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PARLIAMENT OF TASMANIA

**REPORT OF THE
AUDITOR-GENERAL
No. 10 of 2012-13**

**Hospital bed management and primary
preventive health**

May 2013

Presented to both Houses of Parliament in accordance with the provisions of Audit Act 2008

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28 May 2013

President
Legislative Council
HOBART

Speaker
House of Assembly
HOBART

Dear Mr President
Dear Mr Speaker

REPORT OF THE AUDITOR-GENERAL
No. 10 of 2012–13
Hospital bed management and primary preventive health

This report has been prepared consequent to examinations conducted under section 23 of the *Audit Act 2008*. The performance audit determined whether the Department of Health and Human Services was effective in its efforts to:

- improve patient throughput in hospitals
- prevent people acquiring chronic conditions through primary preventive health strategies.

Yours sincerely

H M Blake
AUDITOR-GENERAL

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Foreword

Effective management of public hospital beds is essential as is the need to ensure the development of primary health prevention strategies that, in both the medium and longer term, lead to declining demand for hospital beds. This audit set out to establish how effectively beds are managed by our four largest public hospitals and whether or not the Department of Health and Human Services' strategies to prevent people acquiring chronic conditions through primary preventive health were effective.

Effectively managing the utilisation of hospital beds is essential in our current environment of increasing demand for health services. Many mechanisms for improving patient throughput in hospitals are already being implemented with this audit identifying how well these are working and suggesting nine options for improvement.

Adopting effective primary preventive health strategies can also impact utilisation of hospital beds although causal linkages, if any, are less clearly defined and it can take many years before outcomes from strategies adopted become evident. It is, therefore, essential that strategic planning documents clearly define the basis for adopting chosen primary preventive health interventions and programs, measures be established at the outset for assessing progress and outcomes be regularly evaluated based on those measures.

H M Blake

Auditor-General

28 May 2013

List of acronyms and abbreviations

AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
DHHS	Department of Health and Human Services
HITH	Hospital in the home
MCH or Mersey	Mersey Community Hospital
LGH	Launceston General Hospital
NWRH	North West Regional Hospital
RHH	Royal Hobart Hospital
RSI	Relative stay index
SNAPPs	Smoking, poor nutrition, alcohol misuse, physical inactivity and psycho-social conditions
TIPCU	Tasmanian Infection Prevention and Control Unit

Executive summary

Executive summary

Background

In the Australian public health sector there is a persistent demand for hospital beds that is fuelled by numerous factors that include an ageing population and increasing rates of illness caused by lifestyle factors.

To ensure that government achieves maximum value for its investment in public health, maximising the use of existing hospital beds is an important strategy. In this audit, we took the approach that more efficient use of existing facilities could be attained through two strategies at opposite ends of the health care spectrum; improving patient throughput in hospitals and preventing people acquiring chronic conditions that could lead to hospitalisation in future years.

Patient throughput in hospitals could be aided through the use of out-of-hospital alternatives (e.g. outpatient treatment, clinics, Hospital in The Home (HITH), aged care or home care), minimising the length of stay and inter-hospital transfers (to free up beds in busy hospitals).

With a focus on improving public health into the future, we examined two areas of primary preventive health; vaccination and encouraging healthier lifestyle choices.

Accordingly, the objective of the audit was to assess the effectiveness of the Department of Health and Human Services' efforts to improve patient throughput in hospitals and to prevent people acquiring chronic conditions through primary preventive health strategies.

Our audit mainly spanned the period July 2008 to June 2012. Where more recent data became available we expanded the period under review. Organisationally, the scope encompassed the Department of Health and Human Services, with a focus on Tasmania's public hospitals, community nursing, and non-government organisations.

Detailed audit conclusions

These audit conclusions are based on criteria that we developed to support the audit's objective and are aligned to the chapter structure of the Report.

1 Maximising patient throughput: measures of success

Occupancy rates of hospitals varied widely from excessive rates at the Royal Hobart Hospital to under-utilisation at North-West

and district hospitals. A related factor was that the average length of stay and the relative stay index in Tasmania hospitals were above the Australian average and increasing.

In addition, rates of unplanned readmission compared unfavourably with other jurisdictions. On the other hand, it was pleasing to note that Tasmania had been achieving substantial reductions in rates of hospital-acquired infections.

Regarding alternatives to hospital beds:

- Tasmania made similar use of outpatient services to other jurisdictions.
- HITH appeared to be under-utilised.
- Delays in patients waiting for nursing home placement were generally reasonable, but were longer in the North-West.

2 Maximising patient throughput: planning and usage

We considered that there was reasonable attention to throughput in strategic planning documents, although inclusion of relevant performance indicators would increase the likelihood of effective implementation.

Separate bed management systems existed in the state's three regions and varied in their capacity to assist bed managers to maximise use of hospital beds in acute care hospitals or to make better use of spare capacity available at district hospitals. There is a strong case for adoption of a single state-wide bed management system.

3 Primary preventive health: comparative information

Tasmania has achieved high rates of vaccination and hence reduced the risk of children contracting related conditions.

However, for chronic conditions, Tasmania's rates of illness were higher than the rest of Australia, although the rates have decreased over an eight-year period. Rates for smoking, alcohol misuse and overweight/obesity were higher than the rest of Australia and, in the case of alcohol misuse and overweight/obesity, increasing.

4 Primary preventive health: strategic planning

It was very difficult to get a sense of what interventions and programs were being undertaken by the department or on what basis. The difficulty was largely due to the considerable number and volume of strategic planning documents, lack of clear

linkages between and within documents and evaluation deficiencies.

Recommendations made

The Report contains the following recommendations.

Rec	Section	We recommend that ...
1	1.2.1	... DHHS investigates why its RSI compares unfavourably with other jurisdictions and why it deteriorated so markedly since 2008. We suggest that that investigation include review of individual hospital performance.
2	1.2.2	... DHHS investigates why its average length of stay compares unfavourably with other jurisdictions. The investigation should also include comparisons between state hospitals.
3	1.3	... DHHS and the Royal Hobart Hospital explore ways to avoid excessive bed occupancy at the Royal Hobart Hospital. We also recommend that DHHS should aim to increase bed occupancy at the NWRH and Mersey, including consideration of greater rationalisation of hospital services.
4	1.4.1	... DHHS investigates the reasons why some surgical procedures have rates of unplanned readmission above the national average.
5	1.5.2	... DHHS revisits the utilisation of HITH programs at a state-wide level focusing on a community based model of services delivery, as a means to prevent or reduce the length of stay experienced by some patients in hospitals.
6	1.5.3	... DHHS, in association with Tasmanian Health Organisation — North West investigates reasons North West Coast placement times for elderly patients are longer than for the rest of the state and develops strategies to reduce waiting times.
7	2.2	... DHHS implements performance indicators to monitor the effectiveness of patient throughput and facilitates benchmarking at a state and national level.
8	2.3	... DHHS considers a state-wide bed management system to facilitate efficient use of the separate public hospitals.
9	2.3	... DHHS investigates the feasibility of making greater use of beds located at district hospitals.
10	4.2	<p>... DHHS</p> <ul style="list-style-type: none"> • clearly defines responsibilities for primary preventive health activities within the department • opts for a single, multi-year strategic document that

		<p>will provide effective strategic direction</p> <ul style="list-style-type: none"> continues to support the strategic plan with annual business plans.
11	4.3.1	<p>... DHHS</p> <ul style="list-style-type: none"> indicates which activities are statutory requirements and which are non-statutory introduces greater flexibility into taking up high priority interventions and discontinuing those of a lower priority better identifies likely benefits of interventions and prioritise accordingly.
12	4.4	<p>... strategic planning specifically outlines actions and initiatives as flowing from high-level concepts and data.</p>
13	4.5.1	<p>... DHHS</p> <ul style="list-style-type: none"> adopts a top-down approach flowing from high-level concepts to clearly defined actions or programs lists actions that give a clear sense of what would be done and what will be achieved conducts research before setting strategic direction rather than making research an action point.
14	4.5.2	<p>... the Health and Wellbeing Mapping Report be a key input to a revised strategic plan.</p>
15	4.6	<p>... strategic plans identify high-level and practical indicators of success and frequency of measurement. Alternatively, strategic plans might be cross-referenced to indicators of success in funding agreements.</p>
16	4.6	<p>... DHHS reviews existing business plans and funding agreements to ensure that the level of information being sought is practical and capable of providing a reasonable indication of success.</p>

Audit Act 2008 section 30 — Submissions and comments received

Audit Act 2008 section 30 — Submissions and comments received

Introduction

In accordance with section 30(2) of the *Audit Act 2008*, a copy of this Report was provided to the Department of Health and Human Services.

A summary of findings, with a request for comments or submissions, was also provided to the Minister for Health.

Comments and submissions provided are not subject to the audit nor the evidentiary standards required in reaching an audit conclusion. Responsibility for the accuracy, fairness and balance of these comments rests solely with those who provided the response or comment.

Department of Health and Human Services (DHHS)

The Department of Health and Human Services (DHHS) and the Tasmanian Health Organisations accept all of the recommendations made in the report and anticipate that their implementation will contribute to the improvement of patient throughput and in preventing people acquiring chronic conditions through primary preventive health strategies. We will consider how the recommendations outlined in the report can best be implemented within the Tasmanian health system.

In considering the report, we wish to comment on the focus of the audit on primary preventive health as an indicator of the effectiveness of the DHHS efforts to improve patient throughput in hospitals.

The main purpose of primary preventive health prevention, whilst having a secondary impact on hospital bed management, is to improve individual and population health and wellbeing.

Initially, the audit referred to in the Tasmanian Audit Office's *Annual Plan of Work 2011–12* was 'Reducing demand for hospitals beds', which then broadened out into 'Managing hospitals beds', and then changed once more for the final draft of the report to 'Hospital bed management and primary preventive health'.

We appreciate that the Report looks at hospital bed management and primary preventive health. Consideration may be given in the future to examining a wider focus of factors that drive operational and policy change, with the potential to improve patient throughput in our hospital system and have a

greater positive impact on the management of public hospital beds.

Examination of secondary and tertiary interventions, patient flow and operational policy and processes that exist in the public hospital system to manage demand for and use of hospital beds would give a further more extensive oversight of the issues related to bed management. These issues are constantly under management within our Tasmanian Health Organisations and the system more broadly.

