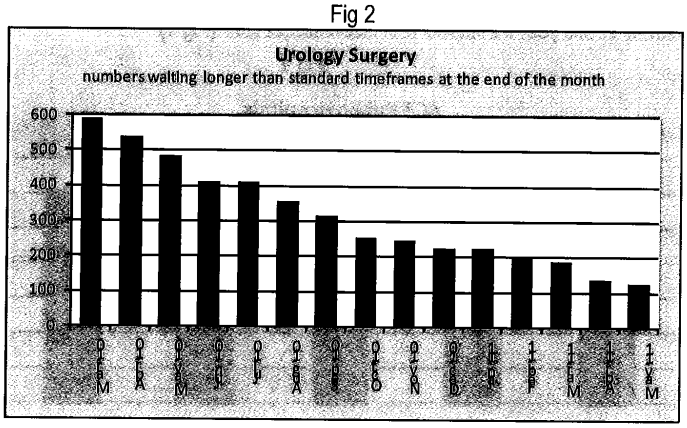
2.7 As a result, the ACT Government, together with a commitment from the Commonwealth under the new National Health and Hospitals Reform Program, committed more than $14 million over the four years to 2013-14 to significantly increase access to elective surgery.

2.8 This funding will be directed to specifically target those specialties with large proportions of long wait patients, such as urology, ear, nose and throat surgery, orthopaedic surgery and plastic surgery. The Government's focus on purchasing services from the private sector will also focus on these surgical specialties.

2.9 Activity over the 18 months from January 2010 to June 2011 demonstrates that this additional investment is working to significantly boost access to surgery and reduce the numbers of people on the elective surgery waiting list with longer than recommended waiting times.

2.10 Over the last 18 months our public hospitals reported a 21 percent drop in the number of people with extended waiting times for elective surgery. In urology surgery – an area which had been noted as experiencing considerably long waiting times – the number of people with extended waiting times dropped by 79 percent between March 2010 and May 2011 (Fig 2).

Fig 2



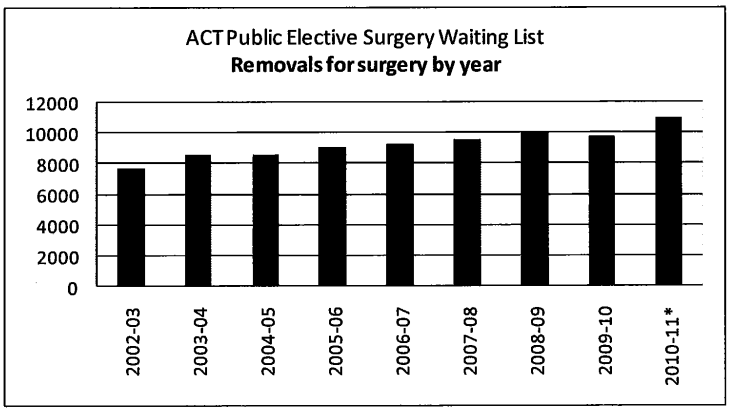
Source: Elective Surgery Data Set (Census Data) 2009-10 and 2010-11

2.11 Our public hospitals are on track to provide over 10,930 elective surgery operations over the 2010-11 financial year – a 12 percent increase on the previous year's activity, with activity to the end of May 2011 suggesting that this total may be exceeded. On top of this, we have entered into partnerships with a number of private providers to further boost access to elective surgery. Additional activity in the public sector and work provided in the private sector will provide approximately 300 more operations by 30 June 2011.

2.12 The Government is committed to continuing this increased access to surgery into 2011-12 - including the continuation of partnerships with private providers – to maximise access to elective surgery for our community, with the potential to provide an extra 300 elective surgery cases in the private sector in 2011-12.

2.13 The Government accepts that too many people have been waiting too long for surgery over recent years. However, the Government was required to balance increasing demands for elective surgery (and other health services) at a time when the then Commonwealth Government was reducing its share of hospital funding. This placed considerable pressures on the ACT Budget. Despite these pressures, the Government managed to significantly increase access to elective surgery from 7,661 in our first full year of Government (2002-03) to 9,778 in the most recent full year (2009-10), with an estimated total of over 11,000 in the current financial year (Fig 3).

Fig 3



Source: Elective Surgery Data Set by year (* 2010-11 estimated only)

2.13 However, the commitment by the ACT Government was not sufficient to meet growing demands. The new national health reform program provides the biggest change to health system funding in a generation and provides the potential to both meet growing demand for surgery while addressing the number of people on the waiting list with longer than recommended waiting times.

