2009

PARLIAMENT OF TASMANIA

AUDITOR-GENERAL
SPECIAL REPORT No. 79

Follow up of performance audits:
April – August 2006

May 2009

Presented to both Houses of Parliament in accordance with the provisions of Section 30 of the Audit Act 2008.

By Authority:

Government Printer, Tasmania

Auditor-General's reports are available from the Tasmanian Audit Office, HOBART. This report and the recent titles shown at the back of this report can be accessed via the Office's home page. For further information please contact:

Tasmanian Audit Office

GPO Box 851

Hobart

TASMANIA 7001

Phone: (03) 6226 0100, Fax (03) 6226 0199

Email: admin@audit.tas.gov.au

Home Page: http://www.audit.tas.gov.au

This report is printed on recycled paper.

ISBN 978-0-9804409-7-3

21 May 2009

President

Legislative Council

HOBART

Speaker

House of Assembly

HOBART

Dear Mr President

Dear Mr Speaker

SPECIAL REPORT NO. 79

Follow up of performance audits: April – August 2006

This Report has been prepared consequent to examinations conducted under section 23 of the *Audit Act 2008*, for submission to Parliament under the provisions of section 30 of the Act.

Performance audits seek to provide Parliament with assessments of the effectiveness and efficiency of public sector programs and activities, thereby identifying opportunities for improved performance. Our follow up of completed performance audits is aimed at assessing the extent to which state entities implemented recommendations made in previous reports.

This performance audit assessed the extent to which state entities implemented recommendations made in six previous reports tabled between April and August 2006.

Yours sincerely

H M Blake

AUDITOR-GENERAL

CONTENTS

Contents

List of Tables

List of Figures

Foreword

Performance audits are conducted with the goal of assessing the effectiveness, efficiency and economy of activities undertaken by the public sector. Whereas, compliance audits are aimed at assessing compliance by state entities with laws, regulations or internal policies. Identification of areas where improvements can be made is one of our primary objectives as is gaining acceptance by accountable authorities and their implementation of any resultant recommendations. Using a collaborative approach with accountable authorities, we aim to reach agreement so that audit recommendations are practical. They also add value to public sector programs or processes. Accordingly, there is an expectation that our recommendations will be implemented.

This follow-up audit was completed to provide Parliament with information about the extent to which accountable authorities acted on recommendations made in six performance and compliance audit reports tabled during the period April to August 2006, namely:

- Special Report No. 59 (April 2006):
  - Delegations in government agencies
  - Local government delegations
  - Overseas travel
- Special Report No. 60 (May 2006):
  - Building security
  - Contracts appointing Global Value Management
- Special Report No. 61 (August 2006):
  - Elective surgery in public hospitals

We were pleased that management had made changes to implement most of the recommendations of each report. One audit achieved 100% implementation. We achieved our 70% implementation benchmark rate in four of the six audits we reviewed. Where recommendations had not been implemented, we sought and received explanations as to why this was the case. This Report addresses each of the above audits, examining the original context of the recommendations and detailing the subsequent rate of implementation.

H M Blake

Auditor-General

21 May 2009

List of acronyms and abbreviations

Accountable authority	The person or body (however described) having the general direction and control of, and the overall responsibility for, the operations of a state entity.
Agencies	Collective term used for government departments
Brighton	Brighton Council
Burnie	Burnie City Council
CEO	Chief Executive Officer
Clarence	Clarence City Council
Council	Local government entity
DEDT	Department of Economic Development and Tourism formerly Department of Economic Development (DED)
Derwent Valley	Derwent Valley Council
DFAT	Department of Foreign Affairs and Trade [Commonwealth]
DHHS	Department of Health and Human Services
DIER	Department of Infrastructure, Energy and Resources
DoE	Department of Education
DPAC	Department of Premier and Cabinet
DPIW	Department of Primary Industries and Water formerly Department of Primary Industries, Water and Environment (DPIWE)
DEPM	Department of Police and Emergency Management formerly Department of Police and Public Safety (DPPS)
Justice	Department of Justice
DEPHA	Department of Environment, Parks, Heritage and the Arts formerly Department of Tourism, Parks, Heritage and the Arts (DTPHA)
Dorset	Dorset Council
ENT	Ear nose and throat
Entities	Collective term used to cover public sector organisations, see also state entities
ESMIS	Elective surgery management information system
FMAA	*Financial Management and Audit Act 1990*
Forestry	Forestry Tasmania
FTE	Full-time equivalent
George Town	George Town Council
GM	General Manager
GP	General Practitioner
GVM	Global Value Management

HoA	Head of Agency, see also Accountable authority
HOMER	Hospital information management system
HR	Human Resources
Huon	Huon Valley Council
King Island	King Island Council
LCC	Launceston City Council
LGA	*Local Government Act 1993*
LGH	Launceston General Hospital
Mersey	Mersey campus of the NWRH located at Latrobe
Metro	Metro Tasmania Pty Ltd
MRP	Motor Registry Project
Southern Midlands	Southern Midlands Council
State entities	Collective term used to cover all public sector entities such as: government departments; government business enterprises; state-owned companies; statutory authorities and other public bodies
TAFE	TAFE Tasmania
TAO	Tasmanian Audit Office
TECA	Treasurer's Expenditure Control Authority
TI	Treasurer's Instruction
TOTE	TOTE Tasmania Pty Ltd
Treasury	Department of Treasury and Finance
RHH	Royal Hobart Hospital
UTAS	University of Tasmania
West Coast	West Coast Council
VMO	Visiting medical officer

This page left blank intentionally

Executive summary

Executive summary

We conduct audits with the goal of assessing the performance and compliance of public sector entities. Identifying areas for potential improvement is an essential part of such audits and recommendations are made in support of that objective.

Follow-up audits inform Parliament about the extent to which state entities have acted on recommendations made in previous Special Reports.

Our previous follow-up audit, Special Report No. 74, was tabled in June 2008. That report looked at six audits tabled between April and October 2005. During 2006 we tabled reports on nine further audits not all of which required follow up. The six 2006 reports selected for follow up are:

- Special Report No. 59 contained three compliance audits:
  - Delegations in government agencies
  - Local government delegations
  - Overseas travel
- Special Report No. 60 contained two audits, a performance audit and an investigation:
  - Building security
  - Contracts appointing Global Value Management
- Special Report No. 61, a performance audit examining:
  - Elective surgery in public hospitals.

Audit opinion

Overview

In addition to being a yardstick on the performance of accountable authorities, the follow-up process provides feedback on our own effectiveness. A low rate of implementation would tend to indicate that recommendations were impractical or pitched at an inappropriate level. Consequently, in follow-up audits we regard an implementation rate of 70% as satisfactory.

Delegations in government agencies

Five public sector entities were assessed during the *Delegations in government agencies* audit which produced nine recommendations. The recommendations related to the use of instruments of delegation in financial transactions and human resource approvals. They were

aimed at strengthening delegation processes. The overall level of implementation was 80%.

We found Recommendations 4 and 8 had been fully implemented. Justice had not implemented Recommendation 1. Neither DEPHA nor Justice supported Recommendation 3. Metro had not implemented Recommendations 5 and 7. However, in the course of the follow-up audit Metro indicated they would reconsider those recommendations.

Local government delegations

Nine councils were assessed during the original *Local government delegations* audit resulting in seven recommendations. The recommendations related to policies and procedures as well as strengthening the control provided by instruments of delegation.

All nine of the councils involved in the audit had fully implemented Recommendations 3 and 7. Seven councils had also fully implemented Recommendations 1 and 2. Most of the councils involved in the audit had not implemented Recommendations 4, 5 or 6 and indicated that to do so would be administratively burdensome.

While we recognise that including delegates' names and specimen signatures in each instrument of delegation would require administrative resources, we maintain that implementation of these recommendations would provide the most robust system controls. Furthermore, we continue to maintain that transaction documents being approved for payment should bear the name and position title of approving or authorising officers to facilitate processing controls.

This Report determined that the overall implementation level of the recommendations was only 61%.

Overseas travel

The *Overseas travel* audit made four recommendations to improve the Department of Premier and Cabinet's Overseas Travel Policy. The recommendations all related to the submission of travel plans and reports. The follow-up audit determined that all four of the recommendations had been fully implemented.

Building security

The 2006 audit assessed security within the administrative buildings of four government departments. This resulted in seven recommendations which related to policies and procedures including risk assessment and staff training. We found that two of the four audited departments had fully implemented the nine recommendations. The overall implementation rate was 84% which exceeds our benchmark.

Contracts appointing Global Value Management

In February 2006 media speculation highlighted a potential conflict of interest in public bodies appointing a consulting company (Global Value Management Pty Ltd — GVM) part owned by the then Premier's brother. We conducted an audit of procurement practices to verify compliance with Treasurer's Instructions (TIs). Six state entities were involved in the 2006 audit which resulted in four recommendations. We found each of the four recommendations had been implemented by the relevant entities. The overall implementation rate was 94%.

Enquires made for the follow-up audit found there had been no changes made to the Tasmanian legislation or the code of conduct for Members of Parliament regarding the disclosure of family interests.

Elective surgery in public hospitals

The *Elective surgery in public hospitals* report analysed elective surgery processes, waiting list data, performance by surgical specialty and resources as well as management and reporting information. We made 27 recommendations to DHHS aimed at improving the efficiency and effectiveness of elective surgery. Only eleven recommendations had been fully implemented. In the majority of instances of partial implementation we found planning, reviews or implementation underway and further progress predicted in 2009 and 2010.

We found admissions from the elective surgery waiting list had not increased as at June 2008, although there was some evidence of improvement in the following financial year. To report 2008–09 performance we extrapolated year-to-date admissions data (i.e. using 1 July 2008 to 28 February 2009 data).

Our view in the original report was that more admissions could be achieved with better information about efficiency and possible bottlenecks. Several recommendations relating to improving information were amongst those that were only partially implemented. At 67%, the overall rate of implementation of our recommendations was below our benchmark of 70%.

Management responses

Management responses to this Report have been included at the end of each chapter.

Introduction

Introduction

Background

We conduct audits with the goal of assessing the performance and compliance of public sector entities. Identifying areas for potential improvement is an essential part of such audits and recommendations are made in support of that objective.

As a matter of course, we try to reach agreement with clients when framing our recommendations. Due to this collaboration we have an expectation that our recommendations will be actively implemented.

Follow-up audits are undertaken to provide Parliament with information about the extent to which public sector entities have acted on recommendations made in previous Special Reports.

Objective

The purpose of the audit was to:

- ascertain the extent to which recommendations in the previous audit reports were implemented
- determine reasons for non-implementation.

Scope

Our previous follow-up audit, *Special Report No. 74*, was tabled in June 2008. That report looked at audits tabled between April and October 2005. During 2006 we tabled reports on nine further audits not all of which required follow up. The six 2006 audits selected for follow up are:

- Special Report No. 59 contained three compliance audits:
  - Delegations in government agencies
  - Local government delegations
  - Overseas travel.
- Special Report No. 60 contained a performance audit and an investigation:
  - Building security
  - Contracts appointing Global Value Management
- Special Report No. 61, a performance audit examining:
  - Elective surgery in public hospitals.

Audit methodology

Findings in this audit are based on evidence collected from state entities through survey questionnaires that gauged the extent to which recommendations had been implemented. Those surveys were supplemented by supporting data and documentation. As necessary, we held discussions with entity staff. In two instances we updated analyses that had been undertaken in the original audits using more current data.

About this Report

The following chapters, summarised from the original audits, reflect the findings and recommendations that we made in 2006. Where we made no findings, there was nothing to follow up. For that reason, the section headings and paragraph numbering in this Report will not always align with those used in the 2006 reports.

The 2006 audits were conducted under the *Financial Management and Audit Act 1990* which was subsequently amended by the *Audit Act 2008.* The new Act defines a collective term — state entities — to cover all public sector organisations including, government departments, local government councils, government business enterprises, state-owned companies, statutory authorities and other public bodies. Where necessary in this Report, the term Agency has been replaced with state entity.

Management responses published in the 2006 reports have not been reproduced here.

Timing

Planning for this follow-up performance audit began in September 2008. Questionnaires were forwarded to clients in October 2008 with the fieldwork completed in March 2009. The report was finalised in May 2009.

Acknowledgement

We acknowledge the assistance given by all the state entities involved with this follow up.

Resources

The total cost of the audit excluding report production costs was approximately $88 700.

This page left blank intentionally

1 Delegations in government agencies

1 Delegations in government agencies

The 2006 report

Acts of Parliament delegate the provision of government services to Ministers of the Crown. For practical application, Ministers further delegate these functions to an officer of a government agency, typically the Head of Agency or the Chief Executive Officer (CEO). Many of these functions may then be further delegated to other officers within the state entity.