Matthew Daly
Secretary

Introduction

Introduction

Across Australia, public hospitals are hard pressed to keep up with increasing costs and consistently high demand for beds, a situation that is unlikely to change. Demand for hospital services is exacerbated by:

- an ageing population
- increasing rates of illness caused by lifestyle factors
- an expanding range of treatment options
- increased expectations of treatment.

Supplying more hospital beds is costly, either through expanding existing hospitals or building new ones, let alone recruiting and retaining more staff¹. To ensure that government achieves value for its investment in public health, maximising the use of existing hospital beds is an important strategy. Making more efficient use of existing facilities could be attained through two strategies at opposite ends of the health care spectrum, namely:

- improving patient throughput in hospitals
- preventing people acquiring chronic conditions that could lead to hospitalisation in future years.

Improving patient throughput in hospitals

There are many mechanisms for improving patient throughput including:

- out of hospital alternatives (e.g. outpatient treatment, clinics, Hospital in The Home (HITH), aged care or home care)
- minimising the length of stay
- reducing hospital-acquired infections
- inter-hospital transfers (to free up beds in busy hospitals)
- minimising unplanned readmissions.

¹ A hospital bed is not just a physical resource, as each ward bed has to be supported by adequate numbers of nurses, access to doctors and equipment. A 2008 NSW audit report (*Delivering Health Care out of Hospitals*) found that the annual cost of a hospital bed ranged from \$135 000 to \$375 000.

This audit reviews these matters².

*Preventing people acquiring chronic conditions through primary preventive health strategies*³

There is much evidence to support the benefits of expenditure in primary preventive health:

- Smoking rates in Australia have dropped from 75 per cent to less than 20 per cent since the 1950s⁴. In Tasmania the smoking rate was estimated at 25 per cent in 2007⁵.
- Deaths from cardiovascular disease have decreased dramatically⁶.
- Every \$1 invested into evidence-based prevention programs (e.g. targeting smoking, physical activity, nutrition), delivers an estimated \$5.60 in savings to the community within five years⁷.
- Tasmania, as a participant in the Commonwealth's National Partnership Agreement on Preventive Health (now extended to mid-2018), can access facilitation and reward payments by agreeing to strive for certain performance benchmarks.
- The Australian Institute of Health and Welfare (AIHW) reported that for 2010–11, 6.7 per cent of all Tasmanian hospital separations were potentially preventable⁸.

In this Report we examined two areas of primary preventive health; vaccination and encouraging healthier lifestyle choices. We excluded a potential focus area, secondary preventive health, despite the department's preference for us to include it. The department's view was based on the greater capacity for

² Whilst not included in this audit we acknowledge that there are a wide range of other drivers and factors impacting on the management of hospital beds, such as private health providers, general practitioners and other areas within government.

³ Primary preventive health refers to strategies to limit the incidence of disease and disability in the population.

⁴ <http://www.tobaccoinaustralia.org.au>

⁵ *National Health Survey 2007/8*, Australian Bureau of Statistics (ABS).

⁶ *National Chronic Disease Strategy* Australian Health Ministers Conference 2005.

⁷ *Prevention for a Healthier America: Investments in Disease prevention Yield Significant Savings, Stronger Communities*, Trust for America's Health, February 2009, p.3.

⁸ *Australian hospital statistics 2010–11*. Australian Institute of Health and Welfare.

secondary prevention to divert people from hospital in the short to medium term ⁹.

Why the audit was selected

We selected this audit as it presented us with an opportunity to undertake work with the potential to generate savings and achieve better health outcomes from greater efficiencies achieved in the health sector. We recognise that some of those benefits will be long term/intergenerational.

Audit objective

The objective of the audit was to assess the effectiveness of the Department of Health and Human Services' efforts to:

- improve patient throughput in hospitals (Chapters 1 and 2)
- prevent people acquiring chronic conditions through primary preventive health strategies (Chapters 3 and 4).

Audit scope

Our audit mainly spanned the period July 2008 to June 2012. Where more recent data became available we expanded the period under review. Organisationally, the scope encompassed the Department of Health and Human Services, with a focus on Tasmania's public hospitals, community nursing, and non-government organisations.

Audit criteria

The criteria that we applied come directly from the audit's objective.

Audit approach

To conduct the audit, we:

- evaluated performance indicators
- held discussions with departmental staff and staff at each of the major hospitals
- evaluated relevant reports
- analysed performance-related data
- reviewed strategic plans.

⁹ Secondary prevention aims to reduce progression of disease through early detection and intervention.

Timing

Planning for this audit began in October 2011. Fieldwork was completed in October 2012 and the report was finalised in May 2013.

Resources

The audit plan recommended 1400 hours and a budget, excluding production costs, of \$186 283. Total hours were 1690 and actual costs, excluding production, were \$220 452, which was in excess of our budget.

Acknowledgement

We would like to acknowledge the work done on the audit by Ms Megan Sim who was on a six-month exchange from The Office of the Auditor General of Ontario in Canada.

1 Maximising patient throughput: measures of success

1 Maximising patient throughput: measures of success

1.1 Background

In this Chapter, we look at some measures of success including:

- length of stay
- bed occupancy rates
- unscheduled readmissions
- use of alternatives to a hospital bed.

1.2 Has Tasmania minimised the length of stay in hospital?

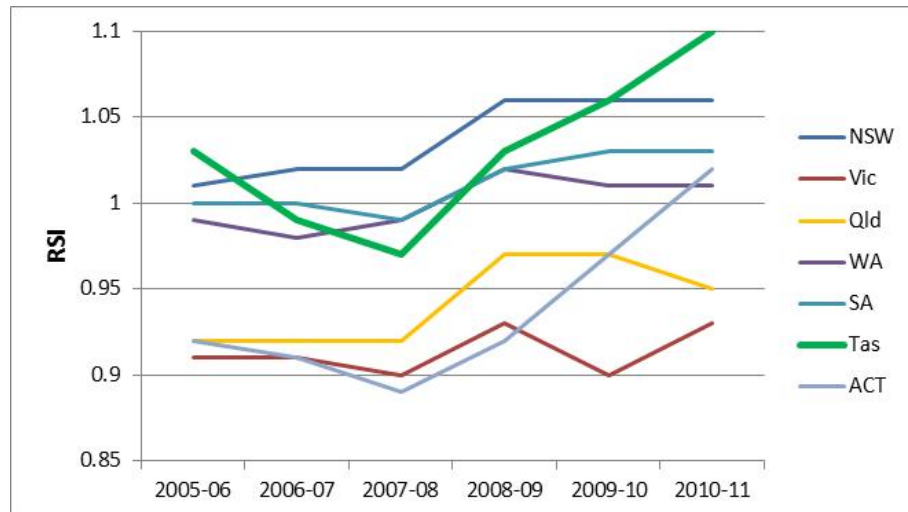
To measure this aspect of efficiency in hospitals, health administrators use a number of indicators with the following being relevant to this audit:

- Relative Stay Index (RSI)
- Average Length of Stay (ALOS)¹⁰.

1.2.1 Relative Stay Index (RSI)

RSI measures how quickly a hospital is discharging patients compared to its peers. A value greater than 1 indicates that an average patient's length of stay is longer than the Australian average. Figure 1 compares Tasmania's public hospitals' performance against other jurisdictions from 2005.

¹⁰ The Relative Stay Index (RSI) is a measure of how quickly a hospital is discharging patients compared to its peers, adapted for casemix. Another measure of hospital efficiency is the average length of stay (ALOS). The AIHW uses 20 selected procedures as a yardstick for Australian hospitals.

Figure 1: Relative Stay Index for public hospitals 2005–06 to 2010–11^{11 12}

Source: Australian Institute of Health and Welfare, *Australian hospital statistics*, 2006–11.

AIHW hospital statistics show that in 2010–11:

- Tasmania's RSI was six per cent above the Australian average and increasing.
- Tasmania had the highest RSI of the jurisdictions included in Figure 1.

Recommendation 1

We recommend that DHHS investigates why its RSI compares unfavourably with other jurisdictions and why it deteriorated so markedly since 2008. We suggest that that investigation include review of individual hospital performance.

1.2.2 Average Length of Stay (ALOS)

Another measure of hospital efficiency is Average Length of Stay expressed in days. We calculated a weighted average length of stay (WALOS) based on 20 of the more common ('indicator') hospital procedures used nationally.

Figure 2 compares Tasmania's public hospitals' WALOS performance against other jurisdictions using the indicator procedures.

¹¹ We excluded the Northern Territory due to it being an RSI outlier, with an RSI well above any of the other jurisdictions.

¹² Care must be exercised when comparing cross-jurisdictional data, as there can be comparability issues.

Figure 2: WALOS (in days) in Tasmanian public hospitals 2010–11



Source: Tasmanian Audit Office and Australian Institute of Health and Welfare, *Australian Hospital Statistics 2010–11*.

Statistics show that Tasmania's WALOS was higher than other jurisdictions in 2010–11.

Recommendation 2

We recommend that DHHS investigates why its average length of stay compares unfavourably with other jurisdictions. The investigation should also include comparisons between state hospitals.