2.14 I have directed the Health Directorate to develop an Action Plan to ensure that each of the Auditor General's recommendations is addressed as agreed by Government. That Action Plan will be reviewed each month by the Surgical Services Taskforce, a body which includes representation by senior surgeons and anaesthetists as well as senior health administrators. The Taskforce is chaired by either the Health Minister or the Director General of the Health Directorate and meets on a monthly basis from February 2011.

3 Response to the Recommendations

The following provides details of the Government's responses to each of the individual recommendations in the Audit Report.

3.1 Recommendation one

3.1.1 The Health Directorate should progress with the development of a single waiting list by integrating the two hospitals' databases to better manage the waiting list across the ACT.

Agreed in Principle

3.1.2 The Health Directorate is working to establish a single waiting list for access to public elective surgery in the ACT. A single waiting list will assist in ensuring that patients are provided with access to surgery according to clinical priority across the Territory. As identified in the report, this can only happen if we have a single patient administration system (PAS) across both public hospitals.

3.1.3 While work to implement a single PAS across the ACT is estimated to be finalised in October 2012, the Health Directorate does not have operational control of Calvary Public Hospital. The establishment of a single ACT waiting list will remove some control of access to elective surgery at the Calvary site from Calvary Public Hospital, by placing that control within the Health Directorate. Accordingly, any agreement will require changes to the operation of Calvary Public Hospital and agreement from the Little Company of Mary Health Care.

3.2 Recommendation two

3.2.1 The Health Directorate should:

- review and revise the hospitals' Request for Admission (RFA) forms and patient's consent form to ensure the standardised forms be used by both public hospitals;
- provide additional guidelines to medical staff to ensure that patients' consent forms be properly completed; and
- provide additional information to, and seek commitment from, doctors and surgeons, for improvements in the timeliness of lodging RFAs to the hospitals.

Agreed

3.2.2 This issue will be discussed by the Surgical Services Taskforce in order to develop systems and processes that minimise errors or missing information in the documentation provided by surgeons to place a person on the elective surgery waiting list.

3.2.3 The Request for Admission (RFA) form for access to elective surgery is often completed within surgeons' private rooms, by surgeons operating as contractors to the Health Directorate (not health Directorate employees). This can limit the health Directorate's capacity to ensure that RFAs are completed as required prior to submission to the Health Directorate.

3.2.4 Where information is missing on an RFA prepared in private rooms, correcting the information requires that the hospital sends the form back to the rooms. This takes time and can delay the listing of a patient on the waiting list, and the impact of any delays on patients needs to be taken into account when deciding whether the forms should be returned to the private rooms to correct them or to provide further information.

3.3 Recommendation three

3.3.1 The Health Directorate should in consultation with each hospital, implement and monitor the regular conduct of clerical audit by surgical booking staff to mitigate the risks of processing errors.

Agreed

3.3.2 The Health Directorate conducts a regular clerical audit of the waiting list at a Territory wide level which includes contact with all patients on the waiting list but the Health Directorate agrees that processes for clerical audit by surgical bookings staff at each Hospital should be improved.

3.3.3 Both public hospitals are developing new Standard Operating Procedures for the management of elective surgery that include processes to ensure that records are audited to ensure that all aspects of the Health Directorate waiting list policy are being implemented.

3.4 Recommendation four

3.4.1 The Health Directorate, in conjunction with both hospitals, should:

- develop a comprehensive procedural manual for surgical bookings in line with Health Directorate policy; and
- provide adequate training to booking staff to ensure consistent and correct practices and procedures are being adopted

Agreed

3.4.2 The Health Directorate has developed a new procedure manual for surgical booking clerks at both public hospitals, which includes a range of Standard Operating Procedures for each aspect of the waiting list policy. These manuals provide clear direction for administrative staff on the procedures that need to be followed. These were completed early in 2011 and are utilised at Calvary and Canberra Hospitals.

3.4.3 In addition to the development of the manuals, all staff will be trained in the use of the Standard Operating Procedures with a quarterly audit of performance of staff against the procedures. All staff will undertake individual training sessions. This training is to be repeated every three months for the first twelve months and reviewed regularly to ensure that the information is conveyed in an appropriate manner.