The objectives of the 2006 compliance audit entitled *Delegations in government agencies* were to:

- assess the adequacy of instruments of delegation associated with the expenditure of public monies and the administration of human resources in accordance with applicable legislation, government policy and internal controls
- determine by testing transactions the level of compliance with instruments of delegation
- identify weaknesses and recommend improvements as necessary to current procedures to ensure best practice[1].

The 2006 audit was supported by transaction testing covering the four-month period 1 February to 30 April 2005. The five state entities included in the scope of the 2006 audit were:

- Department of Environment, Parks, Heritage and the Arts (DEPHA) that at the time of the original audit was known as the Department of Tourism, Parks, Heritage and the Arts
- Department of Justice (Justice)
- TAFE Tasmania (TAFE)
- Metro Tasmania Pty Ltd (Metro)
- University of Tasmania (UTAS).

Most, but not all the agencies we examined in 2006 had instruments of delegation in place to support their policies and procedures. However, we found shortcomings in the day-to-day application of delegations in some entities and a number of transactions had been approved by officers with inappropriate delegation. Despite these

[1] Best practice was defined by the Audit Office of New South Wales in the following way: 'Delegations should be current, documented and readily available to staff. They should agree with applicable legislation, be adequate and be issued to a position, not a person. Most importantly, staff of agencies must observe them' (AONSW 2001).

findings, we were able to confirm the validity of all transactions tested in 2006.

The next sections of this Chapter briefly outline the original report together with audit findings and the recommendations made at that time. In this Report, we have revisited some of the original findings and sought new information from some of the entities involved in the audit.

1.1 Policies and procedures to manage delegations

We expected agencies to have written policies and procedures for the management of delegations. The 2006 audit considered the adequacy or otherwise of entities' policies and written procedures for managing delegations for both financial and human resource functions.

1.1.1 Financial delegations

In government departments Heads of Agency are responsible to the appropriate Minister for the financial management of that agency[2]. Financial delegations are described by the *Financial Management and Audit Act 1990* (*FMAA)*, requiring the Treasurer to issue a Treasurer's Expenditure Control Authority[3] (TECA) to the appropriate Minister. Relevant Treasurer's Instructions (TIs) provide additional detail for managing delegations.

While TIs are written specifically for government departments and do not apply in state-owned corporations or statutory authorities, all entities should develop their own policies and procedures for controlling the delegation process.

State entities' own policies should expand on the basic requirements of FMAA and TIs and set the delegation framework in a context relevant to the entity in question. The value of such policies is that they could be used to identify specific powers and authorisations that may be exercised by particular positions.

Of the entities reviewed, only Justice did not have any policies or written procedures for managing financial delegations. Instead, Justice relied on TI 504 (*Certifying Officers*) and TI 1103 (*Procurement Delegations and Authorisations*) for policy guidance and as a basis for framing their instruments of delegation. Reliance upon these TIs was reinforced by a requirement in Justice's accounting manual obligating staff to authorise purchases in accordance with delegations approved by the Secretary.

[2] Section 22 *Financial Management and Audit Act 1990*
[3] Section 14 *Financial Management and Audit Act 1990*

Whilst TIs provide an adequate control mechanism, we considered that the adoption of written policies and procedures would enhance the control processes relating to the management of financial delegations.

Recommendation 1

Agencies (now state entities) should ensure that they have appropriate policies and procedures in place to manage financial delegation processes. These policies and procedures should be made available to all relevant staff.

1.1.2 Human resource delegations

Powers to delegate can be found in the primary legislation that many state entities administer, as well as other legislation and policies that most entities are required to observe. These include:

- relevant enabling legislation in the case of state-owned companies and statutory authorities
- Treasurer's Instructions
- *State Service Act 2000*
- *Financial Management and Audit Act 1990*.

To enable Heads of Agency to meet their obligations, it is necessary that departments have effective control structures and systems of internal control to govern the main business processes. Payment of accounts for goods and services and the administration of human resources are considered to be significant business processes, a key component of which is having a system for delegation of authority. In order to be effective, instruments of delegation need to be unambiguous and give clear guidance to delegates.

Delegations should be made in writing under the hand of the officer holding the position defined in the legislation and should be available for audit inspection. In the 2006 audit, not all of the entities we reviewed had written policies or procedures to manage their human resource (HR) delegations.

- Justice and TAFE had none.
- TAFE indicated that the introduction of policies to manage HR delegations was under consideration
- Metro's HR delegations just covered staff employment procedures.

We considered that written policies and procedures would enhance the control processes relating to the management of HR delegations.

Recommendation 2

State entities should adopt policies and procedures to inform staff processing HR transactions of the processes to be followed. Clear policies would also enhance controls by ensuring that approvals are in accordance with delegated responsibilities.

1.2 Appropriate instruments of delegation

The 2006 audit commenced with a review of each state entities' TECA or an equivalent process where the requirement did not apply. We also assessed the appropriateness of instruments of delegation to support policies and procedures to manage delegations.

1.2.1 Instruments of delegation

As stated previously, an instrument of delegation needs to be current, unambiguous and give clear guidance to the delegate. In our opinion, the instrument of delegation should include:

- specimen signature of the delegate
- position title of the delegate
- financial or other limits of the delegation.

Instruments of delegation could be further enhanced by the inclusion of the delegate's name.

Specimen signature

As instruments required that delegations be made to positions and not to individuals, none had specimen signatures attached to them. Identification of authorising signatures was assisted at both TAFE and UTAS by the use of ancillary documentation that provided a specimen signature of each delegate. We considered that the inclusion of specimen signatures in instruments of delegation would make the identification of approving or authorising officers much simpler.

Recommendation 3

State entities should include specimen signatures in instruments of delegation to facilitate the identification of approving or authorising officers.

Delegate's position title

Delegates' position titles were included in instruments of delegation in all agencies reviewed except Metro.

Lack of detailed instruments of delegation is detrimental to effective control processes normally associated with the management of the payment of accounts and the administration of human resources.

Recommendation 4

State entities should ensure that instruments of delegation are complete and that all functions subject to normal day-to-day processing are included to facilitate management of payment of accounts and administration of human resources.

Delegate's name

Although instruments of delegation in each state entity related to positions and not to individuals as stated previously, names of delegates were included at some agencies. For example, DEPHA provided delegates' names in both financial and HR delegations, whereas at Justice and TAFE only financial delegations contained names. Delegates' names were available at UTAS in supplementary documentation already described. Delegates' names were not included in HR instruments of delegation at either Justice or TAFE.

It is our view that the inclusion of delegate's names in instruments of delegation would assist with the identification of approving or authorising officers and improve control process.

Recommendation 5

State entities should consider the inclusion of names in instruments of delegation to facilitate identification of delegates.

1.3 Signature of approving or authorising officer

Overall, four transactions (less than 1% of the total tested) lacked signatures of approving or authorising officers. Manual signatures of approving or authorising officers may not always be found as approvals may be given by emails in which case they should be printed and kept on hand as evidence of authorisation. Alternatively, approval may be conducted electronically via the state government's payroll system (Empower) by an officer with appropriate delegation without any signature being required.

Recommendation 6

State entities should develop policies to address electronic approval of transactions and establish documented procedures to ensure compliance.

1.3.1 Name and position title of approving or authorising officer

To ensure that staff processing transactions can properly fulfil their duties, the name and position title of the approving or authorising officer must be evident particularly as signatures are sometimes hard to decipher. Our testing in 2006 showed 23% of sampled transactions did not bear the name of the approving or authorising officer and 20% did not show the position title.

Names of delegates approving transactions were subsequently confirmed at UTAS and TAFE by reference to ancillary documents described earlier.

Recommendation 7

State entities should ensure that names and position titles of approving or authorising officers are clearly shown on transaction documentation.

1.3.2 Transaction was within approved delegation limit

As well as considering appropriate authorisation, the original audit sampled entities' financial and HR transaction documents to determine whether staff were aware of authorisation limits and the responsibilities associated with them.

Testing conducted in 2006 indicated that not all staff authorising transactions were fully aware of their authorisation limits or the general responsibilities associated with a delegation. That finding led to the following recommendation.

Recommendation 8

Controls to ensure that delegated authorities are in accordance with State entities' delegation schedules should be strengthened to ensure compliance with delegated limits. Finance staff processing payments should ensure that transaction documents contain all of the information required in the agency's policy to ensure that authorising officers have the appropriate delegation.

As part of our follow-up audit, we retested a sample of financial transactions at those state entities where error rates had previously exceeded 5%. Table 1 compares the error rates for 2006 and 2008.

Table 1: Financial transaction within approved delegation limit: error rates

State entity	2006 Financial transactions	2008 Financial transactions
DEPHA	5.4%	2%
Justice	23.1%	0%
TAFE	10.4%	0%
Metro	2.9%	n/a
UTAS	1.7%	n/a
All	**9.5%**	**0.7%**

The reduction in error rates detected in financial transactions — evident in Table 1 — supported the conclusion that all entities had fully implemented Recommendation 8.

1.4 Monitoring and review of delegations

The audit revealed that state entities were reviewing their policies and instruments of delegation on a regular basis or as otherwise required and promulgating them to staff in a timely manner.

There was evidence that staff training on delegations was adequate to ensure that controls over delegations were upheld. However, Justice was the exception, where training provided to staff processing HR transactions was limited to induction processes on initial appointment.

Recommendation 9

State entities should ensure that all staff are given adequate training in the delegation process to enable delegates and staff processing transactions to be fully aware of their responsibilities in managing the delegation process.

1.5 Status of recommendations

Table 2 indicates the degree to which agencies have implemented the nine recommendations made in our original report.

Table 2: Delegations in government agencies — Degree of implementation of recommendations

Recommendations (abbreviated)		DEPHA	Justice	TAFE	Metro	UTAS*	ALL
1	Appropriate policies and procedures in place to manage financial delegation processes.	100%	0	100%	100%		**75%**
2	Policies and procedures to inform staff processing HR transactions of their responsibilities.	100%	100%	50%	100%		**88%**
3	Specimen signatures in instruments of delegation.	0	0	100%	100%		**50%**
4	Instruments of delegation are complete and include all functions subject to normal day-to-day processing .	100%	100%	100%	100%		**100%**
5	Include names in instruments of delegation to facilitate ID of delegates.	100%	100%	100%	0		**75%**
6	Develop policies to address electronic approval of transactions.	100%	50%	75%	100%		**81%**
7	Ensure names and position titles of approving or authorising officers are clearly shown.	75%	75%	75%	0		**56%**
8	Controls to ensure that delegated authorities are in accordance with agencies' delegation schedules should be strengthened.	100%	100%	100%	100%		**100%**
9	Staff are adequately trained in the delegation process.	75%	100%	100%	100%		**94%**
	Average degree of implementation	**83%**	**69%**	**89%**	**78%**		**80%**

* No specific actions were recommended for implementation at UTAS and it was not included in this follow-up audit.

1.6 Conclusion

Justice indicated the department had not yet implemented Recommendation 1. However we were advised that policies and procedures to manage financial delegation processes would be developed as part of a review of the accounting manual.

With respect to Recommendation 6, TAFE and Justice both indicated that electronic approval processes were being developed and would help overcome the audit findings made in 2006.

Justice, DEPHA and TAFE indicated Recommendation 7 had been implemented to 75%. Continued improvement was predicted at each agency, facilitated by use of a rubber stamp requiring details to be provided by officers as they authorised transactions.

DEPHA indicated partial implementation of Recommendation 9 since specific training courses had not been conducted across the department. While Metro had not implemented Recommendations 5 and 7 to date, in the course of the follow-up audit it indicated that it would reconsider those recommendations. Neither DEPHA nor Justice supported Recommendation 3.

This Report determined that the overall implementation level of the recommendations was 80%.

1.7 Management response to the follow-up audit

Metro management was supportive of the recommendations from the 2006 audit. Metro has achieved a high degree of implementation of the recommendations, with the exception of recommendations 5 & 7. On reflection, these recommendations together represent a small process change to introduce 'stamps' that include names and position titles of approving officers. Metro is committed to continuous review and improvement of processes and procedures and finance staff will once again review this recommendation with a view to introducing this measure shortly which will then result in 100% achievement of the recommendations.

Overall management concurs with the assessment of the degree of implementation of all recommendations by the auditors as outlined in Table 2.

TAFE Tasmania considered these reviews valuable and whilst TAFE ceased to exist from 31 December 2008 the results of the follow-up audit will be progressed as part of the establishment of Shared Services in the Tasmanian Polytechnic.

The Department of Justice (Justice) notes the recommendations made within the report and plans to implement associated policies and procedures where they relate to this agency and will be incorporated as part of the current review of the accounting manual.

Recommendation 3 proposes that specimen signatures be included in instruments of delegation to facilitate the identification of approving officers. Justice does not propose to implement this recommendation due to the administrative costs of maintaining specimen signatures in the instruments of delegation.