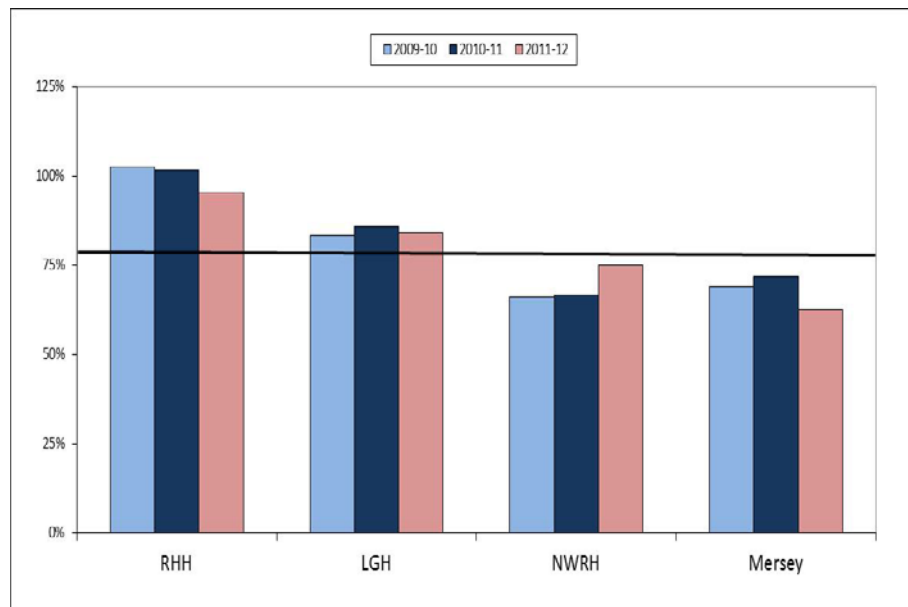
1.3 *Are Tasmanian bed occupancy rates satisfactory?*

The Australian Medical Association (AMA) regards 85 per cent as the optimum level for hospital occupancy¹³. Performance below that level can represent under-utilisation while occupancy over 85 per cent can indicate stress that may compromise the ability to cope with fluctuations (such as winter peaks of admissions or reduced staffing levels). Accordingly, we reviewed bed occupancy in public hospitals against the 85 per cent standard.

Figure 3 indicates how the state's four acute care public hospitals had performed against that measure over the last three years.

¹³ The AMA has for some years held this position. However, this assertion has been challenged in recent years, with critics arguing that there is no ideal or safe occupancy suitable for all situations.

Figure 3: Bed occupancy rates in Tasmanian hospitals



Source: Tasmanian Audit Office calculations based on data supplied by the Department of Health and Human Services¹⁴.

In Tasmania, the average occupancy rate at the RHH was well above the optimum level. The LGH was consistently operating at or very close to the AMA benchmark while NWRH and Mersey were consistently operating well below capacity.

Recommendation 3

We recommend that DHHS and the Royal Hobart Hospital explore ways to avoid excessive bed occupancy at the Royal Hobart Hospital. We also recommend that DHHS should aim to increase bed occupancy at the NWRH and Mersey, including consideration of greater rationalisation of hospital services.

1.4 *Has Tasmania minimised unscheduled readmissions?*

Unplanned readmissions impact on efficient use of hospital beds and also benchmark the safety and quality of hospital care. The term is used to cover adverse events such as hospital-acquired infections, falls resulting in injuries, and problems with medication or medical devices.

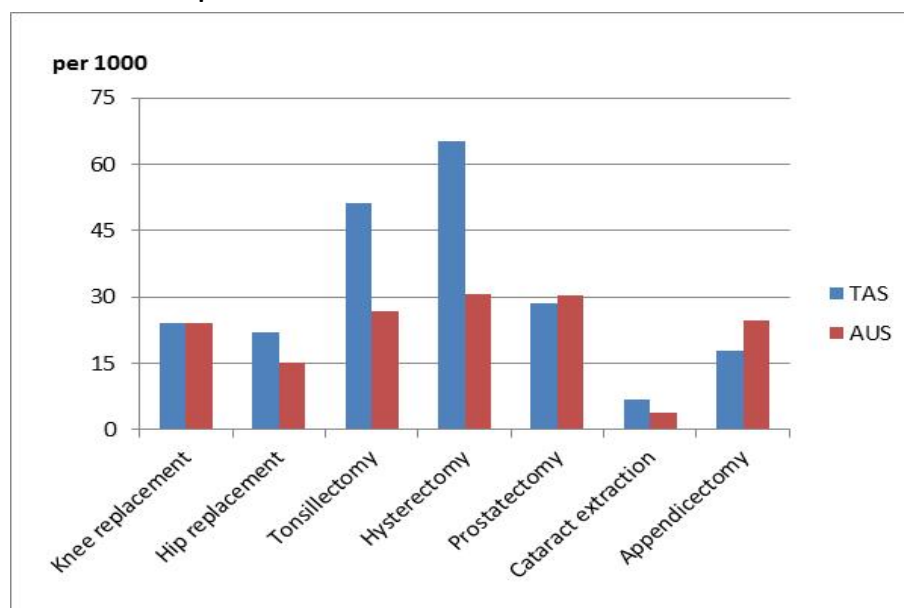
1.4.1 *Rates of readmission within 28 days*

The standard measure here is the rate of unplanned readmission, compared to all discharges, occurring within 28

¹⁴There may be some comparability issues with the occupancy data due to it being directly collected from the hospitals.

days of separation. Figure 4 compares Tasmanian and national readmission rates for a range of surgical procedures.

Figure 4: Rate of unplanned readmissions within 28 days 2009–10 per 1000 separations



Source: *Australian hospital statistics 2009–10*. Australian Institute of Health and Welfare

In four of the procedures listed, the state’s performance exceeded the national average. Of those, tonsillectomy and hysterectomy exceeded the national average by a wide margin. The department advised us that the population was low and that small movements in numbers triggered high rates. Nonetheless, nationally-reported data indicated that Tasmanian rates for individual procedures had substantially exceeded national rates for several years. The department could not provide us with an explanation for the above-average rates of readmission.

More generally, a weighted average of readmission rates for the seven procedures was 22.8 per cent for Tasmania compared to an Australian rate of 16.7 per cent.

Recommendation 4
We recommend that DHHS investigates the reasons why some surgical procedures have rates of unplanned readmission above the national average.

1.4.2 Infection control

The spread of infectious diseases in hospitals is a significant contributor to elevated bed occupancy mainly through extended

hospital stays¹⁵. Strategies need to be developed to deal with infections in hospitals. The infection rate of *Staphylococcus aureus* bacteraemia in hospitals is used as a key indicator by the department.

Figure 5 shows the Tasmanian rate of *Staphylococcus aureus* in public hospitals in 2011–12 against other jurisdictions. Tasmania had the second lowest rate of *Staphylococcus aureus*.

Figure 5: Rate of *Staphylococcus aureus* in public hospitals per 10 000 patient care days 2011–12

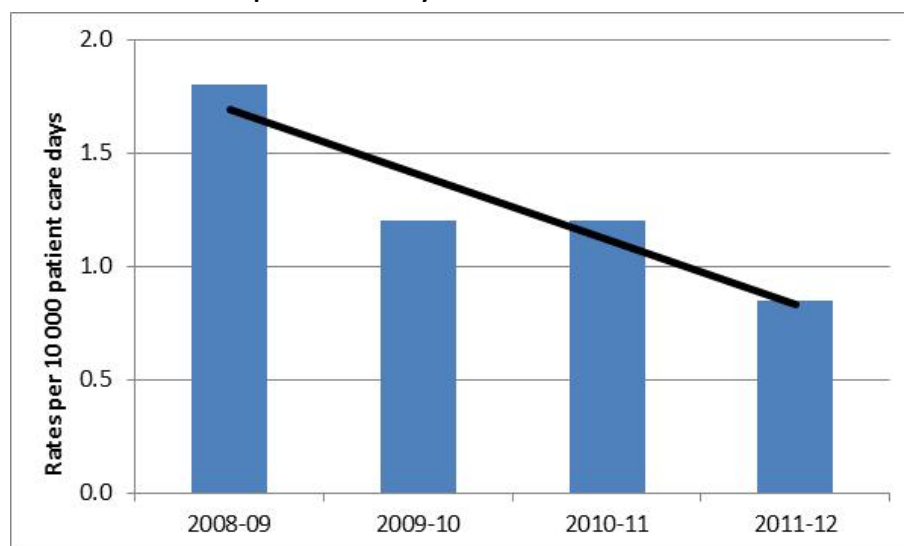


Source: AIHW, *Australian hospital statistics 2011–12: Staphylococcus aureus bacteraemia in Australian public hospitals*

We also examined whether the rate of *Staphylococcus aureus* infection in Tasmanian public hospitals was improving. The situation for the last four years is shown in Figure 6.

¹⁵ 'Hospital-acquired infections place a significant burden on the health system, with an estimated 180 000 cases in Australia each year that occupy almost two million bed days.' Productivity Commission 2009, *Public and Private Hospitals*, Research Report, Canberra.

Figure 6: Rate of *Staphylococcus aureus* in Tasmanian public hospitals per 10 000 patient care days



Source: DHHS and AIHW, *Australian hospital statistics 2011–12: Staphylococcus aureus bacteraemia in Australian public hospitals*

The Tasmanian rate of infection has improved over the last four years, having reduced from a rate of 1.8 cases per 10 000 patient care days to 0.8 cases per 10 000 patient care days in 2012.

In 2008, DHHS launched the Tasmanian Infection Prevention and Control Unit (TIPCU) to monitor and reduce the level of hospital-acquired infections. The introduction of TIPCU has coincided with a significant reduction in the rate of *Staphylococcus aureus*, from 2008–09.

The department also prepared a strategic document for 2009–11 whose overall aim was to provide a consistent approach in reducing the impact of hospital-acquired infections in Tasmania¹⁶.

In summary, the reduction in rate of *Staphylococcus aureus* together with evidence of infection control measures suggests that Tasmania has been achieving reductions in rates of hospital-acquired infections.

1.5 *Has adequate use been made of treatment alternatives that do not require a hospital bed?*

One method of improving hospital bed throughput is to use alternatives for some or all the time the patient would otherwise have occupied a hospital bed.

In this Section we look at the following alternatives:

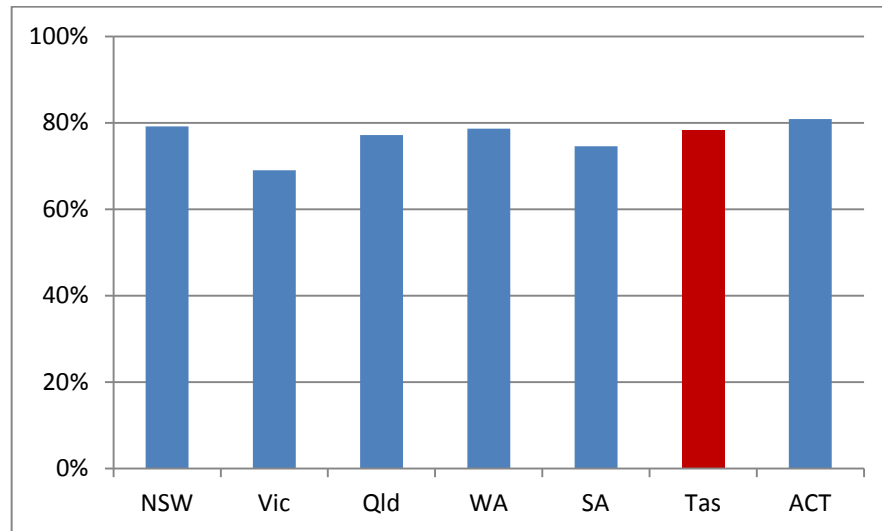
¹⁶ *Sharing the Responsibility: Tasmanian Healthcare Associated Infection Prevention Strategy 2009–2011*. Department of Health and Human Services.