3.5 Recommendation five

3.5.1 The Health Directorate, in conjunction with both hospitals should:

- ensure that all reclassification of patients' clinical urgency category be properly documented by an authorised doctor based on sound medical reasons;
- enhance controls and procedures in recording reclassifications on the electronic waiting lists and the RFA forms; and
- improve accountability and transparency in the priority change processes by advising patients of any category reclassification

Agreed

3.5.2 The Health Directorate has already established processes to ensure all reclassifications of a patient's urgency category are undertaken in line with Health Directorate policy. This includes a monthly audit of all reclassifications

of category one patients to ensure all aspects of the policy are fully documented.

3.5.3 However, it is important to note that audit found no evidence that surgical booking clerks or any other administrative officer made any changes to the reclassification of patient without the direction of the treating surgeon. The principal issue relates to adequate documentation – not deliberate manipulation of data to achieve a required result.

3.5.4 It is also important to emphasise that patients reclassified from Category 1 to Category 2 represent 2.5 percent of all elective surgery patients in 2009-10. While the Government accepts that processes for these patients should reflect established policies, it is important to understand the breadth of the issue in the context of overall elective surgery activity.

3.5.5 The reclassification of patients is an essential tool for surgeons to ensure that changes to patient conditions are reflected in their current clinical urgency category. It is possible for the public to have the idea that, based on comments made in the media, reclassifications only occur when a patient is downgraded from a higher category to a less urgent category. However, over 2009-10 there were almost as many people upgraded to a more urgent category (47 percent) as there were downgrades (53 percent).

3.6 Recommendation six

3.6.1 The Health Directorate, in conjunction with both hospitals should:

- Clarify the circumstances that warrant clinical review of patients on the elective surgery waiting list; and
- Ensure that the Canberra Hospital and Calvary Public Hospital conduct regular clinical reviews of patients on the elective surgery waiting list within the recommended timeframes.

Agreed in part

3.6.2 The purpose of clinical review is to identify whether a patient's condition has changed and would require a change to a patient's urgency category. The Health Directorate encourages all patients to stay in regular contact with their GPs, and to contact the Health Directorate if they believe their condition has changed to determine the need for a clinical review.

3.6.3 This provides flexibility to organise a timely clinical review rather than waiting for a set time period, and minimises the potential for a large number of clinical reviews which are not required to effectively manage a person's condition.

3.6.4 As such, the Government **agrees** that there are times when it is appropriate for the hospital to undertake clinical review of patients. The current waiting list policy includes some advice on the processes for clinical review. However, the revised ACT Elective Surgery Access Policy, which is currently under development will provide clearer guidance about the circumstances in which clinical review should occur.

3.6.5 However, the Government **does not agree** to the second part of the recommendation which states that

> "....the Canberra Hospital and Calvary Public Hospital [should] conduct regular clinical reviews of patients on the elective surgery waiting list within the recommended timeframes."

3.6.6 The Health Directorate policy does not recommend that all patients who wait longer than the recommended waiting times be clinical reviewed. If all patients were reviewed it would mean diverting the Health Directorate resources from caring for other patients to provide reviews for patients for whom the review may provide no benefit.

3.7 Recommendation seven

3.7.1 The Health Directorate should, in consultation with doctors, implement strategies as outlined in its policy to avoid elective surgery patients waiting longer than their clinical urgency timeframes. This includes transferring patients to other doctors with a shorter waiting list, to another hospital and increasing theatre utilisation.

Agreed

3.7.2 The Government will work with the ACT Surgical Services Taskforce to ensure that processes are agreed across the ACT to minimise delays in accessing surgery. The membership of the ACT Surgical Services Taskforce comprises senior surgeons, anaesthetists and administrators and is chaired by either the Minister for Health or the Director General of the Health Directorate. As such,

it has the experience and authority to make decisions about the management and operation of elective surgery in the ACT.

3.7.3 While there has been some opposition to the sharing of patients within a specialty group in the past, there has been progress in this area in recent times. In addition, there is evidence of improvements in the utilisation of our operating theatres over the last three years.

3.7.4 In 2009-10 surgical activity was 10.1 percent higher than in 2006-07, the year immediately prior to the audited period. In addition, in the 2009 calendar year, 516 patients were transferred between hospital waiting lists to improve access to elective surgery, increasing to 695 in the 2010 calendar year.

3.7.5 This practice is continuing into 2011, with the provision of additional options for surgery in the private sector, which includes options for patients to transfer between surgeons in some specialties.

3.7.6 The Health Directorate is undertaking the establishment of a new theatre management system to provide surgeons, anaesthetists, nurses and administrators with better information to make decisions about how our operating theatres are managed. The new system is expected to be in place by the end of 2011.