DEPHA maintains its previous position on Recommendation 3 in that it has not, and does not intend to, include specimen signatures in instruments of delegations. The risk of a transaction being inappropriately authorised is adequately mitigated by the existing control of requiring an officer's position, name and signature to be included when authorising a payment. In addition, where an officer's signature is not readily recognised, appropriate enquiries are made to substantiate his/her identity, before a transaction is approved. These controls are supplemented by automatic transaction reports sent to Project Managers on a monthly basis for their review. To review signatures back to a specimen list would also have resource implications.

In relation to Recommendation 7 DEPHA encourages the use of a stamp to identify the name and position title of an officer authorising an accounts payable transaction. This occurs in the majority of cases and continues to be encouraged where it is not. In cases where an approving officer's name and position title is not recorded, the identity of the approving officer is established, before an account payment is made.

In relation to Recommendation 9 DEPHA provides training as follows:

- Operational staff within Human Resources and the Finance Branch are provided with specific training to enable them to competently perform their roles;
- As part of the induction process for new employees, a summary of requirements in respect of delegations of authority is outlined; and
- Further training is provided on an 'as needed basis', where issues are noted and resolved as part of payment review processes.

With a general level of satisfaction with the compliance process, DEPHA will continue with the combination of the training elements above.

This page left blank intentionally

2 Local government delegations

2 Local government delegations

The 2006 report

The administration of local government by councils is governed by the *Local Government Act 1993* (LGA or the Act). The Act specifies the powers of authority that can or cannot be delegated to council General Managers (GMs) or council committees, in order to manage council affairs. Under the Act delegations must be in writing and supported by documented policies and procedures to manage the delegations.

The 2006 audit looked at compliance with the LGA by examining the contents of instruments of delegation, supporting policies and procedures and transaction approval processes.

The objectives of the 2006 audit were to:

- assess the level of compliance with the relevant sections of the *Local Government Act 1993* (LGA)
- identify weaknesses and recommend improvements as necessary to current processes
- establish whether councils are setting expenditure or investment limits in the delegation process
- ensure that the appropriate delegated authorities are in place for writing off of bad debts and also for approving community grants
- determine the level of awareness and compliance by local government and report accordingly.

The scope of the audit was limited to the following local government councils:

- Brighton Council (Brighton)
- Burnie City Council (Burnie)
- Clarence City Council (Clarence)
- Derwent Valley Council (Derwent Valley)
- Dorset Council (Dorset)
- Huon Valley Council (Huon Valley)
- King Island Council (King Island)
- Southern Midlands Council (Southern Midlands)
- West Coast Council (West Coast).

The original audit reviewed financial transactions in the period April to July 2005.

To achieve the 2006 audit objective, we developed the following audit criteria:

- adequacy of councils' policies and procedures for managing delegations
- appropriate instruments of delegation exist to support the policies and procedures
- awareness by key personnel of their delegations and related responsibilities
- authorisations in compliance with instruments of delegation and relevant council policies and procedures
- adequacy of agencies' monitoring and review of the delegations system.

The original report is summarised below, together with audit findings and the recommendations made at that time.

2.1 Adequate policies and procedures to manage delegations

The 2006 audit looked at the adequacy of council policies and procedures required to support the management of council delegations, in accordance with LGA.

Of the nine councils reviewed, two (West Coast and King Island) did not have written policies or procedures in place at the time of the original audit. Instead they relied directly on the provisions of the LGA to manage their delegation processes.

The seven remaining councils had documented policies and procedures relating to delegations, each of which complied with the Act. However, for the purpose of our testing, legislative compliance was the minimum standard and we considered documentation at some councils was incomplete.

Recommendation 1

Councils should ensure that appropriate documented policies and procedures are in place for the management of all delegations.

2.2 Instruments of delegation adequately supported

The 2006 audit of councils' instruments of delegation commenced with a review of council meeting minutes to ensure that the first step in the delegation process had been observed. The LGA requires that annual estimates of revenue and expenditure are approved by

councils and that the GM of each council has been delegated the power to manage those funds. We found that without exception, councils had appropriately fulfilled these obligations.

A number of examples of inappropriate delegations to the GM were detected at the time of the 2006 audit and reported to the councils concerned. These delegations related to:

- borrowings
- staff employment
- authorisations.

Recommendation 2

Councils should ensure that they adhere strictly to the provisions of the LGA in managing their delegations so as to ensure compliance with this Act.

2.2.1 Instruments of delegation

The 2006 audit included an examination of councils' instruments of delegation to assess whether:

- GMs had delegated powers to other officers in accordance with the Act
- instruments of delegation were current
- instruments of delegation contained monetary limits.

In 2006 we found that generally, GMs had delegated relevant financial and other functions to staff in accordance with the Act. Anomalies found in this regard included:

- one council did not have any delegations from its GM to staff
- one council had exercised delegations direct from council to staff
- one instrument of delegation empowered senior managers to delegate to other officers
- one set of delegation instruments that were in use had been made to a predecessor.

We were advised that each of these anomalies had been addressed by the time the 2006 audit was completed. There were no instances of delegations having been made without any monetary limits being attached. However, we found some instruments that contained delegation limits defined 'as per LGA'. We considered this too broad and that it exposed the council to a risk of inappropriate delegation being exercised.

Recommendation 3

Councils should ensure that instruments of delegation are clear and unambiguous so as to prevent exposure to possible risk of inappropriate delegations being exercised.

2.2.2 Name and position title of delegates

Council delegations are made to positions and not to individuals. Most of the councils audited were of the opinion that the names of delegates were not required in instruments of delegation. It is our view that the inclusion of delegates' names in instruments of delegation represented best practice and would enhance the transaction approval process.

Recommendation 4

Instruments of delegation should include the names of delegates so as to aid identification of approving or authorising officers and enhance the transaction approval process.

2.2.3 Specimen signatures of delegates

As instruments of delegation were made to positions and not to individuals, none had specimen signatures attached.

We considered that the inclusion of specimen signatures in instruments of delegation would greatly enhance the identification of approving or authorising officers.

Overall, we were satisfied that instruments of delegation adequately reflected the contents of councils' delegation policies and had been developed to identify, assess and manage risks relating to delegations.

Recommendation 5

The inclusion of specimen signatures in instruments of delegation would significantly enhance the identification of approving or authorising officers.

2.3 Authorisations comply with instruments of delegation

We tested a number of transactions to determine whether authorisations complied with instruments of delegation and to ascertain whether transactions were adequately supported by appropriate documentation.

Specifically, we tested the selected transactions against the following criteria:

- signature of approving or authorising officer
- name and position title of approving or authorising officer
- transaction was within approved delegation limit.

2.3.1 Signature of approving or authorising officer

All transactions tested carried the signature of an approving or authorising officer with delegated authority to do so.

2.3.2 Name and position title of approving or authorising officer

To ensure that staff processing transactions can properly fulfil their duties, the name and position title of the approving or authorising officer should be evident, particularly as signatures are often difficult to decipher.

In the majority of transactions tested, neither name nor position title of the approving or authorising officers was shown.

We understand that councils do not require these details to be shown on transaction documents when accounts are being approved for payment. Councils justified this viewpoint on the basis of the scale of their operations.

Recommendation 6

Transaction documents being approved for payment should bear the name and position title of approving or authorising officers to facilitate processing.

2.3.3 Transactions were within approved delegation limit

We were unable to confirm that all payments had been approved by authorising officers acting within their delegated limits. The practice in many councils to link authorisations to approved budget levels made it difficult to test whether each individual payment had been appropriately approved by authorising officers within their delegated limit. Some test results suggested up to 82% of one council's transactions had not been supported by current delegation instruments.

At the three councils where we were able to fully apply the 2006 testing we found 15 transactions (3.3% of the total tested for all councils), had been inappropriately approved. Of that total, 11

transactions related to one example of inappropriate delegations. The remaining four breaches were considered to be immaterial.

Other delegated limits are imposed via the LGA and by councils' own policies. These included the write-off of bad debts and approval of community grants and tenders. Our testing revealed that these policies were being complied with.

Recommendation 7

Councils should ensure delegates properly approve all transactions within their approved limits.

2.4 Status of recommendations

The seven recommendations from the original report are summarised in Table 3, which also rates as a percentage the extent to which they have been implemented.

Table 3: Local government delegations — Degree of implementation of recommendations

	Recommendations (abbreviated)	Brighton	Burnie	Clarence	Derwent Valley	Dorset	Huon	King Island	Southern Midlands	West Coast	All Councils
1	… documented policies and procedures	100	100	100	0	100	100	0	100	100	**78%**
2	… instruments of delegation comply with LGA	100	100	100	0	100	100	0	100	100	**78%**
3	… instruments of delegation are clear and unambiguous	100	100	100	100	100	100	100	100	100	**100%**
4	… instruments of delegation include delegates names	25	25	25	25	0	0	0	100	100	**33%**
5	… instruments of delegation include specimen signatures	0	0	0	0	0	0	0	0	100	**11%**
6	…transaction documents bear authorising officer's name and position title	50	0	0	50	25	50	0	0	50	**25%**
7	… delegates properly approve all transactions	100	100	100	100	100	100	100	100	100	**100%**

	Average degree of implementation	**68%**	**61%**	**61%**	**39%**	**61%**	**64%**	**29%**	**71%**	**93%**	**61%**

2.5 Conclusion

All nine of the councils involved in the audit had fully implemented Recommendations 3 and 7. Seven councils had also fully implemented Recommendations 1 and 2. Most of the councils involved in the audit had not implemented Recommendations 4, 5 or 6 and indicated that to do so would be administratively burdensome.

While we recognise that including delegates' names and specimen signatures in each instrument of delegation would require administrative resources we maintain that implementation of these recommendations would provide the most robust system controls. We also continue to maintain that transaction documents being approved for payment should bear the name and position title of approving or authorising officers to facilitate processing controls.

This Report determined that the overall implementation level of the recommendations was only 61%.

2.6 Management response to the follow-up audit

The Southern Midlands Council (SMC) — acknowledges the findings as reported in the 'Follow-up of the Local Government Delegations Report', and in particular the degree that the recommendations contained in the original report has been implemented (as summarised in Table 3). SMC will progress implementation of the remaining two recommendations.

Derwent Valley Council — During an audit of delegations by the Auditor-General it came to Council's attention that a delegation to the Mayor to approve grants up to $100 did not comply with the Local Government Act 1993 as the Act does not make provision of delegation to an Elected Member.
At an ordinary meeting held in February 2009 Council corrected its previous decision authorising the Mayor to approve donations by delegating to the General Manager the authority to make public donations up to and including $100. Council also adopted a Donations Policy for the management of the delegation.

King Island Council — Recommendation 1 — Document policies for delegations, will be followed up and initiated
Recommendation 2 — Borrowings will be removed from instrument of delegation
Recommendation 4 — Delegate's names will not be included in instruments of delegations as this means every time there is a change of personnel we need to change delegations

Recommendation 5 — Delegation to include specimen signatures — No, as per response to Recommendation 4 above
Recommendation 6 — Transaction documents to bear officers name and title — stamp will be created and stamped on all documents before authorizing.

Burnie City Council — does not support Recommendations 4 and 5. Delegations do include names where required by law. Other delegations are position based and it is not considered warranted to include specific names as this will add a administrative burden for no demonstrable benefit. If names are not generally included as contended above, the issue of including specimen signatures is not relevant.
Although recommendation 6 has not been implemented to date, on balance, it is understood that this does improve control over the proper authorisation of transaction documents under the purchasing delegation. Burnie City Council intends to implement this recommendation in due course in preference to recommendations 4 and 5.

All of the other councils involved in the audit accepted the report, indicated their satisfaction with the report or had no further comments to make on the recommendations.

This page left blank intentionally

3 Overseas travel

3 Overseas travel

The 2006 report

The objectives of the 2006 *Overseas travel* audit were to:

- review individual departments' policies for compliance with Department of Premier and Cabinet (DPAC) policy
- assess the adequacy of documents supporting requests for overseas travel
- examine departments' records relating to individual requests for overseas travel
- test whether departments' overseas travel reports to DPAC were accurate and timely.

The audit covered overseas travel in the 2004–05 financial year and involved a review of policies and procedures used in the following departments:

- Economic Development and Tourism (DEDT) formerly Economic Development (DED)
- Infrastructure, Energy and Resources (DIER)
- Justice
- Primary Industries and Water (DPIW) formerly Primary Industries, Water and Environment (DPIWE)
- Environment, Parks, Heritage and the Arts (DEPHA) formerly Tourism, Parks, Heritage and the Arts (DTPHA)
- DPAC.

The next sections of this Chapter outline the original report together with audit findings and recommendations made at that time.

3.1 Introduction

DPAC is responsible for overseas travel policy. The DPAC policy draws attention to measures aimed at protecting employee safety and ensuring that the state government receives the best value for money for travel undertaken.

Until July 2004, all requests for overseas travel by government departments had to be approved by the Premier. A change of policy from 1 August 2004 enabled Ministers to authorise overseas travel.