- outpatient services
- hospital in the home (HITH) and community nursing
- nursing homes.

1.5.1 Use of outpatient services

A possible cause of high occupancy rates is under-use of outpatient services. Figure 7 looks at outpatient numbers as a percentage of total patients treated at public hospitals.

Figure 7: Outpatients as a percentage of total patients



Source: Australian Institute of Health and Welfare *Australian hospital statistics 2010–11*

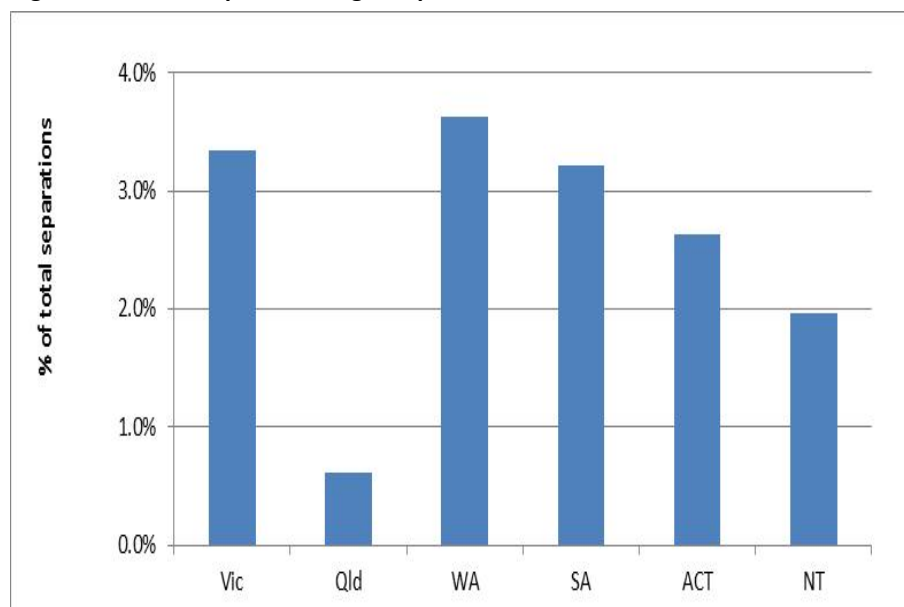
Tasmanian public hospitals are using outpatient services at a similar level to most other states.

1.5.2 Tasmanian 'Hospital in the home' programs

Hospital in the home (HITH) programs can provide treatments by a range of health care professionals at a patient's home. HITH programs provide a range of services, including administration of intravenous antibiotics, management of acute wounds and surgical drains.

Most jurisdictions have HITH programs under which admitted patients are provided with hospital care at home. Figure 8 shows public hospital separations with HITH care in 2010–11.

Figure 8: Public hospital overnight separations with HITH care 2010–11



Source: Australian Institute of Health and Welfare *Australian hospital statistics 2010–11*. Tasmania and New South Wales did not provide HITH activity to AIHW.

Based on Figure 8, between two and three per cent of public hospital overnight separations would involve a HITH component. In Tasmania, that would equate to 1500 overnight separations per year that would include a HITH component.

In 2011, consultants produced a report to investigate the cost effectiveness of home-based care relative to hospital care for the Hospital in the Home Society of Australasia¹⁷. That report found that the clinical outcomes of patients receiving HITH care was equivalent to those receiving in-patient care. However, HITH care significantly decreased hospital length of stay.

For five out of six indicative conditions, HITH care was found to be less costly¹⁸. On average, a cost saving of 22 per cent was calculated using the cost minimisation analysis for HITH care compared to hospital care.

Tasmania does not have a single state-wide HITH program; instead, each hospital decides whether or not to run a HITH program in its region.

¹⁷ *Economic analysis of Hospital in the Home (HITH)*. Deloitte Access Economics

¹⁸ These representative conditions were cellulitis, venous thrombosis, pulmonary embolus, respiratory infection/ inflammation, chronic obstructive pulmonary disease [greater cost in HITH], knee replacement.

Southern Tasmania

RHH has an out-of-hospital-care program for paediatric patients only. The RHH did not establish broader HITH programs due to the limiting service area. Instead, the RHH has relied on Community Nursing to provide healthcare to patients.

Northern Tasmania

In January 2012, the HITH program at LGH was suspended to achieve budget savings. The Minister defended the decision on the grounds that, in the previous year, the program was under-utilised with just 23 patients regularly using the service. Clinicians at the LGH indicated to us that the impact of the withdrawal of the HITH program would have a minimal impact on bed management because the users were mainly same-day patients¹⁹. However, the consultant's report referred to above suggested that is not the case in other jurisdictions. In particular, the report found that the HITH services were being provided in regional areas smaller than Launceston such as Mildura, Echuca and Bairnsdale in Victoria. On that basis, it appears that Northern Tasmania had been making insufficient use of HITH to free up hospital beds compared to the way it was used elsewhere.

North Western Tasmania

At the time of our audit, the HITH program at NWRH was changing and was to be incorporated in Community Nursing activities in the North West Area Health Service area. However, the concept of HITH was continuing and nursing staff associated with the HITH program indicated that it had a significant impact on bed management as it improved patient flow by freeing up beds and reducing hospital length of stay.

Mersey continues to run a standalone HITH program. We were advised that there are normally around 10 patients using the program at any one time. Patients brought into Mersey's Department of Emergency Medicine can be transferred directly into HITH without having to be admitted to the hospital. Nursing staff at Mersey again indicated to us that the HITH program improved patient flow and freed up beds.

Summary

The department's belief is that Tasmania's dispersed population and small patient base undermine the viability of HITH

¹⁹ Minister for Health Michelle O'Byrne, Hospital in the Home, Tasmanian Government Media Release, Minister for Health, 5 January 2012.

programs. On the other hand, a number of smaller regional areas such as Mildura and Echuca in Victoria have established successful HITH programs. A 2009 review of Victoria's HITH program found that patients were very supportive of the program²⁰. It appeared to us that the department has made insufficient efforts to make effective use of HITH to free up hospital beds in the northern and southern regions.

Recommendation 5

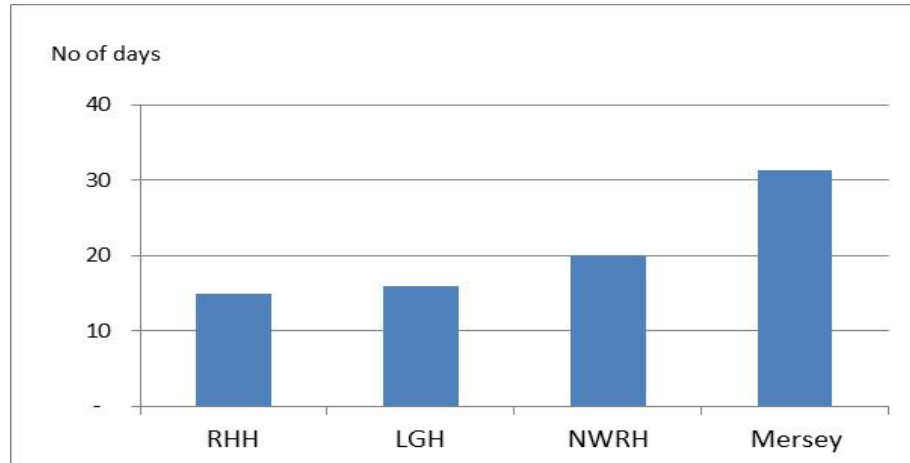
We recommend that DHHS revisits the utilisation of HITH programs at a state-wide level focusing on a community based model of services delivery, as a means to prevent or reduce the length of stay experienced by some patients in hospitals.

1.5.3 Nursing homes

Elderly patients who are unable to return home following hospital treatment can only be placed in an aged-care facility after being assessed by an Aged Care Assessment Team (ACAT) and a place being found. Also, because of Tasmania's dispersed population, locating an aged-care facility acceptable by both the patient and the patient's family can sometimes take time. We were advised that delays in getting an ACAT assessment were not considered to be excessive, at around seven days on average. However, some time is needed to find an aged-care place, stabilise the patient's condition and arrange for a visiting GP at the facility, which can sometimes be difficult. Our interest was in whether there were excessive delays in these processes. Figure 9 indicates the average days waited at each of the state's public hospitals in 2011–12.

²⁰Report on evaluation of Hospital in the Home Programs, Victorian Department of Health, 2009.

Figure 9: Average wait from ACAT referral to placement



For the RHH and LGH, the days waited appeared reasonable, given the abovementioned actions that need to be arranged. However, North West data indicated longer times, particularly for the Mersey campus. That might reflect difficulties obtaining placements there, or there could be a reduced incentive to finalise these matters due to lower bed occupancy.

Recommendation 6

We recommend that DHHS, in association with Tasmanian Health Organisation — North West, investigates reasons North West Coast placement times for elderly patients are longer than for the rest of the state and develops strategies to reduce waiting times.

1.6 Conclusion

Occupancy rates of hospitals varied widely from excessive rates at the RHH to under-utilisation at North-West and district hospitals. A related factor was that the average length of stay and the relative stay index in Tasmania hospitals were above the Australian average and increasing.

In addition, rates of unplanned readmission compared unfavourably with other jurisdictions. On the other hand, it was pleasing to note that Tasmania had been achieving substantial reductions in rates of hospital-acquired infections.

Regarding alternatives to hospital beds:

- Tasmania made similar use of outpatient services to other jurisdictions.
- HITH appeared to be under-utilised.
- Delays in patients waiting for nursing home placement were generally reasonable, but were longer in the North-West.