3.7.8 Notwithstanding these improvements, the Government will work with the Surgical Services Taskforce to identify further options for improving both the utilisation of public hospital operating theatres and the establishment of new processes to minimise waiting times for elective surgery.

3.8 Recommendation eight

3.8.1 The Health Directorate, in conjunction with the doctors, should develop and implement systems and procedures to manage more effectively doctors' leave and patients' management plans, to ensure that the surgical need of affected patients has not been compromised.

Agreed

3.8.2 The Government will work with the Surgical Services Taskforce to develop procedures that further reduce delays to surgery caused by doctors' leave arrangements that are inconsistent with the agreed waiting list policy.

3.8.3 However, it is important to note that postponements due to surgeon unavailability with less than four weeks' notice comprises only 18.5 percent of total postponements – and one quarter of this total relates to surgeons being away due to illness (which is not under the control of ACT Government). It is also important to note that doctors need to be especially cautious with their own illnesses while working within a hospital environment

3.8.4 The 148 postponements relating to a surgeon being away without sufficient notice (due to illness or other reasons) comprised just 1.4% of total planned elective surgery over 2009-10.

3.9 Recommendation nine

3.9.1 The Health Directorate should establish appropriate systems to monitor and manage 'avoidable' factors to minimise the number of postponements and cancellations of surgery initiated by hospitals

Agreed.

3.9.2 The Government will work with the Surgical Services Taskforce to identify the issues related to the postponement of elective surgery and develop initiatives to address these issues.

3.9.3 However, it must be noted that half of all hospital initiated postponements (49.9 percent) are due to substitution by a patient with more urgent needs. As the majority of surgeons working in our public hospitals are Visiting Medical Officers with busy private practices, it is not always possible to provide access to alternative surgeons where a surgeon has to postpone a patient's surgery due to the urgent needs of another patient.

3.9.4 Notwithstanding this, over the three years to 2009-10, the proportion of patients who had their elective surgery postponed dropped from 11.9 percent to 7.6 percent. This result was driven by improvements at the Canberra Hospital, with postponements there dropping from 17.0 percent to 7.1 percent over the same period.

3.9.5 This drop is a result of systems being put in place to monitor and manage postponements. However, as noted above, the Government is continuing to work through the Surgical Services Taskforce to improve these systems and reduce the rate of postponements further.

3.10 Recommendation ten

3.10.1 The Canberra Hospital should implement processes for routine data integrity audits of all outpatient department waiting lists to ensure that all data is valid, complete and accurate. All waiting lists should be subject to a detailed audit at least annually.

Agreed.

3.10.2 A national minimum data set for outpatient services has been developed recently and the Health Directorate has worked with both hospitals over the last two years to ensure that outpatient collections meet the new national requirements. However, regular annual audits of the outpatient data set will be initiated to highlight areas that need to be addressed over time.

3.10.3 A thorough process related to the management of the endoscopy waiting list was completed in April 2010. This process included the development of clear procedure manuals to ensure that data entered into the system is timely and accurate. The Health Directorate will conduct similar processes across all outpatient services.

3.10.4 In addition, as part of the review of the outpatient service at the Canberra Hospital, the Health Directorate is implementing additional data validation and reporting processes. Senior managers will be responsible for a range of waiting time performance measures and the collection and collation of data will be subject to regular reviews and audits.

3.11 Recommendation eleven

3.11.1 The Health Directorate should develop appropriate governance and accountability framework to monitor, review and report on the progress of the implementation of the agreed recommendations arising from the *Review of The Canberra Hospital Outpatients Service Redesign Project.* Particular attention should be paid to:

- implementing a strategy to manage increased demand for services within the outpatients department (OPD)of the Canberra Hospital; and
- implementing consistent policies, practices and procedures for managing the waiting lists for individual OPD units.

Agreed

3.11.2 Demand for outpatient services at the Canberra Hospital has grown by 17 percent in just two years between March 2009 and March 2011. This level of increased demand has place considerable pressures on outpatient services. The level of increased demand could not be predicted over such a short period, resulting in difficulties in providing additional capacity for outpatient services.

3.11.3 The outpatient services redesign project is being governed by the Canberra Hospital Outpatient Services Governance Committee, which reports to the General Manager of the Canberra Hospital.

3.11.4 The Canberra Hospital Outpatient Services Redesign Project commenced in July 2010 with the principle objective to review current business processes within the Outpatient Service and implement changes to improve efficiency and to support access to services for consumers

3.11.5 Development of recommendations and implementation plans arising from the review were completed in February 2011.

3.11.6 The governance of the management of outpatient clinics has been placed under a single governance arrangement within the Capital Region Cancer Service. This will ensure a coordinated and consolidated approach to improvements in the management of outpatient care. However, the responsibility for clinical services within outpatient services will remain with the head of the relevant clinical unit.