In line with policy objectives, requests for overseas travel must include written evidence that the officer has viewed the website of the Commonwealth Department of Foreign Affairs and Trade

(DFAT) to check any travel warnings for the intended destination. Ministers are required to be aware of any perceived risk to either the officer or the state from either a security or health perspective.

Officers planning to travel must prepare a report of their intended travel arrangements and forward it to the Minister for approval through their Head of Agency.

To maintain a comprehensive record of all approved overseas travel, departments are required to submit monthly reports to DPAC for inclusion in a consolidated report to the Premier. Departmental reports are due by the end of the first week of each month and must include:

- employee name(s) and position(s)
- department(s)
- country(ies) of destination
- purpose of travel
- dates of travel
- overall costs
- source of funds.

Departments should have their own policies to manage overseas travel requests that accord with DPAC policy. In the absence of such in-house policies, departments should at least ensure compliance with DPAC's policy.

3.2 Adequacy of departments' policies and procedures

In 2006, we tested to determine whether departments had issued policies on, and procedures for, managing overseas travel requests or had adopted DPAC's policy as their own. In the event that they had their own policies, we tested to ensure the level of compliance with the DPAC policy.

At the time of the original audit, all five departments had their own policies and procedures on overseas travel, all of which differed from the DPAC policy.

Three departments had included additional requirements that we considered better practice:

- DED's policy required overseas travellers to submit a report following their overseas travel to their Minister within eight weeks.
- DTPHA's policy required overseas travellers to:

  - present applications to the Minister's office at least four weeks prior to the expected departure date
  - review the DFAT website a second time, one week prior to departure, and submit a second signed *Acknowledgement of Travel Warning Advice* to their manager
  - forward a trip report within one month of return through their Minister to DPAC.

- DIER's policy also required overseas travellers to review the DFAT website to assess risks of destinations and resubmit another signed *Acknowledgement of Travel Warning Advice* to the Secretary one week prior to departure.

Two departments did not fully comply:

- Justice's policy required statutory body staff (e.g. the Ombudsman and the Director of Public Prosecutions) to forward travel requests direct to the Minister and not through the Head of Agency. Details of these travel arrangements were not always being advised to DPAC. This was of concern as the state government has an obvious duty of care, for safety reasons, to know where employees are at any time when they are on government business overseas. This was especially important when the classification of normally "safe" destinations could be changed unexpectedly. However, we were of the view that statutory office holders (as opposed to any state servants that might be assigned to their office) could not be bound by such procedural policies.
- DPIWE's policy did not require travellers to forward a report on their overseas travel; but this has been amended since our audit.

3.3 Compliance with DPAC policy

To determine whether travel requests had been submitted in accordance with the DPAC policy, we tested to ensure that:

- intending travellers had viewed the DFAT website and assessed the possible travel risks
- a report of the intending travel had been submitted to and approved by Head of Agency
- travel requests had been approved by the relevant Minister.

Four of the five departments satisfied the above tests. DTPHA could not supply evidence that intending travellers had viewed the DFAT website in three of nine cases tested.

3.4 Submission of reports on completed trips

DPAC policy obliges all overseas travellers to forward a report through their Minister on return but does not stipulate any time frame.

All departments' policies, except DPIWE's, required travellers to submit such reports. DIER's policy allowed for overseas attendance at routine meetings to be supported by the submission of an agenda and meeting notes in lieu of a report.

Only two departments stipulated a time frame in their policies for the submission of trip reports. Our testing found one of five reports at DTPHA and five of 14 reports at DED were late.

3.5 Appropriate approval of overseas travel

We tested from the general ledger (or other departmental records where the general ledger was not suitable for our purposes) to ensure that all overseas travel complied with DPAC policy. We noted no irregularities.

3.6 Recommendations

In 2006, we found not all departments' overseas travel policies complied fully with the requirements of the DPAC overseas travel policy, whilst some policies exceeded those requirements. To ensure all departments adopted better practice, we recommended the following changes be made to DPAC's policy.

Recommendation 1

Overseas travel applications requiring the Minister's approval should be presented to the Minister's office at least four weeks prior to departure, except in exceptional circumstances.

Recommendation 2

The Commonwealth's DFAT website should be re-visited again one week prior to travel where the proposed destination is considered to not be a 'safe' destination. The Head of Agency should re-endorse his or her support for the application.

Recommendation 3

A trip report should be provided to Ministers via the Head of Agency with copy to DPAC within one month of the applicant's return to work unless the overseas travel was for attendance at a routine conference.

Recommendation 4

Details of all approved overseas travel by employees and officers of state Service agencies and associated statutory authorities, and statutory office holders engaged in government business should be notified to DPAC prior to travel so as to ensure a record of all overseas travel is maintained centrally.

3.7 Status of recommendations

The four recommendations reviewed in this Report are listed below in Table 3 using the recommendation numbers from the original report.

Table 4: Overseas travel — Degree of implementation of recommendations

Recommendations (abbreviated)		Degree of implementation
1	Overseas travel applications requiring the Minister's approval should be presented to the Minister's office at least four weeks prior to departure, except in exceptional circumstances.	100%
2	The Commonwealth's DFAT website should be re-visited again one week prior to travel where the proposed destination is considered to not be a 'safe' destination. The Head of Agency should re-endorse his or her support for the application.	100%
3	A trip report should be provided to Ministers via the Head of Agency with copy to DPAC within one month of the applicant's return to work unless the overseas travel was for attendance at a routine conference.	100%
4	Details of all approved overseas travel by employees and officers of state Service agencies and associated statutory authorities, and statutory office holders engaged in government business should be notified to DPAC prior to travel so as to ensure a record of all overseas travel is maintained centrally.	100%
	Average degree of implementation	**100%**

3.8 Conclusion

We found the DPAC policy had been updated to fully implement recommendations made in the 2006 report. Each of the client agencies involved in the original audit also provided copies of their overseas travel policies, except Justice where the DPAC policy is used directly. Each of the auditees' policies had also been updated to demonstrate 100% support of the implementation of the recommendations.

3.9 Management response to the follow-up audit

The Department of Infrastructure, Energy and Resources (DIER) complied with three of the four recommendations at the time of the initial audit and supported the remaining recommendation. It is

pleasing to note that this follow-up audit report records full compliance by DIER with all recommendations.

All of the other agencies involved in the audit accepted the report, indicated their satisfaction with the report or had no further comments to make on the recommendations.

4 Building security

4 Building security

The 2006 report

The objective of the 2006 *Building security* audit was to: 'ascertain whether agencies had adequate physical security procedures in place to meet their requirements'.

We focused on administrative buildings (rather than public access facilities) at four government departments, namely:

- DPAC
- Justice
- DPIW
- DIER.

To support the objective, we applied the following audit criteria to determine whether departments had:

- undertaken a security risk analysis to identify risks and vulnerability
- restricted physical access to buildings or, in the case of areas subject to access by the general public, appropriately controlled access
- maintained the security environment by
  - issuing policies and guidelines
  - allocating security responsibilities
  - implementing specific security measures
- kept tabs on crime through
  - adequate record keeping
- regularly reviewed and monitored security breaches.

The following sections of this Chapter examine the 2006 recommendations together with the degree to which they have been implemented.

4.1 Security risk analysis

As part of their overall risk strategy, departments should assess any potential risks to the general security environment in which they operate. Standards Australia provides an essential tool for undertaking general risk analysis that can easily be applied to security management[4]. We tested to determine whether departments had undertaken a security risk analysis to identify risks and vulnerability. We commenced by issuing a questionnaire to each department under review to ascertain the current status of their security profile.

Not all of the departments we reviewed had initially adopted a security risk analysis such as that proposed by Standards Australia. DPAC, DIER and DPIWE had earlier utilised the services of the Department of Police and Public Safety (DPPS, now Department of Police and Emergency Management) to do a security audit of their major buildings as the starting point for their security assessment. A DPPS report noted that:

> It would be appropriate … to consider the recommendations, arising from this audit, and undertake a security risk review to analyse and assess the risks faced.

Similarly, DIER had used a private security firm to conduct a risk assessment that included a risk analysis procedure. A number of recommendations had resulted from those respective reports, many of which the departments concerned subsequently adopted.

DPAC and DIER had conducted risk profile analyses to develop their risk management processes.

Risk assessments can rapidly date as circumstances change and should be updated regularly. Examples of changes in departments' security environments that have prompted review included:

- refurbishment of accommodation areas within buildings
- relocation to another site
- changed use of an area (e.g. from one with no public access requirements to one requiring a significant amount of public access)
- actual security breaches.

The above-mentioned DPPS reviews had been undertaken as early as 2002 and security arrangements in three departments had been subject to subsequent on-going review. However, we found that some of these late reviews had been more ad hoc than systematic.

4 Australian/New Zealand Standard *Risk Management* AS/NZS 4360

Recommendation 1

Agencies should undertake comprehensive security risk assessments and ensure that they are regularly reviewed and kept up-to-date.

4.2 Maintenance of security environment

Policies and guidelines can link risk assessments to the development of appropriate and cost effective security measures. However, to be effective, policies and guidelines need to be concise, unambiguous and readily available to all staff to ensure that they are appropriately understood and implemented.

Only two departments, DPAC and DIER, had documented security policies covering all of the buildings that they occupied. At the other two departments, documentation varied significantly:

- DPIWE did not have a security policy as such but there were comprehensive procedures covering a number of security matters available to all staff via its Intranet. We were advised at the time of our audit that the department was considering establishing a security policy.
- Justice did not have any agency-wide documented security policies and procedures, but we were advised that they did exist for some of the department's sites. However, the department did not have any procedures for the two buildings that we reviewed where, at time of audit, it had sole occupancy. Security documentation relating to another major building managed by the department was sighted.

Recommendation 2

Agencies should develop security policies and guidelines on an agency-wide basis to deal with assessed risks covering all of the sites they occupy to ensure the most appropriate and cost effective security measures are implemented.

To gauge the effectiveness with which departments' policies and guidelines had been implemented, we interviewed staff at a number of sites and were disturbed by the results. Some examples of our findings included:

- lack of training in security matters generally, other than normal induction processes
- lack of awareness of security policies and guidelines generally, and of procedures for dealing with threats, particularly those made by telephone (e.g. bomb threats)

- unsure of action to be taken (or inconsistent action taken) in the event of a security breach
- reluctance, or lack of awareness, by staff to challenge unbadged visitors
- lack of awareness of name of fire wardens or evacuation procedures together with infrequent conduct of fire evacuation drills.

We observed that it was normal practice for departments to make policies and guidelines available to staff via the Intranet. However, little attempt appears to be made beyond that to ensure staff awareness. It is our view that departments must do more to ensure that all staff are conscious of and comply with those policies and guidelines. There is a need to broaden induction procedures for new staff to include more detailed security measures. There should also be regular and planned information sessions to keep staff up-to-date.

Recommendation 3

Agencies should ensure that details of security policies and guidelines are effectively communicated to staff and that appropriate procedures are in place to keep staff up-to-date.

We also tested to ensure that security responsibilities had been allocated or delegated to relevant senior staff to ensure that agreed security measures, once implemented, were being adequately maintained. We found this to be so, but it varied. There were parallels between the level and complexity of policy documentation and the extent to which security duties were allocated to staff. We considered that security responsibilities should be detailed in security policies and be allocated to staff at all levels of the organisation. Examples should include:

- general duties with which all staff must comply
- specific duties assigned to
  - supervisors
  - reception or security officers
  - departmental or floor managers
  - building managers
  - general management.

Recommendation 4

Agencies should ensure that security responsibilities are clearly defined and allocated appropriately so that security measures, once implemented, are satisfactorily maintained.

4.3 Security breaches

Analysing and using feedback from security breaches is essential to sound security management. Unfortunately, many breaches go unreported because they may be considered insignificant.

We tested to determine the extent to which security breaches were being reported, whether incident responses were appropriate and whether adequate records were maintained.

We found that documented procedures for reporting and recording incidents were present in three of the four departments but to varying degrees:

- DPAC and DIER security policies required incident report forms to be completed and outcomes recorded in a register.
- Justice claimed to follow similar procedures but they were not documented.
- DPIWE advised us that a system of formal reporting and recording of incidents was under consideration.

Recommendation 5

Agencies should implement systems to ensure that all security breaches are reported and appropriate action is taken and details are recorded in a register for review purposes.

During the audit, we found little evidence of any special training for staff whose workplace or role could be reasonably considered to expose them to significant risk, particularly in areas where difficult or unpleasant encounters may occur. We were concerned that staff at one department expressed the view that they had sufficient experience to equip them to handle any difficult situation with which they may be confronted and that special training was not required. However, staff in other departments held a contrary view, maintaining they were not adequately prepared for such situations. Frontline staff should be properly trained so that there is a consistent approach with customers and to give staff the assurance that they are suitably skilled to fulfil their duties.

Recommendation 6

Staff whose normal work exposes them to significant potential risk should be suitably trained to deal with situations that could arise.