2 Maximising patient throughput: planning and usage

2 Maximising patient throughput: planning and usage

2.1 *Background*

In this Chapter, we review the department's processes for maximising hospital bed throughput, including:

- strategic planning
- systems and procedures to support bed management.

2.2 *How effective is strategic planning for patient throughput?*

DHHS had developed an overarching strategy (*Admission and Discharge Policy*). Its objectives included provision of optimal patient care as well as efficient and effective resource utilisation. At a more specific level, the policy required consideration of:

- minimising length of stay within clinical guidelines
- same-day treatment options
- availability of resources
- alternatives for post-acute care
- admitting patients no earlier than necessary
- developing discharge plans as soon as possible after admission
- post-discharge options such as outreach services.

We considered that there was reasonable attention to throughput for such a high-level document. The strategy was supported by individual hospital-level policies but these were more procedural than strategic.

An omission from the strategic planning documents was the lack of performance indicators. In particular, we considered throughput statistics such as RSI or ALOS to be important measures for assessing implementation (see Section 1.2).

Recommendation 7

We recommend that DHHS implements performance indicators to monitor the effectiveness of patient throughput and facilitates benchmarking at a state and national level.

2.3 *Did hospitals have effective bed management systems and procedures?*

Systems for tracking bed availability were specific to each of the state's public hospitals:

- At the RHH, an electronic management system was used to track beds across all units and wards with details of available beds with their current occupancy status. RHH was transitioning to an on-line system.
- LGH used a module of its hospital IT management system to track bed usage.
- NWRH used a spread sheet.
- Mersey used a paper-based system.

We also reviewed two district hospitals, at New Norfolk and Deloraine. These functioned as satellites of their larger regional hospitals, namely RHH and LGH respectively. From 2009–10 to 2011–12, New Norfolk’s occupancy rate varied from 64 to 78 per cent; at Deloraine, the corresponding range was 48 to 60 per cent. Such low occupancy rates at district hospitals suggest under-utilisation, even though we were advised that RHH and LGH do use bed capacity at the district hospitals.

However, we noted that the RHH bed management system did not include district hospital information or assist bed managers to make better use of the spare capacity available in district hospitals. By contrast, data for Deloraine District Hospital was accessible in the LGH system. Thus, LGH staff could assess Deloraine’s current occupancy status and determine whether beds were available there.

More generally, we think it likely that longer-term patients could potentially be identified and transferred between the major hospitals to ease excessive bed occupancy situations. Such a possibility would benefit from a state-wide bed management system.

Recommendation 8

We recommend that DHHS considers a state-wide bed management system to facilitate efficient use of the separate public hospitals.

Recommendation 9

We recommend that DHHS investigates the feasibility of making greater use of beds located at district hospitals.

2.4 Conclusion

We considered that there was reasonable attention to throughput in strategic planning documents, although inclusion of relevant performance indicators would increase the likelihood of effective implementation.

Separate bed management systems existed in the state's three regions and varied in their capacity to assist bed managers to maximise use of hospital beds in acute care hospitals or to make better use of spare capacity available at district hospitals. There is a strong case for adoption of a single state-wide bed management system.

3 Primary preventive health: comparative information

3 Primary preventive health: comparative information

3.1 *Background*

This Chapter looks at how Tasmania compares with other jurisdictions and prior periods in areas related to primary preventive health. The Chapter's focus is on the areas of vaccination and encouragement of healthier lifestyle choices. Included is review of rates of underlying behavioural risk factors, often referred to as SNAPPs (i.e. smoking, nutrition, alcohol misuse, physical inactivity and psycho-social conditions).

The information in this Chapter should not be seen as a scorecard on the department's current performance in this area, because:

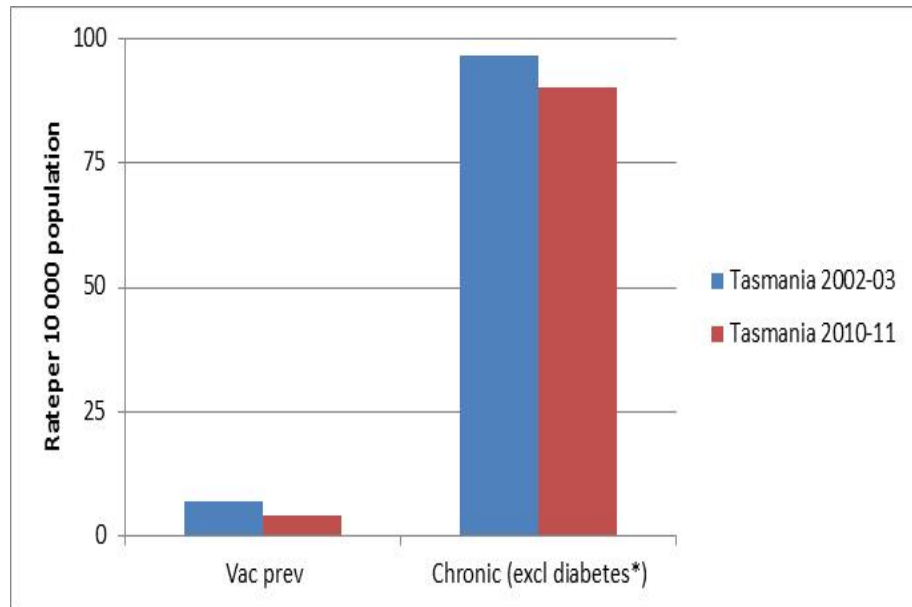
- The health of the population is affected by many factors outside the control of the department.
- It requires long lead times for primary health strategies to make a demonstrable difference.
- Tasmania has amongst the worst levels of social disadvantage in Australia which has been shown to have a substantial impact on population health.
- There are many other organisations working in primary preventive health.

3.2 *What are the rates of preventable illness in Tasmania?*

As discussed, our review focused on vaccination (and consequent prevention of diseases such as whooping cough) and encouragement of healthier lifestyle choices (and consequent prevention of associated chronic conditions such as emphysema and diabetes).

Figure 10 shows change in Tasmania's rates of preventable hospitalisations related to vaccine-preventable and chronic conditions.

Figure 10: Tasmania: preventable hospitalisations from vaccine-preventable and chronic conditions per 10 000 population²¹



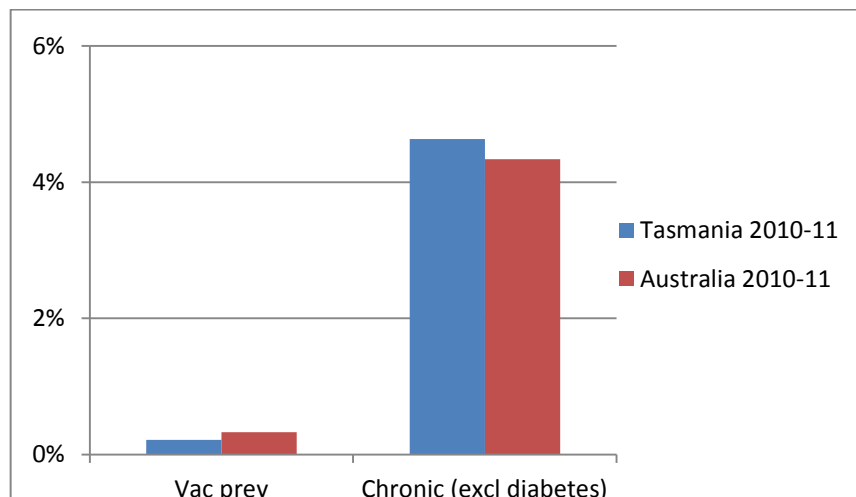
Source: Australian Institute of Health and Welfare *Australian hospital statistics 2002–03 and 2010–11*.

*Diabetes has been excluded from both years due to changed counting rules.

Over time, there has been improvement in the rate of preventable hospitalisations related to vaccine-preventable and chronic conditions.

Figure 11 compares Tasmania’s performance in relation to vaccine-preventable and chronic conditions against the rest of Australia.

Figure 11: Vaccine-preventable and chronic conditions as proportion of total hospital separations — Australia and Tasmania



²¹ Population figures sourced from ABS as at 30 June 2003 and 30 June 2011.

Source: Australian Institute of Health and Welfare *Australian hospital statistics 2010–11*.

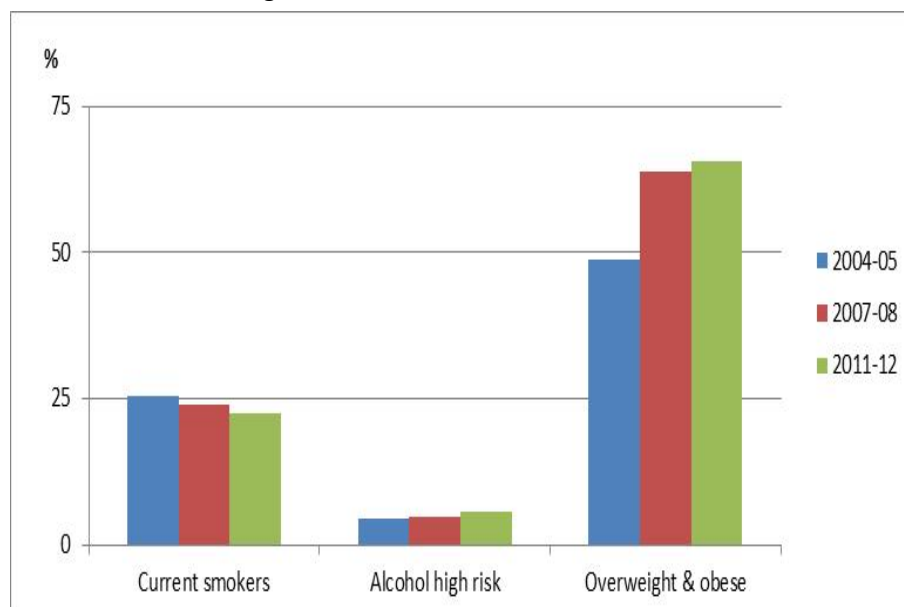
For vaccine-preventable conditions, Tasmania had a result better than the national figure. But, for chronic conditions, the state had a statistically significantly higher rate of preventable hospitalisations (4.64 compared with 4.34 per cent respectively).