APPENDIX B: Witnesses who appeared before the committee

Thursday, 15 March 2012

Ms Katy Gallagher MLA, Minister for Health

- Dr Peggy Brown, Director-General, Health Directorate
- Mr Ian Thompson, Deputy Director-General, Strategy and Corporate, Health Directorate
- Ms Barbara Reid, Executive Director, Division of Surgery and Oral Health, Canberra Hospital, Health Directorate

APPENDIX C: Summary of Auditor-General's recommendations

Reliability of elective surgery waiting lists

Recommendation 1—ACT Health should progress the development of a single waiting list by integrating the two hospitals' databases to better manage the waiting list across the ACT.[70]

Recommendation 2—ACT Health should:

(a) review and revise the hospitals' request for admission (RFA) forms and patient consent forms to ensure that standardised forms are used by both public hospitals;

(b) provide additional guidelines to medical staff to ensure that patient consent forms are properly completed and witnessed; and

(c) provide additional information to, and seek commitment from, doctors and surgeons, for improvements in the timeliness of lodging RFAs to the hospitals.[71]

Recommendation 3—ACT Health should, in consultation with each hospital, implement and monitor the regular conduct of clerical reviews by surgical booking staff to mitigate the risks of processing errors in the electronic waiting lists.[72]

Recommendation 4—ACT Health should, in consultation with each hospital:

(a) develop a comprehensive procedural manual for surgical bookings in line with ACT Health policy; and

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[70] ACT Auditor-General's Office, Report No. 1 of 2011: *Waiting lists for elective surgery and medical treatment*, January, p. 40.

[71] *Ibid.*, p. 43.

[72] *Ibid.*, p. 45.

(b) provide adequate training to booking staff to ensure consistent and correct practices and procedures are being adopted.[73]

Recommendation 5—ACT Health should:

(a) ensure that all reclassifications of patients' clinical urgency category are properly documented by an authorised doctor based on sound medical reasons;

(b) enhance controls and procedures in recording reclassifications on the electronic waiting lists and the RFA forms; and

(c) improve accountability and transparency in the priority change processes by advising patients of any category reclassification.[74]

Management of elective surgery waiting lists

Recommendation 6—ACT Health should:

(a) clarify the circumstances that warrant a clinical review of patients on elective surgery waiting lists; and

(b) ensure TCH and CPH conduct regular clinical reviews of patients on elective surgery waiting lists within the recommended timeframes.[75]

Recommendation 7—ACT Health should, in consultation with the doctors, implement strategies as outlined in its policy to avoid elective surgery patients waiting longer than their clinical urgency timeframes. This includes the options of transferring patients to other doctors with a shorter waiting list, transferring patients to another hospital and increasing theatre utilisation.[76]

Recommendation 8—ACT Health, in conjunction with the doctors, should develop and implement systems and procedures to manage more effectively

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[73] ACT Auditor-General's Office, Report No. 1 of 2011: *Waiting lists for elective surgery and medical treatment*, January 2011, p. 49.

[74] *Ibid*., p. 52.

[75] *Ibid*., p. 61.

[76] *Ibid*., p. 63.

doctors' leave and patients' management plans, to ensure that surgical needs of affected patients have not been compromised.[77]

Recommendation 9—ACT Health should establish appropriate systems to monitor and manage 'avoidable' factors to minimise the number of postponements and cancellations of surgery initiated by hospitals.[78]

Management of medical treatment waiting lists

Recommendation 10—TCH should implement processes for routine data integrity audits of all outpatient department waiting lists to ensure all data is valid, complete and accurate. All waiting lists should be subject to a detailed audit at least annually.[79]

Recommendation 11—ACT Health should develop an appropriate governance and accountability framework to monitor, review and report on the progress of implementation of agreed recommendations arising from the *Review of the Canberra Hospital outpatients' service redesign project*. Particular attention should be paid to:

(a) implementing a strategy to manage increased demand for outpatient services; and

(b) implementing consistent policies, practices and procedures for managing the waiting lists for individual OPD units.[80]

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[77] ACT Auditor-General's Office, Report No. 1 of 2011: *Waiting lists for elective surgery and medical treatment*, January, p. 64.

[78] *Ibid*., p. 66.

[79] *Ibid*., p. 84.

[80] *Ibid*.