4.4 Review and monitoring

Regular monitoring and review of security arrangements provide feedback on the effectiveness of security measures. We tested to ascertain whether departments undertook such reviews.

Evidence was lacking and we were therefore unable to determine whether departments had adopted a system of regular review of security arrangements. On the other hand, we were satisfied that DPAC and DIER had recently reviewed their security policies and updated their procedures. DPIWE had also updated its procedures and indicated to us that it was considering introducing a security policy.

We consider security committees as the best way to ensure that security arrangements are regularly reviewed. Alternatively, the assigning of specific security-related matters to an existing committee could be acceptable for smaller departments.

Recommendation 7

Agencies should undertake regular monitoring and review of their security procedures to ensure that adopted security measures are working as intended and to know when a risk assessment requires review.

4.5 Status of recommendations

The seven recommendations reviewed in this Report are listed in Table 5 below using the recommendation numbers from the original report.

Table 5: Building security — Degree of implementation of recommendations

Recommendations (abbreviated)		DIER	DPAC	DPIW	Justice	All
1	… regular review of comprehensive security risk assessments	100%	100%	75%	50%	**81%**
2	… agency-wide security policies to deal with risks and effective security measures	100%	100%	75%	50%	**81%**
3	… security policies and guidelines effectively communicated to staff	100%	100%	75%	50%	**81%**
4	… security responsibilities clearly defined, allocated and maintained	100%	100%	75%	50%	**81%**
5	… security breaches are reported, action is taken and details are recorded for review	100%	100%	75%	50%	**81%**
6	Staff whose work exposes them to risk trained to deal with situations	100%	100%	100%	100%	**100%**
7	… monitoring and review of security procedures to know measures work or need revising	100%	100%	75%	50%	**81%**
	Average degree of implementation	**100%**	**100%**	**79%**	**57%**	**84%**

DIER and DPAC fully implemented all the recommendations. Likewise, Recommendation 6 — that dealt with staff training — achieved a 100% level of implementation at all departments.

DPIW managed an implementation rate of 75% for the remaining recommendations. The department indicated that it was in the process of drafting a new physical security framework policy that should result in further implementation of the recommendations.

Justice indicated that its rate of implementation for the remaining recommendations was 50%. The department lacked an agency-wide building security policy or guidelines. However, it indicated that the majority of buildings that it occupied had emergency procedures in place that are carried out by designated personnel.

4.6 Conclusion

While building security at both DPIW and Justice still requires improvement, the majority of the recommendations made in the original *Building security* report have been implemented to a high degree. This Report determined that the overall implementation level of the recommendations was 84%.

4.7 Management response to the follow-up audit

The Department of Infrastructure, Energy and Resources (DIER) supported all of the recommendations in the original audit report and was compliant in a number of areas. It is satisfying to note full implementation by DIER of all of the recommendations.

The Department of Primary Industries and Water (DPIW) has made significant progress with the implementation of the noted recommendations. Our policies and procedures will be fully developed and implemented by the end of December 2009.

The Department of Justice (Justice) notes the recommendations made within the report and plans to implement associated policies and procedures where they relate to this agency.

In regard to Recommendation 2, it should be noted that Justice has a number of specific purpose sites with detailed security arrangements and policies in place. An agency-wide security policy covering general administrative sites is unlikely to be appropriate for these specific purpose sites both for operational reasons and because of the need to take account of the wishes of the independent entities such as courts and tribunals to which the agency provides support.

The Department of Premier and Cabinet (DPAC) agrees with the recommendations in the report.

This page left blank intentionally

5 Contracts appointing Global Value Management

5 Contracts appointing Global Value Management

The 2006 report

In February 2006, media speculation highlighted a potential conflict of interest in public bodies appointing a consulting company (Global Value Management Pty Ltd — GVM) part owned by the then Premier's brother.

We conducted an audit of procurement practices to verify compliance with Treasurer's Instructions (TIs), or equivalent, concerning:

- awarding of contracts
- payments to contractors
- disclosure of possible conflicts of interest.

The audit's scope included transactions during the period 2001 to May 2006 between GVM and the following entities with whom the company had had dealings:

- DIER
- Forestry Tasmania (government business enterprise)
- TOTE Tasmania Pty Ltd (state-owned corporation)
- Brighton Council
- Derwent Valley Council
- George Town Council.

To achieve the audit's objective, we applied the following criteria to determine whether:

- policy for dealing with conflicts of interest was adequate
- entities obtained value for money
- accounts for payment were properly processed
- Parliamentary disclosures complied with Tasmanian legislation and a comparison with the requirements in other jurisdictions.

The next sections of this Chapter briefly outline our original report together with audit findings and the recommendations.

5.1 Conflicts of interest — Brighton Council

At Brighton, we found that while the General Manager had disclosed his occasional business connection with GVM to the council, there should also have been an entry in Brighton's register

of interests. Public disclosure of his connection with GVM would have helped to counter perceptions of a lack of transparency in Brighton's dealings with the company.

Recommendation 1

The Brighton Council should review its engagement practices to ensure that all business decisions are open and transparent.

5.2 Value for money — George Town Council

At George Town, we found email records of contract discussions that had not been formalised by letters of engagement.

George Town was pivotal in initiating a $28 000 study concerning the pulp mill proposed for the Tamar Valley. The Council's approach was that the cost would be shared with neighbouring councils (namely West Tamar and Launceston) and the Department of Economic Development.

Council did not send a formal letter of engagement to GVM setting out what they were trying to achieve or the expected project outcomes. Instead, informal discussions were held and GVM was notified by email that council sign off was expected to occur in July 2005, although no confirmation of council approval was sent. Detailing expectations was important because it would have clearly defined the responsibilities of both parties in the engagement.

Recommendation 2

When engaging consultants following approval by council a formal letter of engagement should be sent detailing council requirements and expectations for the project.

5.3 Payments of accounts

5.3.1 DIER

DIER is required to follow TIs that apply to purchasing goods and services. Additionally, Treasury had also issued a *Procurement Practices Manual: Best Practice for the Engagement of Consultants* (procurement manual). The procurement manual should be used when departments undertake building construction projects above a capital value of $100 000.

Where the capital value of a project is less than $1 million (as was the case with DIER's projects), the procurement manual recommends the use of an expert drawn from a register of pre-qualified consultants. There were two pre-qualified consultants on the department's register: GVM and a Sydney-based firm.

DIER had procurement guidelines (issued August 2005) that rotated business between registered value management consultants. The underlying idea was to minimise costs to the department and ensure that more than one firm was registered. DIER intended to supplement the register by seeking biennially expressions of interest from suitably accredited providers. However, at the time of our audit this had not occurred.

Recommendation 3

DIER should ensure that expressions of interest for pre-qualification to the value management register are undertaken every two years.

5.3.2 Local government councils

In February 2005, the Derwent Valley Council and Maydena Community Development Association requested the Premier to provide a value management workshop to help in developing a community plan. The matter was referred to DIER to act as sponsor for the project and assist council to manage the project. The engagement and subsequent payment thus involved DIER and the council.

While council formally accepted GVM's quotation, DIER did not provide formal approval. Council paid GVM and successfully sought reimbursement ($26 265) from the department.

Recommendation 4

DIER should formally approve engagements where it is the sponsoring agency, rather than the contracting entity. Where the department is committed to reimbursement it should consider the contracting entity's terms of procurement when exercising such approvals.

5.4 Status of recommendations

The four recommendations reviewed in this Report are listed below in Table 6.

Table 6: Contracts appointing Global Value Management — Degree of implementation of recommendations

Recommendations		Degree of implementation
1	The Brighton Council should review its engagement practices to ensure that all business decisions are open and transparent.	100%
2	George Town Council — When engaging consultants, following approval by council, a formal letter of engagement should be sent detailing council requirements and expectations for the project.	75%
3	DIER should ensure that expressions of interest for pre-qualification to the value management register are undertaken every two years.	100%
4	DIER should formally approve engagements where it is the sponsoring agency, rather than the contracting entity. Where the department is committed to reimbursement it should consider the contracting entity's terms of procurement when exercising such approvals.	100%
	Average degree of implementation	**92**%

George Town indicated it had implemented its recommendation wherever practicable. The degree of outstanding implementation related to projects that had required some action before a formal letter of engagement could be delivered.

DIER indicated Recommendations 3 and 4 had been fully implemented. The department sought expressions of interest for its pre-qualified value management register in October 2008. Where DIER is the sponsoring agency, it now uses formal Deeds of Agreement with purchasing councils. The Deeds of Agreement are based on template documents prepared by Crown Law.

5.5 Conclusion

Three of the four recommendations made in the original report were fully implemented and the overall rate of implementation was 94%.

Enquires made to the Parliamentary clerks identified that there had been no changes made to the Tasmanian legislation, or the code of conduct for Members of Parliament, regarding the disclosure of family interests.

5.6 Management response to the follow-up audit

While the Department of Infrastructure, Energy and Resources (DIER) had sound practices in place before the initial audit and supported the recommendations of that audit, is it pleasing to note full compliance by DIER with the recommendations.

Brighton and George Town Councils indicated satisfaction and accepted the report.

6 Elective surgery in public hospitals

6 Elective surgery in public hospitals

The 2006 report

Surgery can be either emergency or elective. The latter is defined as planned surgery for which, in the opinion of the treating specialist, admission can be delayed for at least 24 hours.

In the public system, elective surgery is largely confined to Tasmania's major public hospitals:

- Royal Hobart Hospital (RHH)
- Launceston General Hospital (LGH)
- Northwest Regional Hospital (NWRH).

Organisationally, these hospitals are part of the Department of Health and Human Services (DHHS).

The objectives of the original audit were to:

- examine the efficiency and effectiveness of the management of elective surgery by Tasmanian public sector hospitals
- assess whether management has set appropriate objectives, strategies, standards, and performance indicators
- assess the adequacy of measurement and reporting systems.

The scope was limited to:

- public hospitals and DHHS
- data in the period 2000 to 2006.

The audit excluded surgical procedures carried out in small district hospitals.

In support of the audit objectives, we applied the following criteria to the audit:

- was waiting list data accurate?
- were waiting times reasonable at
  - state-wide and hospital level?
  - speciality level?
- were hospital resources efficient and effective?
- did appropriate strategies and performance indicators exist to manage the elective surgery process?

The next sections of this Chapter briefly outline our 2006 report together with audit findings and the recommendations made at that time. In this Chapter we give the rate of implementation after the recommendations as well as providing a summary in Table 7. Updated data and graphs to illustrate the situation in 2008 follow Table 7.

6.1 Elective surgery processes

Access to elective surgery is managed via the elective surgery waiting list. The number of people being added to the waiting list in Tasmania is increasing. Hospital services are finite and patient needs vary from discomfort to life threatening, so the waiting list must be managed under a priority system rather than on a simple first-in, first-out basis.

Being on the waiting list is not like a delicatessen line where patients can be certain of their place in the queue. People on the waiting list that have been categorised by priority and are ready for care may in effect be 'queue jumped' as more urgent patients are added to the list.

To determine priorities for access to elective surgery services, specialists prioritise patients using a three-tiered national system:

- Category 1: Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.
- Category 2: Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency.
- Category 3: Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability and is unlikely to deteriorate quickly and which does not have the potential to become an emergency.

Specialists select patients from their own or pooled waiting lists based on priority, depending on the particular surgery required (complexity, length of procedure, training needs), availability of clinical staff, theatre use and individual hospital's policies and procedures.

Examining the waiting list will indicate how long patients have been on the list but it will not show how long they are likely to continue to wait. We calculated expected waiting times using the rate of removals and the balance of patients ready for care. Our estimate of

total waiting time included time already waited plus expected remaining time before surgery.

6.2 Accuracy of hospital waiting lists

At the time of our audit, hospitals had a management information system (HOMER) for all facets of hospital administration including elective surgery.

Waiting time for elective surgery commenced when the relevant hospital created a record in HOMER following diagnosis of the patient by a specialist.

6.2.1 Hospital data input — accuracy

A number of factors influence accuracy of hospital waiting list data including:

- delayed input of admission forms
- postponed patients not being reinstated on the waiting list
- incorrect data entry (e.g. not removing admitted patients from waiting lists)
- lack of confidence in using data from other hospitals.

Incomplete or inaccurate admission forms can affect the accuracy of waiting list data. We noted an example at NWRH Burnie where specialists had failed to indicate patients' categories on booking forms. Consequently, rather than referring the forms back to the specialists, administrative staff entered the unmarked bookings as Category 3. While patient selection for surgery was not affected (because specialists prepare and prioritise their own theatre listings) waiting list data was distorted.

Such problems arose from deficiencies in user documentation and training of HOMER operators.

Recommendation 1

The department should review user documentation and training methods to ensure operators are able to accurately and consistently perform data input across all campuses.