3.3 *How do Tasmanian risk factors (SNAPPs) compare?*

SNAPPs are behavioural risk factors associated with chronic conditions. One of the difficulties in looking at rates of chronic disease is that we are looking at the effects of lifestyle choices made many years before and consequentially they are often more a measure of previous preventive health efforts than recent ones²². For that reason, we have also looked at rates of some SNAPPs as an indicator of the success of Tasmania’s more recent preventive health activities.

Figures 12 and 13 show longitudinal and jurisdictional studies of smoking, alcohol misuse and obesity. Similar data on other SNAPPs is not as readily available.

Figure 12: Tasmanian comparison of smokers, alcohol misuse and adults overweight over time



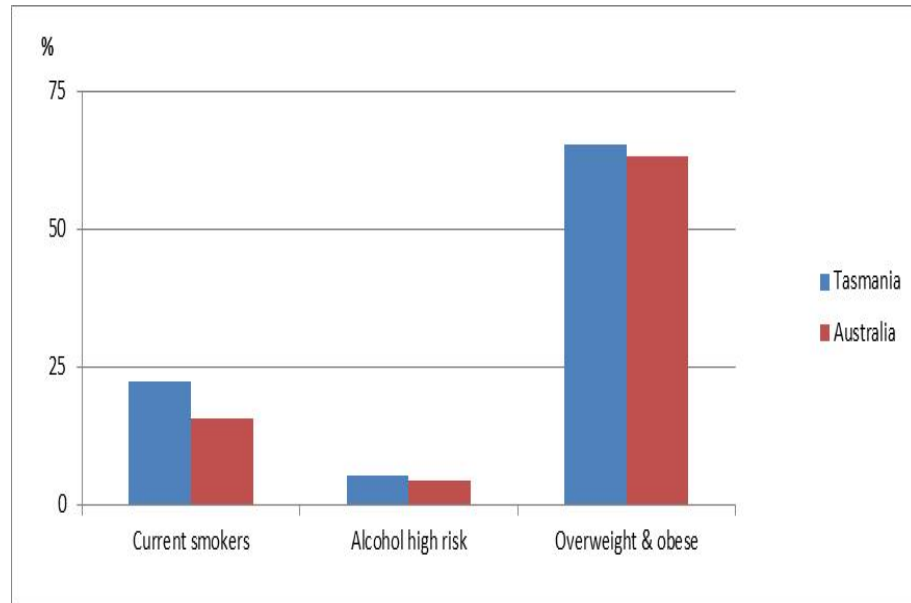
Source: *ABS National Health Survey, 2004–05, 2007–08, and 2011–12*.

While Tasmania’s situation with respect to smokers has improved over the eight-year period, for alcohol misuse there has been deterioration. There has also been deterioration with overweight and obesity but the scale is much worse. However,

²² Also, some chronic diseases have a genetic inheritance component.

due to changes in the data-measurement methodology, we cannot be certain that the increased rate is actually accelerating or as steep as it appears in Figure 12.

Figure 13: 2012 comparisons of smokers, alcohol misuse and people overweight for Australia and Tasmania



Source: ABS National Health Survey 2011-12

Based on the data shown in Figures 12 and 13, compared to national data, Tasmania has a comparative and increasing problem with respect to obesity. It also compares unfavourably with the national average for smoking rates.

Because of the possibility that Tasmania's relatively higher rates of smokers and overweight people might be largely due to socioeconomic factors, we ran a regression analysis of those factors against an index of socio-economic factors. We found evidence of a relationship between obesity levels and our socio-economic measure which suggested that Tasmania's apparently high rate of obesity is only marginally above that of other states when socio-economic factors are taken into account²³.

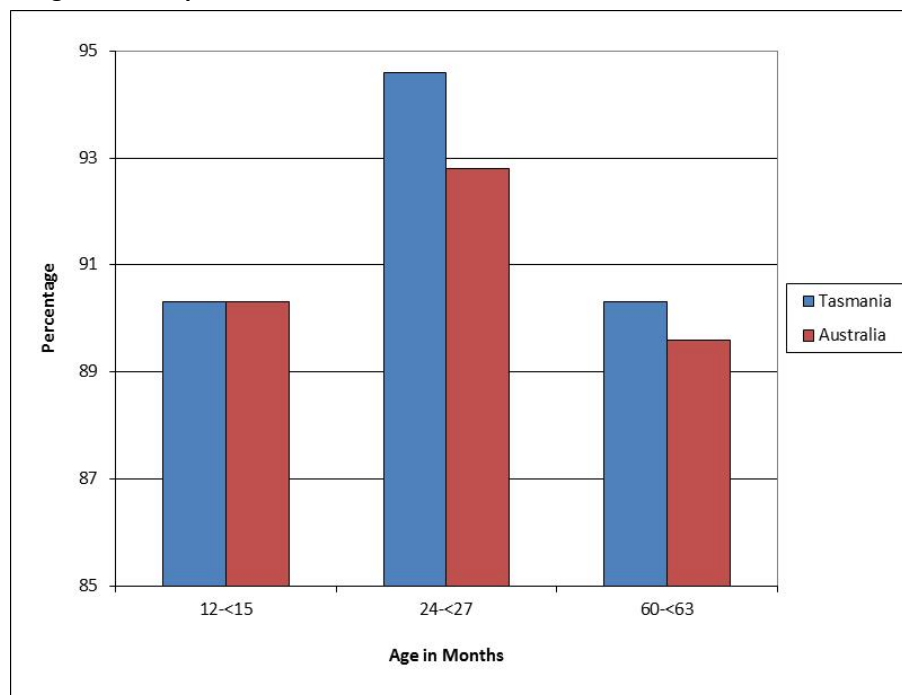
Nonetheless, the two charts indicate that both obesity and smoking are at relatively high levels; in the case of obesity the problem is worsening. In Chapter 4 we examine the department's strategic approach.

²³ The regression analysis was weakened by the low number of data points (i.e. 7), but was still indicative of a likely strong relationship between obesity and socio-economic factors.

3.4 How do Tasmanian rates of vaccination compare?

Tasmania's performance compared to national averages is shown in Figure 14.

Figure 14: Proportion of children vaccinated: Jun 2011



Source: Australian Childhood Immunisation Register²⁴

Tasmania achieved high childhood vaccination coverage with more than 90 per cent in each age group reported and higher vaccination rates than the Australian averages.

3.5 Conclusion

Tasmania has achieved high rates of vaccination and hence reduced the risk of children contracting related conditions.

However, for chronic conditions, Tasmania's rates of illness were higher than the rest of Australia, although the rates have decreased over an eight-year period. Rates for smoking, alcohol misuse and overweight/obesity were higher than the rest of Australia and, in the case of alcohol misuse and overweight/obesity, increasing.

²⁴For the youngest age group, vaccinations include DTP (diphtheria, tetanus and pertussis), Hib (Haemophilus influenzae type B), polio and hepatitis B. For older children, MMR (measles, mumps, and rubella) is added.

4 Primary preventive health: strategic planning

4 Primary preventive health: strategic planning

4.1 Background

A difficulty for us in reviewing preventive health activities is that rates of chronic conditions and of associated risk factors are not an effective measure of the department's activities. This is because of the existence and significance of contaminating variables: other influences unrelated to the department's activities that have an impact on lifestyle choices, such as socioeconomic factors.

As another method of reviewing the department's primary preventive health activities, we also looked at its strategic approach. In our view, the department's strategic approach to primary preventive health was more likely to be effective if:

- It was documented.
- There was a rationale for the total funds allocated to preventive health.
- There was evidence to support the overall approach (including that the department had 'built on the knowledge' from other jurisdictions or countries).
- Regular activities, new initiatives and funding of external programs were clearly outlined in strategic documents and supported by evidence.
- Useful measures of progress and success had been set.

4.2 Was the strategic approach documented?

We found at least nine current planning documents totalling 510 pages, including *Tasmania's health plan: Primary health services plan 2007*, other high-level frameworks, strategic documents, an annual business unit plan and subsidiary plans for individual SNAPPs (see the Appendix). One reason for the large number of strategic planning documents is the diversity of sources with some based on international charters, some on Commonwealth-state agreements and others on relevant departmental units. In our view, this situation has led to some confusion as to the role of individual plans and a possible weakening of lines of responsibility for primary preventive health.

Together, the documents included many of the expected elements of strategic plans including mission, vision, background research, evidence discussion, broad strategies, action areas, performance indicators and organisation charts.

Nonetheless, we did not consider that the existing suite of documents collectively provided effective strategic direction to the department's preventive health efforts for the following reasons:

- excessive number and volume of documents
- lack of clarity across the documents — how they are interrelated — plus, no obvious top-down approach
- lack of detail on resources, in particular, employee numbers and funding of internal and external programs
- insufficient internal linkages from high-level concepts through to activities, initiatives and funded external programs
- no comprehensive lists of activities, initiatives and funded external programs
- inconsistent use of terms such as priorities, strategies, objectives, action areas and actions.

Overall, we do not believe the strategic planning documents provided effective strategic direction or enable a reader to understand what the department does, how it does it and why it chooses those activities and programs. It is also a concern that excessive effort may have been allocated to creation of strategic documents to no great benefit.

Recommendation 10

We recommend that DHHS:

- **clearly defines responsibilities for primary preventive health activities within the department**
- **opts for a single, multi-year strategic document that will provide effective strategic direction**
- **continues to support the strategic plan with annual business plans.**

4.3 *Was there a rationale for total funds allocated?*

With respect to the proportion of the health budget devoted to preventive health, we noted that the Australian proportion was 1.9 per cent compared to the OECD average of 2.4 per cent²⁵.

²⁵ *Public Health and Prevention Expenditure in England: Health Report No. 4 2009.* Department of Health. London.

The *Health and Wellbeing Mapping Report*²⁶ pointed out that advocates have called for a doubling of preventive health funding to four per cent. In reality, any such benchmark has limited validity because:

- The value of preventive health depends on its objective (e.g. minimising medical costs or maximising health outcomes).
- Measuring benefits of funding is virtually impossible because of:
 - long time lags between action and outcome
 - other contributory factors on health outcomes ('noise')
 - inability to know what would have happened if the funding had not been provided.
- There is no standard unit of preventive health for which we can assess the value. Instead, there are many different interventions (e.g. advertisements or legislation).
- The difficulty of defining what is included or excluded under the umbrella term of 'preventive health'.