6.2.2 System limitations with HOMER

A major difficulty imposed by HOMER was data capture and reporting. Due to its age, much of the system documentation and knowledge had been lost with the result that many workarounds had been developed to meet contemporary needs. Data gathering was sometimes based on manual collection and collation that was time

consuming and inflexible compared to computer-based record keeping.

Reporting at a hospital and state level was restricted by system limitations inherent in HOMER. Its replacement was being developed at the time of the original audit and there was an urgent need for the new system to incorporate contemporary hospital practices and capabilities for national reporting.

Recommendation 2

DHHS should ensure that HOMER's replacement incorporates sophisticated and flexible data management that would also support national reporting.

Recommendations 1 and 2 had been implemented to 50%. This indication reflected work in progress on a new state-wide Patient Administration System (PAS) project implementation of which commenced at the beginning of 2009. The target date for PAS to be fully operational was the end of 2009.

6.3 Overall performance

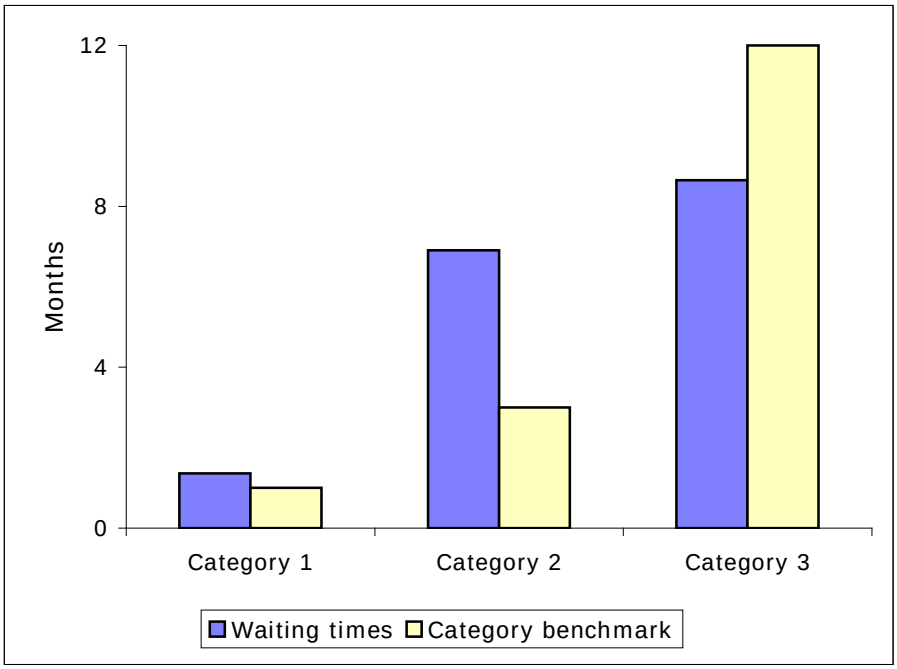
6.3.1 Performance by category

As explained in Section 6.1, national clinical guidelines dictate treatment benchmarks for the three patient categories. We calculated the amount of time that a patient on the waiting list would expect to wait based on current performance[5].

Figure 1 indicates the situation at June 2005. Category 1 and Category 2 patients could expect to wait more than the desired clinical timeframe while Category 3 patients could expect to wait less than 12 months before removal from the waiting list.

[5] We calculated expected waiting times by dividing the number of people on the waiting list on 30 June 2005 (RFC), by the average monthly removals over the previous 12 months. RFC and Removals data used in our calculations were provided by DHHS.

Figure 1: Expected waiting times to benchmark by category at June 2005



Our expectation was that hospitals would give similar emphasis to achieving the benchmark for all three categories. At first glance, the better results for Category 3 compared to the other categories might appear to indicate ineffective prioritisation. However, the good performance for Category 3 patients does not necessarily indicate that they received operations. Other reasons could account for a patient's removal from the waiting list such as:

- admission as an emergency case
- transfer to another specialist's list
- reassessment that an operation was no longer required
- death
- having the operation performed elsewhere
- not being contactable when reviewed.

Anticipated waiting time was also affected by the rate at which additions were made to the list. Between 2001 and 2005, Category 1 additions increased at three times the rate of Category 3 as noted below:

- Category 1 increased 16%
- Category 2 by 12%
- Category 3 by 5%.

The relative decline in Category 3 patients when compared to the other categories may be explained by:

- delays in obtaining an initial consultation at outpatient clinics
- patients choosing not to be included on the waiting list because of awareness of lengthy delays
- surgeons deliberately misusing the categorisation system in order to improve patients' chances of surgery.

Our analysis showed that, on average, a proportion of Category 1 and 2 patients could expect to wait longer than the benchmarks (i.e. 30 or 90 days respectively). Demand from both categories increased by more than 10% between 2001 and 2005. Category 3 expected average waiting times appear to be better than the benchmark. However, such an interpretation may be misleading as other factors affect the number of new additions to the list. Individual waiting times for patients varied depending on the hospital and specialty.

Recommendation 3

The department should actively promote consistent and accurate priority classification information to HOMER to facilitate better decision-making and reporting.

Recommendation 3 had only been implemented to 25%. In 2008 DHHS developed the Tasmanian Elective Surgery Improvement Plan (TESIP). The plan has a two-year implementation schedule and further progress on this recommendation is likely.
An update of Figure 1 is provided in Section 6.8 (See Figure 2).

6.3.2 Performance by resource

Initially, we wanted to determine if there were sufficient operating theatres and, if not, whether shortages of other resources (e.g. specialists, nurses, beds) were causing bottlenecks.

6.3.2.1 Operating theatres

In Australia, operating theatre usage is typically restricted to a maximum of eight hours per day. Using the practical capacity of operating theatres and usage data, we set a theoretical benchmark for reasonable usage at 7 hours. We found the average daily usage was less than six hours at each hospital and at Burnie less than four hours per day.

Recommendation 4

Management should set benchmarks for theatre usage and regularly assess performance against those benchmarks. Decisions about resources should be based on such assessments.

See follow-up comment after Recommendation 5.

6.3.2.2 Reasons for under-usage

We tried to determine why some operating theatre sessions had not been used. Possible reasons included:

- beds not available
- lack of theatre nurses
- patient no-shows
- lack of specialists or anaesthetists
- equipment failure.

We found that reasons for non-use of operating theatre sessions were not recorded, and that no such information was routinely collected or made available to hospital or departmental management. In our opinion, this information is essential to making informed decisions about resources.

Recommendation 5

Hospitals should record the reason for any downtime in operating theatres. Management should regularly review summary data as a basis for decisions about resource acquisition and allocation.

Recommendations 4 and 5 had been implemented to 50%. Explanations for gaps in theatre usage are targeted within TESIP but have not yet been completed.

6.3.3 Cancellations and postponements

Based on our review of a three-month sample period, cancellations and postponements caused by resource constraints accounted for just 1% of all patients booked for surgery. However, we were concerned at reports that in some cases communication problems between operating theatres and booking clerks had resulted in affected patients not being reinstated on the waiting list.

Recommendation 6

Hospitals should ensure that postponed patients are immediately reinstated on the waiting list.

Recommendation 6 had been fully implemented.

6.3.3.1 Effect of emergency admissions

Emergency admissions reduced the overall level of elective surgery by 2% in 2005 because of the conflicting need for theatres and staff[6].

In 2006, we noted that two new theatres were being built at the RHH and expressed some doubts at the need for them based on the current under-utilisation of the existing theatres. The new theatres, if separately staffed, had the potential to eliminate the 2% loss to elective surgery. However, the additional staffing might have had the same beneficial impact without the extra theatres. The LGH and NWRH also have programs to expand their theatre facilities.

Recommendation 7

DHHS should ensure that adequate resources are available to efficiently operate current and planned operating theatres.

Recommendation 7 had been implemented to 50%. TESIP includes strategies to achieve productivity gains.

6.3.3.2 No time or overruns

Postponements or cancellations due to no time or overruns can occur for the following reasons:

- operations run longer that anticipated
- waiting for a post-operative bed
- delays in waiting for equipment
- overbooking.

Often the abovementioned reasons for postponement were not easily identifiable from theatre lists. For example, waiting for a bed or equipment for an earlier patient may cause delays, ultimately resulting in a later theatre case being postponed for ‘no time’. Consequently, it is possible that resource-related postponements and cancellations were understated.

[6] Operating theatres are also used for diagnostic medical procedures (e.g. colonoscopy). We did not include medical case data in the scope of this audit.

Recommendation 8

Hospitals should record the underlying reasons for postponements and cancellations to enable efficiency gains to be made.

Recommendation 8 had been fully implemented.

6.3.4 Other efficiency issues

6.3.4.1 Perioperative review

In 2005, the RHH engaged consultants to review its perioperative services. In an interim report, the consultants suggested numerous changes to management practices and other processes including:

- application of good logistics management to ensure that all required equipment is available at the scheduled time
- scheduling short procedures first since they contain less inherent variability
- scheduling operating theatre time based on reliable historical data so that likely overruns by specific surgeon or procedure combinations are minimised
- reducing time needed between one operation and the next through better team work
- overlapping induction of anaesthesia allowing more intense scheduling of operations.[7]

The hospital has accepted the recommendations and has commenced implementation.

Recommendation 9

Recommendations from the *Perioperative Services Review Project* at the RHH should be considered for implementation at the LGH and NWRH.

Recommendation 9 had been fully implemented. Copies of the *Perioperative Services Review Project* were provided to LGH and NWRH for consideration.

6.3.4.2 Balancing short and long operations

Inevitably, some operations run over time and flexibility is necessary to cover such contingencies. Usually, operating theatres are available between 08:30 and 17:00 on weekdays. However, operating theatre nurses may be unable to stay later and if a session

[7] Wooles Group, 2005, *Perioperative Services Review Project: Royal Hobart Hospital 2005*, Melbourne.

appeared likely to over run due to a flow on from a previous operation, then the last-scheduled procedure could be postponed. As an example, if an operation were to be scheduled for two hours starting at 14:00 over ran to 16:30, an hour-long procedure booked for 16:00 would most likely be postponed to a later date.

In 2006, we observed implementation of recommendations made in the RHH perioperative review could increase operating theatre efficiency. One suggestion made in that report to overcome the problem highlighted above was the use of a scheduling screen so that surgical teams would be aware of the next case due and its timing implications. A further initiative that could be considered is some performance incentive to reward teams for productivity gains.

Recommendation 10

The department or hospitals should consider strategies to achieve productivity gains.

Recommendation 10 had been implemented to 50%. TESIP includes a strategy to reduce postponements.

6.4 Nurses

6.4.1 Background

Operating theatres cannot function properly without trained nurses. In this section, we investigate whether there were adequate numbers of theatre nurses and whether any shortages were disruptive to the supply of elective surgery.

6.4.2 Nurses — impact on elective surgery

We wanted to establish:

- staff numbers and how they had changed over time
- how staff numbers compared with establishment over time and whether periods of shortage had had an impact on elective surgery.

Unfortunately, we were unable to:

- obtain specific information about theatre nurses for any hospital except RHH
- get establishment data for the period for general or theatre nurses
- find management information about nurses.

Recommendation 11

Hospitals should periodically record more information about nursing numbers and vacancies to enable management to conduct longitudinal performance analysis.

Recommendation 11 had been fully implemented.

6.4.3 Benchmarking of theatre nurses

The number of theatres that can operate safely at any time is strongly linked to the staff establishment. A benchmarking exercise was attempted using a WA-based process called 'Nursing hours per patient day' (NHPPD). Although it was applied successfully to other parts of the hospital system, it could not be extended to theatre nurses.

An alternative benchmarking tool was proposed by the Australian College of Operating Room Nurses (ACORN) and has been successfully applied in NSW. An unofficial benchmarking exercise, using the ACORN benchmarking tool, was conducted at the LGH in late 2005 and indicated that the hospital needed 30% more theatre staff in order to effectively and efficiently operate all theatres. A similar exercise was not conducted at the other hospitals.

Official use of this model state-wide was delayed by attempts to use NHPPD. No action resulted from the LGH benchmarking exercise and as a result, the perception at the hospital level was of a lack of commitment to the process.

We have now been advised that a modified version of the ACORN model is to be used.

Recommendation 12

Benchmarking of operating theatre nurses should be completed as a matter of urgency to provide a basis for recruitment of additional staff.

Recommendation 12 had been fully implemented.

6.4.4 Nurses — recruitment

Before December 2004, hospitals had been critical that recruitment was excessively bureaucratic. Recent comments in the media have indicated that that perception persists despite action by management to streamline recruitment and transfer the process to the hospitals. Notwithstanding the negative perceptions, we found that the process was satisfactory.

Some hospital staff expressed the view that greater recruitment flexibility was needed to offer potential employees permanent

employment. Appointment in anticipation of an actual vacancy was one tactic in use at the RHH. This attracted job seekers considering relocation to Tasmania and had proven a useful recruiting tool.

Recommendation 13

To help secure new employees, LGH and NWRH should also consider recruiting nurses in anticipation of an actual vacancy.