We noted that the unit broadly responsible for preventive health (Population Health) received \$39.6m in 2011–12 which was 2.9 per cent of the total health services budget²⁷. Some expenditure within Population Health is arguably not preventive but, on the other hand, some preventive health activity is provided by other sections of the department. In any event, our view is that there is no persuasive evidence available to determine whether the department's funding is too low, about right or excessive. It follows that there is greater than usual necessity that the department's primary preventive health strategies be clearly outlined and supported by convincing rationales.

²⁶ *Health and Wellbeing Mapping Report*, Department of Health and Human Services, October 2012.

²⁷ The 'health services budget' was calculated as the total of Output Groups 1 and 2 of the Department of Health and Human Services being the only output groups whose names refer to health services. As such, it was less than the department's total budget, which also included items such as disability and housing services.

4.3.1 *Is there a need for discretionary funding?*

Whilst we were not persuaded that the overall funding level was insufficient, we were concerned that very little of those funds appeared to be discretionary (that is, flexible):

- Most of the funding to external organisations was ‘locked in’ by Commonwealth requirements, other agreements or contracts, historical decisions and reluctance to cut off regular funding to external bodies that rely on grants.
- Much of the department’s preventive health work force is required for non-discretionary functions (e.g. water and food inspections and investigation of disease outbreaks).

As a consequence, there is little scope for the wealth of information collected by the department to lead to significant change. This may be a reason for the lack of clear linkages in the strategic documents.

Discussions with senior officers disclosed that they held similar concerns with respect to the lack of discretionary funding. An example of a project that they saw as deserving of greater commitment was one related to hepatitis C and prisoner health. However, our view was that funding of new initiatives should compete with other actual or potential interventions — on the basis of expected benefits — rather than be sourced from additional discretionary funding.

Recommendation 11

We recommend that DHHS:

- **indicates which activities are statutory requirements and which are non-statutory**
- **introduces greater flexibility into taking up high priority interventions and discontinuing those of a lower priority**
- **better identifies likely benefits of interventions and prioritise accordingly.**

4.4 *Was there evidence to support the department’s overall approach?*

Most of the strategy documents included high-level, conceptual foundations for the department’s approach to preventive health. Common to these documents was the need for the following elements:

- an intersectoral methodology including government, communities and the private sector
- to focus on behavioural risk factors (e.g. smoking) and the social determinants of health (e.g. poverty)
- to have a wide range of intervention types, such as advertising, partnerships with schools and legal policy.

We were satisfied from scrutiny of strategic documents that the concepts were consistent with national and World Health Organisation approaches. We were also satisfied that the department accesses epidemiological and risk factor data to support its overall approach.

Despite that, we found little evidence of the broad concepts or data linking to specific activities and initiatives.

Recommendation 12

We recommend that strategic planning specifically outline actions and initiatives as flowing from high-level concepts and data.

4.5 Were regular activities, funded programs and new initiatives clearly outlined?

In the following subsections, we discuss:

- perceived shortcomings
- a descriptive document of preventive programs
- some successful interventions.

4.5.1 Perceived shortcomings

As discussed, there were at least nine strategic planning documents with 510 pages and uncertain linkages. Some of our specific concerns included the following:

- Strategic documents were more about the preliminary research needed to inform a plan rather than giving direction.
- Most actions were at a high level and gave little sense of what services would be delivered. Terms like ‘advocate, support, assist, explore, work together, commit to, and review’ were common. We would have preferred a better sense of what would be done and how it was to be measured.

- Many actions outlined processes to be followed (such as forming partnerships) rather than what was to be achieved by those mechanisms.
- A further common action point was to perform research to determine strategy; our expectation was that research would have already been done before setting strategic direction.
- Activity terms such as ‘priorities, strategies, action areas and actions’ were used inconsistently between documents.
- Some strategies were at too high a level to be useful, e.g. ‘invest in strategies that promote health and wellbeing and reorient the health system to increasingly support prevention and health promotion’.

We also found little evidence of rationales for the choice of interventions. However, business cases for the funding of external programs existed. We examined five business cases for funding of external programs and found persuasive documentation for two but unpersuasive rationales relating to need, prior success for continuing programs or the level of funding for the other three.

In any event, individual business cases cannot be a substitute for a strategic plan explaining how various programs work together to meet strategic objectives.

Overall, planning documents did not provide clear direction as to what preventive activities were to be undertaken, why particular activities were chosen and how the success of the department’s strategic approach was to be measured.

Recommendation 13

We recommend that DHHS:

- **adopts a top-down approach flowing from high-level concepts to clearly defined actions or programs**
- **lists actions that give a clear sense of what would be done and what will be achieved**
- **conducts research before setting strategic direction rather than making research an action point.**

4.5.2 A descriptive document of preventive programs

The department’s 2012 *Health and Wellbeing Mapping Report* provided a summary of programs undertaken across government and non-government bodies. It revealed an extremely complex network of service deliverers, programs and

activities performing functions related to preventive health. We counted 88 organisations delivering 70 programs. Those organisations were supported by the department in various ways with 39 receiving funding of \$5.6m in 2011–12.

The *Health and Wellbeing Mapping Report* provided a much better description of preventive health activities performed or supported by DHHS than any of the strategic documents that we reviewed. However, the report was only descriptive and not a strategic document itself. Although it listed current activities and programs, it could not tell us:

- How those programs and activities linked to the broad strategic direction outlined in planning documents?
- Why those programs and activities were selected?
- What resources had been applied to them?
- How success was to be evaluated?

In our view, this document would not have been needed if the strategic planning had better outlined the preventive work being undertaken and why.

Recommendation 14

We recommend that the *Health and Wellbeing Mapping Report* be a key input to a revised strategic plan.

4.5.3 Successful interventions in preventive health

In this Chapter, we have been critical of some aspects of DHHS's strategic planning. Although we struggled to identify actual interventions from strategic planning documents, we would not want to leave the impression that good work has not been done. We found persuasive evidence of substantial achievement by the department, often in collaboration with others in various projects including the following examples.

Tasmanian Food Security Fund

This project encouraged disadvantaged families to eat better quality food using approaches that included:

- preparation and sale of 'vegie boxes' of locally grown fresh produce
- training in nutrition, food budgeting and healthy cooking
- development of micro-enterprise businesses involving fresh food.

Iodine nutrition among children

To address a long-standing dietary deficiency, Tasmania became the first state in Australia to work towards improving iodine levels. In 2001, the baking industry was asked to voluntarily replace salt routinely used in bread making with iodised salt. This initiative in Tasmania influenced action nationally. From 2009, it became law in Australia and New Zealand to standardise this practice.

School canteens

The School Canteen Accreditation Program was delivered in 2003 to:

- expand the availability of healthy foods
- improve knowledge, skills and awareness of school canteen workers
- increase awareness among food manufacturers of foods suitable for sale in school canteens.

4.6 Have useful measures of progress and success been set?

A fundamental part of implementing a program is working out in advance how success would be evaluated. It is important that KPI development and collection be at a practical level rather than overwhelming actual preventive health activities.

We could not find meaningful measurements of success in strategic documents, although some measures were found in the annual business plan. Nonetheless, those measures varied considerably, from useful and sensible to meaningless or unmeasurable.

Funding agreements for programs contained KPIs. However, the measures seemed too numerous and at too low a level to allow for effective program evaluation. Often, the measures were merely counts of marginally relevant data rather than genuine evaluation criteria. As an example, the 'Eat well Tasmania' program included 'diversity and number of potential partners'. By contrast, a performance indicator that we supported was 'Accreditation of school canteens' as a simple but all-encompassing measure of the 'Cool Canteens Program'.

We also found rationales for continued funding which referred to previous funding agreements without outlining current needs; an example was Family Planning.

In addition, for each program, the department intended to use an assessment methodology ('Program Logic') to set up the planned goals and outcomes of the project. Our review of a small

number of evaluations suggested that they were excessively complicated and required impractical levels of data gathering and analysis. One such example was 'Quit Tasmania'.

Recommendation 15

We recommend that strategic plans identify high-level and practical indicators of success and frequency of measurement. Alternatively, strategic plans might be cross-referenced to indicators of success in funding agreements.

Recommendation 16

We recommend that DHHS reviews existing business plans and funding agreements to ensure that the level of information being sought is practical and capable of providing a reasonable indication of success.

4.7 *Conclusion*

It was very difficult to get a sense of what interventions and programs were being undertaken by the department or on what basis. The difficulty was largely due to the considerable number and volume of strategic planning documents, lack of clear linkages between and within documents and evaluation deficiencies.

Independent auditor's conclusion

Independent auditor's conclusion

This independent conclusion is addressed to the President of the Legislative Council and to the Speaker of the House of Assembly.

Audit objective

The objective of the audit was to assess the effectiveness of the Department of Health and Human Services' efforts to:

- improve patient throughput in hospitals
- prevent people acquiring chronic conditions through primary preventive health strategies.

Audit scope

The audit scope mainly centred on the Department of Health and Human Services (the department).

The audit's time scope was from July 2008 to June 2012.

Responsibility of the Secretary of the Department of Health and Human Services

The Secretary, with support from Tasmania's hospitals and the department's Population Health unit, is responsible for managing patient throughput in our hospitals effectively and for the effectiveness of our primary preventive health strategies.

Auditor-General's responsibility

In the context of this performance audit, my responsibility was to carry out sufficient audit work to place me in a position where I could conclude as to the effectiveness of the department's efforts to:

- improve patient throughput in hospitals
- prevent people acquiring chronic conditions through primary preventive health strategies.

I conducted my audit in accordance with Australian Auditing Standard ASAE 3500 *Performance engagements*, which required me to comply with relevant ethical requirements relating to audit engagements. I planned and performed the audit to obtain reasonable assurance as to the department's effectiveness regarding the two matters outlined in my audit objective.

My work involved evaluating performance indicators, discussions with departmental staff and staff at each of the major hospitals, evaluating reports, analysing performance-related data and reviewing strategic plans.