DHHS advised Recommendation 13 was not suitable for implementation. Recruitment to vacancies at LGH or NWRH could not proceed without written confirmation of resignation.

Registered nurses are either recruited externally or begin their careers as students enrolled in the University of Tasmania nursing course. Often though, nurses with theatre experience are difficult to recruit. Usually, student nurses' exposure to operating theatres is brief — just three weeks — and comes at the end of their training when they are more focused on finishing their course rather than broadening their career options. Hospitals have graduate programs where nurses spend six months gaining experience in theatres. However, such on-the-job training of nurses places an extra strain on existing surgical resources.

Recommendation 14

DHHS should work with universities through graduate programs and other projects to develop pathways and experiences leading to an increased number of appropriately trained theatre nurses.

DHHS should explore the possibility of providing more in-house training in theatre nursing.

Recommendation 14 had been fully implemented.

To improve recruitment, the department has also used a *Re-entry to Practice* program as a way of attracting former nurses back to the profession, however for various reasons re-entry nurses are less likely to seek positions in operating theatres.

To relieve some of the duties of existing theatre nursing staff, two options that have been used interstate are:

- theatre technicians with specific technical skills
- expanded duties for enrolled nurses.

Recommendation 15

Hospitals should consider alternate workplace staffing to perform some nursing duties in operating theatres.

Recommendation 15 had been implemented to 25%. See Recommendation 17.

Another approach that could aid recruitment is flexibility in staff rostering. Fractional workloads (ranging from full-time work to one shift per week) maximise the availability of staff and can help to provide a balance for work and other life pressures. We noted that interstate hospitals support family-friendly initiatives such as on-site crèches or subsidised child-care for nurses that would make shift overruns less problematical.

Other possibilities that might be worth considering are earlier start times or introduction of night sessions, which may be preferable for some staff. We noted that Royal North Shore in NSW commences at 06:30.

Recommendation 16

Hospitals should look to maximise the flexibility of rostering arrangements and employment conditions.

Hospitals should consider the introduction of earlier start times or night theatre sessions.

Recommendation 16 had been fully implemented.

Another consideration concerning staffing of nurse positions was the age profile of the existing workforce. A survey[8] in 2001 found that 46% of nurses were over the age of 45. A wave of future retirements can be anticipated and replacement of those staff will be essential. While hospitals were aware of the situation formal planning should be undertaken to formulate strategies to cope with future nurse retirements.

Recommendation 17

Hospitals should introduce forward planning for theatre nursing staff.

Recommendations 15 and 17 had been implemented to 25%. Alternative workplace staffing and nursing staff levels were reviewed within the Operating *Suite Project* October 2006. Consultation relating to the development of a review of the nursing career structure in accordance with the requirements of the *Nurses (Tasmanian Public sector) Enterprise Agreement 2007* is set to commence in the first half of 2009.

[8] Department of Health and Human Services, 2001, *Final report of the Tasmanian Nurse Workforce Planning Project*, Hobart.

6.4.5 Nurses — retention

The 2006 report noted the connection between the nursing establishment and hospitals' capacity to treat elective patients was crucial. Retaining existing staff who are experienced and have demonstrated commitment has added importance in an environment where recruiting nurses is difficult. Hospital HR practices recognised staff retention and examples of initiatives already used were:

- flexibility in rostering
- opportunities to either:
  - stay in close knit teams
  - have job rotation through other theatre roles
- access to professional development with support for study time and fees.

In conjunction with the latter point, post-graduate course fees were paid by some mainland hospitals. Further, funding for initiatives such as bonding post-graduate students through the payment of HECS fees with stipend allocation may help to retain graduate nurses.

A role also exists for further developing HR management skills in nurse managers. Training in contemporary management techniques has shown some success in increasing awareness of improving workplace communications, dealing with performance management and injury prevention.

Recommendation 18

Hospitals should continue to develop HR strategies such as training (e.g. fees assistance, bonding of graduates, management training) or bonuses linked to high output to strengthen nurse retention.

Recommendation 18 had been implemented to 75%. Current industrial agreements and awards limit the scope for further implementation of this recommendation.

6.4.6 Nurses — exit interviews

One way of understanding the factors that drive staff turnover is to hold exit interviews with staff. When people leave an organisation, they are likely to be candid if asked about the reasons for their departure and to provide opinions about workplace problems and even suggest possible solutions.

We wanted to ascertain whether nurses who left the hospitals had received exit interviews. We found that only the Burnie campus of

the NWRH conducted exit interviews with exiting nurses. The department stated that it planned to develop an agency-wide exit interview procedure.

Recommendation 19

DHHS should develop and implement an agency-wide exit interview policy for nurses.

Recommendation 19 had been fully implemented.

6.5 Surgical specialists

6.5.1 Background

In the public system, there are staff specialists who are employees of the hospitals and visiting medical officers (VMOs) who are self-employed specialists contracted by hospitals. VMOs are paid on a sessional basis for a contract period. Treating patients is just one aspect of a specialists' work, research and teaching are also important components.

To retain accreditation status, hospitals need to maintain surgery levels consistent with standards prescribed by the various specialty colleges. If a loss of accreditation occurs, a hospital loses some of its attractiveness as a possible employer.

6.5.2 Medical specialists — impact on elective surgery

We were unable to obtain:

- establishment data over time
- actual specialist numbers over time.

Recommendation 20

Hospitals should periodically record more information about specialist and anaesthetist numbers and vacancies to enable management to conduct longitudinal performance analysis.

Recommendation 20 had been fully implemented.

6.5.3 Medical specialists — retention policies

Maintaining accreditation with the respective colleges affects the retention of medical specialists. Reduced access to operating theatres can lead to necessary volume and casemix not being achieved. As an example, increased Category 1 demand and a 50% reduction in theatre time at the RHH meant that, in at least one specialty, case mix was often sacrificed. Specialists believed the

threat of loss of accreditation was very real and that, if this were to occur, many specialists would seek positions in other accredited hospitals.

Recommendation 21

Adequate volume and casemix to maintain accreditation should be one factor considered when scheduling operating theatre time.

Recommendation 21 had been fully implemented.

6.5.4 Medical specialists — exit interviews

As discussed in regard to nurses, there is also a need for hospitals to routinely hold exit interviews with departing specialists. This can reduce the prevalence of such 'exit interviews' being conducted through the media with adverse impacts on the reputation of the hospital and staff morale.

Recommendation 22

DHHS should develop and implement an agency-wide exit interview policy for medical specialists.

Recommendation 22 had been fully implemented.

6.6 Equipment resources

6.6.1 Background

To avoid delays in elective surgery, theatre equipment must be available, reliable and properly maintained. Decisions about funding medical equipment are included in hospitals' budgeting processes. CEOs have the authority to purchase equipment up to $50 000 (previously $20 000) without reference to the department for approval.

6.6.2 Tendering process

At the time of the original audit all purchases over $50 000 had to be referred to the Contract Review Committee (CRC), comprised of senior DHHS staff. The CRC approved or declined proposals based on a business case submitted by the hospital. Acquisition and replacement of equipment could adversely affect elective surgery throughput if not handled efficiently. We reviewed the CRC process and found no significant delays between the preparation of the business case and approval. This suggested that business processes within the hospital were efficient. We estimated that on average a proposal took less than two weeks from completion until endorsement by the CRC.

However, based on a limited judgment sample examined, there appeared to be significant delays from the time a proposal received CRC endorsement until acceptance of tabled tenders. The following examples were noted:

- coagulation analyser: 224 days
- superficial x-ray therapy system: 217 days.

The CRC itself did not cause lengthy delays when considering business cases. Problems occurred in advertising the tender and in accepting tenders after they closed. There was scope for these timeframes to be reduced.

Recommendation 23

DHHS should review the equipment acquisition process between the initial time of approval by the CRC and completion of the tendering.

Recommendation 23 had been implemented to 50%. The department is currently reviewing the CRC role.

6.6.3 Funding replacement equipment

Hospitals track their medical assets and prioritise their replacement based on age and need. The Mersey campus of the NWRH faced a challenge from inheriting aging medical equipment from the previous private operator. To compensate for this, Mersey was allocated an additional $1 million by the government in its first year back within the public sector and additional funds over the next three years.

The LGH indicated that its annual budget for replacing items of equipment was $1 million. However, the list of required equipment was stated to be over $12 million. Accordingly, in the view of hospital management, equipment replacement was critical.

The RHH had an equipment register to track theatre equipment due for replacement. However, availability of funds was considered by management to be a limiting factor. The hospital had a detailed listing of $3 million worth of equipment that needed replacement.

Recommendation 24

Replacement of theatre equipment should be managed to avoid long-term problems.

Recommendation 24 had been implemented to 50%. As noted above, the department is currently reviewing the CRC role. Additionally, a new central Asset Management System is under development.

6.7 Performance management and reporting

6.7.1 Strategies and objectives

6.7.1.1 Departmental level

To ascertain whether the department had the correct strategic focus for elective surgery we examined strategies and plans that were in place. We found that the department has an elective surgery action plan that was broken down into nine specific focal points. We looked at the appropriateness of these and concluded that on the whole they were addressing the correct issues, though sometimes lacking in detail, for instance:

- theatre utilisation
- staffing issues
- bed management.

The intent of the elective surgery priority plan was to provide incentives to establish and extend access to elective surgical services across the state. Funding was used to boost existing levels of elective surgical services.

The hospital executive team meets monthly and elective surgery performance was a focus during 2005–06. Elective surgery is a standing item on the agenda and a monthly report provides summarised data relating to elective surgery including, performance for each hospital against targets, theatre throughput and numbers on the waiting list. While we were satisfied that the executive team was monitoring waiting list data, we could not be certain that they regularly referred back to the action plan to ascertain progress toward stated goals. In addition, as noted in section 6, insufficient information was provided to facilitate goal-orientated management of resources.

6.7.1.2 Hospital level

At the hospital level, only the RHH had a separate strategic plan for elective surgery. LGH and NWRH relied upon the departmental plan. Although the RHH plan was still being developed, it showed significant progress toward completion of key objectives, responsibilities and milestones. In addition, linkages were present between the RHH plan and the departmental plan.

Hospitals should develop their own strategic plans that operate at a lower level than the executive team plan. This would enable hospital managers to calibrate their operational objectives with those at the higher level.

Recommendation 25

All hospitals should develop strategic plans for elective surgery. Any plan developed should link back to the overall departmental strategic plan.

Recommendation 25 had been fully implemented.

6.7.2 Performance indicators

6.7.2.1 Information published by DHHS

DHHS publishes information in its annual report and on the website but the performance information is primarily qualitative in nature.

Quantitative data in the annual report was limited to:

- day surgery rate (elective)
  - day surgery does not tie up beds overnight and reduces the burden on hospitals but there is no comparison against an anticipated goal
- proportion of Category 1 patients admitted within 30 day target for elective surgery
  - does not consider those still waiting on the list or indicate how long patients for each specialty and urgency category can expect to wait.

Recommendation 26

DHHS should publish quantitative data in the annual report and website about patients still on the waiting list and the length of time they could expect to wait.

Recommendation 26 had been implemented to 50%. Since 2006, the DHHS *Annual Report* and the DHHS *Progress Chart* (which is aimed at providing the Tasmanian community with a wider range of information about the performance of health and human services) have provided data for each hospital including:

- number of patients admitted from the waiting list
- number of patients on the waiting list
- median waiting time of patients admitted from the waiting list.

Further quantitative elective surgery information will become available with the implementation of TESIP.

In 2006 the DHHS web site contained definitions and quarterly data on waiting lists by hospital. It did not provide any information about

expected waiting times for procedures unlike interstate public health systems. For example, on the Victorian health website prospective patients can browse specific procedures by hospital for an indication of waiting times.

Recommendation 27

DHHS should consider expanding the type and timeliness of information about elective surgery available on its website.

Recommendation 27 had only been implemented to 25%. Further quantitative elective surgery information will become available with the implementation of TESIP.

6.8 Status of recommendations

The 27 recommendations reviewed in this Report are listed below in Table 7 using the recommendation numbers from the original report.

Table 7: Elective surgery in public hospitals — Degree of implementation of recommendations

Recommendations		Degree of implementation
1	The department should review user documentation and training methods to ensure operators are able to accurately and consistently perform data input across all campuses.	50%
2	DHHS should ensure that HOMER's replacement incorporates sophisticated and flexible data management that would also support national reporting.	50%
3	The department should actively promote consistent and accurate priority classification information to HOMER to facilitate better decision-making and reporting.	25%
4	Management should set benchmarks for theatre usage and regularly assess performance against those benchmarks. Decisions about resources should take into account such assessments.	50%
5	Hospitals should record the reason for any downtime in operating theatres. Management should regularly review summary data as a basis for decisions about resource acquisition and allocation.	50%
6	Hospitals should ensure that postponed patients are immediately reinstated on the waiting list.	100%
7	DHHS should ensure that adequate resources are available to efficiently operate current and planned operating theatres.	50%

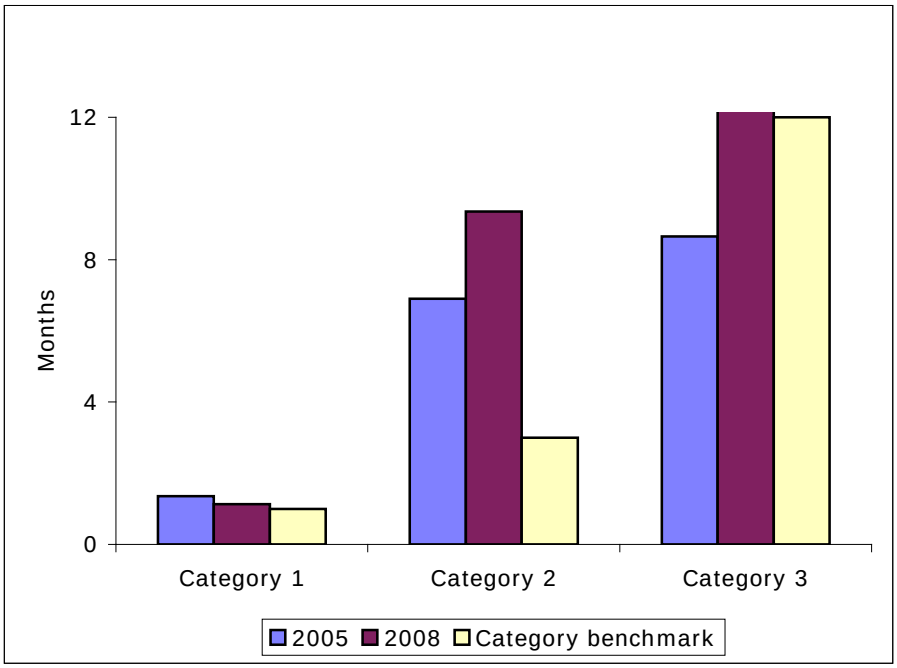
8	Hospitals should record the underlying reasons for postponements and cancellations to enable efficiency gains to be made.	100%
9	Relevant recommendations from the *Perioperative Services Review Project* at the RHH should be considered for implementation at the LGH and NWRH.	100%
10	The department or hospitals should consider strategies to reduce loss of productivity from postponement of surgery where that surgery would over run scheduled theatre time.	50%
11	Hospitals should periodically record sufficient information about nursing numbers and vacancies to enable management to conduct longitudinal performance analysis.	100%
12	Benchmarking of operating theatre nurses should be completed as a matter of urgency to provide a basis for determining appropriate staffing levels.	100%
13	To help secure new employees, LGH and NWRH should also consider recruiting nurses in anticipation of an actual vacancy.	0
14	DHHS should work with universities through graduate programs and other projects to develop pathways and experiences leading to an increased number of appropriately trained theatre nurses. DHHS should explore the possibility of providing more in-house training in theatre nursing.	100%
15	Hospitals should consider alternate workplace staffing to perform some nursing duties in operating theatres.	25%
16	Hospitals should look to maximise the flexibility of rostering arrangements and employment conditions. Hospitals should consider the introduction of earlier start times or night theatre sessions.	100%
17	Hospitals should introduce forward planning for theatre nursing staff.	25%
18	Hospitals should continue to develop HR strategies such as training (e.g. fees assistance, bonding of graduates, management training) or bonuses linked to high output to strengthen nurse retention.	75%
19	DHHS should develop and implement an agency-wide exit interview policy for nurses.	100%

20	Hospitals should periodically record sufficient information about specialist and anaesthetist numbers and vacancies to enable management to conduct longitudinal performance analysis.	100%
21	Adequate volume and casemix to maintain accreditation should be one factor considered when scheduling operating theatre time.	100%
22	DHHS should develop and implement an agency-wide exit interview policy for surgical specialists.	100%
23	DHHS should review the equipment acquisition process between the initial time of approval by the CRC and completion of the tendering.	50%
24	Replacement of theatre equipment should be managed to avoid long-term problems.	50%
25	All hospitals should develop strategic plans for elective surgery. Any plan developed should link back to the overall departmental strategic plan.	100%
26	DHHS should publish quantitative data in the annual report and website about patients still on the waiting list and the length of time they could expect to wait.	50%
27	DHHS should consider expanding the type and timeliness of information about elective surgery available on its website.	25%
	Average degree of implementation	**67%**

Waiting lists in 2008

As part of our follow-up of the original audit, we requested more recent data to extend the 2006 comparison of expected Tasmanian elective surgery waiting times with the national benchmarks.

Figure 2: Expected waiting times to benchmark by category at 30 June 2005 and 30 June 2008 [9]



Since our original report the number of patients on the waiting list has increased substantially (from 6 464 at 30 June 2005 to 8 621 at 30 June 2008) [10]. The most significant increase occurred in the number of Category 3 patients ready for care (RFC).

The increase in RFC has impacted on expected waiting times for elective surgery, which have deteriorated as shown in Figure 2. Expected waiting times in all categories now exceed the national benchmarks.

The size of the waiting list depends on both demand and supply (i.e. admissions). However, hospitals can only control admissions. In Figure 3, we examine movements in admissions over the period 2005–06 to 2008–09[11].

[9] We calculated expected waiting times by dividing the number of people on the waiting list on 30 June (RFC), by the average monthly removals over the previous 12 months. RFC and removals data used in our calculations was provided by DHHS.
[10] Data provided by DHHS 26 March 2009
[11] We extrapolated admission data provided by DHHS for the 2008–09 financial year from 28 February 2009 to predict 2008–09 performance.

Figure 3: Admissions from the waiting list — 2005–09

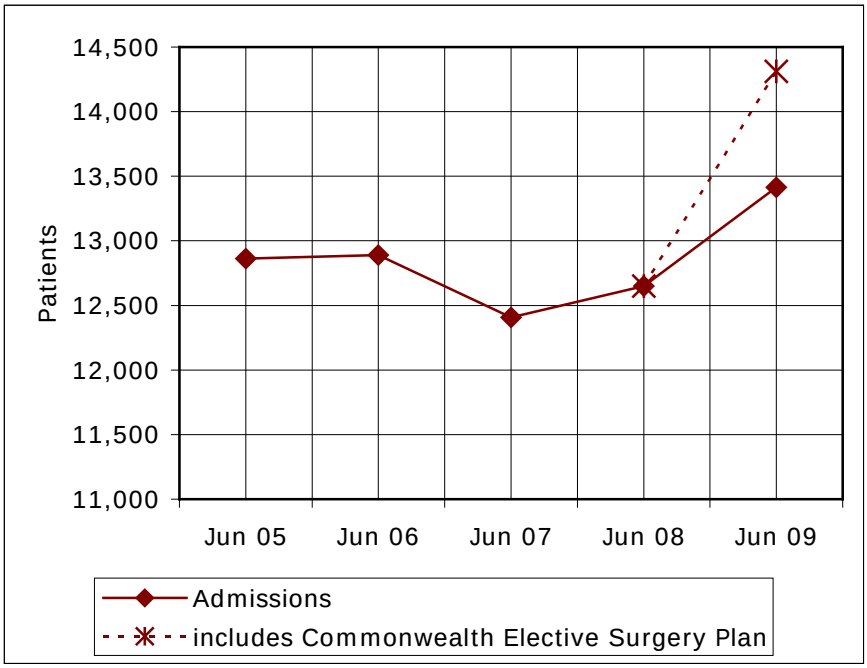


Figure 3 illustrates that the number of admissions from the waiting list fluctuated between June 2005 and June 2008, resulting in a 1.7% net decrease.

To report 2008–09 performance we extrapolated year-to-date admissions (i.e. using 1 July 2008 to 28 February 2009 data[12]). There was a sharp upward spike in admissions from June 2008. To a large extent this was the result of additional funding from both the commonwealth and the state which was used to hire additional casual staff and secure treatment in private hospitals. We are not in a position to conclude whether or not greater efficiency also contributed to the increase in admissions.

It is noteworthy that Tasmania achieved 28.8 admissions per 1000 population compared with 26.7 nationally[13].

6.9 Conclusion

At 67%, the overall rate of implementation was below our benchmark of 70%. In the majority of instances of partial implementation we found planning, reviews or implementation underway with further progress predicted in 2009 and 2010.

We noted that admissions from the elective surgery waiting list had not increased as at June 2008, although there was some evidence of improvement in the following financial year.

[12] Data provided by DHHS 26 March 2009

[13] Australian Institute of Health and Wellbeing, *Australian hospital statistics 2006–07* Health services series no. 31, published 30 May 2008

Our view in the original report was that more admissions could be achieved with better information about efficiency and possible bottlenecks. Several recommendations relating to improving information were amongst those that were only partially implemented.

6.10 Management response to the follow-up audit

Thank you for the opportunity for the Department of Health and Human Services to comment on the Tasmanian Audit Office (TAO) draft report of the follow up to *Special Report No.61 Elective Surgery in Public Hospitals*, August 2006.

The report aims to build on the findings of the original report and assess the level of implementation of the 27 recommendations provided. It is pleasing to note that the department has succeeded in gaining an implementation rating of 50% or more on 22 of the recommendations, with 13 of these being rated at 75–100%. Further the department recognises that as a result of work currently underway there will be ongoing progress on the final 4 recommendations of the 26 from the original report considered to be appropriate for implementation. The department has advised that it does not accept recommendation 13 as suitable for implementation and this has been acknowledged within the draft report. If then this recommendation is excluded from the overall evaluation of the rate of implementation, the department would be considered to have met the benchmark of 70% across the 26 recommendations.

Tasmania's Elective Surgery Plan (TESIP) underpins the reform work currently underway within the department and hospitals across the state. TESIP includes a comprehensive range of evidence based strategies that have been implemented and tested in other Australian states, and will assist in ensuring that the health system is positioned to best meet the elective surgery care needs of the community in the availability and application of information relating to elective surgery performance that was raised by the TAO report.

The data presented in Figure 2 compares the clearance rate of the elective surgery list with national benchmarking figures for waiting times. The methodology used to make the comparison in Figure 2 does not compare like data and is not consistent with definitions used by the Commonwealth to report waiting times. Waiting times are reported to the Commonwealth using median values due to 'average' measures being effected by extreme values within the data .

Elective Surgery within the public system is a complex and multilayered aspect of the health system incorporating not only the process of managing a patient through the surgical pathway, but also

incorporates information systems, workforce, performance, funding and system capacity. As a result, the investigation, assessment and evaluation of such a complex and interwoven component of the public health system present a substantial challenge to deliver on in any depth when the whole of this process is audited. As a result audit processes on elective surgery in recent years undertaken by audit offices interstate have tended to focus upon specific aspects of the elective surgery process, for e.g. waiting times, waiting lists and performance.

Thank you once again for permitting the department to respond to the draft report. We look forward to continued positive change in relation to the performance of elective surgery within public hospitals in Tasmania.

This page left blank intentionally

7 Recent reports

7 Recent reports

Year	Special Report No.	Title
2005	55	Gun control in Tasmania
2005	56	TT-Line: Governance review
2005	57	Public housing: Meeting the need?
2005	58	FBT
		Payment of accounts
		Asset management: Bridges
2006	59	Delegations in government agencies
		Local government delegations
		Overseas Travel
2006	60	Building security
		Contracts appointing Global Value Management
2006	61	Elective surgery in public hospitals
2006	62	Training and development
2006	63	Environmental management and pollution control act by local government
2006	64	Implementation of aspects of the *Build Act 2000*
2007	65	Management of an award breach
		Selected allowances and nurses' overtime
2007	66	Follow-up audits
2007	67	Corporate credit cards
2007	68	Risdon Prison: Business case
2007	69	Public building security
2007	70	Procurement in government departments
		Payment of accounts by government departments
2007	71	Property in police possession
		Control of assets: Portable and attractive items
2008	72	Public sector performance information
2008	73	Timeliness in the Magistrates Court
2008	74	Follow-up audits
2008	75	Executive Termination Payments
2008	76	Complaint handling in local government
2008	77	Food safety: safe as eggs?
2009	78	Management of threatened species

8 Current projects

8 Current projects

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

Profitability, and economic benefits to Tasmania, of Forestry Tasmania	Evaluates Forestry Tasmania's long-term financial and economic performance.
Contract management	Examines the effectiveness of contract management processes for a number of selected contracts.
Speed detection devices	Evaluates Tasmania's speed detection devices enforcement program looking at the efficiency and effectiveness of the program.
Communications by the government	Tests whether advertising, public surveys and websites are used for the benefit of Tasmanians and not for political purposes.
Teaching of science in public high schools	Examines how well Tasmania teaches science in public high schools.
Public servants not working	Looks at the trends, prevention and management of stress leave, long term sick leave, suspension and poor performance.