I believe that the evidence I have obtained was sufficient and appropriate to provide a basis for my conclusion.

Auditor-General's conclusion

For the reasons outlined in the four chapters of this Report, and in relation to my two objectives, I concluded that:

- In relation to my first objective, the department is effective in managing patient throughput in Tasmania's hospitals but there are opportunities to improve this effectiveness.
- In relation to my second objective, while much good work is being done it is very difficult to get a sense of what interventions and programs are being undertaken or on what basis. I was, therefore, unable to conclude as to the department's effectiveness of its primary prevention strategies.

My report contains 16 recommendations which are aimed at improving and monitoring patient throughput, including the implementation of state-wide bed management arrangements, better definition of primary preventive health activities and improving strategic planning such that there are stronger bases for primary health prevention interventions and programs being undertaken.

H M Blake
Auditor-General
28 May 2013

Recent reports

Recent reports

Tabled	No.	Title
Nov	No. 5 of 2011–12	Volume 3 — Government Business Enterprises, State Owned Companies, Water Corporations and Superannuation Funds 2010–11
Nov	No. 6 of 2011–12	Volume 4 Part I — Local Government Authorities 2010–11
Dec	No. 7 of 2011–12	Volume 5 — Other State Entities 30 June 2011 and 31 December 2010
Mar	No. 8 of 2011–12	The assessment of land-use planning applications
Jun	No. 9 of 2011–12	Volume 6 — Other State Entities 30 June 2011 and 31 December 2011
Jun	No. 10 of 2011–12	Public Trustee: Management of minor trusts
Jun	No. 11 of 2011–12	Updating the Motor Registry System
Jun	No. 12 of 2011–12	Follow up of special Reports 75–81
Jul	No. 1 of 2012–13	Sale of TOTE Tasmania
Oct	No. 2 of 2012–13	TasPorts: benefits of amalgamation — October 2012
Nov	No. 3 of 2012–13	Volume 3 — Government Business Enterprises, State Owned Companies and Water Corporations 2011–12
Nov	No. 4 of 2012–13	Volume 4 Parts I & 2 — Local Government Authorities 2011–12
Nov	No. 5 of 2012–13	Volume 1 — Analysis of the Treasurer’s Annual Financial Report 2011–12
Nov	No. 6 of 2012–13	Volume 2 — Executive and Legislature, Government Departments, other General Government Sector State entities, other State entities and Superannuation Funds 2011–12
Dec	No. 7 of 2012–13	Compliance with the <i>Tasmanian Adult Literacy Plan 2010–15</i>
Mar	No. 8 of 2012–13	National Partnership Agreement on Homelessness
Mar	No. 9 of 2012–13	Royal Derwent Hospital: site sale

Current projects

Current projects

Performance and compliance audits that the Auditor-General is currently conducting:

Title	Subject
Fraud control in local government	Assesses whether local government Councils' fraud management strategies are effective to prevent, detect and respond to fraud.
Royal Hobart Hospital redevelopment	A performance audit to assess the effectiveness of the governance, project management and initial implementation of the RHH redevelopment project.
Alcohol, Tobacco and Other Drug Services: five-year plan	Examines whether the Department of Health and Human Services has implemented the strategies listed in the <i>Alcohol, Tobacco and Other Drug Services, Tasmania: Future Service Directions — a five year plan, 2008/09 – 2012/13</i> .
Radio communication networks	The objective of the audit is to assess the efficiency and effectiveness of the current radio communications networks used by police and other emergency service personnel.

Appendix: DHHS strategic documents — preventive health

Appendix: DHHS strategic documents — preventive health

We found at least nine current planning documents with a combined 510 pages, including high-level frameworks, strategic documents, an annual business unit plan and subsidiary plans for individual SNAPPs.

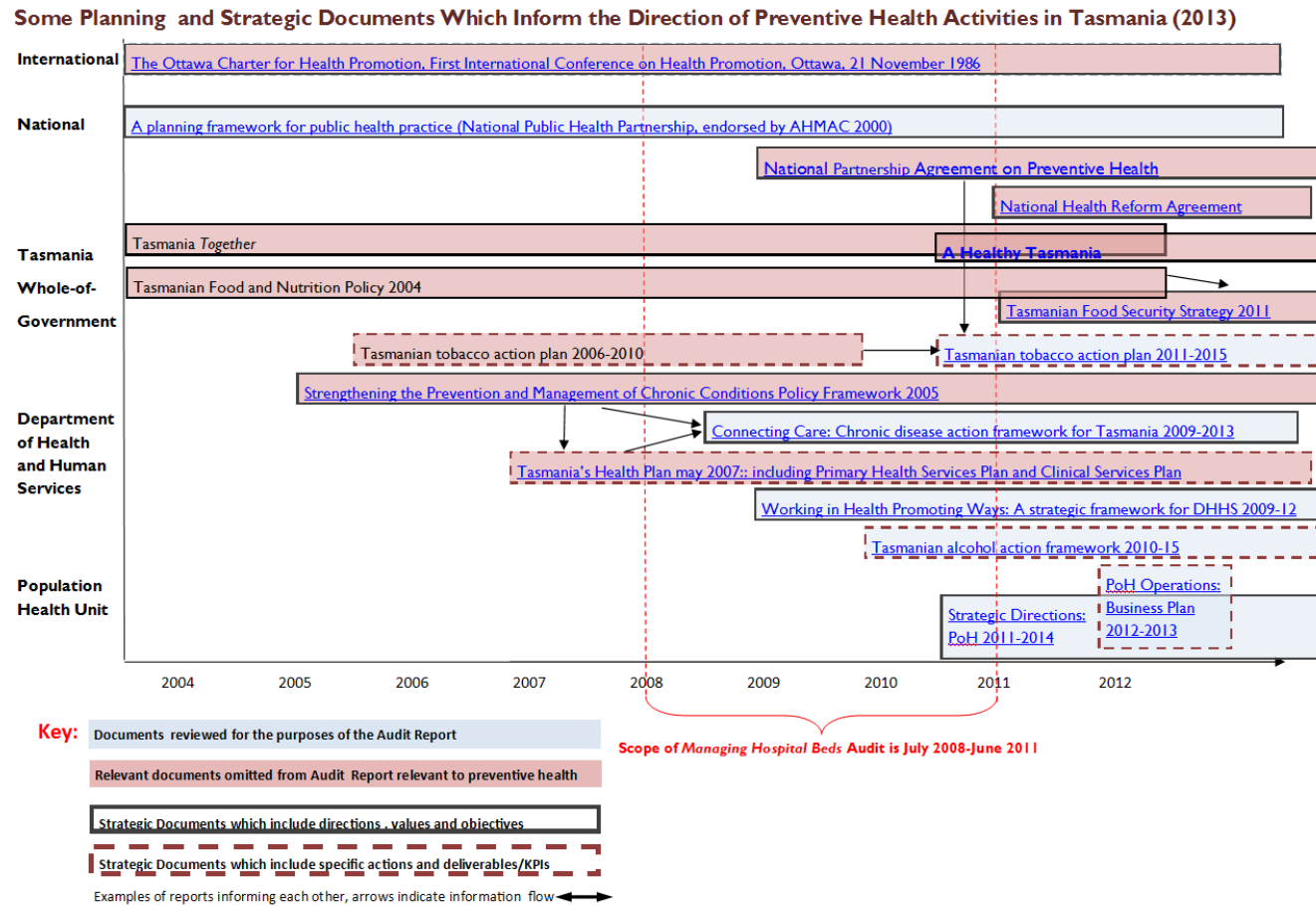
The various documents that we reviewed are listed in Table A1.

Table A1: Current strategic documents relating to preventive health

Document	Description
<i>Tasmania's health plan: Primary health services plan May 2007</i>	Covers all aspects of primary health and not just preventive health. Includes considerable background information. With respect to preventive health strategies, it includes high-level intentions rather than specific strategies. For example, 'there is the potential for an expanded range of services provided in relation to chronic disease' (150 pages).
<i>A planning framework for public health practice</i>	A high-level conceptual approach to addressing problems in public health (26 pages).
<i>Working in health-promoting ways: A strategic framework for DHHS 2009–12</i>	A substantial (i.e. 115 pages) document that includes a wealth of background information, as well as some specific suggestions for strategies in various public health areas.
<i>Strategic directions: Population Health 2011–2014</i>	A brief strategic planning document that covers high-level priorities and principles, organisational structure, relevant legislation and planning themes. It provides no information as to the actions, funding or initiatives to be taken by the Population Health unit (17 pages).
<i>Population Health Operations: Business Plan 2012–13</i>	Outlines objectives, goals, activities and measures at a business unit level. We were unable to make substantial linkages back to the preceding document. The strategies seemed intuitively sensible but there was no explicit evidence base (57 pages).

<p><i>Connecting Care: Chronic disease action framework for Tasmania 2009–2013</i></p>	<p>Complements <i>Working in health-promoting ways: A strategic framework for DHHS 2009–12</i>. Provides further health statistics and outlines a SNAPPs-based approach. It provides broad action areas and similarly strategies such as focussing on ‘reducing health inequities’. To some extent, specifics are fleshed out through use of case studies (e.g. <i>Move well eat well</i>). (59 pages).</p>
<p>Subsidiary SNAPPs-based action plans: <i>Tasmanian tobacco action plan 2011–15</i></p>	<p>Includes objectives and actions. However, both are too high-level to provide meaningful direction. For example, ‘promote a smoke-free lifestyle in communities’ (21 pages).</p>
<p>Subsidiary SNAPPs-based action plans: <i>Tasmanian alcohol action framework 2010–15</i></p>	<p>Outlines areas for action but these are not sufficiently specific to provide meaningful direction (25 pages).</p>
<p><i>A Fair Go: Working Together for a Fair and Healthy Tasmania. Strategic review recommendations</i></p>	<p>Outlines Tasmania’s relative disadvantage to risk factors and presents strong arguments for more preventive care and recommends some high-level strategies. The report also includes some quite specific targets and evidence that preventive health can help to achieve them. It does not, however, suggest practical actions nor refer to lower level documents where that is done (40 pages).</p>

Figure A1: Interrelation of strategic planning documents



Source: Department of Health and Human Services